DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE - SECTION 8.400 Long Term Care, Nursing Facility Care, Adult Day Care Services

10 CCR 2505-10 8.400

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

8.400 LONG-TERM CARE

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

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

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

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

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

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

- Skilled care facilities (SNF)
- Intermediate care facilities (ICF)
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

.12 Home and Community Based Services under the Medicaid Waivers include distinct service programs designed as alternatives to standard Medicaid nursing facility or hospital services for discrete categories of clients. These waivers are Home and Community Based Services Waiver for Persons Who Are Elderly, Blind and Disabled (HCBS-EBD), Home and Community Based Services Waiver for Persons with Spinal Cord Injury (HCBS-SCI), Community Mental Health Supports Waiver (HCBS-CMHS), Home and Community Based Services Waiver for Persons With Brain Injury (HCBS-BI); Home and Community Based Services Waiver for Persons with Developmental Disabilities (HCBS-DD), Supportive Living Services Waiver (HCBS-SLS); Home and Community Based Services Waiver for Children with Autism (HCBS-CWA), Children with Life-limiting Illness Waiver (HCBS-CLLI), Children's Habilitation Residential Program Waiver (HCBS-CHRP), Children Extensive Supports Waiver (HCBS-CES), Children's Home and Community Based Services Waiver (HCBS-CHCBS) and Home and Community Based Services for those inappropriately residing in nursing facilities (OBRA '87).

.13 Unless specified by reference to the specific programs described above, the term Home and Community Based Services where it appears in these rules and regulations shall refer to the programs described herein above, and the rules and regulations within this section shall be applicable to all Home and Community Based Services programs.

.14 Nursing facilities are prohibited from admitting any new client who has mental illness or intellectual or developmental disability, as defined in Section 8.401.18 Determination Criteria for Mentally Ill or Individuals with an Intellectual or Developmental Disability unless that client has been determined to require the level of services provided by a nursing facility as defined in Section 8.401.19.

.15 Clients eligible for Home and Community Based Services are eligible for all Medicaid services including home health services.

.16 Target Population Definitions. For purposes of determining appropriate type of long-term services, including home and community-based services, as well as providing for a means of properly referring clients to the appropriate community agency, the following target group designations are established:

A. Developmentally Disabled - includes all clients whose need for long-term care services is based on a diagnosis of Developmental Disability and Related Conditions, as defined in Section 8.401.18.

B. Mentally Ill - includes all clients whose need for long-term care is based on a diagnosis of mental disease as defined in Section 8.401.18.

C. Functionally Impaired Elderly - includes all clients who meet the level of care screening guidelines for SNF or ICF care, and who are age 65 or over. Clients who are mentally ill, as defined in Section 8.401.18, shall not be included in the target group of Functionally Impaired Elderly, unless the person's need for long-term care services is primarily due to physical impairments that are not caused by any diagnosis included in the definition of mental illness at Section 8.401.18, and determined by (URC) from the medical evidence.

D. Physically Disabled or Blind Adult - includes all clients who meet the level of care screening guidelines for SNF or ICF care, and who are age 18 through 64. Clients who are developmentally disabled or mentally ill, as defined in Section 8.401.18, shall not be included in the Physically Disabled or Blind target group, unless the person's need for long-term care services is primarily due to physical impairments not caused by any diagnosis included in the definition of intellectual or developmental disability or mental illness at Section 8.401.18, as determined by URC from the medical evidence.

E. Persons Living with AIDS - includes all clients of any age who meet either the nursing home level of care or acute level of care screening guidelines for nursing facilities or hospitals and have the -diagnosis of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS). Clients who are diagnosed with HIV or AIDS may alternatively request to be designated as any other target group for which they meet the definitions above.

.17 Services in Home and Community Based Services programs established in accordance with federal waivers shall be provided to clients in accordance with the URC determined target populations as defined herein above.

8.401 LEVEL OF CARE SCREENING GUIDELINES

.01 The client must have been found by the URC to meet the applicable level of care guidelines for the type of services to be provided.

.02 The URC 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.

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

.04 Payment for care in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) will only be made for developmentally disabled clients whose programmatic and/or health care needs meet the level of care guidelines for the appropriate class of ICF/IIDs.

.05 Services provided by nursing facilities are available to those clients that meet the guidelines below and are not identified as mentally ill or individuals with an intellectual or developmental disability by the Determination Criteria for Mentally Ill or Individuals with an Intellectual or Developmental Disability in Section 8.401.18.

8.401.1 GUIDELINES FOR LONG TERM CARE SERVICES (CLASS I SNF AND ICF FACILITIES, *HCBS-EBD, HCBS-CMHS, HCBS-BI, Children's HCBS, HCBS-CES, HCBS-DD, HCBS-SLS, HCBS-CHRP*, and Long-term Home Health)

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

- Mobility
- Bathing
- Dressing
- Eating
- Toileting
- Transferring
- Need for supervision

A. The functional needs of an individual ages 18 and under shall be assessed in accordance with Appendix A, the Age Appropriate Guidelines for the Use of ULTC 100.2 on Children.

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

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

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

- Skin care
- Medication
- Nutrition
- Activities of daily living
- Therapies
- Elimination
- Observation and monitoring

.15

A. The URC shall certify as to the functional need for the nursing facility level of care. A URC reviews the information submitted on the ULTC 100.2 and assigns a score to each of the functional areas described in 10 CCR 2505-10 Section 8.401.11. The scores in each of the functional areas are based on a set of criteria and weights approved by the State which measures the degree of impairment in each of the functional areas. When the score in a minimum of two ADLs or the score for one category of supervision is at least a (2), the URC may certify that the person being reviewed is eligible for nursing facility level of care.

B. The URC's review shall include the information provided by the functional assessment screen.

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

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

LONG-TERM CARE ELIGIBILITY ASSESSMENT

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

ACTIVITIES OF DAILY LIVING

I. BATHING

Definition: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene.

ADL SCORING CRITERIA

☐0=The client is independent in completing the activity safely.

☐1=The client requires oversight help or reminding; can bathe safely without assistance or supervision, but may not be able to get into and out of the tub alone.

☐2=The client requires hands on help or 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)

Physical Impairments:	☐Open Wound
☐Pain	☐Stoma Site
☐Sensory Impairment	Supervision:
☐Limited Range of Motion	☐Cognitive Impairment
☐Weakness	☐Memory Impairment
☐Balance Problems	☐Behavior Issues
☐Shortness of Breath	☐Lack of Awareness
☐Decreased Endurance	☐Difficulty Learning
☐Falls	☐Seizures
☐Paralysis	Mental Health:
☐Neurological Impairment	☐Lack of Motivation/Apathy
☐Oxygen Use	☐Delusional
☐Muscle Tone	☐Hallucinations
☐Amputation	☐Paranoia

Comments:

II. DRESSING

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

ADL 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)

Physical Impairments: ☐Pain ☐Sensory Impairment ☐Limited Range of Motion ☐Weakness ☐Balance Problems ☐Shortness of Breath ☐Decreased Endurance ☐Fine Motor Impairment ☐Paralysis ☐Neurological Impairment ☐Bladder Incontinence ☐Bowel Incontinence ☐Amputation ☐Oxygen Use ☐Muscle Tone	☐Open Wound Supervision: ☐Cognitive Impairment ☐Memory Impairment ☐Behavior Issues ☐Lack of Awareness ☐Difficulty Learning ☐Seizures Mental Health: ☐Lack of Motivation/Apathy ☐Delusional ☐Hallucinations ☐Paranoia

Comments:

III. TOILETING

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

ADL 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)

Physical Impairments: ☐Pain ☐Sensory Impairment ☐Limited Range of Motion ☐Weakness ☐Shortness of Breath ☐Decreased Endurance ☐Fine Motor Impairment ☐Paralysis ☐Neurological Impairment ☐Bladder Incontinence ☐Bowel Incontinence ☐Amputation ☐Oxygen Use ☐Physiological defect ☐Balance ☐Muscle Tone ☐Impaction	☐Ostomy ☐Catheter Supervision Need: ☐Cognitive Impairment ☐Memory Impairment ☐Behavior Issues ☐Lack of Awareness ☐Difficulty Learning ☐Seizures Mental Health: ☐Lack of Motivation/Apathy ☐Delusional ☐Hallucinations ☐Paranoia

Comments:

IV. MOBILITY

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

Physical Impairments:	Supervision Need:
☐Pain	☐Cognitive Impairment
☐Sensory Impairment	☐Memory Impairment
☐Limited Range of Motion	☐Behavior Issues
☐Weakness	☐Lack of Awareness
☐Shortness of Breath	☐Difficulty Learning
☐Decreased Endurance	☐Seizures
☐Fine or Gross Motor Impairment	☐History of Falls
☐Paralysis	Mental Health:
☐Neurological Impairment	☐Lack of Motivation/Apathy
☐Amputation	☐Delusional
☐Oxygen Use	☐Hallucinations
☐Balance	☐Paranoia
☐Muscle Tone	

Comments:

V. TRANSFERRING

Definition: The physical ability to move between surfaces: from bed/chair to wheelchair, walker or standing position; the ability to get in and out of bed or usual sleeping place; the ability to use assisted devices, including properly functioning prosthetics, for transfers. Note: Score Client's ability to transfer 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)

Physical Impairments:	Supervision Need:
☐Pain	☐Cognitive Impairment
☐Sensory Impairment	☐Memory Impairment
☐Limited Range of Motion	☐Behavior Issues
☐Weakness	☐Lack of Awareness
☐Balance Problems	☐Difficulty Learning
☐Shortness of Breath	☐Seizures
☐Falls	Mental Health:
☐Decreased Endurance	☐Lack of Motivation/Apathy
☐Paralysis	☐Delusional
☐Neurological Impairment	☐Hallucinations
☐Amputation	☐Paranoia
☐Oxygen Use	

Comments:

VI. EATING

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

ADL 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)

Physical Impairments: ☐Pain ☐Sensory Impairment ☐Limited Range of Motion ☐Weakness ☐Shortness of Breath ☐Decreased Endurance ☐Paralysis ☐Neurological Impairment ☐Amputation ☐Oxygen Use ☐Fine Motor Impairment ☐Poor Dentition ☐Tremors ☐Swallowing Problems ☐Choking ☐Aspiration	☐Tube Feeding ☐IV Feeding Supervision Need: ☐Cognitive Impairment ☐Memory Impairment ☐Behavior Issues ☐Lack of Awareness ☐Difficulty Learning ☐Seizures Mental Health: ☐Lack of Motivation/Apathy ☐Delusional ☐Hallucinations ☐Paranoia

Comments:

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)

Physical Impairments:	Supervision needs:
☐Chronic Medical Condition	☐Short Term Memory Loss
☐Acute Illness	☐Long Term Memory Loss
☐Pain	☐Agitation
☐Neurological Impairment	☐Aggressive Behavior
☐Choking	☐Cognitive Impairment
☐Sensory Impairment	☐Difficulty Learning
☐Communication Impairment (not inability to speak English)	☐Memory Impairment
Mental Health:	☐Verbal Abusiveness
☐Lack of Motivation/Apathy	☐Constant Vocalization
☐Delusional	☐Sleep Deprivation
☐Hallucinations	☐Self-Injurious Behavior
☐Paranoia	☐Impaired Judgment
☐Mood Instability	☐Disruptive to Others
	☐Disassociation
	☐Wandering
	☐Seizures
	☐Self Neglect
	☐Medication Management

Comments:

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)

Physical Impairments: ☐Metabolic Disorder ☐Medication Reaction ☐Acute Illness ☐Pain ☐Neurological Impairment ☐Alzheimer's/Dementia ☐Sensory Impairment ☐Chronic Medical Condition ☐Communication Impairment (does not include ability to speak English) ☐Abnormal Oxygen Saturation ☐Fine Motor Impairment Supervision Needs: ☐Disorientation ☐Cognitive Impairment ☐Difficulty Learning ☐Memory Impairment	☐Self-Injurious Behavior ☐Impaired Judgment ☐Unable to Follow Directions ☐Constant Vocalizations ☐Perseveration ☐Receptive Expressive Aphasia ☐Agitation ☐Disassociation ☐Wandering ☐Lack of Awareness ☐Seizures ☐Medication Management Mental Health: ☐Lack of Motivation/Apathy ☐Delusional ☐Hallucinations ☐Paranoia ☐Mood Instability

Comments:

8.401.18 PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

.181 Purpose of Program

A. The PASRR program requires pre-screening or reviewing of all clients who apply to or reside in a Medicaid certified nursing facility regardless of:

1. The source of payment for the nursing facility services; or

2. The individual's or resident's diagnosis.

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

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

.182 Definitions

A. Mental Illness

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

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

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

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

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

B. Intellectual or developmental disability and Related Conditions

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

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

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

   a. It is attributable to:

      1) Cerebral palsy or epilepsy; or

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

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

   c. It is likely to continue indefinitely.

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

      1) Self-care,

      2) Understanding and use of language,

      3) Learning,

      4) Mobility,

      5) Self-direction or

      6) Capacity for independent living.

8.401.183 Requirements for the PASRR Program

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

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

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

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

E. PASRR findings, as related to care needs, shall be coordinated with the nursing facility federally prescribed, routine Resident Assessments (Minimum Data Set) requirements. These requirements are described at 42 C.F.R. 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.

8.401.184 Nursing Facilities Responsibilities Under the PASRR Program

A. The Utilization Review Contractor/Single Entry Point shall complete the Level I screening on the functional assessment form for Medicaid clients. The nursing facility shall complete the Level I screening for non-Medicaid individuals admitted from the community or pay source change. The hospital shall complete the Level I for non-Medicaid individuals admitted to nursing facility from the hospital. Medicaid Level I information is on the Level I screen in the ULTC-100.2 and is submitted to the Utilization Review Contractor with the rest of the Level of Care information. Private pay Level I information that indicates the resident may be mentally ill or individuals with an intellectual or developmental disability is submitted to the Utilization Review Contractor as well on the ULTC-100.2.

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

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

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

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

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

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

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

2. The findings; and

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

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

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

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

.185 The State Survey and Certification Process

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

1. A comprehensive Level I and Level II assessment;

2. An appropriate care plan; and

3. Specialized treatment, if needed.

B. The Colorado Department of Public Health and Environment (CDPHE) shall conduct the PASRR program surveys in accordance with the Agency Agreement between CDPHE and the Department.

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

A. For private pay and nursing facility residents on admission with indications of mental illness or intellectual or developmental disability, the Utilization Review Contractor shall first determine appropriate admission to a nursing facility through the following process:

1. A Level of Care review;

2. The Level I identification screen verification;

3. A Categorical determination, if appropriate; and

4. A Level II referral, if appropriate.

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

1. An individual's needs are such that he or she passes the Level of Care screen for admission and the individual is seeking Medicaid reimbursement; and

2. The Level I and II screens indicate nursing facility placement is appropriate.

8.401.19 LEVEL I IDENTIFICATION SCREEN

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

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

1. The individual has a diagnosis of mental illness as defined above; and/or

2. The individual has a recent (within the last two years) history of mental illness, as defined above; and/or

3. A major tranquilizer, anti-depressant or psychotropic medication has been prescribed regularly without a justifiable diagnosis of neurological disorder to warrant the medication; and/or

4. There is presenting evidence of mental illness (except a primary diagnosis of Alzheimer's disease or dementia) including possible disturbances in orientation, affect, or mood, as determined by the Utilization Review Contractor.

B. The Level I Screen, used by the Utilization Review Contractor to identify those who may be individuals with an intellectual or developmental disability or individuals with related conditions, shall be applied under the following conditions:

1. The individual has a diagnosis of intellectual or developmental disability or related conditions as defined above; and/or

2. There is a history of 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 intellectual or developmental disability or related conditions; and/or

4. The individual is referred by an agency that serves individuals with 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 intellectual or developmental disability or related conditions, the individual must undergo the additional 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 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

3) The individual shall receive a Level II evaluation within 10 calendar days of the referral.

4. An individual is severely ill.

a. An individual is considered severely ill if he or she is:

1) comatose;

2) ventilator dependent;

3) in a vegetative state.

b. The following PASRR criteria must be met when an individual is severely ill:

1) A Mental Health referral shall be made and a Level II evaluation shall be completed if the individual no longer meets the above criteria as determined by the Utilization Review Contractor.

2) An Intellectual or developmental disability Level II referral shall be made and an evaluation shall be completed within 60 days of admission, even if the individual meets the above criteria as determined for severely ill by the Utilization Review Contractor.

5. Emergency procedure in C.R.S. section 27-65-105, et. seq., shall supersede the PASRR process. When the State Mental Health authorities, pursuant to C.R.S. section 27-65-106, et.seq., determine that an individual requires inpatient psychiatric care and qualifies under the emergency procedures for a hold and treat order, this procedure shall supersede the PASRR determination process.

.193 For individuals or residents who may have mental illness or intellectual or developmental disability as determined through the Level I screen and who are referred by the State authorities or designees for a PASRR Level II evaluation, the following applies:

A. The designated agencies completing the Level I screen shall send a written notice to the individual or resident and to his or her legal representative stating the Level I findings.

B. The Level I notice to the individual or resident shall be required if the Level I findings result in a referral for a Level II evaluation.

C. The Level I findings are not an appealable action.

.194 Categorical determinations which may delay a Level II referral shall not prevent the nursing facility from meeting the psychosocial, physical and medical needs of the resident.

.195 Categorical Determinations may be applied only if an individual is in no danger to him/herself or others.

8.401.20 LEVEL II PASRR EVALUATION

.201 The purpose of the Level II evaluation is to determine whether:

A. Each individual with mental illness or intellectual or developmental disability requires the level of services provided by a nursing facility.

B. An individual has a major mental illness or is individuals with an intellectual or developmental disability.

C. The individual requires a Specialized Services program for the mental illness or intellectual or developmental disability.

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

A. The State Mental Health authority shall make determinations of whether individuals with mental illness require specialized services that can be provided in a nursing facility as follows:

1. The determination must be based on an independent physical and mental evaluation.

2. The evaluation must be performed by an individual or entity other than the State Mental Health authority.

B. The State Intellectual or developmental disability authority shall conduct both the evaluation and the determination functions of whether individuals with intellectual or developmental disability require specialized services that can be provided in nursing facilities.

C. The PASRR Level II contractor shall complete the evaluation within 10 working days of the referral from the URC.

D. PASRR determinations made by the State Mental Health or Intellectual or developmental disability authorities cannot be countermanded by the Department through the claims payment process or through other utilization control/review processes, or by CDPHE, survey and certification agency, or by any receiving facility or other involved entities.

E. The Final Agency action by the Department may overturn a PASRR adverse determination made by State Mental Health or Intellectual or developmental disability authorities.

F. Timely filing of PASRR billings from providers is 120 days.

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

A. A Depression Diversion Screen shall be applied under the following conditions:

1. Depression is the only Level I positive finding (i.e. a depression diagnosis is the only Yes checked on the Level I screen); and

2. The URC or the PASRR Level II Contractor for that geographic area shall make the determination of need for a Depression Diversion Screen.

B. The nursing facilities are not authorized to apply the Depression Diversion Screen.

C. When a non-major mental illness depression is validated as the only Level I positive finding through the Depression Diversion Screen, a complete Level II referral and evaluation is not required unless the individual's condition changes.

.204 Appeals Hearing Process for the PASRR Program

A. A resident has appeal rights when he or she has been adversely affected by a PASRR determination as a result of the Level II evaluation made by the State Mental Health or Intellectual or developmental disability authorities either at Pre- admission Screening or at Annual Resident Review.

B. Adverse determinations related to PASRR mean a determination made in accordance with Sections 1919(b)(3)(F) or 1919(e)(7)(B) of the Social Security Act that:

1. The individual does not require the level of services provided by a Nursing Facility; and/or

2. The individual does or does not require Specialized Services for mental illness or intellectual or developmental disability.

3. Section 1919 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.

C. Appeals of Level of Care determination are processed through the Appeals Section related to the URC's Level of Care process in Section 8.057.

D. For adverse actions related to the need for Specialized Services, the individual or resident affected by the mental illness or intellectual or developmental disability determination may appeal through procedures established for appeals in the Recipient Appeals and Hearings at Section 8.057.

.205 The Level II PASRR Evaluation Process

A. The URC shall refer all Medicaid clients and private pay individuals who require a Level II evaluation, to the PASRR Level II contractor.

1. The PASRR Level II contractor shall complete the Level II evaluation.

2. The State Medicaid program shall pay for the private pay evaluations.

3. Nursing facilities shall not complete the Level II evaluation.

4. The findings of these evaluations shall be returned to the URC for review and referral to the State Mental Health and/or Intellectual or developmental disability authorities for final review and determination.

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

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

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

a. A comprehensive medical history;

b. An examination of all body systems; and

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

1) Motor functioning;

2) Sensory functioning;

3) Gait and deep tendon reflexes;

4) Cranial nerves; and

5) Abnormal reflexes.

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

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

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

a. Current living arrangements;

b. Medical and support systems; and

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

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

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

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

4. A comprehensive psychiatric evaluation, at a minimum, must address the following areas:

   a. A comprehensive drug history is obtained on all current or immediate past utilization of medications that could mask symptoms or use of medications that could mimic mental illness;

   b. A psychiatric history is obtained;

   c. An evaluation is completed of intellectual functioning, memory functioning, and orientation;

   d. A description is obtained on current attitudes, overt behaviors, affect, suicidal or homicidal ideation, paranoia and degree of reality testing (presence and content of delusions, paranoia and hallucinations); and

   e. Certification status under provisions at 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 PASRR 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 Intellectual 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,

      4) Antianxiety-sedative agents, and

5) Anti-Parkinsonian agents.

2. The Intellectual or developmental disability process must assess:

   a. Self-monitoring of health status;

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

   c. Self-monitoring of nutrition status;

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

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

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

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

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

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

   j. Vocational development, including present vocational skills;

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

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

3. The Level II Intellectual or developmental disability evaluation shall insure that a psychologist, who meets the qualifications of a qualified intellectual or developmental disability professional completes the following:

   a. The individual's intellectual functioning measurement shall be identified; and

   b. The individual's intellectual or developmental disability or related condition shall be validated.

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

a. The inability to:

1) Take care of most personal care needs;

2) Understand simple commands;

3) Communicate basic needs and wants;

4) Be employed at a productive wage level without systematic long-term supervision or support;

5) Learn new skills without aggressive and consistent training;

6) Apply skills learned to a training situation to other environments or settings without aggressive and consistent training; or

7) Demonstrate behavior appropriate to the time, situation or place, without direct supervision.

b. Demonstration of severe maladaptive behavior(s) which place the individual or others in jeopardy to health and safety;

c. Inability or extreme difficulty in making decisions requiring informed consent; and

d. Presence of other skill deficits or specialized training needs which necessitate the availability of trained intellectual or developmental disability personnel, 24 hours per day, to teach the individual functional skills.

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

a. The level of support may be provided in an alternative community setting; or

b. The level of support is such that nursing facility placement is required.

6. The Intellectual or developmental disability evaluation shall determine whether the individuals with an intellectual or developmental disability individual needs a continuous Specialized Services program.

.206 PASRR Findings from Level II Evaluations

A. PASRR Level II findings shall include the following documentation:

1. The individual's current functional level must be addressed;

2. The presence of diagnosis, numerical test scores, quotients, developmental levels, etc. shall be descriptive; and

3. The findings shall be made available to the family or designated representatives of the nursing facility resident, the parent of the minor individual or the legal guardian of the individual.

B. PASRR Findings from the Level II Evaluations shall be used by the URC in making determinations whether an individual with mental illness or intellectual or developmental disability is appropriate or inappropriate for nursing facility care, and

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

D. The results of the PASRR evaluation shall be described in a report by the State Mental Health or Intellectual or developmental disability authorities, which includes:

1. The name and professional title of the person completing the evaluation, and the date on which each portion of the evaluation was administered.

2. A summary of the medical and social history including the individual's positive traits or developmental strengths and weaknesses or developmental needs.

3. The mental health services and/or intellectual or developmental disability services required to meet the individual's identified needs;

4. If specialized services are not recommended, any specific services identified which are of a lesser intensity than specialized services required to meet the evaluated individual's needs;

5. If specialized services are recommended, the specific services identified required to meet each one of the individual's needs; and

6. The basis for the report's conclusions.

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

1. The individual and his or her legal representative;

2. The appropriate state authorities who make the determination;

3. The admitting or retaining nursing facility;

4. The individual's attending physician; and

5. The discharge hospital, if applicable.

.207 PASRR Determinations from the Level II Evaluation

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

1. If an individual meets the level of care and needs the level of services provided in a nursing facility, as determined by the URC, and is determined not mentally ill or individuals with an intellectual or developmental disability, the individual may be admitted to the facility.

2. If an individual does not meet the level of care (as determined by the URC), and is determined to not be mentally ill or individuals with an intellectual or developmental disability through the PASRR determination and is not seeking Medicaid reimbursement, the individual may be admitted to the facility.

3. If the determination is that a resident or applicant for admission to a nursing facility requires BOTH the nursing facility level of care and specialized mental health or intellectual or developmental disability services, as determined by the URC and the State Mental Health and Intellectual or developmental disability authorities:

    a. The individual may be admitted or retained by the nursing facility; and

    b. The State Mental Health or Intellectual or developmental disability authorities shall provide or arrange for the provision of specialized services needed by the individual while he or she resides in the nursing facility.

4. Nursing facilities admitting residents requiring specialized mental health or intellectual or developmental disability services shall be responsible for assuring the provisions of services to meet all the resident needs identified in the Level II evaluations. The provisions of services shall be monitored through the State's survey and certification process.

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

1. If an individual does not require nursing facility services and is seeking Medicaid reimbursement, the individual cannot be admitted to the nursing facility.

2. If the determination is that an individual requires neither the level of services provided in a nursing facility nor specialized services, the nursing facility shall:

    a. Arrange for the safe and orderly discharge of the resident from the facility; and

    b. Prepare and orient the resident for the discharge.

    c. Provide the resident with a written notice of the action to be taken and his or her grievance and appeal rights under the procedure found at C.R.S. section 25-1-120 entitled “Nursing facilities - rights of patients”.

C. If the determination is that a resident does not require nursing facility services but requires specialized services, the following action shall be taken:

1. For long-term residents who have resided continuously in a nursing facility at least 30 months before the date of the first annual review determination and who require only specialized services, the nursing facility, in cooperation with the resident's family or legal representative and care givers, shall complete the following:

    a. The resident shall be offered the choice of remaining in the facility or receiving services in an alternative appropriate setting; and

    b. The resident shall be informed of institutional and non-institutional alternatives; and

c. The effect on eligibility for Medicaid services shall be clarified if the resident chooses to leave the facility, including the effect on readmission to the facility; and

d. The provision of specialized services shall be provided for or arranged regardless of the resident's choice of living arrangements.

2. For short term residents who require only specialized services and who have not resided in a nursing facility for 30 continuous months before the date of PASRR determination, the nursing facility, in conjunction with the State Mental Health or Intellectual or developmental disability authority, in cooperation with the resident's family or legal representative and caregivers, shall complete the following:

a. The safe and orderly discharge of the resident from the facility shall be arranged;

b. The resident shall be prepared and oriented for the discharge; and

c. A written notice shall be given to the resident notifying him or her of the action to be taken and of his or her grievance and appeal rights.

d. The provision of specialized services shall be provided or arranged, regardless of the resident's choice of living arrangements.

D. Any individual with mental illness, determined through the PASRR process, to be in need of in-patient psychiatric hospitalization, shall not be admitted to the nursing facility until treatment has been received and the individual certified as no longer needing in-patient psychiatric hospitalization.

8.401.21 SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

.211 Specialized Services shall include the following requirements:

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

B. These services shall be reimbursed by the Medicaid program to the community mental health centers or community centered boards through The Department of Health Care Policy and Financing. The cost of these services shall not be reported on the Nursing Facility cost report.

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

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

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

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

.213 Specialized services shall have the following characteristics:

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

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

.214 The intent of these specialized services is to:

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

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

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

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

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

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

B. The individual program plan includes the following:

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

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

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

.41 DEFINITION

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

.42 CRITERIA USED FOR DETERMINATION OF IMD STATUS

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

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

295.10 through 295.90
296.0 through 296.9
297.10
298.9
300.40
301.13

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

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

A. The facility is licensed as a psychiatric facility for the care and treatment of individuals with mental diseases;

B. The facility is accredited as a psychiatric facility by the Joint Commission for Accreditation for Health Care Organizations (JCAHCO);

C. The facility is under the jurisdiction of the state's mental health authority;

D. The facility specializes in providing psychiatric/psychological care and treatment as ascertained through a review of patients' records; and

E. The current need for institutionalization for more than 50 percent of all patients in the facility results from major mental diseases.

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

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

.43 FFP DISALLOWANCE

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

.44 ADMINISTRATIVE PROCEDURES AND REQUIREMENTS

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

A. All nursing homes shall indicate on the patient's medical record the primary, secondary and tertiary diagnoses (as applicable) of all their patients, Medicaid and private pay. All medical records shall contain this information no later than three calendar months after the effective date of this regulation.

B. All nursing homes shall report discharges to the Utilization Review Contractor. Discharge information shall include the name of the person, state identification number if applicable, discharge destination, date, payment source Utilization Review Contractor and primary and secondary diagnoses. Discharges of all patients shall be reported within one week of discharge. Discharge is defined to mean death, transfers, discharge to home, and absent without leave.

C. CDPHE shall use the medical records diagnosis information to determine the percentage of patients with mental diseases. In cases where the percentage is higher than 40%, a notice of the potentially high percentage shall be sent to the Department and Utilization Review Contractor.

d. (1) In cases where the percentage is over 40% and less than 50% the nursing home will be instructed by the Department to provide admission data and discharge data on all private pay as well as Medicaid patients to the Utilization Review Contractor. The admission and discharge data is necessary on all patients so that the entire psychiatric census of the facility can be determined and monitored by the Utilization Review Contractor.

(2) In cases where the percentage of psychiatric patients appears to be exceeding or about to exceed 50%, the Department may instruct the Utilization Review Contractor to deny admission authorization for Medicaid patients with psychiatric diagnoses. The facility shall be notified of the Department's intent to limit admissions to only non-psychiatric patients at least five (5) days in advance of the action. The facility may appeal this action in accordance with the regulations at 10 CCR 2505-10 section 8.050 et seq..

e. (1) In cases where the percentage of psychiatric patients in the census of the facility is over fifty (50) percent, and/or the facility meets some of the other criteria, the Department shall conduct an audit of the facility to determine if it is primarily engaged in the care and treatment of persons with mental diseases (i.e. an institution for mental diseases). The basis of such a finding shall be the criteria described in the regulations. This audit shall be conducted with assistance from CDPHE and shall include medical personnel with the necessary qualifications to determine the primary characterization of a facility.

(2) Should the audit indicate a finding that the facility is an Institution for Mental Disease, then all Medicaid funding for patients between the ages of 21 and 65 shall be denied. Furthermore, should the audit indicate the facility has been an IMD for a period of time prior to the time the audit was undertaken, the facility shall refund to the Medicaid program one hundred percent (100%) of the payments for patients between the ages of 21 and 65. Under no circumstances shall the refund extend to periods of time before the effective date of the GUIDELINES FOR INSTITUTIONS FOR MENTAL DISEASES, issued April, 1987.

f. The Department shall make arrangements with the Medicaid patients of the facility determined to be an IMD to do any of the following:

(1) Relocate Medicaid patients between the ages of 21 and 65 in accordance with the regulations entitled NURSING HOME RESIDENT/CLIENT RELOCATION PLAN.

(2) Relocate a sufficient number of psychiatric patients from the facility so as to reduce the facility's psychiatric census to below 50%. Such relocation shall be completed in accordance with the NURSING HOME RESIDENT/CLIENT RELOCATION PLAN.

g. A nursing home facility determined to be an IMD may appeal such a finding in accordance with the regulations at 10 CCR 2505-10 section 8.050 et seq.. In cases where the administrative law judge issues a stay of the agency's action to terminate Medicaid payments to a provider, such an order of stay shall clearly indicate that should the State's IMD finding be correct, the facility shall repay the State one hundred percent (100%) of Medicaid payments it received during the period of the stay. In order to assure that such a payment shall be made, the administrative law judge shall require the facility to post a bond in the amount of one hundred percent (100%) of the anticipated nursing home payment for each month the stay is in effect.

8.401.50 GUIDELINES FOR CLASS V REHABILITATION FACILITIES

Section deleted eff. 3/01/02

8.402 ADMISSION PROCEDURES FOR LONG-TERM CARE

8.402.01 PRE-ADMISSION REVIEW When a physician or designee wishes to obtain skilled or maintenance services for a client, he/she shall contact the regional URC. The URC will request and record information about the client's condition and the proposed treatment plan.

In order to promote the most appropriate placement of individuals with intellectual or developmental disabilities when skilled or maintenance services are sought, the physician shall, unless an emergency admission is required, refer the client to theCommunity Centered Board (CCB) where the client resides. Class I services shall be authorized by the URC only when the following requirements have been met:

a. The CCB determines, in collaboration with the physician and the client or the client's designated representative, that Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) services or services available through Home and Community Based Services for individuals with Developmental Disabilities (HCBS-DD) are not appropriate to meet the health care needs of the client.

b. ICF/IID or HCBS-DD services are not available if such services are appropriate.

c. The physician and the client or the client's designated representative choose Class I services in preference to services available specifically for individuals with intellectual or developmental disabilities, and the client meets the level of care criteria for these services.

Referrals by physicians of individuals with intellectual or developmental disabilities for Class I services without review by the CCB will not be certified by the URC for Medicaid reimbursement. Clients for whom ICF/IID or HCBS-DD services are appropriate as defined in Section 8.401.18, subject to the physician's and the client's or the client's designated representative concurrence, shall be referred immediately to the URC and to the appropriate Community Centered Board under the provisions at Section 8.405.

.02 After reviewing the information taken from the physician or his designee, the URC shall assign a target group designation based upon the primary reason for which long-term care services are needed. The URC shall follow the target group designations established at Section 8.402.32(A) through 8.402.32(D).

8.402.10 ADMISSION PROCEDURES FOR CLASS I NURSING FACILITIES

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

.12 The medically licensed provider must complete the necessary documentation prior to the client's admission.

.13 The ULTC 100.2 and other transfer documents concerning medical information as applicable, must accompany the client to the facility.

.14 The nursing facility or hospital shall notify the URC/SEP agency of the pending admission by faxing or emailing the appropriate form. The date the form is received by the URC/SEP agency shall be the effective start date if the client meets all eligibility requirements for Medicaid long-term care services.

.15 The URC/SEP case manager shall determine the client's length of stay using the appropriate form developed by the Department. The length of stay shall be less than a year, one year or indefinite. All indefinite lengths of stay shall be approved by the case manager's supervisor.

.16 The URC/SEP agency shall notify in writing all appropriate parties of the initial length of stay assigned. Appropriate parties shall include, but are not limited to, the client or the client's designated representative, the attending physician, the nursing facility, the Fiscal Agent, the appropriate County Department of Social/Human Services, the appropriate community agency, and for clients within the developmentally disabled or mentally ill target groups, the Department of Human Services or its designee.

.17 The nursing facility shall be responsible for tracking the length of stay end date so that a timely reassessment is completed by the URC/SEP.

.18 The URC will determine the start date for nursing facility services. The start date of eligibility for nursing facility services shall not precede the date that all the requirements (functional level of care, financial eligibility, disability determination) have been met.

8.402.30 ADMISSION PROCEDURES FOR HOME AND COMMUNITY BASED SERVICES

.31 When the client meets the level of care requirements for long-term care, is currently living in the community, and could possibly be maintained in the community, the URC/SEP agency shall immediately communicate with the appropriate community agency, according to the URC/SEP agency-determined target group, for an evaluation for alternative services. The URC/SEP agency shall forward a copy of the worksheet plus a State prescribed disposition form to the agency either immediately after the telephone referral, or in place of the telephone referral.

.32 Based upon information obtained in the pre-admission review, the URC/SEP case manager shall make the referral to the appropriate community agency based on the client's target group designation, as defined below:

A. Individuals determined by the URC/SEP agency to be in the Mentally Ill target group, regardless of source, shall be referred to the appropriate community mental health center or clinic.

B. Individuals determined by the URC to be in the Functionally Impaired Elderly target group or the Physically Disabled or Blind target group shall be referred to the appropriate Single Entry Point Agency for evaluation for Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD).

C. Individuals identified by the URC to be in the Developmentally Disabled target group shall be referred to the appropriate Community Centered Board.

D. Individuals determined by the URC to be in the Persons Living with AIDS target group shall be referred to the appropriate Single Entry Point Agency for evaluation for HCBS-EBD.

E. The URC shall notify any clients referred to case management agencies of the referral, the provisions of the program, and shall inform them of the complaint procedures.

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

.34 Single Entry Point Agencies shall conduct the evaluation in accordance with the procedures at Sections 8.486 and 8.390.

.35 Community Centered Boards shall conduct the evaluation in accordance with procedures at Section 8.500.

.36 Community mental health centers and clinics shall conduct the evaluation in accordance with Standards/Rules and Regulations for Mental Health 2 CCR 502-1 Section 21.940 and Rules and Regulations Concerning Care and Treatment of the Mentally Ill, 2 CCR 502-1 Section 21.280.

.37 If the community agency develops an approved plan for long-term care services, the URC will approve one (1) certification for long-term care services and the client shall be placed in alternative services. Following receipt of the fully completed ULTC the URC will review the information submitted and make a certification decision. If certification is approved, the URC shall assign an initial length of stay for alternative services. If certification is denied, the decision of the URC may be appealed in accordance with Section 8.057 through 8.057.8.

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

8.402.40 ADMISSION TO NURSING FACILITY WITH REFERRAL FOR COMMUNITY SERVICES

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

8.402.50 DENIALS (ALL TARGET GROUPS)

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

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

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

.53 Denials of certification for long-term care may be appealed in accordance with the procedures described at Section 8.057 through 8.057.8.

.54 Denial of designation into a specifically requested target group may also be appealed in accordance with Section 8.057 through 8.057.8.

8.402.60 CONTINUED STAY REVIEWS: SKILLED AND MAINTENANCE SERVICES

.61 The URC shall authorize all skilled nursing facility and intermediate care facility services, Home and Community Based Services for the Elderly, Blind and Disabled, and mental health clinic services when such services are appropriate and necessary for eligible clients. The URC may also limit the period for which covered long-term care services are authorized by specifying finite lengths of stay, and may perform periodic continued stay reviews, when appropriate, given the eligibility, functional and diagnostic status of any eligible Client.

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

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

.64 Continued Stay Reviews for long-term care clients receiving HCBS-EBD or mental health clinic services may be conducted more frequently at the request of the case manager, client, authorized representative, or the behavioral health organization.

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

.66 As a result of the Continued Stay Review, the URC shall renew or deny certification.

8.403 LONG TERM CARE SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

Long-term care services for individuals with intellectual or developmental disabilities include institutional services available through ICF/IID and Home and Community Based Services for individuals with Developmental Disabilities (HCBS-DD). These specialized services are available to Medicaid eligible clients who meet the target group designation for individuals with developmental disabilities and meet the level of care guidelines described below.

8.403.1 LEVEL OF CARE GUIDELINES FOR LONG-TERM CARE SERVICES FOR TINDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

Level of care guidelines for programs for individuals with intellectual or developmental disabilities are used to determine if the profile of a client's programmatic and/or medical needs are appropriate to a specific ICF/IID nursing home class or equivalent set of HCBS-DD services.

.11 Clients shall be certified for admission to a specific class of ICF/IID based on the following criteria:

A. Minimum/Moderate - individuals with intellectual or developmental disabilities who exhibit the following characteristics:

1. Have deficiencies in adaptive behavior that preclude independent living and require a supervised living environment;

2. Need supervision and training in self-help skills and activities of daily living, but do not display excessive behavior problems which are disruptive to other residents or which prevent participation in group or community activities;

3. Are capable of attending appropriate day services or engaging in supported or competitive employment; and,

4. Are capable of being maintained in a community-based setting.

Clients certified at this level of care may be provided Class II ICF/IID services if HCBS-DD services (as set forth in the regulations at Section 8.500) are not available, after a reasonable search has been conducted by the CCB, due to lack of availability of appropriate providers.

B. Specialized Intensive - individuals with intellectual or developmental disabilities whose psychological, behavioral, and/or developmental needs require 24-hour supervision, and who have potential for movement to a less restrictive living arrangement.. These individuals must conform to one of the profiles described below:

1. Behavior development profile:

- Function at a severe to moderate overall level of intellectual or developmental disability;

- May present a danger to self or others in the absence of supervision and habilitative services;

- Display severe maladaptive and/or anti-social behaviors, and may have exhibited delinquent behaviors;

- May display destructive or physically aggressive behaviors;

- Need specialized behavior management, counseling, and supervision;

2. Social emotional development profile:

- Function at a moderate to mild overall level of intellectual or developmental disability.

- Exhibit severe social and emotional problems attributable to a mental disorder.

- May be verbally abusive and/or physically aggressive toward self, others, or property.

- May display run-away, withdrawal, and/or bizarre behavior attributable to a mental disorder;

- Need social, adaptive, and intensive mental health services.

3. Intensive developmental profile:

   - Function at a profound to severe level of intellectual or developmental disability;

   - Exhibit severe deficiencies in behaviors such as eating, dressing, hygiene, toileting, and communication;

   - May display inappropriate social and/or interpersonal behaviors;

   - Need intensive self-management and adaptive behavior training.

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

Clients certified at this level of care may be provided Class II or Class IV ICF/IID services if HCBS-DD services (as provided in the regulations at Section 8.500) are not available, after a reasonable search has been conducted by the CCB, due to lack of availability of appropriate providers.

C. Intensive Medical/Psychosocial - individuals with intellectual or developmental disabilities who have intensive medical and psychosocial needs that require highly structured, in house, comprehensive, medical, nursing and psychological treatment. These individuals must meet at least one of the following requirements:

1. Exhibits extreme deficiencies in adaptive behaviors in association with profound or severe intellectual or developmental disabilities or in association with medical problems requiring availability of medical life support services on a continuous basis; and/or

   Exhibits maladaptive behavior(s) potentially injurious to self or others to the degree that intensive programming in an institutional or closed setting is required; and

   Inappropriate for placement in less restrictive settings, such as minimum/moderate or specialized intensive community-based services, due to the nature and/or severity of their disabilities.

2. Appropriate for service in less restrictive community residential programs, but all local and statewide avenues for alternative placement have been investigated and exhausted prior to referral to a Class IV facility. Plans for eventual community placement have been established;

3. Committed by court action to a Regional Center under the Division Regional Center Operations, Department of Human Services.

Clients certified at this level of care may be provided Class IV ICF-IID services if HCBS-DD services (as provided in the regulations at Section 8.500) are not available after a reasonable search has been conducted by the CCB, due to lack of availability of appropriate providers.

8.404 ADMISSION CRITERIA: PROGRAMS FOR THE DEVELOPMENTALLY DISABLED

8.404.1 Clients needing ICF/IID level of care are those who:

A. Require aggressive and consistent training to develop, enhance or maintain skills for independence (e.g., on-going reliance on supervision, guidance, support and reassurance); or

B. Are generally unable to apply skills learned in training situations to other settings and environments; or

C. Generally cannot take care of most personal care needs, cannot make basic needs known to others, and cannot understand simple commands, (e.g., requires assistance or prompts in bathing and/or dressing, neglects to wear protective clothing, does not interact appropriately with others, speaks in muffled/unclear manner, fails to take medications correctly, confuses values of coins, spends money inappropriately); or

D. Are unable to work at a competitive wage level without support, (e.g., specially trained managers, job coach, or wage supplements) and are unable to engage appropriately in social interactions (e.g., alienates peers by teasing, arguing or being cruel, does not make decisions); or

E. Are unable to conduct themselves appropriately when allowed to have time away from the facility's premises (e.g., loses self-control when s/he cannot get what s/he wants, performs destructive acts, unsafe crossing streets or following safety signs) or

F. Have behaviors that would put self or others at risk for psychological or physical injury.

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

A. The acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and

B. The prevention or deceleration of regression or loss of current optimal functional status.

8.404.2 CONTINUED STAY REVIEW CRITERIA: PROGRAMS FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES

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

8.404.3 Adherence to the following sections of CDPHE and/or Department of Health Care Policy and Financing rules and regulations are critical to the provision of active treatment and active habilitation:

A. Assessments

B. Individual habilitation plans

C. Individual program plans

D. Community integration

E. Independence training

F. Behavior management

G. Psychotropic medication use

For individuals needing placement in the ICF/IID facility, a list of specific services or interventions needed in order to make progress must be provided.

8.405 ADMISSION PROCEDURES: PROGRAMS FOR THE DEVELOPMENTALLY DISABLED

.10 PREADMISSION REVIEW

For admission to ICF/IID facilities clients must be evaluated by the Community Centered Board (CCB) in the area where the client resides. If services will be provided through a CCB in another area, the client shall be evaluated by that area's CCB.

The client shall be referred by the CCB to the URC for admission review and to the appropriate County Department of Social/Human Services for determination of Medicaid eligibility. The URC shall not determine admission certification under Medicaid for any intellectually or developmentally disabled client in the absence of a referral from the CCB except for emergency admissions to the Class I facilities.

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

.12 CCB ADVERSE RECOMMENDATION

In cases where the CCB declines to recommend placement of a client into an ICF/IID facility, the CCB shall inform the client of the recommendation using the HCBS-DD-21 form. The CCB shall also notify the client or the client's designated representative of the client's right to request a formal URC level of care review.

The client shall have thirty (30) days from the postmark date of the notice to request a formal URC review. If the client requests a formal URC level of care review, the CCB shall submit the required documentation plus any new documentation submitted by the client to the URC. The URC shall review and make a level of care determination in accordance with the admission procedures below.

8.405.2 ADMISSION PROCEDURES FOR ICF/IID FACILITIES

.21 When the client, based on CCB review, cannot reasonably be expected to make use of ICF/IID or HCBS-DD , the CCB shall notify the physician and the URC. The physician and the URC/Community Center Board (URC/CCB) agency then proceed with the SNF or ICF placement under the provisions set forth at Section 8.402.10.Section.

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

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

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

.25 Following receipt of the fully completed ULTC 100.2, the URC/CCB shall review the information and make a final certification decision. If certification is approved, the URC/CCB shall assign an initial length of stay according to Section 8.404.1. If certification is denied, the decision of the URC/CCB may be appealed in accordance with the appeals process at 10 CCR 2505-10 Section 8.057.

8.405.30 ADMISSION PROCEDURES FOR HCBS-DD

.31 CCBs may evaluate clients for HCBS-DD services if, in the judgment of the CCB, such services represent a viable alternative to SNF, ICF, or ICF/IID services. The evaluation shall be carried out in accordance with the procedures set forth in 2 CCR Section 503-1.

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

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

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

If certification is denied, the decision of the URC/CCB may be appealed in accordance with Section 8.057.

8.405.4 CONTINUED STAY REVIEW PROCEDURES; SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

.41 Continued Stay Reviews shall be conducted by the URC for all intellectually and clients in ICF/IID services, in accordance with 42 CFR Part 456 Subpart F.

.42 As a result of the Continued Stay Review, the URC shall renew or deny certification.

8.405.50 GENERAL PROVISIONS

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

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

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

D. All participating skilled nursing care facilities and intermediate health care facilities must be administered by a nursing facility administrator licensed pursuant to C.R.S. section 12-39-101 et seq. For inclusion in the audited cost rate (see 10 CCR 2505-10 section 8.440 et seq.) the administrator must be employed full-time by the applicant facility, and may not have other conflicting employment obligations. The administrator must be responsible on a 24-hour-a-day basis, with primary duties being performed during the day shift.

8.406 NURSING FACILITY CARE - LEVELS OF CARE

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

8.406.1 SKILLED NURSING CARE

Skilled nursing care is available for eligible clients when a physician licensed to practice in the State of Colorado certifies care to be medically necessary. Such care must be provided in a facility that holds a valid and current license from CDPHE as a Nursing Care Facility pursuant to the Standards for Hospitals and Health Facilities, CDPHE, Health Facilities Division. The facility must also meet the standards defined in the U.S. Code of Federal Regulations, Title 42 C.F.R., as rules of the Department. 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.

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

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

B. Conduct periodic inspections of all skilled nursing care facilities which participate in the Medicaid Program (see 10 CCR 2505-10 section 8.420) to ascertain:

1. The actual care being provided;

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

3. The necessity and desirability of the continued placement of eligible clients in skilled nursing care facilities; and

4. The feasibility of meeting the client's health care needs through alternative services.

C. 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.

8.406.2 INTERMEDIATE NURSING CARE

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

The Department shall:

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

B. Conduct periodic inspections of all intermediate health care facilities which participate in the Medicaid Program (see 10 CCR 2505-10 section 8.420) to ascertain:

1. The actual care that is being provided;

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

3. The necessity and desirability of the continued placement of eligible clients in intermediate health care facilities; and

4. The feasibility of meeting the client's health care needs through alternative services.

8.406.3 INTERMEDIATE NURSING CARE - INTELLECTUAL OR DEVELOPMENTAL DISABILITY 15 BEDS OR LESS

A. Intermediate nursing care is available in facilities of 15 beds or less for eligible clients who are individuals with an intellectual or developmental disability or have related conditions provided:

1. The facility holds a valid and current license from CDPHE as a residential care facility or higher classification.

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

3. Clients who are individuals with an intellectual or developmental disability or have related conditions are certified by a physician licensed to practice in the State of Colorado to be (a) ambulatory, (b) receiving active treatment, (c) capable of following directions and taking appropriate action for self-preservation under emergency conditions, and (d) not in need of professional nursing services.

B. All other provisions of these rules shall apply to care and services provided in such facilities in accordance with the provisions of 42 C.F.R Part 442.

8.407 SPECIAL PROVISION CONCERNING CLIENTS ELIGIBLE FOR SOCIAL SECURITY AGE-72 BENEFITS (PROUTY)

8.407.1 SPECIAL AGE-72 BENEFITS (PROUTY)

Federal regulations require that welfare clients cannot receive both the Special Age-72 Benefit and a public assistance payment. Rule A-4232 requires that all available income to a client (or applicant) must be sought by the client or applicant.

