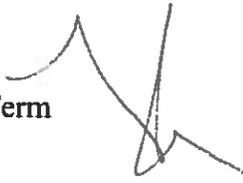


Title of Rule: Revision to the Medical Assistance Rule Concerning Long Term Care Efficiency Rule Review, Sections 8.400 to 8.499

Rule Number: MSB 14-04-15-A

Division / Contact / Phone: Long Term Services and Supports / Micah Jones / 303-866-5185



STATEMENT OF BASIS AND PURPOSE

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

The Long Term Care rules define Colorado's Medical Assistance Programs for long term care, including Nursing Facilities, HCBS waivers, Alternative care facilities, and other programs. These regulations have been enacted over the past several decades to address changes in programs available, changes in state policy, and for other reasons.

In March 2014, the Department of Health Care Policy and Financing (the "Department") completed a review of these rules. This review identified over 300 issues with the rules, ranging from spelling errors, inaccurate citations, invalid incorporations by reference, grammatical errors, and use of outdated terminology.

This rule change will address the non-substantive issues identified by this review. The changes that are being made in this rule change do not affect the Department's policies, but are solely designed to clean up the rules and make them more reader friendly. The changes include:

- (1) Removing outdated offensive language and replacing it with the contemporary acceptable language.
- (2) Correcting identified spelling errors.
- (3) Correcting identified grammatical errors that do not affect the intent or meaning of the rule provisions.
- (4) Standardizing the format for citations within the rules to state statutes and rules.
- (5) Correcting inaccurate citations within the rules.
- (6) Updating rule language to reflect current practice.

2. An emergency rule-making is imperatively necessary

to comply with state or federal law or federal regulation and/or

for the preservation of public health, safety and welfare.

3. Federal authority for the Rule, if any:

42 C.F.R. parts 400-505 and 42. U.S.C. section 1396

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2014)

Initial Review **02/13/2015**
Proposed Effective Date **05/01/2015**

Final Adoption **03/13/2015**
Emergency Adoption

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REGULATORY ANALYSIS

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

The persons who will be affected by the proposed rules are all individuals currently receiving or providing long term care services under the Colorado Medical Assistance Act. Since this rule makes no changes to policy, the only impact will be removing offensive language and replacing it with less offensive language, standardizing references within the rules to improve clarity, fixing spelling errors to improve readability, and fixing inaccurate citations to reduce confusion.

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

There will be no quantitative economic impact on the affected persons. The rules changes are not changes in policy, but changes in presentation.

There may be a positive qualitative impact of the proposed rules. By cleaning up the rules, the rules should be more clear, less confusing, and more easily read. This will reduce frustration for regulated persons in reading and complying with rules, and will make identification of areas for improvement easier.

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

There will be no costs to the Department or any other agency in implementing and enforcing the proposed rules.

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

There are no costs of the proposed rule, and the benefits are clearer, less confusing rules. The costs of inaction are keeping the offensive terminology and non-substantive errors in the rules. There are no costs to affected persons from these rules.

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

There are no less costly or less intrusive methods for achieving the purpose of the proposed rule. The purpose of the proposed rule is to clean up the rule, which can only be accomplished through a rule amendment.

Title of Rule: Revision to the Medical Assistance Rule Concerning Long Term Care Efficiency Rule Review, Sections 8.400 to 8.499

Rule Number: MSB 14-04-15-A

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

No alternative methods for achieving the purpose of the proposed rule were considered by the Department. The purpose is to clean up the rule, which can only be accomplished by amending the rule.

1 **8.400 LONG TERM CARE**

2 .10 Long term care includes nursing facility care as part of the standard Medicaid benefit package,
3 and Home and Community Based Services provided under waivers granted by the Federal
4 government.

5 .101 Nursing facility services and Home and Community Based Services are benefits only under
6 Medicaid. Nursing Facility Services and Home and Community Based Services are non-benefits
7 under the Modified Medical Program.

8 .102 State only funding will pay for nursing facility services for October 1988 and November 1988 for
9 clients under the Modified Medical Program who were residing in a nursing facility October 1,
10 1988. This is intended to give clients time to qualify for Medicaid.

11 .103 Until the implementation of SB 03-176 a legal immigrant, as defined in [26-4-103\(8.5\)](#),
12 [C.R.S. section 25.5-4-103](#), who received Medicaid services in a nursing facility or through
13 Home and Community Based Services for the Elderly, Blind and Disabled on July 1, 1997, who
14 would have lost Medicaid eligibility due to his/her immigrant status, shall continue to receive
15 services under State funding as long as he/she continues to meet Medicaid eligibility
16 requirements.

17 .104 If a nursing facility client, who is only eligible for the Modified Medical Program, is making a valid
18 effort to dispose of excess resources but legal constraints do not allow the conversion to happen
19 by December 1, 1988, the client may have 60 additional days to meet SSI eligibility requirements.

20 .11 Standard Medicaid long term care services are services provided in:

21 - Skilled care facilities (SNF)

22 - Intermediate care facilities (ICF)

23 - ~~Intermediate care facilities for the mentally retarded individuals with an intellectual or~~
24 ~~developmental disability (ICF/MR/ICF/IID)~~ [Intermediate Care Facilities for Individuals with](#)
25 [Intellectual Disabilities \(ICF/IID\)](#)

26 .12 Home and Community Based Services under the Medicaid ~~waivers~~ [Waivers](#) include distinct
27 service programs designed as alternatives to standard Medicaid nursing facility or hospital
28 services for discrete categories of clients. These ~~programs~~ [waivers](#) are Home and Community
29 Based Services [Waiver for Persons Who Are the Elderly, Blind and Disabled \(HCBS-EBD\)](#), [Home](#)
30 [and Community Based Services Waiver for Persons with Spinal Cord Injury \(HCBS-SCI\)](#),
31 [Community Mental Health Supports Waiver \(HCBS-CMHS\)](#), [Home and Community Based](#)
32 [Services Waiver for Persons With Brain Injury \(HCBS-BI\)](#); Home and Community Based Services
33 [Waiver for Persons with the Developmentally Disabilities](#) ~~sabled~~ (HCBS-DD), [Supportive Living](#)
34 [Services Waiver \(HCBS-SLS\)](#); [Home and Community Based Services Waiver for Children with](#)
35 [Autism \(HCBS-CWA\)](#), [Children with Life-limiting Illness Waiver \(HCBS-CLLI\)](#), [Children's](#)
36 [Habilitation Residential Program Waiver \(HCBS-CHRP\)](#), [Children Extensive Supports Waiver](#)
37 [\(HCBS-CES\)](#), [Children's Home and Community Based Services Waiver \(HCBS-CHCBS\)](#) ~~and~~
38 Home and Community Based Services for those inappropriately residing in nursing facilities
39 (OBRA '87) [\[JM1\]](#); ~~and, Home and Community Based Services for Persons Living with AIDS~~
40 ~~(HCBS-PLWA)~~.

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- 2 .13 Unless specified by reference to the specific programs described above, the term Home and
3 Community Based Services where it appears in these rules and regulations shall refer to the
4 programs described herein above, and the rules and regulations within this section shall be
5 applicable to all Home and Community Based Services programs.
- 6 .14 Nursing facilities are prohibited from admitting any new ~~client who has mental illness or mental~~
7 ~~retardation intellectual or developmental disability~~ ~~client who has mental illness or intellectual or~~
8 ~~developmental disability, as defined in 8.401.18~~ ~~as defined in 10 CCR 2505-10 section 8.10 CCR~~
9 ~~2505-10 section 8.401.18~~ ~~Determination Criteria for Mentally Ill and Developmentally~~
10 ~~Disabled~~ ~~Mentally Ill or Individuals with an Intellectual or Developmental Disability~~ unless that
11 client has been determined to require the level of services provided by a nursing facility ~~as~~
12 ~~defined in 8.401.19~~ ~~as defined in 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.401.19.~~
- 13 .15 Clients eligible for Home and Community Based Services are eligible for all Medicaid services
14 including home health services.
- 15 .16 Target Population Definitions. For purposes of determining appropriate type of long term services,
16 including home and community based services, as well as providing for a means of properly
17 referring clients to the appropriate community agency, the following target group designations are
18 established:
- 19 A. Developmentally Disabled - includes all clients whose need for long term care services is
20 based on a diagnosis of Developmental Disability and Related Conditions, ~~as defined in~~
21 ~~Section 8.10 CCR 2505-10 section 8.401.18~~ ~~as defined in 10 CCR 2505-10 section 8.10~~
22 ~~CCR 2505-10 section 8.401.18.~~
- 23 B. Mentally Ill - includes all clients whose need for long term care is based on a diagnosis of
24 mental disease as ~~defined in Section 8.10 CCR 2505-10 section 8.401.18~~ ~~defined in 10~~
25 ~~CCR 2505-10 section 8.10 CCR 2505-10 section 8.401.18.~~
- 26 C. Functionally Impaired Elderly - includes all clients who meet the level of care screening
27 guidelines for SNF or ICF care, and who are age 65 or over. Clients who are mentally ill,
28 as defined in ~~10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.401.18~~ ~~Section 8.10~~
29 ~~CCR 2505-10 section 8.401.18~~, shall not be included in the target group of Functionally
30 Impaired Elderly, unless the person's need for long term care services is primarily due to
31 physical impairments that are not caused by any diagnosis included in the definition of
32 mental illness at ~~10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.401.18~~ ~~8.401.18~~,
33 and determined by Utilization Review Contractor from the medical evidence.
- 34 D. Physically Disabled or Blind Adult - includes all clients who meet the level of care
35 screening guidelines for SNF or ICF care, and who are age 18 through 64. Clients who
36 are developmentally disabled or mentally ill, as defined in ~~10 CCR 2505-10 section 8.10~~
37 ~~CCR 2505-10 section 8.401.18~~ ~~8.401.18~~, shall not be included in the Physically Disabled
38 or Blind target group, unless the person's need for long term care services is primarily
39 due to physical impairments not caused by any diagnosis included in the definition of
40 ~~intellectual or developmental~~ ~~developmental~~ disability or mental illness at ~~10 CCR 2505-~~
41 ~~10 section 8.10 CCR 2505-10 section 8.401.18~~, as determined by Utilization Review
42 Contractor from the medical evidence.
- 43 E. Persons Living with AIDS - includes all clients of any age who meet either the nursing
44 home level of care or acute level of care screening guidelines for nursing facilities or
45 hospitals, and have the -diagnosis of Human Immunodeficiency Virus (HIV) or Acquired
46 Immune Deficiency Syndrome (AIDS). Clients who are diagnosed with HIV or AIDS may

1 alternatively request to be designated as any other target group for which they meet the
2 definitions above.

3 .17 Services in Home and Community Based Services programs established in accordance with
4 federal waivers shall be provided to clients in accordance with the Utilization Review Contractor
5 determined target populations as defined herein above.

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8 **8.401 LEVEL OF CARE SCREENING GUIDELINES**

9 .01 The client must have been found by the Utilization Review Contractor to meet the applicable level
10 of care guidelines for the type of services to be provided.

11 .02 The Utilization Review Contractor shall not make a level of care determination unless the
12 recipient has been determined to be Medicaid eligible or an application for Medicaid services has
13 been filed with the ~~county~~ County department ~~Department of Social/Human~~ social services.

14 .03 Payment for skilled (SNF) and intermediate nursing home care (ICF) and Home and Community
15 Based Services will only be made for clients whose functional assessment and frequency of need
16 for skilled and maintenance services meet the level of care guidelines for long term care.

17 .04 Payment for care in an intermediate care ~~facility for the mentally retarded individuals with an~~
18 ~~intellectual or developmental disability~~ facility for individuals with intellectual disabilities
19 (ICF/MR/ICF/IID) will only be made for developmentally disabled clients whose programmatic
20 and/or health care needs meet the level of care guidelines for the appropriate class of
21 ICF/MR/ICF/IIDs. Payment for Home and Community Based Services for the Developmentally
22 Disabled will only be made for developmentally disabled clients who meet the level of care
23 guidelines for long term care services for the developmentally disabled.

24 .05 Services provided by nursing facilities are available to those clients that meet the guidelines
25 below and are not identified as mentally ill or ~~mentally retarded individuals with an intellectual or~~
26 ~~developmental disability~~ by the Determination Criteria for ~~Mentally Ill and Developmentally~~
27 ~~Disabled~~ Mentally Ill or Individuals with an Intellectual or Developmental Disability in 8.401.18 in 10
28 CCR 2505-10 section 8.10 CCR 2505-10 section 8.401.18.

29 **8.401.1 GUIDELINES FOR LONG TERM CARE SERVICES (CLASS I SNF AND ICF FACILITIES, ~~HCB-~~** 30 **~~EBD~~ HCBS-EBD, ~~HCBS-MICMHS~~, HCBS-BI, *Children's HCBS*, *HCBS-CES*, *HCBS-DD*, *HCBS-* 31 *SLS*, *HCBS-CHRP*, ~~HCBS-PLWA~~, and Long Term Home Health)**

32 .11 The guidelines for long term care are based on a functional needs assessment in which
33 individuals are evaluated in at least the following areas of activities of daily living:

34 - Mobility

35 - Bathing

36 - Dressing

37 - Eating

38 - Toileting

1 - Transferring

2 - Need for supervision

3 .12 Skilled services shall be defined as those services which can only be provided by a skilled person
4 such as a nurse or licensed therapist or by a person who has been extensively trained to perform
5 that service.

6 .13 Maintenance services shall be defined as those services which may be performed by a person
7 who has been trained to perform that specific task, e.g., a family member, a nurses' aide, a
8 therapy aide, visiting homemaker, etc.

9 .14 Skilled and maintenance services are performed in the following areas:

10 - Skin care

11 - Medication

12 - Nutrition

13 - Activities of daily living

14 - Therapies

15 - Elimination

16 - Observation and monitoring

17 .15

18 A. The Utilization Review Contractor shall certify as to the functional need for the nursing
19 facility level of care. A Utilization Review Contractor reviews the information submitted on
20 the ULTC 100.2 and assigns a score to each of the functional areas described in
21 ~~subsection 8.10 CCR 2505-10 section 8.401.11 above in 10 CCR 2505-10 section 8.10~~
22 ~~CCR 2505-10 section 8.401.11~~. The scores in each of the functional areas are based on
23 a set of criteria and weights approved by the State which measures the degree of
24 impairment in each of the functional areas. When the score in a minimum of two ADLs or
25 the score for one category of supervision is at least a (2), the Utilization Review
26 Contractor may certify that the person being reviewed is eligible for nursing facility level
27 of care.

28 B. The Utilization Review Contractor's review shall include the information provided by the
29 functional assessment screen.

30 C. A person's need for basic Medicaid benefits is not a proper consideration in determining
31 whether a person needs long term care services (including Home and Community Based
32 Services).

33 D. The ULTC 100.2 shall be the comprehensive and uniform client assessment process for
34 all individuals in need of long-term care, the purpose of which is to determine the
35 appropriate services and levels of care necessary to meet clients' needs, to analyze
36 alternative forms of care and the payment sources for such care, and to assist in the
37 selection of long-term care programs and services that meet clients' needs most cost-
38 efficiently.

1 **LONG TERM CARE ELIGIBILITY ASSESSMENT**

2 General Instructions: To qualify for Medicaid long-term care services, the recipient/applicant must have
3 deficits in 2 of 6 Activities of Daily Living, ADLs, (2+ score) or require at least moderate (2+ score) in
4 Behaviors or Memory/Cognition under Supervision.

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12 **ACTIVITIES OF DAILY LIVING**

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18 **I. BATHING**

19 Definition: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate
20 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 line of sight 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)

<p>Physical Impairments :</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Balance Problems <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Falls <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Muscle Tone <input type="checkbox"/> Amputation 	<ul style="list-style-type: none"> <input type="checkbox"/> Open Wound <input type="checkbox"/> Stoma Site <p>Supervision:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Seizures <p>Mental Health:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia
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**II.
DRESSING**

1 Definition: The ability to dress and undress as necessary. This includes the ability to put on prostheses,
 2 braces, anti-embolism hose or other assistive devices and includes fine motor coordination for buttons
 3 and zippers. Includes choice of appropriate clothing for the weather. Difficulties with a zipper or buttons at
 4 the back of a dress or blouse do not constitute a functional deficit.

ADL SCORING 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)

<p>Physical Impairments:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Balance Problems <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Fine Motor Impairment <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Bladder Incontinence <input type="checkbox"/> Bowel Incontinence <input type="checkbox"/> Amputation <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Muscle Tone 	<ul style="list-style-type: none"> <input type="checkbox"/> Open Wound <p>Supervision:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Seizures <p>Mental Health:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia
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III. TOILETING

- 1 Definition: The ability to use the toilet, commode, bedpan or urinal. This includes transferring on/off the
- 2 toilet, cleansing of self, changing of apparel, managing an ostomy or catheter and adjusting clothing.

ADL SCORING 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)

<p>Physical Impairments :</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Fine Motor Impairment <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Bladder Incontinence <input type="checkbox"/> Bowel Incontinence <input type="checkbox"/> Amputation <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Physiological defect <input type="checkbox"/> Balance <input type="checkbox"/> Muscle Tone <input type="checkbox"/> Impaction 	<ul style="list-style-type: none"> <input type="checkbox"/> Ostomy <input type="checkbox"/> Catheter <p>Supervision Need:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Seizures <p>Mental Health:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia
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IV. MOBILITY

- 1 Definition: The ability to move between locations in the individual's living environment inside and outside
- 2 the home. Note: Score client's mobility without regard to use of equipment other than the use of
- 3 prosthesis.

ADL SCORING 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)

<p>Physical Impairments:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Fine or Gross Motor Impairment <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Amputation <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Balance <input type="checkbox"/> Muscle Tone 	<p>Supervision Need:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Seizures <input type="checkbox"/> History of Falls <p>Mental Health:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia
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1 **V. TRANSFERRING**

2 Definition: The physical ability to move between surfaces: from bed/chair to wheelchair, walker or
3 standing position; the ability to get in and out of bed or usual sleeping place; the ability to use assisted
4 devices, including properly functioning prosthetics, for transfers. Note: Score Client's ability to transfer
5 without regard to use of equipment.

ADL SCORING 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)

<u>Physical Impairments:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Balance Problems <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Falls <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Amputation <input type="checkbox"/> Oxygen Use	<u>Supervision Need:</u> <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Seizures <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia
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1 VI. EATING

2 Definition: The ability to eat and drink using routine or adaptive utensils. This also includes the ability to
 3 cut, chew and swallow food. Note: If a person is fed via tube feedings or intravenously, check box 0 if
 4 they can do independently, or box 1, 2, or 3 if they require another person to assist.

ADL SCORING 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 line of sight standby assistance for frequent gagging, choking, swallowing difficulty; or aspiration resulting in the 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)

<p><u>Physical Impairments:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Amputation <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Fine Motor Impairment <input type="checkbox"/> Poor Dentition <input type="checkbox"/> Tremors <input type="checkbox"/> Swallowing Problems <input type="checkbox"/> Choking <input type="checkbox"/> Aspiration 	<ul style="list-style-type: none"> <input type="checkbox"/> Tube Feeding <input type="checkbox"/> IV Feeding <p><u>Supervision Need:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Seizures <p><u>Mental Health:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia
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Comments:

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VII. SUPERVISION

A. Behaviors

Definition: The ability to engage in safe actions and interactions and refrain from unsafe actions and interactions (Note, consider the client's inability versus unwillingness to refrain from unsafe actions and interactions).

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 frequently requires more than verbal redirection to interrupt inappropriate behaviors.
- 3=The client exhibits behaviors resulting in physical harm to 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)

<p><u>Physical Impairments:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/>Chronic Medical Condition <input type="checkbox"/>Acute Illness <input type="checkbox"/>Pain <input type="checkbox"/>Neurological Impairment <input type="checkbox"/>Choking <input type="checkbox"/>Sensory Impairment <input type="checkbox"/>Communication Impairment (not inability to speak English) <p><u>Mental Health:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/>Lack of Motivation/Apathy <input type="checkbox"/>Delusional <input type="checkbox"/>Hallucinations <input type="checkbox"/>Paranoia <input type="checkbox"/>Mood Instability 	<p><u>Supervision needs:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/>Short Term Memory Loss <input type="checkbox"/>Long Term Memory Loss <input type="checkbox"/>Agitation <input type="checkbox"/>Aggressive Behavior <input type="checkbox"/>Cognitive Impairment <input type="checkbox"/>Difficulty Learning <input type="checkbox"/>Memory Impairment <input type="checkbox"/>Verbal Abusiveness <input type="checkbox"/>Constant Vocalization <input type="checkbox"/>Sleep Deprivation <input type="checkbox"/>Self-Injurious Behavior <input type="checkbox"/>Impaired Judgment <input type="checkbox"/>Disruptive to Others <input type="checkbox"/>Disassociation <input type="checkbox"/>Wandering <input type="checkbox"/>Seizures <input type="checkbox"/>Self Neglect <input type="checkbox"/>Medication Management
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Comments:

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B. Memory/Cognition Deficit

Definition: The age appropriate ability to acquire and use information, reason, problem solve, complete tasks or communicate needs in order to care for oneself safely.

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 regular monitoring and/or 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.

Due To: (Score must be justified through one or more of the following conditions)

<p><u>Physical Impairments:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Metabolic Disorder <input type="checkbox"/> Medication Reaction <input type="checkbox"/> Acute Illness <input type="checkbox"/> Pain <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Alzheimer's/Dementia <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Chronic Medical Condition <input type="checkbox"/> Communication Impairment (does not include ability to speak English) <input type="checkbox"/> Abnormal Oxygen Saturation <input type="checkbox"/> Fine Motor Impairment <p><u>Supervision Needs:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Disorientation <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Memory Impairment 	<ul style="list-style-type: none"> <input type="checkbox"/> Self-Injurious Behavior <input type="checkbox"/> Impaired Judgment <input type="checkbox"/> Unable to Follow Directions <input type="checkbox"/> Constant Vocalizations <input type="checkbox"/> Perseveration <input type="checkbox"/> Receptive Expressive Aphasia <input type="checkbox"/> Agitation <input type="checkbox"/> Disassociation <input type="checkbox"/> Wandering <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Seizures <input type="checkbox"/> Medication Management <p><u>Mental Health:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
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8.401.18 PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARRPASRR) AND SPECIALIZED SERVICES FOR MENTALLY ILL AND MENTALLY RETARDED INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY INDIVIDUALS

.181 Purpose of Program

A. The PASARRPASRR 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.

1 B. The purpose of the ~~PASARR~~PASRR Level I Identification screening is to identify for further
 2 ~~review;~~review all those clients seeking nursing facility admission, for whom it appears a diagnosis
 3 of mental illness or ~~mental retardation~~intellectual or developmental disability is likely.

4 C. The purpose of the ~~PASARR~~PASRR Level II evaluation is to evaluate and determine whether
 5 nursing facility services are needed, whether an individual has mental illness or ~~mental~~
 6 ~~retardation~~intellectual or developmental disability and whether specialized mental health or
 7 ~~mental retardation~~intellectual or developmental disability services are needed.

8 **.182 Definitions**

9 A. Mental Illness

10 1. [Removed per S.B. 03-088, 26 CR 7]

11 2. A major mental disorder is defined as: A primary diagnosis of schizophrenic, paranoid,
 12 major affective, schizoaffective disorders or other psychosis.

13 3. An individual is considered to not have mental illness if he/she has:

14 a. a primary diagnosis of dementia (including Alzheimer's disease or a related
 15 disorder); or

16 b. a non-primary diagnosis of dementia (including Alzheimer's disease or a related
 17 disorder) without a primary diagnosis of serious mental illness, or ~~mental~~
 18 ~~retardation~~intellectual or developmental disability or a related condition.

19 B. ~~Mental Retardation~~Intellectual or developmental disability and Related Conditions

20 [Removed per S.B. 03-088, 26 CR 7]

21 1. ~~Mental Retardation~~Intellectual or developmental disability refers to significantly sub-
 22 average general intellectual functioning existing concurrently with deficits in adaptive
 23 behavior and manifested during the developmental years.

24 2. The provisions of this section also apply to individuals with "related conditions," as
 25 defined by 42 C. F. R. ~~§ 435.1009 (2000)~~section 435.1010 (2013) which states: "Persons
 26 with related conditions" means individuals who have a severe, chronic disability that
 27 meets all of the following conditions:

28 a. It is attributable to:

29 1) Cerebral palsy or epilepsy; or

30 2) Any other condition, other than mental illness, found closely related to
 31 ~~mental retardation~~intellectual or developmental disability. These related
 32 conditions result in impairment of general intellectual functioning or
 33 adaptive behavior similar to individuals with ~~mental retardation~~intellectual
 34 or developmental disability, and require treatment or services similar to
 35 those required for these individuals.

36 b. It is manifested before the individual reaches age 22.

37 c. It is likely to continue indefinitely.

1 d. It results in substantial functional limitations in three or more of the following
2 areas of major life activity:

- 3 1) Self-care,
4 2) Understanding and use of language,
5 3) Learning,
6 4) Mobility,
7 5) Self-direction or
8 6) Capacity for independent living."

9 **8.401.183 Requirements for the PASARRPASRR Program**

10 A. The Level of Care determination and the Level I screening reviews shall be required by the
11 Utilization Review Contractor prior to admission to a Medicaid certified nursing facility.

12 B. The Utilization Review Contractor admission start date (the first date of care covered by
13 Medicaid) shall be assigned after the required Level II PASARRPASRR evaluation is completed
14 and the Utilization Review Contractor certifies the client is appropriate for nursing facility care.
15 The admission start date for individuals who do not requiring a Level II evaluation shall be the
16 date that the Initial Screening and Intake Form and Professional Medical Information pages from
17 the ULTC 100.2 are faxed to the Single Entry Point.

18 C. Individuals other than Medicaid eligible recipients, who require a Level II evaluation, shall have
19 the Level II evaluation prior to admission. The Level II contractor shall perform the evaluation.
20 The Level II contractor can be a qualified mental health professional, a corporation that
21 specializes in mental health, the community mental health center, or the community centered
22 board.

23 D. The Level II contractor shall conduct a review and determination for individuals or clients found to
24 be mentally ill or retarded who have had a change in mental health or developmental disabled
25 status.

26 E. PASARRPASRR findings, as related to care needs, shall be coordinated with the nursing facility
27 federally prescribed, routine Resident Assessments (Minimum Data Set) requirements. These
28 requirements are described at 42 C.F.R., §part 483.20 (October 1, 2000 edition), ~~which. No~~
29 ~~amendments or later editions are incorporated. Copies are available for inspection at the~~
30 ~~following address: Health and Medical Services, Colorado Department of Health Care Policy and~~
31 ~~Financing, 1575 Sherman Street 1570 Grant Street, Denver, Colorado 80203-1714. is hereby~~
32 ~~incorporated by reference. The incorporation of 42 C.F.R. part 483.20 excludes later~~
33 ~~amendments to, or editions of, the referenced material. The Department maintains copies of this~~
34 ~~incorporated text in its entirety, available for public inspection during regular business hours at:~~
35 ~~Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO~~
36 ~~80203. Certified copies of incorporated materials are provided at cost upon request.~~

37 **8.401.184 Nursing Facilities Responsibilities Under the PASARRPASRR Program**

38 A. The Utilization Review Contractor/Single Entry Point shall complete the Level I screening on the
39 functional assessment form for Medicaid clients. The nursing facility shall complete the Level I
40 screening for non-Medicaid individuals admitted from the community or pay source change. The

1 hospital shall complete the Level I for non-Medicaid individuals admitted to nursing facility from
 2 the hospital. Medicaid Level I information is on the Level I screen in the ULTC-100.2 and is
 3 submitted to the Utilization Review Contractor with the rest of the Level of Care information.
 4 Private pay Level I information that indicates the resident may be mentally ill or mentally
 5 retarded individuals with an intellectual or developmental disability is submitted to the Utilization
 6 Review Contractor as well on the ULTC-100.2.

7 B. Nursing facility staff shall be trained in which diagnoses, medications, history and behaviors
 8 would result in a positive finding in a Level I screening (e.g., a Yes response to a psychiatric
 9 diagnosis or history).

10 C. Following review of information on the Functional Assessment form, the Utilization Review
 11 Contractor determines whether a Level II evaluation is necessary and notifies the facility.

12 D. If a Level II evaluation is necessary, the facility and the Level II contractor shall assure that the
 13 Level II is completed. Level II PASARRPASRR evaluations shall be done at no cost to the
 14 individual or facility by the Level II contractor for that geographic area.

15 E. If the individual is determined to be mentally ill or mentally-retarded individuals with an intellectual
 16 or developmental disability as a result of the Level II, the nursing facility shall retain the results of
 17 the Level II in the resident's charts. The Level II evaluation shall be updated when the resident's
 18 condition changes. The Level II evaluations must be kept current in the resident's charts.

19 F. If a Level II evaluation is not required, documentation must be completed on the reasons a Level
 20 II one was not done and retained in the resident's chart.

21 G. The resident's chart shall contain the following information:

22 1. The psychiatric evaluation and/or Colorado Assessment Review form (COPAR);

23 2. The findings; and

24 3. The determination letter (from either mental health or mental-retardation intellectual or
 25 developmental disability authorities).

26 H. The nursing facility shall assure that the diagnoses are current and accurate by reconciling in the
 27 resident's record any diagnoses conflicting with the PASARRPASRR Level II diagnosis.

28 I. The nursing facility is responsible to arrange for services based on service recommendations
 29 from the Level II evaluation.

30 J. Nursing Facilities may contact the local community mental health centers or community center
 31 boards to make arrangements for the provisions of Specialized Services as indicated on the Level
 32 II reviews. Furthermore, nursing facilities are prohibited from providing Specialized Services.

33 .185 **The State Survey and Certification Process**

34 A. The State Survey and Certification Process will be used to determine whether the resident had
 35 the following:

36 1. A comprehensive Level I and Level II assessment;

37 2. An appropriate care plan; and

1 3. Specialized treatment, if needed.

2 B. The [Colorado](#) Department of Public Health and Environment ([CDPHE](#)) shall conduct the
3 [PASARRPASRR](#) program surveys in accordance with the Agency Agreement between
4 [Department of Public Health and EnvironmentCDPHE](#) and the Department.

5 **.186 Responsibilities of the Utilization Review Contractor in Determining Level of Care**

6 A. For private pay and nursing facility residents on admission with indications of mental illness or
7 ~~mental retardation~~[intellectual or developmental disability](#), the Utilization Review Contractor shall
8 first determine appropriate admission to a nursing facility through the following process:

- 9 1. A Level of Care review;
- 10 2. The Level I identification screen verification;
- 11 3. A Categorical determination, if appropriate; and
- 12 4. A Level II referral, if appropriate.

13 B. A nursing facility placement shall be considered appropriate when the following conditions are
14 met:

- 15 1. An individual's needs are such that he or she passes the Level of Care screen for
16 admission and the individual is seeking Medicaid reimbursement; and
- 17 2. The Level I and II screens indicate nursing facility placement is appropriate.

18 **8.401.19 LEVEL I IDENTIFICATION SCREEN**

19 .191 The Level I Screen criteria shall be as follows:

20 A. The Level I Screen, used by the Utilization Review Contractor to identify those who may
21 be mentally ill shall, be applied under the following conditions:

- 22 1. The individual has a diagnosis of mental illness as defined above; and/or
- 23 2. The individual has a recent (within the last two years) history of mental illness, as
24 defined above; and/or
- 25 3. A major tranquilizer, anti-depressant or psychotropic medication has been
26 prescribed regularly without a justifiable diagnosis of neurological disorder to
27 warrant the medication; and/or
- 28 4. There is presenting evidence of mental illness (except a primary diagnosis of
29 Alzheimer's disease or dementia) including possible disturbances in orientation,
30 affect, or mood, as determined by the Utilization Review Contractor.

31 B. The Level I Screen, used by the Utilization Review Contractor to identify those who may
32 be ~~mentally retarded~~[individuals with an intellectual or developmental disability](#) or
33 individuals with related conditions, shall be applied under the following conditions:

- 34 1. The individual has a diagnosis of ~~mental retardation~~[intellectual or developmental](#)
35 [disability](#) or related conditions as defined above; and/or

2. There is a history of ~~mental retardation~~intellectual or developmental disability 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~~intellectual or developmental disability or related conditions; and/or
4. The individual is referred by an agency that serves individuals with ~~mental retardation~~intellectual or developmental disability 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~~intellectual or developmental disability or related conditions, the individual must undergo the additional ~~PASARR~~PASRR 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~~individuals with an intellectual or developmental disability; 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

- 1 3) The individual shall receive a Level II evaluation within 10
2 calendar days of the referral.
- 3 4. An individual is severely ill.
 - 4 a. An individual is considered severely ill if he or she is:
 - 5 1) comatose;
 - 6 2) ventilator dependent;
 - 7 3) in a vegetative state.
 - 8 b. The following ~~PASARRPASRR~~ criteria must be met when an individual is
9 severely ill:
 - 10 1) A Mental Health referral shall be made and a Level II evaluation
11 shall be completed if the individual no longer meets the above
12 criteria as determined by the Utilization Review Contractor.
 - 13 2) ~~An Mental Retardation~~Intellectual or developmental disability
14 Level II referral shall be made and an evaluation shall be
15 completed within 60 days of admission, even if the individual
16 meets the above criteria as determined for severely ill by the
17 Utilization Review Contractor.
- 18 5. Emergency procedure in C.R.S. ~~§ 27-10-101~~section 27-65-105, et. seq., shall
19 supersede the ~~PASARRPASRR~~ process. When the State Mental Health
20 authorities, pursuant to C.R.S. ~~§ 27-10-101~~section 27-65-106, et.seq., determine
21 that an individual requires inpatient psychiatric care and qualifies under the
22 emergency procedures for a hold and treat order, this procedure shall supersede
23 the ~~PASARRPASRR~~ determination process.
- 24 .193 For individuals or residents who may have mental illness or ~~mental-retardation;intellectual or~~
25 developmental disability as determined through the Level I screen and who are referred by the
26 State authorities or designees for a ~~PASARRPASRR~~ Level II evaluation, the following applies:
 - 27 A. The designated agencies completing the Level I screen shall send a written notice to the
28 individual or resident and to his or her legal representative stating the Level I findings.
 - 29 B. The Level I notice to the individual or resident shall be required if the Level I findings
30 result in a referral for a Level II evaluation.
 - 31 C. The Level I findings are not an appealable action.
- 32 .194 Categorical determinations which may delay a Level II referral shall not prevent the nursing
33 facility from meeting the psychosocial, physical and medical needs of the resident.
- 34 .195 Categorical Determinations may be applied only if an individual is in no danger to him/herself or
35 others.
- 36 **8.401.20 LEVEL II ~~PASARRPASRR~~ EVALUATION**
- 37 .201 The purpose of the Level II evaluation is to determine whether:

- 1 A. Each individual with mental illness or ~~mental retardation~~intellectual or developmental
2 disability requires the level of services provided by a nursing facility.
- 3 B. An individual has a major mental illness or is ~~mentally retarded~~individuals with an
4 intellectual or developmental disability.
- 5 C. The individual requires a Specialized Services program for the mental illness or ~~mental~~
6 ~~retardation~~intellectual or developmental disability.

7 .202 Basic Requirements for LEVEL II ~~PASARR~~PASRR Evaluations and Determinations include:

- 8 A. The State Mental Health authority shall make determinations of whether individuals with
9 mental illness require specialized services that can be provided in a nursing facility as
10 follows:
- 11 1. The determination must be based on an independent physical and mental
12 evaluation.
- 13 2. The evaluation must be performed by an individual or entity other than the State
14 Mental Health authority.
- 15 B. The State ~~Mental Retardation~~Intellectual or developmental disability authority shall
16 conduct both the evaluation and the determination functions of whether individuals with
17 ~~mental retardation~~intellectual or developmental disability require specialized services that
18 can be provided in nursing facilities.
- 19 C. The ~~PASARR~~PASRR Level II contractor shall complete the evaluation within 10 working
20 days of the referral from the Utilization Review Contractor.
- 21 D. ~~PASARR~~PASRR determinations made by the State Mental Health or ~~Mental~~
22 ~~Retardation~~Intellectual or developmental disability authorities cannot be countermanded
23 by the Department through the claims payment process or through other utilization
24 control/review processes, or by ~~the State Department of Public Health and~~
25 ~~Environment~~CDPHE, survey and certification agency, or by any receiving facility or other
26 involved entities.
- 27 E. The Final Agency action by the Department may overturn a ~~PASARR~~PASRR adverse
28 determination made by State Mental Health or ~~Mental Retardation~~Intellectual or
29 developmental disability authorities.
- 30 F. Timely filing of ~~PASARR~~PASRR billings from providers is 120 days.

31 .203 An individual meets the requirements of a Depression Diversion Screen.

- 32 A. A Depression Diversion Screen shall be applied under the following conditions:
- 33 1. Depression is the only Level I positive finding (i.e. a depression diagnosis is the
34 only Yes checked on the Level I screen); and
- 35 2. The Utilization Review Contractor or the ~~PASARR~~PASRR Level II Contractor for
36 that geographic area shall make the determination of need for a Depression
37 Diversion Screen.

- 1 B. The nursing facilities are not authorized to apply the Depression Diversion
2 Screen.
- 3 C. When a non-major mental illness depression is validated as the only Level I positive
4 finding through the Depression Diversion Screen, a complete Level II referral and
5 evaluation is not required unless the individual's condition changes.
- 6 .204 Appeals Hearing Process for the [PASARRPASRR](#) Program
- 7 A. A resident has appeal rights when he or she has been adversely affected by a
8 [PASARRPASRR](#) determination as a result of the Level II evaluation made by the State
9 Mental Health or ~~Mental Retardation~~[Intellectual or developmental disability](#) authorities
10 either at Pre- admission Screening or at Annual Resident Review.
- 11 B. Adverse determinations related to [PASARRPASRR](#) mean a determination made in
12 accordance with sections 1919(b)(3)(F) or 1919(e)(7)(B) of the Social Security Act that:
- 13 1. The individual does not require the level of services provided by a Nursing
14 Facility; and/or
- 15 2. The individual does or does not require Specialized Services for mental illness or
16 ~~mental-retardation~~[intellectual or developmental disability](#).
- 17 3. [Section 1919 of the Social Security Act \(1935\) \(42 U.S.C. section 1396r\) is](#)
18 [hereby incorporated by reference. The incorporation of 42 U.S.C. section 1396r](#)
19 [excludes later amendments to, or editions of, the referenced material. The](#)
20 [Department maintains copies of this incorporated text in its entirety, available for](#)
21 [public inspection during regular business hours at: Colorado Department of](#)
22 [Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203.](#)
23 [Certified copies of incorporated materials are provided at cost upon request.](#)
- 24 C. Appeals of Level of Care determination are processed through the Appeals section
25 related to the Utilization Review Contractor's Level of Care process in [Staff Manual](#)
26 [Volume 8 §8.059.1210 CCR 2505-10 section 8.10 CCR 2505-10 section 8.057](#).
- 27 D. For adverse actions related to the need for Specialized Services, the individual or
28 resident affected by the mental illness or mental-retardation determination may appeal
29 through procedures established for appeals in the Recipient Appeals and Hearings
30 section of [Staff Manual Volume 8 §8.059.1710 CCR 2505-10 section 8.10 CCR 2505-10](#)
31 [section 8.057](#).
- 32 .205 The Level II [PASARRPASRR](#) Evaluation Process
- 33 A. The Utilization Review Contractor shall refer all Medicaid clients and private pay
34 individuals who require a Level II evaluation, to the [PASARRPASRR](#) Level II contractor.
- 35 1. The [PASARRPASRR](#) Level II contractor shall complete the Level II evaluation..
- 36 2. The State Medicaid program shall pay for the private pay evaluations.
- 37 3. Nursing facilities shall not complete the Level II evaluation.
- 38 4. The findings of these evaluations shall be returned to the Utilization Review
39 Contractor for review and referral to the State Mental Health and/or ~~Mental~~

1 ~~Retardation~~Intellectual or developmental disability authorities for final review and
2 determination.

3 B. Evaluations shall be adapted to the cultural background, language, ethnic origin and
4 means of communication used by the individual.

5 C. The Level II Mental Illness Evaluation for Specialized Services shall consist of the
6 following:

7 1. A comprehensive medical examination of the individual. The examination shall
8 address the following areas:

9 a. A comprehensive medical history;

10 b. An examination of all body systems; and

11 c. An examination of the neurological system which consists of an
12 evaluation in the following areas:

13 1) Motor functioning;

14 2) Sensory functioning;

15 3) Gait and deep tendon reflexes;

16 4) Cranial nerves; and

17 5) Abnormal reflexes.

18 d. In cases of abnormal findings, additional evaluations shall be conducted
19 by appropriate specialists; and

20 e. If the history and physical examinations are not performed by a
21 physician, then a physician must review and concur with the conclusions
22 and sign the examination form.

23 2. A psychosocial evaluation of the individual, which at a minimum, includes an
24 evaluation of the following:

25 a. Current living arrangements;

26 b. Medical and support systems; and

27 c. The individual's total need for services are such that:

28 1) The level of support can be provided in an alternative community
29 setting; or

30 2) The level of support is such that nursing facility placement is
31 required.

32 3. A Functional Assessment shall be completed on the individual's ability to engage
33 in activities of daily living.

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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.C.R.S. section 27-65-107](#), 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 [PASARRPASRR](#) 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 RetardationIntellectual or developmental disability](#) 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,

1 4) Antianxiety-sedative agents, and

2 5) Anti-Parkinsonian agents.

3 2. The ~~Mental Retardation~~Intellectual or developmental disability process must
4 assess:

5 a. Self-monitoring of health status;

6 b. Self-administering and/or scheduling of medical treatments;

7 c. Self-monitoring of nutrition status;

8 d. Self-help development such as: toileting, dressing, grooming, and
9 eating);

10 e. Sensorimotor development such as: ambulation, positioning, transfer
11 skills, gross motor dexterity, visual motor/perception, fine motor dexterity,
12 eye-hand coordination, and extent to which prosthetic, orthotic,
13 corrective or mechanical supportive devices improve the individual's
14 functional capacity);

15 f. Speech and language (communication) development, such as:
16 expressive language (verbal and nonverbal), receptive language (verbal
17 and nonverbal), extent to which non-oral communication systems
18 improve the individual's functional capacity, auditory functioning, and
19 extent to which amplification devices (e.g., hearing aid) or a program of
20 amplification improve the individual's functional capacity);

21 g. Social development, such as: interpersonal skills, recreation-leisure
22 skills, and relationships with others;

23 h. Academic/educational development, including functional learning skills;

24 i. Independent living development such as: meal preparation, budgeting
25 and personal finances, survival skills, mobility skills (orientation to the
26 neighborhood, town, city), laundry, housekeeping, shopping, bed
27 making, care of clothing, and orientation skills (for individuals with visual
28 impairments); and

29 j. Vocational development, including present vocational skills;

30 k. Affective development (such as: interests, and skills involved with
31 expressing emotions, making judgments, and making independent
32 decisions); and

33 l. Presence of identifiable maladaptive or inappropriate behaviors of the
34 individual based on systematic observation (including, but not limited to,
35 the frequency and intensity of identified maladaptive or inappropriate
36 behaviors).

37 3. The Level II ~~Mental Retardation~~Intellectual or developmental disability evaluation
38 shall insure that a psychologist, who meets the qualifications of a qualified ~~mental~~

1 ~~retardation~~intellectual or developmental disability professional completes the
2 following:

- 3 a. The individual's intellectual functioning measurement shall be identified;
4 and
- 5 b. The individual's ~~mental retardation~~intellectual or developmental disability
6 or related condition shall be validated.

7 4. The Level II ~~Mental Retardation~~Intellectual or developmental disability evaluation
8 shall identify to what extent the individual's status compares with each of the
9 following characteristics, commonly associated with need for specialized services
10 including:

- 11 a. The inability to:
- 12 1) Take care of most personal care needs;
- 13 2) Understand simple commands;
- 14 3) Communicate basic needs and wants;
- 15 4) Be employed at a productive wage level without systematic long
16 term supervision or support;
- 17 5) Learn new skills without aggressive and consistent training;
- 18 6) Apply skills learned to a training situation to other environments
19 or settings without aggressive and consistent training; or
- 20 7) Demonstrate behavior appropriate to the time, situation or place,
21 without direct supervision.
- 22 b. Demonstration of severe maladaptive behavior(s) which place the
23 individual or others in jeopardy to health and safety;
- 24 c. Inability or extreme difficulty in making decisions requiring informed
25 consent; and
- 26 d. Presence of other skill deficits or specialized training needs which
27 necessitate the availability of trained ~~mental retardation~~intellectual or
28 developmental disability personnel, 24 hours per day, to teach the
29 individual functional skills.

30 5. The ~~Mental Retardation~~Intellectual or developmental disability evaluation shall
31 collect information to determine whether the individual's total needs for services
32 are such that:

- 33 a. The level of support may be provided in an alternative community
34 setting; or
- 35 b. The level of support is such that nursing facility placement is required.

- 1 6. The ~~Mental Retardation~~Intellectual or developmental disability evaluation shall
2 determine whether the ~~mentally retarded~~individuals with an intellectual or
3 developmental disability individual needs a continuous Specialized Services
4 program.

5 .206 PASARRPASRR Findings from Level II Evaluations

6 A. PASARRPASRR Level II findings shall include the following documentation:

- 7 1. The individual's current functional level must be addressed;
- 8 2. The presence of diagnosis, numerical test scores, quotients, developmental
9 levels, etc. shall be descriptive; and
- 10 3. The findings shall be made available to the family or designated representatives
11 of the nursing facility resident, the parent of the minor individual or the legal
12 guardian of the individual.

13 B. PASARRPASRR Findings from the Level II Evaluations shall be used by the Utilization
14 Review Contractor in making determinations whether an individual with mental illness or
15 ~~mental retardation~~intellectual or developmental disability is appropriate or inappropriate
16 for nursing facility care, and

17 C. The individual shall be referred back to the Utilization Review Contractor for a
18 determination of the need for long term care services if at any time it is found that the
19 individual is not mentally ill or ~~mentally retarded~~individuals with an intellectual or
20 developmental disability, or has a primary diagnosis of dementia or Alzheimer's disease
21 or related disorders or a non-primary diagnosis of dementia (including Alzheimer's
22 disease or a related disorder) without a primary diagnosis of serious mental illness, or
23 ~~mental retardation~~intellectual or developmental disability or a related condition.

24 D. The results of the PASARRPASRR evaluation shall be described in a report by the State
25 Mental Health or ~~Mental Retardation~~Intellectual or developmental disability authorities,
26 which includes:

- 27 1. The name and professional title of the person completing the evaluation, and the
28 date on which each portion of the evaluation was administered.
- 29 2. A summary of the medical and social history including the individual's positive
30 traits or developmental strengths and weaknesses or developmental needs.
- 31 3. The mental health services and/or ~~mental retardation~~intellectual or
32 developmental disability services required to meet the individual's identified
33 needs;
- 34 4. If specialized services are not recommended, any specific services identified
35 which are of a lesser intensity than specialized services required to meet the
36 evaluated individual's needs;
- 37 5. If specialized services are recommended, the specific services identified required
38 to meet each one of the individual's needs; and
- 39 6. The basis for the report's conclusions.

1 E. Copies of the evaluation report will be made available to:

- 2 1. The individual and his or her legal representative;
- 3 2. The appropriate state authorities who make the determination;
- 4 3. The admitting or retaining nursing facility;
- 5 4. The individual's attending physician; and
- 6 5. The discharge hospital, if applicable.

7 .207 PASARRPASRR Determinations from the Level II Evaluation

8 A. Determinations which may result in admissions and/or specialized services shall include:

- 9 1. If an individual meets the level of care and needs the level of services provided in
10 a nursing facility, as determined by the Utilization Review Contractor, and is
11 determined not mentally ill or mentally retarded individuals with an intellectual or
12 developmental disability, the individual may be admitted to the facility.
- 13 2. If an individual does not meet the level of care (as determined by the Utilization
14 Review Contractor), and is determined to not be mentally ill or mentally
15 retarded individuals with an intellectual or developmental disability through the
16 PASARRPASRR determination and is not seeking Medicaid reimbursement, the
17 individual may be admitted to the facility.
- 18 3. If the determination is that a resident or applicant for admission to a nursing
19 facility requires BOTH the nursing facility level of care and specialized mental
20 health or mental retardation intellectual or developmental disability services, as
21 determined by the Utilization Review Contractor and the State Mental Health and
22 Mental Retardation Intellectual or developmental disability authorities:
 - 23 a. The individual may be admitted or retained by the nursing facility; and
 - 24 b. The State Mental Health or Mental Retardation Intellectual or
25 developmental disability authorities shall provide or arrange for the
26 provision of specialized services needed by the individual while he or she
27 resides in the nursing facility.
- 28 4. Nursing facilities admitting residents requiring specialized mental health or
29 mental retardation intellectual or developmental disability services shall be
30 responsible for assuring the provisions of services to meet all the resident needs
31 identified in the Level II evaluations. The provisions of services shall be
32 monitored through the State's survey and certification process.

33 B. Determinations which may result in denial of admission include:

- 34 1. If an individual does not require nursing facility services and is seeking Medicaid
35 reimbursement, the individual cannot be admitted to the nursing facility.
- 36 2. If the determination is that an individual requires neither the level of services
37 provided in a nursing facility nor specialized services, the nursing facility shall:

- 1 a. Arrange for the safe and orderly discharge of the resident from the
2 facility; and
- 3 b. Prepare and orient the resident for the discharge.
- 4 c. Provide the resident with a written notice of the action to be taken and
5 his or her grievance and appeal rights under the procedure found at
6 section [25-1-120, C.R.S.](#) [C.R.S. section 25-1-120](#) entitled "Nursing ~~and~~
7 ~~intermediate care~~ facilities - rights of patients".
- 8 C. If the determination is that a resident does not require nursing facility services but
9 requires specialized services, the following action shall be taken:
- 10 1. For long term residents who have resided continuously in a nursing facility at
11 least 30 months before the date of the first annual review determination and who
12 require only specialized services, the nursing facility, in cooperation with the
13 resident's family or legal representative and care givers, shall complete the
14 following:
- 15 a. The resident shall be offered the choice of remaining in the facility or
16 receiving services in an alternative appropriate setting; and
- 17 b. The resident shall be informed of institutional and non-institutional
18 alternatives; and
- 19 c. The effect on eligibility for Medicaid services shall be clarified if the
20 resident chooses to leave the facility, including the effect on readmission
21 to the facility; and
- 22 d. The provision of specialized services shall be provided for, or arranged
23 regardless of the resident's choice of living arrangements.
- 24 2. For short term residents who require only specialized services and who have not
25 resided in a nursing facility for 30 continuous months before the date of
26 [PASARRPASRR](#) determination, the nursing facility, in conjunction with the State
27 Mental Health or [Mental Retardation/Intellectual or developmental disability](#)
28 authority, in cooperation with the resident's family or legal representative and
29 caregivers, shall complete the following:
- 30 a. The safe and orderly discharge of the resident from the facility shall be
31 arranged;
- 32 b. The resident shall be prepared and oriented for the discharge; and
- 33 c. A written notice shall be given to the resident notifying him or her of the
34 action to be taken and of his or her grievance and appeal rights.
- 35 d. The provision of specialized services shall be provided or arranged,
36 regardless of the resident's choice of living arrangements.
- 37 D. Any individual with mental illness, determined through the [PASARRPASRR](#) process, to
38 be in need of in-patient psychiatric hospitalization, shall not be admitted to the nursing
39 facility until treatment has been received and the individual certified as no longer needing
40 in-patient psychiatric hospitalization.

1 **8.401.21** SPECIALIZED SERVICES FOR MENTALLY ILL AND MENTALLY
 2 RETARDED INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL
 3 DISABILITY SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR
 4 INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

5 .211 Specialized Services shall include the following requirements:

6 A. Community Mental Health Centers and Community Centered Boards shall be authorized
 7 by the State to provide specialized services to individuals in Medicaid nursing facilities.

8 B. These services shall be reimbursed by the Medicaid program to the community mental
 9 health centers or community centered boards through Department of Institutions. The
 10 cost of these services shall not be reported on the Nursing Facility cost report.

11
 12 C. Specialized services may be provided by agencies other than community mental health
 13 centers or community centered boards or other designated agencies on a fee for service
 14 basis, but the cost of these services shall not be included in the Medicaid cost report or
 15 the Medicaid rate paid to the nursing facility.

16 .212 Specialized Services for Individuals with Mental Illness shall be defined as services, specified by
 17 the State, which include:

18 A. Specified services combined with the services provided by the nursing facility, resulting in
 19 a program designed for the specific needs of eligible individuals who require the services.

20 B. An aggressive, consistent implementation of an individualized plan of care.

21 .213 Specialized services shall have the following characteristics:

22 A. The specialized services and treatment plan must be developed and supervised by an
 23 interdisciplinary team which includes a physician, a qualified mental health professional
 24 and other professionals, as appropriate.

25 B. Specific therapies, treatments and mental health interventions and activities, health
 26 services and other related services shall be prescribed for the treatment of individuals
 27 with mental illness who are experiencing an episode of severe mental illness which
 28 necessitates supervision by trained mental health personnel.

29 .214 The intent of these specialized services is to:

30 A. Reduce the applicant or resident's behavioral symptoms, that would otherwise
 31 necessitate institutionalization.

32 B. Improve the individual's level of independent functioning.

33 C. Achieve a functioning level that permits reduction in the intensity of mental health
 34 services to below the level of specialized services at the earliest possible time.

35 .215 Levels of Mental Health services shall be provided, as defined by the State, including Enhanced
 36 and General Mental Health services.

1 .216 Specialized Services for Individuals with ~~Mental Retardation~~Intellectual or developmental
 2 disability shall be defined as a continuous program for each individual which includes the
 3 following:

4 A. An aggressive, consistent implementation of a program of specialized and generic
 5 training, specific therapies or treatments, activities, health services and related services,
 6 as identified in the plan of care.

7 B. The individual program plan includes the following:

8 1. The acquisition of the behaviors necessary for the individual to function with as
 9 much self determination and independence as possible; and

10 2. The prevention or deceleration of regression or loss of current optimal functional
 11 status.

12 8.401.4 GUIDELINES FOR INSTITUTIONS FOR MENTAL DISEASES (IMD's)

13 .41 DEFINITION

14 "Institution for Mental Diseases" (IMD) as defined in the Medicaid regulations at 42 C.F.R. 435.100942
 15 C.F.R. section 435.1010 (2013), is an institution of more than sixteen (16) beds that is primarily engaged
 16 in providing diagnosis, treatment or care of persons with mental diseases, including medical attention,
 17 nursing care and related services. Whether an institution is an institution for mental diseases is
 18 determined by its overall character as that of a facility established and maintained primarily for the care
 19 and treatment of individuals with mental diseases, whether or not it is licensed as such.

20 .42 CRITERIA USED FOR DETERMINATION OF IMD STATUS

21 The primary criteria for the determination of the IMD status of an institution is that more than fifty percent
 22 (50%) of all patients in the facility have primary diagnoses of major mental illness as determined by the
 23 Level II Pre-Admission Screening and ~~Annual~~ Resident Review (PASARRPASRR) process which is
 24 verified by the Utilization Review Contractor.

25 The State has defined the following diagnostic codes contained in the DSM IV as valid for the purpose of
 26 determining whether an individual has a "mental disease":

27 295.10 through 295.90

28 296.0 through 296.9

29 297.10

30 298.9

31 300.40

32 301.13

33 [Removed per S.B. 03-088, 26 CR 7]

34 Additional criteria applied for the purpose of IMD determination are as follows:

- 1 A. The facility is licensed as a psychiatric facility for the care and treatment of individuals with mental
2 diseases;
- 3 B. The facility is accredited as a psychiatric facility by the Joint Commission for Accreditation for
4 Health Care Organizations (JCAHCO);
- 5 C. The facility is under the jurisdiction of the state's mental health authority;
- 6 D. The facility specializes in providing psychiatric/psychological care and treatment as ascertained
7 through a review of patients' records; and
- 8 E. The current need for institutionalization for more than 50 percent of all patients in the facility
9 results from major mental diseases.

10 Facilities that meet the primary "50%" criterion at a minimum are at serious risk of being classified as an
11 IMD by the State and federal government. However, facilities meeting any lesser criteria may or may not
12 be at risk of being identified as an IMD.

13 The assurance that a facility is not an IMD is included in all nursing facility contracts.

14

15 **.43 FFP DISALLOWANCE**

16 FFP is not available for any medical assistance under Title XIX for individuals between the ages of 21 and
17 65 who are patients in an IMD. The Department of Social Services, in cooperation with the Departments
18 of Health and Institutions CDPHE, will monitor long term care facilities to determine whether any facility
19 has a census of primary psychiatric patients in excess of fifty percent (50%) of its total census. Facilities
20 whose psychiatric census approaches this fifty percent (50%) limit will be so notified by the Department.
21 Should an on-site review by the Department document a psychiatric census in excess of fifty percent
22 (50%) of total census in a facility, Medicaid reimbursement shall be denied for all residents between the
23 ages of 21 and 65 until the Department determines that the facility is no longer an IMD.

24 **.44 ADMINISTRATIVE PROCEDURES AND REQUIREMENTS**

25 In order to determine whether a nursing home facility is an IMD the following administrative procedures
26 and requirements are necessary:

- 27 A. All nursing homes shall indicate on the patient's medical record the primary, secondary and
28 tertiary diagnoses (as applicable) of all their patients, Medicaid and private pay. All medical
29 records shall contain this information no later than three calendar months after the effective date
30 of this regulation.
- 31 B. All nursing homes shall report discharges to the Utilization Review Contractor. Discharge
32 information shall include the name of the person, state identification number if applicable,
33 discharge destination, date, payment source Utilization Review Contractor and primary and
34 secondary diagnoses. Discharges of all patients shall be reported within one week of discharge.
35 Discharge is defined to mean death, transfers, discharge to home, and absent without leave.
- 36 C. Colorado Department of Public Health and Environment CDPHE shall use the medical records
37 diagnosis information to determine the percentage of patients with mental diseases. In cases
38 where the percentage is higher than 40%, a notice of the potentially high percentage shall be sent
39 to the Department and Utilization Review Contractor.

- 1 d.(1) In cases where the percentage is over 40% and less than 50% the nursing home will be
 2 instructed by the Department to provide admission data and discharge data on all private
 3 pay as well as Medicaid patients to the Utilization Review Contractor. The admission and
 4 discharge data is necessary on all patients so that the entire psychiatric census of the
 5 facility can be determined and monitored by the Utilization Review Contractor.
- 6 (2) In cases where the percentage of psychiatric patients appears to be exceeding or about
 7 to exceed 50%, the Department may instruct the Utilization Review Contractor to deny
 8 admission authorization for Medicaid patients with psychiatric diagnoses. The facility shall
 9 be notified of the Department's intent to limit admissions to only non-psychiatric patients
 10 at least five (5) days in advance of the action. The facility may appeal this action in
 11 accordance with the regulations ~~entitled PROVIDER APPEALS AND HEARINGS~~ at 10
 12 CCR 2505-10 section 8.10 CCR 2505-10-section 8.050 et seq.
- 13 e.(1) In cases where the percentage of psychiatric patients in the census of the facility is over
 14 fifty (50) percent, and/or the facility meets some of the other criteria, the Department shall
 15 conduct an audit of the facility to determine if it is primarily engaged in the care and
 16 treatment of persons with mental diseases (i.e. an institution for mental diseases). The
 17 basis of such a finding shall be the criteria described in the regulations. This audit shall
 18 be conducted with assistance from ~~the Colorado Department of Public Health and~~
 19 ~~Environment~~ CDPHE and shall include medical personnel with the necessary
 20 qualifications to determine the primary characterization of a facility.
- 21 e.(2) Should the audit indicate a finding that the facility is an Institution for Mental Disease,
 22 then all Medicaid funding for patients between the ages of 21 and 65 shall be denied.
 23 Furthermore, should the audit indicate the facility has been an IMD for a period of time
 24 prior to the time the audit was undertaken, the facility shall refund to the Medicaid
 25 program one hundred percent (100%) of the payments for patients between the ages of
 26 21 and 65. Under no circumstances shall the refund extend to periods of time before the
 27 effective date of the GUIDELINES FOR INSTITUTIONS FOR MENTAL DISEASES,
 28 issued April, 1987.
- 29 f. The Department shall make arrangements with the Medicaid patients of the facility determined to
 30 be an IMD to do any of the following:
- 31 (1) Relocate Medicaid patients between the ages of 21 and 65 in accordance with the
 32 regulations entitled NURSING HOME RESIDENT/CLIENT RELOCATION PLAN.
- 33 (2) Relocate a sufficient number of psychiatric patients from the facility so as to reduce the
 34 facility's psychiatric census to below 50%. Such relocation shall be completed in
 35 accordance with the NURSING HOME RESIDENT/CLIENT RELOCATION PLAN.
- 36 g. A nursing home facility determined to be an IMD may appeal such a finding in accordance with
 37 the regulations ~~entitled PROVIDER APPEALS AND HEARINGS~~ at 10 CCR 2505-10 section 8.10
 38 CCR 2505-10-section 8.050 et seq. In cases where the administrative law judge issues a stay of
 39 the agency's action to terminate Medicaid payments to a provider, such an order of stay shall
 40 clearly indicate that should the State's IMD finding be correct, the facility shall repay the State one
 41 hundred percent (100%) of Medicaid payments it received during the period of the stay. In order
 42 to assure that such a payment shall be made, the administrative law judge shall require the
 43 facility to post a bond in the amount of one hundred percent (100%) of the anticipated nursing
 44 home payment for each month the stay is in effect.

45 **8.401.50 GUIDELINES FOR CLASS V REHABILITATION FACILITIES**

46 Section deleted eff. 3/01/02

1 **8.402 ADMISSION PROCEDURES FOR LONG TERM CARE**

2 8.402.01 PRE-ADMISSION REVIEW (NOT FOR DEVELOPMENTAL DISABILITIES)

3 ~~When a physician~~When a physician or designee wishes to obtain skilled or maintenance services
4 for a client, ~~he/she, or his/her designee, shall~~he/she shall contact the regional Utilization Review
5 Contractor (URC). The Utilization Review Contractor will request and record information about the
6 client's condition and the proposed treatment plan.

7 In order to promote the most appropriate placement of developmentally disabled clients when
8 skilled or maintenance services are sought, the physician shall, unless an emergency admission
9 ~~as defined at §8.402.20~~[EJM2][QK3][JM4]s required, refer the client to the Residential Referral and
10 Placement Committee (RR/PC) for the area served by the Community Centered Board (CCB)
11 where the client resides. Class I services shall be authorized by the Utilization Review Contractor
12 only when the following requirements have been met:

- 13 a. The RR/PC determines in collaboration with the physician and the client or the client's
14 designated representative that Intermediate Care ~~Facilities for the Mentally~~
15 ~~Retarded~~Individuals with an intellectual or developmental disabilityFacilities for
16 ~~Individuals with Intellectual Disabilities~~ (ICF/MR/ICF/IID) services or services available
17 through Home and Community Based Services for the Developmentally Disabled (~~HCB-~~
18 ~~DD~~HCBSD) are not appropriate to meet the health care needs of the client.
- 19 b. ~~ICF/MR/ICF/IID~~ or ~~HCB-DD~~HCBSD services are not available if such services are
20 appropriate.
- 21 c. The physician and the client or the client's designated representative chooses Class I
22 services in preference to services available specifically for developmentally disabled
23 clients, and the client meets the level of care criteria for these services.

24 Referrals by physicians of developmentally disabled clients for Class I services without review by
25 the RR/PC will not be certified by the Utilization Review Contractor for Medicaid reimbursement.
26 Clients for whom ~~ICF/MR/ICF/IID~~ or ~~HCB-DD~~HCBSD services are appropriate as defined in 10
27 CGR 2505-10 §section 8.401.18, subject to the physician's and the client's or the client's
28 designated representative concurrence, shall be referred immediately to the Utilization Review
29 Contractor and to the appropriate Community Centered Board under the provisions ~~at §8.405 at~~
30 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.405.

- 31 .02 After reviewing the information taken from the physician or his designee, the Utilization Review
32 Contractor shall assign a target group designation based upon the primary reason for which long
33 ~~-term~~ care services are needed. The Utilization Review Contractor shall follow the target group
34 designations established at 10 CCR 2505-10 sections §8.402.32(A) through §8.402.32(D).

35 **8.402.10 ADMISSION PROCEDURES FOR CLASS I NURSING FACILITIES**

- 36 .11 The URC/SEP shall certify a client for nursing facility admission after a client is determined to
37 meet the functional level of care and passes the ~~PASARR~~PASRR Level 1 screen requirements
38 for long term care. However, the URC/SEP shall not certify a client for nursing facility admission
39 unless the client has been advised of long term care options including Home and Community
40 Based Services as an alternative to nursing facility care.

- 41 .12 The ~~medical provider~~medically licensed provider must complete the necessary documentation
42 prior to the client's admission.

- 1 .13 The ULTC 100.2 and other transfer documents concerning medical information as applicable,
2 must accompany the client to the facility.
- 3 .14 The nursing facility or hospital shall notify the URC/SEP agency of the pending admission by
4 ~~faxing or emailing the Initial Screening and Intake Form~~ faxing or emailing the appropriate form.
5 The date the form is received by the URC/SEP agency shall be the effective start date if the client
6 meets all eligibility requirements for Medicaid long-term care services.
- 7 .15 The URC/SEP case manager shall determine the client's length of stay using the ~~Nursing Facility~~
8 ~~Length of Stay Assignment form~~ appropriate form developed by the Department. The length of
9 stay shall be less than a year, one year or indefinite. All indefinite lengths of stay shall be
10 approved by the case manager's supervisor.
- 11 .16 The URC/SEP agency shall notify in writing all appropriate parties of the initial length of stay
12 assigned. Appropriate parties shall include, but are not limited to, the client or the client's
13 designated representative, the attending physician, the nursing facility, the Fiscal Agent, the
14 appropriate County Department of Social/Human Services, the appropriate community agency,
15 and for clients within the developmentally disabled or mentally ill target groups, the Department of
16 Human Services or its designee.
- 17 .17 ~~Beginning November 1, 2003, t~~The nursing facility shall be responsible for tracking the length of
18 stay end date so that a timely reassessment is completed by the URC/SEP.
- 19 .18 The ~~Statewide~~ Utilization Review Contractor will determine the start date for nursing facility
20 services. The start date of eligibility for nursing facility services shall not precede the date that all
21 the requirements (functional level of care, financial eligibility, disability determination) have been
22 met.
- 23 **8.402.30 ADMISSION PROCEDURES FOR HOME AND COMMUNITY BASED SERVICES**
- 24 .31 When the client meets the level of care requirements for long term care, is currently living in the
25 community, and could possibly be maintained in the community, the URC/SEP agency shall
26 immediately communicate with the appropriate community agency, according to the URC/SEP
27 agency-determined target group, for an evaluation for alternative services. The URC/SEP agency
28 shall forward a copy of the worksheet plus a State prescribed disposition form to the agency
29 either immediately after the telephone referral, or in place of the telephone referral.
- 30 .32 Based upon information obtained in the pre-admission review, the URC/SEP case manager shall
31 make the referral to the appropriate community agency based on the client's target group
32 designation, as defined below:
- 33 A. Individuals determined by the URC/SEP agency to be in the Mentally Ill target group,
34 regardless of source, shall be referred to the appropriate community mental health center
35 or clinic.
- 36 B. Individuals determined by the Utilization Review Contractor to be in the Functionally
37 Impaired Elderly target group or the Physically Disabled or Blind target group shall be
38 referred to the appropriate Single Entry Point agency for evaluation for Home and
39 Community Based Services for the ~~Elderly, Blind or Disabled~~ Elderly, Blind and
40 dDisabled (HCBS-EBD).
- 41 C. Individuals identified by the Utilization Review Contractor to be in the Developmentally
42 Disabled target group shall be referred to the appropriate Community Centered Board.

1 D. Individuals determined by the Utilization Review Contractor to be in the Persons Living
2 with AIDS target group shall be referred to the appropriate single entry point agency for
3 evaluation for ~~Home and Community Based Services for Persons Living with AIDS~~
4 ~~(HCBS-PLWA) or HCBS-EBD.~~

5 E. The Utilization Review Contractor shall notify any clients referred to case management
6 agencies of the referral, the provisions of the program, and shall inform them of the
7 complaint procedures.

8 .33 The case management agency or community mental health center or clinic shall complete an
9 evaluation for alternative services within five (5) working days of the referral by the Utilization
10 Review Contractor.

11 .34 Single Entry Point agencies shall conduct the evaluation in accordance with the procedures at
12 ~~§8.485 through §8.486.50410 CCR 2505-10 sections 8.486 and 8.390.~~

13 .35 Community Centered Boards shall conduct the evaluation in accordance with procedures at
14 ~~§8.50010 CCR 2505-10 section 8.10 CCR 2505-10 section 8.500.~~

15 .36 Community mental health centers and clinics shall conduct the evaluation in accordance with
16 Standards/Rules and Regulations for Mental Health ~~2-C.C.R., 502-22 CCR 502-1 section 21.940~~
17 and Rules and Regulations Concerning Care and Treatment of the Mentally Ill, ~~2-C.C.R., 502-42~~
18 ~~CCR 502-1 section 21.280.~~

19 .37 If the community agency develops an approved plan for long term care services, the Utilization
20 Review Contractor will approve one (1) certification for long term care services and the client shall
21 be placed in alternative services. Following receipt of the fully completed ULTC 100.2, the
22 Utilization Review Contractor will review the information submitted and make a certification
23 decision. If certification is approved, the Utilization Review Contractor shall assign an initial length
24 of stay for alternative services. If certification is denied, the decision of the Utilization Review
25 Contractor may be appealed in accordance with ~~§40 CCR 2505-10, Sections 8.05710 CCR 2505-~~
26 ~~10, Sections 8.057 through § 40 CCR 2505-10, Sections 8.057.810 CCR 2505-10 sections 8.057~~
27 ~~through 8.057.8.~~

28 .38 If the appropriate community agency cannot develop an approved plan for long term care
29 services, the Utilization Review Contractor will approve certification for long term care services
30 and utilize the procedure for nursing home admissions described previously in this section.

31 **8.402.40 ADMISSION TO NURSING FACILITY WITH REFERRAL FOR COMMUNITY** 32 **SERVICES**

33 .41 When a client who meets the level of care requirements for long term care is currently
34 hospitalized but could possibly be maintained in the community, certification shall be issued. The
35 client may be placed in the nursing facility, given a short length of stay and immediately referred
36 to the appropriate community agency for evaluation for alternative services in accordance with
37 the procedure described in the preceding section.

38 **8.402.50 DENIALS (ALL TARGET GROUPS)**

39 .51 When, based on the pre-admission review, the client does not meet the level of care
40 requirements for skilled and maintenance services, certification shall not be issued. The client
41 shall be notified in writing of the denial.

1 .52 If the Utilization Review Contractor denied long term care certification based upon the information
2 on the ULTC 100.2, written notification of the denial shall be sent to the client, the attending
3 physician, and the referral source (hospital, nursing facility, etc.).

4 If the information provided on the ULTC 100.2 indicates the client does meet the level of care
5 requirements, the Utilization Review Contractor shall proceed with the admission and/or referral
6 procedures described above.

7 .53 Denials of certification for long term care may be appealed in accordance with the procedures
8 described at ~~§ 10 CCR 2505-10, Sections 8.057 through § 10 CCR 2505-10, Sections 8.057-810~~
9 ~~CCR 2505-10 sections 8.057 through 8.057.8.~~

10 .54 Denial of designation into a specifically requested target group may also be appealed in
11 accordance with ~~§ 10 CCR 2505-10, Sections 8.057 through § 10 CCR 2505-10, Sections~~
12 ~~8.057-810 CCR 2505-10 sections 8.057 through 8.057.8.~~

13 **8.402.60 CONTINUED STAY REVIEWS: SKILLED AND MAINTENANCE SERVICES**

14 .61 The Utilization Review Contractor shall authorize all skilled nursing facility and intermediate care
15 facility services, Home and Community Based Services for the ~~Elderly, Blind or Disabled~~~~Elderly,~~
16 ~~Blind and eDisabled,~~ and mental health clinic services when such services are appropriate and
17 necessary for eligible clients. The Utilization Review Contractor may also limit the period for
18 which covered long term care services are authorized by specifying finite lengths of stay, and
19 may perform periodic continued stay reviews, when appropriate, given the eligibility, functional
20 and diagnostic status of any eligible Client.

21 .62 Continued stay reviews shall, at a minimum, be conducted as frequently as necessary for the
22 purpose of reviewing and re-establishing eligibility for all Home and Community Based Services
23 waiver programs, in accordance with all applicable statutes, regulations and federal waiver
24 provisions.

25 .63 The frequency of the continued stay reviews and the determination of length of stay for nursing
26 facilities may be conducted for the purpose of program eligibility. The process for these decisions
27 will be prescribed in criteria developed by the Department.

28 .64 Continued stay reviews for long term care clients receiving ~~HCB-EBDH CBS-EBD~~ or mental
29 health clinic services may be conducted more frequently at the request of the case manager,
30 ~~client, authorized representative, or the behavioral health organization or the Community Mental~~
31 ~~Health Center (CMHC).~~

32 .65 The Continued Stay Review will follow the same procedures found at ~~§section~~ 8.401.11-.17(H)
33 and if applicable, ~~§section~~ 8.485.61(B)(3).

34 .66 As a result of the continued stay review, the Utilization Review Contractor shall renew or deny
35 certification.

36 **8.403 LONG TERM CARE - SERVICES TO THE DEVELOPMENTALLY DISABLED**

37 Long term care services for the developmentally disabled include institutional services available through
38 Intermediate Care ~~Facilities for the Mentally Retarded~~~~Individuals with an intellectual or developmental~~
39 ~~disability~~~~Facilities for Individuals with Intellectual Disabilities (ICF/MR|CF/IID)~~ and Home and Community
40 Based Services for the Developmentally Disabled (~~HCB-DDH CBS-DD~~). These specialized services are
41 available to Medicaid eligible clients who meet the target group designation for the developmentally
42 disabled, and meet the level of care guidelines described below.

1 **8.403.1 LEVEL OF CARE GUIDELINES FOR LONG TERM CARE SERVICES FOR THE**
 2 **DEVELOPMENTALLY DISABLED**

3 Level of care guidelines for programs for the developmentally disabled are used to determine if
 4 the profile of a client's programmatic and/or medical needs are appropriate to a specific
 5 ICF/MR/ICF/IID nursing home class or equivalent set of HCB-DDHCBS-DD services.

6 .11 Clients shall be certified for admission to a specific class of ICF/MR/ICF/IID or equivalent set of
 7 HCB-DDHCBS-DD services based on the following criteria:

8 A. Minimum/Moderate - developmentally disabled clients who exhibit the following
 9 characteristics:

- 10 1. Have deficiencies in adaptive behavior that preclude independent living and
 11 require a supervised sheltered living environment;
- 12 2. Need supervision and training in self help skills and activities of daily living, but
 13 do not display excessive behavior problems which are disruptive to other
 14 residents or which prevent participation in group or community activities;
- 15 3. Are capable of attending appropriate day services or engaging in sheltered or
 16 competitive employment; and,
- 17 4. Are capable of being maintained in a community-based setting.

18 Clients certified at this level of care may be provided Class II ICF/MR/ICF/IID services or
 19 those HCB-DDHCBS-DD services as set forth in the ~~sections on HOME AND~~
 20 ~~COMMUNITY BASED SERVICES FOR THE~~ regulations at 10 CCR 2505-10 section 8.10
 21 CCR 2505-10-section 8.500 DEVELOPMENTALLY DISABLED in this manual.

22 B. Specialized Intensive - developmentally disabled individuals whose psychological,
 23 behavioral, and/or developmental needs require 24-hour supervision, and who have
 24 potential for movement to a less restrictive living arrangement within 24 months (on the
 25 average). These individuals must conform to one of the profiles described below:

- 26 1. Behavior development profile:
 - 27 - Function at a severe to moderate overall level of retardation;
 - 28 - May present a danger to self or others in the absence of supervision and
 29 habilitative services;
 - 30 - Display severe maladaptive and/or anti-social behaviors, and may have
 31 exhibited delinquent behaviors;
 - 32 - May display destructive or physically aggressive behaviors;
 - 33 - Need specialized behavior management, counseling, and supervision;
- 34 2. Social emotional development profile:
 - 35 - Function at a moderate to mild overall level of retardation.

- 1 - Exhibit severe social and emotional problems attributable to a mental
2 disorder.
- 3 - May be verbally abusive and/or physically aggressive toward self, others,
4 or property.
- 5 - May display run-away, withdrawal, and/or bizarre behavior attributable to
6 a mental disorder;
- 7 - Need social, adaptive, and intensive mental health services.
- 8 3. Intensive developmental profile:
- 9 - Function at a profound to severe level of ~~mental retardation~~ intellectual or
10 developmental disability;
- 11 - Exhibit severe deficiencies in behaviors such as eating, dressing,
12 hygiene, toileting, and communication;
- 13 - May display inappropriate social and/or interpersonal behaviors;
- 14 - Need intensive self-management and adaptive behavior training.

15 Additionally, these individuals are capable of functioning in a community-based setting.

16 Clients certified at this level of care may be provided Class II or Class IV ~~ICF/MR/ICF/IID~~
17 services or those ~~HCB-DD/HCBS-DD~~ services as provided in the ~~sections on HOME AND~~
18 ~~COMMUNITY BASED SERVICES FOR THE~~ regulations at 10 CCR 2505-10 section 8.10
19 ~~CCR 2505-10-section 8.500~~ DEVELOPMENTALLY DISABLED in this manual.

