

## DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

### Medical Services Board

#### MEDICAL ASSISTANCE - SECTION 8.300 Hospital Services, Long Term Care Single Entry Point System

##### 10 CCR 2505-10 8.300

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

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### 8.300 HOSPITAL SERVICES

#### 8.300.1 Definitions

- 8.300.1.A.** Abbreviated Client Stay means an Inpatient stay ending in client death or in which the client leaves against medical advice.
- 8.300.1.B.** Concurrent Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service during the course of treatment.
- 8.300.1.C.** Continued Stay Review means a review of quality, Medical Necessity and appropriateness of an Inpatient health care procedure, treatment or service.
- 8.300.1.D.** Corrective Action is a step-by-step plan approved by the Department to achieve targeted outcomes and address patterns of inappropriate behavior, including, but not limited to, improper billing, unwarranted utilization, or questionable quality of care. Corrective action may include, but is not limited to, Concurrent Review, Continued Stay Review, Prospective Review, Retrospective Review, requirement to self-audit, or any other action as determined appropriate by the Department.
- 8.300.1.E.** Department means the Department of Health Care Policy and Financing.
- 8.300.1.F.** Diagnosis Related Group (DRG) means a cluster of similar conditions within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of Inpatient hospitalizations that utilize similar amounts of Hospital resources.
- 8.300.1.G.** DRG Hospital means a Hospital that is reimbursed by the Colorado Medicaid program based on a system of DRGs. Those Hospitals reimbursed based on a DRG system are: General Hospitals, Critical Access Hospitals, Pediatric Hospitals.
- 8.300.1.H.** Diagnostic Services means any medical procedures or supplies recommended by a licensed professional within the scope of his/her practice under state law to enable him/her to identify the existence, nature, or extent of illness, injury or other health condition in a client.
- 8.300.1.I.** Disproportionate Share Hospital (DSH) Factor is a percentage add-on adjustment that qualified Hospitals receive for serving a disproportionate share of low-income clients.

**8.300.1.J.** Emergency Care Services, for the purposes of this rule, means services for a medical condition, including active labor and delivery, manifested by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the client's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

**8.300.1.K.** Enhanced Ambulatory Patient Group (EAPG) means a cluster of similar procedures within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of services performed during Outpatient visits that utilize similar amounts of Hospital resources.

**8.300.1.L.** Hospital means an institution that is (1) primarily engaged in providing, by or under the supervision of physicians, Inpatient medical or surgical care and treatment, including diagnostic, therapeutic and rehabilitation services, for the sick, disabled and injured; (2) licensed, when located in Colorado, as a Hospital by the Colorado Department of Public Health and Environment (CDPHE); and, when not located in Colorado, by the state in which it is located; and (3) certified for participation in the Centers for Medicare and Medicaid Services (CMS) Medicare program. Hospitals can have multiple satellite locations as long as they meet the requirements under CMS. For the purposes of the Colorado Medicaid program, distinct part units and satellite locations are considered part of the Hospital under which they are licensed. Transitional Care Units (TCUs) are not considered part of the Hospital for purposes of the Colorado Medicaid program. Types of Hospitals are:

1. A General Hospital is licensed and CMS-certified as a General Hospital that, under an organized medical staff, provides Inpatient services, emergency medical and surgical care, continuous nursing services, and necessary ancillary services. A General Hospital may also offer and provide Outpatient services, or any other supportive services for periods of less than twenty-four hours per day.
2. A Critical Access Hospital (CAH) is licensed and CMS-certified as a Critical Access Hospital. CAHs offer emergency services and limited Inpatient care. CAHs may offer limited surgical services and/or obstetrical services including a delivery room and nursery.
3. A Pediatric Hospital is licensed as a General Hospital and CMS-certified as a children's Hospital providing care primarily to populations aged seventeen years and under.
4. A Rehabilitation Hospital is licensed and CMS-certified as a Rehabilitation Hospital which primarily serves an Inpatient population requiring intensive rehabilitative services including but not limited to stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, and other disorders or injuries requiring intensive rehabilitation.
5. A Long-Term Care Hospital is licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital which primarily serves an inpatient population requiring longterm care services including but not limited to respiratory therapy, head trauma treatment, complex wound care, IV antibiotic treatment and pain management.

6. A Spine/Brain Injury Treatment Specialty Hospital licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital OR CMS-certified as a Rehabilitation Hospital is a Not-for Profit Hospital as determined by the CMS Cost Report for the most recent fiscal year. A Spine/Brain Injury Treatment Specialty Hospital primarily serves an inpatient population requiring long term acute care and extensive rehabilitation for recent spine/brain injuries. To qualify as a Spine/Brain Injury Treatment Specialty Hospital, for at least 50% of Medicaid members discharged in the preceding calendar year the hospital must have submitted Medicaid claims including spine/brain injury treatment codes (previously grouped to APR-DRG 40, 44, 55, 56, and 57). The Department shall revoke the designation if the percentage of Medicaid members discharged falls below the 50% requirement for a calendar year. Designation is removed the calendar year following the disqualifying year.
7. A Psychiatric Hospital is licensed and CMS-certified as a Psychiatric Hospital to plan, organize, operate, and maintain facilities, beds, and treatment, including diagnostic, therapeutic and rehabilitation services, over a continuous period exceeding twenty-four (24) hours, to individuals requiring early diagnosis, intensive and continued clinical therapy for mental illness; and mental rehabilitation. A Psychiatric Hospital can qualify to be a state-owned Psychiatric Hospital if it is operated by the Colorado Department of Human Services.
8. A Medicare Dependent Hospital is defined as set forth at 42 C.F.R § 412.103 (2022). 42 C.F.R. § 412.108(1) (2018) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This regulation is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S § 24-4-410(12.5)(V)(b), the Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.
9. A Non-independent Urban Hospital is a hospital which reports a name of the home office of the chain with which they are affiliated on the CMS-2552-10 Cost Report in Worksheet S-2 Part 1, Line 141, Column 1, with the exception of individual hospitals reporting an affiliation not reported amongst other hospitals located in Colorado.
10. A Sole Community Hospital (SCH) is defined by CMS which classifies a hospital as a sole community hospital if it is located more than 35 miles from other like hospitals, or it is located in a rural area (as defined in 412.64) and meets one of the following conditions. No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital, or, if larger within its service area. The hospital has fewer than 50 beds and intermediary certifies that the hospital would have met the criteria in paragraph (a)(1)(i) of this section were it not for the fact that some beneficiaries or residents were forced to seek care outside the service area due to the unavailability of necessary specialty services at the hospital are inaccessible for at least 30 days in each 2 out of 3 years.

11. For the purposes of Section 8.300: Hospital Services, Prospective Payment System (PPS) inpatient hospitals are categorized by CMS as hospitals which Medicare pays on a prospective basis and which provide data in the Medicare IPPS IMPACT file and supporting data files/tables from which to create their PPS rate. Conversely, non-Prospective Payment System (PPS) inpatient hospitals are categorized by CMS as Pediatric and Critical Access Hospitals for which Medicare does not pay on a prospective basis and which do not have data available on the Medicare IPPS IMPACT file or supporting data files/tables.
  12. Rebasing years are every other odd year starting in state fiscal year 2023-24. Non-rebasing years are every other even year starting in state fiscal year 2024-25.
- 8.300.1.M.** Inpatient is a person who has been admitted to a Hospital for purposes of receiving Inpatient Hospital Services.
- 8.300.1.N.** Inpatient Hospital Services means services that are furnished by a Hospital for the care and treatment of an Inpatient and are provided in the Hospital by or under the direction of a physician.
- 8.300.1.O.** Medical Necessity is defined at Section 8.076.1 and, for members ages 20 and under receiving Early and Periodic Screening, Diagnosis, and Treatment services, at Section 8.280.4.E.2.
- 8.300.1.P.** Non-DRG Hospital means a Hospital that is not reimbursed by the Colorado Medicaid program based on a system of DRGs. Psychiatric Hospitals, Long-Term Care Hospital, Rehabilitation Hospital and Spine/Brain Injury Treatment Specialty Hospital are considered NonDRG Hospitals since their reimbursement is based on a per diem rate.
- 8.300.1.Q.** Observation Stay means Outpatient Hospital Services provided in a Hospital for the purposes of evaluating a person for Inpatient admission, stabilization, or extended recovery.
- 8.300.1.R.** Outlier Days mean the days in a Hospital stay that occur after the Trim Point Day.
- 8.300.1.S.** Outpatient means a person who is receiving professional services at a Hospital or an off campus location of a Hospital but is not admitted as an Inpatient.
- 8.300.1.T.** Outpatient Hospital Services means services that are furnished to Outpatients; and are furnished by or under the direction of a physician or dentist.
- 8.300.1.U.** Prospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service prior to treatment.
- 8.300.1.V.** Rehabilitative Services means any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a client to his/her best possible functional level.
- 8.300.1.W.** Relative Weight (DRG weight or EAPG weight) means a numerical value which reflects the relative resource consumption for the DRG or EAPG to which it is assigned. Modifications to these Relative Weights are made when needed to ensure payments reasonably reflect the average cost for each DRG or EAPG. Relative Weights are intended to be cost effective, and based upon Colorado data as available.
- 8.300.1.X.** Retrospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service following treatment. A Retrospective Review can occur before or after reimbursement has been made.

**8.300.1.Y.** Rural Hospital means a Hospital not located within a metropolitan statistical area (MSA) as designated by the United States Office of Management & Budget.

**8.300.1.Z.** State University Teaching Hospital means a Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education; and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

**8.300.1.AA.** Swing Bed Designation means designation of Hospital beds in a Rural Hospital with less than 100 beds for reimbursement under Medicare for furnishing post-hospital extended care services to Medicare beneficiaries in compliance with the Social Security Act, Sections 1883 and 1866. Such beds are called "swing beds."

**8.300.1.BB.** Trim Point Day (Outlier Threshold Day) means the day during an inpatient stay after which Outlier Days are counted. The Trim Point Day occurs 2.58 standard deviations above the average length of stay for each DRG. Beginning July 1, 2020, the Trim Point Day for delivery and neonate DRGs is equal to the Trim Point Day as calculated in the applicable Hospital-Specific Relative Value National File for Delivery and Neonate DRGs.

**8.300.1.CC.** Urban Hospital means a Hospital located within a MSA as designated by the United States Office of Management & Budget.

**8.300.1.DD.** Urban Safety Net Hospital means an Urban, General Hospital for which the Medicaid Inpatient eligible days plus Colorado Indigent Care Program (CICP) Inpatient days relative to total Inpatient days, rounded to the nearest percent are equal to or exceed sixty-five percent. To qualify as an Urban Safety Net Hospital, a Hospital must submit its most current information on Inpatient days by March 1 of each year for the Inpatient rates effective on July 1 of that same year. The Department may rely on other data sources for the calculation if there are discrepancies between the data submitted by the Hospital and alternative data sources such as claims or cost report data.

## **8.300.2 Requirements for Participation**

### **8.300.2.A In-State Hospitals**

1. In order to qualify as an in-state Hospital, a Hospital must:
  - a. be located in Colorado
  - b. be certified for participation as a Hospital in the Medicare Program;
  - c. have an approved Application for Participation with the Department; and
  - d. have a fully executed contract with the Department.
2. A border-state Hospital (located outside of Colorado) which is more accessible to clients who require Hospital services than a Hospital located within the state may be an in-state Hospital by meeting the requirements of 10 CCR 2505-10 Section 8.300.2.A.1.b – c. The Department shall make the proximity determination for Hospitals to enroll as a border-state Hospital.
3. In-state Hospitals located in Colorado shall be surveyed by the CDPHE. Failure to satisfy the requirements of CDPHE may cause the Department to institute corrective action as it deems necessary.

**8.300.2.B Out-of-State Hospitals**

An out-of-state Hospital may receive payment for emergency Hospital services if:

1. the services meet the definition of Emergency Care;
2. the services are covered benefits;
3. the Hospital agrees on an individual case basis not to charge the client, or the client's relatives, for items and services which are covered Medicaid benefits, and to return any monies improperly collected for such covered items and services; and
4. the Hospital has an approved Application for Participation with the Department.

Out-of-state Hospitals may receive reimbursement for Outpatient Hospital Services if they meet the conditions specified in 10 CCR 2505-10 Section 8.300.2.B.2 – 4.

Out-of-state Hospitals may receive reimbursement for non-emergent Inpatient Hospital Services if they meet the conditions specified in 10 CCR 2505-10 Section 8.300.2.B.2 – 4, and the Department has issued a prior authorization.

**8.300.2.C Hospitals with Swing-Bed Designation**

1. Hospitals which intend to designate beds as swing beds shall apply to CDPHE for certification of swing beds and to the Department for participation as a Medicaid provider of nursing facility services. The criteria in 10 CCR 2505-10 Section 8.430 must be met in order to become a Medicaid provider.
2. Hospitals providing nursing facility services in swing beds shall furnish within the per diem rate the same services, supplies and equipment which nursing facilities are required to provide.
3. Clients and/or their responsible parties shall not be charged for any of these required items or services as specified in 10 CCR 2505-10 Sections 8.440 and 8.482.
4. Hospitals providing nursing facility services to swing-bed clients shall be in compliance with the following nursing facility requirements.
  - a. Client rights: 42 C.F.R. Section 483.10(b)(3), (b)(4), (b)(5), (b)(6), (d), (e), (h), (i), (j)(1)(vii), (j)(1)(viii), (l), and (m).
  - b. Client Admission, transfer and discharge rights: 42 C.F.R. Section 483.12 (a)(1) through (a)(7).
  - c. Client behavior and facility practices: 42 C.F.R. Section 483.13.
  - d. Client activities: 42 C.F.R. Section 483.15(f).
  - e. Social Services: 42 C.F.R. Section 483.15(g).
  - f. Discharge planning: 42 C.F.R. Section 483.20(e)
  - g. Specialized rehabilitative services: 42 C.F.R. Section 483.45.
  - h. Dental services: 42 C.F.R. Section 483.55.

5. Personal Needs Funds and Patient Payments

Swing-bed Hospitals shall maintain personal needs accounts, submit AP-5615 forms, and be responsible for collecting patient payment amounts in accordance with the requirements established for nursing facilities in 10 CCR 2505-10 Section 8.482.

**8.300.3 Covered Hospital Services**

**8.300.3.A Covered Hospital Services - Inpatient**

Inpatient Hospital Services are a covered Medicaid benefit, when provided by or under the direction of a physician, for as many days as determined Medically Necessary.