SSA must receive assurance from the County Departments of Social/Human Services that as of a certain date no further assistance payments (including $50 personal needs allowance) will be paid to the client.

8.407.2 REQUEST FOR ADDITIONAL INFORMATION ON FORM SSA-1610

When a county has authorized a nursing facility placement for a person over 72 years of age, who is eligible for a Prouty Benefit, Social Security must be notified.

8.408 LEVELS OF CARE DEFINED - SKILLED NURSING CARE

A. Skilled nursing services in a licensed nursing care facility are those services performed by licensed nursing personnel, or personnel under their supervision. These services must be performed according to a plan of treatment written by a physician licensed to practice medicine in the State of Colorado. These services apply to clients whose condition(s) require medical services to maintain a degree of stability, which has been achieved. Components of these services include:

1. The medical need for the attending physician to visit the client on a professional basis at least once every thirty (30) days.

2. Observation and assessment of the total needs of the client, utilizing skilled nursing judgment.

3. Planning, organizing, and managing the client care plan which requires specialized training to accomplish delivery of health care, or to attain the desired results or to render direct services to “the patient”.

B. These health care services require regular medical care and 24-hour licensed nursing services for illnesses, injury, or disability. Nursing service shall be organized and maintained to provide 24-hour licensed nursing services under the direction of a registered professional nurse employed full time and at least two (2) hours total nursing staff time for each patient per 24-hour day.

C. Covered skilled nursing services must adhere to one or more of the following principles:

1. A service which requires a substantial specialized judgment and skill based on knowledge and application of the principles of biological, physical, and social sciences, necessary to perform or supervise effectively the services rendered, or

2. A service that is unskilled but which requires skilled performance, supervision, or observation because of special medical complications. Medical complications and special services must be documented by the physician's order and the nursing notes.

D. In addition to meeting the definition of skilled nursing services, coverage of such services is warranted only if skilled nursing personnel must be available on a continuous 24-hour basis. In determining whether the continuous availability of such personnel is warranted, the following principles apply:

1. Frequency of Services - The frequency of skilled nursing services required, rather than their regularity, is the controlling factor in determining whether the continuous availability of skilled nursing personnel is warranted.

2. Observation - Where observation is the principle continuous service provided, because symptoms exist that indicate the need for immediate modification of treatment of institution of medical procedures.

E. The purpose of the above-stated components and principles, and of 10 CCR 2505-10 section 8.408.1 et seq., is to provide general direction and guidelines for admission, utilization review, and medical review; with the intent that the individual's overall medical situation (including mental condition) shall be taken into account in evaluation and determination of the level of care to be provided.

8.408.1 SPECIFIC SERVICES WHICH ARE SKILLED

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

A. Subcutaneous or intramuscular injections and intravenous medications and/or feedings.

B. Levine tube and gastrostomy feedings.

C. Naso-pharyngeal aspiration.

D. Insertion and replacement of catheters.

E. Aseptic application of dressings involving prescription medications.

8.408.2 SPECIFIC SERVICES WHICH ARE SUPPORTIVE

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

A. Provision of routine maintenance medications.

B. Prevent decubiti, keep clean, and comfortable.

C. Safety measures against accident and injury.

D. General maintenance are of colostomy or ileostomy.

E. Routine services in connection with in-dwelling bladder catheters.

F. Changes in dressings in noninfected postoperative or chronic conditions.

G. Prophylactic and palliative skin care, including bathing and application of creams, and care of minor skin problems.

H. General methods of caring for incontinent patients, including use of diapers.

I. General care of patients with a plaster cast.

J. Routine care in connection with braces and similar devices.

K. Use of heat for palliative and comfort purposes.

L. Administration of medical gases after initial phases of institution of therapy.

M. Assistance in dressing, eating, and going to the toilet.

N. General supervision of exercises which have been taught to the patient.

O. Diet supervision and administration for those persons requiring specialized diet.

P. Skilled paramedical services involving specialized training outside the licensed nursing curriculum.

8.408.3 ORGANIZATION OF SKILLED NURSING SERVICE

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

A. Administrative and supervisory responsibilities must be in writing.

B. Duties must be clearly defined in writing and assigned for staff members.

C. Written policies and procedures for client care must be available to all personnel.

D. All professional services rendered by the nursing facility staff, physician, or other professional personnel, must be entered in the client's individual record and signed.

8.408.4 PROFESSIONAL PERSONNEL

8.408.41 DIRECTOR OF NURSING

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

1. Is a registered professional nurse.

2. Is qualified by education, training, or experience for supervisory duties.

3. Is responsible to the administrator for development of standards, policies, and procedures governing skilled nursing care, and for assuring that such standards, policies, and procedures are observed.

4. Is responsible to the administrator for the selection assignment, and direction of the activities of nursing services personnel.

5. Is employed full time in the facility.

6. Devotes his/her full time to direction and supervision of the nursing services; and,

7. Is on duty during the day shift.

8.408.42 CHARGE NURSE (RN OR LPN)

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

1. A registered professional nurse; or,

2. A practical (or vocational) nurse who:

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

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

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

8.408.43 NURSING PERSONNEL

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

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

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

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

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

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

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

   c. Receives proper care to prevent decubitus ulcers;

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

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

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

8.408.44 ANCILLARY PERSONNEL

Authorized subsidiary personnel performing duties in support of professional health care services may or may not be included in arriving at the computation of cost allowances set forth in 10 CCR 2505-10 section 8.400 et seq.

A. Dietary - Professional planning and supervision of meal services.

   Special and restricted diet files shall be maintained for thirty (30) days, and any substitutions or variations noted. The patient's reaction and acceptance of food must be observed and recorded.

   Menus must be planned and supervised by professional personnel meeting the following qualifications:

   1. A dietician who meets the American Dietetic Association's standards for qualification as a dietician; or,

2. A graduate holding at least a Bachelor's Degree from the university program, with major study in food or nutrition; or,

3. A trained food service supervisor, an associate degree dietary technician, or a professional registered nurse, with frequent and regularly scheduled consultation from a dietician or a nutritionist meeting the above-stated qualifications.

   Inclusion of dietary consultation costs are an allowable item in computing the rate of payment above-referenced.

B. Pharmacy Consultant - A person licensed to practice pharmacy in the State of Colorado, and whose duties are related to the nursing facility administration of drugs to patients. Such duties relate to:

1. Drug interactions;

2. Proper medication usage pertinent to the diagnosis and length of medication; specific to proper usage in records, stop orders, etc.;

3. Appropriate storage and safeguards of medications;

4. Study of possible brand interchanges;

5. Check on authenticity of medication pursuant to labeling;

6. Contraindications and other professional activities related to drug administration, receipting, storage, etc.

Costs related to pharmacal consultation are allowable in determining the rate to be paid, under the same conditions as for dietary in item 1 above.

C. Housekeeping and Maintenance - Allowed pursuant to above-cited rules on cost computation.

8.408.5 CLINICAL RECORDS

8.408.51 MAINTENANCE

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

1. Identification and summary sheets.

2. Hospital discharge summary sheet.

3. Medical evaluation and treatment plan.

4. Physician's orders.

5. Physician's progress notes.

6. Nurse's progress notes.

7. Medication and treatment record.

8. Laboratory and X-ray reports.

9. Consultation reports.

10. Dental reports.

11. Social Service notes.

12. Pharmacal Consultant records.

13. PASRR documentation to include the Level I and Level II Reviews and the determination letters.

8.408.52 RETENTION OF RECORDS

1. Files shall be retained for at least six years.

2. In the event that a client is transferred to another health facility, certain transfer information should be incorporated in a record to accompany the client. Such transfer information shall include:

    a. Transfer form with diagnosis;

    b. Aid to daily living information;

    c. Transfer orders;

    d. Nursing care plan;

    e. Physician's orders for care.

8.408.53 CONFIDENTIALITY OF RECORDS

1. Disclosed only to authorized persons.

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

8.408.54 RECORDS ADMINISTRATOR

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

a. A consultant or full-time employee who is a registered records administrator (Medical Records Librarian), or an accredited records technician, or;

b. A registered records administrator or other employee who is trained in medical records, and who receives supervision from a registered records administrator; or,

c. If the facility does not have such employee with such training, an employee of the facility is assigned the responsibility for assuring that records are maintained, completed, and preserved. Such person, however, must be trained by, and receive regular consultation from a registered records administrator or accredited records technician.

8.408.6 MEDICAL BASIS FOR CARE - SKILLED NURSING FACILITY CARE

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

8.408.61 PHYSICIANS' INVOLVEMENT

8.408.62 DETERMINATION FOR SKILLED NURSING CARE

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

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

2. An evaluation by the physician. Physical examination must be accomplished within 48 hours of admission and recorded; unless such an examination has been accomplished within five days prior to admission to the skilled nursing care facility.

3. Physician's orders. Orders must be written for the immediate care of the client. These may be written by the attending physician or by the physician who has the responsibility for emergency care in this facility. The current hospital summary of the course of treatment, with orders used, is acceptable as emergency orders.

4. The physician's treatment plan. The plan must be written and must be directed towards maintaining the health status of the client, preventing further deterioration of the physical well-being of the client, and preparing the client for normal non-institutional life. The plan must be reviewed and revised as necessary, and must include medication and treatment orders which will be in effect for the specified number of days indicated by the physician. This period shall be monthly unless reordered in writing by the physician. Telephone orders may be accepted by licensed nurses only and must be written into the clinical record by the receiving nurse. These orders must be countersigned by the ordering physician within 48 hours.

   The medical necessity for a physician's visit, at least once every thirty (30) days, must be evidenced in the clinical record by a valid signed entry.

5. Plan for Emergency Care - Each skilled nursing care facility must provide for one, or more, physicians to be available to furnish emergency medical care if the attending physician is not immediately available. A schedule listing the name, telephone number and days on call for a given physician will be posted at each nursing station. The skilled nursing care facility must also establish procedures which will be followed in the emergency care of the client, the persons to be notified, and the reports to be prepared.

8.408.63 PHYSICIANS' INVOLVEMENT - REDETERMINATION FOR SKILLED NURSING CARE

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

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

8.408.7 MEDICAL REVIEW AND MEDICAL INSPECTION - SKILLED NURSING CLIENTS

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

8.408.71 MEDICAL REVIEW TEAM

8.408.72 COMPOSITION AND MEMBERSHIP REQUIREMENTS

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

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

8.408.73 FUNCTION - MEDICAL REVIEW AND EVALUATION

1. The medical treatment of skilled nursing clients entitled to medical assistance shall be reviewed at least annually.

2. Annual review shall consist of an evaluation of the treatment, utilizing the medical record and personal contact with, and observation of, each client in the nursing facility surroundings. This review, at a minimum, will elicit:

    a. Medical necessity for visit by attending physician at least once every thirty (30) days.

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

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

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

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

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

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

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

8.408.74 REPORTS

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

    a. After review copies are forwarded to:

1) Nursing care facility

2) Nursing care facility Utilization Review Committee

3) CDPHE

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

8.408.75 STATE DEPARTMENT ACTION

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

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

   a. Attending physician.

   b. Administration of the nursing facility.

   c. County Department of Social/Human Services responsible for the client.

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

8.408.76 REVIEW OF STATE DEPARTMENT ACTION

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

8.409 LEVELS OF CARE DEFINED - INTERMEDIATE NURSING CARE

Intermediate nursing services in a licensed intermediate health care facility are defined as those services furnished in an institution or distinct part thereof to those clients who do not have an illness, disease, injury, or other condition that requires the degree of care and treatment which a hospital, Extended Care Facility, or Skilled Nursing Care Facility is designed to provide. Such services are provided under the supervision of a registered professional nurse or licensed practical nurse during the day shift, seven (7) days per calendar week. Covered intermediate services will be at a level less than those described as skilled nursing services and will include guidance and assistance for each client in carrying out his personal health program to assure that preventive measures, treatment, and medications prescribed by the physician are properly carried out and recorded.

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

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

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

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

A “distinct part” is one that meets the following conditions:

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

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

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

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

8.409.2 ORGANIZATION OF INTERMEDIATE NURSING SERVICE

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

1. Administrative and supervisory responsibilities must be in writing.

2. Duties must be clearly defined in writing and assigned for the staff members.

3. Written policies and procedures for client care must be available to all personnel.

8.409.21 PROFESSIONAL PERSONNEL - “DIRECTOR OF NURSING”

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

1. Is qualified by education, training, or experience for supervisory duties;

2. Is responsible to the administrator for development of standards, policies, and procedures governing intermediate nursing care, and for assuring that such standards, policies and procedures are observed;

3. Is responsible to the administrator for the selection, assignment, and direction of the activities of nursing service personnel;

4. Is employed full time (40 hours per week) in the facility;

5. Is devoted, full-time to direction and supervision of the nursing services; and

6. Is on duty during the day shift.

8.409.22 NURSING PERSONNEL

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

1. There shall be, at all times, a responsible staff member actively on duty in the facility, and immediately accessible to all residents, to whom residents can report injuries, symptoms of illness, or emergencies, and who is immediately responsible for assuring that appropriate action is promptly taken.

2. Assistance as needed to clients with routine activities of daily living including such services as help in bathing, dressing, grooming, and management of personal affairs.

3. Continuous supervision for residents whose mental condition is such that their personal safety requires such supervision.

8.409.23 PROFESSIONAL PLANNING AND SUPERVISION OF MEAL SERVICE

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

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

8.409.24 ANCILLARY PERSONNEL

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

1. Nurse aides

2. Dietary

3. Housekeeping and maintenance

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

1. Numbers and categories of personnel, as determined by the number of clients in the facility and their particular nursing care needs. This determination is made in accordance with accepted policies of effective nursing care and with these regulations.

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

3. Bedside care under direction of the client's physician in the presence of minor illness and for temporary periods to include nursing service provided by, or supervised by, a professional nurse or licensed practical nurse.

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

8.409.3 CLINICAL RECORDS

8.409.31 MAINTENANCE

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

1. Identification and summary sheets.

2. Hospital discharge summary sheet.

3. Medical evaluation and treatment plan.

4. Physician's orders.

5. Physician's progress notes.

6. Nurse's progress notes.

7. Medication and treatment record.

8. Laboratory and X-ray reports.

9. Consultation reports.

10. Dental reports.

11. Social Service notes.

12. Pharmacy Consultant's notes.

8.409.32 RETENTION OF RECORDS

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

2. In the event that a patient is transferred to another health facility, certain transfer information should be incorporated in a record to accompany the patient. This information should include:

    a. A transfer form of diagnosis;

    b. Aid to daily living information;

    c. Transfer orders;

    d. Nursing care plan;

    e. Physician's orders for care.

8.409.33 CONFIDENTIALITY OF RECORDS

1. Disclosed only to authorized persons.

2. Form APA 4, “Authorization for Release of Medical Information” shall be executed in duplicate (original to the nursing home medical record with a copy to the county department) at the time of admission. This form must be signed by the client, or the client's designated representative, parent (if a minor), guardian, or other legally responsible person.

8.409.34 RECORDS ADMINISTRATOR

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

1. A consultant who is a registered records administrator, or a person who is accredited as a records technician.

2. An employee who is trained or is receiving training in medical records management for accreditation as a records technician or a registered records administrator.

8.409.4 MEDICAL BASIS FOR CARE - INTERMEDIATE NURSING CARE

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

8.409.41 PHYSICIANS' INVOLVEMENT

8.409.42 DETERMINATION FOR INTERMEDIATE NURSING CARE

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

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

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

2. An evaluation by the physician. Physical examination must be accomplished within 48 hours of admission and recorded, unless such an examination has been accomplished within five days prior to admission to the Intermediate Nursing Care Facility.

3. Physician's Orders. Orders must be written for the immediate care of the client. These may be written by the attending physician or by the physician who has the responsibility for emergency care in this facility. The current hospital summary of the course of treatment, with orders used, is acceptable as emergency orders.

4. The physician's treatment plan. The plan must be written and must be directed towards maintaining the health status of the client, preventing further deterioration of the physical well-being of the client, and preparing the client for normal noninstitutional life. The plan must be reviewed consistent with the continuing professional care by the physician, and revised as necessary, and must include medication and treatment orders which will be in effect for the specified number of days indicated by the physician. This period shall not exceed ninety (90) days unless reordered in writing by the physician. Telephone orders may be accepted by licensed nurses, but must be written into the clinical record by the receiving nurse. These orders must be countersigned by the ordering physician within 48 hours. The medical necessity for a physician's visit, at least once every quarter, must be evidenced in the clinical record by a valid signed entry.

5. Plan for Emergency Care. Each Intermediate Nursing Care Facility must provide for one, or more, physicians to be available to furnish emergency medical care, or surgical procedures, if the attending physician is not immediately available. A schedule listing the name, telephone number, and days on call for a given physician will be posted at each nursing station. An RPN or LPN must be on call (for availability to handle emergencies; to contact the physician, receive orders or medications) for all shifts other than the day shift. The Intermediate Nursing Care Facility must also establish procedures which will be followed in the emergency care of the client, the persons to be notified, and the reports to be prepared.

8.409.43 PHYSICIANS' INVOLVEMENT REDETERMINATION FOR INTERMEDIATE NURSING CARE

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

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

8.409.5 MEDICAL REVIEW AND MEDICAL INSPECTION - INTERMEDIATE CARE NURSING CLIENTS

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

8.409.51 MEDICAL REVIEW TEAM

8.409.52 COMPOSITION AND MEMBERSHIP REQUIREMENTS

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

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

8.409.53 FUNCTION - MEDICAL REVIEW AND EVALUATION

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

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

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

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

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

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

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

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

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

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

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

8.409.54 REPORTS

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

   a. After review copies are forwarded to:

      1) The intermediate care facility.

      2) The intermediate care facility Utilization Review Committee.

      3) CDPHE.

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

8.409.55 STATE DEPARTMENT ACTION

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

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

   a. Attending physician.

   b. Administration of the Intermediate Nursing Care Facility.

   c. County department responsible for the client.

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

8.409.56 REVIEW OF STATE DEPARTMENT ACTION

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

8.415 ROLE OF COUNTIES AND NURSING FACILITIES

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

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

A. The determination of existing or potential eligibility for medical assistance.

B. The referral, whenever possible, of all Medicaid eligible clients/applicants who are eligible for Medicare benefits to facilities certified for participation in the Medicare Program.

C. In those instances in which an individual residing in a nursing facility under some method of reimbursement other than Medicaid makes application for medical assistance, the county must provide notice of the application referral date to both the nursing facility and the Utilization Review Contractor.

1. Such notice must be provided verbally to both the facility and the Utilization Review Contractor within two (2) working days of the application referral date.

2. Written notice must be mailed to the facility within five (5) working days.

3. Such notice is critical to the timely conduct of admission review by the Utilization Review Contractor.

D. In those instances where eligibility is determined to be effective three months prior to the date of application pursuant to Department rules and regulations, the County Department of Social/Human Services shall notify the nursing facility of this circumstance in writing.

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

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

A. Verify, correct, and complete, when necessary, the client/applicant's name, State ID number, and all other identifying data:

B. Verify client/applicant income. Such verification must occur on a regular basis. All income of the client which is in excess of the amount reserved for personal needs allowance, less earned income (if appropriate), less spousal and dependent care allowance, and less home maintenance allowance, and less allowable expenses for medical and remedial care (see PETI deductions as defined in 10 CCR 2505-10 sections 8.100.7.T and 8.482.33), must be applied by the client/applicant toward his/her care. Changes in income must be reflected in submission of a new eligibility reporting form and a new AP-5615.

C. Verify client payment. This amount must be calculated by per diem appropriately in all months for which Medicaid reimbursement covers less than a full month's care.

1. Client payment may be waived and zero (-0-) client payment applied only under the conditions as defined in 10 CCR 2505-10 section 8.482.34.D.1.

2. Client payment may not be waived (other than for the exceptions provided for in 10 CCR 2505-10 section 8.415.11.C.1), in the instances as defined in10 CCR 2505-10 section 8.482.34.D.2.

3. When client payment is calculated by per diem, the amount shown on the AP-5615 will be that amount to be paid by the resident, rather than the amount to be calculated by per diem calculation.

4. Corrections to income or client payment shall be initialed and dated by the income maintenance technician from the County Department of Social/Human Services.

D. Review the date of action, such as admission, readmission, discharge, death, or change in client payment being reported and verify as necessary;

E. Indicate approval or denial of action being reported and effective date of that approval or denial; and

F. Sign and date all copies, and distribute in accordance with instructions on the reverse side of page three of the AP-5615 form.

8.415.20 RESPONSIBILITY OF THE NURSING FACILITY IN NURSING FACILITY PLACEMENTS

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

A. Admission

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

1. Determine, prior to an applicant's admission, whether or not the individual is a client of medical assistance or has made application for medical assistance;

2. Complete the ULTC 100.2 prior to or on the day of admission. Based on this information, the Utilization Review Contractor will determine the level of care and assign an initial length-of-stay.

8.415.21

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

a. any new admission; or

b. any change from other sources of reimbursement to the Medical Assistance Program.

B. Changes in Resident Status

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

1. The nursing facility shall initiate Form AP-5615 (in accordance with instructions on the reverse side), for all admissions, readmissions, transfers from private pay or Medicare, discharges, deaths, changes in client pay, and leaves of absence; and shall submit three (3) copies to the responsible county.

2. The nursing facility is solely responsible for collecting the correct amount of client payment due from the resident, his family, or representatives. Failure to collect client pay, in whole or in part, shall not allow the nursing facility to bill the Medical Assistance Program for the uncollected client payment.

3. The county department may initiate the AP-5615 when appropriate, which may include, but is not limited to, changes in resident income of which the county becomes aware.

C. Transfer and Discharge

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

8.420 REQUIREMENTS AND PROVISIONS FOR PARTICIPATION BY COLORADO NURSING FACILITIES

In order to receive vendor payments from the State Department for care of assistance recipients, a nursing facility must enter into a provider agreement with the Department, in such form as the Department prescribes. For the purposes of this section, the term “nursing facility” includes an intermediate care facility for individuals with intellectual disabilities (ICF/IID). The facility's provider agreement with the Department carries with it the responsibility of said nursing facility to subscribe to the terms and conditions for payment of care to recipients promulgated by the Colorado Medical Services Board in its rules and regulations set forth in this staff manual. Such nursing facilities also must adhere to all pertinent requirements of federal and state law, and to the rules, regulations, and requirements as prescribed by CDPHE in its minimum standards for nursing facilities. This means that the nursing facility must be duly and appropriately licensed, provide for the use of qualified staff and the provision of nursing care, and adhere to those regulations with respect to the number and qualifications of nursing personnel required by CDPHE in giving services to recipient patients.

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

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

Participation in the Colorado Medicaid program of nursing facilities and/or nursing facility beds is limited to the regulations at 10 CCR 2505-10 sections 8.430 et seq.

8.421 RESPONSIBILITY OF COUNTY DEPARTMENT CONCERNING PARTICIPATION

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

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

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

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

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

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

8.423 VISITS TO RECIPIENTS BY THE COLORADO LONG-TERM CARE OMBUDSMAN AND DESIGNATED REPRESENTATIVES

A. Definitions:

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

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

Official Colorado Ombudsman Program - the agency which has received the Ombudsman grant from the Older Americans Act through the Colorado Department of Human Services is for purposes of this regulation considered to be the official State Ombudsman Program.

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

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

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

1. The Ombudsman authorizes the disclosure and

2. In cases of identifying a patient, the patient or the legal representative of the patient must consent in writing to the disclosure and specify to whom the identity may be disclosed or

3. A court orders the disclosure.

D. Non-compliance with the provisions of this Section of the regulation will not be considered sufficient good cause as defined in Section 8.130.4.

8.424 PERIODIC VISITS - NURSING HOME RECORDS TO BE MADE AVAILABLE

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

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

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

8.425 Repealed, effective June 30, 2005

8.430 MEDICAID CERTIFICATION OF NEW NURSING FACILITIES OR ADDITIONAL BEDS

8.430.1 DEFINITIONS

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

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

Licensed Bed Capacity means the licensed bed capacity of a nursing facility on file with CDPHE.

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

8.430.2 APPLICABILITY

8.430.2.A. 10 CCR 2505-10 section 8.430 applies to all nursing facilities except:

1. A nursing facility change of ownership or placement into receivership if the ownership change or receivership action involves no increase to its previously approved Medicaid bed total.

2. A nursing facility exclusively serving the developmentally disabled (intermediate care facility for individuals with intellectual disabilities and home and community based services for the developmentally disabled group homes).

3. A replacement facility for existing residents in a facility owned/operated by the applicant. Approval for the beds shall only be granted if:

   a. The applicant clearly documents that the old structure was substantially inadequate to efficiently and effectively promote quality of care for the residents.

   b. The replacement facility is located no more than five miles from the original facility.

   c. The number of beds in the replacement facility is limited to the original number of Medicaid-certified beds being replaced.

   d. Residents living in the original facility at the time it is closed are given the right of first refusal for beds in the replacement facility.

8.430.3 NEW NURSING FACILITY CERTIFICATION

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

1. The burden of demonstrating the need for a new Medicaid facility shall be entirely on the applicant.

2. The applicant for Medicaid certification of a new nursing facility shall:

   a. File a letter of intent to apply for certification with the Department in January or July of the year in which the application will be filed. The letter of intent shall specify:

      i) The person or corporation who will submit the application.

      ii) The proposed service area.

      iii) The number of beds in the new facility for which Medicaid approval will be requested.

   b. No later than five months from the date of filing the letter of intent, the applicant shall submit a complete application. The application shall include:

      i) The name, address and phone number of the person or corporation requesting approval for the new nursing facility.

      ii) The total number of proposed beds and the number of beds requested for Medicaid certification.

      iii) A description of the service area and justification that the service area can be reasonably served by the new nursing facility.

iv) If construction of the additional beds or the new nursing facility has not been completed by the date the application is filed, the following documentation shall also be provided:

1) Official written documentation showing ownership of the proposed new nursing facility.

2) Location of the proposed new nursing facility including documentation of ownership, lease or option to buy the land.

3) Documentation from a financial institution regarding financing support for the new nursing facility.

4) Complete, written documentation that preliminary architectural plans for the proposed new nursing facility have been submitted to CDPHE.

5) Expected completion date of the new nursing facility.

v) A statement regarding any previous contracts with or enrollment in any state's Medicaid program. The statement shall assure that the applicant has never been found guilty of fraud or been decertified from participation in the Medicaid program in Colorado or any other state.

3. A completed application shall be made available on the Department's Internet website for public review and comment. In addition, the applicant shall provide newspaper notice at the applicant's expense, that the application has been submitted. A public hearing on the application may be conducted.

4. As a condition of approval, the new provider may be required to execute an appropriate performance agreement.

5. Approval or denial of an application for Medicaid certification of a new nursing facility shall be based on the following information from the applicant:

a. Planned resident capacity and payer mix.

b. Planned differentiation of the proposed new facility from existing nursing facilities in the same service area (e.g., new models of care, special programs, or targeted populations).

c. The applicant's marketing plan, including planned communications and presentations to discharge personnel and placement agencies.

d. Demographic analysis of the applicant's designated service area, including a market analysis of other available long-term care services, e.g., assisted living, home health, home and community-based services, etc., and the extent to which such alternative services are utilized.

e. Projections of net patient revenue and operating costs.

f. Audited financial statements for the most recently closed fiscal year for the entity seeking Medicaid certification.

g. Additional financial, market or programmatic information requested by the Department within two months after the application date;

h. Historical information concerning the quality of care and survey compliance in other nursing facilities owned or managed by the applicant or a related entity or individual.

i. A statement assuring cooperation with de-institutionalization and community placement efforts.

j. Documentation of whether the proposed new facility provides needed beds to an underserved geographical area, as described in Section 8.430.3.A.5.j.i., or to an underserved special population, as described in Section 8.430.3.A.5.j.ii.

i) To qualify as an underserved geographical area of the state, the application must demonstrate, with appropriate documentation, that:

1) The new nursing facility is located in the service area defined by the application. The service area shall be no more than two contiguous counties in the state.

2) The service area shall have a nursing facility bed to population ratio of less than 40 beds per 1,000 persons over the age of 75 years.

a) The population projections shall be based upon statistics issued by the State Department of Local Affairs.

b) The applicable statistics for applications involving beds for which construction is complete at the time of application shall be the population statistics for the period including the date on which the application is filed.

c) The applicable statistics for applications involving beds for which construction is not complete at the time of application shall be the population projections for the expected date of completion of the beds set forth in the application.

3) The occupancy of existing nursing facilities in the proposed service area exceeds ninety percent (90%) for the six (6) months preceding the filing date of the application, as demonstrated by the nursing facility quarterly census statistics maintained by CDPHE.

ii) An application for a new nursing facility to serve an underserved special population shall contain the following information and documentation:

1) A description of the special populations to be served and why they cannot be served in the community.

2) Justification for the service area to be served.

3) A determination of whether there are existing excess beds in the proposed service area and, if so, why the existing excess beds cannot be used by or converted for use by the special populations.

   a) The determination of existing excess beds shall include a population ratio analysis and occupancy analysis as set forth in Section 8.430.3.A.5.j.i., and shall be calculated by utilizing the formulas, methods and statistics set forth therein.

   b) The justification of why existing excess beds cannot be used for or converted for use by the special populations(s) must be clearly demonstrated and supported by relevant and competent evidence.

4) Applications based on underserved special populations must document that one or more of the following special populations is underserved in the proposed service area:

   a) Clients with AIDS.

   b) Clients with mental, intellectual or developmental disabilities, as defined by the Preadmission Screening and Annual Resident Review (PASRR) process described at Section 8.401.18.

   c) Clients with a traumatic head injury.

   d) Clients who have been certified for a hospital level of care in accordance with Section 8.470.

5) The following requirements also apply to approval of new nursing facilities for special populations:

   a) The Statewide URC shall certify long-term care prior authorization requests for Medicaid clients who are verified as meeting the special populations definitions provided in Section 8.430.3.A.5.j.ii.4.

   b) In the case of applications for approval of new nursing facilities for individuals with intellectual or developmental disabilities, all restrictions concerning Medicaid reimbursement described at Section 8.401.41 et seq., Guidelines for Institutions for Mental Diseases (IMD's), shall apply.

6) A bed approved for a specific underserved special population shall not be used for any other population, even if a Medicaid client occupying this type of bed is discharged or experiences a change in physical condition which requires transfer to a general skilled nursing unit bed.

8.430.4 COMPLETION OF APPROVED BEDS

8.430.4.A. Construction of approved beds shall adhere strictly to the specifications provided in the application. A new application shall be submitted and shall be subject to the criteria for approval in effect at the time of the new application when any of the following changes apply to new beds for a new facility:

1. Person or corporation which has ownership.

2. The site upon which the new beds were built or will be constructed.

3. Proposed service area.

4. Condition under which approval of beds is requested.

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

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

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

   a. Natural disasters.

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

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

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

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

   b. Delays due to litigation.

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

8.430.4.D. Applicants who complete the project within the 30 month period or any extension period shall be eligible for a Medicaid provider agreement provided the facility is inspected on-site and found by CDPHE to be in compliance with standards for licensure as a nursing facility and certification for Medicaid participation.

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

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

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

8.430.5 NOTIFICATION OF INCREASED OR DECREASED MEDICAID BEDS

8.430.5.A. Beginning June 1, 2004, any existing Colorado nursing facility shall notify the Department when it increases or decreases the number of certified Medicaid beds, i.e., when it converts some or all of its licensed non-Medicaid beds to or from general skilled Medicaid nursing facility beds

8.430.5.B. The notification shall contain the following:

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

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

8.435 ENFORCEMENT REMEDIES

8.435.1 DEFINITIONS

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

Enforcement Action means the process of the Department imposing against a Class I non-State operated Medicaid-only nursing facility one (or more) of the remedies for violation of federal requirements for participation as a nursing facility enumerated in the Federal Omnibus Reconciliation Act of 1987, 1989, and 1990, 42 U.S.C. 1396r(h), 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.

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

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

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

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

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

8.435.2 GENERAL PROVISIONS

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

1. Termination of the Medicaid provider agreement.

2. CMP.

3. Denial of payment for new admissions of Medicaid clients.

4. Temporary management.

5. Transfer of residents.

6. Transfer of residents in conjunction with facility closure.

7. The following three remedies with imposition delegated to CDPHE:

   a. State monitoring.

   b. Directed plan of correction.

   c. Directed in-service training.

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

1. The scope and severity of the Deficiency(ies).

2. The most serious Deficiency in relationship to other cited Deficiencies.

3. The nursing facility's past Deficiencies and willingness to become compliant with program rules and regulations.

4. The recommendation of CDPHE pursuant to C.R.S. section 25-1-107.5.

5. [Expired 05/15/2016 per House Bill 16-1257]

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 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. [Expired 05/15/2016 per House Bill 16-1257]

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 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 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.

2. The Department and CDPHE have joint authority for administering the Nursing Home Penalty Cash fund, with final authority in the Department.

   a. For measures aimed at improving the quality of life of residents of nursing facilities, the Nursing Facility Culture Change Accountability Board shall review and make recommendations to the departments regarding the use of the funds in the Nursing Home Penalty Cash Fund available for quality of life measures as specified in 10 CCR 2505-10 section 8.435.2.E.4.b.

3. The maximum amount of funds to be distributed from the Nursing Home Penalty Cash Fund each fiscal year for the purposes in 10 CCR 2505-10 section 8.435.2.E.4.b is specified in C.R.S. section 25-1-107.5.

4. As a basis for distribution of funds from the Nursing Home Penalty Cash Fund:

   a. The Department and CDPHE shall consider the need to pay costs to:

      1) Relocate residents to other facilities when a nursing facility closes

      2) Maintain the operation of a nursing facility pending correction of violations;

      3) Close a nursing facility;

      4) Reimburse residents for personal funds lost.

   b. The Nursing Facility Culture Change Accountability Board shall review and recommend distribution of funds for measures that will benefit residents of nursing facilities by improving their quality of life at the facilities, including:

      1) Consumer education to promote resident-centered care in nursing facilities;

      2) Training for state surveyors, supervisors and the state and local long term care ombudsman, established pursuant to C.R.S. section 26-11.5-104 et seq., regarding resident-centered care in nursing facilities;

3) Development of a newsletter and web site detailing information on resident-centered care in nursing facilities and related information;

4) Education and consultation for purposes of identifying and implementing resident-centered care initiatives in nursing facilities.

c. Expenses to administer and operate the accountability board, including reimbursement of expenses of accountability board members.

1) This expense shall not exceed 10 percent of the fiscal year amount authorized under 10 CCR 2505-10 section 8.435.2.E.3.

5. The Department and CDPHE shall consider the recommendations of the Nursing

Facility Culture Change Accountability Board regarding the use of the funds available each fiscal year for quality of life improvement purposes specified in 10 CCR 2505-10 section 8.435.2.E.4.b.

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

a. This total amount of $194,997.00 is in accordance with the recommendations of the Nursing Facility Culture Change Accountability Board and approved by the Department and CDPHE, with final authority in the Department.

b. This appropriation of $194,997.00 from the Nursing Home Penalty Cash Fund is within the maximum appropriation of $200,000.00 authorized in C.R.S. section 25-1-107.5 for fiscal year 2009-2010.

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

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

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

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

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

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

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

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

   c. If the Department and CDPHE, based on the review of the Nursing Facility Culture Change Accountability Board, determine that any portions of the moneys received for the purposes described in 10 CCR 2505-10 section 8.435.2.E.4.b was not used appropriately, the grantee shall return that portion of the moneys, within thirty days of Nursing Facility Culture Change Accountability Board notification, to the Department to be credited to the Nursing Home Penalty Cash Fund.

   d. Misuse of the funds by a grantee is subject to the false Medicaid claims provisions of C.R.S. sections 25.5-4-304 through 25.5-4-307.

8.440 NURSING FACILITY BENEFITS

Special definitions relating to nursing facility reimbursement:

1. “Acquisition Cost” means the actual allowable cost to the owners of a capital-related asset or any improvement thereto as determined in accordance with generally accepted accounting principles.

2. “Actual cost” or “cost” means the audited cost of providing services.

3. “Administration and General Services Costs” means costs as defined at Section 8.443.8.

4. “Appraised value” means the determination by a qualified appraiser who is a member of an institute of real estate appraisers, or its equivalent, of the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the valuation system as determined by the Department.

   The depreciated cost of replacement appraisal shall be redetermined every four years by new appraisals of the nursing facilities. The new appraisals shall be based upon rules promulgated by the state board.

5. “Array of facility providers” means a listing in order from lowest per diem cost facility to highest for that category of costs or rates, as may be applicable, of all Medicaid-participating nursing facility providers in the state.

6. a. “Base value” means:

i) The appraised value of a capital-related asset for the fiscal year 1986-87 and every fourth year thereafter.

ii) The most recent appraisal together with fifty percent of any increase or decrease each year since the last appraisal, as reflected in the index, for each year in which an appraisal is not done pursuant to subparagraph (i) of this paragraph (a).

b. For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars per licensed bed at any participating facility, and, for each succeeding fiscal year, the base value shall not exceed the previous year's limitation adjusted by any increase or decrease in the index.

c. An improvement to a capital-related asset, which is an addition to that asset, as defined by rules adopted by the state board, shall increase the base value by the acquisition cost of the improvement.

7. "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility.

8. "Case-mix" means a relative score or weight assigned for a given group of residents based upon their levels of resources, consumption, and needs.

9. "Case-mix adjusted direct health care services costs" means those costs comprising the compensation, salaries, bonuses, workers' compensation, employer-contributed taxes, and other employment benefits attributable to a nursing facility provider's direct care nursing staff whether employed directly or as contract employees, including but not limited to DONs, registered nurses, licensed practical nurses, certified nurse aides and restorative nurses.

10. "Case-mix index" means a numeric score assigned to each nursing facility resident based upon a resident's physical and mental condition that reflects the amount of relative resources required to provide care to that resident.

11. "Case-mix neutral" means the direct health care costs of all facilities adjusted to a common case-mix.

12. "Case-mix reimbursement" means a payment system that reimburses each facility according to the resource consumption in treating its case-mix of Medicaid residents, which case-mix may include such factors as the age, health status, resource utilization, and diagnoses of the facility's Medicaid residents as further specified in this section.

13. "Class I nursing facility provider" means a private for-profit or not-for-profit nursing facility provider or a facility provider operated by the state of Colorado, a county, a city and county, or special district that provides general skilled nursing facility care to residents who require twenty-four-hour nursing care and services due to their ages, infirmity, or health care conditions, including residents who are behaviorally challenged by virtue of severe mental illness or dementia. Swing bed facilities are not included as Class I nursing facility providers.

14. "Core Component per diem rate" means the per diem rate for direct and indirect health care services costs, administrative and general services costs, and fair rental allowance for capital-related assets for Class 1 nursing facility providers.

15. "Direct health care services costs" means those costs subject to case-mix adjusted direct health care services costs.

16. "Direct or indirect health care services costs" means the costs incurred for patient support services as defined at Section 8.443.7.

17. "Facility population distribution" means the number of Colorado nursing facility residents who are classified into each resource utilization group as of a specific point in time.

18. "Fair rental allowance" means the product obtained by multiplying the base value of a capital-related asset by the rental rate.

19. "Improvement" means the addition to a capital-related asset of land, buildings, or fixed equipment.

20. "Index" means the R. S. Means construction systems cost index or an equivalent index that is based upon a survey of prices of common building materials and wage rates for nursing home construction.

21. "Index maximization" means classifying a resident who could be assigned to more than one category to the category with the highest case-mix index.

22. "Median per diem cost" means the daily cost of care and services per patient for the nursing facility provider that represents the middle of all of the arrayed facilities participating as providers or as the number of arrayed facilities may dictate, the mean of the two middle providers.

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

24. "Minimum data set" means a set of screening, clinical, and functional status elements that are used in the assessment of a nursing facility provider's residents under the Medicare and Medicaid programs.

25. "MMIS per diem reimbursement rate" means the per diem rate used for Medicaid Management Information Systems (MMIS) claims based reimbursement.

26. "Normalization ratio" means the statewide average case-mix index divided by the facility's cost report period case-mix index.

27. "Normalized" means multiplying the nursing facility provider's per diem case-mix adjusted direct health care services cost by its case-mix index normalization ratio for the purpose of making the per diem cost comparable among facilities based upon a common case-mix in order to determine the maximum allowable reimbursement limitation.

28. "Nursing facility provider" means a facility provider that meets the state nursing facility licensing standards established pursuant to C.R.S. §25-1.5-103, and is maintained primarily for the care and treatment of inpatients under the direction of a physician.

29. "Nursing salary ratios" means the relative difference in hourly wages of registered nurses, licensed practical nurses, and nurse's aides.

30. "Nursing weights" means numeric scores assigned to each category of the resource utilization groups that measure the relative amount of resources required to provide nursing care to a nursing facility provider's residents.

31. "Occupancy-imputed days" means the use of a predetermined number for patient days rather than actual patient days in computing per diem cost.

32. "Per diem cost" means the daily cost of care and services per patient for a nursing facility provider.

33. "Per diem fee" means the dollar amount of provider fee that the Department shall charge a nursing facility provider per non-Medicare day.

34. "Provider fee" means a licensing fee, assessment, or other mandatory payment as specified under 42 C.F.R. § 433.55.

35. "Raw food" means the food products and substances, including but not limited to nutritional supplements, that are consumed by residents.

36. "Rental rate" means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent. The rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

37. "Resource utilization group" (RUG) means the system for grouping a nursing facility's residents according to their clinical and functional status identified from data supplied by the facility's minimum data set as published by the United States Department of Health and Human Services.

38. "Statewide average per diem rate" means the average per diem rate for all Medicaid-participating nursing facility providers in the state.

39. "Substandard Quality of Care" means one or more deficiencies related to participation requirements under 42 C.F.R § 483.12 Freedom from abuse, neglect, and exploitation, 42 C.F.R. § 483.24 Quality of life, or 42 C.F.R. § 483.25, Quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

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

8.440.1 SERVICES AND ITEMS INCLUDED IN THE PER DIEM PAYMENT

8.440.1.A. Payment to nursing facilities, swing-bed facilities and intermediate care Facilities for Individuals with Intellectual Disabilities shall be an all-inclusive per diem rate, except as provided for within this rule. This rate covers the necessary services to the resident, including room and board, as well as nursing and ordinary supplies and equipment related to the day-to-day care of the resident and the operation of the facility.

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

1. Nursing services, therapies, aide services and medically related social services;

2. Dietary services;

3. Activities program;

4. Room/bed maintenance services;

5. Routine personal hygiene items and services; and

6. Laboratory services.

a. Waivered laboratory services provided by nursing facilities enrolled in the Medicaid program are subject to the requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as set forth in 42 C.F.R. part 493, October 1, 1994 edition.. Facilities that collect specimens, including drawing blood specimens, but do not perform testing of specimens, are not subject to CLIA requirements. A facility shall obtain a Certificate of Waiver from the Centers for Medicare and Medicaid or its designated agency if the facility only performs waivered tests as defined by CLIA.

b. 42 C.F.R. part 493 (1994) is hereby incorporated by reference. The incorporation of 42 C.F.R. part 493 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.

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

1. Adaptive equipment for activities of daily living;

2. Air mattresses, other special mattresses, sheepskins and other devices for preventing/treating decubitus ulcers;

3. Apnea monitors and necessary supplies and equipment;

4. Atomizers;

5. Autoclaves and sterilizers;

6. Bath equipment, i.e., raised and/or padded toilet seats, trapeze benches, tub/shower stools or benches;

7. Bedrails, footboards, trapeze bars, traction and fracture frames, bedside stands;

8. Bed linens;

9. Beds, including hospital beds;

10. Blood glucose monitors;

11. Commode chairs;

12. Deodorizers;

13. Emesis basins;

14. Flameproof curtains;

15. Flashlights;

16. Foot pumps;

17. Gerry chairs, cushioned chairs;

18. Ice bags or equivalent;

19. Intermittent positive pressure breathing equipment, including Sodium Chloride or sterile water required for operation;

20. Irrigating solutions, i.e., Acetic Acid, Potassium Permanganate, Sodium Chloride, and sterile water;

21. Lifts, i.e., hydraulic, tub, slings;

22. Lymphedema pumps and compressors;

23. Medically necessary manual or power wheelchairs for intermittent and full-time use, including cushions and pads as required for the prevention or treatment of skin breakdown, if purchased by the nursing facilities.

    a. Wheelchairs, if required, shall meet the specific needs of the resident and shall be ordered by a physician. The Primary Care Physician shall concur that the wheelchair being prescribed for the resident is medically necessary.

    b. All costs associated with the purchase of the wheelchair shall be charged to the health care line of the nursing facility. Wheelchair expenses shall be reported in the appropriate health care line of the Med-13

    c. The wheelchair shall be sent with the resident in the event the resident is transferred to another facility or returns home. The transferring facility shall expense the remainder of the chair in the fiscal year during which the transfer occurs.

24. Medicine cups;

25. Oxygen masks, regulators, humidifiers, hoses, nasal catheters, as needed, for the administration of oxygen;

26. Percussors and respirators;

27. Positioning pillows;

28. Reading lights;

29. Scissors, forceps, and nail files;

30. Sitz baths;

31. Sphygmomanometers, stethoscopes, and other examination equipment;

32. Splints;

33. Stryker pads;

34. Suction apparatus and gavage tubing;

35. Supplies and equipment necessary for delivery of special dietary needs;

36. Surgical stockings for routine use;

37. Ventilators and related equipment and supplies;

38. Walkers, crutches, canes and medically necessary accessories for ambulatory devices;

39. Weighing scales.

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

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

2. Bedside utensils, bedpans, basins;

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

4. Charting supplies;

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

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

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

8. Fleece pads;

9. Foot soaks;

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

11. Minor medical surgical supplies;

12. Miscellaneous applicators;

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

14. Safety pins;

15. Thermometers;

16. Tongue depressors;

17. Tracheostomy care kits, cleaning supplies;

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

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

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

1. Artificial tears;

2. Aspirin, acetaminophen, ibuprofen, and other non-prescription analgesics available now or in the future;

3. Cough and cold supplies, i.e., cold tablets, decongestants, cough syrup/tablets;

4. Douches;

5. Evacuant suppositories, laxatives, stool softeners, enemas;

6. First aid supplies, i.e., alcohol, hydrogen peroxide, merthiolate and other antiseptics/germicides, Betadine, Phisohex, chlorhexidene gluconate, providone/iodine solution and wash, epsom salt;

7. Lubricants, rubbing compounds and ointments, i.e., petroleum jelly, bag balm, other body lotions for treatment of dry skin or skin breakdowns, bacitracin ointment and other ointments used in treatment of wounds;

8. Vitamins (multi and single) and mineral supplements.

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

1. Food and dietary services, including special diets, supplements and nutrients ordered by the physician, in accordance with the needs of the residents and appropriate licensing requirements;

2. Room for accommodation of the resident in accordance with licensing requirements, including storage for personal belongings, bedside equipment, suitable bed, clean and comfortable mattress, pillows and an adequate supply of clean linen;

3. Maintenance of clean, comfortable and sanitary environment through provision of heat, light, ventilation and sanitation to meet health and aesthetic needs of the resident, in accordance with the physicians' orders and licensing regulations;

4. Basic personal laundry, excluding dry-cleaning, mending, hand washing, or other specialties.

5. Consultant services when the facility employs or contracts with consultants in an effort to meet regulations.

6. Specialized rehabilitative services, including, but not limited to, physical therapy, speech-language pathology, occupational therapy and mental health rehabilitative services for mental illness and intellectual or developmental disability, when required in the resident's comprehensive plan of care. Specialized rehabilitative services shall be provided under the written order of a physician by qualified personnel. The facility shall provide the required services or obtain the required services from a provider of specialized rehabilitative services.

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

8.440.2 SERVICES AND ITEMS NOT INCLUDED IN THE PER DIEM PAYMENT

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

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

2. Gifts purchased on behalf of a resident;

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

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

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

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

5. Personal clothing and dry cleaning;

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

7. Personal reading material, subscriptions;

8. Private room;

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

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

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

12. Provider fee.

13. Prescription drugs, with certain specific exemptions.

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

15. Oxygen

16. Physician fees

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

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

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 employed by the nursing facility and has duties limited to the care of a particular resident, or two such residents in the same room.

2. The physician orders a private room.

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

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

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

1. Eye/Hearing examinations

2. Eyeglasses and repairs

3. Hearing aids and batteries

4. Provider fees

8.441 NURSING FACILITY COST REPORTING

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

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

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

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

    b. Subchapter “S” corporations required by law to have a fiscal year end of December 31.

2. Provide adequate cost data that:

    a. Is based on their financial and statistical records. All financial and statistical records of the facility shall be maintained in accordance with generally accepted accounting principles as approved by the American Institute of Certified Public Accountants.

    b. Is verifiable through adequate supporting documentation provided to auditors during the normal course of their audit;

    c. Is based on the accrual basis of accounting.

        i) Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected and expenses are reported in the period in which they are incurred, regardless of when they are paid.

        ii) Where a governmental institution operates on a cash basis of accounting, cost data based on such accounting shall be acceptable, subject to appropriate treatment of capital expenditures.

    d. Includes the Medicare cost report that was most recently filed with the Medicare fiscal intermediary. If the facility cannot file a current Medicare cost report for reasons beyond its control, the facility shall submit other reliable Medicare cost information that the Department has approved.

3. Maintain financial and statistical records in a manner consistent from one reporting period to another in order to provide the required cost data and not impair comparability.

4. Retain all records required to support information supplied on the MED-13 for a period of at least five (5) years from the date of submission.

8.441.1.B. Nursing facilities shall submit all Minimum Data Set (MDS) resident assessments and tracking documents to the Centers for Medicare and Medicaid Services (CMS) MDS database for Colorado maintained at CDPHE. All assessment data submitted shall conform to federal and state specifications and meet minimum editing and validation requirements.

8.441.1.C. Failure to maintain adequate accounting and/or statistical records shall be cause for termination or suspension of the facility’s provider agreement.