- 20 C. Intensive Medical/Psychosocial - developmentally disabled individuals who have
21 intensive medical and psychosocial needs that require highly structured, in house,
22 comprehensive, medical, nursing and psychological treatment. These individuals must
23 meet at least one of the following requirements:
- 24 1. Exhibits extreme deficiencies in adaptive behaviors in association with profound
25 or severe retardation or in association with medical problems requiring availability
26 of medical life support services on a continuous basis; and/or
- 27 Exhibits maladaptive behavior(s) potentially injurious to self or others to the
28 degree that intensive programming in an institutional or closed setting is required;
29 and
- 30 Inappropriate for placement in less restrictive settings, such as
31 minimum/moderate or specialized intensive community-based services, due to
32 the nature and/or severity of their handicaps.
- 33 2. Appropriate for service in less restrictive community residential programs, but all
34 local and statewide avenues for alternative placement have been investigated
35 and exhausted prior to referral to a Class IV facility. Plans for eventual
36 community placement have been established;
- 37 3. Committed by court action to a Regional Center under the Division for
38 Developmental Disabilities, Department of Institutions.

1 Clients certified at this level of care may be provided Class IV ICF-MR services or ~~ICB-~~
 2 ~~DD~~HCBS-DD services as provided in the ~~sections on HOME AND COMMUNITY BASED~~
 3 ~~SERVICES FOR THE~~ regulations at 10 CCR 2505-10 section 8.10 CCR 2505-10-section
 4 ~~8.500~~DEVELOPMENTALLY DISABLED in this manual.

5 8.404 ADMISSION CRITERIA: PROGRAMS FOR THE DEVELOPMENTALLY DISABLED

6 8.404.1 Clients needing ~~ICF/MR~~ICF/IID and HCBS/DD level of care are those who:

- 7 A. Require aggressive and consistent training to develop, enhance or maintain skills
 8 for independence (e.g., on-going reliance on supervision, guidance, support and
 9 reassurance); or
- 10 B. Are generally unable to apply skills learned in training situations to other settings
 11 and environments; or
- 12 C. Generally cannot take care of most personal care needs, cannot make basic
 13 needs known to others, and cannot understand simple commands, (e.g., requires
 14 assistance or prompts in bathing and/or dressing, neglects to wear protective
 15 clothing, does not interact appropriately with others, speaks in muffled/unclear
 16 manner, fails to take medications correctly, confuses values of coins, spends
 17 money inappropriately); or
- 18 D. Are unable to work at a competitive wage level without support,(e.g., specially
 19 trained managers, job coach, or wage supplements) and are unable to engage
 20 appropriately in social interactions (e.g., alienates peers by teasing, arguing or
 21 being cruel, does not make decisions); or
- 22 E. Are unable to conduct themselves appropriately when allowed to have time away
 23 from the facility's premises (e.g., loses self-control when s/he cannot get what
 24 s/he wants, performs destructive acts, unsafe crossing streets or following safety
 25 signs) or
- 26 F. Have behaviors that would put self or others at risk for psychological or physical
 27 injury.

28 .11 Clients needing placement in an ~~ICF/MR~~ICF/IID are those who require an active
 29 treatment program. An active treatment program is defined as the aggressive, consistent
 30 implementation of a program of specialized and generic training, treatment, health
 31 services and related services that is directed toward:

- 32 A. The acquisition of the behaviors necessary for the client to function with as much
 33 self-determination and independence as possible; and
- 34 B. The prevention or deceleration of regression or loss of current optimal functional
 35 status.

36 .12 Clients needing placement in the HCBS/DD program are those who require an active
 37 habilitation program. Active habilitation is determined by assessing that the quantity,
 38 quality, and importance of a client's opportunities for independence, social integration,
 39 and responsible decision making are being provided consistent with his/her needs and
 40 directed toward:

- 1 A. The acquisition of the behaviors necessary for the client to function with as much
2 self-determination and independence as possible; and
- 3 B. The prevention or deceleration of regression or loss of current optimal functional
4 status.

5 **8.404.2 CONTINUED STAY REVIEW CRITERIA: PROGRAMS FOR THE DEVELOPMENTALLY**
6 **DISABLED**

7 Same as admission criteria unless the individual needs the help of an [ICF/MR/ICF/IID](#) to continue
8 to function independently because s/he has learned to depend upon the programmatic structure it
9 provides. The fact that s/he is not yet independent, even though s/he can be, makes it
10 appropriate for s/he to receive active treatment services directed at achieving needed and
11 possible independence.

12 **8.404.3 Adherence to the following sections of [Colorado Department of Public Health and](#)**
13 **[Environment/CDPHE](#) and/or Division for Developmental Disabilities rules and regulations are**
14 **critical to the provision of active treatment and active habilitation:**

- 15 A. Assessments
- 16 B. Individual habilitation plans
- 17 C. Individual program plans
- 18 D. Community integration
- 19 E. Independence training
- 20 F. Behavior management
- 21 G. Psychotropic medication use

22 For individuals needing placement in the [ICF/MR/ICF/IID](#) facility and [HCBS/DD](#) Program, a list of
23 specific services or interventions needed in order to make progress must be provided.

24 **8.405 ADMISSION PROCEDURES: PROGRAMS FOR THE DEVELOPMENTALLY DISABLED**

25 **.10 PREAMISSION REVIEW**

26 For admission to [ICF/MR/ICF/IID](#) facilities or the provision of services through programs of Home
27 and Community Based Services for the Developmentally Disabled (~~HCB-DD~~[HCBS-DD](#)),
28 Developmentally Disabled clients must be evaluated by the Residential Referral/ Placement
29 Committee (RR/PC) serving the Community Centered Board (CCB) in the area where the client
30 resides. If services will be provided through a CCB in another area, the client shall be evaluated
31 by that area's RR/PC.

32 The client shall be referred by the RR/PC to the Utilization Review Contractor for admission
33 review and to the appropriate County Department of Social/Human Services for determination of
34 Medicaid eligibility. The Utilization Review Contractor shall not determine admission certification
35 under Medicaid for any Developmentally Disabled client in the absence of a referral from the
36 RR/PC except for emergency admissions to the Class I facilities.

1 .11 The RR/PC evaluation must contain background information as well as currently valid
 2 assessments of functional, developmental, behavioral, social, health, and nutritional status to
 3 determine if the facility can provide for the client's needs and if the client is likely to benefit from
 4 placement in the facility.

5 .12 **RR/PC ADVERSE RECOMMENDATION**[JM5]

6 In cases where the RR/PC declines to recommend placement of a developmentally disabled
 7 individual into an **ICF/MR/ICF/IID** facility or equivalent **HCB-DDHCBS-DD** services, the RR/PC
 8 shall inform the client of the recommendation using the **HCB-DDHCBS-DD-21** [JM6]Form. The
 9 RR/PC shall also notify the client or the client's designated representative of the client's right to
 10 request a formal Utilization Review Contractor level of care review.

11 The client shall have thirty (30) days from the postmark date of the notice to request a formal
 12 Utilization Review Contractor review. If the client requests a formal Utilization Review Contractor
 13 level of care review, the RR/PC shall submit the required documentation plus any new
 14 documentation submitted by the client to the Utilization Review Contractor. The Utilization Review
 15 Contractor shall review and make a level of care determination in accordance with the admission
 16 procedures below.

17 **8.405.2 ADMISSION PROCEDURES FOR **ICF/MR/ICF/IID** FACILITIES**

18 .21 When the client, based on RR/PC review, cannot reasonably be expected to make use of
 19 **ICF/MR/ICF/IID** or Home and Community Based Services for the Developmentally Disabled, the
 20 RR/PC shall notify the physician and the Utilization Review Contractor. The physician and the
 21 Utilization Review Contractor/Community Center Board (URC/CCB) agency then proceed with
 22 the SNF or ICF placement under the provisions set forth at **10 CCR 2505-10 §section 8.402.10**
 23 through **10 CCR 2505-10 §section 8.402.16**.

24 22 When the RR/PC determines that a client is not appropriately served through **HCB-DDHCBS-DD**
 25 services or, in accordance with provisions permitting the client or the client's designated
 26 representative to choose institutional services as an alternative to **HCB-DDHCBS-DD** services,
 27 the RR/PC shall recommend placement to an **ICF/MR/ICF/IID** facility. The RR/PC shall seek the
 28 approval of the client's physician. The physician shall notify the URC/CCB agency of the
 29 proposed placement. Based on information provided by the RR/PC and the client's physician, the
 30 URC/SEP agency may certify the client for long term care prior to **ICF/MR/ICF/IID** admission.

31 .23 The URC/CCB agency shall advise the County Department of Social/Human Services of the
 32 certification to enable the County Department staff to assist with the placement arrangements.

33 24. The ULTC-100.2 and other transfer documents concerning medical information as applicable
 34 must accompany the client to the facility.

35 .25 Following receipt of the fully completed ULTC 100.2, the URC/CCB shall review the information
 36 and make a final certification decision. If certification is approved, the URC/CCB shall assign an
 37 initial length of stay according to ~~the guidelines at 10 CCR 2505-10 section 8.10 CCR 2505-10~~
 38 ~~section 8.404.1§8.404.4~~. If certification is denied, the decision of the URC/CCB may be appealed
 39 in accordance with the appeals process at ~~§10 CCR 2505-10 section 8.10 CCR 2505-10 section~~
 40 ~~8.057~~.

41 **8.405.30 ADMISSION PROCEDURES FOR THE HOME AND COMMUNITY BASED SERVICES**
 42 **FOR THE DEVELOPMENTALLY DISABLED (**HCB-DDHCBS-DD**)**

1 .31 RR/PC's may evaluate clients for HCB-DDHCBS-DD services if, in the judgment of the RR/PC,
 2 such services represent a viable alternative to SNF, ICF, or ICF/MR/ICF/IID services. The
 3 evaluation shall be carried out in accordance with the procedures set forth in 2 C.G.R., CCR
 4 section 503-1.

5 .32 If the RR/PC recommends HCB-DDHCBS-DD placement, then the URC/CCB will approve
 6 certification for services for the developmentally disabled at the level of care recommended by the
 7 RR/PC. The client will be placed in alternative service.

8 Following receipt of the completed ULTC 100.2 and any other supporting information, the
 9 URC/CCB will review the information and make a final certification determination.

10 If certification is approved, the URC/CCB shall assign an initial length of stay for HCB-DDHCBS-
 11 DD services.

12 If certification is denied, the decision of the URC/CCB may be appealed in accordance with
 13 §section 8.057.

14 **8.405.4 CONTINUED STAY REVIEW PROCEDURES; SERVICES FOR THE DEVELOPMENTALLY** 15 **DISABLED**

16 .41 Continued stay reviews shall be conducted by the Utilization Review Contractor for all
 17 developmentally disabled clients in ICF/MR/ICF/IID services. The frequency of these reviews will
 18 be based on the length of stay assigned by the Utilization Review Contractor consistent with the
 19 following guidelines:

20 A. Minimum/Moderate Level of Care: No less than twelve months but no more than twenty-
 21 four months.

22 B. Specialized Intensive Level of Care: Twenty-four months.

23 C. Medical/Psychosocial Level of Care: No less than twelve months and no more than
 24 twenty-four months.

25 .42 Continued stay reviews shall be conducted by the Utilization Review Contractor for all
 26 developmentally disabled clients in HCB-DDHCBS-DD services at least annually.

27 .43 Continued stay reviews may be conducted more frequently at the request of the Community
 28 Centered Board case manager.

29 .44 As a result of the continued stay review, the Utilization Review Contractor shall renew or deny
 30 certification.

31 **8.405.50 GENERAL PROVISIONS**

32 A. These rules shall not be construed nor interpreted to expand, diminish, or change any statutory
 33 provisions or duties of registered professional nurses, licensed practical nurses, or any other
 34 person subject to, or under the supervision of registered professional nurses or licensed practical
 35 nurses pursuant to the Professional Nurses Act, but are intended to explain the method by which
 36 the Department shall reimburse the providers of nursing care services available under the
 37 Colorado Medical Assistance Program.

1

2 B. The Department of Health Care Policy and Financing ("Department") is the single state agency
3 responsible for administration of the Medical Assistance Program ("Medicaid") pursuant to Title
4 XIX of the Social Security Act. The Department is responsible for determining eligibility for
5 program benefits; providers of medical care; level of reimbursement for the provision of medical
6 care; and terms and conditions that shall govern the payment of such providers for the medical
7 care services provided.

8 C. The Department receives partial reimbursement from federal funds pursuant to Titles I, X, XIV,
9 XVI, and XIX of the Social Security Act.

10 D. All participating skilled nursing care facilities and intermediate health care facilities must be
11 administered by a nursing facility administrator licensed pursuant to ~~91-8-1 et seq., C.R.S. 1973,~~
12 ~~as amended-C.R.S. section 12-39-101 et seq.~~ For inclusion in the audited cost rate (see ~~§-10~~
13 ~~CCR 2505-10 section 8.10 CCR 2505-10 section 8.~~ 440 et seq.) the administrator must be
14 employed full-time by the applicant facility, and may not have other conflicting employment
15 obligations. The administrator must be responsible on a 24-hour-a-day basis, with primary duties
16 being performed during the day shift.

17 **8.406 NURSING FACILITY CARE - LEVELS OF CARE**

18 The Department provides payment for nursing facility care in three (3) categories or levels of care: (1)
19 "skilled nursing care", (2) "intermediate nursing care", and (3) "residential care."

20

21 **8.406.1 SKILLED NURSING CARE**

22 Skilled nursing care is available for eligible clients when a physician licensed to practice in the State of
23 Colorado certifies care to be medically necessary. Such care must be provided in a facility that holds a
24 valid and current license from ~~the Colorado Department of Public Health and Environment~~CDPHE as a
25 Nursing Care Facility pursuant to the Standards for Hospitals and Health Facilities, ~~Colorado Department~~
26 ~~of Public Health and Environment~~CDPHE, Health Facilities Division. The facility must also meet the
27 standards defined in the U.S. Code of Federal Regulations, Title 42 C.F.R., ~~incorporated herein by~~
28 ~~reference~~ as rules of the Department. Title 42 of the Code of the Federal Regulations is hereby
29 incorporated by reference. The Department maintains copies of this incorporated text in its entirety,
30 available for public inspection during regular business hours at: Colorado Department of Health Care
31 Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials
32 are provided at cost upon request.

33 Section 1902(a)(26) of the Social Security Act (~~42 U.S.C. section 1396af~~) and 42 C.F.R. ~~section 400 et~~
34 ~~seq.~~ require the Department to:

35 A. Pursue a regular program of medical review and evaluation of each eligible client's medical need
36 for skilled nursing care; and

37 B. Conduct periodic inspections of all skilled nursing care facilities which participate in the Medicaid
38 Program (see ~~10-CCR-2505-10 section 8.10 CCR 2505-10 section 8.~~ 420) to ascertain:

39 1. The actual care being provided;

40 2. The adequacy of the services available to meet the current health needs and to promote
41 the maximum physical well-being of the eligible client;

- 1 3. The necessity and desirability of the continued placement of eligible clients in skilled
2 nursing care facilities; and
- 3 4. The feasibility of meeting the client's health care needs through alternative services.

4 C. Section 1902 of the Social Security Act (1935) (42 U.S.C. section 1396r) is hereby incorporated
5 by reference. The incorporation of 42 U.S.C. section 1396r excludes later amendments to, or
6 editions of, the referenced material. The Department maintains copies of this incorporated text in
7 its entirety, available for public inspection during regular business hours at: Colorado Department
8 of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of
9 incorporated materials are provided at cost upon request.

10 8.406.2 INTERMEDIATE NURSING CARE

11 [Removed per S.B. 03-088, 26 CR 7]

12 The Department shall:

- 13 A. Pursue a regular program of medical review and evaluation of each eligible client's medical need
14 for intermediate nursing care; and
- 15 B. Conduct periodic inspections of all intermediate health care facilities which participate in the
16 Medicaid Program (see ~~40 CCR 2505-10 section 8.10~~ CCR 2505-10 section 8.420) to ascertain:
- 17 1. The actual care that is being provided;
- 18 2. The adequacy of the services available to meet the current health needs and to promote
19 the maximum physical well-being of the eligible client;
- 20 3. The necessity and desirability of the continued placement of eligible clients in
21 intermediate health care facilities; and
- 22 4. The feasibility of meeting the client's health care needs through alternative services.

23 8.406.3 INTERMEDIATE NURSING CARE - ~~MENTAL RETARDATION~~INTELLECTUAL OR 24 ~~DEVELOPMENTAL DISABILITY~~ 15 BEDS OR LESS

- 25 A. Intermediate nursing care is available in facilities of 15 beds or less for eligible clients who are
26 ~~mentally retarded~~individuals with an intellectual or developmental disability or have related
27 conditions provided:
- 28 1. The facility holds a valid and current license from ~~the Colorado Department of Public~~
29 ~~Health and Environment~~CDPHE as a residential care facility or higher classification.
- 30 2. [Removed per S.B. 03-088, 26 CR 7]
- 31 3. Clients who are ~~mentally retarded~~individuals with an intellectual or developmental
32 ~~disability~~ or have related conditions are certified by a physician licensed to practice in the
33 State of Colorado to be (a) ambulatory, (b) receiving active treatment, (c) capable of
34 following directions and taking appropriate action for self-preservation under emergency
35 conditions, and (d) not in need of professional nursing services.
- 36 B. All other provisions of these rules shall apply to care and services provided in such facilities in
37 accordance with the provisions of 42 C.F.R Part 442., ~~but where these rules conflict with the~~

~~provisions of 42 C.F.R., Sections 442.300 and 442.400, the federal rules shall control. Where these rules conflict with the provisions of 42 C.F.R. sections 442.300 and 442.400 et seq., the C.F.R. provisions 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.

- 1 D. In addition to meeting the definition of skilled nursing services, coverage of such services is
2 warranted only if skilled nursing personnel must be available on a continuous 24-hour basis. In
3 determining whether the continuous availability of such personnel is warranted, the following
4 principles apply:
- 5 1. Frequency of Services - The frequency of skilled nursing services required, rather than
6 their regularity, is the controlling factor in determining whether the continuous availability
7 of skilled nursing personnel is warranted.
- 8 2. Observation - Where observation is the principle continuous service provided, because
9 symptoms exist that indicate the need for immediate modification of treatment of
10 institution of medical procedures.
- 11 E. The purpose of the above-stated components and principles, and of ~~Rules §8.408.1, et seq.10~~
12 ~~CCR 2505-10 section 8.10 CCR 2505-10 section 8.408.1 et seq.~~, is to provide general direction
13 and guidelines for admission, utilization review, and medical review; with the intent that the
14 individual's overall medical situation (including mental condition) shall be taken into account in
15 evaluation and determination of the level of care to be provided.

16 **8.408.1 SPECIFIC SERVICES WHICH ARE SKILLED**

17 Based upon the principles set forth, skilled nursing services include but are not limited to the following:

- 18 A. Subcutaneous or intramuscular injections and intravenous medications and/or feedings.
19 B. Levine tube and gastrostomy feedings.
20 C. Naso-pharyngeal aspiration.
21 D. Insertion and replacement of catheters.
22 E. Aseptic application of dressings involving prescription medications.

23 **8.408.2 SPECIFIC SERVICES WHICH ARE SUPPORTIVE**

24 Supportive services which can be learned and performed by the average non-medical person who has
25 been trained in these procedures, provided to either skilled or intermediate care patients include but are
26 not limited to the following:

- 27 A. Provision of routine maintenance medications.
28 B. Prevent decubiti, keep clean, and comfortable.
29 C. Safety measures against accident and injury.
30 D. General maintenance care of colostomy or ileostomy.
31 E. Routine services in connection with in-dwelling bladder catheters.
32 F. Changes in dressings in noninfected postoperative or chronic conditions.
33 G. Prophylactic and palliative skin care, including bathing and application of creams, and care of
34 minor skin problems.

- 1 H. General methods of caring for incontinent patients, including use of diapers.
- 2 I. General care of patients with a plaster cast.
- 3 J. Routine care in connection with braces and similar devices.
- 4 K. Use of heat for palliative and comfort purposes.
- 5 L. Administration of medical gases after initial phases of institution of therapy.
- 6 M. Assistance in dressing, eating, and going to the toilet.
- 7 N. General supervision of exercises which have been taught to the patient.
- 8 O. Diet supervision and administration for those persons requiring specialized diet.
- 9 P. Skilled paramedical services involving specialized training outside the licensed nursing
- 10 curriculum.

11 **8.408.3 ORGANIZATION OF SKILLED NURSING SERVICE**

12 The following nursing care services and organization must be established as a minimum in order for a
13 skilled nursing care facility to receive reimbursement.

- 14 A. Administrative and supervisory responsibilities must be in writing.
- 15 B. Duties must be clearly defined in writing and assigned for staff members.
- 16 C. Written policies and procedures for client care must be available to all personnel.
- 17 D. All professional services rendered by the nursing facility staff, physician, or other professional
- 18 personnel, must be entered in the client's individual record and signed.

19 **8.408.4 PROFESSIONAL PERSONNEL**

20 **8.408.41 DIRECTOR OF NURSING**

21 The nursing services must be under the direction of a director of nursing service who:

- 22 1. Is a registered professional nurse.
- 23 2. Is qualified by education, training, or experience for supervisory duties.
- 24 3. Is responsible to the administrator for development of standards, policies, and procedures
- 25 governing skilled nursing care, and for assuring that such standards, policies, and procedures are
- 26 observed.
- 27 4. Is responsible to the administrator for the selection assignment, and direction of the activities of
- 28 nursing services personnel.
- 29 5. Is employed full time in the facility.
- 30 6. Devotes his/her full time to direction and supervision of the nursing services; and,

1 7. Is on duty during the day shift.

2 **8.408.42 CHARGE NURSE (RN OR LPN)**

3 At all times, there must be on duty and in charge of the facility's nursing activities either:

4 1. A registered professional nurse; or,

5 2. A practical (or vocational) nurse who:

6 a. Is licensed by the State as a practical (or vocational) nurse; and

7 b. Has graduated from a State-approved school of practical nursing; or,

8 c. Has other education and formal training that is found by the State authority responsible
9 for licensing of practical nurses to provide a background considered to be equivalent to
10 graduation from a State-approved school of practical nursing.

11 **8.408.43 NURSING PERSONNEL**

12 Nursing personnel means registered nurse (RN), licensed practical nurse (LPN), and those auxiliary
13 workers, other than RN or LPN, in the nursing service.

14 To assure the provision of adequate nursing services, each nursing care facility must provide sufficient:

15

16 1. Numbers and categories of personnel as determined by the number of patients in the facility and
17 their particular nursing care needs. This determination is made in accordance with accepted
18 policies of effective nursing care and with these guidelines will provide at least two (2) hours total
19 nursing staff time for each patient per 24-hour day.

20 2. Nursing and auxiliary personnel employed and assigned to duties on the basis of their
21 qualifications or experience to perform designated duties.

22 3. Amounts of nursing time to assure that each patient:

23 a. Receives treatments, medications, and diet as prescribed;

24 b. Is kept comfortable, clean, and well-groomed;

25 c. Receives proper care to prevent decubitus ulcers;

26 d. Is protected from accident and injury by appropriate safety measures;

27 e. Is encouraged to perform out-of-bed activities as permitted; and,

28 f. Receives assistance to maintain optimal physical and mental function.

29 **8.408.44 ANCILLARY PERSONNEL**

30 Authorized subsidiary personnel performing duties in support of professional health care services may or
31 may not be included in arriving at the computation of cost allowances set forth in [§ 10 CCR 2505-10](#)
32 [section 8-10 CCR 2505-10 section 8.400](#), et seq.

- 1 A. Dietary - Professional planning and supervision of meal services.
- 2 Special and restricted diet files shall be maintained for thirty (30) days, and any substitutions or
3 variations noted. The patient's reaction and acceptance of food must be observed and recorded.
- 4 Menus must be planned and supervised by professional personnel meeting the following
5 qualifications:
- 6 1. A dietician who meets the American Dietetic Association's standards for qualification as a
7 dietician; or,
- 8 2. A graduate holding at least a Bachelor's Degree from the university program, with major
9 study in food or nutrition; or,
- 10 3. A trained food service supervisor, an associate degree dietary technician, or a
11 professional registered nurse, with frequent and regularly scheduled consultation from a
12 dietician or a nutritionist meeting the above-stated qualifications.
- 13 Inclusion of dietary consultation costs are an allowable item in computing the rate of
14 payment above-referenced.
- 15 B. Pharmacy Consultant - A person licensed to practice pharmacy in the State of Colorado, and
16 whose duties are related to the nursing facility administration of drugs to patients. Such duties
17 relate to:
- 18 1. Drug interactions;
- 19 2. Proper medication usage pertinent to the diagnosis and length of medication; specific to
20 proper usage in records, stop orders, etc.;
- 21 3. Appropriate storage and safeguards of medications;
- 22 4. Study of possible brand interchanges;
- 23 5. Check on authenticity of medication pursuant to labeling;
- 24 6. Contraindications and other professional activities related to drug administration,
25 receipting, storage, etc.
- 26 Costs related to pharmacal consultation are allowable in determining the rate to be paid, under
27 the same conditions as for dietary in item 1 above.
- 28 C. Housekeeping and Maintenance - Allowed pursuant to above-cited rules on cost computation.

29 8.408.5 CLINICAL RECORDS

30 8.408.51 MAINTENANCE

31 The following records, as a minimum, must be kept current, dated and signed, and must be made
32 available for review if applicable:

- 33 1. Identification and summary sheets.
- 34 2. Hospital discharge summary sheet.

- 1 3. Medical evaluation and treatment plan.
- 2 4. Physician's orders.
- 3 5. Physician's progress notes.
- 4 6. Nurse's progress notes.
- 5 7. Medication and treatment record.
- 6 8. Laboratory and X-ray reports.
- 7 9. Consultation reports.
- 8 10. Dental reports.
- 9 11. Social Service notes.
- 10 12. Pharmacal Consultant records.
- 11 13. [PASARRPASRR](#) documentation to include the Level I and Level II Reviews and the
12 determination letters.

13 **8.408.52 RETENTION OF RECORDS**

- 14 1. Files shall be retained for at least six years.
- 15 2. In the event that a client is transferred to another health facility, certain transfer information
16 should be incorporated in a record to accompany the client. Such transfer information shall
17 include:
 - 18 a. Transfer form with diagnosis;
 - 19 b. Aid to daily living information;
 - 20 c. Transfer orders;
 - 21 d. Nursing care plan;
 - 22 e. Physician's orders for care.

23 **8.408.53 CONFIDENTIALITY OF RECORDS**

- 24 1. Disclosed only to authorized persons.
- 25 2. Form APA-4, "Authorization for Release of Medical Information" shall be executed in duplicate
26 (original to the nursing facility medical record with a copy to the County Department of
27 Social/Human Services) at the time of admission. This form must be signed by the client, the
28 client's designated representative, the client's parent (if a minor), guardian, or other legally
29 responsible person.

30 **8.408.54 RECORDS ADMINISTRATOR**

- 31 The nursing care facility must have available, and a staff person designated:

- 1 a. A consultant or full-time employee who is a registered records administrator (Medical Records
2 Librarian), or an accredited records technician, or;
- 3 b. A registered records administrator or other employee who is trained in medical records, and who
4 receives supervision from a registered records administrator; or,
- 5 c. If the facility does not have such employee with such training, an employee of the facility is
6 assigned the responsibility for assuring that records are maintained, completed, and preserved.
7 Such person, however, must be trained by, and receive regular consultation from a registered
8 records administrator or accredited records technician.

9 **8.408.6 MEDICAL BASIS FOR CARE - SKILLED NURSING FACILITY CARE**

10 Eligible clients may be admitted to approved facilities only upon the certification of a physician licensed to
11 practice in Colorado that there is a medical need for such admission (Form ULTC-100). The clients'
12 freedom of choice of physician shall be respected. Health care of the client must continue under the
13 supervision of a physician. The facility must have a physician available for necessary medical care in
14 case of emergency.

15 **8.408.61 PHYSICIANS' INVOLVEMENT**

16 **8.408.62 DETERMINATION FOR SKILLED NURSING CARE**

17 The medical need of a client for skilled nursing care shall be delineated in the plan of treatment and
18 substantiating orders written by the physician and by the performance of the necessary skilled nursing
19 services implementing such plans and orders. Upon admission to a skilled nursing care facility, the facility
20 must obtain for the medical record of each such client:

- 21 1. A summary of the course of treatment by the attending physician or which was followed in the
22 hospital, the diagnosis(es) and current medical findings, and the rehabilitation potential.
- 23 2. An evaluation by the physician. Physical examination must be accomplished within 48 hours of
24 admission and recorded; unless such an examination has been accomplished within five days
25 prior to admission to the skilled nursing care facility.
- 26 3. Physician's orders. Orders must be written for the immediate care of the client. These may be
27 written by the attending physician or by the physician who has the responsibility for emergency
28 care in this facility. The current hospital summary of the course of treatment, with orders used, is
29 acceptable as emergency orders.
- 30 4. The physician's treatment plan. The plan must be written and must be directed towards
31 maintaining the health status of the client, preventing further deterioration of the physical well-
32 being of the client, and preparing the client for normal non-institutional life. The plan must be
33 reviewed and revised as necessary, and must include medication and treatment orders which will
34 be in effect for the specified number of days indicated by the physician. This period shall be
35 monthly unless reordered in writing by the physician. Telephone orders may be accepted by
36 licensed nurses only and must be written into the clinical record by the receiving nurse. These
37 orders must be countersigned by the ordering physician within 48 hours.
- 38 The medical necessity for a physician's visit, at least once every thirty (30) days, must be
39 evidenced in the clinical record by a valid signed entry.
- 40 5. Plan for Emergency Care - Each skilled nursing care facility must provide for one, or more,
41 physicians to be available to furnish emergency medical care if the attending physician is not

1 immediately available. A schedule listing the name, telephone number and days on call for a
 2 given physician will be posted at each nursing station. The skilled nursing care facility must also
 3 establish procedures which will be followed in the emergency care of the client, the persons to be
 4 notified, and the reports to be prepared.

5 **8.408.63 PHYSICIANS' INVOLVEMENT - REDETERMINATION FOR SKILLED NURSING CARE**

6 The medical need of the client for skilled nursing care shall be redetermined monthly at the time of the
 7 physician's required monthly visit.

8 The term "substantial change" does not encompass short-term treatment regimens for temporary illness,
 9 adjustments to prescribed medications, or changes to be in effect for less than a thirty (30) day period.

10 **8.408.7 MEDICAL REVIEW AND MEDICAL INSPECTION - SKILLED NURSING CLIENTS**

11 Medical review of the treatment of all clients in skilled nursing care facilities who are entitled to medical
 12 assistance will be accomplished prior to May 2, 1972 (to meet requirements of 42 C.F.R. [section 456.2](#)),
 13 and annually thereafter. Medical review procedures herein are in addition to those set forth in [§10-CCR](#)
 14 [2505-10-section-8-10 CCR 2505-10 section 8.449](#) concerning Utilization Review.

15 **8.408.71 MEDICAL REVIEW TEAM**

16 **8.408.72 COMPOSITION AND MEMBERSHIP REQUIREMENTS**

17 The medical review team for skilled nursing care clients will be led by a Colorado Registered Nurse or a
 18 Colorado Licensed Physician. The teams will include other appropriate health and social service
 19 personnel. Nurse-led teams will report to a physician.

20 No member of the team may be employed by or have financial interest in any nursing facility. No
 21 physician member of a team may inspect the care of clients for whom he is the attending physician.

22 **8.408.73 FUNCTION - MEDICAL REVIEW AND EVALUATION**

- 23 1. The medical treatment of skilled nursing clients entitled to medical assistance shall be reviewed
 24 at least annually.
- 25 2. Annual review shall consist of an evaluation of the treatment, utilizing the medical record and
 26 personal contact with, and observation of, each client in the nursing facility surroundings. This
 27 review, at a minimum, will elicit:
 - 28 a. Medical necessity for visit by attending physician at least once every thirty (30) days.
 - 29 b. Adequacy in quality and quantity as well as the timeliness of treatment to meet health
 30 needs.
 - 31 c. Adherence to the written physician's treatment plan.
 - 32 d. Tests, or observations of clients, indicated by their medication regimen have been made
 33 at appropriate times and properly recorded.
 - 34 e. Physician, nurse, and other professional staff progress notes are made as required, and
 35 appear to be consistent with observed condition of the client.

- 1 f. Adequate services are being rendered to each client as shown by such observations as
 2 cleanliness, absence of decubiti, absence of signs of malnutrition or dehydration, and
 3 apparent maintenance of optimal physical, mental, and psychosocial function.
- 4 g. Client's need for any service not available in, or actually being furnished by the particular
 5 facility, or through arrangements with others.
- 6 h. Each client actually needs continued placement in the facility, or there is an appropriate
 7 plan to transfer the client to an alternate method of care.

8 **8.408.74 REPORTS**

- 9 1. Review reports of care in each facility are submitted to the Department.
- 10 a. After review copies are forwarded to:
- 11 1) Nursing care facility
- 12 2) Nursing care facility Utilization Review Committee
- 13 3) [Colorado Department of Public Health and Environment CDPHE](#)
- 14 2. Reports will cover observations, conclusions and recommendations with respect to adequacy and
 15 quality of client services in the facility, and of physician services to clients in the facility. They will
 16 also cover specific findings with respect to individual clients and any recommendations resulting
 17 therefrom.

18 **8.408.75 STATE DEPARTMENT ACTION**

- 19 1. Reports submitted as a result of Medical Review may result in decisions to reclassify clients into a
 20 different level of care, or recommendations for modification of treatment.
- 21 Such decisions or recommendations will be transmitted as appropriate, to the:
- 22 a. Attending physician.
- 23 b. Administration of the nursing facility.
- 24 c. County Department of Social/Human Services responsible for the client.
- 25 2. Changes in classification recommended will be effected prior to the next billing period.

26 **8.408.76 REVIEW OF STATE DEPARTMENT ACTION**

27 Disagreements with the decisions and recommendations of the Review Team may be adjudicated
 28 through the Administrative Review mechanism of the Department; however, the Division of Medical
 29 Assistance will retain the right to final decision.

30 **8.409 LEVELS OF CARE DEFINED - INTERMEDIATE NURSING CARE**

31 Intermediate nursing services in a licensed intermediate health care facility are defined as those services
 32 furnished in an institution or distinct part thereof to those clients who do not have an illness, disease,
 33 injury, or other condition that requires the degree of care and treatment which a hospital, Extended Care
 34 Facility, or Skilled Nursing Care Facility is designed to provide. Such services are provided under the

1 supervision of a registered professional nurse or licensed practical nurse during the day shift, seven (7)
 2 days per calendar week. Covered intermediate services will be at a level less than those described as
 3 skilled nursing services and will include guidance and assistance for each client in carrying out his
 4 personal health program to assure that preventive measures, treatment, and medications prescribed by
 5 the physician are properly carried out and recorded.

6 These services are provided for according to a plan of treatment written by a physician licensed to
 7 practice medicine in the State of Colorado, and apply to clients whose conditions require medical services
 8 to maintain a degree of stability which has been achieved.

9 There must exist a medical need for the attending physician to visit the client on a professional basis at
 10 least once in every calendar quarter.

11 **8.409.1 SEPARATION OF SKILLED NURSING FACILITY PATIENTS FROM THOSE REQUIRING** 12 **INTERMEDIATE CARE: DISTINCT PART REQUIREMENT**

13 All nursing facilities which provide both skilled nursing facility care and care and services to clients
 14 classified as requiring intermediate nursing care, shall set aside a distinct part, or identifiable unit in such
 15 facility for the provision of such intermediate care to such clients.

16 A "distinct part" is one that meets the following conditions:

17 Identifiable unit - The distinct part of the nursing facility is an entire unit such as an entire ward or
 18 contiguous wards, wing, floor, or rooms. With respect to facilities having 2 or more rooms, such
 19 must be contiguous. The identifiable unit must consist of all beds and related facilities in the unit
 20 and house all patient-clients classified as intermediate care clients for whom payment is being
 21 made, except as provided in paragraph (d) below. It is clearly identified and is approved, in writing
 22 (licensed), by [the Colorado Department of Public Health and Environment CDPHE](#).

23 Staff - Appropriate personnel shall be assigned to the identifiable unit and must work regularly
 24 therein. Immediate supervision of staff shall be provided at all times by qualified personnel as
 25 required for licensure.

26 Shared Facilities and Services - The identifiable unit may share such control services and
 27 facilities as management services, dietary, building maintenance and laundry, with other units.

28 Transfers Between Distinct Parts - Nothing herein shall be construed to require transfer of a client
 29 within the nursing facility, when, in the opinion of the client's physician, such transfer might be
 30 harmful to the physical or mental health of the client. Such opinion of the physician must be
 31 recorded on the patient's nursing facility medical chart and stand as a continuing order unless the
 32 circumstances requiring such exception change.

33 **8.409.2 ORGANIZATION OF INTERMEDIATE NURSING SERVICE**

34 The following nursing care services and organization must be established as a minimum in order for an
 35 intermediate nursing care facility to receive reimbursement:

- 36 1. Administrative and supervisory responsibilities must be in writing.
- 37 2. Duties must be clearly defined in writing and assigned for the staff members.
- 38 3. Written policies and procedures for client care must be available to all personnel.

39 **8.409.21 PROFESSIONAL PERSONNEL - "DIRECTOR OF NURSING"**

1 There must be on duty and in charge of the facility's nursing activities either a registered professional
2 nurse or a licensed practical nurse who:

- 3 1. Is qualified by education, training, or experience for supervisory duties;
- 4 2. Is responsible to the administrator for development of standards, policies, and procedures
5 governing intermediate nursing care, and for assuring that such standards, policies and
6 procedures are observed;
- 7 3. Is responsible to the administrator for the selection, assignment, and direction of the activities of
8 nursing service personnel;
- 9 4. Is employed full time (40 hours per week) in the facility;
- 10 5. Is devoted, full-time to direction and supervision of the nursing services; and
- 11 6. Is on duty during the day shift.

12 **8.409.22 NURSING PERSONNEL**

13 For the two day shifts (16 hours per calendar week) not covered by the Director of Nursing, there shall be
14 a Registered Professional Nurse or a licensed Practical Nurse, and:

- 15 1. There shall be, at all times, a responsible staff member actively on duty in the facility, and
16 immediately accessible to all residents, to whom residents can report injuries, symptoms of
17 illness, or emergencies, and who is immediately responsible for assuring that appropriate action
18 is promptly taken.
- 19 2. Assistance as needed to clients with routine activities of daily living including such services as
20 help in bathing, dressing, grooming, and management of personal affairs.
- 21 3. Continuous supervision for residents whose mental condition is such that their personal safety
22 requires such supervision.

23 **8.409.23 PROFESSIONAL PLANNING AND SUPERVISION OF MEAL SERVICE**

24 At least three meals a day, constituting a nutritionally adequate diet must be served in one or more dining
25 areas separate from the sleeping quarters. Tray service must be provided for clients temporarily unable to
26 leave their rooms.

27 If the facility accepts or retains clients in need of medically prescribed special diets, the menus for such
28 diets shall be planned by a professionally qualified dietitian, or must be reviewed and approved by the
29 attending physician. The facility must provide supervision of the preparation and serving of the meals and
30 their acceptance by clients.

31 **8.409.24 ANCILLARY PERSONNEL**

32 Authorized subsidiary personnel performing duties in support of professional health care services include:

- 33 1. Nurse aides
- 34 2. Dietary
- 35 3. Housekeeping and maintenance

1 To assure the provision of adequate nursing services, each intermediate nursing care facility must
2 provide sufficient:

- 3 1. Numbers and categories of personnel, as determined by the number of clients in the facility and
4 their particular nursing care needs. This determination is made in accordance with accepted
5 policies of effective nursing care and with these [guidelinesregulations](#).
- 6 2. Nursing and auxiliary personnel are employed and assigned to duties on the basis of their
7 qualifications or experience to perform designated duties.
- 8 3. Bedside care under direction of the client's physician in the presence of minor illness and for
9 temporary periods to include nursing service provided by, or supervised by, a professional nurse
10 or licensed practical nurse.

11 An intermediate care facility may, at its option, secure the services of a pharmacy consultant. If such
12 facility takes this option, the provisions of rule item 2- are applicable.

13 **8.409.3 CLINICAL RECORDS**

14 **8.409.31 MAINTENANCE**

15 The following records, as a minimum, must be kept current, dated and signed, and must be made
16 available for review if applicable:

- 17 1. Identification and summary sheets.
- 18 2. Hospital discharge summary sheet.
- 19 3. Medical evaluation and treatment plan.
- 20 4. Physician's orders.
- 21 5. Physician's progress notes.
- 22 6. Nurse's progress notes.
- 23 7. Medication and treatment record.
- 24 8. Laboratory and X-ray reports.
- 25 9. Consultation reports.
- 26 10. Dental reports.
- 27 11. Social Service notes.
- 28 12. Pharmacy Consultant's notes.

29 **8.409.32 RETENTION OF RECORDS**

- 30 1. Files retained at least six (6) years. (Before destruction of records, however, the nursing home's
31 legal counsel should be consulted.)

- 1 2. In the event that a patient is transferred to another health facility, certain transfer information
2 should be incorporated in a record to accompany the patient. This information should include:
 - 3 a. A transfer form of diagnosis;
 - 4 b. Aid to daily living information;
 - 5 c. Transfer orders;
 - 6 d. Nursing care plan;
 - 7 e. Physician's orders for care.

8 **8.409.33 CONFIDENTIALITY OF RECORDS**

- 9 1. Disclosed only to authorized persons.
- 10 2. Form APA 4, "Authorization for Release of Medical Information" shall be executed in duplicate
11 (original to the nursing home medical record with a copy to the county department) at the time of
12 admission. This form must be signed by the client, or the client's designated representative,
13 parent (if a minor), guardian, or other legally responsible person.

14 **8.409.34 RECORDS ADMINISTRATOR**

15 It is recommended that the Intermediate Health Care Facility have available:

- 16 1. A consultant who is a registered records administrator, or a person who is accredited as a
17 records technician.
- 18 2. An employee who is trained or is receiving training in medical records management for
19 accreditation as a records technician or a registered records administrator.

20 **8.409.4 MEDICAL BASIS FOR CARE - INTERMEDIATE NURSING CARE**

21 Eligible clients may be admitted to approved facilities only upon the certification of a physician licensed to
22 practice in Colorado that there is a functional need for such admission. The client's freedom of choice of
23 physician shall be respected. Health care of the client must continue under the supervision of a physician.
24 The facility must have a physician available for necessary medical care in case of emergency.

25 **8.409.41 PHYSICIANS' INVOLVEMENT**

26 **8.409.42 DETERMINATION FOR INTERMEDIATE NURSING CARE**

27 The medical need of a client for Intermediate Nursing Care shall be delineated in the plan of treatment
28 and substantiating orders written by the physician and by the performance of the necessary Intermediate
29 nursing services implementing such plans and orders.

30 Upon admission to an Intermediate Nursing Care Facility, the facility must obtain for the medical record of
31 each such client:

- 32 1. A summary of the course of treatment by the attending physician or which was followed in the
33 hospital, the diagnosis(es) and current medical findings, and the rehabilitation potential.

- 1 2. An evaluation by the physician. Physical examination must be accomplished within 48 hours of
 2 admission and recorded, unless such an examination has been accomplished within five days
 3 prior to admission to the Intermediate Nursing Care Facility.
- 4 3. Physician's Orders. Orders must be written for the immediate care of the client. These may be
 5 written by the attending physician or by the physician who has the responsibility for emergency
 6 care in this facility. The current hospital summary of the course of treatment, with orders used, is
 7 acceptable as emergency orders.
- 8 4. The physician's treatment plan. The plan must be written and must be directed towards
 9 maintaining the health status of the client, preventing further deterioration of the physical well-
 10 being of the client, and preparing the client for normal noninstitutional life. The plan must be
 11 reviewed consistent with the continuing professional care by the physician, and revised as
 12 necessary, and must include medication and treatment orders which will be in effect for the
 13 specified number of days indicated by the physician. This period shall not exceed ninety (90)
 14 days unless reordered in writing by the physician. Telephone orders may be accepted by licensed
 15 nurses, but must be written into the clinical record by the receiving nurse. These orders must be
 16 countersigned by the ordering physician within 48 hours. The medical necessity for a physician's
 17 visit, at least once every quarter, must be evidenced in the clinical record by a valid signed entry.
- 18 5. Plan for Emergency Care. Each Intermediate Nursing Care Facility must provide for one, or more,
 19 physicians to be available to furnish emergency medical care, or surgical procedures, if the
 20 attending physician is not immediately available. A schedule listing the name, telephone number,
 21 and days on call for a given physician will be posted at each nursing station. An RPN or LPN
 22 must be on call (for availability to handle emergencies; to contact the physician, receive orders or
 23 medications) for all shifts other than the day shift. The Intermediate Nursing Care Facility must
 24 also establish procedures which will be followed in the emergency care of the client, the persons
 25 to be notified, and the reports to be prepared.

26 **8.409.43 PHYSICIANS' INVOLVEMENT REDETERMINATION FOR INTERMEDIATE NURSING**
 27 **CARE**

28 The medical need of the client for Intermediate Nursing Care shall be redetermined every six months or at
 29 the time of the physician's required quarterly visit if the client's condition has changed.

30 The term "substantial change" does not encompass short-term treatment regimens for temporary illness,
 31 adjustments to prescribed medications when the frequency and dosage is not affected, or changes to be
 32 in effect for less than a thirty (30) day period.

33 **8.409.5 MEDICAL REVIEW AND MEDICAL INSPECTION - INTERMEDIATE CARE NURSING**
 34 **CLIENTS**

35 Medical review of the treatment of all clients in intermediate nursing care facilities who are entitled to
 36 medical assistance will be accomplished annually.

37 **8.409.51 MEDICAL REVIEW TEAM**

38 **8.409.52 COMPOSITION AND MEMBERSHIP REQUIREMENTS**

39 The medical review team for intermediate nursing clients shall be composed of one or more nurses and
 40 other appropriate health and social service personnel as indicated and will function under the supervision
 41 of a physician.

1 No member of the team may be employed by or have financial interest in any nursing home. No physician
2 member of a team may inspect the care of patients for whom he is the attending physician.

3 **8.409.53 FUNCTION - MEDICAL REVIEW AND EVALUATION**

4 1. The medical treatment of intermediate nursing facility clients entitled to medical assistance shall
5 be reviewed at least annually.

6 2. Annual review consists of an evaluation of the treatment, utilizing the medical record and physical
7 contact with, and observation of, each client in the nursing facility surroundings. This review, at a
8 minimum, will elicit:

9 a. Medical necessity for visit by attending physician at least once every calendar quarter.

10 b. Adequacy in quality and quantity as well as the timeliness of treatment to meet health
11 needs.

12 c. Adherence to the written physician's treatment plan.

13 d. Review of prescribed medications by the attending physician at least every ninety (90)
14 days during the necessary client visit.

15 e. Tests, or observations of clients, indicated by their medication regimen have been made
16 at appropriate times and properly recorded.

17 f. Physician, nurse, and other professional staff progress notes are made as required, and
18 appear to be consistent with observed condition of the client.

19 g. Adequate services are being rendered to each client as shown by such observations as
20 cleanliness, absence of decubiti, absence of signs of malnutrition or dehydration, and
21 apparent maintenance of optimal physical, mental, and psychosocial function.

22 h. Client's need for any service not available in, or actually being furnished by the particular
23 facility, or through arrangements with others.

24 i. Each client actually needs continued placement in the facility, or there is an appropriate
25 plan to transfer the client to an alternate method of care.

26 **8.409.54 REPORTS**

27 1. Review reports of care in each facility are submitted to the Department.

28 a. After review copies are forwarded to:

29 1) The intermediate care facility.

30 2) The intermediate care facility Utilization Review Committee.

31 3) [Colorado Department of Public Health and Environment CDPHE](#).

32 2. Reports will cover observations, conclusions, and recommendations with respect to adequacy
33 and quality of client services in the facility, and of physician services to clients in the facility. They
34 will also cover specific findings with respect to individual clients and any recommendations
35 resulting therefrom.

1 **8.409.55 STATE DEPARTMENT ACTION**

2 1. Reports submitted as a result of Medical Review may result in decisions to reclassify clients into a
3 different level of care, or recommendations for modification of treatment.

4 Such decisions or recommendations will be transmitted as appropriate to the:

- 5 a. Attending physician.
- 6 b. Administration of the Intermediate Nursing Care Facility.
- 7 c. County department responsible for the client.

8 2. Changes in classification recommended will be effected prior to the next billing period.

9 **8.409.56 REVIEW OF STATE DEPARTMENT ACTION**

10 Disagreements with the decisions and recommendations of the Review Team may be adjudicated
11 through the Administrative Review mechanism of the Department; however, the Division of Medical
12 Services will retain the right to final decision.

13 **8.415 ROLE OF COUNTIES AND NURSING FACILITIES**

14 **.10 ROLE OF THE COUNTY DEPARTMENT OF SOCIAL/HUMAN SERVICE STAFF IN NURSING**
15 **FACILITY PLACEMENTS**

16 The County Department of Social/Human Services shall be responsible for the following in all nursing
17 facility placements involving either clients of medical assistance or applicants for assistance:

- 18 A. The determination of existing or potential eligibility for medical assistance.
- 19 B. The referral, whenever possible, of all Medicaid eligible clients/applicants who are eligible for
20 Medicare benefits to facilities certified for participation in the Medicare Program.
- 21 C. In those instances in which an individual residing in a nursing facility under some method of
22 reimbursement other than Medicaid makes application for medical assistance, the county must
23 provide notice of the application referral date to both the nursing facility and the Utilization Review
24 Contractor.
 - 25 1. Such notice must be provided verbally to both the facility and the Utilization Review
26 Contractor within two (2) working days of the application referral date.
 - 27 2. Written notice must be mailed to the facility within five (5) working days.
 - 28 3. Such notice is critical to the timely conduct of admission review by the Utilization Review
29 Contractor.
- 30 D. In those instances where eligibility is determined to be effective three months prior to the date of
31 application pursuant to Department rules and regulations, the County Department of
32 Social/Human Services shall notify the nursing facility of this circumstance in writing.

33 This should be written in the area reserved for comments in Section VI(5) of the Form AP-5615.
34 Similar verbal or written notice must be given or mailed to the Utilization Review Contractor,
35 utilizing a format as determined by the Department.

1 .11 The Form AP-5615 is intended as a method for communicating the status of a resident or
 2 applicant, or actions which change that status, between nursing facility, the County Department of
 3 Social/Human Services, and the Department. Examples of such actions are admission,
 4 discharge, readmission, death or changes in resident income. Failure to complete the AP-5615,
 5 or to properly verify information reported thereon in a timely fashion, results in inappropriate
 6 reimbursement to nursing facilities, inequitable assistance payments, and the loss of
 7 documentation necessary for Department field audit staff. Upon receipt of Form AP-5615, the
 8 County Department of Social/Human Services shall be responsible for the following.

- 9 A. Verify, correct, and complete, when necessary, the client/applicant's name, State ID
 10 number, and all other identifying data:
- 11 B. Verify client/applicant income. Such verification must occur on a regular basis. All income
 12 of the client which is in excess of the amount reserved for personal needs allowance, less
 13 earned income (if appropriate), less spousal and dependent care allowance, and less
 14 home maintenance allowance, and less allowable expenses for medical and remedial
 15 care (see PETI deductions as defined in Medical Assistance Staff Manual § 8.110.49
 16 and 8.482.33 10 CCR 2505-10 sections 8.100.7.T and 8.482.33), must be applied by the
 17 client/applicant toward his/her care. Changes in income must be reflected in submission
 18 of a new eligibility reporting form and a new AP-5615.
- 19 C. Verify client payment. This amount must be calculated by per diem appropriately in all
 20 months for which Medicaid reimbursement covers less than a full month's care.
- 21 1. Client payment may be waived and zero (-0-) client payment applied only under
 22 the conditions as defined in §8.483.34, D., 10 CCR 2505-10 section 8.10 CCR
 23 2505-10 section 8.483.34.D.1.
- 24 2. Client payment may not be waived (other than for the exceptions provided for in
 25 §8.415.11, C., 10 CCR 2505-10 section 8.10 CCR 2505-10 section
 26 8.415.11.C.1), in the instances as defined in §8.482.34, D., 2.10 CCR 2505-
 27 10 section 8.10 CCR 2505-10 section 8.482.34.D.2.
- 28 3. When client payment is calculated by per diem, the amount shown on the AP-
 29 5615 will be that amount to be paid by the resident, rather than the amount to be
 30 calculated by per diem calculation.
- 31 4. Corrections to income or client payment shall be initialed and dated by the
 32 income maintenance technician from the County Department of Social/Human
 33 Services.
- 34 D. Review the date of action, such as admission, readmission, discharge, death, or change
 35 in client payment being reported and verify as necessary;
- 36 E. Indicate approval or denial of action being reported and effective date of that approval or
 37 denial; and
- 38 F. Sign and date all copies, and distribute in accordance with instructions on the reverse
 39 side of page three of the AP-5615 form.

40 **8.415.20 RESPONSIBILITY OF THE NURSING FACILITY IN NURSING FACILITY**
 41 **PLACEMENTS**

1 These rules set forth the administrative procedures which must be followed by all facilities participating in
 2 the Medical Assistance Nursing Facility Program. Failure of the facility to meet the requirements set forth
 3 herein shall cause the facility to be denied reimbursement.

4 A. Admission

5 When an admission to the nursing facility is proposed, it is the responsibility of the nursing facility
 6 to:

- 7 1. Determine, prior to an applicant's admission, whether or not the individual is a client of
 8 medical assistance or has made application for medical assistance;
- 9 2. Complete the ULTC 100.2 prior to or ~~on~~ on the day of admission. Based on this
 10 information, the Utilization Review Contractor will determine the level of care and assign
 11 an initial length-of-stay.

12 **8.415.21**

13 3. For purposes of this regulation, admission is defined as

- 14 a. any new admission; or
- 15 b. any change from other sources of reimbursement to the Medical Assistance
 16 Program.

17 B. Changes in Resident Status

18 Form AP-5615 shall be used by the nursing facility to notify the County Department of the current
 19 or changed status of all clients and applicants residing within the nursing facility.

- 20 1. The nursing facility shall initiate Form AP-5615 (in accordance with instructions on the
 21 reverse side), for all admissions, readmissions, transfers from private pay or Medicare,
 22 discharges, deaths, changes in client pay, and leaves of absence; and shall submit three
 23 (3) copies to the responsible county.
- 24 2. The nursing facility is solely responsible for collecting the correct amount of client
 25 payment due from the resident, his family, or representatives. Failure to collect client pay,
 26 in whole or in part, shall not allow the nursing facility to bill the Medical Assistance
 27 Program for the uncollected client payment.
- 28 3. The county department may initiate the AP-5615 when appropriate, which may include,
 29 but is not limited to, changes in resident income of which the county becomes aware.

30 C. Transfer and Discharge

31 The nursing facility must determine that all requirements for an orderly transfer or discharge are
 32 met before relinquishing their responsibility to the resident. This is necessary in order to assure
 33 continuity of total care. Therefore, the nursing facility is responsible for following the procedures
 34 as outlined at section ~~25-1-120, C.R.S.C.R.S. section 25-1-120~~ et. seq., entitled "Nursing and
 35 intermediate care facilities - rights of patients", including the section on grievance procedures.

36 **8.420 REQUIREMENTS AND PROVISIONS FOR PARTICIPATION BY COLORADO NURSING**
 37 **FACILITIES**

1 In order to receive vendor payments from the State Department for care of assistance recipients, a
 2 nursing facility must enter into a provider agreement with the Department, in such form as the Department
 3 prescribes. For the purposes of this section, the term "nursing facility" includes an intermediate care
 4 ~~facility for the mentally retarded individuals with an intellectual or developmental disability facility for~~
 5 ~~individuals with intellectual disabilities~~ (ICF/MR/ICF/IID). The facility's provider agreement with the
 6 Department carries with it the responsibility of said nursing facility to subscribe to the terms and
 7 conditions for payment of care to recipients promulgated by the Colorado Medical Services Board in its
 8 rules and regulations set forth in this staff manual. Such nursing facilities also must adhere to all pertinent
 9 requirements of federal and state law, and to the rules, regulations, and requirements as prescribed by
 10 ~~the Colorado Department of Public Health and Environment (CDPHE)~~ in its minimum standards for
 11 nursing facilities. This means that the nursing facility must be duly and appropriately licensed, provide for
 12 the use of qualified staff and the provision of nursing care, and adhere to those regulations with respect to
 13 the number and qualifications of nursing personnel required by ~~the~~ CDPHE in giving services to recipient
 14 patients.

15 All nursing facilities are required, as a condition for both initial and continuing participation, to comply with
 16 the provisions of Section 601 of Title VI of the Civil Rights Act of 1964. Annual on-site inspections for
 17 assurance of compliance will be made by ~~the CDPHE~~ Colorado Department of Public Health and
 18 Environment.

19 In addition, the nursing facility is required to maintain proper accounting of the personal needs funds of
 20 recipients as provided in 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.482.5.

21 Participation in the Colorado Medicaid program of nursing facilities and/or nursing facility beds is limited
 22 to the regulations ~~found in this manual entitled LIMITATIONS ON THE NUMBER OF NURSING~~
 23 ~~FACILITY BEDS ENROLLED IN THE COLORADO MEDICAID PROGRAM~~ at 10 CCR 2505-10 sections
 24 8.430 et seq.

25 **8.421 RESPONSIBILITY OF COUNTY DEPARTMENT CONCERNING PARTICIPATION**

26 It shall be the responsibility of each county department to inform the State Department whenever it is
 27 aware that:

28 A licensed nursing home has permanently discontinued or decreased the qualified nursing service under
 29 which it was licensed.

30 Any person is operating an unlicensed nursing home or violating terms of license for a nursing home in
 31 which there are three or more recipients not related to the owner, and is providing any nursing service in
 32 an unlicensed home or one with a limited license to such recipients in addition to board and room
 33 services.

34 Any other condition exists which operates to the detriment of the patients in the home. This would include
 35 observation by the county department of such things as uncleanliness, poor or inadequate food, safety
 36 hazards, overcrowding, poor or inhumane treatment of patients, etc.

37 **8.422 VISITS TO RECIPIENTS BY SOCIAL SERVICES PERSONNEL, PRIVACY FOR** 38 **CONFERENCES WITH RECIPIENTS**

39 In order to maintain continuing eligibility to recipients, to provide necessary services to recipients, and to
 40 conduct other official business pertaining to nursing home payment, the nursing home is required to admit
 41 duly authorized representatives of the Colorado Department of Human Services ~~State~~ or County
 42 ~~Departments~~ of Social/Human Services at any reasonable time. Social Services personnel shall be
 43 afforded privacy for conferences with nursing home recipient ~~patients~~. All such information is considered
 44 in terms of the rules contained in the Income Maintenance Manual.

1 **8.423 VISITS TO RECIPIENTS BY THE COLORADO LONG TERM CARE OMBUDSMAN AND**
2 **DESIGNATED REPRESENTATIVES**

3 A. Definitions:

4 Designated Representatives - are persons who have been specifically appointed by the Colorado
5 Ombudsman to be an official part of the statewide ombudsman program.

6 Such designated representatives shall receive a minimum of twenty (20) hours of training using
7 the manual provided by the Colorado Long Term Care Ombudsman Program as well as other
8 materials. Included in this training shall be material regarding the rights of patients and
9 specifically procedures which protect the confidentiality of information regarding Medicaid
10 patients.

11 Official Colorado Ombudsman Program - the agency which has received the Ombudsman grant
12 from the Older Americans Act through the Colorado Department of [Social-Human](#) Services is for
13 purposes of this regulation considered to be the official State Ombudsman Program.

14 B. The Colorado Ombudsman and designated representatives shall have access to the physical
15 premises of nursing home facilities and the Medicaid residents of these facilities. Visits to the
16 nursing home should be during reasonable hours except in instances where the nature of a
17 complaint investigation requires visitation during off hours.

18 All designated representatives (after they have completed the necessary training) will be provided
19 with identification showing them to be a part of the State Ombudsman Program. Under normal
20 circumstances such identifications will be presented to the nursing home administrator or person
21 in charge during the administrator's absence.

22 C. The Colorado Ombudsman or designees shall only disclose information received from a Medicaid
23 patient's records and/or files when:

- 24 1. The Ombudsman authorizes the disclosure and
- 25 2. In cases of identifying a patient, the patient or the legal representative of the patient must
26 consent in writing to the disclosure and specify to whom the identity may be disclosed or
- 27 3. A court orders the disclosure.

28 D. Non-compliance with the provisions of this section of the regulation will not be considered
29 sufficient good cause as defined in [10 CCR 2505-10 section 8.130.4](#). ~~the section of this manual~~
30 ~~called STANDARDS FOR DENIAL, TERMINATION, AND NON-RENEWAL OF PROVIDER~~
31 ~~AGREEMENTS.~~

32 **8.424 PERIODIC VISITS - NURSING HOME RECORDS TO BE MADE AVAILABLE**

33 Members of the Department of Health and Human Services, the staff of the State Department of [Social](#)
34 [Human](#) Services or specialized staff acting as agents of said Department or members of the Medicaid
35 Fraud Control Unit, will make periodic visits to nursing homes for purposes of determining compliance of
36 nursing homes with the rules set forth concerning nursing home care to Medicaid recipients, for purposes
37 concerned with the appropriate rate to be paid for care of recipients under applicable rules, and such
38 other purposes as may be related to administration of the Colorado Medical Assistance Program.

1 All medical records and documents related to the above purposes of visits by the staff members
2 mentioned shall promptly be made available in Colorado to such persons by the nursing facility
3 administrator or his delegated alternate.

4 "Closing" audits also are to be made at the point of impending change of ownership of a nursing facility in
5 order to determine whether payment adjustments are necessary with respect to continuing payment to
6 the new owner or such adjustments in payments, recoveries, etc., covering former owners or sellers.

7 **8.425 Repealed, effective June 30, 2005**

8 **8.430 MEDICAID CERTIFICATION OF NEW NURSING FACILITIES OR ADDITIONAL BEDS**

9 **8.430.1 DEFINITIONS**

10 Action means denial or approval of the application or request for additional information regarding
11 an application.

12 Existing Colorado Nursing Facility means any nursing facility continuously licensed in Colorado
13 for a period of at least 30 days prior to the date of application and which meets state and federal
14 requirements.

15 Licensed Bed Capacity means the licensed bed capacity of a nursing facility on file with ~~the~~
16 [CDPHE Colorado Department of Public Health and Environment](#).

17 New Nursing Facility means any nursing facility not licensed as a Colorado nursing facility as of
18 the date of application or any nursing facility, which for a period of 30 or more days subsequent to
19 the date of application, has not been licensed as a Colorado nursing facility.

20 **8.430.2 APPLICABILITY**

21 8.430.2.A. ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10 10 CCR 2505-10 section~~
22 ~~8.430~~ applies to all nursing facilities except:

- 23 1. A nursing facility change of ownership or placement into receivership if the
24 ownership change or receivership action involves no increase to its previously
25 approved Medicaid bed total.
- 26 2. A nursing facility exclusively serving the developmentally disabled (intermediate
27 care ~~facility for the mentally retarded individuals with an intellectual or~~
28 ~~developmental disability~~ [facility for individuals with intellectual disabilities](#) and
29 home and community based services for the developmentally disabled group
30 homes).
- 31 3. A replacement facility for existing residents in a facility owned/operated by the
32 applicant. Approval for the beds shall only be granted if:
- 33 a. The applicant clearly documents that the old structure was substantially
34 inadequate to efficiently and effectively promote quality of care for the
35 residents.
- 36 b. The replacement facility is located no more than five miles from the
37 original facility.

- 1 c. The number of beds in the replacement facility is limited to the original
2 number of Medicaid-certified beds being replaced.
- 3 d. Residents living in the original facility at the time it is closed are given the
4 right of first refusal for beds in the replacement facility.

5 8.430.3 NEW NURSING FACILITY CERTIFICATION

6 8.430.3.A. Procedures and Criteria for Medicaid Certification of a New Nursing Facility

- 7 1. The burden of demonstrating the need for a new Medicaid facility shall be entirely
8 on the applicant.
- 9 2. The applicant for Medicaid certification of a new nursing facility shall:
- 10 a. File a letter of intent to apply for certification with the Department in
11 January or July of the year in which the application will be filed. The letter
12 of intent shall specify:
- 13 i) The person or corporation who will submit the application.
- 14 ii) The proposed service area.
- 15 iii) The number of beds in the new facility for which Medicaid
16 approval will be requested.
- 17 b. No later than five months from the date of filing the letter of intent, the
18 applicant shall submit a complete application. The application shall
19 include:
- 20 i) The name, address and phone number of the person or
21 corporation requesting approval for the new nursing facility.
- 22 ii) The total number of proposed beds and the number of beds
23 requested for Medicaid certification.
- 24 iii) A description of the service area and justification that the service
25 area can be reasonably served by the new nursing facility.
- 26 iv) If construction of the additional beds or the new nursing facility
27 has not been completed by the date the application is filed, the
28 following documentation shall also be provided:
- 29 1) Official written documentation showing ownership of the
30 proposed new nursing facility.
- 31 2) Location of the proposed new nursing facility including
32 documentation of ownership, lease or option to buy the
33 land.
- 34
- 35 3) Documentation from a financial institution regarding
36 financing support for the new nursing facility.

- 1 4) Complete, written documentation that preliminary
2 architectural plans for the proposed new nursing facility
3 have been submitted to ~~the CDPHE~~
4 [Colorado Department of Public Health and Environment](#).
- 5 5) Expected completion date of the new nursing facility.
- 6 v) A statement regarding any previous contracts with or enrollment
7 in any state's Medicaid program. The statement shall assure that
8 the applicant has never been found guilty of fraud or been
9 decertified from participation in the Medicaid program in
10 Colorado or any other state.
- 11 3. A completed application shall be made available on the Department's Internet
12 website for public review and comment. In addition, the applicant shall provide
13 newspaper notice at the applicant's expense, that the application has been
14 submitted. A public hearing on the application may be conducted.
- 15 4. As a condition of approval, the new provider may be required to execute an
16 appropriate performance agreement.
- 17 5. Approval or denial of an application for Medicaid certification of a new nursing
18 facility shall be based on the following information from the applicant:
 - 19 a. Planned resident capacity and payer mix.
 - 20 b. Planned differentiation of the proposed new facility from existing nursing
21 facilities in the same service area (e.g., new models of care, special
22 programs, or targeted populations).
 - 23 c. The applicant's marketing plan, including planned communications and
24 presentations to discharge personnel and placement agencies.
 - 25 d. Demographic analysis of the applicant's designated service area,
26 including a market analysis of other available long-term care services,
27 e.g., assisted living, home health, home and community based services,
28 etc., and the extent to which such alternative services are utilized.
 - 29 e. Projections of net patient revenue and operating costs.
 - 30 f. Audited financial statements for the most recently closed fiscal year for
31 the entity seeking Medicaid certification.
 - 32 g. Additional financial, market or programmatic information requested by
33 the Department within two months after the application date;
 - 34 h. Historical information concerning the quality of care and survey
35 compliance in other nursing facilities owned or managed by the applicant
36 or a related entity or individual.
 - 37 i. A statement assuring cooperation with de-institutionalization and
38 community placement efforts.

- 1 j. Documentation of whether the proposed new facility provides needed
2 beds to an underserved geographical area, as described in [10-CCR](#)
3 [2505-10 section 8-10 CCR 2505-10 section 8.430.3.A.5.j.i](#)), or to an
4 underserved special population, as described in [10-CCR-2505-10 section](#)
5 [8-10 CCR 2505-10 section 8.430.3.A.5.j.ii](#)).
- 6 i) To qualify as an underserved geographical area of the state, the
7 application must demonstrate, with appropriate documentation, that:
- 8 1) The new nursing facility is located in the service area defined by the application.
9 The service area shall be no more than two contiguous counties in the state.
- 10 2) The service area shall have a nursing facility bed to population ratio of less than
11 40 beds per 1,000 persons over the age of 75 years.
- 12 a) The population projections shall be based upon statistics issued by the
13 State Department of Local Affairs.
- 14 b) The applicable statistics for applications involving beds for which
15 construction is complete at the time of application shall be the population
16 statistics for the period including the date on which the application is
17 filed.
- 18 c) The applicable statistics for applications involving beds for which
19 construction is not complete at the time of application shall be the
20 population projections for the expected date of completion of the beds
21 set forth in the application.
- 22 3) The occupancy of existing nursing facilities in the proposed service area exceeds
23 ninety percent (90%) for the six (6) months preceding the filing date of the
24 application, as demonstrated by the nursing facility quarterly census statistics
25 maintained by [the CDPHE Colorado Department of Public Health and](#)
26 [Environment](#).
- 27 ii) An application for a new nursing facility to serve an
28 underserved special population shall contain the
29 following information and documentation:
- 30 1) A description of the special populations to be served and
31 why they cannot be served in the community.
- 32 2) Justification for the service area to be served.
- 33 3) A determination of whether there are existing excess
34 beds in the proposed service area and, if so, why the
35 existing excess beds cannot be used by or converted for
36 use by the special populations.
- 37 a) The determination of existing excess beds shall include a population
38 ratio analysis and occupancy analysis as set forth in [10-CCR-2505-10](#)
39 [section 8-10 CCR 2505-10 section 8.430.3.A.5.j.i](#)), and shall be
40 calculated by utilizing the formulas, methods and statistics set forth
41 therein.

- 1 b) The justification of why existing excess beds cannot be used for or
2 converted for use by the special populations(s) must be clearly
3 demonstrated and supported by relevant and competent evidence.
- 4 4) Applications based on underserved special populations must document that one
5 or more of the following special populations is underserved in the proposed
6 service area:
- 7 a) Clients with AIDS.
- 8 b) Clients with mental or developmental disabilities, as defined by the
9 Preadmission Screening and Annual Resident Review
10 (PASARRPASRR) process described at [10 C.C.R. CCR 2505-10,](#)
11 [Section 8.10 CCR 2505-10 section 8.401.18 et seq.](#)
- 12 c) Clients with a traumatic head injury.
- 13 d) Clients who have been certified for a hospital level of care in accordance
14 with [10 C.C.R. CCR 2505-10, Section 8.10 CCR 2505-10 section 8.470.](#)
- 15 5) The following requirements also apply to approval of new nursing facilities for
16 special populations:
- 17 a) The Statewide Utilization Review Contractor shall certify long-term care
18 prior authorization requests for Medicaid clients who are verified as
19 meeting the special populations definitions provided in [10 CCR 2505-10](#)
20 [Section 8.10 CCR 2505-10 section 8.430.3.A.5.j.ii.4.](#)
- 21 b) In the case of applications for approval of new nursing facilities for
22 mentally disabled populations, all restrictions concerning Medicaid
23 reimbursement described at [10 C.C.R. CCR 2505-10, Section 8.10 CCR](#)
24 [2505-10 section 8.401.41 et seq.](#), Guidelines for Institutions for Mental
25 Diseases (IMD's), shall apply.
- 26 6) A bed approved for a specific underserved special population shall not be used
27 for any other population, even if a Medicaid client occupying this type of bed is
28 discharged or experiences a change in physical condition which requires transfer
29 to a general skilled nursing unit bed.

30 **8.430.4 COMPLETION OF APPROVED BEDS**

- 31 8.430.4.A. Construction of approved beds shall adhere strictly to the specifications provided
32 in the application. A new application shall be submitted and shall be subject to the criteria
33 for approval in effect at the time of the new application when any of the following changes
34 apply to new beds for a new facility:
- 35 1. Person or corporation which has ownership.
- 36 2. The site upon which the new beds were built or will be constructed.
- 37 3. Proposed service area.
- 38 4. Condition under which approval of beds is requested.

1 8.430.4.B. The applicant shall complete the project within 30 months of the date of the
2 Department's approval of the application.

3 8.430.4.C. No extension beyond the 30 month period shall be considered unless completion
4 of the project is delayed for reasons beyond the applicant's control.

5 1. The following shall be considered reasons beyond the applicant's control:

6 a. Natural disasters.

7 b. Hazardous soil or water conditions documented by local authorities.

8 c. Fires or explosions at the construction site serious enough to
9 substantially delay the project.

10 2. The following shall not be considered beyond the applicant's control:

11 a. Lack of financing or changes in need for financing.

12 b. Delays due to litigation.

13 c. Construction delays (examples of construction delays which would not
14 be granted an extension: weather, management-labor problems,
15 subcontractor missed deadlines, permit or zoning variance problems).

16 8.430.4.D. Applicants who complete the project within the 30 month period or any extension
17 period shall be eligible for a Medicaid provider agreement provided the facility is
18 inspected on-site and found by [the CDPHE Colorado Department of Public Health and](#)
19 [Environment](#) to be in compliance with standards for licensure as a nursing facility and
20 certification for Medicaid participation.

21 8.430.4.E. When two or more applications for the same service area or special population
22 are received in the same application period the following conditions apply:

23 1. Upon request, each applicant shall submit the estimated per diem costs to be
24 incurred by the provider/developer over the first five (5) years of the project. The
25 applicant shall provide assurances that the per diem costs shall be sufficient to
26 meet all quality of care standards during this period. The application with the
27 lowest per diem costs shall be chosen for enrollment in the Medicaid program.

28 2. The rate to be paid for the new beds shall be based on the estimated per diem
29 costs for all costs not including registered nurses, licensed practical nurses and
30 nurses' aides for the five year period or the actual audited Medicaid rate during
31 the period, whichever is lower. Should the estimated per diem costs for
32 registered nurses, licensed practical nurses and nurses' aides be higher than the
33 estimate, these costs shall be subject to the actual audited Medicaid rate-setting
34 procedures. The rate to be paid to an existing provider is the per diem rate
35 approved by the Department for that facility.

36 **8.430.5 NOTIFICATION OF INCREASED OR DECREASED MEDICAID BEDS**

37 8.430.5.A. Beginning June 1, 2004, any existing Colorado nursing facility shall notify the
38 Department when it increases or decreases the number of certified Medicaid beds, i.e.,

1 when it converts some or all of its licensed non-Medicaid beds to or from general skilled
2 Medicaid nursing facility beds

3 8.430.5.B. The notification shall contain the following:

4 1. The prior number of Medicaid beds, the number of additional or decreased
5 Medicaid beds and the date effective.

6 2. The nursing facility's total licensed bed capacity, consisting of Medicaid-certified
7 beds and licensed non-Medicaid beds. A copy of the current facility license shall
8 be attached.

9 **8.435 ENFORCEMENT REMEDIES**

10 **8.435.1 DEFINITIONS**

11 Civil Money Penalty (CMP) means any penalty, fine or other sanction for a specific monetary amount that
12 is assessed or enforced by the Department for a Class I non-State-operated Medicaid-only Nursing
13 Facility or by the Centers for Medicare and Medicaid Services (CMS) for all other Class I nursing facilities.

14 Deficiency means a nursing facility's failure to meet a participation requirement specified in 42 C.F.R. Part
15 483 Subpart B-, ~~which is hereby incorporated by reference. The incorporation of 42 C.F.R. Part 483~~
16 ~~Subpart B excludes later amendments to, or editions of, the referenced material. The Department~~
17 ~~maintains copies of this incorporated text in its entirety, available for public inspection during regular~~
18 ~~business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street,~~
19 ~~Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request. No~~
20 ~~amendments or later editions are incorporated. Copies are available for inspection from the following~~
21 ~~person at the following address: Custodian of Records, Colorado Department of Health Care Policy and~~
22 ~~Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by~~
23 ~~reference in this rule may be examined at any state publications repository library.~~

24 Enforcement Action means the process of the Department imposing against a Class I non-State operated
25 Medicaid-only nursing facility one (or more) of the remedies for violation of federal requirements for
26 participation as a nursing facility enumerated in the Federal Omnibus Reconciliation Act of 1987, 1989,
27 and 1990, 42 U.S.C. 1396r(h),- ~~which is hereby incorporated by reference. The incorporation of 42~~
28 ~~U.S.C. 1396r(h) excludes later amendments to, or editions of, the referenced material. The Department~~
29 ~~maintains copies of this incorporated text in its entirety, available for public inspection during regular~~
30 ~~business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street,~~
31 ~~Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.~~

32 ~~No amendments or later editions are incorporated. Copies are available for inspection from the following~~
33 ~~person at the following address: Custodian of Records, Colorado Department of Health Care Policy and~~
34 ~~Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by~~
35 ~~reference in this rule may be examined at any state publications repository library.~~

36 ~~Nursing Facility Culture Change Accountability Board~~Nursing Home Innovations Grant Board means a
37 board authorized by ~~25-1-107.5 C.R.S. (2009)~~C.R.S. section 25-1-107.5 (2013) to distribute funds from
38 the nursing home penalty cash fund for measures that will benefit residents of nursing facilities by
39 improving their quality of life at the facilities.

40 Grantee means a recipient of funds from the Nursing Home Penalty Cash Fund for measures that will
41 benefit residents of nursing facilities by improving their quality of life as specified in ~~10 CCR 2505-10~~
42 ~~Section 8-10 CCR 2505-10 section 8.435.2.E.4.b.~~

1 Immediate Jeopardy means a situation in which the nursing facility's non-compliance with one or more
 2 requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death
 3 to a resident.

