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.

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

- Skilled care facilities (SNF)
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Long-Term Care Hospitals
- Inpatient Psychiatric Institution for Individuals under 21.

.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 Complementary and Integrative Health (HCBS-CHI), 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); Children with Complex Health Needs Waiver (HCBS-CwCHN), Children's Habilitation Residential Program Waiver (HCBS-CHRP), Children Extensive Supports Waiver (HCBS-CES), and Children's Home and Community Based Services Waiver (HCBS-CHCBS).

.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 for SNF or ICF care, as determined by the LOC Screen and who are age 65 or over.

D. Physically Disabled or Blind Adult - includes all clients who meet the level of care for SNF or ICF care, as determined by the LOC Screen and who are age 18 through 64.

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 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 SCREEN

The Level of Care Screen assesses whether applicants require an institutional level of care typically provided in the following settings:

- Nursing Facility
- Hospital
- Inpatient Psychiatric Institution for Individuals under the age of 21
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

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

.02 The Case Management Agency shall not make a Level of Care Eligibility 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 Level of Care Eligibility Determination and frequency of need for skilled and maintenance services meet the level of care 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 for the appropriate class of ICF/IIDs.

.05 Services provided by nursing facilities are available to those individuals who meet the level of care 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

.11 Eligibility for long-term care is based on a LOC Screen, as defined in Section 8.390.1, in which an individual's needs are evaluated in at least the following areas of activities of daily living:

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

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

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

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

- Skin care
- Medication
- Nutrition
- Activities of daily living

- Therapies
- Elimination
- Observation and monitoring

.15

A. The case management agency shall certify as to the need for the nursing facility level of care, as demonstrated by the Level of Care Eligibility Determination Screen outcome using criteria outlined in 10 CCR 2505-10 Section 8.401.

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

.16 LONG-TERM CARE ELIGIBILITY ASSESSMENTS

The Department is implementing a new Level of Care Eligibility Determination Screen instrument- the Colorado Single Assessment Level of Care Screen, or CSA LOC Screen. The new LOC Screen will replace the current instrument, the Uniform Long-Term Care (ULTC) 100.2. The intent of the new instrument is to better understand individual needs, obtain objective and consistent assessment data, including standardized Functional Assessment Standardized Items (FASI), and is not intended to reduce eligibility or services. The Department will implement the new LOC Screen gradually, meaning the ULTC 100.2 and the new CSA LOC Screen instruments will both be in use concurrently for Level of Care Eligibility Determination Screens until the new CSA LOC Screen has been fully implemented across Colorado. During the transition, Case Management Agencies will use one of the two instruments, as determined by the Department, for initial and ongoing Level of Care Eligibility Determinations.

A. UNIFORM LONG-TERM CARE 100.2

To qualify for Medicaid long-term care services using the ULTC 100.2, the member/Applicant must have deficits in 2 of 6 Activities of Daily Living (ADL), (2+ score) or require at least moderate (2+ score) in Behaviors or Memory/Cognition under Supervision as outlined below. The 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. Specific ULTC scoring criteria is as follows:

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

Comments:

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:

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:

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:

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:

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:

SUPERVISION

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:

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 their 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:

B. COLORADO SINGLE ASSESSMENT (CSA) LEVEL OF CARE SCREEN

The Level of Care Eligibility Determination outcome is based on an individual's performance level as documented in the LOC Screen, in areas including, but not limited to, completing Activities of Daily Living, memory and cognition, sensory and communication, and behavior, as well as other criteria specific to applicable program. The eligibility criteria and thresholds are as follows:

1. Nursing Facility Level of Care Eligibility for ages four (4) and older

    a. Participants four (4) years of age or older must meet the Nursing Facility Level of Care criteria and thresholds outlined in 10 CCR 2505-10 Section 8.401.16.B.1 to be determined eligible for Long-Term Services and Supports.

        i. Eligibility Criteria

            1. Meets one or more ADL and Health Condition criteria thresholds in at least two areas to include Mobility, Transferring, Bathing, Dressing, Toileting, Eating (ADLs) or Health Condition; or

            2. Meets one or more Behavior threshold(s); or

            3. Meets one or more Memory and Cognition threshold(s); or

            4. Meets the Sensory & Communication threshold.

        ii. Criteria Thresholds

            1. ADL and Health Condition criteria thresholds are as follows:

                a. Mobility threshold is met with either of the following:

                    i. Participant does not walk but walking is indicated in the future or Participant does not walk and walking is not indicated in the future; or

                    ii. Participant requires a cane or walker during all mobility activities; or

                    iii. Participant uses a wheelchair or scooter as their primary mechanism for mobility; or

                    iv. Participant requires, at minimum, partial moderate assistance to walk (once standing) 10 feet indoors; or

                    v. Participant requires, at minimum, supervision or touching assistance to walk (once standing) 150 feet indoors; or

                    vi. Participant requires, at minimum, supervision or touching assistance to walk 10 feet outside of the home; or

                    vii. Participant requires, at minimum, supervision or touching assistance to walk 150 feet outside of the home.

                b. Transferring threshold is met with either of the following:

i. Participant requires use of a cane or walker during all transfer activities; or

ii. Participant requires, at minimum, partial/moderate assistance for the ability to roll left and right: from lying on back to left and right side, and return to lying on back on the bed; or

iii. Participant requires, at minimum, partial/moderate assistance for the ability to complete a sit to stand transfer: safely come to a standing position from sitting in a chair or on the side of the bed.

c. Bathing threshold is met with the following:

i. Participant requires, at minimum, partial/moderate assistance for the ability to shower/bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower

d. Dressing threshold is met with either of the following:

i. Participant requires, at minimum, partial/moderate assistance with upper body dressing; or

ii. Participant requires, at minimum, partial/moderate assistance with lower body dressing; or

iii. Participant requires, at minimum, partial/moderate assistance with putting on/taking off footwear.

e. Toileting threshold is met with either of the following:

i. Participant requires, at minimum, partial/moderate assistance with toilet hygiene; or

ii. Participant requires, at minimum, partial/moderate assistance with toilet transfers; or

iii. Participant requires, at minimum, partial/moderate assistance with menses care; or

iv. Participant requires assistance with managing equipment related to bladder incontinence; or

v. Participant is currently using a bladder program to manage participant's bladder continence; or

vi. Participant requires assistance with managing equipment related to bowel incontinence; or

vii. Participant is currently using a bowel program to manage the participant's bowel continence.

f. Eating threshold is met with either of the following:

i. Participant requires, at minimum, partial/moderate assistance for eating; or

ii. Participant requires, at minimum, partial/moderate assistance for tube feeding.

g. Health Condition threshold is met with the following:

i. Participant has a diagnosis of paralysis; or

ii. A missing limb.

2. **Behavior** criteria thresholds are as follows:

a. Behavior threshold area one is as follows:

i. Participant's behavior status previously or currently requires interventions or presents symptoms for Injury to Self, Physical Aggression or Property Destruction; and

ii. One or more of the following are met:

1. Cueing frequency, at minimum, is required more than once per month and up to weekly; or

2. Physical intervention frequency, at minimum, is required more than once per month up to weekly; or

3. Planned intervention frequency, at minimum, is required less than monthly up to once per month.

b. Behavior criteria threshold area two is as follows:

i. Participant's behavior status for Verbal Aggression currently requires interventions or presents symptoms for this behavior; and

ii. Participant presents threat(s) to own or other's safety; and

iii. One or more of the following are met:

1. Cueing frequency, at minimum, is required more than once per month and up to weekly; or

2. Physical intervention frequency, at minimum, is required more than once per month up to weekly; or

3. Planned intervention frequency, at minimum, is required less than monthly up to once per month.

c. Behavior criteria threshold area three is as follows:

i. Injurious to Self, property destruction, physical aggression, or verbal aggression behavior status currently requires intervention and/or displays symptoms and

ii. Likelihood behavior would occur and/or escalate if HCBS services were withdrawn is likely or highly likely.

3. Memory and Cognition criteria thresholds are as follows:

a. Participant has a Level of Impairment of moderately or higher in at least one area (Memory, Attention, Problem Solving, Planning, or Judgment); or

b. Participant has a level of impairment of mildly or higher in at least two areas (Problem Solving, Planning, Judgment).

4. Sensory and Communication criteria threshold is as follows:

a. Participant frequently exhibits difficulty expressing needs and/or ideas with individuals they are familiar with; or

b. Participant rarely or never expresses themself or is very difficult to understand.

2. Nursing Facility Level of Care Eligibility Criteria for individuals zero to three (0-3) years of age

a. Participants zero to three (0-3) years of age must meet the Nursing Facility Level of Care criteria and thresholds outlined in 10 CCR 2505-10 Section 8.401.16.B.2, according to age, to be determined eligible for Long-Term Services and Supports.

i. Eligibility Criteria

1. The participant must meet the criteria threshold for two or more Activities of Daily Living, based on participant age.

2. If the participant meets one or more of the two required ADL thresholds by selecting only “Other Concerns,” a second level review is required to determine eligibility.

3. Participants may also meet LOC using the behavior criteria for adults in Section 8.401.16.B.1.ii.2.

ii. Activities of Daily Living thresholds by age 0-5 months

1. Bathing:

a. Needs adaptive equipment, or

b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., or

c. Other concerns that may affect the amount of support the child needs and

d. at least one of the bathing impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:

a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., or

b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., or

c. Other concerns that may affect the amount of support the child needs and

d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:

a. Requires more than one hour per feeding, or

b. Receives tube feedings or TPN, or

c. Requires more than three hours per day for feeding or eating, or

d. Other concerns that may affect the amount of support the child needs and

e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

iii. Activities of Daily Living thresholds by age 6-11 months

1. Bathing:

a. Needs adaptive equipment, or

b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR

c. Other concerns that may affect the amount of support the child needs AND

d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:

a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR

b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR

c. Other concerns that may affect the amount of support the child needs AND

d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:

a. Requires more than one hour per feeding, OR

b. Receives tube feedings or TPN, OR

c. Requires more than three hours per day for feeding or eating, OR

d. Other concerns that may affect the amount of support the child needs AND

e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Mobility:

a. Unable to maintain a sitting position when placed, OR

b. Unable to move self by rolling, crawling, or creeping, OR

c. Other concerns that may affect the amount of support the child needs AND

d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

iv. Activities of Daily Living thresholds by age 12-17 months

1. Bathing:

a. Needs adaptive equipment, OR

b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR

c. becomes agitated requiring alternative bathing methods OR

d. Other concerns that may affect the amount of support the child needs AND

e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:

    a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR

    b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR

    c. Other concerns that may affect the amount of support the child needs AND

    d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:

    a. Requires more than one hour per feeding, OR

    b. Receives tube feedings or TPN, OR

    c. Requires more than three hours per day for feeding or eating, OR

    d. Other concerns that may affect the amount of support the child needs AND

    e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Mobility:

    a. Unable to sit alone, OR

    b. Requires a stander or someone to support the child's weight in a standing position, OR

    c. Unable to crawl or creep, OR

    d. Other concerns that may affect the amount of support the child needs AND

    e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

v. Activities of Daily Living thresholds by age 18-23 months

1. Bathing:

    a. Needs adaptive equipment, OR

    b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR

c. becomes agitated requiring alternative bathing methods OR Other concerns that may affect the amount of support the child needs AND

d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:

a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR

b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., Does not assist with dressing by helping to place arms in sleeves or legs into pants, OR

c. Other concerns that may affect the amount of support the child needs AND

d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:

a. Receives tube feedings or TPN, OR

b. Requires more than three hours per day for feeding or eating, OR

c. Other concerns that may affect the amount of support the child needs AND

d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Mobility:

a. Requires a stander or someone to support the child’s weight in a standing position, OR

b. Uses a wheelchair or other mobility device not including a single cane, OR

c. Unable to take steps holding on to furniture, OR

d. other concerns that may affect the amount of support the child needs AND

e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

vi. Activities of Daily Living thresholds by age 24-35 months

1. Bathing:

a. Needs adaptive equipment, OR

b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR

c. becomes agitated requiring alternative bathing methods OR Other concerns that may affect the amount of support the child needs AND

d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:

a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR

b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., Does not assist with dressing by helping to place arms in sleeves or legs into pants, OR

c. Unable to pull hats, socks, and mittens, OR

d. Other concerns that may affect the amount of support the child needs AND

e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:

a. Receives tube feedings or TPN, OR

b. Requires more than three hours per day for feeding or eating, OR

c. Cannot pick up appropriate foods with hands and bring them to his/her mouth, OR

d. Other concerns that may affect the amount of support the child needs AND

e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Mobility:

a. Requires a stander or someone to support the child’s weight in a standing position, OR

b. Does not walk or needs physical help to walk, OR

c. Uses a wheelchair or other mobility device not including a single cane, OR

d. Other concerns that may affect the amount of support the child needs AND

e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

5. Transfers:

a. Requires transfer assistance due to physical or cognitive deficits, OR

b. Other concerns that may affect the amount of support the child needs AND

c. at least one of the impairments above is expected to last for at least one year from the date of assessment.

vii. Activities of Daily Living thresholds by age 36-47 months

1. Bathing:

a. Needs adaptive equipment, OR

b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR

c. Is combative during bathing (e.g., flails, takes two caregivers to accomplish task), OR

d. Other concerns that may affect the amount of support the child needs AND

e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Grooming:

a. Is combative during grooming (e.g., flails, clamps mouth shut, takes two caregivers to accomplish task), OR

b. Has physical limitations that prevent completing the task (e.g. limited range of motion, unable to grasp brush), OR

c. Other concerns that may affect the amount of support the child needs AND

d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Dressing:

   a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR

   b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR

   c. Is combative during dressing (e.g., flails, resists efforts to put clothes on, takes two caregivers to accomplish task), OR

   d. Does not or cannot assist with dressing by helping to place arms in sleeves or legs into pants, OR

   e. Unable to undress self independently, OR

   f. Other concerns that may affect the amount of support the child needs AND

   g. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Eating:

   a. Is combative while eating (e.g., flails, throws food so will not have to eat, takes two caregivers to accomplish task), OR

   b. Receives tube feedings or TPN, OR

   c. Requires more than three hours per day for feeding or eating, OR

   d. Needs to be fed by another individual, OR

   e. Needs one-on-one monitoring to prevent choking, aspiration, or other serious complications, OR

   f. Other concerns that may affect the amount of support the child needs AND

   g. at least one of the impairments above is expected to last for at least one year from the date of assessment.