8.441.2 COMPLETION OF THE MED-13 – GENERAL INSTRUCTIONS

8.441.2.A. The MED-13 consists of the certification page and all schedules. All information called for in the schedules must be furnished unless:

1. It is not applicable to the nursing facility operation; or

2. The books and records do not provide the information and it is not available by other reasonable means.

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

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

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

8.441.3 COMPLETION OF THE MED-13 CERTIFICATION PAGE

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

8.441.3.B. Accounting basis:

1. Accrual Recording revenue when earned and expenses when incurred.

2. Modified Cash Recording revenue when received and expenses when incurred.

3. Cash Recording revenue when received and expenses when paid after giving effect to adjustments for pre payments, etc. and depreciation.

4. Nursing facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis.

8.441.3.C. Statistical Data

1. The statistical data shall be accurate. A resident day is that period of service rendered to resident between the census taking hours on two (2) successive days, the day of discharge being counted only when the resident was admitted that same day.

2. The total resident days for the period shall be accurate and not an estimate of days of care provided. Resident days shall include days for residents having special duty nurses.

3. The accumulation method format set forth in Form NH 1 ("Monthly Census Summary -- Nursing Home Patients") shall be used. Such monthly record shall be kept concerning all patients, both Medicaid residents and non-Medicaid residents, by the nursing facility. Sample copies of the required format may be obtained from the Department.

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

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

8.441.4 COMPLETION OF REVENUES SCHEDULE

8.441.4.A. Revenues shall be listed as recorded in the general books and records and are affected by the accounting basis and procedures used. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues for purposes of completing the revenue schedule.

8.441.4.B. Revenue from patients shall be classified sufficiently in the accounting records to allow preparation of this schedule.

1. "Routine services" or "daily services" are those services that include room, board, nursing services and such services as supervision, feeding, and incontinency for which the associated costs are in nursing service.

2. "Routine services" or "daily services" shall represent only the established charge for daily care, excluding additional charged, if any, for other services.

8.441.4.C. Revenue from ancillary services provided to residents, such as pharmacy, medical supplies and occupational therapy supplies shall be applied in reduction of the related expense. The resulting expense, after adjustment, shall not be a negative figure. A revenue classification "Miscellaneous" or "Sundry" requires an analysis and determination of the amounts included therein, which represent expense recoveries or income to be applied in reduction of a related expense.

8.441.4.D. Medical supplies, with certain specific exceptions, shall be provided to Medicaid residents without separate additional charges to the resident or relatives. The costs of these supplies or services shall be included in audited costs.

8.441.4.E. Account for specific medical supplies or services for which a separate additional charge is allowed as "Items Purchased for Resale." Show the cost on the appropriate line for elimination.

8.441.4.F. Revenues related to services rendered which are not an obligation of the state shall be offset against allowable costs if the associated expense cannot be determined. If the associated expense can be determined, related expense should be removed as non-allowable (i.e., if barber and beauty shop revenue is $1,000 and the related expense is $900, enter $900; however, if expenses cannot be determined, enter $1,000).

8.441.4G. Revenues not related to patient care ("Other Revenue Centers") shall be applied in reduction of the related expense. Remove the cost, if known, (such as employee meals or telephone expense) or the gross revenue if cost cannot be determined.

8.441.4.H Revenue from residents, or others, resultant from charges made for room reservations, shall be classified sufficiently in the accounting records, and such amount shall be entered on the Revenue Schedule and identified as room reservation charges. This revenue shall also be offset against allowable expenses.

8.441.4.I. An investment or interest income adjustment shall be necessary only if interest expense is incurred, and only to the extent of such interest expense.

8.441.4.J. Laundry revenue shall be applied to laundry expense.

8.441.4.K. Open lines are provided for entry of sundry sources of revenue not directly related to patients, such as pay telephone commissions, contributions and grants received. These items need not be applied as a reduction of expense.

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

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

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

1. Fees paid directors and non-working officers' salaries shall not be allowed as reimbursable costs.

2. Loan acquisition fees and standby fees shall not be considered part of the current expense of patient care but shall be amortized over the life of the related loan.

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

1. For purposes of 10 CCR 2505-10 section 8.441.5.B, the following definitions shall apply:

   a. Compensation means the total benefit received by the owner for services rendered to the facility. Such compensation shall only include:

      i) Salary amounts paid for managerial, administration, professional and other services;

      ii) Amounts paid by the facility for the personal benefits of the owner;

      iii) The costs of assets and services which the owner receives from the facility; and

      iv) Deferred compensation.

   b. Necessary Services means those services needed for the efficient operation and sound management of the facility such that, had the owners or owner-related individuals not rendered the services, the facility would have had to employ another individual to perform the services.

   c. Owner means an individual with a five percent (5%) or more ownership interest in the facility.

   d. Owner-Related Individual means an individual who is a member of an owner's immediate family which includes a spouse, natural or adoptive parent, natural or adopted child, step-parent, step-child, sibling or step-sibling, in-laws, grandparents and grandchildren.

e. Ownership Interest means the entitlement to a legal or equitable interest in any property of the facility whether such interest is in the form of capital, stock or profits of the facility.

2. Compensation for services of owners and owner related employees shall be adequately documented to be necessary and such employees shall adequately documented to be qualified to provide these services. Adequate documentation shall include but not be limited to:

   a. Date and time of services;

   b. Position description;

   c. Individual's educational qualifications, professional title and work experience;

   d. Type and extent of ownership interest;

   e. Relationship to and name of owner (if an owner related individual).

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

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

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

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

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

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

5. Exceptions to the application of the median as the maximum allowable salary for owner and owner-related employees shall be approved by the Department only where the nursing home can demonstrate that it has unique characteristics or the employee in question has special qualifications and experience which would make application of the median for that size facility unreasonable. Requests for exceptions shall be submitted to the Department in writing no later than 90 days prior to the end of the facility's fiscal year.

8.441.5.C. LEGAL FEES, EXPENSES AND COSTS

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

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

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

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

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

d. Legal fees, expenses and costs incurred in connection with an investigation by federal, state, or local governments and their agencies that might lead to a civil or criminal proceeding against the provider as a result of alleged fraud or other misconduct by the provider in the course of the provider's participation in the Medicaid program shall not be allowable where the provider makes any payment of funds to any federal, state, or local governments and their agencies as a result of the alleged fraud or misconduct which was the subject of the investigation.

e. Legal fees, expenses and costs incurred for lobbying Congress, the Legislature of Colorado, or the Medical Services Board, Health or Human Services.

f. Legal fees, expenses and costs incurred by the seller in the normal course of the sale of a nursing home.

g. Nonrefundable retainers paid to Counsel.

h. Legal fees, expenses and costs associated with a change of ownership incurred for any reason after a change of ownership has occurred.

i. Legal fees, expenses, or costs as a result of an attorney entering an appearance in person or in writing by counsel for the provider during the Informal Reconsideration. Legal fees, expenses and costs that are advisory in nature before and during the Informal Reconsideration process will be allowable.

8.441.5.D. DEPRECIATION

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

   “MAI Appraiser” means the designation “Member, Appraisal Institute” awarded by the American Institute of Real Estate Appraisers.

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

2. Except as specified in this manual, Medicare rules and regulations as delineated in the Medicare and Medicaid Guide, 1981, published by Commerce Clearing House, paragraph 4501-4897P, shall be utilized in the treatment of depreciation costs for purposes of reimbursement under Medicaid. 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.

3. Depreciation on assets used to provide covered services to Medicaid recipients may be included as an allowable patient cost. Only the straight-line method of computing depreciation may be utilized for purposes of Medicaid reimbursement. Depreciation costs shall be identifiable as such, and shall be recorded in the provider's accounting records in accordance with “generally accepted accounting principles.”

4. Depreciable items must be capitalized and written off over the estimated useful life of the item using the straight-line method of depreciation. With respect to expenditures during every facility fiscal year which begins on or after July 1, 1998, the following items must be depreciated:

    a. Assets that, at the time of acquisition, had an estimated useful life of (2) two years or more; and a historical cost of $5,000 or more.

    b. Betterments or improvements that extend the original estimated useful life of an asset by (2) two years or more, or increase the productivity of an asset significantly; and cost $5,000 or more.

    c. For the purpose of applying the $5,000 threshold in paragraphs A and B above, the costs of assets, betterments, and/or improvements shall be combined if the costs:

        i) Are incurred within the same fiscal year of the nursing facility; and

        ii) Are of the same type or relate to the same project. For example, costs related to renovations or improvements to a facility's kitchen must be combined.

    d. Major repairs are repairs which:

        i) Occur infrequently, involve significant amounts of money, and increase the economic usefulness of the asset in the future, because of either increased efficiency, greater productivity, or longer life; or

        ii) Restore the original estimated useful life of an asset where without such repairs, the useful life of the asset would be reduced or immediately ended; these repairs occur infrequently and have a significant cost in relation to the asset being repaired.

    e. If the composite method of depreciation is used, the time period over which the major repair must be depreciated is not necessarily the remaining life of the composite asset. For example, a major repair to a roof of a facility that has a remaining useful life of thirty (30) years would not have to be depreciated over thirty (30) years if the normal life of the roof is only fifteen (l5) to twenty (20) years; the shorter period could be used.

    f. The following are examples of major repairs and are not intended as a complete list: replacement or partial replacement of a roof, flooring, boiler, or electrical wiring.

8.441.5.E. EXPENSED ITEMS

1. Items which are to be entirely expensed in the year of purchase, rather than depreciated, are as follows:

    a. All repair and maintenance costs, except major repairs.

    b. Assets that, at the time of acquisition, had an estimated useful life of less than two (2) years; or cost less than $5,000.

c. Betterments or improvements that do not extend the useful life of an asset by two (2) years or more, or do not increase the productivity of an asset significantly; or cost less than $5,000.

d. For the purpose of applying the $5,000 threshold in paragraphs “b” and “c” above, assets, betterments, and/or improvements that are purchased separately shall be combined if they meet the criteria described in 10 CCR 2505-10 section 8.441.5.D.

8.441.5.F. HISTORICAL COSTS

1. 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.

2. When the Internal Revenue Service requires a facility to change its allocation of costs of land, buildings or equipment for purposes of tax reporting, a copy of the IRS notice shall be submitted to the Department in order for the changes to be reflected in the cost report.

3. In regards to a determination of a bona fide sale, an initial presumption that the sale was not bona fide may be offset by a valuation report of an MAI appraiser of the reproduction cost depreciated to date on a straight-line basis. Cost determined in this manner shall be accepted for future depreciation purposes.

4. An initial presumption that a sale was not bona fide shall be made when any of the following factors exist:

   a. The seller and purchaser are persons for whom a loss from the sale or exchange of property is not allowed under the Internal Revenue Services Code between:

      i) Members of a family;

      ii) An individual and a corporation if the individual owns (directly or indirectly) more than 50% in value of the outstanding stock;

      iii) Two corporations if more than 50% in value of the outstanding stock in both is owned, directly or indirectly, by the same individual, but only if either one of the corporations was a personal holding company or a foreign personal holding company for the taxable year preceding the date of the sale or exchange;

      iv) A grantor and a fiduciary of any trust;

      v) A fiduciary of one trust and a fiduciary of another trust, if the same person is grantor of both trusts;

      vi) A fiduciary of a trust and any beneficiary of such trust;

vii) A fiduciary of a trust and a beneficiary of another trust, if the same person is a grantor of both trusts;

viii) A fiduciary of a trust and a corporation more than 50% in value of the outstanding stock of which is directly or indirectly owned by or for the trust or a grantor of the trust. This would, for example, have the effect of denying a loss in a transaction between a corporation, more than 50% of the stock of which was owned by a father, and a trust established for his children. Under the constructive ownership rules (below), the children are treated as owning the stock owned by the father; and

ix) A person and an exempt charitable or education organization controlled by the person or, if the person is an individual, by the individual or his family.

b. The term “family” means a brother or sister (whole or half-blood relationship, spouse, ancestor, or lineal descendant, including in laws and in laws of ancestors of lineal descendants.

c. In determining stock ownership;

d. The transaction was effected without significant investment on the part of the purchaser; i.e., cash or property was not transferred from the purchaser to the seller and the sales price was met by assumption of existing debt and promises to pay additional amounts or issuance of life annuities to the seller.

e. The sales price could be considered excessive when compared with other sales or costs of constructing, furnishing, and equipping other facilities of comparable size and quality during the preceding twelve months.

8.441.5.G. INTEREST

1. For purposes of this section concerning interest, the following definitions shall apply:

a. Interest means the cost incurred for the use of borrowed funds.

b. Interest on current indebtedness means the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expense.

c. Interest on capital indebtedness means the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long term loans.

d. Necessary means that the interest:

i) Is incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or investments shall not be considered necessary;

ii) Is incurred on a loan made for a purpose reasonably related to patient care; and

iii) Is reduced by investment income except where such income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded depreciation or provider's qualified pension fund shall not be used to reduce interest expense.

e. Proper means that interest:

i) Is incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made; and

ii) Is paid to a lender not related through control or ownership or personal relationship to the borrowing organization. However, interest shall be allowable if paid on loans from the provider's donor restricted funds, the funded depreciation account or provider's qualified pension funds.

2. To be allowable, the interest expense shall be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors affects the bargaining process that usually accompanies the making of a loan and could be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans shall be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed and that the interest rate is reasonable.

3. Interest on loans to providers by partners, stockholders or related organizations are allowable as costs at a rate not in excess of the prime rate.

4. Where the general fund of a provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, the interest shall be an allowable cost. The same treatment shall be accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund. In addition, if a provider operated by members of a religious order borrows from the order, interest paid to the order shall be an allowable cost.

5. Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where such deposits are used for other than the purpose for which the fund was established.

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

8.441.5.H. MANAGEMENT SERVICES

1. The following requirements apply to all management companies:

a. Management company costs shall be considered administrative costs except as described at 10 CCR 2505-10 section 8.443.7.A.13.

b. Management company costs allocated to facilities shall be based on actual services provided to the facility. The allocation shall be documented.

c. If the compensation to on-site management staff is separately reported on the cost report, that compensation shall not also be included in the allowable management costs for the facility. This rule shall apply regardless of whether owners or owner-related organizations are involved in the administration or management services.

2. In addition to the requirements of 10 CCR 2505-10 section 8.441.5.H.1, the following requirements shall apply to owner-related management companies:

a. "Owner-related management company" means an individual or organization that is related to, owned or controlled by the owner(s) of the nursing facility, as described in 10 CCR 2505-10 section 8.441.5.B.

b. Management services provided to the nursing facility by an owner-related management company are subject to the related party rules at 10 CCR 2505-10 section 8.441.5.B.

c. When management services are provided to a nursing facility by an owner-related management company, the nursing facility shall compile and present for inspection supporting documentation of actual costs incurred in providing the management company services. This shall include, at a minimum, the following:

i) Documentation supporting the reasonableness of salaries paid to owners and owner-related employees of the management company, as specified in 10 CCR 2505-10 section 8.441.5.B;

ii) Allocation schedules;

iii) Medicare Home Office cost reports;

iv) All tax records and filings of the management company;

v) All management company records to support financial statements.

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Common ownership means that an individual or individuals directly or indirectly possess a significant (5% or more) ownership interest, as defined in 10 CCR 2505-10 section 8.441.5.B, in the nursing facility and the institution or organization serving the nursing facility.

b. Control means that an individual or an organization has common ownership with or is related to another organization or institution, or has the power, directly or indirectly, to influence significantly or to direct the actions or policies of another organization or an institution.

c. Related to the nursing facility means:

i) The nursing facility, to a significant extent, is associated or affiliated with, or has control of, or is controlled by the organization furnishing the services, facilities or supplies; or

ii) An owner-related individual, as defined in 10 CCR 2505-10 section 8.441.5.B, is employed by the nursing facility at the time that the nursing facility is obtaining services, facilities or supplies from an organization whose owner is related to the nursing facility employee; or

iii) An owner-related individual, as defined in 10 CCR 2505-10 section 8.441.5.B, is employed by an organization which is providing services, facilities or supplies to a nursing facility whose owner is related to the supplier's employee.

3. Related providers or organizations shall be identified by the nursing facility on Schedule F of the MED-I3.

4. The charge by the related provider or organizations for the services, facilities or supplies shall be considered an allowable cost when the nursing facility demonstrates all of the following by clear and convincing evidence:

a. The supplying organization is a bona fide separate organization; and

b. A substantial part of the supplier's business activity of the type carried on with a nursing facility is transacted with others than the nursing facility and organizations related to the supplier by common ownership or control; and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization; and

c. The services, facilities or supplies are those which commonly are obtained by institutions, such as the nursing facility, from other organizations and are not basic elements of patient care ordinarily furnished directly to the patients by such institutions; and

d. The charge to the nursing facility is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities or supplies.

8.441.5.J. NON-SALARIED STAFF

1. Members of religious orders serving under an agreement with their administrative offices shall be allowed comparable salaries paid persons performing comparable services.

2. If maintenance is provided such persons by the nursing facility, i.e., room board, clothing, the amount of these benefits shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

8.441.5.K. OXYGEN

1. Only purchased oxygen concentrator costs, whether expensed or capitalized, shall be allowable costs on the MED-13. Such costs include, but are not limited to, all supplies, equipment and servicing expenses related to the maintenance of the purchased concentrators.

2. Oxygen concentrators of any size leased by medical supply companies to Medicaid nursing facility residents shall not be allowable costs and shall not be included in the MED-13.

8.441.5.L. LIMITATION ON MEDICARE PART A AND PART B COSTS

1. Only those Medicare costs that are reasonable, necessary and patient-related shall be included in calculating the allowable Medicaid reimbursement for class I nursing facilities.

2. The Medicare Part A ancillary costs ("Part A costs") allowed in calculating the Medicaid per diem rate for a class I facility shall be: The level of Part A costs allowed in the facility's latest Medicare cost report submitted by the facility to the Department prior to July 1, 1997.

3. The Medicare Part A ancillary costs ("Part A costs") allowed in calculating the Medicaid per diem rate for newly certified Medicaid nursing facilities shall be: The level of Part A costs allowed in the facility's first full year Medicaid cost report submitted by the facility to the Department.

4. Part B direct costs for Medicare shall be excluded from the allowable Medicaid reimbursement for class I nursing facilities.

8.441.6 COMPLETION OF OPERATING EXPENSES SCHEDULE

8.441.6.A. All expenses should be reported on the operating expenses schedule. All adjustments to eliminate expenses or to apply expense recoveries shall be made on the operating expenses schedule.

8.441.6.B. Expense centers in operating expenses shall be used for distribution of expenses by object or natural classifications within the department or function. The expenses shall be classified sufficiently within the accounting records to allow preparation of operating expenses schedule.

8.441.6.C. Total expenses reported on the operating expenses schedule shall agree with the total expenses in the general ledger.

8.442 SUBMISSION OF COST REPORTING INFORMATION

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

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

1. Be in writing and shall be submitted to the Department.

2. Properly document the reasons for the failure to comply.

3. Be submitted no less than ten (10) working days prior to the due date for submission of the MED-13.

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

1. When a nursing facility fails to submit a complete and auditable MED-13 (i.e., the information represented on the MED-13 can not be verified by reference to adequate documentation as required by generally accepted auditing standards) on time, the MED-13 shall be returned to the facility with written notification that it is unacceptable.

    a. The facility shall have either 30 days from the postmark date of the notice or until the end of the original 90-day submission period, whichever is later, to submit a corrected MED-13.

    b. If the corrected MED-13 is still determined to be incomplete or unauditable, the nursing facility shall be given written notification that it shall, at its own expense, submit a MED-13 that has been prepared by a certified public accountant (CPA). The CPA shall certify that the report is in compliance with all Department regulations and shall give an opinion of fairness of presentation of operating results or revenues and expenses.

    c. The Department shall withhold all warrants not yet released to the provider once the original 90-day filing period and 30-day extension have expired and no acceptable MED-13 has been submitted.

2. If the audit of the MED-13 is delayed by the nursing facility's lack of cooperation, the effective date for the new rate shall be delayed until the first day of the month in which the audit is completed. Lack of cooperation shall mean failure of the nursing facility to meet its responsibility to submit a timely MED-13 or failure to provide documents, personnel or other resources within its control and necessary for completion of the audit, within a reasonable time.

3. When the rate for the facility during a period of delay is found to have been higher than the new rate, the new rate shall be applied retroactively to this period and the Department shall make any adjustments and/or recoveries of overpayments.

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

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

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

1. Requests shall be in writing and shall include an explanation of the need for the revision.

2. If the revision will not be submitted to the Department's designee within the original 90-day filing period, the date of submission of the MED-13 shall be the date of receipt of the submission. The Department may grant a 30-day extension of the filing period.

3. Once the original 90-day filing period and 30-day extension have expired, the Department shall withhold all warrants not yet released to the provider if the revision still has not been submitted to the Department.

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

1. The Department shall withhold all warrants not yet released to the provider for services rendered in the prior three calendar months (four months if an extension was granted) and thereafter until an acceptable MED-13 is received.

2. Once the Department determines that the MED-13 submitted is complete and auditable, the provider's withheld payments shall be released.

3. If an acceptable MED-13 has not been submitted within 90 days after the Department began withholding payments, the provider's participation in the Medicaid program shall be terminated and the payments withheld shall be released to the provider.

4. Interest paid by the provider on loans for working capital while payments are being withheld shall not be allowable costs for purposes of reimbursement under Medicaid.

5. When the delayed submission of the MED-13 causes the effective date of a new lower rate to be delayed, the new rate shall be applied retroactively to this period and the Department shall make recoveries of overpayments.

8.442.3 PROPOSED ADJUSTMENTS

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

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

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

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

8.443 NURSING FACILITY REIMBURSEMENT

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

1. Medicare statutes.

2. Medicare regulations.

3. Medicaid and Medicare guidelines.

4. Generally accepted accounting principles.

8.443.1.B Effective July 1 of each year, a MMIS per diem reimbursement rate for Class I nursing facility providers shall be established for reimbursement of billed claims.

1. The MMIS per diem reimbursement rate shall equal the July 1 Core Component per diem rate multiplied by a percent factor. The percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by the statutory limit pursuant to C.R.S 25.5-6-202(9)(b)(VII)(2020) for SFY 2020-21 and SFY 2021-22. The increase for all subsequent years shall be limited pursuant to C.R.S 25.5-6-202(9)(b)(I)(2020).

2. For state fiscal year (SFY) 2019-20, if the MMIS per diem reimbursement rate is less than ninety-five percent (95%) of the SFY 2018-19 MMIS per diem reimbursement rate, the SFY 2019-20 MMIS per diem reimbursement rate shall be the lesser of 95% of the SFY 2018-19 MMIS per diem reimbursement rate or the SFY 2019-20 Core Component per diem rate.

3. In the event that MMIS per diem reimbursement rate is greater than the Core Component per diem rate, the Department shall reduce the rate to no greater than the Core Component per diem rate.

The Core Component per diem rate shall be determined using information on the MED-13, the Minimum Data Set (MDS) resident assessment information and information obtained by the Department or its designee retained for cost auditing purposes.

The Core Component per diem rate shall be the sum of the following per diem rates:

1. Health care per diem rate described in Section 8.443.7.D,

2. Administrative and general per diem rate described in Section 8.443.8.E, and

3. Fair rental allowance per diem rate described in Section 8.443.9.B.

In addition to the MMIS claims reimbursement, a Class 1 nursing facility provider may be reimbursed supplemental payments. Supplemental payments are funded using available provider fee dollars collected as described in Section 8.443.17. Supplemental payments shall be funded in the subsequent order based upon the statutory hierarchy pursuant to C.R.S § 25.5-6-203(2)(b).

1. Medicaid utilization supplemental payment described in Section 8.443.10.C,

2. Acuity Adjusted Core Component supplemental payment described in Section 8.443.11.B,

3. Pay-For-Performance supplemental payment described in Section 8.443.12,

4. Cognitive Performance Scale supplemental payment described in Section 8.443.10.A,

5. Preadmission Screening and Resident Review II Resident supplemental payment described in Section 8.443.10.B,

6. Preadmission Screening and Resident Review II Facility supplemental payment described in Section 8.443.10.B, and

7. Core Component supplemental payment described in Section 8.443.11.A.

8.443.1.C For class II and privately-owned class IV intermediate care Facilities for Individuals with Intellectual Disabilities, a payment rate for each participating facility shall be determined on the basis of the MED-13 and information obtained by the Department or its designee retained for the purpose of cost auditing.

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

1. Health Care.

2. Administrative and General.

3. Fair Rental Allowance for Capital-Related Assets.

8.443.1.D For state-operated class IV intermediate care Facilities for Individuals with Intellectual Disabilities, a payment rate for each participating facility shall be determined on the basis of the MED-13 and information obtained by the Department or its designee retained for the purpose of cost auditing.

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

1. Health Care.

2. Administrative and General, which includes capital.

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

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

1. Has a license from CDPHE, and

2. Is a Medicaid participating provider of nursing care services, and

3. Meets the requirements of the Department's regulations.

8.443.2 NURSING FACILITY CLASSIFICATIONS

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

2. Class II (ICF/IID) facilities are those facilities whose program of care is designed to provide services for individuals with intellectual or developmental disabilities who have intensive medical and psychosocial needs which require a highly structured in-house comprehensive medical, nursing, developmental and psychological treatment program.

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

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

c. Class II (ICF/IID) 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.

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

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

b. Class IV (ICF/IID) 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.

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

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

8.443.3 IMPUTED OCCUPANCY FOR CLASS II FACILITIES

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

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

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

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

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

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

1. A county with a population of less than fifteen thousand; or

2. A municipality with a population of less than fifteen thousand which is located ten miles or more from a municipality with a population of over fifteen thousand; or

3. The unincorporated part of a county ten miles or more from a municipality with a population of fifteen thousand or more.

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

1. Be entitled to the higher of the imputed occupancy rate or the median rate computed by the Department for two cost reporting periods.

2. The imputed occupancy calculation shall be applied when required at the end of this period.

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

1. A new nursing facility means a facility not in the Colorado Medicaid program within thirty days prior to the start date of the Medicaid provider agreement.

2. For the first cost report submitted by a new facility, the facility shall be entitled to the higher of the imputed rate or the median rate computed by the Department.

3. For the second cost report submitted by a new facility, imputed occupancy shall be applied but the rate for the new facility shall not be lower than the 25th percentile nursing facility rate as computed by the Department in the median computation.

4. For the third cost report and cost reports thereafter, imputed occupancy shall be applied without exception.

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

1. Be entitled to the higher of the imputed occupancy rate or the monthly weighted average rate computed by the Department for two cost reporting periods.

2. At the end of this period, the imputed occupancy calculation shall be applied when required.

8.443.4 INFLATION ADJUSTMENT

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

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

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

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

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

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

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

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

8.443.5 ADMINISTRATIVE COST INCENTIVE ALLOWANCE FOR CLASS II ANDCLASS IV FACILITIES

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

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

8.443.6 CASE MIX ADJUSTMENTS

8.443.6.A. The resource utilization group–III (RUG-III) 34 category, index maximizer model, version 5.12b, as published by the Centers for Medicare and Medicaid Services (CMS), 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. The Department may update the classification methodology to reflect advances in resident assessment or classification subject to federal requirements.

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

1. The listings shall identify resident social security numbers, names, assessment reference date, the calculated RUG-III category and the payor source as reflected on the prior full assessment and/or current claims data.

2. Resident listings shall be reviewed by the nursing facility for completeness and accuracy.

3. If data reported on the resident listings is in error or if there is missing data, facilities shall have until the last day of the second month of each quarter to correct data submissions, or until a later date if approved by the Department pursuant to 10 CCR 2505-10 section 8.442.2.

   a. Errors or missing data on the resident listings due to untimely submissions to the CMS database maintained by CDPHE shall be corrected by the nursing facility transmitting the appropriate assessments or tracking documents to CDPHE.

   b. Errors in key field items shall be corrected by following the CMS key field specifications through CDPHE

   c. Errors on the current payor source shall be noted on the resident listings prior to signing and returning to the Department.

4. Each nursing facility shall sign and return its resident listing to the Department no later than 15 calendar days after it was mailed by the Department.

5. Residents shall be assigned a RUG-III group calculated on their most current non-delinquent assessment available on the 1st day of the first month of each quarter as amended during the correction period.

   a. The RUG-III group shall be translated to the appropriate case mix index or weight.

   b. Two average case mix indices for each Medicaid nursing facility shall be determined from the individual case mix weights for the applicable quarter:

      i) The facility average case mix index shall be a simple average, carried to four decimal places, of all resident case mix indices.

      ii) The Medicaid average case mix index shall be a simple average, carried to four decimal places, of all residents where Medicaid is the per diem payor source anytime during the 30 days prior to their current assessment.

   c. Any incomplete assessments and current assessment in the database older than 122 days shall be included in the calculation of the averages using the case mix index established in these rules.

8.443.7 HEALTH CARE REIMBURSEMENT RATE CALCULATION

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

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

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

   a. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

   b. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

   c. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

   d. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

   e. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

   f. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

2. The salaries, payroll taxes, workers compensation payments, training and other employee benefits of medical records librarians, social workers, central or medical supplies personnel and activity personnel.

   Health Information Managers (Medical Records Librarians): Must work directly with the maintenance and organization of medical records.

   Social Workers: Includes social workers, life enhancement specialists and admissions coordinators.

   Central or Medical Supply personnel: Includes duties associated with stocking and ordering medical and/or central supplies.

Activity personnel: Personnel classified as “activities” must have a direct relationship (i.e., providing entertainment, games, and social opportunities) to residents. For instance, security guards and hall monitors do not qualify as activities personnel. Costs associated with security guards and hall monitors are classified as administrative and general.

3. If the provider’s chart of accounts directly identifies payroll taxes and benefits associated with health care versus administrative and general cost centers, the amounts directly identified will be appropriately allowed as either health care or administrative and general. If these costs are comingled in the chart of accounts, payroll taxes and benefits shall be allocated to the cost centers (health care and administrative and general) based on total employee wages reported in those cost centers. The reporting method for payroll taxes and benefits by cost center is required to be consistent from year to year. When a provider wishes to change its reporting method because it believes the change will result in more appropriate and a more accurate allocation, the provider must make a written request to the Department for approval of the change ninety (90) days prior to the end of that cost reporting period. The Department has sixty (60) days from receipt of the request to make a decision or the change is automatically accepted. The provider must include with the request all supporting documentation to establish that the new method is more accurate. If the Department approves the provider's request, the change must be applied to the cost reporting period for which the request was made and to all subsequent cost reporting periods. The approval will be for a minimum three-year period. The provider cannot change methods until the three-year period has expired.

4. Personnel licensed to perform patient care duties shall be reported in the administrative and general cost center if the duties performed by these personnel are administrative in nature.

5. Non-prescription drugs ordered by a physician that are included in the per diem rate, including costs associated with vaccinations.

    a. Pharmacies are eligible for reimbursement for administration of the COVID-19 vaccine

6. Consultant fees for nursing, medical records, registered dieticians, patient activities, social workers, pharmacies, physicians and therapies. Consultants shall be appropriately licensed and/or certified, as applicable and professionally qualified in the field for which they are consulting. The guidance provided in (1) above for employees also applies to consultants.

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

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

9. Copier lease expense.

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

11. Related Party Management Fees and Home Office Costs

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

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

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

    Auditable documentation supporting the number of facilities worked on during the year must be maintained. Even if a related party exception is granted in accordance with Section 8.441.5.I.4, no mark-up or profit will be allowed in the health care cost center, only supported actual costs.

    Non-Related Party Management Fees

    Non-related party management fees shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the management company which are listed in this section, may be included in the health care cost center. Management contracts which specify percentages related to health care services will not be considered a direct charge from the management company.

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

13. Medical director fees.

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

    Utilization review
    Dental care, when required by federal law
    Audiology
    Psychology and mental health services
    Physical therapy
    Recreational therapy
    Occupational therapy
    Speech therapy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Acuity information used in the calculation of the health care reimbursement rate shall be determined as follows:

a. A facility's cost report period resident acuity case mix index shall be the average of quarterly resident acuity case mix indices, carried to four decimal places, using the facility wide resident acuity case mix indices. The quarters used in this average shall be the quarters that most closely coincide with the cost reporting period.

b. The facility's Medicaid resident acuity case mix index shall be a two-quarter average, carried to four decimal places, of the Medicaid resident acuity average case mix indices. The two-quarter average used in the July 1 rate calculation shall be the same two quarter average used in the rate calculation for the rate effective date prior to July 1.

c. The statewide average case mix index shall be a simple average, carried to four decimal places, of the cost report period case mix indices for all Medicaid facilities calculated effective each July 1.

d. The normalization ratio shall be determined by dividing the statewide average case mix index by the facility's cost report period case mix index.

e. The facility Medicaid acuity ratio shall be determined by dividing the facility's Medicaid resident acuity case mix index by the facility cost report period case mix index.

f. The facility overall resident acuity ratio shall be determined by dividing the facility cost report period case mix index by the statewide average case mix acuity index.

2. The annual facility specific direct health care maximum reimbursement rate shall be determined as follows:

a. The percentage of the normalized per diem case mix adjusted nursing cost to total health care cost shall be determined by dividing the normalized per diem case mix adjusted nursing cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

b. The statewide health care maximum allowable reimbursement rate (calculated at Section 8.443.7B) shall be multiplied by the percentage established in the preceding paragraph to determine the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component.

c. The facility specific maximum reimbursement rate for case mix adjusted nursing costs shall be determined by multiplying the facility specific overall acuity ratio by the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component as established in the preceding paragraph.

3. The annual facility specific indirect health care maximum allowable reimbursement shall be determined as follows:

a. The percentage of the indirect health care per diem cost to total health care cost shall be determined by dividing the indirect health care per diem cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

b. The facility specific in direct health care maximum reimbursement rate shall be determined by multiplying the statewide health care maximum allowable reimbursement rate by the percentage established in the preceding paragraph.

4. The case mix reimbursement rate component shall be determined as follows:

a. The case mix reimbursement rate component shall be established using the facility Medicaid resident acuity ratio.

b. This ratio shall be multiplied by the lesser of the facility's allowable case mix adjusted nursing cost or the facility specific maximum reimbursement rate for case mix adjusted nursing costs. The resulting calculation shall the case mix reimbursement rate component.

5. The indirect health care reimbursement rate shall be the lesser of the facility's allowable other health care cost or the facility specific other health care maximum reimbursement rate.

8.443.7.E DETERMINATION OF THE HEALTH CARE SERVICES MAXIMUM ALLOWABLE RATE (LIMIT) FOR CLASS II AND IV (ICF/IID) FACILITIES

1. For class II (ICF/IID) facilities, one hundred twenty-five percent (125%) of the median actual costs of all class II (ICF/IID) facilities;

2. For non-state administered class IV (ICF/IID) facilities, one hundred twenty-five percent (125%) of the median actual costs of all class IV (ICF/IID) facilities.

3. State-administered class IV (ICF/IID) facilities shall not be subject to the health care limit. The Med-13s of the state-administered class IV (ICF/IID) facilities shall be included in the health care limit calculation for other class IV (ICF/IID) facilities.

4. The determination of the reasonable cost of services shall be made every 12 months.

5. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed in accordance with these regulations, by each facility on or before May 2.

6. The MED-13 cost report shall be deemed submitted if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before May 2nd.

7. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the class, the Department may:

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

b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the change in the "medical care" component of the Consumer Price Index published for all urban consumers (CPI-U) by the United States Department of Labor, Bureau of Labor Statistics over the time period from the provider's most recent audited cost report.

8. State-administered class IV (ICF/IID) facilities shall not be subject to the maximum reasonable rate ceiling. The Med-13s of the state-administered class IV (ICF/IID) facilities shall be included in the maximum rate calculation for other class IV (ICF/IID) facilities.

9. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

10. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

8.443.8 REIMBURSEMENT FOR ADMINISTRATIVE AND GENERAL COSTS

8.443.8.A. Administration Costs means the following categories of reasonable, necessary and patient-related costs:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of the administrator, assistant administrator, bookkeeper, secretarial, other clerical help, hall monitors, security guards, janitorial and plant staff and food service staff. Staff who perform duties in both administrative and health care services shall maintain contemporaneous time records or perform a time study in order to properly allocate their salaries between cost centers. Time studies used must meet the criteria described in Section 8.443.7.A.1.

2. Any portion of other staff costs directly attributable to administration.

3. Advertising and public relations.

4. Recruitment costs and staff want ads for all personnel.

5. Office supplies.

6. Telephone costs.

7. Purchased services: accounting fees, legal fees; computer network infrastructure fees. Computers and software used in administrative and general departments.

8. Management fees and home office costs, except as described in Section 8.443.7.A.13.

9. Licenses and permits (except health care licenses and permits) and training for administrative personnel, dues for professional associations and organizations.

10. All business-related travel of facility staff and consultants, except that required for transporting residents to activities or for medical purposes.

11. Insurance, including insurance on vehicles used for resident transport, is an administrative cost. The only exception is professional liability insurance, which is a health care cost.

12. Facility membership fees and dues in trade groups or professional organizations.

13. Miscellaneous general and administrative costs.

14. Purchase or rental of motor vehicles and related expenses for operating or maintaining the vehicles. However, such costs shall be considered health care services to the extent that the motor vehicles are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs.

15. Purchases (including depreciation and interest), rentals, repairs, betterments and improvements of equipment utilized in administrative departments, including but not limited to the following:

Resident room furniture and decor, excluding beds and mattresses
Office furniture and décor
Dining room and common area furniture and décor
Lighting fixtures
Artwork
Computers and related software used in administrative departments

16. Allowable audited interest not covered by the fair rental allowance or related to the property costs listed below.

17. All other reasonable, necessary and patient-related costs which are not specifically set forth in the description of “health care services” above, and which are not property, room and board, food or capital-related assets.

18. Background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.

19. Provider fees for Class II and Class IV facilities.

8.443.8.B Property costs include:

1. Depreciation costs of non-fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care).

2. Rental costs of non-fixed equipment (i.e., major moveable equipment and minor equipment not used for direct health care).

3. Property taxes.

4. Property insurance.

5. Mortgage insurance.

6. Interest on loans associated with property costs covered in this section.

7. Repairs, betterments and improvements to property not covered by the fair rental allowance.

8. Repair, maintenance, betterments or improvement costs to property covered by the fair rental allowance payment which are to be expensed as required by the regulations regarding expensing of items.

8.443.8.C Room and board includes:

1. Dietary, other than raw food, and salaries related to dietary personnel including tray help, except registered dieticians which are health care.

2. Laundry and linen.

3. Housekeeping.

4. Plant operation and maintenance (except removal of infectious material or medical waste which is health care).

5. Repairs, betterments and improvements to equipment related to room and board services.

8.443.8.D Determination of the Administrative and General Maximum Allowable Rate (Limit) for Class II and IV (ICF/IID) Facilities.

The determination of the reasonable cost of services shall be made every 12 months. The maximum allowable reimbursement of administration, property and room and board costs, excluding raw food, land, buildings and fixed equipment, shall not exceed:

1. For class II (ICF/IID) facilities, one hundred twenty percent (120%) of the median actual costs of all class II facilities.

2. For class IV (ICF/IID) facilities, one hundred twenty percent (120%) of the median actual costs of all class IV (ICF/IID) facilities.

3. Determination of the rates beginning on July 1 each year shall utilize the most current MED-13 cost report filed, in accordance with these regulations, by each facility on or before May 2.

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

5. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the class, the Department may:

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

   b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the change in the "medical care" component of the Consumer Price Index published for all urban consumers (CPI-U) by the United States Department of Labor, Bureau of Labor Statistics over the time period from the provider's most recent audited cost report to May 2.

6. State-administered class IV (ICF/IID) facilities shall not be subject to the maximum reasonable rate ceiling. The Med-13s of the state-administered class IV (ICF/IID) facilities shall be included in the maximum rate calculation for other class IV (ICF/IID) facilities.

7. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

8. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

8.443.8.E. Class I Administrative and General Per Diem Reimbursement Rate

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of its administrative and general services, the Department shall establish an annually readjusted schedule to pay each facility a reasonable price for the costs.

1. Determination of the class I rates beginning on July 1 each year shall utilize the most current MED-13 cost report submitted, in accordance with these regulations, by each facility on or before December 31 of the preceding year.

2. The reasonable price shall be a percentage of the median per diem cost of administrative and general services as determined by an array of all nursing facility providers.

3. For facilities of sixty licensed beds or fewer, the reasonable price shall be one hundred ten percent of the median per diem cost for all class I facilities. For facilities of sixty-one or more licensed beds, the reasonable price shall be one hundred five percent of the median per diem cost for all class I facilities.

4. In computing per diem cost, each nursing facility provider shall annually submit cost reports to the Department.

5. Actual days of care shall be counted rather than occupancy-imputed days of care.

6. The cost reports used to establish this median per diem cost shall be those filed during the period ending December 31 of the prior year following implementation.

7. Amounts contained in cost reports used to establish this median shall be adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc., measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

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

    b. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

8. The reasonable price determined at July 1, 2008 will be adjusted annually at July 1st for three subsequent years. The reasonable price shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

9. For each succeeding fourth year, the Department shall re-determine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

10. The reasonable price established by the median per diem costs determined each succeeding fourth year will be adjusted annually at July 1st for the three intervening years. The reasonable price shall be adjusted by the annual percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. The percentage change shall be rounded at least to the fifth decimal point. The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

11. For fiscal years commencing on and after July 1, 2008, through the fiscal year commencing July 1, 2014, the state department shall compare a nursing facility provider's administrative and general per diem rate to the nursing facility provider's administrative and general services per diem rate as of June 30, 2008, and the state department shall pay the nursing facility provider the higher per diem amount for each of the fiscal years.

12. For fiscal years commencing on and after July 1, 2009, through the fiscal year commencing July 1, 2014, if a reallocation of management costs between administrative and general costs and the health care costs causes a nursing facility provider's administrative and general costs to exceed the reasonable price established by the state department, the state department may pay the nursing facility provider the higher per diem payment for administrative and general services.

13. The reasonable price will be phased in over three years in accordance with the following 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

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

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

1. In computing per diem cost, each class II and class IV (ICF/IID) facility provider shall annually submit cost reports to the Department.

2. The per diem reimbursement rate will be total allowable costs for administrative and general and health care services (actual or the limit per Section 8.443.7.D) divided by the higher of actual resident days or occupancy imputed days per Section 8.443.3.

3. An inflation adjustment per Section 8.443.4B will be applied to the per diem administrative and general and health care reimbursement rates.

4. An incentive allowance for administrative and general costs may be included per Section 8.443.5.

5. Each facility will be paid a per diem for capital-related assets per Section 8.443.9.A.

8.443.9 FAIR RENTAL ALLOWANCE FOR CAPITAL-RELATED ASSETS

8.443.9.A. FAIR RENTAL ALLOWANCE: DEFINITIONS AND SPECIFICATIONS

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

a. [Expired 05/15/2016 per House Bill 16-1257].

b. Appraised Value means the determination by a qualified appraiser who is a member of an institute of real estate appraisers or its equivalent, the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the most recent edition of the Boeckh™ Commercial Building Valuation System available on December 31st of the year preceding the year in which the appraisals are to be performed.

c. Base Value means the value of the capital related assets as determined by the most current appraisal report completed by the Department or its designee and any additional information considered relevant by the Department. For each year in which an appraisal is not done, base value means the most recent appraisal value increased or decreased by fifty percent (50%) of the change in the Index. Under no circumstances shall the base value exceed $25,000 per bed plus the percentage rate of change referred to as the per bed limit.

d. Capital-Related Asset means the land, buildings and fixed equipment of a participating facility.

e. Fair Rental Allowance means the product obtained by multiplying the base value of a capital-related asset by the rental rate.

f. Fair Rental Allowance Per Diem Rate means the fair rental allowance described above, divided by the greater of the audited patient days on the provider's annual cost report or ninety percent (90%) of licensed bed capacity on file. This calculation applies to both rural and urban facilities.

g. Fiscal Year means the State fiscal year from July 1 through June 30.

h. Fixed equipment means building equipment as defined under the Medicare principle of reimbursement as specified in the Medicare provider reimbursement manual, part 1, section 104.3. Specifically, building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. The general characteristics of this equipment are:

   i) Affixed to the building and not subject to transfer; and

   ii) A fairly long life but shorter than the life of the building to which it is affixed.

i. [Expired 05/15/2016 per House Bill 16-1257]

j. Index means the square foot construction costs for nursing facilities in the Means Square Foot Costs Book, which shall be the most recent publication of R.S.Means Company, Inc. that is updated quarterly (section M.450, "Nursing Home"), hereafter referred to as the Means Index.

k. Rental Rate means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent; except that the rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

2. In the case of facilities for which an appraisal was completed pursuant to RFP GB 347 (October 21, 1985) and no major physical plant expansions or additions were completed prior to the Department's reappraisal of the property, the following data shall remain unchanged through following appraisals:

    a. Average story height.

    b. Gross floor area.

    c. Total perimeter.

    d. Construction classification.

    e. Construction quality.

    f. Year built.

3. In the case of those facilities that have completed a major physical plant expansion, addition or deletion, the initial appraisal measurements and data specified in paragraph 2 above shall be modified only to the extent of the relevant appraisal data specific to the new expansion, addition or deletion.

4. The appraisal shall take into consideration the economic impact the addition, deletion or use modification may have had on the overall value of the entire facility.

5. The variables from the Boeckh program that are to be calculated/determined by the Department or its designee, and which will be incorporated into the Request for Proposal (RFP) which defines the scope of the appraisals, include:

    a. Record information: State identification number of the nursing facility as provided by the Department.

    b. Property owner: Name of nursing facility.

    c. Street, address, city.

    d. Zip code.

    e. Land value.

    f. Section number: Assign lowest to oldest section and have basements immediately follow the section they are beneath.

    g. Occupancy: Primarily nursing facility or basement.

    h. Construction classification.

    i. Number of stories.

    j. Gross floor area: The determination of the exterior dimensions of all interior areas including stairwells of each floor. In addition, interior square footage measurements shall be reported for (a) non-nursing facility areas; (b) shared service area by type of service; and (c) revenue-generating areas so that these non-nursing facility portions of the facility can be omitted from the total square footage or allocated based on their nursing facility related use.

k. Construction quality.

l. Year nursing facility was built.

m. Building effective age.

n. Building condition.

o. Exterior wall material.

p. Total perimeter: Common walls between sections shall be excluded from both sections.

q. Average story height.

r. Roof material.

s. Roof pitch.

t. Heating System.

u. Cooling system.

v. Plumbing fixtures (Basements only).

w. Passenger Elevators: Actual number.

x. Freight elevators: Actual number.

y. Sprinkler system: Percent of gross area served.

z. Manual Fire Alarm System: Percent of gross area served.

aa. Automatic fire detection: Percent of gross area served.

bb. Floor finish.

cc. Ceiling finish.

dd. Total partition walls (Basement only).

ee. Partition wall structure.

ff. Partition wall finish.

gg. Miscellaneous additional items: All components not included in the preceding list and also not automatically calculated by the Boeckh Program shall be included here. The appraiser shall use professional judgment when valuing such items. Items shall be entered at depreciated value.

hh. Site improvements: Items shall be included at depreciated value, except landscaping, to be determined by the appraiser based upon professional judgment. Depreciation for site improvements, in many instances, is different from the depreciation for the structure. A list of site improvements and corresponding values shall be retained with the appraiser's work papers.

ii. User adjustment factor: Used in those cases where facilities are appraised in total and only partly used as a nursing facility, i.e., hospital and nursing facility combined or a residential and nursing facility combined.

6. The fair rental allowance shall only be adjusted due to the following:

a. The base value of a facility shall be increased in subsequent cost reports due to improvements. Construction-in-progress will not be considered an improvement until the project is complete and the asset is placed into service.

b. At the start of a new state fiscal year by a new rental rate amount or additional indices.

c. The base value of a facility can be decreased by a change in either the physical (structural) condition and/or use modification of the facility.

d. The provider has constructed and occupied a new physical plant and is no longer using the old structure for providing care to nursing facility residents. Base value shall be a new appraisal conducted by the Department or its designee at the time the new physical plant is ready for occupancy.

i) The provider shall continue to be reimbursed at the old fair rental allowance rate until the first scheduled MED-13 after the move sets a new rate.

ii) A new appraisal shall be performed to coincide with the filing of the next scheduled cost report following the move.

8.443.9.B FAIR RENTAL ALLOWANCE PER DIEM REIMBURSEMENT RATES

In addition to the reimbursement components paid pursuant to 10 CCR 2505-10 section 8.443.7 (Health Care Services) and 8.443.8 (Administrative and General Costs), a per diem rate constituting a fair rental allowance for capital-related assets shall be paid to each nursing facility provider as a rental rate based upon the nursing facility's appraised value.

1. For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem rate for capital-related assets, the state department shall establish an annual per bed limit.

2. The annual per bed limit established July 1, 1985 is $25,000 per bed plus the percentage rate of change in the Means Index.

3. The Means Index means the square foot construction costs for nursing facilities in the Means Square Foot Costs Book, a publication of R.S.Means Company, Inc. that is updated annually (section M.450, “Nursing Home”).

4. The per bed limit shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

5. The fair rental allowance will be calculated for each facility using the lesser of the Base Value plus non-appraisal year modifications to the physical structure due to improvements or a change in the condition and/or use of the facility subsequent to the appraisal increased or decreased by fifty percent (50%) of the change in the Means Index or the annual per bed limit.

6. In computing the fair rental allowance per diem rate, the fair rental allowance is multiplied by the rental rate to obtain the annual allowable fair rental payment.

7. The rental rate is the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent; except that the rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

8. The resulting fair rental payment amount is divided by the greater of the audited patient days based on the provider's annual cost report or ninety percent (90%) of licensed bed capacity on file. This calculation applies to both rural and urban facilities.

8.443.10 COGNITIVE PERFORMANCE SCALE, PREADMISSION SCREENING AND RESIDENT REVIEW II, AND MEDICAID UTILIZATION SUPPLEMENTAL PAYMENTS

8.443.10.A COGNITIVE PERFORMANCE SCALE SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers who have residents with moderate to very severe mental health conditions, cognitive dementia, or acquired brain injury, based upon the resident's score on the Cognitive Performance Scale (CPS).