4 Medicaid-Only Nursing Facility means a nursing facility that is reimbursed by Medicaid, but not Medicare.

5 Nursing Home Penalty Cash Fund means the account that contains the money collected from CMPs
 6 imposed by the Department and also the amount transmitted by CMS from CMPs imposed by CMS. CMS
 7 computes the amount to be transmitted, the Medicaid portion, by applying the percentage of Medicaid
 8 clients in the nursing facility to the total CMP amount.

9 **8.435.2 GENERAL PROVISIONS**

10 8.435.2.A. The Department enforces remedies for Class I Non-State-Operated Medicaid-Only
 11 Nursing Facilities and CMS enforces remedies for all other Class I nursing facilities, pursuant to
 12 42 C.F.R. [section](#) 488.330. Class I nursing facilities are subject to one or more of the following
 13 remedies when found to be in substantial non-compliance with program requirements:

- 14 1. Termination of the Medicaid provider agreement.
- 15 2. CMP.
- 16 3. Denial of payment for new admissions of Medicaid clients.
- 17 4. Temporary management.
- 18 5. Transfer of residents.
- 19 6. Transfer of residents in conjunction with facility closure.

20 7. The following three remedies with imposition delegated to [the Department of Public](#)
 21 [Health and Environment \(CDPHE\[JM7\]\)](#):

- 22 a. State monitoring.
- 23 b. Directed plan of correction.
- 24 c. Directed in-service training.

25 8.435.2.B. The following factors shall be considered by the Department in determining what remedy
 26 will be imposed on the Class I non-State-operated Medicaid-only nursing facility:

- 27 1. The scope and severity of the Deficiency(ies).
- 28 2. The most serious Deficiency in relationship to other cited Deficiencies.
- 29 3. The nursing facility's past Deficiencies and willingness to become compliant with program
 30 rules and regulations.
- 31 4. The recommendation of [CDPHE](#) pursuant to [Section 25-1-107.5, C.R.S.](#)
 32 [C.R.S. section 25-1-107.5](#).
- 33 5. The requirements and guidelines for selecting remedies in 42 C.F.R. [sSections 488.408-](#)
 34 [414, which are hereby incorporated by reference. The incorporation of 42 C.F.R.](#)

sections 488.408-414 excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.~~No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.~~

8.435.2.C. Enforcement Guidelines for Class I Non-State-Operated Medicaid-Only Nursing Facilities

1. At the Department's discretion, nursing facilities may be given an opportunity to correct Deficiencies before remedies are imposed or recommended for imposition except as stated below.
2. Nursing facilities shall not be given the opportunity to correct Deficiencies prior to a remedy being imposed or recommended for imposition under the following:
 - a. Nursing facilities with Deficiencies of actual harm or of greater severity on the current survey, and
 - i) Deficiencies of actual harm or of greater severity on the previous standard survey, or
 - ii) Deficiencies of actual harm or of greater severity on any type of survey between the current survey and the last standard survey.
 - b. Nursing facilities, previously terminated, with Deficiencies of actual harm or of greater severity on the first survey after re-entry into the Medicaid program.
 - c. Nursing facilities for which a determination of Immediate Jeopardy is made during the course of a survey.
 - d. Nursing facilities with a per instance CMP imposed due to non-compliance.
3. The Class I non-State-operated Medicaid-only nursing facility shall be notified of any adverse action and may appeal these actions pursuant to ~~40 C.C.R. CCR 2505-10, Ssection 8-10 CCR 2505-10 section 8.050.~~
 - a. Advance notice for state monitoring is not required.
 - b. The advance notice requirement for other remedies is two days when Immediate Jeopardy exists and 15 days in other situations, with the exception of CMP.
 - c. The notice requirement for CMP is in accordance with 42 C.F.R. ~~Ssections~~ 488.434 and 488.440, which are hereby incorporated by reference. The incorporation of 42 C.F.R. sections 488.434 and 488.440 excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.~~No~~

~~amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.~~

8.435.2.D. Enforcement Actions

1. Termination of the Medicaid provider agreement:

- a. Shall be effective within 23 days after the last day of the survey if the nursing facility has not removed the Immediate Jeopardy as determined by [CDPHE](#).
- b. May be rescinded by the Department when [CDPHE](#) notifies the Department that an Immediate Jeopardy is removed.

2. Denial of payment for new Medicaid admissions shall end on the date [CDPHE](#) finds the nursing facility to be in substantial compliance with all participation requirements.

3. CMP

- a. CMP amounts range in \$50 increments from \$50-\$3,000 per day for Deficiencies that do not constitute immediate jeopardy, but either caused actual harm or caused no actual harm with the potential for more than minimal harm, and from \$3,050 to \$10,000 per day for Deficiencies constituting immediate jeopardy, or \$1,000 to \$10,000 per instance as recommended by [CDPHE](#).
- b. CMPs are effective on the date the non-compliance began.
- c. If the nursing facility waives its right to an appeal in writing within 60 calendar days from the date the CMP is imposed, the CMP shall be reduced by 35%, notwithstanding the provisions of [10 C.C.R. 2505-10, Section 2505-10 section 8.10 CCR 2505-10 section 8.050](#).
- d. The CMP shall be submitted to the Department by check or subsequent Medicaid payment to the provider shall be withheld until the CMP is satisfied.
- e. Upon notice to the Department of change in ownership or intent to terminate the Medicaid agreement, the Department shall withhold all Medicaid payments to satisfy any CMP that has not been paid in full.
- f. Payment of CMP shall not be an allowable cost on the nursing facility's annual Med-13 cost reports as described in [10 C.C.R. CCR 2505-10, Section 8.10 CCR 2505-10 section 8.441](#).

8.435.2.E. Nursing Home Penalty Cash Fund

1. All CMPs collected from non-State-operated Medicaid-only nursing facilities shall be transmitted by the Department to the state treasurer to be credited to the Nursing Home Penalty Cash Fund.

- a. The Medicaid portions of CMPs imposed by CMS and transmitted to the State shall be credited to the Nursing Home Penalty Cash Fund.

- 1 2. The Department and [CDPHE](#) have joint authority for administering the Nursing Home
2 Penalty Cash fund, with final authority in the Department.
- 3 a. For measures aimed at improving the quality of life of residents of nursing
4 facilities, the Nursing Facility Culture Change Accountability Board shall review
5 and make recommendations to the departments regarding the use of the funds in
6 the Nursing Home Penalty Cash Fund available for quality of life measures as
7 specified in [10 CCR 2505-10 Ssection 8.10 CCR 2505-10 section 8.435.2.E.4.b.](#)
- 8 3. The maximum amount of funds to be distributed from the Nursing Home Penalty Cash
9 Fund each fiscal year for the purposes in [10 CCR 2505-10 Ssection 8.10 CCR 2505-10](#)
10 [section 8.435.2.E.4.b](#) is specified in [C.R.S. Ssection 25-1-107.5, C.R.S.](#)
- 11 4. As a basis for distribution of funds from the Nursing Home Penalty Cash Fund:
- 12 a. The Department and [CDPHE](#) shall consider the need to pay costs to:
- 13 1) Relocate residents to other facilities when a nursing facility closes
- 14 2) Maintain the operation of a nursing facility pending correction of
15 violations;
- 16 3) Close a nursing facility;
- 17 4) Reimburse residents for personal funds lost.
- 18 b. The Nursing Facility Culture Change Accountability Board shall review and
19 recommend distribution of funds for measures that will benefit residents of
20 nursing facilities by improving their quality of life at the facilities, including:
- 21 1) Consumer education to promote resident-centered care in nursing
22 facilities;
- 23 2) Training for state surveyors, supervisors and the state and local long-
24 term care ombudsman, established pursuant to [article 11.5 of Title 26,](#)
25 [C.R.S.C.R.S. section 26-11.5-104 et seq.](#), regarding resident-centered
26 care in nursing facilities;
- 27 3) Development of a newsletter and web site detailing information on
28 resident-centered care in nursing facilities and related information;
- 29 4) Education and consultation for purposes of identifying and implementing
30 resident-centered care initiatives in nursing facilities.
- 31 c. Expenses to administer and operate the accountability board, including
32 reimbursement of expenses of accountability board members.
- 33 1) This expense shall not exceed 10 percent of the fiscal year amount
34 authorized under [10 CCR 2505-10 Ssection 8.435.2.E.3.](#)
- 35 5. The Department and [CDPHE](#) shall consider the recommendations of the Nursing

1 Facility Culture Change Accountability Board regarding the use of the funds available
2 each fiscal year for quality of life improvement purposes specified in [10 CCR 2505-10](#)
3 [Section 8.10 CCR 2505-10 section 8.435.2.E.4.b.](#)

- 4 6. For fiscal year 2009-2010 only, the Department shall contract with Colorado Health Care
5 Education Foundation (CHCEF) to serve as the agent to disburse to grantees
6 \$194,997.00, the fiscal year 2009-2010 appropriation for measures that will benefit
7 residents of nursing facilities by improving their quality of life.

8 a. This total amount of \$194,997.00 is in accordance with the recommendations of
9 the Nursing Facility Culture Change Accountability Board and approved by the
10 Department and [CDPHE](#), with final authority in the Department.

11 b. This appropriation of \$194,997.00 from the Nursing Home Penalty Cash Fund is
12 within the maximum appropriation of \$200,000.00 authorized in [Section 25-1-](#)
13 [107.5, C.R.S.C.R.S. section 25-1-107.5](#) for fiscal year 2009-2010.

14 c. If any grantee does not accept any portion of its approved disbursement amount,
15 within thirty days of grantee notification to CHCEF, CHCEF shall return that
16 portion to the Department to be credited to the Nursing Home Penalty Cash
17 Fund.

- 18 7. For fiscal year 2010-2011 and successive fiscal years:

19 a. If any grantee does not accept any portion of its approved disbursement amount:

20 i. If funds are disbursed through an agent, the disbursement agent shall
21 return that portion, within thirty days of grantee notification, to the
22 Department to be credited to the Nursing Home Penalty Cash Fund.

23 ii. If funds are disbursed directly to the grantee, the grantee shall return that
24 portion to the Department, within thirty days of disbursement, to be
25 credited to the Nursing Home Penalty Cash Fund.

- 26 8. By October 1, 2010, and by each October 1 thereafter, the Department and [CDPHE](#), with
27 the assistance of the Nursing Facility Culture Change Accountability Board, shall jointly
28 submit a report to the governor and the health and human services committees of the
29 senate and house of representatives of the general assembly, or their successor
30 committees, regarding the expenditure of moneys in the Nursing Home Penalty Cash
31 Fund for the purposes described in [10 CCR 2505-10 Section 8.10 CCR 2505-10 section](#)
32 [8.435.2.E.4.b.](#) The report shall detail the amount of moneys expended for such purposes,
33 the recipients of the funds, the effectiveness of the use of the funds, and any other
34 information deemed pertinent by the Department and [CDPHE](#) or requested by the
35 governor or the committees.

36 a. The Nursing Facility Culture Change Accountability Board is responsible for
37 monitoring grantee compliance in expending moneys for the approved measures.

38 b. If the total amount distributed to the grantee is not expended on the approved
39 measure, the grantee shall return the remaining amount, within thirty days of
40 completion of the measure, to the Department to be credited to the Nursing
41 Home Penalty Cash Fund.

- 1 c. If the Department and CDPHE, based on the review of the Nursing Facility
 2 Culture Change Accountability Board, determine that any portions of the moneys
 3 received for the purposes described in [40 CCR 2505-10 Section 8.10 CCR](#)
 4 [2505-10 section 8.435.2.E.4.b](#) was not used appropriately, the grantee shall
 5 return that portion of the moneys, within thirty days of Nursing Facility Culture
 6 Change Accountability Board notification, to the Department to be credited to the
 7 Nursing Home Penalty Cash Fund.
- 8 d. Misuse of the funds by a grantee is subject to the false Medicaid claims
 9 provisions of [Sections 25.5-4-304 through 25.5-4-305, C.R.S.C.R.S. sections](#)
 10 [25.5-4-304 through 25.5-4-307.](#)

11 8.440 NURSING FACILITY BENEFITS

12 Special definitions relating to nursing facility reimbursement:

- 13 1. "Acquisition Cost" means the actual allowable cost to the owners of a capital-related asset or any
 14 improvement thereto as determined in accordance with generally accepted accounting principles.
- 15 2. "Actual cost" or "cost" means the audited cost of providing services.
- 16 3. "Administration and General Services Costs" means costs as defined [at 8.4 at 10 CCR 2505-10](#)
 17 [section 8.10 CCR 2505-10 section 8.443.8.](#)
- 18 4. "Appraised value" means the determination by a qualified appraiser who is a member of an
 19 institute of real estate appraisers, or its equivalent, of the depreciated cost of replacement of a
 20 capital-related asset to its current owner. The depreciated replacement appraisal shall be based
 21 on the "Boechk Commercial Underwriter's Valuation System for Nursing Homes."
- 22 The depreciated cost of replacement appraisal shall be redetermined every four years by new
 23 appraisals of the nursing facilities. The new appraisals shall be based upon rules promulgated by
 24 the state board.
- 25 5. "Array of facility providers" means a listing in order from lowest per diem cost facility to highest for
 26 that category of costs or rates, as may be applicable, of all Medicaid-participating nursing facility
 27 providers in the state.
- 28 6. a. "Base value" means:
- 29 i) The appraised value of a capital-related asset for the fiscal year 1986-87 and
 30 every fourth year thereafter.
- 31 ii) The most recent appraisal together with fifty percent of any increase or decrease
 32 each year since the last appraisal, as reflected in the index, for each year in
 33 which an appraisal is not done pursuant to subparagraph (i) of this paragraph (a).
- 34 b. For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars
 35 per licensed bed at any participating facility, and, for each succeeding fiscal year, the
 36 base value shall not exceed the previous year's limitation adjusted by any increase or
 37 decrease in the index.
- 38 c. An improvement to a capital-related asset, which is an addition to that asset, as defined
 39 by rules adopted by the state board, shall increase the base value by the acquisition cost
 40 of the improvement.

- 1 7. "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility.
- 2 8. "Case-mix" means a relative score or weight assigned for a given group of residents based upon
3 their levels of resources, consumption, and needs.
- 4 9. "Case-mix adjusted direct health care services costs" means those costs comprising the
5 compensation, salaries, bonuses, workers' compensation, employer-contributed taxes, and other
6 employment benefits attributable to a nursing facility provider's direct care nursing staff whether
7 employed directly or as contract employees, including but not limited to DONs, registered nurses,
8 licensed practical nurses, certified nurse aides and restorative nurses.
- 9 10. "Case-mix index" means a numeric score assigned to each nursing facility resident based upon a
10 resident's physical and mental condition that reflects the amount of relative resources required to
11 provide care to that resident.
- 12 11. "Case-mix neutral" means the direct health care costs of all facilities adjusted to a common case-
13 mix.
- 14 12. "Case-mix reimbursement" means a payment system that reimburses each facility according to
15 the resource consumption in treating its case-mix of Medicaid residents, which case-mix may
16 include such factors as the age, health status, resource utilization, and diagnoses of the facility's
17 Medicaid residents as further specified in this section.
- 18 13. "Class I facility" means a private for-profit or not-for-profit nursing facility provider or a facility
19 provider operated by the state of Colorado, a county, a city and county, or special district that
20 provides general skilled nursing facility care to residents who require twenty-four-hour nursing
21 care and services due to their ages, infirmity, or health care conditions, including residents who
22 are behaviorally challenged by virtue of severe mental illness or dementia. Swing bed facilities
23 are not included as class I facilities.
- 24 14. "Core Components" means the health care, administrative and general and fair rental allowance
25 for capital-related assets prospective per diem rate components.
- 26 15. "Direct health care services costs" means those costs subject to case-mix adjusted direct health
27 care services costs.
- 28 16. "Direct or indirect health care services costs" means the costs incurred for patient support
29 services as defined at [10 CCR 2505-10 section 8-10 CCR 2505-10 section 8.443.7.](#)
- 30 17. "Facility population distribution" means the number of Colorado nursing facility residents who are
31 classified into each resource utilization group as of a specific point in time.
- 32 18. "Fair rental allowance" means the product obtained by multiplying the base value of a capital-
33 related asset by the rental rate.
- 34 19. "Improvement" means the addition to a capital-related asset of land, buildings, or fixed
35 equipment.
- 36 20. "Index" means the R. S. Means construction systems cost index or an equivalent index that is
37 based upon a survey of prices of common building materials and wage rates for nursing home
38 construction.
- 39 21. "Index maximization" means classifying a resident who could be assigned to more than one
40 category to the category with the highest case-mix index.

- 1 22. "Median per diem cost" means the daily cost of care and services per patient for the nursing
2 facility provider that represents the middle of all of the arrayed facilities participating as providers
3 or as the number of arrayed facilities may dictate, the mean of the two middle providers.
- 4 23. "Minimum data set" means a set of screening, clinical, and functional status elements that are
5 used in the assessment of a nursing facility provider's residents under the Medicare and Medicaid
6 programs.
- 7 24. "Normalization ratio" means the statewide average case-mix index divided by the facility's cost
8 report period case-mix index.
- 9 25. "Normalized" means multiplying the nursing facility provider's per diem case-mix adjusted direct
10 health care services cost by its case-mix index normalization ratio for the purpose of making the
11 per diem cost comparable among facilities based upon a common case-mix in order to determine
12 the maximum allowable reimbursement limitation.
- 13 26. "Nursing facility provider" means a facility provider that meets the state nursing facility licensing
14 standards established pursuant to C.R.S. section 25-1.5-103 ~~(1) (a)~~, C.R.S., and is maintained
15 primarily for the care and treatment of inpatients under the direction of a physician.
- 16 27. "Nursing salary ratios" means the relative difference in hourly wages of registered nurses,
17 licensed practical nurses, and nurse's aides.
- 18 28. "Nursing weights" means numeric scores assigned to each category of the resource utilization
19 groups that measure the relative amount of resources required to provide nursing care to a
20 nursing facility provider's residents.
- 21 29. "Occupancy-imputed days" means the use of a predetermined number for patient days rather
22 than actual patients days in computing per diem cost.
- 23 30. "Per diem cost" means the daily cost of care and services per patient for a nursing facility
24 provider.
- 25 31. "Per diem rate" means the daily dollar amount of reimbursement that the state department shall
26 pay a nursing facility provider per patient.
- 27 32. "Provider fee" means a licensing fee, assessment, or other mandatory payment as specified
28 under 42 CFR section 433.55.
- 29 33. "Raw food" means the food products and substances, including but not limited to nutritional
30 supplements, that are consumed by residents.
- 31 34. "Rental rate" means the average annualized composite rate for United States treasury bonds
32 issued for periods of ten years and longer plus two percent. The rental rate shall not exceed ten
33 and three-quarters percent nor fall below eight and one-quarter percent.
- 34 35. "Resource utilization group" (RUG) means the system for grouping a nursing facility's residents
35 according to their clinical and functional status identified from data supplied by the facility's
36 minimum data set as published by the United States Department of Health and Human Services.
- 37 36. "Statewide average per diem rate" means the average daily dollar amount of the per patient
38 payments to all Medicaid-participating facility providers in the state.

1 ~~2737.~~ "Medicare patient day" means all days paid for by Medicare. For instance, a Medicare patient day
2 includes those days where Medicare pays a Managed Care Organization for the resident's care.

3 38. "Per diem fee" means the daily dollar amount of provider fee that the state department shall
4 charge a nursing facility provider per non-Medicare day.

5 39. "Substandard Quality of Care means one or more deficiencies related to participation
6 requirements under 42 CFR [section 483.13](#) , resident behavior and facility practices, 42 CFR
7 [section 483.15](#) , quality of life, or 42 CFR [section 483.25](#) , quality of care, that constitute either
8 immediate jeopardy to resident health or safety (level J, K, or L); a pattern of widespread actual
9 harm that is not immediate jeopardy (level H or I); or a widespread potential for more than
10 minimal harm, but less than immediate jeopardy, with no actual harm (level F)" per State
11 Operations Manual, chapter 7.

12 40. "Supplemental Medicaid Payment" means a lump sum payment that is made in addition to a
13 provider's per diem rate. A supplemental Medicaid payment is calculated on an annual basis
14 using historical data and paid as a fixed monthly amount with no retroactive adjustment.

15 **8.440.1 SERVICES AND ITEMS INCLUDED IN THE PER DIEM PAYMENT**

16 8.440.1.A. Payment to nursing facilities, swing-bed facilities and intermediate care ~~facilities for the~~
17 ~~mentally retarded individuals with an intellectual or developmental disability~~ [Facilities for](#)
18 [Individuals with Intellectual Disabilities](#) shall be an ~~all-inclusive~~ [all-inclusive](#) per diem rate, except
19 as provided for within this rule. This rate covers the necessary services to the resident, including
20 room and board, as well as nursing and ordinary supplies and equipment related to the day-to-
21 day care of the resident and the operation of the facility.

22 8.440.1.B. The following general service areas shall be provided within the per diem rate:

- 23 1. Nursing services, therapies, aide services and medically related social services;
- 24 2. Dietary services;
- 25 3. Activities program;
- 26 4. Room/bed maintenance services;
- 27 5. Routine personal hygiene items and services; and
- 28 6. Laboratory services.

29 a. Waivered laboratory services provided by nursing facilities enrolled in the
30 Medicaid program are subject to the requirements of the Clinical Laboratory
31 Improvement Amendments of 1988 (CLIA) as set forth in 42 C.F.R. [section part](#)
32 [493](#), October 1, 1994 edition. ~~No amendments or later editions are incorporated.~~
33 Facilities that collect specimens, including drawing blood specimens, but do not
34 perform testing of specimens, are not subject to CLIA requirements. A facility
35 shall obtain a Certificate of Waiver from the Centers for Medicare and Medicaid
36 or its designated agency if the facility only performs waived tests as defined by
37 CLIA.

38 [b. 42 C.F.R. part 493 \(1994\) is hereby incorporated by reference. The](#)
39 [incorporation of 42 C.F.R. part 493 excludes later amendments to, or editions of,](#)
40 [the referenced material. The Department maintains copies of this incorporated](#)

1 [text in its entirety, available for public inspection during regular business hours at:](#)
2 [Colorado Department of Health Care Policy and Financing, 1570 Grant Street,](#)
3 [Denver, CO 80203. Certified copies of incorporated materials are provided at](#)
4 [cost upon request.](#)

5 ~~b. — Copies are available for inspection and available at cost at the following address:~~
6 ~~Director, Office of Medical Assistance, Colorado Department of Health Care~~
7 ~~Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1818; or may~~
8 ~~be examined at any State Publications Depository Library.~~

9 8.440.1.C. Each nursing facility shall furnish, within the per diem rate, equipment necessary to the
10 operation of the facility and provide for necessary medical, nursing, respiratory and rehabilitation
11 care. Such equipment includes, but is not limited to, the following:

- 12 1. Adaptive equipment for activities of daily living;
- 13 2. Air mattresses, other special mattresses, sheepskins and other devices for
14 preventing/treating decubitus ulcers;
- 15 3. Apnea monitors and necessary supplies and equipment;
- 16 4. Atomizers;
- 17 5. Autoclaves and sterilizers;
- 18 6. Bath equipment, i.e., raised and/or padded toilet seats, trapeze benches, tub/shower
19 stools or benches;
- 20 7. Bedrails, footboards, trapeze bars, traction and fracture frames, bedside stands;
- 21 8. Bed linens;
- 22 9. Beds, including hospital beds;
- 23 10. Blood glucose monitors;
- 24 11. Commode chairs;
- 25 12. Deodorizers;
- 26 13. Emesis basins;
- 27 14. Flameproof curtains;
- 28 15. Flashlights;
- 29 16. Foot pumps;
- 30 17. Gerry chairs, cushioned chairs;
- 31 18. Ice bags or equivalent;
- 32 19. Intermittent positive pressure breathing equipment, including Sodium Chloride or sterile
33 water required for operation;

- 1 20. Irrigating solutions, i.e., Acetic Acid, Potassium Permanganate, Sodium Chloride, and
2 sterile water;
- 3 21. Lifts, i.e., hydraulic, tub, slings;
- 4 22. Lymphedema pumps and compressors;
- 5 23. Medically necessary manual or power wheelchairs for intermittent and full-time use,
6 including cushions and pads as required for the prevention or treatment of skin
7 breakdown, if purchased by the nursing facilities.
 - 8 a. Wheelchairs, if required, shall meet the specific needs of the resident and shall
9 be ordered by a physician. The Primary Care Physician shall concur that the
10 wheelchair being prescribed for the resident is medically necessary.
 - 11 b. All costs associated with the purchase of the wheelchair shall be charged to the
12 health care line of the nursing facility. Wheelchair expenses shall be reported in
13 the appropriate health care line of the Med-13
 - 14 c. The wheelchair shall be sent with the resident in the event the resident is
15 transferred to another facility or returns home. The transferring facility shall
16 expense the remainder of the chair in the fiscal year during which the transfer
17 occurs.
- 18 24. Medicine cups;
- 19 25. Oxygen masks, regulators, humidifiers, hoses, nasal catheters, as needed, for the
20 administration of oxygen;
- 21 26. Percussors and respirators;
- 22 27. Positioning pillows;
- 23 28. Reading lights;
- 24 29. Scissors, forceps, and nail files;
- 25 30. Sitz baths;
- 26 31. Sphygmomanometers, stethoscopes, and other examination equipment;
- 27 32. Splints;
- 28 33. Stryker pads;
- 29 34. Suction apparatus and gavage tubing;
- 30 35. Supplies and equipment necessary for delivery of special dietary needs;
- 31 36. Surgical stockings for routine use;
- 32 37. Ventilators and related equipment and supplies;
- 33 38. Walkers, crutches, canes and medically necessary accessories for ambulatory devices;

1 39. Weighing scales.

2 8.440.1.D. All supplies, including disposables, necessary for effective resident care shall be provided
3 by the nursing facility within the per diem rate. Such supplies include, but are not limited to, the
4 following:

5 1. Band-Aids, gauze pads, dressings and bandages;

6 2. Bedside utensils, bedpans, basins;

7 3. Catheters and related supplies, irrigating trays and accessories;

8 4. Charting supplies;

9 5. Colostomy and ileostomy bags, supplies, and dressings, ostomy supplies;

10 6. Disposable sterile nursing supplies including, but not limited to, cotton, face masks,
11 gloves, tape, finger cots;

12 7. Drinking tubes/straws, water pitchers/glasses;

13 8. Fleece pads;

14 9. Foot soaks;

15 10. Hypodermic syringes and needles, including syringes and needles for insulin
16 administration, intravenous supplies and equipment and related equipment;

17 11. Minor medical surgical supplies;

18 12. Miscellaneous applicators;

19 13. Nebulizers, recreational/therapeutic equipment and supplies to conduct on-going
20 activities program;

21 14. Safety pins;

22 15. Thermometers;

23 16. Tongue depressors;

24 17. Tracheostomy care kits, cleaning supplies;

25 18. Urinals, urinary bags, and tubes and supplies.

26 8.440.1.E. Routine personal hygiene items/services shall be provided by the nursing facility within
27 the per diem rate. These items include, but are not limited to, hair hygiene services (i.e., simple
28 trims, such as trimming bangs or cutting of some hair that may need minor cutting in the back)
29 hair hygiene supplies (i.e., shampoo, hair conditioner, comb, brush); bath soap, disinfecting
30 soaps or specialized cleaning agents when indicated to treat special skin problems or to fight
31 infection; razors, shaving cream; toothbrush, toothpaste, mouthwash, denture adhesive, denture
32 cleanser, dental floss; moisturizing lotion; tissues, cotton balls, cotton swabs; deodorant
33 incontinence care and supplies (i.e., pads, cloth and disposable diapers, pants, liners, sanitary

1 napkins and related supplies) towels, washcloths; and hospital gowns; bathing; shaving; nail
2 hygiene services (i.e., routine trimming, cleaning and filing, not polishing).

3 8.440.1.F. Various over-the-counter (OTC) drugs and supplies as required to meet the residents'
4 assessed needs shall be furnished by the facility, within the per diem rate, at no charge to the
5 resident. OTC drugs/supplies including but not limited to:

- 6 1. Artificial tears;
- 7 2. Aspirin, acetaminophen, ibuprofen, and other non-prescription analgesics available now
8 or in the future;
- 9 3. Cough and cold supplies, i.e., cold tablets, decongestants, cough syrup/tablets;
- 10 4. Douches;
- 11 5. Evacuant suppositories, laxatives, stool softeners, enemas;
- 12 6. First aid supplies, i.e., alcohol, hydrogen peroxide, merthiolate and other
13 antiseptics/germicides, Betadine, PhisoHex, chlorhexidene gluconate, providone/iodine
14 solution and wash, epsom salt;
- 15 7. Lubricants, rubbing compounds and ointments, i.e., petroleum jelly, bag balm, other body
16 lotions for treatment of dry skin or skin breakdowns, bacitracin ointment and other
17 ointments used in treatment of wounds;
- 18 8. Vitamins (multi and single) and mineral supplements.

19 8.440.1.G. The following services and provisions shall be provided by the facility within the per diem
20 rate:

- 21 1. Food and dietary services, including special diets, supplements and nutrients ordered by
22 the physician, in accordance with the needs of the residents and appropriate licensing
23 requirements;
- 24 2. Room for accommodation of the resident in accordance with licensing requirements,
25 including storage for personal belongings, bedside equipment, suitable bed, clean and
26 comfortable mattress, pillows and an adequate supply of clean linen;
- 27 3. Maintenance of clean, comfortable and sanitary environment through provision of heat,
28 light, ventilation and sanitation to meet health and aesthetic needs of the resident, in
29 accordance with the physicians' orders and licensing regulations;
- 30 4. Basic personal laundry, excluding dry-cleaning, mending, hand washing, or other
31 specialties.
- 32 5. Consultant services when the facility employs or contracts with consultants in an effort to
33 meet regulations.
- 34 6. Specialized rehabilitative services, including, but not limited to, physical therapy, speech-
35 language pathology, occupational therapy and mental health rehabilitative services for
36 mental illness and ~~mental retardation~~ intellectual or developmental disability, when
37 required in the resident's comprehensive plan of care. Specialized rehabilitative services
38 shall be provided under the written order of a physician by qualified personnel. The

1 facility shall provide the required services or obtain the required services from a provider
2 of specialized rehabilitative services.

3 7. Ongoing activities program directed by a qualified professional, to meet the interests and
4 the physical, mental and psychosocial well-being of each resident. The nursing facility
5 can charge for entertainment and social events that are outside the scope of the required
6 activities program.

7 **8.440.2 SERVICES AND ITEMS NOT INCLUDED IN THE PER DIEM PAYMENT**

8 8.440.2.A. The following general categories and examples of items and services are not included in
9 the facility's per diem rate. Items 1 – 11 may be charged to the resident's personal needs funds if
10 requested, in writing by a resident and/or the resident's family:

11 1. Cosmetic and grooming items and services in excess of those for which payment is
12 allowed under the per diem rate, i.e., beauty permanents, hair relaxing, hair coloring, hair
13 styling, hair curling, shaving lotion and cosmetics such as lipstick, perfume, eye shadow,
14 rouge/blush, haircuts, beyond simple trimming, normally performed by licensed barbers
15 or beauticians;

16 2. Gifts purchased on behalf of a resident;

17 3. Non-covered special care services, i.e., a private duty nurse not employed by the nursing
18 facility.

19 4. Items or services requested by the resident, including but not limited to, over the counter
20 drugs/related items not prescribed by a physician, not included in the nursing care plan
21 and not ordinarily furnished for effective patient care. In these instances, it is required
22 that:

23 a. The resident has made an informed decision supported by a statement in the
24 Personal Needs Funds file that he/she/family is willing to use personal funds.

25 b. The balance in the Personal Needs Funds in the resident's ledger is sufficient to
26 cover the charge.

27 5. Personal clothing and dry cleaning;

28 6. Personal comfort items, including smoking materials, notions, novelties and
29 confections/candies;

30 7. Personal reading material, subscriptions;

31 8. Private room;

32 9. Social events and entertainment offered off premises and outside the scope of the
33 regular facility activities program;

34 10. The facility shall provide each resident with a nourishing, palatable, well-balanced diet
35 that meets the daily nutritional and special dietary needs of each resident. If the resident
36 refuses the prepared food the facility shall offer substitutes. Residents may be charged
37 only for specially prepared food only if they are informed that there will be a charge, and
38 the charge may be only the difference in price between the requested item and the
39 covered item pursuant to 42 C.F.R. 483.35.[JM8][QK9]

1 11. Telephone, television/radio for personal use, if not equally available to all residents.

2 12. Provider fee.

3 13. Prescription drugs, with certain specific exemptions.

4 14. Ambulance and medical transport, including emergent and non-emergent.

5 15. Oxygen

6 16. Physician fees

7 17. Non-nursing costs, including but not limited to direct and indirect outpatient therapy,
8 assisted living, independent living, adult day care and meals-on-wheels.

9 8.440.2.B. The Department's approval shall be required in order for a resident or his/her relatives to
10 be billed for the following:

11 1. The physician orders that a full-time R.N. or L.P.N. is needed. The R.N. or L.P.N. is not
12 employed by the nursing facility and has duties limited to the care of a particular resident,
13 or two such residents in the same room.

14 2. The physician orders a private room.

15 3. The attending physician shall indicate the medical necessity on the resident's chart for
16 either service above and shall submit to the Department a completed copy of Form
17 10013 (Physician's Request for Additional Benefits).

18 4. Upon approval of the Form 10013, payment for such services may be received from the
19 resident's personal needs fund, relatives or others.

20 8.440.2.C The following items are allowable costs for class II and class IV facilities only:

21 1. Eye/Hearing examinations

22 2. Eyeglasses and repairs

23 3. Hearing aids and batteries

24 4. Provider fees

25 **8.441 NURSING FACILITY COST REPORTING**

26 **8.441.1 SUBMISSION OF THE MED-13 AND MINIMUM DATA SET (MDS)**

27 8.441.1.A. For purposes of completing ~~MED-13~~MED-13, each nursing facility shall:

28 1. Establish a 12-month period that is designated to the Department as the facility's fiscal
29 year. The fiscal year shall remain the same as designated to the Department with two
30 exceptions:

31 a. Providers seeking to coordinate their fiscal year with the fiscal year they have
32 established with the Internal Revenue Service.

- 1 b. Subchapter "S" corporations required by law to have a fiscal year end of
2 December 31.
- 3 2. Provide adequate cost data that:
- 4 a. Is based on their financial and statistical records. All financial and statistical
5 records of the facility shall be maintained in accordance with generally accepted
6 accounting principles as approved by the American Institute of Certified Public
7 Accountants.
- 8 b. Is verifiable ~~by reference to~~through adequate supporting documentation ~~by~~
9 ~~qualified~~provided to auditors during the normal course of their audit;
- 10 c. Is based on the accrual basis of accounting.
- 11 i) Under the accrual basis of accounting, revenue is reported in the period
12 when it is earned, regardless of when it is collected and expenses are
13 reported in the period in which they are incurred, regardless of when they
14 are paid.
- 15 ii) Where a governmental institution operates on a cash basis of
16 accounting, cost data based on such accounting shall be acceptable,
17 subject to appropriate treatment of capital expenditures.
- 18 d. Includes the Medicare cost report that was most recently filed with the Medicare
19 fiscal intermediary. If the facility cannot file a current Medicare cost report for
20 reasons beyond its control, the facility shall submit other reliable Medicare cost
21 information that the Department has approved.
- 22 3. Maintain financial and statistical records in a manner consistent from one reporting period
23 to another in order to provide the required cost data and not impair comparability.
- 24 4. Retain all records required to support information supplied on the MED-13 for a period of
25 at least five (5) years from the date of submission.
- 26 8.441.1.B. Nursing facilities shall submit all Minimum Data Set (MDS) resident assessments and
27 tracking documents to the Centers for Medicare and Medicaid Services (CMS) MDS database for
28 Colorado maintained at ~~the Colorado Department of Public Health and Environment (CDPHE)~~. All
29 assessment data submitted shall conform to federal and state specifications and meet minimum
30 editing and validation requirements.
- 31 8.441.1.C. Failure to maintain adequate accounting and/or statistical records shall be cause for
32 termination or suspension of the facility's provider agreement.
- 33 **8.441.2 COMPLETION OF THE MED-13 – GENERAL INSTRUCTIONS**
- 34 8.441.2.A. The MED-13 consists of the certification page and ~~and~~all schedules. All information
35 called for in the schedules must be furnished unless:
- 36 1. It is not applicable to the nursing facility operation; or
- 37 2. The books and records do not provide the information and it is not available by other
38 reasonable means.

1 8.441.2.B. The financial information included shall be based on that appearing in the facility's
2 audited financial statements. Adjustments to convert to the accrual basis of accounting shall be
3 required if the records are maintained on other accounting bases.

4 8.441.2.C. Nursing facilities that are a part of a larger health facility extending short term, intensive
5 or other health care not generally considered nursing facility care may submit a cost
6 apportionment schedule prepared in accordance with recognized methods and procedures. In
7 certain instances, such cost apportionment schedules may be required by the Department if
8 deemed necessary for a fair presentation of expenses attributable to nursing facility patients.

9 8.441.2.D. The instructions regarding the MED-13 are designed to cover those items that may
10 require additional explanation or to provide an example.

11 **8.441.3 COMPLETION OF THE MED-13 CERTIFICATION PAGE**

12 8.441.3.A. Type of control indicates ownership or auspices under which the nursing facility is
13 conducted.

14 8.441.3.B. Accounting basis:

- 15 1. Accrual Recording revenue when earned and expenses when incurred.
- 16 2. Modified Cash Recording revenue when received and expenses when incurred.
- 17 3. Cash Recording revenue when received and expenses when paid after giving effect to
18 adjustments for pre payments, etc. and depreciation.
- 19 4. Nursing facilities not using the accrual basis of accounting shall adjust recorded amounts
20 to the accrual basis.

21 8.441.3.C. Statistical Data

- 22 1. The statistical data shall be accurate. A resident day is that period of service rendered to
23 resident between the census taking hours on two (2) successive days, the day of
24 discharge being counted only when the resident was admitted that same day.
- 25 2. The total resident days for the period shall be accurate and not an estimate of days of
26 care provided. Resident days shall include days for residents having special duty nurses.
- 27 3. The accumulation method format set forth in Form NH 1 ("Monthly Census Summary --
28 Nursing Home Patients") shall be used. Such monthly record shall be kept concerning all
29 patients, both Medicaid residents and non-Medicaid residents, by the nursing facility.
30 Sample copies of the required format may be obtained from the Department.

31 8.441.3.D. The certification statement on the MED-13 shall be read and signed by the licensed
32 owner or corporate officer and the preparer of the MED-13.

33 8.441.3.E. The Department may require a nursing facility to provide the opinion of a certified public
34 accountant if, in the Department's opinion, adjustments made to prior reports indicate disregard of
35 the certification and reporting instructions. The CPA shall certify that the report is in compliance
36 with the Department's regulations and shall give an opinion of fairness of presentation of
37 operating results or revenues and expenses.

38 **8.441.4 COMPLETION OF REVENUES SCHEDULE**

- 1 8.441.4.A. Revenues shall be listed as recorded in the general books and records and are affected
2 by the accounting basis and procedures used. Expense recoveries credited to expense accounts
3 shall not be reclassified in order to be reflected as revenues for purposes of completing the
4 revenue schedule.
- 5 8.441.4.B. Revenue from patients shall be classified sufficiently in the accounting records to allow
6 preparation of this schedule.
- 7 1. "Routine services" or "daily services" are those services that include room, board, nursing
8 services and such services as supervision, feeding, and incontinency for which the
9 associated costs are in nursing service.
- 10 2. "Routine services" or "daily services" shall represent only the established charge for daily
11 care, excluding additional charged, if any, for other services.
- 12 8.441.4.C. Revenue from ancillary services provided to residents, such as pharmacy, medical
13 supplies and occupational therapy supplies shall be applied in reduction of the related expense.
14 The resulting expense, after adjustment, shall not be a negative figure. A revenue classification
15 "Miscellaneous" or "Sundry" requires an analysis and determination of the amounts included
16 therein, which represent expense recoveries or income to be applied in reduction of a related
17 expense.
- 18 8.441.4.D. Medical supplies, with certain specific exceptions, shall be provided to Medicaid residents
19 without separate additional charges to the resident or relatives. The costs of these supplies or
20 services shall be included in audited costs.
- 21 8.441.4.E. ~~These Account for~~ specific medical supplies or services for which a separate additional
22 charge is allowed ~~are to be accounted for as "Items Purchased for Resale," and the cost thereof~~
23 ~~shown on the appropriate line for elimination. Show the cost on the appropriate line for elimination.~~
- 24 8.441.4.F. Revenues related to services rendered which are not an obligation of the state shall be
25 offset against allowable costs if the associated expense can-not be determined. If the associated
26 expense can be determined, related expense should be removed as non-allowable (i.e., if barber
27 and beauty shop revenue is \$1,000 and the related expense is \$900, enter \$900; however, if
28 expenses cannot be determined, enter \$1,000).
- 29 8.441.4.G. Revenues not related to patient care ("Other Revenue Centers") shall be applied in
30 reduction of the related expense. Remove the cost, if known, (such as employee meals or
31 telephone expense) or the gross revenue if cost cannot be determined.
- 32 8.441.4.H Revenue from residents, or others, resultant from charges made for room reservations,
33 shall be classified sufficiently in the accounting records, and such amount shall be entered on the
34 Revenue Schedule and identified as room reservation charges. This revenue shall also be offset
35 against allowable expenses.
- 36 8.441.4.I. An investment or interest income adjustment shall be necessary only if interest expense
37 is incurred, and only to the extent of such interest expense.
- 38 8.441.4.J. Laundry revenue shall be applied to laundry expense.
- 39 8.441.4.K. Open lines are provided for entry of sundry sources of revenue not directly related to
40 patients, such as pay telephone commissions, contributions and grants received. These items
41 need not be applied as a reduction of expense.

1 8.441.4.L. Accounts receivable charged off or provision for uncollectible accounts shall be reported
 2 on the Revenue Schedule as a deduction from gross revenue. However, if a nursing home
 3 accounts for such revenue deductions as an administrative expense, the amounts shall be
 4 entered as "Other expenses not related to patient care."

5 **8.441.5 COMPLETION OF NON-REIMBURSABLE EXPENSES AND EXPENSE LIMITATIONS AND**
 6 **ADDITIONS SCHEDULE**

7 8.441.5.A. The following expenses shall be excluded or limited from operating expenses because
 8 they are not normally incurred in providing patient care:

- 9 1. Fees paid directors and non-working officers' salaries shall not be allowed as
 10 reimbursable costs.
- 11 2. Loan acquisition fees and standby fees shall not be considered part of the current
 12 expense of patient care but shall be amortized over the life of the related loan.

13 8.441.5.B. COMPENSATION OF OWNERS AND OWNER-RELATED EMPLOYEES

14 1. For purposes of ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10~~
 15 ~~section 8.441.5.B~~, the following definitions shall apply:

- 16 a. Compensation means the total benefit received by the owner for ~~the~~ services
 17 ~~he/she~~ rendered to the facility. Such compensation shall only include:
 - 18 i) Salary amounts paid for managerial, administration, professional and
 19 other services;
 - 20 ii) Amounts paid by the facility for the personal benefits of the owner;
 - 21 iii) The costs of assets and services which the owner receives from the
 22 facility; and
 - 23 iv) Deferred compensation.
- 24 b. Necessary Services means those services needed for the efficient operation and
 25 sound management of the facility such that, had the owners or owner-related
 26 individuals not rendered the services, the facility would have had to employ
 27 another individual to perform the services.
- 28 c. Owner means an individual with a five percent (5%) or more ownership interest in
 29 the facility.
- 30 d. Owner-Related Individual means an individual who is a member of an owner's
 31 immediate family which includes a spouse, natural or adoptive parent, natural or
 32 adopted child, step-parent, step-child, sibling or step-sibling, in-laws,
 33 grandparents and grandchildren.
- 34 e. Ownership Interest means the entitlement to a legal or equitable interest in any
 35 property of the facility whether such interest is in the form of capital, stock or
 36 profits of the facility.
- 37 2. Compensation for services of owners and owner related employees shall be adequately
 38 documented to be necessary and such employees shall adequately documented to be

1 qualified to provide these services. Adequate documentation shall include but not be
2 limited to:

- 3 a. Date and time of services;
- 4 b. Position description;
- 5 c. Individual's educational qualifications, professional title and work experience;
- 6 d. Type and extent of ownership interest;
- 7 e. Relationship to and name of owner (if an owner related individual).

8 3. The methods set forth below shall determine the allowable costs of salaries paid to owner
9 and owner related employees. For each method, if an owner or owner-related employee
10 is compensated for services to the facility, any compensation paid to another individual in
11 the same position shall be excluded from the allowable costs for that cost reporting
12 period.

13 a. Owner and Owner-Related Administrators: The maximum allowable cost of
14 salaries paid to owner and owner-related administrators shall be equal to the
15 median of salaries paid to all non-owner and non-owner related administrators in
16 facilities of comparable size. The median shall be computed by the Department
17 from a survey of all Colorado Medicaid participating facilities conducted each
18 January, and shall be applied to salaries for that calendar year. Categories of
19 facilities, based on licensed bed capacity, for purposes of determining
20 comparability shall be as follows: 1 to 74; 74-75 to 99; 100 to 149; 150 to 200 and
21 more than 200.

22 b. Owner and Owner-Related Assistant Administrator: The maximum allowable cost
23 for such services shall be 75% of the maximum allowable salary of an owner or
24 owner related assistant administrator of a comparable facility. No costs shall be
25 allowable for owner or owner related assistant administrators in facilities with
26 licensed bed capacities less than 150.

27 c. Owner and Owner-Related Physicians Performing Administrative Services:
28 Salaries shall be an allowable cost up to the maximum established for owner and
29 owner-related administrators in a comparable facility.

30 d. Owner and Owner-Related Nursing Directors: Salaries shall be an allowable cost
31 up to a maximum of 65% of the maximum allowable salary of an owner or owner-
32 related administrator of a comparable facility.

33 4. Fringe benefits for owner and owner-related employees shall be allowable costs up to a
34 maximum established by the Department each March for that calendar year. This
35 maximum shall be equal to the fringe benefit percentage of private employees in
36 Colorado as determined by the survey conducted by the State Department of Personnel,
37 minus that portion of the computation that includes holidays, vacation and sick leave
38 days.

39 5. Exceptions to the application of the median as the maximum allowable salary for owner
40 and owner-related employees shall be approved by the Department only where the
41 nursing home can demonstrate that it has unique characteristics or the employee in
42 question has special qualifications and experience which would make application of the

1 median for that size facility unreasonable. Requests for exceptions shall be submitted to
2 the Department in writing no later than 90 days prior to the end of the facility's fiscal year.

3 8.441.5.C. LEGAL FEES, EXPENSES AND COSTS

4 1. Legal fees, expenses and costs incurred by nursing facilities shall be allowable, in the
5 period incurred, if said costs are reasonable, necessary and patient-related. These legal
6 fees, expenses and costs shall be documented in the provider's files, and shall be clearly
7 identifiable, including identification by case number and title, if possible. Failure to clearly
8 identify these costs shall result in disallowance.

9 2. The following categories shall not be deemed reasonable, necessary and patient-related:

10
11
12
13 a. Legal fees, expenses and costs incurred in connection with the appeal of a
14 Medicaid classification or reimbursement rate, rate adjustment, personal needs
15 audit, or payment for any financial claim by or against the State of Colorado, or
16 its agencies by a provider, in the event the State of Colorado or any of its
17 agencies prevails in such a proceeding. In the event that each party prevails on
18 one or more issues in litigation, allowable legal fees, expenses and costs in such
19 cases shall be apportioned by percentage, for reimbursement purposes, by the
20 administrative law judge rendering the final agency decision. In the event of the
21 stipulated settlement of any such appeal, the parties shall, by agreement,
22 determine the allowability for the provider's legal fees, expenses and costs. If a
23 settlement agreement is silent concerning legal fees, expenses or costs, they
24 shall not be allowable.

25 b. Legal fees, expenses and costs incurred in connection with a proceeding by the
26 Department or ~~the~~ CDPHE to deny, suspend, revoke or fail to renew or terminate
27 the license or provider contract of a long-term care facility, or to refuse to certify,
28 decertify or refuse to recertify a long-term care facility as a provider under
29 Medicaid and the Departments prevail in such a proceeding. Legal fees,
30 expenses and costs incurred in connection with a proceeding by the United
31 States Department of Health and Human Services to refuse to certify, decertify,
32 or refuse to recertify a long-term care facility and the Department prevails in
33 such a proceeding. For the purposes of this paragraph, the word "prevail" shall
34 mean a result, whether by settlement, administrative final agency action or
35 judicial judgment, which results in a change of the terms of a previously granted
36 provider license, certification, or contract, including involuntary change of
37 ownership or probation.

38 c. Legal fees, expenses and costs incurred in connection with a civil or criminal
39 judicial proceeding against the provider by the State of Colorado and any of its
40 agencies as the result of the provider's participation in the Medicaid program,
41 resulting from fraud or other misconduct by the provider, and the State or its
42 agencies prevail in such proceeding. For the purposes of this paragraph, the
43 word "prevail" shall mean any result but dismissal or acquittal of a criminal action
44 or dismissal, directed judgment, or judgment for the provider in a civil action.

- 1 d. Legal fees, expenses and costs incurred in connection with an investigation by
 2 federal, state, or local governments and their agencies that might lead to a civil or
 3 criminal proceeding against the provider as a result of alleged fraud or other
 4 misconduct by the provider in the course of the provider's participation in the
 5 Medicaid program shall not be allowable where the provider makes any payment
 6 of funds to any federal, state, or local governments and their agencies as a result
 7 of the alleged fraud or misconduct which was the subject of the investigation.
- 8 e. Legal fees, expenses and costs incurred for lobbying Congress, the Legislature
 9 of Colorado, or the ~~State Boards of Medical Services~~ Medical Services Board,
 10 Health or Human Services.
- 11 f. Legal fees, expenses and costs incurred by the seller in the normal course of the
 12 sale of a nursing home.
- 13 g. Nonrefundable retainers paid to Counsel.
- 14 h. Legal fees, expenses and costs associated with a change of ownership incurred
 15 for any reason after a change of ownership has occurred.
- 16
- 17 i. Legal fees, expenses, or costs as a result of an attorney entering an appearance
 18 in person or in writing by counsel for the provider during the Informal
 19 Reconsideration. Legal fees, expenses and costs that are advisory in nature
 20 before and during the Informal Reconsideration process will be allowable.

21 8.441.5.D. DEPRECIATION

- 22 1. For purposes of this section concerning depreciation, the following definitions shall apply:

23 "MAI Appraiser" means the designation "Member, Appraisal Institute" awarded by the
 24 American Institute of Real Estate Appraisers.

25 "Straight Line Method of Depreciation" means the method of depreciation where the
 26 amount to be depreciated is first determined by subtracting the estimated salvage value
 27 of the asset from its cost or fair market value in the case of donated assets. The amount
 28 to be depreciated is then distributed equally over the estimated useful life of the asset.

- 29 2. Except as specified in this manual, Medicare rules and regulations as delineated in the
 30 Medicare and Medicaid Guide, 1981, published by Commerce Clearing House,
 31 paragraph 4501-4897P, shall be utilized in the treatment of depreciation costs for
 32 purposes of reimbursement under Medicaid. ~~→~~ The Medicare and Medicaid Guide (1981)
 33 is hereby incorporated by reference. The incorporation of The Medicare and Medicaid
 34 Guide (1981) excludes later amendments to, or editions of, the referenced material. The
 35 Department maintains copies of this incorporated text in its entirety, available for public
 36 inspection during regular business hours at: Colorado Department of Health Care Policy
 37 and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated
 38 materials are provided at cost upon request. No amendments or later editions are
 39 incorporated. Copies are available for inspection from the following person at the
 40 following address: Custodian of Records, Colorado Department of Health Care Policy
 41 and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has
 42 been incorporated by reference in this rule may be examined at any state publications
 43 depository library.

- 1 3. Depreciation on assets used to provide covered services to Medicaid recipients may be
2 included as an allowable patient cost. Only the straight-line method of computing
3 depreciation may be utilized for purposes of Medicaid reimbursement. Depreciation costs
4 shall be identifiable as such, and shall be recorded in the provider's accounting records in
5 accordance with "generally accepted accounting principles."
- 6 4. Depreciable items must be capitalized and written off over the estimated useful life of the
7 item using the straight-line method of depreciation. With respect to expenditures during
8 every facility fiscal year which begins on or after July 1, 1998, the following items must be
9 depreciated:
- 10 a. Assets that, at the time of acquisition, had an estimated useful life of (2) two
11 years or more; and a historical cost of \$5,000 or more.
- 12 b. Betterments or improvements that extend the original estimated useful life of an
13 asset by (2) two years or more, or increase the productivity of an asset
14 significantly; and cost \$5,000 or more.
- 15 c. For the purpose of applying the \$5,000 threshold in paragraphs A and B above,
16 the costs of assets, betterments, and/or improvements shall be combined if the
17 costs:
- 18 i) Are incurred within the same fiscal year of the nursing facility; and
- 19 ii) Are of the same type or relate to the same project. For example, costs
20 related to renovations or improvements to a facility's kitchen must be
21 combined.
- 22 d. Major repairs are repairs which:
- 23 i) Occur infrequently, involve significant amounts of money, and increase
24 the economic usefulness of the asset in the future, because of either
25 increased efficiency, greater productivity, or longer life; or
- 26 ii) Restore the original estimated useful life of an asset where without such
27 repairs, the useful life of the asset would be reduced or immediately
28 ended; these repairs occur infrequently and have a significant cost in
29 relation to the asset being repaired.
- 30 e. If the composite method of depreciation is used, the time period over which the
31 major repair must be depreciated is not necessarily the remaining life of the
32 composite asset. For example, a major repair to a roof of a facility that has a
33 remaining useful life of thirty (30) years would not have to be depreciated over
34 thirty (30) years if the normal life of the roof is only fifteen (15) to twenty (20)
35 years; the shorter period could be used.
- 36 f. The following are examples of major repairs and are not intended as a complete
37 list: replacement or partial replacement of a roof, flooring, boiler, or electrical
38 wiring.
- 39 8.441.5.E. EXPENSED ITEMS
- 40 1. Items which are to be entirely expensed in the year of purchase, rather than depreciated,
41 are as follows:

- 1 a. All repair and maintenance costs, except major repairs.
- 2 b. Assets that, at the time of acquisition, had an estimated useful life of less than
- 3 two (2) years; or cost less than \$5,000.
- 4 c. Betterments or improvements that do not extend the useful life of an asset by two
- 5 (2) years or more, or do not increase the productivity of an asset significantly; or
- 6 cost less than \$5,000.
- 7 d. For the purpose of applying the \$5,000 threshold in paragraphs "b" and "c"
- 8 above, assets, betterments, and/or improvements that are purchased separately
- 9 shall be combined if they meet the criteria described in [10 CCR 2505-10 section](#)
- 10 [8-10 CCR 2505-10 section 8.441.5.D](#).

11 8.441.5.F. HISTORICAL COSTS

- 12 1. Historical costs shall be established in accordance with the Medicare and Medicaid
- 13 Guide, ~~1981~~[1981](#), published by Commerce Clearing House, paragraphs 4501-4897P,
- 14 except that any appraisals required or recommended shall be performed by an MAI
- 15 Appraiser rather than an "appraisal expert" as defined in the [Medicare and Medicaid](#)
- 16 [Guide](#).- [The Medicare and Medicaid Guide \(1981\) is hereby incorporated by reference.](#)
- 17 [The incorporation of The Medicare and Medicaid Guide \(1981\) excludes later](#)
- 18 [amendments to, or editions of, the referenced material. The Department maintains](#)
- 19 [copies of this incorporated text in its entirety, available for public inspection during regular](#)
- 20 [business hours at: Colorado Department of Health Care Policy and Financing, 1570](#)
- 21 [Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided](#)
- 22 [at cost upon request.](#)

23 ~~No amendments or later editions are incorporated. Copies are available for inspection from the~~

24 ~~following person at the following address: Custodian of Records, Colorado Department of~~

25 ~~Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818.~~

26 ~~Any material that has been incorporated by reference in this rule may be examined at any~~

27 ~~state publications depository library.~~

- 28 2. When the Internal Revenue Service requires a facility to change its allocation of costs of
- 29 land, buildings or equipment for purposes of tax reporting, a copy of the IRS ~~A~~^S notice shall
- 30 be submitted to the Department in order for the changes to be reflected in the cost report.
- 31 3. In regards to a determination of a bona fide sale, an initial presumption that the sale was
- 32 not bona fide may be offset by a valuation report of an MAI appraiser of the reproduction
- 33 cost depreciated to date on a straight-line basis. Cost determined in this manner shall be
- 34 accepted for future depreciation purposes.
- 35 4. An initial presumption that a sale was not bona fide shall be made when any of the
- 36 following factors exist:
- 37 a. The seller and purchaser are persons for whom a loss from the sale or exchange
- 38 of property is not allowed under the Internal Revenue Services Code between:
- 39 i) Members of a family;
- 40 ii) An individual and a corporation if the individual owns (directly or
- 41 indirectly) more than 50% in value of the outstanding stock;

- 1 iii) Two corporations if more than 50% in value of the outstanding stock in
2 both is owned, directly or indirectly, by the same individual, but only if
3 either one of the corporations was a personal holding company or a
4 foreign personal holding company for the taxable year preceding the
5 date of the sale or exchange;
- 6 iv) A grantor and a fiduciary of any trust;
- 7 v) A fiduciary of one trust and a fiduciary of another trust, if the same
8 person is grantor of both trusts;
- 9 vi) A fiduciary of a trust and any beneficiary of such trust;
- 10 vii) A fiduciary of a trust and a beneficiary of another trust, if the same
11 person is a grantor of both trusts;
- 12 viii) A fiduciary of a trust and a corporation more than 50% in value of the
13 outstanding stock of which is directly or indirectly owned by or for the
14 trust or a grantor of the trust. This would, for example, have the effect of
15 denying a loss in a transaction between a corporation, more than 50% of
16 the stock of which was owned by a father, and a trust established for his
17 children. Under the constructive ownership rules (below), the children are
18 treated as owning the stock owned by the father; and
- 19 ix) A person and an exempt charitable or education organization controlled
20 by the person or, if the person is an individual, by the individual or his
21 family.
- 22 b. The term "family" means a brother or sister (whole or half-blood relationship,
23 spouse, ancestor, or lineal descendant, including in laws and in laws of ancestors
24 of lineal descendants.
- 25 c. In determining stock ownership;
- 26 d. The transaction was effected without significant investment on the part of the
27 purchaser; i.e., cash or property was not transferred from the purchaser to the
28 seller and the sales price was met by assumption of existing debt and promises
29 to pay additional amounts or issuance of life annuities to the seller.
- 30 e. The sales price could be considered excessive when compared with other sales
31 or costs of constructing, furnishing, and equipping other facilities of comparable
32 size and quality during the preceding twelve months.

33 8.441.5.G. INTEREST

- 34 1. For purposes of this section concerning interest, the following definitions shall apply:
- 35 a. Interest means the cost incurred for the use of borrowed funds.
- 36 b. Interest on current indebtedness means the cost incurred for funds borrowed for
37 a relatively short term. This is usually for such purposes as working capital for
38 normal operating expense.

- 1 c. Interest on capital indebtedness means the cost incurred for funds borrowed for
2 capital purposes such as acquisition of facilities and equipment, and capital
3 improvements. Generally, loans for capital purposes are long-term loans.
- 4 d. Necessary means that the interest:
- 5 i) Is incurred on a loan made to satisfy a financial need of the provider.
6 Loans which result in excess funds or investments shall not be
7 considered necessary;
- 8 ii) Is incurred on a loan made for a purpose reasonably related to patient
9 care; and
- 10 iii) Is reduced by investment income except where such income is from gifts
11 and grants whether restricted or unrestricted, and which are held
12 separate and not commingled with other funds. Income from funded
13 depreciation or provider's qualified pension fund shall not be used to
14 reduce interest expense.
- 15 e. Proper means that interest:
- 16 i) Is incurred at a rate not in excess of what a prudent borrower would have
17 had to pay in the money market existing at the time the loan was made;
18 and
- 19 ii) Is paid to a lender not related through control or ownership or personal
20 relationship to the borrowing organization. However, interest shall be
21 allowable if paid on loans from the provider's donor restricted funds, the
22 funded depreciation account or provider's qualified pension funds.
- 23 2. To be allowable, the interest expense shall be incurred on indebtedness established with
24 lenders or lending organizations not related through control, ownership, or personal
25 relationship to the borrower. Presence of any of these factors affects the bargaining
26 process that usually accompanies the making of a loan and could be suggestive of an
27 agreement on higher rates of interest or of unnecessary loans. Loans shall be made
28 under terms and conditions that a prudent borrower would make in arms-length
29 transactions with lending institutions. The intent of this provision is to assure that loans
30 are legitimate and needed and that the interest rate is reasonable.
- 31 3. Interest on loans to providers by partners, stockholders or related organizations are
32 allowable as costs at a rate not in excess of the prime rate.
- 33 4. Where the general fund of a provider "borrows" from a donor-restricted fund and pays
34 interest to the restricted fund, the interest shall be an allowable cost. The same treatment
35 shall be accorded interest paid by the general fund on money "borrowed" from the funded
36 depreciation account of the provider or from the provider's qualified pension fund. In
37 addition, if a provider operated by members of a religious order borrows from the order,
38 interest paid to the order shall be an allowable cost.
- 39 5. Where funded depreciation is used for purposes other than improvement, replacement,
40 or expansion of facilities or equipment related to patient care, allowable interest expense
41 is reduced to adjust for offsets not made in prior years for earnings on funded
42 depreciation. A similar treatment will be accorded deposits in the provider's qualified

1 pension fund where such deposits are used for other than the purpose for which the fund
2 was established.

- 3 6. Allowable interest expense on current indebtedness of a provider shall be adjusted to
4 reflect the extent to which working capital needs which are attributable to covered
5 services for beneficiaries have been met by payment to the provider designed to
6 reimburse currently as services are furnished to beneficiaries.

7 8.441.5.H. MANAGEMENT SERVICES

- 8 1. The following requirements apply to all management companies:

- 9 a. Management company costs shall be considered administrative costs except as
10 described at [10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.443.7.A.13](#).
- 11 b. Management company costs allocated to facilities shall be based on actual
12 services provided to the facility. The allocation shall be documented.
- 13 c. If the compensation to on-site management staff is separately reported on the
14 cost report, that compensation shall not also be included in the allowable
15 management costs for the facility. This rule shall apply regardless of whether
16 owners or owner-related organizations are involved in the administration or
17 management services.

- 18 2. In addition to the requirements of [10 CCR 2505-10 section 8.10 CCR 2505-10 section](#)
19 [8.441.5.H.1](#), the following requirements shall apply to owner-related management
20 companies:

- 21 a. "Owner-related management company" means an individual or organization that
22 is related to, owned or controlled by the owner(s) of the nursing facility, as
23 described [in 8.441 in 10 CCR 2505-10 section 8.10 CCR 2505-10 section](#)
24 [8.441.5.B](#).
- 25 b. Management services provided to the nursing facility by an owner-related
26 management company are subject to the related party rules [at 8.441 at 10 CCR](#)
27 [2505-10 section 8.10 CCR 2505-10 section 8.441.5.B](#).
- 28 c. When management services are provided to a nursing facility by an owner-
29 related management company, the nursing facility shall compile and present for
30 inspection supporting documentation of actual costs incurred in providing the
31 management company services. This shall include, at a minimum, the following:
- 32 i) Documentation supporting the reasonableness of salaries paid to owners
33 and owner-related employees of the management company, as specified
34 [in 8.441 in 10 CCR 2505-10 section 8.10 CCR 2505-10 section](#)
35 [8.441.5.B](#);
- 36 ii) Allocation schedules;
- 37 iii) Medicare Home Office cost reports;
- 38 iv) All tax records and filings of the management company;
- 39 v) All management company records to support financial statements.

1 d. Documentation supporting the reasonableness of salaries and other
 2 compensation paid to owners and employees of an owner-related management
 3 company shall be available for inspection and shall include, but not be limited to,
 4 the following:

5 i) Salary survey(s) for the geographic location demonstrating that the
 6 salaries and other compensation are comparable to market for their
 7 respective position and size of entity;

8 1) If the provider does not provide a salary survey, the auditor shall
 9 use the latest survey of the Healthcare Financial Management
 10 Association (HFMA).

11 2) Salary surveys are to be of a sufficiently large sample, including
 12 non-related nursing facility management companies, to lend
 13 support to the salaries. Surveys including a small number of
 14 facilities (less than ten), facilities related through common
 15 ownership or control or facilities of incomparable size shall be
 16 considered unacceptable.

17 ii) A position description for the person listing the duties performed;

18 iii) Date and time of services provided by each owner-related individual;

19 iv) Job applications, resumes, professional title, educational qualifications,
 20 and other documentation of work experience and qualifications; and

21 v) The type and extent of ownership interest for each owner or owner-
 22 related individual employed by or performing services for the
 23 management company.

24 e. Limitations shall be based on the median salaries included in the survey(s)
 25 referenced [in 8.441 in 10 CCR 2505-10 section 8.10 CCR 2505-10 section](#)
 26 [8.441.5.H.2.d](#). If the owner or owner-related party receives compensation from
 27 two or more entities, the total compensation received from those entities shall be
 28 evaluated for reasonableness. In the absence of reasonable documentation that
 29 the owners and/or owner-related parties are working employees, the
 30 compensation claimed for these persons shall be disallowed as a cost not related
 31 to patient care.

32 f. Compensation to owners of related party companies, regardless of organizational
 33 structure, must be paid within seventy-five (75) days of the end of the fiscal year.
 34 Payment of the compensation shall be evidenced by documentation submitted to
 35 the IRS. Failure to provide adequate documentation during the field audit process
 36 shall result in disallowance of unsupported or unpaid amounts. Disallowed
 37 compensation shall not be allowed in any future period.

38 8.441.5.I. ITEMS FURNISHED BY RELATED ORGANIZATIONS OR COMMON OWNERSHIP

39 1. Costs applicable to services, facilities and supplies furnished by organizations related to
 40 the nursing facility by common ownership or control are allowable costs of the nursing
 41 facility at the cost to the related organization or the open market price, whichever is less.

42 2. The following definitions are applicable for the purposes of this regulation:

- 1 a. Common ownership means that an individual or individuals directly or indirectly
2 possess a significant (5% or more) ownership interest, as defined ~~in 8.441 in 10~~
3 ~~CCR 2505-10 section 8.10 CCR-2505-10 section 8.441~~.5.B, in the nursing facility
4 and the institution or organization serving the nursing facility.
- 5 b. Control means that an individual or an organization has common ownership with
6 or is related to another organization or institution, or has the power, directly or
7 indirectly, to influence significantly or to direct the actions or policies of another
8 organization or an institution.
- 9 c. Related to the nursing facility means:
- 10 i) The nursing facility, to a significant extent, is associated or affiliated with,
11 or has control of, or is controlled by the organization furnishing the
12 services, facilities or supplies; or
- 13 ii) An owner-related individual, as defined ~~in 8.441 in 10 CCR 2505-10~~
14 ~~section 8.10 CCR-2505-10 section 8.441~~.5.B, is employed by the nursing
15 facility at the time that the nursing facility is obtaining services, facilities
16 or supplies from an organization whose owner is related to the nursing
17 facility employee; or
- 18 iii) An owner-related individual, as defined ~~in 8.441 in 10 CCR 2505-10~~
19 ~~section 8.10 CCR-2505-10-section 8.441~~.5.B, is employed by an
20 organization which is providing services, facilities or supplies to a nursing
21 facility whose owner is related to the supplier's employee.
- 22 3. Related providers or organizations shall be identified by the nursing facility on Schedule F
23 of the MED-I3.
- 24 4. The charge by the related provider or organizations for the services, facilities or supplies
25 shall be considered an allowable cost when the nursing facility demonstrates all of the
26 following by clear and convincing evidence:
- 27 a. The supplying organization is a bona fide separate organization; and
- 28 b. A substantial part of the supplier's business activity of the type carried on with a
29 nursing facility is transacted with others than the nursing facility and
30 organizations related to the supplier by common ownership or control; and there
31 is an open, competitive market for the type of services, facilities, or supplies
32 furnished by the organization; and
- 33 c. The services, facilities or supplies are those which commonly are obtained by
34 institutions, such as the nursing facility, from other organizations and are not
35 basic elements of patient care ordinarily furnished directly to the patients by such
36 institutions; and
- 37 d. The charge to the nursing facility is in line with the charge for such services,
38 facilities, or supplies in the open market and no more than the charge made
39 under comparable circumstances to others by the organization for such services,
40 facilities or supplies.

41 8.441.5.J. NON-SALARIED STAFF

- 1 1. Members of religious orders serving under an agreement with their administrative offices
2 shall be allowed comparable salaries paid persons performing comparable services.
- 3 2. If maintenance is provided such persons by the nursing facility, i.e., room board, clothing,
4 the amount of these benefits shall be deducted from the amount otherwise allowed for a
5 person not receiving maintenance.
- 6 **8.441.5.K. OXYGEN**
- 7 1. Only purchased oxygen concentrator costs, whether expensed or capitalized, shall be
8 allowable costs on the MED-13. Such costs include, but are not limited to, all supplies,
9 equipment and servicing expenses related to the maintenance of the purchased
10 concentrators.
- 11 2. Oxygen concentrators of any size leased by medical supply companies to Medicaid
12 nursing facility residents shall not be allowable costs and shall not be included in the
13 MED-13.
- 14 **8.441.5.L. LIMITATION ON MEDICARE PART A AND PART B COSTS**
- 15 1. Only those Medicare costs that are reasonable, necessary and patient-related shall be
16 included in calculating the allowable Medicaid reimbursement for class I nursing facilities.
- 17 2. The Medicare Part A ancillary costs ("Part A costs") allowed in calculating the Medicaid
18 per diem rate for a class I facility shall be: The level of Part A costs allowed in the
19 facility's latest Medicare cost report submitted by the facility to the Department prior to
20 July 1, 1997.
- 21 3. The Medicare Part A ancillary costs ("Part A costs") allowed in calculating the Medicaid
22 per diem rate for newly certified Medicaid nursing facilities shall be: The level of Part A
23 costs allowed in the facility's first full year Medicaid cost report submitted by the facility to
24 the Department.
- 25 4. Part B direct costs for Medicare shall be excluded from the allowable Medicaid
26 reimbursement for class I nursing facilities.
- 27 **8.441.6 COMPLETION OF OPERATING EXPENSES SCHEDULE**
- 28 8.441.6.A. All expenses should be reported on the operating expenses schedule. All adjustments to
29 eliminate expenses or to apply expense recoveries shall be made on the operating expenses
30 schedule.
- 31 8.441.6.B. Expense centers in operating expenses shall be used for distribution of expenses by
32 object or natural classifications within the department or function. The expenses shall be
33 classified sufficiently within the accounting records to allow preparation of operating expenses
34 schedule.
- 35 8.441.6.C. Total expenses reported on the operating expenses schedule shall agree with the total
36 expenses in the general ledger.
- 37 **8.442 SUBMISSION OF COST REPORTING INFORMATION**

1 8.442.1 Each nursing facility shall complete a Financial and Statistical Report for Nursing Facilities (MED-
2 13) and submit it to the Department's designee at 12-month intervals within ninety (90) days of
3 the close of the facility's fiscal year.

4 8.442.1.A. A nursing facility may request an extension of time to submit the MED-13. The request for
5 extension shall:

- 6 1. Be in writing and shall be submitted to the Department.
- 7 2. Properly document the reasons for the failure to comply.
- 8 3. Be submitted no less than ten (10) working days prior to the due date for submission of
9 the MED-13.

10 8.442.1.B. Failure of a nursing facility to submit its MED-13 within the required ninety (90) day period
11 shall result in the Department withholding all warrants not yet released to the provider as
12 described below:

- 13 1. When a nursing facility fails to submit a complete and auditable MED-13 (i.e., the
14 information represented on the MED-13 can not be verified by reference to adequate
15 documentation as required by generally accepted auditing standards) on time, the MED-
16 13 shall be returned to the facility with written notification that it is unacceptable.
 - 17 a. The facility shall have either 30 days from the postmark date of the notice or until
18 the end of the original 90-day submission period, whichever is later, to submit a
19 corrected MED-13.
 - 20 b. If the corrected MED-13 is still determined to be incomplete or unauditable, the
21 nursing facility shall be given written notification that it shall, at its own expense,
22 submit a MED-13 that has been prepared by a certified public accountant (CPA).
23 The CPA shall certify that the report is in compliance with all Department
24 regulations and shall give an opinion of fairness of presentation of operating
25 results or revenues and expenses.
 - 26 c. The Department shall withhold all warrants not yet released to the provider once
27 the original 90-day filing period and 30-day extension have expired and no
28 acceptable MED-13 has been submitted.
- 29 2. If the audit of the MED-13 is delayed by the nursing facility's lack of cooperation, the
30 effective date for the new rate shall be delayed until the first day of the month in which
31 the audit is completed. Lack of cooperation shall mean failure of the nursing facility to
32 meet its responsibility to submit a timely MED-13 or failure to provide documents,
33 personnel or other resources within its control and necessary for completion of the audit,
34 within a reasonable time.
- 35 3. When the rate for the facility during a period of delay is found to have been higher than
36 the new rate, the new rate shall be applied retroactively to this period and the Department
37 shall make any adjustments and/or recoveries of overpayments.

38 **8.442.2 DELAYS OR CORRECTIONS IN MINIMUM DATA SET (MDS) SUBMITTAL**

39

40

1 8.442.2.A. A nursing facility shall be notified each quarter of its residents' case mix index values,
2 and shall be granted not less than 14 calendar days in which to make any corrections to the
3 resident MDS assessments. After the period of time for correcting resident assessments has
4 passed each quarter, the final nursing facility resident assessment data shall be used by the
5 Department, or its designee, to calculate that quarter's resident case mix acuity adjustment for
6 each facility.

7 8.442.2.B. A nursing facility may request to amend or correct the MED-13 after it has been
8 submitted to the Department's designee as follows:

- 9 1. Requests shall be in writing and shall include an explanation of the need for the revision.
- 10 2. If the revision will not be submitted to the Department's designee within the original 90-
11 day filing period, the date of submission of the MED-13 shall be the date of receipt of the
12 submission. The Department may grant a 30-day extension of the filing period.
- 13 3. Once the original 90-day filing period and 30-day extension have expired, the Department
14 shall withhold all warrants not yet released to the provider if the revision still has not been
15 submitted to the Department.

16 8.442.2.C. Where the Department withholds warrants not yet released to the provider, the following
17 shall apply:

- 18 1. The Department shall withhold all warrants not yet released to the provider for services
19 rendered in the prior three calendar months (four months if an extension was granted)
20 and thereafter until an acceptable MED-13 is received.
- 21 2. Once the Department determines that the ~~MED-13~~MED-13 submitted is complete and
22 auditable, the provider's withheld payments shall be released.
- 23 3. If an acceptable MED-13 has not been submitted within 90 days after the Department
24 began withholding payments, the provider's participation in the Medicaid program shall
25 be terminated and the payments withheld shall be released to the provider.
- 26 4. Interest paid by the provider on loans for working capital while payments are being
27 withheld shall not be allowable costs for purposes of reimbursement under Medicaid.
- 28 5. When the delayed submission of the MED-13 causes the effective date of a new lower
29 rate to be delayed, the new rate shall be applied retroactively to this period and the
30 Department shall make recoveries of overpayments.

31 8.442.3 PROPOSED ADJUSTMENTS

32 8.442.3.A. Following completion of a field audit, desk review or rate calculation, the Department or
33 its contract auditor shall notify the affected provider in writing of any proposed adjustment(s) to
34 the costs reported on the facility's MED-13 form and the basis of the proposed adjustment(s).

35 8.442.3.B. The provider may submit additional documentation in response to proposed adjustments.
36 The department or its contract auditor must receive the additional documentation or other
37 supporting information from the provider within 60 calendar days of the date of the proposed
38 adjustments letter or the documentation will not be considered.

1 8.442.3.C. The Department may grant an additional period, not to exceed 30 calendar days, for the
 2 facility to submit such documents and information, when necessary and appropriate, given the
 3 facility's particular circumstances.

4 8.442.3.D. The Department's contract auditor shall complete the field audit, desk review or rate
 5 calculation within 30 days of the expiration of the 60 day provider response period. The contract
 6 auditor shall also complete and deliver the resulting rate letter to the Department by the 30th day
 7 following the expiration of the 60 day provider response period.

8 **8.443 NURSING FACILITY REIMBURSEMENT**

9 8.443.1.A. Where no specific Medicaid authority exists, the sources listed below shall be considered
 10 in reaching a rate determination:

- 11 1. Medicare statutes.
- 12 2. Medicare regulations.
- 13 3. Medicaid and Medicare guidelines.
- 14 4. Generally accepted accounting principles.

15 8.443.1.B. For class I nursing facilities, a payment rate for each participating nursing facility shall be
 16 determined on the basis of information on the MED-13, the Minimum Data Set (MDS) resident
 17 assessment information and information obtained by the Department or its designee retained for
 18 the purpose of cost auditing.

19 The nursing facility prospective per diem rate includes the following components:

- 20 1. Health Care.
- 21 2. Administrative and General.
- 22 3. Fair Rental Allowance for Capital-Related Assets.