1. To support the Medical Necessity of an Inpatient admission, the provider must adequately document in the member's medical record that a provider with applicable expertise expressly determined that, based on the client's severity of illness, the client required services involving the intensity of services that cannot be provided safely and effectively in an Outpatient setting. Such determination may take into account the amount of time the client is expected to require Inpatient Hospital Services. However, the decision to admit a client to Inpatient may not be based solely on the expected length of stay. The decision to admit a client to Inpatient is a medical determination that is based on a multitude of clinical factors, including, but not limited to the:
  - a. Client's current medical needs;
  - b. Client's medical history;
  - c. Severity of the signs and symptoms exhibited by the client at the time of presentation to the hospital, and at the point of admission decision;
  - d. Medical predictability of an adverse clinical event occurring with the client;
  - e. Results of diagnostic studies, laboratory tests, and other clinical tests and examinations; and
  - f. Types of services available to Inpatients and Outpatients at the specific hospital of admission
2. Inpatient Hospital services include:
  - a. bed and board, including special dietary service, in a semi-private room to the extent available;
  - b. professional services of Hospital staff;
  - c. laboratory services provided within the Hospital, therapeutic or Diagnostic Services involving use of radiology & radioactive isotopes;
  - d. related outpatient services, including but not limited to emergency department services, provided prior to Inpatient admission;
  - e. drugs, blood products; and
  - f. medical supplies, equipment and appliances as related to care and treatment

3. Medical treatment for the acute effects and complications of substance abuse toxicity is a covered benefit.
4. Prior to July 1, 2020, Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.

Beginning July 1, 2020, reimbursement for a mother's hospitalization for delivery does not include reimbursement for the newborn's hospitalization. Services shall be reimbursed under the identification number of each client.

**5 Psychiatric Hospital Services**

Inpatient Hospital psychiatric care is a Medicaid benefit for individuals age 20 and under when provided as a service of an in-state Hospital.

- a. Inpatient care in a Psychiatric Hospital may require prior-authorization by the Department's utilization review vendor or other Department representative, and includes physician services, as well as all services identified in 8.300.3.A.1, above.
- b. Inpatient psychiatric care in Psychiatric Hospitals is a Medicaid benefit only when
  - i. services involve active treatment which a team has determined is necessary on an Inpatient basis and can reasonably be expected to improve the condition or prevent further regression so that the services shall no longer be needed; the team must consist of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof; and
  - ii. services are provided prior to the date the individual attains age 21 or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, the date such individual no longer requires such services or, if earlier, the date such individual attains age 22.
- c. Medicaid clients obtain access to inpatient psychiatric care through the Community Mental Health Services Program defined in 10 CCR 2505-10, Section 8.212.

**6 Inpatient Hospital Dialysis**

Inpatient Hospital dialysis treatment is a Medicaid benefit at in-state DRG Hospitals for eligible recipients who are Inpatients only in those cases where hospitalization is required for:

- a. an acute medical condition for which dialysis treatments are required; or
- b. any other medical condition for which the Medicaid Program provides payment when the eligible recipient receives regular maintenance treatment in an Outpatient dialysis program; or
- c. placement or repair of the dialysis route.



**7 Inpatient Subacute Care**

Administration of subacute care by an enrolled hospital in its inpatient hospital or alternate care facilities is covered for the duration of the Coronavirus Disease 2019 (COVID-19) public health emergency. Subacute care in a hospital setting shall be equivalent to the level of care administered by a skilled nursing facility for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409. Members may be admitted to subacute care after an inpatient admission, or directly from an emergency department, observation status, or primary care referral to the administering hospital.

**8.300.3.B Covered Hospital Services – Outpatient**

Outpatient Hospital Services are a Medicaid benefit when determined Medically Necessary and provided by or under the direction of a physician. Outpatient Hospital Services are limited to the scope of Outpatient Hospital Services as defined in 42 C.F.R. Section 440.20. Outpatient Hospital Services include:

**1. Observation Stays**

Observation Stays are a covered Medicaid benefit when provided by or under the direction of a physician, for as many days as determined Medically Necessary. The physician must adequately document in the client's medical records that Observation Stay is Medically Necessary for the purposes of evaluating a client for possible Inpatient admission, treating a client expected to be stabilized and released without the need for Inpatient admission, or allowing extended recovery following a complication of an Outpatient procedure. In a majority of cases, the decision whether to admit a client to Inpatient admission or discharge from the hospital can be made in less than twenty-four hours. Only rarely shall Observation Stay exceed forty-eight hours in length.

Observation Stays end when a physician orders either Inpatient admission or discharge from the hospital. An Inpatient admission cannot be converted to an Outpatient Observation Stay after the client is discharged unless for purposes of rebilling after an audit finding as specified in 10 CCR 2505-10 8.043.

The decision to admit a client to Observation Stay is a medical determination that is based on a multitude of factors, including, but not limited to the:

- a. Client's current medical needs;
- b. Client's medical history;
- c. Severity of the signs and symptoms exhibited by the client at the time of presentation to the hospital, and at the point of the admission to observation status;
- d. Medical predictability of an adverse clinical event occurring with the client;
- e. Results of diagnostic studies, laboratory tests, and other clinical tests and examinations; and
- f. Types of services available to Inpatient and Outpatients at the specific hospital of admission

2. Outpatient Hospital Psychiatric Services

Outpatient psychiatric services, including prevention, diagnosis and treatment of emotional or mental disorders, are Medicaid benefits at non-Psychiatric Hospitals..

- a. Psychiatric outpatient services are not a Medicaid benefit in Psychiatric Hospitals.

3. Emergency Care

- a. Emergency Care Services are a Medicaid benefit, and are exempt from primary care provider referral.
- b. An appropriate medical screening examination and ancillary services such as laboratory and radiology shall be available to any individual who comes to the emergency treatment facility for examination or treatment of an emergent or apparently emergent medical condition and on whose behalf the examination or treatment is requested.

**8.300.3.C. Bariatric Surgery**

1. Eligible Members

- a. All currently enrolled Medicaid members over the age of sixteen when:
  - i) The member has clinical obesity; and
  - ii) It is Medically Necessary.

2. Eligible Providers

- a. Providers must enroll in Colorado Medicaid.
- b. Surgeons must be trained and credentialed in bariatric surgery procedures.
- c. Preoperative evaluations and treatment may be performed by:
  - i) Primary care physician,
  - ii) Nurse Practitioner,
  - iii) Physician Assistant,
  - iv) Registered dietician,
  - v) Behavioral health providers available through the member's Behavioral Health Organization.

3. Eligible Places of Service

- a. All surgeries shall be performed at a Hospital, as defined at 8.300.1.
  - i) Facilities must have safety protocols in place specific to the care and treatment of bariatric members.

- b. Pre- and Post- operative care may be performed at a physician's office, clinic, or other medically appropriate setting.

4. Covered Services and Limitations

- a. Colorado Medicaid covers participating providers for one bariatric procedure per member lifetime unless a revision is appropriate based one of the identified complications.

- i) Appropriate revision procedures are identified at section 8.300.3.C.4.d.

- b. Covered primary procedures Include:

- i) Roux-en-Y Gastric Bypass;
  - ii) Adjustable Gastric Banding;
  - iii) Biliopancreatic Diversion with or without Duodenal Switch;
  - iv) Vertical-Banded Gastroplasty;
  - v) Vertical Sleeve Gastroplasty.

- c. Criteria for Primary Procedures

When determining medical necessity or the appropriate level of care for members diagnosed with an eating disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, the Body Mass Index (BMI), ideal body weight, or any other standard requiring an achieved weight must not be used, in accordance with the requirements of Sections 25.5-5-336(1-2) (2023). Such members must meet criteria in Sections 8.300.3.C.4.c.iii-iv, and Section 8.300.3.C.4.c.v if under age 18. All other members must meet the first four following criteria, members under age 18 must also meet criteria five:

- i) The member is clinically obese with one of the following:
    - 1) BMI of 40 or higher, or
    - 2) BMI of 35-40 with objective measurements documenting one or more of the following co-morbid conditions:
      - a) Severe cardiac disease;
      - b) Type 2 diabetes mellitus;
      - c) Obstructive sleep apnea or other respiratory disease;
      - d) Pseudo-tumor cerebri;
      - e) Hypertension;
      - f) Hyperlipidemia;

- g) Severe joint or disc disease that interferes with daily functioning;
    - h) Intertriginous soft-tissue infections, nonalcoholic steatohepatitis, stress urinary incontinence, recurrent or persistent venous stasis disease, or significant impairment in Activities of Daily Living (ADL).
  - ii) The BMI level qualifying the member for surgery (>40 or >35 with one of the above co-morbidities) must be of at least two years' duration. A member's BMI may fluctuate around the required levels during this period around the required levels, and will be reviewed on a case-by-case basis.
  - iii) The member must have made at least one clinically supervised attempt to lose weight lasting at least six consecutive months or longer within the past eighteen months of the prior authorization request, monitored by a registered dietician that is supervised by a physician, nurse practitioner, or physician's assistant.
  - iv) Medical and psychiatric contraindications to the surgical procedure must have been ruled out through:
    - 1) A complete history and physical conducted by or in consultation with the requesting surgeon; and
    - 2) A psychiatric or psychological assessment, conducted by a licensed behavioral health professional, no more than three months prior to the requested authorization. The assessment must address both potential psychiatric contraindications and member's ability to comply with the long-term postoperative care plan.
  - v) For members under the age of eighteen, the following must be documented:
    - 1) The exclusion or diagnosis of genetic or syndromic obesity, such as Prader-Willi Syndrome;
    - 2) Whether female members have attained Tanner stage IV breast development; and
    - 3) Whether bone age studies estimate the attainment of 95% of projected adult height.
    - 4) Mental health evaluations for members age 17 must address issues specific to these members' maturity as it relates to compliance with postoperative instructions.
- d. Revision Procedures
  - i) Colorado Medicaid covers Revisions of a surgery for clinical obesity if it is used to correct complications such as slippage of an adjustable gastric band, intestinal obstruction, or stricture, following a primary procedure.

- ii) Indications for surgical revision:
  - 1) Weight loss to 20% below the ideal body weight;
  - 2) Esophagitis, unresponsive to nonsurgical treatment;
  - 3) Hemorrhage or hematoma complicating a procedure;
  - 4) Excessive bilious vomiting following gastrointestinal surgery;
  - 5) Complications of the intestinal anastomosis and bypass;
  - 6) Stomal dilation, documented by endoscopy;
  - 7) Documented slippage of the adjustable gastric band;
  - 8) Pouch dilation documented by upper gastrointestinal examination or endoscopy producing weight gain of 20% or more, provided that:
    - a) The primary procedure was successful in inducing weight loss prior to the pouch dilation; and
    - b) The member has been compliant with a prescribed nutrition and exercise program following the procedure (weight and BMI prior to surgery, at lowest stable point, and at current time must be submitted along with surgeon's statement to document compliance with diet and exercise);
  - 9) Other and unspecified post-surgical non-absorption complications.

e. Non-Covered Services:

- i) For Members with clinically diagnosed COPD (Chronic Obstructive Pulmonary Disease), including Chronic Bronchitis or Emphysema.
- ii) Repeat procedures not associated with surgical complications.
- iii) Cosmetic Follow-up: Weight loss following surgery for clinical obesity can result in skin and fat folds in locations such as the medial upper arms, lower abdominal area, and medial thighs. Surgical removal of this skin and fat for solely cosmetic purposes is not a covered benefit.
- iv) During pregnancy.

5. Prior Authorization Requirements

All bariatric surgical procedures require prior authorization, which must include:

- a) The Member's height, weight, BMI with duration.

- b) A list and description of each co-morbid condition, with attention to any contraindication which might affect the surgery including all objective measurements.
- c) A detailed account of the Member's clinically supervised weight loss attempt(s), including duration, medical records of attempts, identification of the supervising clinician, and evidence of successful completion and compliance.
- d) A current psychiatric or psychological assessment regarding contraindications for bariatric surgery, as described in 8.300.3.C.4.c(iv)(2).
- e) A statement written or agreed to by the member, detailing for the interdisciplinary team the member's:
  - i) Commitment to lose weight;
  - ii) Expectations of the surgical outcome;
  - iii) Willingness to make permanent life-style changes;
  - iv) Be willing to participate in the long-term postoperative care plan offered by the surgery program, including education and support, diet therapy, behavior modification, and activity/exercise components; and
  - v) If female, member's statement that she is not pregnant or breast-feeding and does not plan to become pregnant within two years of surgery.
- f) A description of the post-surgical follow-up program.
- g) For members under the age of eighteen, documentation of the physical criteria requirements at 8.300.3.C.4.c(v).

#### **8.300.4 Non-Covered Services**

The following services are not covered benefits:

1. Inpatient Hospital Services defined as experimental by the United States Food and Drug Administration.
2. Inpatient Hospital Services which are not a covered Medicare benefit.
3. Court-ordered psychiatric Inpatient care which does not meet the Medical Necessity criteria established for such care by the Department's utilization review vendor or other Department representative.
4. Substance abuse rehabilitation treatment is not covered unless individuals are aged 20 and under. Services must be provided by facilities which attest to having in place rehabilitation components required by the Department. These facilities must be approved by the Department to receive reimbursement.

#### **8.300.5 Payment for Inpatient Hospital Services**

##### **8.300.5.A Payments to DRG Hospitals for Inpatient Hospital Services**

1. Peer Groups

For the purposes of Inpatient reimbursement, DRG Hospitals are assigned to one of the following peer groups. Hospitals which do not fall into the peer groups described in a and b shall default to the peer groups described in c and d based on geographic location.:

- a. Pediatric Hospitals
- b. Rural Hospitals
- c. Urban Hospitals

**2. Base Payment and Outlier Payment**

DRG Hospitals shall be reimbursed for Inpatient Hospital Services based on a system of DRGs and a hospital-specific Medicaid Inpatient base rate. The reimbursement for Inpatient Hospital Services shall be referred to as the DRG base payment.

- a. The DRG base payment shall be equal to the DRG Relative Weight multiplied by the Medicaid Inpatient base rate as calculated in Section 8.300.5.A.3 – 6.
- b. Outlier days shall be reimbursed at 80% of the DRG per diem rate. The DRG per diem rate shall be the DRG base payment divided by the DRG average length of stay.
- c. The DRG base payment plus any corresponding outlier payment is considered the full reimbursement for an Inpatient Hospital stay where the client was Medicaid-eligible for the entire stay.
- d. When a client was not Medicaid-eligible for an entire Inpatient Hospital stay, reimbursement shall be equal to the DRG per diem rate for every eligible day, with payment up to the full DRG base payment. If applicable, the Hospital shall receive outlier reimbursement.