1. Annually, the Department shall calculate the payment by multiplying a CPS per diem rate by CPS Medicaid days.

2. The CPS per diem rate is calculated based on the number of standard deviations a nursing facility provider's CPS percentage is above the statewide average CPS percentage. The CPS per diem rate shall be determined in accordance with the following table:

Standard Deviation Above Statewide Average	CPS Per Diem
Greater Than or Equal to Statewide Average + 1 Standard Deviation	1x
Greater Than or Equal to Statewide Average + 2 Standard Deviation	2x
Greater Than or Equal to Statewide Average + 3 Standard Deviation	3x

The CPS per diem rate multiplier (x) shall equal an amount such that the total statewide CPS supplemental payment divided by total statewide CPS Medicaid days equal one percent of the statewide average MMIS per diem reimbursement rate.

3. The CPS percentage is the sum of Medicaid residents with a CPS score of 4, 5, or 6 divided by the sum of Medicaid residents.

   a. Medicaid residents with a CPS score of 4, 5, or 6 are determined using the RUG-III classification system and reported on the MDS form.

   b. The determination of Medicaid residents with a CPS score of 4, 5, or 6 shall be made using the April MDS roster.

4. CPS Medicaid patient days shall equal the count of Medicaid residents with a CPS score of 4, 5, 6, or equivalent, multiplied by the days in the year.

5. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

8.443.10.B PREADMISSION SCREENING AND RESIDENT REVIEW II SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers who have residents with severe mental health conditions or developmental disabilities that are classified at Level II by the Medicaid program's preadmission screening and resident review assessment tool (PASRR II).

1. Annually, the Department shall calculate the payment by multiplying a PASRR II per diem rate by Medicaid PASRR II days.

2. Medicaid PASRR II days shall equal the count of PASRR II residents on May 1, multiplied by the days in the year.

3. The PASRR II per diem rate shall equal two percent of the statewide MMIS per diem reimbursement rate as described Section 8.443.1.B.

4. The Department shall pay an additional PASSRR II supplemental payment to facilities that offer specialized behavioral services to residents who have severe behavioral health needs. These services shall include enhanced staffing, training, and programs designed to increase the resident's skills for successful community reintegration.

5. The additional PASRR II supplemental payment for nursing facility providers that have an approved specialized behavioral services program shall be calculated using the methodology described in Section 8.443.10.B.1 through Section 8.443.10.B.3.

6. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

8.443.10.C MEDICAID UTILIZATION SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers for care and services rendered to Medicaid residents.

1. Annually, the Department shall calculate the payment by multiplying the percentage of Medicaid patient days by the provider fee as described in Section 8.443.17.

2. The percentage of Medicaid patient days shall be Medicaid patient days divided by total patient days.

3. Medicaid patient days shall be determined using Medicaid paid claims for the calendar year ending prior to July 1. The Department shall annualize or estimate Medicaid patient days for nursing facility providers with less than a full year of paid claims.

4. Total patient days shall be reported by a nursing facility provider to the Department for the calendar year ending prior to July 1. The Department shall annualize or estimate total patient days for nursing facility providers reporting less than a full year.

5. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

8.443.11 CORE COMPONENT AND ADJUSTED CORE COMPONENT SUPPLEMENTAL PAYMENTS

8.443.11.A CORE COMPONENT SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers for the difference between the Core Component per diem rate and the MMIS per diem reimbursement rate.

1. Annually, the Department shall calculate the payment by taking the difference between the MMIS per diem reimbursement rate and the Core Component per diem rate, both described in Section 8.443.1.B, multiplied by applicable Medicaid patient days.

2. For SFY 2019-20, the Department shall include the difference between the SFY 2018-19 MMIS per diem reimbursement rate and the SFY 2018-19 Core Component per diem rate, multiplied by applicable Medicaid patient days.

3. Applicable Medicaid patient days shall equal Medicaid patient days divided by the days in the year, multiplied by the days the Core Component per diem rate was effective.

4. Medicaid patient days shall be determined using Medicaid paid claims for the calendar year ending prior to July 1. The Department shall annualize or estimate Medicaid patient days for nursing facility providers with less than a full year of paid claims.

5. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

8.443.11.B ACUITY ADJUSTED CORE COMPONENT SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers for the difference between the Core Component per diem rate and the adjusted Core Component per diem rate for the prior year.

1. Annually, the Department shall calculate the payment by taking the difference between the prior year Core Component per diem rate and the prior year adjusted Core Component per diem rate, multiplied by applicable Medicaid patient days.

2. Applicable Medicaid patient days shall equal Medicaid patient days divided by the days in the prior year, multiplied by the days an adjusted Core Component per diem rate was effective.

3. Medicaid patient days shall be determined using Medicaid paid claims for the calendar year ending prior to July 1. The Department shall annualize or estimate Medicaid patient days for nursing facility providers with less than a full year of paid claims.

4. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

8.443.12 PAY-FOR-PERFORMANCE SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to those nursing facility providers that provide services resulting in better care and higher quality of life for their residents.

1. Annually, the Department shall calculate the payment by multiplying a Pay-for-Performance (P4P) per diem rate by Medicaid patient days.

2. The P4P per diem rate shall be calculated according to the following table:

P4P Points	Per Diem Rate
0 – 20 points	No add on
21 – 45 points	$1.00
46 – 60 points	$2.00
61 – 79 points	$3.00
80 – 100 points	$4.00

3. The P4P points will be based on a completed and verified/audited application including performance measures in 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.

4. 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 survey will be considered for pay for performance. Substandard quality of care means one or more deficiencies related to participation requirements under 42 C.F.R. § 483.12 Freedom from Abuse, Neglect, and Exploitation, 42 C.F.R. § 483.24 Quality of Life quality of life, or 42 C.F.R. § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm

   b. The facility must perform a resident/family satisfaction survey. The survey must (a) be developed, recognized, and standardized by an entity external to the facility; and, (b) be administered on an annual basis with results tabulated by an agency external to the facility. The facility must report their response rate, and a summary report must be made publicly available along with the facility's State's survey results.

5. To apply the facility must have the requirements for each Domain/sub-category in place at the time of submitting an application for additional payment. The facility must maintain documentation supporting its representations for each performance measure the facility represents it meets or exceeds the specified criteria. The required documentation for each performance measure is identified on the application and must be submitted with the application. In addition, the facility must include a written narrative for each sub-category to be considered that describes the process used to achieve and sustain each measure.

6. The Department or the Department's designee will review and verify the accuracy of each facility's representations and documentation submissions. Facilities will be selected for onsite verification of performance measures representations based on risk.

7. Medicaid patient days shall be determined using Medicaid paid claims for the calendar year ending prior to July 1. The Department shall annualize or estimate Medicaid patient days for nursing facility providers with less than a full year of paid claims.

8. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

8.443.13 RATE EFFECTIVE DATE

8.443.13.A For cost reports filed by Class 1 nursing facility providers, a July 1 Core Component per diem rate and subsequent adjusted Core Component per diem rates shall be established by the Department based on the last day of the cost reporting fiscal year end.

Core Component per diem rates shall be established as follows:

1. On July 1 in accordance with the table below.

2. On the first day of the 23rd month following the end of the facility's cost reporting period.

3. On the first day of the 6th month following the 23rd month rate effective date.

4. If the 23-month or 6-month rate coincide with July 1, only a July 1 and a January 1 rate shall be established

5. If the 6-month rate is after the July 1 rate set by the subsequent cost report, only a July 1 and 23-month rate shall be established.

Cost Report Fiscal Year End	July 1 Rate Effective Date	23 Month Rate Effective Date	6 Month Rate Effective Date
01/31/Year 1	07/01/Year 2	12/01/Year 2	06/01/Year 3
02/28/Year 1	07/01/Year 2	01/01/Year 3	(N/A)
03/31/Year 1	07/01/Year 2	02/01/Year 3	(N/A)
04/30/Year 1	07/01/Year 2	03/01/Year 3	(N/A)
05/31/Year 1	07/01/Year 3	04/01/Year 3	10/01/Year 3
06/30/Year 1	07/01/Year 3	05/01/Year 3	11/01/Year 3
07/31/Year 1	07/01/Year 3	06/01/Year 3	12/01/Year 3
08/31/Year 1	07/01/Year 3	(N/A)	01/01/Year 4
09/30/Year 1	07/01/Year 3	08/01/Year 3	02/01/Year 4
10/31/Year 1	07/01/Year 3	09/01/Year 3	03/01/Year 4
11/30/Year 1	07/01/Year 3	10/01/Year 3	04/01/Year 4
12/31/Year 1	07/01/Year 3	11/01/Year 3	05/01/Year 4

8.443.13.B For 12-month cost reports filed by the State-administered Class IV nursing facility (ICF/IID) providers, the rate shall be effective on the first day covered by the cost report.

8.443.13.C Any delay in completion of the audit of the MED-13 that is attributable to the provider, shall operate, on a time equivalent basis, to extend the time in which the Department shall establish the Schedule of Core Components Reimbursement Rates, under the provisions set forth in Section 8.443.13.A above.

8.443.13.D Delay in completion of the audit that is attributable to the provider shall include, but not be limited to, the following:

1. Failure of the provider to meet with the contract auditor at reasonable times requested by the auditor;

2. Failure of the provider to supply the contract auditor with information reasonably needed to complete the audit, including the Medicare cost report that the provider most recently filed with the Medicare fiscal intermediary or other Medicare information approved by the Department.

3. The time period that elapses during completion of the procedures described Section 8.442.1.

8.443.14 RATES FOR NEW FACILITIES

8.443.14.A. A new nursing facility means a facility:

1. That has not previously been certified for participation under Title XIX of the Social Security Act (42 U.S.C. section 1396r); or

2. That has not participated in Title XIX for a period in excess of 30 days prior to the effective date of the current Title XIX certification; or

3. That has changed from one class designation to another.

8.443.14.B. Nursing facilities that have undergone a transfer of ownership are not new nursing facilities provided the previous owner had participated in Title XIX in the last 30 days prior to ownership change.

8.443.14.C. A new nursing facility shall receive a per diem rate equal to the most recent average weighted rate for the appropriate nursing facilities class at the time the new facility begins business as a Medicaid provider.

1. This per diem rate shall remain in effect until a new rate is established based on the first cost report submitted as specified below.

2. The average weighted rate shall be calculated by the Department on the 30th of each month and shall not be revised when new rates are established which would retroactively affect the calculation.

3. The average weighted rate paid a new facility shall be adjusted on July 1 each year by the average weighted rate in effect on July 1.

8.443.14.D. New nursing facilities shall submit MED-13s during their initial year of operation as follows:

1. The first cost report shall be for a period covering the first day of operation through the facility's fiscal year end.

   a. If the first cost report for the period covers a period of 90 days or more, imputed occupancy shall be applied as described in Section 8.443.3.A.

   b. If the first cost report for the period covers a period of 90 days or more, the first cost report shall set the base for limitations on growth of allowable costs as described in Section 8.443.11.A.

2. If the first cost report for the period specified above covers a period of 89 days or less, the facility's first cost report shall not be submitted until the next fiscal year end.

3. The next cost report shall be submitted for the twelve-month period following the period of the first cost report.

4. A new nursing facility shall advise the Department of the date its fiscal year will end and of the reporting option selected.

8.443.14.E. Imputed occupancy shall be applied to the first cost report submitted by a new class II (ICF/IID) facility. The facility shall be entitled to the higher of the imputed rate or the monthly weighted average rate computed by the Department.

8.443.14.F. Imputed occupancy shall be applied to the second cost report submitted by a new class II (ICF/IID) facility. The rate for the new facility shall not be lower than the 25th percentile nursing facility rate as computed by the Department in median computation.

8.443.15 CHANGE OF OWNERSHIP OR WITHDRAWAL FROM MEDICAID

8.443.15.A. A licensed nursing facility owner(s) that intends to change the ownership of a Medicaid nursing facility, or that intends to terminate its participation in the Medicaid program, shall notify the Department in writing at least 45 calendar days in advance of the proposed change or termination.

1. The advance written notice shall include a specific date for the proposed change or termination and shall be delivered to the Department.

2. The exact date of the change of ownership or termination of Medicaid participation shall be subject to approval by the Department, after consultation with the parties to the proposed transaction and CDPHE.

8.443.15.B. In the case of a change of ownership that does not require a new license from CDPHE, the existing Medicaid provider agreement shall continue in effect, together with all associated rights and responsibilities.

8.443.15.C. In the case of a change of ownership which does require a new license from CDPHE, the transferring owner's Medicaid provider agreement shall be assigned to the successor owner, unless the successor owner refuses in writing to accept assignment of that provider agreement.

1. The assignment of an existing Medicaid provider agreement shall be accomplished by the successor owner's signature of an appropriate acceptance document, as specified by the Department.

2. The assignment of the Medicaid provider agreement shall not be effective prior to the effective date of the successor owner's nursing facility license from CDPHE.

3. In the event that a successor owner refuses to accept assignment of the transferring owner's Medicaid provider agreement, the successor owner shall indicate such refusal in a written communication to the Department.

4. Until a successor owner has signed a written acceptance of assignment, the Department shall assume that the successor owner intends to refuse such assignment, and the Department shall act accordingly to protect its interests and those of the facility's residents.

8.443.15.D. An assigned Medicaid provider agreement shall be subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued, including but not limited to the following:

1. Any existing plan of correction;

2. Any expiration date for a Class II provider agreement;

3. Compliance with applicable health and safety requirements;

4. Compliance with the ownership and financial interest disclosure requirements, and any other requirements described elsewhere in this staff manual;

5. Compliance with the civil rights requirements cited in the provider agreement; and

6. At the discretion of the Department, payment of any debts or other obligations, whether known, fixed, definite, liquidated, or not, owed to the Department by the transferring owner. Such liability may also apply, at the discretion of the Department, to any debts or obligations that arose under any earlier, assigned provider agreement(s), but shall not apply to any debt or obligation that was assigned prior to August 1, 2003.

7. The assignment of liability described in the preceding paragraph 6 shall not prejudice the Department's right to pursue any remedy against a previous facility owner or owners for repayment of the assigned debts or obligations.

8.443.15.E. In the event that a successor owner refuses to accept assignment of the transferring owner's Medicaid provider agreement:

1. The transferring owner's Medicaid provider agreement shall terminate on the date approved by the Department for the change of ownership.

2. Prior to the termination of the transferring owner's Medicaid provider agreement, the Department shall have the discretion to withhold reimbursement to the transferring owner for whatever period of time is necessary to recover overpayments or other debts owed to the Department by the transferring owner.

3. The successor owner shall file a new application for a Medicaid provider agreement with the Department or its designated agent. The Department shall not approve the new agreement until the successor owner complies with all requirements for such approval. The Department may delay the effective date of the successor owner's Medicaid provider agreement until the expiration of the withholding period described in the preceding paragraph 2, or until the Department has approved alternative payment arrangements or security for the transferring owner's debts.

4. The Department may require a new facility survey as part of the successor owner's application for a new Medicaid provider agreement even if a new facility survey is not required by the federal Medicare program (e.g., where the successor owner has accepted assignment of an existing Medicare provider agreement).

5. No Medicaid reimbursement shall be paid to the successor owner until the application for a Medicaid provider agreement has been approved, regardless of the effective date of the successor owner's license from CDPHE.

6. Where appropriate in connection with a proposed change of ownership, the Department shall have the discretion to notify facility residents and/or their guardians that Medicaid reimbursement for facility care may be temporarily or permanently discontinued.

8.443.15.F. A licensed nursing facility owner that transfers ownership or terminates its Medicaid participation shall submit a final MED-13 covering the period from the ending date of the last previous report through the date of the transfer or termination.

1. The initial rate for the successor owner shall be the rate which would have been paid to the previous owner based on the audited final cost report.

2. If the previous owner's final cost report is for a period of less than 89 days, that report shall be disregarded and the previous owner's last cost report for a twelve (12) month period shall be used to set a rate for the successor owner.

8.443.16 STATE-OPERATED ICF/IID (CLASS IV)

8.443.16.A State-operated ICF/IID (class IV) shall be reimbursed based on the actual costs of administration, property, including capital-related assets, and room and board, and the actual costs of providing health care services. Actual costs will be determined on the basis of information on the MED-13 and information obtained by the Department or its designee retained for the purpose of cost auditing.

1. These costs shall be projected by such facilities and submitted to the state department by July 1 of each year for the ensuing twelve-month period.

2. Reimbursement to state-operated Intermediate Care Facilities for Individuals with Intellectual Disabilities shall be adjusted retrospectively at the close of each twelve-month period.

3. The retrospective per diem rate will be calculated as total allowable costs divided by total resident days.

8.443.17 CLASS I NURSING FACILITY PROVIDER FEES

8.443.17.A The Department shall charge and collect provider fees on health care items or services provided by nursing facility providers for the purpose of obtaining federal financial participation under the state's medical assistance program. The provider fees shall be used to sustain or increase reimbursement for providing medical care under the state's medical assistance program for nursing facility providers.

1. A Class I nursing facility provider that is licensed in this State shall pay a fee assessed by the Department.

2. The following nursing facility providers are exempt from the provider fee:

   a. A nursing facility provider operated as a continuing care retirement community (CCRC) that provides a continuum of services by one operational entity providing independent living services, assisted living services and skilled nursing care on a single, contiguous campus. Assisted living services include assisted living residences as defined in C.R.S. § 25-27-102(1.3), or that provide assisted living services on-site, twenty-four hours per day, seven days per week;

   b. A nursing facility provider owned and operated by the state;

   c. A nursing facility provider that is a distinct part of a facility that is licensed as a general acute care hospital; and

   d. A nursing facility provider that has forty-five or fewer licensed beds.

3. Annually, the Department shall calculate the provider fee by multiplying a per diem fee by non-Medicare patient days.

4. The per diem fee shall equal the previous year per diem fee increased by an inflation factor.

   a. The inflation factor shall be based on a national skilled nursing facility market basket index. The inflation factor is the inflation index at the midpoint of the current year divided by the inflation index at the midpoint of the previous year.

   b. The Department shall lower the per diem fee for nursing facility providers with 55,000 total patient days or more to meet the requirements of 42 C.F.R. § 433.68(e). The 55,000 total patient day threshold may be modified to meet the requirements of 42 C.F.R. § 433.68(e).

5. Non-Medicare patient days shall be reported by a nursing facility provider to the Department for the calendar year ending prior to July 1.

   a. A nursing facility provider's non-Medicare patient days shall be estimated to determine the provider fee if and only if one of the following conditions exist:

      i) A new nursing facility provider,

      ii) A nursing facility provider that will close during the rate year, or

      iii) A nursing facility provider that has had a change of certification or licensure.

      The nursing facility provider shall have non-Medicare patient days estimated for each model year until the nursing facility provider has twelve months of data for the calendar year preceding the calendar year ending prior to July 1.

      If a nursing facility provider's non-Medicare patient days are estimated, the Department shall compare estimated non-Medicare patient days to actual non-Medicare patient days in the subsequent year. If a nursing facility provider's actual non-Medicare days differ by more than five percent from estimated non-Medicare patient days, the Department shall multiply the difference by the prior year per diem fee and add it in the current year provider fee.

6. These calculations will be performed annually to coincide with the July 1st rate setting process.

7. The Department shall assess the provider fee monthly.

8. The fee assessed pursuant to this section is due at most thirty days after the end of the month for which the fee was assessed.

8.443.17.B All provider fees collected pursuant to this section by the state department shall be transmitted to the state treasurer, who shall credit the same to the Medicaid nursing facility cash fund, which fund is hereby created and referred to in this section as the "fund".

1. All monies in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the administrative cost of implementing C.R.S. section 25.5-6-202 and this section and to pay a portion of the per diem rates established pursuant to C.R.S. section 25.5-6-202 (1) to (4).

2. Following payment of the amounts described above, the moneys remaining in the fund shall be subject to federal matching as authorized under federal law and subject to annual appropriation by the general assembly for the purpose of paying the rates established under C.R.S. section 25.5-6-202 (5) to (7).

3. Any monies in the fund not expended for these purposes may be invested by the state treasurer as provided by law.

    a. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.

    b. Any unexpended and unencumbered moneys remaining in the fund at the end of any fiscal year shall remain in the fund and shall not be credited or transferred to the general fund or any other fund but may be appropriated by the general assembly to pay nursing facility providers in future fiscal years.

8.443.17.C The state department shall establish administrative penalties for the late payment by a nursing facility of a fee assessed pursuant to this section.

1. The state department may recoup any payments made to nursing facilities providing services pursuant to the Medicaid program up to the amount of the fees owed as determined pursuant to this section and any administrative penalties owed if a nursing facility fails to remit the fees and administrative penalties owed within 30 days after the date they are due. Before recoupment of payments pursuant to this section, the state department may allow a nursing facility that fails to remit fees and administrative penalties owed an opportunity to negotiate a repayment plan with the state department. The terms of the repayment plan may be established at the discretion of the state department.

8.443.17.D The state department will prepare an annual reconciliation of provider fees received and payments made. Any shortfall or excess in the provider fee cash fund will be used to increase or reduce provider fees in the following year. Except that in the event the state department determines there is not enough provider fee available, the state department may reduce payments to facilities proportionately to the amount of provider fee available. The state department can, at its discretion, establish a provider fee fund minimum balance or cash reserve.

8.443.18 RATES FOR RECEIVERSHIP

8.443.18.A. The following rate provisions apply for a facility where a receiver has been appointed by the Court, pursuant to C.R.S. section 25-3-108, at the request of CDPHE:

1. During the Receivership

    a. During the term of the receivership, the facility shall be reimbursed the rate payable to the previous operator.

        i) The Department may increase the rate if it finds that the patient-related, necessary and reasonable costs of the facility operation are not covered by the rate payable to the previous operator.

ii) The Department's analysis of necessary, patient related and reasonable costs incurred by the receiver shall not include any previous unpaid expenses of the prior owner or the mortgage costs of the facility.

b. The receiver shall submit a cost report for the time beginning when the receiver is appointed until the time the receiver is no longer operationally in control of the nursing facility operation.

i) This cost report shall set a rate payable to the receiver for the date the receiver took operational control of the facility.

ii) This retrospective rate may set a rate higher or lower than the initial rate established and paid to the receiver in which case the under or over payment shall be either paid to or collected from the receiver.

iii) The retrospectively set rate shall not exceed the established maximum allowable rates for that period.

2. New providers after the receivership period

a. The new operator shall receive the rate paid to the prior owner until the new provider submits a cost report unless the new operator chooses the retrospective option described below where a new operator takes control and ownership of a nursing facility from the receiver.

b. The new operator may elect to have a retrospective rate set for the initial three months of operation.

i) In order to exercise this option, the new operator shall file a cost report for the first three months of operation.

ii) The first day of operation shall mean the first day of licensure of the new operator. The last day of the initial three months of operation shall be the last day of the month in which the 90th day occurs.

iii) The cost report shall be filed within 90 days of the end of the initial three months of operation.

c. The retrospective rate established from the three month cost report shall be in effect from the first date of licensure of the new owner until the last day of the month in which the 90th day occurs. This rate shall be a prospectively paid rate to the new operator beginning with the first day of the month after the three month cost reporting period.

d. The initial rate paid to the new operator shall be the prior owner's rate.

i) The retrospective rate established by the three month cost report shall replace the initial rate paid to the operator.

ii) The retrospective rate may be higher or lower than the initial rate established and paid to the new operator in which case the under or over payment shall be either paid to or collected from the new operator.

iii) The retrospectively established rate shall not exceed the maximum reasonable cost rates for that period.

e. The three month cost report shall establish the prospective rate for the period established by the regulations at 10 CCR 2505-10 section 8.443.13.

f. The provider shall file the first cost report after the three month cost report. If the first cost report filed for the period immediately following the three month cost report demonstrates a reduction in per diem costs more than five percent which is caused by a reduction in per diem costs and not an increase in census, the following special provision shall apply:

i) The provider's prospective per diem rate driven by the three month cost report shall be retroactively reduced to the per diem rate as determined by the actual costs of the provider.

ii) The Department shall recover the difference between the provider's actual costs and the prospective rate paid to the provider. This recovery shall not apply to the three month retrospective rate as established by the initial three month cost report.

8.443.18.B. These special provisions do not apply when the receiver is appointed at the request of any other party such as the previous operator, landlord or other interested party.

8.443.19 PAYMENT FOR OUT OF STATE NURSING FACILITY CARE

8.443.19.A. Payments for out-of-state nursing facility care shall be made to providers when:

1. The nursing facility services are needed because of a medical emergency.

2. The nursing facility services are needed because the resident's health would be endangered if he/she were required to travel to Colorado and the attending physician has certified to such in the resident's medical records.

3. The Department determines, on the notification from the client’s primary care physician, the needed medical services or necessary supplementary resources, are not available in Colorado but are available in another state;

a. The Department’s State Utilization Review Contractor may review the appropriateness of care plan and documentation that the resident will demonstrate significant improvement.

8.443.19.B. Where the resident needs rehabilitation services, the resident shall meet all of the following criteria:

1. The resident's medical condition, as documented by the physician, shall be stable to the extent that the resident's primary need is no longer for acute medical care but for intensive, multi-disciplinary rehabilitation care.

2. The resident's disability shall be within 12 months of admission.

8.443.19.C. The out-of-state nursing facility shall send the following to the Department monthly:

1. Problem list and rehabilitation goals;

a. Treatment plan relative to each rehabilitation goal;

b. Time frame for goal achievement; and

2. Statement of expected discharge status (e.g., timing and the resident's condition on discharge).

8.443.19.D. Those residents without need for rehabilitation services shall be expected to meet Colorado nursing facility admission requirements as described in 10 CCR 2505-10 section 8.402.01 through 8.402.10 and can be admitted if:

1. It is general practice for residents in a particular locality to use nursing facility services in another state; or

2. The resident of an out-of-state nursing facility has been determined to be eligible for Colorado Medicaid due to his inability to indicate his/her intended state of residence.

8.443.19.E. The out-of-state nursing facility shall:

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 (ICF/IID) 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 (ICF/IID) 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 (ICF/IID) nursing facility providers.

1. Each class II and class IV (ICF/IID) 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 (ICF/IID) 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.

b. The total annual fees will be divided by annual patient days for class II and class IV (ICF/IID) facilities from the most recently available MED-13 cost reports to establish the per patient day fee.

c. The Department may use estimated patient days in the per patient day fee calculation to adjust for expected changes in utilization.

d. When final audited MED-13 cost reports are available, the Department will review the fees charged during each state fiscal year to ensure that the fee amount was less than five percent of the total costs for all class II and class IV (ICF/IID) nursing facilities five percent statutory limit. If the fees were greater than five percent of the total costs for all class II and class IV (ICF/IID) nursing facilities, the Department will retroactively adjust the fees.

3. The Department shall calculate the fee to collect from each class II and class IV (ICF/IID) nursing facility by August 1 for the state fiscal year.

a. The Department shall notify the providers of their fee obligation in writing at least 30 days prior to due date of the fee.

b. The Department shall assess the provider fee on a monthly basis.

i. Each facility's annual provider fee amount will be divided by twelve to determine the facility's monthly amount owed to the Department.

ii. The monthly fee is due by last day of the month for which the fee was assessed

iii. Fees may be paid through intragovernmental transfer, Automated Clearing House, or check.

8.443.21 MINIMUM WAGE SUPPLEMENTAL PAYMENT

8.443.21.A The Department shall pay a supplemental payment to eligible class I nursing facility providers for the increase in hourly wages due to a local government increasing their minimum hourly wage above the statewide minimum hourly wage pursuant to section 25.5-6-208, C.R.S.

1. At least once a year, the Department shall calculate the supplemental payment for an eligible class 1 nursing facility provider by multiplying each eligible employee's minimum hourly wage gap by the eligible employee's paid hours. The sum of this calculation for all eligible employees is multiplied by the eligible class 1 nursing facility provider's Medicaid utilization percentage.

a. An eligible class 1 nursing facility provider resides within a local government that increases its minimum hourly wage above the statewide minimum hourly wage or resides within fifteen (15) driving miles of a class 1 nursing facility provider required to increase its minimum hourly wage above the statewide minimum hourly wage.

i. A local government means any city, home rule city, town, territorial charter city, city and county, county, or home rule county.

b. An eligible employee is an employee whose hourly wage increases to or above the local government minimum hourly wage when the local government minimum wage is enacted.

2. The minimum hourly wage gap is calculated as the difference between the enacted local government minimum hourly wage and the hourly wage for an eligible employee immediately before the local government minimum hourly wage is enacted.

a. Hourly wages for an eligible employee include the base hourly wage and the overtime hourly wage.

b. The overtime local government minimum hourly wage is limited to one and one-half times (1.5x) the local government minimum hourly wage.

c. Hourly wages exclude any shift differential adjustments.

3. The paid hours include base, overtime, paid time off, and shift differential hours.

4. The Medicaid utilization percentage is a class 1 nursing facility provider's Medicaid patient days divided by total patient days.

a. Medicaid patient days are determined using Medicaid paid claims for the most recent calendar year with at least four months of claims runout. The Department shall annualize or estimate Medicaid patient days for class 1 nursing facility providers with less than a full year of paid claims.

b. Total patient days are reported by a class 1 nursing facility provider to the Department for the most recent calendar year with at least four months of claim runout. The Department shall annualize or estimate total patient days for class 1 nursing facility providers reporting less than a full year.

5. A class I nursing facility provider that resides within a local government that increases its minimum hourly wage above the statewide minimum hourly wage shall provide the Department with data necessary to calculate the supplemental payment. Class 1 nursing facility providers not providing the Department with data necessary to calculate the supplemental payment may not receive the supplemental payment.

6. A class I nursing facility provider that resides within fifteen (15) driving miles of a class I nursing facility provider required to increase its minimum hourly wage above the statewide minimum hourly wage, and that applies to the Department for the supplemental payment, shall provide documentation sufficient to prove that hourly wages have been increased in line with the adjacent local government minimum hourly wage. Class 1 nursing facility providers not providing the Department with data necessary to calculate the supplemental payment may not receive the supplemental payment.

7. The supplemental payment shall be limited by available appropriations. If the total supplemental payment for all eligible class 1 nursing facility providers is greater than available appropriations, the Department shall reduce all supplemental payments by a designated percent so that the total supplemental payment for all eligible class 1 nursing facility providers is less than or equal to available appropriations.

8. The submission of data for the calculation of the supplemental payment shall be considered the application for the supplemental payment. The submission of such data must include a statement by the licensed owner or corporate officer certifying that the data is true and accurate. Instructions for the data submission process will be communicated annually to all eligible class I nursing facility providers.

9. The Minimum Wage Supplemental Payment shall only be made if there is available federal financial participation under the Upper Payment Limit after all other Medicaid fee-for-service payments and Medicaid supplemental payments are considered.

8.444 through 8.446 Repealed, effective June 30, 2005

8.448 Repealed, effective May 30, 2006

8.449.1 REQUIREMENTS FOR UTILIZATION REVIEW

Utilization review requirements are that all long-term health care facilities participating in the Medical Assistance Program make provision for utilization review and medical care appraisal to assure quality patient care and appropriate use of health care facilities. Each facility shall submit to the Department of Health Care Policy and Financing a plan for doing so that agrees in principle with the model plan attached. Individual case reviews are to be so scheduled as to provide for annual review of each patient certified for skilled nursing care and semi-annual review of each patient certified for intermediate care.

The Utilization Review Plan developed by the long-term care facility lists the members of the Utilization Review Committee. Any change in membership of the Committee is to be communicated to the State Department of Health Care Policy and Financing and the State Department of Public Health and Environment.

The minutes of Utilization Review Committee meetings are to be kept on file in the facility and available to representatives of the Department of Health Care Policy and Financing and the State Department of Public Health and Environment.

8.449.2 USE OF FORMS AND COMMUNICATION CONCERNING RESULTS OF UTILIZATION REVIEW

Recommendations as to individual patients shall be recorded in duplicate on Forms MED-60. The original is filed with the committee minutes, the copy in the patient's administrative file.

When the U.R. Committee recommends a change in the level of care to be given to the patient, form letter Med-60A is completed in triplicate and sent to the patient's physician by the nursing home. If the attending physician agrees with the recommendations, he should date and sign the Med-60A and return it to the Nursing Home U.R. Committee. The nursing home shall then complete Form NH-8 to be sent, together with the Med-60A to the State Department of Health Care Policy and Financing and to the county department. The original of Form Med-60A shall be kept in the patient's chart.

If the attending physician disagrees with the recommendations, he shall return the Form Med-60A with the reasons entered in the space provided, to the U.R. Committee. The U. R. Committee will review the reasons the physician did not accept the recommendations, and if valid, the classification will remain the same, and the U.S. Committee will notify the State and County Departments. If the Committee does not agree, a copy of the minutes and the form will be sent to the Colorado Medical Society Utilization Review Committee for review and evaluation. The results of that review will be communicated to the physician, the State Department of Health Care Policy and Financing, the County Department of Social Services, and to the U.R. Committee.

It shall be the responsibility of the Department to make the final decision, in all such cases, following a review of the recommendations of the Colorado Medical Society Utilization Review Committee, the facility Utilization Review Committee, and the attending physician.

8.461 Repealed, effective May 30, 2006

8.470 HOSPITAL BACK UP LEVEL OF CARE

8.470.1 DEFINITION

The Hospital Back Up (HBU) Program is a long-term care program that provides hospital level care in a skilled nursing facility (SNF) setting. Clients who no longer need acute care in a hospital but require 24-hour monitoring and life sustaining technology for complex medical conditions may apply to receive long-term care in an HBU certified facility.

8.470.2 PROGRAM ELIGIBILITY

In order to be eligible for the hospital back up program, a client shall:

1. Meet ULTC 100.2 level of care eligibility for long term care as determined by the appropriate single-entry point agency (SEP); and

2. Meet the client clinical eligibility requirements as identified in 8.470.3 as determined by the State Utilization Review Contractor (SURC);

3. Be medically stable in a chronically acute state;

4. Be in a hospital or **long-term** acute care facility prior to approval; or

5. Be in An HBU skilled facility under a qualified Medicare stay

8.470.3 CLIENT CLINICAL ELIGIBILITY

All prospective clients must meet the requirements of at least one of the following three categories in the clinical eligibility criteria in to participate in the Hospital Back Up Program:

1. Complex Wound as outlined in 8.470.3.A;

2. Ventilator Dependent as outlined in 8.470.3.B; or

3. Medically Complex as outlined in 8.470.3.C

8.470.3.A. Complex Wound Care means the client must meet all the following criteria:

1. At least one stage 3-4 pressure ulcer or injury, second- or third-degree burns, or a Medicare "pressure relieving support surface" rating of 2-3 to heal or prevent skin breakdown;

2. Documentation of extensive skin loss, active infection, compromised blood flow, sloughing, tunneling, fistulae, or undermining of surrounding tissue or necrosis with potential extension to underlying fascia;

3. Documentation of nutritional deficiencies including:

   a. Identification of diagnostic markers and specific nutritional deficiencies;

   b. A plan of treatment to address underlying conditions such as malabsorption or excess loss of nutrients; and

   c. The modality of supplementation: oral, intramuscular or intravenous, and

4. Documentation of <u>at least one</u> of the following:

   a. Full thickness wound graft surgery;

   b. Negative pressure wound therapy, electromagnetic therapy, compression therapy or hyperbaric oxygen therapy;

   c. Debridement (surgical, mechanical, chemical, autolytic or larval biotherapy); or

   d. Advanced dressings with growth factors, silver/alginates, hyaluronic acid or collagens.

8.470.3.B. Ventilator dependent clients must meet <u>all</u> requirements in <u>at least one</u> of the following three subsections:

1. If the client is actively weaning off the ventilator, the client must:

   a. Require direct assessment and monitoring of weaning at least 2 hours each day by a respiratory therapist;

   b. Require supportive care at least 12 hours a day by a respiratory therapist or pulmonary trained nurse (under the supervision of a respiratory therapist) for ventilator management;

   c. Require physical therapy, occupational therapy, speech therapy, or a combination of such therapies at least 5 days per week;

   d. Have documented rehabilitation potential and a plan of treatment by a respiratory therapist in place at the time of the HBU referral; and

   e. Have clinical documentation including (but not limited to) arterial bloods gas labs, standard breathing and capping trial results, pulmonary function tests, capnography, respiratory and speech language pathology progress notes and any other documentation to support active weaning efforts.

2. If active weaning fails, the client must:

a. Have documentation of failed weaning efforts by a respiratory therapist and a plan of treatment with prognosis for liberation from a respiratory therapist or pulmonologist;

b. Require continuous ventilator support at least 8 hours per day and skilled respiratory care at least 3.5 hours per day to remain medically stable;

c. Have difficulty communicating needs to others and/or requires assistance from skilled staff to set up adaptive equipment, or is unable to speak due to physical or cognitive impairment; and

d. Have one of the following scores on the ULTC 100.2 assessment form:

i. A score of at least 2 in a minimum of two activities of daily living (ADL); or

ii. A score of at least 2 in one category of supervision.

3. If the client has been successfully weaned off the ventilator and is actively working to reduce oxygen levels and/or removal of the tracheostomy tube, the client must:

a. Have one of the following scores on the ULTC 100.2 assessment form:

i. A score of at least 2 in a minimum of two activities of daily living (ADL); or

ii. A score of at least 2 in one category of supervision;

b. Have documentation from a respiratory therapist and pulmonologist verifying the client has been weaned off active ventilation and/or is working to have a further reduction to standard home oxygen levels (1-6 LPM);

c. Require the support of a respiratory therapist under the supervision of a pulmonologist at least 3.5 hours a day to remain medically stable and/or show progress toward decannulation; and

d. Be capable of:

i. Communicating needs and following simple commands; and/or

ii. Managing basic tracheostomy care or respiratory hygiene.

8.470.3.C. Medically complex clients include ventilator dependent individuals and individuals successfully weaned off the ventilator with co-morbidities. To be deemed medically complex under the HBU program, clients must meet <u>all</u> of the following requirements:

1. Have a score of at least 2 in a minimum of 2 activities of daily living or a score of at least 2 in one category of supervision on the ULTC 100.2 assessment form;

2. Have difficulty communicating needs to others and requires assistance from skilled staff to set up adaptive equipment or be unable to seek assistance due to cognitive or physical impairment;

3. Require on-site assessment by a rounding physician or subspecialist at least once a week to remain stable;

4. Require artificial nourishment to be administered by registered nurse, including but not limited to a gastro-intestinal tube (G tube or NG tube) and/or jejunostomy tube (J tube), total parenteral nutrition (TPN) with or without lipids, or central line in active use for fluids or medication (excluding TPN);

5. Require documentation of rehabilitative therapies including physical, occupational and speech language therapy, and/or skilled nursing notes documenting assessment, monitoring and intervention at a greater frequency than is provided in a class 1 nursing facility;

6. Require suctioning and/or airway maintenance at least every four hours by a respiratory therapist or pulmonary trained nurse under the supervision of a respiratory therapist for ventilator dependent clients or clients with a tracheostomy;

7. Physician documentation of life limiting disease which will require ongoing care in the HBU skilled nursing facility; and

8. Documentation of quarterly updates to plan of treatment, prognosis, status evaluation, care conference and/or palliative consult.

8.470.4 INITIAL ELIGIBILITY DETERMINATION AND ADMISSION

8.470.4.A. SURC Review for Initial Hospital Eligibility Determination

Upon receipt of the completed Hospital Back Up Application, patient choice form and the ULTC 100.2 assessment, the SURC nurse reviewer shall:

1. Conduct a program eligibility review to determine whether the client meets the hospital back up level of care criteria and may successfully be treated in the requested skilled nursing facility;

2. Review the ULTC 100.2 assessment by the SEP;

3. Provide initial assessment for secondary review by SURC physician reviewer;

4. Request additional medical documentation deemed necessary to make such determination;

5. Notify the Department of final eligibility determination;

6. Document all final physician determinations and maintain these records for the Department;

7. Issue a denial letter to the Department and referring provider within 10 business days of determination if the prospective client does not meet HBU level of care;

8. Notify the Department in writing within 10 days of determination if the SURC determines the Client meets HBU level of care; and

9. Issue a 90-day initial length of stay letter to the client and skilled nursing facility within 24 hours of approval from the Department, in accordance with the criteria specified below in subsection 8.470.4.C.

8.470.4.B. Hospital Back Up Skilled Nursing Facility Requirements

Upon receipt of a new client referral, the hospital back up skilled nursing facility shall:

1. Conduct a face to face assessment with the client and current care provider and review clinical documentation to determine if the hospital back up skilled nursing facility can provide the appropriate level of care for the client;

2. Notify the SURC and Department that it is considering admitting the client to the hospital back up skilled nursing facility;

3. Prepare a care plan and provide this to the SURC and Department for review;

4. Verify the status of the Client's enrollment in Health First Colorado LTC Medicaid;

5. Notify the Department of date of transfer and arrange for secure transport of client;

6. Maintain the HBU approval letter for the SEP and County to initiate services and payment for the client;

7. Provide to the Department a monthly status report on the last business day of each month for all Hospital Back Up Program clients admitted to or residing in the hospital back up skilled nursing facility during the preceding month.

8. Failure to provide a status report each month could result in a temporary cessation of payment to the hospital back up skilled nursing facility.

8.470.4.C. 90-Day Initial Length of Stay

1. The 90-day initial length of stay letter issued by the SURC nurse reviewer in accordance with subsection 8.470.4.A shall provide prior authorization for the initial length of stay in the hospital back up skilled nursing facility not to exceed 90 days.

2. 15 days before the end of each hospital back up client's 90-day initial length of stay, the SURC nurse shall conduct an on-site review for each client, which will determine if:

    a. The client continues to meet the hospital back up level of care criteria;

    b. The client's care needs are being adequately met in the hospital back up skilled nursing facility;

    c. The hospital back up skilled nursing facility has updated the existing plan of treatment to reflect any change in the client's condition; and

    d. The appropriate level of care and services are being provided and documented in the client's record.

1. The SURC nurse shall report the results of the on-site visit to the SURC physician reviewer within 24 hours of completion of the visit.

2. The SURC shall notify the Department and the hospital back up skilled nursing facility of the final determination in writing within 10 business days of the on site visit and include supporting documentation for this determination.

3. If the client continues to meet the hospital back up program level of care, the SURC shall issue a continued stay letter to the hospital back up skilled nursing facility and client within 24 hours of approval from the Department.

4. If the SURC physician reviewer determines that the client no longer meets the hospital back up level of care criteria or the nursing facility fails to provide documentation to support level of care and services provided, the SURC shall notify the hospital back up nursing facility administrator in writing within 24 hours of the determination and reimbursement for the client's stay shall be reduced to the nursing facility class one rate within 60 days of receipt of the letter.

5. The Department shall notify the client in writing of the SURC determination and appeal rights as outlined in 10 CCR 2505-10 section 8.057.

6. The SURC shall maintain all records for eligibility determinations and provide these documents upon request to the Department for contract reporting and client appeals.

8.470.5.D. Annual Continued Stay Review

1. The SURC nurse shall conduct an on-site continued stay review for each hospital back up client 15 days prior to the end of the client's currently approved annual stay.

2. The SURC may conduct an unscheduled on-site review at any time during the length of stay for client clinical change of condition or at the request of the Department.

3. The SURC shall observe the same review criteria and determination requirements as outlined in 8.470.4.C of the 90-day initial eligibility criteria for determining ongoing annual eligibility.

4. A new ULTC 100.2 assessment must be completed annually by the SEP agency. The nursing facility shall provide a current ULTC 100.2 to the SURC as part of the annual eligibility assessment.

5. If the SURC determines that the client no longer meets the hospital back up level of care criteria or the nursing facility fails to provide documentation to support level of care and services provided, the SURC shall notify the Department within 24 hours of completion of the eligibility review.

6. The SURC shall observe the same determination and notification requirements as outlined in 8.470.4.C.6-7 of the 90-day initial eligibility criteria for determining ongoing annual eligibility.

8.470.6 CLIENT TRANSFERS AND DISCHARGES FROM THE HBU PROGRAM

8.470.6.A. Requirements for HBU skilled nursing facility discharges

1. If a hospital back up skilled nursing facility receives CSR denial letter that a client ceases to meet hospital back up level of care criteria, the hospital back up skilled nursing facility must notify the Department within 15 days of the date of the notice whether it may continue to provide care for the client under the standard nursing facility class 1 rate.

2. If the hospital back up skilled nursing facility chooses to discharge or transfer a client who ceases to meet hospital back up level of care criteria, the skilled nursing facility shall comply with the notification requirements of section 8.057.1.D and E, including notifying the client of their right to appeal the transfer or discharge.

3. The discharging skilled nursing facility shall adhere to the Colorado Department of Public Health and Environment's rules regarding client discharge or transfer as outlined in 6 CCR 1011-1, Chapter V, Section 12.6.

8.470.6.B. Requirements for HBU transfers within participating HBU Program facilities

1. If a client requests a transfer to another hospital back up skilled nursing facility and the individual's care needs may be met by another hospital back up skilled nursing facility, each nursing facility must notify the Department of their intent to transfer the client.

2. A new plan of treatment and must be provided by the accepting nursing facility to the SURC for review prior to transfer and the SURC shall notify the Department of the eligibility determination within 10 business days of review of the plan of treatment.

3. The SURC will issue a new approval letter to the accepting nursing facility, with change of billing effective on the date of transfer stated in the letter.

4. The accepting facility is responsible for arranging medical transport and notifying the SEP and County of the transfer for their records.

8.4707 NURSING FACILITY REQUIREMENTS FOR PARTICIPATION IN THE HBU PROGRAM

8.470.7.A In order to participate in the Hospital Back Up Program, the nursing facility shall submit a letter of intent to the Department that demonstrates the nursing facility:

1. Is Medicaid certified and licensed to provide skilled care;

2. is financially stable;

3. can provide skilled nursing facility services 24 hours a day;

4. Has staff stability;

5. Has a history of survey compliance;

6. Complies with the direct client care regulations administered by CDPHE as outlined in 6 CCR 1011-1 Chapter 2: General Licensure Standards and "Chapter 5: Nursing Care Facilities";

7. Has a recommendation from CDPHE for the nursing facility to participate in the hospital back up level of care program.

8. Has the desired number of beds available to be designated for the HBU Program, not to exceed 25 beds.

8.470.7.B. The Department may request evidence of financial stability and survey compliance at any time during the nursing facility's participation.

8.470.7.C. The Department may deny or revoke authorization of a nursing facility to participate as a hospital back up level of care facility if they do not meet the requirements outlined in section 8.470.7.A.

8.470.7.D. If the nursing facility has applied to admit clients who are ventilator dependent, the nursing facility shall also meet the following additional requirements:

1. Maintain clinical care staff trained in critical care and/or pulmonary medicine on the ventilator unit 24 hours a day, 7 days a week;

2. Have a back-up generator capable of providing heat, cooling and continuous electricity for needed equipment in the event of power outages; and

3. Maintain 24-hour on-site coverage by a respiratory therapist, who shall monitor any client weaning off of a ventilator and adjust ventilator settings as needed.

8.407.8 REIMBURSEMENT OF NURSING FACILITIES FOR PARTICIPATING CLIENTS WHO MEET HOSPITAL BACK UP LEVEL OF CARE

8.470.8.A Medicaid reimbursement for services provided to a hospital back up level of care nursing facility client shall be based upon the Resource Utilization Group IV (RUG-IV) classification determined through the client's minimum data set (MDS) resident assessment as transmitted to and accepted by the Centers for Medicare and Medicaid services (CMS).

1. The Medicaid reimbursement for each client shall correspond to the RUG IV case mix adjusted federal RUG reimbursement rate prior to the application of any wage index component determined from a client's CMS accepted resident assessment and related RUG classification.

2. All HBU facilities will receive a 60-day interim rate after the admission of the client to the facility.

   a. The interim rate will be the average RUG-IV case mix adjusted federal RUG reimbursement rates for all clients enrolled in HBU and will be recalculated annually.

   b. All claims billed during the interim rate payment period will be retroactively mass adjusted to reflect the permanent Medicaid reimbursement rate assigned to the client's RUG classification.

   c. The HBU facility must complete an MDS resident assessment accepted by CMS no later than 60 days post admission.

   d. The nursing facility must assign a RUG classification determined by the MDS resident assessment no later than 60 days post-admission.

   e. If no MDS resident assessment has been accepted by CMS within 60 days post admission, the Department shall withhold all future payments until the assessment has been accepted by CMS.

3. Medicaid reimbursement for a client who meets HBU level of care shall not be based upon or related to the audited, cost-based reimbursement for a nursing facility's class 1 residents.

4. The appeals rights and procedures applicable to the Department's determination of a nursing facility's class 1 rate shall not apply to the reimbursement the Department offers or pays for a client who meets HBU level of care criteria.

5. If the Department determines the client's third party coverage (private insurance or Medicare) will cover the cost of the client's care in either a hospital or nursing facility, the Medicaid payment under this program shall be approved only after utilization of third party benefits.

8.470.8.B Providers shall bill for drugs and oxygen separately from the per diem rate as fee-for-service claims.

8.470.8.C Twice yearly, the Department's contractor shall audit and validate all MDS resident assessments and related RUG classifications that have been utilized to set Medicaid reimbursement rates for HBU clients.

1. Audit and validation will occur each June and December.

2. The contractor shall report all invalid MDS resident assessment scores to the Department and the facility.

3. For any score identified as invalid, the Department will adjust the rate to reflect the validated MDS resident assessments and corresponding RUG-IV reimbursement rate retroactively to the date of the previous validated MDS; claims will be reprocessed to reflect the corrected RUG-IV reimbursement rate.

8.470.8.D In the event the facility disputes the contractor's determination of the RUG classification, the facility may file an informal reconsideration related to the RUG classification in accordance with Section 8.050.

1. The Department must receive a request for informal consideration of a disputed RUG classification in writing within 30 days of the date of the contractor's notice of the disputed RUG classification.

2. The request shall state, with specificity, each error disputed in the RUG classification.

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

4. The Department will notify the facility of the final determination of the disputed RUG classification within 45 days of the receipt of the request for informal reconsideration.

5. The facility may file an appeal of the final informal reconsideration determination of the disputed RUG classification with the Office of Administrative Courts within 30 days from the date of the Department's notice of final determination of the informal reconsideration.