23 The Health Care, Administrative and General and Fair Rental Allowance for Capital-Related
 24 Assets components are referred to as "core components".

25 In addition to the above per diem reimbursement for core components, a nursing facility
 26 prospective supplemental payment shall be made for:

- 27 1. Residents who have moderately to very severe mental health conditions, cognitive
 28 dementia, or acquired brain injury.
- 29 2. Residents who have severe mental health conditions that are classified at Level II by the
 30 Medicaid program's Preadmission Screening and Resident Review (PASRR) assessment
 31 tool.
- 32 3. Care and services rendered to Medicaid residents to recognize the costs of the provider
 33 fee. Only Medicaid's portion of the provider fee will be included in the supplemental
 34 payment. The provider fee supplemental payment shall not be equal to the amount of the
 35 fee charged and collected but shall be an amount equal to a calculated per diem fee
 36 charged multiplied by the number of Medicaid resident days for the facility. Costs
 37 associated with the provider fee are not an allowable cost on the MED-13.

1 4. Facilities that have implemented a program meeting specified performance criteria
2 beginning July 1, 2009.

3 8.443.1.C For class II and privately-owned class IV intermediate care ~~facilities for the mentally~~
4 ~~retarded individuals with an intellectual or developmental disability~~ Facilities for Individuals with
5 Intellectual Disabilities, a payment rate for each participating facility shall be determined on the
6 basis of the MED-13 and information obtained by the Department or its designee retained for the
7 purpose of cost auditing.

8 The facility's prospective per diem rate includes the following components:

- 9 1. Health Care.
- 10 2. Administrative and General.
- 11 3. Fair Rental Allowance for Capital-Related Assets.

12 8.443.1.D For state-operated class IV intermediate care ~~facilities for the mentally~~
13 ~~retarded individuals with an intellectual or developmental disability~~ Facilities for Individuals with
14 Intellectual Disabilities, a payment rate for each participating facility shall be determined on the
15 basis of the MED-13 and information obtained by the Department or its designee retained for the
16 purpose of cost auditing.

17 The facility's retrospective per diem rate includes the following components:

- 18 1. Health Care.
- 19 2. Administrative and General, which includes capital.

20 8.443.1.E. For swing-bed facilities, the annual payment rate shall be determined as the state-wide
21 average class I nursing facilities payment rate at January 1 of each year.

22 8.443.1.F. No nursing facility care shall receive reimbursement unless and until the nursing facility:

- 23 1. Has a license from ~~the Colorado Department of Public Health and Environment~~
24 ~~(CDPHE)~~, and
- 25 2. Is a Medicaid participating provider of nursing care services, and
- 26 3. Meets the requirements of the Department's regulations.

27 8.443.2 NURSING FACILITY CLASSIFICATIONS

28 1. Class I facilities are those facilities licensed and certified to provide general skilled nursing facility
29 care.

30 2. Class II facilities are those facilities whose program of care is designed to treat developmentally
31 disabled individuals whose medical and psychosocial needs are best served by receiving care in
32 a community setting.

33 a. Class II facilities shall provide care and services designed to maximize each resident's
34 capacity for independent living and shall seek out and utilize other community programs
35 and resources to the maximum extent possible according to the needs and abilities of
36 each individual resident.

1 b. Class II facilities serve persons whose medical and psychosocial needs require services
 2 in an institutional setting and are expected to provide such services in an environment
 3 which approximates a home-like living arrangement to the maximum extent possible
 4 within the constraints and limitations inherent in an institutional setting.

5 c. Class II facilities shall be certified in accordance with 42 C.F.R. [sectionpart](#) 442, Subpart
 6 C, [and](#) 42 C.F.R. [sectionpart](#) 483 and shall be licensed by ~~the~~ CDPHE. Class II facilities
 7 shall provide care and a program of services consistent with licensure and certification
 8 requirements.

9 3. Class IV facilities are those facilities whose program of care is designed to treat developmentally
 10 disabled individuals who have intensive medical and psychosocial needs which require a highly
 11 structured in-house comprehensive medical, nursing, developmental and psychological treatment
 12 program.

13 a. Class IV facilities shall offer full-time, 24-hour interdisciplinary and professional treatment
 14 by staff employed at such facility. Staff must be sufficient to implement and carry out a
 15 comprehensive program to include, but not necessarily be limited to, care, treatment,
 16 training and education for each individual.

17 b. Class IV facilities shall be certified in accordance with 42 C.F.R. [sectionpart](#) 442, Subpart
 18 C, [and](#) 42 C.F.R. [sectionpart](#) 483 and shall be licensed by ~~the~~ CDPHE. Class IV facilities
 19 shall provide care and a program of services consistent with licensure and certification
 20 requirements.

21 c. State-administered, tax-supported facilities are not subject to the maximum
 22 reimbursement provisions and do not earn an incentive allowance.

23 d. Private, non-profit or proprietary facilities that are not tax-supported or state-administered
 24 are subject to the maximum reimbursement provisions and may earn an incentive
 25 allowance.

26 **8.443.3 IMPUTED OCCUPANCY FOR CLASS II AND PRIVATELY OWNED CLASS IV FACILITIES**

27 8.443.3.A. The Department or its designee shall determine the audited allowable costs per patient
 28 day.

29 1. The Department shall utilize the total audited patient days on the MED-13 unless the
 30 audited patient days on the MED-13 constitute an occupancy rate of less than 85 percent
 31 of licensed bed day capacity when computing the audited allowable cost per patient day
 32 for all rates.

33 2. In such cases, the patient days shall be imputed to an 85 percent rate of licensed bed
 34 day capacity for the nursing facility and the per diem cost along with the resulting per
 35 diem rate shall be adjusted accordingly except that imputed occupancy shall not be
 36 applied in calculating the facility's health care services and food costs.

37 3. The licensed bed capacity shall remain in effect until the Department is advised that the
 38 licensed bed capacity has changed through the filing of a subsequent cost report.

39 4. The imputed patient day calculation shall remain in effect until a new rate from a
 40 subsequent cost report is calculated. Should the subsequent cost report indicate an
 41 occupancy rate of less than 85 percent of licensed bed day capacity, the resulting rate
 42 shall be imputed in accordance with the provisions of this section.

1 8.443.3.B. Nursing facilities located in rural communities with a census of less than 85 percent shall
 2 not be subject to imputed occupancy. A nursing facility in a rural community shall be defined as a
 3 nursing facility in:

- 4 1. A county with a population of less than fifteen thousand; or
- 5 2. A municipality with a population of less than fifteen thousand which is located ten miles or
 6 more from a municipality with a population of over fifteen thousand; or
- 7 3. The unincorporated part of a county ten miles or more from a municipality with a
 8 population of fifteen thousand or more.

9 8.443.3.C. Any nursing facility that has a reduction in census, causing it to be less than 85 percent,
 10 resulting from the relocation of mentally ill or developmentally disabled residents to alternative
 11 facilities pursuant to the provisions of the Omnibus Reconciliation Act of 1987 shall:

- 12 1. Be entitled to the higher of the imputed occupancy rate or the median rate computed by
 13 the Department for two cost reporting periods.
- 14 2. The imputed occupancy calculation shall be applied when required at the end of this
 15 period.

16 8.443.3.D. Imputed occupancy shall be applied to a new nursing facility as follows:

- 17 1. A new nursing facility means a facility not in the Colorado Medicaid program within thirty
 18 days prior to the start date of the Medicaid provider agreement.
- 19 2. For the first cost report submitted by a new facility, the facility shall be entitled to the
 20 higher of the imputed rate or the median rate computed by the Department.
- 21 3. For the second cost report submitted by a new facility, imputed occupancy shall be
 22 applied but the rate for the new facility shall not be lower than the 25th percentile nursing
 23 facility rate as computed by the Department in the median computation.
- 24 4. For the third cost report and cost reports thereafter, imputed occupancy shall be applied
 25 without exception.

26 8.443.3.E. Nursing facilities undergoing a state-ordered change in case mix or patient census that
 27 significantly reduces the level of occupancy in the facility shall:

- 28 1. Be entitled to the higher of the imputed occupancy rate or the monthly weighted average
 29 rate computed by the Department for two cost reporting periods.
- 30 2. At the end of this period, the imputed occupancy calculation shall be applied when
 31 required.

32 **8.443.4 INFLATION ADJUSTMENT**

33 8.443.4.A For class I nursing facilities, the per diem amount paid for direct and indirect health care
 34 services and administrative and general services costs shall include an allowance for inflation in
 35 the costs for each category using a nationally recognized service that includes the federal
 36 government's forecasts for the prospective Medicare reimbursement rates recommended to the
 37 United States Congress. Amounts contained in cost reports used to determine the per diem
 38 amount paid for each category shall be adjusted by the percentage change in this allowance

1 measured from the midpoint of the reporting period of each cost report to the midpoint of the
2 payment-setting period.

3 1. The percentage change shall be rounded at least to the fifth decimal point.

4
5 2. The index used for this allowance will be the Skilled Nursing Facility Market Basket
6 (without capital) published by Global Insight, Inc. The latest available publication prior to
7 July 1 rate setting shall be used to determine inflation indexes. The inflation indexes shall
8 be revised and published every July 1 to be used for rate effective dates between July 1,
9 and June 30.

10 8.443.4.B For class II and privately-owned class IV facilities , at the beginning of each facility's new
11 rate period, the inflation adjustment shall be applied to all costs except provider fees, interest, and
12 costs covered by fair rental allowance.

13 1. The inflation adjustment shall equal the annual percentage change in the National
14 Bureau of Labor Statistics Consumer Price Index (U.S. city average, all urban
15 consumers), from the preceding year, times actual costs (less interest expense and costs
16 covered by the fair rental allowance) or times reasonable cost for that class facility,
17 whichever is less.

18 2. The annual percentage change in the National Bureau of Labor Statistics Consumer
19 Price Index shall be rounded at least to the fifth decimal point.

20 3. The price indexes listing in the latest available publication prior to the July 1 limitation
21 setting shall be used to determine inflation indexes. The inflation indexes shall be revised
22 and published every July 1 to be used for rate effective dates between July 1 and June
23 30.

24 4. The provider's allowable cost shall be multiplied by the change in the consumer price
25 index measured from the midpoint of the provider's cost report period to the midpoint of
26 the provider's rate period.

27 **8.443.5 ADMINISTRATIVE COST INCENTIVE ALLOWANCE FOR CLASS II AND PRIVATELY**
28 **OWNED CLASS IV FACILITIES**

29 8.443.5.A. If the nursing facility's combined audited administration, property, and room and board
30 (excluding raw food, land, buildings, leasehold and fixed equipment) cost per patient day is less
31 than the maximum reasonable cost for administration, property and room and board (excluding
32 raw food, land, buildings, leasehold and fixed equipment) costs for the class, the provider will
33 earn an incentive allowance.

34 8.443.5.B. The incentive allowance for class II and privately owned class IV facilities shall be
35 calculated at 25 percent of the difference between the facility's audited inflation adjusted cost and
36 the maximum reasonable cost for that class. The incentive allowance will not exceed 12 percent
37 of the reasonable cost.8.443.5.C. No incentive allowance shall be paid on health care services,
38 raw food, fair rental value allowance and leasehold costs.

39 **8.443.6 CASE MIX ADJUSTMENTS**

40 8.443.6.A. The resource utilization group—III (RUG-III) 34 category, index maximizer model, version
41 5.12b, as published by the Centers for Medicare and Medicaid Services (CMS), [The resource](#)

1 [utilization group—III \(RUG-III\) 34 category, index maximizer model, version 5.12b- is hereby](#)
 2 [incorporated by reference. The incorporation of RUG-III 34 category, index maximizer model,](#)
 3 [version 5.12b excludes later amendments to, or editions of, the referenced material. The](#)
 4 [Department maintains copies of this incorporated text in its entirety, available for public inspection](#)
 5 [during regular business hours at: Colorado Department of Health Care Policy and Financing,](#)
 6 [1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at](#)
 7 [cost upon request, shall be used to adjust costs reported in the health care cost center in the](#)
 8 [determination of limits and in the rate calculation. No amendments or later editions are](#)
 9 [incorporated. Copies are available for inspection from the following person at the following](#)
 10 [address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570](#)
 11 [Grant Street, Denver, Colorado 80203-1818. Any material that has been incorporated by](#)
 12 [reference in this rule may be examined at any state publications depository library. The](#)
 13 Department may update the classification methodology to reflect advances in resident
 14 assessment or classification subject to federal requirements.

15 8.443.6.B. The Department shall distribute facility listings identifying current assessments for
 16 residents in the nursing facility on the 1st day of the first month of each quarter as reflected in the
 17 Department's MDS assessment database.

- 18 1. The listings shall identify resident social security numbers, names, assessment reference
 19 date, the calculated RUG-III category and the payor source as reflected on the prior full
 20 assessment and/or current claims data.
- 21 2. Resident listings shall be reviewed by the nursing facility for completeness and accuracy.
- 22 3. If data reported on the resident listings is in error or if there is missing data, facilities shall
 23 have until the last day of the second month of each quarter to correct data submissions,
 24 or until a later date if approved by the Department pursuant to [10-C.C.R.-2505-10,](#)
 25 [Section 2505-10 section 8.10 CCR 2505-10 section 8.442.2.](#)
 - 26 a. Errors or missing data on the resident listings due to untimely submissions to the
 27 CMS database maintained by ~~the~~ CDPHE shall be corrected by the nursing
 28 facility transmitting the appropriate assessments or tracking documents to
 29 CDPHE.
 - 30 b. Errors in key field items shall be corrected by following the CMS key field
 31 specifications through ~~the~~ CDPHE
 - 32 c. Errors on the current payor source shall be noted on the resident listings prior to
 33 signing and returning to the Department.
- 34 4. Each nursing facility shall sign and return its resident listing to the Department no later
 35 than 15 calendar days after it was mailed by the Department.
- 36 5. Residents shall be assigned a RUG-III group calculated on their most current non-
 37 delinquent assessment available on the 1st day of the first month of each quarter as
 38 amended during the correction period.
 - 39 a. The RUG-III group shall be translated to the appropriate case mix index or
 40 weight.
 - 41 b. Two average case mix indices for each Medicaid nursing facility shall be
 42 determined from the individual case mix weights for the applicable quarter:

- 1 i) The facility average case mix index shall be a simple average, carried to
2 four decimal places, of all resident case mix indices.
- 3 ii) The Medicaid average case mix index shall be a simple average, carried
4 to four decimal places, of all residents where Medicaid is the per diem
5 payor source anytime during the 30 days prior to their current
6 assessment.
- 7 c. Any incomplete assessments and current assessment in the database older than
8 122 days shall be included in the calculation of the averages using the case mix
9 index established in these rules.

10 **8.443.7 HEALTH CARE REIMBURSEMENT RATE CALCULATION**

11 8.443.7.A Health Care Services Defined: Health Care Services means the categories of
12 reasonable, necessary and patient-related support services listed below. No service shall be
13 considered a health care service unless it is listed below:

- 14 1. The salaries, payroll taxes, worker compensation payments, training and other employee
15 benefits of registered nurses, licensed practical nurses, restorative aides, nurse aides,
16 feeding assistants, registered dietician, MDS coordinators, nursing staff development
17 personnel, nursing administration (not clerical) case manager, patient care coordinator,
18 quality improvement, clinical director. These personnel shall be appropriately licensed
19 and/or certified, although nurse aides may work in any facility for up to four months
20 before becoming certified.

21 If a facility employee or a management company/home office employee or owner has
22 dual health care and administrative duties, the provider must keep contemporaneous
23 time records or perform time studies to verify hours worked performing health care
24 related duties. If no contemporaneous time records are kept or time studies performed,
25 total salaries, payroll taxes and benefits of personnel performing health care and
26 administrative functions will be classified as administrative and general. Licenses are not
27 required unless otherwise specified. Periodic time studies in lieu of contemporaneous
28 time records may be used for the allocation. Time studies used must meet the following
29 criteria:

- 30 a. A minimally acceptable time study must encompass at least one full week per
31 month of the cost reporting period.
- 32 b. Each week selected must be a full work week (Monday to Friday, Monday to
33 Saturday, or Sunday to Saturday).
- 34 c. The weeks selected must be equally distributed among the months in the cost
35 reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must
36 be the first week beginning in the month, 3 weeks the 2nd week beginning in the
37 month, 3 weeks the 3rd, and 3 weeks the fourth.
- 38 d. No two consecutive months may use the same week for the study, e.g., if the
39 second week beginning in April is the study week for April, the weeks selected for
40 March and May may not be the second week beginning in those months.
- 41 e. The time study must be contemporaneous with the costs to be allocated. Thus, a
42 time study conducted in the current cost reporting year may not be used to
43 allocate the costs of prior or subsequent cost reporting years.

- 1 f. The time study must be provider specific. Thus, chain organizations may not use
2 a time study from one provider to allocate the costs of another provider or a time
3 study of a sample group of providers to allocate the costs of all providers within
4 the chain.
- 5 2. The salaries, payroll taxes, workers compensation payments, training and other
6 employee benefits of medical records librarians, social workers, central or medical
7 supplies personnel and activity personnel.
- 8 Health Information Managers (Medical Records Librarians): Must work directly with the
9 maintenance and organization of medical records.
- 10 Social Workers: Includes social workers, life enhancement specialists and admissions
11 coordinators.
- 12 Central or Medical Supply personnel: Includes duties associated with stocking and
13 ordering medical and/or central supplies.
- 14 Activity personnel: Personnel classified as "activities" must have a direct relationship (i.e.,
15 providing entertainment, games, and social opportunities) to residents. For instance,
16 security guards and hall monitors do not qualify as activities personnel. Costs associated
17 with security guards and hall monitors are classified as administrative and general.
- 18 3. If the provider's chart of accounts directly identifies payroll taxes and benefits associated
19 with health care versus administrative and general cost centers, the amounts directly
20 identified will be appropriately allowed as either health care or administrative and general.
21 If these costs are comingled in the chart of accounts, payroll taxes and benefits shall be
22 allocated to the cost centers (health care and administrative and general) based on total
23 employee wages reported in those cost centers. The reporting method for payroll taxes
24 and benefits by cost center is required to be consistent from year to year. When a
25 provider wishes to change its reporting method because it believes the change will result
26 in more appropriate and a more accurate allocation, the provider must make a written
27 request to the Department for approval of the change ninety (90) days prior to the end of
28 that cost reporting period. The Department has sixty (60) days from receipt of the request
29 to make a decision or the change is automatically accepted. The provider must include
30 with the request all supporting documentation to establish that the new method is more
31 accurate. If the Department approves the provider's request, the change must be applied
32 to the cost reporting period for which the request was made and to all subsequent cost
33 reporting periods. The approval will be for a minimum three year period. The provider can
34 not change methods until the three year period has expired.
- 35 4. Personnel licensed to perform patient care duties shall be reported in the administrative
36 and general cost center if the duties performed by these personnel are administrative in
37 nature.
- 38 5. Non-prescription drugs ordered by a physician that are included in the per diem rate,
39 including costs associated with vaccinations.
- 40 6. Consultant fees for nursing, medical records, registered dieticians, patient activities,
41 social workers, pharmacies, physicians and therapies. Consultants shall be appropriately
42 licensed and/or certified, as applicable and professionally qualified in the field for which
43 they are consulting. The guidance provided in (1) above for employees also applies to
44 consultants.

1 7. Purchases, rental, depreciation, interest and repair expenses of health care equipment
 2 and medical supplies used for health care services such as nursing care, medical
 3 records, social services, therapies and activities. Purchases, lease expenses or fees
 4 associated with computers and software (including the associated training and upgrades)
 5 used in departments within the facility that provide direct or indirect health care services
 6 to residents. Dual purpose software that includes both a health care and administrative
 7 and general component will be considered a health care service.

8 8. Purchase or rental of motor vehicles and related expenses, including salary and benefits
 9 associated with the van driver(s), for operating or maintaining the vehicles to the extent
 10 that they are used to transport residents to activities or medical appointments. Such use
 11 shall be documented by contemporaneous logs if there is dual purpose. An example of
 12 the dual purpose vehicle is one used for both resident transport and maintenance
 13 activities.

14 9. Copier lease expense.

15 10. Salaries, fees, or other expenses related to health care duties performed by a facility
 16 owner or manager who has a medical or nursing credential. Note that costs associated
 17 with the Nursing Home Administrator are an administrative and general cost.

18 11. Related Party Management Fees and Home Office Costs

19 Related party management fees and home office costs shall be classified as
 20 administrative and general. However, costs incurred by the facility as a direct charge from
 21 the related party which are listed in this section, may be included in the health care cost
 22 center equal to the actual costs incurred by the related party. Documentation supporting
 23 the cost and health care licenses must be maintained. Only salaries, payroll taxes and
 24 employee benefits associated with health care personnel will be considered as allowable
 25 in the health care cost center. No overhead expenses will be included. The amount
 26 allowable in the health care cost category will be calculated in one of two ways:

27 a. Keeping contemporaneous time logs in 15 minute increments supporting the
 28 number of hours worked at each facility.

29 b. Distributing the cost evenly across all facilities as follows: the amount allowable
 30 in each health care facility's health care costs shall be equal to the total salary,
 31 payroll taxes and benefits of the health care personnel divided by the number of
 32 facilities where the health care personnel worked during the year. For example, if
 33 a nurse's total salary, payroll taxes, and benefits total \$80,000, and the nurse
 34 worked on five facilities during the year, \$16,000 is allowable in each of the
 35 facility's health care costs.

36 Auditable documentation supporting the number of facilities worked on during the year
 37 must be maintained. Even if a related party exception is granted in accordance with [49](#)
 38 [CCR 2505-10-section-8.10 CCR 2505-10 section 8.441.5.I.4](#), no mark-up or profit will be
 39 allowed in the health care cost center, only supported actual costs.

40 Non-Related Party Management Fees

41 Non-related party management fees shall be classified as administrative and general.
 42 However, costs incurred by the facility as a direct charge from the management company
 43 which are listed in this section, may be included in the health care cost center.

1 Management contracts which specify percentages related to health care services will not
2 be considered a direct charge from the management company.

3 12. Professional liability insurance, whether self-insurance or purchased, loss settlements,
4 claims paid and insurance deductibles.

5 13. Medical director fees.

6 14. Therapies and services provided by an individual qualified to provide these services
7 under Federal Medicare/Medicaid regulations including:

8 Utilization review

9 Dental care, when required by federal law

10 Audiology

11 Psychology and mental health services

12 Physical therapy

13 Recreational therapy

14 Occupational therapy

15 Speech therapy

16 15. Nursing licenses and permits, disposal costs associated with infectious material (medical
17 or hazardous waste), background checks and flu or hepatitis shots and uniforms for
18 personnel listed in (1) above.

19 16. Food Costs. Food costs means the cost of raw food, and shall not include the costs of
20 property, staff, preparation or other items related to the food program.

21 8.443.7.B CLASS I HEALTH CARE STATE-WIDE MAXIMUM ALLOWABLE PER DIEM
22 REIMBURSEMENT RATES (LIMIT)

23 For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem rate for
24 direct and indirect health care services and raw food, the state department shall establish an
25 annual maximum allowable rate (limit). In computing the health care per diem limit, each nursing
26 facility provider shall annually submit cost reports, and actual days of care shall be counted, not
27 occupancy-imputed days of care. The health care limit will be calculated as follows:

28 1. Determination of the health care limit beginning on July 1 each year shall utilize the most
29 current MED-13 cost report filed, in accordance with these regulations, by each facility on
30 or before December 31 of the preceding year.

31 2. The MED-13 cost report shall be deemed filed if actually received by the Department's
32 designee or postmarked by the U.S. Postal Service on or before December 31.

33 3. If, in the judgment of the Department, the MED-13 contains errors, whether willful or
34 accidental, that would impair the accurate calculation of the limit, the Department may:

35 a. Exclude part, or all, of a provider's MED-13.

1 b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider
2 submitted in its most recent audited cost report adjusted by the percentage
3 change in the Skilled Nursing Facility Market Basket (without capital) published
4 by Global Insight, Inc. measured from the midpoint of the reporting period to the
5 midpoint of the payment-setting period.

6 4. The health care limit and the data used in that computation shall be subject to
7 administrative appeal only on or before the expiration of the thirty (30) day period
8 following the date the information is made available.

9 5. The health care limit shall not exceed one hundred twenty-five percent (125%) of the
10 median costs of direct and indirect health care services and raw food as determined by
11 an array of all class I facility providers; except that, for state veteran nursing homes, the
12 health care limit will be one hundred thirty percent (130%) of the median cost.

13 a. In determining the median cost, the cost of direct health care shall be case-mix
14 neutral.

15 b. Actual days of care shall be counted, not occupancy-imputed days of care, for
16 purposes of calculating the health care limit.

17 c. Amounts contained in cost reports used to determine the health care limit shall
18 be adjusted by the percentage change in the Skilled Nursing Facility Market
19 Basket (without capital) inflation indexes published by Global Insight, Inc.
20 measured from the midpoint of the reporting period of each cost report to the
21 midpoint of the payment-setting period.

22 i). The percentage change shall be rounded at least to the fifth decimal
23 point.

24 ii). The latest available publication prior to July 1 rate setting shall be used
25 to determine the inflation indexes.

26 6. Annually, the state department shall redetermine the median per diem cost based upon
27 the most recent cost reports filed during the period ending December 31 of the prior year.

28 7. The health care limit for health care reimbursement shall be changed effective July 1 of
29 each year and individual facility rates shall be adjusted accordingly.

30 8.443.7.C. CLASS I HEALTH CARE PER DIEM LIMITATION ON HEALTH CARE GROWTH

31 For the fiscal year beginning July 1, 2009, and for each fiscal year thereafter, any increase in the
32 direct and indirect health care services and raw food costs shall not exceed eight percent (8%)
33 per year. The calculation of the eight percent per year limitation for rates effective on July 1,
34 2009, shall be based on the direct and indirect health care services and raw food costs in the as-
35 filed facility's cost reports up to and including June 30, 2009. For the purposes of calculating the
36 eight percent limitation for rates effective after July 1, 2009, the limitation shall be determined and
37 indexed from the direct and indirect health care services and raw food costs as reported and
38 audited for the rates effective July 1, 2009.

39 8.443.7.D. CLASS I HEALTH CARE PER DIEM REIMBURSEMENT RATES AND MEDICAID CASE
40 MIX INDEX (CMI):

1 For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem
 2 rate for the cost of direct and indirect health care services and raw food, the State Department
 3 shall establish an annually readjusted schedule to pay each nursing facility provider the actual
 4 amount of the costs. This payment shall not exceed the health care limit described at 8.4 at 10
 5 CCR 2505-10 section 8-10 CCR 2505-10 section 8.443.7B. The health care per diem
 6 reimbursement rate is the lesser of the provider's acuity adjusted health care limit or the
 7 provider's acuity adjusted actual allowable health care costs.

8 The state department shall adjust the per diem rate to the nursing facility provider for the cost of
 9 direct health care services based upon the acuity or case-mix of the nursing facility provider's
 10 residents in order to adjust for the resource utilization of its residents. The state department shall
 11 determine this adjustment in accordance with each resident's status as identified and reported by
 12 the nursing facility provider on its federal Medicare and Medicaid minimum data set assessment.
 13 The state department shall establish a case-mix index for each nursing facility provider according
 14 to the resource utilization groups system, using only nursing weights. The state department shall
 15 calculate nursing weights based upon standard nursing time studies and weighted by facility
 16 population distribution and Colorado-specific nursing salary ratios. The state department shall
 17 determine an average case-mix index for each nursing facility provider's Medicaid residents on a
 18 quarterly basis

- 19 1. Acuity information used in the calculation of the health care reimbursement rate shall be
 20 determined as follows:
- 21 a. A facility's cost report period resident acuity case mix index shall be the average
 22 of quarterly resident acuity case mix indices, carried to four decimal places, using
 23 the facility wide resident acuity case mix indices. The quarters used in this
 24 average shall be the quarters that most closely coincide with the cost reporting
 25 period.
- 26 b. The facility's Medicaid resident acuity case mix index shall be a two quarter
 27 average, carried to four decimal places, of the Medicaid resident acuity average
 28 case mix indices. The two quarter average used in the July 1 rate calculation
 29 shall be the same two quarter average used in the rate calculation for the rate
 30 effective date prior to July 1.
- 31 c. The statewide average case mix index shall be a simple average, carried to four
 32 decimal places, of the cost report period case mix indices for all Medicaid
 33 facilities calculated effective each July 1.
- 34 d. The normalization ratio shall be determined by dividing the statewide average
 35 case mix index by the facility's cost report period case mix index.
- 36 e. The facility Medicaid acuity ratio shall be determined by dividing the facility's
 37 Medicaid resident acuity case mix index by the facility cost report period case mix
 38 index.
- 39 f. The facility overall resident acuity ratio shall be determined by dividing the facility
 40 cost report period case mix index by the statewide average case mix acuity
 41 index.
- 42 2. The annual facility specific direct health care maximum reimbursement rate shall be
 43 determined as follows:

- 1 a. The percentage of the normalized per diem case mix adjusted nursing cost to
 2 total health care cost shall be determined by dividing the normalized per diem
 3 case mix adjusted nursing cost by the sum of the normalized per diem case mix
 4 adjusted nursing cost and other health care per diem cost.
- 5 b. The statewide health care maximum allowable reimbursement rate (calculated at
 6 ~~8.4~~ ~~at 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.443.7B~~) shall be
 7 multiplied by the percentage established in the preceding paragraph to determine
 8 the amount of the statewide health care maximum allowable reimbursement rate
 9 that is attributable to the case mix reimbursement rate component.
- 10 c. The facility specific maximum reimbursement rate for case mix adjusted nursing
 11 costs shall be determined by multiplying the facility specific overall acuity ratio by
 12 the amount of the statewide health care maximum allowable reimbursement rate
 13 that is attributable to the case mix reimbursement rate component as established
 14 in the preceding paragraph.
- 15 3. The annual facility specific indirect health care maximum allowable reimbursement shall
 16 be determined as follows:
- 17 a. The percentage of the indirect health care per diem cost to total health care cost
 18 shall be determined by dividing the indirect health care per diem cost by the sum
 19 of the normalized per diem case mix adjusted nursing cost and other health care
 20 per diem cost.
- 21 b. The facility specific in direct health care maximum reimbursement rate shall be
 22 determined by multiplying the statewide health care maximum allowable
 23 reimbursement rate by the percentage established in the preceding paragraph.
- 24 4. The case mix reimbursement rate component shall be determined as follows:
- 25 a. The case mix reimbursement rate component shall be established using the
 26 facility Medicaid resident acuity ratio.
- 27
- 28 b. This ratio shall be multiplied by the lesser of the facility's allowable case mix
 29 adjusted nursing cost or the facility specific maximum reimbursement rate for
 30 case mix adjusted nursing costs. The resulting calculation shall be the case mix
 31 reimbursement rate component.
- 32 5. The indirect health care reimbursement rate shall be the lesser of the facility's allowable
 33 other health care cost or the facility specific other health care maximum reimbursement
 34 rate.
- 35 8.443.7.E DETERMINATION OF THE HEALTH CARE SERVICES MAXIMUM ALLOWABLE RATE
 36 (LIMIT) FOR CLASS II AND IV FACILITIES
- 37 1. For class II facilities, one hundred twenty-five percent (125%) of the median actual costs
 38 of all class II facilities;
- 39 2. For non-state administered class IV facilities, one hundred twenty-five percent (125%) of
 40 the median actual costs of all class IV facilities.

- 1 3. State-administered class IV facilities shall not be subject to the health care limit. The
2 Med-13s of the state-administered class IV facilities shall be included in the health care
3 limit calculation for other class IV facilities.
- 4 4. The determination of the reasonable cost of services shall be made every 12 months.
- 5 5. Determination of the health care limit beginning on July 1 each year shall utilize the most
6 current MED-13 cost report filed in accordance with these regulations, by each facility on
7 or before May 2.
- 8 6. The MED-13 cost report shall be deemed submitted if actually received by the
9 Department's designee or postmarked by the U.S. Postal Service on or before May 2nd.
- 10 7. If, in the judgment of the Department, the MED-13 contains errors, whether willful or
11 accidental, that would impair the accurate calculation of reasonable costs for the class,
12 the Department may:
- 13 a. Exclude part, or all, of a provider's MED-13; or
- 14 b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider
15 submitted in its most recent audited cost report adjusted by the change in the
16 "medical care" component of the Consumer Price Index published for all urban
17 consumers (CPI-U) by the United States Department of Labor, Bureau of Labor
18 Statistics over the time period from the provider's most recent audited cost
19 report.
- 20 8. State-administered class IV facilities shall not be subject to the maximum reasonable rate
21 ceiling. The Med-13s of the state-administered class IV facilities shall be included in the
22 maximum rate calculation for other class IV facilities.
- 23 9. The maximum reasonable rate and the data used in that computation shall be subject to
24 administrative appeal only on or before the expiration of the thirty (30) day period
25 following the date the information is made available.
- 26 10. The maximum rate for reimbursement shall be changed effective July 1 of each year and
27 individual facility rates shall be adjusted accordingly.

28 8.443.8 REIMBURSEMENT FOR ADMINISTRATIVE AND GENERAL COSTS

- 29 8.443.8.A. Administration Costs means the following categories of reasonable, necessary and
30 patient-related costs:
- 31 1. The salaries, payroll taxes, worker compensation payments, training and other employee
32 benefits of the administrator, assistant administrator, bookkeeper, secretarial, other
33 clerical help, hall monitors, security guards, janitorial and plant staff and food service
34 staff. Staff who perform duties in both administrative and health care services shall
35 maintain contemporaneous time records or perform a time study in order to properly
36 allocate their salaries between cost centers. Time studies used must meet the criteria
37 described [in 8.4 in 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.443.7.A.1.](#)
- 38 2. Any portion of other staff costs directly attributable to administration.
- 39 3. Advertising and public relations.

- 1 4. Recruitment costs and staff want ads for all personnel.
- 2 5. Office supplies.
- 3 6. Telephone costs.
- 4 7. Purchased services: accounting fees, legal fees; computer network infrastructure fees.
- 5 Computers and software used in administrative and general departments.
- 6 8. Management fees and home office costs, except as described ~~in 8.4 in 10 CCR 2505-10~~
- 7 ~~section 8.10 CCR 2505-10 section 8.443.7.A.13.~~
- 8 9. Licenses and permits (except health care licenses and permits) and training for
- 9 administrative personnel, dues for professional associations and organizations.
- 10 10. All business related travel of facility staff and consultants, except that required for
- 11 transporting residents to activities or for medical purposes.
- 12 11. Insurance, including insurance on vehicles used for resident transport, is an
- 13 administrative cost. The only exception is professional liability insurance, which is a
- 14 health care cost.
- 15 12. Facility membership fees and dues in trade groups or professional organizations.
- 16 13. Miscellaneous general and administrative costs.
- 17 14. Purchase or rental of motor vehicles and related expenses for operating or maintaining
- 18 the vehicles. However, such costs shall be considered health care services to the extent
- 19 that the motor vehicles are used to transport residents to activities or medical
- 20 appointments. Such use shall be documented by contemporaneous logs.
- 21 15. Purchases (including depreciation and interest), rentals, repairs, betterments and
- 22 improvements of equipment utilized in administrative departments, including but not
- 23 limited to the following:
- 24 Resident room furniture and decor, excluding beds and mattresses
- 25 Office furniture and decor
- 26 Dining room and common area furniture and decor
- 27 Lighting fixtures
- 28 Artwork
- 29 Computers and related software used in administrative departments
- 30 16. Allowable audited interest not covered by the fair rental allowance or related to the
- 31 property costs listed below.
- 32 17. All other reasonable, necessary and patient-related costs which are not specifically set
- 33 forth in the description of "health care services" above, and which are not property, room
- 34 and board, food or capital-related assets.

- 1 18. Background checks and flu or hepatitis shots and uniforms for personnel listed in (1)
2 above.
- 3 19. Provider fees for Class II and Class IV facilities.
- 4 8.443.8.B Property costs include:
- 5 1. Depreciation costs of non fixed equipment (i.e., major moveable equipment and minor
6 equipment not used for direct health care).
- 7 2. Rental costs of non fixed equipment (i.e., major moveable equipment and minor
8 equipment not used for direct health care).
- 9 3. Property taxes.
- 10 4. Property insurance.
- 11 5. Mortgage insurance.
- 12 6. Interest on loans associated with property costs covered in this section.
- 13 7. Repairs, betterments and improvements to property not covered by the fair rental
14 allowance.
- 15 8. Repair, maintenance, betterments or improvement costs to property covered by the fair
16 rental allowance payment which are to be expensed as required by the regulations
17 regarding expensing of items.
- 18 8.443.8.C Room and board includes:
- 19 1. Dietary, other than raw food, and salaries related to dietary personnel including tray help,
20 except registered dieticians which are health care.
- 21 2. Laundry and linen.
- 22 3. Housekeeping.
- 23 4. Plant operation and maintenance (except removal of infectious material or medical waste
24 which is health care).
- 25 5. Repairs, betterments and improvements to equipment related to room and board
26 services.
- 27 8.443.8.D Determination of the Administrative and General Maximum Allowable Rate (Limit) for
28 Class II and IV Facilities.
- 29 The determination of the reasonable cost of services shall be made every 12 months. The
30 maximum allowable reimbursement of administration, property and room and board costs,
31 excluding raw food, land, buildings and fixed equipment, shall not exceed:
- 32 1. For class II facilities, one hundred twenty percent (120%) of the median actual costs of all
33 class II facilities.

- 1 2. For class IV facilities, one hundred twenty percent (120%) of the median actual costs of
2 all class IV facilities.
- 3 3. Determination of the rates beginning on July 1 each year shall utilize the most current
4 MED-13 cost report filed, in accordance with these regulations, by each facility on or
5 before May 2.
- 6 4. The MED-13 cost report shall be deemed submitted if actually received by the
7 Department's designee or postmarked by the U.S. Postal Service on or before May 2.
- 8 5. If, in the judgment of the Department, the MED-13 contains errors, whether willful or
9 accidental, that would impair the accurate calculation of reasonable costs for the class,
10 the Department may:
- 11 a. Exclude part, or all, of a provider's MED-13 or
- 12 b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider
13 submitted in its most recent audited cost report adjusted by the change in the
14 "medical care" component of the Consumer Price Index published for all urban
15 consumers (CPI-U) by the United States Department of Labor, Bureau of Labor
16 Statistics over the time period from the provider's most recent audited cost report
17 to May 2.
- 18 6. State-administered class IV facilities shall not be subject to the maximum reasonable rate
19 ceiling. The Med-13s of the state-administered class IV facilities shall be included in the
20 maximum rate calculation for other class IV facilities.
- 21 7. The maximum reasonable rate and the data used in that computation shall be subject to
22 administrative appeal only on or before the expiration of the thirty (30) day period
23 following the date the information is made available.
- 24 8. The maximum rate for reimbursement shall be changed effective July 1 of each year and
25 individual facility rates shall be adjusted accordingly.
- 26 8.443.8.E. Class I Administrative and General Per Diem Reimbursement Rate
- 27 For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem
28 rate for the cost of its administrative and general services, the Department shall establish an
29 annually readjusted schedule to pay each facility a reasonable price for the costs.
- 30 1. Determination of the class I rates beginning on July 1 each year shall utilize the most
31 current MED-13 cost report submitted, in accordance with these regulations, by each
32 facility on or before December 31 of the preceding year.
- 33 2. The reasonable price shall be a percentage of the median per diem cost of administrative
34 and general services as determined by an array of all nursing facility providers.
- 35 3. For facilities of sixty licensed beds or fewer, the reasonable price shall be one hundred
36 ten percent of the median per diem cost for all class I facilities. For facilities of sixty-one
37 or more licensed beds, the reasonable price shall be one hundred five percent of the
38 median per diem cost for all class I facilities.
- 39 4. In computing per diem cost, each nursing facility provider shall annually submit cost
40 reports to the Department.

- 1 5. Actual days of care shall be counted rather than occupancy-imputed days of care.
- 2 6. The cost reports used to establish this median per diem cost shall be those filed during
3 the period ending December 31 of the prior year following implementation.
- 4 7. Amounts contained in cost reports used to establish this median shall be adjusted by the
5 percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation
6 indexes published by Global Insight, ~~Inc.~~, measured from the midpoint of the reporting
7 period of each cost report to the midpoint of the payment-setting period.
- 8 a. The percentage change shall be rounded at least to the fifth decimal point.
- 9 b. The latest available publication prior to July 1 rate setting shall be used to
10 determine the inflation indexes.
- 11 8. The reasonable price determined at July 1, 2008 will be adjusted annually at July 1st for
12 three subsequent years. The reasonable price shall be adjusted by the annual
13 percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation
14 indexes published by Global Insight, Inc. The percentage change shall be rounded at
15 least to the fifth decimal point. The latest available publication prior to July 1 rate setting
16 shall be used to determine the inflation indexes.
- 17 9. For each succeeding fourth year, the Department shall re-determine the median per diem
18 cost based upon the most recent cost reports filed during the period ending December 31
19 of the prior year.
- 20 10. The reasonable price established by the median per diem costs determined each
21 succeeding fourth year will be adjusted annually at July 1st for the three intervening
22 years. The reasonable price shall be adjusted by the annual percentage change in the
23 Skilled Nursing Facility Market Basket (without capital) inflation indexes published by
24 Global Insight, Inc. The percentage change shall be rounded at least to the fifth decimal
25 point. The latest available publication prior to July 1 rate setting shall be used to
26 determine the inflation indexes.
- 27 11. For fiscal years commencing on and after July 1, 2008, through the fiscal year
28 commencing July 1, 2014, the state department shall compare a nursing facility provider's
29 administrative and general per diem rate to the nursing facility provider's administrative
30 and general services per diem rate as of June 30, 2008, and the state department shall
31 pay the nursing facility provider the higher per diem amount for each of the fiscal years.
- 32 12. For fiscal years commencing on and after July 1, 2009, through the fiscal year
33 commencing July 1, 2014, if a reallocation of management costs between administrative
34 and general costs and the health care costs causes a nursing facility provider's
35 administrative and general costs to exceed the reasonable price established by the state
36 department, the state department may pay the nursing facility provider the higher per
37 diem payment for administrative and general services.
- 38 13. The reasonable price will be phased in over three years in accordance with the following
39 schedule:

July 1, 2008 50% reasonable price

. 50% cost-based rate

July 1, 2009	50% reasonable price
.	50% cost-based rate
July 1, 2010	75% reasonable price
.	25% cost-based rate
July 1, 2011	100% reasonable price

1
2 The phase in will allow a percentage of the reasonable price established in accordance
3 with these rules (reasonable price) and a percentage of the July 1, 2008 administrative
4 and general rate in accordance with the rules in effect prior to implementation of these
5 rules (cost-based rate). The cost-based rate determined at July 1, 2008 will be adjusted
6 annually at July 1st for two subsequent years. The cost-based rate shall be adjusted by
7 the annual percentage change in the Skilled Nursing Facility Market Basket (without
8 capital) inflation indexes published by Global Insight, Inc. The percentage change shall
9 be rounded at least to the fifth decimal point. The latest available publication prior to July
10 1 rate setting shall be used to determine the inflation indexes.

11 8.443.8.F For the purpose of reimbursing class II and privately-owned class IV facilities a per diem
12 rate for the cost of administrative and general services, the Department shall establish an
13 annually readjusted schedule to reimburse each facility, as nearly as possible, for its actual or
14 reasonable cost of services rendered, whichever is less, its case-mix adjusted direct health care
15 services costs and a fair rental allowance for capital-related assets.

16 1. In computing per diem cost, each class II and class IV facility provider shall annually
17 submit cost reports to the Department.

18 2. The per diem reimbursement rate will be total allowable costs for administrative and
19 general and health care services (actual or the limit per [10 CCR 2505-10 section](#)
20 8.443.7.D) divided by the higher of actual resident days or occupancy imputed days per
21 [10 CCR 2505-10 section](#) 8.443.3.

22 3. An inflation adjustment per [10 CCR 2505-10 section](#) 8.443.4B will be applied to the per
23 diem administrative and general and health care reimbursement rates.

24 4. An incentive allowance for administrative and general costs may be included per [10 CCR](#)
25 [2505-10 section](#) 8.443.5.

26 5. Each facility will be paid a per diem for capital-related assets per [10 CCR 2505-10](#)
27 [section](#) 8.443.9.A.

28 8.443.9 FAIR RENTAL ALLOWANCE FOR CAPITAL-RELATED ASSETS

29 8.443.9.A. FAIR RENTAL ALLOWANCE: DEFINITIONS AND SPECIFICATIONS

30 1. For purposes of this section concerning fair rental allowance, the following definitions
31 shall apply:

- 1 a. Appraised Value means the determination by a qualified appraiser who is a
 2 member of an institute of real estate appraisers or its equivalent, the depreciated
 3 cost of replacement of a capital-related asset to its current owner. The
 4 depreciated replacement appraisal shall be based on the most recent edition of
 5 the Boeckh™ Commercial Building Valuation System available on December
 6 31st of the year preceding the year in which the appraisals are to be performed.
 7 [Boeckh™ Commercial Building Valuation System](#) is hereby incorporated by
 8 [reference. The Department maintains copies of this incorporated text in its](#)
 9 [entirety, available for public inspection during regular business hours at:](#)
 10 [Colorado Department of Health Care Policy and Financing, 1570 Grant Street,](#)
 11 [Denver, CO 80203. Certified copies of incorporated materials are provided at](#)
 12 [cost upon request.](#)

13 ~~This material is incorporated by reference into these rules. Information about obtaining or~~
 14 ~~examining the applicable edition is available from the Custodian of Records,~~
 15 ~~Department of Health Care Policy and Financing, 1570 Grant Street, Denver,~~
 16 ~~Colorado 80203-1818. The incorporated material may also be examined at any~~
 17 ~~State Publications Depository Library.~~

- 18 b. Base Value means the value of the capital related assets as determined by the
 19 most current appraisal report completed by the Department or its designee and
 20 any additional information considered relevant by the Department. For each year
 21 in which an appraisal is not done, base value means the most recent appraisal
 22 value increased or decreased by fifty percent (50%) of the change in the Index.
 23 Under no circumstances shall the base value exceed \$25,000 per bed plus the
 24 percentage rate of change referred to as the per bed limit.
- 25 c. Capital-Related Asset means the land, buildings and fixed equipment of a
 26 participating facility.
- 27 d. Fair Rental Allowance means the product obtained by multiplying the base value
 28 of a capital-related asset by the rental rate.
- 29 e. Fair Rental Allowance Per Diem Rate means the fair rental allowance described
 30 above, divided by the greater of the audited patient days on the provider's annual
 31 cost report or ninety percent (90%) of licensed bed capacity on file. This
 32 calculation applies to both rural and urban facilities.
- 33 f. Fiscal Year means the State fiscal year from July 1 through June 30.
- 34 g. Fixed equipment means building equipment as defined under the Medicare
 35 principle of reimbursement as specified in the Medicare provider reimbursement
 36 manual, part 1, section 104.3. Specifically, building equipment includes
 37 attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators,
 38 heating systems, air conditioning systems, etc. The general characteristics of this
 39 equipment are:
- 40 i) Affixed to the building and not subject to transfer; and
- 41 ii) A fairly long life but shorter than the life of the building to which it is
 42 affixed.
- 43

1 h. Index means the square foot construction costs for nursing facilities in the Means
 2 Square Foot Costs Book, a publication of R.S.Means Company, Inc. that is
 3 updated annually (section M.450, "Nursing Home"), hereafter referred to as the
 4 Means Index. The Means index is hereby incorporated by reference. The
 5 Department maintains copies of this incorporated text in its entirety, available for
 6 public inspection during regular business hours at: Colorado Department of
 7 Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203.
 8 Certified copies of incorporated materials are provided at cost upon request.

9 ~~This material is incorporated by reference into these rules. Information about obtaining or~~
 10 ~~examining the applicable edition is available from the Custodian of Records,~~
 11 ~~Department of Health Care Policy and Financing, 1570 Grant Street, Denver,~~
 12 ~~Colorado 80203-1818. The incorporated material may also be examined at any~~
 13 ~~State Publications Depository Library.~~

14 i. Rental Rate means the average annualized composite rate for United States
 15 treasury bonds issued for periods of ten years and longer plus two percent;
 16 except that the rental rate shall not exceed ten and three-quarters percent nor fall
 17 below eight and one-quarter percent.

18 2. In the case of facilities for which an appraisal was completed pursuant to RFP GB 347
 19 (October 21, 1985) and no major physical plant expansions or additions were completed
 20 prior to the Department's reappraisal of the property, the following data shall remain
 21 unchanged through following appraisals:

- 22 a. Average story height.
- 23 b. Gross floor area.
- 24 c. Total perimeter.
- 25 d. Construction classification.
- 26 e. Construction quality.
- 27 f. Year built.

28 3. In the case of those facilities that have completed a major physical plant expansion,
 29 addition or deletion, the initial appraisal measurements and data specified in paragraph 2
 30 above shall be modified only to the extent of the relevant appraisal data specific to the
 31 new expansion, addition or deletion.

32 4. The appraisal shall take into consideration the economic impact the addition, deletion or
 33 use modification may have had on the overall value of the entire facility.

34 5. The variables from the Boeckh program that are to be calculated/determined by the
 35 Department or its designee, and which will be incorporated into the Request for Proposal
 36 (RFP) which defines the scope of the appraisals, include:

- 37 a. Record information: State identification number of the nursing facility as provided
 38 by the Department.
- 39 b. Property owner: Name of nursing facility.

- 1 c. Street, address, city.
- 2 d. Zip code.
- 3 e. Land value.
- 4 f. Section number: Assign lowest to oldest section and have basements
5 immediately follow the section they are beneath.
- 6 g. Occupancy: Primarily nursing facility or basement.
- 7 h. Construction classification.
- 8 i. Number of stories.
- 9 j. Gross floor area: The determination of the exterior dimensions of all interior
10 areas including stairwells of each floor. In addition, interior square footage
11 measurements shall be reported for (a) non-nursing facility areas; (b) shared
12 service area by type of service; and (c) revenue-generating areas so that these
13 non-nursing facility portions of the facility can be omitted from the total square
14 footage or allocated based on their nursing facility related use.
- 15 k. Construction quality.
- 16 l. Year nursing facility was built.
- 17 m. Building effective age.
- 18 n. Building condition.
- 19 o. Exterior wall material.
- 20 p. Total perimeter: Common walls between sections shall be excluded from both
21 sections.
- 22 q. Average story height.
- 23 r. Roof material.
- 24 s. Roof pitch.
- 25 t. Heating System.
- 26 u. Cooling system.
- 27 v. Plumbing fixtures (Basements only).
- 28 w. Passenger Elevators: Actual number.
- 29 x. Freight elevators: Actual number.
- 30 y. Sprinkler system: Percent of gross area served.
- 31 z. Manual Fire Alarm System: Percent of gross area served.

- 1 aa. Automatic fire detection: Percent of gross area served.
- 2 bb. Floor finish.
- 3 cc. Ceiling finish.
- 4 dd. Total partition walls (Basement only).
- 5 ee. Partition wall structure.
- 6 ff. Partition wall finish.
- 7 gg. Miscellaneous additional items: All components not included in the preceding list
8 and also not automatically calculated by the Boeckh Program shall be included
9 here. The appraiser shall use professional judgment when valuing such items.
10 Items shall be entered at depreciated value.
- 11 hh. Site improvements: Items shall be included at depreciated value, except
12 landscaping, to be determined by the appraiser based upon professional
13 judgment. Depreciation for site improvements, in many instances, is different
14 from the depreciation for the structure. A list of site improvements and
15 corresponding values shall be retained with the appraiser's work papers.
- 16 ii. User adjustment factor: Used in those cases where facilities are appraised in
17 total and only partly used as a nursing facility, i.e., hospital and nursing facility
18 combined or a residential and nursing facility combined.
- 19 6. The fair rental allowance shall only be adjusted due to the following:
- 20 a. The base value of a facility shall be increased in subsequent cost reports due to
21 improvements. Construction-in-progress will not be considered an improvement
22 until the project is complete and the asset is placed into service.
- 23 b. At the start of a new state fiscal year by a new rental rate amount or additional
24 indices.
- 25 c. The base value of a facility can be decreased by a change in either the physical
26 (structural) condition and/or use modification of the facility.
- 27 d. The provider has constructed and occupied a new physical plant and is no longer
28 using the old structure for providing care to nursing facility residents. Base value
29 shall be a new appraisal conducted by the Department or its designee at the time
30 the new physical plant is ready for occupancy.
- 31 i) The provider shall continue to be reimbursed at the old fair rental
32 allowance rate until the first scheduled MED-13 after the move sets a
33 new rate.
- 34 ii) A new appraisal shall be performed to coincide with the filing of the next
35 scheduled cost report following the move.
- 36 8.443.9.B FAIR RENTAL ALLOWANCE PER DIEM REIMBURSEMENT RATES

1 In addition to the reimbursement components paid pursuant ~~to 8.4 to 10 CCR 2505-10 section~~
 2 ~~8.10 CCR 2505-10 section 8.4~~43.7 (Health Care Services) and 8.443.8 (Administrative and
 3 General Costs), a per diem rate constituting a fair rental allowance for capital-related assets shall
 4 be paid to each nursing facility provider as a rental rate based upon the nursing facility's
 5 appraised value.

- 6 1. For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem
 7 rate for capital-related assets, the state department shall establish an annual per bed
 8 limit.
- 9 2. The annual per bed limit established July 1, 1985 is \$25,000 per bed plus the percentage
 10 rate of change in the Means Index.
- 11 3. The Means Index means the square foot construction costs for nursing facilities in the
 12 Means Square Foot Costs Book, a publication of R.S.Means Company, Inc. that is
 13 updated annually (section M.450, "Nursing Home").
- 14 4. The per bed limit shall be changed effective July 1 of each year and individual facility
 15 rates shall be adjusted accordingly.
- 16 5. The fair rental allowance will be calculated for each facility using the lesser of the Base
 17 Value plus non-appraisal year modifications to the physical structure due to
 18 improvements or a change in the condition and/or use of the facility subsequent to the
 19 appraisal increased or decreased by fifty percent (50%) of the change in the Means Index
 20 or the annual per bed limit.
- 21 6. In computing the fair rental allowance per diem rate, the fair rental allowance is multiplied
 22 by the rental rate to obtain the annual allowable fair rental payment.
- 23 7. The rental rate is the average annualized composite rate for United States treasury
 24 bonds issued for periods of ten years and longer plus two percent; except that the rental
 25 rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter
 26 percent.
- 27 8. The resulting fair rental payment amount is divided by the greater of the audited patient
 28 days based on the provider's annual cost report or ninety percent (90%) of licensed bed
 29 capacity on file. This calculation applies to both rural and urban facilities.

30 **8.443.10 SUPPLEMENTAL PAYMENTS FOR FACILITIES WITH COGNITIVE IMPAIRED AND**
 31 **PASRR II RESIDENTS, PROVIDER FEE AND QUALITY PERFORMANCE FOR CLASS I**
 32 **NURSING FACILITIES**

33 8.443.10.A In addition to the reimbursement components paid pursuant ~~to 8.4 to 10 CCR 2505-10~~
 34 ~~section 8.10 CCR 2505-10 section 8.4~~43.7 (Health Care Services) and 8.443.8 (Administrative
 35 and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-Related Assets), the state
 36 department shall pay a supplemental payment to nursing facility providers who have residents
 37 who have moderately to very severe mental health conditions, cognitive dementia, or acquired
 38 brain injury. To reimburse the nursing facility providers who serve residents with severe cognitive
 39 dementia or acquired brain injury, the state department shall pay a supplemental payment based
 40 upon the resident's score on the Cognitive Performance Scale (CPS) used in the RUG-III
 41 Classification system and reported on the MDS form. Resident CPS scores range from zero
 42 (intact) to six (very severe impairment).

- 1 1. Annually the Department will identify those Medicaid residents with a CPS score of 4, 5,
2 or 6 for each nursing facility. They will then calculate the percent of Medicaid residents
3 with a CPS score of 4, 5, or 6 as a percentage of all Medicaid residents for the facility.
4 This amount is the facility's CPS percentage. The MDS for residents on the April roster
5 will be the source data used in these calculations.
- 6 2. The state-wide mean (average) CPS percentage will be determined, along with the
7 standard deviation from the mean.
- 8 3. Those facilities with a CPS percentage greater than the mean plus one, two or three
9 standard deviations will receive an add-on rate for their Medicaid residents with a CPS
10 score of 4, 5, or 6 in accordance with the following table:
- 11 Mean plus one standard deviation \$1.00
- 12 Mean plus two standard deviations \$2.00
- 13 Mean plus three or more standard deviations \$3.00
- 14 4. If the expected average payment for those residents receiving a supplemental payment is
15 less than one percent of the average nursing facility rate (prior to supplemental
16 payments), the above table rates will be proportionately increased or decreased in order
17 to have an expected average Medicaid supplemental payment equal to one percent of
18 the average nursing facility rate prior to supplemental payments.
- 19 5. These calculations will be performed annually to coincide with the July 1st rate setting
20 process. Each facility's aggregate CPS add-on will be calculated by taking the add-on
21 rate times Medicaid days with a CPS score of 4, 5 or 6.
- 22 6. The CPS supplemental payment will be calculated by dividing the facility aggregate CPS
23 amount determined above by the facility's expected Medicaid case load (Medicaid patient
24 days). Medicaid case load for each facility will be determined using Medicaid paid claims
25 data for the calendar year ending prior the July 1st rate setting. Providers with less than a
26 full year of paid claims data will have their case load annualized.
- 27 8.443.10.B For those residents who have severe mental health conditions or developmental
28 disabilities that are classified at Level II by the Medicaid program's preadmission screening and
29 resident review assessment tool (PASRR II), the nursing facility provider shall be paid a
30 supplemental payment.
- 31 1. On May 1st each year, the Department will identify those Medicaid residents meeting the
32 PASRR II criteria for each nursing facility.
- 33 2. The Department will determine the number of PASRR II days eligible for the PASRR II
34 add-on by taking the number of PASRR II residents in each facility on May 1st times 365
35 days. The Department will then calculate the aggregate PASRR II payment for each
36 facility by taking the number of PASRR II eligible days times the per diem PASRR II rate.
- 37 3. The supplemental PASRR II payment will be calculated as two percent of the statewide
38 average per diem rate for the combined rate components paid pursuant ~~to 8.4 to 10 CCR~~
39 ~~2505-10 section 8.10 CCR 2505-10 sections 8.4~~3.7 (Health Care Services) and 8.443.8
40 (Administrative and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-
41 Related Assets),

- 1 4. The supplemental PASRR II payment for each facility will be calculated by dividing the
2 aggregate PASRR II payment by expected Medicaid case load (Medicaid patient days).
3 Medicaid case load for each facility will be determined using Medicaid paid claims data
4 for the calendar year ending prior to the July 1st rate setting. Providers with less than a
5 full year of paid claims data will have their case load annualized.
- 6 5. These calculations will be performed annually to coincide with the July 1st rate setting
7 process.

- 8
- 9
- 10
- 11 6. An additional supplemental payment will be made to facilities that offer specialized
12 behavioral services to residents who have severe mental health conditions that are
13 classified at a PASRR Level II. Specialized services include, but are not limited to,
14 enhanced staffing in social services and activities, specialized training for staff on
15 behavior management, creating resident specific written guidelines with positive
16 reinforcement, crisis intervention and psychotropic medication training. Specialized
17 programs also include daily therapeutic groups such as anger management, conflict
18 resolution, effective communication skills, hygiene, art therapy, goal setting, problem
19 solving Alcoholics Anonymous and Narcotics Anonymous, in addition to stress
20 management/relaxation groups such as Yoga, Tai Chi, drumming and medication.
21 Therapeutic work programming, community safety training, and life skills training that
22 include budgeting and learning how to navigate public transportation and shopping, for
23 example, are also required to increase the resident's skills for successful community
24 reintegration.

- 25 7. Facilities that offer specialized behavioral services must meet the specified criteria
26 described above and have the program approved by the Department. The additional
27 payment for facilities that have an approved specialized behavioral services program will
28 be calculated as follows:

29 On May 1st each year, the Department will identify those Medicaid residents meeting the
30 PASRR II criteria for the nursing facility with an approved specialized behavioral program.

31 The Department will determine the number of PASRR II days eligible for the PASRR II
32 specialized behavioral program add-on by taking the number of PASRR II residents in the
33 facility on May 1st times 365 days. The Department will then calculate the aggregate
34 PASRR II payment for the facility by taking the number of PASRR II eligible days times
35 the per diem PASRR II rate.

36 The supplemental PASRR II payment will be calculated as two percent of the statewide
37 average per diem rate for the combined rate components paid pursuant ~~to 8.4 to 10 CCR~~
38 ~~2505-10 section 8.10 CCR 2505-10 sections 8.4~~43.7 (Health Care Services) and 8.443.8
39 (Administrative and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-
40 Related Assets),

- 41 8.443.10.C In addition to the per diem core rate components paid pursuant ~~to 8.4 to 10 CCR 2505-10~~
42 ~~section 8.10 CCR 2505-10 sections 8.4~~43.7 (Health Care Services) and 8.443.8 (Administrative
43 and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-Related Assets) the state
44 department shall pay a nursing facility provider an additional supplemental amount for care and

1 services rendered to Medicaid residents to offset payment of the provider fee. This amount shall
 2 not be equal to the amount of the fee charged and collected but shall be an amount equal to the
 3 per diem fee charged multiplied by the number of Medicaid resident days for the facility.

4 1. Each July 1st the Department will calculate the funding obligation required to pay for
 5 supplemental payments related to CPS (~~8.443(10 CCR 2505-10 section 8.10 CCR 2505-~~
 6 ~~10 section 8.443-10A)~~, PASRR II (~~8.443(10 CCR 2505-10 section 8.10 CCR 2505-10~~
 7 ~~section 8.443.10B)~~, Pay for Performance (~~8.443(10 CCR 2505-10 section 8.10 CCR~~
 8 ~~2505-10 section 8.443.12)~~ and any annual increase greater than the statutory limitation in
 9 the growth of the general fund share of the aggregate statewide average per diem rate
 10 described ~~in 8.4 in 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.443.11.~~

11 2. Once the funding obligation is determined, that amount will be divided by twelve to
 12 determine the supplemental payment amount that will be paid monthly to each facility as
 13 a pass through payment.

14 The following example illustrates how the state department will calculate the per diem
 15 amount to be added to each facility's Medicaid per diem rate to offset the provider fee:

16 Example Facility's Provider Fee Medicaid Supplemental Payment

7/1/xx provider fee per diem required to c over funding obligation	\$7.30
TIMES: Expected non-Medicare resident days during the state fiscal year	17,000
EQUALS: 7/1/xx FY actual facility provider fees which will be paid	\$124,100
DIVIDED BY: Expected total resident days during the state fiscal year	20,000
EQUALS: per diem amount per resident	\$6.21.
TIMES: Medicaid resident days	16,000
Total annual supplemental payment	\$99,360
DIVIDE BY: Twelve Months for monthly supplemental payment	\$8,280

17
 18 **8.443.11 FUNDING SPECIFICATIONS**

19 The general fund share of the aggregate statewide average of the per diem rate net of patient payment
 20 pursuant ~~to 8.4 to 10 CCR 2505-10 section 8.10 CCR 2505-10 sections 8.443.7~~ (Health Care Services)
 21 and 8.443.8 (Administrative and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-Related
 22 Assets) shall be limited by statute. Any provider fee used as the state's share and all federal funds shall
 23 be excluded from the calculation of the general fund limitation. In the event that the reimbursement
 24 system described in this section would result in anticipated payments to nursing facility providers
 25 exceeding the statutory limitation on annual growth in the general fund share of the aggregate statewide
 26 average of the per diem rate net of patient payment, proportional decreases will be made to the rates so
 27 that anticipated payments will equal the statutory growth limitation in the general fund share of the per
 28 diem rate. The percentage will be determined in accordance with the following fraction: Legislative

- 1 appropriations / The Sum of Each Facility's Calculated Rate Multiplied by Each Facility's Proportional
2 Share of the Anticipated (Budgeted) Case Load for all class I Nursing Facilities.
- 3 1. Non-state and federal payment percent: Annually the Department will determine the percent of
4 nursing facility per diem rates paid by non-state and non-federal fund sources. This determination
5 will be based on an analysis of Medicaid nursing facility class I paid claims. A sample period of
6 claims may be used to perform this analysis. The analysis will be prepared prior to the annual
7 July 1st rate setting.
- 8 2. Legislative appropriation base year amount: The base year will be the state fiscal year (SFY)
9 ending June 30, 2008. The legislative appropriation for the base year will be determined by
10 multiplying each nursing facility's time weighted average Medicaid per diem rate during the base
11 year by their expected Medicaid case load (Medicaid patient days) for the base year. This amount
12 will be reduced by the non-state and non-federal payment percentage, and then the residual will
13 be split between state and federal sources using the time weighted Federal Medical Assistance
14 Percentage (FMAP) during the base year.
- 15
- 16 3. Medicaid case load for each facility will be determined using Medicaid paid claims data for the
17 calendar year ending prior to the July 1st rate setting. Providers with less than a full year of paid
18 claims data will have their case load annualized. Providers with no paid claims data for the
19 calendar year ending prior to the July 1st rate setting will have their Medicaid caseload estimated
20 by the Department.
- 21 4. Preliminary state share: Effective July 1, 2009 and each succeeding year the Department shall
22 calculate a preliminary state share commitment towards the class I Medicaid nursing facility
23 reimbursement system. The preliminary state share shall be calculated using the same
24 methodology used to calculate the legislative appropriation base year amount. The Medicaid per
25 diem rates used in this calculation are the preliminary rates that would be effective July 1st prior
26 to any rate reduction provided for within this section of the rule.
- 27 5. For SFY 2009 and each succeeding year the final state share of Medicaid per diem rates will be
28 limited to the legislative appropriation amount from the base year increased by the statutory
29 growth limitation over the prior SFY. These determinations will be made during the July 1st rate
30 setting process each year. If the preliminary state share (less the amount applicable to provider
31 fees) is greater than the indexed legislative base year amount, proportional reductions will be
32 made to the preliminary nursing facility rates to reduce the state share to the indexed legislative
33 appropriation base year amount.
- 34 6. Provider fee revenue will first be used to pay the provider fee offset payment, then the payment
35 for acuity or case-mix of residents, then the Pay-for-Performance program, then payments for
36 residents who have moderately to severe mental health conditions, cognitive dementia or
37 acquired brain injury, and then the supplemental Medicaid payments for the amount by which the
38 average statewide per diem rate exceeds the general fund share established under [Section 25.5-
39 6-202\(9\)\(b\)\(II\), C.R.S.-C.R.S. section 25.5-6-202\(9\)\(b\)\(II\)](#). Any difference between the amount of
40 provider fees expected to be available, and the amount needed to fund these programs will be
41 used to adjust the preliminary state share above.
- 42 7. The following calculation illustrates the above and, for illustration purposes, assumes the
43 statutory limit on general fund is 3%:

		Rate Components paid pursuant to 8.443.7 Health Care Services (HC) and 8.443.8 Administrative and General Costs (A&G) and 8.443.9 Fair Rental Allowance for Capital-Related Assets (FRV)
Actual Prior Year General Fund Legislative Appropriations	55,000,000	
Actual Medicaid Days	324,000	
Average of the Per Diem Rate Net of Patient Payment	189.75	
Three Percent Increase	103.00 %	
Current Year Limit on Legislative Appropriations	174.85	
Times Estimated Medicaid Days	325,844	
Current Year Limit on Legislative Appropriations	56,937,446	(Legislative Appropriation)

Provider fee revenue will first be used to pay the state share of CPS, PASRR II, provider fee and pay for performance rate add-ons. Any difference between the amount of the provider fees expected to be available, and the amount needed to fund these programs will be used to adjust the preliminary state share. In this example, the General Fund (GF) anticipated increase is \$1,067,867 more than the 3% limit and the provider fees expected to be available equal \$1,000,000. After considering the \$1,000,000, the provider fee is at the limit (currently 5.5% of revenue).

3% Limit in GF Growth Funded by Increase in Provider Fees Expenditure Limit	1,000,000	
	(d)	57,937,446
Estimated Current Fiscal Year Expenditures	(e)	58,808,313
Estimated Impact of General Fund Cap	(e) - (d)	870,867
3% Cap Adjustment Factor	(d) / (e)	0.98855338

(The Sum of Each Facility's Calculated Rate Multiplied by Each Facility's Proportional Share of the Anticipated (Budgeted) Case Load)

The following calculation is an example of how the 3% cap adjustment factor will be applied:

Facility	Estimated Medicaid Days (a)	Estimate of Per Diem Rate for FRV, A&G, HC (b)	Total Projected Payments (c) = (a) * (b)	3% Cap Adjustment Factor (f) = (d) / (e)	Facility Medicaid Rate for FRV, A&G, HC (g) = (c) * (f)	Legislative Appropriations (a) * (g)
Facility #1	7,021	187.70	1,317,842	0.98855338	185.55	1,302,757
Facility #2	49,933	201.57	10,064,745	0.98855338	199.26	9,949,538
Facility #3	24,958	195.40	4,876,868	0.98855338	193.16	4,820,847
Facility #4	46,512	183.54	8,353,272	0.98855338	181.44	8,257,856
Facility #5	25,315	163.66	4,142,826	0.98855338	161.78	4,095,504
Facility #6	17,513	195.42	3,422,303	0.98855338	193.18	3,383,129
Facility #7	24,529	173.85	4,264,244	0.98855338	171.86	4,215,433
Facility #8	51,164	159.80	8,175,751	0.98855338	157.97	8,082,167
Facility #9	53,070	165.99	8,808,824	0.98855338	164.09	8,707,993
Facility #10	26,629	194.59	5,181,737	0.98855338	192.36	5,122,424
	325,844		58,808,313			57,937,446

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8.443.12 PAY-FOR-PERFORMANCE COMPONENT

Starting July 1, 2009, the Department shall make a supplemental payment based upon performance to those nursing facility providers that provide services that result in better care and higher quality of life for their residents (pay-for-performance). The payment will be based on a nursing facility's performance in the domains of quality of life, quality of care and facility management.

1. The application for the additional quality performance payment includes specific performance measures in each of the domains, quality of life, quality of care and facility management. The application includes the following:
 - a. The number of points associated with each performance measure;
 - b. The criteria the facility must meet or exceed to qualify for the points associated with each performance measure.
2. The prerequisites for participating in the program are as follows:
 - a. No facility with substandard deficiencies on a regular annual, complaint, or any other [CDPHE Colorado Department of Public Health and Environment](#) survey will be considered for pay for performance.

- 1 b. The facility must perform a resident/family satisfaction survey. The survey must (a) be
2 developed, recognized, and standardized by an entity external to the facility; and, (b) be
3 administered on an annual basis with results tabulated by an agency external to the
4 facility. The facility must report their response rate, and a summary report must be made
5 publically available along with the facility's State's survey results.
- 6 3. To apply the facility must have the requirements for each Domain/sub-category in place at the
7 time of submitting an application for additional payment. The facility must maintain documentation
8 supporting its representations for each performance measure the facility represents it meets or
9 exceeds the specified criteria. The required documentation for each performance measure is
10 identified on the application and must be submitted with the application. In addition, the facility
11 must include a written narrative for each sub-category to be considered that describes the
12 process used to achieve and sustain each measure.
- 13 4. The Department or the Department's designee will review and verify the accuracy of each
14 facility's representations and documentation submissions. Facilities will be selected for onsite
15 verification of performance measures representations based on risk.
- 16 5. A nursing facility will accumulate a maximum of 100 points by meeting or exceeding all
17 performance measures indicated on the matrix.
- 18 6. The per diem rate add-on will be calculated according to the following table:
- 19 0 – 20 points = No add-on
- 20 21 – 45 points = \$1.00 per day add-on
- 21 46 – 60 points = \$2.00 per day add-on
- 22 61 – 79 points = \$3.00 per day add-on
- 23 80 – 100 points = \$4.00 per day add-on
- 24 If the expected average payment for those facilities receiving a supplemental payment is less
25 than twenty-five hundredths of one percent of the statewide average per diem base rate, the
26 above table rates will be proportionately increased or decreased in order to have an expected
27 average Medicaid add-on payment equal to twenty-five hundredths of one percent of the average
28 nursing facility base rate.
- 29 7. These calculations will be performed annually to coincide with the July 1st rate setting process.

30 **8.443.13 RATE EFFECTIVE DATE**

- 31 8.443.13.A. For cost reports filed by all facilities except the State-administered Class IV facilities, the
32 rate shall be effective on the first day of the eleventh (11th) month following the end of the nursing
33 facility's cost reporting period.
- 34 8.443.13.B. For 12-month cost reports filed by the State-administered Class IV facilities, the rate shall
35 be effective on the first day covered by the cost report.
- 36 8.443.13.C. The permanent rate shall be established, issued and shall pay Medicaid claims billed on
37 and after the later of the following dates:

- 1 1. The beginning of the provider's new rate period, as set forth ~~in 8.4 in 10 CCR 2505-10~~
2 ~~section 8.10 CCR 2505-10 section 8.4~~43.13.A, or
- 3 2. One hundred (100) days after the date the MED-13 is filed by the provider.
- 4 8.443.13.D. In the event a permanent rate cannot be established, issued and paid as set forth ~~at 8.4 at~~
5 ~~10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.4~~43.13.A:
- 6 1. The Department shall establish and issue a temporary rate calculated on the provider's
7 filed cost report without adjustments.
- 8 2. All temporary rates shall, at the time the permanent rate is established, issued and paid,
9 be subject to adjustment and recovery of any over or under payments.
- 10 8.443.13.E. Any delay in completion of the audit of the MED-13 that occurs within 90 days from the
11 filing of the MED-13, and that is attributable to the provider, shall operate, on a time equivalent
12 basis, to extend the time in which the Department shall establish, issue and pay a temporary rate
13 under the provisions set forth above.
- 14 8.443.13.F. Delay in completion of the audit that is attributable to the provider shall include, but not be
15 limited to, the following:
- 16 1. Failure of the provider to meet with the contract auditor at reasonable times requested by
17 the auditor;
- 18 2. Failure of the provider to supply the contract auditor with information reasonably needed
19 to complete the audit, including the Medicare cost report that the provider most recently
20 filed with the Medicare fiscal intermediary or other Medicare information approved by the
21 Department.
- 22 3. The time period that elapses during completion of the procedures described in 10
23 ~~C.C.R. CCR 2505-10, Section 2505-10 section 8.442.1,~~ whichever is relevant and later in
24 a particular case.
- 25 **8.443.14 RATES FOR NEW FACILITIES**
- 26 8.443.14.A. A new nursing facility means a facility:
- 27 1. That has not previously been certified for participation ~~in under~~ Title XIX ~~of the Social~~
28 ~~Security Act (42 U.S.C. section 1396r)~~; or
- 29 2. That has not participated in Title XIX for a period in excess of 30 days prior to the
30 effective date of the current Title XIX certification; or
- 31 3. That has changed from one class designation to another.
- 32 8.443.14.B. Nursing facilities that have undergone a transfer of ownership are not new nursing
33 facilities provided the previous owner had participated in Title XIX in the last 30 days prior to
34 ownership change.
- 35 8.443.14.C. A new nursing facility shall receive a per diem rate equal to the most recent average
36 weighted rate for the appropriate nursing facilities class at the time the new facility begins
37 business as a Medicaid provider.

- 1 1. This per diem rate shall remain in effect until a new rate is established based on the first
2 cost report submitted as specified below.
- 3 2. The average weighted rate shall be calculated by the Department on the 30th of each
4 month and shall not be revised when new rates are established which would retroactively
5 affect the calculation.
- 6 3. The average weighted rate paid a new facility shall be adjusted on July 1 each year by
7 the average weighted rate in effect on July 1.
- 8 8.443.14.D. New nursing facilities shall submit MED-13s during their initial year of operation as
9 follows:
- 10 1. The first cost report shall be for a period covering the first day of operation through the
11 facility's fiscal year end.
- 12 a. If the first cost report for the period covers a period of 90 days or more, imputed
13 occupancy shall be applied as described in ~~10 C.C.R. CCR 2505-10,~~
14 ~~Section2505-10-section 8.10 CCR 2505-10 section 8.443.3.A.~~
- 15 b. If the first cost report for the period covers a period of 90 days or more, the first
16 cost report shall set the base for limitations on growth of allowable costs as
17 described in ~~10 C.C.R. CCR 2505-10, Section2505-10-section 8.10 CCR 2505-10~~
18 ~~section 8.443.11.A.~~
- 19 2. If the first cost report for the period specified above covers a period of 89 days or less,
20 the facility's first cost report shall not be submitted until the next fiscal year end.
- 21 3. The next cost report shall be submitted for the twelve month period following the period of
22 the first cost report.
- 23 4. A new nursing facility shall advise the Department of the date its fiscal year will end and
24 of the reporting option selected.
- 25 8.443.14.E. Imputed occupancy shall be applied to the first cost report submitted by a new class II or
26 privately owned class IV facility. The facility shall be entitled to the higher of the imputed rate or
27 the monthly weighted average rate computed by the Department.
- 28 8.443.14.F. Imputed occupancy shall be applied to the second cost report submitted by a new class II
29 or privately owned class IV facility. The rate for the new facility shall not be lower than the 25th
30 percentile nursing facility rate as computed by the Department in median computation.
- 31 **8.443.15 CHANGE OF OWNERSHIP OR WITHDRAWAL FROM MEDICAID**
- 32 8.443.15.A. A licensed nursing facility owner(s) that intends to change the ownership of a Medicaid
33 nursing facility, or that intends to terminate its participation in the Medicaid program, shall notify
34 the Department in writing at least 45 calendar days in advance of the proposed change or
35 termination.
- 36 1. The advance written notice shall include a specific date for the proposed change or
37 termination and shall be delivered to the Department.