5. Toileting:

   a. Is combative during toileting (e.g., flails, takes two caregivers to accomplish task), OR

   b. Has no awareness of being wet or soiled, OR

   c. Requires caregiver assistance to be placed onto the toilet/potty chair, OR

d. Does not use toilet/potty chair when placed there by a caregiver, OR

e. Other concerns that may affect the amount of support the child needs AND

f. at least one of the impairments above is expected to last for at least one year from the date of assessment.

6. Mobility:

a. Does not walk or needs physical help to walk, OR

b. Uses a wheelchair or other mobility device not including a single cane, OR

c. Other concerns that may affect the amount of support the child needs AND

d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

7. Transfers:

a. Needs physical help with transfers, OR

b. Uses a mechanical lift, OR

c. Other concerns that may affect the amount of support the child needs AND

d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Nursing Facility Level of Care Eligibility Alternative Criteria

a. Alternative ADL criteria shall be applicable for participants four (4) and older whose level of support for Activities of Daily Living (Mobility, Transferring, Bathing, Dressing Toileting, Eating) has varied over the last 30 days; and

i. Meet the following alternate ADL thresholds in two or more ADL areas (Mobility, Transferring, Bathing, Dressing Toileting, Eating):

1. Participant's performance level is, at minimum, scored at partial/moderate assistance or higher AND

2. Frequency of enhanced support is scored, at minimum, 1-2 times per month in the past 30 days, or

ii. Meets at least one Nursing Facility Level of Care ADL (Mobility, Transferring, Bathing, Dressing Toileting, Eating) thresholds as required at 10 CCR 2505-10 Section 8.401.16.B.1.a.ii.1., and

iii. Meets the alternate ADL thresholds in at least one ADL area.

b. If the alternative LOC criteria is used, a second level review is required to determine eligibility.

4. Hospital Level of Care Eligibility Criteria

a. Complementary and Integrative Health (CIH), Brain Injury (BI), Children's Home and Community Based Services (CHCBS), and Children with Complex Health Needs (CwCHN) have a Hospital Level of Care (H-LOC).

i. CIH and BI may be met through NF-LOC and H-LOC Criteria.

ii. CHCBS and CwCHN have distinct criteria.

b. H-LOC for SCI and BI participants must meet in at least one of the following areas:

i. Transfers:

1. Participant has met Nursing Facility Level of Care (NF-LOC) AND

2. Participant's performance level is, at minimum, substantial/maximum assistance for Chair/Bed -to-Chair Transfers-the ability to safely transfer to and from a bed to a chair.

ii. Bathing:

1. Participant has met NF-LOC AND

2. Participant's performance level is, at minimum, substantial/maximum assistance for Shower/bathe self-the ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.

iii. Dressing:

1. Participant has met NF-LOC AND

2. Participant's performance level is, at minimum, substantial/maximum assistance for Upper Body Dressing-the ability to put on and remove shirt or pajama top. Includes buttoning, if applicable OR

3. Participant's performance level is, at minimum, substantial/maximum for Lower Body Dressing-the ability to dress and undress below the waist, including fasteners. Does not include footwear.

iv. Toileting:

1. Participant has met NF-LOC AND

2. Participant's performance level is, at minimum, substantial/maximum assist for Toilet hygiene-the ability to maintain perineal/feminine hygiene, adjust clothes before and after using toilet, commode, bedpan, urinal. If managing ostomy, include wiping opening but not managing equipment. OR

3. Participant's performance level is, at minimum, substantial/maximum assistance for Toilet Transfers: the ability to safely get on and off a toilet or commode.

v. Eating:

1. Participant has met NF-LOC AND

2. Participant's performance level is, at minimum, substantial/maximum assistance for Eating - the ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. This includes modified food consistency OR

3. Participant's performance level is, at minimum, substantial/maximum assistance for Tube feeding - the ability to manage all equipment/supplies related to obtaining nutrition.

c. H-LOC for CwCHN participants must be met in at least ONE of the following threshold areas:

i. Threshold Area 1:

1. Participant has met NF-LOC and has one or more ADL at the “substantial/maximal level” (scoring option related to assistance needed with ADL completion)

ii. Threshold Area 2:

1. Participant has met NF-LOC and one of the following conditions applies to the participant;

a. Participant has been diagnosed with a life limiting illness

b. Technologically dependent for life or health-sustaining functions, or

c. Complex medication regimen or medical interventions to maintain or improve health status, or

d. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health or development at risk

iii. Threshold Area 3:

1. Participant has not met NF-LOC or Alt-LOC and one of the following conditions applies to the participant:

a. Technologically dependent for life or health-sustaining functions, or

b. Complex medication regimen or medical interventions to maintain or improve health status, or

c. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health or development at risk

iv. Threshold Area 4:

1. Participant has not met NF-LOC or Alt-LOC, and

2. Participant has been diagnosed with a life limiting illness by a licensed medical professional, and

3. One of the following conditions applies to the participant:

a. Technologically dependent for life or health-sustaining functions, OR

b. Complex medication regimen or medical interventions to maintain or improve health status, OR

c. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health or development at risk

c. d. H-LOC for CHCBS participants must meet in at least ONE of the following threshold areas:

i. Threshold Area 1:

1. Transferring:

a. Participant met NF-LOC or Alt-LOC AND

b. Participant's performance level is, at minimum, substantial/maximum assistance for Chair/Bed -to-Chair Transfer -The ability to safely transfer to and from a bed to a chair.

2. Bathing:

a. Participant has met NF-LOC or Alt-LOC AND

b. Participant's performance level is, at minimum, substantial/maximum assistance for Shower/bathe self- The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.

3. Dressing:

a. Participant has met NF-LOC or Alt-LOC AND

b. Participant's performance level is, at minimum, substantial/maximum assistance for Upper Body Dressing - The ability to put on and remove shirt or pajama top. Includes buttoning, if applicable OR

c. Participant's performance level is, at minimum, substantial/maximum assistance for Lower Body Dressing - The ability to dress and undress below the waist, including fasteners. Does not include footwear.

4. Toileting:

a. Participant has met NF-LOC or Alt-LOC AND

b. Participant's performance level is, at minimum, substantial/maximum assistance for toilet hygiene-The ability to maintain perineal/feminine hygiene, adjust clothes before and after using toilet, commode, bedpan, urinal. If managing ostomy, include wiping opening but not managing equipment. OR

c. Participant's performance level is, at minimum, substantial/maximum assistance for Toilet Transfer: The ability to safely get on and off a toilet or commode.

5. Eating:

a. Participant has met NF-LOC or Alt-LOC AND

b. Participant's performance level is, at minimum, substantial/maximum assistance for Eating - The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. This includes modified food consistency OR

c. Participant's performance level is, at minimum, substantial/maximum assistance for Tube feeding - The ability to manage all equipment/supplies related to obtaining nutrition.

ii. Threshold Area 2:

1. Participant has not met NF-LOC or Alt-LOC AND

2. One of the following conditions apply to the participant:

a. Technologically dependent for life or health-sustaining functions, OR

b. Complex medication regimen or medical interventions to maintain or improve health status, OR

c. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health or development at risk.

3. A second-level review is required to verify whether the conditions documented justify a H-LOC.

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. Serious Mental Illness

1. Serious mental illness (SMI) is defined as: a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.

2. For the purposes of the PASRR program, a person is considered to have serious mental illness if they meet the diagnosis, level of impairment and recent treatment criteria found at 42 C.F.R. § 483.102.

3. An individual is considered to not have serious mental illness if they have:

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

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 member 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 Case Management Agency.

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 Comprehensive Community Behavioral Health Provider, or the Case Management Agency.

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

E. PASRR findings, as related to care needs, shall be coordinated with the federally prescribed, routine nursing facility Resident Assessments (Minimum Data Set) requirements. These requirements are described at 42 C.F.R. part 483.20 (2024), 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, 303 E. 17th Avenue, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request and incorporated materials may also be obtained from the original issuer at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.20.

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 members. 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 Comprehensive Community Behavioral Health Providers 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 Comprehensive Community Behavioral Health Providers 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 serious 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 serious 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. Comprehensive Community Behavioral Health Providers and Provider Agencies 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 Comprehensive Community Behavioral Health Providers or Provider Agencies 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 Comprehensive Community Behavioral Health Providers or Provider Agencies 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 serious 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 serious 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 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 Level of Care Eligibility Determination Screen 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 member'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 an appropriate Comprehensive Community Behavioral Health Providers or other Medicaid enrolled behavioral health provider. .

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 members 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 Comprehensive Community Behavioral Health Providers, 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 Comprehensive Community Behavioral Health Providers, and clinics shall conduct the evaluation in accordance with Standards for Conducting Evaluations and Establishing a Report, 2 CCR 505-1 Section 21.940 and Care and Treatment of Persons With A Mental Health Disorder In A Designated Facility, 2 CCR 502-1 Section 21.280. 2 CCR 505-1 Section 21.940 and 2 CCR 502-1 Section 21.280 are incorporated herein by reference. The incorporation of these Sections excludes later amendments to, or editions of, the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 303 E. 17th Avenue, Suite 1100, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request. Incorporated materials may also be obtained from the original issuer at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=10931&fileName=2%20CCR%20505-1, and at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=12100&fileName=2%20CCR%20502-1.

.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 member shall be placed in alternative services. Following receipt of the fully completed LOC Screen 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 Sections 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 LOC Screen 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 LOC Screen 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 10 CCR 2505-10 Section 8.057 through 8.057.8.

.54 Denial of designation into a specifically requested target group may also be appealed in accordance with 10 CCR 2505-10 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 Case Management Agency in the area where the client resides. If services will be provided through an agency in another area, the client shall be evaluated by that area's Case Management Agency.

The client shall be referred by the Case Management Agency 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 Case Management Agency except for emergency admissions to the Class I facilities.

.11 The Case Management Agency 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 Case Management Agency Adverse Recommendation

In cases where the Case Management Agency declines to recommend placement of a client into an ICF/IID facility, the Case Management Agency shall inform the client of the recommendation

using the HCBS-DD-21 form. The Case Management Agency 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 Case Management Agency 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, based on Case Management Agency review, the Member cannot reasonably be expected to make use of ICF/IID or HCBS-DD, the Case Management Agency shall notify the physician and the URC. The physician and the URC/ Case Management Agency shall then proceed with the SNF or ICF placement under the provisions set forth at Section 8.402.10.

22 When the Case Management Agency 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 Case Management Agency shall recommend placement to an ICF/IID facility. The Case Management Agency shall seek the approval of the client's physician. The physician shall notify the URC/ Case Management Agency agency of the proposed placement. Based on information provided by the Case Management Agency and the client's physician, the URC Case Management Agency may certify the client for long-term care prior to ICF/IID admission.

.23 The URC/ Case Management 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 LOC Screen and other transfer documents concerning medical information as applicable must accompany the client to the facility.

.25 Following receipt of the fully completed LOC Screen, the URC/ Case Management Agency shall review the information and make a final certification decision. If certification is approved, the URC/ Case Management Agency 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 Section 8.057.

8.405.30 ADMISSION PROCEDURES FOR HCBS-DD

.31 Case Management Agencies shall use evaluation and admission criteria at Sections 8.7100-8.7200 et seq.for HCBS-DD admissions Case Management Agencies may evaluate clients for HCBS-DD services if 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 C.C.R. Section 503-1.

.32 If the Case Management Agency recommends HCBS-DD placement, then the URC shall approve certification for services for the developmentally disabled at the level of care recommended by the Case Management Agency. The Member shall be placed in alternative service.

Following receipt of the completed LOC Screen and any other supporting information, the URC Case Management Agency shall review the information and make a final certification determination.

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

If certification is denied, the decision of the URC/Case Management Agency 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

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. 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 their 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 affected 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 their 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 made 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 any other applicable changes to patient payment per Sections 8.100.5.E. through 8.100.7.V., must be applied by the client/applicant toward their care or retained within an income trust as required under applicable regulations. Changes in income must be reflected in submission of a new eligibility reporting form and a new AP-5615.

C. Calculation of Patient Payment. Other medical and remedial expenses covered under the nursing facility PETI must be preapproved by the Department. Nursing facility PETI-approved expenses are allowed only for residents with a patient payment but do not change the patient payment amount. For nursing facility PETI, see Sections 8.482.33 and 8.100.7.V.3.) The Department may make an exception for:

1. Hospice related PETI-IME adjustments.

2. Resolution of appeals related to patient liability or PETI-IME adjustments.

D. 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 Section 8.482.34.D.1.

2. Client payment may not be waived (other than for the exceptions provided for in Section 8.415.11.C.1), in the instances defined in 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.

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

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

G. Sign and date all copies. Provide a copy to the facility and the Department at HCPF_LTC_FinCompliance@state.co.us.

8.415.20 RESPONSIBILITY OF THE NURSING FACILITY IN NURSING FACILITY PLACEMENTS

These rules set forth the administrative procedures that must be followed by nursing facilities. Failure of the facility to meet the requirements set forth herein will result in denial of 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 member or has applied 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.