8.470.8.E Each month, the HBU facility must report the status of every HBU client in the facility using the Department's approved reporting form.

1. The HBU facility shall report all discharges, whether permanent or temporary, the death of a client, all changes in status, or no changes in status.

2. Reports must be submitted by no later than 5:30 p.m. on the last day of the month.

3. If no report is received by the deadline, the Department will notify the facility that payment will be immediately suspended until the facility submits the required status report, and will immediately suspend all HBU payments to the facility.

8.470.9 REPORTING ON THE MED-13 FORM

8.470.9.A The Medicaid reimbursement for clients who meet 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 1 Medicaid clients based on the Med-13 cost reporting process.

8.470.9.B The hospital level reimbursement shall be reported on the Med-13 cost report form in the following manner so that it does not impact the class 1 Medicaid per diem rate established by the cost report:

1. The hospital level reimbursement shall be included on the appropriate line in columns 1 through 8 on Schedule C; and

2. Offset of the hospital level reimbursement shall be on Schedule B with a detailed supplemental schedule attached.

8.481 [Expired 05/15/2016 per House Bill 16-1257]

8.481.1 [Expired 05/15/2016 per House Bill 16-1257]

8.482 RESIDENT INCOME AND POSSESSIONS

8.482.1 PURPOSE AND LIMITATIONS

Resident income, whether contributed or direct, shall be used for the care of the resident, except for 2 personal needs allowance as see forth in 10 CCR 2505-10 section 8.482.5.

No person, institution, partnership, corporation or other entity shall divert resident income from the control and exclusive use of the resident, without proper legal authorization or power.

8.482.2 DEFINITIONS

A. “Contributed income” is defined as the amount of income of parent or unseparated spouse, over and above the needs of such spouse or parent, which is contributed toward the needs of the resident.

B. “County Department” is defined as the County Departments of Social/Human Services.

C. “Department” is defined as the Colorado Department of Health Care Policy and Financing.

D. “Direct income” is defined as payments made directly to the resident, or to a conservator or guardian for the exclusive use of the resident. Examples of such income are Social Security benefits, supplementary security income, railroad or other retirement benefits.

E. “Nursing facility” is defined as an intermediate or skilled care facility, the owners, administrators, and staff thereof.

F. “Personal needs” is amount specified in 10 CCR 2505-10 section 8.110.42 to be deducted from resident income, end used for the exclusive benefit of the resident prior to application of income to nursing facility care.

G. “Resident income” is defined as all income used in the determination of eligibility for Medicaid payments.

H. “Patient payment” is defined as the payment made by the resident for nursing facility care, after the personal needs allowance is deducted.

I. “Responsible Party” is defined as any of the persons below, who accepts the responsibility for a resident's funds, mail or personal possessions and is willing to sign a written declaration of such responsibility:

1. a legally appointed guardian, conservator or trustee;

2. relative or friend;

3. the county department.

J. “Post Eligibility Treatment of Income (PETI)” is defined as the reduction of resident payment to a nursing facility, for the costs of care provided to an individual by the amount that remains after certain deductions are applied to reduce the individual's total income. The individual is liable to pay the remaining amount to the institution.

8.482.3 RESIDENT INCOME

The control of resident income is vested in the resident, or in such person as the resident may designate. Such designee may be a conservator, administrator, family member or other representative. The income is to be used by the resident, or on behalf of the resident. No such designee, or any other person or institution, shall convert any of these monies to their own use for any reason.

8.482.31 DETERMINATION OF INCOME

A. The initial determination of resident income shall be made by the county department. The county department shall then notify the nursing facility of current resident income as detailed in 10 CCR 2505-10 section 8.482.34.B.

B. The nursing facility must notify the county immediately of any changes in resident income. And, if the facility is authorized to receive the resident's income, the facility has the duty and obligation to verify the amount of resident income.

C. If the nursing facility is not authorized to receive the payments for resident income, it is the responsibility of the resident, or the person administering such income on behalf of the resident, to report all changes in such income, as required by the Colorado Department of Human Services Income Maintenance Staff Manual, Volume 3, under the penalties set forth in 10 CCR 2505-10 section 8.482.45.

8.482.32 COLLECTION OF INCOME

A. Responsibility of Nursing Facility

1. It shall be the responsibility of the nursing facility to collect from the resident, or from the resident's family, conservator or administrator, all income which is to be applied to the cost of resident care. The Department is not responsible for any deficiency in patient payment accounts, due to failure of the nursing facility to collect such income.

2. If, however, the nursing facility is unable to collect such funds, through refusal of the resident or the resident's family, conservator, or administrator to release such income, the nursing facility shall immediately notify the county department.

B. Responsibility of County Department

When notified by the nursing facility of the refusal of the resident or the resident's family, conservator or administrator to release resident income due, the County Department shall immediately contact the refusing party. If, after such contact, the party still refuses to release such income, the action shall be deemed a failure to cooperate, and the county department shall proceed to discontinue Medicaid benefits for the resident.

8.482.33 Nursing Facility Post Eligibility Treatment of Income – Incurred Medical Expenses (PETI-IME)

Effective April 8, 1988, with respect to the post-eligibility treatment of income of individuals who are institutionalized there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by Colorado Medicaid or third party insurance, including health insurance premiums, deductibles or co-insurance; dental care; hearing aids, supplies, and care; corrective lenses, eye care, and supplies; and other incurred expenses for medical or remedial care that are not subject to payment by a third party.

A. All PETI-IME expenses in excess of $400 per calendar year shall be prior authorized by the Department or its designee. The purpose of the prior authorization process is to verify the medical necessity of the services or supplies, to validate that the requested expense is not a benefit of the Medicaid program, and to determine if the expenses requested are a duplication of expenses previously prior authorized.

B. Prior Authorization Request Process:

For allowable PETI-IME expenses that exceed $400 per client in a calendar year, costs shall be prior authorized by the Department or its designee. The process is as follows:

1. Prior authorization requests must be submitted to the Department as prescribed by the State through the Provider Web Portal. In addition to the information requested on the web portal form, the following attachments must be included:

    a. For All PETI-IME requests: The medical necessity form signed by the physician and resident or resident representative.

    b. For All PETI-IME requests: An itemized invoice for the service or supply being requested.

    c. Additionally, for Hearing Aids: an audiogram

    d. Additionally, for Health Insurance: premium statement and health Insurance card (front and back).

    e. Additionally, for Dental: Medicaid denial of coverage.

2 Prior authorizations will be certified by The Department based on the following criteria:

    a. The request is not a benefit of the Medicaid program.

    b. The cost of the request does not exceed the basic Medicaid rate for such services or supply.

    c. The special medical service or supply is medically necessary.

3. The Department or its designee shall review and approve/deny the Prior Authorization Request within fifteen working days of receipt. The Provider Web Portal shall reflect the status of the request.

4. Upon receipt of the approved Prior Authorization Request (PAR), the nursing facility shall submit the PETI-IME reimbursement on the following month's Medicaid billing or on the nursing facility's next billing cycle.

a. PETI-IME PAR requests must be submitted within the timely filing period of 120 days from the date of service.

b. For approved PETI-IME PARs requested prior to services rendered, the Department has the discretion to close the PAR if reimbursement is not requested within 12 months from the date of Department approval.

C. Private health insurance premiums, deductibles, or co-insurance as defined by state law.

1. Monthly premium payment paid by the resident for private health insurance.

a. If premium payments exceed the patient payment amount for one month, a monthly average is calculated by dividing the total premium by the number of months of coverage. The resulting amount is to be applied as a monthly PETI-IME expense for the months of coverage.

2. Health insurance premiums will be allowed for the resident only.

3. Private Health insurance premiums, deductibles, and coinsurance must be reviewed by the Department or its designee yearly for final approval.

a. If duplicate coverage has been purchased, only the cost of the least expensive policy will be allowed. Premiums, deductibles and co-insurances which the Department or its designee determine to be too expensive in relation to coverage purchased shall not be allowed.

b. Upon approval, private health insurance premiums are billable for 12 months.

D. The allowable expenses for special medical services are subject to the following criteria:

1. General Instructions (applies to all special medical services).

a. If the client does not make a patient payment; then no PETI-IME will be allowed.

b. Costs will be allowed only if they are not a benefit of the Medicaid program, or not a benefit of other insurance coverage the resident may have.

c. All allowable costs must be for items that are medically necessary as described in section 8.076.1.8, and medical necessity must be documented by the attending physician. The physician statement must be current, within one year of the authorization.

d. The resident or resident representative must agree to the purchase of the service/equipment and related charge, with signed authorization in the resident's record.

e. Nursing facilities are not permitted to assess a surcharge or handling fee to the resident's income.

f. The allowable costs for services and supplies may not exceed the basic Medicaid rate.

g. In the case of damage or loss of supplies, replacement items may be requested with relevant documentation. If the damage or loss is due to negligence on the part of the nursing facility, the nursing facility is responsible for the cost of replacement.

h. Costs will not be allowed if the equipment, supplies or services are for cosmetic reasons only.

i. Monthly PETI-IME payments may not exceed the monthly patient payment. Approval for reimbursement shall only be allowed if the provider agrees to accept installment payments.

j. For special medical services/supplies provided but not yet paid for, the encumbrance agreement and monthly payment schedule must be documented in the resident's record, as well as receipts of payment.

2. Dental Care Instructions

In 2013, the state legislature passed Senate Bill 242 which authorized the Department to create a new limited dental benefit in Medicaid for adults age 21 and over. Once the benefit has been exhausted, then a PETI-IME request may be submitted to the Department for approval for the additional services.

a. Documentation showing the allowed benefit has been exhausted for the current year shall be attached to the prior authorization request.

b. The signed medical necessity form and itemized invoice shall be attached to the prior authorization request.

3. Hearing Aid Instructions

a. All referrals for hearing aids must be authorized by the attending physician, and must include an evaluation for suitability and specifications of the appropriate appliance performed by a licensed audiologist.

b. Purchase of new hearing aids to replace pre-existing hearing aids must include documentation of necessity of replacement of the pre-existing hearing aid.

c. Documentation attached to the prior authorization request should include the signed medical necessity form, itemized invoice and audiogram.

4. Corrective Lenses Instructions

PETI-IME expenses for corrective lenses will be limited to services not covered under 10 CCR 2505-10, section 8.203 Vision Services.

a. The evaluation of the need for corrective eyeglasses (lenses) must be a part of a comprehensive general visual examination conducted by a licensed ophthalmologist or optometrist.

b. The medical necessity for prescribed corrective lenses should not be based on the determination of the refractive state of the visual system alone, but should be identified by the current procedural terminology in the Physician Current Procedures Terminology (CPT) Code as established by the American Medical Association.

i. Documentation attached to the prior authorization request should include the signed medical necessity form and itemized invoice.

5. All documentation of the incurred expenses must be available in the client's financial and medical record for audit purposes by the Department or its designee. Lack of documentation shall cause the PETI-IME to be disallowed and shall be considered an overpayment subject to recovery by the Department. Documentation shall include:

a. Printed copy of approved PAR.

b. Copy of all attachments to the PAR.

c. Yearly Activity Log that includes the dental, vision and PETI-IME reimbursement activity. Specifically:

1) Member number and name receiving the service;

2) Type of service requested;

3) Date service was requested by the member;

4) Date PAR was added to Provider Web Portal:

5) Date PAR was approved by the Department;

6) Date facility received payment from Medicaid for service;

7) Date service provider was paid by the facility;

8) Date service was rendered to the member;

9) When/if the member's personal needs account funds were used;

10) When applicable, documentation that the member's personal needs account was reimbursed;

11) Documentation that the member was still at the facility when the service was rendered;

d. All documentation shall be retained for six years.

8.482.34 THE "STATUS OF NURSING FACILITY CARE" FORM, AP-5615

A. Responsibilities of the Nursing Facility

1. The AP-5615 form is to be completed by the nursing facility, in duplicate, for all admissions, readmissions, transfers from private pay or Medicare, discharges, deaths, changes in income and/or patient payment, and leaves of absence.

2. Each form must carry the date completed and the actual signature of the nursing facility administrator or his/her authorized representative.

3. All copies of the AP-5615 must be mailed to the appropriate county department within five working days of the action which is being reported, or in the case of a change in resident income, within five working days of the time the change becomes known, in order to expedite reimbursement.

4. The nursing facility will be responsible for assuring that the patient payment, as shown on the AP-5615 and approved by the County Department, is identical to that claimed on the monthly nursing facility, billing form. Failure to enter the latest patient payment data on the billing form will render the nursing facility liable for any discrepancies.

B. Responsibilities of the County Department

On receipt of Form AP-5615, the county department will, within five working days:

1. For an admission, a readmission or a transfer from/to private pay or Medicare:

   a. Verify and correct, if necessary, data entered by the nourishing 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 of readmission.

   b. If client is already on the Medicare Buy-In program, do no: 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 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 10 CCR 2505-10 section 8.482.43.

5. For discharge or death of resident:

a. Verify the date of death or discharge, and verify the correct patient payment (or resident's monthly income) for the discharged month, and the amount calculated by per diem. All corrections must be initialed.

b. Note if the resident entered another nursing facility and, if so, provide the name of the new nursing facility. This information is needed to assure that duplicate payment will not be made.

c. In the event the resident may return to the same facility, the AP-5615 may be completed at the end of the month for discharges due to hospitalization.

d. Make necessary changes on the automated system to reflect the appropriate circumstances. Submit the AP-5615 to the Department

6. Failure to submit the correct form may result in the refusal of the Department to reimburse such nursing facility care.

7. General Instructions:

a. The AP-5615 form must be verified and the original returned to the nursing facility.

b. The AP-5615 form must be signed and dated by the director of the County Department, or by his/her designee.

c. AP-5615 forms may be initiated by either the nursing facility or County Department. If the County Department is aware of information requiring a change in financial arrangements of a resident, and a new AP-5615 form is not forthcoming from the nursing facility, the County Department may initiate the revision to the AP-5615. In such case, one copy of the AP-5615 showing the changes, will be sent to the nursing facility.

8. The Department may deduct excess payments from the county administrative reimbursement as stated in the Colorado Department of Human Services Finance Staff Manual, Volume 5 if the County Department fails to:

a. Perform the duties as detailed in section B; or

b. Adhere to the limitations on $0.00 patient payment; as detailed in 10 CCR 2505-10 section 8.482.34.D.; or

c. Notify the nursing facility immediately of any changes in resident income, provided the nursing facility is not authorized to receive the resident's income; and excessive Medicaid funds are paid to the nursing facility as a result of this negligence.

C. Calculating Partial Month Payments

1. Whenever a resident is in the nursing facility on the first day of the month, remains a resident for each day of the month, and is still a resident on the first day of the next month, the total resident income. in excess of the amount reserved for personal needs allowance, less earned income (if appropriate), less spousal and dependent care allowance, less home maintenance allowance, and less allowable expenses for medical and remedial care (see PETI deductions as defined in 10 CCR 2505-10 sections 8.110.49 and 8.482.33) will be used as the patient payment, regardless of the actual number of days in that month. If the resident is in the facility less than this period, the rate is computed using the calculation below.

2. In figuring the number of days for payment, the day of admission is included, but not the day of discharge (i.e., the resident dies or leaves the facility).

3. In order to calculate the patient payment:

   a. determine the amount of available resident income for the month (see subsection 1. above).

   b. subtract the cost of the care provided to the resident during that month (computed by multiplying the number of days in the facility times the per diem cost of care).

4. If the cost of care exceeds the available resident income, Medicaid will pay the difference. If the available resident income exceeds the cost of care, the excess income is the property of the resident (10 CCR 2505-10 section 8.482.3) and must be refunded to the resident or the legal guardian/designated responsible party.

5. When patient payment is calculated by per diem, the final amount shown will be that amount to be paid by the resident, not the amount to be returned to the resident

6. If, at the time the resident is discharged or dies, the patient payment for that month is greater than the properly computed per diem patient payment, the following rules apply:

   a. If the resident is discharged to another nursing facility, or to the resident's own home, the excess patient payment and personal needs monies must be forwarded to the resident in his/her own home or in the transferred nursing facility, within 45 working days of the date of discharge.

   b. If the resident is discharged to a hospital, other medical institution, or if the resident dies, the excess patient payment must be immediately transferred from the nursing care account to the resident's personal needs account. These funds then are to be disposed of as detailed in 10 CCR 2505-10 section 8.482.52.F. If the nursing facility does not handle the resident's personal needs funds, the excess patient payment must be immediately returned to the responsible party.

1) However, if the resident is discharged from the nursing facility to a hospital or other medical institution and is admitted with Medicaid as the primary source of funding, the patient payment in excess of the amount due to the discharging nursing facility may be due to the hospital or medical institution. Any excess patient payment should be sent to the hospital at the end of the month (see10 CCR 2505-10 section 8.358.1). If the resident discharged to a hospital or other medical institution is not readmitted to the nursing facility, the resident's funds, either excess patient payment or personal needs, must be lawfully disposed of as indicated in 10 CCR 2505-10 section 8.482.52.F.

2) If the resident dies in the nursing facility or is discharged to a hospital or other medical institution where he/she subsequently dies, the resident's funds entrusted to the nursing facility must be transferred as indicated in 10 CCR 2505-10 section 8.482.52.F.

7. Changes of financial status within the facility:

a. Residents transferring from private pay to Medicaid may have a patient payment liability for the Medicaid-funded portion of the month depending on the amount of income applicable to care, as determined on the AP-5615 form.

If the resident's income exceeds the cost of care paid for the private resident portion of the month, the excess income is applicable to the remaining Medicaid portion of the month.

b. The same patient payment calculation applies for residents transferring from Medicaid to private pay status. The patient payment is first applied to the Medicaid portion of the month and any excess is then applied to the remaining private pay days.

D. Zero Patient Payment

1. Patient payment may be waived and zero $0.00 patient payment applied only under the following conditions:

a. A resident's income is equal to or less than the personal needs allowance (see 10 CCR 2505-10 section 8.110.42); or

b. A resident's income is equal to or less than the personal needs allowance, less earned income (if appropriate), less spousal and dependent care allowance, or less home maintenance allowance, or less allowable expenses for Medicare premiums (see PETI deductions as defined in 10 CCR 2505-10 sections 8.110.49 and 8.482.33); or

c. A resident is admitted to the nursing facility from his/her home and the resident's funds are committed elsewhere for that month; or

d. The resident is admitted from his/her home, where his/her funds were previously committed, to the hospital, and subsequently to the nursing facility, in the same calendar month; or

e. The resident is discharged to his/her home, and the county department determines that the income is necessary for living expenses; or

f. The resident is admitted from another nursing facility or from private pay within the facility and has committed the entire patient payment for the month in payment of care already provided in the month of admission.

2. Patient payment may not be waived (other than for the exceptions provided for in 10 CCR 2505-10 section 8.482.34.D.1.) in the following instances:

a. A resident with income in excess of the personal needs allowance, less earned income (if appropriate), less spousal and dependent care allowance, or less home maintenance allowance, or less allowable expenses for Medicare premiums (see PETI deductions as defined in 10 CCR 2505-10 sections 8.110.49 and 8.482.33), except as provided in the Colorado Department of Human Services Income Maintenance Staff Manual Volume 3, concerning increased personal needs allowance; or

b. Transfers between nursing facilities; or

c. Discharges from nursing facility to a hospital or other medical institution; or

d. Changes from private pay within the facility and patient payment not already committed for care provided; or

e. The death of the resident

3. The amount of SSI benefits received by a person who is institutionalized is not considered when calculating patient payment

8.482.4 NO DUPLICATE OR ADDITIONAL PAYMENTS

8.482.41 DUPLICATE PAYMENTS

A. "Duplicate payment" is defined as:

1. Payment to two or more facilities, hospitals or other institutions for per diem or room and board care for the same resident for the same time period;

2. Payment from two sources, including but not limited to, Medicare and Medicaid, for the same service to the same resident. Supplementary payments in which each source pays a portion (not overlapping) of the total due, is not considered duplicate payment.

B. Duplicate payment shall not be made:

1. To a hospital and a nursing facility for the same period of time for care of any one resident;

2. To two or more nursing facilities for the same period of time for the care of any one resident;

3. For any other instance, whether billed by the provider in good faith or in error.

C. Any provider billing for such duplicate services for any period of time during which the resident was not actually in the facility or the resident did not actually receive any facility billing for services will be subject to the penalties as set forth in 10 CCR 2505-10 section 8.482.45.

D. In any instance in which duplicate billings result in Medicaid reimbursement to both providers, a recovery shall be made by the Department against one or both providers.

8.482.42 ADDITIONAL PAYMENTS

A. "Additional payments" are defined as payments made by the resident, or by a resident's family, conservator or administrator for items which are not a benefit of the Medicaid program, such as:

1. Items covered in 10 CCR 2505-10 section 8.442.1, Services and items not included in the Per Diem Rate (chargeable to Patient Trust Funds).

2. Room reservations for medical leave in accordance with 10 CCR 2505-10 section 8.482.43.

3. Room reservations for non-medical and/or programmatic leave days in excess of 42 days per calendar year in accordance with 10 CCR 2505-10 section 8.482.44.

4. Limitations covered in 10 CCR 2505-10 section 8.462.

B. Additional payment for resident care and services which are to be furnished within the nursing facility per diem rate are specifically prohibited (10 CCR 2505-10 section 8.442). The nursing facility can neither solicit additional funds for such care and services nor accept voluntary monetary contributions for them, from residents or responsible parties. Any such monies collected or accepted by the nursing facility shall render such facility liable for the penalties set forth in 10 CCR 2505-10 section 8.482.48.

C. Additional payments may be charged for:

1. Services and items not included in the per diem rate, as specified in 10 CCR 2505-10 section 8.442.1. These items may be billed to the resident, to the resident's estate or other responsible party, subject to the restrictions set forth in 10 CCR 2505-10 section 8.442.1.

2. Room reservations. "Room reservation" is hereby defined as that charge made to a resident or to a resident's family, conservator or administrator, or other responsible party, to retain the resident's room and provide space for clothing and other personal items during the time which the resident is absent from the facility. Room reservation charges may be made under the circumstances outlined at 10 CCR 2505-10 sections 8.482.43 and 8.482.44.

a. Medical leave. See 10 CCR 2505-10 section 8.482.43 for conditions and restrictions.

b. Non-medical and/or programmatic leave. See 10 CCR 2505-10 section 8.482.44.

D. Failure to comply with the following restrictions on additional payment will render the nursing facility liable for repayment of any such funds, or to prosecution as set forth in 10 CCR 2505-10 section 8.482.45, or both:

1. Exact physician's orders on the nursing facility charts, for such additional care or services;

2. Fully itemized billings to the resident or responsible party;

E. Additional payments by persons other than the resident shall not be regarded as income to the resident, and shall not affect the eligibility of the resident for the Medicaid program.

F. Additional payments may not be deducted from the resident's personal needs funds, nor may they be applied to a PETI deduction as described in 10 CCR 2505-10 section 8.482.33, unless authorized by such resident or the party responsible for such resident. Such authorization must be a separate written authorization for each billing from the nursing facility.

8.482.43 MEDICAL LEAVE FROM NURSING FACILITY

A. Definition. “Medical leave” is defined as absence of the resident from the nursing facility due to admittance to a hospital or other institution.

B. Medical leave, as addressed in this section, is subject to the following restrictions:

1. Such absence of the resident must be on the specific orders of a physician, as noted in the resident's chart;

2. There must be a presumption by the doctor and by the resident that the resident will return to the nursing facility;

3. The nursing facility must prepare an AP-5615 showing the dates such medical leave commenced and ended. See 10 CCR 2505-10 section 8.482.34.

4. The resident, or the responsible party if the resident is unable to respond, must be advised, in writing, that payment for holding the nursing facility room cannot be made by Medicaid. In addition, he/she must give written consent to the additional charge, both the daily rate thereof and the anticipated number of days. If the resident is absent from the facility longer than the anticipated number of days shown on the consent form, the nursing facility must obtain agreement on another consent form before continuing to charge for medical leave. The consent form(s) must be retained with other resident records and be subject to audit.

C. Room reservation charges for Medical leave:

1. The per diem charge for room reservations for medical leave cannot exceed the per diem rate currently authorized for the nursing facility, less total food and linen service costs. In no case shall the charge be greater than the current per diem rate less $2.

2. The specific bed which the resident had occupied prior to leave must be reserved. No other resident may occupy a bed so reserved.

3. If no source of payment, other than the resident's funds, are available, and the nursing facility's current occupancy is less than 90 percent of capacity. The room must be reserved at no charge to the resident.

4. Revenues to the nursing facility from room reservations must be used in reduction of related expenses, on the MED-13 form.

5. If no other funds are available, the room reservation charges may be deducted from the resident's personal needs funds, subject to the restrictions in 10 CCR 2505-10 section 8.482.42. However, the resident's personal needs must retain at least $10 at all times, if used for room reservations payment. In case of death of the resident, the entire personal needs account may be used, if necessary.

8.482.44 Room Reservations for Non-Medical and/or Programmatic Leave

Medicaid will pay a nursing facility to hold a bed for non-medical and/or programmatic leave days up to a combined total of 42 days per resident per calendar year.

Non-medical leave days are defined as days of leave from the nursing facility for non-medical reasons. Programmatic leave days are days of leave prescribed by a physician for therapeutic and/or rehabilitative reasons. Programmatic leave may entail visits to family, friends or guardians, or leave to participate in approved therapeutic and/or rehabilitative programs. A leave day is considered to have been incurred for any day during which the resident is absent from the nursing facility for therapeutic and/or rehabilitative purposes and does not return by midnight of that day.

Before Medicaid payment is made for room reservation costs for non-medical and/or programmatic leave, the attending physician must approve each leave and affirm that such leave is not contrary to the resident's written plan of care. In the case of programmatic leave, this approval must be in writing and noted on the resident's chart and/or Individual Habilitation Plan (IHP). In addition, the physician must affirm that the resident's programmatic leave is of therapeutic and rehabilitative value and consistent with the overall plan of care and/or Individual Habilitation Plan developed for the resident.

If the resident has the approval of the attending physician in writing, and such approval is noted on the resident's chart, room reservations for non-medical and/or programmatic leave may be paid for by the resident, after the allowable 42 days per calendar year has been paid from Medicaid funds. Charges to residents for this leave are subject to the following restrictions:

A. Such charges must not commence until after 42 days of non-medical and/or programmatic leave in any one calendar year.

B. The Medicaid Program has not been billed for such leave. Billing both Medicaid and the resident for the same leave period will subject the nursing facility to the penalties as set forth in10 CCR 2505-10 section 8.482.45.

C. The resident or the resident's family must be advised that payment for the nursing facility room cannot be paid from Medical Assistance funds after the resident's allowable leave has been consumed. In addition, the resident and/or legal guardian must give written consent to the room reservation charges, both the daily rate and the anticipated number of days. The consent form must be retained with other resident records and subject to audit.

D. The maximum allowable charge for non-medical and/or programmatic leave is the same as stated for medical leave in paragraph C of 10 CCR 2505-10 section 8.482.43.

E. The specific bed which the resident occupied prior to leave must be reserved. No other resident may occupy a bed so reserved.

F. Revenues to the nursing facility from room reservations must be used in reduction of related expenses, on the MED-13 form.

G. In no case shall the nursing facility deduct non-medical and/or programmatic leave charges from the resident's personal needs account, unless specific authorization has been received, in writing, from the resident and/or legal guardian.

8.482.45 PENALTIES

A. Obtaining vendor payments fraudulently, as outlined in C.R.S. section 26-1-127 (1995 Supp).

B. Obtaining additional payments from residents, or resident's families, as outlined in C.R.S. section 25.5-4-301.

C. License may be revoked according to the provisions of C.R.S. section 25-3-103.

D. Falsification of reports as outlined in C.R.S. section 26-1-127.

E. Incorrect payments due to omission, error or fraud may be recovered as outlined in C.R.S. section 25.5-4-301(2).

F. Duty of resident to report changes in income and penalties for non compliance, as outlined in C.R.S. section 26-2-128.

G. In addition to all penalties imposed above, the Department may also require the reimbursement of the entire amount of any benefits unlawfully obtained.

8.482.46 UTILIZATION OF MEDICARE BENEFITS

A. [Expired 05/15/2016 per House Bill 16-1257]

B. Part “B” deductible and co-insurance amounts for Medicare-eligible Medicaid recipients will be reimbursed by Medicaid. Reimbursement will be made for any service covered by Part “B” of the Medicare program, as described in 42 CFR sections 405.230-.252, even though that service is not ordinarily covered under the medical assistance program. The services paid for by Medicare cannot be included in costs for calculation of the nursing home provider's daily reimbursement rate. If Medicare Part “B” type services are provided by the facility and the facility has a provider number which it used to bill Medicare, then the following entries must be made to the cost report (MED-13):

1. The cost of the care reimbursed by Medicare and/or Medicaid crossover for residents who are Medicaid recipients may be deducted from Schedule “C” of the MED-13 Schedule “B” if the costs for providing that care are determinable and auditable; or

2. The Medicare and/or Medicaid crossover revenue for residents who are Medicare eligible will be deducted from Schedule “C” on Schedule “A”.

C. When the facility provides Medicare Part “B” type services to non-residents of the facility, the following entries must be made to the cost report (MED-13):

1. Cost of the care reimbursed by Medicare and/or Medicaid crossover for non-residents of the facility must be deducted from Schedule “C” of the MED-13 on Schedule “B” if the costs for providing that care are determinable and auditable; or

2. The Medicare and/or Medicaid crossover revenue for non-residents of the facility must be deducted from Schedule “C” on Schedule “A”.

D. Co-insurance and deductible costs for the following services (which are covered by Medicare Part “B”) may be billed to the Medicaid program without prior authorization:

1. Laboratory Services

2. Medical Supplies

3. Durable Medical Equipment

4. Speech Therapy

5. Occupational and Physical Therapy

6. Practitioner Services

E. Facilities or their suppliers when billing the Medicaid program for those services reimbursed by Medicare, are to use the Medicare/Medicaid crossover system of billing. The facility, in order to bill through the Medicare/Medicaid crossover system, needs only to complete a Medicare billing form and indicate on that form that they wish to "accept assignment." A Medicare claim form for a Medicare/Medicaid patient, indicating acceptance of assignment, will cross over to Medicare, and co-insurance and/or deductibles will be paid on a Medicaid remittance advice.

8.482.5 RESIDENT'S PERSONAL NEEDS FUNDS

8.482.51 STATEMENT OF POLICY

A. All residents receiving nursing facility care are allowed to retain the amount of income specified in 10 CCR 2505-10 section 8.110.42 as personal needs funds, to purchase necessary clothing or incidentals. These funds may not be used to supplement the Medicaid nursing facility payment, and such funds cannot be used for any other purpose whatsoever by the nursing facility.

B. Personal needs money is for the exclusive use of the resident as he/she desires. The resident or relatives may not be charged for such items as Chux, tripads, toilet paper, or other nursing facility maintenance items since these items are included in the audited cost described in 10 CCR 2505-10 section 8.442. Other charges which could be disallowed are as follows:

1. Nursing facility maintenance items and nursing care supplies and services.

2. Charges without the following documentation:

   a. vendor receipts;

   b. signed cash receipts; or

   c. statement signed by the resident for any specifically requested over-the-counter drug.

3. Charges which constitute a duplicate payment as defined in10 CCR 2505-10 section 8.482.41.

4. Charges which constitute an additional payment as defined in 10 CCR 2505-10 section 8.482.42.

5. Handling charges, such as personal needs trust account bank service fees.

C. Items not covered by Medicaid, such as personal items, clothing, private room, etc., may be charged to the personal needs account of the resident. However, all of the restrictions of 10 CCR 2505-10 section 8.442.1 apply. In addition, only those items actually requested by the resident may be charged to his/her personal needs funds, and there must be a signed, dated receipt for each such item or service signed by the resident, the resident's conservator, guardian or relative, or by a responsible party, retained in the resident's accounts.

8.482.52 RESPONSIBILITIES OF NURSING FACILITIES

A. General Accounting Practices

1. Nursing facilities must administer a resident personal needs fund for those residents who are unable to or have no desire to handle their own personal needs monies. The nursing facility is obligated to exercise due care in the handling of resident funds per federal regulations.

2. If a resident elects to have the nursing facility handle his/her personal needs monies, a personal needs trust agreement must be entered into and signed by the resident or the resident's legal personal representative. This agreement creates a fiduciary relationship between the nursing facility and the resident which includes the legal rights and responsibilities provided for in C.R.S. section 15-1-101. As a condition of the trust agreement, the nursing home is allowed to return the personal needs allowance portion of the resident's income. (See 10 CCR 2505-10 section 8.110.42).

3. If the resident or responsible party does not elect to have the facility handle the personal needs monies, the resident or responsible party must enter into and sign a personal needs exclusion agreement with the facility.

4. If the total personal needs trust fund balance is less than $50.00, the resident's personal needs trust fund monies may be held in either an interest or non-interest-bearing account with a depository institution or in cash at the facility.

5. If the total personal needs trust fund balance is $50.00 or more, the resident's personal needs funds must be kept in an interest-bearing account. The account can be a checking account, a savings account, or a certificate of deposit.

6. The bank account must be designated as “resident trust funds account.”

7. The funds in the depository institution (most often a bank) must be insured.

8. The personal needs trust monies must not be commingled with either the operating funds of the facility or with any other individual's fund who is not a resident of the facility.

9. The personal needs monies of more than one resident: can be commingled in the same bank account as long as separate accounting records (i.e., subsidiary ledgers) are maintained.

10. No charge for handling such trust accounts may be made to the recipient or to the estate of the recipient at any time. Such expenses should be included as a part of the audited costs as determined in 10 CCR 2505-10 section 8.440.

11. A subsidiary ledger, as specified by the Department, must be kept for each resident for recording personal needs transactions.

12. A reconciliation of the sum of the ledger balances to the bank balance (plus petty cash, if applicable) must be performed on a monthly basis.

13. Deposits and disbursements from the personal needs trust account must be recorded in an accurate amount and in accordance with 10 CCR 2505-10 section 8.482.51.B for purchases and 10 CCR 2505-10 section 8.482.52.F for refunds.

14. Any interest income must be recorded on the ledgers. If the resident trust funds are pooled in one interest - bearing account, the interest earned on the account must be allocated to each resident's account proportionately (i.e., by dividing the individual resident's account balance by the total personal needs trust fund balance then multiplying that quotient times the amount of interest income).

15. The resident shall be notified when his/her personal needs trust fund balance reaches $200 less than the SSI resource limit as provided in 10 CCR 2505-10 section 8.110.53.A

16. This accounting system must be adequate for audit by the representative of the Department, and in accordance with generally accepted accounting principles.

17. All such accounts, original bank statements, and supporting documentation must be available for audit by any authorized employee of the county department. State Department, or agent of the State Department at any time.

18. Personal needs money is the property of the residents and all accounting records, bank accounts and other documents must remain with the nursing facility when ownership is transferred.

B. Bonding Requirements

1. An additional condition of nursing facility participation in the Medicaid program is the purchase of a surety bond as required by C.R.S. section 25.5-6-206(3)(c) The sum of the surety bond must not be less than the personal needs trust fund liability as computed quarterly during interest proration, or the licensed operator (“licensee”) shall otherwise demonstrate to the satisfaction of the Department that the security of the residents' personal needs funds is assured. State owned/operated facilities are bonded separately under the risk management program up to $100,000 and are exempt from this requirement.

2. The effective dates of the surety bond shall be from January of each calendar year through December 31 of the following calendar year. The nursing facility licensee's Medicaid participation shall be terminated immediately upon lapse of such bond.

3. A copy of the Surety Bond Patient Needs Trust Fund (Form MED-181), or the Certificate of Insurance (Surety Bond), fully executed, signed and sealed, shall be filed with the Department within 15 days prior to the effective date thereof.

4. Upon the termination of Medicaid participation of a nursing facility provider for any reason, either voluntarily or through Departmental action, the bond must be kept in effect until the final audits of resident personal needs funds and resident nursing care accounts can be completed by the Department, and until any adjustments required by such audits have been made.

C. Change of Licensed Operator -Requirements

1. When the licensed operator (“licensee”) of a nursing facility is changed, as described in 10 CCR 2505-10 section 8.441.5, it shall be the duty of the new Medicaid provider:

   a. To execute a new personal needs account agreement on behalf of Medicaid residents, as required by this section. The new provider shall furnish proof to the Department that it has properly established resident's personal needs accounts and carried forward the proper balance remaining in each resident's ledger.

b. To post a surety bond as required by C.R.S. section 25.5-6-206 (3)(c). , and 10 CCR 2505-10 section 8.482.52.B. above, or to otherwise demonstrate to the satisfaction of the Department that the security of residents' personal needs funds is assured.

c. Upon notice to the Department that a nursing facility's licensed operator will change or Medicaid participation will be terminated as required in 10 CCR 2505-10 section 8.441.5, the Department may withhold all or part of any monies due the prior nursing facility licensee until the personal needs accounts of the residents have been determined to be correct. If such accounts are found to be deficient, the amount of the bond established by the prior licensee shall be forfeited to the Department, and any additional deficit shall be deducted from such monies due to the prior licensee of fee nursing facility. (See also 10 CCR 2505-10 section 8.444.) The Department will, in such cases, assume the responsibility for proper distribution of such monies to the deficient resident accounts.

2. It shall be the duty of the prior licensee to provide the new licensee written verification, by a public accountant, of the amount of personal needs money being transferred for each resident's personal needs fund. This verification shall include a statement that this amount corresponds to the total of the balances shown on the resident's individual ledger

D. New Admission

When a patient is admitted to a nursing facility for the first time. or transferred from Medicare or private pay, the nursing facility shall set up a new account for personal needs funds, which lists a beneficiary or beneficiaries (with percentages), as specified in A. of this subsection.

E. Readmissions, Transfers from Another Nursing Facility.

1. Upon readmission or transfer of a resident, the nursing facility shall determine the amount of personal needs funds currently in the resident's account in the previous facility, make every effort to obtain such funds, and show this amount as a balance forward in the current ledger. Reconfirmation of the listed beneficiary or beneficiaries shall also be done at this time.

2. Failure to make such effort shall be considered a breach of trust agreement, and may be cause for cancellation of the participation agreement.

3. If, upon making every effort, the current nursing facility is unable to obtain the balance of funds from the resident's previous facility, the current nursing facility should notify the Department immediately. Failure to do so may be construed as a failure to make every effort.

F. Discharge from a Nursing Facility

1. Upon discharge of a resident to the resident's home, to another nursing facility or to the care of a responsible party, the nursing facility shall determine the amount remaining in the personal needs account within 45 days, and make payment of this amount to the resident, responsible party, or transfer these funds to the current nursing facility, if appropriate. Failure to so dispose of the resident's personal needs funds shall render the nursing facility liable for cancellation of the participation agreement or to the penalties as set forth in 10 CCR 2505-10 section 8.482.45, or both. All patient's personal possessions shall also be relinquished, as required by 10 CCR 2505-10 section 8.482.6.

2. At the end of the month in which a resident is discharged to a hospital, the nursing facility shall:

   a) set aside the personal needs allowance of S50 for the resident;

   b) apply the balance of any monies to the established Medicaid rate for the number of days the resident lived in the facility; and

   c) if there is still a balance, transfer the funds to the receiving hospital, if Medicaid is the primary funding source.

   If the resident returns to the same nursing facility, no additional accounting is necessary. If the resident does not return to the same facility, however, disposition of the personal needs funds shall be made as specified in this section.

3. Death of a resident.

   a. The nursing facility is required to determine if:

      1) The nursing facility resident dies intestate (i.e., without a will) with known relatives, or a listed beneficiary, for whom current addresses are known; or

      2) The nursing facility is unsure of the existence of a will or whether there are known relatives and there is no listed beneficiary; or

      3) There is a public administrator in the county in which the death occurred. If not, the nursing facility shall, within ten days from the date of death, contact the Department. It shall then be the responsibility of the Department to turn the funds over to the Colorado State Treasurer for inclusion in the next Great Colorado Payback listing.

      Within 60 days after a resident's death, the facility shall transfer the resident's personal needs funds and a final accounting of the funds to the person responsible for settling the resident's estate or, if there is none, to the resident's heirs in accordance with the provisions of C.R.S. sections 15-1-101 et seq. Within 15 days after receiving the funds, the executor, administrator, or other appropriate representative of the resident's estate shall provide written notice to the Department regarding the receipt of the funds. Upon receipt of the notice, the Department may initiate action to recover the funds pursuant to the provisions of this article.

   b. When a nursing facility resident dies intestate (i.e., without a will) and is known to be without relatives or a listed beneficiary, the nursing facility is required to pay any funds remaining in the personal needs account to the Public Administrator of the county in which the nursing facility resident died. C.R.S. section 15-12-620(4) specifically requires that whenever a person without known heirs dies intestate on the premises of another, the personnel in possession of such premises must give immediate notice thereof to the public administrator or incur liability for any damages that may be sustained through neglect. The Clerk of the District Court should be contacted to obtain the name of the current Public Administrator appointed for the county.

c. In those instances in which the nursing facility resident dies testate (i.e., with a will) the funds in his personal needs account must be transferred to the executor of the estate, unless another person or persons are listed as beneficiaries, in which case the funds can be passed outside the will. Other personal property of the deceased should be given to the executor. C.R.S. section 15-12-711 provides that a personal representative or executor has the same power over the title of the property of the estate as an absent owner.

d. If the proper disposition of the deceased resident's personal needs funds and/or personal property cannot be made, the nursing facility may elect to use the following provisions of the Colorado Small Estate Act to be discharged from further liability.

1) In accordance with C.R.S. sections 15-12-1201 et seq. after ten or more days following the death of a nursing facility resident, a person claiming to be the successor or acting on behalf of all successors of the deceased resident may present an affidavit (Form CPC-40, Rev. 6/81) stating that:

a) The fair market value of the property owned by the decedent and subject to disposition by will or intestate succession, less liens and encumbrances, does not exceed $27,000;

b) At least ten days have elapsed since the death of the decedent;

c) No application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction; and

d) The claiming affiant(s) and successor (s) are entitled to payment of all monies due and to delivery of all tangible personal property.

2) In accordance with C.R.S. section 15-12-1202, the nursing facility administrator is discharged and released from further responsibility once funds or personal property have been released to an individual presenting an affidavit as referenced above. The nursing facility need not inquire as to the truth of the affidavit or of any successor's right to succeed to the deceased resident.

e. The nursing facility shall also require a signed and dated receipt listing all the resident's personal property items released to a successor, as required by 8.482.6.C.

4. Any failure of the nursing facility to properly dispose of the resident's personal needs funds within 90 days of death or discharge will be considered a breach of trust, and may be cause for cancellation of the participation agreement, forfeiture of the required surety bond, and prosecution under the penalties provided in 10 CCR 2505-10 section 8.482.45.

8.482.53 RESPONSIBILITIES OF COUNTY DEPARTMENT

A. It shall be the responsibility of the county department, to explain to the resident the various options for handling the personal needs monies, as well as the resident's rights to such funds. If the resident chooses to allow the nursing facility to hold such funds in trust, the county department is responsible for assuring that the resident assigns all income to the nursing facility. See 10 CCR 2505-10 section 8.482.52.A.2.

B. It shall be the responsibility of the county department, to assure that the nursing facility properly transfers or disposes of the resident's personal needs funds within 45 days of discharge from the nursing facility, or transfer to another nursing facility.

C. The county department shall notify the State Department if they become aware that a nursing facility has retained personal needs funds more than 90 days after the death of a resident.

8.482.54 RESPONSIBILITIES OF THE STATE DEPARTMENT

A. It shall be the responsibility of the State Department to accept and to properly dispose of residual personal needs funds, upon the death of the resident, in any of the following conditions:

1. The resident dies intestate (i.e., without a will), but with known relatives or a listed beneficiary for whom current addresses are unknown;

2. There is no Public Administrator in the county and there are no listed relatives or beneficiaries;

3. The nursing facility is unsure of the existence of a will, or whether there are known relatives.

B. The facility shall be obligated to provide explanation for withholding personal needs funds beyond 90 days after the death of a resident. The Department may apply any or all of the following remedies:

1. Demand immediate return of such funds,-

2. Order an audit of all personal needs accounts;

3. Cancel the participation agreement of such nursing facility.

C. Perform periodic audits of nursing facility accounts. Audits may be performed at such intervals as determined necessary by the Department. Audits will always be performed when a nursing facility is discontinued from the Medicaid program for any reason and when a change of ownership or management occurs.

D. If an audit of personal needs accounts reveals discrepancies the Department, on behalf of the resident, may take administrative action as outlined in Volume 8, Recoveries from Providers; or the Executive Director may refer the case to the appropriate legal authorities. See 10 CCR 2505-10 section 8.482.45.

E. If the nursing facility cannot offer proof that any apparent discrepancies in personal needs accounts have been corrected the Department may withhold payment of nursing care costs in the amount shown due and payable by the audit.

8.482.55 MANAGEMENT OF PERSONAL NEEDS FUNDS BY OTHER THAN RESIDENT

A. For residents unable to manage their own funds due to a physical or mental condition, a conservator, guardian-trustee, or other responsible person may carry out these acts for the resident.

B. Personal needs funds shall not be turned over to persons other than a duly accredited agent or guardian of the resident. With the written consent of the resident (is the resident is able and willing to give such consent) the administrator may turn over personal funds belonging to said resident to a close relative or friend to purchase a particular item. However, a signed, itemized, dated receipt will be required.

8.482.6 PATIENT'S PERSONAL POSSESSIONS

A. The Department rules and regulations are designed to insure that clothing and other property of each resident shall be properly safeguarded and reserved for personal use, and to comply with standards established by CDPHE.

B. The nursing facility shall be responsible for safeguarding personal possessions (including money) and to:

1. Provide a method of identification of the resident's suitcases, clothing, and other personal effects, listing the items on an appropriate form attached to the resident's nursing facility record at the time of admission. Such listings are to be kept current. Any personal effects released to a relative or designated representative of a resident must be delineated in a signed receipt.

2. Provide adequate storage facilities for the resident's personal effects.

3. Exercise careful Judgment in the release of resident's personal property to other than the actual owner, and to secure an itemized statement of release, the signature of the resident, duly authorized agent, or responsible party.

4. Insure that all mail is delivered unopened to the resident to whom it is addressed, except for those residents who have a legal guardian or conservator, other legal arrangement, or have voluntarily given written consent to allow opening such mail, in which case the mail is held, unopened, until delivered to the resident.

C. In the event of death of a resident in the nursing facility, or in a medical institution or on medical leave from a nursing facility, the following rules apply:

1. The nursing facility shall provide the deceased resident's executor, administrator or successor claiming under the Small Estates Act (See 10 CCR 2505-10 section 8.482.F.3.d) with a copy of the resident's personal needs ledger.

2. The nursing facility shall turn over to such responsible party all of the deceased resident's personal property in its possession. All items shown by the personal needs ledger as purchased by or in behalf of the resident must be returned to the responsible party.

3. The responsible party claiming the possessions must sign a dated, itemized receipt for all such items before removal of the items from the nursing facility.

D. In the event of discharge of a resident, all personal possessions and a copy of the personal needs ledger signed and dated by the administrator shall be turned over to the patient, or to the responsible party, as is required for a deceased patient in C above.

8.482.7 NURSING FACILITY RESPONSIBILITY FOR ESTABLISHING PERSONAL NEEDS ACCOUNT

Many nursing facility residents are either unable or unwilling to manage their personal funds and the residents or their families or guardians wish this responsibility to be assumed by the nursing facility. Also, since nursing facility residents who are recipients of Medicaid benefits often have income from Social Security, Supplemental Security Income, Railroad Retirement, or other sources, it is necessary for participating nursing facilities to maintain a system of accounting for Medicaid funds, resident income, and resident's personal needs funds. Such system shall be maintained in accordance with standards required by the Department, and adequate for audit by representatives thereof. The following sections outline a standard system of accounting to be used by participating nursing facilities for these purposes. Any deviation from this system must have written approval of the Department.

8.482.71 REQUIRED ITEMS

A. Book of money receipts in triplicate.

B. Cash receipts journal including columns for nursing facility operating and resident trust cash accounts.

C. Checking accounts for nursing facility operating and resident trust accounts.

D. Cash Disbursements Journal including columns for nursing facility operating and resident trust cash accounts.

E. General Ledger accounts as follows:

1. Cash-General or Operating account

2. Cash-Patient Trust Fund

3. Cash-Patient Trust Imprest Fund

4. Accounts Receivable - Nursing Care (Control Account.)

5. Accounts Payable - Personal Needs Liability (Control Account)

(Note: This is not a complete listing of every account which would normally appear in a General Ledger, but includes the accounts necessary for purposes of this system of accounting.)

F. Subsidiary Ledger for Accounts Receivable-Nursing Care sub-classified by resident name.

G. Subsidiary Ledger for Personal Needs sub-classified by resident name.

H. Personal Needs Cash Paid Out and Personal Needs Cash Request Slips for use with Personal Needs Imprest Fund.

I. Forms for Certificate of no responsibility for resident's personal needs funds and Appointment of Agent and authorization to handle resident's personal needs funds.

J. Cash box or other secure place for petty cash used in Personal Needs Imprest Fund.

8.482.72 GLOSSARY

A. Basic Bookkeeping Terms

1. ACCOUNT -- Basic classification device used in bookkeeping. In a double-entry bookkeeping system, an account consists of a Debit side and a Credit side. Individual accounts within a ledger serve as the basis for financial statements.

2. ACCRUAL OR ACCRUED CHARGE -- A charge arising from an individual or business entity providing goods or services to another individual or entity. An accrual or charge is entered on the Debit side of an individual account. A charge may be accrued in advance of the goods or services provided, or may be accrued afterward, depending upon the basis of accounting used (See ACCRUAL BASIS and/or CASH BASIS)

3. ACCRUAL BASIS -- A basis of accounting wherein revenues are recognized at the time they are "earned" (i.e., at the time goods or services are provided) and expenses are recognized when they are incurred as liabilities. (Opposite of CASH BASIS accounting- See CASH BASIS.)