**3. Medicaid Inpatient Base Rate for In-network Colorado DRG Hospitals**

**a. Calculation of the Starting Point for the Medicaid Inpatient Base Rate**

For in-state Colorado DRG Hospitals (both PPS and non-PPS), the starting point shall be the hospital-specific Medicare Federal base rate with the specific adjustments listed. The Operating Federal Portion and Federal Capital Rate (source: CMS Tables 1A-1B & IE) will be adjusted by the Wage Index and Geographic Adjustment Factor (GAF) from the CMS IMPACT File. For CAH and Pediatric hospitals (non-PPS Medicare hospitals), both adjustment factors as listed above will be set to 1.0 and the corresponding labor and non-labor related amounts will be applied because these factors are not available from CMS. Additionally, the Quality and Meaningful Electronic Health Records (EHR) User adjustments will be applied to all PPS hospitals as indicated on the CMS corrected IMPACT file, while all non-PPS hospitals are assumed to have submitted Quality Data and be meaningful EHR users since no data exists for them. The corrected Medicare base rate IMPACT File shall be used to set the Federal Base Rate and other adjustments detailed above effective on October 1 of the previous fiscal year.

b. Policy Adjustments

Indirect Medical Education (IME) / Value Based Purchasing Adjustment (VBP) Factor / Readmission Adjustment Factor and Hospital Acquired Conditions (HAC) Reduction:

- 1) For PPS hospitals, Operating IME% will be multiplied by Adjusted Operating Federal Portion and the Capital IME% will be multiplied by the Adjusted Federal Capital Rate. The VBP Adjustment Factor and Readmission Adjustment Factor taken from CMS Final Rule Correcting Amendment Tables 16B and 15 respectively will be multiplied by the Adjusted Operating Federal Portion. The Hospital Acquired Conditions Reduction taken from the most recent CMS.gov Data Set as of January 1 will be applied against the Medicare Federal Base Rate with Wage Index/GAF Adjustments.
- 2) For non-PPS hospitals, Operating & Capital IME % are not calculated in the IMPACT File so the Department's Contractor will compute their Operating and Capital IME using the most recently available cost report as of January 1 in rebasing years and will require that hospitals have a CMS approved teaching program as detailed in Section 8.300.5.A.3.e. Additionally, non-PPS Hospitals will have the opportunity to review their calculated Operating and Capital IME percent during a 30-day review period and request changes if necessary. The VBP Adjustment Factor, Readmission Adjustment Factor and HAC Reduction will not be applied to non-PPS hospitals since they are not calculated by CMS.

c. Mutually Exclusive Medicaid Add-ons:

Four Add-ons will be mutually exclusive and applied as described here and will be applied as a percentage against the Medicare Federal Base Rate w/Wage Index/GAF Adjustments as detailed below.

- 1) Critical Access Hospital (CAH) Add-on will be set at 25% and is only open to those hospitals categorized as CAH by Medicare,
- 2) Sole Community Hospital (SCH)/Medicare Dependent Hospital (MDH) will be set at 20% and is only open those hospitals categorized as SCH/MDH in section 8.300.1.K,
- 3) Low Discharge Add-on based on the average of up to three years of Total Discharges of most recently available cost reports on HCRIS as of January 1 of rebasing years and excludes hospitals that are classified as Pediatric, SCH/MDH or CAH. For hospitals with subunits of Psychiatric, Rehabilitation and other subunits discharges in those subunits will be added to total discharges. The percentage add-on is set at 10% and distributed on a sliding scale with a ceiling of 2,500 and floor of 500 discharges,
- 4) The Pediatric Add-on is open only to hospitals defined as Pediatric in Section 8.300.1.K.3 and the percentage add-on is set at 25%.



d. Remaining Medicaid Add-ons:

The remaining add-ons are open to all hospitals who qualify and are applied as a percentage of the Medicare Federal Base Rate with Wage Index/GAF Adjustments and distributed on a sliding scale between the respective ceiling and floor.

1. Payer Mix Add-on is based on the percentage of Medicaid patient days treated at the hospital using up to three years of the most recently available cost reports. The add-on is set at up to 10% with a ceiling and floor of 50% and 35% respectively. For hospitals with subunits of Psychiatric, Rehabilitation and other subunits Payer Mix utilization in those subunits will be added to the calculations.
2. Operating Cash Flow Margin Percent Add-on (also known as the solvency metric) is set at 20% with a ceiling of 8% and floor of 0%. The source for this data is up to 3 years of Hospital Transparency Data that is generated by each hospital and sent into the Department. The Operating Cash Flow Margin Percent Add-on is calculated for all hospitals and is based on the maximum of the hospital or the hospital system's operating cash flow margin percent. System hospital list can be found on the Department's website. Operating Cash Flow Margin Percent is calculated by taking (Total Operating Net Income + Depreciation Expense) / Total Operating Revenue.

e. Application of Graduate Medical Education (GME) Cost Add-on to Determine Medicaid Inpatient Base Rate:

- 1) The Medicaid Inpatient base rate shall be equal to the rate as calculated in Sections 8.300.5.A.3.a-b plus the GME Medicaid hospital-specific cost add-on. The GME Medicaid hospital-specific cost add-on is calculated from the most recently available Medicare/Medicaid cost report (CMS 2552) worksheet B, Part I. Partial year cost reports shall not be used to calculate the GME cost add-on. The GME cost add-on shall not be applied to the Medicaid Inpatient base rates for State University Teaching Hospitals. State University Teaching Hospitals shall receive reimbursement for GME costs as described in Section 8.300.9.B.

The GME Medicaid hospital-specific cost add-on shall be an estimate of the cost per discharge for GME based on: Medicare approved GME program where legitimate GME expenses have been reported in accordance with Medicare's rules detailed in 42 C.F.R. § 413.75, et. seq. GME will be calculated when the following two criteria are met:

- i. Hospitals that appear on the most recent list as of January 1 of CMS qualified teaching hospitals on the CMS Open Payments website or the hospital will need to provide documentation to the State by proving Medicare approval of the GME program.
  - ii. Have countable GME costs in the most recent cost report available as of January 1 of rebasing years in worksheet B, part 1 and discharges from worksheet S-3, part I.
- 2) Ten percent of the GME Medicaid hospital-specific cost add-on shall be applied.

f. Application of Adjustment Based on General Assembly Funding

In rebasing years, for all in-state, Colorado DRG Hospitals (both PPS and non-PPS), the starting point for the Medicaid Inpatient base rate, as determined in Section 8.300.5.A.3.a - e, shall be adjusted by an equal percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the General Assembly. Additionally, a 10% corridor has been implemented to prevent any hospital's inpatient base rate from increasing or decreasing more than 10% each rebasing year.

g. Annual Adjustments

The Medicaid Inpatient base rates are rebased every other year as described in Section 8.300.5.A.3.a - f and are effective each July 1. In non-rebasing years, the Medicaid Inpatient base rates will be adjusted by the State Budget Action as set by Legislature and are effective each July 1. The Medicaid base rate shall be adjusted during the fiscal year, if necessary, based on appropriations available to the Department and/or adjustments necessary to balance the DRG payment equation.

4. Medicaid Inpatient Base Rate for New In-State Colorado DRG Hospitals

The Medicaid Inpatient base rate for new in-state Colorado DRG Hospitals shall be the average Colorado Medicaid Inpatient base rate for their corresponding peer group. A Hospital is considered "new" until the next Inpatient rate rebasing year after the Hospital's contract effective date. For the next Inpatient rate rebasing year, the Hospital's Medicaid Inpatient base rate shall be equal to the rate as determined in Section 8.300.5.A.3-6. If the Hospital does not have a Medicare Inpatient base rate or a full year Medicare/Medicaid cost report to compute a starting point as described in Section 8.300.5.A.3.a, their initial rate shall be equal to the average Colorado Medicaid Inpatient base rate for their corresponding peer group.

5. Medicaid Inpatient Base Rate for Border-state Hospitals

The Medicaid Inpatient base rate for border-state Hospitals shall be equal to the average Medicaid Inpatient base rate for the corresponding peer group.

6. Medicaid Inpatient Base Rate for Out-of-state Hospitals

a. The Medicaid Inpatient base rate for out of state Hospitals shall be equal to 90% of the average Medicaid Inpatient base rate for the corresponding peer group.

b. The Department may reimburse an out-of-state Hospital for non-emergent services at an amount higher than the DRG base payment when the needed services are not available in a Colorado Hospital. Reimbursement to the out-of-state Hospital shall be made at a rate mutually agreed upon by the parties involved.

7. Reimbursement for Inpatient Hospital claims that (a) include serious reportable events identified by the Department in the Provider Bulletin with (b) discharge dates on or after October 1, 2009, may be adjusted by the Department.

**8.300.5.B Abbreviated Client Stays**

1. DRG Hospitals shall receive the DRG base payment and any corresponding outlier payment for Abbreviated Client Stays. The DRG base payment and outlier payment shall be subject to any necessary reduction for ineligible days.

**8.300.5.C Transfer Pricing**

1. Reimbursement for a client who is transferred from one DRG Hospital to another DRG Hospital is calculated at a DRG per diem rate for each Hospital with payment up to the DRG base payment to each DRG Hospital. If applicable, both Hospitals may receive outlier reimbursement.
2. Reimbursement for a client who is transferred from one DRG Hospital to a Non-DRG Hospital, or the reverse, is calculated at the DRG per diem rate for the DRG Hospital with payment up to the DRG base payment. Reimbursement for the Non-DRG Hospital shall be calculated based on the assigned per diem rate. If applicable, the DRG Hospital may receive outlier reimbursement.
3. For transfers within the DRG Hospital, the Hospital is required to submit one claim for the entire stay, regardless of whether or not the client has been transferred to different parts of the Hospital. Since the Colorado Medicaid program does not recognize distinct part units, Hospitals may not submit two claims for a client who is admitted to the Hospital and then transferred to the distinct part unit or vice versa.

**8.300.5.D APR-DRG Payment Methodology Exclusions**

1. Long-acting reversible contraceptives (LARC) devices, inserted following a delivery, are excluded from the DRG Relative Weight calculation and are paid according to the Department's fee schedule.
2. Pursuant to § 25.5-5-509, C.R.S. opiate antagonists identified by the Department shall be paid according to the Department's fee schedule when dispensed to a medical assistance recipient upon discharge.
3. Effective January 1, 2024, for services meeting the criteria of an Inpatient Hospital Specialty Drug that would have otherwise been compensated through the APR-DRG methodology, a hospital must submit a request for authorization to the Department prior to administration of the drug. If the request is approved, then the payment will be negotiated between the Department and the hospital on a case-by-case basis.

**8.300.5.E Payments to Non-DRG Hospitals for Inpatient Services**

1. Payments to Psychiatric Hospitals
  - a. The Department shall reimburse Psychiatric Hospitals for inpatient services provided to Medicaid clients on a per diem basis. The per diem rates shall follow a step-down methodology. Each step has a corresponding per diem rate based on historical Medicaid payment rates and evaluation of Hospital data concerning the relationship between Hospital costs and client length of stay. Criteria for each step are described below:
    - i Step 1: Day 1 through Day 7
    - ii Step 2: Day 8 through remainder of care at acute level

- b. Hospital rates may be adjusted annually on July 1 to account for changes in funding by the General Assembly and inflationary adjustments as determined by the Medicare Economic Index.

2. Payment to State-Owned Psychiatric Hospitals

The Department shall reimburse State-Owned Psychiatric Hospitals on an interim basis according to a per diem rate. The Department will determine the per diem rate based on an estimate of 100% of Medicaid costs from the Hospital's Medicare cost report. Periodically, the Department will audit actual costs and may require a cost settlement to insure reimbursement is 100% of actual audited Medicaid costs.

3. Payments to Long-Term Care and Rehabilitation Hospitals (excludes distinct part units and satellite locations as defined under Section 8.300) shall be divided into three (3) subgroups: Long-Term Care Hospital, Rehabilitation Hospital and Spine/Brain Injury Treatment Specialty Hospital.

The Department shall reimburse Long-Term Care, Rehabilitation, and Spine/Brain Injury Treatment Specialist Hospitals for inpatient services provided to Medicaid patients on a per diem basis. The per diem rates shall follow a step-down methodology based on length of stay, with a decrease of five (5) percent with each step. Each step shall be assigned a corresponding per diem rate based on historical Medicaid payment rates and evaluation of Hospital data concerning the relationship between Hospital costs and client length of stay. The Department may adjust hospital rates annually on July 1 to account for changes in funding by the General Assembly. The criteria for each of the steps are described below:

a. Payments to Long-Term Care Hospitals:

- i. Step 1: Day 1 through Day 21
- ii. Step 2: Day 22 through Day 35
- iii. Step 3: Day 36 through Day 56
- iv. Step 4: Day 57 through remainder of stay

b. Payments to Rehabilitation Hospitals:

- i. Step 1: Day 1 through Day 6
- ii. Step 2: Day 7 through Day 10
- iii. Step 3: Day 11 through Day 14
- iv. Step 4: Day 14 through remainder of stay

c. Payments to Spine/Brain Injury Treatment Specialty Hospitals:

- i. Step 1: Day 1 through Day 28
- ii. Step 2: Day 29 through Day 49
- iii. Step 3: Day 50 through Day 77

- iv. Step 4: Day 78 through remainder of stay
- d. The Classification-specific per diem for 2019, the year of this methodology implementation shall be calculated using the following method:
  - i. The Department shall assign the claims submitted by each hospital for fiscal year 2017 to one of the following peer groups:
    - 1) Long-Term Care Hospital
    - 2) Rehabilitation Hospital
    - 3) Spine/Brain Injury Treatment Specialty Hospital
  - ii. The Department shall process Medicaid inpatient hospital claims from state fiscal year 2017 through the methodology described in Section 8.300.5.D.3 a-c. This will create per diems that are budget neutral to fiscal year 2017.
  - iii. The Department shall adjust the per diems annually to reflect budget changes. For state fiscal year 2018, rates shall be increased 1.4%. For state fiscal year 2019, rates shall be increased 1%. The Department shall adjust rates in subsequent years by the percentage changes in the budget as appropriated by the General Assembly.