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 members and applicants residing within the nursing facility.

1. The nursing facility shall initiate Form AP-5615 for all admissions, readmissions, transfers from private pay or Medicare, discharges, deaths, changes in resident income, and leaves of absence; and shall submit copies to the responsible county and the Department at HCPF_LTC_FinCompliance@state.co.us.

2. The nursing facility is solely responsible for collecting the correct amount of client payment due from the resident, the 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

Prior to receiving reimbursement from the Department, nursing facility must be enrolled as a Medicaid provider. . For the purposes of this section, the term "nursing facility" includes an intermediate care facility for individuals with intellectual disabilities (ICF/IID).

Nursing facilities are required to maintain proper accountings of resident personal needs accounts as provided in Section 8.482.5.

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 OR REQUESTS FOR DOCUMENTATION - NURSING HOME RECORDS TO BE MADE AVAILABLE

Staff of the county Department of Health and Human Services, the staff of the State Department of Human Services, the staff of the Colorado Department of Public Health and Environment or contractors of said Department or members of the Medicaid Fraud Control Unit, may make periodic visits and request documentation to nursing facilities for purposes of determining compliance with applicable regulations and to determine the appropriate rate to be paid to the facility , and for other purposes as may be authorized for the administration of the Colorado Medical Assistance Program.

All medical and financial records and documents related to the above purposes shall promptly be made available to the Department.

“Closing” The Department will conduct an audit when there is a pending change of ownership in order to determine whether payment adjustments or recoveries are necessary pursuant to Section 8.443.15 Change of Ownership, Change in Tax ID or Withdrawal from Medicaid.

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 licensed nursing facility currently Medicaid certified by the Colorado Department of Health Care Policy and Finance and licensed by the Colorado Department of Public Health and Environment.

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

New nursing facility means a facility not licensed and Medicaid certified as a Colorado nursing facility as of the date of application of June 30, 2021.

Financially solvent means the ability of a company to meet its long-term financial obligations, as verified by an approved and qualified third-party auditor.

Case-Mix means the system determined by the State Department for grouping a nursing facility's residents according to their clinical and functional status as identified from data supplied by the facility's minimum data set (MDS) as published by the United States Department of Health and Human Services.

Special Focus Facility means a nursing facility that has a history of serious quality issues or is included in the Centers for Medicare & Medicaid Services (CMS) program to stimulate improvements in the nursing facility's quality of care.

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 that is currently Colorado Medicaid certified and experiences a change of ownership or a facility that is placed into receivership under the United States Bankruptcy Code and/or pursuant to C.R.S. § 25-3-108.

2. A nursing facility exclusively serving the developmentally disabled (intermediate care facility for individuals with intellectual disabilities (ICF/IID) 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 replacement facility shall only be granted if the conditions in subparagraphs a. through e, are met:

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

    b. The replacement facility is located no more than five miles from the original facility, or fifteen (15) miles if the original facility is in a rural community.

    c.

        i) If the facility is the only Medicaid certified facility in the county, the replacement facility shall have no distance limitation, but must be in the same county

    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.

    e. The replacement facility has measurable innovative practices and design features exceeding that of the current facility. Examples of measurable innovative practices may include but are not limited to:

        i) Improvements in technology

        ii) Access to private rooms.

        iii) Access to outdoor common areas.

iv) Improvements to noise control features.

v) Lighting modifications that support safety and independence.

vi) General features that promote safety and independence.

vii) Air quality/airflow measures that serve to prevent infections.

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 website for public review and comment. In addition, the applicant shall submit a local public newspaper notice published within the service area defined in the application at the applicant's expense. The applicant must provide a copy of the newspaper notice after the application has been posted for public review. 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, as specified by the Department.

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

a. Planned resident capacity and payer mix.

b. Planned measurable innovative practices 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. Demographic analysis of the applicant's designated service area, including review of State demography data and 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. A statement from an actuary, certified public accountant, or financial firm indicating the applicant will be able to remain financially solvent for a time period of no less than thirty-six (36) months post project. .

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. Facilities facing enhanced oversight or designated as a Special Focus Facility or Special Focus Facility candidate will not be considered for Medicaid certification.

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

k.. 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 must be no smaller than one (1) full county. 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.

d) The service area ratio will exempt Colorado Veterans Community Living Centers and include only beds generally available to the public.

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 an underserved special population must document the special population of clients who have been certified for a hospital level of care in accordance with Section 8.470 is underserved in the proposed service area. Health Care Policy and Finance will verify the need using utilization records, hospital backlogs, and historical admission denials.

5) The following requirements may also apply to approval of new nursing acilities 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.

a) The Department may authorize an additional number of beds for individuals transitioning in/out of the specific special need or to support solvency of the special population program.

b) The Department’s approval or denial determination will be communicated through Operational Memos.

8.430.4 COMPLETION OF APPROVED NURSING FACILITY

8.430.4.A. Construction of approved nursing facilities 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 the new facility with approved Medicaid beds:

1. Persons or corporations which have ownership.

2. The site upon which the new facility will be constructed.

3. Proposed service area.

4. Condition under which approval of facility is requested with reference to underserved geographical or underserved population criteria in accordance with Section 8.430.3.A.5.j.

8.430.4.B. The applicant shall complete the project within sixty (60)- months of the date of the Department's approval of the application. The Department may authorize one (1) extension of up to thirty (30) months if the applicant can show a good effort towards completion of the project.

8.430.4.C. No extension beyond the ninety (90)-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 and unknown to applicant at time of acquisition of the property.

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

d. Public health emergency.

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 sixty (60)-month period or any extension period are 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 and so long as the applicant meets all other conditions of 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.

1. The Department will select the applicant that demonstrates the more measurable innovative practices, including but not limited to:

a. Improvements in technology;

b. Access to private rooms;

c. Access to outdoor common areas;

d. Improvements to noise control features;

e. Lighting modifications that support safety and independence;

f. General features that promote safety and independence; and

g. Air quality/airflow measures that serve to prevent infections.

8.430.6 LIMITED MEDICAID CERTIFICATION

1. 8.430.6.A. Beginning June 30, 2021, non-Medicaid certified facilities may reserve up to five beds for the purpose of minimizing transfer trauma, coordinating transfers, and accommodating long term residents of the facility that have outlived their third-party coverage or ability to privately pay for room and board. Facilities will not be considered Medicaid certified and not subject to the criteria in 8.430.3 New Medicaid Certification.

2. Facilities seeking to add up to the allowable five (5) beds shall submit a Provider Enrollment and letter requesting the beds to the Department.

3. Facilities seeking more than the allowable five (5) beds must meet the application process in Section 8.430.

8.435 ENFORCEMENT REMEDIES RELATED TO SURVEY DEFICIENCIES

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. Remedies for all other Class I nursing facilities are enforced 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. Civil Money Penalty (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.C. The Class I non-State-operated Medicaid-only nursing facility will receive a Notice of Adverse Action from the Department. The appeal procedures set forth at Section 8.050 apply.

8.435.2.D. Enforcement Actions for Class I nursing facilities

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 the Colorado Department of Public Health and Environment (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 will end on the date CDPHE finds the nursing facility to be in substantial compliance with all participation requirements.

    a. If substantial compliance is achieved before the denial of payment effective date, the denial of payment will be rescinded.

    b. If substantial compliance is not achieved before the denial of payment effective date, the denial of payment will stop as of midnight on the date determined by CDPHE.

(1) Medicaid monies paid to the nursing facility for any resident admitted during the denial of payment effective period is subject to recoupment by the Department.

3. Civil Money Penalty (CMP)

a. CMPs are effective on the date the non-compliance began.

b. 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 Section 8.050.

c. The CMP shall be submitted to the Department or the federal Centers for Medicare and Medicaid Services (CMS) as defined by the adverse action notification.

d. Payment of CMP shall not be an allowable cost on the nursing facility's annual Med-13 cost reports as described in Section 8.441.

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 (a) of this paragraph (1).

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

38. "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.

39. "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 account if requested in writing by a resident and/or the responsible party. (Refer to Section 8.482 for policy guidance on resident personal needs accounts):

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. Purchases on behalf of a resident if:

   a. The resident's basic financial needs must be covered before the purchase.

   b. The resident is able to approve the purchase or in the event the responsible party is making the purchase, the purchase is in line with what the resident wants or needs.

   c. The balance in the resident's personal needs account is sufficient to cover the purchase and the resident's personal needs account is not depleted below one month's personal needs allowance amount.

   d. Outstanding debt due the facility related to uncollectible patient payment for room and board is an allowable purchase.

   e. Reasonable funeral or burial expenses per 9 CCR 2503-5 section 3.570.43 are allowed.

3. Non-covered special care services, i.e., a private duty nurse not employed by the nursing facility or non-medical leave expenses incurred in supporting or benefitting the resident.

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 resident personal needs account file that the resident/responsible party is willing to use personal needs funds.

   b. The balance in the resident's personal needs account is sufficient to cover the charge and does not deplete the account.

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.

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.

18. Non-Medicaid ancillary services such as laboratory, radiology, physical therapy, occupational therapy, speech therapy and respiratory therapy.

8.440.2.B. The Department's approval shall be required in order for a resident or their 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 account, 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 are not 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, resident personal needs account 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 parent, and a trust established for the children. Under the constructive ownership rules (below), the children are treated as owning the stock owned by the parent; 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 the 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 affected 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 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 Section 8.441.5.B;

ii) Allocation schedules;

iii) Home Office Cost Statement, Form CMS-287-22;

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 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. Effective July 1, 2024, Medicare and other third party (non-Medicaid) ancillary costs 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 cannot 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 PROVIDER 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 CLASS 1 NURSING FACILITY PROVIDER REIMBURSEMENT

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).

i. 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.

b. For SFY 2020-21 and SFY 2021-22, 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 a two percent (2.00%) statutory limit.

c. For SFY 2023-24, 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 a ten percent (10.00%) statutory limit.

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).

a. Medicaid utilization supplemental payment described in Section 8.443.10.C,

b. Acuity Adjusted Core Component supplemental payment described in Section 8.443.11.B,

c. Pay-For-Performance supplemental payment described in Section 8.443.12,

d. Cognitive Performance Scale supplemental payment described in Section 8.443.10.A,

e. Preadmission Screening and Resident Review II Resident supplemental payment described in Section 8.443.10.B,

f. Preadmission Screening and Resident Review II Facility supplemental payment described in Section 8.443.10.B, and

g. 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 A resident's case mix index shall be determined using a case mix classification system. The case mix classification system shall be maintained through public postings on the Department's website. The case mix classification system may be updated to reflect advances in resident assessment or classification subject to federal requirements.

8.443.6.B A resident's case mix index shall be determined on a Quarterly basis.

1. 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.

    a. The listings shall identify resident social security numbers, names, assessment reference date, the calculated case mix index, 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 case mix index based 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.

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. 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.

b. 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 (b).

iii) 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.

iv) An improvement to a capital-related asset, which is an addition to that asset, shall increase the base value by the acquisition cost of the improvement.

c. Capital-Related Asset means the land, buildings, and fixed equipment of a participating facility.

d. Fair Rental Allowance means the product obtained by multiplying the base value of a capital-related asset by the rental rate.

e. 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.

f. Fiscal Year means the State fiscal year from July 1 through June 30.

g. 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.

h. 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.

i. 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 nationally-recognized valuation system determined by the Department 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 nationally-recognized valuation system determined by the Department 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 two percent of the statewide average July 1 Core Component per diem 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 Department utilized case mix 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 four percent of the statewide July 1Core Component per diem rate.

4. The Department shall pay an additional PASRR 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 Class I nursing facilities 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 for a Class I nursing facility is determined using their P4P points. The per diem rates are tiered such that Class I nursing facilities with greater points receive a higher per diem rate than facilities with lesser points. There are five tiers delineating the per diem rates with each tier assigned a certain points range. For each tier, the per diem rate increases by a multiplier.

The multiplier and point range for each tier are:

P4P Points	Per Diem Rate
0 – 20 points	0(x)
21 – 45 points	1(x)
46 – 60 points	2(x)
61 – 79 points	3(x)
80 – 100 points	4(x)

For SFY 2024-25 and 2025-26, the P4P per diem rates shall equal an amount such that total P4P payments made to all Class I nursing facilities shall be no less than twelve percent (12%) of the total of all annual Provider Fee supplemental payments. For SFY 2026-27 and all subsequent years, the P4P per diem rates shall equal an amount such that total P4P supplemental payments made to all Class I nursing facilities shall be no less than fifteen percent (15%) of the total of all annual Provider Fee supplemental payments.

3. The P4P points shall be based on a completed and verified/audited application including performance measures in the domains of quality of life, quality of care, and nursing facility management.

   The application includes the following:

   a. The number of points associated with each performance measure;

   b. The criteria the nursing 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. A nursing facility with substandard deficiencies on a regular annual, complaint, or any other CDPHE survey that qualifies for the P4P supplemental payment shall receive one half the calculated payment. Substandard quality of care means one or more deficiencies related to participation requirements set forth at 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.

b. The facility must perform a resident/family satisfaction survey in the manner determined by the department and published annually on the pay for performance application published to the department's website.

5. To apply for a P4P supplemental payment, the nursing facility must have the requirements for each Domain/sub-category in place at the time of submitting an application for additional payment. The nursing facility must maintain documentation supporting its representations for each performance measure for which the facility represents it meets or exceeds the specified criteria. Additionally, the nursing facility must submit with its application the required documentation for each performance measure as identified on the application.

6. Applications and supporting documentation shall be considered complete as received. No post receipt or additional information shall be accepted after submission of the application. Facilities shall be selected for onsite verification of performance measures representations based on risk.