- 1 2. The exact date of the change of ownership or termination of Medicaid participation shall
2 be subject to approval by the Department, after consultation with the parties to the
3 proposed transaction and ~~the~~ CDPHE.
- 4 8.443.15.B. In the case of a change of ownership that does not require a new license from ~~the~~
5 CDPHE, the existing Medicaid provider agreement shall continue in effect, together with all
6 associated rights and responsibilities.
- 7 8.443.15.C. In the case of a change of ownership which does require a new license from ~~the~~ CDPHE,
8 the transferring owner's Medicaid provider agreement shall be assigned to the successor owner,
9 unless the successor owner refuses in writing to accept assignment of that provider agreement.
- 10 1. The assignment of an existing Medicaid provider agreement shall be accomplished by
11 the successor owner's signature of an appropriate acceptance document, as specified by
12 the Department.
- 13 2. The assignment of the Medicaid provider agreement shall not be effective prior to the
14 effective date of the successor owner's nursing facility license from ~~the~~ CDPHE.
- 15 3. In the event that a successor owner refuses to accept assignment of the transferring
16 owner's Medicaid provider agreement, the successor owner shall indicate such refusal in
17 a written communication to the Department.
- 18 4. Until a successor owner has signed a written acceptance of assignment, the Department
19 shall assume that the successor owner intends to refuse such assignment, and the
20 Department shall act accordingly to protect its interests and those of the facility's
21 residents.
- 22 8.443.15.D. An assigned Medicaid provider agreement shall be subject to all applicable statutes and
23 regulations and to the terms and conditions under which it was originally issued, including but not
24 limited to the following:
- 25 1. Any existing plan of correction;
- 26 2. Any expiration date for a Class II provider agreement;
- 27 3. Compliance with applicable health and safety requirements;
- 28 4. Compliance with the ownership and financial interest disclosure requirements, and any
29 other requirements described elsewhere in this staff manual;
- 30 5. Compliance with the civil rights requirements cited in the provider agreement; and
- 31 6. At the discretion of the Department, payment of any debts or other obligations, whether
32 known, fixed, definite, liquidated, or not, owed to the Department by the transferring
33 owner. Such liability may also apply, at the discretion of the Department, to any debts or
34 obligations that arose under any earlier, assigned provider agreement(s), but shall not
35 apply to any debt or obligation that was assigned prior to August 1, 2003.
- 36 7. The assignment of liability described in the preceding paragraph 6 shall not prejudice the
37 Department's right to pursue any remedy against a previous facility owner or owners for
38 repayment of the assigned debts or obligations.

1 8.443.15.E. In the event that a successor owner refuses to accept assignment of the transferring
2 owner's Medicaid provider agreement:

- 3 1. The transferring owner's Medicaid provider agreement shall terminate on the date
4 approved by the Department for the change of ownership.
- 5 2. Prior to the termination of the transferring owner's Medicaid provider agreement, the
6 Department shall have the discretion to withhold reimbursement to the transferring owner
7 for whatever period of time is necessary to recover overpayments or other debts owed to
8 the Department by the transferring owner.
- 9
- 10 3. The successor owner shall file a new application for a Medicaid provider agreement with
11 the Department or its designated agent. The Department shall not approve the new
12 agreement until the successor owner complies with all requirements for such approval.
13 The Department may delay the effective date of the successor owner's Medicaid provider
14 agreement until the expiration of the withholding period described in the preceding
15 paragraph 2, or until the Department has approved alternative payment arrangements or
16 security for the transferring owner's debts.
- 17 4. The Department may require a new facility survey as part of the successor owner's
18 application for a new Medicaid provider agreement even if a new facility survey is not
19 required by the federal Medicare program (e.g., where the successor owner has
20 accepted assignment of an existing Medicare provider agreement).
- 21 5. No Medicaid reimbursement shall be paid to the successor owner until the application for
22 a Medicaid provider agreement has been approved, regardless of the effective date of
23 the successor owner's license from ~~the~~ CDPHE.
- 24 6. Where appropriate in connection with a proposed change of ownership, the Department
25 shall have the discretion to notify facility residents and/or their guardians that Medicaid
26 reimbursement for facility care may be temporarily or permanently discontinued.

27 8.443.15.F. A licensed nursing facility owner that transfers ownership or terminates its Medicaid
28 participation shall submit a final MED-13 covering the period from the ending date of the last
29 previous report through the date of the transfer or termination.

- 30 1. The initial rate for the successor owner shall be the rate which would have been paid to
31 the previous owner based on the audited final cost report.
- 32 2. If the previous owner's final cost report is for a period of less than 89 days, that report
33 shall be disregarded and the previous owner's last cost report for a twelve (12) month
34 period shall be used to set a rate for the successor owner.

35 **8.443.16 STATE-OPERATED INTERMEDIATE CARE FACILITIES FOR THE MENTALLY**
36 **~~RETARDED INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL~~**
37 **~~DISABILITY FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (CLASS IV)~~**

38 8.443.16.A State-operated ~~intermediate~~ Intermediate care ~~Care~~ facilities for the mentally
39 retarded individuals with an intellectual or developmental disability Facilities for Individuals with
40 Intellectual Disabilities (class IV) shall be reimbursed based on the actual costs of administration,
41 property, including capital-related assets, and room and board, and the actual costs of providing
42 health care services. Actual costs will be determined on the basis of information on the MED-13

1 and information obtained by the Department or its designee retained for the purpose of cost
2 auditing.

3 1. These costs shall be projected by such facilities and submitted to the state department by
4 July 1 of each year for the ensuing twelve-month period.

5 2. Reimbursement to state-operated ~~intermediate-Intermediate care-Care facilities for the~~
6 ~~mentally retarded individuals with an intellectual or developmental disability~~ Facilities for
7 Individuals with Intellectual Disabilities shall be adjusted retrospectively at the close of
8 each twelve-month period.

9 3. The retrospective per diem rate will be calculated as total allowable costs divided by total
10 resident days.

11 **8.443.17 CLASS I NURSING FACILITY PROVIDER FEES**

12
13 8.443.17.A The state department shall charge and collect provider fees on health care items or
14 services provided by nursing facility providers for the purpose of obtaining federal financial
15 participation under the state's medical assistance program. The provider fees shall be used to
16 sustain or increase reimbursement for providing medical care under the state's medical
17 assistance program for nursing facility providers.

18 1. Each class I nursing facility that is licensed in this State shall pay a fee assessed by the
19 state department.

20 2. The following nursing facility providers are excluded from the provider fee:

21 a. A facility operated as a continuing care retirement community that provides a
22 continuum of services by one operational entity providing independent living
23 services, assisted living services and skilled nursing care on a single, contiguous
24 campus. Assisted living services include assisted living residences as defined in
25 Section 25-27-102 (1.3), C.R.S.C.R.S. section 25-27-102(1.3), or that provide
26 assisted living services on-site, twenty-four hours per day, seven days per week;

27 b. A skilled nursing facility owned and operated by the state;

28 c. A nursing facility that is a distinct part of a facility that is licensed as a general
29 acute care hospital; and

30 d. A facility that has forty-five or fewer licensed beds.

31 3. To determine the amount of the fee to assess pursuant to this section, the state
32 department shall establish a rate per non-Medicare patient day that is equivalent to a
33 percentage of accrual basis gross revenue (net of contractual allowances) for services
34 provided to patients of all class I nursing facilities licensed in this State. The percentage
35 used to establish the rate must not exceed that allowed by federal law. For the purposes
36 of this section, total annual accrual basis gross revenue does not include charitable
37 contributions or revenues received by a nursing facility that are not related to services
38 provided to nursing facility residents (for example, outpatient revenue).

39 4. The state department shall calculate the fee to collect from each nursing facility during
40 the July 1 rate-setting process.

- 1 a. Each July 1, the state department will determine the aggregate dollar amount of
2 provider fee funds necessary to pay for the following:
- 3 (i) State department's administrative cost pursuant ~~to 8.4 to 10 CCR 2505-~~
4 ~~10 section 8.10 CCR 2505-10 section 8.4~~43.17.B.1
- 5 (ii) CPS pursuant ~~to 8.4 to 10 CCR 2505-10 section 8.10 CCR 2505-10~~
6 ~~section 8.4~~43.10.A
- 7 (iii) PASRR pursuant ~~to 8.4 to 10 CCR 2505-10 section 8.10 CCR 2505-10~~
8 ~~section 8.4~~43.10.B
- 9 (iv) Pay for Performance pursuant ~~to 8.4 to 10 CCR 2505-10 section 8.10~~
10 ~~CCR 2505-10 section 8.4~~43.12
- 11 (v) Provider Fee Offset Payment pursuant ~~to 8.4 to 10 CCR 2505-10 section~~
12 ~~8.10 CCR 2505-10 section 8.4~~43.10.C
- 13 (vi) Excess of the statutory limited growth in the general fund pursuant ~~to~~
14 ~~8.4 to 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.4~~43.11
- 15 (vii) Acuity or case-mix of residents pursuant ~~to 8.4 to 10 CCR 2505-10~~
16 ~~section 8.10 CCR 2505-10 section 8.4~~43.7.D
- 17 b. This calculation will be based on the most current information available at the
18 time of the July 1 rate-setting process.
- 19 c. The aggregate dollar amount of provider fee funds necessary will be divided by
20 non-Medicare patient days for all class I nursing facilities to obtain a per day
21 provider fee assessment amount for each of the two following categories:
- 22 (i) nursing facilities with 55,000 total patient days or more;
- 23 (ii) nursing facilities with less than 55,000 total patient days.
- 24 The state department will lower the amount of the provider fee charged to
25 nursing facility providers with 55,000 total patient days or more to meet the
26 requirements of 42 CFR [section](#) 433.68-(e). In addition, the 55,000 total patient
27 day threshold can be modified to meet the requirements of 42 CFR [section](#)
28 433.68-(e).
- 29 d. Each facility's annual provider fee amount will be determined by taking the per
30 day provider fee calculated above times the facility's reported annual non-
31 Medicare patient days.
- 32 e. Each nursing facility will report annually its total number of days of care provided
33 to non-Medicare residents to the Department of Health Care Policy & Financing.
34 The non-Medicare patient days reported will be from the calendar year prior to
35 the July 1 rate setting process. Providers with less than a full year of non-
36 Medicare patient days data will have their non-Medicare days annualized. New
37 providers with no non-Medicare patient days data will have their non-Medicare
38 days estimated by the Department. The non-Medicare patient days will be used
39 for the provider fee calculation.

1 f. A facility's non-Medicare patient days will be estimated in order to determine the
2 provider's fee payment if and only if one of the following conditions exist:

3 A new facility

4 A facility that will close during the rate year

5 A facility that has had a change of certification or licensure

6 The facility will have their non-Medicare patient days estimated for each model
7 year until the facility has 12 months of data for the calendar year preceding the
8 rate year.

9 If a facility's non-Medicare patient days are estimated, and the facility's actual
10 non-Medicare days differ by more than 5% from the prior year estimated non-
11 Medicare patient days used to determine the provider's fee payment, the state
12 department will review the facility's provider fee calculation, and an adjustment to
13 the facility's annual provider fee payment will be made in the subsequent year.

14 g. Each facility's annual provider fee amount will be divided by twelve to determine
15 the facility's monthly amount owed the state department.

16 h. The state department shall assess the provider fee on a monthly basis.

17 i. The fee assessed pursuant to this section is due 30 days after the end of
18 the month for which the fee was assessed.

19 8.443.17.B All provider fees collected pursuant to this section by the state department shall be
20 transmitted to the state treasurer, who shall credit the same to the Medicaid nursing facility cash
21 fund, which fund is hereby created and referred to in this section as the "fund".

22 1. All monies in the fund shall be subject to federal matching as authorized under federal
23 law and subject to annual appropriation by the general assembly for the purpose of
24 paying the administrative cost of implementing [C.R.S. section 25.5-6-202](#) and this section
25 and to pay a portion of the per diem rates established pursuant to [C.R.S. sections](#) 25.5-6-
26 202 (1) to (4).

27 2. Following payment of the amounts described above, the moneys remaining in the fund
28 shall be subject to federal matching as authorized under federal law and subject to
29 annual appropriation by the general assembly for the purpose of paying the rates
30 established under [C.R.S. sections](#) 25.5-6-202 (5) to (7).

31 3. Any monies in the fund not expended for these purposes may be invested by the state
32 treasurer as provided by law.

33 a. All interest and income derived from the investment and deposit of moneys in the
34 fund shall be credited to the fund.

35 b. Any unexpended and unencumbered moneys remaining in the fund at the end of
36 any fiscal year shall remain in the fund and shall not be credited or transferred to
37 the general fund or any other fund but may be appropriated by the general
38 assembly to pay nursing facility providers in future fiscal years.

1 8.443.17.C The state department shall establish administrative penalties for the late payment by a
2 nursing facility of a fee assessed pursuant to this section.

3 1. The state department may recoup any payments made to nursing facilities providing
4 services pursuant to the Medicaid program up to the amount of the fees owed as
5 determined pursuant to this section and any administrative penalties owed if a nursing
6 facility fails to remit the fees and administrative penalties owed within 30 days after the
7 date they are due. Before recoupment of payments pursuant to this section, the state
8 department may allow a nursing facility that fails to remit fees and administrative
9 penalties owed an opportunity to negotiate a repayment plan with the state department.
10 The terms of the repayment plan may be established at the discretion of the state
11 department.

12 8.443.17.D The state department will prepare an annual reconciliation of provider fees received and
13 payments made. Any shortfall or excess in the provider fee cash fund will be used to increase or
14 reduce provider fees in the following year. Except that in the event the state department
15 determines there is not enough provider fee available, the state department may reduce
16 payments to facilities proportionately to the amount of provider fee available. The state
17 department can, at its discretion, establish a provider fee fund minimum balance or cash reserve.

18 **8.443.18 RATES FOR RECEIVERSHIP**

19 8.443.18.A. The following rate provisions apply for a facility where a receiver has been appointed by
20 the Court, pursuant to [C.R.S. Ssection 25-3-108](#), ~~C.R.S.~~, at the request of ~~the~~ CDPHE:

21 1. During the Receivership

22 a. During the term of the receivership, the facility shall be reimbursed the rate
23 payable to the previous operator.

24 i) The Department may increase the rate if it finds that the patient-related,
25 necessary and reasonable costs of the facility operation are not covered
26 by the rate payable to the previous operator.

27 ii) The Department's analysis of necessary, patient related and reasonable
28 costs incurred by the receiver shall not include any previous unpaid
29 expenses of the prior owner or the mortgage costs of the facility.

30 b. The receiver shall submit a cost report for the time beginning when the receiver
31 is appointed until the time the receiver is no longer operationally in control of the
32 nursing facility operation.

33 i) This cost report shall set a rate payable to the receiver for the date the
34 receiver took operational control of the facility.

35 ii) This retrospective rate may set a rate higher or lower than the initial rate
36 established and paid to the receiver in which case the under or over
37 payment shall be either paid to or collected from the receiver.

38 iii) The retrospectively set rate shall not exceed the established maximum
39 allowable rates for that period.

40 2. New providers after the receivership period

- 1 a. The new operator shall receive the rate paid to the prior owner until the new
2 provider submits a cost report unless the new operator chooses the retrospective
3 option described below where a new operator takes control and ownership of a
4 nursing facility from the receiver.
- 5 b. The new operator may elect to have a retrospective rate set for the initial three
6 months of operation.
- 7 i) In order to exercise this option, the new operator shall file a cost report
8 for the first three months of operation.
- 9 ii) The first day of operation shall mean the first day of licensure of the new
10 operator. The last day of the initial three months of operation shall be the
11 last day of the month in which the 90th day occurs.
- 12 iii) The cost report shall be filed within 90 days of the end of the initial three
13 months of operation.
- 14 c. The retrospective rate established from the three month cost report shall be in
15 effect from the first date of licensure of the new owner until the last day of the
16 month in which the 90th day occurs. This rate shall be a prospectively paid rate
17 to the new operator beginning with the first day of the month after the three
18 month cost reporting period.
- 19 d. The initial rate paid to the new operator shall be the prior owner's rate.
- 20 i) The retrospective rate established by the three month cost report shall
21 replace the initial rate paid to the operator.
- 22 ii) The retrospective rate may be higher or lower than the initial rate
23 established and paid to the new operator in which case the under or over
24 payment shall be either paid to or collected from the new operator.
- 25 iii) The retrospectively established rate shall not exceed the maximum
26 reasonable cost rates for that period.
- 27 e. The three month cost report shall establish the prospective rate for the period
28 established by the regulations at [Section 8.10 CCR 2505-10 section 8.10 CCR](#)
29 [2505-10-10 CCR 2505-10 section 8.443.13](#).
- 30 f. The provider shall file the first cost report after the three month cost report. If the
31 first cost report filed for the period immediately following the three month cost
32 report demonstrates a reduction in per diem costs more than five percent which
33 is caused by a reduction in per diem costs and not an increase in census, the
34 following special provision shall apply:
- 35 i) The provider's prospective per diem rate driven by the three month cost
36 report shall be retroactively reduced to the per diem rate as determined
37 by the actual costs of the provider.
- 38 ii) The Department shall recover the difference between the provider's
39 actual costs and the prospective rate paid to the provider. This recovery
40 shall not apply to the three month retrospective rate as established by
41 the initial three month cost report.

1 8.443.18.B. These special provisions do not apply when the receiver is appointed at the request of
2 any other party such as the previous operator, landlord or other interested party.

3 **8.443.19 PAYMENT FOR OUT OF STATE NURSING FACILITY CARE**

4 8.443.19.A. Payments for out-of-state nursing facility care shall be made to providers when:

- 5 1. The nursing facility services are needed because of a medical emergency.
- 6 2. The nursing facility services are needed because the resident's health would be
7 endangered if he/she were required to travel to Colorado and the attending physician has
8 certified to such in the resident's medical records.
- 9 3. The Department determines, on the notification from the client's primary care physician,
10 the needed medical services or necessary supplementary resources, are not available in
11 Colorado but are available in another state;
 - 12 a. The Department's State Utilization Review Contractor may review the
13 appropriateness of care plan and documentation that the resident will
14 demonstrate significant improvement.

15 8.443.19.B. Where the resident needs rehabilitation services, the resident shall meet all of the
16 following criteria:

- 17 1. The resident's medical condition, as documented by the physician, shall be stable to the
18 extent that the resident's primary need is no longer for acute medical care but for
19 intensive, multi-disciplinary rehabilitation care.
- 20 2. The resident's disability shall be within 12 months of admission.

21 8.443.19.C. The out-of-state nursing facility shall send the following to the Department monthly:

- 22 1. Problem list and rehabilitation goals;
 - 23 a. Treatment plan relative to each rehabilitation goal;
 - 24 b. Time frame for goal achievement; and
- 25 2. Statement of expected discharge status (e.g., timing and the resident's condition on
26 discharge).

27 8.443.19.D. Those residents without need for rehabilitation services shall be expected to meet
28 Colorado nursing facility admission requirements as described in 10 [C.C.R. CCR 2505-10,](#)
29 [Section 2505-10 sections 8.402.01- through 8.402.10](#) and can be admitted if:

- 30 1. It is general practice for residents in a particular locality to use nursing facility services in
31 another state; or
- 32 2. The resident of an out-of-state nursing facility has been determined to be eligible for
33 Colorado Medicaid due to his inability to indicate his/her intended state of residence.

34 8.443.19.E. The out-of-state nursing facility shall:

- 35 1. Enroll as a provider in the Colorado Medicaid Program;

2. Submit a copy of the re-certification survey yearly upon completion done by the survey and certification and/or licensure agency in their state;
3. Submit a copy of the following documentation with the claims:
 - a. The current Medicaid provider agreement with the state where it is located;
 - b. The provider number in the state where it is located; and
 - c. Their Medicaid rate, at the time services were rendered, in the state where it is located.

8.443.19.F. Payment shall not exceed 100 percent of audited Medicaid costs as determined by the Department or its designee. Audited costs shall be based on Medicaid costs in the state where the facility is located.

8.443.19.G. If the facility is not a Medicaid participant in the state where it is located, it shall submit to the Department an audited Medicare cost report. The payment shall not exceed 100 percent of audited Medicare costs.

8.443.20 CLASS II AND CLASS IV NURSING FACILITY PROVIDER FEE

8.443.20.A. The Department shall charge and collect provider fees on services provided by all class II and class IV nursing facility providers for the purpose of obtaining federal financial participation under the state's medical assistance program. The provider fees and federal matching funds shall be used to sustain reimbursement for providing medical care under the state's medical assistance program for class II and class IV nursing facility providers.

1. Each class II and class IV nursing facility that is licensed in Colorado shall pay a fee assessed by the Department.
2. To determine the amount of the fee to assess pursuant to this section, the Department shall establish a fee rate on a per patient day basis.
 - a. The total annual fees due for class II and class IV nursing facilities will be calculated such that they do not exceed the federal limits as established in 42 C.F.R. ~~§-section~~ 433.68(f)(3)(i)(A), or five percent of the total costs for all class II and class IV nursing facilities, whichever is lower.

42 C.F.R. ~~§-section~~ 433.68(f)(3)(i)(A) ~~{(2013)}~~ is hereby incorporated by reference. The incorporation of 42 C.F.R. section 433.68(f)(3)(i)(A) excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request. ~~is hereby incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S., C.R.S. section 24-4-103(12.5), the Department of Health Care Policy and Financing maintains either electronic or written copies of incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado 80203-1818.~~

- 1 b. The total annual fees will be divided by annual patient days for class II and class
2 IV facilities from the most recently available MED-13 cost reports to establish the
3 per patient day fee.
- 4 c. The Department may use estimated patient days in the per patient day fee
5 calculation to adjust for expected changes in utilization.
- 6 d. When final audited MED-13 cost reports are available, the Department will review
7 the fees charged during each state fiscal year to ensure that the fee amount was
8 less than five percent of the total costs for all class II and class IV nursing
9 facilities five percent statutory limit. If the fees were greater than five percent of
10 the total costs for all class II and class IV nursing facilities, the Department will
11 retroactively adjust the fees.
- 12 3. The Department shall calculate the fee to collect from each class II and class IV nursing
13 facility by August 1 for the state fiscal year.
- 14 a. The Department shall notify the providers of their fee obligation in writing at least
15 30 days prior to due date of the fee.
- 16 b. The Department shall assess the provider fee on a monthly basis.
- 17 i. Each facility's annual provider fee amount will be divided by twelve to
18 determine the facility's monthly amount owed to the Department.
- 19 ii. The monthly fee is due by last day of the month for which the fee was
20 assessed
- 21 iii. Fees may be paid through intragovernmental transfer, Automated
22 Clearing House, or check.

23 **8.444 through 8.446 Repealed, effective June 30, 2005**

24 Repealed, effective June 30, 2005

25 **8.448 REPEALED, EFFECTIVE MAY 30, 2006**

26 **8.449.1 REQUIREMENTS FOR UTILIZATION REVIEW**

27 Utilization review requirements are that all long-term health care facilities participating in the Medical
28 Assistance Program make provision for utilization review and medical care appraisal to assure quality
29 patient care and appropriate use of health care facilities. Each facility shall submit to the Department of
30 [Social+Human](#) Services a plan for doing so that agrees in principle with the model plan attached.
31 Individual case reviews are to be so scheduled as to provide for annual review of each patient certified for
32 skilled nursing care and semi-annual review of each patient certified for intermediate care.

33 The Utilization Review Plan developed by the long-term care facility lists the members of the Utilization
34 Review Committee. Any change in membership of the Committee is to be communicated to the State
35 Department of [Social+Human](#) Services and the State Department of [Public Health and Environment](#).

36 The minutes of Utilization Review Committee meetings are to be kept on file in the facility and available to
37 representatives of the Department of [Social+Human](#) Services and the State Department of [Public Health](#)
38 [and Environment](#).

1 **8.449.2 USE OF FORMS AND COMMUNICATION CONCERNING RESULTS OF UTILIZATION**
2 **REVIEW**

3 Recommendations as to individual patients shall be recorded in duplicate on Forms MED-60. The original
4 is filed with the committee minutes, the copy in the patient's administrative file. ~~(Forms are secured by~~
5 ~~nursing homes from the Claridge Printing Company, 1505 So. Pearl, Denver.)~~

6 When the U.R. Committee recommends a change in the level of care to be given to the patient, form
7 letter Med-60A is completed in triplicate and sent to the patient's physician by the nursing home. If the
8 attending physician agrees with the recommendations, he should date and sign the Med-60A and return it
9 to the Nursing Home U.R. Committee. The nursing home shall then complete Form NH-8 to be sent,
10 together with the Med-60A to the State Department of Social-Human Services and to the county
11 department. The original of Form Med-60A shall be kept in the patient's chart.

12 If the attending physician disagrees with the recommendations, he shall return the Form Med-60A with
13 the reasons entered in the space provided, to the U.R. Committee. The U. R. Committee will review the
14 reasons the physician did not accept the recommendations, and if valid, the classification will remain the
15 same, and the U.S. Committee will notify the State and County Departments. If the Committee does not
16 agree, a copy of the minutes and the form will be sent to the Colorado Medical Society Utilization Review
17 Committee for review and evaluation. The results of that review will be communicated to the physician,
18 the State Department of Social-Human Services, the County Department of Social Services, and to the
19 U.R. Committee.

20 It shall be the responsibility of the Department to make the final decision, in all such cases, following a
21 review of the recommendations of the Colorado Medical Society Utilization Review Committee, the facility
22 Utilization Review Committee, and the attending physician.

23 **8.461 REPEALED, EFFECTIVE MAY 30, 2006**

24 **8.470 HOSPITAL BACK UP LEVEL OF CARE**

25 **8.470.1 DEFINITIONS**

26 "Complex wound care" means that the client meets the following criteria:

- 27 1. Has at least one of the following:
 - 28 a. A complex surgical or traumatic wound;
 - 29 b. Complicated wound graft surgery;
 - 30 c. At least one stage IV pressure ulcer; or
 - 31 d. A specialized wound-healing device, (e.g., Wound-Vac).
- 32 2. Requires a Medicare-rated group 2 or 3 pressure-relieving surface in order to heal.
- 33 3. Be receiving treatment for existing nutritional deficiencies.
- 34 4. Had any required debridement therapy initiated.
- 35 5. Had a consultation with a wound specialist and a resulting care plan has been initiated.

1 "Medically complex" means that a client meets the requirements of at least one of the following two
 2 subsections:

- 3 1. The client shall meet five of the seven following criteria:
- 4 a. Have difficulty communicating needs verbally, or require use of specialized
 5 adaptive equipment to communicate which requires set up by trained staff, or is
 6 unable to seek assistance through use of call light due to physical impairment;
- 7 b. Require on-site assessment by a physician once per week;
- 8 c. Require artificial nourishment via a gastro-intestinal tube (G-tube or NG-tube),
 9 and/or jejunostomy tube (J-tube);
- 10 d. Have a tracheotomy requiring suctioning, airway maintenance, or both at least
 11 every four hours;
- 12 e. Require total parenteral nutrition (TPN) with or without lipids;
- 13 f. Require central line in active use for fluids and/or medications, excluding TPN;
- 14 g. Require skilled therapy, skilled nursing, or both for assessment, monitoring, and
 15 intervention at a greater frequency than is usually provided in a class I nursing
 16 facility.
- 17 2. The client shall meet all of the following criteria:
- 18 a. Be a participant in the hospital back up level of care program immediately prior to
 19 qualifying under the criteria of **the first subsection of the definition of medically**
 20 **complex or any subsection of the ventilator-dependent definition**; and
- 21 b. Have difficulty communicating needs verbally, or require use of specialized
 22 adaptive equipment to communicate which requires set up by trained staff, or is
 23 unable to seek assistance through use of call light due to physical impairment;
 24 and
- 25 c. Require on-site assessment by a physician once every other week; and
- 26 d. Require artificial nourishment via a gastro-intestinal tube (G-tube or NG-tube), a
 27 jejunostomy tube (J-tube), or both; and
- 28 e. Have a tracheotomy requiring respiratory assessment, treatment or both at least
 29 every six hours; and
- 30 f. Require suctioning, assessment, and/or treatment by a skilled therapist or skilled
 31 nurse **with specialized training and demonstrated skill in respiratory**
 32 **therapy evaluation and treatment** as necessary in addition to the regular
 33 respiratory assessment, treatment, or both equating to a greater frequency than
 34 usually provided in a class I nursing facility.

35 "Client who is Ventilator-dependent" means that a client meets the requirements of at least one of the
 36 following **three** subsections:

- 37 1. If the client is actively weaning from the ventilator, the client shall:

- 1 a. Require intermittent ventilator support between two and 24 hours each day; and
- 2 b. Require skilled nursing or respiratory therapy at least 12 hours each day in order
- 3 to progress with weaning; and
- 4 c. Require physical therapy, occupational therapy and/or speech therapy five days
- 5 per week; and
- 6 d. Have documented rehabilitation potential.
- 7 2. If active weaning fails, the client shall:
 - 8 a. Require continuous ventilator support between eight and 24 hours each day; and
 - 9 b. Require respiratory therapy at least 3.5 hours each day in order to remain
 - 10 medically stable; and
 - 11 c. Have one of the following scores on the ULTC 100.2 assessment form:
 - 12 i) A score of at least two, in a minimum of two ADLs; or
 - 13 ii) A score of at least two, in one category of supervision; and
 - 14 d. Have difficulty communicating needs verbally, or require use of specialized
 - 15 adaptive equipment to communicate which requires set up by trained staff, or is
 - 16 unable to seek assistance through use of call light due to physical impairment.
- 17 3. If the client has been weaned off the ventilator and is actively weaning to reduce oxygen
- 18 needs and/or remove the tracheotomy tube, the client shall:
 - 19 a. Have one of the following scores on the ULTC 100.2 assessment form:
 - 20 i) A score of at least two, in a minimum of two ADLs; or
 - 21 ii) A score of at least two, in one category of supervision; and
 - 22 b. Have documented rehabilitation potential from a physician; and
 - 23 c. Require the expertise of a respiratory therapist under the direction of a
 - 24 pulmonologist at least 3.5 hours each day in order to remain medically stable
 - 25 and/or show progression towards decannulation; and
 - 26 d. Require the expertise of a speech therapist to evaluate for a complete functioning
 - 27 swallow and/or require speech therapy treatment for strengthening of the oral
 - 28 muscles required to swallow properly; and
 - 29 e. Have minimal difficulty communicating needs and be able to follow simple
 - 30 commands.

31 **8.470.2 CLIENT ELIGIBILITY**

- 32 8.470.2.A. In order to be eligible for the hospital back up level of care, a client shall:

- 1 1. Meet long-term level of care requirements as determined by the appropriate Single Entry Point (SEP) agency;
- 2
- 3 2. Fall into one of the following categories:
 - 4 a. Ventilator-dependent;
 - 5 b. Complex wound care; or
 - 6 c. Medically complex.
- 7 3. Be medically stable in a chronically acute state;
- 8 4. Be in the hospital prior to approval; and
- 9 5. Have a ~~rate-level of care reimbursement~~ authorized by the Department. The ~~rate-level of~~
10 ~~care reimbursement~~ shall be determined by the Department to exceed nursing facility's
11 Class I reimbursement rate.

12 8.470.3 CLIENT ELIGIBILITY DETERMINATION

13 8.470.3.A. Upon referral from a hospital, the State Utilization Review Contractor (SURC) shall:

- 14 1. Conduct a review to determine whether the client meets the hospital back up level of care
15 criteria and may be successfully treated in a nursing facility; and
- 16 2. Consider all other Medicaid programs and services and determine whether those
17 programs would fail to meet the client's needs if the client were to be returned to the
18 home.

19 8.470.3.B. When a hospital contacts a nursing facility regarding a potential client's eligibility for the
20 hospital back up level of care, the nursing facility shall:

- 21 1. Assess the client on-site (in the hospital) to determine if the nursing facility can provide
22 appropriate care.
- 23 2. Notify the SURC and the Department that it is considering admitting the client.
- 24 3. Prepare a care plan and submit it to the SURC.
- 25 4. Secure a transfer agreement with the discharging hospital in which the hospital agrees to
26 readmit the client should care problems develop.

27

28 8.470.3.C. The care plan submitted to the SURC shall demonstrate that the nursing facility
29 proposing to provide hospital back up level of care can meet the needs of the prospective client.
30 The SURC shall review care plans to determine whether they meet pre-established professional
31 standards of care.

32 8.470.3.D. The SURC shall review the medical documentation, the nursing facility care plan and the
33 Single Entry Point (SEP) required documentation to determine whether or not the client meets the
34 established hospital back up level of care criteria. The SURC may request any medical
35 information and any other demographic information that the SURC deems necessary to make

1 such determination. The SURC shall notify the Department in writing whether the client can be
2 successfully treated in the nursing facility.

3 8.470.3.E. The SURC shall obtain a physician review for all clients who are considered to meet the
4 hospital back up level of care criteria on initial evaluation. The physician's determination upon
5 review shall be in writing and submitted to the SURC and the Department.

6 8.470.3.F. The SURC shall submit the care plan and supporting documentation to the Department
7 with the written determination of approval or denial.

8 8.470.3.G. The SURC shall notify the client and the hospital, in writing, of the final determination.
9 Notification to the client shall include recipient appeal rights as outlined in ~~10 C.C.R. CCR 2505-~~
10 ~~10, Section 2505-10 section 8.10 CCR 2505-10 section 8.057.~~

11 **8.470.4 INITIAL LENGTH OF STAY**

12 8.470.4.A. Prior authorization for the initial length of stay of hospital back up nursing facility clients
13 shall not exceed 90 days.

14 **8.470.5 CONTINUED STAY REVIEW FOR HOSPITAL BACK UP LEVEL OF CARE NURSING** 15 **FACILITY CLIENTS**

16 8.470.5.A. The SURC shall conduct an on-site continued stay review for each hospital back up level
17 nursing facility client 15 days prior to the end of the client's currently approved stay.

18 8.470.5.B. A continued stay review shall be conducted at least annually. The Department may
19 request the SURC to conduct an unscheduled continued stay review at any time during the length
20 of stay.

21 8.470.5.C. The continued stay review shall determine whether:

- 22 1. The client continues to meet the hospital back up level of care criteria for hospital-level
23 care in a nursing facility.
- 24 2. The client's care needs are adequately being met;
- 25 3. The approved care plan is being implemented;
- 26 4. Appropriate services are being provided; and
- 27 5. The care plan for the client should be adjusted to more appropriately meet the client's
28 needs.

29 8.470.5.D. If the SURC determines, during the on-site continued stay review, that the client no
30 longer meets the hospital back up level of care criteria:

- 31 1. A physician shall conduct an additional review to confirm the determination of the SURC.
- 32 2. If the physician review confirms that the client no longer meets the hospital back up level
33 of care criteria, the SURC shall notify the client of the SURC's determination in writing.
34 This letter shall include recipient appeal rights as outlined in ~~10 C.C.R. CCR 2505-10,~~
35 ~~Section 2505-10 section 8.10 CCR 2505-10 section 8.057.~~

- 1 3. The SURC shall notify the Department in writing if both the physician review and the
2 SURC determine the client no longer meets the hospital back up level of care criteria and
3 shall include the supporting documentation.
- 4 4. The Department shall notify the client and/or the client's legal representative, the nursing
5 facility currently providing the hospital back up level of care and the treating primary care
6 physician that the SURC and the physician reviewer have determined that the client no
7 longer meets hospital back up level of care criteria and that within 60 days the rate shall
8 be reduced to the nursing facility's class I rate. Within 15 days of the date on the notice
9 the nursing facility providing the hospital back up level of care shall notify the Department
10 in writing whether it will provide care for the client at its standard class I rate.
- 11 a. In circumstances in which the nursing facility chooses to transfer or discharge a
12 client who ceases to meet the hospital back up level of care criteria, the nursing
13 facility shall comply with notification requirements of ~~10 C.C.R. CCR 2505-10,~~
14 ~~Section 2505-10 section 8.10 CCR 2505-10, section 8.057.1.D. and Section 8.10~~
15 ~~CCR 2505-10 section 8.10 CCR 2505-10 10 CCR 2505-10 section 8.057.1.E,~~
16 including notification of the client's right to appeal the transfer or discharge.
- 17 b. The discharging nursing facility shall adhere to ~~the Colorado Department of~~
18 ~~Public Health and Environment (CDPHE)~~ rules specific to client discharge or
19 transfer as outlined in 6 ~~C.C.R. CCR~~ 1011-1, Chapter V, Section 12.6.
- 20 5. The receiving class I nursing facility shall prepare a care plan and submit it to the SURC.
21 The care plan submitted to the SURC shall demonstrate that the receiving class I nursing
22 facility can meet the needs of the prospective client. The SURC shall review care plans to
23 determine whether they meet pre-established professional standards of care.
- 24 6. The Department shall notify CDPHE at the time of the transfer from the hospital back up
25 level of care the name of the client being transferred and the name of the receiving class
26 I nursing facility.

27 **8.470.6 NURSING FACILITY QUALIFICATION FOR HOSPITAL BACK UP LEVEL**

- 28 8.470.6.A. In order to participate as a hospital back up level nursing facility, the nursing facility shall
29 submit an application to the Department that demonstrates:
- 30 1. The nursing facility is Medicaid certified and licensed to provide skilled care;
- 31 2. Financial stability for corporate and individual nursing facility;
- 32 3. Availability of skilled nursing services 24 hours per day;
- 33 4. Staff stability;
- 34 5. History of survey compliance;
- 35 6. Compliance with the direct client care regulations "Chapter II – General Licensure
36 Standards" and "Chapter V – Long Term Care Facilities" administered by ~~the Colorado~~
37 ~~Department of Public Health and Environment (CDPHE);~~ and
- 38 7. A recommendation from ~~_~~CDPHE for the nursing facility to participate in the hospital back
39 up level of care program.

- 1 8.470.6.B. The Department may request evidence of financial stability and survey compliance
2 periodically throughout the nursing facility's participation.
- 3 8.470.6.C. If the nursing facility has applied to admit ~~ventilator-dependent clients~~clients who are
4 ventilator dependent, the nursing facility shall meet the following additional requirements:
- 5 1. Maintain staff dedicated to the ventilator unit 24 hours a day, seven days a week;
 - 6 2. Have a generator that is capable of providing heating, cooling and continuous electricity
7 for needed equipment in the event of power outages;
 - 8 3. Maintain staff that has experience and current training in the care of ~~ventilator-dependent~~
9 clients who are ventilator dependent;
 - 10 4. Have a wound care consultant available as needed; and
 - 11 5. Maintain 24 hour on-site coverage by a respiratory therapist.
- 12 8.470.6.D. If the nursing facility has applied to admit ~~wound care clients~~clients with complex wounds,
13 the nursing facility shall meet the following additional requirements:
- 14 1. Have a wound care specialist nurse or nurses capable of providing the wound care
15 required by the ~~wound care clients~~clients with complex wounds on a 24 hour basis; and
 - 16 2. Have access to specialized wound care equipment necessary to meet the needs of the
17 ~~wound care clients~~clients with complex wounds.
- 18 8.470.6.E. If the nursing facility has applied to admit ~~medically complex clients~~clients who are
19 medically complex, the nursing facility shall meet the following additional requirements:
- 20 1. Maintain sufficient skilled nursing staff experienced in and trained in the care of ~~medically~~
21 complex clients who are medically complex;
 - 22 2. Have 24 hour on-site coverage by a respiratory therapist or therapists to meet the
23 assessed respiratory therapy needs of each medically complex client;
 - 24 3. Have access to respiratory equipment necessary to meet the assessed needs of each
25 medically complex client;
 - 26 4. Have a wound care consultant available as needed; and
 - 27 5. Provide physician support necessary for onsite monitoring of ~~medically complex~~
28 clients who are medically complex at least one time per week.
- 29 8.470.6.F. A nursing facility participating in the hospital back up level of care program shall:
- 30 1. Use the forms approved by the Department to document the care of ~~hospital back up~~
31 level of care clients who meet the hospital back up level of care.
 - 32 2. Evaluate all clients upon admission, whenever there is a change in the client's condition
33 and annually.
 - 34 3. Notify the Department of a client's change of condition, discharge or death.

1 8.470.6.G. The Department may deny a nursing facility's request to participate as a hospital back up
2 level of care nursing facility if the nursing facility does not meet all of the criteria for participation.

3 8.470.6.H. The Department may revoke a nursing facility's authorization to participate in the hospital
4 back up level of care program if the nursing facility is not in compliance with the criteria.

5 **8.470.7 REIMBURSEMENT OF NURSING FACILITIES SERVING ~~HOSPITAL BACK UP LEVEL OF~~**
6 **~~CARE CLIENTS~~ CLIENTS WHO MEET THE HOSPITAL BACK UP LEVEL OF CARE**

7 8.470.7.A. The Medicaid reimbursement for services provided to a hospital-back up level of care
8 nursing facility client shall be negotiated between the Department and nursing facility in
9 accordance with this subsection.

10 1. The Medicaid reimbursement for each client shall correspond to the negotiated cost of
11 the services, durable medical equipment, and supplies as identified in the client's SURC
12 approved care plan.

13 2. The Medicaid reimbursement for a client who meets the hospital back up level of care
14 ~~client~~ shall not be based upon or related to the audited, cost-based reimbursement for a
15 nursing facility's class I nursing facility residents. The appeal rights and procedures
16 applicable to the Department's determination of a nursing facility's class I rate shall not
17 apply to the reimbursement offered or paid by the Department for a client who meets the
18 hospital back up level of care~~hospital back up level of care client~~.

19 3. The Department and nursing facility shall negotiate the Medicaid reimbursement for an
20 approved client who meets the hospital back up level of care~~hospital back up level of~~
21 ~~care client~~, at the time of initial placement in the nursing facility and whenever there is a
22 significant change in the client's approved care plan or other relevant circumstances.

23 4. In the event that the Department and nursing facility are unable to reach agreement on
24 an appropriate level of Medicaid reimbursement for a client who meets the hospital back
25 up level of care~~hospital back up level of care client~~, arrangements shall be made for the
26 discharge of the client to another appropriate placement. The Department shall continue
27 to reimburse the nursing facility for the client's care at the most recently agreed level of
28 reimbursement until the nursing facility can provide appropriate placement, not to exceed
29 60 days.

30 5. Under no circumstances shall the payment for a client who meets the hospital back up
31 level of care~~hospital back up level of care client~~ exceed 90 percent of the Medicaid
32 payment to the discharging hospital.

33 6. If the Department determines that the client's third party coverage (private insurance or
34 Medicare) will cover the cost of the client's care in either a hospital or nursing facility,
35 Medicaid payment under this program shall be approved only after utilization of third
36 party benefits.

37 8.470.7.B. Drugs and oxygen shall be billed directly to Medicaid by providers.

38 **8.470.8 REPORTING ON MED-13**

39

40 8.470.8.A. The Medicaid reimbursement for ~~hospital back up level of care clients~~clients who meet
41 the hospital back up level of care (hereafter referred to in this paragraph as "hospital-level

reimbursement") shall not impact the Medicaid per diem cost and rate set for the nursing facility's class I Medicaid clients based on the ~~MED-43~~MED-13 cost reporting process. The hospital-level reimbursement shall be reported on the ~~MED-43~~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.

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.

[The Memorandum of Understanding between the Department and the PRO is hereby incorporated by reference. The incorporation of the Memorandum of Understanding excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.](#)

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

1 Resident income, whether contributed or direct, shall be used for the care of the resident, except for 2
 2 personal needs allowance as see forth ~~in 8.4 in 10 CCR 2505-10 section 8.10 CCR 2505-10 section~~
 3 ~~8.482.5.~~

4 No person, institution, partnership, corporation or other entity shall divert resident income from the control
 5 and exclusive use of the resident, without proper legal authorization or power.

6 **8.482.2 DEFINITIONS**

7 A. "Contributed income" is defined as the amount of income of parent or unseparated spouse, over
 8 and above the needs of such spouse or parent, which is contributed toward the needs of the
 9 resident.

10 B. "County Department" is defined as the County Departments of Social/Human Services[JM10].

11 C. "Department" is defined as the Colorado Department of Health Care Policy and Financing.

12 D. "Direct income" is defined as payments made directly to the resident, or to a conservator or
 13 guardian for the exclusive use of the resident. Examples of such income are Social Security
 14 benefits, supplementary security income, railroad or ~~other~~ retirement benefits.

15 E. "Nursing facility" is defined as an intermediate or skilled care facility, the owners, administrators,
 16 and staff thereof.

17 F. "Personal needs" is amount specified in 10 CCR 2505-10 section 8.110.42 to be deducted from
 18 resident income, end used for the exclusive benefit of the resident prior to application of income
 19 to nursing facility care.

20 G. "Resident income" is defined as all income used in the determination of eligibility for Medicaid
 21 payments.

22 H. "Patient payment" is defined as the payment made by the resident for nursing facility care, after
 23 the personal needs allowance is deducted.

24 I. "Responsible Party" is defined as any of the persons below, who accepts the responsibility for a
 25 resident's funds, mail or personal possessions and is willing to sign a written declaration of such
 26 responsibility:

27 1. a legally appointed guardian, conservator or trustee;

28 2. relative or friend;

29 3. the county department.

30 J. "Post Eligibility Treatment of Income (PETI)" is defined as the reduction of resident payment to a
 31 nursing facility, for the costs of care provided to an individual by the amount that remains after
 32 certain deductions are applied to reduce the individual's total income. The individual is liable to
 33 pay the remaining amount to the institution.

34 **8.482.3 RESIDENT INCOME**

35 The control of resident income is vested in the resident, or in such person as the resident may designate.
 36 Such designee may be a conservator, administrator, family member or other representative. The income

1 is to be used by the resident, or on behalf of the resident. No such designee, or any other person or
2 institution, shall convert any of these monies to their own use for any reason.

3 **8.482.31 DETERMINATION OF INCOME**

- 4 A. The initial determination of resident income shall be made by the county department. The county
5 department shall then notify the nursing facility of current resident income as detailed in 10-CCR
6 2505-10-Section-8.10 CCR 2505-10 section 8.482.34. B.
- 7 B. The nursing facility must notify the county immediately of any changes in resident income. And, if
8 the facility is authorized to receive the resident's income, the facility has the duty and obligation to
9 verify the amount of resident income.
- 10 C. If the nursing facility is not authorized to receive the payments for resident income, it is the
11 responsibility of the resident, or the person administering such income on behalf of the resident,
12 to report all changes in such income, as required by the Colorado Department of Human Services
13 Income Maintenance Staff Manual, Volume 3, under the penalties set forth in 10-CCR-2505-10
14 Section-8.10 CCR 2505-10 section 8.482.45 of this Staff Manual.

15 **8.482.32 COLLECTION OF INCOME**

- 16 A. Responsibility of Nursing Facility
- 17 1. It shall be the responsibility of the nursing facility to collect from the resident, or from the
18 resident's family, conservator or administrator, all income which is to be applied to the
19 cost of resident care. The Department is not responsible for any deficiency in patient
20 payment accounts, due to failure of the nursing facility to collect such income.
- 21 2. If, however, the nursing facility is unable to collect such funds, through refusal of the
22 resident or the resident's family, conservator, or administrator to release such income, the
23 nursing facility shall immediately notify the county department.
- 24 B. Responsibility of County Department
- 25 When notified by the nursing facility of the refusal of the resident or the resident's family,
26 conservator or administrator to release resident income due, the County Department shall
27 immediately contact the refusing party. If, after such contact, the party still refuses to release such
28 income, the action shall be deemed a failure to cooperate, and the county department shall
29 proceed to discontinue Medicaid benefits for the resident.

30 **8.482.33 POST ELIGIBILITY TREATMENT OF INCOME**

31 Effective April 8, 1988, with respect to the post-eligibility treatment of income of individuals who are
32 institutionalized there shall be taken into account amounts for incurred expenses for medical or remedial
33 care that are not subject to payment by Colorado Medicaid or third ~~party~~ insurance, including health
34 insurance premiums, deductibles or co-insurance, dental care, hearing aids, supplies and care, and
35 corrective lenses, eye care, and supplies, and other incurred expenses for medical or remedial care that
36 are not subject to payment by a third party.

- 37 A. All PETI expenses in excess of \$400 per calendar year must be prior authorized by the
38 Department or its designee. The purpose of the prior authorization process is to verify the medical
39 necessity of the services or supplies, to validate that the requested expense is not a benefit Of
40 the Medicaid program, and to determine if the expenses requested are a duplication of expenses
41 previously prior authorized.

- 1 B. Health insurance premiums, deductibles, or co-insurance as defined by state law.
- 2 1. Monthly premium payment paid by the resident for health insurance. If payments exceed
3 the patient payment amount for one month, a monthly average is calculated by dividing
4 the total premium by the number of months of coverage. The resulting amount is to be
5 applied as a monthly PETI expense for the months of coverage.
- 6 2. Medicare premiums are not an allowable deduction except in "medical only" eligibility
7 cases and only ~~for me first~~for the first two months not covered by Medicaid.
- 8 3. Health insurance premiums will be allowed for the resident only.
- 9 4. Health insurance premiums will only be allowed if the health, insurance information is
10 entered into the automated system for purposes of third party recovery.
- 11 5. Health insurance premiums, deductibles, and coinsurance must be reviewed by the
12 Department or its designee for final approval. If duplicate coverage has been purchased,
13 only the cost of the least expensive policy will be allowed. Premiums, deductibles and co-
14 insurances which the Department or its designee determine to be too expensive in
15 relation to coverage purchased shall not be allowed.
- 16 C. The allowable expenses for special medical services (dental care, hearing corrective lenses) are
17 subject to the following criteria:
- 18 1. General Instructions (applies to all special medical services).
- 19 a. All PETI expenses exceeding \$400 per calendar year for equipment, supplies, or
20 services must be authorized by the Department or its designee to be considered
21 an allowable cost.
- 22 b. Costs will be allowed only if they are not a benefit of the Medicaid program, or
23 not a benefit of other insurance coverage the resident may have.
- 24 c. All allowable costs must be documented in the resident's record with date of
25 purchase and receipt of payment, whether or not these costs meet the
26 requirements for prior authorization. Lack of documentation shall cause the
27 patient payment deduction to be disallowed, causing the provider to be overpaid
28 by the Medicaid program.
- 29 d. All allowable costs must be for items that are medically necessary as described
30 in 8.011, and medical necessity must be documented by the attending physician.
31 The physician statement must be current, within one year of the authorization.
- 32 e. The resident or legally-appointed guardian must agree to the purchase of the
33 service/equipment and related charge, with signed authorization in the resident's
34 record.
- 35 f. Nursing facilities are not permitted to assess surcharge or handling fee to the
36 resident's income.
- 37 g. For special medical services/supplies provided but not yet paid for, the
38 encumbrance agreement and monthly payment schedule must be documented in
39 the resident's record, as well as receipts of payment.

- 1 h. The allowable costs for services and supplies may not exceed the basic Medicaid
2 rate.
- 3 i. In the case of damage or loss of supplies, replacement items may be requested
4 with relevant documentation. If the damage or loss is due to negligence on the
5 part of the nursing facility, the nursing facility is responsible for the cost of
6 replacement.
- 7 j. Costs will not be allowed if the equipment, supplies or services are for cosmetic
8 reasons only.
- 9 k. If the client does not make a patient payment; then no PETI will be allowed.
- 10 l. PETI payments may not exceed the patient payment Payments made over a
11 period of time shall only be allowed if the provider agrees to accept installment
12 payments.
- 13 2. Dental Care Instructions
- 14 a. Prescription of dentures (partial or full plate, fixed or removable) must be made
15 by a licensed dentist (Doctor of Dental Surgery, Doctor of Medical Dentistry).
- 16 b. The prescription (as defined in [Section 8.10 CCR 2505-10 section 8.10 CCR](#)
17 [2505-10-10 CCR 2505-10 section 8.482.33.2.a.](#)) must be part of a
18 comprehensive evaluation to determine the medical necessity and suitability for
19 wearing dentures.
- 20 c. Oral and maxillofacial surgery that is required to render soft-tissue and bony
21 structures suitable for wearing dentures must be prior authorized by the
22 Department as defined in [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10](#)
23 [10 CCR 2505-10 section 8.200 et seq.](#)
- 24 3. Hearing Aid Instructions
- 25 a. All referrals for hearing aids must be certified by the attending physician, and
26 must include an evaluation for suitability and specifications of the appropriate
27 appliance, in accordance with [Section 8.10 CCR 2505-10 section 8.10 CCR](#)
28 [2505-10-10 CCR 2505-10 section 8.287.02.](#)
- 29 b. Purchase of new hearing aids to replace pre-existing hearing aids must include
30 documentation of necessity of replacement of the pre-existing hearing aid. The
31 documentation shall also describe the trade-in value given for the pre-existing
32 aid, if appropriate.
- 33 4. Corrective Lenses Instructions
- 34 a. The evaluation of the need for corrective eyeglasses (lenses) must be a part of a
35 comprehensive general visual examination conducted by a licensed
36 ophthalmologist or optometrist.
- 37 b. The medical necessity for prescribed corrective lenses should not be based on
38 the determination of the refractive state of the visual system alone, but should be
39 identified by the current procedural terminology in the Physician Current
40 Procedures Terminology (CPT) Code as established by the American Medical

1 Association. This document is available through the American Medical
 2 Association, 515 North State Street, Chicago, Illinois 60610 or [http://www.ama-](http://www.ama-assn.org/catalog)
 3 [assn.org/catalog](http://www.ama-assn.org/catalog). The document referred to does not include later amendments
 4 to or editions of the CPT4. Copies are available for inspection and available at
 5 cost at the following address: Director, Office of Medical Assistance, Colorado
 6 Department of Health Care Policy and Financing, ~~1575 Sherman Street~~ [1570](#)
 7 [Grant Street](#), Denver, Colorado 80203-1714; or may be examined at any State
 8 Publications Depository Library.

9 D. Prior Authorization Request Process:

10 For allowable PETI expenses that exceed \$400 per client in a calendar year, costs must be prior
 11 authorized by the Department or its designee. The process is as follows:

- 12 1. Prior authorization requests must be submitted to the Department or its designee on the
 13 form prescribed by the State. In addition to the information requested on the form, the
 14 following attachments must be included:
 - 15 a. A description of the service or supply, and the estimated cost.
 - 16 b. A physician's statement indicating the medical necessity of the service or supply.
- 17 2. Prior authorizations will be certified based on the following criteria:
 - 18 a. The request is not a benefit of the Medicaid program.
 - 19 b. The cost of the request does not exceed the basic Medicaid rate for such
 20 services or supply.
 - 21 c. The special medical service or supply is medically necessary.
- 22 3. The Department or its designee shall review and approve/deny the Prior Authorization
 23 Request within ten working days of receipt
- 24 4. Upon receipt of the approved Prior Authorization Request ([PAPPAR](#)), the nursing facility
 25 shall adjust the patient payment by the amount authorized on the following month's
 26 Medicaid billing or on the nursing facility's next billing cycle.
- 27 5. All documentation of the incurred expenses must be available in the client's financial and
 28 medical record for audit purposes. Lack of documentation shall cause the patient
 29 payment deduction to be disallowed causing the provider to be overpaid by the Medicaid
 30 program.

31 **8.482.34 THE "STATUS OF NURSING FACILITY CARE" FORM, AP-5615**

32 A. Responsibilities of the Nursing Facility

- 33 1. The AP-5615 form is to be completed by the nursing facility, in duplicate, for all
 34 admissions, readmissions, transfers from private pay or Medicare, discharges, deaths,
 35 changes in income and/or patient payment, and leaves of absence.
- 36 2. Each form must carry the date completed and the actual signature of the nursing facility
 37 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 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 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 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.482.43](#).

- 1 5. For discharge or death of resident:
- 2 a. Verify the date of death or discharge, and verify the correct patient payment (or
- 3 resident's monthly income) for the discharged month, and the amount calculated
- 4 by per diem. All corrections must be initiated.
- 5 b. Note if the resident entered another nursing facility and, if so, provide the name
- 6 of the new nursing facility. This information is needed to assure that duplicate
- 7 payment will not be made.
- 8 c. In the event the resident may return to the same facility, the AP-5615 may be
- 9 completed at the end of the month for discharges due to hospitalization.
- 10 d. Make necessary changes on the automated system to reflect the appropriate
- 11 circumstances. Submit the AP-5615 to the Department
- 12 6. Failure to submit the correct form may result in the refusal of the Department to
- 13 reimburse such nursing facility care.
- 14 7. General Instructions:
- 15 a. The AP-5615 form must be verified and the original returned to the nursing
- 16 facility.
- 17 b. The AP-5615 form must be signed and dated by the director of the County
- 18 Department, or by his/her designee.
- 19 c. AP-5615 forms may be initiated by either the nursing facility or County
- 20 Department. If the County Department is aware of information requiring a change
- 21 in financial arrangements of a resident, and a new AP-5615 form is not
- 22 forthcoming from the nursing facility, the County Department may initiate the
- 23 revision to the AP-5615. In such case, one copy of the AP-5615 showing the
- 24 changes, will be sent to the nursing facility.
- 25 8. The Department may deduct excess payments from the county administrative
- 26 reimbursement as stated in the Colorado Department of Human Services Finance Staff
- 27 Manual, Volume 5 if the County Department fails to:
- 28 a. Perform the duties as detailed in section B; or
- 29 b. Adhere to the limitations on \$0.00 patient payment; as detailed in [Section 8-10](#)
- 30 [CCR 2505-10 section 8.482.34-D.](#); or
- 31 c. Notify the nursing facility immediately of any changes in resident income,
- 32 provided the nursing facility is not authorized to receive the resident's income;
- 33 and excessive Medicaid funds are paid to the nursing facility as a result of this
- 34 negligence.
- 35 C. Calculating Partial Month Payments
- 36 1. Whenever a resident is in the nursing facility on the first day of the month, remains a
- 37 resident for each day of the month, and is still a resident on the first day of the next
- 38 month, the total resident income, in excess of the amount reserved for personal needs
- 39 allowance, less earned income (if appropriate), less spousal and dependent care

1 allowance, less home maintenance allowance, and less allowable expenses for medical
2 and remedial care (see PETI deductions as defined in [10 CCR 2505-10 sections](#)
3 [8.110.49](#) and [8.482.33](#)) will be used as the patient payment, regardless of the actual
4 number of days in that month. If the resident is in the facility less than this period, the rate
5 is computed using the calculation below.

6 2. In figuring the number of days for payment, the day of admission is included, but not the
7 day of discharge (i.e., the resident dies or leaves the facility).

8 3. In order to calculate the patient payment:

9 a. determine the amount of available resident income for the month (see subsection
10 1. above).

11 b. subtract the cost of the care provided to the resident during that month
12 (computed by multiplying the number of days in the facility times the per diem
13 cost of care).

14
15 4. If the cost of care exceeds the available resident income, Medicaid will pay the
16 difference. If the available resident income exceeds the cost of care, the excess income
17 is the property of the resident ([10 CCR 2505-10 section 8.482.3](#)) and must be refunded to
18 the resident or the legal guardian/designated responsible party.

19 5. When patient payment is calculated by per diem, the final amount shown will be that
20 amount to be paid by the resident, not the amount to be returned to the resident

21 6. If, at the time the resident is discharged or dies, the patient payment for that month is
22 greater than the properly computed per diem patient payment, the following rules apply:

23 a. If the resident is discharged to another nursing facility, or to the resident's own
24 home, the excess patient payment and personal needs monies must be
25 forwarded to the resident in his/her own home or in the transferred nursing
26 facility, within 45 working days of the date of discharge.

27 b. If the resident is discharged to a hospital, other medical institution, or if the
28 resident dies, the excess patient payment must be immediately transferred from
29 the nursing care account to the resident's personal needs account. These funds
30 then are to be disposed of as detailed in [10 CCR 2505-10 Section 8.10 CCR](#)
31 [2505-10 section 8.482.52-F](#). If the nursing facility does not handle the resident's
32 personal needs funds, the excess patient payment must be immediately returned
33 to the responsible party.

34 1) However, if the resident is discharged from the nursing facility to a
35 hospital or other medical institution and is admitted with Medicaid as the
36 primary source of funding, the patient payment in excess of the amount
37 due to the discharging nursing facility may be due to the hospital or
38 medical institution. Any excess patient payment should be sent to the
39 hospital at the end of the month (see [10 CCR 2505-10 8.10 CCR 2505-](#)
40 [10 section 8.358.1](#)). If the resident discharged to a hospital or other
41 medical institution is not readmitted to the nursing facility, the resident's
42 funds, either excess patient payment or personal needs, must be lawfully

1 disposed of as indicated ~~in 8.4 in 10 CCR 2505-10 section 8.10 CCR~~
 2 ~~2505-10 section 8.482.52, F.~~

- 3 2) If the resident dies in the nursing facility or is discharged to a hospital or
 4 other medical institution where he/she subsequently dies, the resident's
 5 funds entrusted to the nursing facility must be transferred as indicated ~~in~~
 6 ~~8.4 in 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.482.52, F.~~

7 7. Changes of financial status within the facility:

- 8 a. Residents transferring from private pay to Medicaid may have a patient payment
 9 liability for the Medicaid-funded portion of the month depending on the amount of
 10 income applicable to care, as determined on the AP-5615 form.

11 If the resident's income exceeds the cost of care paid for the private resident portion of
 12 the month, the excess income is applicable to the remaining Medicaid portion of the
 13 month.

- 14 b. The same patient payment calculation applies for residents transferring from
 15 Medicaid to private pay status. The patient payment is first applied to the
 16 Medicaid portion of the month and any excess is then applied to the remaining
 17 private pay days.

18 D. Zero Patient Payment

- 19 1. Patient payment may be waived and zero \$0.00 patient payment applied only under the
 20 following conditions:

- 21 a. A resident's income is equal to or less than the personal needs allowance (see
 22 ~~10 CCR 2505-10 8.10 CCR 2505-10 section 8.110.42~~); or
- 23 b. A resident's income is equal to or less than the personal needs allowance, less
 24 earned income (if appropriate), less spousal and dependent care allowance, or
 25 less home maintenance allowance, or less allowable expenses for Medicare
 26 premiums (see PETI deductions as defined in ~~10 CCR 2505-10 Ssections~~
 27 ~~8.110.49, and 8.482.33~~); or
- 28 c. A resident is admitted to the nursing facility from his/her home and the resident's
 29 funds are committed elsewhere for that month; or
- 30 d. The resident is admitted from his/her home, where his/her funds were previously
 31 committed, to the hospital, and subsequently to the nursing facility, in the same
 32 calendar month; or
- 33 e. The resident is discharged to his/her home, and the county department
 34 determines that the income is necessary for living expenses; or
- 35 f. The resident is admitted from another nursing facility or from private pay within
 36 the facility and has committed the entire patient payment for the month in
 37 payment of care already provided in the month of admission.

- 38 2. Patient payment may not be waived (other than for the exceptions provided for ~~in 8.4 in 10~~
 39 ~~CCR 2505-10 section 8.10 CCR 2505-10 section 8.482.34, D.1.~~) in the following
 40 instances:

- 1 a. A resident with income in excess of the personal needs allowance, less earned
2 income (if appropriate), less spousal and dependent care allowance, or less
3 home maintenance allowance, or less allowable expenses for Medicare
4 premiums (see PETI deductions as defined in [10 CCR 2505-10 Ssections](#)
5 [8.110.49](#) and [8.482.33](#)), except as provided in the Colorado Department of
6 Human Services Income Maintenance Staff Manual Volume 3, concerning
7 increased personal needs allowance; or
- 8 b. Transfers between nursing facilities; or
- 9 c. Discharges from nursing facility to a hospital or other medical institution; or
- 10 d. Changes from private pay within the facility and patient payment not already
11 committed for care provided; or
- 12 e. The death of the resident
- 13 3. The amount of SSI benefits received by a person who is institutionalized is not
14 considered when calculating patient payment

15 **8.482.4 NO DUPLICATE OR ADDITIONAL PAYMENTS**

16 **8.482.41 DUPLICATE PAYMENTS**

17 A. "Duplicate payment" is defined as:

- 18 1. Payment to two or more facilities, hospitals or other institutions for per diem or room and
19 board care for the same resident for the same time period;
- 20 2. Payment from two sources, including but not limited to, Medicare and Medicaid, for the
21 same service to the same resident. Supplementary payments in which each source pays
22 a portion (not overlapping) of the total due, is not considered duplicate payment.

23 B. Duplicate payment shall not be made:

- 24 1. To a hospital and a nursing facility for the same period of time for care of any one
25 resident;
- 26 2. To two or more nursing facilities for the same period of time for the care of any one
27 resident;
- 28 3. For any other instance, whether billed by the provider in good faith or in error.

29 C. Any provider billing for such duplicate services for any period of time during which the resident
30 was not actually in the facility or the resident did not actually receive any facility billing for services
31 will be subject to the penalties as set forth ~~in 8.4 in 10 CCR 2505-10 section 8.10 CCR 2505-10~~
32 [section 8.482.45](#).

33 D. In any instance in which duplicate billings result in Medicaid reimbursement to both providers, a
34 recovery shall be made by the Department against one or both providers.

35 **8.482.42 ADDITIONAL PAYMENTS**

- 1 A. "Additional payments" are defined as payments made by the resident, or by a resident's family,
2 conservator or administrator for items which are not a benefit of the Medicaid program, such as:
- 3 1. Items covered in ~~10 CCR 2505-10 Section 8.10~~ CCR 2505-10 section 8.442.1, Services
4 and items not included in the Per Diem Rate (chargeable to Patient Trust Funds).
- 5 2. Room reservations for medical leave in accordance with ~~10 CCR 2505-10 Section 8.10~~
6 CCR 2505-10 section 8.482.43.
- 7 3. Room reservations for non-medical and/or programmatic leave days in excess of 42 days
8 per calendar year in accordance with ~~10 CCR 2505-10 Section 8.10~~ CCR 2505-10
9 section 8.482.44.
- 10 4. Limitations covered in ~~10 CCR 2505-10 Section 8.10~~ CCR 2505-10 section 8.462.
- 11 B. Additional payment for resident care and services which are to be furnished within the nursing
12 facility per diem rate are specifically prohibited (~~10 CCR 2505-10 Section 8.10~~ CCR 2505-10
13 section 8.442). The nursing facility can neither solicit additional funds for such care and services
14 nor accept voluntary monetary contributions for them, from residents or responsible parties. Any
15 such monies collected or accepted by the nursing facility shall render such facility liable for the
16 penalties set forth ~~in 8.4 in 10 CCR 2505-10 section 8.10~~ CCR 2505-10 section 8.482.48.
- 17 C. Additional payments may be charged for:
- 18 1. Services and items not included in the per diem rate, as specified in ~~10 CCR 2505-10~~
19 ~~Section 8.10~~ CCR 2505-10 section 8.442.1. These items may be billed to the resident, or
20 the resident's estate or other responsible party, subject to the restrictions set forth in ~~10~~
21 CCR 2505-10 ~~Section 8.10~~ CCR 2505-10 section 8.442.1.
- 22
- 23
- 24 2. Room reservations. "Room reservation" is hereby defined as that charge made to a
25 resident or to a resident's family, conservator or administrator, or other responsible party,
26 to retain the resident's room and provide space for clothing and other personal items
27 during the time which the resident is absent from the facility. Room reservation charges
28 may be made under the circumstances outlined at ~~10 CCR 2505-10~~ Sections 8.482.43
29 and 8.482.44.
- 30 a. Medical leave. See ~~Section 8.10 CCR 2505-10 section 8.10~~ CCR 2505-10-10
31 CCR 2505-10 section 8.482.43 for conditions and restrictions.
- 32 b. Non-medical and/or programmatic leave. See ~~Section 8.10 CCR 2505-10 section~~
33 ~~8.10 CCR 2505-10-10~~ CCR 2505-10 section 8.482.44.
- 34 D. Failure to comply with the following restrictions on additional payment will render the nursing
35 facility liable for repayment of any such funds, or to prosecution as set forth ~~in 8.4 in 10 CCR~~
36 ~~2505-10 section 8.10~~ CCR 2505-10 section 8.482.45, or both:
- 37 1. Exact physician's orders on the nursing facility charts, for such additional care or
38 services;
- 39 2. Fully itemized billings to the resident or responsible party;

- 1 E. Additional payments by persons other than the resident shall not be regarded as income to the
2 resident, and shall not affect the eligibility of the resident for the Medicaid program.
- 3 F. Additional payments may not be deducted from the resident's personal needs funds, nor may
4 they be applied to a PETI deduction as described ~~in 8.4 in 10 CCR 2505-10 section 8.10 CCR~~
5 ~~2505-10 section 8.482.33~~, unless authorized by such resident or the party responsible for such
6 resident. Such authorization must be a separate written authorization for each billing from the
7 nursing facility.

8 **8.482.43 MEDICAL LEAVE FROM NURSING FACILITY**

- 9 A. Definition. "Medical leave" is defined as absence of the resident from the nursing facility due to
10 admittance to a hospital or other institution.
- 11 B. Medical leave, as addressed in this section, is subject to the following restrictions:
- 12 1. Such absence of the resident must be on the specific orders of a physician, as noted in
13 the resident's chart;
- 14 2. There must be a presumption by the doctor and by the resident that the resident will
15 return to the nursing facility;
- 16 3. The nursing facility must prepare an AP-5615 showing the dates such medical leave
17 commenced and ended. See ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10 10~~
18 ~~CCR 2505-10 section 8.482.34~~.
- 19 4. The resident, or the responsible party if the resident is unable to respond, must be
20 advised, in writing, that payment for holding the nursing facility room cannot be made by
21 Medicaid. In addition, he/she must give written consent to the additional charge, both the
22 daily rate thereof and the anticipated number of days. If the resident is absent from the
23 facility longer than the anticipated number of days shown on the consent form, the
24 nursing facility must obtain agreement on another consent form before continuing to
25 charge for medical leave. The consent form(s) must be retained with other resident
26 records and be subject to audit.
- 27 C. Room reservation charges for Medical leave:
- 28 1. The per diem charge for room reservations for medical leave cannot exceed the per diem
29 rate currently authorized for the nursing facility, less total food and linen service costs. In
30 no case shall the charge be greater than the current per diem rate less \$2.
- 31 2. The specific bed which the resident had occupied prior to leave must be reserved. No
32 other resident may occupy a bed so reserved.
- 33 3. If no source of payment, other than the resident's funds, are available, and the nursing
34 facility's current occupancy is less than 90 percent of capacity. ~~the~~The room must be
35 reserved at no charge to the resident.
- 36 4. Revenues to the nursing facility from room reservations must be used in reduction of
37 related expenses, on the MED-13 form.
- 38 5. If no other funds are available, the room reservation charges may be deducted from the
39 resident's personal needs funds, subject to the restrictions in ~~Section 8.10 CCR 2505-10~~
40 ~~section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.482.42~~. However, the resident's

1 personal needs must retain at least \$10 at all times, if used for room reservations
 2 payment. In case of death of the resident, the entire personal needs account may be
 3 used, if necessary.

4 **8.482.44 Room Reservations for Non-Medical and/or Programmatic Leave**

5 Medicaid will pay a nursing facility to hold a bed for non-medical and/or programmatic leave days up to a
 6 combined total of 42 days per resident per calendar year.

7 Non-medical leave days are defined as days of leave from the nursing facility for non-medical reasons.
 8 Programmatic leave days are days of leave prescribed by a physician for therapeutic and/or rehabilitative
 9 reasons. Programmatic leave may entail visits to family, friends or guardians, or leave to participate in
 10 approved therapeutic and/or rehabilitative programs. A leave day is considered to have been incurred for
 11 any day during which the resident is absent from the nursing facility for therapeutic and/or rehabilitative
 12 purposes and does not return by midnight of that day.

13 Before Medicaid payment is made for room reservation costs for non-medical and/or programmatic leave,
 14 the attending physician must approve each leave and affirm that such leave is not contrary to the
 15 resident's written plan of care. In the case of programmatic leave, this approval must be in writing and
 16 noted on the resident's chart and/or Individual Habilitation Plan (IHP). In addition, the physician must
 17 affirm that the resident's programmatic leave is of therapeutic and rehabilitative value and consistent with
 18 the overall plan of care and/or Individual Habilitation Plan developed for the resident.

19 If the resident has the approval of the attending physician in writing, and such approval is noted on the
 20 resident's chart, room reservations for non-medical and/or programmatic leave may be paid for by the
 21 resident, after the allowable 42 days per calendar year has been paid from Medicaid funds. Charges to
 22 residents for this leave are subject to the following restrictions:

- 23 A. Such charges must not commence until after 42 days of non-medical and/or programmatic leave
 24 in any one calendar year.
- 25 B. The Medicaid Program has not been billed for such leave. Billing both Medicaid and the resident
 26 for the same leave period will subject the nursing facility to the penalties as set forth [in 8.4 in 10](#)
 27 [CCR 2505-10 section 8.10 CCR 2505-10 section 8.482.45](#).
- 28 C. The resident or the resident's family must be advised that payment for the nursing facility room
 29 cannot be paid from Medical Assistance funds after the resident's allowable leave has been
 30 consumed. In addition, the resident and/or legal guardian must give written consent to the room
 31 reservation charges, both the daily rate and the anticipated number of days. The consent form
 32 must be retained with other resident records and subject to audit.
- 33 D. The maximum allowable charge for non-medical and/or programmatic leave is the same as stated
 34 for medical leave in paragraph C of [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10](#)
 35 [CCR 2505-10 section 8.482.43](#).
- 36 E. The specific bed which the resident occupied prior to leave must be reserved. No other resident
 37 may occupy a bed so reserved.
- 38 F. Revenues to the nursing facility from room reservations must be used in reduction of related
 39 expenses, on the MED-13 form.
- 40 G. In no case shall the nursing facility deduct non-medical and/or programmatic leave charges from
 41 the resident's personal needs account, unless specific authorization has been received, in writing,
 42 from the resident and/or legal guardian.

1 **8.482.45 PENALTIES**

- 2 A. Obtaining vendor payments fraudulently, as outlined in [26-1-127, C.R.S.](#)~~C.R.S. section 26-1-127~~
3 (1995 Supp).
- 4 B. Obtaining additional payments from residents, or resident's families, as outlined in [26-4-112,](#)
5 [C.R.S. 1989.C.R.S. section 26-4-112\(2\) 25-4-301.](#)
- 6 C. License may be revoked according to the provisions of [25-3-103, C.R.S.](#)~~C.R.S. section 25-3-103.~~
- 7 D. Falsification of reports as outlined in [26-1-127, C.R.S., \(1995 Supp.\)](#)~~C.R.S. section 26-1-127.~~
- 8 E. Incorrect payments due to omission, error or fraud may be recovered as outlined in [26-4-112\(2\),](#)
9 [C.R.S. 1989.C.R.S. section 26-4-112\(2\) 25-4-301\(2\).](#)
- 10 F. Duty of resident to report changes in income and penalties for non compliance, as outlined in [26-](#)
11 [2-128, C.R.S. \(1995 Supp.\)](#)~~C.R.S. section 26-2-128.~~
- 12 G. In addition to all penalties imposed above, the Department may also require the reimbursement of
13 the entire amount of any benefits unlawfully obtained.

14 **8.482.46 UTILIZATION OF MEDICARE BENEFITS**

- 15 A. Services and equipment which are a benefit of Medicare, as described in 42 CFR [Part sections](#)
16 405.230-252, must be billed to Medicare before billing Medicaid. ~~The 42 CFR Part 405.230-252~~
17 ~~is hereby incorporated by reference. The incorporation of 42 U.S.C. section 1396r excludes later~~
18 ~~amendments to, or editions of, the referenced material. The Department maintains copies of this~~
19 ~~incorporated text in its entirety, available for public inspection during regular business hours at:~~
20 ~~Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO~~
21 ~~80203. Certified copies of incorporated materials are provided at cost upon request.~~

22 ~~refers to the Code of Federal Regulations, Part 400 to end, Published by Office of the Federal Register,~~
23 ~~National Archives and Records Service, General Services Administration, as a Special Edition of~~
24 ~~the Federal Register. This document is for sale by the Superintendent of Documents, U.S.~~
25 ~~Government Printing Office, Washington, D.C., 20402. The document may also be examined at~~
26 ~~any State Publications Depository Library.~~

- 27 B. Part "B" deductible and co-insurance amounts for Medicare-eligible Medicaid recipients will be
28 reimbursed by Medicaid. Reimbursement will be made for any service covered by Part "B" of the
29 Medicare program, as described in 42 CFR [sections](#) 405.230-.252, even though that service is
30 not ordinarily covered under the medical assistance program. The services paid for by Medicare
31 cannot be included in costs for calculation of the nursing home provider's daily reimbursement
32 rate. If Medicare Part "B" type services are provided by the facility and the facility has a provider
33 number which it used to bill Medicare, then the following entries must be made to the cost report
34 (MED-13):

- 35 1. The cost of the care reimbursed by Medicare and/or Medicaid crossover for residents
36 who are Medicaid recipients may be deducted from Schedule "C" of the MED-13
37 Schedule "B" if the costs for providing that care are determinable and auditable; or
- 38 2. The Medicare and/or Medicaid crossover revenue for residents who are Medicare eligible
39 will be deducted from Schedule "C" on Schedule "A".