**8.300.5.E [Emergency rule expired 04/10/2021]**

**8.300.5.F Payment for Inpatient Subacute Care**

- 1. Inpatient Subacute Care days shall be paid at a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State plan approved by the Centers for Medicare and Medicaid Services (CMS), for the State in which such hospital is located.

**8.300.5.G Payment for High Acuity In-State Services**

- 1. The Department may negotiate a higher reimbursement rate for in-state inpatient hospital services up to, but no greater than, 100% of the costs anticipated by the hospital—which must be demonstrated by evidence, including but not limited to an anticipated cost report submitted to the Department for review—where, as determined by the Department, all of the following conditions are fulfilled:
  - a. The in-state inpatient payment methodology insufficiently accounts for the level of acuity;
  - b. All other placement options have been exhausted; and
  - c. The services have been reviewed and authorized by the Medical Director for the Department.

**8.300.6 Payments For Outpatient Hospital Services**

**8.300.6.A Payments to DRG Hospitals for Outpatient Services**

- 1. Payments to In-Network Colorado DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges multiplied by the Medicare cost-to-charge ratio less 28%. When the Department determines that the Medicare cost-to-charge ratio is not representative of a Hospital's Outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited Medicaid cost less 28% or billed charges less 28%.

Effective September 1, 2009, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.1 percent (29.1%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1 percent (29.1%) or billed charges less 29.1 percent (29.1%).

Effective January 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30 percent (30%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30 percent (30%) or billed charges less 30 percent (30%).

Effective July 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30.7 percent (30.7%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30.7 percent (30.7%) or billed charges less 30.7 percent (30.7%).

Effective July 1, 2011, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 31.2 percent (31.2%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 31.2 percent (31.2%) or billed charges less 31.2 percent (31.2%).

Effective July 1, 2013, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.8 percent (29.8%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.8 percent (29.8%) or billed charges less 29.8 percent (29.8%).

Effective July 1, 2014, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28.4 percent (28.4%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28.4 percent (28.4%) or billed charges less 28.4 percent (28.4%).

Effective July 1, 2015, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28 percent (28%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28 percent (28%) or billed charges less 28 percent (28%).

Effective October 31, 2016, DRG Hospitals will be reimbursed for Outpatient Hospital Services based on a system of Enhanced Ambulatory Patient Grouping and a Hospital-specific Medicaid Outpatient base rate. The reimbursement for Outpatient Hospital Services shall be referred to as the EAPG Payment.

- a. The EAPG Payment will be equal to the EAPG Weight multiplied by the Hospital-specific Medicaid Outpatient base rate for that hospital as calculated in 10 CCR 2505-10, Section 8.300.6.A.1.k. If the EAPG Weight is modified due to any action impacting payment as described in sections 8.300.6.A.1.d-j, the modified EAPG Weight will be referred to as the EAPG Adjusted Weight. EAPG Payment will then be equal to the EAPG Adjusted Weight multiplied by the Hospital-specific Medicaid Outpatient base rate. If the billed amount is less than the EAPG Payment, reimbursement will be the billed amount.
- b. The EAPG Payment is calculated for each detail on the claim. Claim details with the same dates of service are grouped into a visit. Claims containing details describing charges for emergency room, treatment room services or patients placed under observation will have all its details grouped into a single visit.
- c. Each detail on a claim is assigned an EAPG. EAPGs can have the following types:
  - (1) Per Diem
  - (2) Significant Procedure. Subtypes of Significant Procedures Are:
    - (a) General Significant Procedures
    - (b) Physical Therapy and Rehabilitation
    - (c) Behavioral Health and Counseling
    - (d) Dental Procedure
    - (e) Radiologic Procedure
    - (f) Diagnostic or Therapeutic Significant Procedure
  - (3) Medical Visit
  - (4) Ancillary
  - (5) Incidental
  - (6) Drug
  - (7) Durable Medical Equipment

(8) Unassigned

- d. A detail will be subject to EAPG Consolidation when it is assigned the same Significant Procedure EAPG as a detail not already subjected to EAPG Consolidation for that visit. EAPG Consolidation will also occur for details assigned EAPGs considered to be clinically similar to another EAPG during the visit. Details subject to EAPG Consolidation will have an EAPG Payment calculated using an EAPG Weight of 0.
- e. A detail will be subject to EAPG Packaging when its assigned EAPG is considered an ancillary service to a Significant Procedure EAPG or Medical Visit EAPG present on the claim for that visit. Details describing additional undifferentiated medical visits and services will be exempt from EAPG Packaging. A detail is also subject to EAPG Packaging when it is assigned a Medical Visit EAPG while a Significant Procedure EAPG is present on the claim for that visit. Details assigned Significant Procedure EAPGs that are not General Significant Procedures do not cause details with Medical Visit EAPGs to be subject to EAPG Packaging. Details subject to EAPG Packaging will be calculated using an EAPG Weight of 0.
- f. A detail will qualify for Multiple Significant Procedure Discounting when a Significant Procedure of the same subtype is present on the claim for that visit. Details qualifying for Multiple Significant Procedure Discounting are ordered by their EAPG Weight, by visit. Per visit, the qualifying detail with the greatest EAPG Weight will have its EAPG Payment calculated at 100 percent (100%) of its EAPG Weight. The qualifying detail for that visit with the next greatest EAPG Weight will have its EAPG Payment calculated at 50 percent (50%) of its EAPG Weight. All other qualifying details for that visit will have its EAPG Payment calculated at 25 percent (25%) of its EAPG Weight.
- g. Details assigned the same Ancillary EAPG on the same visit will qualify for Repeat Ancillary Discounting. EAPG Payment for the first occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 100 percent (100%) of its EAPG Weight. EAPG Payment for the second occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 50 percent (50%) of its EAPG Weight. EAPG Payment for all other details qualifying for Repeat Ancillary Discounting for that visit and EAPG will be calculated using 25 percent (25%) of their EAPG Weights.
- h. Details describing terminated procedures will be subject to Terminated Procedure Discounting. EAPG Payment for a detail subject to Terminated Procedure Discounting is calculated using 50 percent (50%) of the EAPG Weight. Terminated procedures are not subject to other types of discounting.
- i. Details describing bilateral services will have EAPG Payment calculated using 150 percent (150%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.
- j. Details describing 340B Drugs will have an EAPG Payment calculated using 80 percent (80%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.
- k. The Hospital-specific Medicaid Outpatient base rate for January 1, 2022 for each hospital is calculated using the following method.



- (1) Assign each hospital to one of the following groups based on hospital type and location:
  - (a) Pediatric Hospitals
  - (b) Critical Access Hospitals
  - (c) Non-Critical Access, System Hospitals
  - (d) Independent Hospitals
  - (e) Rehabilitation, Long-term Acute Care, and Brain/Spine Injury Hospitals
- (2) Rehabilitation, Long-term Acute Care, and Brain/Spine Injury Hospitals are assigned their same hospital-specific base rate as effective immediately prior to January 1, 2022.
- (3) Process Medicaid outpatient hospital claims from calendar year 2019 through the methodology described in 8.300.6.A.1.a-j using 3M's EAPG Relative Weights, scaled for budget neutrality purposes, and version 3.16 of the Enhanced Ambulatory Patient Grouping methodology. Hospital payment rates from version 3.10 of the methodology are then compared to the version 3.16 payment rates using the hospital-specific base rates immediately prior to January 1, 2022.
- (4) For Critical Access Hospitals, a weighted average base rate by outpatient hospital visit is calculated EAPG payments for Critical Access Hospitals under version 3.10 and 3.16 are calculated using this weighted average base rate, then an inflation factor is applied to determine a revenue neutral rate for the Critical Access Hospital group. This inflation factor is then applied to all Critical Access Hospital rates effective immediately prior to January 1, 2022. For all other hospitals, with the exception of Rehabilitation, Long-term Acute Care, and Spine/Brain Injury Hospitals, a revenue neutral rate is calculated which aligns payment under version 3.16 of EAPGs to payments calculated under version 3.10.
- (5) For Critical Access Hospitals, the average and standard deviation of their rates with the inflation factor applied is calculated. All Critical Access Hospitals with a rate falling below 1 standard deviation of the average is given a rate at 1 standard deviation below the average. For Critical Access Hospitals with a rate above 2 standard deviations of the average is given a rate at 2 standard deviations above the average. For each other hospital group, except Rehabilitation, Long-term Acute Care, and Spine/Brain Injury Hospitals, the average and standard deviation of their rates are calculated. For hospitals that have a rate below 1.5 standard deviations of the average rate of their assigned group, the hospital is assigned a rate at 1.5 standard deviations below the group's average rate. For hospitals that have a rate above 1.5 standard deviations of the average rate of their assigned group, the hospital is assigned a rate at 1.5 standard deviations above the group's average rate.

- (6) For new, in-state hospitals, such hospitals will be assigned to a Pediatric, Long Term Acute Care, or Rehabilitation peer group depending on hospital type. If a provider does not meet the criteria for any of the above peer groups, it will be assigned to a Rural or Urban peer group based on location. The hospital will receive a base rate of the average peer-group rate as calculated from Colorado hospitals base rate statistics.
    - (7) For all hospitals, the Medicaid Outpatient base rate, as determined in 8.300.6.A.k.(1)-(6), shall be adjusted by an equal percentage, when required due to changes in the available funds appropriated by the General Assembly. The application of this change to the Medicaid Outpatient base rate shall be determined by the Department.
  - I. Effective June 1, 2020, by the modification of the EAPG Weights, the allowed reimbursement of outpatient hospital drugs shall be increased by 42.93% for drugs provided at Critical Access Hospitals and Medicare Dependent Hospitals, and decreased by 3.47% for drugs provided at non-independent urban hospitals.
2. **Payments to Out-of-Network DRG Hospitals**

Excluding items that are reimbursed according to the Department's fee schedule, border-state Hospitals and out-of-network Hospitals, including out-of-state Hospitals, shall be paid 30% of billed charges for Outpatient Hospital Services. Consideration of additional reimbursement shall be made on a case-by-case basis in accordance with supporting documentation submitted by the Hospital.

Out-of-Network DRG Hospitals will be reimbursed for Outpatient Hospital Services based on the system of Enhanced Ambulatory Patient Grouping described in Section 8.300.6.A.1. Such hospitals will be assigned to a Pediatric, Long Term Acute Care, or Rehabilitation peer group depending on hospital type. If a provider does not meet the criteria for any of the above peer groups, it will be assigned to a Rural or Urban peer group based on location. The hospital will receive a base rate of 90% of the average peer group rate as calculated from Colorado hospitals base rate statistics. Out-of-Network DRG Hospitals will periodically have their Medicaid Outpatient base rates adjusted as determined in Section 8.300.6.A.k.7.
3. **Payments for Outpatient Hospital Specialty Drugs**

Effective August 11, 2018, for services meeting the criteria of an Outpatient Hospital Specialty Drug that would have otherwise been compensated through the EAPG methodology, a hospital must submit a request for authorization to the Department prior to administration of the drug. If the request is approved, then the payment will be negotiated between the Department and the hospital on a case-by-case basis.
4. **Payments for Select Outpatient Hospital Opioid Antagonist Drugs**

Pursuant to C.R.S. § 25.5-5-509, effective July 8, 2022, payments for select Outpatient Hospital Opioid Antagonist Drugs that would have otherwise been compensated through the EAPG methodology will be reimbursed at either the lower of the billed charges or the fee schedule rate.

**8.300.7 Graduate Medical Education (GME) Payments to Hospitals for Medicaid Managed Care**

GME costs for Medicaid managed care clients shall be paid directly to qualifying Hospitals rather than to managed care organizations (MCOs).

**8.300.7.A GME for Medicaid Managed Care – Inpatient Services**

1. The Hospital cost report used for the most recent rebasing year shall be used to determine the Medicaid Inpatient GME cost per day for each Hospital that has GME costs in its fee-for-service base rate, excluding State University Teaching Hospitals. Each Hospital's GME cost per day shall be computed when Hospital rates are rebased according to the schedule outlined in Section 8.300.5.A.3.e. Years when rates are updated with the State Budget Action as set by Legislature, GME cost per day will remain unchanged from the cost report rebasing year.
2. MCOs shall provide to the Department Inpatient days by Hospital for discharges (net of adjustments) during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.
3. The Medicaid managed care Inpatient days for each Hospital shall be the total of the Inpatient days for each Hospital received from the MCOs for each quarter. That total shall be multiplied by the GME cost per day to determine the Inpatient GME reimbursement for each Hospital per quarter. The GME reimbursement will be paid at least annually through a gross adjustment process to each Hospital by June 30th of each year.

**8.300.7.B GME for Medicaid Managed Care – Outpatient Services**

1. The Hospital cost report used for the most recent rebasing year shall be used to determine the Outpatient GME cost-to-charge ratio for each Hospital that has a graduate medical education program. Each Hospital's GME cost-to-charge ratio shall be computed when Hospital rates are rebased according to the schedule outlined in Section 8.300.5.A.3.e. Years when rates are updated with the State Budget Action as set by Legislature, GME cost-to-charge ratio will remain unchanged from the cost report rebasing year.
2. MCOs shall provide to the Department Outpatient charges for Medicaid clients by Hospital for Outpatient dates of service during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.
3. The Medicaid managed care Outpatient charges for each Hospital shall be the total of the Outpatient charges for each Hospital received from the MCOs for each quarter. That total shall be multiplied by the cost-to-charge ratio and reduced by 28 percent to determine the Outpatient GME reimbursement for each Hospital per quarter. The GME reimbursement shall be paid at least annually through a gross adjustment process to each Hospital by June 30th of each year.

**8.300.8 Disproportionate Share Hospital Adjustment**

- 8.300.8.A** Federal regulations require that Hospitals which provide services to a disproportionate share of Medicaid recipients shall receive an additional payment amount to be based upon the following minimum criteria:

1. A Hospital must have a Medicaid Inpatient utilization rate at least one standard deviation above the mean Medicaid Inpatient utilization rate for Hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent; and
2. A Hospital must have at least two obstetricians with staff privileges at the Hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan.
  - a. In the case where a Hospital is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the Hospital to perform non-emergency obstetric procedures.
3. Number (2) above does not apply to a Hospital in which:
  - a. the Inpatients are predominantly under 18 years of age; or
  - b. does not offer non-emergency obstetric services as of December 21, 1987.
4. The Medicaid Inpatient utilization rate for a Hospital shall be computed as the total number of Medicaid Inpatient days for a Hospital in a cost reporting period, divided by the total number of Inpatient days in the same period.
5. The low income utilization rate shall be computed as the sum of:
  - a. The fraction (expressed as a percentage),
    - i. the numerator of which is the sum (for a period) of
      - 1) total revenues paid the Hospital for client services under a State Plan under this title and
      - 2) the amount of the cash subsidies for client services received directly from state and local governments; and
    - ii. the denominator of which is the total amount of revenues of the Hospital for client services (including the amount of such cash subsidies) in the period; and
  - b. a fraction (expressed as a percentage),
    - i. the numerator of which is the total amount of the Hospital's charge for Inpatient Hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (I) (ii) of subparagraph a) of Section 1923 of the Social Security Act, in the period reasonably attributable to Inpatient Hospital services, and
    - ii. the denominator of which is the total amount of the Hospital's charges for Inpatient Hospital services in the Hospital in the period.
6. The numerator under subparagraph (b)(i) shall not include contractual allowances and discounts.