7. A nursing facility may accumulate a maximum of 100 points by meeting all performance measures indicated on the application.

8. Medicaid patient days shall be determined based on claims data from the MMIS and/or information provided by the nursing facility for the most recently completed calendar year ending prior to the calculation of the supplemental payment.

9. The supplemental Medicaid payment shall be divided by twelve and reimbursed monthly to Class I nursing facilities. For state administered Class I nursing facilities the amount shall be divided by four and reimbursed quarterly.

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, CHANGE IN TAX ID ONLY, 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, change in tax ID only, 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.

3. If the facility is terminating participation with the Medicaid program, and there is no successor owner, the licensed nursing facility must maintain documentation and contact with the Department until the closing audit can be performed per Section8.424.

4. If the change does not require a change in tax ID, the licensed nursing facility billing provider number and NPI will continue.

5. If the change requires a change in tax ID, and maintains the same owner, the facility must submit a new enrollment application with the Department, with a new NPI number to obtain a new billing provider number.

6. If the change is to a successor owner, the transferring owner must disenroll after the change of ownership effective date, as determined by the Department under Section8.443.15.E.

    a. The successor owner must submit an enrollment application to obtain a new billing provider number.

    b. The successor owner shall not bill for services using the transferring owner's billing provider number, and any such payments are subject to recoupment.

7. A change of ownership or closing audit is required under Section 8.424.

    a. The Department may withhold all or part of any monies due the prior nursing facility licensee until the change of ownership or closing audit is completed.

8. The transferring owner must perform a Personal Needs Account reconciliation prior to transferring funds to the successor owner per Section 8.482.52.C.

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. A physician has verified in the resident’s medical records that the resident's health would be endangered if they were required to travel to Colorado. .

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. Residents without need for rehabilitation services must meet admission requirements set forth at Sections 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 is found eligible for Colorado Medicaid due to the inability to indicate their 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 WAGE ENHANCEMENT SUPPLEMENTAL PAYMENT

8.443.21.A The Department shall pay a supplemental payment to eligible class I nursing facility providers that pay their employees an hourly wage as described in section 25.5-6-208(1)(a), C.R.S.

Annually, the Department shall calculate the supplemental payment for an eligible class 1 nursing facility provider by multiplying its percent of total Medicaid hours for all eligible class 1 nursing facility providers by the annual appropriations.

1. Medicaid hours are calculated as Medicaid patient days multiplied by total hours-per-day.

    a. Medicaid patient days are determined using Medicaid fee-for-service (FFS) patient days and Medicaid Hospice Room & Board (R&B) patient days from the most recent calendar year.

        i. The Department shall annualize or estimate Medicaid FFS patient days and Medicaid Hospice R&B patient days for eligible class 1 nursing facility providers with less than a full calendar year of patient days.

    b. Total hours-per-day are calculated as total hours divided by total days.

        i. Total hours are from the most recently filed unaudited MED-13 cost report.

        ii. Total days are from the most recently filed unaudited MED-13 cost report.

        iii. Total hours-per-day for eligible class 1 nursing facility providers without a MED-13 cost report shall equal the average hours-per-day for comparable eligible class 1 nursing facility providers by Medicaid patient days (FFS and Hospice R&B) and rural/urban designation.

2. Payments made to rural eligible class 1 nursing facility providers shall be increased by an additional twenty percent (20%). Payments made to all other eligible class 1 nursing facility providers shall be reduced by a corresponding amount. A rural eligible class 1 nursing facility provider is located outside of a metropolitan statistical area as defined by the U.S. Office of Management and Budget.

3. For state fiscal year 2022-23, a class 1 nursing facility provider is eligible if every employee is paid a base hourly wage of at least fifteen dollars per hour as of April 30, 2023. For state fiscal year 2023-24, a class 1 nursing facility provider is eligible if every employee is paid a base hourly wage of at least fifteen dollars per hour for the period May 1, 2023 through December 31, 2023. For all subsequent state fiscal years, a class 1 nursing facility provider is eligible if every employee is paid a base hourly wage of at least fifteen dollars per hour for the previous calendar year.

    a. A newly enrolled class 1 nursing facility provider shall be eligible if every employee is paid a base hourly wage of at least fifteen dollars per hour for the portion of the payment period they are Medicaid enrolled.

4. An eligible class 1 nursing facility provider shall certify that all employees are paid a base hourly wage of at least fifteen dollars per hour. The certification shall be due by the last business day of April each year. The certification shall be made by the Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

5. At least ten percent (10%) of all eligible class 1 nursing facility providers may be reviewed for compliance, at the Department's discretion. If selected by the Department, an eligible class 1 nursing facility provider shall provide payroll journal data for all employees for the payment period within ten business days of request.

    a. If payroll journal data is not provided within ten business of request or the provided payroll journal data is incomplete, a class 1 nursing facility provider the Department may determine that the provider is not eligible for the payment.

6. The supplemental payment shall only be made if federal financial participation is available under the Upper Payment Limit after all other Medicaid fee-for-service payments and Medicaid supplemental payments are considered.

8.443.23 SUPPLEMENTAL PAYMENT FOR DISPROPORTIONATELY HIGH MEDICAID UTILIZATION OR GEOGRAPHICALLY CRITICAL TO ENSURING ACCESS TO CARE

1. The Department shall pay a supplemental payment to Class 1 nursing facilities either with disproportionately high Medicaid utilization or that are geographically critical to ensuring access to care for Colorado residents.Annually, based on the previous calendar year, the Department shall calculate the percentage of Medicaid patient days to total patient days for each facility participating in the Medicaid program to determine qualification for the high Medicaid utilization payment.

2. The Medicaid utilization shall be calculated by dividing Medicaid patient days by total patient days from the previous calendar year, and exempting days with no payor source or paid by the Veterans Health Administration.

    a. Medicaid patient days shall be determined from the MMIS for the calendar year prior to the state fiscal year. Total patient days shall be determined from the nursing facility provider for the calendar year ending prior to the state fiscal year.

3. Facilities will qualify for a tiered payment based on the following factors:

    a. Tier 1: Having a Medicaid utilization of 85% of greater based on the above calculation.

    b. Tier 2: Having a Medicaid utilization of 75% to 84.99% based on the above calculation or being the only Medicaid nursing home provider in the county.

4. Tier 1 facilities will be paid a $10/Medicaid day supplemental payment. Tier 2 facilities will be paid a $5/Medicaid day supplemental payment. Both payments will be calculated Section 8.443.23.1.-2. and paid annually with the following proration:

    a. For the non-state administered nursing facility providers, the amount shall be divided by twelve and reimbursed monthly via ACH transaction or check.

    b. For state administered nursing facility providers the amount shall be divided by four and reimbursed quarterly via intergovernmental transfer.

5. The payment will only be made if there is available federal financial participation under the Upper Payment Limit (UPL). For the purposes of UPL limitations, this payment will be prioritized after all provider fee related supplemental payments but prior to all other nursing facility supplemental payments.

8.443.24 NURSING FACILITY PAROLEES SUPPLEMENTAL MEDICAID PAYMENT

The Department shall make a supplemental Medicaid payment to Class I nursing facilities that admit residents directly from the Colorado Department of Corrections (DOC) who are released on parole due to compassionate care or medical release.

1. Eligible population includes individuals discharged from the DOC whose medical, behavioral, or social needs are beyond the scope of what is provided in a typical nursing facility setting, which limits their access to care options under the standard nursing home reimbursement rate. The payment for each individual shall be prior authorized for tiered reimbursement, based on their needs.

    a. Tiered reimbursement add-ons include:

        i. Tier I add-on for individuals who require one or more of the following:

            1) Enhanced staff training/education cost,

            2) Psychosocial supports,

            3) Community readjustment and reintegration supports/resources,

            4) A secure unit or neighborhood,

            5) Specialty intervention,

            6) Medically complex needs,

            7) Personal needs items,

            8) Psychiatry,

            9) Guardianship needs, and

            10) Sex offender treatment (if needed).

        ii. Tier II add-on for individuals who meet Tier I criteria and additionally meet one or more of the following criteria:

            1) 1:1 behavioral health support,

            2) High behavioral health needs that require a private room,

            3) Higher acuity needs, and

            4) High-cost medication or specialty equipment needs.

2. Quarterly, the Department shall complete a count of Medicaid patient days for the eligible population. Medicaid-covered patient days shall be pulled from the MMIS. The supplemental payment shall be calculated by multiplying the actual dates of care provided to the eligible population by the applicable per-diem rate. Per-diem rates for Tier I and Tier II individuals shall be published in the Colorado Medicaid Provider Bulletin found on the Department's website at: www.Colorado.gov/hcpf/bulletins. The payment may be adjusted, subject to the following limitations:

a. The per diem rate shall not exceed fifty percent (50%) of the statewide average MMIS per diem reimbursement rate,

b. Payments shall be withheld or reduced subject to available UPL reimbursement, and

c. Payments may be adjusted to account for data corrections in previous payments.

3. The DOC will have a licensed physician review each eligible individual being discharged on parole to verify each individual meets criteria. The licensed physician will document the services needed and submit a prior authorization request to the Department for approval. Both the Department and DOC administration will approve the prior authorization of each individual being discharged on parole prior to the Department authorizing payment to a nursing facility.

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.

8.450 FINANCIAL TRANSPARENCY REPORTING REQUIREMENTS

8.450.A Definitions

1. Audited Financial Statements means a company's financial statements that have been examined by an independent auditor and received an opinion signed by a Certified Public Accountant (CPA). An audit provides the highest level of assurance that the applicable financial statements are free from material misstatement.

2. Reviewed Financial Statements means a company's financial statements that have been examined by an independent auditor and received a review report signed by a CPA. A review provides a limited assurance that the applicable financial statements are free from material misstatement.

3. Managing Entity means any entity that provides administrative or management support to a group a facility. This includes management companies, home offices or back-offices.

4. Common Ownership means one of more individuals directly or indirectly possesses a 5% or greater ownership interest, as defined in Section 8.441.5.B, in both the nursing facility and the institution or organization serving the nursing facility.

8.450.B Financial Reporting Requirements

Beginning with fiscal year end cost reports submitted during State Fiscal Year 2025, all Medicaid certified nursing homes and management entities must annually provide the following documentation in accordance with C.R.S § 25.5-6-202 (13):

1. Audited Financial Statements

   a. Audited financial statements for each nursing facility and management entity, including management companies, home office or back-office entities, directly or indirectly accepting Medicaid funds in Colorado; or

   b. Audited consolidated financial statements for any organization or company operating or managing multiple facilities within Colorado. Consolidated financial statements must include a supplemental schedule that specifies facility level income statement data as well as statements from the managing entity (including management companies, home office or back-office entities), the revenue and expense stated on the supplemental schedule for each facility must reconcile to the MED-13; or

   c. Any combination of (a) and (b) that is necessary to include all applicable nursing facilities and managing entities should the managing entity not have common ownership with all individual facility under its management.

      i. Annual facility and managing entity audit dates may differ based on their specific entity's fiscal year end.

2. A disclosure of nursing facility ownership or affiliation with other corporations, foundation, etc., including an explanation of the type or relationship for each facility operator, management entity and real estate investment trust (REIT) associated with each facility accepting Medicaid funds.

3. Identification of all related parties engaged in a financial transaction with the nursing facility or management entity, and the sum of all annual transactions.

4. At its discretion, the Department may require:

    a. Details on transactions between related parties.

    b. Additional audited financial statements for related parties determined to be of material value in transaction volume.

    c. Individual ownership details of any corporate level ownership provided as part of disclosures required in this section.

8.450.C Waiver Process

1. The Department may allow for the waiver of certain requirements at its discretion. Waivers should be limited in duration and will only be granted based on atypical or unexpected occurrences that prevent the facility from meeting all compliance requirements. To receive a waiver, the facility or management entity must:

    a. Provide evidence of a good faith effort to comply with all applicable transparency requirements in this section,

    b. Identify and explain the specific requirement requested to be waived,

    c. Provide a timeline in which full compliance can be regained, and

    d. Submit compliance documentation to the greatest extent possible to meet the intent of this section in lieu of the item being waived (i.e. submission of reviewed financial statement in lieu of audited financial statements).

2. In limited circumstances an organization's structure may require the submission of combined financial statements rather than consolidated financial statements. This waiver additionally requires:

    a. An explanation why combined financial statements are being requested.

    b. A summary of the nature of any business entities omitted from financial reporting

    c. Omitted business entities must not have any financial transactions with nursing home related entities

3. For SFY 2025 only, the Department will accept reviewed financial statements in lieu of audited financial statements for compliance with Section 8.450.2 (A).

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 LOC Screen 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 10 CCR 2505-10 Section 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 at least one 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 all requirements in at least one 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. Meet Nursing Facility Level of Care as determined by the LOC Screen.

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. Meet Nursing Facility Level of Care as determined by the LOC Screen.

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 all of the following requirements:

1. Meet Nursing Facility Level of care as determined by the LOC Screen.

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 LOC Screen, 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 LOC Screen 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 LOC Screen must be completed annually by the SEP agency. The nursing facility shall provide a current LOC Screen 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.

8.470.7 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.

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 limit the number of HBU beds at a nursing facility based on staffing, survey compliance and/or financial stability. Additionally, 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.

8.470.8 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 member shall be based upon the Resource Utilization Group IV (RUG-IV) classification determined through the member'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 a member's third party coverage (private insurance, LTC insurance, or Medicare) will cover the cost of the member'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.

8.482 RESIDENT INCOME AND POSSESSIONS

8.482.1 PURPOSE AND LIMITATIONS

Personal needs funds, whether contributed or direct, shall be used for the care of the resident, as set forth in 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.

Refer to Section 8.440.1 for services and items included in the per diem payment and to Section 8.440.2 for services and items not included in the per diem payment.