- 1 C. When the facility provides Medicare Part "B" type services to non-residents of the facility, the
2 following entries must be made to the cost report (MED-13):
- 3 1. Cost of the care reimbursed by Medicare and/or Medicaid crossover for non-residents of
4 the facility must be deducted from Schedule "C" of the MED-13 on Schedule "B" if the
5 costs for providing that care are determinable and auditable; or
- 6 2. The Medicare and/or Medicaid crossover revenue for non-residents of the facility must be
7 deducted from Schedule "C" on Schedule "A".
- 8 D. Co-insurance and deductible costs for the following services (which are covered by Medicare Part
9 "B") may be billed to the Medicaid program without prior authorization:
- 10 1. Laboratory Services
- 11 2. Medical Supplies
- 12 3. Durable Medical Equipment
- 13 4. Speech Therapy
- 14 5. Occupational and Physical Therapy
- 15 6. Practitioner Services
- 16 E. Facilities or their suppliers when billing the Medicaid program for those services reimbursed by
17 Medicare, are to use the Medicare/Medicaid crossover system of billing. The facility, in order to
18 bill through the Medicare/Medicaid crossover system, needs only to complete a Medicare billing
19 form and indicate on that form that they wish to "accept assignment." A Medicare claim form for a
20 Medicare/Medicaid patient, indicating acceptance of assignment, will cross over to Medicare, and
21 co-insurance and/or deductibles will be paid on a Medicaid remittance advice.

22 8.482.5 RESIDENT'S PERSONAL NEEDS FUNDS

23 8.482.51 STATEMENT OF POLICY

- 24 A. All residents receiving nursing facility care are allowed to retain the amount of income specified in
25 ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.110.42~~ as
26 personal needs funds, to purchase necessary clothing or incidentals. These funds may not be
27 used to supplement the Medicaid nursing facility payment, and such funds cannot be used for any
28 other purpose whatsoever by the nursing facility.
- 29 B. Personal needs money is for the exclusive use of the resident as he/she desires. The resident or
30 relatives may not be charged for such items as Chux, tripads, toilet paper, or other nursing facility
31 maintenance items since these items are included in the audited cost described in ~~Section 8.10~~
32 ~~CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.442~~. Other charges which
33 could be disallowed are as follows:
- 34 1. Nursing facility maintenance items and nursing care supplies and services.
- 35 2. Charges without the following documentation:
- 36 a. vendor receipts;

- 1 b. signed cash receipts; or
- 2 c. statement signed by the resident for any specifically requested over-the-counter
- 3 drug.
- 4 3. Charges which constitute a duplicate payment as defined [in 8.4 in 10 CCR 2505-10](#)
- 5 [section 8.10 CCR 2505-10 section 8.482.41.](#)
- 6 4. Charges which constitute an additional payment as defined [in 8.4 in 10 CCR 2505-10](#)
- 7 [section 8.10 CCR 2505-10 section 8.482.42.](#)
- 8 5. Handling charges, such as personal needs trust account bank service fees.
- 9 C. Items not covered by Medicaid, such as personal items, clothing, private room, etc., may be
- 10 charged to the personal needs account of the resident. However, all of the restrictions of [Section](#)
- 11 [8.10 CCR 2505-10 section 8.10 CCR 2505-10 10 CCR 2505-10 section 8.442.1](#) apply. In
- 12 addition, only those items actually requested by the resident may be charged to his/her personal
- 13 needs funds, and there must be a signed, dated receipt for each such item or service signed by
- 14 the resident, the resident's conservator, guardian or relative, or by a responsible party, retained in
- 15 the resident's accounts.

16 **8.482.52 RESPONSIBILITIES OF NURSING FACILITIES**

17 A. General Accounting Practices

- 18 1. Nursing facilities must administer a resident personal needs fund for those residents who
- 19 are unable to or have no desire to handle their own personal needs monies. The nursing
- 20 facility is obligated to exercise due care in the handling of resident funds per federal
- 21 regulations.
- 22 2. If a resident elects to have the nursing facility handle his/her personal needs monies, a
- 23 personal needs trust agreement must be entered into and signed by the resident or the
- 24 resident's legal personal representative. This agreement creates a fiduciary relationship
- 25 between the nursing facility and the resident which includes the legal rights and
- 26 responsibilities provided for in [15-1-101, C.R.S. 1987 C.R.S. section 15-1-101](#). As a
- 27 condition of the trust agreement, the nursing home is allowed to return the personal
- 28 needs allowance portion of the resident's income. (See [Section 8.10 CCR 2505-10](#)
- 29 [section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.110.42](#)).
- 30 3. If the resident or responsible party does not elect to have the facility handle the personal
- 31 needs monies, the resident or responsible party must enter into and sign a personal
- 32 needs exclusion agreement with the facility.
- 33 4. If the total personal needs trust fund balance is less than \$50.00, the resident's personal
- 34 needs trust fund monies may be held in either an interest or non-interest-bearing account
- 35 with a depository institution or in cash at the facility.
- 36 5. If the total personal needs trust fund balance is \$50.00 or more, the resident's personal
- 37 needs funds must be kept in an interest-bearing account. The account can be a checking
- 38 account, a savings account, or a certificate of deposit.
- 39 6. The bank account must be designated as "resident trust funds account."
- 40 7. The funds in the depository institution (most often a bank) must be insured.

- 1 8. The personal needs trust monies must not be commingled with either the operating funds
2 of the facility or with any other individual's fund who is not a resident of the facility.
- 3 9. The personal needs monies of more than one resident: can be commingled in the same
4 bank account as long as separate accounting records (i.e., subsidiary ledgers) are
5 maintained.
- 6 10. No charge for handling such trust accounts may be made to the recipient or to the estate
7 of the recipient at any time. Such expenses should be included as a part of the audited
8 costs as determined ~~in 8.4 in 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.440.~~
- 9 11. A subsidiary ledger, as specified by the Department, must be kept for each resident for
10 recording personal needs transactions.
- 11 12. A reconciliation of the sum of the ledger balances to the bank balance (plus petty cash, if
12 applicable) must be performed on a monthly basis.
- 13 13. Deposits and disbursements from the personal needs trust account must be recorded in
14 an accurate amount and in accordance with 10 CCR 2505-10 section 8.482.51.B for
15 purchases and 10 CCR 2505-10 section 8.482.52.F for refunds.
- 16 14. Any interest income must be recorded on the ledgers. If the resident trust funds are
17 pooled in one interest - bearing account, the interest earned on the account must be
18 allocated to each resident's account proportionately (i.e., by dividing the individual
19 resident's account balance by the total personal needs trust fund balance then multiplying
20 that quotient times the amount of interest income).
- 21 15. The resident shall be notified when his/her personal needs trust fund balance reaches
22 \$200 less than the SSI resource limit as provided in 10 CCR 2505-10 section 8.110.53.A
- 23 16. This accounting system must be adequate for audit by the representative of the
24 Department, and in accordance with generally accepted accounting principles.
- 25 17. All such accounts, original bank statements, and supporting documentation must be
26 available for audit by any authorized employee of the county department, State
27 Department, or agent of the State Department at any time.
- 28 18. Personal needs money is the property of the residents and all accounting records, bank
29 accounts and other documents must remain with the nursing facility when ownership is
30 transferred.

31 B. Bonding Requirements

- 32 1. An additional condition of nursing facility participation in the Medicaid program is the
33 purchase of a surety bond as required by ~~C.R.S. §section 26-4-50425.5-6-206(3)(c)~~
34 ~~C.R.S.)~~ The sum of the surety bond must not be less than the personal needs trust fund
35 liability as computed quarterly during interest proration, or the licensed operator
36 ("licensee") shall otherwise demonstrate to the satisfaction of the Department that the
37 security of the residents' personal needs funds is assured. State owned/operated
38 facilities are bonded separately under the risk management program up to \$100,000 and
39 are exempt from this requirement.

- 1 2. The effective dates of the surety bond shall be from January of each calendar year
2 through December 31 of the following calendar year. The nursing facility licensee's
3 Medicaid participation shall be terminated immediately upon lapse of such bond.
- 4 3. A copy of the Surety Bond Patient Needs Trust Fund (Form MED-181), or the Certificate
5 of Insurance (Surety Bond), fully executed, signed and sealed, shall be filed with the
6 Department within 15 days prior to the effective date thereof.
- 7 4. Upon the termination of Medicaid participation of a nursing facility provider for any
8 reason, either voluntarily or through Departmental action, the bond must be kept in effect
9 until the final audits of resident personal needs funds and resident nursing care accounts
10 can be completed by the Department, and until any adjustments required by such audits
11 have been made.

12 C. Change of Licensed Operator -Requirements

- 13 1. When ~~me~~the licensed operator ("licensee") of a nursing facility is changed, as described
14 in ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10 CCR 2505-10 section~~
15 8.441.5, it shall be the duty of the new Medicaid provider:
- 16 a. To execute a new personal needs account agreement on behalf of Medicaid
17 residents, as required by this section. The new provider shall furnish proof to the
18 Department that it has properly established resident's personal needs accounts
19 and carried forward the proper balance remaining in each resident's ledger.
- 20 b. To post a surety bond as required by C.R.S. Section 25.5-6-206 26-4-504(3)(c)¹⁷
21 [QK11][JM12] C.R.S.¹⁷ and ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10~~
22 10 CCR 2505-10 section 8.482.52. ~~B.~~ above, or to otherwise demonstrate to the
23 satisfaction of the Department that the security of residents' personal needs
24 funds is assured.
- 25 c. Upon notice to the Department that a nursing facility's licensed operator will
26 change or Medicaid participation will be terminated as required in ~~Section 8.10~~
27 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.441.5, the
28 Department may withhold all or part of any monies due the prior nursing facility
29 licensee until the personal needs accounts of the residents have been
30 determined to be correct. If such accounts are found to be deficient, the amount
31 of the bond established by the prior licensee shall be forfeited to the Department,
32 and any additional deficit shall be deducted from such monies due to the prior
33 licensee of fee nursing facility. (See also ~~Section 8.10 CCR 2505-10 section 8.10~~
34 CCR 2505-10-10 CCR 2505-10 section 8.444.) The Department will, in such
35 cases, assume the responsibility for proper distribution of such monies to the
36 deficient resident accounts.
- 37 2. It shall be the duty of the prior licensee to provide the new licensee written verification, by
38 a public accountant, of the amount of personal needs money being transferred for each
39 resident's personal needs fund. This verification shall include a statement that this
40 amount corresponds to the total of ~~the~~ balances shown on the resident's individual
41 ledger.

42 D. New Admission

1 When a patient is admitted to a nursing facility for the first time, or transferred from Medicare or
 2 private pay, the nursing facility shall set up a new account for personal needs funds, which lists a
 3 beneficiary or beneficiaries (with percentages), as specified in A. of this subsection.

4 E. Readmissions, Transfers from Another Nursing Facility.

5 1. Upon readmission or transfer of a resident, the nursing facility shall determine the amount
 6 of personal needs funds currently in the resident's account in the previous facility, make
 7 every effort to obtain such funds, and show this amount as a balance forward in the
 8 current ledger. Reconfirmation of the listed beneficiary or beneficiaries shall also be done
 9 at this time.

10 2. Failure to make such effort shall be considered a breach of trust agreement, and may be
 11 cause for cancellation of the participation agreement.

12 3. If, upon making every effort, the current nursing facility is unable to obtain the balance of
 13 funds from the resident's previous facility, the current nursing facility should notify the
 14 Department immediately. Failure to do so may be construed as a failure to make every
 15 effort.

16 F. Discharge from a Nursing Facility

17 1. Upon discharge of a resident to the resident's home, to another nursing facility or to the
 18 care of a responsible party, the nursing facility shall determine the amount remaining in
 19 the personal needs account within 45 days, and make payment of this amount to the
 20 resident, responsible party, or transfer these funds to the current nursing facility, if
 21 appropriate. Failure to so dispose of the resident's personal needs funds shall render the
 22 nursing facility liable for cancellation of the participation agreement or to the penalties as
 23 set forth in 8.4 in 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.482.45, or both.
 24 All patient's personal possessions shall also be relinquished, as required by 10 CCR
 25 2505-10 section 8.482.6.

26 2. At the end of the month in which a resident is discharged to a hospital, the nursing facility
 27 shall:

28 a) set aside the personal needs allowance of \$50 for the resident;

29 b) apply the balance of any monies to the established Medicaid rate for the number
 30 of days the resident lived in the facility; and

31 c) if there is still a balance, transfer the funds to the receiving hospital, if Medicaid is
 32 the primary funding source.

33 If the resident returns to the same nursing facility, no additional accounting is necessary.
 34 If the resident does not return to the same facility, however, disposition of the personal
 35 needs funds shall be made as specified in this section.

36 3. Death of a resident.

37 a. The nursing facility is required to determine if:

38 1) The nursing facility resident dies intestate (i.e., without a will) with known
 39 relatives, or a listed beneficiary, for whom current addresses are known;
 40 or

- 1 2) The nursing facility is unsure of the existence of a will or whether there
2 are known relatives and there is no listed beneficiary; or
- 3 3) There is a public administrator in the county in which the death occurred.
4 If not, the nursing facility shall, within ten days from the date of death,
5 contact the Department. It shall then be the responsibility of the
6 Department to turn the funds over to the Colorado State Treasurer for
7 inclusion in the next Great Colorado Payback listing.

8

9

10 Within 60 days after a resident's death, the facility shall transfer the resident's
11 personal needs funds and a final accounting of the funds to the person
12 responsible for settling the resident's estate or, if there is none, to the resident's
13 heirs in accordance with the provisions of [Title 15, C.R.S.C.R.S. sections 15-1-](#)
14 [101 et seq.](#) Within 15 days after receiving the funds, the executor, administrator,
15 or other appropriate representative of the resident's estate shall provide written
16 notice to the Department regarding the receipt of the funds. Upon receipt of the
17 notice, the Department may initiate action to recover the funds pursuant to the
18 provisions of this article.

- 19 b. When a nursing facility resident dies intestate (i.e., without a will) and is known to
20 be without relatives or a listed beneficiary, the nursing facility is required to pay
21 any funds remaining in the personal needs account to the Public Administrator of
22 the county in which the nursing facility resident died. [15-12-621\(2\), C.R.S. \(1995](#)
23 [Supp.\)C.R.S. section 15-12-620\(24\)](#) specifically requires that whenever a person
24 without known heirs dies intestate on the premises of another, the personnel in
25 possession of such premises must give immediate notice thereof to the public
26 administrator or incur liability for any damages that may be sustained through
27 neglect. The Clerk of the District Court should be contacted to obtain the name of
28 the current Public Administrator appointed for the county.

- 29 c. In those instances in which the nursing facility resident dies testate (i.e., with a
30 will) the funds in his personal needs account must be transferred to the executor
31 of the estate, unless another person or persons are listed as beneficiaries, in
32 which case the funds can be passed outside the will. Other personal property of
33 the deceased should be given to the executor. [15-12-711, C.R.S. 1987C.R.S.](#)
34 [section 15-12-711](#) provides that a personal representative or executor has the
35 same power over the title of the property of the estate as an absent owner.

- 36 d. If the proper disposition of the deceased resident's personal needs funds and/or
37 personal property cannot be made, the nursing facility may elect to use the
38 following provisions of the Colorado Small Estate Act to be discharged from
39 further liability.

- 40 1) In accordance with [C.R.S. sections 15-12-1201, et seq., C.R.S.,](#) after
41 ten or more days following the death of a nursing facility resident, a
42 person claiming to be the successor or acting on behalf of all successors
43 of the deceased resident may present an affidavit (Form CPC-40, Rev.
44 6/81) stating that:

- 1 a) The fair market value of the property owned by the decedent and
 2 subject to disposition by will or intestate succession, less liens
 3 and encumbrances, does not exceed \$27,000;
- 4 b) At least ten days have elapsed since the death of the decedent;
- 5 c) No application or petition for the appointment of a personal
 6 representative is pending or has been granted in any jurisdiction;
 7 and
- 8 d) The claiming affiant(s) and successor (s) are entitled to payment
 9 of all monies due and to delivery of all tangible personal
 10 property.
- 11
- 12 2) In accordance with [C.R.S. section 15-12-1202](#), ~~C.R.S. 1987~~, the nursing
 13 facility administrator is discharged and released from further
 14 responsibility once funds or personal property have been released to an
 15 individual presenting an affidavit as referenced above. The nursing
 16 facility need not inquire as to the truth of the affidavit or of any
 17 successor's right to succeed to the deceased resident.
- 18 e. The nursing facility shall also require a signed and dated receipt listing all the
 19 resident's personal property items released to a successor, as required by
 20 [8.482.6\(C\)](#).
- 21 4. Any failure of the nursing facility to properly dispose of the resident's personal needs
 22 funds within 90 days of death or discharge will be considered a breach of trust, and may
 23 be cause for cancellation of the participation agreement, forfeiture of the required surety
 24 bond, and prosecution under the penalties provided ~~in 8.4 in 10 CCR 2505-10 section~~
 25 [8.10 CCR 2505-10 section 8.482.45](#).

26 **8.482.53 RESPONSIBILITIES OF COUNTY DEPARTMENT**

- 27 A. It shall be the responsibility of the county department, to explain to the resident the various
 28 options for handling the personal needs monies, as well as the resident's rights to such funds. If
 29 the resident chooses to allow the nursing facility to hold such funds in trust, the county
 30 department is responsible for assuring that the resident assigns all income to the nursing facility.
 31 See ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section~~
 32 [8.482.52\(A\)\(2\)](#).
- 33 B. It shall be the responsibility of the county department, to assure that the nursing facility properly
 34 transfers or disposes of the resident's personal needs funds within 45 days of discharge from the
 35 nursing facility, or transfer to another nursing facility.
- 36 C. The county department shall notify the State Department if they become aware that a nursing
 37 facility has retained personal needs funds more than 90 days after the death of a resident.

38 **8.482.54 RESPONSIBILITIES OF THE STATE DEPARTMENT**

- 39 A. It shall be the responsibility of the State Department to accept and to properly dispose of residual
 40 personal needs funds, upon the death of the resident, in any of the following conditions:

- 1 1. The resident dies intestate (i.e., without a will), but with known relatives or a listed
2 beneficiary for whom current addresses are unknown;
- 3 2. There is no Public Administrator in the county and there are no listed relatives or
4 beneficiaries;
- 5 3. The nursing facility is unsure of the existence of a will, or whether there are known
6 relatives.
- 7 B. The facility shall be obligated to provide explanation for withholding personal needs funds beyond
8 90 days after the death of a resident. The Department may apply any or all of the following
9 remedies:
- 10 1. Demand immediate return of such funds,-
- 11 2. Order an audit of all personal needs accounts;
- 12 3. Cancel the participation agreement of such nursing facility.
- 13 C. Perform periodic audits of nursing facility accounts. Audits may be performed at such intervals as
14 determined necessary by the Department. Audits will always be performed when a nursing facility
15 is discontinued from the Medicaid program for any reason and when a change of ownership or
16 management occurs.
- 17 D. If an audit of personal needs accounts reveals discrepancies the Department, on behalf of the
18 resident, may take administrative action as outlined in Volume 8, Recoveries from Providers; or
19 the Executive Director may refer the case to the appropriate legal authorities. See [Section 8.10](#)
20 [CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.482.45](#) of this Staff Manual.
- 21 E. If the nursing facility cannot offer proof that any apparent discrepancies in personal needs
22 accounts have been corrected the Department may withhold payment of nursing care costs in the
23 amount shown due and payable by the audit.

24 **8.482.55 MANAGEMENT OF PERSONAL NEEDS FUNDS BY OTHER THAN RESIDENT**

- 25 A. For residents unable to manage their own funds due to a physical or mental condition, a
26 conservator, guardian-trustee, or other responsible person may carry out these acts for the
27 resident.
- 28 B. Personal needs funds shall not be turned over to persons other than a duly accredited agent or
29 guardian of the resident. With the written consent of the resident (is the resident is able and
30 willing to give such consent) the administrator may turn over personal funds belonging to said
31 resident to a close relative or friend to purchase a particular item. However, a signed, itemized,
32 dated receipt will be required.

33 **8.482.6 PATIENT'S PERSONAL POSSESSIONS**

- 34 A. The Department rules and regulations are designed to insure that clothing and other property of
35 each resident shall be properly safeguarded and reserved for personal use, and to comply with
36 standards established by [the CDPHE Colorado Department of Public Health and Environment](#).
- 37 B. The nursing facility shall be responsible for safeguarding personal possessions (including money)
38 and to:

- 1 1. Provide a method of identification of the resident's suitcases, clothing, and other personal
2 effects, listing the items on an appropriate form attached to the resident's nursing facility
3 record at the ~~time~~ time of admission. Such listings are to be kept current. Any personal
4 effects released to a relative or designated representative of a resident must be
5 delineated in a signed receipt.
- 6 2. Provide adequate storage facilities for the resident's personal effects.
- 7 3. Exercise careful Judgment in the release of resident's personal property to other than the
8 actual owner, and to secure an itemized statement of release, the signature of the
9 resident, duly authorized agent, or responsible party.
- 10 4. Insure that all mail is delivered unopened to the resident to whom it is addressed, except
11 for those residents who have a legal guardian or conservator, other legal arrangement, or
12 have voluntarily given written consent to allow opening such mail, in which case the mail
13 is held, unopened, until delivered to the resident.
- 14 C. In the event of death of a resident in the nursing facility, or in a medical institution or on medical
15 leave from a nursing facility, the following rules apply:
 - 16 1. The nursing facility shall provide the deceased resident's executor, administrator or
17 successor claiming under the Small Estates Act (See **10 CCR 2505-10 section**
18 **8.482-5F-3.5d**) with a copy of the resident's personal needs ledger.
 - 19 2. The nursing facility shall turn over to such responsible party all of the deceased resident's
20 personal property in its possession. All items shown by the personal needs ledger as
21 purchased by or in behalf of the resident must be returned to the responsible party.
 - 22 3. The responsible party claiming the possessions must sign a dated, itemized receipt for all
23 such items before removal of the items from the nursing facility.
- 24 D. In the event of discharge of a resident, all personal possessions and a copy of the personal
25 needs ledger signed and dated by the administrator shall be turned over to the patient, or to the
26 responsible party, as is required for a deceased patient in C above.

27 8.482.7 NURSING FACILITY RESPONSIBILITY FOR ESTABLISHING PERSONAL NEEDS ACCOUNT

28 Many nursing facility residents are either unable or unwilling to manage their personal funds and the
29 residents or their families or guardians wish this responsibility to be assumed by the nursing facility. Also,
30 since nursing facility residents who are recipients of Medicaid benefits often have income from Social
31 Security, Supplemental Security Income, Railroad Retirement, or other sources, it is necessary for
32 participating nursing facilities to maintain a system of accounting for Medicaid funds, resident income, and
33 resident's personal needs funds. Such system shall be maintained in accordance with standards required
34 by the Department, and adequate for audit by representatives thereof. The following sections outline a
35 standard system of accounting to be used by participating nursing facilities for these purposes. Any
36 deviation from this system must have written approval of the Department.

37 8.482.71 REQUIRED ITEMS

- 38 A. Book of money receipts in triplicate.
- 39 B. Cash receipts journal including columns for nursing facility operating and resident trust cash
40 accounts.

- 1 C. Checking accounts for nursing facility operating and resident trust accounts.
- 2 D. Cash Disbursements Journal including columns for nursing facility operating and resident trust
3 cash accounts.
- 4 E. General Ledger accounts as follows:
- 5 1. Cash-General or Operating account
- 6 2. Cash-Patient Trust Fund
- 7 3. Cash-Patient Trust Imprest Fund
- 8 4. Accounts Receivable - Nursing Care (Control Account.)
- 9 5. Accounts Payable - Personal Needs Liability (Control Account)
- 10 (Note: This is not a complete listing of every account which would normally appear in a General
11 Ledger, but includes the accounts necessary for purposes of this system of accounting.)
- 12 F. Subsidiary Ledger for Accounts Receivable-Nursing Care sub-classified by resident name.
- 13 G. Subsidiary Ledger for Personal Needs sub-classified by resident name.
- 14 H. Personal Needs Cash Paid Out and Personal Needs Cash Request Slips for use with Personal
15 Needs Imprest Fund.
- 16 I. Forms for Certificate of no responsibility for resident's personal needs funds and Appointment of
17 Agent and authorization to handle resident's personal needs funds.
- 18 J. Cash box or other secure place for petty cash used in Personal Needs Imprest Fund.

19 **8.482.72 GLOSSARY**

- 20 A. Basic Bookkeeping Terms
- 21 1. ACCOUNT -- Basic classification device used in bookkeeping. In a double-entry
22 bookkeeping system, an account consists of a Debit side and a Credit side. Individual
23 accounts within a ledger serve as the basis for financial statements.
- 24 2. ACCRUAL OR ACCRUED CHARGE -- A charge arising from an individual or business
25 entity providing goods or services to another individual or entity. An accrual or charge is
26 entered on the Debit side of an individual account. A charge may be accrued in advance
27 of the goods or services provided, or may be accrued afterward, depending upon the
28 basis of accounting used (See ACCRUAL BASIS and/or CASH BASIS)
- 29 3. ACCRUAL BASIS -- A basis of accounting wherein revenues are recognized at the time
30 they are "earned" (i.e., at the time goods or services are provided) and expenses are
31 recognized when they are incurred as liabilities. (Opposite of CASH BASIS accounting-
32 See CASH BASIS.)
- 33 4. BOOK OF ORIGINAL ENTRY -- An accounting book or record which serves as the point
34 of original entry of accounting transactions recorded. The book of original entry serves as

- 1 the basis for classification of items to individual accounts. Examples of Books of Original
2 Entry include Cash Receipts Journal, Cash Disbursements Journal, General Journal, etc.
- 3 5. CASH BASIS -- A basis of accounting wherein revenues are recognized for accounting
4 purposes at the time they are collected in cash and expenses are recognized at the time
5 that they are paid in cash (Opposite of ACCRUAL BASIS accounting - See ACCRUAL
6 BASIS.)
- 7 6. CASH DISBURSEMENTS JOURNAL -- A book of original entry in which transactions
8 involving payments of cash are recorded and summarized for later classification to
9 individual accounts. A Cash Disbursements Journal usually consists of one column for
10 entries to a cash account and another column (or columns) for entries to other accounts
11 affected by the transactions recorded.
- 12 7. CASH RECEIPTS JOURNAL -- A book of original entry used to facilitate accounting for
13 receipts of cash by an enterprise. A Cash Receipts Journal usually consists of one
14 column for entries to a cash account and another column (or columns) for entries to other
15 accounts affected by the transactions recorded.
- 16 8. CONTROL ACCOUNT -- A general ledger account which summarizes items which are
17 classified in SUBSIDIARY ACCOUNTS or SUBSIDIARY LEDGERS (See SUBSIDIARY
18 ACCOUNT.) The total of the balances in the subsidiary accounts should equal the
19 balance of the control account in the general ledger.
- 20 9. CREDIT (Abbreviated CR.) -- In a double-entry bookkeeping system, an entry made on
21 the right-hand side of an account is called a "Credit" entry.
- 22 10. DEBIT (Abbreviated DR.) -- In a double-entry bookkeeping system an entry made to the
23 left-hand side of an account is called a "Debit" entry.
- 24 11. DOCUMENTATION - Supporting data or proof explaining an entry in the accounting
25 records; e.g., a payment on account may be "documented" by an invoice, cancelled
26 check, etc.
- 27 12. DOUBLE ENTRY BOOKKEEPING SYSTEM -- A system of bookkeeping wherein at least
28 two entries are made for every transaction recorded; for each entry made to the "debit"
29 side, a corresponding entry (or entries) must be made to the "credit" side. A double-entry
30 system is used for purposes of proof of accuracy of transactions recorded; total of
31 "debits" must be equal to the total of "credits" for the system to be "in balance." (See
32 ACCOUNT, DEBIT, and CREDIT.)
- 33 13. GAAP -- Generally Accepted Accounting Principles.
- 34 14. IMPREST FUND (Also called PETTY CASH FUND) -- A fund set up for the purpose of
35 control over cash transactions; most often used when a large number of small
36 transactions must be made. The balance of an imprest fund is constant, and must consist
37 of either cash or receipts or other documentation showing the use of the cash. An imprest
38 fund is "replenished" periodically when the cash in the fund reaches a low point by
39 removing the receipts, totalling them, and replacing them with the amount of cash spent.
40 An imprest fund is sometimes called a "revolving fund".
- 41 15. LIABILITY -- An "obligation" or "debit" of an individual or business enterprise to pay a
42 sum of money at some future time. Examples of liabilities are accounts payable, notes

- 1 payable, bonds payable, monies held in a fiduciary or trust capacity, such as the personal
2 trust funds.
- 3 16. LEDGER -- A grouping of accounts in a bookkeeping or accounting system. For example,
4 a "general ledger" may contain all the accounts of a business enterprise, while a
5 "subsidiary ledger" may consist of sub-classifications of one particular account in a
6 "general ledger." (See SUBSIDIARY ACCOUNT or SUBSIDIARY LEDGER.)
- 7 17. POSTING -- A basic bookkeeping operation wherein information for accounting records is
8 transferred from one place to another; as in "posting" to the general ledger from the cash
9 receipts journal, etc. Posting is usually a preliminary operation to summarization of data
10 for preparation of financial statements, etc.
- 11 18. RECONCILIATION -- An explanation of differences in accounting records for the purpose
12 of ensuring accuracy of the records. An example is the "Reconciliation" of a bank
13 statement balance to the balance in the check book or cash book.
- 14 19. SUBSIDIARY ACCOUNT or SUBSIDIARY LEDGER -- An account or group of accounts
15 sub-classifying a particular account in a general ledger which is used with a CONTROL
16 ACCOUNT. An example is Accounts Receivable. The Accounts Receivable would be
17 represented in the general ledger by a control account and sub-classified by name of
18 debtor in a subsidiary ledger. Each account in the subsidiary ledger has an individual
19 balance, and the total of all the balances in the subsidiary ledger should equal to the
20 balance of the control account in the general ledger. (See CONTROL ACCOUNT.)
- 21 20. TRIAL BALANCE -- A bookkeeping operation in which balances of all accounts in a
22 ledger are taken and summarized to ascertain that postings of debts equal postings of
23 credits. A "Trial Balance" may also be taken of a subsidiary ledger to be certain that the
24 postings to the subsidiary ledger agree with those to the control account in the general
25 ledger.
- 26 21. FIDUCIARY OR TRUST -- A party who is entrusted to conduct the financial affairs of
27 another person. ~~is act~~
- 28 B. Terms Related to Nursing Facility Bookkeeping
- 29 1. BENEFICIARY -- The listed person/persons/charitable institution or other agency a
30 resident has elected to receive the balance of his/her personal needs trust monies in the
31 event of death.
- 32 2. CENSUS -- A nursing facility record of admissions and/or discharges of residents within a
33 given time period (examples are 24-hour or "midnight" census, monthly census, etc.) The
34 census is used to determine the number of patient days of care provided by the nursing
35 facility.
- 36 3. FISCAL AGENT -- Agency under contract to the State Department of Health Care Policy
37 and Financing for the purpose of disbursing funds to providers of services under the
38 Medicaid Program. The fiscal agent collects eligibility and payment information from the
39 county and state Departments and processes this information for payment to providers
40 (nursing care facilities).
- 41 4. FORM AP-5615 -- For purposes of reporting change in patient status, admissions
42 discharges, changes in resident payments, etc. to the county department(s). Commonly
43 referred to as "5615"s.

- 1 5. GENERAL (OR OPERATING) ACCOUNT -- May describe either an account in the
2 general ledger (as Cash-Genera] or Operating) or a bank account. Used to record
3 monies due to the nursing facility for care or services provided to the resident, are
4 recorded in this account (as distinguished from a Personal Needs or Resident Trust
5 account, which is used to account for personal funds belonging to residents of a facility).
- 6 6. INTESTATE -- A person who dies without leaving a will is said to have died "intestate."
- 7 7. MEDICAID (TITLE XIX) PROGRAM -- Program funded by federal and state governments
8 which provides for nursing facility care for the categorically eligible. It is administered in
9 Colorado through the Department of Health Care Policy and Financing.
- 10 8. NURSING CARE (ACCOUNTS RECEIVABLE) ACCOUNT -- Account in a subsidiary
11 patient ledger which is used to record accrued nursing care charges, patient payments,
12 and Medicaid payments for a Medicaid eligible resident.
- 13 9. PERSONAL NEEDS ACCOUNT - An account in a subsidiary resident ledger used to
14 record personal needs fund transactions of a resident. Same as "Patient Trust Fund".
- 15 10. PERSONAL NEEDS ALLOWANCE - A nursing facility resident's monthly allowance for
16 spending money and personal items.
- 17
- 18 11. PERSONAL NEEDS LIABILITY - The liability of a nursing facility or its representatives for
19 funds which the facility is managing on behalf of its residents. If the resident elects to
20 have the facility manage these funds, a fiduciary (trust) capacity is established for the
21 resident, and the facility is responsible to the resident for due care of the funds and
22 sufficient accounting of transactions made by the facility on behalf of the resident.
- 23 12. PROVIDER (OR VENDOR) - A nursing facility which provides services to residents under
24 the Medicaid Program. A provider facility must be licensed and certified by various
25 government agencies to become eligible to participate in this program.
- 26 13. PUBLIC ADMINISTRATOR -- An appointed government official with various fiduciary
27 responsibilities, including that of disposition of funds of deceased residents with no
28 known heirs. (Nursing facility residents often die without leaving a will and with no known
29 heirs, and their remaining funds are paid to the Public Administrator.)
- 30 14. RESIDENT TRUST FUND - Same as "Patients' or Resident's Personal Needs Account".
31 Most often used as a title for a bank account for residents' personal needs funds.
- 32 15. RESIDENT OR PATIENT PAYMENT - The portion of a nursing facility resident's income
33 which is applied toward his/her care at the facility (according to state department
34 regulations, all income received by a resident, with the exception of the monthly personal
35 needs allowance, or the allowable cost with respect to the post -eligibility treatment of
36 income as defined in [10 CCR 2505-10 section 8.110.49](#), shall be applied toward the
37 resident's care, with the balance paid by Medicaid). A resident's income may be from
38 Social Security, Veterans' Administration, Railroad Retirement, government pensions, an
39 estate or trust, or other sources. The amount of SSI benefits received by a person who is
40 institutionalized is not considered when calculating patient payment.
- 41 16. RESPONSIBLE PARTY -- A party who is responsible for a nursing facility resident's
42 financial affairs. A nursing facility, a friend or designated representative, or a county

1 department may be a responsible party, or a resident may act as his/her own responsible
2 party, if he/she is managing his/her own affairs.

3 17. TESTATE -- A person who dies leaving a will is said to have died "testate."

4 18. UB92 CLAIM FORM -- Form utilized by providers to bill nursing facility services.

5 **8.483 ADULT FOSTER CARE - REPEALED**

6 [Repealed effective April 2, 2007]

7 **8.484 HOME CARE ALLOWANCE - REPEALED**

8 [Repealed effective April 2, 2007]

9 **8.485 HOME AND COMMUNITY BASED SERVICES FOR THE ELDERLY, BLIND AND DISABLED** 10 **(HCBS-EBD) GENERAL PROVISIONS**

11 **8.485.10 LEGAL BASIS**

12 The Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program in
13 Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained
14 in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States
15 Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-
16 EBD program is also authorized under state law at C.R.S. [§section 25.5-6-301](#) et seq. – as amended.

17 **8.485.20 KEYS AMENDMENT COMPLIANCE**

18 All congregate facilities where any HCBS client resides must be in compliance with the “Keys
19 Amendment” as required under Section 1616(e) of the Social Security Act of 1935 and 45 C.F.R. Part
20 1397 (October 1, 1991), by possession of a valid Assisted Living Residence license issued under C.R.S.
21 [§section 25-27-105](#), and regulations of ~~the CDPHE Colorado Department of Public Health and~~
22 ~~Environment~~ at 6 [C.C.R.CCR 1011-1](#), Chapters 2 and 7. C.R.S. [§section 25-27-105](#) and 6 [C.C.R.CCR](#)
23 [1011-1](#) are hereby incorporated by reference. The incorporation of C.R.S. [§section 25-27-105](#) and 6
24 [C.C.R.CCR 1011-1](#) excludes later amendments to, or editions of, the referenced material. Pursuant to
25 [C.R.S. § 24-4-103\(12.5\)](#), ~~†~~The Department maintains copies of this incorporated text in its entirety,
26 available for public inspection during regular business hours at: Colorado Department of Health Care
27 Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated
28 materials are provided at cost upon request.

29 **8.485.30 SERVICES PROVIDED [Eff. 12/30/2007]**

30 .31 HCBS-EBD services provided as an alternative to nursing facility or hospital care include:

31 A. Adult day services; and

32 B. Alternative care facility services, including homemaker and personal care services in a
33 residential setting; and

34 C. Electronic monitoring; and

35 D. Home modification; and

36 E. Homemaker services; and

- 1 F. Non-medical transportation; and
- 2 G. Personal care; and
- 3 H. Respite care; and
- 4 I. In-Home Support Services; and
- 5 J. Community Transition Services; and
- 6 K. Consumer Directed Attendant Support Services.

7 .32 Case management is not a service of the HCBS-EBD waiver program, but shall be provided as
8 an administrative activity through Single Entry Point Agencies.

9 .33 HCBS-EBD clients are eligible for all other Medicaid state plan benefits, including the Home
10 Health program.

11 **8.485.40 DEFINITIONS OF SERVICES [Eff. 12/30/2007]**

- 12 A. Adult day services shall be as defined at Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10
13 10 CCR 2505-10 section 8.491.
- 14 B. Alternative Care Facility services shall be as defined at Section 8.10 CCR 2505-10 section 8.10
15 CCR 2505-10-10 CCR 2505-10 section 8.495.
- 16 C. Electronic monitoring services shall be as defined at Section 8.10 CCR 2505-10 section 8.10
17 CCR 2505-10-10 CCR 2505-10 section 8.488.
- 18 D. Home modification shall be as defined at Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10
19 10 CCR 2505-10 section 8.493.
- 20 E. Homemaker services shall be as defined at Section 8.10 CCR 2505-10 section 8.10 CCR 2505-
21 10-10 CCR 2505-10 section 8.490.
- 22 F. Non-medical transportation services shall be as defined at Section 8.10 CCR 2505-10 section
23 8.10 CCR 2505-10 10 CCR 2505-10 section 8.494.
- 24 G. Personal care services shall be as defined at Section 8.10 CCR 2505-10 section 8.10 CCR 2505-
25 10-10 CCR 2505-10 section 8.489.
- 26 H. Respite care shall be as defined at Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10
27 CCR 2505-10 section 8.492.
- 28 I. In-Home Support Services shall be as defined at Section 8.10 CCR 2505-10 section 8.10 CCR
29 2505-10-10 CCR 2505-10 section 8.552.
- 30 J. Community Transition Services (CTS) shall be as defined at Section 8.10 CCR 2505-10 section
31 8.10 CCR 2505-10-10 CCR 2505-10 section 8.553.
- 32 K. Consumer Directed Attendant Support Services (CDASS) shall be defined at Section 8.10 CCR
33 2505-10 section 8.10 CCR 2505-10 10 CCR 2505-10 section 8.510.

34 **8.485.50 GENERAL DEFINITIONS**

- 1 A. Agency shall be defined as any public or private entity operating in a for-profit or nonprofit
2 capacity, with a defined administrative and organizational structure. Any sub-unit of the agency
3 that is not geographically close enough to share administration and supervision on a frequent and
4 adequate basis shall be considered a separate agency for purposes of certification and contracts.
- 5 B. Assessment shall be as defined at [10 CCR 2505-10 section 8.390.1\(B\)](#).
- 6 C. Case management shall be as defined at [10 CCR 2505-10 section 8.390.1\(D\)](#), including the
7 calculation of client payment and the determination of individual cost-effectiveness.
- 8 D. Categorically eligible shall be defined in the HCBS-EBD program as any client eligible for medical
9 assistance (Medicaid), or for a combination of financial and medical assistance; and who retains
10 eligibility for medical assistance even when the client is not a resident of a nursing facility or
11 hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who
12 are eligible for financial assistance, but not for medical assistance, or persons who are eligible for
13 HCBS-EBD as three hundred percent eligible persons, as defined [at 8.4 at 10 CCR 2505-10](#)
14 [section 8.10 CCR 2505-10 section 8.485.50\(U\)](#).
- 15 E. Congregate facility shall be defined as a residential facility that provides room and board to three
16 or more adults who are not related to the owner and who, because of impaired capacity for
17 independent living, elect protective oversight, personal services and social care but do not require
18 regular twenty-four hour medical or nursing care.
- 19 F. Uncertified Congregate Facility shall be a facility as defined [at 8.4 at 10 CCR 2505-10 section](#)
20 [8.10 CCR 2505-10 section 8.485.50\(F\)](#) that is not certified as an Alternative Care Facility. See
21 [10 CCR 2505-10 section 8.495.1](#).
- 22 G. Continued stay review shall be a re-assessment as defined at [section 8.10 CCR 2505-10](#)
23 [sections 8.402.60 and 8.390.1\(C\)](#).
- 24 H. Corrective action plan shall be as defined at [10 CCR 2505-10 section 8.390.1\(E\)](#).
- 25 I. Cost containment shall be defined as the determination that, on an individual client basis, the cost
26 of providing care in the community is less than the cost of providing care in an institutional setting.
27 The cost of providing care in the community shall include the cost of providing HCBS-EBD
28 services and long term home health services.
- 29 J. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility type
30 services reimbursed by Medicaid, within forty-five (45) calendar days of admission to HCBS-EBD.
31 These include hospitalized clients who were in a nursing facility immediately prior to inpatient
32 hospitalization and who would have returned to the nursing facility if they had not elected HCBS-
33 EBD.
- 34 K. Diverted shall be defined as HCBS-EBD waiver recipients who were not deinstitutionalized, as
35 defined [at 8.4 at 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.485.50\(K\)](#).
- 36 L. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) shall be
37 defined as services provided in a home or community setting to clients who are eligible for
38 Medicaid reimbursement for long term care, who would require nursing facility or hospital care
39 without the provision of HCBS-EBD, and for whom HCBS-EBD services can be provided at no
40 more than the cost of nursing facility or hospital care.
- 41 M. Intake/screening/referral shall be as defined [10 CCR 2505-10 section 8.390.1\(J\)](#).

- 1 N. Level of care screen shall be as defined ~~at 8.4 at 10 CCR 2505-10 section 8.10 CCR 2505-10~~
2 ~~section 8.401.~~
- 3 O. Provider agency shall be defined as an agency, certified by the Department and which has a
4 contract with the Department to provide one of the services listed ~~at 8.4 at 10 CCR 2505-10~~
5 ~~section 8.10 CCR 2505-10 section 8.485.40.~~ A single entry point agency is not a provider agency,
6 as case management is an administrative activity, not a service. Single Entry Point Agencies may
7 become service providers if the criteria at 10 CCR 2505-10 section 8.393.61 are met.
- 8 P. Reassessment shall be as defined at 10 CCR 2505-10 section 8.390.1 ~~(N).~~
- 9 Q. Service plan shall be as defined 10 CCR 2505-10 section 8.390.1-C, including the funding
10 source, frequency, amount and provider of each service. This case plan shall be written on a
11 State-prescribed Long Term Care Plan form.
- 12 R. Single entry point agency shall be defined as an organization as described at 10 CCR 2505-10
13 ~~section 8.390.1 (R).~~
- 14 S. Department shall be defined as the state agency designated as the single state Medicaid agency
15 for Colorado, or any divisions or sub-units within that agency.
- 16 T. Three hundred percent (300%) eligible shall be defined as persons:
- 17 1) Whose income does not exceed 300% of the SSI benefit level; and
- 18 2) Who, except for the level of their income, would be eligible for an SSI payment; and
- 19 3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an
20 HCBS program, or are in a nursing facility or hospitalized for thirty consecutive days.
- 21 U. Transition Coordination Agency (TCA) shall be defined as an agency certified by the Department
22 to provide CTS. To be a certified TCA, the agency shall provide at least two independent living
23 core services. Independent living core services means information and referral services,
24 independent living skills training, peer counseling, including cross-disability peer counseling and
25 individual and systems advocacy.

26 **8.485.60 ELIGIBLE PERSONS**

27 .61 HCBS-EBD services shall be offered to persons who meet all of the eligibility requirements below
28 provided the individual can be served within the capacity limits in the federal waiver:

29 A. Financial Eligibility

30

31

32 Clients shall meet the eligibility criteria as specified in the Income Maintenance Staff
33 Manual of the Colorado Department of Human Services at 9 ~~C.C.R.CCR~~ 2503-1 and the
34 Colorado Department of Health Care Policy and Financing regulations at 10 ~~C.C.R.CCR~~
35 2505-10 Section ~~98~~.100, Medical Assistance Eligibility, which are hereby incorporated by
36 reference. The incorporation of 9 ~~C.C.R.CCR~~ 2503-1 and 10 ~~C.C.R.CCR~~ 2505-10
37 ~~Section 8.10 CCR 2505-10 section 8.100~~ exclude later amendments to, or editions of, the
38 referenced material. Pursuant to C.R.S. §-section 24-4-103(12.5), the Department

1 maintains copies of this incorporated text in its entirety, available for public inspection
 2 during regular business hours at: Colorado Department of Health Care Policy and
 3 Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated
 4 materials are provided at cost upon request.

5 B. Level of Care and Target Group

6 Clients who have been determined to meet the level of care and target group criteria shall
 7 be certified by a Single Entry Point agency as eligible for HCBS-EBD. The Single Entry
 8 Point agency shall only certify HCBS-EBD eligibility for those clients:

- 9 1. Determined by the Single Entry Point agency to meet the target group definition
 10 for functionally impaired elderly, or the target group definition for physically
 11 disabled or blind adult, or persons living with AIDS as defined at [Section 8-10](#)
 12 [CCR 2505-10-section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.400.16](#); and
- 13 2. Determined by a formal level of care assessment to require the level of care
 14 available in a nursing facility, according to [Section 8-10 CCR 2505-10-section](#)
 15 [8.10-CCR 2505-10-10 CCR 2505-10 section 8.401.11](#) through 8.401.15; or
- 16 3. Determined by a formal level of care assessment to require the level of care
 17 available in a hospital;
- 18 4. A length of stay shall be assigned by the Single Entry Point agency for approved
 19 admissions, according to guidelines at [Section 8-10 CCR 2505-10-section 8.10](#)
 20 [CCR 2505-10-10 CCR 2505-10 section 8.402.60](#).

21 C. Receiving HCBS-EBD Services

- 22 1. Only clients who receive HCBS-EBD services, or who have agreed to accept
 23 HCBS-EBD services as soon as all other eligibility criteria have been met, are
 24 eligible for the HCBS-EBD program.
- 25 2. Case management is not a service and shall not be used to satisfy this
 26 requirement
- 27 3. Desire or need for home health services or other Medicaid services that are not
 28 HCBS-EBD services, as listed at [Section 8-10 CCR 2505-10-section 8.10-CCR](#)
 29 [2505-10-10 CCR 2505-10 section 8.485.30](#), shall not satisfy this eligibility
 30 requirement
- 31 4. HCBS-EBD clients who have received no HCBS-EBD services for one month
 32 must be discontinued from the program.

33 D. Institutional Status

- 34 1. Clients who are residents of nursing facilities or hospitals are not eligible for
 35 HCBS-EBD services while residing in such institutions unless the single entry
 36 point agency determines the client is eligible for EBD as described in 10
 37 [C.C.R.CCR 2505-10 §section 8.486.33](#).
- 38 2. A client who is already an HCBS-EBD recipient and who enters a hospital for
 39 treatment may not receive HCBS-EBD services while in the hospital. If the

1 hospitalization continues for 30 days or longer, the case manager must terminate
2 the client from the HCBS-EBD program.

3 3. A client who is already an HCBS-EBD recipient and who enters a nursing facility
4 may not receive HCBS-EBD services while in the nursing facility.

5 (a) The case manager must terminate the client from the HCBS-EBD
6 program if Medicaid pays for all or part of the nursing facility care, or if
7 there is a Utilization Review Contractor-certified ULTC-100.2 for the
8 nursing facility placement, as verified by telephoning the Utilization
9 Review Contractor.

10 (b) A client receiving HCBS-EBD services who enters a nursing facility for
11 respite care as a service under the HCBS-EBD program shall not be
12 required to obtain a nursing facility ULTC-100.2, and shall be continued
13 as an HCBS-EBD client in order to receive the HCBS-EBD service of
14 respite care in a nursing facility.

15 E. Cost-effectiveness

16 Only clients who can be safely served within cost containment, as defined at [section 8.10](#)
17 [CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.485.50](#), are eligible
18 for the HCBS-EBD program.

19 F. Waiting List

20 Persons who are determined eligible for services under the HCBS-EBD waiver, who
21 cannot be served within the capacity limits of the federal waiver, shall be eligible for
22 placement on a waiting list.

23 1. The waiting list shall be maintained by the Department.

24 2. The date used to establish the person's placement on the waiting list shall be the
25 date on which eligibility for services under the HCBS-EBD waiver was initially
26 determined.

27 3. As openings become available within the capacity limits of the federal waiver,
28 persons shall be considered for services based on the following priorities:

29 a. Clients being deinstitutionalized from nursing facilities.

30 b. Clients being discharged from a hospital who, absent waiver services,
31 would be discharged to a nursing facility at a greater cost to Medicaid.

32 c. Clients who receive long term home health benefits who could be served
33 at a lesser cost to Medicaid.

34 d. Clients with high ULTC 100.2 scores who are at risk of imminent nursing
35 facility placement.

36 **8.485.70 START DATE**

37 .71 The start date of eligibility for HCBS-EBD services shall not precede the date that all of the
38 requirements at [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section](#)

1 8.485.60, have been met. The first date for which HCBS-EBD services can be reimbursed shall
2 be the later of any of the following:

3 A. Financial: The financial eligibility start date shall be the effective date of eligibility, as
4 determined by the income maintenance technician, according to ~~Section 8.10 CCR 2505-~~
5 ~~10 section 8.10 CCR 2505-10 10 CCR 2505-10 section 8.100~~. This may be verified by
6 consulting the income maintenance technician, or by looking it up on the eligibility
7 system.

8 B. Level of Care: This date is determined by the official Utilization Review Contractor's
9 stamp and the Utilization Review Contractor -assigned start date on the ULTC 100.2
10 form.

11 C. Receiving Services: This date shall be determined by the date on which the client signs
12 either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the
13 state, agreeing to accept services.

14 D. Institutional Status: HCBS-EBD eligibility cannot precede the date of discharge from the
15 hospital or nursing facility.

16 .72 The start date for CTS may precede HCBS-EBD enrollment when a client meets the conditions
17 set forth at 10 ~~C-C-R-CCR 2505-10~~ section 8.486.33. The start date for CTS shall be no more
18 than 180 calendar days before a client's discharge from a nursing facility.

19 **8.485.80 CLIENT PAYMENT OBLIGATION-POST ELIGIBILITY TREATMENT OF INCOME**
20 **(PETI)**

21 .81 When a client has been determined eligible for Home and Community Based Services (HCBS)
22 under the 300% income standard, according to ~~Section 8.10 CCR 2505-10 section 8.10 CCR~~
23 ~~2505-10-10 CCR 2505-10 section 8.100~~, the Department may reduce Medicaid payment for
24 Alternative Care Facility services according to the procedures at ~~Section 8.10 CCR 2505-10~~
25 ~~section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.486.60~~.

26 **8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES**

27 .91 The Department or its agent shall develop the Prior Authorization Request (PAR) form in
28 compliance with all applicable regulations, and determine whether services requested are (a)
29 consistent with the client's documented medical condition, and functional capacity, (b) reasonable
30 in amount, frequency and duration, (c) not duplicative, (d) not services for which the client is
31 receiving funds to purchase, and (e) do not total more than twenty four (24) hours per day of care.

32 A. The case manager shall submit prior authorization approvals for all HCBS-EBD services
33 to the fiscal agent within one (1) calendar month after the utilization review contractor's
34 assigned start date and approval of financial eligibility.

35 B. The Department or its fiscal agent will approve, deny or return for additional information
36 home modification PARs over \$1,000 within ten (10) working days of receipt.

37 .92 When home modifications are denied, in whole or in part, the single entry point agency shall
38 notify the client or the client's designated representative of the adverse action and their appeal
39 rights on a state-prescribed form, according to ~~Section 8.10 CCR 2505-10 section 8.10 CCR~~
40 ~~2505-10-10 CCR 2505-10 section 8.057~~, et. seq.

- 1 .93 Revisions requested by providers six months or more after the end date shall always be
2 disapproved.
- 3 .94 Approval of the PAR by the Department or its agent shall authorize providers of services under
4 the Service Plan to submit claims to the fiscal agent and to receive payment for authorized
5 services provided during the period of time covered by the PAR. Payment is also conditional upon
6 the client's financial eligibility for long term care medical assistance (Medicaid) on the dates of
7 service; and upon provider's use of correct billing procedures.
- 8 .95 Every PAR shall be supported by information on the Service Plan, the ULTC-100.2 and written
9 documentation from the income maintenance technician of the client's current monthly income.
10 All units of service requested on the PAR shall be listed on the Service Plan.
- 11 .96 If a PAR is for an Alternative Care Facility client who is 300% eligible, all medical and remedial
12 care requested as deductions shall be listed on the Client Payment form.
- 13 .97 The start date on the Prior Authorization Request form shall not precede the start date of eligibility
14 for HCBS-EBD services, according to [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10](#)
15 [CCR 2505-10 section 8.485.70](#), except for CTS. A TCA may provide CTS up to 180 days prior to
16 nursing facility discharge when authorized by the single entry point agency. The TCA is eligible
17 for reimbursement beginning on the first day of the client's HCBS-EBD enrollment.
- 18 .98 The PAR shall not cover a period of time longer than the length of stay assigned by the Utilization
19 Review Contractor.

20 Note: Sections 8.485.100 - 8.485.101 were deleted effective 7/1/02.

21 **8.485.200 LIMITATIONS ON PAYMENT TO FAMILY**

- 22 .201 In no case shall any person be reimbursed to provide HCBS-EBD services to his or her spouse.
- 23 .202 Family members other than spouses may be employed by certified personal care agencies to
24 provide personal care services to relatives under the HCBS-EBD program subject to the
25 conditions below. For purposes of this section, family shall be defined as all persons related to
26 the client by virtue of blood, marriage, adoption or common law.
- 27 .203 The family member shall meet all requirements for employment by a certified personal care
28 agency, and shall be employed and supervised by the personal care agency.
- 29 .204 The family member providing personal care shall be reimbursed, using an hourly rate, by the
30 personal care agency which employs the family member, with the following restrictions:
- 31 A. The total number of Medicaid personal care units for a member of the client's family shall
32 not exceed the equivalent of 444 hours per annual certification for HCBS-EBD.
- 33 1. The maximum number of Medicaid personal care units per annual certification for
34 HCBS-EBD shall include any portions of the Medicaid reimbursement which are
35 kept by the personal care agency for unemployment insurance, worker's
36 compensation, FICA, cost of training and supervision, and all other administrative
37 costs.
- 38 2. The maximum number of hours for personal care units HCBS-EBD shall be 444.
39 Family members must average at least 1.2164 hours of care per day (as

1 indicated on the client's Service Plan) in order to receive the maximum
2 reimbursement.

3
4 a. If the certification period for HCBS-EBD is less than one year, the
5 maximum reimbursement for relative personal care shall be calculated
6 by multiplying the number of days the client is receiving care by the
7 average hours per day of personal care for a full year (444/365=1.2164).

8 B. If two or more HCBS-EBD clients reside in the same household, family members may be
9 reimbursed up to the maximum for each client if the services are not duplicative and are
10 appropriate to meet the client's needs.

11 C. When HCBS-EBD funds are utilized for reimbursement of personal care services
12 provided by the client's family, the home care allowance cannot be used to reimburse the
13 family.

14 D. Restrictions on allowable personal care units shall not apply to parents who provide
15 Attendant services to their eligible children under In-Home Support Services ([10 CCR](#)
16 [2505-10 §section 8.552](#)).

17 E. Services other than personal care shall not be reimbursed with HCBS-EBD funds when
18 provided by the client's family, with the exception of Attendant services provided under
19 In-Home Support Services ([10 CCR 2505-10 §section 8.552](#)).

20 **8.485.300 CLIENT RIGHTS**

21 .301 The case manager shall inform persons eligible for HCBS-EBD, in writing, of their right to choose
22 between HCBS-EBD services and nursing facility or hospital care. In addition, the case manager
23 shall discuss the option and potential benefits of in-home support services with all eligible HCBS-
24 EBD clients.

25 **8.486 HCBS-EBD CASE MANAGEMENT FUNCTIONS**

26 **8.486.10 HCBS-EBD PROGRAM REQUIREMENTS FOR SINGLE ENTRY POINT AGENCIES**

27 Single entry point agencies shall comply with single entry point rules at [Section 8-10-CCR-2505-10](#)
28 [section 8-10-CCR-2505-10-10 CCR 2505-10 section 8.390](#), et. seq., governing case management
29 functions, and shall comply with all HCBS-specific requirements in the rest of this section on HCBS-EBD
30 case management functions.

31 **8.486.20 INTAKE**

32 .21 Refer to [10 CCR 2505-10 section 8.393.21](#) for single entry point intake procedures. The Intake
33 form shall be completed before an assessment is initiated. The Intake form may also be used as
34 a preliminary case plan form when signed by the applicant, for purposes of establishing a start
35 date.

36 .22 Based upon information gathered on the Intake form, the case manager shall determine the
37 appropriateness of a referral for a comprehensive uniform long term care client assessment
38 (ULTC-100), and shall explain the reasons for the decision on the Intake form. The client shall be
39 informed of the right to request an assessment if the client disagrees with the case manager's
40 decision.

1 **88.486.30 ASSESSMENT**

2 .31 If the client is being discharged from a hospital or other institutional setting, the discharge planner
3 shall contact the URC/SEP agency for assessment by emailing or faxing the Initial Intake and
4 Screening form as required at [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR](#)
5 [2505-10 section 8.393.21](#).

6 .32 The URC/SEP case manager shall view and document the current Personal Care Boarding
7 Home license, if the client lives, or plans to live, in a congregate facility as defined at [Section 8.10](#)
8 [CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.485.50](#), in order to ensure
9 compliance with [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section](#)
10 [8.485.20](#).

11 .33 A SEP may determine that a client is eligible for HCBS-EBD while the client resides in a nursing
12 facility when the client meets the eligibility criteria as established at 10 [C.C.R.CCR 2505-10-](#)
13 [§section 8.400](#), *et seq.*, the client requests CTS and the SEP includes CTS in the client's long
14 term care plan. If the client has been evaluated with the ULTC 100.2 and has been assigned a
15 length of stay that has not lapsed, the SEP shall not conduct another review when CTS is
16 requested.

17 **8.486.40 HCBS-EBD DENIALS**

18 .41 If a client is determined, at any point in the assessment process, to be ineligible for HCBS-EBD
19 according to any of the requirements at [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10](#)
20 [CCR 2505-10 section 8.485.60](#), the client or the client's designated representative shall be
21 notified of the denial and the client's appeal rights in accordance with Long Term Care Single
22 Entry Point System regulations at [10 CCR 2505-10 section section 8.393.28](#).

23 **8.486.50 Case Planning**

24 .51 Case planning shall include the following tasks:

25 A. Documentation of the client's choice of HCBS-EBD services, nursing home placement, or
26 other services, including a signed statement of choice from the client;

27 B. Documentation that the client was informed of the right to free choice of providers from
28 among all the available and qualified providers for each needed service, and that the
29 client understands his/her right to change providers;

30 C. Except when a client is residing in an alternative care facility, documentation to include a
31 process, developed in coordination with the client, the client's family or guardian and the
32 client's physician, by which the client may receive necessary care if the client's family or
33 service provider is unavailable due to an emergency situation or to unforeseen
34 circumstances. The client and the client's family or guardian shall be duly informed of
35 these alternative care provisions at the time the case plan is initiated.

36 **8.486.60 CALCULATION OF CLIENT PAYMENT (PETI)**

37 The case manager shall calculate the client payment (PETI) for 300% eligible HCBS-EBD clients
38 according to the following procedures:

39 A. For 300% eligible HCBS-EBD clients who are not Alternative Care Facility clients, the
40 case manager shall allow an amount equal to the 300% standard as the client

1 maintenance allowance. No other deductions are necessary and no form is required to be
2 completed.

3 B. For 300% eligible clients who are Alternative Care Facility clients, the case manager shall
4 complete a State-prescribed form, which calculates the client payment according to the
5 following procedures:

6 1. An amount equal to the current Old Age Pension standard, including any
7 applicable income disregards, shall be deducted from the client's gross income to
8 be used as the client maintenance allowance, from which the state-prescribed
9 Alternative Care Facility room and board amount shall be paid; and

10 2. For an individual with financial responsibility for only a spouse, an amount equal
11 to the state Aid to the Needy and Disabled (AND) standard, less the amount of
12 any spouse's income, shall be deducted from the client's gross income; or

13 3. For an individual with financial responsibility for a spouse plus other dependents,
14 or with financial responsibility for other dependents only, an amount equal to the
15 appropriate Temporary Assistance to Needy Families (TANF) grant level less any
16 income of the spouse and/or dependents (excluding part-time employment
17 earnings of dependent children as defined at [Section 8.10 CCR 2505-10 section](#)
18 [8.10 CCR 2505-10-10 CCR 2505-10 section 8.112.3\(F\)100.1 of Staff Manual](#)
19 [Volume 8](#)), shall be deducted from the client's gross income; and

20 4. Amounts for incurred expenses for medical or remedial care for the individual
21 that are not subject to payment by Medicare, Medicaid, or other third party shall
22 be deducted from the client's gross income as follows:

23 a. Health insurance premiums if health insurance coverage is documented
24 in the eligibility system and the MMIS; deductible or co-insurance
25 charges; and

26 b. Necessary dental care not to exceed amounts equal to actual expenses
27 incurred; and

28 c. Vision and auditory care expenses not to exceed amounts equal to
29 actual expenses incurred; and

30 d. Medications, with the following limitations:

31 1) The need for such medications shall be documented in writing by
32 the attending physician. For this purpose, documentation on the
33 Utilization Review Contractor certification form shall be
34 considered adequate. The documentation shall list the
35 medication; state why it is medically necessary; be signed by
36 the physician; and shall be renewed at least annually or
37 whenever there is a change.

38 2) Medications which may be purchased with the Medical
39 Identification Card shall not be allowed as deductions.

40 3) Medications which may be purchased through regular Medicaid
41 prior authorization procedures shall not be allowed.

- 1 4) The full cost of brand-name medications shall not be allowed if a
2 generic form is available at a lower price.
- 3 5) Only the amount spent for medications which exceeds the
4 current Old Age Pension Standard allowance for medicine chest
5 expense shall be allowed as a deduction.
- 6 e. Other necessary medical or remedial care shall be deducted from the
7 client's gross income, with the following limitations:
- 8
- 9
- 10 1) The need for such care must be documented in writing by the
11 attending physician. For this purpose documentation on the
12 Utilization Review Contractor certification form shall be
13 considered adequate. The documentation shall list the service,
14 supply, or equipment; state why it is medically necessary; be
15 signed by the physician; and, shall be renewed at least annually
16 or whenever there is a change.
- 17 2) Any service, supply or equipment that is available under regular
18 Medicaid, with or without prior authorization, shall not be allowed
19 as a deduction.
- 20 f. Deductions for medical and remedial care may be allowed up to the end
21 of the next full month while the physician's prescription is being obtained.
22 If the physician's prescription cannot be obtained by the end of the next
23 full month, the deduction shall be discontinued.
- 24 g. When the case manager cannot immediately determine whether a
25 particular medical or remedial service, supply, equipment or medication
26 is a benefit of Medicaid, the deduction may be allowed up to the end of
27 the next full month while the case manager determines whether such
28 deduction is a benefit of the Medicaid program. If it is determined that the
29 service, supply, equipment or medication is a benefit of Medicaid, the
30 deduction shall be discontinued.
- 31 5. Any remaining income shall be applied to the cost of the Alternative Care Facility
32 services, as defined at ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10~~
33 ~~CCR 2505-10 section 8.495~~, and shall be paid by the client directly to the facility;
34 and
- 35 6. If there is still income remaining after the entire cost of Alternative Care Facility
36 services is paid from the client's income, the remaining income shall be kept by
37 the client and may be used as additional personal needs or for any other use that
38 the client desires, except that the Alternative Care Facility shall not charge more
39 than the Medicaid rate for Alternative Care Facility services.
- 40 C. Case managers shall inform HCBS-EBD Alternative Care Facility clients of their client
41 payment obligation on a form prescribed by the state at the time of the first assessment
42 visit; by the end of each plan period; or within ten (10) working days whenever there is a
43 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 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 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 [10 CCR 2505-10 section 8.485.50.J](#) by using a State-prescribed PAR form to:

- A. Determine the maximum authorized costs for all [HCBS-EBD waiver](#) 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

1 on the original care plan form, must re entered on the revised Prior Authorization
2 Request form, for purposes of reimbursement

3 2. The dates on the revision must be identical to the dates of the original PAR,
4 unless the purpose of the revision is to revise the PAR dates.

5 B. If a revised PAR includes a new request for home modification service above the
6 Department prescribed amount, the revised PAR shall also include all documentation
7 listed at [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section](#)
8 [8.493](#).

9 .102 DECREASE OF SERVICES ON THE CARE PLAN

10 A. A revised PAR does not need to be submitted if services on the care plan are decreased
11 or not used, unless the services are being eliminated or reduced in order to add other
12 services while maintaining cost-effectiveness.

13 B. If services are decreased without the client's agreement, the case manager shall notify
14 the client of the adverse action and of appeal rights, according to Long Term Care Single
15 Entry Point System regulations at [10 CCR 2505-10 section 8.393.28](#).

16 8.486.200 REASSESSMENT

17 .201 The case manager shall complete a reassessment of each [HCBS-EBD client SEP-managed](#)
18 [waiver client](#) before the end of the length of stay assigned by the Utilization Review Contractor at
19 the last level of care determination. The case manager shall initiate a reassessment more
20 frequently if required by single entry point regulations at [10 CCR 2505-10 section 8.393.25](#), or
21 when warranted by significant changes that may affect HCBS-EBD eligibility.

22 .202 The case manager shall submit a continued stay review PAR, in accordance with requirements at
23 [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.485.90](#). For
24 clients who have been denied by the Utilization Review Contractor at continued stay review, and
25 are eligible for services during the appeal, written documentation that an appeal is in progress
26 may be used as a substitute for the approved ULTC 100.2. Acceptable documentation of an
27 appeal includes: (a) a copy of the request for reconsideration or the request for appeal, signed by
28 the client and sent to the Utilization Review Contractor or to the Office of Administrative Courts;
29 (b) a copy of the notice of a scheduled hearing, sent by the Utilization Review Contractor or the
30 Office of Administrative Courts to the client; or (c) a copy of the notice of a scheduled court date.
31 Copies of denial letters, and written statements from case managers, are not acceptable
32 documentation that an appeal was actually filed, and shall not be accepted as a substitute for the
33 approved ULTC 100.2. The length of the PAR on appeal cases may be up to one year, with the
34 PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

35 8.486.300 TERMINATION

36 .301 In accordance with Long Term Care Single Entry Point System regulations at [10 CCR 2505-10](#)
37 [section 8.393.28](#), clients shall be terminated from [any SEP-managed waiver the HCBS-EBD](#)
38 [program](#) whenever they no longer meet one or more of the eligibility requirements at [Section 8.10](#)
39 [CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.485.60](#). Clients shall also be
40 terminated from the [program-waiver](#) if they die, move out of state or voluntarily withdraw from the
41 [program-waiver](#).

42 8.486.400 COMMUNICATION

- 1 .401 In addition to any communication requirement specified elsewhere in these rules, the case
2 manager shall be responsible for the following communications:
- 3 A. The case manager shall inform all Alternative Care Facility clients of their obligation to
4 pay the full and current State-prescribed room and board amount, from their own income,
5 to the Alternative Care Facility provider.
- 6 B. Within five (5) working days of receipt of the approved PAR form, from the fiscal agent,
7 the case manager shall provide copies to all the HCBS-EBD providers in the care plan.
- 8 C. Within five (5) working days of receipt from the Utilization Review Contractor of the
9 certified ULTC 100.2 form, the case manager shall send a copy of the ULTC 100.2 form
10 to all personal care, and adult day services provider agencies on the care plan and to
11 alternative care facilities listed on the care plan.
- 12 D. The case manager shall notify the Utilization Review Contractor, on a form prescribed by
13 the Department, within thirty (30) calendar days, of the outcome of all non-diversions, as
14 defined at ~~section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10~~
15 ~~section 8.485.50.~~

16 **8.486.500 CASE RECORDING/DOCUMENTATION**

- 17 .501 Case management documentation shall meet all of the standards found at 10 CCR 2505-10
18 sections 8.393.16, and at 8.393.26.

19 **8.487 HCBS-EBD WAIVER PROVIDER AGENCIES**

20 **8.487.10 GENERAL CERTIFICATION STANDARDS**

- 21 .11 Provider agencies shall:
- 22 A. Conform to all State established standards for the specific services they provide under
23 this program; and
- 24 B. Abide by all the terms of their provider agreement with the Department; and
- 25 C. Comply with all federal and state statutory requirements. A provider shall not discontinue
26 or refuse services to a client unless documented efforts have been made to resolve the
27 situation that triggers such discontinuation or refusal to provide services.
- 28 .12 Provider agencies shall have written policies and procedures for recruiting, selecting, retaining
29 and terminating employees.
- 30 .13 Provider agencies shall have written policies governing access to duplication and dissemination
31 of information from the client's records in accordance with ~~state statutes on CONFIDENTIALITY~~
32 ~~OF INFORMATION at C.R.S. section 26-1-114, C.R.S.~~, as amended. Provider agencies shall
33 have written policies and procedures for providing employees with client information needed to
34 provide the services assigned, within the agency policies for protection of confidentiality.
- 35 .14 Provider agencies shall maintain liability insurance in at least such minimum amounts as set
36 annually by the Department of Health Care Policy and Financing, and shall have written policies
37 and procedures regarding emergency procedures.

- 1 .15 Provider agencies shall have written policies and procedures regarding the handling and
2 reporting of critical incidents, including accidents, suspicion of abuse, neglect or exploitation, and
3 criminal activity. Provider agencies shall maintain a log of all complaints and critical incidents,
4 which shall include documentation of the resolution of the problem.
- 5 .16 Provider agencies shall maintain records on each client. The specific record for each client shall
6 include at least the following information:
- 7 A. Name, address, phone number and other identifying information about the client; and
- 8 B. Name, address and phone number of the case manager and single entry point agency;
9 and
- 10 C. Name, address and phone number of the client's physician; and
- 11 D. Special health needs or conditions of the recipient; and
- 12 E. Documentation of the services provided, including where, when, to -whom and by whom
13 the service was provided, and the exact nature of the specific tasks performed, as well as
14 the amount or units of service. Records shall include date, month and year of service,
15 and when applicable, the beginning and the ending time of day; and
- 16
- 17 F. Documentation of any changes in the client's condition or needs, as well as
18 documentation of appropriate reporting and action taken as a result; and
- 19 G. For personal care agencies, documentation concerning advance directives shall be
20 present in the client record; and
- 21 H. Documentation of supervision of care; and
- 22 I. All information regarding a client shall be kept together for easy access and review by
23 supervisors, program monitors and auditors.
- 24 .17 Provider agencies shall maintain a personnel record for each employee. The employee record
25 shall contain at least the following:
- 26 A. Documentation of employee qualifications.
- 27 B. Documentation of training.
- 28 C. Documentation of supervision and performance evaluation.
- 29 D. Documentation that the employee was informed of all policies and procedures required
30 by these rules.
- 31 E. A copy of the employee's job description.
- 32 .18 A provider agency may become separately certified to provide more than one type of HCBS-EBD
33 service if all requirements are met for certification. Administration of the different services
34 provided shall be clearly separate for auditing purposes. The provider agency shall also
35 understand and be able to articulate its different functions and roles as a provider of each service,

1 as well as all the rules that separately govern each of the types of services, in order to avoid
2 confusion on the part of clients and others.

3 .19 Provider agencies shall send billing and other staff to the provider billing training offered by the
4 fiscal agent, at least once each year.

5 **8.487.20 GENERAL CERTIFICATION PROCESS**

6 .21 An agency, as defined at ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10~~
7 ~~section 8.485.50~~, seeking certification as an HCBS-EBD provider agency, shall submit a written
8 request to the Department or its agent

9 .22 Upon receipt of the written request, the Department or its agent shall forward certification
10 information and relevant state application forms to the requesting agency.

11 .23 Upon receipt of the completed application from the requesting agency, the Department or its
12 agent shall review the information and complete an on-site review of the agency, based on the
13 state regulations for the service for which certification has been requested.

14 .24 Following completion of the on-site review the Department or its agent shall notify the provider
15 agency applicant of its recommendation by forwarding the following information:

16 A. Results of the on-site survey;

17 B. Recommendation of approval, denial or provisional approval of certification;

18 AC. If appropriate, a corrective action plan to satisfy the requirements of a provisional
19 approval.

20 .25 Determination of certification approval, provisional approval or denial shall be made by the
21 Department within sixty (60) days of receipt of the completed application from the agency.

22 **8.487.30 APPROVAL OF CERTIFICATION**

23 If certification is approved, the Department shall enter into a provider agreement with the certified agency
24 in accordance with ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section~~
25 ~~8.130~~.

26 **8.487.40 PROVISIONAL APPROVAL OF CERTIFICATION**

27 .41 If agencies do not meet all state established certification standards, but the deficiencies do not
28 constitute a threat to clients' health and safety such agencies may be provisionally certified for a
29 period not to exceed sixty (60) days at the discretion of the state.

30 .42 If provisional approval has been granted, the Department or its agent shall assure that corrective
31 action has been taken according to the approved plan, and shall conduct an on-site review, if
32 necessary, within the designated time period.

33 **8.487.50 DENIAL OF CERTIFICATION**

34 If the agency is unable to complete an adequate corrective action plan within the prescribed time,
35 certification shall be denied, in accordance with ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10~~
36 ~~CCR 2505-10 section 8.130~~.

1 **8.487.60 RECERTIFICATION PROCESS**

2 The Department or its agent shall follow the same procedures as those followed for certification, as
3 described at [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.487.20](#).

4 **8.487.70 TERMINATION OF PROVIDER AGREEMENTS**

5 The Department shall initiate termination of a provider agreement if an agency is in violation of any
6 applicable certification standard or provision of the provider agreement and does not adequately respond
7 to a corrective action plan within the prescribed period of time. The state shall follow procedures at
8 [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.130](#).

9 **8.487.80 EMERGENCY TERMINATION OF PROVIDER AGREEMENTS**

10 Emergency termination of any provider agreement shall be in accordance with procedures at [Section 8.10](#)
11 [CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.050](#).

12 **8.487.90 TRANSFER OF OWNERSHIP**

13 .91 The provider shall notify the Department or its agent within five (5) working days of any change of
14 ownership.'

15 .92 Upon transfer of ownership of the provider agency or facility, the provider certification may be
16 assigned to the new owner only upon the prior written consent of the Department or its agent.
17 Such assignment of the duties and obligations of the existing certification to the new owner shall
18 be for a period of time determined at the discretion of the Department, but not to extend beyond
19 the current end date of the original certification period.

20 .93 Upon transfer of ownership, the previous owner's existing provider agreement with the
21 Department is immediately terminated, and the new owner must enter into a new provider
22 agreement.

23 **8.487.100 PROVIDER RIGHTS**

24 The Department shall notify provider agencies in writing of any adverse action taken by the Department
25 against the agency, and shall inform the agency of its appeal rights in accordance with the procedures
26 described in [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.050](#).

27 **8.487.200 PROVIDER REIMBURSEMENT**

28 .201 Payment to certified HCBS-EBD providers for services provided to eligible clients shall be made
29 when claims are submitted in accordance with the following procedures:

30 A. Claims shall be submitted to the fiscal agent on State-prescribed forms provided by the
31 fiscal agent according to [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR](#)
32 [2505-10 section 8.040](#) and [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10](#)
33 [CCR 2505-10 section 8.043](#); and

34 B. Claim forms shall be filled out completely and correctly; and

35 C. Payment shall not exceed Department established limits as described under the
36 reimbursement sections for each HCBS-EBD service; and

- 1 D. Payment shall be made only for the service or services for which the agency is certified;
2 and
- 3 E. Payment shall be made only for the types and amounts of services that are prior
4 authorized by the Department or its agent; and
- 5 F. Payment shall be made only for services provided by persons employed by the agency at
6 the time the services were provided.

7 .202 Provider agencies shall maintain adequate financial records for all claims, including
8 documentation of services as specified at ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10~~
9 ~~10 CCR 2505-10 section 8.040.02, Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10~~
10 ~~CCR 2505-10 section 8.130, and Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR~~
11 ~~2505-10 section 8.487.10.~~

12 8.488 ELECTRONIC MONITORING

13 8.488.10 DEFINITIONS

14 .11 Electronic monitoring services means the installation purchase or rental of electronic monitoring
15 devices which:

- 16 A. enable the individual to secure help in the event of an emergency;
- 17 B. may be used to provide reminders to the individual of medical appointments, treatments,
18 or medication schedules;
- 19 C. are required because of the individual's illness, impairment or disability, as documented
20 on the ULTC-100 form and the care plan form; and
- 21 D. are essential to prevent institutionalization of the individual.