**8.300.8.B Colorado Determination of Individual Hospital Disproportionate Payment Adjustment**

1. Eligible hospitals will receive a Disproportionate Share Hospital Supplemental Payment according to the terms defined in 10 CCR 2505-10 section 8.3004.D.

**8.300.9 Supplemental Inpatient Hospital Payments**

**8.300.9.A Family Medicine Residency Training Program Payment**

A Hospital qualifies for a Family Medicine Residency Training Program payment when it is recognized by the Commission on Family Medicine and has at least 10 residents and interns. The Family Medicine Residency Training Program payment will only be made to Medicaid in-network Hospitals. For each program which qualifies under this section, the additional Inpatient Hospital payment will be calculated based upon historical data and paid in 12 equal monthly installments. The Family Medicine Residency Training Program payment is a fixed amount subject to annual appropriation by the General Assembly.

**8.300.9.B State University Teaching Hospital Payment**

State University Teaching Hospitals shall receive a supplemental Inpatient Hospital payment for GME costs associated with Inpatient Hospital Services provided to Medicaid fee-for-service and managed care clients. The State University Teaching Hospital payment is calculated based on GME costs and estimated Medicaid discharges using the same methodology as that used to calculate the GME add-on to the Medicaid Inpatient base rate described in 10 CCR 2505-10 Section 8.300.5.A.3.c., and the GME payments to Hospitals for Medicaid managed care described in 10 CCR 2505-10 Section 8.300.7. The State University Teaching Hospital payment is a fixed amount subject to annual appropriation by the General Assembly.

**8.300.10 Patient Payment Calculation for Nursing Facility Clients Who are Hospitalized**

**8.300.10.A** When an eligible client is admitted to the Hospital from a nursing facility, the nursing facility shall, at the end of the month, apply all of the available patient payment to the established Medicaid rate for the number of days the client resided in the nursing facility. The nursing facility shall notify the county department of any amount of patient payment that applies, using form AP-5615. An allowed exception to the usual five (5) day completion requirement is that the AP-5615 for hospitalized clients may be completed at the end of the month. If the nursing facility has calculated an excess amount, the county will notify the Hospital of the amount. If directed by the county department, the nursing facility shall transfer the excess amount to the Hospital and this payment will be shown as a patient payment when the Hospital submits a claim to the Medicaid Program.

**8.300.10.B** The Hospital is responsible for collecting the correct amount of patient payment due from the client, the client's family, or representatives. Failure to collect patient payment, in whole or in part, does not allow the Hospital to bill Medicaid for the patient payment.

**8.300.11. Payment for Hospital Beds Designated as Swing Beds**

**8.300.11.A Swing Bed Payment Rates**

1. Payment for swing-bed services will be made at the average rate per client day paid to Class I nursing facilities for services furnished during the previous calendar year.
2. Oxygen provided to swing-bed clients shall be reimbursed as specified in 10 CCR 2505-10, Sections 8.580 and 8.585.

3. Clients shall be required to contribute their patient payment to the cost of their nursing care. Collection as well as determination of the patient payment amount shall be in accordance with 10 CCR 2505-10, Section 8.482.

**8.300.11.B Swing Bed Claim Submission**

1. Hospitals shall submit claims for swing-bed routine services as nursing facility claims.
2. Ancillary services (services not required to be provided by nursing facilities participating in the Medicaid program within their per diem rate, but reimbursable under Medicaid, including but not limited to laboratory and radiology) shall be billed separately on the appropriate claim form.

**8.300.12 Utilization Management and Reviews**

All participating Hospitals are required to comply with utilization management and review, prior authorization requirements, audit and/or program integrity, and quality improvement activities administered by the Department's utilization review vendor, external quality review organization or other representative.

**8.300.12.A Conduct of Reviews**

1. All reviews will be conducted in compliance with 10 CCR 2505-10, Sections 8.058 Request for Prior Authorization, 8.076, Program Integrity, and 8.079, Quality Improvement.
2. Reviews will be conducted relying on the professional expertise of health professionals, prior experience and professional literature; and nationally accepted evidence-based utilization review screening criteria whenever possible. These criteria shall be used to determine the quality, Medical Necessity and appropriateness of a health care procedure, treatment or service under review.
3. The types of reviews conducted may include, but are not limited to the following:
  - a. Prospective Reviews;
  - b. Concurrent Reviews;
  - c. Reviews for continued stays and transfers;
  - d. Retrospective Reviews.
4. These reviews, for selected Inpatient or Outpatient procedures and/or services, shall include but are not limited to:
  - a. Medical Necessity;
  - b. Appropriateness of care;
  - c. Service authorizations;
  - d. Payment reviews;
  - e. DRG validations;

- f. Outlier reviews;
  - g. Second opinion reviews; and
  - h. Quality of care reviews.
- 5. If criteria for Inpatient hospitalization or outpatient Hospital services are not met at any point in a hospitalization (i.e., at the point-of-admission review, Continued Stay Review or Retrospective Review) the provider will be notified of the finding.
  - a. When appropriate, payment may be adjusted, denied or recouped.
- 6. When the justification for services is not found, a written notice of denial shall be issued to the client, attending physician and Hospital. Clients and providers may follow the Department's procedures for appeal. See 10 CCR 2505-10 Sections 8.050, Provider Appeals, and 8.057, Recipient Appeals.

**8.300.12.B Corrective Action**

- 1. The Department may require or recommend Corrective Action when documentation indicates a pattern of inappropriate behavior, including, but not limited to, improper billing, unwarranted utilization, or questionable quality of care.
- 2. The Department may initiate sanctions, as set forth in 10 CCR 2505-10, Section 8.076 and Section 8.130 if the required Corrective Action is not implemented or the implemented Corrective Action fails to resolve the pattern of inappropriate behavior.
- 3. Requirement to self-audit, Retrospective Reviews, and other actions as determined appropriate by the Department may be required or performed as a type of Corrective Action for an identified Hospital or client.

**8.300.12.C Prior Authorization of Swing-Bed Care**

Care for Medicaid clients in hospital beds designated as swing beds shall be prior authorized and subject to the Continued Stay Review process in accordance with the criteria and procedures found in 10 CCR 2505-10, Sections 8.393 and 8.400 through 8.415. Prior authorization requires a level of care determination using the Uniform Long Term Care 100.2 and a Pre-Admission Screening and Resident Review (PASRR) screening.

**8.300.13 – 8.375.60 [Repealed effective 11/30/2009]**

**8.310 DIALYSIS TREATMENT CENTERS**

**8.310.1 Definitions**

Acute Kidney Injury (AKI) is the sudden loss of kidney function, the ability of the kidneys to remove waste and excess fluid. AKI is typically a condition in which kidney function can be expected to recover after a short period of time with treatment (i.e. pharmaceuticals or dialysis). However, AKI can progress to a complete recovery of kidney function, development of Chronic Kidney Disease (CKD) or End Stage Renal Disease (ESRD).

Chronic Kidney Disease (CKD) is the slow loss of kidney function over time until the kidneys reach ESRD.

Dialysis is the process of cleaning the blood when the kidneys have failed and are no longer filtering the blood to remove waste and excess fluid. Kidney failure can stem from AKI or CKD. Dialysis includes both peritoneal dialysis and hemodialysis.

End Stage Renal Disease (ESRD) is defined as irreversible and permanent damage to the kidneys that requires either a regular course of dialysis treatment or kidney transplantation to maintain life.

Provider means a Dialysis Treatment Center that is hospital-affiliated or independent of a licensed hospital, and licensed by the Colorado Department of Public Health and Environment to provide outpatient dialysis services or training for home or self-dialysis.

Home Dialysis Training is a program that trains Clients to perform dialysis in the client's home with little or no professional assistance, and trains other individuals to assist clients in performing home dialysis.

Self-Dialysis Training is a program that trains Clients to perform self-dialysis in the treatment facility with little or no professional assistance, and trains other individuals to assist Clients in performing self-dialysis.

**8.310.2. Eligibility**

**8.310.2.A. Client Eligibility**

1. Any Colorado Medicaid Client diagnosed with CKD, AKI or ESRD, which requires dialysis treatments to restore kidney function or maintain life shall be eligible.

**8.310.2.B. Provider Eligibility**

1. To provide services, a Dialysis Treatment Center must be:
  - a. Enrolled in the Colorado Medical Assistance Program;
  - b. Certified by the Centers for Medicare and Medicaid Services (CMS) to participate in the Medicare program as a dialysis treatment center;
  - c. Certified by the Colorado Department of Public Health and Environment

**8.310.2.C. Prior Authorization**

1. Prior Authorization is not required for services listed at Section 8.310.3.B.

**8.310.3. General Services**

**8.310.3.A. Provider Requirements**

1. The Provider must utilize the most cost efficient method of dialysis treatment appropriate for each client, as assessed through an evaluation for peritoneal dialysis based upon an individual medical diagnosis and condition.
2. The Provider Facility must develop and implement a written, individualized comprehensive plan of care for each patient, which must include:
  - a. The services necessary to address the patient's needs;
  - b. The comprehensive assessment and changes in the patient's condition;



- c. Measurable and expected outcomes, and estimated timetables to achieve these outcomes;
- d. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards; and
- e. The plan of care must represent the selection of a suitable treatment modality (e.g., dialysis or transplantation) and dialysis setting (e.g., home, self-care) for each patient (42 CFR 405, 410, 413, 414, 488 and 494).

**8.310.3.B. Covered Dialysis Services**

The following are covered services under the Colorado Medicaid Dialysis Center Program:

- 1. In-Center Dialysis
  - a. Dialysis treatments completed by facility staff, and all necessary equipment and supplies.
  - b. In-Center dialysis is a benefit when the client meets one of the following conditions:
    - i) The client requires dialysis treatments prior to completing home dialysis training;
    - ii) Training to perform self-treatment in the home environment is contraindicated;
    - iii) The client is otherwise not a proper candidate for self-treatment in a home environment;
    - iv) The home environment of the eligible client contraindicates self-treatment; or
    - v) The eligible client is awaiting a kidney transplant.
  - c. Self-dialysis may be performed within the facility with limited professional assistance, if the client has completed an appropriate course of training.
    - i) The benefit includes training of the client by qualified personnel.
- 2. Home Dialysis
  - a. To be eligible for home dialysis a client or client's caregiver must receive appropriate training to perform dialysis at home.
  - b. The benefit includes training by qualified personnel, necessary supplies, and equipment for dialysis services.
  - c. The Benefit includes delivery, installation, and maintenance of equipment for home dialysis
- 3. The following are included in the Dialysis Center reimbursement and should not be billed separately:

- a. Costs associated with home dialysis other than necessary delivery, equipment, installation, maintenance, supplies, or training.
- b. Blood and blood products.
- c. Additional staff time or personnel costs.
- d. Routine Laboratory Services
  - i) All laboratory services considered routine for dialysis treatment, and performed by a dialysis treatment facility, are included as part of the dialysis treatment reimbursement.
  - ii) A Provider performing routine laboratory services must be a certified clinical laboratory.
- e. Routine Pharmaceuticals for Dialysis Treatment
  - i) All pharmaceuticals considered routine for dialysis treatment, and dispensed by a dialysis treatment facility, are included as part of the dialysis treatment reimbursement.
  - ii) Pharmaceuticals not dispensed by the dialysis provider are billed by and reimbursed to the dispensing pharmacy.

**8.310.3.C. Non-Covered Services**

The following are non-covered services under the Colorado Medicaid Dialysis Center benefit:

- 1. Personal care items such as slippers or toothbrushes.

**8.320 COMMUNITY CLINIC, INCLUDING FREESTANDING EMERGENCY DEPARTMENTS**

**8.320.1 Definitions**

- A. Community Clinic (CC) means a hospital-owned health care facility, licensed as a Community Clinic under 6 CCR 1011-1, Chapter IX or as a Freestanding Emergency Department (FSED) under 6 CCR 1011-1, Chapter XIII and enrolled as a CC provider type, that provides health care services on an ambulatory basis.
- B. CMS means the Centers for Medicare and Medicaid Services.
- C. Department means the Department of Health Care Policy and Financing.
- D. Emergency Care Services, for the purposes of this rule, has the same meaning as Section 8.300.1.I.
- E. Observation Stay, for the purposes of this rule, has the same meaning as Section 8.300.1.Q.

**8.320.2 Requirements for Enrollment as a CC**

**8.320.2.A.**

1. The facility is licensed as a Community Clinic or FSED by the Colorado Department of Public Health and Environment (CDPHE) in accordance with CDPHE rule at 6 CCR 1011-1, Chapter IX or Chapter XIII; and
2. The facility location is certified by CMS under the operating hospital's Medicare certification.

**8.320.3 Services**

8.320.3.A The following services provided by a CC are eligible for reimbursement:

1. Outpatient services, as defined in the Department's rule at 10 CCR 2505-10, section 8.300.3.B, section 8.300.B.2, 8.300.B.3; and
2. Observation stays, as defined in the Department's rule at 10 CCR 2505-10, section 8.300.3.B.1.

**8.320.4 Reimbursement**

8.320.4.A CC services are reimbursed as:

1. Outpatient services, in accordance with the Department's rule at 10 CCR 2505-10, section 8.300.6, using the hospital base rate for the hospital that is identified in the CMS certification of the CC.

**8.390 LONG TERM CARE SINGLE ENTRY POINT SYSTEM**

The long-term care Single Entry Point system consists of Single Entry Point Agencies, representing geographic districts throughout the state, for the purpose of enabling persons in need of long-term services and supports to access appropriate services and supports.