4. BOOK OF ORIGINAL ENTRY -- An accounting book or record which serves as the point of original entry of accounting transactions recorded. The book of original entry serves as the basis for classification of items to individual accounts. Examples of Books of Original Entry include Cash Receipts Journal, Cash Disbursements Journal, General Journal, etc.

5. CASH BASIS -- A basis of accounting wherein revenues are recognized for accounting purposes at the time they are collected in cash and expenses are recognized at the time that they are paid in cash (Opposite of ACCRUAL BASIS accounting - See ACCRUAL BASIS.)

6. CASH DISBURSEMENTS JOURNAL -- A book of original entry in which transactions involving payments of cash are recorded and summarized for later classification to individual accounts. A Cash Disbursements Journal usually consists of one column for entries to a cash account and another column (or columns) for entries to other accounts affected by the transactions recorded.

7. CASH RECEIPTS JOURNAL -- A book of original entry used to facilitate accounting for receipts of cash by an enterprise. A Cash Receipts Journal usually consists of one column for entries to a cash account and another column (or columns) for entries to other accounts affected by the transactions recorded.

8. CONTROL ACCOUNT -- A general ledger account which summarizes items which are classified in SUBSIDIARY ACCOUNTS or SUBSIDIARY LEDGERS (See SUBSIDIARY ACCOUNT.) The total of the balances in the subsidiary accounts should equal the balance of the control account in the general ledger.

9. CREDIT (Abbreviated CR.) -- In a double-entry bookkeeping system, an entry made on the right-hand side of an account is called a "Credit" entry.

10. DEBIT (Abbreviated DR.) -- In a double-entry bookkeeping system an entry made to the left-hand side of an account is called a "Debit" entry.

11. DOCUMENTATION - Supporting data or proof explaining an entry in the accounting records; e.g., a payment on account may be "documented" by an invoice, cancelled check, etc.

12. DOUBLE ENTRY BOOKKEEPING SYSTEM -- A system of bookkeeping wherein at least two entries are made for every transaction recorded; for each entry made to the “debit” side, a corresponding entry (or entries) must be made to the “credit” side. A double-entry system is used for purposes of proof of accuracy of transactions recorded; total of “debits” must be equal to the total of “credits” for the system to be “in balance.” (See ACCOUNT, DEBIT, and CREDIT.)

13. GAAP -- Generally Accepted Accounting Principles.

14. IMPREST FUND (Also called PETTY CASH FUND) -- A fund set up for the purpose of control over cash transactions; most often used when a large number of small transactions must be made. The balance of an imprest fund is constant, and must consist of either cash or receipts or other documentation showing the use of the cash. An imprest fund is “replenished” periodically when the cash in the fund reaches a low point by removing the receipts, totalling them, and replacing them with the amount of cash spent. An imprest fund is sometimes called a “revolving fund”.

15. LIABILITY -- An “obligation” or “debit” of an individual or business enterprise to pay a sum of money at some future time. Examples of liabilities are accounts payable, notes payable, bonds payable, monies held in a fiduciary or trust capacity, such as the personal trust funds.

16. LEDGER -- A grouping of accounts in a bookkeeping or accounting system. For example, a “general ledger” may contain all the accounts of a business enterprise, while a “subsidiary ledger” may consist of sub-classifications of one particular account in a “general ledger.” (See SUBSIDIARY ACCOUNT or SUBSIDIARY LEDGER.)

17. POSTING -- A basic bookkeeping operation wherein information for accounting records is transferred from one place to another; as in “posting” to the general ledger from the cash receipts journal, etc. Posting is usually a preliminary operation to summarization of data for preparation of financial statements, etc.

18. RECONCILIATION -- An explanation of differences in accounting records for the purpose of ensuring accuracy of the records. An example is the “Reconciliation” of a bank statement balance to the balance in the check book or cash book.

19. SUBSIDIARY ACCOUNT or SUBSIDIARY LEDGER -- An account or group of accounts sub-classifying a particular account in a general ledger which is used with a CONTROL ACCOUNT. An example is Accounts Receivable. The Accounts Receivable would be represented in the general ledger by a control account and sub-classified by name of debtor in a subsidiary ledger. Each account in the subsidiary ledger has an individual balance, and the total of all the balances in the subsidiary ledger should equal to the balance of the control account in the general ledger. (See CONTROL ACCOUNT.)

20. TRIAL BALANCE -- A bookkeeping operation in which balances of all accounts in a ledger are taken and summarized to ascertain that postings of debts equal postings of credits. A “Trial Balance” may also be taken of a subsidiary ledger to be certain that the postings to the subsidiary ledger agree with those to the control account in the general ledger.

21. FIDUCIARY OR TRUST -- A party who is entrusted to conduct the financial affairs of another person.

B. Terms Related to Nursing Facility Bookkeeping

1. BENEFICIARY -- The listed person/persons/charitable institution or other agency a resident has elected to receive the balance of his/her personal needs trust monies in the event of death.

2. CENSUS -- A nursing facility record of admissions and/or discharges of residents within a given time period (examples are 24-hour or “midnight” census, monthly census, etc.) The census is used to determine the number of patient days of care provided by the nursing facility.

3. FISCAL AGENT -- Agency under contract to the State Department of Health Care Policy and Financing for the purpose of disbursing funds to providers of services under the Medicaid Program. The fiscal agent collects eligibility and payment information from the county and state Departments and processes this information for payment to providers (nursing care facilities).

4. FORM AP-5615 -- For purposes of reporting change in patient status, admissions discharges, changes in resident payments, etc. to the county department(s). Commonly referred to as “5615”s.

5. GENERAL (OR OPERATING) ACCOUNT -- May describe either an account in the general ledger (as Cash-Genera] or Operating) or a bank account. Used to record monies due to the nursing facility for care or services provided to the resident, are recorded in this account (as distinguished from a Personal Needs or Resident Trust account, which is used to account for personal funds belonging to residents of a facility).

6. INTESTATE -- A person who dies without leaving a will is said to have died “intestate.”

7. MEDICAID (TITLE XIX) PROGRAM -- Program funded by federal and state governments which provides for nursing facility care for the categorically eligible. It is administered in Colorado through the Department of Health Care Policy and Financing.

8. NURSING CARE (ACCOUNTS RECEIVABLE) ACCOUNT -- Account in a subsidiary patient ledger which is used to record accrued nursing care charges, patient payments, and Medicaid payments for a Medicaid eligible resident.

9. PERSONAL NEEDS ACCOUNT - An account in a subsidiary resident ledger used to record personal needs fund transactions of a resident. Same as “Patient Trust Fund”.

10. PERSONAL NEEDS ALLOWANCE - A nursing facility resident's monthly allowance for spending money and personal items.

11. PERSONAL NEEDS LIABILITY - The liability of a nursing facility or its representatives for funds which the facility is managing on behalf of its residents. If the resident elects to have the facility manage these funds, a fiduciary (trust) capacity is established for the resident, and the facility is responsible to the resident for due care of the funds and sufficient accounting of transactions made by the facility on behalf of the resident.

12. PROVIDER (OR VENDOR) - A nursing facility which provides services to residents under the Medicaid Program. A provider facility must be licensed and certified by various government agencies to become eligible to participate in this program.

13. PUBLIC ADMINISTRATOR -- An appointed government official with various fiduciary responsibilities, including that of disposition of funds of deceased residents with no known heirs. (Nursing facility residents often die without leaving a will and with no known heirs, and their remaining funds are paid to the Public Administrator.)

14. RESIDENT TRUST FUND - Same as “Patients' or Resident's Personal Needs Account”. Most often used as a title for a bank account for residents' personal needs funds.

15. RESIDENT OR PATIENT PAYMENT - The portion of a nursing facility resident's income which is applied toward his/her care at the facility (according to state department regulations, all income received by a resident, with the exception of the monthly personal needs allowance, or the allowable cost with respect to the post -eligibility treatment of income as defined in 10 CCR 2505-10 section 8.110.49, shall be applied toward the resident's care, with the balance paid by Medicaid). A resident's income may be from Social Security, Veterans' Administration, Railroad Retirement, government pensions, an estate or trust, or other sources. The amount of SSI benefits received by a person who is institutionalized is not considered when calculating patient payment.

16. RESPONSIBLE PARTY -- A party who is responsible for a nursing facility resident's financial affairs. A nursing facility, a friend or designated representative, or a county department may be a responsible party, or a resident may act as his/her own responsible party, if he/she is managing his/her own affairs.

17. TESTATE -- A person who dies leaving a will is said to have died “testate.”

18. UB92 CLAIM FORM -- Form utilized by providers to bill nursing facility services.

8.483 ADULT FOSTER CARE - REPEALED

[Repealed effective April 2, 2007]

8.484 HOME CARE ALLOWANCE - REPEALED

[Repealed effective April 2, 2007]

8.485 HOME AND COMMUNITY BASED SERVICES FOR THE ELDERLY, BLIND AND DISABLED (HCBS-EBD) GENERAL PROVISIONS

8.485.10 LEGAL BASIS

The Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-EBD program is also authorized under state law at C.R.S. section 25.5-6-301 et seq. – as amended.

8.485.20 KEYS AMENDMENT COMPLIANCE

All congregate facilities where any HCBS client resides must be in compliance with the "Keys Amendment" as required under Section 1616(e) of the Social Security Act of 1935 and 45 C.F.R. Part 1397 (October 1, 1991), by possession of a valid Assisted Living Residence license issued under C.R.S. section 25-27-105, and regulations of CDPHE at 6 CCR 1011-1, Chapters 2 and 7. C.R.S. section 25-27-105 and 6 CCR 1011-1 are hereby incorporated by reference. The incorporation of C.R.S. section 25-27-105 and 6 CCR 1011-1 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 Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

8.485.30 SERVICES PROVIDED [Eff. 12/30/2007]

.31 HCBS-EBD services provided as an alternative to nursing facility or hospital care include:

A. Adult day services;

B. Alternative care facility services, including homemaker and personal care services in a residential setting; and

C. Consumer Directed Attendant Support Services;

D. Electronic monitoring;

E. Home Delivered Meals;

F. Home modification;

G. Homemaker services;

H. In-Home Support Services;

I. Life Skills Training;

J. Non-medical transportation;

K. Peer Mentorship;

L. Personal care;

M. Respite care; and

N. Transition Setup.

.32 Case management is not a service of the HCBS-EBD waiver program, but shall be provided as an administrative activity through Single Entry Point Agencies.

.33 HCBS-EBD clients are eligible for all other Medicaid state plan benefits, including the Home Health program.

8.485.40 DEFINITIONS OF SERVICES [Eff. 12/30/2007]

A. Adult day services shall be as defined at Section 8.491.

B. Alternative Care Facility services shall be as defined at Section 8.495.

C. Consumer Directed Attendant Support Services (CDASS) shall be defined at Section 8.510.

D. Electronic monitoring services shall be as defined at Section 8.488.

E. Home Delivered Meals services shall be defined at Section 8.553.

F. Home modification shall be as defined at Section 8.493.

G. Homemaker services shall be as defined at Section 8.490.

H. In-Home Support Services shall be as defined at Section 8.552.

I. Life Skills Training (LST) services shall be as defined at Section 8.553.

J. Non-medical transportation services shall be as defined at 10 CCR 2505-10 Section 8.494.

K. Peer Mentorship services shall be defined at Section 8.553.

L. Personal care services shall be as defined at Section 8.489.

M. Respite care shall be as defined at Section 8.492.

N. In-Home Support Services shall be as defined at Section 8.552.

O. Transition Setup services shall be as defined at Section 8.553

8.485.50 GENERAL DEFINITIONS

A. Agency shall be defined as any public or private entity operating in a for-profit or nonprofit capacity, with a defined administrative and organizational structure. Any sub-unit of the agency that is not geographically close enough to share administration and supervision on a frequent and adequate basis shall be considered a separate agency for purposes of certification and contracts.

B. Assessment shall be as defined at Section 8.390.1.B.

C. Case Management shall be as defined at Section 8.390.1.C, including the calculation of client payment and the determination of individual cost-effectiveness.

D. Categorically eligible shall be defined in the HCBS-EBD program as any client eligible for medical assistance (Medicaid), or for a combination of financial and medical assistance; and who retains eligibility for medical assistance even when the client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, but not for medical assistance, or persons who are eligible for HCBS-EBD as three hundred percent eligible persons, as defined at Section 8.485.50.T.

E. Congregate facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.

F. Uncertified Congregate Facility shall be a facility as defined at Section 8.485.50.E. that is not certified as an Alternative Care Facility. See Section 8.495.1.

G. Continued Stay Review shall be a Reassessment as defined at Sections 8.402.60 and 8.390.1.R.

H. Corrective Action Plan shall be as defined at Section 8.390.1.D.

I. Cost containment shall be defined as the determination that, on an individual client basis, the cost of providing care in the community is less than the cost of providing care in an institutional setting. The cost of providing care in the community shall include the cost of providing HCBS-EBD services and long-term home health services.

J. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility type services reimbursed by Medicaid, within forty-five (45) calendar days of admission to HCBS-EBD. These include hospitalized clients who were in a nursing facility immediately prior to inpatient hospitalization and who would have returned to the nursing facility if they had not elected HCBS-EBD.

K. Diverted shall be defined as HCBS-EBD waiver recipients who were not deinstitutionalized.

L. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) shall be defined as services provided in a home or community setting to clients who are eligible for Medicaid reimbursement for long-term care, who would require nursing facility or hospital care without the provision of HCBS-EBD, and for whom HCBS-EBD services can be provided at no more than the cost of nursing facility or hospital care.

M. Intake/Screening/Referral shall be as defined Section 8.390.1.M.

N. Level of care screen shall be as defined as an assessment conducted in accordance with Section 8.401.

O. Provider agency shall be defined as an agency certified by the Department and which has a contract with the Department to provide one or more of the services listed at Section 8.485.40. A Single Entry Point Agency is not a provider agency, as case management is an administrative activity, not a service. Single Entry Point Agencies may become service providers if the criteria in Sections 8.390-8.393 are met.

P. Reassessment shall be as defined at Section 8.390.1.R.

Q. Service Plan means the written document that identifies approved services, including Medicaid and non-Medicaid services, regardless of funding source, necessary to assist a client to remain safely in the community and developed in accordance with the Department rules, including the funding source, frequency, amount and provider of each service, and written on a State-prescribed Long-term Care Plan form.

R. Single Entry Point Agency shall be defined as an organization described at Section 8.390.1.U.

S. The Department shall be defined described in 8.390.1.F.

T. Three hundred percent (300%) eligible shall be defined as persons:

1) Whose income does not exceed 300% of the SSI benefit level; and

2) Who, except for the level of their income, would be eligible for an SSI payment; and

3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program or are in a nursing facility or hospitalized for thirty consecutive days.

8.485.60 ELIGIBLE PERSONS

.61 HCBS-EBD services shall be offered to persons who meet all of the eligibility requirements below provided the individual can be served within the capacity limits in the federal waiver:

A. Financial Eligibility

Clients shall meet the eligibility criteria as stated at Section 8.100. Clients must also meet criteria specified in the Colorado Department of Human Services Income Maintenance Staff Manual, 9 CCR 2503-1, (2018).

B. Level of Care and Target Group

Clients who have been determined to meet the level of care and target group criteria shall be certified by a Single Entry Point Agency as eligible for HCBS-EBD. The Single Entry Point Agency shall only certify HCBS-EBD eligibility for those clients:

1. Determined by the Single Entry Point Agency to meet the target group definition for functionally impaired elderly, or the target group definition for physically disabled or blind adult; and

2. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to Section 8.401.11 through 8.401.15; or

3. Determined by a formal level of care assessment to require the level of care available in a hospital;

4. A length of stay shall be assigned by the Single Entry Point Agency for approved admissions, according to guidelines at Section 8.402.60.

C. Receiving HCBS-EBD Services

1. Only clients who receive HCBS-EBD services, or who have agreed to accept HCBS-EBD services as soon as all other eligibility criteria have been met, are eligible for the HCBS-EBD program.

2. Case management is not a service and shall not be used to satisfy this requirement

3. Desire or need for home health services or other Medicaid services that are not HCBS-EBD services, as listed at Section 8.485.30, shall not satisfy this eligibility requirement

4. HCBS-EBD clients who have received no HCBS-EBD services for one month must be discontinued from the program.

D. Institutional Status

1. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-EBD services while residing in such institutions unless the Single Entry Point Agency determines the client is eligible for EBD as described in Section 8.486.33.

2. A client who is already an HCBS-EBD recipient and who enters a hospital for treatment may not receive HCBS-EBD services while in the hospital. If the hospitalization continues for 30 days or longer, the case manager must terminate the client from the HCBS-EBD program.

3. A client who is already an HCBS-EBD recipient and who enters a nursing facility may not receive HCBS-EBD services while in the nursing facility.

   (a) The case manager must terminate the client from the HCBS-EBD program if Medicaid pays for all or part of the nursing facility care, or if there is a URC-certified ULTC-100.2 for the nursing facility placement, as verified by telephoning the URC.

   (b) A client receiving HCBS-EBD services who enters a nursing facility for respite care as a service under the HCBS-EBD program shall not be required to obtain a nursing facility ULTC-100.2, and shall be continued as an HCBS-EBD client in order to receive the HCBS-EBD service of respite care in a nursing facility.

E. Cost-effectiveness

Only clients who can be safely served within cost containment, as defined at Section 8.485.50, are eligible for the HCBS-EBD program.

F. Waiting List

Persons who are determined eligible for services under the HCBS-EBD waiver, who cannot be served within the capacity limits of the federal waiver, shall be eligible for placement on a waiting list.

1. The waiting list shall be maintained by the Department.

2. The date used to establish the person's placement on the waiting list shall be the date on which eligibility for services under the HCBS-EBD waiver was initially determined.

3. As openings become available within the capacity limits of the federal waiver, persons shall be considered for services based on the following priorities:

   a. Clients being deinstitutionalized from nursing facilities.

   b. Clients being discharged from a hospital who, absent waiver services, would be discharged to a nursing facility at a greater cost to Medicaid.

   c. Clients who receive long-term home health benefits who could be served at a lesser cost to Medicaid.

   d. Clients with high ULTC 100.2 scores who are at risk of imminent nursing facility placement.

8.485.70 START DATE

.71 The start date of eligibility for HCBS-EBD services shall not precede the date that all of the requirements at Section 8.485.60 have been met. The first date for which HCBS-EBD services can be reimbursed shall be the later of any of the following:

A. Financial: The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.

B. Level of Care: This date is determined by the official URC's stamp and the URC-assigned start date on the ULTC 100.2 form.

C. Receiving Services: This date shall be determined by the date on which the client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept services.

D. Institutional Status: HCBS-EBD eligibility cannot precede the date of discharge from the hospital or nursing facility.

.72 The start date for CTS may precede HCBS-EBD enrollment when a client meets the conditions set forth at Section 8.486.33. The start date for CTS shall be no more than 180 calendar days before a client's discharge from a nursing facility.

8.485.80 CLIENT PAYMENT OBLIGATION-POST ELIGIBILITY TREATMENT OF INCOME (PETI)

.81 When a client has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to 10 CCR 2505-10 section 8.100, the Department may reduce Medicaid payment for Alternative Care Facility services according to the procedures at 10 CCR 2505-10 section 8.486.60.

8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES

.91 The Department or its agent shall develop the Prior Authorization Request (PAR) form in compliance with all applicable regulations, and determine whether services requested are (a) consistent with the client's documented medical condition, and functional capacity, (b) reasonable in amount, frequency and duration, (c) not duplicative, (d) not services for which the client is receiving funds to purchase, and (e) do not total more than twenty four (24) hours per day of care.

A. The case manager shall submit prior authorization approvals for all HCBS-EBD services to the fiscal agent within one (1) calendar month after the URC's assigned start date and approval of financial eligibility.

B. The Department or its fiscal agent will approve, deny or return for additional information home modification PARs over $1,000 within ten (10) working days of receipt.

.92 When home modifications are denied, in whole or in part, the Single Entry Point Agency shall notify the client or the client's designated representative of the adverse action and their appeal rights on a state-prescribed form, according to Section 8.057, et. seq.

.93 Revisions requested by providers six months or more after the end date shall always be disapproved.

.94 Approval of the PAR by the Department or its agent shall authorize providers of services under the Service Plan to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. Payment is also conditional upon the client's financial eligibility for long-term care medical assistance (Medicaid) on the dates of service; and upon provider's use of correct billing procedures.

.95 Every PAR shall be supported by information on the Service Plan, the ULTC-100.2 and written documentation from the income maintenance technician of the client's current monthly income. All units of service requested on the PAR shall be listed on the Service Plan.

.96 If a PAR is for an Alternative Care Facility client who is 300% eligible, all medical and remedial care requested as deductions shall be listed on the Client Payment form.

.97 The start date on the Prior Authorization Request form shall not precede the start date of eligibility for HCBS-EBD services, according to Section 8.485.70, except for CTS. A TCA may provide CTS up to 180 days prior to nursing facility discharge when authorized by the Single Entry Point Agency. The TCA is eligible for reimbursement beginning on the first day of the client's HCBS-EBD enrollment.

.98 The PAR shall not cover a period longer than the length of stay assigned by the URC.

Note: Sections 8.485.100 - 8.485.101 were deleted effective 7/1/02.

8.485.200 LIMITATIONS ON PAYMENT TO FAMILY

.201 In no case shall any person be reimbursed to provide HCBS-EBD services to his or her spouse.

.202 Family members other than spouses may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS-EBD program subject to the conditions below. For purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage, adoption or common law.

.203 The family member shall meet all requirements for employment by a certified personal care agency, and shall be employed and supervised by the personal care agency.

.204 The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:

A. The total number of Medicaid personal care units for a member of the client's family shall not exceed the equivalent of 444 hours per annual certification for HCBS-EBD.

1. The maximum number of Medicaid personal care units per annual certification for HCBS-EBD shall include any portions of the Medicaid reimbursement which are kept by the personal care agency for unemployment insurance, worker's compensation, FICA, cost of training and supervision, and all other administrative costs.

2. The maximum number of hours for personal care units HCBS-EBD shall be 444. Family members must average at least 1.2164 hours of care per day (as indicated on the client's Service Plan) in order to receive the maximum reimbursement.

a. If the certification period for HCBS-EBD is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the client is receiving care by the average hours per day of personal care for a full year (444/365=1.2164).

B. If two or more HCBS-EBD clients reside in the same household, family members may be reimbursed up to the maximum for each client if the services are not duplicative and are appropriate to meet the client's needs.

C. When HCBS-EBD funds are utilized for reimbursement of personal care services provided by the client's family, the home care allowance cannot be used to reimburse the family.

D. Restrictions on allowable personal care units shall not apply to parents who provide Attendant services to their eligible children under In-Home Support Services (10 CCR 2505-10 section 8.552).

E. Services other than personal care shall not be reimbursed with HCBS-EBD funds when provided by the client's family, with the exception of Attendant services provided under In-Home Support Services (10 CCR 2505-10 section 8.552).

8.485.300 CLIENT RIGHTS

.301 The case manager shall inform persons eligible for HCBS-EBD, in writing, of their right to choose between HCBS-EBD services and nursing facility or hospital care. In addition, the case manager shall discuss the option and potential benefits of in-home support services with all eligible HCBS-EBD clients.

8.486 HCBS-EBD CASE MANAGEMENT FUNCTIONS

8.486.10 HCBS-EBD PROGRAM REQUIREMENTS FOR SINGLE ENTRY POINT AGENCIES

Single entry point agencies shall comply with single entry point rules at 10 CCR 2505-10 section 8.390, et. seq., governing case management functions, and shall comply with all HCBS-specific requirements in the rest of this section on HCBS-EBD case management functions.

8.486.20 INTAKE

.21 Refer to Section 8.393.2.B for single entry point intake procedures. The intake form shall be completed before an assessment is initiated. The intake form may also be used as a preliminary case plan form when signed by the applicant, for purposes of establishing a start date.

.22 Based upon information gathered on the intake form, the case manager shall determine the appropriateness of a referral for a comprehensive uniform long-term care client assessment (ULTC-100), and shall explain the reasons for the decision on the Intake form. The client shall be informed of the right to request an assessment if the client disagrees with the case manager's decision.

8.486.30 ASSESSMENT

.31 If the client is being discharged from a hospital or other institutional setting, the discharge planner shall contact the URC/SEP agency for assessment by emailing or faxing the initial intake and screening form.

.32 The URC/SEP case manager shall view and document the current Personal Care Boarding Home license, if the client lives, or plans to live, in a congregate facility as defined at Section 8.485.50, in order to ensure compliance with Section 8.485.20.

.33 A SEP may determine that a client is eligible for HCBS-EBD while the client resides in a nursing facility when the client meets the eligibility criteria as established at Section 8.400, et seq., the client requests CTS and the SEP includes CTS in the client’s long-term care plan. If the client has been evaluated with the ULTC 100.2 and has been assigned a length of stay that has not lapsed, the SEP shall not conduct another review when CTS is requested.

8.486.40 HCBS-EBD DENIALS

.41 If a client is determined, at any point in the assessment process, to be ineligible for HCBS-EBD according to any of the requirements at Section 8.485.60, the client or the client's designated representative shall be notified of the denial and the client's appeal rights in accordance with Long-term Care Single Entry Point System regulations at Section 8.393.3.A.

8.486.50 Case Planning

.51 Case planning shall include the following tasks:

A. Documentation of the client's choice of HCBS-EBD services, nursing home placement, or other services, including a signed statement of choice from the client;

B. Documentation that the client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the client understands his/her right to change providers;

C. Except when a client is residing in an alternative care facility, documentation to include a process, developed in coordination with the client, the client's family or guardian and the client's physician, by which the client may receive necessary care if the client's family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The client and the client's family or guardian shall be duly informed of these alternative care provisions at the time the case plan is initiated.

8.486.60 CALCULATION OF CLIENT PAYMENT (PETI)

The case manager shall calculate the client payment (PETI) for 300% eligible HCBS-EBD clients according to the following procedures:

A. For 300% eligible HCBS-EBD clients who are not Alternative Care Facility clients, the case manager shall allow an amount equal to the 300% standard as the client maintenance allowance. No other deductions are necessary and no form is required to be completed.

B. For 300% eligible clients who are Alternative Care Facility clients, the case manager shall complete a State-prescribed form, which calculates the client payment according to the following procedures:

1. An amount equal to the current Old Age Pension standard, including any applicable income disregards, shall be deducted from the client's gross income to be used as the client maintenance allowance, from which the state-prescribed Alternative Care Facility room and board amount shall be paid; and

2. For an individual with financial responsibility for only a spouse, an amount equal to the state Aid to the Needy and Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the client's gross income; or

3. For an individual with financial responsibility for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level less any income of the spouse and/or dependents (excluding pan-time employment earnings of dependent children as defined at 10 CCR 2505-10 section 8.100.1 shall be deducted from the client's gross income; and

4. Amounts for incurred expenses for medical or remedial care for the individual that are not subject to payment by Medicare, Medicaid, or other third party shall be deducted from the client's gross income as follows:

   a. Health insurance premiums if health insurance coverage is documented in the eligibility system and the MMIS; deductible or co-insurance charges; and

   b. Necessary dental care not to exceed amounts equal to actual expenses incurred; and

   c. Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred; and

   d. Medications, with the following limitations:

      1) The need for such medications shall be documented in writing by the attending physician. For this purpose, documentation on the Utilization Review Contractor certification form shall be considered adequate. The documentation shall list the medication; state why it is medically necessary; be; signed by the physician; and shall be renewed at least annually or whenever there is a change.

      2) Medications which may be purchased with the Medical Identification Card shall not be allowed as deductions.

      3) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

      4) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price.

      5) Only the amount spent for medications which exceeds the current Old Age Pension Standard allowance for medicine chest expense shall be allowed as a deduction.

   e. Other necessary medical or remedial care shall be deducted from the client's gross income, with the following limitations:

      1) The need for such care must be documented in writing by the attending physician. For this purpose documentation on the Utilization Review Contractor certification form shall be considered adequate. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and, shall be renewed at least annually or whenever there is a change.

      2) Any service, supply or equipment that is available under regular Medicaid, with or without prior authorization, shall not be allowed as a deduction.

f. Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

g. When the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.

5. Any remaining income shall be applied to the cost of the Alternative Care Facility services, as defined at 10 CCR 2505-10 section 8.495, and shall be paid by the client directly to the facility; and

6. If there is still income remaining after the entire cost of Alternative Care Facility services is paid from the client's income, the remaining income shall be kept by the client and may be used as additional personal needs or for any other use that the client desires, except that the Alternative Care Facility shall not charge more than the Medicaid rate for Alternative Care Facility services.

C. Case managers shall inform HCBS-EBD Alternative Care Facility clients of their client payment obligation on a form prescribed by the state at the time of the first assessment visit; by the end of each plan period; or within ten (10) working days whenever there is a significant change in the diem payment amount.

1. Significant change is defined as fifty dollars ($50) or more.

2. Copies of client payment forms shall be kept in the client files at the single entry point agency, and shall not be mailed to the State of its agent except as required for a prior authorization request, according to 10 CCR 2505-10 section 8.509.31(G), 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 Section 8.485.50.J by using a State-prescribed PAR form to:

A. Determine the maximum authorized costs for all 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 on the original care plan form, must be entered on the revised Prior Authorization Request form, for purposes of reimbursement.

2. The dates on the revision must be identical to the dates of the original PAR, unless the purpose of the revision is to revise the PAR dates.

B. If a revised PAR includes a new request for home modification service above the Department prescribed amount, the revised PAR shall also include all documentation listed at Section 8.493.

.102 DECREASE OF SERVICES ON THE CARE PLAN

A. A revised PAR does not need to be submitted if services on the care plan are decreased or not used, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness.

B. If services are decreased without the client's agreement, the case manager shall notify the client of the adverse action and of appeal rights, according to Long-term Care Single Entry Point System regulations at Section 8.393.3.A.

8.486.200 REASSESSMENT

.201 The case manager shall complete a reassessment of each SEP-managed waiver client before the end of the length of stay assigned by the Utilization Review Contractor at the last level of care determination. The case manager shall initiate a reassessment more frequently if required by single entry point regulations at 10 CCR 2505-10 section 8.393.25, or when warranted by significant changes that may affect HCBS-EBD eligibility.

.202 The case manager shall submit a continued stay review PAR, in accordance with requirements at 10 CCR 2505-10 section 8.485.90. For clients who have been denied by the Utilization Review Contractor at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the approved ULTC 100.2. Acceptable documentation of an appeal includes: (a) a copy of the request for reconsideration or the request for appeal, signed by the client and sent to the Utilization Review Contractor or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by the Utilization Review Contractor or the Office of Administrative Courts to the client; or (c) a copy of the notice of a scheduled court date. Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed, and shall not be accepted as a substitute for the approved ULTC 100.2. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

8.486.300 TERMINATION

.301 In accordance with Long-term Care Single Entry Point System regulations at Section 8.393.28, clients shall be terminated from any SEP-managed waiver whenever they no longer meet one or more of the eligibility requirements at Section 8.485.60. Clients shall also be terminated from the waiver if they die, move out of state or voluntarily withdraw from the waiver.

8.486.400 COMMUNICATION

.401 In addition to any communication requirement specified elsewhere in these rules, the case manager shall be responsible for the following communications:

A. The case manager shall inform all Alternative Care Facility clients of their obligation to pay the full and current State-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.

B. Within five (5) working days of receipt of the approved PAR form, from the fiscal agent, the case manager shall provide copies to all the HCBS-EBD providers in the care plan.

C. Within five (5) working days of receipt from the URC of the certified ULTC 100.2 form, the case manager shall send a copy of the ULTC 100.2 form to all personal care, and adult day services provider agencies on the care plan and to alternative care facilities listed on the care plan.

D. The case manager shall notify the URC, on a form prescribed by the Department, within thirty (30) calendar days, of the outcome of all non-diversions, as defined at Section 8.485.50.

8.486.500 CASE RECORDING/DOCUMENTATION

.501 Case management documentation shall meet all of the standards found at Sections 8,393.2.H.

8.487 HCBS WAIVER PROVIDER AGENCIES

8.487.10 GENERAL CERTIFICATION STANDARDS

.11 Provider agencies shall:

A. Conform to all State established standards for the specific services they provide under this program; and

B. Abide by all the terms of their provider agreement with the Department; and

C. Comply with all federal and state statutory requirements. A provider shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

.12 Provider agencies shall have written policies and procedures for recruiting, selecting, retaining and terminating employees.

.13 Provider agencies shall have written policies governing access to duplication and dissemination of information from the client's records in accordance with C.R.S. Section 26-1-114, as amended. Provider agencies shall have written policies and procedures for providing employees with client information needed to provide the services assigned, within the agency policies for protection of confidentiality.

.14 Provider agencies shall maintain liability insurance in at least such minimum amounts as set annually by the Department of Health Care Policy and Financing and shall have written policies and procedures regarding emergency procedures.

.15 Provider agencies shall have written policies and procedures regarding the handling and reporting of Critical Incidents, including accidents, suspicion of abuse, neglect or exploitation, and criminal activity. Provider agencies shall maintain a log of all complaints and Critical Incidents, which shall include documentation of the resolution of the problem.

.16 Provider agencies shall maintain records on each client. The specific record for each client shall include at least the following information:

A. Name, address, phone number and other identifying information about the client; and

B. Name, address and phone number of the case manager and Single Entry Point Agency; and

C. Name, address and phone number of the client's physician; and

D. Special health needs or conditions of the recipient; and

E. Documentation of the services provided, including where, when, to -whom and by whom the service was provided, and the exact nature of the specific tasks performed, as well as the amount or units of service. Records shall include date, month and year of service, and when applicable, the beginning and the ending time of day; and

F. Documentation of any changes in the client's condition or needs, as well as documentation of appropriate reporting and action taken as a result; and

G. For personal care agencies, documentation concerning advance directives shall be present in the client record; and

H. Documentation of supervision of care; and

I. All information regarding a client shall be kept together for easy access and review by supervisors, program monitors and auditors.

.17 Provider agencies shall maintain a personnel record for each employee. The employee record shall contain at least the following:

A. Documentation of employee qualifications.

B. Documentation of training.

C. Documentation of supervision and performance evaluation.

D. Documentation that the employee was informed of all policies and procedures required by these rules.

E. A copy of the employee's job description.

.18 A provider agency may become separately certified to provide more than one type of HCBS-EBD service if all requirements are met for certification. Administration of the different services provided shall be clearly separate for auditing purposes. The provider agency shall also understand and be able to articulate its different functions and roles as a provider of each service, as well as all the rules that separately govern each of the types of services, in order to avoid confusion on the part of clients and others.

.19 Provider agencies shall send billing and other staff to the provider billing training offered by the fiscal agent, at least once each year.

8.487.20 GENERAL CERTIFICATION PROCESS

.21 An agency, as defined at 10 CCR 2505-10 section 8.485.50, seeking certification as an HCBS-EBD provider agency, shall submit a written request to the Department or its agent

.22 Upon receipt of the written request, the Department or its agent shall forward certification information and relevant state application forms to the requesting agency.

.23 Upon receipt of the completed application from the requesting agency, the Department or its agent shall review the information and complete an on-site review of the agency, based on the state regulations for the service for which certification has been requested.

.24 Following completion of the on-site review the Department or its agent shall notify the provider agency applicant of its recommendation by forwarding the following information:

A. Results of the on-site survey;

B. Recommendation of approval, denial or provisional approval of certification;

C. If appropriate, a corrective action plan to satisfy the requirements of a provisional approval.

.25 Determination of certification approval, provisional approval or denial shall be made by the Department within sixty (60) days of receipt of the completed application from the agency.

8.487.30 APPROVAL OF CERTIFICATION

If certification is approved, the Department shall enter into a provider agreement with the certified agency in accordance with 10 CCR 2505-10 section 8.130.

8.487.40 PROVISIONAL APPROVAL OF CERTIFICATION

.41 If agencies do not meet all state established certification standards, but the deficiencies do not constitute a threat to clients' health and safety such agencies may be provisionally certified for a period not to exceed sixty (60) days at the discretion of the state.

.42 If provisional approval has been granted, the Department or its agent shall assure that corrective action has been taken according to the approved plan, and shall conduct an on-site review, if necessary, within the designated time period.

8.487.50 DENIAL OF CERTIFICATION

If the agency is unable to complete an adequate corrective action plan within the prescribed time, certification shall be denied, in accordance with 10 CCR 2505-10 section 8.130.

8.487.60 RECERTIFICATION PROCESS

The Department or its agent shall follow the same procedures as those followed for certification, as described at 10 CCR 2505-10 section 8.487.20.

8.487.70 TERMINATION OF PROVIDER AGREEMENTS

The Department shall initiate termination of a provider agreement if an agency is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The state shall follow procedures at 10 CCR 2505-10 section 8.130.

8.487.80 EMERGENCY TERMINATION OF PROVIDER AGREEMENTS

Emergency termination of any provider agreement shall be in accordance with procedures at 10 CCR 2505-10 section 8.050.

8.487.90 TRANSFER OF OWNERSHIP

.91 The provider shall notify the Department or its agent within five (5) working days of any change of ownership.'

.92 Upon transfer of ownership of the provider agency or facility, the provider certification may be assigned to the new owner only upon the prior written consent of the Department or its agent. Such assignment of the duties and obligations of the existing certification to the new owner shall be for a period of time determined at the discretion of the Department, but not to extend beyond the current end date of the original certification period.

.93 Upon transfer of ownership, the previous owner's existing provider agreement with the Department is immediately terminated, and the new owner must enter into a new provider agreement.

8.487.100 PROVIDER RIGHTS

The Department shall notify provider agencies in writing of any adverse action taken by the Department against the agency, and shall inform the agency of its appeal rights in accordance with the procedures described in 10 CCR 2505-10 section 8.050.

8.487.200 PROVIDER REIMBURSEMENT

.201 Payment to certified HCBS-EBD providers for services provided to eligible clients shall be made when claims are submitted in accordance with the following procedures:

A. Claims shall be submitted to the fiscal agent on State-prescribed forms provided by the fiscal agent according to 10 CCR 2505-10 section 8.040 and 10 CCR 2505-10 section 8.043: and

B. Claim forms shall be filled out completely and correctly; and

C. Payment shall not exceed Department established limits as described under the reimbursement sections for each HCBS-EBD service; and

D. Payment shall be made only for the service or services for which the agency is certified; and

E. Payment shall be made only for the types and amounts of services that are prior authorized by the Department or its agent; and

F. Payment shall be made only for services provided by persons employed by the agency at the time the services were provided.

.202 Provider agencies shall maintain adequate financial records for all claims, including documentation of services as specified at 10 CCR 2505-10 section 8.040.02, 10 CCR 2505-10 section 8.130, and 10 CCR 2505-10 section 8.487.10.

8.488 ELECTRONIC MONITORING

8.488.10 DEFINITIONS

.11 Electronic monitoring services means the installation purchase or rental of electronic monitoring devices which:

A. enable the individual to secure help in the event of an emergency;

B. may be used to provide reminders to the individual of medical appointments, treatments, or medication schedules;

C. are required because of the individual's illness, impairment or disability, as documented on the ULTC-100 form and the care plan form; and

D. are essential to prevent institutionalization of the individual.

.12 Electronic monitoring provider means a provider agency as defined at 10 CCR 2505-10 section 8.484.50.Q which has met all the certification standards for electronic monitoring services specified below.

8.488.20 INCLUSIONS

.21 Electronic monitoring services shall include personal emergency response systems, medication reminders, or other devices which comply with the definition above and are not included in the non-benefit items below at 10 CCR 2505-10 section 8.488.31.

8.488.30 EXCLUSIONS, RESTRICTIONS AND NON-BENEFIT ITEMS

.31 Electronic monitoring services shall be authorized only for individuals who live alone, or who are alone for significant parts of the day, or whose only companion for significant parts of the day is too impaired to assist in an emergency, and who would otherwise require extensive supervision.

.32 Electronic monitoring services shall be authorized only for individuals who have the physical and mental capacity to utilize the particular system requested for that individual.

.33 Electronic monitoring services shall not be authorized under HCBS if the service or device is available as a state plan Medicaid benefit

.34 The following are not benefits of electronic monitoring services:

A. Augmentative communication devices and communication boards;

B. Hearing aids and accessories;

C. Phonic ears;

D. Environmental control units, unless required for me medical safety of a client living alone unattended;

E. Computers and computer software;

F. Wheelchair lifts for automobiles or vans;

G. Exercise equipment, such as exercise cycles;

H. Hot tubs, Jacuzzis, or similar items.

8.488.40 CERTIFICATION STANDARDS FOR ELECTRONIC MONITORING SERVICES

.41 Electronic monitoring providers shall conform to all general certification standards and procedures at 10 CCR 2505-10 section 8.487, HCBS-EBD PROVIDER AGENCIES.

.42 In addition, electronic monitoring providers shall conform to the following standards for electronic monitoring services:

A. All equipment, materials or appliances used as part of the electronic monitoring service shall carry a UL (Underwriter's Laboratory) number or an equivalent standard. All telecommunications equipment shall be FCC registered

B. All equipment, materials or appliances shall be installed by properly trained individuals, and the installer shall train the client in the use of the device.

C. All equipment, materials or appliances shall be tested for proper for functioning at the time of installation and at periodic intervals thereafter. Any malfunction shall be promptly repaired and equipment shall be replaced when necessary, including buttons and batteries.

D. All telephone calls generated by electronic monitoring equipment shall be toll-free and all clients shall be allowed to run unrestricted tests on their equipment

E. Electronic monitoring providers shall send written information to each client's case manager about the system, how it works, and how it will be maintained

8.488.50 REIMBURSEMENT METHOD FOR ELECTRONIC MONITORING

.51 Payment for electronic monitoring services shall be the lower of the billed charges or the prior authorized amount The unit of reimbursement shall be one unit per service for non-recurring services, or one unit per month for services recurring monthly.

.52 Effective 2/1/99, there shall be no reimbursement under this section for electronic monitoring services provided in uncertified congregate facilities.

8.489 PERSONAL CARE

8.489.10 DEFINITIONS

.11 Personal care services means services which are furnished to an eligible client in the client's home to meet the client's physical, maintenance and supportive needs, when those services are not skilled personal care as described in the EXCLUSIONS section below, do not require the supervision of a nurse, and do not require physician's orders.

.12 Personal care provider means a provider agency as defined at 10 CCR 2505-10 section 8.484.50.Q which has met all the certification standards for personal care providers listed below.

.13 Personal care staff means those employees of the personal care provider agency who perform the personal care tasks.

.14 Skilled personal care means skilled care which may only be provided by a certified home health aide, as further defined at 10 CCR 2505-10 section 8.522, and in the EXCLUSIONS section below.

.15 Unskilled personal care means personal care which is not skilled personal care, as defined above.

8.489.20 GENERAL PERSONAL CARE RULES

.21 Personal care services shall include unskilled personal care as defined under INCLUSIONS for each personal care task listed in 10 CCR 2505-10 section 8.489.30.

.22 EXCLUSIONS AND RESTRICTIONS

A. Personal care services shall not include any skilled personal care, which must be provided as home health aide services or as nursing services under non-HCBS programs. These services as defined under EXCLUSIONS for each personal care task listed in 10 CCR 2505-10 section 8.489.30, shall not be provided as personal care services under HCBS, regardless of the level of the training, certification, or supervision of the personal care employee.

B. Personal care staff shall not perform tasks that are not included under INCLUSIONS for each personal care task listed in 10 CCR 2505-10 section 8.489.30, or tasks that are not listed. For example, personal care staff shall not provide transportation services and shall not provide financial management services. Clients, family, or others may choose to make private pay arrangements with the provider agency for services that are not Medicaid benefits, such as companionship.

C. The amount of personal care that is prior authorized is only an estimate. The prior authorization of a certain number of hours does not create an entitlement on the part of the client or the provider for that exact number of hours. All hours provided and reimbursed by Medicaid must be for covered services and must be necessary to meet the client's needs.

D. Personal care provider agencies may decline to perform any specific task, if the supervisor or the personal care staff feels uncomfortable about the safety of the client or the personal care staff, regardless of whether the task may be included in the INCLUSIONS section for the task.

E. Family members shall not be reimbursed to provide only homemaker services. Family members must provide relative personal care in accordance with 10 CCR 2505-10 SECTION 8.485.200. Documentation of services provided must indicate that the provider is a relative.

8.489.30 SPECIFIC PERSONAL CARE TASKS

.31 The specific personal care tasks shall be authorized and provided according to the following rules.

A. BATHING

1. INCLUSIONS:

Bathing is considered unskilled only when skilled skin care, skilled transfer, or skilled dressing, as described under EXCLUSIONS, is not required in conjunction with the bathing.

2. EXCLUSIONS:

Bathing is considered skilled when skilled skin care, skilled transfer or skilled dressing is required, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2. EXCLUSIONS for transfers at 10 CCR 2505-10 section 8.489.31.K.2, or EXCLUSIONS for dressing at 10 CCR 2505-10 section 8.489.31.G.2.

B. SKIN CARE:

1. INCLUSIONS:

Skin care is considered unskilled only when skin is unbroken, and when any chronic skin problems are not active. Unskilled skin care must be of a preventive rather than a therapeutic nature, and may include application of non-medicated lotions and solutions, or of lotions and solutions not requiring a physician's prescription; rubbing of reddened areas; reporting of changes to supervisor, and application of preventive spray on unbroken skin areas that may be susceptible to development of decubiti. Unskilled skin care does not include any of the care described under skilled skin care in the EXCLUSIONS section below.

2. EXCLUSIONS:

Skin care is considered skilled when there is broken skin, or potential for infection due to a chronic skin condition in an active stage. Skilled skin care includes wound care, dressing changes, application of prescription medications, skilled observation and. reporting, but does not include use of sterile technique.

C. HAIR CARE

1. INCLUSIONS:

Hair care is considered unskilled only when skilled skin care, skilled transfer, or skilled dressing, as described under EXCLUSIONS, is not required in conjunction with the hair care. Hair care under these limitations may include shampooing with non-medicated shampoo or shampoo that does not require a physician's prescription, drying, combing and styling of hair.

2. EXCLUSIONS:

Hair care is considered skilled when skilled skin care, skilled transfer, or skilled dressing, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2. EXCLUSIONS for transfers at 10 CCR 2505-10 section 8.489.31.K.2. or EXCLUSIONS for dressing at 10 CCR 2505-10 section 8.489.31.G.2is required in conjunction with the hair care.

D. NAIL CARE

1. INCLUSIONS:

Nail care is considered unskilled only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the nail care; and only in the absence of any medical conditions that might involve peripheral circulatory problems or loss of sensation. Nail care under these limitations may include soaking of the nails, pushing back cuticles, and trimming and filing of nails.

2. EXCLUSIONS:

Nail care is considered skilled when skilled skin care, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 is required in conjunction with the nail care; and in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation.

E. MOUTH CARE

1. INCLUSIONS:

Mouth care is considered unskilled only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the mouth care. Mouth care under these limitations may include denture care and basic oral hygiene.

2. EXCLUSIONS:

Mouth care is considered skilled when skilled skin care, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 is required in conjunction with the mouth care; or when there is injury or disease of the face, mouth, head or neck; or in the presence of communicable disease; or when the client is unconscious; or when oral suctioning is required.

F. SHAVING

1. INCLUSIONS:

Shaving is considered unskilled only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with shaving; and only an electric razor may be used.

2. EXCLUSIONS

Shaving is considered skilled when skilled skin care, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 is required in conjunction with shaving.

G. DRESSING

1. INCLUSIONS:

Dressing is considered unskilled only when skilled skin care or skilled transfer, as described under EXCLUSIONS, is not required in conjunction with the dressing. Unskilled dressing may include assistance with ordinary clothing; application of support stockings of the type that can be purchased without a physician's prescription; application of orthopedic devices such as splints and braces, or of artificial limbs, if considerable manipulation of the device or limb is not necessary, and if the client is fully trained in the use of the device or limb and is able to instruct the personal care staff.

2. EXCLUSIONS:

Dressing is considered skilled when skilled skin care or skilled transfer, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 or EXCLUSIONS for transfers at 10 CCR 2505-10 section 8.489.31.K.2 is required in conjunction with the dressing. Skilled dressing may include application of anti-embolic or other pressure stockings that can be purchased only with a physician's prescription; application of orthopedic devices such as splints and braces, or of artificial limbs, if considerable manipulation of the device or limb is necessary, or if the client is still learning to use the device or limb.

H. FEEDING

I. INCLUSIONS:

Feeding is considered unskilled only when skilled skin care or skilled dressing, as described under EXCLUSIONS, is not required in conjunction with the feeding, and when oral suctioning is not needed on a stand-by or other basis. Unskilled feeding includes assistance with eating by mouth, using common eating utensils, such as forks, knives and straws.

2. EXCLUSIONS:

Feeding is considered skilled when skilled skin care or skilled dressing, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 or EXCLUSIONS for dressing at 10 CCR 2505-10 section 8.489.31.G.2 is required in conjunction with the feeding, and when oral suctioning is needed on a stand-by or other basis. Syringe feeding is also considered skilled. Feeding is skilled if there is a high risk of choking that could result in the need for emergency measures such as CPR or Heimlich maneuver.

I. AMBULATION

1. INCLUSIONS:

Assistance with ambulation is considered unskilled only when skilled transfers, as described under EXCLUSIONS, are not required in conjunction with the ambulation. In addition, when assisting a client with adaptive equipment, the client must be fully trained in the use of such equipment; and when assisting someone in a cast, there must be no need for observation and reporting to a nurse, and no need for skilled skin care, as described under EXCLUSIONS. Adaptive equipment may include, but is not limited to, gait belts, walkers, canes and wheelchairs.

2. EXCLUSIONS:

Assistance with ambulation is considered skilled when skilled transfers, as described under EXCLUSIONS for transfers at 10 CCR 2505-10 section 8.489.31.K.2 are required in conjunction with the ambulation. In addition, when assisting a client with adaptive equipment, it is considered skilled if the client is still being trained in the use of such equipment; and assisting someone in a cast is considered skilled there is a need for observation and reporting to a nurse, or if there is a need for skilled skin care, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2.