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 allowance (PNA)" is the amount specified in Section 8.110.7.V. to be deducted from resident income, and used for the exclusive benefit of the resident prior to application of income to nursing facility care.

G. "Resident income" is defined as all income used in the determination of eligibility for Medicaid payments.

H. "Patient payment" is defined as the payment made by the resident for nursing facility care, after the personal needs allowance is deducted.

I. "Responsible Party" is defined as any of the persons below, who accepts the responsibility for a resident's funds, mail or personal possessions and is willing to sign a written declaration of such responsibility:

1. a legally appointed guardian, conservator or trustee; or

2. relative or friend; or

3. the county department; or

4. the resident if they are competent to manage their own affairs.

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.

K. "PETI-IME" is defined as nursing facility post eligibility treatment of income – incurred medical expenses, as further defined at Section 8.482.33.

8.482.3 RESIDENT INCOME

The control of resident income is vested in the resident, or in such person as the resident may designate. A designee may be a conservator, administrator, family member or other representative. The resident's income is to be used by the resident, or on behalf of the resident. No designee, or any other person or institution, shall convert any of these monies to their own use or use the income on behalf anyone for any reason, except the resident.

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.

C. The County or nursing facility must report suspected financial exploitation to a law enforcement agency in accordance with C.R.S. § 18-6.5-108.

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; 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 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 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 legibly signed by the physician (and the physician name legibly written) and resident or resident representative.

    b. For All PETI-IME requests: An itemized invoice with codes and fees for the service or supply being requested.

    c. Additionally, for hearing aids: a current audiogram test less than one year old.

    d. Additionally, for medical health Insurance: premium statement to identify the type of plan, monthly fee and copy of health Insurance card (front and back).

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, approved and signed by a physician.

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 365 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 each month of coverage until spent.

2. Medical health insurance premiums will be allowed for the resident only. This does not include prescription drug, vision, dental or life insurance.

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 medical 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 resident does not make a patient payment; then no PETI-IME will be allowed. The resident must be Medicaid approved and not in pending status for any PETI-IME service request to be approved.

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 or providers 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 signed 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. 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. New hearing aids are a benefit after five (5) years with appropriate documentation.

c. Documentation attached to the prior authorization request should include the signed medical necessity form, itemized invoice with codes and fees and current (within one (1) year) audiogram.

3. Corrective Lenses Instructions

PETI-IME expenses for corrective lenses will be limited to services not covered under Section 8.203 Vision Services. Corrective lenses are limited to one (1) pair per twenty-four (24) month period under Section 8.203.4.B. For a change in vision within twenty-four (24) months, an eye exam is required to show the change in vision.

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.

4. 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 nursing facility tracking activity log that includes the 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 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 and is subject to audit by the Department or its designee.

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 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 include the date completed and the actual signature of the nursing facility administrator or their authorized representative.

3. All copies of the AP-5615 must be submitted to the appropriate county department and the Department at HCPF_LTC_FinCompliance@state.co.us within five working days of the action which is being reported, or in the case of a change in resident income, within five working days of the time the change becomes known, in order to expedite reimbursement.

4. The nursing facility will be responsible for assuring that the patient payment, as shown on the AP-5615 and approved by the County Department, is identical to that claimed on the monthly nursing facility, billing form. Failure to enter the latest patient payment data on the billing form will render the nursing facility liable for any discrepancies.

B. Responsibilities of the County Department

On receipt of Form AP-5615, the county department will, within five working days:

1. For an admission, a readmission or a transfer from/to private pay or Medicare:

a. Verify and correct, if necessary, data entered by the nursing facility.

b. List and/or verify the resident's monthly income; and compute patient payment.

c. Verify and 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 nursing facility and the Department at HCPF_LTC_FinCompliance@state.co.us.

(1) The CBMS system shall be updated to reflect the resident's current nursing facility name and provider number to ensure residential placement is accurately reported in the system.

(2) Any report generated by the county reflecting a current list of residents residing in a single facility shall be accurate. This includes, but is not limited to, the yearly cost of living adjustment (COLA) report generated by the county.

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 the AP-5615 and submit to the nursing facility and the department at HCPF_LTC_FinCompliance@state.co.us.

3. For change in patient payment with respect to the Medicare premium deduction allowance, 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 the member is enrolled in the Medicare Buy-In program, do not: adjust patient payment on Form 5615 for the Medicare premium deduction. If member 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 nursing facility and the Department at HCPF_LTC_FinCompliance@state.co.us.

(1) The Colorado Benefits Management System (CBMS) system must be updated with the resident’s current nursing facility name and provider number to ensure the yearly COLA report for the county includes all residents residing in nursing facilities located in their county.

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 and the Department at HCPF_LTC_FinCompliance@state.co.us.

   b. The AP-5615 form must be signed and dated by the director of the County Department, or by their 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 and the Department at HCPF_LTC_FinCompliance@state.co.us.

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, and remains a resident for each day of the month, the total resident income in excess of the amount reserved for personal needs allowance, less adjusted earned income, less spousal, and dependent care allowance, less home maintenance allowance, will be used as the patient payment. 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 (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 on the AP-5615 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 fund must be forwarded to the resident in their 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 refunded to the resident's personal needs account. These funds should be disbursed as detailed in Section 8.482.52.F. If the nursing facility does not handle the resident's personal needs funds, the excess patient payment must be immediately returned to the responsible party.

        1) However, if the resident is discharged from the nursing facility to a hospital or other medical institution and is admitted with Medicaid as the primary source of funding, the patient payment in excess of the amount due to the discharging nursing facility may be due to the hospital or medical institution. Any excess patient payment should be sent to the hospital at the end of the month (see Section 8.300.10). If the resident discharged to a hospital or other medical institution is not readmitted to the nursing facility, the resident's personal needs funds, either excess patient payment or resident personal needs funds, must be lawfully disposed of as indicated in 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 they subsequently die, the resident's funds entrusted to the nursing facility must be transferred as indicated in Section 8.482.52.F.

        (3) If resident personal needs funds are unable to be transferred due to an uncashed check after ninety (90) days, the resident personal needs funds must be submitted to the Department with a copy of the cancelled check as indicated in Section 8.482.52.F.3.

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 Section 8.100.7.V.3.); 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 as defined in Section 8.100.7.V.3.; or

c. A resident is admitted to the nursing facility from their home and the resident's funds are committed elsewhere for that month; or

d. The resident is admitted from their home, where their 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 their 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 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 as defined in Section 8.100.7.V.3., 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 Section 8.440.2.A., Services and items not included in the Per Diem Rate (chargeable to resident personal needs account).

2. Room reservations for medical leave in accordance with Section 8.482.43.

3. Room reservations for non-medical and/or programmatic leave days in excess of 42 days per calendar year in accordance with Section 8.482.44.

B. Additional payment for resident care and services which are to be furnished within the nursing facility per diem rate (Section 8.440.1) are specifically prohibited. 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 Section 8.482.45.

C. Additional payments may be charged for:

1. Services and items not included in the per diem rate, as specified in Section 8.440.2. These items may be billed to the resident, to the resident's estate or other responsible party, subject to the restrictions set forth in Section 8.440.2.

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 account, nor may they be applied to a PETI deduction as described in Section 8.482.33, unless authorized by the resident or the party responsible for the resident. The 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 admission to a hospital or other institution.

B. Medical Leave is subject to the following restrictions:

1. The resident’s absence must be on the orders of a physician, as noted in the resident's chart;

2. The resident plans to return to the nursing facility;

3. The nursing facility must prepare an AP-5615 showing the dates the Medical Leave commenced and ended. See Section 8.482.34.

4. The resident, or the responsible party, must be advised, in writing, that payment for holding the nursing facility room cannot be made by Medicaid. In addition, the resident, or responsible party, must give written consent to the additional charge, including the daily rate 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 the resident’s 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 the reserved bed.

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 account, subject to the restrictions in Section 8.482.42. However, the resident's personal needs account must maintain a balance of at least $10 at all times, if used for room reservations payment. In case of death of the resident, the entire resident 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 ENFORCEMENT BY THE DEPARTMENT

The Department shall assess, enforce, and collect penalties for noncompliance with regulations, in accordance and as authorized under C.R.S. §25.5-6-205(1)(a), including but not limited to the following:

A. Obtaining vendor payments fraudulently, as outlined in C.R.S. § 25.5-4-305.

B. Obtaining additional payments from residents, or resident's families, as outlined in C.R.S. § 25.5-4-301.

C. License revocation or provisional license according to the provisions of C.R.S. § 25-3-103.

D. Fraudulent acts to assist any person in obtaining public assistance, vendor payments, medical assistance, or child care assistance to which the person is not entitled to as outlined in C.R.S. § 25.5-4-301.

E. Overpayments or incorrect payments due to omission, error or fraud as outlined in C.R.S. §25.5-4-301(2).

F. Duty of resident to report changes in income as outlined in C.R.S. § 26-2-128.

G. Crimes against at-risk persons as outlined in C.R.S. § 18-6.5-103

H. Illegal retention and use of resident personal needs account as outlined in C.R.S. § 25.5-6-206.

I. Rules as defined in this section 8.400 through 8.482.

8.482.46 UTILIZATION OF MEDICARE BENEFITS

A. Part “B” deductible and co-insurance amounts for Medicare-eligible Medicaid recipients will be reimbursed by Medicaid. Reimbursement will be made for any service covered by Part “B” of the Medicare program, as described in 42 CFR § 405, Subpart B, even though that service is not ordinarily covered under the medical assistance program. The services paid 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”.

B. 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”.

C. 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

D. Facilities or their suppliers when billing the Medicaid program for those services reimbursed by Medicare, must use the Medicare/Medicaid crossover system of billing. The facility, in order to bill through the Medicare/Medicaid crossover system, needs 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 ACCOUNTS

8.482.51 STATEMENT OF POLICY

A. All residents receiving nursing facility care are allowed to retain the amount of income specified in Section 8.100.7.v.3. as personal needs funds, to purchase necessary clothing or incidentals as specified in Section 8.440.2.A.. 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 funds are for the exclusive use of the resident as they desire. The resident or relatives may not be charged for such items as Chux, tripads, toilet paper, or other nursing facility maintenance items because these items are included in the audited cost described in Section 8.442. Other charges which could be disallowed are as follows:

1. Nursing facility maintenance items and nursing care supplies and services.

2. Charges without the following documentation:

   a. vendor receipts;

   b. signed cash receipts; or

   c. statement signed by the resident for any specifically requested over-the-counter drug.

3. Charges which constitute a duplicate payment as defined in Section 8.482.41.

4. Charges which constitute an additional payment as defined in Section 8.482.42.

5. Handling charges, such as personal needs account bank service fees.

C. Items not covered by Medicaid, as described in Section 8.440.2.A.,such as personal items, clothing, etc., may be charged to the resident’s personal needs account. However, all of the restrictions in Section 8.442.1 apply. In addition, only those items actually requested by the resident may be charged to the personal needs funds, and there must be a signed, dated receipt for each item or service signed by the resident, the resident's conservator, guardian or relative, or by a responsible party, retained in the resident's personal needs accounts file.

1. Acceptable signed consent formats:

   a. Petty cash receipt form signed by the resident, responsible party or two facility witnesses, if the resident is unable to sign.

   b. Email from the responsible party on file for the resident.

2. Copy or original itemized receipt for purchase obtained at time purchased item(s) is/are delivered to the resident. Receipt must be attached to the signed consent form.

3. Disallowed consent forms include text messages and verbal approvals.

D. Facility is responsible to document and maintain procedures for handling resident personal needs accounts and reporting fraud and/or financial exploitation

E. Facility is responsible to report to a law enforcement agency any suspected mistreatment of at-risk elders as described in C.R.S. § 18-6.5-108.

F. Resident personal needs accounts are subject to audit by the Department or its designee. Any deficiencies identified may result in corrective action plans, recoupment of funds, including interest, to the Department from the facility, forfeiture of the surety bond, or any penalty listed in Section 8.482.45.

1. Any instances of insufficient documentation or misuse of funds identified during an audit may be referred to the County Department.

8.482.52 RESPONSIBILITIES OF NURSING FACILITIES

A. General Accounting Practices

1. Nursing facilities must administer a resident personal needs account for those residents who are unable to or have no desire to handle their own personal needs funds. 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 their personal needs funds, a resident personal needs account 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. §15-1-101. As a condition of the resident personal needs account agreement, the nursing home is allowed to return the personal needs allowance portion of the resident's income. (See Section 8.100.7.V.3.).

3. If the resident or responsible party does not elect to have the facility handle the personal needs funds, the resident or responsible party must enter into and sign a resident personal needs account exclusion agreement with the facility.

4. If the total personal needs fund balance is less than $50.00, the resident's personal needs fund may be held in either an interest or non-interest-bearing account with a depository institution or in cash at the facility as described at 42 C.F.R. § 483.10(f)(10)(ii)(B).

5. If the total personal needs 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 as described at 42 C.F.R. § 483.10(f)(10)(ii)(B).

6. The bank account must be designated as “resident personal needs account.”

7. The funds in the depository institution (most often a bank) must be insured (bonded) per Part B below.

8. The personal needs funds 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 funds 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 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 Section 8.440.

11. A subsidiary ledger, as specified by the Department, must be kept for each resident for recording resident personal needs account 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 resident personal needs account must be recorded in an accurate amount and in accordance with Section 8.482.51.B for purchases and Section 8.482.52.F for refunds.

14. Any interest income must be recorded on the ledgers. If the resident personal needs account funds are pooled in one interest - bearing account, the interest earned on the accounts must be allocated to each resident's account proportionately (i.e., by dividing the individual resident's account balance by the total personal needs account fund balance then multiplying that quotient times the amount of interest income).