**8.390.1 DEFINITIONS**

- A. Applicant means an individual who is seeking a long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in a Level of Care Eligibility Determination Screen.
- C. Assessment means a comprehensive evaluation of an Applicant or Member, including but not limited to the individual's level of care, service needs, available resources, and potential funding resources using Department prescribed instrument(s), as required by the program for which they are applying or in which they are enrolled.
- D. Case Management means the Assessment of an individual seeking or receiving long-term services and supports' needs, the development and implementation of a Person-Centered Support Plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness, and the periodic Reassessment of such individual's needs.
- E. Corrective Action Plan means a written plan by the CMA, which includes a detailed description of actions to be taken to correct non-compliance with waiver requirements, regulations, and direction from the Department, and which sets forth the date by which each action shall be completed and the persons responsible for implementing the action.

- F. Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; and it may endanger or negatively impact the mental and/or physical well-being of an individual. Critical Incidents include, but are not limited to, injury/illness; abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death.
- G. Department means the Colorado Department of Health Care Policy and Financing, the Single State Medicaid Agency.
- HF. Failure to Satisfy the Scope of Work means acts or failures to act by the Single Entry Point Agency that constitute nonperformance or breach of the terms of its contract with the Department.
- I. Financial Eligibility means an individual meets the eligibility criteria for a publicly funded program, based on the individual's financial circumstances, including income and resources.
- J. Home and Community Based Services (HCBS) waivers means services and supports authorized through a waiver under Section 1915(c) of the Social Security Act and provided in home- and community-based settings to individuals who require a level of care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).
- K. Information Management System (IMS) means an automated data management system prescribed by the Department to document case management activities and information for each individual seeking or receiving long-term and/or State General Fund services as well as to compile and generate standardized or custom summary reports.
- L. Intake, Screening and Referral means the initial contact with individuals by the Single Entry Point Agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term services and supports; an individual's need for referral to other programs or services; an individual's need for financial and program assistance; and the need for an Assessment of the individual seeking services.
- M. Level of Care Eligibility means an individual requires the level of care that is provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities, as determined by the Department prescribed Level of Care Eligibility Determination Screen.
- O. Level of Care Eligibility Determination means the outcome of the LOC Screen,
- P. Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation of the Applicant or Member using a Department prescribed assessment instrument as outlined in section 8.401.
- Q. Long-Term Services and Supports (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.
- R. LTSS Program means any of the following: publicly funded programs, Home and Community-Based Services Elderly, Blind and Disabled Waiver (HCBS-EBD), Home and Community-Based Services Complementary and Integrative Health Waiver (HCBS-CIH), Home and Community-Based Services Brain Injury Waiver (HCBS-BI), Home and Community-Based Services Community Mental Health Supports Waiver (HCBS-CMHS), Home and Community-Based Services Children with a Life Limiting Illness Waiver (HCBS-CLLI), Medicaid Nursing Facility Care, Program for All-Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU) and Adult Long-Term Home Health (LTHH).

- S. Member means an individual who meets long-term services and support eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).
- T. Person-Centered Support Planning means the process of collaborating with the individual receiving services and other people of their choosing to identify goals, needed services, individual choices and preferences, and service providers. This is based on Assessment and knowledge of the individual and of community resources and includes informing the individual of their rights and responsibilities.
- U. Person-Centered Support Plan (PCSP) means the documentation of the Person-Centered Planning Process in the Department prescribed IMS using the Department prescribed format, including but not limited to the individual's chosen goals, services and providers.
- V. Pre-Admission Screening and Resident Review (PASRR) means the pre-screening of individuals seeking nursing facility admission to identify individuals with mental illness (MI) and/or intellectual disability (ID), to ensure that individuals are placed appropriately, whether in the community or in a NF, and to ensure that individuals receive the services they require for their MI or ID.
- W. Professional Medical Information Page (PMIP) means the medical information form signed by a licensed medical professional used to verify the individual's medical necessity for Long-Term Care Services.
- X. Reassessment means a comprehensive reevaluation of an Applicant or Member, including but not limited to the individual's level of care, service needs, available resources, and potential funding resources using Department prescribed instrument(s), as required by the program for which they are applying or in which they are enrolled.
- Y. Resource Development means the study, establishment and implementation of additional resources or services which will extend the capabilities of community LTSS systems to better serve individuals receiving long-term services and individuals likely to need long-term services in the future.
- Z. Single Entry Point (SEP) means the availability of a single access or entry point within a local area where an individual seeking or currently receiving LTSS can obtain LTSS information, screening, assessment of need and referral to appropriate LTSS programs and case management services.
- AA. Single Entry Point Agency means the organization selected to provide intake, screening, referral, eligibility determination, and case management functions for persons in need of LTSS within a Single Entry Point District.
- BB. Single Entry Point District means one or more counties that have been designated as a geographic region in which one agency serves as the Single Entry Point for persons in need of LTSS.
- CC. Target Group Criteria means the factors that define a specific population to be served through an HCBS waiver. Target Group Criteria can include physical or behavioral disabilities, chronic conditions, age, or diagnosis, and May include other criteria such as demonstrating an exceptional need.

#### **8.390.2 LEGAL AUTHORITY**

Pursuant to Section 25.5.6.105, C.R.S., the State Department is authorized to provide for a statewide Single Entry Point system.

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**8.390.3 CHARACTERISTICS OF INDIVIDUALS RECEIVING SERVICES IN LTSS PROGRAMS**

- A. An individual served by the SEP Agency shall meet the following criteria:
1. The individual requires skilled, maintenance and/or supportive services long term;
  2. The individual has functional impairment in activities of daily living (ADL) and/or a need for supervision, necessitating LTSS provided in a nursing facility, an alternative residential setting, the individual's home or other services and supports in the community;
  3. The individual receives or is eligible to receive medical assistance (Medicaid) and/or financial assistance under one or more of the following programs: Old Age Pension, Aid to Blind, Aid to Needy Disabled, Supplemental Security Income, or Colorado Supplemental, or as a 300% eligible, as defined at 8.485.50.T, receiving LTSS in a nursing facility or through one of the HCBS Programs.

**8.391 SINGLE ENTRY POINT DISTRICT DESIGNATION**

**8.391.1.A. District Designation Requirements**

Single Entry Point (SEP) districts shall meet the following requirements:

1. Counties composing a multi-county district shall be contiguous.
2. A single county may be designated a district provided the county serves a monthly average of 200 or more individuals for LTSS programs.
3. Multi-county districts shall not be required to serve a minimum number of individuals receiving services.
4. Each district shall assure adequate staffing and infrastructure by the district's SEP agency, including at least one full-time case manager employed by the SEP agency, to provide coverage for all case management functions and administrative support, in accordance with rules at Section 8.393.

**8.391.1.B. Changes in Single Entry Point District Designation**

1. In order to change SEP district designation, a county or district shall submit an application to the Department, six (6) months prior to commencement date of the proposed change. The application shall include the following information:
  - a. The geographic boundaries of the proposed SEP district;
  - b. Assurances that the proposed district meets all criteria set forth in Department rules for SEP district designation;
  - c. The designation of a contact person for the proposed district; and
  - d. A resolution supporting the application passed by the county commissioners of each county or parts of counties in the proposed district.
2. The application shall be approved provided the proposed district meets the SEP district designation requirements.

**8.391.2 Single Entry Point Agency Selection**

- A. Except as otherwise provided herein, upon a change in SEP district designation or upon expiration of the district's existing SEP agency contract, a SEP district may select a county agency, including a county department of social/human services, a county nursing service, an area agency on aging or a multicounty agency to serve as the SEP agency for the district. Once the SEP functions in a district are provided through a contract between the Department and an entity other than as listed above, the SEP agency for that district shall thereafter be selected by the Department pursuant to applicable state statutes and regulations.
- B. The agency selected by the SEP district shall serve as the SEP agency for the district unless the agency selected by the district has previously had its SEP agency contract terminated by the Department.
- C. The SEP district's selection shall be delivered to the Department no less than six (6) months prior to the effective date of the change in district designation or expiration of the contract with the district's existing SEP agency.
- D. If the SEP district has not delivered to the Department its selection within the timeframe specified in subsection (C) of this rule, the SEP agency for the district shall be selected by the Department pursuant to applicable state statutes and regulations.

**8.391.3 Single Entry Point Contract**

- A. A SEP agency shall be bound to the terms of the contract between the agency and the Department including quality assurance standards and compliance with the Department's rules for SEP agencies and for LTSS Programs.

**8391.4 Certification of Single Entry Point Agencies**

- 1. A SEP agency shall be certified annually in accordance with quality assurance standards and requirements set forth in the Department's rules and in the contract between the agency and the Department.
  - a. Certification as a SEP agency shall be based on an evaluation of the agency's performance in the following areas:
    - i. The quality of the services provided by the agency;
    - ii. The agency's compliance with program requirements, including compliance with case management standards adopted by the Department;
    - iii. The agency's performance of administrative functions, including reasonable costs per individual receiving services, timely reporting, managing programs in one consolidated unit, on-site visits to individuals, community coordination and outreach and individual monitoring;
    - iv. Whether targeted populations are being identified and served;
    - v. Financial accountability; and
    - vi. The maintenance of qualified personnel to perform the contracted duties.
  - b. The Department or its designee shall conduct reviews of the SEP agency.

- c. At least sixty (60) days prior to expiration of the previous year's certification, the Department shall notify the SEP agency of the outcome of the review, which may be approval, provisional approval, or denial of certification.

**8.391.4.A. Provisional Approval of Certification**

1. In the event a SEP agency does not meet all of the quality assurance standards established by the Department, the agency may receive provisional approval of certification for a period not to exceed sixty (60) days, provided the deficiencies do not constitute a threat to the health and safety of individuals receiving services.
2. The agency will receive notification of the deficiencies, a request to submit a corrective action plan to be approved by the Department and upon receipt and review of the corrective action plan, at the Department's option, a second sixty-day (60) provisional certification may be approved.
3. The Department or its designee shall provide technical assistance to facilitate corrective action.

**8.391.4.B. Denial of Certification**

In the event certification as a SEP agency is denied, the procedure for SEP agency termination or non-renewal of contract shall apply.

**8.392 FINANCING OF THE SINGLE ENTRY POINT SYSTEM - Single Entry Point agencies are paid for deliverables completed and accepted by the Department and a Per Member Per Month (PMPM) payment for ongoing case management activities performed as identified in contract.**

**8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY**

**8.393.1.A Administration of a Single Entry Point**

1. The SEP Agency shall be required by federal or state statute, mission statement, by-laws, articles of incorporation, contracts, or rules and regulations which govern the Agency, to comply with the following standards:
  - a. The SEP Agency shall serve persons in need of LTSS programs as defined in Section 8.390.3;
  - b. The SEP Agency shall have the capacity to accept funding from multiple sources;
  - c. The SEP Agency may contract with individuals, for-profit entities and not-for-profit entities to provide some or all SEP functions;
  - d. The SEP Agency may receive funds from public or private foundations and corporations; and
  - e. The SEP Agency shall be required to publicly disclose all sources and amounts of revenue.



2. For individuals with intellectual or developmental disabilities seeking or receiving services, the SEP will refer to the appropriate Community Centered Board (CCB) for programs that serve this population. In the event that the individual is eligible for programs administered by both the SEP and the CCB, the individual will have the right to choose the program in which he or she will participate.

**8.393.1.B. Community Advisory Committee**

1. The SEP Agency shall, within thirty (30) days of designation, establish a community advisory committee for the purpose of providing public input and guidance for SEP Agency operation.
  - a. The membership of the Community Advisory Committee shall include, but not be limited to, regional representation from the district's county commissioners, area agencies on aging, medical professionals, LTSS providers, LTSS ombudsmen, human service agencies, county government officials and individuals receiving LTSS.
  - b. The Community Advisory Committee shall provide public input and guidance to the SEP Agency in the review of service delivery policies and procedures, marketing strategies, resource development, overall SEP Agency operations, service quality, individual satisfaction and other related professional problems or issues.

**8.393.1.C. Personnel System**

1. The SEP Agency shall have a system for recruiting, hiring, evaluating and terminating employees.
  - a. SEP Agency employment policies and practices shall comply with all federal and state affirmative action and civil rights requirements.
  - b. The SEP Agency shall maintain current written job descriptions for all positions.

**8.393.1.D. Information Management**

1. The SEP Agency shall, in a format specified by the Department, be responsible for the collection and reporting of summary and individual-specific data including but not limited to information and referral services provided by the Agency, program eligibility determination, financial eligibility determination, Support Planning, service authorization, critical incident reporting, monitoring of health and welfare, monitoring of services, resource development and fiscal accountability.
  - a. The SEP Agency shall have adequate phone and computer hardware and software, compatible with - IMS with such capacity and capabilities as prescribed by the Department to manage the administrative requirements necessary to fulfill the SEP Agency responsibilities.
  - b. The SEP Agency shall have adequate staff support to maintain a computerized information system in accordance with the Department's requirements.

**8.393.1.E. Recordkeeping**

1. The SEP Agency shall maintain individual records in accordance with program requirements.

- a. The case manager shall use the Department-prescribed IMS for purposes of documentation of all case activities, monitoring of service delivery, and service effectiveness. If applicable, the individual's designated representative (such as guardian, conservator, or person given power of attorney) shall be identified in the case record, with a copy of appropriate documentation.
2. If the individual is unable to sign a form requiring his/her signature because of a medical condition, a digital signature or any mark the individual is capable of making will be accepted in lieu of a signature. If the individual is not capable of making a mark or performing a digital signature, the physical or digital signature of a guardian or authorized representative will be accepted.

**8.393.1.F. Confidentiality of Information**

The SEP Agency shall protect the confidentiality of all records of individuals seeking and receiving services in accordance with State statute (Section 26-1-114). Release of information forms obtained from the individual must be signed, dated, and kept in the client's record. Release of information forms shall be renewed at least annually, or sooner if there is a change of provider. Fiscal data, budgets, financial statements and reports which do not identify individuals by name or Medicaid ID number, and which do not otherwise include protected health information, are open records.