J. EXERCISES

1. INCLUSIONS:

Assistance with exercises is considered unskilled only when the exercises are not prescribed by a nurse or other licensed medical professional. Unskilled assistance with exercise is limited to the encouragement of normal bodily movement, as tolerated, on the par: of the client. Personal care staff shall not prescribe nor direct any type of exercise program for the client.

2. EXCLUSIONS:

Assistance with exercises is considered skilled when the exercises are prescribed by a nurse or other licensed medical professional. This may include passive range of motion.

K. TRANSFERS

1. INCLUSIONS:

Assistance with transfers is considered unskilled only when the client has sufficient balance and strength to assist with the transfer to some extent. Except for Hoyer lifts, adaptive equipment may be used in transfers, provided that the client is fully trained in the use of the equipment and can direct the transfer step by step. Adaptive equipment may include, but is not limited to, gait belts, wheel chairs, tub seats, grab bars.

2. EXCLUSIONS:

Assistance with transfers is considered skilled when the client is unable to assist with the transfer. Use of Hoyer lifts is considered skilled, and use of other adaptive equipment is considered skilled if the client is still being trained in the use of the equipment.

L. POSITIONING

1. INCLUSIONS:

Positioning is considered unskilled only when the client is able to identify to the personal care staff, verbally, non-verbally or through others, when the position needs to be changed; and only when skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the positioning. Positioning may include simple alignment in a bed, wheelchair, or other furniture.

2. EXCLUSIONS:

Positioning is considered skilled when the client is not able to identify to the caregiver when the position needs to be changed, and when skilled skin care, as described under EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 is required in conjunction with the positioning.

M. BLADDER CARE

1. INCLUSIONS:

Bladder care is considered unskilled only when skilled transfer or skilled skin care, as described under EXCLUSIONS, is not required in conjunction with the bladder care. Unskilled bladder care may include assisting the client to and from the bathroom; assistance with bedpans, urinals, and commodes; and changing of clothing and pads of any kind used for the care of incontinence. Emptying of Foley catheter bags or suprapubic catheter bags is considered unskilled only if there is no disruption of the closed system; the personal care staff must be trained to understand what constitutes disruption of the closed system.

2. EXCLUSIONS:

Bladder care is considered skilled whenever it involves disruption of the closed system for a foley or suprapubic catheter, such as changing from a leg bag to a night bag. Care of external catheters is also considered skilled.

N. BOWEL CARE

1. INCLUSIONS:

Bowel care is considered unskilled only when skilled transfer or skilled skincare, as described under EXCLUSIONS, is not required in conjunction with the bowel care. Unskilled bowel care may include assisting the client to and from the bathroom; assistance with bed pans and commodes; and changing of clothing and pads of any kind used for the care of incontinence. Emptying of ostomy bags and assistance with other client-directed ostomy care is unskilled only when there is no need for skilled skin care or for observation and reporting to a nurse.

2. EXCLUSIONS:

Bowel care is considered skilled when skilled transfer or skilled skin care, as described under EXCLUSIONS for transfers at 10 CCR 2505-10 section 8.489.31.K.2 or EXCLUSIONS for skin care at 10 CCR 2505-10 section 8.489.31.B.2 is required in conjunction with the bowel care. Skilled bowel care includes digital stimulation and enemas. Skilled bowel care may include care of ostomies that are new and care of ostomies when the client is unable to self-direct the care, provided that sterile technique is not required.

O. MEDICATION REMINDING

1. INCLUSIONS:

Medication reminding is allowed as unskilled personal care only when medications have been preselected, by the client, a family member, a nurse, or a pharmacist, and are stored in containers other than the prescription bottles, such as medication minders. Medication minder containers must be clearly marked as to day and time of dosage, and must be kept in such a way as to prevent tampering. Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the client, and opening the appropriately marked medication minder container for the client if the client is physically unable to open the container. Medication reminding does not include taking the medication out of the container. These limitations apply to all prescription and all over the counter medications, including pm medications. Any irregularities noted in the preselected medications, such as medications taken too often or not often enough, or not at the correct time as marked on the medication minder container, shall be immediately reported by the personal care staff to a supervisor.

2. EXCLUSIONS:

Medication assistance is considered skilled care and consists of putting the medication in the client's hand when the client can self-direct in the taking of medications.

P. RESPIRATORY CARE

1. INCLUSIONS:

Respiratory care is not considered unskilled. However, personal care staff may clean or change the tubing for oxygen equipment, may fill the distilled water reservoir, and may temporarily remove and replace the cannula or mask from the client's face for purposes of shaving or washing the client's face. Adjustments of the oxygen flow are not allowed.

2. EXCLUSIONS:

Respiratory care is skilled care, and includes postural drainage, cupping, adjusting oxygen flow within established parameters, and suctioning of mouth and nose.

Q. ACCOMPANYING

1. INCLUSIONS:

Accompanying the client to medical appointments, banking errands, basic household errands, clothes shopping, and grocery shopping to the extent necessary and as specified on the care plan is considered unskilled, when all the care that is provided by the personal care staff in relation to the trip is unskilled personal care, as described in these regulations. Accompanying the client to other services is also permissible as specified on the care plan, to the extent of time that the client would otherwise receive personal care services in the home.

Personal care for the purpose of accompanying the client shall only be authorized when a personal care provider is needed during the trip to provide one or more other unskilled personal care services listed in this Section. Accompanying the client primarily to provide companionship is not a covered benefit.

2. EXCLUSIONS:

Accompanying is considered skilled when any of the tasks performed in conjunction with the accompanying are skilled tasks. Accompanying does not include transporting the client.

R. HOMEMAKING

Homemaking, as described at 10 CCR 2505-10 section 8.490, may be provided by personal care staff, if provided during the same visit as unskilled personal care, as described in these regulations.

S. PROTECTIVE OVERSIGHT

1. INCLUSIONS:

Protective oversight is considered unskilled when the client requires stand-by assistance with any of the unskilled personal care described in these regulations, or when the client must be supervised at all times to prevent wandering.

2. EXCLUSIONS:

Protective oversight for standby assistance with personal care tasks is considered skilled if any of the tasks performed are skilled tasks. Protective oversight to prevent wandering is considered skilled if any skilled personal care tasks are performed while providing oversight.

.32 Personal care services as described above may be used to provide respite care for primary care givers, provided that the respite care does not duplicate any care which the primary caregiver may be receiving payment to provide.

8.489.40 CERTIFICATION STANDARDS FOR PERSONAL CARE SERVICES

.41 Personal care provider agencies shall conform to all general certification standards and procedures at 10 CCR 2505-10 section 8.487, HCBS-EBD PROVIDER AGENCIES, and shall meet all the additional personal care certification requirements in this section.

.42 Personal care provider agencies shall assure and document that all personal care staff have received at least twenty hours of training, or have passed a skills validation test, in the provision of unskilled personal care as described above. Training, or skills validation, shall include the areas of bathing, skin care, hair care, nail care, mouth care, shaving, dressing, feeding, assistance with ambulation, exercises and transfers, positioning, bladder care, bowel care, medication reminding, homemaking, and protective oversight. Training shall also include instruction in basic first aid, and training in infection control techniques, including universal precautions. Training or skills validation shall be completed prior to service delivery, except for components of training that may be provided in the client's home, in the presence of the supervisor.

.43 All employees providing personal care shall be supervised by a person who, at a minimum, has received the training, or passed the skills validation test, required of personal care staff, as specified above. Supervision shall include, but not be limited to, the following activities:

A. Orientation of staff to agency policies and procedures.

B. Arrangement and documentation of training.

C. Informing staff of policies concerning advance directives and emergency procedures.

D. Oversight of scheduling, and notification to clients of changes; or close communication with scheduling staff.

E. Written assignment of duties on a client-specific basis.

F. Meetings and conferences with staff as necessary.

G. Supervisory visits to client's homes at least every three months, or more often as necessary, for problem resolution, skills validation of staff, client-specific or procedure-specific training of staff, observation of client's condition and care, and assessment of client's satisfaction with services. At least one of the assigned personal care staff must be present at supervisory visits at least once every three months.

H. Investigation of complaints and critical incidents.

I. Counseling with staff on difficult cases, and potentially dangerous situations.

J. Communication with the case managers, the physician, and other providers on the care plan, as necessary to assure appropriate and effective care.

K. Oversight of record keeping by staff.

.44 A personal care agency may be denied or terminated from participation in Colorado Medicaid, according to procedures found at 10 CCR 2505-10 sections 8.050 through 8.051.44, based on good cause, as defined at 10 CCR 2505-10 section 8.051.01. Good cause for denial or termination of a personal care agency shall include, but not be limited to, the following:

A. Improper Billing Practices: Any personal care/homemaker agency that is found to have engaged in the following practices may be denied or terminated from participation in Colorado Medicaid:

1. Billing for visits without documentation to support the claims billed. Acceptable documentation for each visit billed shall include the nature and extent of services, the care provider's signature, the month, day, year, and the exact time in and time out of the client's home. Providers shall submit or produce requested documentation in accordance with rules at 10 CCR 2505-10 section 8.079.62.

2. Billing for excessive hours that are not justified by the documentation of services provided, or by the client's medical or functional condition. This includes billing all units prior authorized when the allowed and needed services do not require as such time as that authorized.

3. Billing for time spent by the personal care provider performing any tasks that are not allowed according to regulations in this 10 CCR 2505-10 section 8.489. This includes but is not limited to companionship, financial management, transporting of clients, skilled personal care, or delegated nursing tasks.

4. Unbundling of home health aide and personal care or homemaker services, which is defined as any and all of the following practices by any personal care/homemaker agency that is also certified as a Medicaid Home Health Agency, for all time periods during which regulations were in effect that defined the unit for home health aide services as one visit up to a maximum of two and one-half hours:

    a. One employee makes one visit, and the agency bills Medicaid for one home health aide visit, and bills all the hours as HCBS personal care or homemaker.

    b. One employee makes one visit, and the agency bills for one home health aide visit, and bills some of the hours as HCBS personal care or homemaker, when the total time spent on the visit does not equal at least 2 1/2 hours plus the number of hours billed for personal care and homemaker.

    c. Two employees make contiguous visits, and the agency bills one visit as home health aide and the other as personal care or homemaker, when the time spent on the home health aide visit was less than 2 1/2 hours.

    d. One or more employees make two or more visits at different times on the same day, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related, to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled at different times of the day.

    e. One or more employees make two or more visits on different days of the week, and the agency bills one or more visits as home health aide and one or more visits as personal care or homemaker, when any of the aide visits were less than 2 1/2 hours and there is no reason related to the client's medical condition or needs that required the home health aide and personal care or homemaker visits to be scheduled on different days of the week.

f. Any other practices that circumvent these rules and result in excess Medicaid payment through unbundling of home health aide and personal care or homemaker services.

5. For all time periods during which the unit of reimbursement for home health aide is defined as hour and/or half-hour increments, all the practices described in 4 above shall constitute unbundling if the home health aide does not stay for the maximum amount of time for each unit billed.

6. Billing for travel time is prohibited.

B. Refusal to Provide Necessary and Allowed Personal Care or Homemaker Services Without Also Receiving Payment For Home Health Services. A personal care/homemaker agency that is also certified as a Medicaid Home Health Agency may be terminated from Medicaid participation if the agency refuses to provide necessary and allowed HCBS personal care or homemaker services to clients who do not need Home Health services or who receive their Home Health services from a Home Health Agency not affiliated with the personal care/homemaker agency.

C. Prior Termination From Medicaid Participation. A personal care/homemaker agency shall be denied or terminated from Medicaid participation if the agency or its owner(s) have previously been involuntarily terminated from Medicaid participation as a personal care/homemaker agency or any other type of service provider.

D. Abrupt Prior Closure. A personal care/homemaker agency may be denied or terminated from Medicaid participation if the agency or its owner(s) have abruptly closed, as any type of Medicaid provider, without proper prior client notification.

.45 Any Medicaid overpayments to a provider for services that should not have been billed shall be subject to recovery. Overpayments that are made as a result of a provider's false representation shall be subject to recovery plus civil monetary penalties and interest. False representation means an inaccurate statement that is relevant to a claim which is made by a provider who has actual knowledge of the false nature of the statement, or who acts in deliberate ignorance or with reckless disregard for truth. A provider acts with reckless disregard for truth if the provider fails to maintain records required by the department or if the provider fails to become familiar with rules, manuals, and bulletins issued by the State, the Medical Services Board, or the State's fiscal agent.

.46 When a personal care agency voluntarily discloses improper billing, and makes restitution, the State shall consider deferment of interest and penalties in the context of the particular situation.

8.489.50 REIMBURSEMENT

.51 Payment for personal care services shall be the lower of the billed charges or the maximum rate of reimbursement. Reimbursement shall be per unit of one hour. The maximum unit rate shall be adjusted by the State as funding becomes available.

.52 Payment does not include travel time to or from the client's residence.

.53 When personal care services are used to provide respite for unpaid primary care givers, the exact services rendered must be specified in the documentation.

.54 when an employee of a personal care agency provides services to a client who is a relative, the personal care agency shall bill under a special procedure code, in hourly units, using rates and hours which shall not exceed a total cost to Medicaid of more than $13.00 per day when averaged out over the number of days in the plan period.

.55 If a visit by a personal care staff includes some homemaker services, as defined at 10 CCR 2505-10 section 8.490., the entire visit shall be billed as personal care services. If the visit includes only homemaker services, and no personal care is provided, the entire visit shall be billed as homemaker services.

.56 If a visit by a Home Health Aide from a Home Health Agency includes unskilled personal care, as defined in this section, only the Home Health Aide visit shall be billed.

.57 Effective 2/1/99, there shall be no reimbursement under this section for personal care services provided in uncertified congregate facilities. Case managers may submit a written request to the Department for a waiver not to exceed six months for clients receiving these services in uncertified congregate facilities prior to the effective date of this rule. After that time, services shall be discontinued.

.58 Cost Reporting

A. All personal care agencies shall report and submit to the Department cost report information on a Department prescribed form.

B. By dates set forth by the Department, personal care providers shall submit an annual cost report for the provider agency's most recent complete fiscal year or the State fiscal year.

C. Providers that do not comply with 10 CCR 2505-10 section 8.489.58 shall have their Medicaid provider agreement terminated.

8.490 HOMEMAKER SERVICES

8.490.1 DEFINITIONS

Homemaker Provider Agency means a provider agency that is certified by the state fiscal agent to provide Homemaker Services.

Homemaker Services means general household activities provided in the home of an eligible client provided by a Homemaker Provider Agency to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

8.490.2 ELIGIBLE CLIENTS

8.490.2.A. Homemaker Services are available to clients in the Home and Community Based Services waivers for Elderly, Blind and Disabled and Persons with Mental Illness.

8.490.2.B. Homemaker Services are available to clients in the Home and Community Based Services waiver for Persons with Brain Injury when the client is also receiving personal care services.

8.490.3 BENEFITS

8.490.3.A. Covered benefits shall be for the benefit of the client and not for the benefit of other persons living in the home. Services shall be applied only to the permanent living space of the client.

8.490.3.B. Benefits include:

1. Routine light housecleaning, such as dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas.

2. Meal preparation.

3. Dishwashing.

4. Bedmaking.

5. Laundry.

6. Shopping.

7. Teaching the skills listed above to clients who are capable of learning to do such tasks for themselves. Teaching shall result in a decrease of weekly units required within ninety days. If such a savings in service units is not realized, teaching shall be deleted from the care plan.

8.490.3.C. Benefits do not include:

1. Personal care services.

2. Services the person can perform independently.

3. Homemaker services provided by family members per 10 CCR 2505-10 section 8.485.200.F

8.490.3.D. Homemakers Services provided in uncertified congregate facilities are not a benefit.

8.490.4 HOMEMAKER PROVIDER AGENCY RESPONSIBILITIES

8.490.4.A. All providers shall be certified by the Department as a Homemaker Provider Agency.

8.490.4.B. The Homemaker Provider Agency shall conform to all general certification standards and procedures at 10 CCR 2505-10 section 8.487

8.490.4.C. The Homemaker Provider Agency shall assure and document that all staff receive at least eight hours of training or have passed a skills validation test prior to providing unsupervised homemaker services. Training or skills validation shall include:

1. The areas detailed in 10 CCR 2505-10 section 8.490.3.B.

2. Proper food handling and storage techniques.

3. Basic infection control techniques including universal precautions.

4. Informing staff of policies concerning emergency procedures.

8.490.4.D. All Homemaker Provider Agency staff shall be supervised by a person who, at a minimum, has received training or passed the skills validation test required of homemakers, as specified above. Supervision shall include, but not be limited to, the following activities:

1. Train staff on agency policies and procedures.

2. Arrange and document training.

3. Oversee scheduling and notify clients of schedule changes.

4. Conduct supervisory visits to client's homes at least every three months or more often as necessary for problem resolution, staff skills validation, observation of the home's condition and assessment of client's satisfaction with services.

5. Investigate complaints and critical incidents.

8.490.5 REIMBURSEMENT

8.490.5.A. Payment for Homemaker Services shall be the lower of the billed charges or the maximum rate of reimbursement set by the Department. Reimbursement shall be per unit of 15 minutes.

8.490.5.B. Payment does not include travel time to or from the client's residence.

8.490.5.C. If a visit by a home health aide from a home health agency includes Homemaker Services, only the home health aide visit shall be billed.

8.490.5.D. If a visit by a personal care provider from a personal care provider agency includes Homemaker Services, the Homemaker Services shall be billed separately from the personal care services.

8.490.5.E. Each visit shall be billed to the Medicaid fiscal agent with the following documentation to be retained at the provider agency

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.

8.491 ADULT DAY SERVICES

8.491.1 Definitions

Adult Day Services (ADS) Center is a certified center that provides Basic Adult Day Services and Specialized Adult Day Services to participants.

Adult Day Services (ADS) are provided in an Adult Day Services Center or through Non-Center-Based means including Telehealth, on a regularly scheduled basis, as specified in the Person Centered Care Plan, promoting social, recreational, physical, and emotional well-being that encompasses the supportive services needed to ensure the optimal wellness of the participant.

A. Basic Adult Day Services (ADS) Center means a community-based entity that provides basic Adult Day Services in conformance with all state established requirements as described in 10 CCR 2505-10 section 8.130 and 10 CCR 2505-10 section 8.491.

B. Center-Based Adult Day Services are services provided in a certified ADS Center.

C. Non-Center-Based Adult Day Services are services that may be provided outside of the certified ADS Center, where participants can engage in activities and community life, either in-person or through virtual means.

D. Specialized Adult Day Services (SADS) Center means a community-based entity providing Adult Day Services for participants with a primary diagnosis of dementia related diseases, Multiple Sclerosis, Brain Injury, chronic mental illness, Intellectual and Developmental Disabilities, Huntington's Disease, Parkinson's, or post-stroke participants, who require extensive rehabilitative therapies. To be designated as specialized, two-thirds of an ADS Center's population must have a diagnosis which is one of any of the above diagnoses. Each diagnosis must be verified by a Licensed Medical Professional, either directly or through Case Management Agency documentation, in accordance with Section 8.491.14.A.

E. Telehealth Adult Day Services are provided through virtual means in a group or on an individual basis. Telehealth ADS are ways for participants to engage in activities, with their community, and connect to staff and other ADS participants virtually or over the phone, only if a participant does not have access or the ability to use video chat technology. Services provided through Telehealth are not required to provide nutrition services.

Care Plan means the individualized goal-oriented plan of services, supports, and preferences developed collaboratively with the participant and/or the designated or legal representative and the service provider, as outlined in 10 CCR 2505-10 8.495.6.F.

Designated Representative means a representative who is designated by the participant to act on the participant's behalf, as defined in 10 CCR 2505-10 Section 8.500.1.

Direct Care Staff means staff who provide hands-on care and services, including personal care, to participants. Direct Care Staff must have the appropriate knowledge, skills and training to meet the individual needs of the participants before providing care and services. Training must be completed prior to the provision of services, as outlined in 10 CCR 2505-10 8.491.4.I.

Director means any person who owns and operates an ADS Center or SADS Center or is a managing employee with delegated authority by ownership to manage, control, or perform the day-to-day tasks of operating the Center as described in 10 CCR 2505-10 Section 8.491.

Licensed Medical Professional (LMP) means a medical professional that possesses one or more of the following Colorado licenses, which must be active and in good standing: Physician, Physician Assistant, Registered Nurse (RN) or Licensed Practical Nurse (LPN) governed by the Colorado Medical License Act, and as defined in 10 CCR 2505-10 Section 8.503.

Participant means any individual found to be eligible for and enrolled in Center-Based or Non-Center-Based Adult Day Services regardless of payment source.

Provider means a service agency enrolled with the Department to provide Center-Based and/or Non-Center-Based Adult Day Services.

Qualified Medication Administration Personnel (QMAP) means an individual that has completed training, passed a competency evaluation, and is included in the Colorado Department of Public Health and Environment's (CDPHE) public list of individuals who have passed the requisite competency evaluation, as outlined in 6 CCR 1011-1 Chapter 24.

Restraint means any physical or chemical device, application of force, or medication, which is designed or used for restricting freedom of movement, and/or modifying, altering, or controlling behavior, excluding medication prescribed by a physician as part of an ongoing treatment plan or pursuant to a diagnosis.

Staff means a paid or voluntary employee or contracted professional of the ADS Center or SADS Center.

Universal Precautions refers to a system of infection control that prevents the transmission of communicable diseases. Precautions include, but are not limited to, disinfecting of instruments, isolation and disinfection of environment, use of personal protective equipment, hand washing, and proper disposal of contaminated waste.

8.491.2 PARTICIPANT BENEFITS

8.491.2.A. Adult Day Services

1. Only participants whose needs can be met by the ADS provider within its certification category and populations served may be admitted by the ADS provider.

2. ADS shall include, but are not limited to, the following:

    a. Monitoring to ensure participants are maintaining activity levels and goals set forth in the Care Plan, pursuant to Section 8.491.4.E; and assistance with activities of daily living (ADL) as needed when ADS is provided in-person. (ADLs include but are not limited to eating, ambulation, positioning, transferring, toileting, and incontinence care).

    b. Services provided to monitor the participant's health status, monitor or administer medications (administration of medication only during the in-person delivery of services), and carry out physicians' orders as set forth in participant's individual Care Plan.

    c. Center-Based ADS must be provided in an integrated, community-based setting, which, supports participation and engagement in community life and gaining access to the greater community; participants may engage in meaningful activities in integrated and community settings.

    d. Emergency services including written procedures to meet medical crises.

    e. Activities that assist in the development of self-care capabilities, personal hygiene, and social support services.

    f. Nutrition services including therapeutic diets and snacks in accordance with the participant's individual Care Plan and hours of attendance. Nutrition services are not required during the delivery of Non-Center-Based ADS.

    g. Social and recreational supportive services as appropriate for each participant and their needs, as documented in the participant's Care Plan. Activities shall take into consideration individual differences in age, health status, sensory deficits, religious affiliation, interests, abilities, and skills by providing opportunities for a variety of types and levels of involvement.

    h. Participants have the right to choose not to participate in social and recreational activities.

8.491.2.B. Adult Day Service Requirements

1. The participant's Care Plan must include documentation of their diagnosis(es) and service goals.

2. A Specialized Adult Day Services (SADS) provider must verify all Medicaid participant's diagnosis(es) using the Professional Medical Information Page (PMIP) which shall be supplied by the case manager or documentation from the participant's Licensed Medical Professional (LMP). Documentation must be verified at the time of admission and whenever there is a significant change in the participant's condition. Any significant change must be recorded in the participant's record or Care Plan.

    a. For participants from other payment sources, diagnosis(es) must be documented in a care plan, or other admission form, and verified by the participant's physician or LMP. This documentation must be verified at the time of admission, and whenever there is a significant change in the participant's condition.

8.491.3 PROVIDER REQUIREMENTS

A. General

1. ADS providers shall conform to all provider participation requirements, as defined in 10 CCR 2505-10 Section 8.130. ADS Centers shall have in effect all required licenses, certifications, and insurance, as applicable. ADS Center providers shall comply with ADS Center regulations and Life Safety Code (LCS) regulations, as determined by the Colorado Division of Fire Protection and Control.

2. ADS providers shall be Medicaid certified by the Department as an ADS provider, in accordance with 10 CCR, 2505-10 Section 8.487.20. Proof of Medicaid certification consists of a completed Provider Agreement approved by the Department and the Department's fiscal agent, and recommendation for certification by CDPHE.

    a. Certification shall be denied, revoked, suspended, or terminated when a Provider is unable to meet, or adequately correct deficiencies relating to, certification standards as defined at 10 CCR 2505-10 section 8.491.

3. The Department or its designee will review an ADS Center's designation as a Specialized Adult Day Services (SADS) Center at the time of initial approval and during the recertification survey.

4. Denial, termination, or non-renewal of the Provider Agreement shall be for "Good Cause" as defined in 10 CCR 2505-10 section 8.076.

5. All providers of ADS shall operate in full compliance with all applicable federal, State and local laws, ordinances and regulations related to fire, health, safety, zoning, sanitation and other standards prescribed in law or regulations. This includes certification of building use occupancy.

8.491.4 PROVIDER ROLES AND RESPONSIBILITIES

A. Environment

1. All ADS providers must comply with the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Settings Final Rule requirements, 42 C.F.R. § 441.301(c)(4). This includes:

a. ADS Center must be integrated in and supports full access of individuals to the greater community;

b. ADS provider is selected by the individual from among setting options including non-disability specific settings;

c. ADS provider ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;

d. ADS provider optimizes individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact; and

e. ADS provider facilitates individual choice regarding services and supports, and who provides them.

2. ADS Centers presumed to have institutional qualities will be subject to heightened scrutiny and reviewed by the Department and CMS, per 42 C.F.R. § 441.301(a)(2)(v). Settings in which this may apply include but are not limited to those where:

a. The provision of inpatient institutional treatment within a publicly or privately-operated facility happens within the same building.

b. Located on the grounds of, or adjacent to, a public institution.

c. The effect of isolating participants receiving Medicaid Home and Community Based Services (HCBS) from the broader community.

2. If an ADS Center is subject to heightened scrutiny, Medicaid reimbursement by the Department may not be issued if the center fails CMS's heightened scrutiny review or until CMS approves the center.

3. ADS Centers shall provide a clean and sanitary environment that is free of obstacles that could pose a hazard to participant health and safety, allowing individuals the freedom to safely move about inside and outside the ADS Center.

4. ADS Centers shall provide lockers or a safe and secure place for participants' personal items.

5. ADS Centers shall provide recreational areas and recreational activities appropriate to the number and needs of the participants, at the times desired by the participants.

6. ADS Centers shall ensure the following are physically accessible to the participants at all times during hours of operation:

a. Access to drinking water and other beverages;

b. Bathrooms, sinks, and paper towel dispensers or hand dryers;

c. Appliances and equipment used by or in the delivery of activities offered by the ADS Center, such as, tables/desks and chairs at a convenient height and location; and

d. Free from obstructions such as steps, lips in doorways, narrow hallways, limiting individuals' mobility in the ADS Center. If obstructions are present, environmental adaptations are to be made to allow for participant access.

7. ADS Centers must provide for a private shower and/or bathing area located on site to address the emergency hygiene needs of participants as needed.

8. To accommodate the activities and program needs of the ADS Center, the center must provide eating and activity areas that are consistent with the number and needs of the participants being served, which is at a minimum of 40 square feet per participant.

9. ADS Centers shall maintain a comfortable temperature throughout the center. At no time shall the temperature fall outside the range of 68 degrees to 76 degrees Fahrenheit.

10. ADS Centers must provide an environment free from restraints.

11. ADS Centers, in accordance with 10 CCR 2505-10 section 8.491.4.A above, must provide a safe environment for all participants, including participants exhibiting behavioral problems, wandering behavior, or limitations in mental/cognitive functioning.

B. Food Safety Requirements

1. ADS providers shall comply with all applicable local food safety regulations. In addition, all ADS Centers must ensure:

a. Access to a handwashing sink, soap and disposable paper towels;

b. Food handlers, cooks and servers, including participants engaged in food preparation, properly wash their hands using proper hand-washing guidelines;

c. The ADS Centers do not allow any staff or participants who are not in good health and free of communicable disease to handle, prepare or serve food or handle utensils;

d. Refrigerated foods opened or prepared and not used within 24 hours are marked with a "use by" or "discard by" date. The "use by" or "discard by" date may not exceed 7 days following opening or preparation, or exceed or surpass the manufacturer's expiration date for the product or its ingredients;

e. For food service, foods are maintained at the proper temperatures at all times. Foods that are stored cold must be held at or below 41 degrees Fahrenheit and foods that are stored hot must be held at or above 135 degrees Fahrenheit in order to control the growth of harmful bacteria;

f. Kitchen and food preparation equipment are maintained in working order and cleanable; and

g. Any equipment or surfaces used in the preparation and service of food are washed, rinsed and sanitized before use or at least every 4 hours of continual use. Dish detergent must be labeled for its intended purpose. Sanitizer must be approved for use as a no-rinse food contact sanitizer. Sanitizers must be registered with the Environmental Protection Agency (EPA) and used in accordance with labeled instructions.

C. Medication Administration and Monitoring

1. All medications shall be administered by Qualified Medication Administration Personnel (QMAP) staff, LMP staff or self-administered, regardless of the location where services are rendered.

2. Center-Based and Non-Center-Based ADS providers shall require each staff person who administers medication, that is not a LMP, to have completed training, passed a competency evaluation and be included in the Colorado Department of Public Health and Environment's (CDPHE) public list of individuals who have passed the QMAP competency evaluation, as outlined in 6 CCR 1011-1 Chapter 24.

3. All medication, when stored and administered by the ADS provider, shall be stored in a locked cabinet when unattended by QMAP or LMP staff.

4. Non-prescription medications, when stored by the ADS provider, shall be labeled with the recipient's name, and shall not be taken by any other participants.

5. A QMAP shall not conduct feeding or administer medication through a gastrostomy tube or administer intravenous, intramuscular or subcutaneous injections.

D. Records and Information

1. All ADS providers shall keep records and information necessary to document the services provided to participants receiving Adult Day Services. Records shall include but not be limited to:

   a. Name, address, gender, and date of birth of each participant;

   b. Name, address and telephone number of designated representative and/or emergency contact;

   c. Name, address and telephone number of primary physician;

   d. Documentation of the supervision and monitoring of services provided;

   e. Documentation that all participants and their designated representatives (if any) were oriented to the ADS Center, their policies and procedures, to the services provided by the ADS provider, and delivery methods offered.;

   f. A service agreement signed by the participant and/or the designated representative and appropriate staff; and

   g. For SADS providers only, a copy of the PMIP, or diagnosis documentation from the participant's LMP;

   h. Documentation specifically stating the types of services and monitoring that are provided when rendered via Telehealth, ensuring the integrity of the service provided and the benefit the service provides the participant.

E. Care Plan

1. The following information must be documented in the Care Plan and used to direct the participant's care and must be reviewed annually.

a. Medical Information:

i. All medications the participant is taking, including those while receiving Center-Based or Non-Center-Based ADS, and whether they are being self-administered;

ii. Special dietary considerations, instructions, or restrictions;

iii. Services that are administered to the participant while receiving Center-Based and/or Non-Center-Based ADS (may include nursing or medical interventions, speech therapy, physical therapy, or occupational therapy);

iv. Any restrictions on social and/or recreational activities identified by participant's LMP; and

v. Any other special health or behavioral management services or supports recommended to assist the participant by the participant's LMP.

b. Care Planning Documentation:

i. Documentation that the provider was selected by the individual and/or designated representative or legal representative;

ii. Individual choices, including location and delivery method for ADS, preferences, and needs shall be incorporated into the goals and services outlined in the Care Plan;

iii. All participant information and the Care Plan are considered protected health information and shall be kept confidential; and

iv. Participant and/or designated representative or legal representative must review and sign the Care Plan.

c. Modifications to the Care Plan must be supported by a specific and assessed need. Informed consent and proper documentation in the Care Plan are required for any changes including but not limited to:

i. Identification of the specific and individualized assessed need; and

ii. Documentation of any intervention and/or additional supports offered to support the participant appropriately.

d. Documentation that the participant and/or designated representative was provided with written information about the participant's right to establish an advance directive.

e. Documentation as to whether the participant has executed an advance directive or other declaration regarding medical decisions. Such documentation shall be maintained in the participant's record.

f. All entries into the record shall be legible, written in ink, dated, and signed with name and title designation, or records shall be maintained electronically with electronic signatures in accordance with standards for electronic medical record keeping practices.

F. Critical Incident Reporting

1. A Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a participant. A Critical Incident may endanger or negatively impact the mental and/or physical well-being of a participant. Critical Incidents include, but are not limited to:

   a. Death;

   b. Abuse/neglect/exploitation;

   c. Serious injury to participant or illness of participant;

   c. Damage or theft of participant's property;

   d. Medication mismanagement;

   e. Lost or missing person; and

   f. Criminal activity.

2. A provider must submit a verbal or written report of a Critical Incident to the HCBS participant's Case Management Agency (CMA) case manager within 24 hours of discovery of the actual or alleged incident. The report must include:

   a. Participant name;

   b. Participant Medicaid identification number;

   c. Waiver;

   d. Incident type;

   e. Date and time of incident;

   f. Location of incident;

   g. Persons involved;

   h. Description of incident; and

   i. Resolution, if applicable.

3. If any of the above information is not available within 24 hours of incident and not reported to the CMA case manager, a follow-up to the initial report must be completed.

G. Staff Requirements

1. In determining appropriate staffing levels, the ADS provider shall adjust staffing ratios based on the individual acuity and needs of the participants being served. At a minimum, staffing must be sufficient in number to provide the services outlined in the Care Plans, considering the individual needs, level of assistance, and risks of accidents. A staff person can have multiple functions, as long as they meet the definition of Direct Care Staff defined at 10 CCR 2505-10, Sections 8.491.1. Staff counted in the staff-participant ratio are those who are trained and able to provide direct services to participants.

a. Staffing for Center-Based and in person Non-Center-Based ADS shall be no less than the following standard:

i. A minimum of 1 staff to 8 participants with continuous supervision of participants during program operation.

b. Staffing for Telehealth ADS shall be no less than the following standard:

i. A minimum of 1 staff to 15 virtual participants with continuous virtual supervision of participants during Telehealth program operation.

c. Staff shall provide the following:

i. Immediate response to emergency situations to assure the safety, health and welfare of participants;

ii. Activities that are planned to support the plans of care for the participants; and

iii. Administrative, recreational, social, and supportive functions and duties.

d. Nursing services for regular monitoring of the on-going medical needs of participants and the supervision of medications. These services must be available a minimum of two hours daily during Center-Based ADS, and as needed for Non-Center-Based ADS, and must be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Certified Nursing Assistant's (CNA) may provide nursing services under the direction of a RN or an LPN, in conformance with nurse delegation provisions outlined in CRS 12-38-132. Supervision of CNAs must include documented consultation and oversight on a weekly basis or more according to the participant's needs. If the supervising RN or LPN is an ADS provider staff member, with consultation and oversight of CNAs included in the member's job description, the supervising nurse's documented attendance shall be sufficient to document consultation and oversight.

2. In addition to the above services, Specialized Adult Day Services (SADS) Centers shall have sufficient staff to provide nursing services during all hours of operation.

a. Nursing services must be provided by a licensed RN or LPN or by a CNA under the supervision of an RN or LPN, as per 10 CCR 2505-10 section 8.491.4.G.1.e above and employed or contracted by the SADS Center.

3. The ADS provider shall require any individual seeking employment with that agency to submit to a criminal history record check to ascertain whether the individual seeking employment has been convicted of a felony or misdemeanor that involves conduct that the provider determines could pose a risk to the health, safety or welfare of participants.

4. The criminal history record check shall, at a minimum, include a search of criminal history in the State of Colorado and be conducted not more than 90 days prior to employment of the individual.

5. In assessing whether to employ an applicant with a felony or misdemeanor conviction, the ADS provider shall consider the following factors:

a. The history of convictions, pleas of guilty or no contest,

b. The nature and seriousness of the crimes;

c. The time that has elapsed since the conviction(s);

d. Whether there are any mitigating circumstances; and

e. The nature of the position for which the applicant would be employed.

6. The ADS provider shall develop and implement policies and procedures regarding the employment of any individual who is convicted of a felony or misdemeanor to ensure that the individual does not pose a risk to the health, safety and welfare of the consumer.

H. Director Qualifications

1. All Directors hired or designated after January 1, 2019, shall meet one of the following qualifications:

a. At least a bachelor's degree from an accredited college or university and a minimum of two years of social services or health services experience and shall have demonstrated ability to perform all aspects of the position; or

b. A licensure by the state of Colorado as a Licensed Practical Nurse or Registered Nurse and completion of two years of paid or volunteer experience in planning or delivering health or social services including experience in supervision and administration; or

c. A high school diploma or GED equivalent, a minimum of four years of experience in a social services or health services setting, skills to work with aging adults or adults with functional impairment, and skills to supervise ADS Center staff persons.

I. Training Requirements

1. All ADS staff and volunteers must be trained in the ADS provider's programmatic policies and procedures.

2. ADS providers providing medication administration as a service must have QMAP staff qualified in accordance with C.R.S. 6 CCR 1011-1 Chapter 24, unless medications are administered only by LMPs.

3. All staff and volunteers must be trained in the use of universal precautions and infection control, as defined at 10 CCR 2505-10 section 8.491.1.

4. The ADS Director and staff must receive training specific to the needs and diagnoses of the participants served. Training may include, but is not limited to: behavioral expression and management techniques, effective communication techniques, redirection, cardiopulmonary resuscitation, validation theory and communication, seizure response, and brain injuries.

a. Documentation of staff member and Director trainings must include, but is not limited to: training provided, who completed trainings, who conducted trainings, and completion date.

5. All ADS staff must be trained in the handling of emergency services including written procedures to meet medical crises, and natural and manmade disasters.

6. All required training must be documented, and documentation must be maintained in individual staff's personnel files. Each staff person's training must be up-to-date.

J. Written Policies

1. The ADS provider shall have written policies and procedures relevant to its operation. Such policies shall include, but not be limited to, statements describing:

a. Admission criteria for participants who can be appropriately served by the ADS provider;

b. Intake procedures conducted for participants and/or designated representatives prior to admission with the ADS provider;

c. The meals and nourishments including special diets that are provided;

d. The hours and days that Center-Based ADS are open and available, and the days and times that Non-Center-Based ADS are available to participants, including the availability of nursing services;

e. Medication administration and storage;

f. The personal items that the participants may bring with them to the ADS Center;

g. Emergency services including written procedures to meet medical crises, and natural and manmade disasters; and

h. The administration of Telehealth Adult Day Services, if provided. This includes telehealth options, provision of services, and examples of virtually offered services.

2. There shall be a written, signed agreement between the participant and/or designated representative and the ADS provider outlining the rules and responsibilities of the ADS provider and the participant. Each party in the agreement shall be provided a copy.

K. Exclusions

1. The delivery of a meal, workbook, activity packet, etc. does not constitute rendered ADS and therefore are not reimbursable, unless in-person ADS service was provided in addition to the delivery of food or item.

8.491.5 REIMBURSEMENT METHOD FOR ADULT DAY SERVICES

A. Reimbursement for ADS for participants in the HCBS Elderly, Blind and Disabled (EBD) waiver, Community Mental Health Supports waiver (CMHS), and the Spinal Cord Injury (SCI) waiver is to be billed in accordance with the current rate schedule:

1. Providers may bill in 15-minute units or for 1-2 units of 3-5-hours depending on the participant's needs and how the service is delivered. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 12 units or three (3) hours per day of Basic Adult Day Services. A provider may bill the maximum of 15-minute units for ADS in combination with no more than 1 unit of 3-5 hour ADS on the same day, as long as services were rendered at separate times.

B. For persons in the HCBS waiver for Persons with a Brain Injury (BI), reimbursement for BI-ADS is to be billed in accordance with the current rate schedule.

1. A unit is defined as the following:

a. Providers may bill in units of 15 minutes or a unit of 2 or more hours depending on the participant's needs and how the service is delivered. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 8 units or two (2) hours per day of services. Units of 2 hours or more can only be delivered in-person. A provider cannot bill for 15-minute units of ADS if a unit of 2-hour BI ADS was provided on the same day.

C. ADS Centers are permitted to utilize funding from other Federal sources, such as the Child and Adult Care Food Program (CACFP), in addition to the Medicaid per diem. If such funding is utilized, a Center must acknowledge the use of multiple funding sources and demonstrate that Federal funds are not used in a duplicative manner to Medicaid-funded services.

D. Only providers certified as a Specialized Adult Day Services Center are permitted to receive the SADS reimbursement rate, for participants needing SADS. The SADS reimbursement rate applies to every participant at a SADS Center, even if the participant does not have a specialized diagnosis.

E. Certified SADS providers may provide Non-Center-Based Adult Day Services, including Telehealth ADS, billing only for Basic Adult Day Services using the 15-minute unit, up to 3 hours per day. The SADS provider may bill the maximum of 15-minute units for Basic ADS in combination with no more than 1 unit of 3-5 hour SADS on the same day, as long as services were rendered at separate times.

F. Providers shall not bill for services on the same day of service for a participant in an HCBS residential program, unless the following criteria have been met:

1. ADS and residential services have been authorized by the Department and are included on the prior authorization request (PAR);

2. Participant's diagnoses must meet the criteria for a SADS Center;

3. Documentation from the participant's physician demonstrating the required specialized services in the SADS Center are necessary because of the qualifying diagnosis(es), are essential to the care of the participant, and are not included in the residential per diem;

4. Documentation that the extensive rehabilitative therapies and therapeutic needs of the participant are not being met by the residential program and are not included in the residential per diem; and

5. Documentation from the participant's physician recommending SADS and how it will meet the previously mentioned needs.

8.492 RESPITE CARE

8.492.10 DEFINITIONS

.11 Respite care means services provided to an eligible client on a short-term basis because of the absence or need for relief of those persons normally providing the care.

.12 Respite care provider means a Class I nursing facility, an alternative care facility, or respite care provided in a residence by an employee of a certified personal care agency which meets the certification standards for respite care specified below.

8.492.20 INCLUSIONS

.21 A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite client, as ordered by the physician.

.22 An alternative care facility shall provide all the alternative care facility services as listed at 10 CCR 2505-10 section 8.495, which are required by the individual respite client.

8.492.30 RESTRICTIONS

.31 An individual client shall be authorized for no more than thirty (30) days of respite care in each certification period unless otherwise authorized by the Department.

.32 Alternative care facilities shall not admit individuals for respite care who are not appropriate for alternative care facility placement, as specified at 10 CCR 2505-10 section 8.495.

.33 Only those portions of the facility that are Medicaid certified for nursing facility or alternative care facility services may be utilized for respite clients.

8.492.40 CERTIFICATION STANDARDS AND PROCEDURES

.41 Respite care standards and procedures for nursing facilities are as follows:

A. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. Such contract shall constitute automatic certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.

B. The nursing facility does not have to maintain or hold open separately designated beds for respite clients, but may accept respite clients on a bed available basis.

C. For each HCBS-EBD respite client, the nursing facility must provide an initial nursing assessment, which will serve as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the client. The chart must identify the client as a respite client. If the respite stay is for fourteen (14) days or longer, the MDS must be completed.

D. An admission to a nursing facility under HCBS-EBD respite does not require a new ULTC-100.2, a PASRR review, an AP-5615 form, a physical, a dietitian assessment, a therapy assessment, or labwork as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than fourteen (14) days.

E. The nursing facility shall have written policies and procedures available to staff regarding respite care clients. Such policies could include copies of these respite rules, the facility's policy regarding self administration of medication, and any other policies and procedures which may be useful to the staff in handling respite care clients.

F. The nursing facility should obtain a copy of the ULTC-100.2 and the approved Prior Authorization Request (PAR) form from the case manager prior to the respite client's entry into the facility.

.42 Respite care standards and procedures for alternative care facilities are as follows:

A. The alternative care facility shall have a valid contract with the Department as a Medicaid certified HCBS-EBD alternative care facility provider. Such contract shall constitute automatic certification for HCBS-EBD respite care.

B. For each respite care client, the alternative care facility shall follow normal procedures for care planning and documentation of services rendered.

.43 Individual respite care providers shall be employees of certified personal care agencies. Family members providing respite services shall meet the same competency standards as all other providers and be employed by the certified provider agency.

8.492.50 REIMBURSEMENT

.51 Respite care reimbursement to nursing facilities shall be as follows:

A. The nursing facility shall bill using the facility's assigned respite provider number, and on the HCBS-EBD claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four hour day of respite provided by the nursing facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

C. Reimbursement shall be the lower of billed charges or the average weighted rate for administrative and health care for Class I nursing facilities in effect on July 1 of each year.

.52 Respite care reimbursement to alternative care facilities shall be as follows:

A. The alternative care facility shall bill using the alternative care facility provider number, on the HCBS-EBD claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four hour day of respite provided by the alternative care facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

C. Reimbursement shall be the lower of billed charges; or the maximum Medicaid rate for alternative care services, plus the standard alternative care facility room and board amount prorated for the number of days of respite.

.53 Individual respite providers shall bill according to a unit rate or daily institutional Nursing Facility rate, whichever is less.

.54 The respite care provider shall provide all the respite care that is needed, and other HCBS-EBD services shall not be reimbursed during the respite stay.

.55 There shall be no reimbursement provided under this section for respite care in uncertified congregate facilities.

8.493 HOME MODIFICATION

8.493.1 DEFINITIONS

Case Management Agency (CMA) means an agency within a designated service area where an applicant or client can obtain Case Management services. CMAs include Single Entry Points (SEP), Community Centered Boards (CCB), and private case management agencies.

Case Manager means an individual employed by a CMA who is qualified to perform the following case management activities: determination of an individual client's functional eligibility for the Home and Community Based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such client's needs.

Department means the Department of Health Care Policy and Financing.

The Division of Housing (DOH) is a State entity within the Department of Local Affairs that is responsible for approving Home Modification PARs, oversight on the quality of Home Modification projects, and inspecting Home Modification projects, as described in 10 CCR 2505-10 section 8.493.

Eligible Client means a client who is enrolled in the following Home and Community-Based Services (HCBS) waivers: Brain Injury, Spinal Cord Injury, Community Mental Health Supports, or Elderly, Blind and Disabled.

Home Modification means specific modifications, adaptations or improvements in an Eligible Client's existing home setting which, based on the client's medical condition:

1. Are necessary to ensure the health, welfare and safety of the client, and

2. Enable the client to function with greater independence in the home, and

3. Are required because of the client's illness, impairment or disability, as documented on the ULTC-100.2 form and the care plan; and

4. Prevents institutionalization or supports the deinstitutionalization of the client.

Home Modification Provider means a provider agency that has met all the standards for Home Modification described in 10 CCR 2505-10 section 8.493.5.B and is an enrolled Medicaid provider.

Person-Centered Planning as applies to Home Modifications means that Home Modifications shall be agreed upon through a process that is driven by the individual client and can include people chosen by the client, as well as the appropriate health care professionals, providers, and appropriate state and local officials or organizations. The home modification process provides necessary information, support, and choice to the client to ensure that the client directs the process to the maximum extent possible. Client choice shall be documented throughout according to Department prescribed processes and procedures.

8.493.2 BENEFITS

8.493.2.A. Home Modifications, adaptations, or improvements may include but are not limited to the following:

1. Installing or building ramps.

2. Installing grab-bars and installing other Durable Medical Equipment (DME) project if such installation cannot be performed by a DME supplier.

3. Widening doorways.

4. Modifying bathrooms.

5. Modifying kitchen facilities.

6. Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and supplies.

7. Installing stair lifts or vertical platform lifts.

8. Modifying an existing second exit or egress window for emergency purposes.

   a. The modification of a second exit or egress window must be approved by the Department or its agent as recommended by an occupational or physical therapist (OT/PT) for the health, safety, and welfare, of the client.

8.493.2.B. Previously completed home modifications, regardless of original funding source, shall be eligible for maintenance or repair within the client's remaining lifetime cap while remaining subject to 8.493.3, Exceptions and Restrictions.

8.493.2.C. There shall be a lifetime cap of $14,000 per client. The Department may authorize funds in excess of the client's lifetime cap if there is:

1. An immediate risk of the client being institutionalized; or

2. A significant change in the client's needs since a previous home modification.

8.493.3 EXCEPTIONS AND RESTRICTIONS

8.493.3.A. Home Modifications must be a direct benefit to the client as defined in 10 CCR 2505-10 Section 8.493.1 and not for the benefit or convenience of caregivers, family members, or other residents of the home.

8.493.3.B. Duplicate adaptations, improvements, or modifications are not a benefit. This includes, but is not limited to, multiple bathrooms within the same home.

8.493.3.C. Adaptations, improvements, or modifications as a part of new construction costs are not a benefit.

8.493.3.D. The purchase of Durable Medical Equipment (DME) is not a benefit.

8.493.3.E. The Department may deny requests for Home Modification projects that exceed usual and customary charges or do not meet local building requirements, the LTSS Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards. The LTSS Home Modification Benefit Construction Specifications (2016) are hereby incorporated by reference. The incorporation of these guidelines excludes later amendments to, or editions of, the referenced material. The 2016 LTSS Home Modification Benefit Construction Specifications can be found on the Department website. Pursuant to §24-4-103(12.5), C.R.S., 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.

8.493.3.F. Home Modification projects are not a benefit in any type of certified or non-certified congregate facility, as defined in 10 CCR 2505-10 Section 8.485.50.F and G.

8.493.3.G. Volunteer work on a Home Modification project approved by the Department shall be completed under the supervision of the Home Modification Provider as stated on the bid.

1. Volunteer work performed by Department-approved organizations must be described according to Department prescribed processes and procedures. A list of these organizations can be found on the Department website.

2. Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or family member, or work performed by a private contractor hired by the client or family, must be described and agreed upon, in writing, by the provider responsible for completing the home modification, according to Department prescribed processes and procedures.

8.493.3.H. If a client lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by the Fair Housing Act, the client's Home Modification funds may not be used unless reasonable accommodations have been denied. The Fair Housing Act (42 U.S.C. § 3601, et seq.)(1995) is hereby incorporated by reference. The incorporation of this Act excludes later amendments to, or editions of, the referenced material. Pursuant to §24-4-103(12.5), C.R.S., 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.