15. The resident shall be notified when their personal needs account fund balance reaches $200 less than the SSI resource limit.

16. This accounting system must be adequate for audit by the 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, Department, or agent of the Department at any time.

18. Personal needs funds are 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. § 25.5-6-206(3)(c). The sum of the surety bond must not be less than the resident’s personal needs accounts funds 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' 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.

3. A copy of the Surety Bond Patient Needs Fund (Form MED-181), or the Certificate of Insurance (Surety Bond), fully executed, signed and sealed, shall be filed each year with the Department within 15 days prior to the effective date thereof.

    a. Each year, upon surety bond renewal, a copy of the renewed surety bond shall be filed with the Department within thirty (30) calendar days of the renewal date at HCPF_LTC_FinCompliance@state.co.us.

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 account funds and nursing facility billing accounts can be completed by the Department, and until any adjustments required by such audits have been made.

C. Change in Licensed Operator, Change in Ownership - Requirements

1. When the licensed operator ("licensee") of a nursing facility is changed, as described in Section 8.443.15, it shall be the duty of the new licensee:

   a. To execute a new resident personal needs account agreement on behalf of Medicaid residents, as required by this section. The new licensee 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. § 25.5-6-206 (3)(c) and Section 8.482.52.B., or to otherwise demonstrate to the satisfaction of the Department that the security of residents' personal needs accounts is assured.

   c. Upon notice to the Department that a nursing facility's licensed operator will change or Medicaid participation will be terminated as required in Section 8.443.15, the Department may withhold all or part of any monies due the prior nursing facility licensee until the resident personal needs accounts 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. 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 funds being transferred for each resident's personal needs account. 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 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 resident's 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 Section 8.482.45, or both. All patient's personal possessions shall also be relinquished, as required by 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 amount for the resident;

   b) apply the balance of any patient liability amount 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 shall distribute the balance of the resident personal needs account in the following order:

      (1) Pay outstanding debt due the facility related to uncollectible patient payment for room and board;

      (2) Transfer the personal needs amount and a final accounting of the funds to the person responsible for settling the resident's estate. The responsible party may be a Public Administrator or other interested or appointed person. The facility can accept the Collection of Personal Property by Affidavit pursuant to C.R.S. § 15-12-1201 if the estate assets are under the published threshold for that year, the Letters Testamentary, or Letters of Administration. Transfer of funds shall occur within 60 days from the date of death. The facility shall provide written notice to the Department that funds were transferred to the person responsible for settling the resident's estate. Notice shall include the patient's name, Medicaid State ID, amount transferred, name of person that received the funds, and the contact information for the person that received the funds. Upon receipt of the notice, the Department may initiate action to recover the funds pursuant to C.R.S. § 25.5-4-302.

(3) Pay remaining funds to the Public Administrator of the county according to the provisions of C.R.S. §15-12-620(4). The Clerk of the District Court should be contacted to obtain the name of the current Public Administrator appointed for the county. The facility shall provide written notice to the Department that funds were transferred to the Public Administrator for settling the resident's estate. Notice shall include the patient's name, Medicaid State ID, amount transferred, county, and the name of the Public Administrator.

(4) The facility shall have defined policies and procedures to determine whether the balance of a resident's personal needs account should be remitted to a burial or funeral service provider for outstanding costs. The facility shall follow the burial assistance rules of the Colorado Department of Human Services per 9 CCR 2503-5 § 3.570.43. The facility should ensure that the value of the member's estate, including any cash or property, is identified and subtracted from the burial grant per 9 CCR 2503-5 §3.570.43.D.2 and that payments from the decedent's estate are paid directly to the service provider per 9 CCR 2503-5 § G;

(5) If the facility is unable to properly disposition the deceased resident's personal needs funds in any of the means described in the above provisions, the facility may transfer the funds to the Department for collection to offset the medical assistance paid on the member's behalf.

4. Any failure of the nursing facility to properly dispose of the resident personal needs account within 90 days of death or discharge will be considered a breach of resident personal needs account agreement and may be cause for cancellation of the participation agreement, forfeiture of the required surety bond, and prosecution under the penalties provided in 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 funds, as well as the resident's rights to such funds. If the resident chooses to allow the nursing facility to hold such funds in a resident personal needs account, the county department is responsible for assuring that the resident assigns all income to the nursing facility. See Section 8.482.52.A.2.

8.482.54 RESPONSIBILITIES OF THE STATE DEPARTMENT

A. It shall be the responsibility of the 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 resident 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 a resident personal needs account reveals discrepancies the Department, on behalf of the resident, may take administrative action as outlined in Sections 8.040 and 8.482.45, Recoveries from Providers.

E. If the nursing facility cannot offer proof that any apparent discrepancies identified in an audit 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, 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 the resident's authorized agent when establishing the resident personal needs account.

1. With resident's written consent (if able and willing to give such consent) the administrator may authorize the purchase of specific items on behalf of the resident.

2. An itemized, dated, and signed receipt is required for the purchase.

3. A copy or original itemized receipt must be submitted to facility at the time the purchase is delivered to the resident.

4. The facility must verify purchased items were delivered to the resident.

5. The Facility will only reimburse the responsible party for items the resident requested.

C. Refer to Section 8.482.51 for the account management policy and Section 8.440.2.A.2 for the acceptable purchases policy.

8.482.6 PATIENT'S PERSONAL POSSESSIONS

A. The Department's 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 anyone 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. Ensure 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 Section 8.482.52.F.3.d) with a copy of the resident's personal needs account ledger.

2. The nursing facility shall turn over to the responsible party all of the deceased resident's personal property in its possession. All items shown by the resident personal needs account 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 resident personal needs account 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 RESIDENT 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. Because nursing facility residents who are Medicaid members 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 accounts. This system shall be maintained in accordance with standards required by the Department, and subject to audit. 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 personal needs accounts.

C. Checking accounts for nursing facility operating and resident personal needs accounts.

D. Cash Disbursements Journal including columns for nursing facility operating and resident personal needs accounts.

E. General Ledger accounts as follows:

1. Cash-General or Operating account

2. Cash-Patient Resident Personal Needs Account

3. Cash-Patient Petty Cash (Resident Personal Needs 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.

K. Reconciliation personal needs bank statement with personal needs account records.

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. PETTY CASH FUND (Also called IMPREST 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, totaling 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 capacity, such as the personal needs 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 the resident personal needs account in the event of death.

2. CENSUS -- A nursing facility record of admissions and/or discharges of residents within a given time period (examples are 24-hour or “midnight” census, monthly census, etc.) The census is used to determine the number of patient days of care provided by the nursing facility.

3. FISCAL AGENT -- Agency under contract to the State Department of Health Care Policy and Financing for the purpose of disbursing funds to providers of services under the Medicaid Program. The fiscal agent collects eligibility and payment information from the county and state Departments and processes this information for payment to providers (nursing care facilities).

4. FORM AP-5615 -- For purposes of reporting change in patient status, admissions discharges, changes in resident payments, etc. to the county department(s). Commonly referred to as “5615”s.

5. GENERAL (OR OPERATING) ACCOUNT -- May describe either an account in the general ledger (as Cash-General or Operating) or a bank account. Used to record monies due to the nursing facility for care or services provided to the resident, are recorded in this account (as distinguished from a resident personal needs account, which is used to account for personal needs 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 (PNA) - is the amount specified in Section 8.100.7.V. to be deducted from resident income and used for the exclusive benefit of the resident prior to application of income to nursing facility care.

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 PERSONAL NEEDS ACCOUNT – An account in a subsidiary resident ledger used to record personal needs fund transactions of a resident. 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 their 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 8.100.7.V.1., 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" is 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:

    a. a legally appointed guardian, or conservator;

    b. relative or friend;

    c. the county department; or

    d. a resident may act as their own responsible party, if they are managing their own affairs.

17. TESTATE -- A person who dies leaving a will is said to have died "testate."

18. UB04 CLAIM FORM -- Form utilized by providers to bill nursing facility services.

8.497 PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

8.497.1 STATUTORY AUTHORITY AND APPLICABILITY

8.497.1.A. The statutory authority for these rules is set forth in § 25.5-5-412, C.R.S.

8.497.1.B. A PACE organization, as defined herein, must comply with all applicable federal, state, and local statutes, regulations, and laws including but not limited to the following:

1. Code of Federal Regulations (CFR), Title 42 – Public Health, Chapter IV – Centers for Medicare & Medicaid Services, Department of Health and Human Services, Subchapter E Programs of All-Inclusive Care for the Elderly (PACE), Part 460 – Programs of All-Inclusive Care for the Elderly (PACE). This will be referred to in this regulation as 42 CFR 460.

2. Section 25.5-5-412, C.R.S.

8.497.1.C. A PACE organization must have an agreement with the CMS and the Department, as defined herein, for the operation of a PACE program.

8.497.2 SCOPE AND PURPOSE

8.497.2.A. The purpose of these rules is to implement § 25.5-5-412, C.R.S. which require the Department to establish, administer, and enforce minimum regulatory standards and rules for the PACE program, including for contracted entities of the PACE program, to ensure the health, safety and welfare of PACE participants.

8.497.2.B. Scope and purpose.

1. General. This regulation sets forth the following:

    a. The requirements that an entity must meet to be approved as a PACE organization that operates a PACE program under Medicaid in the State of Colorado;

    b. Marketing requirements for PACE organizations;

    c. Requirements for ensuring fiscal soundness of PACE organizations;

d. Procedures for sanctions, enforcement actions, and terminations;

e. How individuals may qualify to enroll in a PACE program;

f. Reimbursement for PACE services;

g. Provisions for State monitoring of PACE programs;

h. General PACE organization requirements and PACE services;

i. Requirements to collect data, maintain records and report information, including encounter data; and

j. Requirements for PACE quality improvement monitoring.

2. Program purpose. PACE provides, prepaid, capitated, comprehensive health care services designed to meet the following objectives:

a. Enhance the quality of life and autonomy for older adults who require the level of care provided in a nursing facility;

b. Maximize dignity of, and respect for, older adults;

c. Enable older adults to live in the community as long as medically and socially feasible; and

d. Preserve and support the older adult's family unit.

8.497.3 DEFINITIONS

As used in this regulation, unless the context indicates otherwise, the following definitions apply:

A. CMS means Centers for Medicare and Medicaid Services.

B. Dementia diseases and related disabilities means a condition where mental ability declines and is severe enough to interfere with an individual's ability to perform everyday tasks. Dementia diseases and related disabilities include Alzheimer's disease, mixed dementia, Lewy Body Dementia, vascular dementia, frontotemporal dementia, and other types of dementia.

C. Department means the Colorado Department of Health Care Policy and Financing.

D. Designated Representative means a representative who is designated by the participant to act on the participant's behalf.

E. Medicaid participant means an individual determined eligible for Medicaid who is enrolled in a PACE program.

F. PACE means the programs of all-inclusive care for the elderly.

G. PACE center is a facility which includes a primary care clinic, and areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining, and which serves as the focal point for coordination and provision of most PACE services.

H. PACE contract means the contract between the Department and a PACE organization.

I. PACE organization means an entity that has in effect a PACE program agreement to operate a PACE program under this regulation.

J. PACE program means a program of all-inclusive care for the elderly that is operated by an approved PACE organization and that provides comprehensive healthcare services to PACE enrollees in accordance with a PACE program agreement.

K. PACE program agreement means an agreement between a PACE organization, CMS, and the Department.

L. Participant means an individual who is enrolled in a PACE program.

M. Service, as used in this regulation, means all services that could be required under Section 8.497.8.B., including items and drugs.

N. State administering agency means the Department.

O. Survey Agency means either the Colorado Department of Public Health and Environment or any contractor the Department engages to conduct onsite inspections of a PACE center.

P. Subcontractor means a third party contracted with a PACE organization to aid in performance of the PACE contract work.

Q. Telehealth means a mode of delivery of health care services through HIPAA-compliant telecommunications systems, including information, electronic, and communication technologies, remote monitoring technologies and store-and-forward transfers, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a covered person's health care while the covered person is located at an originating site and the provider is located at a distant site.

R. The Act means the Social Security Act.

S. Trial period means the first 3 contract years in which a PACE organization operates under a PACE program agreement, including any contract year during which the entity operated under a PACE demonstration waiver program.

8.497.4 PACE ORGANIZATION APPLICATION AND WAIVER PROCESS

8.497.4.A. This section sets forth the application procedures and the process by which a PACE organization may request a waiver of certain regulatory requirements, pursuant to 42 CFR § 460.10.

8.497.4.B. Application requirements.

1. The application requirements for PACE organizations shall be in accordance with 42 CFR § 460.12.

2. Letter of intent. Prior to submission of an application. Any individual authorized to act for an entity seeking to become a PACE organization or a PACE organization that seeks to expand its service area and/or add a PACE center site must notify the Department by submitting a letter of intent in the form and manner specified by the Department at least 90 calendar days before the anticipated application date.

3. Department-specific application requirements. An entity's application to the Department to become a PACE organization or to expand its service area and/or add a PACE center must contain information to demonstrate financial and operational stability. This includes, but is not limited to:

   a. Financial assets;

   b. Additional owners and/or financially invested organizations;

   c. Risk reserve;

   d. Reinsurance; and

   e. Staff recruitment and retention program.

4. The Department may allow more than one PACE organization per zip code.

8.497.4.C. Department evaluation of applications. The Department evaluates an application in accordance with the requirements of 42 CFR § 460.18 and based on the following information.

1. Information contained in the application;

2. Information obtained by the Department or a Survey Agency through on-site visits or any other means;

3. Department and/or state of Colorado budgetary considerations and constraints; and

4. Financial and operational stability of the applicant.

8.497.4.D. Notice of the Department's determination will be conducted in accordance with 42 CFR § 460.20.