**8.393.1.G. Individual Rights**

1. The SEP Agency shall assure the protection of the rights of individuals receiving services as defined by the Department under applicable programs.
  - a. The SEP Agency shall assure that the following rights are preserved for all individuals served by the SEP Agency, whether the individual is a recipient of a state-administered program or a private pay individual:
    - i. The individual and/or the individual's authorized representative is fully informed of the individual's rights and responsibilities;
    - ii. The individual and/or the individual's authorized representative participates in the development and approval of, and is provided a copy of, the individual's Support Plan;
    - iii. The individual and/or the individual's authorized representative selects service providers from among available qualified and willing providers;
    - iv. The individual and/or the individual's authorized representative has access to a uniform complaint system provided for all individuals served by the SEP Agency; and
    - v. The individual who applies for or receives publicly funded benefits and/or the individual's authorized representative has access to a uniform appeal process, which meets the requirements of Section 8.057, when benefits or services are denied or reduced and the issue is appealable.
2. At least annually, the SEP Agency shall survey a random sample of individuals receiving services to determine their level of satisfaction with services provided by the agency.
  - a. The random sample of individuals shall constitute ten (10) individuals or ten percent (10%) of the SEP Agency's average monthly caseload, whichever is higher.

- b. If the SEP Agency's average monthly caseload is less than ten (10) individuals, all individuals shall be included in the survey.
- c. The individual satisfaction survey shall conform to guidelines provided by the Department.
- d. The results of the individual satisfaction survey shall be made available to the Department and shall be utilized for the SEP Agency's quality assurance and resource development efforts.
- e. The SEP Agency shall assure that consumer information regarding LTSS is available for all individuals at the local level.

**8.393.1.H. Access**

- 1. There shall be no physical barriers which prohibit individual participation, in accordance with the Americans with Disabilities Act (ADA), 42 U.S.C. 12101 et seq.
  - a. The SEP Agency shall not require individuals receiving services to come to the Agency's office in order to receive SEP services.
  - b. The SEP Agency shall comply with nondiscrimination requirements, as defined by federal and Department rules and outlined in contract.
  - c. The functions to be performed by a SEP Agency shall be based on a case management model of service delivery.

**8.393.1.I. Staffing Patterns**

- 1. The SEP Agency shall provide staff for the following functions: receptionist/clerical, administrative/supervisory, case management, and medical consulting services.
  - a. The receptionist/clerical function shall include, but not be limited to, answering incoming telephone calls, providing information and referral, and assisting SEP Agency staff with clerical duties.
  - b. The administrative/supervisory function of the SEP Agency shall include, but not be limited to, supervision of staff, training and development of Agency staff, fiscal management, operational management, quality assurance, case record reviews on at least a sample basis, resource development, marketing, liaison with the Department, and, as needed, providing case management services in lieu of the case manager.
  - c. The case management function shall include, but not be limited to, all of the case management functions defined in Section 8.393.1.M. for SEP case management services, as well as resource development and attendance at staff development and training sessions.
  - d. Medical consultant services functions shall include, but not be limited to, employing or otherwise contracting with a physician and/or registered nurse who shall provide consultation to SEP Agency staff regarding medical and diagnostic concerns and Adult Long-Term Home Health prior authorizations.

**8.393.1.J. Qualifications of Staff**

1. The SEP case manager(s) hired on or after October 8, 2021 shall meet minimum standards for HCBS case managers required in Section 8.519.5.B and shall be able to demonstrate competency in pertinent case management knowledge and skills.
- 2.. The case manager must demonstrate competency in each of the following areas:
  - a. Application of a person-centered approach to planning and practice;
  - b. Knowledge of and experience working with populations served by the SEP Agency;
  - c. Interviewing and assessment skills;
  - d. Knowledge of the policies and procedures regarding public assistance programs;
  - e. Ability to develop Support Plans and service agreements;
  - f. Knowledge of LTSS and other community resources; and
  - g. Negotiation, intervention and interpersonal communication skills.
3. The SEP Agency supervisor(s) shall meet all qualifications for case managers and have a minimum of two years of experience in the field of LTSS.

**8.393.1.M. Functions of the Case Manager.**

1. The SEP Agency's case manager(s) shall be responsible for: intake, screening and referral, Assessment/Reassessment, development of Person-Centered Support Plans, ongoing case management, monitoring of individuals' health and welfare, documentation of contacts and case management activities in the Department-prescribed IMS, resource development, and case closure.
  - a. The case manager shall contact the individual at least once within each quarterly period, or more frequently if warranted by the individual's condition or as determined by the rules of the LTSS Program in which the individual is enrolled.
  - b. The case manager shall have in-person monitoring at least one (1) time during the PCSP year. The case manager shall ensure one required monitoring is conducted in-person with the Member, in the Member's place of residence. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which in-person meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).
  - c. The case manager shall complete a new LOC Screen during a in-person Reassessment annually, or more frequently if warranted by the individual's condition or if required by the rules of the LTSS Program in which the individual is enrolled. Upon Department approval, Reassessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which in-person meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

- d. The case manager shall monitor the delivery of services and supports identified within the PCSP and the Prior Authorization Request (PAR). This includes monitoring:
  - i. The quality of services and supports provided;
  - ii. The health and safety of the individual; and
  - iii. The utilization of services.
- e. The following criteria may be used by the case manager to determine the individual's level of need for case management services:
  - i. Availability of family, volunteer, or other support;
  - ii. Overall level of functioning;
  - iii. Mental status or cognitive functioning;
  - iv. Duration of disabilities;
  - v. Whether the individual is in a crisis or acute situation;
  - vi. The individual's perception of need and dependency on services;
  - vii. The individual's move to a new housing alternative; and
  - viii. Whether the individual was discharged from a hospital or Nursing Facility.

**8.393.1.N. Functions of the Single Entry Point Agency Supervisor**

- 1. SEP Agencies shall provide adequate supervisory staff who shall be responsible for:
  - a. Supervisory case conferences with case managers on a regular basis;
  - b. Approval of indefinite lengths of stay, pursuant to 8.402.15;
  - c. Regular, systematic review and remediation of case records and other case management documentation, on at least a sample basis;
  - d. Communication with the Department when technical assistance is required by case managers and the supervisor is unable to provide answers after reviewing the regulations and other departmental publications;
  - e. Allocation and monitoring of staff to assure that all standards and time frames are met; and
  - f. Assumption of case management duties when necessary.

**8.393.1.L. Training of Single Entry Point Agency Staff**

- 1. SEP Agency staff, including supervisors, shall attend training sessions as directed and/or provided by the Department for SEP agencies.

- a. Prior to start-up, the SEP Agency staff shall receive training provided by the Department or its designee, which will include, but not be limited to, the following content areas:
  - i. Background information on the development and implementation of the SEP system;
  - ii. Mission, goals, and objectives of the SEP system;
  - iii. Regulatory requirements and changes or modifications in federal and state programs;
  - iv. Contracting guidelines, quality assurance mechanisms, and certification requirements; and
  - v. Federal and state requirements for the SEP Agency.
- b. During the first year of Agency operation, in addition to an Agency's own training, the Department or its designee will provide in-service and skill development training for SEP Agency staff. Thereafter, the SEP Agency will be responsible for in-service and staff development training.

**8.393.1.M. Provision of Direct Services**

- 1. The SEP Agency may be granted a waiver by the Department to provide direct services provided the Agency complies with the following:
  - a. The SEP Agency shall document at least one of the following in a formal letter of application for the waiver:
    - i. The service is not otherwise available within the SEP district or within a sub-region of the district; and/or
    - ii. The service can be provided more cost effectively by the SEP Agency, as documented in a detailed cost comparison of its proposed service with all other service providers in the district or sub-region of the district.
  - b. The SEP Agency that is granted a waiver to provide direct services due to its ability to provide the service cost effectively shall provide an annual report, at such time and on a form as prescribed by the Department, which includes a cost comparison of the service with other service providers in the area in order to document continuing cost effectiveness.
  - c. The SEP Agency shall assure the Department that efforts have been made, and will continue to be made, to develop the needed service within the SEP district or within the sub-region of the district, as a service external to the SEP Agency. The SEP Agency shall submit an annual progress report, at such time as prescribed by the Department, on the development of the needed service within the district.
  - d. The direct service provider functions and the SEP Agency functions shall be administratively separate.
  - e. In the event other service providers are available within the district or sub-region of the district, the SEP Agency case manager shall document in the individual's case record that the individual has been offered a choice of providers.

**8.393.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY**

The SEP Agency shall provide intake and screening for LTSS Programs, information and referral assistance to other services and supports, eligibility determination, case management and, if applicable, Utilization Management services in compliance with standards established by the Department. The SEP Agency shall provide sufficient staff to meet all performance standards. In the event a SEP Agency sub-contracts with an individual or entity to provide some or all service functions of the SEP Agency, the sub-contractor shall serve the full range of LTSS programs served by the SEP Agency. Subcontractors must abide by the terms of the SEP Agency's contract with the Department and are obligated to follow all applicable federal and state rules and regulations. The SEP Agency is responsible for subcontractor performance.

**8.393.2.A. Protective Services**

1. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of mistreatment, abuse, neglect, exploitation or a harmful act, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence and/or the local law enforcement agency. The agency shall ensure that employees and contractors obligated by statute, including but not limited to, Section 19-13-304, C.R.S., (Colorado Children's Code), Section 18-6.5-108, C.R.S., (Colorado Criminal Code - Duty To Report A Crime), and Section 26-3.1-102, C.R.S., (Human Services Code - Protective Services), to report suspected abuse, mistreatment, neglect, or exploitation, are aware of the obligation and reporting procedures.

**8.393.2.B. Intake, Screening and Referral**

1. The intake, screening and referral function of a SEP Agency shall include, but not be limited to, the following activities:
  - a. The completion and documentation of the intake, screening and referral functions using the Department prescribed intake, screening and referral instruments in the IMS;  
  
SEPs may ask referring agencies to complete and submit an intake and screening form to initiate the process;
  - b. The provision of information and referral to other agencies, as needed, and the documentation of those referrals in the IMS;
  - c. A screening to determine whether a LOC Screen is indicated;
  - d. The identification of potential payment source(s), including the availability of private funding resources; and
  - e. The implementation of a SEP Agency procedure for prioritizing urgent inquiries.
2. When LTSS are to be reimbursed through one or more of the publicly funded LTSS Programs served by the SEP system:
  - a. The SEP Agency shall verify the individual's demographic information collected during the intake;
  - b. The SEP Agency shall coordinate the completion of the financial eligibility determination by:

- i. Verifying the individual's current financial eligibility status; or
  - ii. Referring the individual to the county department of social services of the individual's county of residence for application; or
  - iii. Providing the individual with financial eligibility application form(s) for submission, with required attachments, to the county department of social services for the county in which the individual resides; and
  - iv. Conducting and documenting follow-up activities to complete the LOC Screen and facilitate the completion of the financial eligibility determination, as needed.
- c. The determination of the individual's financial eligibility shall be completed by the county department of social services for the county in which the individual resides, pursuant to Section 8.100.7 A-U.
  - d. Individuals shall be notified by the SEP Agency at the time of their application for publicly funded LTSS that they have the right to appeal actions of the SEP Agency, the Department, and contractors acting on behalf of the Department. The notification shall include the right to request a fair hearing before an Administrative Law Judge.
  - e. The county department shall notify the SEP Agency of the Medicaid application date for the individual seeking services upon receipt of the Medicaid application.
  - f. The county shall not notify the SEP Agency for individuals being discharged from a hospital or nursing facility or Adult Long-Term Home Health.

**8.393.2.C. Initial Level of Care Eligibility Determination**

- 1. The SEP Agency shall complete the LOC Screen within the following time frames:
  - a. For an individual who is not being discharged from a hospital or a nursing facility, the LOC Screen shall be completed within ten (10) working days after receiving confirmation that the Medicaid application has been received by the county department of social services, unless a different time frame specified below applies.
  - b. For a resident who is changing pay source (Medicare/private pay to Medicaid) in the nursing facility, the SEP Agency shall complete the LOC Screen within five (5) working days after notification by the nursing facility.
  - c. For a resident who is being admitted to the nursing facility from the hospital, the SEP Agency shall complete the LOC Screen, including a PASRR Level 1 Screen within two (2) working days after notification, as required by Section 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
  - d. For an individual who is being transferred from a nursing facility to an HCBS program or between nursing facilities, the SEP Agency shall complete the LOC Screen within five (5) working days after notification by the nursing facility.



- e. For an individual who is being transferred from a hospital to an HCBS program, the SEP Agency shall complete the LOC Screen within two (2) working days after notification from the hospital.
- 2. The start date of the Level of Care Eligibility Determination shall not be back dated by the SEP. Neither the state nor its agent(s) will approve late PAR revisions. See Section 8.486.30 LEVEL OF CARE ELIGIBILITY DETERMINATION and Section 8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES.
- 3. A trained SEP Agency Case Manager shall complete the LOC Screen for LTSS programs, in accordance with Section 8.401.1.
  - a. If enrolled as a provider of case management services for Children's Home and Community Based Services (CHCBS), SEP agencies may complete the LOC Screen for CHCBS.
- 4. The SEP Agency shall assess the individual's level of care in-person, in the location where the person currently resides. Upon Department approval, the LOC Screen may be conducted by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which in-person meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).
- 5. The Applicant may choose to have family members, advocates, friends and/or caregivers, as appropriate, participate as respondents in the assessment process either by attending with the Applicant or separate interviews with the case manager.
- 5. The SEP Agency shall conduct the following activities for a Level of Care Eligibility Determination of an Applicant:
  - a. Obtain supporting diagnostic information, including but not limited to, the Professional Medical Information Page (PMIP) form from the individual's medical provider for individuals in nursing facilities, HCBS Community Mental Health Supports Waiver (HCBS-CMHS), Brain Injury Waiver (HCBS-BI), Elderly, Blind and Disabled Wavier (HCBS-EBD), Complementary and Integrated Health Waiver (HCBS-CHI) and Children with a Life Limiting Illness Waiver (HCBS-CLLI).
    - i. If enrolled as a provider of case management services for Children's Home and Community Based Services (CHCBS), SEP agencies may obtain diagnosis(es) information from the individual's medical provider.
  - b. Determine the individual's level of care during an evaluation, with observation of the individual and family, if appropriate, in his or her residential setting using a Department prescribed instrument as outlined in Section 8.401.1.
  - c. Determine the length of stay for individuals seeking/receiving nursing facility care using the Nursing Facility Length of Stay Assignment Form in accordance with Section 8.402.10.15.
  - d. Assess the need for LTSS services using a Department prescribed instrument.