8.493.4 CASE MANAGEMENT AGENCY RESPONSIBILITIES

8.493.4.A. The Case Manager shall consider alternative funding sources to complete the Home Modification, including, but not restricted to those sources identified and recommended by the Department and DOH on the Department website. These alternatives and the reason they are not available shall be documented in the case record.

1. The Case Manager must confirm that the client is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by the Fair Housing Act.

8.493.4.B. The Case Manager may approve Home Modification projects estimated at less than $2,500 without prior authorization, contingent on client authorization and confirmation of Home Modification fund availability.

8.493.4.C. The Case Manager shall obtain prior approval by submitting a Prior Authorization request form (PAR) to the Department for Home Modification projects estimated at between $2,500 and $14,000.

1. The Case Manager must submit the required PAR and all supporting documentation according to Department prescribed processes and procedures. Home Modifications submitted with improper documentation are not authorized.

2. The Case Manager and CMA are responsible for retaining and tracking all documentation related to a client's home modification lifetime cap use and communicating that information to the client and providers. The Case Manager may request confirmation of a client's home modification lifetime cap use from the Department, its fiscal agent, or DOH.

8.493.4.D. Home Modifications estimated to cost $2,500 or more shall be evaluated according to the following procedures:

1. An occupational or physical therapist (OT/PT) shall assess the client's needs and the therapeutic value of the requested Home Modification. When an OT/PT with experience in Home Modification is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Home Modification would contribute to a client's ability to remain in or return to his/her home, and how the Home Modification would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.

2. The evaluation services may be provided by a home health agency or other qualified and approved OT/PT through Medicaid Home Health consistent with Home Health rules set forth in Section 8.520, including physician orders and plans of care.

    a. A Case Manager may initiate the OT/PT evaluation process before the client has been approved for waiver services, as long as the client is Medicaid eligible.

    b. A Case Manager may initiate the OT/PT evaluation process before the client physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.

3. The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the client's needs. The Case Manager shall document these alternatives in the client’s case file.

8.493.4.E. The Case Manager shall solicit bids according to the following procedures:

1. The Case Manager shall solicit bids from at least two Home Modification Providers.

    a. The Case Manager must verify that the provider is an enrolled Home Modification Provider.

    b. The bids must be submitted according to Department prescribed processes and procedures as found on the Department website.

2. The bids shall include a breakdown of the costs of the project including:

    a. Description of the work to be completed.

    b. Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour.

    c. Estimate for building permits, if needed.

    d. Estimated timeline for completing the project.

    e. Name, address and telephone number of the Home Modification Provider.

    f. Signature, including option for digital signature, of the Home Modification Provider.

g. Signature, including option for digital signature, of the client or other indication of approval.

h. Signature, including option for digital signature, of the homeowner or property manager if applicable.

3. Home Modification Providers have a maximum of thirty (30) days to submit a bid for the Home Modification project after the Case Manager has solicited the bid.

a. If the Case Manager has made three attempts to obtain a written bid from a Home Modification Provider and the Home Modification Provider has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the PAR.

5. The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation with the PAR to the Department. The Department shall authorize the lowest bid that complies with the requirements of Section 8.493 and the recommendations of the OT/PT evaluation.

a. If a client or homeowner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the PAR.

6. A revised PAR and Change Order request shall be submitted according to the procedures outlined in this section for any changes from the original approved PAR according to Department prescribed processes and procedures.

8.493.4.F. If a property to be modified is not owned by the client, the Case Manager shall obtain signatures from the homeowner or property manager on the submitted bids authorizing the specific modifications described therein. Signatures may be completed using a digital signature based on preference of the individual signing the form.

1. Written consent of the homeowner or property manager, as evidenced by the above-mentioned signatures, is required for all projects that involve permanent installation within the client's residence or installation or modification of any equipment in a common or exterior area.

2. If the client vacates the property, these signatures evidence that the homeowner or property manager agrees to allow the client to leave the modification in place or remove the modification as the client chooses. If the client chooses to remove the modification, the property must be left equivalent or better to its pre-modified condition. The homeowner or property manager may not hold any party responsible for removing all or part of a home modification project.

8.493.4.G. If the CMA does not comply with the process described above resulting in increased cost for a home modification, the Department may hold the CMA financially liable for the increased cost.

8.493.4.H. The Department or its agent may conduct on-site visits, or any other investigations deemed necessary prior to approving or denying the Home Modification request.

8.493.5 PROVIDER RESPONSIBILITIES

8.493.5.A. Home Modification Providers shall conform to all general certification standards and procedures set forth in 10 CCR 2505-10 section 8.487.11.

8.493.5.B. Home Modification Providers shall be licensed in the city or county in which they propose to provide Home Modification services to perform the work proposed, if required by that city or county.

8.493.5.C. Home Modification Providers shall begin work within sixty (60) days of signed approval from the Department. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original deadline period and be supported by documentation, including client notification. Reimbursement may be reduced for delays in accordance with Section 8.493.6.F.

1. If any changes to the approved scope of work are made without Department authorization, the cost of those changes will not be reimbursed.

2. Projects shall be completed within thirty (30) days of beginning work. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original deadline period and be supported by documentation, including client notification. Reimbursement may be reduced for delays in accordance with Section 8.493.6.F.

8.493.5.D. The Home Modification Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work and perform work covered under that warranty at their expense.

8.493.5.E. The Home Modification Provider shall comply with the LTSS Home Modification Benefit Construction Specifications developed by the DOH, which can be found on the Department website, and with local, and state building codes.

8.493.5.F. All Home Modification projects within a Department-established sampling threshold shall be inspected upon completion by DOH, a state, local or county building inspector or a licensed engineer, architect, contractor or any other person as designated by the Department. Home Modification projects may be inspected by DOH upon request by the client at any time determined to be reasonable by DOH or the Department. Clients must provide access for inspections.

1. DOH shall perform an inspection within fourteen (14) days of receipt of notification of project completion or receipt of a client's reasonable request.

2. DOH shall produce a written inspection report within three (3) days of performing an inspection that notes the client's specific complaints. The inspection report shall be sent to the client, Case Manager, and provider.

3. Home Modification providers must repair or correct any noted deficiencies within twenty (20) days or the time required by the inspection, whichever is shorter. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original deadline period and be supported by documentation, including client notification. Reimbursement may be reduced for delays in accordance with Section 8.493.6.D.

8.493.5.G. Copies of building permits and inspection reports shall be submitted to DOH. In the event that a permit is not required, the Home Modification Provider shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be justification for recovery of payment by the Department.

8.493.6 REIMBURSEMENT

8.493.6.A. Payment for Home Modification services shall be the prior authorized amount or the amount billed, whichever is lower. Reimbursement shall be made in two payments per Home Modification.

8.493.6.B. The Home Modification Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.

8.493.6.C. The Home Modification Provider may submit a claim for final payment when the Home Modification project has been completed satisfactorily as shown by the submission of the documentation below to DOH:

1. Signed lien waivers for all labor and materials, including lien waivers from sub-contractors;

2. Required permits;

3. One year written warranty on materials and labor; and

4. Documentation in the client's file that the Home Modification has been completed satisfactorily through:

    a. Receipt of inspection report approving work from the building inspector or other inspector as referenced at 10 C.C.R. 2505-10, Section 8.493.5.F;

    b. Approval by the client, representative, or other designee;

    c. Approval by the home owner or property manager;

    d. By conducting an on-site inspection; or

    e. DOH acceptance of photographs taken both before and after the Home Modification.

8.493.6.D. If DOH notifies a Home Modification Provider that an additional inspection is required, the Home Modification Provider may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.

8.493.6.E. The Home Modification Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Modification Provider Bid form or Home Modification Provider Change Order form.

1. All recommended repairs noted on inspections shall be completed before the Home Modification Provider submits a final claim for reimbursement.

2. If a Home Modification Provider has not completed work satisfactorily, DOH shall determine the value of the work completed satisfactorily by the Provider during an inspection. The Provider shall only be reimbursed for the value of the work completed satisfactorily.

    a. A Home Modification Provider may request DOH perform one (1) redetermination of the value of the work completed satisfactorily. This request may be supported by an independent appraisal of the work, performed at the Provider's expense.

8.493.6.F. Reimbursement may be reduced at a rate of 1% (one percent) of the total project amount every seven (7) calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies inspection deficiencies.

1. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original deadline period and be supported by documentation, including client notification.

2. The home modification reimbursement reduced pursuant to this subsection shall be incorporated into the computation of the client's remaining lifetime cap.

8.493.6.G. The Home Modification Provider shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the client. The Home Modification Provider may be reimbursed for the installation of DME if such installation is outside of the scope of the client's DME benefit.

8.494 NON-MEDICAL TRANSPORTATION

8.494.1 DEFINITIONS

Non-Medical Transportation (NMT) services means transportation which enable eligible clients to gain physical access to non-medical community services and supports, as required by the care plan to prevent institutionalization.

Non-Medical Transportation Provider (provider) means a provider agency that has met all of the standards and requirements as specified in subsection 8.494.40 of this regulation.

Medicaid Client Transport (MCT) Permit means a permit that is issued to a Non-Medical Transportation provider by the Public Utilities Commission (PUC).

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 supports such as Adult Day Centers, shopping, activities that encourage community integration, therapeutic swimming, counseling sessions not covered by State Plan, 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 10 CCR 2505-10 sections 8.680 through 8.691.

.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 PROVIDER STANDARDS FOR NON-MEDICAL TRANSPORTATION SERVICES

.41 Transportation providers shall conform to all general standards and procedures set forth within Department regulations 10 CCR 2505-10 sections 8.494 and 8.487 with the following exceptions:

A. Existing Non-Medical Transportation providers have until January 1st, 2018 to fully comply with section 8.494 regarding the new Medicaid Provider and MCT Permit applications.

.42 Transportation providers shall ensure that all drivers possess a valid Colorado driver's license, are 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.

.43 Transportation providers shall ensure that all vehicles and related auxiliary equipment shall meet all applicable federal, state, and local safety inspection and maintenance requirements, and transportation providers shall be in compliance with commercial liability insurance requirements and PUC financial responsibility requirements, as set forth in section 40-10.1-107, C.R.S.

.44 Provider and Driver Qualifications:

A. Each Provider must have and maintain a valid MCT Permit from the PUC, as required by section 40-10.1-302, C.R.S.; and

B. Each Provider must maintain safe and functioning vehicles, free of deficiencies, and in compliance with PUC safety rules as required by 4 C.C.R. 723-6, § 6100-6199; and

C. Each Provider shall ensure that all drivers, prior to providing NMT services, have been qualified based upon the results of the statutorily required criminal history record check as conducted via the PUC, as outlined in Section 40-10.1-110, C.R.S.

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 Provider charges shall not accrue when the recipient is not physically present in the vehicle.

.54 Providers shall not bill for services before they are an approved Medicaid provider and may bill only for those NMT services performed by a driver that has been qualified based upon the results of the statutorily required criminal history record check.

.55 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.

.56 A bus pass or other public conveyance may be used only when it is more cost effective than, or comparable to, the applicable service type and duration. Costs cannot exceed the total Wheelchair Van, Mileage Band 1 allowable per service plan. The most current HCBS Rate Schedule can be found on the Department website.

8.495 ALTERNATIVE CARE FACILITIES

8.495.1 DEFINITIONS

Alternative Care Facility (ACF) authorized in 25.5-6-303(3), C.R.S., means an Assisted Living Residence as defined at 6 CCR 1011-1, Chapter VII, Section 2, which has been licensed by the Colorado Department of Public Health and Environment (CDPHE) and has been certified by the Department to provide Alternative Care Services and Protective Oversight to Medicaid participants.

Alternative Care Services as described in 25.5-6-303(4), C.R.S., means, but is not limited to, a package of personal care and homemaker services provided in a state licensed and certified alternative care facility including: assistance with bathing, skin, hair, nail and mouth care, shaving, dressing, feeding, ambulation, transfers, positioning, bladder & bowel care, medication reminding and monitoring, accompanying, routine housecleaning, meal preparation, bed making, laundry, and shopping. Alternative Care Services also includes Medication Administration.

Care Plan means the individualized goal-oriented plan of services, supports, and preferences developed collaboratively with the participant and/or the designated or legal representative and the service provider, as outlined in 6 CCR 1011-1, Chapter VII, Section 2 and , Section 8.495.6.F.

Direct Care Staff means staff who provide hands-on care and services, including personal care, to participants. Direct Care Staff must have the appropriate knowledge, skills and training to meet the individual needs of the participants before providing care and services. Training must be completed prior to the provision of services, as outlined in 6 CCR 1011-1, Chapter VII, Section 7.9 and 6 CCR 1011-1, Chapter VII, Section 7.16.

Medication Administration as described in 25-1.5-301, C.R.S., means assisting a participant with taking medications while using standard healthcare precautions, according to the legibly written or printed order of an attending physician or other authorized practitioner. Medication administration may include assistance with ingestion, application, inhalation, and rectal or vaginal insertion of medication, including prescription drugs. Provider must document and keep record of each medication administered, including the time and the amount taken. “Administration” does not include judgment, evaluation, assessment, or the injections of medication, the monitoring of medication, or the self-administration of medication, including prescription drugs and including the self-injection of medication by the participant.

Non-Medical Leave Days mean days of leave from the ACF by the participant for non-medical reasons such as family visits.

Programmatic Leave Days mean days of leave from the ACF prescribed for a participant by a physician for therapeutic and/or rehabilitative purposes.

Protective Oversight means care and service as defined at 6 CCR 1011-1, Chapter VII, Section 2 and , Section 8.489.31.S., which includes the monitoring and guidance of a participant to assure their health, safety, and well-being, and a general awareness of a participant’s whereabouts. Protective oversight also includes but is not limited to: monitoring the participant while on the premises, monitoring the participant’s needs, and ensuring that the participant receives the services and care necessary to protect the participant’s health and welfare.

Provider means the entity that holds the Assisted Living Residence/Facility license and certification and shall be responsible or delegate responsibility to appropriate staff for the delivery of Alternative Care Services.

Resident Agreement means a written agreement specifying at a minimum the services to be provided, charges and refund policies, written disclosures of information, discharge procedures, and management of participant funds/property, which shall be signed by the participant and/or participant’s guardian or other legal representative as outlined in 6 CCR 1011-1, Chapter VII, Section 11.3-6.

Secured Environment means an ACF that operates as defined in 6 CCR 1011-1, Chapter VII Section 2.

8.495.2 PARTICIPANT ELIGIBILITY

A. Participants in the Home and Community Based Services (HCBS) Elderly, Blind and Disabled waiver pursuant to , Section 8.485 and the HCBS Community Mental Health Supports waiver pursuant to , Section 8.509 are eligible to receive services in an Alternative Care Facility.

B. Potential participants shall be assessed, at a minimum, by a team that includes the participant and/or guardian or other legal representative, the ACF administrator or appointed representative, and Case Management Agency (CMA) case manager. If one of the parties listed above is not available, input or information must be obtained from each party prior to making an admission determination. It may also include family members, Accountable Care Collaborative or Mental Health Center case managers, and any other interested parties as approved by the participant, to determine that the ACF is an appropriate community setting that will meet the individual's choice and need for independence and community integration.

1. An assessment will be conducted prior to admission, annually, and whenever there is a significant change in physical, cognitive, or behavioral needs, or as requested by the participant. The annual assessment must be completed by the team outlined in , Sections 8.495.2.B.

2. The assessment will document that the facility is able to support the participant and their needs. The assessment will also document the participant's physical, behavioral and social needs, so that supports can be identified to enable them to lead as independent a life as possible. The assessment will be used to develop the participant's Care Plan.

8.495.3 PARTICIPANT BENEFITS

A. Alternative Care Services which include, but are not limited to, personal care and homemaker services pursuant to , Sections 8.489 and 8.490, are benefits to participants residing in an ACF.

1. Medication Administration is included in the reimbursement rate for Alternative Care Services and shall not be additionally reimbursed or billed in any other manner.

B. Room and board shall not be a benefit of Alternative Care Services. Participants shall be responsible for room and board in an amount not to exceed the Department's established rate.

C. Participant engagement opportunities shall be provided by the ACF, as outlined in 6 CCR 1011-1, Chapter VII, Section 12.19-26.

8.495.4 PARTICIPANT RIGHTS

A. An ACF must be integrated in the community and foster the independence of the participant while promoting each participant's individuality, choice of care, and lifestyle.

1. The participant's choice to live in an ACF shall afford the participant the opportunity to responsibly contribute to the home in meaningful ways and shall avoid reducing personal choice and initiative. The participant's individual behaviors shall not negatively impact the harmony of the ACF.

B. The facility must ensure that a lease, residency agreement, or other form of a written agreement will be in place for each HCBS participant and provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

1. A violation of a lease or resident agreement that leads to a discharge must include at least 30 days' notice to the participant and/or their guardian or other legal representative, and a copy of the written notice shall be sent to the state or local ombudsman within five calendar days of the date that it was provided to the participant.

C. Participants shall be informed of their rights, according to 6 CCR 1011-1, Chapter VII, Section 13. Pursuant to 6 CCR 1011-1, Chapter VII, Section 13.1, the policy on resident rights shall be in a visible location so that they are always available to participants and visitors.

1. These rights include but are not limited to:

    a. Participants have the choice in selecting the ACF in which they reside;

    b. Participants are afforded the right and opportunity to responsibly contribute to the home in meaningful ways, engage in community life, and express personal choice;

    c. Participants have the right to dignity and privacy, including in their living/sleeping units;

    d. Participants shall have choice in a roommate, with the provider accommodating roommate choices. If the facility only has one bed in a two-bed room available, the new individual and the current occupant must at least have a chance to meet and determine whether they are willing to share a room; and

    e. Communication with staff that is respectful and in a dignified manner.

2. The following rights may be modified when supported by a specific and assessed need, as determined by the provider, participant, and case manager:

    a. Participants have the right to furnish and decorate their sleeping and/or living units in the way that suits them, while maintaining a safe and sanitary environment;

    b. Participants shall have access to food at all times, choose when and what to eat, and shall have access to food preparation areas if they can appropriately handle kitchen equipment as documented in the Care Plan;

    c. Participants and their roommates shall have personal quarters with entrance doors lockable by the individual and shall control access to their quarters, unless otherwise specified in their Care Plan. Only appropriate staff shall have keys to private quarter doors, as specified in the Care Plan;

    d. Participants shall have the freedom and support to determine their own schedules and activities, including methods of accessing the greater community;

    e. Participants shall have the right to possess and self-administer medications with a physician's written order and approval of the self-administration of medications, (along with a copy of the physician's written order supporting self-administration) which shall be documented in the Care Plan;

    f. The right to have visitors at any time;

    g. The right to control his/her personal resources;

    h. The right to have access to the entire facility; and

    i. The right to receive unopened mail.

3. The Care Plan must include proper documentation supporting the modification, which includes but is not limited to:

    a. Identification of a specific and individualized assessed need;

b. Documentation of the positive interventions and less intrusive methods that have been used to support the well-being and needs of the participant;

c. Informed consent of the participant or their guardian/other legal representative;

d. Documentation of the participant's case manager involvement of any rights modification; and

e. Modifications to the Care Plan and supporting documentation must be reviewed, at a minimum, on an annual basis.

D. Participants shall be informed of all ACF policies upon admission to the facility, and when changes to policies are made, rules and/or policies shall apply consistently to the administrator, staff, volunteers, and participants residing in the facility and their family or friends who visit. Participant acknowledgement of rules and policies must be documented in the Care Plan or a participant agreement.

E. Participants shall be informed of the facility's policies and procedures for implementation of an individual's advance directives, should the need arise.

F. If requested by the participant, the ACF shall provide bedroom furnishings, including but not limited to a bed, bed and bath linens, a lamp, chair and dresser and a way to secure personal possessions.

G. Providers shall not require a Medicaid participant to take part in performing household or other related tasks.

8.495.5 PROVIDER ELIGIBILITY

A. The Provider shall be licensed in accordance with 6 CCR 1011-1, Chapters II and VII.

B. Certification Standards

1. The Provider shall be Medicaid certified by the Department as an ACF in accordance with 10 CCR, 2505-10, Section 8.487.20.

2. Certification shall be denied, revoked, terminated or suspended when a Provider is unable to meet, or adequately correct deficiencies relating to, licensure and/or certification standards as defined at 6 CCR 1011-1, Chapter VII and , Section 8.495.

3. ACF Providers shall maintain a copy of any license, ACF certification, proof of insurance or bond, W-9, and any other documentation as required by state or local authority. Providers shall submit to the Department a copy of the assisted living residence license upon renewal or change of ownership.

4. Administrators shall be qualified as defined at 6 CCR 1011-1, Chapter VII, Section 6, prior to Medicaid certification.

C. The Provider shall enter into a Provider Agreement with the Department upon the completion of the provider application and ACF certification.

D. The Provider Agreement shall be denied, revoked, suspended, or terminated if an ACF provider does not operate in full compliance with all applicable federal, State and local laws, ordinances and regulations related to fire, health, safety, zoning, sanitation, and other standards prescribed in law or regulations.

E. Notification to the Department of Significant ACF Change

1. Suspension, Revocation or Termination

a. ACF Providers shall notify the Department within five working days when any required license, certification, insurance or bond has a change in status, including any suspension, revocation or termination.

2. Change of Ownership

a. Providers shall provide written notice to the Department of intent to change ownership no later than 30 days before the sale of the facility.

i. The new owner shall not automatically become a Medicaid provider without meeting licensing, certification, and approval process standards.

8.495.6 PROVIDER ROLES AND RESPONSIBILITIES

A. All documentation, including but not limited to, individual resident agreements and Care Plans, employee files, activity schedules, licenses, insurance policies, claim submission documents and program and financial records, shall be maintained according to , Section 8.130 and provided to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request.

B. Participant Engagement

1. Providers shall, in consultation with the participants, provide social and recreational engagement opportunities both within and outside the facility.

a. Opportunities for social and recreational engagement shall take into consideration the individual interests and wishes of the participants.

b. In determining the types of opportunities and activities offered, the provider shall consider the physical, social, and mental stimulation needs of the participants.

C. Critical Incident Reporting

1. A Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a participant. A Critical Incident may endanger or negatively impact the mental and/or physical well-being of a participant. Critical Incidents include, but are not limited to:

a. Death;

b. Abuse/neglect/exploitation;

c. Injury to participant or illness of participant;

c. Damage or theft of participant’s property;

d. Medication mismanagement;

e. lost or missing person;

f. criminal activity;and

g. A harmful act committed against the participant by a person with a relationship to the participant when such act is not defined as abuse, caretaker neglect, or exploitation but causes harm to the health, safety, or welfare of a participant.

2. A provider must submit a written or verbal report of a Critical Incident to the participant's case manager within 24 hours of discovery of the actual or alleged incident. The report must include:

a. Participant name;

b. Participant identification number;

c. Waiver;

d. Incident type;

i. Mistreatment, Abuse, Neglect or Exploitation (MANE)

ii. Non-Mane: A Critical Incident, including but not limited to, a category of criminal activity, damage to a consumer's property, theft, death, injury, illness, medication management issues, missing persons, unsafe housing or displacement, other high risk issues.

e. Date and time of incident;

f. Location of incident, including name of facility, if applicable;

g. Persons involved;

h. Description of incident; and

i. Resolution, if applicable.

j. Case Manager shall complete required follow up activities and reporting in the State approved IMS within assigned timelines.

3. If any of the above information is not available within 24 hours of incident and not reported to the case manager, a follow-up to the initial report must be completed. Failure to report incidents may result in corrective action by the Department.

D. Participant Leave

1. Providers shall notify the participant's case manager of any participant planned or unplanned non-medical and/or programmatic leave for greater than 24 hours.

2. The therapeutic and/or rehabilitative purpose of leave shall be documented in the participant's Care Plan.

E. Additional Charges

1. Any additional monies assessed to the participant or their family and/or guardian:

a. Shall not be for Medicaid services;

b. Shall be clearly delineated in the resident agreement; and

c. Shall be fully refunded except for withholdings which are in accordance with the resident agreement and are clearly defined on the day of discharge.

F. Care Plan

1. The following information must be documented in the Care Plan:

a. Medical Information:

i. If the participant is taking any medications and how they are administered, with reference to the Medication Administration Record (MAR);

ii. Special dietary needs, if any; and

iii. Reference to any documented physician orders.

b. Social and recreational engagement:

i. The participant's preferences and current relationships; and

ii. Any restrictions on social and/or recreational activities identified by a physician.

c. Any other special health or behavioral management needs that supports the participant's individual needs.

d. Additional Care Planning Documentation:

i. Documentation from the admission process which demonstrates that the facility was selected by the participant;

ii. Identification of the Individual's goals, choices, preferences, and needs and incorporation of these elements into the supports and services outlined in the Care Plan;

iii. Any modifications to the participants rights, with the required supporting documentation; and

iv. Evidence the participant and/or their guardian, designated representative, or legal representative has had the opportunity to participate in the development of the Care Plan, has reviewed it, and has signed in agreement with the plan.

G. Environmental Standards

1. The Alternative Care Facility is an environment that supports individual comfort, independence and preference, maintains a home-like quality and feel for participants at all times, and provides participants with unrestricted access to the facility in accordance with the residency agreement or modifications as agreed to and documented in the participant's Care Plan.

2. Facilities shall provide an outdoor area accessible to participants without staff assistance that is well maintained, facilitates community gatherings, and is appropriately equipped for the population served.

3. Facilities shall provide access for participants to make private phone calls at their preference and convenience.

4. Facilities shall provide comfortable places for private visits with family, friends and other visitors.

5. Facilities shall provide easily accessible common areas and a physical environment that meets the needs of any participant needing support.

6. Facilities shall maintain a comfortable temperature throughout the facility and participant rooms, sufficient to accommodate the use and needs of the participants, never to exceed 80 degrees.

7. The facility shall develop and follow written policies and procedures to ensure the continuation of necessary care to all residents for at least 72 hours immediately following any emergency including, but not limited to, a long-term power failure.

8. The monthly schedule of daily recreational and social engagement opportunities shall be in a visible location so that they are always available to participants and visitors, and developed in accordance with 6 CCR 1011-1, Chapter VII, Section 12.26, pertaining to Resident Engagement.

    a. Staff shall be responsible for ensuring that the daily schedule of recreational and social engagement opportunities is implemented and offered to all participants.

9. Reading material shall be available in the common areas at all times, reflecting the interests, hobbies, and requests of the participants.

10. Facilities shall provide nutritious food and beverages that participants have access to at all times. Access to food and cooking of food shall be in accordance with 6 CCR 1011-1, Chapter VII, Section 17.1-3. The access to food shall be provided in at least one of the following ways:

    a. Access to the ACF kitchen.

    b. Access to an area separate from the ACF kitchen stocked with nutritious food and beverages.

    c. A kitchenette with a refrigerator, sink, and stove or microwave, separate from the participant's bedroom.

    d. A safe, sanitary way to store food in the participant's room.

11. Each participant's cooking capacity shall be assessed as part of the pre-admission process and updated in the Care Plan as necessary.

H. Provider Service Requirements

1. The facility shall provide Protective Oversight and Alternative Care services to participants every day of the year, 24 hours per day.

2. Alternative Care Facility Providers shall maintain and follow written policies and procedures for the administration of medication in accordance with 6 CCR 1011-1, Chapter VII and XXIV, Medication Administration Regulations.

3. Providers shall not discontinue services to a participant unless documented efforts have been ineffective to resolve the conflict leading to the discontinuance of services.

4. The facility shall develop emergency policies that address, at a minimum, a plan that ensures the availability of, or access to, emergency power for essential functions and all resident-required medical devices or auxiliary aids.

5. Providers shall have written policies and procedures for employment practices.

6. Providers shall maintain the following records/files:

    a. Personnel files for all staff and volunteers shall include:

        i. Name, home address, phone number and date of hire.

        ii. The job description, chain of supervision and performance evaluation(s).

    b. It shall be the responsibility of the Administrator to establish written policies concerning employee health, as outlined in 6 CCR 1011-1, Chapter VII, Section 7.6.

    c. Participant files shall be kept confidential and shall include:

        i. The participant's assessment outlined in , Sections 8.495.2. B. and Care Plan per 8.495.6.F.

7. The facility shall encourage and assist participants' participation in engagement opportunities and activities within the ACF community and the wider community, when appropriate.

I. Staffing Requirements

1. Each facility will divide the 24-hour day into two 12-hour blocks which will be considered daytime and nighttime. The designation of daytime and nighttime hours shall be permanently documented in facility policy and disclosed in the written resident agreements. In determining appropriate staffing levels, the facility shall adjust staffing ratios based on the individual acuity and needs of the participants in the facility. At a minimum, staffing must be sufficient in number to provide the services outlined in the Care Plans, considering the individual needs, level of assistance, and risks of accidents. A staff person can have multiple functions, as long as they meet the definition Direct Care Staff defined at , Sections 8.495.1. Staff counted in the staff-participant ratio are those who are trained and able to provide direct services to participants.

2. Staffing at a facility shall be no less than the following standards:

    a. A minimum of 1 staff to 10 participants during the daytime.

    b. A minimum of 1 staff to 16 participants during the nighttime.

    c. A minimum of 1 staff to 6 participants in a Secured Environment at all times.

        i. There shall be a minimum of one awake staff member that is on duty during all hours of operation in a Secured Environment.

3. Staffing Ratio Waiver

a. Staffing waiver requests shall be submitted to the Department's ACF Benefit Administrator. They will be evaluated and granted based on several criteria. This includes, but is not limited to:

i. Years facility has been in operation;

ii. Past Critical Incidents at the facility;

iii. The Provider has adequately documented how a staffing waiver would not jeopardize the health, safety or quality of life of the participants;

iv. Provider availability and client access; and

v. Free of deficiencies impacting participant health and safety in both the CDPHE and Life Safety Code survey and inspections.

b. An approved staffing waiver is only applicable for nighttime hours, with the exception for Secured Environments.

c. A staffing waiver expires five years from the date of approval. Continuance of staffing waiver requires Department approval.

d. Any existing staffing waiver may be subject to revocation if a facility does not comply with any applicable regulations, is cited with deficiencies impacting participant health and safety by CDPHE or the Division of Fire Protection Control, has substantiated patient care complaints, or the staffing waiver has jeopardized the health, safety or quality of life of the participants.

i. In the event of a staffing waiver denial or revocation, a facility may reapply for a staffing waiver only after the facility receives a CDPHE and Life Safety survey with no deficiencies impacting participant health and safety

ii. Existing staffing waivers shall be null and void upon a change in the total number of licensed beds or a change of ownership in a facility.

4. The facility shall ensure that all staff and volunteer training be completed within the first 30 days of employment. Training shall include, but is not limited to, the training topics outlined in 6 CCR 1011-1, Chapter VII, Section 7.9.

5. The Provider shall ensure the Administrator and all staff meet the qualifications and employment standards set forth in 6 CCR 1011-1, Chapter VII, Section 7.4-7.

J. Standards for Secured Environment ACFs

1. Facilities providing a secured environment may be licensed for a maximum of 30 secured beds.

a. A waiver may be granted by the Department when adequate documentation of the need for additional beds has been proven and the number of beds would not jeopardize the health, safety and quality of care of participants.

2. The facilities shall establish an environment that promotes independence and minimizes agitation and unsafe wandering through the use of visual cues and signs.

3. Provide a secured outdoor area accessible without staff assistance, which shall be level, well maintained, and appropriately equipped for the population served.

K. Appropriateness of Medicaid Participant Placement

1. An ACF shall not admit, or shall discharge within 30 days, any participant, who:

a. Needs skilled services on more than an intermittent basis. Skilled services shall only be provided on an intermittent basis by a Medicaid certified home health provider.

b. Is diagnosed with a substance abuse issue and refuses treatment by the appropriate mental health and/or medical professionals and cannot be safely served by the facility.

c. Has an acute physical illness which cannot be managed through medications or prescribed therapy.

e. Exhibits behavior that:

i. Disrupts the safety, health and social needs of the home.

ii. Poses a physical threat to self or others, including but not limited to, violent and disruptive behavior and/or any behavior which involves physical, sexual, or psychological force or intimidation and fails to respond to interventions, as outlined in the participant's Care Plan.

iii. Demonstrates an unwillingness or inability to maintain appropriate personal hygiene under supervision or with assistance.

iv. Is consistently disorientated to time, person and place to such a degree they pose a danger to self or others and the ACF does not provide a Secured Environment.

h. Has physical limitations that:

i. Limit ambulation, unless compensated for by assistive device(s) or with assistance from staff.

2. All discharges, including emergency discharges, shall be in accordance to 6 CCR 1011-1, Chapter VII, Section 11.11.

3. Participants admitted for Respite Care to the ACF must meet the same criteria as other participants for appropriate placement.

8.495.7 REIMBURSEMENT

A. Effective January 1 of each year, the Department shall establish a uniform room and board payment for all Medicaid participants in ACFs. The standard room and board payment shall be permitted to rise in a dollar-for-dollar relationship to any increase in the Supplemental Security Income grant standard if the Colorado Department of Human Services also raises its grant amounts.

1. Providers shall not charge a Medicaid participant more than the Department's annually established room and board rate. The room and board rate shall include but is not limited to: basic furniture, linens, utilities, and basic toiletries to include: toilet paper, soap, tissues, shampoo, toothpaste, and toothbrush.

B. ACFs must bill for reimbursement in accordance with the Department rules, policies and procedures.

1. Reimbursement shall be per unit, with one unit equaling one day of care, as outlined on the Prior Authorization (PAR) form.

2. When a participant is determined eligible for HCBS services under the 300% income standard pursuant to 10 CCR 2505-10, Section 8.100, Medicaid reimbursement shall be determined for Alternative Care Services according to 10 CCR 2505-10, Section 8.486.60.

C. Reimbursement shall be the lower of:

1. The Medicaid unit rate; or

2. The rate the ACF charges its private-pay residents for similar services.

D. Non-Medical/Programmatic Leave Reimbursement

1. The ACF may receive reimbursement for a maximum of 42 days in a calendar year for Non-Medical/Programmatic Leave Days combined.

2. The ACF cannot bill for services during Leave Days if participant is receiving Medicaid services over 24 hours in another approved Medicaid Facility, such as a nursing facility or hospital.

8.496 (Repealed effective March 30, 2014)

8.497 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

8.497.1 ENROLLMENT BROKER

8.497.1.A. PACE organizations shall be allowed to contract with the Department's enrollment broker to include information on PACE in materials the enrollment broker provides to clients.

8.497.1.B. PACE organizations shall be responsible for all costs associated with the marketing of PACE through the enrollment broker.

8.497.1.C. [Expired 05/15/2016 per House Bill 16-1257]

8.497.2 ENROLLMENT

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 care organization, the Accountable Care Collaborative program or other risk-bearing entity may elect to disenroll and enroll in and receive services through a PACE organization. The effective date of an eligible person's disenrollment shall be no later than the first day of the second month following the month in which the eligible person files the request.

8.497.2.B. [Expired 05/15/2016 per House Bill 16-1257]

10 CCR 2505-10, Section 8.400-499, Appendix A: Age Appropriate Guidelines for the Use of ULTC 100.2 Assessment on Children

These guidelines provide instructions for using the Uniform Long Term Care (ULTC) – 100.2 assessment to assess the needs of children for the following Home and Community-Based Services (HCBS) Waivers: Children's Extensive Support (CES), Children's HCBS (CHCBS), Children's Habilitation Residential Program (CHRP), Children with Life Limiting Illness (CLLI) and Children with Autism (CWA). Each individual and their circumstances must be considered when completing the assessment. Case Managers must score each child according to his/her age and individual needs.

Please consult evidence based resources and references to further your understanding of child development.

A. What is child development?

1. Child development refers to the various stages of physical, biological, social, intellectual and psychological changes that occur from birth through the end of adolescence.

2. Growing process refers to the process of becoming physically larger in size and more mature through natural development.

3. The following are child development categories:

    a. Gross Motor Skill: The ability to coordinate and control large muscles of the body. Some examples of gross motor control are sitting upright, balancing, walking, lifting, kicking and throwing a ball.

    b. Fine Motor Skill: The ability to coordinate small muscles for precise small movements involving the hands, wrists, feet, toes, lips and tongue. Some examples of fine motor control are handwriting, drawing, grasping objects, dressing, cutting and controlling a computer mouse.

    c. Speech and Language: The ability to both understand and use language to communicate thoughts and feelings through speaking, body language and gestures.

    d. Cognitive: The ability to learn, understand, remember, reason, and solve problems.

    e. Social and Emotional: The ability to interact with others, have relationships with family, friends, and teachers, exercise self-control, cooperate and respond to the feelings of others.

B. What are developmental milestones?

1. Developmental milestones refer to abilities achieved by most children by a certain age.

    Milestones are used to gauge how a child is developing. Each milestone is associated with a specific age, however, the age when a developing child actually reaches each milestone may vary.

C. What is the Uniform Long Term Care (ULTC) 100.2 Assessment?

The ULTC 100.2 is an assessment to determine the functional needs of a client by evaluating the client's ability to independently complete Activities of Daily Living (ADLs). ADLs are activities performed in the course of a typical day in a person's life such as: bathing, dressing, toileting, mobility, transferring, and eating. ADLs also include behavior and memory supervision activities needed for daily life. The ULTC 100.2 is a foundational component of the service planning process that helps:

1. Determine the appropriate services

2. Determine the care that is necessary to meet clients' needs, and

3. Assist in the selection of long-term care supports and services that meet clients' needs.

The assessment measures what the child is able to do, not what he/she prefers to do. In other words, assess the child's ability to do particular activities, even if he/she doesn't usually do the activity.

Consider age-appropriate behavior when assessing the child's ability to complete any ADL. If the child is not able to complete the ADL due to his or her age, then the child will not score in the ADL. However, if a child needs assistance in completing an ADL that is above and beyond the assistance a typically developing peer would require, then a score above 0 may be warranted.

D. Scoring

The ULTC 100.2 asks you to give the child a score between 0 and 3 based on the child's abilities in eight ADL areas. Scoring is completed as follows:

0 = Independent:

The child requires no greater assistance to successfully complete this task than would a child of similar age and stage that does not have a disability or impairment. The child has age-appropriate independence and reliability in the use of adaptive equipment necessary to complete this task, if needed.

1 = Minimal Assistance:

The child is able to perform all essential components of the activity with some impairment, with or without assistive device within a reasonable amount of time.

A score of 1 indicates the child is able to perform most of the essential components of the activity within a reasonable amount of time and may require:

a. Minimal assistance to successfully complete the task compared to a child of similar age and stage.

b. Minimal assistance with adaptation and assistive device(s)/medical equipment(s).

c. Minimal interventions such as occasional standby assistance, oversight and/or cueing.

2 = Moderate Assistance:

The child is unable to perform most of the essential components of the activity even with assistive device, requires a great deal of supervision or exceeds a reasonable amount of time to perform the activity with or without assistive device.

A score of 2 indicates that the child is unable to perform essential components of the activity due to requiring:

a. Hands-on assistance.

b. Hands-on assistance to use assistive device(s)/medical equipment(s).

c. Interventions such as regular line of sight.

d. Significant prompting or step by step cueing to begin a task and to complete it successfully.

3 = Total Assistance:

The child is totally unable to perform the essential components of the activity and needs extensive assistance.

A score of 3 indicates that the child is unable to perform the essential components of the activity due to requiring (but not limited to):

a. Assistance with complex assistive device(s)/medical equipment(s).

b. Extensive for hands-on assistance.

c. A trained attendant to perform ADLs or prevent complications.

E. Justification of Scoring (Due To's)

All scores must be justified through one or more of the following conditions. Select all applicable "due to's" to support the ADL score.

1. Physical Impairment

a. Example: client requires assistance due to paralysis

2. Supervision

a. Example: client requires assistance due to lack of awareness

3. Mental Health

a. Example: client requires assistance due to hallucinations

D. Comment Box (Narratives)

Narratives are required in the "Comment box" to support each score and to help others who read the assessment understand a client's over all need. Descriptions should be person-centered, meaningful and should justify level of assistance required based on "due to's." Comment descriptions should include:

a. How/Source: How the information obtained: Individual/caregiver, Case Manager Observation, or other?

b. What: What type of assistance is required to complete the task and how does the child manage to complete the task?

c. Who: Who is providing assistance?

d. When: How often is the child able or not able to complete the task each day?

e. Why: Why is the child able or not able to complete the activity (task)?

In May 2015, the Department published information on the best practices for what to include in narrative statements in the assessment in the Departments training website as well as in a Dear Administrator Letter. For additional information or examples of narrative statements, please find these resources on our website:

a. Writing Narrative Statements in the Assessment

b. Dear Administrator Letter – May 11, 2015

E. Activities of Daily Living (ADL)

1. BATHING

Definition: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene.

For older children, this includes the ability to get in and out of the tub and/or shower, the ability to turn the faucets on and off, regulate water temperature and to wash and dry.

A child should be able to physically and/or cognitively perform all essential components of the task safely and without assistance at 10 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child the same age without a disability or impairment.

Considerations for a child from birth to 59 months:

a. A child younger than 12 months is dependent on a caregiver for bathing.

b. A child 12-24 months can typically sit-up in the bath and begin to participate, however, the child still requires assistance and supervision.

c. A child 24-59 months typically participates in bathing, however, still requires assistance and supervision.

Considerations for a child from 5 to 18 years:

a. A child 5-18 years old typically has the ability to bathe and does not require assistance, supervision, and/or help transferring in and out of the tub.

A child may score if the child has a unique medical reason or cognitive impairment that impacts bathing, needs adaptive equipment or skilled/medical care during bathing. Please remember that all children under 4 years of age need some assistance in bathing.

2. DRESSING

Definition: The ability to dress and undress as appropriate.

This includes the ability to put on and remove basic garments such as underwear, shirts, sweaters, pants, socks, hats, and jackets. It also includes fine motor coordination for buttons, snaps, zippers, and the ability to choose appropriate clothing for the weather. For older children, this activity includes the ability to put on prostheses, braces, anti-embolism hose or other assistive devices.

A child should be able to physically and/or cognitively perform all essential components of the task safely and without assistance at 5 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child the same age without a disability or impairment.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for dressing.

b. A child 12-24 months can typically pull off hat, socks, and mittens.

c. A child 24-35 months can typically begin to help dress self.

d. A child 36-47 months can typically put on shoes (but cannot tie laces) and dress self with some help (buttons, snaps, zippers).

A child 48-59 months can typically dress self without much help.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-18 years old typically participates in dressing and may require supervision or reminders with selecting appropriate clothing.

A child may score if the child has physical characteristics that makes dressing difficult such as contractures, hypotonia/hypertonia causing a lack of endurance or range of motion, or paralysis. Consider safety and the need to assist with dressing due to seizure activity, lack of balance or cognitive impairment when scoring a child. Difficulties with a zipper or buttons at the back of a garment is not unusual and does not mean there is a functional deficit.

3. TOILETING

Definition: The ability to use the toilet, commode, bedpan, or urinal.

This includes independent transferring on and off the toilet, cleansing appropriately, and adjusting clothes. In older children, this activity could include managing their ostomy or catheter.

A child should be able to physically and cognitively perform all essential components of the task safely and without assistance at 5 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child the same age without a disability or impairment.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for toileting.

b. A child 12-42 months typically requires the use of diapers, though begins to gain some control of bowels/bladder.

c. A child 43-59 months is typically toilet trained; however occasional night time bedwetting or accidents may occur.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-6 years old may need to have intermittent supervision, cueing, or minor physical assistance and/or; have occasional night time bedwetting or accidents during waking hours.

b. A child age 7-18 years old should have the ability to toilet without assistance.

A child may score if he/she has cognitive impairment or skilled/medical care needs that affect toileting, such as ostomy, suppositories, or frequent infections. Children younger than 4 years old may still require diapers or need to have intermittent supervision, cueing, or minor physical assistance, or they may have occasional night time bedwetting or accidents during waking hours. Children should have an awareness of being wet or soiled and show interest in toilet training and/or appliances such as ostomies or urinary catheters.

4. MOBILITY

Definition: The ability to move between locations in the child's environment inside and outside the home.

This includes the ability to safely maneuver (ambulate) without assistance, go up/down the stairs, kneel without support, and assume a standing position.

A child should be able to physically and/or cognitively perform all essential components of the task safely and without assistance at 3 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child the same age without a disability or impairment.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 6 months is dependent on a caregiver for mobility.

b. A child 6-12 months can typically maintain a sitting position, may begin to move by rolling or crawling, and may begin to pull self up using furniture.

c. A child 12-18 months can typically pull self to standing position, sit or stand alone, and move by crawling and/or walking with or without the use of furniture for balance.

d. A child 18-59 months can typically stand and walk without assistance.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-18 years old should be totally mobile and have the ability to move between locations without assistance.

A child may score if the child is unable to maintain seated balance, unable to bear weight on one or both legs, has a high risk of falling and/or uses mobility devices. Consideration is given to safety and the need to assist with mobility due to visual concerns, seizure activity, frequent falls, and/or lack of balance.

5. TRANSFERS

Definition: The physical ability to move between surfaces.

This includes the physical ability to get in/out of bed or usual sleeping place; to transfer from a bed/chair to a wheelchair, walker or standing position; to transfer on/off the toilet; and the ability to use assisted devices for transfers.

A child should be able to physically and/or cognitively perform all essential components of the task safely and without assistance at 3 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child without a disability or impairment at the same age.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for transfers.

b. A child 12-36 months may require physical assistance with transfers.

c. A child 36-59 months should require minimal assistance with transfers.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-6 years old may still require minimal assistance with transfers.

b. A child age 7-18 years old should be independent and be able to transfer without physical assistance.

A child may score if the child has limited ability to independently move between two nearby surfaces and/or use assisted devices to transfer. Consideration is given to safety and the need to assist with transfer due to visual concerns, seizure activity, and awareness to surrounding and/or lack of balance.

6. EATING

Definition: The ability to eat and drink using routine or adaptive utensils.

This includes the ability to cut, regulate the amount of intake, chew, swallow foods, and use utensils. Note other forms of feeding such as a tube or intravenous on the assessment.

A child should typically be able to physically and cognitively perform all essential components of the task safely and without assistance if 5 years of age or older.

Consider what the parent or caregiver is doing that is above and beyond the requirements of another child without a disability or impairment at the same age.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for feeding.

b. A child 12-24 months can typically eat finger foods and begin to use a utensils and cup.

c. A child 24-47 months can typically feed self solid foods and begin to try new flavors of foods.

d. A child 48-59 months can typically use spoon, fork, and dinner knife independently.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-6 years old should physically participate in eating, and may need some supervision and/or assistance.

b. A child age 7-18 years old should have the ability to eat without assistance.

A child may score if the child requires more than one hour per feeding, tube feedings (or TPN), or requires more than three hours per day for feeding or eating. Consideration is given to safety and the need to assist with eating due to choking, dietary restrictions, allergies and eating disorders. Children younger than 5 years of age may require verbal prompting and assistance with cutting food.

7. SUPERVISION: (Behavioral)

Definition: The ability to engage in safe actions and interactions and refrain from unsafe actions and interactions.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 48 months requires supervision and surveillance.

b. A child 18-36 months often gets physically aggressive when frustrated.

c. A child 36-59 months should begin to understand and refrain from unsafe actions and interactions.

Considerations for a Child from 5 to 18 Years:

a. A child 5-18 years old should begin to understand and refrain from unsafe actions and interactions with occasional reminders.

A child may score if the ultimate responsibility for the safety, care, wellbeing, and behavior of dependent children remains with the parent or caregiver. Consideration should be given if the child is not able to manage appropriate behaviors and requires constant supervision/prompting.

Examples of behaviors that may justify scoring a functional deficiency for children over 36 months include:

a. Verbal or physical threats and/or actions against self and/or others.

b. Socially inappropriate or sexually aggressive behaviors.

c. Wandering with little safety awareness.

d. Removing or destroying property.

8. SUPERVISION: (Memory/Cognition)

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

Considerations for a Child from Birth to 59 Months:

a. A child 12-18 months typically says 8-20 words, identifies objects in a book, and follows simple one step directions.

b. A child 18-24 months typically uses two to three word phrases, refers to self by name, and points to parts of face when asked.

c. A child 25-36 months typically enjoys simple make-believe games and enjoys simple stories or songs.

d. A child 36-59 months typically begins counting; identifying colors and letters; and can follow simple rules of a game.

Considerations for a Child from 5 to 18 years:

a. A child 5-9 years old may require occasional supervision necessary to acquire and use information, reason, problem-solve, complete tasks, or communicate needs in order to care for oneself safely.

b. A child 5-18 years old has the ability to recognize and adjust to daily routines, interact with peers and others appropriately, understand directions, understand basic home safety and stranger awareness.

A child may score if the child requires consistent reminding, planning or adjusting for both new and familiar routines; if the child needs preparation and assistance when transitioning between activities; or if the child has impaired ability to assure his or her safety in a strange environment (for example, the child cannot give name or address or would not be aware of dangerous situations).

Examples of behaviors that may justify scoring a functional deficiency for children over 59 months include:

a. Failure to recognize and adjust to daily routines.

b. Inappropriate interactions with peers and other.

c. Lack of basic home safety understanding and stranger awareness.

F. Activities of Daily Living Scores

To be eligible for waiver services a child must have deficits in a minimum of two out of six ADLs (2+ score) or a moderate score (2+ score) in Behaviors or Memory/Cognition under Supervision category.

G. Assessment Demographic

Check the appropriate box that best identifies the client situation. If one of the categories does not apply, select 'Other' and enter a description for the different categories in Assessment Demographics.

F. Summary

Summarize the assessment findings and enter any additional comments that provide more information about the client's situation such as background information, current status, hospital visits, surgeries, seizure activities/frequency or police interactions. Comments can address issues not already identified by the assessment or expand on information presented in the assessment document. Please do not copy and paste entire assessment in this space.

Editor's Notes

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 03/04/2007, Statements of Basis and Purpose, and rule history are located in the first section, 10 CCR 2505-10. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 03/04/2007, select the desired section of the rule, for example 10 CCR 2505-10 8.100, or 10 CCR 2505-10 8.500.

History

[For history of this section, see Editor's Notes in the first section, 10 CCR 2505-10]