8.497.4.E. Submission and evaluation of waiver requests. A PACE organization, or an entity submitting an application to become a PACE organization, must submit its waiver request in accordance with 42 CFR § 460.26.

8.497.4.F. Notice of the Department's determination on waiver requests will be conducted in accordance with 42 CFR § 460.28.

8.497.5 PACE PROGRAM AGREEMENT

8.497.5.A. A PACE program agreement must meet the requirements set forth at 42 CFR § 460.30.

8.497.5.B. Content and terms of PACE program agreement.

1. The PACE program agreement must include:

   a. All content required by 42 CFR § 460.32.

   b. The criteria used to determine if an individual's health or safety would be jeopardized by living in a community setting at the time of enrollment.

8.497.5.C. The duration of the PACE program agreement shall be in accordance with 42 CFR § 460.34.

8.497.5.D. The PACE organization must comply with all requirements of the PACE program agreement. If the PACE program agreement is amended or modified in any way, the amendment or modification must be automatically incorporated herein as of the effective date of the amendment or modification, and the PACE organization must comply with all requirements of the amendment or modification as of that date.

8.497.6 SANCTIONS, ENFORCEMENT ACTIONS, AND TERMINATION

8.497.6.A. Violations for which the Department may impose sanctions.

1. In addition to other remedies authorized by law or contract, the Department may impose any of the sanctions specified in Section 8.497.6.B., if the Department or a Survey Agency determines that a PACE organization commits any of the violations specified in 42 CFR § 460.40(a) or the following violations:

    a. Makes payment to or employs or contracts with any individual or organization that has a criminal conviction as defined in 42 § CFR 460.68(a); or

    b. Makes payment to individuals and entities excluded by the Office of Inspector General or included on the preclusion list as pursuant to 42 § CFR 460.86.

2. If the Department or a Survey Agency makes a determination that could lead to termination of a PACE program agreement under Section 8.497.6.C., the Department may impose any of the sanctions specified in Section 8.497.6.B. If the Department determines that the circumstances in Section 8.497.6.C.2.a. exist, the Department does not have to determine that the circumstances in Section 8.497.6.C.2.b. exist prior to imposing an enrollment and/or payment suspension.

8.497.6.B. Suspension of enrollment or payment by the Department.

1. Enrollment Suspension. If a PACE organization commits one or more violations specified in 42 CFR § 460.40(a), the Department may suspend enrollments or place a limit on enrollments after the date the Department notifies the organization of the violation.

2. Payment Suspension. If a PACE organization commits one or more violations specified in 42 CFR § 460.40(a), for participants enrolled after the date the Department notifies the PACE organization of the violation, the Department may suspend Medicaid payment to the PACE organization.

3. Term of suspension. A suspension or denial of payment remains in effect until the Department is satisfied that the following conditions are met:

    a. The PACE organization has corrected the cause of the violation; and

    b. The violation is not likely to recur.

4. Restrictions and Conditions. The Department may impose restrictions or conditions on a PACE organization, which may include at least one of the following:

    a. Retaining a consultant to monitor the effectiveness of corrective measures for a specific period determined by the Department;

    b. Monitoring the effectiveness of corrective measures by the Department for a specific period; or

c. Requiring additional training for personnel, owners, or operators of the PACE organization.

5. Notification and Plan Requirements.

a. If the Department imposes any restriction or condition that is not the result of a serious and immediate threat to the health, safety, or welfare of a PACE participant, the Department shall notify the PACE organization of the restriction or condition in writing.

b. If the Department imposes any restriction or condition that is the result of a serious and immediate threat to the health, safety, or welfare of a PACE participant, the Department shall notify the PACE organization of the restriction or condition in writing, by telephone, or in person during an on-site visit.

i. The PACE organization must remedy the circumstances creating the harm or likelihood of harm immediately upon receiving notice of the restriction or condition.

c. If the Department provides notice of a restriction or condition by telephone or in person, the Department shall send written confirmation of the restriction or condition to the PACE organization.

d. A PACE organization must complete corrective action as specified in Section 8.497.13.C.1.

8.497.6.C. Termination of a PACE program agreement. The Department may terminate a PACE program agreement for cause, pursuant to 42 CFR § 460.50.

8.497.6.D. Transitional care during termination. The PACE organization must meet the transitional care requirements set forth in 42 CFR § 460.52.

8.497.6.E. Termination procedures.

1. Except as provided in Section 8.497.6.E.2., if the Department terminates a PACE program agreement with a PACE organization, it will furnish the PACE organization with a reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Department's determination that cause exists for termination:

2. The Department may terminate a PACE program agreement and PACE contact without invoking the procedures in Section 8.497.6.E.1. if the Department determines that a delay in termination, resulting from compliance with these procedures before termination, would pose an imminent and serious risk to the health of participants enrolled with the organization..

8.497.7 PACE ADMINISTRATIVE REQUIREMENTS

8.497.7.A. PACE organizational structure. The PACE organizational structure must comply with the requirements set forth in 42 CFR § 460.60.

8.497.7.B. Governing body. The governing body of the PACE organization must comply with the requirements set forth in 42 CFR § 460.62

8.497.7.C. Compliance oversight requirements. The PACE organization must adopt and implement compliance oversight requirements in accordance with 42 CFR § 460.63.

8.497.7.D. Personnel qualifications for staff with direct participant contact. The PACE organization must comply with the personnel qualifications set forth in 42 CFR § 460.64.

8.497.7.E. Training.

1. The PACE organization must provide training to maintain and improve the skills and knowledge of each staff member with respect to the individual's specific duties that results in their continued ability to demonstrate the skills necessary for the performance of the position.

2. In addition to the general qualification requirements specified in 42 CFR § 460.66, all PACE organization personnel having direct participant contact must complete the following trainings annually. Newly hired personnel must complete the training before working independently:

    a. Mandatory reporting of adult mistreatment. Staff members must complete training that includes reporting requirements as specified in C.R.S. § 18-6.5-108;

    b. The service determination process as specified in Section 8.497.9.G; and

    c. Dementia diseases and related disabilities. The training must be culturally competent and include at least the following content:

        i. Dementia disease and related disabilities.

        ii. Person-centered care.

        iii. Care planning.

        iv. Activities of daily living.

        v. Dementia-related behaviors and communication.

3. All orientation, training, competency, and personnel action documentation must be retained in the personnel files.

8.497.7.F. Program integrity. The PACE organization must comply with the program integrity requirements set forth in 42 CFR § 460.68.

8.497.7.G. Contracted services. The PACE organization must comply with the contracted service requirements set forth in 42 CFR § 460.70.

8.497.7.H. Oversight of direct participant care. The PACE organization must oversee direct participant care in accordance with the requirements set forth in 42 CFR § 460.71.

8.497.7.I. Physical environment. The PACE center must meet the physical environment requirements set forth in 42 CFR § 460.72.

8.497.7.J. Infection control. The PACE organization must comply with the infection control requirements set forth in 42 CFR § 460.74.

8.497.7.K Transportation services.

1. Safety, accessibility, and equipment. A PACE organization's transportation services must be safe, in good working order, accessible, and equipped to meet the needs of the participant population and meet the transportation services requirements set forth in 42 CFR § 460.76.

2. Maintenance of vehicles.

    a. If the PACE organization owns, rents, or leases transportation vehicles, it must maintain these vehicles in accordance with the manufacturer's recommendations.

    b. If a contractor provides transportation services, the PACE organization must ensure that the vehicles are maintained in accordance with the manufacturer's recommendations.

    c. Safety inspections must include the inspection of items as described in Rules Regulating Transportation by Motor Vehicle, 4 CCR 723-6; § 6103 and § 6104.

3. Drivers.

    a. PACE organizations must ensure that each driver meets the following requirements:

        i. Drivers must be 18 years of age or older;

        ii. Have at least one year of driving experience;

        iii. Possess a valid Colorado driver’s license.

        iv. Provide a copy of their current Colorado motor driving vehicle record, with the previous seven years of driving history; and

        v. Complete a Colorado or National-based criminal history record check.

    b. Drivers must be disqualified from serving as drivers for any program participants for any of the following reasons:

        i. A conviction of substance abuse occurring within the seven (7) years preceding the date the criminal history record check is completed;

        ii. A conviction in Colorado, at any time, of any Class 1 or 2 felony under Title 18, C.R.S.;

        iii. A conviction in Colorado, within seven (7) years preceding the date the criminal history record check is completed, of a crime of violence, as defined in C.R.S. § 18-1.3-406(2);

        iv. A conviction in Colorado, within four (4) years preceding the date the criminal history record check is completed, of any Class 4 felony under Title 18, Articles 2, 3, 3.5, 4, 5, 6, 6.5, 8, 9, 12, or 15, C.R.S.;

        v. A conviction of an offense in any other state that is comparable to any offense listed in subparagraphs (f)(II)(A) through (D) within the same time periods as listed in subparagraphs (f)(II)(A) through (D) of Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; § 6114;

vi. A conviction in Colorado, at any time, of a felony or misdemeanor unlawful sexual offense against a child, as defined in § 18-3-411, C.R.S., or of a comparable offense in any other state or in the United States at any time;

vii. A conviction in Colorado within two (2) years preceding the date the criminal history record check is completed of driving under the influence, as described in § 42-4-1301(1)(f), C.R.S. or driving with excessive alcoholic content, as described in §42-4-1301(1)(g), C.R.S;

viii. A conviction within two (2) years preceding the date the criminal history record check is completed of an offense comparable to those included in subparagraph (f)(III)(B), 4 C.C.R. 723-6; § 6114 in any other state in the United States; and

ix. For purposes of 4 C.C.R. 723-6; § 6114(f)(IV), a deferred judgment and sentence pursuant to § 18-1.3-102, C.R.S., shall be deemed to be a conviction during the period of the deferred judgment and sentence.

8.497.7.L. Dietary services. The PACE organization must comply with the dietary services requirements set forth in 42 CFR § 460.78.

8.497.7.M. Fiscal Soundness. The PACE organization must comply with the fiscal soundness requirements set forth in 42 CFR § 460.80.

8.497.7.N. Marketing.

1. The PACE organization must comply with the marketing requirements set forth in 42 CFR § 460.82.

2. Marketing information must be free of material inaccuracies, misleading information, or misrepresentations on all platforms.

3. The Department retains the right to disapprove previously approved marketing materials if they are subsequently found to be inaccurate, altered, or otherwise non-compliant.

8.497.7.O. Emergency preparedness. The PACE organization must comply with all applicable federal, state, and local emergency preparedness requirements and must establish and maintain an emergency preparedness program that meets the requirements set forth in 42 CFR § 460.84.

8.497.8 PACE SERVICES

8.497.8.A. Pursuant to 42 CFR § 460.90, if an eligible Medicaid participant elects to enroll in a PACE program:

1. Medicare and Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply.

2. The participant, while enrolled in a PACE program, must receive Medicare and Medicaid benefits solely through the PACE organization.

8.497.8.B. Required services. The PACE organization must comply with the requirements set forth in 42 CFR § 460.92.

8.497.8.C. Excluded services. The services set forth in 42 CFR § 460.96 are excluded from coverage under PACE.

8.497.8.D. Service delivery.

1. Access to services. The PACE organization is responsible for providing care that meets the needs of each participant across all care settings, 24 hours a day, every day of the year, and must establish and implement a written plan to ensure that care is appropriately furnished.

2. Provision of services.

   a. The PACE organization must provide services in accordance with 42 CFR § 460.98(b).

   b. The PACE organization must visit each participant in-person or via telehealth across all care settings as often as the participant's condition requires, but no less than once each calendar month.

      i. If a participant does not receive a visit during a calendar month, the PACE organization must notify the Department, in writing, within 15 calendar days of the following calendar month. The notice must explain the reason(s) why the participant did not receive a visit.

      ii. For the purposes of this requirement, a visit must be provided directly by PACE staff or a contracted specialist. The delivery of items or medications and services routinely provided by a contracted residential care provider are not considered a visit.

      iii. If the PACE organization provides these visits via telehealth, the PACE organization must ensure the telehealth delivery option meets the following requirements:

         1) Participants must have an informed choice between in-person and telehealth services;

         2) The use of the telehealth delivery option will not prohibit or discourage the use of in-person services;

         3) Telehealth will not be used for the provider's convenience; and

         4) Telehealth must be provided using technology compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security and Breach Notification Rules.

      iv. The telehealth permissions in this section do not apply to the in-person assessment and reassessment requirements as described in 8.497.8.G.

3. Minimum services furnished at each PACE center. At a minimum, the PACE organization must provide the services set forth in 42 CFR § 460.98(c) at each PACE center.

4. PACE center operation. The PACE organization must operate its center(s) in accordance with 42 CFR § 460.98(d).

a. Services at the PACE center must be provided consistent with any applicable standards of practice for that service, and, when applicable, by staff with the requisite qualifications to perform the service.

5. Center attendance. The frequency of a participant's attendance at a center is determined by the interdisciplinary team, based on the needs and preferences of each participant.

8.497.8.E. Emergency care. The PACE organization must comply with the emergency care requirements set forth in 42 CFR § 460.100.

8.497.8.F. Interdisciplinary team. The PACE organization must comply with the interdisciplinary team requirements set forth in 42 CFR § 460.102.

8.497.8.G. Participant assessment.

1. The PACE organization must comply with the assessment and plan of care requirements set forth in 42 CFR § 460.104.

2. Unscheduled reassessments. In addition to the requirements set forth in 42 CFR § 460.104(d), as it relates to a participant being discharged from a hospital, the appropriate members of the interdisciplinary team, as identified by the interdisciplinary team, must conduct an in-person assessment within 72 hours of a participant's hospital discharge for a participant who was admitted for 24 hours or more.