22 .12 Electronic monitoring provider means a provider agency as defined at ~~Section 8.10 CCR 2505-10~~
23 ~~section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.484.50.~~ Q. GENERAL DEFINITIONS,
24 which has met all the certification standards for electronic monitoring services specified below.

25 8.488.20 INCLUSIONS

26 .21 Electronic monitoring services shall include personal emergency response systems, medication
27 reminders, or other devices which comply with the definition above and are not included in the
28 non-benefit items below at ~~8.4 at 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.10 CCR~~
29 ~~2505-10-10 CCR 2505-10 section 8.488.31.~~

30 8.488.30 EXCLUSIONS, RESTRICTIONS AND NON-BENEFIT ITEMS

- 31 .31 Electronic monitoring services shall be authorized only for individuals who live alone, or who are
32 alone for significant parts of the day, or whose only companion for significant parts of the day is
33 too impaired to assist in an emergency, and who would otherwise require extensive supervision.
- 34 .32 Electronic monitoring services shall be authorized only for individuals who have the physical and
35 mental capacity to utilize the particular system requested for that individual.
- 36 .33 Electronic monitoring services shall not be authorized under HCBS if the service or device is
37 available as a regular-state plan Medicaid benefit

- 1 .34 The following are not benefits of electronic monitoring services:
- 2 A. Augmentative communication devices and communication boards;
- 3 B. Hearing aids and accessories;
- 4 C. Phonic ears;
- 5 D. Environmental control units, unless required for the medical safety of a client living alone
- 6 unattended;
- 7 E. Computers and computer software;
- 8 F. Wheelchair lifts for automobiles or vans;
- 9 G. Exercise equipment, such as exercise cycles;
- 10 H. Hot tubs, Jacuzzis, or similar items.

11 **8.488.40 CERTIFICATION STANDARDS FOR ELECTRONIC MONITORING SERVICES**

12 .41 Electronic monitoring providers shall conform to all general certification standards and procedures

13 at [Section 8.10 CCR 2505-10 section 8.487](#), HCBS-EBD PROVIDER AGENCIES.

14 .42 In addition, electronic monitoring providers shall conform to the following standards for electronic

15 monitoring services:

- 16 A. All equipment, materials or appliances used as part of the electronic monitoring service
- 17 shall carry a UL (Underwriter's Laboratory) number or an equivalent standard. All
- 18 telecommunications equipment shall be FCC registered
- 19 B. All equipment, materials or appliances shall be installed by properly trained individuals,
- 20 and the installer shall train the client in the use of the device.
- 21
- 22 C. All equipment, materials or appliances shall be tested for proper functioning at the
- 23 time of installation and at periodic intervals thereafter. Any malfunction shall be promptly
- 24 repaired and equipment shall be replaced when necessary, including buttons and
- 25 batteries.
- 26 D. All telephone calls generated by electronic monitoring equipment shall be toll-free and all
- 27 clients shall be allowed to run unrestricted tests on their equipment
- 28 E. Electronic monitoring providers shall send written information to each client's case
- 29 manager about the system, how it works, and how it will be maintained

30 **8.488.50 REIMBURSEMENT METHOD FOR ELECTRONIC MONITORING**

31 .51 Payment for electronic monitoring services shall be the lower of the billed charges or the prior

32 authorized amount The unit of reimbursement shall be one unit per service for non-recurring

33 services, or one unit per month for services recurring monthly.

1 .52 Effective 2/1/99, there shall be no reimbursement under this section for electronic monitoring
2 services provided in uncertified congregate facilities.

3 **8.489 PERSONAL CARE**

4 **8.489.10 DEFINITIONS**

5 .11 Personal care services means services which are furnished to an eligible client in the client's
6 home to meet the client's physical, maintenance and supportive needs, when those services are
7 not skilled personal care as described in the EXCLUSIONS section below, do not require the
8 supervision of a nurse, and do not require physician's orders.

9 .12 Personal care provider means a provider agency as defined at ~~Section 8.10 CCR 2505-10~~
10 ~~section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.484.50.~~ ~~PQ- GENERAL DEFINITIONS,~~
11 which has met all the certification standards for personal care providers listed below.

12 .13 Personal care staff means those employees of the personal care provider agency who perform
13 the personal care tasks.

14 .14 Skilled personal care means skilled care which may only be provided by a certified home health
15 aide, as further defined at ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-~~
16 ~~10 section 8.526522, HOME HEALTH AIDE SERVICES,~~ and in the EXCLUSIONS section below.

17 .15 Unskilled personal care means personal care which is not skilled personal care, as defined
18 above.

19 **8.489.20 GENERAL PERSONAL CARE RULES**

20 .21 Personal care services shall include unskilled personal care as defined under INCLUSIONS for
21 each personal care task listed in ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR~~
22 ~~2505-10 section 8.489.30.~~

23 .22 EXCLUSIONS AND RESTRICTIONS

24
25

26 A. Personal care services shall not include any skilled personal care, which must be
27 provided as home health aide services or as nursing services under non-HCBS
28 programs. These services as defined under EXCLUSIONS for each personal care task
29 listed in ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section~~
30 ~~8.489.30,~~ shall not be provided as personal care services under HCBS, regardless of the
31 level of the training, certification, or supervision of the personal care employee.

32 B. Personal care staff shall not perform tasks that are not included under INCLUSIONS for
33 each personal care task listed in ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10~~
34 ~~10 CCR 2505-10 section 8.489.30,~~ or tasks that are not listed. For example, personal
35 care staff shall not provide transportation services and shall not provide financial
36 management services. Clients, family, or others may choose to make private pay
37 arrangements with the provider agency for services that are not Medicaid benefits, such
38 as companionship.

- 1 C. The amount of personal care that is prior authorized is only an estimate, including
 2 estimated travel time. The prior authorization of a certain number of hours does not
 3 create an entitlement on the part of the client or the provider for that exact number of
 4 hours. All hours provided and reimbursed by Medicaid must be for covered services and
 5 must be necessary to meet the client's needs.
- 6 D. Personal care provider agencies may decline to perform any specific task, if the
 7 supervisor or the personal care staff feels uncomfortable about the safety of the client or
 8 the personal care staff, regardless of whether the task may be included in the
 9 INCLUSIONS section for the task.
- 10 E. Family members shall not be reimbursed to provide only homemaker services. Family
 11 members must provide relative personal care in accordance with [SECTION 8.10 CCR](#)
 12 [2505-10 SECTION 8.10 CCR 2505-10-10 CCR 2505-10 SECTION 8.485.200,](#)
 13 [LIMITATIONS ON PAYMENT TO FAMILY.](#) Documentation of services provided must
 14 indicate that the provider is a relative.

15 8.489.30 SPECIFIC PERSONAL CARE TASKS

16 .31 The specific personal care tasks shall be authorized and provided according to the following
 17 rules.

18 A. BATHING

19 1. INCLUSIONS:

20 Bathing is considered unskilled only when skilled skin care, skilled transfer, or skilled
 21 dressing, as described under EXCLUSIONS, is not required in conjunction with the
 22 bathing.

23 2. EXCLUSIONS:

24 Bathing is considered skilled when skilled skin care, skilled transfer or skilled dressing is
 25 required, as described under EXCLUSIONS for skin care [at 8.4 at 10 CCR 2505-10](#)
 26 [section 8.10 CCR 2505-10 section 8.489.31-B,2,](#) EXCLUSIONS for transfers [at 8.4 at](#)
 27 [10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.489.31-K,2,](#) or EXCLUSIONS for
 28 dressing [at 8.4 at 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.489.31-G.2.](#)

29 B. SKIN CARE:

30 1. INCLUSIONS:

31
 32 Skin care is considered unskilled only when skin is unbroken, and when any chronic skin
 33 problems are not active. Unskilled skin care must be of a preventive rather than a
 34 therapeutic nature, and may include application of non-medicated lotions and solutions,
 35 or of lotions and solutions not requiring a physician's prescription; rubbing of reddened
 36 areas; reporting of changes to supervisor, and application of preventive spray on
 37 unbroken skin areas that may be susceptible to development of decubiti. Unskilled skin
 38 care does not include any of the care described under skilled skin care in the
 39 EXCLUSIONS section below.

40 2. EXCLUSIONS:

1 Skin care is considered skilled when there is broken skin, or potential for infection due to
 2 a chronic skin condition in an active stage. Skilled skin care includes wound care,
 3 dressing changes, application of prescription medications, skilled observation and
 4 reporting, but does not include use of sterile technique.

5 C. HAIR CARE

6 1. INCLUSIONS:

7 Hair care is considered unskilled only when skilled skin care, skilled transfer, or skilled
 8 dressing, as described under EXCLUSIONS-, is not required in conjunction with the hair
 9 care. Hair care under these limitations may include shampooing with non-medicated
 10 shampoo or shampoo that does not require a physician's prescription, drying, combing
 11 and styling of hair.

12 2. EXCLUSIONS:

13 Hair care is considered skilled when skilled skin care, skilled transfer, or skilled dressing,
 14 as described under EXCLUSIONS for skin care ~~at 8.4at 10 CCR 2505-10 section 8.10~~
 15 ~~CCR 2505-10 section 8.489.31331.B.2,~~ EXCLUSIONS for transfers ~~at 8.4at 10 CCR~~
 16 ~~2505-10 section 8.10 CCR 2505-10 section 8.489.31.K.2,~~ or EXCLUSIONS for
 17 dressing ~~at 8.4at 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.489.31.G.2,~~ is
 18 required in conjunction with the hair care.

19 D. NAIL CARE

20 1. INCLUSIONS:

21 Nail care is considered unskilled only when skilled skin care, as described under
 22 EXCLUSIONS, is not required in conjunction with the nail care; and only in the absence
 23 of any medical conditions that might involve peripheral circulatory problems or loss of
 24 sensation. Nail care under these limitations may include soaking of the nails, pushing
 25 back cuticles, and trimming and filing of nails.

26 2. EXCLUSIONS:

27 Nail care is considered skilled when skilled skin care, as described under EXCLUSIONS
 28 for skin care ~~at 8.4at 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.489.31.B.2~~
 29 is required in conjunction with the nail care; and in the presence of medical conditions
 30 ~~th~~at may involve peripheral circulatory problems or loss of sensation.

31 E. MOUTH CARE

32 1. INCLUSIONS:

33 Mouth care is considered unskilled only when skilled skin care, as described under
 34 EXCLUSIONS, is ~~not not~~ required in conjunction with the mouth care. Mouth care under
 35 these limitations may include denture care and basic oral hygiene.

36 2. EXCLUSIONS:

37 Mouth care is considered skilled when skilled skin care, as described under
 38 EXCLUSIONS for skin care ~~at 8.4at 10 CCR 2505-10 section 8.10 CCR 2505-10 section~~
 39 ~~8.489.31.B.2,~~ is required in conjunction with the mouth care; or when there is injury or

1 disease of the face, mouth, head or neck; or in the presence of communicable disease;
2 or when the client is unconscious; or when oral suctioning is required.

3 F. SHAVING

4 1. INCLUSIONS:

5 Shaving is considered unskilled only when skilled skin care, as described under
6 EXCLUSIONS, is not required in conjunction with shaving; and only an electric razor may
7 be used.

8 2. EXCLUSIONS

9 Shaving is considered skilled when skilled skin care, as described under EXCLUSIONS
10 for skin care ~~at 8.4 at 10 CCR 2505-10 section 8.10 CCR 2505-10 section 8.489.31.B.2,~~
11 is required in conjunction with shaving.

12 G. DRESSING

13 1. INCLUSIONS:

14 Dressing is considered unskilled only when skilled skin care or skilled transfer, as
15 described under EXCLUSIONS, is not required in conjunction with the dressing. Unskilled
16 dressing may include assistance with ordinary clothing; application of support stockings
17 of the type that can be purchased without a physician's prescription; application of
18 orthopedic devices such as splints and braces, or of artificial limbs, if considerable
19 manipulation of the device or limb is not necessary, and if the client is fully trained in the
20 use of the device or limb and is able to instruct the personal care staff.

21 2. EXCLUSIONS:

22 Dressing is considered skilled when skilled skin care or skilled transfer, as described
23 under EXCLUSIONS for skin care ~~at 8.4 at 10 CCR 2505-10 section 8.10 CCR 2505-10~~
24 ~~section 8.489.31.B.2~~ or EXCLUSIONS for transfers ~~at 8.4 at 10 CCR 2505-10 section~~
25 ~~8.10 CCR 2505-10 section 8.489.31.K.2~~ is required in conjunction with the dressing.
26 Skilled dressing may include application of anti-embolic or other pressure stockings that
27 can be purchased only with a physician's prescription; application of orthopedic devices
28 such as splints and braces, or of artificial limbs, if considerable manipulation of the device
29 or limb is necessary, or if the client is still learning to use the device or limb.

30 H. FEEDING

31 I. INCLUSIONS:

32
33
34 Feeding is considered unskilled only when skilled skin care or skilled dressing, as
35 described under EXCLUSIONS, is not required in conjunction with the feeding, and when
36 oral suctioning is not needed on a stand-by or other basis. Unskilled feeding includes
37 assistance with eating by mouth, using common eating utensils, such as forks, knives
38 and straws.

1 2. EXCLUSIONS:

2 Feeding is considered skilled when skilled skin care or skilled dressing, as described
3 under EXCLUSIONS for skin care [at 8.4 at 10 CCR 2505-10 section 8.10 CCR 2505-10](#)
4 [section 8.489.31.3.B.2](#) or EXCLUSIONS for dressing [at 8.4 at 10 CCR 2505-10 section](#)
5 [8.10 CCR 2505-10 section 8.489.31.0.G.2](#), is required in conjunction with the feeding,
6 and when oral suctioning is needed on a stand-by or other basis. Syringe feeding is also
7 considered skilled. Feeding is skilled if there is a high risk of choking that could result in
8 the need for emergency measures such as CPR or Heimlich maneuver.

9 I. AMBULATION

10 1. INCLUSIONS:

11 Assistance with ambulation is considered unskilled only when skilled transfers, as
12 described under EXCLUSIONS, are not required in conjunction with the ambulation. In
13 addition, when assisting a client with adaptive equipment, the client must be fully trained
14 in the use of such equipment; and when assisting someone in a cast, there must be no
15 need for observation and reporting to a nurse, and no need for skilled skin care, as
16 described under EXCLUSIONS. Adaptive equipment may include, but is not limited to,
17 gait belts, walkers, canes and wheelchairs.

18 2. EXCLUSIONS:

19 Assistance with ambulation is considered skilled when skilled transfers, as described
20 under EXCLUSIONS for transfers [at 8.4 at 10 CCR 2505-10 section 8.10 CCR 2505-10](#)
21 [section 8.489.31.K.2](#), are required in conjunction with the ambulation. In addition, when
22 assisting a client with adaptive equipment, it is considered skilled if the client is still being
23 trained in the use of such equipment; and assisting someone in a cast is considered
24 skilled there is a need for observation and reporting to a nurse, or if there is a need for
25 skilled skin care, as described under EXCLUSIONS for skin care [at 8.4 at 10 CCR 2505-](#)
26 [10 section 8.10 CCR 2505-10 section 8.489.31.B.2](#).

27 J. EXERCISES

28 1. INCLUSIONS:

29 Assistance with exercises is considered unskilled only when the exercises are not
30 prescribed by a nurse or other licensed medical professional. Unskilled assistance with
31 exercise is limited to the encouragement of normal bodily movement, as tolerated, on the
32 part of the client. Personal care staff shall not prescribe nor direct any type of exercise
33 program for the client.

34 2. EXCLUSIONS:

35 Assistance with exercises is considered skilled when the exercises are prescribed by a
36 nurse or other licensed medical professional. This may include passive range of motion.

37 K. TRANSFERS

38 1. INCLUSIONS:

39 Assistance with transfers is considered unskilled only when the client has sufficient
40 balance and strength to assist with the transfer to some extent. Except for Hoyer lifts,

1 adaptive equipment may be used in transfers, provided that the client is fully trained in
 2 the use of the equipment and can direct the transfer step by step. Adaptive equipment
 3 may include, but is not limited to, gait belts, wheel chairs, tub seats, grab bars.

4 2. EXCLUSIONS:

5 Assistance with transfers is considered skilled when the client is unable to assist with the
 6 transfer. Use of Hoyer lifts is considered skilled, and use of other adaptive equipment is
 7 considered skilled if the client is still being trained in the use of the equipment.

8 L. POSITIONING

9 1. INCLUSIONS:

10 Positioning is considered unskilled only when the client is able to identify to the personal
 11 care staff, verbally, non-verbally or through others, when the position needs to be
 12 changed; and only when skilled skin care, as described under EXCLUSIONS, is not
 13 required in conjunction with the positioning. Positioning may include simple alignment in a
 14 bed, wheelchair, or other furniture.

15 2. EXCLUSIONS:

16 Positioning is considered skilled when the client is not able to identify to the caregiver
 17 when the position needs to be changed, and when skilled skin care, as described under
 18 EXCLUSIONS for skin care ~~at 8.4 at 10 CCR 2505-10 section 8.10 CCR 2505-10 section~~
 19 ~~8.489.31.B.2~~ is required in conjunction with the positioning.

20 M. BLADDER CARE

21 1. INCLUSIONS:

22 Bladder care is considered unskilled only when skilled transfer or skilled skin care, as
 23 described under EXCLUSIONS, is not required in conjunction with the bladder care.
 24 Unskilled bladder care may include assisting the client to and from the bathroom;
 25 assistance with ~~bed pans~~bedpans, urinals, and commodes; and changing of clothing and
 26 pads of any kind used for the care of incontinence. Emptying of ~~foley~~Foley catheter bags
 27 or suprapubic catheter bags is considered unskilled only if there is no disruption of the
 28 closed system; the personal care staff must be trained to understand what constitutes
 29 disruption of the closed system.

30 2. EXCLUSIONS:

31 Bladder care is considered skilled whenever it involves disruption of the closed system
 32 for a foley or suprapubic catheter, such as changing from a leg bag to a night bag. Care
 33 of external catheters is also considered skilled.

34 N. BOWEL CARE

35 1. INCLUSIONS:

36
 37 Bowel care is considered unskilled only when skilled transfer or skilled skincare, as
 38 described under EXCLUSIONS, is not required in conjunction with the bowel care.

1 Unskilled bowel care may include assisting the client to and from the bathroom;
 2 assistance with bed pans and commodes; and changing of clothing and pads of any kind
 3 used for the care of incontinence. Emptying of ostomy bags and assistance with other
 4 client-directed ostomy care is unskilled only when there is no need for skilled skin care or
 5 for observation and reporting to a nurse.

6 2. EXCLUSIONS:

7 Bowel care is considered skilled when skilled transfer or skilled skin care, as described
 8 under EXCLUSIONS for transfers ~~at 8.4 at 10 CCR 2505-10 section 8.10 CCR 2505-10~~
 9 ~~section 8.489.31, K-2,~~ or EXCLUSIONS for skin care ~~at 8.4 at 10 CCR 2505-10 section~~
 10 ~~8.10 CCR 2505-10 section 8.489.31, L-B-2,~~ is required in conjunction with the bowel
 11 care. Skilled bowel care includes digital stimulation and enemas. Skilled bowel care may
 12 include care of ostomies that are new and care of ostomies when the client is unable to
 13 self-direct the care, provided that sterile technique is not required.

14 O. MEDICATION REMINDING

15 1. INCLUSIONS:

16 Medication reminding is allowed as unskilled personal care only when medications have
 17 been preselected, by the client, a family member, a nurse, or a pharmacist, and are
 18 stored in containers other than the prescription bottles, such as medication minders.
 19 Medication minder containers must be clearly marked as to day and time of dosage, and
 20 must be kept in such a way as to prevent tampering. Medication reminding includes only
 21 inquiries as to whether medications were taken, verbal prompting to take medications,
 22 handing the appropriately marked medication minder container to the client, and opening
 23 the appropriately marked medication minder container for the client if the client is
 24 physically unable to open the container. Medication reminding does not include taking the
 25 medication out of the container. These limitations apply to all prescription and all over the
 26 counter medications, including pm medications. Any irregularities noted in the
 27 preselected medications, such as medications taken too often or not often enough, or not
 28 at the correct time as marked on the medication minder container, shall be immediately
 29 reported by the personal care staff to a supervisor.

30 2. EXCLUSIONS:

31 Medication assistance is considered skilled care and consists of putting the medication in
 32 the client's hand when the client can self-direct in the taking of medications.

33 P. RESPIRATORY CARE

34 1. INCLUSIONS:

35 Respiratory care is not considered unskilled. However, personal care staff may clean or
 36 change the tubing for oxygen equipment, may fill the distilled water reservoir, and may
 37 temporarily remove and replace the cannula or mask from the client's face for purposes
 38 of shaving or washing the client's face. Adjustments of the oxygen flow are not allowed.

39 2. EXCLUSIONS:

40 Respiratory care is skilled care, and includes postural drainage, cupping, adjusting
 41 oxygen flow within established parameters, and suctioning of mouth and nose.

1 Q. ACCOMPANYING

2 1. INCLUSIONS:

3 Accompanying the client to medical appointments, banking errands, basic household
4 errands, clothes shopping, and grocery shopping to the extent necessary and as
5 specified on the care plan is considered unskilled, when all the care that is provided by
6 the personal care staff in relation to the trip is unskilled personal care, as described in
7 these regulations. Accompanying the client to other services is also permissible as
8 specified on the care plan, to the extent of time that the client would otherwise receive
9 personal care services in the home.

10 Personal care for the purpose of accompanying the client shall only be authorized when a
11 personal care provider is needed during the trip to provide one or more other unskilled
12 personal care services listed in this Section. Accompanying the client primarily to provide
13 companionship is not a covered benefit.

14 2. EXCLUSIONS:

15 Accompanying is considered skilled when any of the tasks performed in conjunction with
16 the accompanying are skilled tasks. Accompanying does not include transporting the
17 client.

18 R. HOMEMAKING

19 Homemaking, as described at ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10 10~~
20 ~~CCR 2505-10 section 8.490, HOMEMAKER SERVICES,~~ may be provided by personal
21 care staff, if provided during the same visit as unskilled personal care, as described in
22 these regulations.

23 S. PROTECTIVE OVERSIGHT

24 1. INCLUSIONS:

25 Protective oversight is considered unskilled when the client requires stand-by assistance
26 with any of the unskilled personal care described in these regulations, or when the client
27 must be supervised at all times to prevent wandering.

28 2. EXCLUSIONS:

29 Protective oversight for standby assistance with personal care tasks is considered skilled
30 if any of the tasks performed are skilled tasks. Protective oversight to prevent wandering
31 is considered skilled if any skilled personal care tasks are performed while providing
32 oversight.

33 .32 Personal care services as described above may be used to provide respite care for primary care
34 givers, provided that the respite care does not duplicate any care which the primary caregiver
35 may be receiving payment to provide.

36 **8.489.40 CERTIFICATION STANDARDS FOR PERSONAL CARE SERVICES**

37 .41 Personal care provider agencies shall conform to all general certification standards and
38 procedures at ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10 10 CCR 2505-10 section~~

- 1 [8.487](#), HCBS-EBD PROVIDER AGENCIES, and shall meet all the additional personal care
2 certification requirements in this section.
- 3 .42 Personal care provider agencies shall assure and document that all personal care staff have
4 received at least twenty hours of training, or have passed a skills validation test, in the provision
5 of unskilled personal care as described above. Training, or skills validation, shall include the
6 areas of bathing, skin care, hair care, nail care, mouth care, shaving, dressing, feeding,
7 assistance with ambulation, exercises and transfers, positioning, bladder care, bowel care,
8 medication reminding, homemaking, and protective oversight. Training shall also include
9 instruction in basic first aid, and training in infection control techniques, including universal
10 precautions. Training or skills validation shall be completed prior to service delivery, except for
11 components of training that may be provided in the client's home, in the presence of the
12 supervisor.
- 13 .43 All employees providing personal care shall be supervised by a person who, at a minimum, has
14 received the training, or passed the skills validation test, required of personal care staff, as
15 specified above. Supervision shall include, but not be limited to, the following activities:
- 16 A. Orientation of staff to agency policies and procedures.
- 17 B. Arrangement and documentation of training.
- 18 C. Informing staff of policies concerning advance directives and emergency procedures.
- 19 D. Oversight of scheduling, and notification to clients of changes; or close communication
20 with scheduling staff.
- 21 E. Written assignment of duties on a client-specific basis.
- 22 F. Meetings and conferences with staff as necessary.
- 23 G. Supervisory visits to client's homes at least every three months, or more often as
24 necessary, for problem resolution, skills validation of staff, client-specific or procedure-
25 specific training of staff, observation of client's condition and care, and assessment of
26 client's satisfaction with services. At least one of the assigned personal care staff must be
27 present at supervisory visits at least once every three months.
- 28 H. Investigation of complaints and critical incidents.
- 29 I. Counseling with staff on difficult cases, and potentially dangerous situations.
- 30 J. Communication with the case managers, the physician, and other providers on the care
31 plan, as necessary to assure appropriate and effective care.
- 32 K. Oversight of ~~record-keeping~~record keeping by staff.
- 33 .44 A personal care agency may be denied or terminated from participation in Colorado Medicaid,
34 according to procedures found at ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR~~
35 ~~2505-10 sections 8.050 through 8.051.44~~, based on good cause, as defined at ~~10 CCR 2505-10~~
36 ~~section section~~-8.051.01. Good cause for denial or termination of a personal care agency shall
37 include, but not be limited to, the following:

- 1 A. Improper Billing Practices: Any personal care/homemaker agency that is found to have
2 engaged in the following practices may be denied or terminated from participation in
3 Colorado Medicaid:
- 4
- 5 1. Billing for visits without documentation to support the claims billed. Acceptable
6 documentation for each visit billed shall include the nature and extent of services,
7 the care provider's signature, the month, day, year, and the exact time in and
8 time out of the client's home, as well as time of departure and time of arrival for
9 all travel time billed. Providers shall submit or produce requested documentation
10 in accordance with rules at [10 CCR 2505-10 section 8.079.62](#).
- 11 2. Billing for excessive hours that are not justified by the documentation of services
12 provided, or by the client's medical or functional condition. This includes billing all
13 units prior authorized when the allowed and needed services do not require as
14 such time as that authorized.
- 15 3. Billing for time spent by the personal care provider performing any tasks that are
16 not allowed according to regulations in this [SECTION 8-10 CCR 2505-10](#)
17 [SECTION 8-10 CCR 2505-10-10 CCR 2505-10 SECTION 8.489](#). This
18 includes but is not limited to companionship, financial management, transporting
19 of clients, skilled personal care, or delegated nursing tasks.
- 20 4. Unbundling of home health aide and personal care or homemaker services,
21 which is defined as any and all of the following practices by any personal
22 care/homemaker agency that is also certified as a Medicaid Home Health
23 Agency, for all time periods during which regulations were in effect that defined
24 the unit for home health aide services as one visit up to a maximum of two and
25 one-half hours:
- 26 a. One employee makes one visit, and the agency bills Medicaid for one
27 home health aide visit, and bills all the hours as HCBS personal care or
28 homemaker.
- 29 b. One employee makes one visit, and the agency bills for one home health
30 aide visit, and bills some of the hours as HCBS personal care or
31 homemaker, when the total time spent on the visit does not equal at least
32 2 1/2 hours plus the number of hours billed for personal care and
33 homemaker.
- 34 c. Two employees make contiguous visits, and the agency bills one visit as
35 home health aide and the other as personal care or homemaker, when
36 the time spent on the home health aide visit was less than 2 1/2 hours.
- 37 d. One or more employees make two or more visits at different times on the
38 same day, and the agency bills one or more visits as home health aide
39 and one or more visits as personal care or homemaker, when any of the
40 aide visits were less than 2 1/2 hours and there is no reason related, to
41 the client's medical condition or needs that required the home health aide
42 and personal care or homemaker visits to be scheduled at different times
43 of the day.

- 1 e. One or more employees make two or more visits on different days of the
 2 week, and the agency bills one or more visits as home health aide and
 3 one or more visits as personal care or homemaker, when any of the aide
 4 visits were less than 2 1/2 hours and there is no reason related to the
 5 client's medical condition or needs that required the home health aide
 6 and personal care or homemaker visits to be scheduled on different days
 7 of the week.
- 8 f. Any other practices that circumvent these rules and result in excess
 9 Medicaid payment through unbundling of home health aide and personal
 10 care or homemaker services.
- 11 5. For all time periods during which the unit of reimbursement for home health aide
 12 is defined as hour and/or half-hour increments, all the practices described in 4
 13 above shall constitute unbundling if the home health aide does not stay for the
 14 maximum amount of time for each unit billed.
- 15 B. Refusal to Provide Necessary and Allowed Personal Care or Homemaker Services
 16 Without Also Receiving Payment For Home Health Services. A personal
 17 care/homemaker agency that is also certified as a Medicaid Home Health Agency may be
 18 terminated from Medicaid participation if the agency refuses to provide necessary and
 19 allowed HCBS personal care or homemaker services to clients who do not need Home
 20 Health services or who receive their Home Health services from a Home Health Agency
 21 not affiliated with the personal care/homemaker agency.
- 22 C. Prior Termination From Medicaid Participation. A personal care/homemaker agency shall
 23 be denied or terminated from Medicaid participation if the agency or its owner(s) have
 24 previously been involuntarily terminated from Medicaid participation as a personal
 25 care/homemaker agency or any other type of service provider.
- 26 D. Abrupt Prior Closure. A personal care/homemaker agency may be denied or terminated
 27 from Medicaid participation if the agency or its owner(s) have abruptly closed, as any
 28 type of Medicaid provider, without proper prior client notification.
- 29 .45 Any Medicaid overpayments to a provider for services that should not have been billed shall be
 30 subject to recovery. Overpayments that are made as a result of a provider's false representation
 31 shall be subject to recovery plus civil monetary penalties and interest. False representation
 32 means an inaccurate statement that is relevant to a claim which is made by a provider who has
 33 actual knowledge of the false nature of the statement, or who acts in deliberate ignorance or with
 34 reckless disregard for truth. A provider acts with reckless disregard for truth if the provider fails to
 35 maintain records required by the department or if the provider fails to become familiar with rules,
 36 manuals, and bulletins issued by the State, the Medical Services Board, or the State's fiscal
 37 agent.
- 38 .46 When a personal care agency voluntarily discloses improper billing, and makes restitution, the
 39 State shall consider deferment of interest and penalties in the context of the particular situation.

40 **8.489.50 REIMBURSEMENT**

- 41 .51 Payment for personal care services shall be the lower of the billed charges or the maximum rate
 42 of reimbursement. Reimbursement shall be per unit of one hour. The maximum unit rate shall be
 43 adjusted by the State as funding becomes available.

- 1 .52 Payment may include travel time to and from the client's residence, to be billed at the same unit
 2 rate as personal care services. The time billed for travel shall be listed separately from, but
 3 documented on the same form as, the time for service provision on each visit. Travel time must
 4 be summed over a period of at least a week and then rounded to the nearest hour for billing
 5 purposes. Travel time to one client's residence may not also be billed as travel time from another
 6 clients residence, as this would represent duplicate billing for the same ~~time~~time period.
- 7 .53 When personal care services are used to provide respite for unpaid primary care givers, the exact
 8 services rendered must be specified in the documentation.
- 9 .54 when an employee of a personal care agency provides services to a client who is a relative, the
 10 personal care agency shall bill under a special procedure code, in hourly units, using rates and
 11 hours which shall not exceed a total cost to Medicaid of more than \$13.00 per day, when
 12 averaged out over the number of days in the plan period.
- 13 .55 If a visit by a personal care staff includes some homemaker services, as defined at ~~Section 8.10~~
 14 ~~CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.490.~~ **HOMEMAKER**
 15 **SERVICES**, the entire visit shall be billed as personal care services. If the visit includes only
 16 homemaker services, and no personal care is provided, the entire visit shall be billed as
 17 homemaker services.
- 18 .56 If a visit by a Home Health Aide from a Home Health Agency includes unskilled personal care, as
 19 defined in this section, only the Home Health Aide visit shall be billed.
- 20 .57 Effective 2/1/99, there shall be no reimbursement under this section for personal care services
 21 provided in uncertified congregate facilities. Case managers may submit a written request to the
 22 Department for a waiver not to exceed six months for clients receiving these services in
 23 uncertified congregate facilities prior to the effective date of this rule. After that time, services
 24 shall be discontinued.
- 25 .58 Cost Reporting
- 26 A. All personal care agencies shall report and submit to the Department cost report
 27 information on a Department prescribed form.
- 28 B. By dates set forth by the Department, personal care providers shall submit an annual
 29 cost report for the provider agency's most recent complete fiscal year or the State fiscal
 30 year.
- 31 C. Providers that do not comply with ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10~~
 32 ~~10 CCR 2505-10 section 8.489.58~~ shall have their Medicaid provider agreement
 33 terminated.

34 **8.490 HOMEMAKER SERVICES**

35 **8.490.1 DEFINITIONS**

36 Homemaker Provider Agency means a provider agency that is certified by the state fiscal agent to provide
 37 Homemaker Services.

38 Homemaker Services means general household activities provided in the home of an eligible client
 39 provided by a Homemaker Provider Agency to maintain a healthy and safe home environment for a client,
 40 when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

1 **8.490.2 ELIGIBLE CLIENTS**

2 8.490.2.A. Homemaker Services are available to clients in the Home and Community Based
3 Services waivers for Elderly, Blind and Disabled, ~~Persons Living with Aids~~ and Persons with
4 Mental Illness.

5 8.490.2.B. Homemaker Services are available to clients in the Home and Community Based
6 Services waiver for Persons with Brain Injury when the client is also receiving personal care
7 services.

8 **8.490.3 BENEFITS**

9 8.490.3.A. Covered benefits shall be for the benefit of the client and not for the benefit of other
10 persons living in the home. Services shall be applied only to the permanent living space of the
11 client.

12 8.490.3.B. Benefits include:

- 13 1. Routine light housecleaning, such as dusting, vacuuming, mopping, and cleaning
14 bathroom and kitchen areas.
- 15 2. Meal preparation.
- 16 3. Dishwashing.
- 17 4. Bedmaking.
- 18 5. Laundry.
- 19 6. Shopping.
- 20 7. Teaching the skills listed above to clients who are capable of learning to do such tasks for
21 themselves. Teaching shall result in a decrease of weekly units required within ninety
22 days. If such a savings in service units is not realized, teaching shall be deleted from the
23 care plan.

24 8.490.3.C. Benefits do not include:

- 25 1. Personal care services.
- 26 2. Services the person can perform independently.
- 27 3. Homemaker services provided by family members per ~~10 C.C.R. CCR 2505-10,~~
28 ~~Section 2505-10 section 8.10 CCR 2505-10 section 8.485.200.F~~

29 8.490.3.D. Homemakers Services provided in uncertified congregate facilities are not a benefit.

30 **8.490.4 HOMEMAKER PROVIDER AGENCY RESPONSIBILITIES**

31 8.490.4.A. All providers shall be certified by the Department as a Homemaker Provider Agency.

32 8.490.4.B. The Homemaker Provider Agency shall conform to all general certification standards and
33 procedures at ~~10 C.C.R. CCR 2505-10, Section 2505-10 section 8.10 CCR 2505-10 section 8.487~~

1 8.490.4.C. The Homemaker Provider Agency shall assure and document that all staff receive at
 2 least eight hours of training or have passed a skills validation test prior to providing unsupervised
 3 homemaker services. Training or skills validation shall include:

- 4 1. The areas detailed in ~~Section 8.10 CCR 2505-10~~ ~~section 8.10 CCR 2505-10-10 CCR~~
 5 ~~2505-10~~ section 8.490.3.B.
- 6 2. Proper food handling and storage techniques.
- 7 3. Basic infection control techniques including universal precautions.
- 8 4. Informing staff of policies concerning emergency procedures.

9 8.490.4.D. All Homemaker Provider Agency staff shall be supervised by a person who, at a
 10 minimum, has received training or passed the skills validation test required of homemakers, as
 11 specified above. Supervision shall include, but not be limited to, the following activities:

- 12 1. Train staff on agency policies and procedures.
- 13 2. Arrange and document training.
- 14 3. Oversee scheduling and notify clients of schedule changes.
- 15 4. Conduct supervisory visits to client's homes at least every three months or more often as
 16 necessary for problem resolution, staff skills validation, observation of the home's
 17 condition and assessment of client's satisfaction with services.
- 18 5. Investigate complaints and critical incidents.

19 **8.490.5 REIMBURSEMENT**

20 8.490.5.A. Payment for Homemaker Services shall be the lower of the billed charges or the
 21 maximum rate of reimbursement set by the Department. Reimbursement shall be per unit of 15
 22 minutes.

23 8.490.5.B. Payment may include travel time to and from the client's residence, to be billed at the
 24 same unit rate as Homemaker Services. The time billed for travel shall be listed separately from,
 25 but documented on the same form as the actual service provided. Travel time shall be totaled
 26 over a period of at least a week and rounded to the nearest 15 minutes for billing purposes.
 27 Travel time to one client's residence shall not be billed as travel time from another client's
 28 residence.

29 8.490.5.C. If a visit by a home health aide from a home health agency includes Homemaker
 30 Services, only the home health aide visit shall be billed.

31 8.490.5.D. If a visit by a personal care provider from a personal care provider agency includes
 32 Homemaker Services, the Homemaker Services shall be billed separately from the personal care
 33 services.

34 8.490.5.E. Each visit shall be billed to the Medicaid fiscal agent with the following documentation to
 35 be retained at the provider agency

- 36 1. The nature and extent of services.

2. The provider's signature.
3. The date and time of arrival and departure from a client's home.
4. The date and time of arrival and departure time for travel.

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 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.130~~ and ~~Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 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 ~~more 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 ~~mat that~~ assist in the development of self-care capabilities, personal hygiene, and social support services.

- 1 D. Nutrition services including therapeutic diets and snacks appropriate to the participant's
2 care plan and hours in which the participant is served
- 3 E. Daily services provided to monitor the participant's health status, supervise medications,
4 and carry out physicians' orders in participant's care plan as needed.
- 5 F. Social and recreational services as prescribed to meet the participant's needs and as
6 documented in the participant's care plan. Participants have the right to choose not to
7 participate in social and recreational activities.
- 8 G. Adult day services centers certified on or after July 1, 1996, or upon change of
9 ownership, shall provide basic personal care services including bathing in emergency
10 situations.
- 11
- 12
- 13 H. Any additional services such as physical therapy, occupational therapy and speech
14 therapy, if such services are prescribed by the participant's physician, documented in the
15 participant's care plan and if such services are not being provided in the participant's
16 home. Such services must be included in the budget submitted to the State in
17 accordance with ~~the section on REIMBURSEMENT METHOD FOR ADULT DAY~~
18 ~~SERVICES~~ 10 CCR 2505-10 section 8.491.30, and determined by the State to be
19 necessary for adult day services.

20 **8.491.15 DEFINITIONS**

- 21 A. Director means any person who owns and operates an ADS center, or is a managing
22 employee with delegated authority by ownership to manage, control, or perform the day-
23 to-day tasks of operating the facility as described in ~~section 8.10 CCR 2505-10 section~~
24 ~~8.10 CCR 2505-10-10 CCR 2505-10 section 8.495.C.22~~.
- 25 B. Participant means any individual found to be eligible for adult day services regardless of
26 payment source.
- 27 C. Restraint means any physical or chemical device, application of force, or medication,
28 which is designed or used for the purpose of modifying, altering, or controlling behavior
29 for the convenience of the facility, excluding medication prescribed by a physician as part
30 of an ongoing treatment plan or pursuant to a diagnosis.
- 31 D. Staff means a paid or voluntary employee of the facility.
- 32 E. Universal Precautions refers to a system of infection control which assumes that every
33 direct contact with body fluids is potentially infectious. This includes any reasonably
34 anticipated skin, eye, mucous membrane or contact with blood-tinged body fluids, or
35 other potentially infectious material

36 **8.491.20 CERTIFICATION STANDARDS**

37 All ADS centers shall conform to all of the following State established standards:

- 38 A. General

1. Conforms to all established State standards in the section on general provider participation requirements, as defined in [Section 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 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 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 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 ~~me the~~ participants being served. Centers certified on or after July 1, 1996, shall provide a minimum of 40 sq. feet per participants
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 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.491.15-C](#) of these rules.

1 13. ADS Centers, in accordance with [10 CCR 2505-10 section](#) 8.491.14 above, must
2 provide a safe environment for all participants, including participants exhibiting
3 behavioral problems, wandering behavior, or limitations in mental/cognitive
4 functioning.

5 C. Records and Information

6 ADS providers shall keep such records and information necessary to document the
7 services provided to participants receiving adult day services. Records shall include but
8 not be limited to:

- 9 1. a. Name, address, sex, and age of each participant
10 b. Name, address and telephone number of responsible party,
11 c. Name, address and telephone number of primary physician
12 d. Documentation of the supervision and monitoring of the services
13 provided,
14 e. Documentation that all participants were oriented to the center, the
15 policies, and procedures relevant to the facility and the services
16 provided.
17 f. A services agreement signed by the participant and/or his or her
18 designated representative and appropriate center staff.
19 g. A plan of care. Plans of care for participants from other payment
20 sources, receiving supportive services in a specialized ADS center must
21 include a primary diagnosis and a physician's signature.
- 22 2. Medical Information included in the plan of care:
- 23 a. Medications the client participant is taking and whether they are being
24 self-administered.
25 b. Special dietary needs, if any.
26 c. Any restrictions on social and/or recreational activities identified by
27 physician in the care plan.
28 d. Documentation of any nursing or medical inter-ventions; physical,
29 speech, and/or occupational therapy administered to participants whose
30 physician has prescribed such services to be included in the participant's
31 individual plan of care.
32 e. Any other special health or behavioral management needs.
- 33 3. Documentation that the participant and/or other responsible party was provided
34 with written information about his/her rights under state law regarding advance
35 directives in accordance with regulations at [10 CCR 2505-10 section](#) 8.130.65.
36 Documentation as to whether the participant has executed an advance directive
37 shall be kept in his/her case record.

1 4. All entries into the record shall be legible, written in ink, dated, and signed with
2 name and title designation.

3 5. Records shall be maintained in such a manner as to ensure safety and
4 confidentiality

5 D. Staffing Requirements

6 1. All ADS centers must maintain a staff to participant ratio of 1:8 or lower to
7 provide for the needs of the population served, as described above ~~at 8.4 at 10~~
8 ~~CGR 2505-10 section 8.10 CGR 2505-10 section 8.491.12 and .13~~, and shall
9 provide the following:

10 a. Supervision of participants at all times during the operating hours of the
11 program;

12 b. Immediate response to emergency situations to assure the welfare of
13 participants;

14 c. Prescribed recreational and social activities;

15 d. Nursing services for regular monitoring of the on-going medical needs of
16 participants and the supervision of medications. These services must be
17 available a minimum of two hours daily and must be provided by an RN
18 or LPN. CNAs may provide these services under the direction of a RN or
19 an LPN. Supervision of CNAs must include consultation and oversight on
20 a weekly basis or more according to the participant's needs.

21 e. Administrative, recreational, social and supportive functions of the ADS
22 center.

23 2. In addition to the above services, specialized adult day care services (SADS)
24 centers providing a restorative model of care shall have sufficient staff to provide
25 the following:

26 a. Nursing services during all hours of operation. Nursing services must be
27 provided by a licensed RN or LPN or by a CNA under the supervision of
28 an RN or LPN, as per ~~10 CGR 2505-10 section~~ 8.491.20-D.1.d, above.

29 b. Therapies, if included in the center's budget and as prescribed by the
30 participant's physician, to meet the restorative needs of the client
31 participant

32 E. Training Requirements

33 1. ADS centers providing medication administration as a service must have
34 qualified persons on their staff who have been trained in accordance with ~~State~~
35 ~~Law, Chapter XXIV, Section 25-1-107(1)(ee)(I)(A) Qualified Medication~~
36 ~~Administration Staff Members C.R.S. section 25-1-107(1)(ee)(I)(A) 25-1.5-~~
37 ~~302 ITE~~. [QK13][JM14]

38 2. All staff must be trained in the use of universal precautions as defined at ~~Section~~
39 ~~8.10 CGR 2505-10 section 8.10 CGR 2505-10-10 CGR 2505-10 section~~

1 8.491.15 E. Facilities certified prior to the effective date of these rules shall have
2 sixty (60) days to satisfy this training requirement

3 3. The operator and staff must have training specific to the needs of the populations
4 served, e.g., elderly, blind and disabled, and as defined in Section 8.10 CCR
5 2505-10 section 8.10 CCR 2505-10 10 CCR 2505-10 section 8.491.13 of these
6 rules.

7 4. All staff and volunteers must be trained in the handling of emergencies including
8 written procedures to meet medical crises.

9 5. All required training must be documented in employees' personnel files.

10 F. Written Policies

11 The ADS center shall have a written policy relevant to its operation. Such policy shall
12 include, but not be limited to, statements describing:

13 1. Admission criteria ~~mat qualify~~that qualify participants to be appropriately
14 served the center;

15 2. Interview procedure conducted for qualified participants and/or family
16 member prior to admission to the center,

17 3. The meals and nourishments including special diets that will be provided;

18 4. The hours that the participants will be served in the center and days of
19 the week services will be available;

20 5. Medication administration;

21 6. The personal items that the participants may bring with them to the
22 center, and

23 7. A written, signed agreement drawn up between the participant or
24 responsible party and the center outlining rules and responsibilities of the
25 center and of the participant ~~Each each party to me agreement~~party to
26 the agreement shall be provided a copy.

27 **8.491.30 REIMBURSEMENT METHOD FOR ADULT DAY SERVICES**

28 .31 Reimbursement for ADS services shall be based upon a single all-inclusive payment rate per unit
29 of service for each participating provider which shall be prospectively determined A unit is defined
30 as:

31 one (1) unit = a partial day = three (3) to five (5) hours of service

32 two (2) units = a full day = more than five (5) hours of service

33 **8.491.32 The ADS center's rate of reimbursement shall be the lower of:**

34 A. The maximum allowable applicable Medicaid rate for either

1 TRANSPORTATION below, and receiving reimbursement for transportation of ADS
2 participants.

3 B. There shall be no reimbursement for ADS provided to any participant who is a resident of
4 any residential care facility, except for services as defined at [Section 8.10 CCR 2505-10](#)
5 [section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.491.14.H](#).

6 C. There shall be no reimbursement for overnight services in an ADS.

7 **8.492 RESPITE CARE**

8 **8.492.10 DEFINITIONS**

9 .11 Respite care means services provided to an eligible client on a short-term basis because of the
10 absence or need for relief of those persons normally providing the care.

11 .12 Respite care provider means a Class I nursing facility, an alternative care facility or an employee
12 of a certified personal care agency which meets the certification standards for respite care
13 specified below.

14 **8.492.20 INCLUSIONS**

15 .21 A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a
16 nursing facility which are required by the individual respite client, as ordered by the physician.

17 .22 An alternative care facility shall provide all the alternative care facility services as listed at [Section](#)
18 [8.10 CCR 2505-10 section 8.10 CCR 2505-10 10 CCR 2505-10 section 8.495](#), ~~ALTERNATIVE~~
19 ~~CARE FACILITIES~~, which are required by the individual respite client.

20 **8.492.30 RESTRICTIONS**

21 .31 An individual client shall be authorized for no more than thirty (30) days of respite care in each
22 calendar year.

23 .32 Alternative care facilities shall not admit individuals for respite care who are not appropriate for
24 alternative care facility placement, as specified at [Section 8.10 CCR 2505-10 section 8.10 CCR](#)
25 [2505-10-10 CCR 2505-10 section 8.495](#), ~~ALTERNATIVE CARE FACILITIES~~.

26 .33 Only those portions of the facility that are Medicaid certified for nursing facility or alternative care
27 facility services may be utilized for respite clients.

28 **8.492.40 CERTIFICATION STANDARDS AND PROCEDURES**

29 .41 Respite care standards and procedures for nursing facilities are as follows:

30 A. The nursing facility must have a valid contract with the State as a Medicaid certified
31 nursing facility. Such contract shall constitute automatic certification for respite care. A
32 respite care provider billing number shall automatically be issued to all certified nursing
33 facilities.

34 B. The nursing facility does not have to maintain or hold open separately designated beds
35 for respite clients, but may accept respite clients on a bed available basis.

- 1 C. For each HCBS-EBD respite client, the nursing facility must provide an initial nursing
2 assessment, which will serve as the plan of care, must obtain physician treatment orders
3 and diet orders; and must have a chart for the client. The chart must identify the client as
4 a respite client. If the respite stay is for fourteen (14) days or longer, the MDS must be
5 completed.
- 6 D. An admission to a nursing facility under HCBS-EBD respite does not require a new
7 ULTC-100.2, a [PASARRPASRR](#) review, an AP-5615 form, a physical, a dietitian
8 assessment, a therapy assessment, or labwork as required on an ordinary nursing facility
9 admission. The MDS does not have to be completed if the respite stay is shorter than
10 fourteen (14) days.
- 11 E. The nursing facility shall have written policies and procedures available to staff regarding
12 respite care clients. Such policies could include copies of these respite rules, the facility's
13 policy regarding self administration of medication, and any other policies and procedures
14 which may be useful to the staff in handling respite care clients.
- 15 F. The nursing facility should obtain a copy of the ULTC-100.2 and the approved Prior
16 Authorization Request (PAR) form from the case manager prior to the respite client's
17 entry into the facility.
- 18 .42 Respite care standards and procedures for alternative care facilities are as follows:
- 19 A. The alternative care facility shall have a valid contract with the Department as a Medicaid
20 certified HCBS-EBD alternative care facility provider. Such contract shall constitute
21 automatic certification for HCBS-EBD respite care.
- 22 B. For each respite care client, the alternative care facility shall follow normal procedures for
23 care planning and documentation of services rendered.
- 24 .43 Individual respite care providers shall be employees of certified personal care agencies. Family
25 members providing respite services shall meet the same competency standards as all other
26 providers and be employed by the certified provider agency.

27 **8.492.50 REIMBURSEMENT**

- 28 .51 Respite care reimbursement to nursing facilities shall be as follows:
- 29 A. The nursing facility shall bill using the facility's assigned respite provider number, and on
30 the HCBS-EBD claim form according to fiscal agent instructions.
- 31
- 32 B. The unit of reimbursement shall be a unit of one day. The day of admission and the day
33 of discharge may both be reimbursed as full days, provided that there was at least one
34 full twenty-four hour day of respite provided by the nursing facility between the date of
35 admission and the date of discharge. There shall be no other payment for partial days.
- 36 C. Reimbursement shall be the lower of billed charges or the average weighted rate for
37 administrative and health care for Class I nursing facilities in effect on July 1 of each
38 year.
- 39 .52 Respite care reimbursement to alternative care facilities shall be as follows:

- 1 A. The alternative care facility shall bill using the alternative care facility provider number, on
2 the HCBS-EBD claim form according to fiscal agent instructions.
- 3 B. The unit of reimbursement shall be a unit of one day. The day of admission and the day
4 of discharge may both be reimbursed as full days, provided that there was at least one
5 full twenty-four hour day of respite provided by the alternative care facility between the
6 date of admission and the date of discharge. There shall be no other payment for partial
7 days.
- 8 C. Reimbursement shall be the lower of billed charges; or the maximum Medicaid rate for
9 alternative care services, plus the standard alternative care facility room and board
10 amount prorated for the number of days of respite.
- 11 .53 Individual respite providers shall bill according to an hourly rate or daily institutional rate,
12 whichever is less.
- 13 .54 The respite care provider shall provide all the respite care that is needed, and other HCBS-EBD
14 services shall not be reimbursed during the respite stay.
- 15 .55 Effective 2/1/99, there shall be no reimbursement provided under this section for respite care in
16 uncertified congregate facilities.

17 **8.493 HOME MODIFICATION**

18 **8.493.1 DEFINITIONS**

19 Eligible Client means a client who is enrolled in a Home and Community-Based Services (HCBS) waiver
20 for Persons with Brain Injury, Persons with Major Mental Illness or Persons who are Elderly, Blind and
21 Disabled.

22 Home Modification means specific modifications, adaptations or improvements in an Eligible Client's
23 existing home setting which, based on the client's medical condition:

- 24 1. Are necessary to ensure the health, welfare and safety of the client, and
- 25 2. Enable the client to function with greater independence in the home, and
- 26 3. Are required because of the client's illness, impairment or disability, as documented on
27 the ULTC-100.2 form and the care plan; and
- 28 4. Prevents institutionalization of the client.

29 Home Modification Provider means a provider agency that has met all the standards for Home
30 Modification described in ~~10 C.C.R. CCR 2505-10, Section 2505-10 section 8.10~~ CCR 2505-10 section
31 8.493.5.B and is an enrolled Medicaid provider.

32 **8.493.2 BENEFITS**

- 33 8.493.2.A. Home Modifications, adaptations or improvements may include but are not limited to the
34 following:
- 35 1. Installing or building ramps.

- 1 2. Installing grab-bars and installing other durable medical equipment as part of a larger
2 Home Modification project.
- 3 3. Widening doorways.
- 4 4. Modifying bathrooms.
- 5 5. Modifying kitchen facilities.
- 6 6. Installing specialized electric and plumbing systems that are necessary to accommodate
7 medically necessary equipment and supplies.

8 **8.493.3 EXCEPTIONS AND RESTRICTIONS**

- 9 8.493.3.A. Modifications to an existing home that are not a direct medical or remedial benefit to the
10 client are not a benefit.
- 11 8.493.3.B. Duplicate adaptations, modifications or improvements and modifications as a part of new
12 construction costs are not a benefit.
- 13 8.493.3.C. The Department may deny requests for Home Modification projects that exceed usual
14 and customary charges or do not meet industry standards.
- 15 8.493.3.D. Home Modification projects are not a benefit in any type of certified or non-certified
16 congregate facility, as defined in 10 ~~C.C.R. CCR 2505-10, Section 2505-10 section~~ 8.485.50, F,
17 and G.
- 18 8.493.3.E. There shall be a lifetime cap of \$10,000.00 per client.
- 19 8.493.3.F. Volunteer work on a Home Modification project approved by the Department shall be
20 completed under the supervision of the Home Modification Provider as stated on the bid.

21 **8.493.4 SINGLE ENTRY POINT AGENCY RESPONSIBILITIES**

- 22 8.493.4.A. The SEP case manager shall consider alternative funding sources to complete the Home
23 Modification. These alternatives shall be documented in the case record.
- 24 8.493.4.B. The SEP case manager shall obtain prior approval by submitting a Prior Authorization
25 request form (PAR) to the Department for Home Modification projects estimated at between
26 \$1,000.00 and \$10,000.00.
- 27 8.493.4.C. The SEP case manager may approve Home Modification projects estimated at less than
28 \$1,000.00 without prior authorization.
- 29 8.493.4.D. The Department may conduct on-site visits or any other investigations deemed
30 necessary prior to approving or denying the Home Modification request.
- 31 8.493.4.E. Home Modifications estimated to cost \$1,000.00 or more shall be evaluated according to
32 the following procedures:
 - 33 1. An occupational therapist shall assess the client's needs and the therapeutic value of the
34 requested Home Modification. When an occupational therapist with experience in Home
35 Modification is not available, a Department-approved physical therapist or other qualified
36 individual may be substituted. A report specifying how the Home Modification would

1 contribute to a client's ability to remain in or return to his/her home, and how the Home
2 Modification would increase the individual's independence and decrease the need for
3 other services, shall be completed before bids are solicited. This evaluation shall be
4 submitted with the PAR.

5 2. The occupational therapist services may be provided by a home health agency and billed
6 to Medicaid Home Health consistent with Home Health rules set forth in ~~40 C.C.R. CCR~~
7 ~~2505-10, Section 2505-10 section 8.10 CCR 2505-10 section 8.520~~, including physician
8 orders and plans of care.

9 3. The SEP case manager and the occupational therapist shall consider less expensive
10 alternative methods of addressing the client's needs. The case manager shall document
11 these alternatives in the client's case file.

12 8.493.4.F. The SEP case manager shall follow a bid process according to the following procedures:

13 1. The SEP case manager shall solicit and receive bids from at least two Home Modification
14 Providers.

15 2. The bids shall include a breakdown of the costs of the project including:

16 a. Description of the work to be completed.

17 b. Estimate of the materials and labor needed to complete the project.

18 c. Estimate for building permits, if needed.

19 d. Estimated timeline for completing the project.

20 e. Name, address and telephone number of the Home Modification Provider.

21 f. Signature of the Home Modification Provider.

22 3. Home Modification Providers have a maximum of 30 days to submit a bid for the Home
23 Modification project after the SEP case manager has solicited the bid.

24 4. The SEP case manager shall submit copies of the bids and occupational therapist's
25 evaluation with the PAR to the Department. The Department shall authorize payment to
26 the lowest bidder.

27 5. The SEP case manager may request approval of bid that is not the lowest by submitting
28 a written justification or explanation to the Department with the PAR.

29 6. If the SEP case manager has made three attempts to obtain a written bid from Home
30 Modification Providers and the Home Modification Providers have not responded within
31 30 calendar days, the case manager may accept one bid. Documentation of the
32 contacts and an explanation of these attempts shall be attached to the PAR.

33 7. A revised PAR and bid request shall be submitted according to the procedures outlined in
34 this Section for any changes from the original approved PAR.

35 8. Home Modification projects shall be initiated within 60 days of signed approval from the
36 Department.

1 8.493.4.G. If a property to be modified is not owned by the client or the client's family, the SEP case
 2 manager shall obtain a letter from the owner of the property authorizing modifications to the
 3 property prior to initiation of the project and allowing the client to leave the modification in place if
 4 the property is vacated by the client.

5 **8.493.5 PROVIDER RESPONSIBILITIES**

6 8.493.5.A. Home Modification Providers shall conform to all general certification standards and
 7 procedures set forth in [10 C.C.R. CCR 2505-10, Section 2505-10 section 8-10 CCR 2505-10](#)
 8 [section 8.487.11](#).

9 8.493.5.B. Home Modification Providers shall be licensed in the city or county in which they propose
 10 to provide Home Modification services to perform the work proposed, if required by that city or
 11 county.

12 8.493.5.C. The Home Modification Provider shall provide a one-year written warranty on materials
 13 and labor from date of final inspection on all completed work.

14 8.493.5.D. The Home Modification Provider shall assure that the project complies
 15 with local and/or state building codes. In areas where there is no building authority, the
 16 Home Modification Provider shall assure that the project complies with the appropriate
 17 provisions of the 2003 edition of the International Residential Code and the accessibility
 18 provisions contained within the 2003 edition of the International Building Code. The
 19 Home Modification project shall also comply with the Colorado Plumbing Code as
 20 adopted by the Colorado Examining Board of Plumbers and the National Electrical Code
 21 as adopted by the Colorado Electrical Board, effective July 1, 2005. [The International](#)
 22 [Residential Code \(2003\), the accessibility provisions within the International Building](#)
 23 [Code \(2003\), and the Colorado Plumbing Code \(2005\) are hereby incorporated by](#)
 24 [reference. The incorporation of those materials exclude later amendments to, or editions](#)
 25 [of, the referenced material. Pursuant to C.R.S. section 24-4-103\(12.5\), the Department](#)
 26 [maintains copies of this incorporated text in its entirety, available for public inspection](#)
 27 [during regular business hours at: Colorado Department of Health Care Policy and](#)
 28 [Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated](#)
 29 [materials are provided at cost upon request.](#)

30 ~~No amendments or later editions are incorporated. Any material that has been incorporated by reference~~
 31 ~~in this rule may be examined at any state publications repository library. Copies of the 2003~~
 32 ~~International Building Code and copies of the rules and regulations of the State Electrical Board~~
 33 ~~and State Examining Board of Plumbers are available for inspection from: Custodian of Records,~~
 34 ~~Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado,~~
 35 ~~80203-1714.~~

36 8.493.5.E. All Home Modification projects shall be inspected and approved by a state, local or
 37 county building inspector or a licensed engineer, architect, contractor or any other person as
 38 designated by the Department.

39 8.493.5.F. Copies of building permits and inspection reports shall be submitted to the SEP case
 40 manager and all problems noted on inspections shall be corrected before the Home Modification
 41 Provider submits a final invoice for the payment. In the event that a permit is not required, the
 42 Home Modification Provider shall submit to the SEP case manager a signed statement indicating
 43 that a permit is not required.

44 **8.493.6 REIMBURSEMENT**

1 8.493.7 Payment for Home Modification services shall be the lower of the billed charges or the prior
2 authorized amount. Reimbursement shall be made in two payments per Home Modification.

3 8.493.7.A. The Home Modification Provider may submit a claim for an initial payment of no more
4 than fifty percent of the project cost for materials, permits and initial labor costs.

5 8.493.7.B. Final payment shall be made when the Home Modification project has been completed
6 and the SEP agency has in the client's file copies of:

7 1. Signed lien waivers for all labor and materials, including lien waivers from sub-
8 contractors.

9 2. Required permits.

10 3. One year written warranty on parts and labor.

11 4. Final inspection documentation verified by the SEP case manager and documented in
12 the client's file that the Home Modification has been completed through:

13 a. Contact with the building inspector or other inspector as referenced at [40](#)
14 [C.C.R.CCR 2505-10, Section 2505-10 section 8.10 CCR 2505-10 section](#)
15 [8.493.5.E](#), or

16 b. Contact with the client , or

17 c. Contact with the family member or responsible party, or

18 d. By conducting an on-site visit.

19 8.493.7.C. The Home Modification Provider shall only be reimbursed for materials and labor for work
20 that has been completed satisfactorily. If another Home Modification Provider is required to
21 complete the work, the original Home Modification Provider shall be paid only the difference
22 between the amount paid originally to the Home Modification Provider and the amount needed to
23 complete the Home Modification paid to the second Home Modification Provider, up to the
24 \$10,000.00 maximum lifetime cap.

25 8.493.7.D. The Home Modification Provider shall not be reimbursed for durable medical equipment
26 available as a Medicaid state plan benefit unless the purchase and installation of the equipment is
27 part of a larger Home Modification project.

28 **8.494 NON-MEDICAL TRANSPORTATION**

29 **8.494.10 DEFINITIONS**

30 .11 Non-medical transportation services means transportation which enable eligible clients to gain
31 personal physical access to non-medical community services and resources, as required by the
32 care plan to prevent institutionalization.

33 .12 Non-medical transportation provider means a provider agency as defined at [Section 8.10 CCR](#)
34 [2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.484.50](#), [GENERAL](#)
35 [DEFINITIONS](#), which has met all the certification standards for transportation providers listed
36 below.

37 **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 resources 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 8.10 CCR 2505-10 section 8.10 CCR 2505-10 10 CCR 2505-10 sections 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 8.10 CCR 2505-10 section 8.10 CCR 2505-10-10 CCR 2505-10 section 8.487~~, ~~HCBS-EBD PROVIDER AGENCIES.~~

.42 Transportation providers shall assure that:

- A. All drivers shall possess a valid Colorado driver's 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 LIMITATIONS AND 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.

.55 Effective 12/01/2009, excluding transportation to HCBS Adult Day facilities, a client may not receive more than the equivalent of two (2) round trip services per week, or 104 round trip services per annual certification period utilizing NMT, unless otherwise authorized by the Department.

8.495 ALTERNATIVE CARE FACILITIES [Eff. 03/30/2009]

1 8.495.1 DEFINITIONS

2 Alternative Care Facility (ACF) as defined in [C.R.S. section 25.5-6-303\(3\)](#) ~~C.R.S. (2008)~~ means an
3 Assisted Living Residence as defined at 6 ~~C.C.R.CCR~~ 1011-1, Chapter VII, Section 1.102, licensed by
4 [the CDPHE Colorado Department of Public Health and Environment](#), pursuant to certification by the
5 Department to provide Alternative Care Services and Protective Oversight to Medicaid clients.

6 Alternative Care Services as defined in [C.R.S. section 25.5-6-303\(4\)](#) ~~C.R.S. (2008)~~ means, but is not
7 limited to, a package of personal care and homemaker services provided in a state-certified alternative
8 care facility including: assistance with bathing, skin, hair, nail and mouth care, shaving, dressing, feeding,
9 ambulation, transfers, and positioning, bladder & bowel care, medication reminding, accompanying,
10 routine housecleaning, meal preparation, bed making, laundry and shopping.

11 Life Skills Training means services designed and directed at the development and maintenance of the
12 resident's ability to independently sustain himself/herself physically, emotionally, and economically in the
13 community.

14 Medication Administration as defined in [C.R.S. section 25-1.5-301](#) ~~C.R.S. (2008)~~ means assisting a
15 person in the ingestion, application, inhalation, or, using universal precautions, rectal or vaginal insertion
16 of medication, including prescription drugs, according to the legibly written or printed directions of the
17 attending physician or other authorized practitioner or as written on the prescription label and making a
18 written record thereof with regard to each medication administered, including the time and the amount
19 taken, but "administration" does not include judgment, evaluation, or assessments or the injections of
20 medication, the monitoring of medication, or the self-administration of medication, including prescription
21 drugs and including the self-injection of medication by the resident.

22 Non-Medical Leave Days mean days of leave from the ACF by the client for non-medical reasons such as
23 family visits or field trips.

24 Programmatic Leave Days mean days of leave prescribed for a Medicaid client by a physician for
25 therapeutic and/or rehabilitative purposes.

26 Protective Oversight means guidance to a resident as defined at 6 ~~C.C.R.CCR~~ 1011-1, Chapter VII,
27 Section 1.102.(32) It is the monitoring and guidance of a resident to assure his/her health, safety, and
28 well being. Protective oversight includes, but is not limited to: monitoring the resident while on the
29 premises, monitoring ingestion and reactions to prescribed medications, if appropriate, reminding the
30 resident to carry out activities of daily living, and facilitating medical and other health appointments.
31 Protective oversight includes the resident choice and ability to travel and engage independently in the
32 wider community, and guidance on safe behavior while outside the ACF.

33 Provider means the entity that holds the Assisted Living Residence / Facility license and that shall be
34 responsible or delegate responsibility to appropriate staff for the delivery of Alternative Care Services.

35 Secured Environment means an ACF that operates as defined in 6 ~~C.C.R.CCR~~ 1011-1, Chapter VII,
36 Section 1.108.

37 8.495.2 CLIENT ELIGIBILITY

38 8.495.2.A. Clients who are participating in the Home and Community Based Services (HCBS)
39 Elderly, Blind and Disabled waiver pursuant to 10 ~~C.C.R.CCR 2505-10, Section 2505-10 section~~
40 ~~8.10 CCR 2505-10 section 8.485~~ or the HCBS Mental Illness waiver pursuant to 10 ~~C.C.R.CCR~~
41 ~~2505-10, Section 2505-10 section 8.10 CCR 2505-10 section 8.509~~ are eligible to receive
42 Alternative Care Services.

1 8.495.2.B. Potential clients shall be assessed by a team which includes the client and his/her family
 2 and/or guardian, the ACF administrator or appointed representative, Single Entry Point (SEP)
 3 case manager, as appropriate case managers and other care givers, to determine that the ACF is
 4 an appropriate community setting that will meet the individual's choice and need for
 5 independence and community integration.

6 1. The assessment will be conducted prior to admission, annually and when-ever there is a
 7 significant change in physical, medical or mental condition or behavior. The assessment
 8 will document that the facility is able to support the client and their needs.

9 2. The assessment will document physical, cognitive, behavioral and social care needs.

10 **8.495.3 CLIENT BENEFITS**

11 8.495.3.A. Alternative Care Services which include, but are not limited to, personal care and
 12 homemaker services pursuant to 10 [C.C.R.CCR 2505-10, Section 2505-10 sections](#) 8.489 and
 13 8.490, are benefits to clients residing in an ACF.

14 1. Medication Administration is an Alternative Care Service included in the reimbursement
 15 rate for Alternative Care Services and shall not be additionally reimbursed or billed in any
 16 other manner.

17 8.495.3.B. Room and board shall not be a benefit of ACF services. Clients shall be responsible for
 18 room and board in an amount not to exceed the Department annually established rate.

19 **8.495.4 CLIENT RIGHTS**

20 8.495.4.A. An ACF shall foster the independence of the client while promoting each client's
 21 individuality, choice of care and lifestyle.

22 1. The client's choice to live in an ACF shall afford the client the opportunity to responsibly
 23 contribute to the home in meaningful ways and shall avoid reducing personal choice and
 24 initiative. The client's individual behaviors shall not negatively impact the harmony of the
 25 ACF.

26 8.495.4.B. Clients shall be informed of their rights. Pursuant to 6 [C.C.R.CCR](#) 1011-1, Chapter VII,
 27 Section 104 (5) (e) (ii), the policy on resident rights shall be posted in a conspicuous place.

28 8.495.4.C. Clients shall be informed of all ACF rules and/or policies. Rules and/or policies shall
 29 apply consistently to the administrator, staff, volunteers, and as appropriate, to clients residing in
 30 the facility and their family or friends who visit.

31 8.495.4.D. Clients shall be informed of the facility's policy regarding the implementation of an
 32 individual's advance directives, should the need arise.

33 8.495.4.E. Clients shall be allowed to decorate and use personal furnishings in their bedrooms in
 34 accordance with house rules while maintaining a safe and sanitary environment at all times.

35 1. If requested by the client, the ACF shall provide bedroom furnishings, including but not
 36 limited to a bed, bed and bath linens, a lamp, chair and dresser and a way to secure
 37 personal articles.

38 8.495.4.F. As documented in the admission assessment ([10 CCR 2505-10 section](#) 8.495.2.B), the
 39 provider will accommodate roommate choices within reason.

- 1 8.495.4.G. Clients and their roommates determined capable to control access to private personal
2 quarters, shall be allowed to lock their doors and control access to their quarters.
- 3 8.495.4.H. Clients shall have unscheduled access to food and food preparation areas if determined
4 capable to appropriately handle cooking activities.
- 5 8.495.4.I. Providers shall not require a Medicaid client to participate in performing household or
6 other tasks unless such tasks have been outlined in the client's individual care plan as necessary
7 Life Skills Training.
- 8 8.495.4.J. Clients shall have the right to possess and self-administer medications with a physician's
9 written order, as appropriate.

10 **8.495.5 PROVIDER ELIGIBILITY**

- 11 8.495.5.A. The Provider shall be licensed in accordance with 6 [C.C.R.CCR](#) 1011-1, Chapter VII.
- 12 8.495.5.B. Certification Standards for ACFs
- 13 1. The Provider shall be Medicaid certified by the Department as an ACF in accordance with
14 10 [C.C.R.CCR](#), Volume 8.
- 15 2. Administrators as defined at 6 [C.C.R.CCR](#) 1011-1, Chapter VII, Section 1.102 shall
16 satisfactorily complete the Department authorized training on ACF rules and regulations
17 prior to Medicaid certification.
- 18 3. ACF Providers shall maintain any license, permit, certification, insurance or bond as
19 required by state or local authority.
- 20 4. Provisional certification may be granted at the discretion of the Department for up to 60
21 days.
- 22 5. Certification shall be denied when a Provider is unable to meet, or adequately correct
23 licensure and/or certification standards as defined at 6 [C.C.R.CCR](#) 1011-1, Chapter VII,
24 Section 1.102 and detailed at 6 [C.C.R.CCR](#) 1011-1, Chapter VII, Section 1.103.; ~~40~~
25 [C.C.R.CCR 2505-10, Section 2505-10 section 8.10 CCR 2505-10 section 8.495.](#)
- 26 8.495.5.C. The Provider shall enter into a Provider Agreement with the Department.
- 27 8.495.5.D. Notification to the Department of Significant ACF Change
- 28 1. Suspension, Revocation or Termination
- 29 a. ACF Providers shall notify the Department within five working days when any
30 required license, permit, certification, insurance or bond has a change in status,
31 including any suspension, revocation or termination.
- 32 2. Change of Ownership.
- 33 a. Providers shall provide written notice to the Department of intent to change
34 ownership no later than 30 days before the sale of the facility.
- 35 i) The new owner shall meet all licensing, certification or approval
36 processes and shall not automatically become a Medicaid Provider.

- 1 3. The Department may terminate or not renew the Provider Agreement if a Provider is in
2 violation of any applicable standards or regulations.

3 **8.495.6 PROVIDER RESPONSIBILITIES**

4 8.495.6.A. All documentation, including but not limited to individual resident agreements and care
5 plans, employee files, activity schedules, licenses, insurance policies, claim submission
6 documents and program and financial records, shall be maintained according to ~~10 C.C.R. CCR~~
7 ~~2505-10, Section 2505-10 section 8.10~~ CCR 2505-10 section 8.130 and provided to supervisor(s),
8 program monitor(s) and auditors(s) upon request.

9 8.495.6.B. Using the State approved Critical Incident Reporting Form, Providers shall notify the
10 client's Single Entry Point (SEP) case manager within 24 hours of any incident or situation that
11 would be communicated to other interested parties.

12 8.495.6.C. Providers shall notify the client's SEP case manager of any client planned or unplanned
13 non-medical and/or programmatic leave for greater than 24 hours.

- 14 1. The therapeutic and/or rehabilitative purpose of leave shall be documented as part of the
15 client's care plan.

16 8.495.6.D. Any additional monies assessed the client or his/her family and/or guardian

- 17 1. Shall not be for Medicaid services.
18 2. Shall be clearly delineated in the client agreement.
19 3. Shall be fully refunded or withholdings clearly defined on the day of discharge.

20 8.495.6.E. Environmental Standards

- 21 1. Alternative Care Facilities are responsible and shall maintain a home-like quality and feel
22 for all residents at all times.
23 2. Facilities shall provide an accessible private telephone with toll free local calls.
24 3. Facilities shall provide a private area where clients in shared bedrooms may have
25 visitors.
26 4. Facilities shall provide access to common areas that is not through another resident's
27 bedroom.
28 5. Facilities shall be heated to at least 70 degrees during the day and 65 degrees at night.
29 Bedroom temperatures shall not exceed 85 degrees. During the summer months the
30 facility shall provide at least one common area that can accommodate all residents where
31 the temperature is no more than 76 degrees.
32 6. Facilities shall have a battery or generator-powered alternative lighting system available
33 in the event of power failure.
34 7. The monthly schedule of daily recreational and social activities shall be posted in a
35 conspicuous place at all times and developed in accordance with 6 ~~C.C.R. CCR~~ 1011-1,
36 Chapter VII, Section 1.107.2 Social and Recreation Activities.

- 1 a. The daily schedule of recreational and social activities shall be implemented by
2 staff and offered to all clients.
- 3 8. Appropriate reading material that reflects the residents' interests and hobbies shall be
4 made available in the common area(s).
- 5 9. Facilities shall provide nutritious food and beverage that clients have access to at all
6 times. Access to food and cooking of food shall be in accordance with 6 ~~C.C.R.CCR~~
7 1011-1, Chapter VII, Section 1.105(4) House Rules and Section 1.111 (1) Interior
8 Environment. The access to food shall be provided in at least one of the following ways:
- 9 a. Access to the ACF kitchen.
- 10 b. Access to an area separate from the ACF kitchen stocked with nutritious food
11 and beverage.
- 12 c. A kitchenette with a refrigerator, sink, and stove or microwave, separate from the
13 client's bedroom.
- 14 d. A safe, sanitary way to store food in the client's room.
- 15 10. The cooking capacity of residents shall be assessed in the original pre-admission team
16 evaluation and on-going care plans.
- 17 a. Cooking may be limited to supervised access, if necessary for the client's safety
18 and well-being.
- 19 8.495.6.F. Service Standards
- 20 1. The facility shall provide Protective Oversight to clients every day of the year, 24 hours
21 per day.
- 22 2. Alternative Care Service Providers shall maintain and follow written policies and
23 procedures for the administration of medication in accordance with 6 ~~C.C.R.CCR~~ 1011-1,
24 Chapter VII and XXIV, Medication Administration Regulations, if the facility administers
25 medication to clients.
- 26 3. Providers shall not discontinue nor refuse services to a client unless documented efforts
27 have been ineffective to resolve the conflict leading to the discontinuance or refusal of
28 services.
- 29 4. Providers shall have written policies and procedures for employment practices.
- 30 5. Providers shall maintain the following records/files:
- 31 a. Personnel files for all staff and volunteers shall include:
- 32 i) Name, home address, phone number and date of hire.
- 33 ii) The job description, chain of supervision and performance evaluation(s).
- 34 iii) For staff with direct resident contact, including food handlers, evidence of
35 pre-hire and annual tuberculin (TB) testing or chest x-ray, where
36 appropriate.