8.497.8.H. Plan of care.

1. The PACE organization must comply with the plan of care requirements set forth in 42 CFR § 460.106.

2. Residential care provider involvement in plan of care. For participants receiving residential care, the PACE organization must include residential care providers in the evaluation of the plan of care and share the plan of care with residential care providers.

8.497.9 PARTICIPANT RIGHTS

8.497.9.A. Bill of rights. The PACE organization must comply with the requirements set forth in 42 CFR § 460.110.

8.497.9.B. Specific rights to which a participant is entitled. The PACE organization must comply with the requirements set forth in 42 CFR § 460.112.

1. Information disclosure. In addition to the requirements set forth in 42 CFR § 460.112(b), the participant has the following rights:

a. To receive a list of the employees of the PACE organization who furnish direct care to the participant upon enrollment and upon request. At a minimum, the list must include each discipline of the interdisciplinary team as set forth in 42 CFR § 460.102(b).

b. To have an equal opportunity to receive meaningful communication and to participate fully in discussions involving the PACE program, services, activities, eligibility, enrollment and other benefit information, in the language preferred by the participant.

8.497.9.C. Restraints. The PACE organization must comply with the requirements set forth in 42 CFR § 460.114.

8.497.9.D. Explanation of rights. The PACE organization must comply with the requirements set forth in 42 CFR § 460.116 and must display the contact information for the Colorado PACE Ombudsman in a prominent place in the PACE center.

8.497.9.E. Violation of rights. The PACE organization must have established documented procedures to respond to and rectify a violation of a participant's rights.

8.497.9.F. Grievance process. The PACE organization must comply with the requirements set forth in 42 CFR § 460.120.

8.497.9.G. Service determination process.

1. The PACE organization must comply with the requirements set forth in 42 CFR § 460.121.

2. PACE organization decisions to reduce or terminate services. If the PACE organization terminates or reduces a service, without the participant requesting the termination or reduction, the PACE organization must provide written notice to the participant of the right to file a service determination request to continue the service.

8.497.9.H. PACE organization's appeals process.

1. The PACE organization must comply with the requirements set forth in 42 CFR § 460.122.

2. A PACE participant must exhaust the internal appeals process described in this part prior to requesting a State Fair Hearing as described in Section 8.497.9.I. and 10 CCR 2505-10 8.057.

8.497.9.I. Additional Appeal Rights Under Medicare or Medicaid.

1. A PACE organization must comply with the requirements set forth in 42 CFR § 460.124.

2. Medicaid participants have the right to a state fair hearing under Section 8.057. Appeals must be filed within 60 calendar days of the date of the notice of adverse action.

8.497.10 QUALITY IMPROVEMENT

8.497.10.A. Quality improvement program and plan. A PACE organization must establish, implement, maintain, and evaluate an effective data-driven quality improvement program and plan, pursuant to 42 CFR § 460.130 and 460.132, that contains all requirements set forth in 42 CFR § 460.134.

8.497.10.B. Internal quality improvement activities. A PACE organization must comply with the requirements set forth in 42 CFR § 460.136.

8.497.10.C. Committees with community input. A PACE organization must comply with the requirements set forth in 42 CFR § 460.138.

1. Minimum program requirements. A PACE organization's quality improvement program must include, but is not limited to, the use of objective measures to demonstrate improved performance with regard to the following:

8.497.11 PARTICIPANT ENROLLMENT AND DISENROLLMENT

8.497.11.A. Eligibility to enroll in a PACE program. A PACE organization must comply with the requirements set forth in 42 CFR § 460.150.

8.497.11.B. Enrollment process.

1. A PACE organization must comply with the requirements set forth in 42 CFR § 460.152.

2. Additional intake process requirements.

   a. At least one member of an interdisciplinary team must assess the individual in the individual's place of residence prior to enrollment. This assessment must be completed by a Registered Nurse, Physical Therapist, Occupational Therapist, Home Care Coordinator, or appropriate members of an interdisciplinary team as appointed by an interdisciplinary team.

   b. The appropriate members of an interdisciplinary team, as identified by an interdisciplinary team, must review and discuss each potential participant and decide to approve or deny the individual's enrollment based on that review.

8.497.11.C. Enrollment agreement. If the potential participant meets the eligibility requirements and wants to enroll, he or she must sign an enrollment agreement which contains, at a minimum, the information required by 42 CFR § 460.154.

8.497.11.D. Other enrollment procedures. The PACE organization must comply with the requirements set forth in 42 CFR § 460.156.

8.497.11.E. Effective date of enrollment. A participant's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

8.497.11.F. Continuation of enrollment.

1. The PACE organization must comply with the requirements set forth in 42 CFR § 460.160.

2. In addition to the waiver of annual requirement regulations set forth in 42 CFR § 460.160(b)(1), a participant who continues to meet nursing facility level of care during their first annual recertification, is permanently waived from the annual recertification requirement.

3. In addition to the deemed continued eligibility regulations set forth in 42 CFR § 460.160(b)(2), the following apply:

   a. If the PACE organization believes the participant would be expected to meet the nursing facility level of care within the next 6 months, the organization must submit a request for deemed continued eligibility in the form and manner specified by the Department.

   b. The Department will notify the PACE organization of the Department's decision in writing within 15 calendar days upon receipt of all requested information.

c. If the Department determines the participant does not qualify for deemed continuous eligibility, the PACE organization must follow involuntary disenrollment procedures as described in Section 8.497.11.H., unless the participant chooses to voluntarily disenroll.

8.497.11.G. Voluntary disenrollment. The PACE organization must comply with the voluntary disenrollment requirements set forth in 42 CFR § 460.162.

8.497.11.H. Involuntary disenrollment.

1. The PACE organization must comply with the involuntary disenrollment requirements set forth in 42 CFR § 460.164.

2. In addition to the reasons for involuntary disenrollment regulations set forth in 42 CFR § 460.164(b), the following applies for involuntary disenrollment:

a. As it relates to 42 CFR § 460.164(b)(1) and 460.164(b)(2), the PACE organization must provide written notice to the participant, designated representative, or both explaining the amount due.

b. A participant may be involuntarily disenrolled if the participant engages in noncompliant behavior, as described in 42 CFR § 460.164(e).

3. Involuntary disenrollment request requirements.

a. A PACE organization must submit an involuntary disenrollment request to the Department in a timely manner and in the form and manner specified by the Department.

b. Before an involuntary disenrollment is effective, the Department must review it and determine in a timely manner that the PACE organization has adequately documented acceptable grounds for disenrollment.

8.497.11.I. Disenrollment responsibilities. The PACE organization must comply with the disenrollment responsibilities requirements set forth in 42 CFR § 460.166.

8.497.11.J. Reinstatement in Medicaid programs. The PACE organization must comply with the reinstatement in other Medicaid program requirements set forth in 42 CFR § 460.168.

8.497.11.K. Reinstatement in PACE. The PACE organization must comply with the reinstatement in PACE requirements set forth in 42 CFR § 460.170.

8.497.11.L. Documentation of disenrollment. The PACE organization must comply with the documentation of disenrollment requirements set forth in 42 CFR § 460.172.

8.497.12 PAYMENT

8.497.12.A. Medicaid payment.

1. The PACE organization shall receive Medicaid payments in accordance with 42 CFR § 460.182.

2. The Department may also recover, at the Department's discretion, payments made to the PACE organization in error for any reason, including, but not limited to, overpayments, improper payments, and excess funds received by the PACE organization by deduction from subsequent payments as specified in the PACE contract, deduction from any payment due under any other contracts, grants or agreements between Colorado and the PACE organization, or by any other appropriate method for collecting debts owed to the Department.

3. Payment Reconciliations. A PACE organization must adhere to the terms related to the participant-specific amount reconciliation, participant-specific reconciliation payments, and annual reconciliation as specified in the PACE contract.

8.497.12.B. Post-eligibility treatment of income.

1. The Department may provide for post-eligibility treatment of income for PACE participants as set forth in Sections 8.482.33 and 8.485.80.

2. Post-eligibility treatment of income is applied, as specified in 42 CFR § 460.184(b).

8.497.12.C. PACE premiums. The PACE organization must comply with the PACE premiums requirements set forth in 42 CFR § 460.186.

8.497.13 STATE MONITORING

8.497.13.A. Monitoring during trial period. During the trial period, the Department conducts comprehensive annual reviews of the operation of a PACE organization, in accordance with the requirements and scope set forth in 42 CFR § 460.190.

8.497.13.B. Ongoing monitoring after trial period. At the conclusion of the trial period, the Department continues to conduct review of a PACE organization, as appropriate, in accordance with the requirements set forth in 42 CFR § 460.192.

8.497.13.C. Corrective action. The PACE organization must comply with the requirements set forth in 42 CFR § 460.194. In addition, as it relates to a corrective action plan, a PACE organization must:

1. Submit an acceptable corrective action plan in the form, manner and timeframe specified by the Department, when corrective action is deemed necessary by the Department. An acceptable plan must include but is not limited to:

a. The corrective action the PACE organization will take on behalf of the participants affected by the deficient practice;

b. How the PACE organization will identify other participants who could be affected by the same deficient practice;

c. The measures or systemic changes the PACE organization has or will implement to ensure the deficient practice will not recur, including the responsible staff;

d. How the PACE organization will monitor the corrective action to ensure the deficient practice is corrected and the solution is sustained, including the responsible staff; and

e. The date each plan was or will be completed.

8.497.13.D. Disclosure of review results. The PACE organization must comply with the requirements set forth in 42 CFR § 460.196.

8.497.14 DATA COLLECTION, RECORD MAINTENANCE, AND REPORTING

8.497.14.A. Maintenance of records and reporting of data. The PACE organization must collect data, maintain records, and submit reports as required by the Department and in accordance with 42 CFR § 460.200.

8.497.14.B. Participant health outcomes data. The PACE organization must comply with the requirements set forth in 42 CFR § 460.202.

8.497.14.C. Financial recordkeeping and reporting requirements. The PACE organization must comply with the requirements set forth in 42 CFR § 460.204.

8.497.14.D. Financial statements.

1. The PACE organization must comply with the financial statement reporting requirements set forth in 42 CFR § 460.208.

2. Annual financial report. A PACE organization must submit the financial data as specified in the PACE contract.

8.497.14.E. Medical records.

1. A PACE organization must maintain a single, comprehensive medical record for each participant in accordance with the requirement set forth in 42 CFR § 460.210.

2. Additional content of medical records. In addition to the medical record content requirements set forth in 42 CFR § 460.210(b), the PACE organization must document whether a service or visit was provided in person or via telehealth.

8.497.14.F. Encounter data submission requirements.

1. Encounter data submission report. A PACE organization must submit encounter data, as directed by the Department, directly to the Department or its designee.

   a. The PACE organization must use the Healthcare Common Procedure Coding System (HCPCS), ICD-10 Procedure Coding System (ICD-10 PCS), and Current Procedural Terminology (CPT) for provided services in each submission of encounter data.

   b. A PACE organization must prepare and submit all pharmacy and non-pharmacy encounter data monthly, as specified by the Department, to the Department through its Fiscal Agent. Unless otherwise directed by the Department, encounter data must not be submitted to the Department, or its designated Fiscal Agent, more than 30 days from the final day of the previous month.

      i. Submissions must be comprised of encounter records or adjustments to previously submitted records from provider encounter or claim records of any contracted or directly provided services rendered to the participant in the current or any prior months.

ii. Submission of encounter records of services rendered from all providers, including PACE organizations and their respective subcontractors, must have a valid, enrolled National Provider Identifier (NPI) with the Department. Subcontractors who submit encounter records to the Department must be enrolled and approved through the Department.

1) If a PACE organization's encounter is not established in the HCPCS, ICD-10 PCS, or CPT, the PACE organization must document the encounter and submit an Encounter Data Submission Report to the Department for review and for coding consideration through a process defined by the Department in collaboration with the PACE organization.

2. Encounter data submission to the Pharmacy Benefit Management (PBM) vendor. A PACE organization must ensure pharmacy encounters are submitted to the PACE organization's PBM vendor.

a. If a business need is identified by the Department, or non-compliance is identified, the Department or the Department's PBM vendor will notify the PACE organization 90 days in advance of any requirement changes that are deemed necessary to ensure compliance, as set forth in the Colorado Pharmacy Benefit Management System Batch Pharmacy Encounters Companion Guide, unless there are unforeseen circumstances that require immediate system changes, in which case the PACE organization will be notified as soon as possible.

3. Annual signed encounter data certification. The PACE organization must submit an Annual Signed Encounter Data Certification to show that the encounter data submitted through the designated Fiscal Agent is accurate to the best of the PACE organization's information, knowledge and belief.

a. The encounter data submission must comply with the format prescribed by the Department or its designated Fiscal Agent. The encounter data submission must include:

i. The name and provider ID of any ordering, referring, prescribing, or attending provider and information on the rendering, operating, or other professional.

1) Generic provider IDs shall be used only when specific Provider IDs remain unknown after reasonable inquiry.

2) NPI numbers of providers not enrolled in Medicaid must be reported.

3) If the NPI is not available, the PACE organization must report the tax payer ID.

ii. The PACE organization must require subcontractors and non-contracting providers to provide encounter data to the PACE organization.

b. The PACE organization must obtain an Annual Signed Encounter Data Certification from either the Chief Executive Officer or the Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to, the Chief Executive Officer or Chief Financial Officer.

c. The PACE organization must provide an Annual Signed Encounter Data Certification to the Department or its designees covering all of the submissions for the preceding year of Encounter Data as specified in the PACE contract.

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 Level of Care 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 Person-Centered Support 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

F. 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

G. 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.

H. 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.

I. 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.

J. 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]