- 1 b. Client files shall include:
- 2 i) The team assessment outlined in ~~10 C.C.R. CCR 2505-10, Section 2505-~~
3 ~~10 section 8.10 CCR 2505-10 section 8.~~ 495.2. B. and care plan per 6
4 ~~C.C.R. CCR~~ 1011-1, Chapter VII, [section](#) 1.107(3).
- 5 6. The facility shall ensure that its staff has a clear understanding of all regulations
6 pertaining to the facility's licensure and certification by the State of Colorado.
- 7 7. The facility shall encourage and assist client's participation in activities within the ACF
8 community and the wider community, when appropriate.
- 9 8.495.6.G. Staffing Standards
- 10
- 11 1. Each facility will divide and document the 24-hour day into two 12 hour blocks which will
12 be considered daytime and nighttime. The designation of daytime and nighttime hours
13 shall be permanently documented in facility policy and disclosed in the written resident
14 agreements. The facility shall comply with the following staffing standards:
- 15 a. A minimum of 1 staff to 10 residents during the daytime.
- 16 b. A minimum of 1 staff to 16 residents during the nighttime.
- 17 c. A minimum of 1 staff to 6 residents in a Secured Environment at all times.
- 18 i) There shall be a minimum of one awake staff that is on duty during all
19 hours of operation in a Secured Environment.
- 20 2. Prior to receiving consideration for a staffing waiver, the facility shall be free of
21 deficiencies for both fire safety and patient care issues in Life Safety and Health surveys.
- 22 3. Subject to Departmental approval, the Department may grant staffing waivers for
23 nighttime hours only except in a Secured Environment.
- 24 a. The Provider shall adequately document that a staffing waiver would not
25 jeopardize the health, safety or quality of life of the residents.
- 26 b. Any existing staffing waiver may be subject to revocation if a facility is cited with
27 fire safety or patient care deficiencies or substantiated patient care complaints.
- 28 c. In the event of a staffing waiver denial or revocation, a facility may reapply for a
29 staffing waiver only after the facility receives an annual survey with no
30 deficiencies in either fire safety or patient care.
- 31 d. Existing staffing waivers shall be null and void upon a change in the total number
32 of licensed beds or a change of ownership in a facility.
- 33 8.495.6.H. Standards for Secured Environment ACFs
- 34 1. Facilities providing a secured environment may be licensed for a maximum of 30 secured
35 beds.

- 1 a. A waiver may be granted by the Department when adequate documentation of
2 the need for additional beds has been proven and the number of beds would not
3 jeopardize the health, safety and quality of care of residents.
- 4 2. The facilities shall establish an environment that promotes independence and minimizes
5 agitation through the use of visual cues and signs.
- 6 3. Doors to bedrooms shall not be locked unless the resident is able to manage the key
7 independently.
- 8 4. Provide a secured outdoor area accessible without staff assistance, which shall be level,
9 well maintained and appropriately equipped for the population served.
- 10 8.495.6.I. Appropriateness of Medicaid Client Placement
- 11 1. An ACF shall not admit, or shall discharge within 30 days, any client, who:
- 12 a. Needs skilled services on more than an intermittent basis. Skilled services shall
13 only be provided on an intermittent basis by **and** certified home health provider.
- 14 b. Is incapable of self-administration of medication, and the facility does not
15 administer medications.
- 16 c. Is consistently unwilling to take medication prescribed by a physician.
- 17 d. Is diagnosed with substance abuse issue and refuses treatment by the
18 appropriate mental health/medical professionals.
- 19 e. Has an acute physical illness which cannot be managed through medications or
20 prescribed therapy.
- 21 f. Has a seizure disorder which is not adequately controlled.
- 22 g. Exhibits behavior that:
- 23 i) Disrupts the safety, health and social needs of the home.
- 24 ii) Poses a physical threat to self or others, including but not limited to,
25 violent and disruptive behavior and/or any behavior which involves
26 physical, sexual, or psychological force or intimidation and fails to
27 respond to interventions, as outlined in the client's care plan.
- 28 iii) Indicates an unwillingness or inability to maintain appropriate personal
29 hygiene under supervision or with assistance.
- 30 iv) Is consistently disorientated to time, person and place to such a degree
31 he/she poses a danger to self or others and the ACF does not provide a
32 Secured Environment.
- 33 h. Has physical limitations that:
- 34 i) Limit ambulation, unless compensated for by assistive device(s) or with
35 assistance from staff.

- 1 ii) Require tray food services on a continuous basis.
- 2 2. Clients admitted for respite care to the ACF must meet the same criteria as other clients
- 3 for appropriate placement.

4 **8.495.7 REIMBURSEMENT**

5 8.495.7.A. Effective January 1 of each year, the Department shall establish a uniform room and

6 board payment for all Medicaid clients in ACFs. The standard room and board payment shall be

7 permitted to rise in a dollar-for-dollar relationship to any increase in the Supplemental Security

8 Income grant standard if the Colorado Department of Human Services also raises its grant

9 amounts.

10 8.495.7.B. Facilities shall bill for reimbursement according to ~~10 C.C.R. CCR 2505-10, Section 2505-~~

11 ~~10-section 8.10 CCR 2505-10 section 8.040.~~

12 1. Reimbursement shall be per unit, with one unit equaling one day of care, as estimated on

13 the Prior Authorization (PAR) form.

14 2. When a client is determined eligible for HCBS services under the 300% income standard

15 pursuant to ~~10 C.C.R. CCR 2505-10, Section 2505-10 section 8.10 CCR 2505-10 section~~

16 8.100, Medicaid reimbursement shall be determined for Alternative Care Services

17 according to ~~10 C.C.R. CCR 2505-10, Section 2505-10 section 8.10 CCR 2505-10 section~~

18 8.486.60.

19 8.495.7.C. Reimbursement shall be the lower of:

20 1. The Medicaid unit rate; or

21 2. The rate the ACF charges its private-pay residents for similar services.

22 8.495.7.D. Non-Medical/Programmatic Leave Reimbursement

23 1. The ACF may receive reimbursement for a maximum of 42 days in a calendar year for

24 Non-Medical/Programmatic Leave Days combined.

25 **8.496 (Repealed effective March 30, 2014)**

26 **8.497 PROGRAM OF ~~ALL INCLUSIVE~~ ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)**

27 **8.497.1 ENROLLMENT BROKER**

28 8.497.1.A. PACE organizations shall be allowed to contract with the Department's enrollment broker

29 to include information on PACE in materials the enrollment broker provides to clients.

30 8.497.1.B. PACE organizations shall be responsible for all costs associated with the marketing of

31 PACE through the enrollment broker.

32 8.497.1.C. PACE organizations must comply with federal marketing regulations at 42 CFR 460.82

33 which is hereby incorporated by reference. The incorporation of the PACE marketing regulations

34 excludes later amendments to, or editions of, the referenced material. This regulation is available

35 from the U.S. Government Printing Office website at: [http://www.gpo.gov/fdsys/pkg/CFR-2011-](http://www.gpo.gov/fdsys/pkg/CFR-2011-
36 title42-vol4/pdf/CFR-2011-title42-vol4-part460.pdf)

37 [title42-vol4/pdf/CFR-2011-title42-vol4-part460.pdf](http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-part460.pdf). The Department maintains copies of this

 incorporated text in its entirety, available for public inspection during regular business hours at:

1 Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO
2 80203. Certified copies of incorporated materials are provided at cost upon request.

3 **8.497.2 ENROLLMENT**

4 8.497.2.A. An eligible person, as defined by 25.5-5-412 (7)(b) C.R.S., who is enrolled in a managed
5 care organization, the Accountable Care Collaborative program or other risk-bearing entity may
6 elect to disenroll and enroll in and receive services through a PACE organization. The effective
7 date of an eligible person's disenrollment shall be no later than the first day of the second month
8 following the month in which the eligible person files the request.

9 8.497.2.B. PACE organizations and eligible persons shall comply with all applicable federal
10 regulations regarding PACE enrollment and disenrollment at 42 C.F.R. Part 460, subpart I which
11 is hereby incorporated by reference. The incorporation of the PACE enrolment regulations
12 excludes later amendments to, or editions of, the referenced material. This regulation is available
13 from the U.S. Government Printing Office website at: [http://www.gpo.gov/fdsys/pkg/CFR-2011-
15 title42-vol4/pdf/CFR-2011-title42-vol4-part460.pdf](http://www.gpo.gov/fdsys/pkg/CFR-2011-
14 title42-vol4/pdf/CFR-2011-title42-vol4-part460.pdf). The Department maintains copies of this
16 incorporated text in its entirety, available for public inspection during regular business hours at:
17 Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO
18 80203. Certified copies of incorporated materials are provided at cost upon request.

8.482.33.C.4.b	1575 Sherman Street	1570 Grant street	address change	
8.485.20	1575 Sherman Street	1570 Grant street	address change	
8.400.12	Home and Community Based Services under the Medicaid waivers include distinct service programs	See Rule	clarity	
8.401.02	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.	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/Human services.	clarity	

8.402.01	when a physician	when a physician or designee	clarity	
8.402.01	he/she, or his/her designee, shall	he/she shall	clarity	
8.402.12	medical provider	medically licensed provider	clarity	
8.402.18	The statewide utilization	The utilization	clarity	
8.402.37	approve (1) certification	approve one (1) certification	clarity	
8.443.7.A.15	above.	above, as well as nursing facilities	clarity	
8.470.2.A.5	have a rate authorized by the Department	Have a level of care reimbursement authorized by the Department	clarity	
8.470.2.A.5	The rate shall	The level of care reimbursement shall	clarity	
8.492.41.C	Minimum Data Set must be completed	Minimum Data Set ("MDS") must be completed	clarity	
8.400.103	26-4-103(8.5), C.R.S.,	C.R.S. section 25.5-4-103(10)	correct citation	Statute moved in 1997; need to update citation.
8.401.182.B.2	42 C.F.R. section 435.1009 (2000)	42 C.F.R. section 435.1010 (2013)	correct citation	
8.401.192.B.5	C.R.S. section 27-10-101	C.R.S. section 27-65-105	correct citation	
8.401.192.B.5	C.R.S. section 27-10-102	C.R.S. section 27-65-106	correct citation	
8.401.204.C	Staff manual Volume 10 CCR 2505-10 section 8.059.12	10 CCR 2505-10 section 8.057	correct citation	
8.401.204.D	Staff Manual Volume 10 CCR 2505-10 section 8.059.17	10 CCR 2505-10 section 8.057	correct citation	

8.401.205.C.4.e	27-10-101, C.R.S.	C.R.S. section 27-65-107	correct citation	
8.401.41	42 C.F.R. 435.1009	42 C.F.R. section 435.1010 (2013)	correct citation	
8.401.44.D.2	regulations entitled PROVIDER APPEALS AND HEARINGS	regulations at 10 CCR 2505-10 section 8.050 et seq	correct citation	
8.401.44.G	regulations entitled PROVIDER APPEALS AND HEARINGS	regulations at 10 CCR 2505-10 section 8.050 et seq	correct citation	
8.402.34	at section 8.485 through 8.486.501	at 10 CCR 2505-10 sections 8.486 and 8.390	correct citation	
8.402.36	2 CCR section 502-2	2 CCR 502-1 section 21.940	correct citation	
8.402.36	2 CCR section 502-1	2 CCR 502-1 section 21.280	correct citation	
8.402.37	with section 10 CCR 2505-10, sections 8.057, 10 CCR 2505-10, sections 8.057 through section 10 CCR 2505-10, sections 8.057.8	with 10 CCR 2505-10 section 8.057 through 8.057.8.	correct citation	
8.402.53	at section 10 CCR 2505-10, sections 8.057 through section 10 CCR 2505-10 sections 8.057.8	at 10 CCR 2505-10 section 8.057 through 8.057.8	correct citation	
8.402.54	with section 10 CCR 2505-10, sections 8.057 through section 10 CCR 2505-10, sections 8.057.8	with 10 CCR 2505-10 section 8.057 through 8.057.8.	correct citation	
8.403.11.A.4	sections on HOME AND COMMUNITY BASED SERVICES FOR THE person(s) with an intellectual or developmental disability in this manual	regulations at 10 CCR 2505-10 section 8.500	correct citation	
8.403.11.B.3	the sections on HOME AND COMMUNITY BASED SERVICES FOR THE person(s) with an intellectual or developmental disability in this manual	regulations at 10 CCR 2505-10 section 8.500	correct citation	

8.403.11.C.3	the sections on HOME AND COMMUNITY BASED SERVICES FOR THE person(s) with an intellectual or developmental disability in this manual	regulations at 10 CCR 2505-10 section 8.500	correct citation	
8.405.50.D	91-8-1 et seq., C.R.S. 1973, as amended.	C.R.S. section 12-39-101 et seq.	correct citation	
8.406.1	Social Security Act and 42 C.F.R.	Social Security Act (42 U.S.C. section 1396a) and 42 C.F.R. section 400 et seq.	correct citation	
8.406.3.B	wehre these rules conflict with the provisions of 42 C.F.R. sections 442.300 and 442.400 et seq., the C.F.R. provisions control	in accordance with the provisions of 42 C.F.R Part 442.	correct citation	
8.408.7	42 C.F.R. 456.2	42 C.F.R. section 456.2	correct citation	
8.415.11.C.1	10 CCR 2505-10 section 8.483.34.D.1	10 CCR 2505-10 section 8.482.34.D.1	correct citation	
8.42	found in this manual entitled LIMITATIONS ON THE NUMBER OF	at 10 CCR 2505-10 sections 8.430 et seq.	correct citation	
8.441.5.H.1.a	8.443.7.A.13	10 CCR 2505-10 section 8.443.7.A.11	correct citation	
8.482.33.C.1.d	8.011	10 CCR 2505-10 section 8.076.1.8	correct citation	
8.482.34.C.1	sections 8.110.49	10 CCR 2505-10 sections 8.100.7.T	correct citation	
8.482.42.A.4	section 8.462	10 CCR 2505-10 sections 8.485.200 et seq.	correct citation	
88.486.30	88.486.30	8.486.30	correct citation	
8.486.32	section 8.485.50	10 CCR 2505-10 section 8.485.50	correct citation	
8.486.60.B.3	section 8.112.3(F) of Staff Manual Volume 8	10 CCR 2505-10 section 8.100.1	correct citation	
8.487.24.A	A	C	correct citation	
8.487.70	section 8.130	10 CCR 2505-10 section 8.130.4	correct citation	
8.489.12	at section 8.484.50.P GENERAL DEFINITIONS	at 10 CCR 2505-10 section 8.484.50.Q	correct citation	

8.489.14	at section 8.526, HOME HEALTH AIDE SERVICES	at 10 CCR 2505-10 section 8.522.	correct citation	
8.489.31.C.2	8.489.313,2	10 CCR 2505-10 section 8.489.31.B.2	correct citation	
8.489.31.N.2	8.489.3 LB2	10 CCR 2505-10 section 8.489.31.B.2	correct citation	
8.491.14.H	the section on REIMBURSEMENT METHOD FOR ADULT DAY SERVICES	10 CCR 2505-10 section 8.491.30	correct citation	
8.494.12	section 8.484.50,P, GENERAL DEFINITIONS	10 CCR 2505-10 section 8.484.50	correct citation	
8.494.31	section 8.680 through 8.681, OTHER HEALTH SERVICES TRANSPORTATION	10 CCR 2505-10 sections 8.611	correct citation	
8.482.45.B	26-4-112, C.R.S.	C.R.S. section 25.5-4-301	correct citation	
8.482.45.E	26-4-112, C.R.S.	C.R.S. section 25.5-4-301(2)	correct citation	
8.485.61.A	10 CCR 2505-10 Section 9.100	10 CCR 2505-10 Section 8.100	correct citation	
8.435.1	C.R.S. section 25-1-107.5	by C.R.S. section 25-1-107.5 (2013)	correct citation	

8.401.183.E	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.	42 C.F.R. part 483.20 (October 1, 2000 edition), which is hereby incorporated by reference. The incorporation of 42 C.F.R. part 483.20 excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.	correct incorporation by reference language	Required to Incorporate federal regulation.
8.435.1	No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.	which is hereby incorporated by reference. The incorporation of 42 C.F.R. Part 483 Subpart B excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request..	correct incorporation by reference language	

<p>8.435.1</p>	<p>. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.</p>	<p>, which is hereby incorporated by reference. The incorporation of 42 U.S.C. 1396r(h) excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.</p>	<p>correct incorporation by reference language</p>	<p>This change was in the rule when the Board voted for initial approval. I just had to add it to the crosswalk.</p>
<p>8.441.5.D.2</p>	<p>No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.</p>	<p>The Medicare and Medicaid Guide (1981) is hereby incorporated by reference. The incorporation of The Medicare and Medicaid Guide (1981) excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.</p>	<p>correct incorporation by reference language</p>	

<p>8.441.5.F.1</p>	<p>Historical costs shall be established in accordance with the Medicare and Medicaid Guide, 1981, published by Commerce Clearing House, paragraphs 4501-4897P, except that any appraisals required or recommended shall be performed by an MAI Appraiser rather than an "appraisal expert" as defined in the Guide. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.</p>	<p>Historical costs shall be established in accordance with the Medicare and Medicaid Guide, 1981, published by Commerce Clearing House, paragraphs 4501-4897P, except that any appraisals required or recommended shall be performed by an MAI Appraiser rather than an "appraisal expert" as defined in the Medicare and Medicaid Guide. The Medicare and Medicaid Guide (1981) is hereby incorporated by reference. The incorporation of The Medicare and Medicaid Guide (1981) excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.</p>	<p>correct incorporation by reference language</p>	
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<p>8.443.6.A.</p>	<p>No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.</p>	<p>The resource utilization group–III (RUG-III) 34 category, index maximizer model, version 5.12b is hereby incorporated by reference. The incorporation of RUG-III 34 category, index maximizer model, version 5.12b excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.</p>	<p>correct incorporation by reference language</p>	
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<p>8.493.5.D</p>	<p>No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. Copies of the 2003 International Building Code and copies of the rules and regulations of the State Electrical Board and State Examining Board of Plumbers are available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.</p>	<p>The International Residential Code (2003), the accessibility provisions within the International Building Code (2003), and the Colorado Plumbing Code (2005) are hereby incorporated by reference. The incorporation of those materials exclude later amendments to, or editions of, the referenced material. Pursuant to C.R.S. section 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.</p>	<p>correct incorporation by reference language</p>	
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<p>8.482.46.A</p>	<p>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.</p>	<p>Services and equipment which are a benefit of Medicare, as described in 42 CFR Part 405.230-252, must be billed to Medicare before billing Medicaid. 42 CFR Part 405.230-252 is hereby incorporated by reference. The incorporation of 42 U.S.C. section 1396r excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.</p>	<p>correct incorporation by reference language</p>	
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8.406.1	incorporated herein by reference as rules of the Department	<p>Title 42 of the Code of the Federal Regulations is hereby incorporated by reference. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.</p>	correct incorporation by reference language	
8.406.1.C	BLANK	<p>Section 1902 of the Social Security Act (1935) (42 U.S.C. section 1396r) is hereby incorporated by reference. The incorporation of 42 U.S.C. section 1396r excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.</p>	correct incorporation by reference language	

<p>8.443.9.A.1.a</p>	<p>This material is incorporated by reference into these rules. Information about obtaining or examining the applicable edition is available from the Custodian of Records, Department of Health</p>	<p>Boeckh™ Commercial Building Valuation System is hereby incorporated by reference. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.</p>	<p>correct incorporation by reference language</p>	
<p>8.443.9.A.1.h</p>	<p>This material is incorporated by reference into these rules. Information about obtaining or examining the applicable edition is available from the Custodian of Records, Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. The incorporated material may also be examined at any State Publications Depository Library.</p>	<p>The Means index is hereby incorporated by reference. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.</p>	<p>correct incorporation by reference language</p>	

8.443.20.A.2.a	is hereby incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S.C.R.S. section 24-4-103(12.5), the Department of Health Care Policy and Financing maintains either electronic or written copies of incorporated tests for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado 80203-1818	is hereby incorporated by reference. The incorporation of 42 C.F.R. section 433.68(f)(3)(i)(A) excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.	correct incorporation by reference language	
8.401.207.B.2.c	Nursing and intermediate care facilities - rights of patients	Nursing facilities - rights of patients	Correct title of statute	
8.443.16.A	intermediate care	Intermediate Care	Grammar	
8.443.16.A.2	intermediate care	Intermediate Care	Grammar	
8.440.37	27	37	grammar	
8.443.6.A	The resource utilization group—III (RUG-III) 34 category, index maximizer model, version 5.12b	the resource utilization group—III (RUG-III) 34 category, index maximizer model, version 5.12b	grammar	
8.482.43.C.3	the	The	grammar	
8.400.11	Intermediate Care Facilities for the mentally retarded (ICF/MR)	Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	outdated language	
8.400.14	client who has mental illness or mental retardation	Check with waivers to see if this is acc	outdated language	

8.401.04	facility for the mentally retarded (ICF/MR)	facility for individuals with intellectual disabilities (ICF/IID)	outdated language	
8.401.04	class of ICF/MR	class of ICF/IID	outdated language	
8.401.05	mentally ill or mentally disabled	mentally ill or person(s) with an intellectual or developmental disability	outdated language	
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)	GUIDELINES FOR LONG TERM CARE SERVICES (CLASS I SNF AND ICF FACILITIES, HCB-EBD, HCBS-CMHS, HCBS-BI, Children's HCBS, HCBS-CES, HCBS-DD, HCBS-SLS, HCBS-CHRP, and Long Term Home Health)	outdated language	
8.401.18	PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASARR) AND SPECIALIZED SERVICES FOR MENTALLY ILL AND MENTALLY RETARDED INDIVIDUALS	PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY	outdated language	
8.401.181.A, B and C	PASARR/mental retardation	PASRR/intellectual or developmental disability	outdated language	
8.401.182.A.3.b	mental retardation	intellectual or developmental disability	outdated language	
8.401.182.B	mental retardation	intellectual or developmental disability	outdated language	
8.401.182.B.1	mental retardation	intellectual or developmental disability	outdated language	
8.401.182.B.2.a.2	mental retardation	intellectual or developmental disability	outdated language	
8.401.182.B.2.a.2	mental retardation	intellectual or developmental disability	outdated language	
8.401.183	PASARR	PASRR	outdated language	

8.401.183.B	PASARR	PASRR	outdated language	
8.401.183.E	PASARR	PASRR	outdated language	
8.401.184	PASARR	PASRR	outdated language	
8.401.184.D	PASARR	PASRR	outdated language	
8.401.184.H	PASARR	PASRR	outdated language	
8.401.184.A	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.401.184.E	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.401.184.G.3	mental retardation	intellectual or developmental disability	outdated language	
8.401.184	PASARR	PASRR	outdated language	
8.401.191.B	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.401.191.B.1	mental retardation	intellectual or developmental disability	outdated language	
8.401.191.B.2	mental retardation	intellectual or developmental disability	outdated language	
8.401.191.B.3	mental retardation	intellectual or developmental disability	outdated language	
8.401.191.B.4	mental retardation	intellectual or developmental disability	outdated language	
8.401.192	mental retardation	intellectual or developmental disability	outdated language	
8.401.192	PASSAR	PASSR	outdated language	
8.401.192.A	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.401.192.B.4. b	PASSAR	PASSR	outdated language	
8.401.192.B.4. b.2	mental retardation	intellectual or developmental disability	outdated language	
8.401.192.B.5	PASSAR	PASSR	outdated language	
8.401.192.B.5	PASSAR	PASSR	outdated language	

8.401.193	mental retardation	intellectual or developmental disability	outdated language	
8.401.193	PASSAR	PASSR	outdated language	
8.401.20	PASSAR	PASSR	outdated language	
8.401.201.A	mental retardation	intellectual or developmental disability	outdated language	
8.401.201.B	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.401.201.C	mental retardation	intellectual or developmental disability	outdated language	
8.401.202	PASSAR	PASSR	outdated language	
8.401.202.B	mental retardation	intellectual or developmental disability	outdated language	
8.401.202.B	mental retardation	intellectual or developmental disability	outdated language	
8.401.202.C	PASSAR	PASSR	outdated language	
8.401.202.D	PASSAR	PASSR	outdated language	
8.401.202.D	mental retardation	intellectual or developmental disability	outdated language	
8.401.202.E	mental retardation	intellectual or developmental disability	outdated language	
8.401.202.E	PASSAR	PASSR	outdated language	
8.401.202.F	PASSAR	PASSR	outdated language	
8.401.204	mental retardation	intellectual or developmental disability	outdated language	
8.401.204.B.2	mental retardation	intellectual or developmental disability	outdated language	
8.401.205	PASSAR	PASSR	outdated language	
8.401.205.A.4	mental retardation	intellectual or developmental disability	outdated language	
8.401.205.D	mental retardation	intellectual or developmental disability	outdated language	
8.401.D.2	mental retardation	intellectual or developmental disability	outdated language	

8.401.205.D.3	mental retardation	intellectual or developmental disability	outdated language	
8.401.205.D.3	mental retardation	intellectual or developmental disability	outdated language	
8.401.205.D.3. b	mental retardation	intellectual or developmental disability	outdated language	
8.401.205.D.4	mental retardation	intellectual or developmental disability	outdated language	
8.401.205.D.4. d	mental retardation	intellectual or developmental disability	outdated language	
8.401.205.D.5	mental retardation	intellectual or developmental disability	outdated language	
8.401.205.D.6	mental retardation	intellectual or developmental disability	outdated language	
8.401.205.D.6	mental retardation	intellectual or developmental disability	outdated language	
8.401.206	PASSAR	PASSR	outdated language	
8.401.206.B	mental retardation	intellectual or developmental disability	outdated language	
8.401.206.C	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.401.206.C	mental retardation	intellectual or developmental disability	outdated language	
8.401.206.D	mental retardation	intellectual or developmental disability	outdated language	
8.401.206.D.3	mental retardation	intellectual or developmental disability	outdated language	
8.401.207	PASSAR	PASSR	outdated language	
8.401.207.A.1	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.401.207.A.2	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.401.207.A.3	mental retardation	intellectual or developmental disability	outdated language	

8.401.207.A.3	mental retardation	intellectual or developmental disability	outdated language	
8.401.207.A.3. b	mental retardation	intellectual or developmental disability	outdated language	
8.401.207.A.4	mental retardation	intellectual or developmental disability	outdated language	
8.401.207.C.2	mental retardation	intellectual or developmental disability	outdated language	
8.401.21	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.401.216	mental retardation	intellectual or developmental disability	outdated language	
8.401.42	PASSAR	PASSR	outdated language	
8.402.01.a	the mentally retarded (ICF/IID)	individuals with intellectual disabilities (ICF/IID)	outdated language	
8.402.01.b	ICF/MR	ICF/IID	outdated language	
8.402.01.c	ICF/MR	ICF/IID	outdated language	
8.403.1	ICF/MR	ICF/IID	outdated language	
8.403.11	ICF/MR	ICF/IID	outdated language	
8.403.11.A.4	ICF/MR	ICF/IID	outdated language	
8.403.11.B.3	mental retardation	intellectual or developmental disability	outdated language	
8.403.11.B.3	ICF/MR	ICF/IID	outdated language	
8.404.1	ICF/MR	ICF/IID	outdated language	
8.404.11	ICF/MR	ICF/IID	outdated language	
8.404.2	ICF/MR	ICF/IID	outdated language	
8.404.3.G	ICF/MR	ICF/IID	outdated language	
8.405.10	ICF/MR	ICF/IID	outdated language	
8.405.12	ICF/MR	ICF/IID	outdated language	
8.405.31	ICF/MR	ICF/IID	outdated language	
8.405.41	ICF/MR	ICF/IID	outdated language	
8.406.3	mental retardation	intellectual or developmental disability	outdated language	

8.406.3.A	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.406.3.A.3	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.420	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.42	ICF/MR	ICF/IID	outdated language	
8.421	the patients in the home.	the residents in the facility.	outdated language	
8.430.2.A.2	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.440.1.A	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.440.1.G.6	mental retardation	intellectual or developmental disability	outdated language	
8.443.1.C	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.443.1.D	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.443.16	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.443.16.A	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.443.16.A.2	mentally retarded	person(s) with an intellectual or developmental disability	outdated language	
8.481.1	hones	Does this stay?	outdated language	
8.422	State or County Departments of Social Services	Colorado Department of Human Services or County Department of Social/Human Services	outdated language	There is no state Department of of Social Services
8.449.2	State Department of Social Services	State Department of Human Services	outdated language	
8.423.A	the Colorado Department of Social Services	the Colorado Department of Human Services	outdated language	
8.470.6.C	ventilator dependent clients	clients who are ventilator dependent	person first language	

8.470.6.C.3	ventilator dependent clients	clients who are ventilator dependent	person first language	
8.470.6.D	wound care clients	clients with complex wounds	person first language	
8.470.6.D.1	wound care clients	clients with complex wounds	person first language	
8.470.6.D.2	wound care clients	clients with complex wounds	person first language	
8.470.6.E	medically complex clients	clients who are medically complex	person first language	
8.470.6.E.1	medically complex clients	clients who are medically complex	person first language	
8.470.6.E.2	medically complex clients	clients who are medically complex	person first language	
8.470.6.E.3	medically complex clients	clients who are medically complex	person first language	
8.470.6.E.5	medically complex clients	clients who are medically complex	person first language	
8.470.6.F	hospital back up level of care clients	clients who meet the hospital back up level of care	person first language	
8.470.7	hospital back up level of care clients	clients who meet the hospital back up level of care	person first language	
8.470.7.A.2	hospital back up level of care client	client who meets the hospital back up level of care	person first language	
8.470.7.A.2	hospital back up level of care client	client who meets the hospital back up level of care	person first language	
8.470.7.A.3	hospital back up level of care client	client who meets the hospital back up level of care	person first language	
8.470.7.A.4	hospital back up level of care client	client who meets the hospital back up level of care	person first language	
8.470.7.A.5	hospital back up level of care client	client who meets the hospital back up level of care	person first language	
8.470.8.A	hospital back up level of care clients	clients who meet the hospital back up level of care	person first language	
Rule Section	Language Pre-change	Language Post-change	Reason	Rationale/Justification

8.401.15.B	review,	review	Spelling	
8.402.01.a	HCB-DD	HCBS-DD	Spelling	
8.402.01.b	HCB-DD	HCBS-DD	Spelling	
8.402.01.c	HCB-DD	HCBS-DD	Spelling	
8.402.32.B	Elderly, Blind or disabled	elderly, blind and disabled	Spelling	Consistent with statute: C.R.S. section 25.5-6-301 "Home and Community Based Services for the Elderly, Blind, and disabled Act
8.402.61	Elderly, Blind or disabled	Elderly, Blind and disabled (HCBS-EBD)	Spelling	Consistent with statute: C.R.S. section 25.5-6-301 "Home and Community Based Services for the Elderly, Blind, and disabled Act
8.402.64	HCB-EBD	HCBS-EBD	Spelling	
8.403.1	HCB-DD	HCBS-DD	Spelling	
8.403.11	HCB-DD	HCBS-DD	Spelling	
8.403.11.A.4	HCB-DD	HCBS-DD	Spelling	
8.403.11.B.3	HCB-DD	HCBS-DD	Spelling	
8.403.11.C.3	HCB-DD	HCBS-DD	Spelling	
8.404.1	HCB/IID	HCBS-DD	Spelling	
8.404.12	HCB/IID	HCBS-DD	Spelling	
8.405.10	(HCB-DD)	(HCBS-DD)	Spelling	
8.405.12	HCB-DD	HCBS-DD	Spelling	
8.405.12	HCB-DD	HCBS-DD	Spelling	
8.405.30	(HCB-DD)	(HCBS-DD)	Spelling	
8.405.31	HCB-DD	HCBS-DD	Spelling	
8.405.31	2 CCR, section 503-1	2 CCR section 503-1	Spelling	
8.405.32	HCB-DD	HCBS-DD	Spelling	
8.405.32	HCB-DD	HCBS-DD	Spelling	
8.405.42	HCB-DD	HCBS-DD	Spelling	
8.409.24	these guidelines	these regulations	Spelling	
8.409.24	rule item 2., are applicable	rule item 2 are applicable	Spelling	
8.415.20.A.2	on day	on the day	Spelling	
8.422	recipient-patients	recipients/patients	Spelling	
8.435.2.E.4.b	qualify of life	quality of life	Spelling	

8.440.5	in the state	in the state.	Spelling	
8.440.29	patients	patient	Spelling	
8.440.1.A	all inclusive	all-inclusive	Spelling	hyphenate words prefaced by ex-, self- or all-
8.440.2.A.10	charged only for specially prepared food if they are informed	charged for specially prepared food only if they are informed	Spelling	
8.441.1.A	MED 13	MED-13	Spelling	
8.441.1.A.2.b	verifiable by reference to adequate	verifiable through adequate	Spelling	
8.441.1.A.2.b	by qualified auditors	provided to auditors	Spelling	
8.441.2.A	page and and all schedules	page and all schedules	Spelling	
8.441.2.B	audited financial statement.	audited financial statements.	Spelling	
8.441.2.C	presentation of expense	presentation of expenses	Spelling	
8.441.4.B	supervision, feeding, incontinency	supervision, feeding, and incontinency	Spelling	
8.441.4.E	Those specific medical supplies	Account for specific medical supplies	Spelling	
8.441.4.E	additional charge is allowed are to be accounted for as "Items Purchased for Resale" and the cost thereof shown on the appropriate line for elimination.	additional charge is allowed as "Items Purchased for Resale." Show the cost on the appropriate line for elimination.	Spelling	
8.441.5.B.1.a	owner for the services he/she renders to the facility	owner for services rendered to the facility	Spelling	
8.441.5.B.3.a	non owner	non-owner	Spelling	
8.441.5.B.3.a	non owner	non-owner	Spelling	
8.441.5.B.3.a	1 74; 74 99; 100 149; 150 200 and more than 200	1 to 74, 75 to 99, 100 to 149, 150 to 200, and more than 200	Spelling	
8.441.5.C.2.e	State Boards of Medical Services	Medical Services Board	Spelling	Consistent with statute: C.R.S. section 25.5-1-301 "Medical Services Board - creation"
8.441.5.F.2	IRA	IRS	Spelling	

8.441.5.G.1.d.ii i	shall not used	shall not be used	Spelling	
8.442.2.C.2	MED 13	MED-13	Spelling	
8.443.7.E.7.a	MED-13 or	MED-13; or	Spelling	
8.443.8.E.7	Global Insight, Inc	Global Insight, Inc.,	Spelling	
8.470.1	Complex wound care	"Complex wound care"	Spelling	
8.470.1	Medically complex wound	"Medically complex"	Spelling	
8.470.1	Ventilator Dependent	"Client who is ventilator-dependent"	Spelling	
8.470.6	Qualifica tion	Qualification	Spelling	
8.470.8.A	MED 13	MED-13	Spelling	
8.470.8.A	MED 13	MED-13	Spelling	
8.481	bones	homes	Spelling	
8.482.2.D	otter	other	Spelling	
8.482.33	parry	party	Spelling	
8.482.33.B.2	for me first	for the first	Spelling	
8.482.33.C.1.e	residents	resident's	Spelling	
8.482.33.C.1.f	residents	resident's	Spelling	
8.482.33.D.4	Prior Authorization Request (PAP)	Prior Authorization Request (PAR)	Spelling	
8.482.34.C.6.b. 2	residents	resident's	Spelling	
8.482.43.C.3	capacity. the room	capacity. The room	Spelling	
8.482.43.C.5	residents	resident's	Spelling	
8.482.52.C.1	when me licensed operator	when the licensed operator	Spelling	
8.482.52.E	Aother	Another	Spelling	
8.482.52.F.1	parry	party	Spelling	
8.482.6.B.1	the tine of admission	the time of admission	Spelling	
8.482.71.I	residents	resident's	Spelling	
8.482.72.A.21	person is act	person.	Spelling	
8.485.94	providers	provider's	Spelling	
8.485.201	HCBS EBD	HCBS-EBD	Spelling	
8.485.202	HCBS EBD	HCBS-EBD	Spelling	

8.485.204.B	HCBS EBD	HCBS-EBD	Spelling	
8.485.204.C	HCBS EBD	HCBS-EBD	Spelling	
8.486.401.C	care,,	care,	Spelling	
8.488.34.D	unattended	unattended	Spelling	
8.489.31.D.2	conditions mat may	conditions that may	Spelling	
8.489.52	clients residence	client's residence	Spelling	
8.489.54	per day. when averaged	per day when averaged	Spelling	
8.489.57	effective 21/99	effective 2/1/99	Spelling	
8.491.13.B	whenever mere is a	whenever there is a	Spelling	
8.491.14.C	Activities mat assist	Activities that assist	Spelling	
8.491.20.B.6	needs of me participants	needs of the participants	Spelling	
8.491.20.C.2.d	medical inter ventions	medical interventions	Spelling	
8.491.20.D.1	a staff o participant	a staff to participant	Spelling	
8.491.20.F.1	Admission criteria mat qualify	Admission criteria that qualify	Spelling	
8.491.20.F.7	party to me agreement	party to the agreement	Spelling	
8.491.32.C	considered until me next	considered until the next	Spelling	
8.491.32.C	sub nit	submit	Spelling	
8.493.2.A.6	su pplies	supplies	Spelling	
8.493.4.F.6	calender	calendar	Spelling	
8.494.21	such such as	such as	Spelling	
8.494.42.A	Colorado drivers license	Colorado Driver's license	Spelling	
8.494.52	to 'the general	to the general	Spelling	
8.495.2.B.1	when ever	whenever	Spelling	
8.495.6.I.1.a	basis by and certified	basis by a certified	Spelling	
8.404.1	HCB/DD	HCBS/DD	Spelling	
8.404.12	HCB/DD	HCBS/DD	Spelling	
8.404.3.G	HCB/DD	HCBS/DD	Spelling	
8.400.14	as defined in 8.401.18	as defined in 10 CCR 2505-10 section 8.401.18	Standardize citations	
8.400.14	as defined in 8.401.19	as defined in 10 CCR 2505-10 section 8.401.19	Standardize citations	
8.400.16.A	defined in section 8.401.18	defined in 10 CCR 2505-10 section 8.401.18	Standardize citations	

8.400.16.B	defined in Section 8.401.18.	defined in 10 CCR 2505-10 section 8.401.18	Standardize citations	
8.400.16.C	defined in Section 8.401.18	defined in 10 CCR 2505-10 section 8.401.18	Standardize citations	
8.400.16.C	definition of mental illness at 8.401.18	definition of mental illness at 10 CCR 2505-10 section 8.401.18	Standardize citations	
8.400.16.D	defined in 8.401.18	defined in 10 CCR 2505-10 section 8.401.18	Standardize citations	
8.400.16.D	definition of intellectual or developmental disability or mental illness at 8.401.18	definition of developmental disability or mental illness at 10 CCR 2505-10 section 8.401.18	Standardize citations	
8.401.05	in 8.401.18	in 10 CCR 2505-10 section 8.401.18	Standardize citations	
8.401.15.A	in subsection 8.401.11 above	in 10 CCR 2505-10 section 8.401.11	Standardize citations	
8.401.207.B.2.c	25-1-120, C.R.S.	C.R.S. section 25-1-120	Standardize citations	
8.402.01	the physician shall, unless an emergency admission as defined at section 8.402.20 is required, refer the client to the	the physician shall, unless an emergency admission is required, refer the client to the	Standardize citations	
8.402.01.c	defined in section 8.401.18	defined in 10 CCR 2505-10 section 8.401.18	Standardize citations	
8.402.01.c	at section 8.405	at 10 CCR 2505-10 section 8.405	Standardize citations	
8.402.35	at section 8.500	at 10 CCR 2505-10 section 8.500	Standardize citations	
8.405.25	according to the guidelines at section 8.404.1	according to 10 CCR 2505-10 section 8.404.1	Standardize citations	
8.405.25	at section 8.057	at 10 CCR 2505-10 section 8.057	Standardize citations	
8.405.50.D	see section 8.440 et seq.	see 10 CCR 2505-10 section 8.440 et seq.	Standardize citations	

8.406.1.B	see section 8.420	see 10 CCR 2505-10 section 8.420	Standardize citations	
8.406.2.B	see section 8.420	see 10 CCR 2505-10 section 8.420	Standardize citations	
8.408.E	Rules section 8.408.1 et seq.	10 CCR 2505-10 section 8.408.1 et seq.	Standardize citations	
8.408.44	in section 8.400 et seq.	in 10 CCR 2505-10 section 8.400 et seq.	Standardize citations	
8.408.7	in section 8.449	in 10 CCR 2505-10 section 8.449	Standardize citations	
8.415.11.B	Medical Assistance Staff Manual sections 8.110.49 and 8.482.33	10 CCR 2505-10 sections 100.7.T and 8.482.33	Standardize citations	
8.415.11.C.1	in section 8.483.34,D,1.	in 10 CCR 2505-10 section 8.483.34.D.1	Standardize citations	
8.415.11.C.2	in section 8.415.11,C,1	in 10 CCR 2505-10 section 8.415.11.C.1	Standardize citations	
8.415.11.C.2	in section 8.482.34,D,2	in 10 CCR 2505-10 section 8.482.34.D.2	Standardize citations	
8.415.21.C	section 25-1-120 et. Seq., C.R.S.	C.R.S. sections 25-1-120 et. Seq.	Standardize citations	
8.42	in section 8.482.5	in 10 CCR 2505-10 section 8.482.5	Standardize citations	
8.430.3.A.5.j	section 8.430.A.5.j.i	10 CCR 2505-10 section 8.430.A.5.j.i	Standardize citations	
8.430.3.A.5.j	section 8.430.A.5.j.ii	10 CCR 2505-10 section 8.430.A.5.j.ii	Standardize citations	
8.430.3.A.5.j.ii.3.a	in 8.430.3.A.5.j.i	in 10 CCR 2505-10 section 8.430.3.A.5.j.i	Standardize citations	
8.430.3.A.5.j.ii.4.b	at 10 CCR 2505-10, section 8.401.18 et seq.	at 10 CCR 2505-10 sections 8.401.18 et seq.	Standardize citations	
8.430.3.A.5.j.ii.4.d	10 CCR 2505-10, section 8.470.	10 CCR 2505-10 section 8.470.	Standardize citations	

8.430.3.A.5.j.ii.5.a	section 8.430.3.A.5.j.ii.4	10 CCR 2505-10 section 8.430.3.A.5.j.ii.4	Standardize citations	
8.430.3.A.5.j.ii.5.b	10 CCR 2505-10, section 8.401.41 et seq.	10 CCR 2505-10 sections 8.401.41 et seq.	Standardize citations	
8.435.1	section 25-1-107.5 C.R.S. (2009)	C.R.S. section 25-1-107.5 (2013)	Standardize citations	
8.435.1	in section 8.435.2.E.4.b	in 10 CCR 2505-10 section 8.435.2.E.4.b	Standardize citations	
8.435.2.A	42 C.F.R. 488.330	42 C.F.R. section 488.330	Standardize citations	
8.435.2.B.4	section 25-1-107.5, C.R.S.	C.R.S. section 25-1-107.5.	Standardize citations	
8.435.2.C.3	10 CCR 2505-10, section 8.050	10 CCR 2505-10 section 8.050	Standardize citations	
8.435.2.D.3.c	10 CCR 2505-10, section 8.050	10 CCR 2505-10 section 8.050	Standardize citations	
8.435.2.D.3.f	10 CCR 2505-10, section 8.441	10 CCR 2505-10 section 8.441	Standardize citations	
8.435.2.E.2.a	section 8.435.2.E.4.b	10 CCR 2505-10 section 8.435.2.E.4.b	Standardize citations	
8.435.2.E.3	section 8.435.2.e.4.b	10 CCR 2505-10 section 8.435.2.E.4.b	Standardize citations	
8.435.2.E.3	section 25-1-107.5, C.R.S.	C.R.S. section 25-1-107.5.	Standardize citations	
8.435.2.E.4.b.2	article 11.5 of Title 26, C.R.S.	C.R.S. section 26-11.5-104 et seq.	Standardize citations	
8.435.2.E.4.c	section 8.435.2.E.3	10 CCR 2505-10 section 435.2.E.3	Standardize citations	
8.435.2.E.5	section 8.435.2.E.4.b	10 CCR 2505-10 section 8.435.2.E.4.b	Standardize citations	
8.435.2.E.6.b	section 25-1-107.5, C.R.S.	C.R.S. section 25-1-107.5	Standardize citations	
8.435.2.E.8	section 8.435.2.E.4.b	10 CCR 2505-10 section 8.435.2.E.4.b	Standardize citations	

8.435.2.E.8.c	section 8.435.2.E.4.b	10 CCR 2505-10 section 8.435.2.E.4.b	Standardize citations	
8.435.2.E.8.d	sections 25.5-4-304 through 25.5-4-305, C.R.S.	C.R.S. sections 25.5-4-304 through 25.5-4-307.	Standardize citations	
8.440.16	at 8.443.7	at 10 CCR 2505-10 section 8.443.7.	Standardize citations	
8.440.26	section 25-1.5-103(1)(a), C.R.S.,	C.R.S. section 25-1.5-103	Standardize citations	
8.440.32	42 C.F.R. 433.55	42 C.F.R. section 433.55	Standardize citations	
8.440.39	42 C.F.R. 483.13	42 C.F.R. section 483.13	Standardize citations	
8.440.39	42 C.F.R. 483.15	42 C.F.R. section 483.15	Standardize citations	
8.440.39	42 C.F.R. 483.25	42 C.F.R. section 483.25	Standardize citations	
8.440.1.B	42 C.F.R. 493	42 C.F.R. part 493	Standardize citations	
8.441.5.E.1.d	section 8.441.5.D.	10 CCR 2505-10 section 8.441.5.D.	Standardize citations	
8.441.5.H.2	8.441.5.H.1	10 CCR 2505-10 section 8.441.5.H.1	Standardize citations	
8.441.5.H.2.a	8.441.5.B	10 CCR 2505-10 section 8.441.5.B	Standardize citations	
8.441.5.H.2.b	8.441.5.B	10 CCR 2505-10 section 8.441.5.B	Standardize citations	
8.441.5.H.2.c.i	8.441.5.B	10 CCR 2505-10 section 8.441.5.B	Standardize citations	
8.441.5.H.2.e	8.441.5.H.2.d	10 CCR 2505-10 section 8.441.5.H.2.d	Standardize citations	
8.441.5.I.2.a	8.441.5.B	10 CCR 2505-10 section 8.441.5.B	Standardize citations	
8.441.5.I.2.c.ii	8.441.5.B	10 CCR 2505-10 section 8.441.5.B	Standardize citations	

8.441.5.1.2.c.iii	8.441.5.B	10 CCR 2505-10 section 8.441.5.B	Standardize citations	
8.443.2.2.c	Class II facilities shall be certified in accordance with 42 C.F.R. 442, Subpart C, 42 C.F.R. 483 and shall be licensed by the CDPHE. Class II facilities shall provide care and a program of services consistent with licensure and certification requirements.	Class II facilities shall be certified in accordance with 42 C.F.R. part 442, Subpart C, and 42 C.F.R. part 483 and shall be licensed by CDPHE. Class II facilities shall provide care and a program of services consistent with licensure and certification requirements.	Standardize citations	
8.443.2.3.b	Class IV facilities shall be certified in accordance with 42 C.F.R. 442, Subpart C, 42 C.F.R. 483 and shall be licensed by the CDPHE. Class IV facilities shall provide care and a program of services consistent with licensure and certification requirements.	Class IV facilities shall be certified in accordance with 42 C.F.R. part 442, Subpart C, and 42 C.F.R. part 483 and shall be licensed by CDPHE. Class IV facilities shall provide care and a program of services consistent with licensure and certification requirements.	Standardize citations	
8.443.7.D	8.443.7.B	10 CCR 2505-10 section 8.443.7.B	Standardize citations	
8.443.7.D.2.b	8.443.7.B	10 CCR 2505-10 section 8.443.7.B	Standardize citations	
8.443.8.A.1	8.443.7.A.1	10 CCR 2505-10 section 8.443.7.A.1	Standardize citations	
8.443.8.A.8	8.443.7.A.13	10 CCR 2505-10 section 8.443.7.A.13	Standardize citations	
8.443.8.F.2	8.443.7.D	10 CCR 2505-10 section 8.443.7.D	Standardize citations	
8.443.8.F.2	8.443.3	10 CCR 2505-10 section 8.443.3	Standardize citations	
8.443.8.F.3	8.443.4.B	10 CCR 2505-10 section 8.443.4.B	Standardize citations	

8.443.8.F.4	8.443.5	10 CCR 2505-10 section 8.443.5	Standardize citations	
8.443.8.F.5	8.443.9.A	10 CCR 2505-10 section 8.443.9.A	Standardize citations	
8.443.10.A	Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1818. The incorporated material may also be examined at any State Publications Depository Library.	pursuant to 10 CCR 2505-10 sections 8.443.7 (Health Care Services), 8.443.8	Standardize citations	
8.443.10.B.3	pursuant to 8.443.7 (Health Care Services) and 8.443.8	pursuant to 10 CCR 2505-10 sections 8.443.7 (Health Care Services), 8.443.8	Standardize citations	
8.443.10.B.7	pursuant to 8.443.7 (Health Care Services) and 8.443.8	pursuant to 10 CCR 2505-10 sections 8.443.7 (Health Care Services), 8.443.8	Standardize citations	
8.443.10.C	pursuant to 8.443.7 (Health Care Services) and 8.443.8	pursuant to 10 CCR 2505-10 sections 8.443.7 (Health Care Services), 8.443.8	Standardize citations	
8.443.10.C.1	CPS (8.443 10A), PASRR II (8.443.10 B), Pay for Performance (8.443.12)	CPS (10 CCR 2505-10 section 8.443.10.A), PASRR II (10 CCR 2505-10 section 8.443.10.B), Pay for Performance (10 CCR 2505-10 section 8.443.12)	Standardize citations	
8.443.10.C.1	8.443.11	10 CCR 2505-10 section 8.443.11	Standardize citations	
8.443.11	pursuant to 8.443.7 (Health Care Services) and 8.443.8	pursuant to 10 CCR 2505-10 sections 8.443.7 (Health Care Services), 8.443.8	Standardize citations	
8.443.11.6	section 25.5-6-202(9)(b)(II), C.R.S.	C.R.S. section 25.5-6-202(9)(b)(II)	Standardize citations	
8.443.13.D	8.443.13.A	10 CCR 2505-10 section 8.443.13.A	Standardize citations	

8.443.13.F.3	sections 8.442.1	10 CCR 2505-10 section 8.442.1	Standardize citations	
8.443.14.A	Participation in Title XIX	participation under Title XIX of the Social Security Act (42 U.S.C. section 1396r)	Standardize citations	Rationale for change here is twofold: standardizing the citations so that they are uniform across the regulations, and making finding the relevant statutes easier. While Title XIX of the social security act is codified at 42 U.S.C. section 1396r, it is often easier to read and find as title XIX of the SSA, so including both citations is probably the best compromise.
8.443.14.D.1.a	10 CCR 2505-10, section 8.443.3.A	10 CCR 2505-10 section 8.443.3.A	Standardize citations	
8.443.14.D.1.b	10 CCR 2505-10, section 8.443.11.A	10 CCR 2505-10 section 8.443.11.A	Standardize citations	
8.443.17.A.2	section 25-27-102(1.3), C.R.S.	C.R.S. section 25-27-102(1.3)	Standardize citations	
8.443.17.A.4.a. i	8.443.17.B.1	10 CCR 2505-10 section 8.443.17.B.1	Standardize citations	
8.443.17.A.4.a. ii	8.443.10.A	10 CCR 2505-10 section 8.443.10.A	Standardize citations	
8.443.17.A.4.a. iii	8.443.10.B	10 CCR 2505-10 section 8.443.10.B	Standardize citations	
8.443.17.A.4.a. iv	8.443.12	10 CCR 2505-10 section 8.443.12	Standardize citations	
8.443.17.A.4.a. v	8.443.10.C	10 CCR 2505-10 section 8.443.10.C	Standardize citations	
8.443.17.A.4.a. vi	8.443.11	10 CCR 2505-10 section 8.443.11	Standardize citations	
8.443.17.A.4.a. vii	8.443.7.D	10 CCR 2505-10 section 8.443.7.D	Standardize citations	

8.443.17.A.4.c	42 C.F.R. 433.68	42 C.F.R. section 433.68	Standardize citations	
8.443.17.B.1	section 25.5-6-202	C.R.S. section 25.5-6-202	Standardize citations	
8.443.17.B.1	section 25.5-6-202	C.R.S. section 25.5-6-202	Standardize citations	
8.443.17.B.2	section 25.5-6-202	C.R.S. section 25.5-6-202	Standardize citations	
8.443.18.A	section 25-3-108, C.R.S.	C.R.S. section 25-3-108	Standardize citations	
8.443.18.A.2.e	8.443.13	10 CCR 2505-10 section 8.443.13	Standardize citations	
8.443.19.D	10 CCR 2505-10, sections 8.402.01	10 CCR 2505-10 sections 8.402.01	Standardize citations	
8.443.20.A.2.a	24-4-103(12.5), C.R.S.	C.R.S. section 24-4-103(12.5)	Standardize citations	
8.470.3.G	8.057	10 CCR 2505-10 section 8.057	Standardize citations	
8.470.5.D.2	8.057	10 CCR 2505-10 section 8.057	Standardize citations	
8.470.5.D.4.a	10 CCR 2505-10, section 8.057.1.D and section 8.057.1.E	10 CCR 2505-10 sections 8.057.1.D and 8.057.1.E	Standardize citations	
8.482.1	as see forth in 8.482.5	as set forth in 10 CCR 2505-10 section 8.482.5	Standardize citations	
8.482.2.F	8.110.42	10 CCR 2505-10 section 8.110.42	Standardize citations	
8.482.31	section 8.482.34,B	10 CCR 2505-10 section 8.482.34.B	Standardize citations	
8.482.31.C	section 8.482.45 of this Staff Manual	10 CCR 2505-10 section 8.482.45.	Standardize citations	
8.482.33.C.2.b	section 8.482.33.2.a	10 CCR 2505-10 section 8.482.33.2.a	Standardize citations	
8.482.33.C.2.c	section 8.200 et seq.	10 CCR 2505-10 sections 8.200 et seq.	Standardize citations	

8.482.33.C.3.a	seccion 8.287.02	10 CCR 2505-10 section 8.287.02	Standardize citations	
8.482.34.B.4.a	section 8.482.44	10 CCR 2505-10 section 8.482.44	Standardize citations	
8.482.34.B.4.b	section 8.482.43	10 CCR 2505-10 section 8.482.43	Standardize citations	
8.482.34.B.8.b	section 8.482.44,D	10 CCR 2505-10 section 8.482.44.D	Standardize citations	
8.482.34.C.4	8.482.3	10 CCR 2505-10 section 8.482.3	Standardize citations	
8.482.34.C.6.b	section 8.482.52,F	10 CCR 2505-10 section 8.482.52.F	Standardize citations	
8.482.34.C.6.b. 1	8.358.1	10 CCR 2505-10 section 8.358.1	Standardize citations	
8.482.34.C.6.b. 1	section 8.482.52,F	10 CCR 2505-10 section 8.482.52.F	Standardize citations	
8.482.34.C.6.b. 2	section 8.482.52,F	10 CCR 2505-10 section 8.482.52.F	Standardize citations	
8.482.34.D.1.a	8.110.42	10 CCR 2505-10 section 8.110.49	Standardize citations	
8.482.34.D.1.b	sections8.110.49, and 8.482.33	10 CCR 2505-10 sections 8.110.49 and 8.482.33	Standardize citations	
8.482.34.D.2	8.482.34,D.1	10 CCR 2505-10 section 8.482.34.D.1	Standardize citations	
8.482.34.D.2.a	sections8.110.49 and 8.482.33	10 CCR 2505-10 sections 8.110.49 and 8.482.33	Standardize citations	
8.482.41.C	8.482.45	10 CCR 2505-10 section 8.482.45.	Standardize citations	
8.482.42.A.1	section 8.442.1	10 CCR 2505-10 section 8.442.1	Standardize citations	
8.482.42.A.2	section 8.482.43	10 CCR 2505-10 section 8.482.43	Standardize citations	
8.482.42.A.3	section 8.482.44	10 CCR 2505-10 section 8.482.44	Standardize citations	

8.482.42.B	8.482.48	10 CCR 2505-10 section 8.482.48	Standardize citations	
8.482.42.C.1	section 8.442.1	10 CCR 2505-10 section 8.442.1	Standardize citations	
8.482.42.C.1	section 8.442.1	10 CCR 2505-10 section 8.442.1	Standardize citations	
8.482.42.C.2	sections 8.482.43 and 8.482.44	10 CCR 2505-10 sections 8.482.43 and 8.482.44	Standardize citations	
8.482.42.D	8.482.45	10 CCR 2505-10 section 8.482.45	Standardize citations	
8.482.43.B.3	section 8.482.34	10 CCR 2505-10 section 8.482.34	Standardize citations	
8.482.43.C.5	section 8.482.42	10 CCR 2505-10 section 8.482.42	Standardize citations	
8.482.44.B	8.482.45	10 CCR 2505-10 section 8.482.45	Standardize citations	
8.482.44.D	section 8.482.43	10 CCR 2505-10 section 8.482.43	Standardize citations	
8.482.45.A	26-1-127, C.R.S.	C.R.S. section 26-1-127	Standardize citations	
8.482.45.C	25-3-103, C.R.S.	C.R.S. section 25-3-103	Standardize citations	
8.482.45.D	26-1-127, C.R.S.	C.R.S. section 26-1-127	Standardize citations	
8.482.45.F	26-2-128, C.R.S.	C.R.S. section 26-2-128	Standardize citations	
8.482.46.A	42 CFR 405.230-252	42 C.F.R. sections 405.230-252	Standardize citations	
8.482.46.B	42 CFR 405.230-252	42 C.F.R. sections 405.230-252	Standardize citations	
8.482.51.A	section 8.110.42	10 CCR 2505-10 section 8.110.42	Standardize citations	
8.482.51.B	section 8.442	10 CCR 2505-10 section 8.442	Standardize citations	

8.482.51.B.3	8.482.41	10 CCR 2505-10 section 8.482.41	Standardize citations	
8.482.51.B.4	8.482.42	10 CCR 2505-10 section 8.482.42	Standardize citations	
8.482.52.A.2	15-1-101, C.R.S.	C.R.S. section 15-1-101	Standardize citations	
8.482.52.A.2	section 8.110.42	10 CCR 2505-10 section 8.110.42	Standardize citations	
8.482.52.A.10	8.44	10 CCR 2505-10 section 8.440	Standardize citations	
8.482.52.A.13	8.482.51	10 CCR 2505-10 sections 8.482.51	Standardize citations	
8.482.52.A.15	8.110.53.A	10 CCR 2505-10 section 8.100.5.M	Standardize citations	
8.482.52.B.1	section 26-4-504(3)(c), C.R.S.	C.R.S. section 25.5-6-206(3)(c)	Standardize citations	
8.482.52.C.1	section 8.441.5	10 CCR 2505-10 section 8.441.5	Standardize citations	
8.482.52.C.1.b	section 26-4-504(3)(c), C.R.S.	C.R.S. section 25.5-6-206 (3)(c)	Standardize citations	
8.482.52.C.1.b	8.482.52,B	10 CCR 2505-10 sections 8.482.52.B	Standardize citations	
8.482.52.C.1.c	section 8.441.5	10 CCR 2505-10 section 8.441.5	Standardize citations	
8.482.52.C.1.c	section 8.444	10 CCR 2505-10 section 8.444	Standardize citations	
8.482.52.F.1	8.482.45	10 CCR 2505-10 section 8.482.45	Standardize citations	
8.482.52.F.1	8.482.6	10 CCR 2505-10 section 8.482.6	Standardize citations	
8.482.52.F.3.a	Title 15, C.R.S.	C.R.S. sections 15-1-101 et seq.	Standardize citations	
8.482.52.F.3.b	15-12-621(2.), C.R.S.	C.R.S. section 15-12-620(4)	Standardize citations	

8.482.52.F.3.c	15-12-711, C.R.S.	C.R.S. section 15-12-711	Standardize citations	
8.482.52.F.3.d. 1	15-12-1201, et seq., C.R.S.	C.R.S. section 15-12-1201, et seq.	Standardize citations	
8.482.52.F.3.d. 2	15-12-1202, C.R.S.	C.R.S. section 15-12-1202	Standardize citations	
8.482.52.F.3.e	8.482.6(c)	10 CCR 2505-10 section 8.482.6.C	Standardize citations	
8.482.52.F.4	8.482.45	10 CCR 2505-10 section 8.482.45	Standardize citations	
8.482.53.A	section 8.482.52(A)(2)	10 CCR 2505-10 section 8.482.52.A.2	Standardize citations	
8.482.54.D	section 8.482.45 of this Staff Manual	10 CCR 2505-10 section 8.482.45	Standardize citations	
8.482.6.C.1	see 8.482,F,3,d	10 CCR 2505-10 section 8.482.F.3.d	Standardize citations	
8.482.72.B.15	8.110.49	10 CCR 2505-10 section 8.110.49	Standardize citations	
8.485.10	26-4-601 et seq., C.R.S.	C.R.S. section 25.5-3-301 et seq.	Standardize citations	
8.485.40.A	section 8.491	10 CCR 2505-10 section 8.491	Standardize citations	
8.485.40.B	section 8.495	10 CCR 2505-10 section 8.495	Standardize citations	
8.485.40.C	section 8.488	10 CCR 2505-10 section 8.488	Standardize citations	
8.485.40.D	section 8.493	10 CCR 2505-10 section 8.493	Standardize citations	
8.485.40.E	section 8.490	10 CCR 2505-10 section 8.490	Standardize citations	
8.485.40.F	section 8.494	10 CCR 2505-10 section 8.494	Standardize citations	
8.485.40.G	section 8.489	10 CCR 2505-10 section 8.489	Standardize citations	

8.485.40.H	section 8.492	10 CCR 2505-10 section 8.492	Standardize citations	
8.485.40.I	section 8.552	10 CCR 2505-10 section 8.552	Standardize citations	
8.485.40.J	section 8.553	10 CCR 2505-10 section 8.553	Standardize citations	
8.485.40.K	section 8.510	10 CCR 2505-10 section 8.510	Standardize citations	
8.485.50.B	section 8.390.1(B)	10 CCR 2505-10 section 8.390.1.B	Standardize citations	
8.485.50.C	section 8.390.1(D)	10 CCR 2505-10 section 8.390.1.D	Standardize citations	
8.485.50.D	8.485.50(U)	10 CCR 2505-10 section 8.485.50.U	Standardize citations	
8.485.50.F	8.485.50(F)	10 CCR 2505-10 section 8.485.50.F	Standardize citations	
8.485.50.G	sections 8.402.60 and 8.390.1(C)	10 CCR 2505-10 sections 8.402.60 and 8.390.1.C	Standardize citations	
8.485.50.H	8.390.1(E)	10 CCR 2505-10 section 8.390.1.E	Standardize citations	
8.485.50.M	8.390.1(J)	10 CCR 2505-10 section 8.390.1.J	Standardize citations	
8.485.50.N	8.401	10 CCR 2505-10 section 8.401	Standardize citations	
8.485.50.O	8.485.40	10 CCR 2505-10 section 8.485.40	Standardize citations	
8.485.50.P	section 8.390.1(N)	10 CCR 2505-10 section 8.390.1.N	Standardize citations	
8.485.50.Q	section 8.390.1(C)	10 CCR 2505-10 section 8.390.1.C	Standardize citations	
8.485.50.R	8.390.1(R)	10 CCR 2505-10 section 8.390.1.R	Standardize citations	
8.485.61.A	the Income Maintenance Staff Manual, at 9.100	10 CCR 2505-10 section 8.100	Standardize citations	

8.485.61.B.1	section 8.400.16	10 CCR 2505-10 section 8.400.16	Standardize citations	
8.485.61.B.2	section 8.401.11	10 CCR 2505-10 sections 8.401.11	Standardize citations	
8.485.61.B.3	section 8.402.60	10 CCR 2505-10 section 8.402.60	Standardize citations	
8.485.61.C.3	section 8.485.30	10 CCR 2505-10 section 8.485.30	Standardize citations	
8.485.61.E	section 8.485.50	10 CCR 2505-10 section 8.485.50	Standardize citations	
8.485.71	section 8.485.60	10 CCR 2505-10 section 8.485.60	Standardize citations	
8.485.71.A	section 8.100	10 CCR 2505-10 section 8.100	Standardize citations	
8.485.72	10 CCR 2505-10 8.486.33	10 CCR 2505-10 section 8.486.33	Standardize citations	
8.485.80	section 8.100	10 CCR 2505-10 section 8.100	Standardize citations	
8.485.80	section 8.485.60	10 CCR 2505-10 section 8.485.60	Standardize citations	
8.485.92	section 8.057, et. Seq.	10 CCR 2505-10 sections 8.057 et seq.	Standardize citations	
8.485.97	section 8.485.70	10 CCR 2505-10 section 8.485.70	Standardize citations	
8.485.204.E	section 8.552	10 CCR 2505-10 section 8.552	Standardize citations	
8.486.10	section 8.390, et. Seq.	10 CCR 2505-10 sections 8.390 et seq.	Standardize citations	
8.486.21	section 8.393.21	10 CCR 2505-10 section 8.393.21	Standardize citations	
8.486.31	section 8.393.21	10 CCR 2505-10 section 8.393.21	Standardize citations	
8.486.32	section 8.485.20	10 CCR 2505-10 section 8.485.20	Standardize citations	

8.486.41	section 8.485.60	10 CCR 2505-10 section 8.485.60	Standardize citations	
8.486.41	section 8.393.28	10 CCR 2505-10 section 8.393.28	Standardize citations	
8.486.60.B.5	section 8.495	10 CCR 2505-10 section 8.495	Standardize citations	
8.486.60.C.2	section 8.509.31(G) of Staff Manual Volume 8	10 CCR 2505-10 section 8.509.31.G	Standardize citations	
8.486.81	8.485.50. J	10 CCR 2505-10 section 8.485.50.J	Standardize citations	
8.486.101.B	section 8.493	10 CCR 2505-10 section 8.493	Standardize citations	
8.486.102.B	8.393.28	10 CCR 2505-10 section 8.393.28	Standardize citations	
8.486.201	8.393.25	10 CCR 2505-10 section 8.393.25	Standardize citations	
8.486.202	section 8.485.90	10 CCR 2505-10 section 8.485.90	Standardize citations	
8.486.301	8.393.28	10 CCR 2505-10 section 8.393.28	Standardize citations	
8.486.301	section 8.485.60	10 CCR 2505-10 section 8.485.60	Standardize citations	
8.486.401.D	section 8.485.50.P	10 CCR 2505-10 section 8.485.50	Standardize citations	
8.486.501	at 8.393.16, and at 8.393.26	at 10 CCR 2505-10 sections 8.393.16 and 8.393.26	Standardize citations	
8.487.13	accordance with state statutes on CONFIDENTIALITY OF INFORMATION at 26-1-114, C.R.S.	accordance with C.R.S. section 26-1- 114	Standardize citations	
8.487.20	section 8.485.50	10 CCR 2505-10 section 8.485.50	Standardize citations	
8.487.30	section 8.130	10 CCR 2505-10 section 8.130	Standardize citations	

8.487.50	section 8.130	10 CCR 2505-10 section 8.130	Standardize citations	
8.487.60	section 8.487.20	10 CCR 2505-10 section 8.487.20	Standardize citations	
8.487.80	section 8.050	10 CCR 2505-10 section 8.050	Standardize citations	
8.487.100	section 8.050	10 CCR 2505-10 section 8.050	Standardize citations	
8.487.201.A	section 8.040 and section 8.043	10 CCR 2505-10 sections 8.040 and 8.043	Standardize citations	
8.487.202	section 8.040.02, section 8.130, and section 8.487.10	10 CCR 2505-10 sections 8.040, 8.130, and 8.487.10	Standardize citations	
8.488.12	at section 8.484.50,Q, GENERAL DEFINITIONS	at 10 CCR 2505-10 section 8.484.50.Q	Standardize citations	
8.488.20	8.488.31	10 CCR 2505-10 section 8.488.31	Standardize citations	
8.488.41	at 8.487, HCBS-EBD PROVIDER AGENCIES	at 10 CCR 2505-10 section 8.487	Standardize citations	
8.489.21	section 8.489.30	10 CCR 2505-10 section 8.489.30	Standardize citations	
8.489.22.A	section 8.489.30	10 CCR 2505-10 section 8.489.30	Standardize citations	
8.489.22.B	section 8.489.30	10 CCR 2505-10 section 8.489.30	Standardize citations	
8.489.22.E	SECTION 8.485.200, LIMITATIONS ON PAYMENT TO FAMILY.	10 CCR 2505-10 section 8.485.200.	Standardize citations	
8.489.31.A.2	8.489.31,B,2	10 CCR 2505-10 section 8.489.31.B.2	Standardize citations	
8.489.31.A.2	8.489.31,K,2	10 CCR 2505-10 section 8.489.31.K.2	Standardize citations	
8.489.31.A.2	8.489.31,G.2	10 CCR 2505-10 section 8.489.31.G.2	Standardize citations	

8.489.31.C.2	8.489.31,K,2	10 CCR 2505-10 section 8.489.31.K.2	Standardize citations	
8.489.31.C.2	8.489.31,G.2	10 CCR 2505-10 section 8.489.31.G.2	Standardize citations	
8.489.31.D.2	8.489.31,B,2	10 CCR 2505-10 section 8.489.31.B.2	Standardize citations	
8.489.31.E.2	8.489.31,B,2	10 CCR 2505-10 section 8.489.31.B.2	Standardize citations	
8.489.31.F.2	8.489.31,B,2	10 CCR 2505-10 section 8.489.31.B.2	Standardize citations	
8.489.31.G.2	8.489.313,2	10 CCR 2505-10 section 8.489.31.B.2	Standardize citations	
8.489.31.G.2	8.489.31,O	10 CCR 2505-10 section 8.489.31.k.2	Standardize citations	
8.489.31.H.2	8.489.313,2	10 CCR 2505-10 section 8.489.31.B.2	Standardize citations	
8.489.31.H.2	8.489.31,O	10 CCR 2505-10 section 8.489.31.G.2	Standardize citations	
8.489.31.I.2	8.489.31,K,2	10 CCR 2505-10 section 8.489.31.K.2	Standardize citations	
8.489.31.I.2	8.489.31,B,2	10 CCR 2505-10 section 8.489.31.B.2	Standardize citations	
8.489.31.K.2	8.489.31,B,2	10 CCR 2505-10 section 8.489.31.B.2	Standardize citations	
8.489.31.N.2	8.489.31,K,2	10 CCR 2505-10 section 8.489.31.K.2	Standardize citations	
8.489.31.R	section 8.490, HOMEMAKER SERVICES	10 CCR 2505-10 section 8.490	Standardize citations	
8.489.41	section 8.487, HCBS-EBD PROVIDER AGENCIES	10 CCR 2505-10 section 8.487	Standardize citations	
8.489.44	section 8.050	10 CCR 2505-10 sections 8.050	Standardize citations	
8.489.44	section 8.051.01	10 CCR 2505-10 section 8.051.01	Standardize citations	

8.489.44.A.1	8.079.62	10 CCR 2505-10 section 8.079.62	Standardize citations	
8.489.44.A.3	regulations in this SECTION 8.489	10 CCR 2505-10 section 8.489	Standardize citations	
8.489.55	section 8.490, HOMEMAKER SERVICES	10 CCR 2505-10 section 8.490	Standardize citations	
8.489.58	section 8.489.58	10 CCR 2505-10 section 8.489.58	Standardize citations	
8.490.3.C.3	section 8.485.200.F	10 CCR 2505-10 section 8.485.200.F	Standardize citations	
8.490.4.B	10 CCR 2505-10, section 8.487	10 CCR 2505-10 section 8.487	Standardize citations	
8.490.4.C.1	section 8.490.3.B	10 CCR 2505-10 section 8.490.3.B	Standardize citations	
8.491.12	section 8.130 and section 8.491.14	10 CCR 2505-10 sections 8.130 and 8.491.14	Standardize citations	
8.491.15.A	section 8.495.C.22	10 CCR 2505-10 section 8.495.C.22	Standardize citations	
8.491.20.A.1	section 8.130	10 CCR 2505-10 section 8.130	Standardize citations	
8.491.20.A.3	section 8.050	10 CCR 2505-10 section 8.050	Standardize citations	
8.491.20.B.12	8.491.15C	10 CCR 2505-10 section 8.491.15.C	Standardize citations	
8.491.20.B.13	8.491.14	10 CCR 2505-10 section 8.491.14	Standardize citations	
8.491.20.C.3	8.130.65	10 CCR 2505-10 section 8.130.65	Standardize citations	
8.491.20.D.1	8.491.12	10 CCR 2505-10 sections 8.491.12	Standardize citations	
8.491.20.D.2.a	8.491.20,D.1.d	10 CCR 2505-10 section 8.491.20.D.1.d	Standardize citations	

8.491.20.E.1	State Law, Chapter XXIV, section 25-1-107(1)(ee)(I)(A) Qualified Medication Administration Staff Members	C.R.S. section 25-1.5-302	Standardize citations	
8.491.20.E.2	section 8.491.15 E	10 CCR 2505-10 section 8.491.15.E	Standardize citations	
8.491.20.E.2	section 8.491.13	10 CCR 2505-10 section 8.491.13	Standardize citations	
8.491.35.B	section 8.491.14.H	10 CCR 2505-10 section 8.491.14.H	Standardize citations	
8.492.22	section 8.495, ALTERNATIVE CARE FACILITIES	10 CCR 2505-10 section 8.495	Standardize citations	
8.492.32	section 8.495, ALTERNATIVE CARE FACILITIES	10 CCR 2505-10 section 8.495	Standardize citations	
8.493.1.4	section 8.493.5.B	10 CCR 2505-10 section 8.493.5.B	Standardize citations	
8.493.3.D	sections 8.485.50 F. and G.	10 CCR 2505-10 sections 8.485.50.F and G	Standardize citations	
8.493.4.E.2	section 8.520	10 CCR 2505-10 section 8.520	Standardize citations	
8.493.5	section 8.487.11	10 CCR 2505-10 section 8.487.11	Standardize citations	
8.493.7.B.4.a	section 8.493.5.E	10 CCR 2505-10 section 8.493.5.E	Standardize citations	
8.494.41	section 8.487, HCBS-EBD PROVIDER AGENCIES	10 CCR 2505-10 section 8.487	Standardize citations	
8.495.1	25.5-6-303(3) C.R.S.	C.R.S. section 25.5-6-303(3)	Standardize citations	
8.495.1	25.5-6-303(4) C.R.S.	C.R.S. section 25.5-6-303(4)	Standardize citations	
8.495.1	25-1.5-301 C.R.S.	C.R.S. section 25-1.5-301	Standardize citations	
8.495.2.A	10 CCR 2505-10, section 8.485	10 CCR 2505-10 section 8.485	Standardize citations	

8.495.2.A	10 CCR 2505-10, section 8.509	10 CCR 2505-10 section 8.509	Standardize citations	
8.495.3.A	10 CCR 2505-10, sections 8.489 and 8.490	10 CCR 2505-10 sections 8.489 and 8.490	Standardize citations	
8.495.4.F	8.495.2.B	10 CCR 2505-10 section 8.495.2.B	Standardize citations	
8.405.21	section 8.402.10	10 CCR 2505-10 section 8.402.10	Standardize citations	
8.405.21	section 8.402.16	10 CCR 2505-10 section 8.402.16	Standardize citations	
8.482.42.C.2	Sections 8.482.43 and 8.482.44	10 CCR 2505-10 sections 8.482.43 and 8.482.44	Standardize citations	
8.482.52.A.13	8.482.51.B for purchases and 8.482.52.F	10 CCR 2505-10 section 8.482.51.B for purchases and 10 CCR 2505-10 section 8.482.52.F	Standardize citations	
8.482.52.A.15	8.110.53.A	10 CCR 2505-10 section 8.110.53.A	Standardize citations	
8.482.52.C.1.b	8.482.52,B	8.482.52.B	Standardize citations	

8.482.52.F.1	8.482.6	10 CCR 2505-10 section 8.482.6	Standardize citations	
8.482.53.A	8.482.52(A)(2)	8.482.52.A.2	Standardize citations	
8.482.6.C.1	8.482,F,3,d	10 CCR 2505-10 section 8.482.F.3.d	Standardize citations	
8.482.72.B.15	8.110.49	10 CCR 2505-10 section 8.110.49	Standardize citations	
8.485.50.B	8.390.1.B	10 CCR 2505-10 section 8.390.1.B	Standardize citations	
8.485.50.C	8.390.1.D	10 CCR 2505-10 section 8.390.1.D	Standardize citations	
8.485.50.F	8.495.1	10 CCR 2505-10 section 8.495.1	Standardize citations	
8.402.14	faxing or emailing the Initial Screening and Intake Form	faxing or emailing the appropriate forms	update practice	

8.402.15	nursing facility Length of Stay Assignment form	appropriate form	update practice	
8.402.17	Beginning November 1, 2003, the	The	update practice	No longer need reference to start date; open to removing this and keeping the date
8.402.64	case manager or the community mental health center (CMHC)	case manager, client, authorized representative, or the behavioral health organization	update practice	
8.449.1	State Department of Health	State Department of Public Health and Environment	update practice	
8.449.1	Social Services	Human Services	update practice	
8.481		The Memorandum of Understanding between the Department and the PRO is hereby incorporated by reference. The incorporation of the Memorandum of Understanding excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.	update practice	Add incorporation through reference language.
8.486.81.A	HCBS-EBD services	waiver services	update practice	
8.486.201	each HCBS-EBD client	each SEP-managed waiver client	update practice	

8.486.301	the HCBS-EBD program whenever	any SEP-managed waiver whenever	update practice	
8.486.301	terminated from the program	terminated from the waiver	update practice	
8.486.301	withdraw from the program	withdraw from the waiver	update practice	
8.487	HCBS-EBD agencies	HCBS waiver provider agencies	update practice	
8.488.33	a regular Medicaid benefit	a state plan Medicaid benefit	update practice	
8.490.2.A	Elderly Blind and disabled, Persons Living with Aids, and Persons with Mental Illness	Elderly Blind and disabled, and Persons with Mental Illness	update practice	
8.402.64	or 29 the Community Mental Health Center (CMHC).	, client, authorized representative, or the behavioral health organization.	update practice	
8.485.50.K	section 8.485.50(K)	at 10 CCR 2505-10 section 8.485.50.K.		
8.402.37	sections	section		