- e. For HCBS Programs and admissions to nursing facilities from the community, a copy of the LOC Eligibility Determination shall be sent to the prospective provider agency and a copy shall be retained in the agency's case record for the individual. If there are changes in the individual's condition which significantly change the payment or services amount, a copy of the LOC Eligibility Determination documenting the change must be sent to the provider agency and a copy is to be maintained in the agency's case record for the individual.
  - f. When the SEP Agency assesses the individual's level of care using the Department's prescribed instrument, the Assessment is not an adverse action that is directly appealable. The individual's right to appeal arises only when an individual is denied enrollment into an LTSS Program by the SEP based on the thresholds for Level of Care Eligibility Determination as outlined in Section 8.401.1. The appeal process is governed by the provisions of Section 8.057.
- 6. The case manager and the nursing facility shall complete the following activities for discharges from nursing facilities:
  - a. The nursing facility shall contact the SEP Agency in the district where the nursing facility is located to inform the SEP Agency of the discharge if placement into home- or community-based services is being considered.
  - b. The nursing facility and the SEP case manager shall coordinate the discharge date.
  - c. When placement into HCBS Programs is being considered, the SEP Agency shall determine the remaining length of stay.
    - i. If the end date for the nursing facility is indefinite, the SEP Agency shall assign an end date not past one (1) year from the date of the most recent Level of Care Eligibility Determination.
    - ii. If the Level of Care Eligibility Determination is less than six (6) months, the SEP Agency shall generate a new Level of Care Determination that reflects the end date that was assigned to the nursing facility.
    - iii. The SEP Agency shall complete a new LOC Screen if the current completion date is six (6) months old or older. The assessment results shall be used to determine level of care and the new length of stay.
    - iv. The SEP Agency shall provide the Level of Care Determination to the eligibility enrollment specialist at the county department of social services.
    - v. The SEP Agency shall submit the HCBS prior authorization request to the Department or its fiscal agent.
- 7. For individuals receiving services in HCBS Programs who are already determined to be at the nursing facility level of care and seeking admission into a nursing facility, the SEP Agency shall:
  - a. Coordinate the admission date with the facility;

- b. Complete the PASRR Level 1 Screen, and if there is an indication of a mental illness or developmental disability, submit to the Department or its agent to determine whether a PASRR Level 2 evaluation is required;
- c. Maintain the Level 1 Screen in the individual's case file regardless of the outcome of the Level 1 Screen; and
- d. If appropriate, assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the Level of Care Eligibility Determination is not six (6) months old or older.

**8.393.2.D. Ongoing Level of Care Eligibility Determination**

- 1. The case manager shall determine level of care eligibility on an ongoing basis by completing the LOC Screen at least one (1) but no more than three (3) months before the required completion date. The case manager shall complete a LOC Screen of an individual receiving services within twelve (12) months of the initial or most recent LOC screen.
- 2. A Level of Care Eligibility Determination shall be completed sooner if the individual's condition changes or if required by program criteria. The case manager shall document changes utilizing the LOC Screen.
- 3. Ongoing Level of Care Determination assessments shall be made according to 8.393.2.C.4 and shall include the following activities:
  - a. Review Person-Centered Support Plan, service agreements and provider contracts or agreements;
  - b. Evaluate effectiveness, appropriateness and quality of services and supports;
  - c. Verify continuing Medicaid eligibility, other financial and program eligibility;
  - f. Inform the individual's medical provider of any changes in the individual's needs;
  - g. Maintain appropriate documentation, including type and frequency of LTSS the individual is receiving for approval of continued program eligibility, if required by the program;
  - h. Refer the individual to community resources as needed and develop resources for the individual if the resource is not available within the individual's community; and
  - j. Submit appropriate documentation for authorization of services, in accordance with program requirements.
- 4. The SEP Agency shall be responsible for completing Level of Care Eligibility Determination Reassessments of individuals receiving care in a nursing facility. A Reassessment shall be completed if the nursing facility determines there has been a significant change in the resident's physical/medical status, if the individual requests a Reassessment or if the case manager assigns a definite determination end date. The nursing facility shall be responsible to send the SEP Agency a referral for a Reassessment, as needed.

5. In order to assure quality of services and supports and the health and welfare of the individual, the case manager shall ask for permission from the individual to observe the individual's residence as part of the reassessment process, but this shall not be compulsory of the individual. Upon Department approval, observation may be completed using virtual technology methods or delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

**8.393.2.E. Person-Centered Support Plan**

1. The nursing facility shall be responsible for developing a Support Plan for individuals residing in nursing facilities.
2. The SEP Agency shall develop the Person-Centered Support Plan (PCSP) for individuals not residing in nursing facilities within fifteen (15) working days after determination of program eligibility.
3. The SEP Agency shall:
  - a. Address the functional needs identified through the individual assessment;
  - b. Offer informed choices to the individual regarding the services and supports they receive and from whom, as well as the documentation of services needed, including type of service, specific functions to be performed, duration and frequency of service, type of provider and services needed but that may not be available;
  - c. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
  - d. Reflect cultural considerations of the individual and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and individuals who have limited English proficiency;
  - e. Formalize the Person-Centered Support Plan agreement, including appropriate physical or digital signatures, in accordance with program requirements;
  - f. Contain prior authorization for services, in accordance with program directives, including cost containment requirements;
  - g. Contain prior authorization of Adult Long-Term Home Health Services, pursuant to Sections 8.520-8.527;
  - h. Include a method for the individual to request updates to the plan as needed;
  - i. Include an explanation to the individual of complaint procedures;
  - j. Include an explanation to the individual of critical incident procedures; and
  - k. Explain the appeals process to the individual.
4. The case manager shall provide necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions and shall ensure that the development of the Person-Centered Support Plan:

- a. Occurs at a time and location convenient to the individual receiving services;
  - b. Is led by the individual, the individual's parent's (if the individual is a minor), and/or the individual's authorized representative;
  - c. Includes people chosen by the individual;
  - d. Addresses the goals, needs and preferences identified by the individual throughout the planning process;
  - e. Includes the arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the individual regarding service provision and formalizing provider agreements in accordance with program rules; and
  - f. Includes referral to community resources as needed and development of resources for the individual if a resource is not available within the individual's community.
5. Prudent purchase of services:
- a. The case manager shall arrange services and supports using the most cost-effective methods available in light of the individual's needs and preferences.
  - b. When family, friends, volunteers or others are available, willing and able to support the individual at no cost, these supports shall be utilized before the purchase of services, providing these services adequately meet the individual's needs.
  - c. When public dollars must be used to purchase services, the case manager shall encourage the individual to select the lowest-cost provider of service when quality of service is comparable.
  - d. The case manager shall assure there is no duplication in services provided by LTSS programs and any other publicly or privately funded services.
6. In order to assure quality of services and supports and health and welfare of the individual, the case manager shall observe the individual's residence prior to completing and submitting the individual's Person-Centered Support Plan. Upon Department approval, observation may be completed using virtual technology methods may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

**8.393.2.F. Cost Containment**

- 1. If the case manager expects that the cost of services required to support the individual will exceed the Department-determined Cost Containment Review Amount, the Department or its agent will review the Person-Centered Support Plan to determine whether the individual's request for services is appropriate and justifiable based on the individual's condition and quality of life and, if it is, will sign the Prior Authorization Request.
  - a. The individual may request of the case manager that existing services remain intact during this review process.

- b. In the event that the request for services is denied by the Department or its agent, the case manager shall provide the individual with:
  - i. The individual's appeal rights pursuant to Section 8.057; and
  - ii. Alternative options to meet the individual's needs that may include, but are not limited to, nursing facility placement.

**8.393.2.G. Ongoing Case Management**

- 1. The functions of the ongoing case manager shall be:
  - a. **Assessment/Reassessment:** The case manager shall continually identify individuals' strengths, needs, and preferences for services and supports as they change or as indicated by the occurrence of critical incidents;
  - b. **Person Centered Support Plan (PCSP) Development:** The case manager shall work with individuals to design and update a PCSP that address individuals' goals and assessed needs and preferences;
  - c. **Referral:** The case manager shall provide information to help individuals choose qualified providers and make arrangements to assure providers follow the PCSP including any subsequent revisions based on the changing needs of individuals;
  - d. **Monitoring:** The case manager shall ensure that individuals obtain authorized services in accordance with their PCSP and monitor the quality of the services and supports provided to individuals enrolled in LTSS Programs. Monitoring shall:
    - 1. Be performed when necessary to address health and safety and services in the PCSP.
    - 2. Include activities to ensure:
      - A. Services are being furnished in accordance with the individual's PCSP
      - B. Services in the PCSP are adequate; and
      - C. Necessary adjustments in the PCSP and service arrangements with providers are made if the needs of the individual have changed;
    - 3. Include an in-person contact and observation with the individual in their place of residence, at least once per certification period. Additional in person monitoring shall be performed when required by the individual's condition or circumstance. Upon Department approval, observation may be completed using virtual technology methods or delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.)
  - e. **Remediation:** The case manager shall identify, resolve, and to the extent possible, establish strategies to prevent Critical Incidents and problems with the delivery of services and supports.

2. The case manager shall assure quality of services and supports, the health and welfare of the individual, and individual safety, satisfaction and quality of life, by monitoring service providers to ensure the appropriateness, timeliness and amount of services provided. The case manager shall take corrective actions as needed.
3. The case manager may require the Contractor to revise the PCSP and Prior Authorization if the results of the monitoring indicate that the plan is inappropriate, the services as described in the plan are untimely, or the amount of services need to be changed to meet the Client's needs.
4. Ongoing case management shall include, but not be limited to, the following tasks:
  - a. Review of the individual's PCSP and service agreements;;
  - b. Contact with the individual concerning their safety, quality of life and satisfaction with services provided;
  - c. Contact with service providers to coordinate, arrange or adjust services, to address quality issues or concerns and to resolve any complaints raised by individuals or others;
  - d. Conflict resolution and/or crisis intervention, as needed;
  - e. Informal assessment of changes in individual functioning, service effectiveness, service appropriateness and service cost-effectiveness;
  - f. Notification of appropriate enforcement agencies, as needed; and
  - g. Referral to community resources as needed.
5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment or mis-utilization of any public assistance benefit, and shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with Department of Human Services Income Maintenance Rules at 9 C.C.R. 2503-8, Section 3.810 and Section 8.076.
6. The case manager shall contact the individual at least quarterly, or more frequently as determined by the individual's needs or as required by the program.
7. The case manager shall review the Department prescribed assessment and the PCSP with the individual every six (6) months. The review shall be conducted by telephone or at the individual's place of residence, place of service or other appropriate setting as determined by the individual's needs or preferences.
8. The case manager shall complete a new ULTC 100.2 when there is a significant change in the individual's condition and when the individual changes LTSS programs.
9. The case manager shall contact the service providers, as well as the individual, to monitor service delivery as determined by the individual's needs and as required by the authorities applicable to the service.
10. Case Managers shall report critical incidents within 24 hours of notification within the State Approved IMS.
  - a. Critical Incident reporting is required when the following occurs

- i. Injury/Illness;
  - ii. Missing Person;
  - iii. Criminal Activity;
  - iv. Unsafe Housing/Displacement;
  - v. Death;
  - vi. Medication Management Issues;
  - vii. Other High-Risk Issues;
  - viii. Allegations of Abuse, Mistreatment, Neglect, or Exploitation;
  - ix. Damage to the Consumer's Property/Theft.
- b. Allegations of abuse, mistreatment, neglect and exploitation, and injuries which require emergency medical treatment or result in hospitalization or death shall be reported immediately to the Agency administrator or designee.
- c. Case Managers shall comply with mandatory reporting requirements set forth at Section 18-6.5-108, C.R.S, Section 19-3-304, C.R.S and Section 26-3.1-102, C.R.S.
- d. Each Critical Incident Report must include:
  - i. incident type
    - a. Mistreatment, Abuse, Neglect or Exploitation (MANE) as defined at Section 19-1-103, 26-3.1-101, 16-22-102 (9), and 25.5-10-202 C.R.S.
    - b. Non-Mane: A Critical Incident, including but not limited to, a category of criminal activity, damage to a consumer's property, theft, death, injury, illness, medication management issues, missing persons, unsafe housing or displacement, other high risk issues.
  - ii. Date and time of incident;
  - iii. Location of incident, including name of facility, if applicable;
  - iv. Individuals involved;
  - v. Description of incident, and
  - vi. Resolution of incident, if applicable.
- e. The Case Manager shall complete required follow up activities and reporting in the State approved IMS within assigned timelines.



**8.393.2.H. Case Recording/Documentation**

1. The SEP Agency shall complete and maintain all required records included in the State approved IMS and shall maintain individual case records at the Agency level for any additional documents associated with the individual applying for or enrolled in a LTSS Program.
2. The case record and/or IMS shall include:
  - a. Identifying information, including the individual's state identification (Medicaid) number and Social Security number (SSN);
  - b. All State-required forms; and
  - c. Documentation of all case management activity required by these regulations.
3. Case management documentation shall meet all the following standards:
  - a. Documentation must be objective and understandable for review by case managers, supervisors, program monitors and auditors;
  - b. Entries must be written at the time of the activity or no later than five (5) business days from the time of the activity;
  - c. Entries must be dated according to the date of the activity, including the year;
  - d. Entries must be entered into Department's IMS;
  - e. The person making each entry must be identified;
  - f. Entries must be concise, but must include all pertinent information;
  - g. All information regarding an individual must be kept together, in a logical organized sequence, for easy access and review by case managers, supervisors, program monitors and auditors;
  - h. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact or is a judgment or conclusion on the part of anyone;
  - i. All persons and agencies referenced in the documentation must be identified by name and by relationship to the individual;
  - j. All forms prescribed by the Department shall be completely and accurately filled out by the case manager; and
  - k. Whenever the case manager is unable to comply with any of the regulations specifying the time frames within which case management activities are to be completed, due to circumstances outside the SEP Agency's control, the circumstances shall be documented in the case record. These circumstances shall be taken into consideration upon monitoring of SEP Agency performance.
4. Summary recording to update a case record shall be entered into the IMS at least every six (6) months, whenever a case is transferred from one SEP Agency to another, and when a case is closed.

**8.393.2.I. Resource Development Committee**

1. The SEP Agency shall assume a leadership role in facilitating the development of local resources to meet the LTSS needs of individuals seeking or receiving services who reside within the SEP district served by the SEP Agency.
2. Within 90 days of the effective date of the initial contract, the SEP Agency's community advisory committee shall appoint a resource development committee.
3. The membership of the resource development committee shall include, but not be limited to, representation from the following local entities: Area Agency on Aging (AAA), county departments of social services, county health departments, home health agencies, nursing facilities, hospitals, physicians, community mental health centers, community centered boards, vocational rehabilitation agencies, and individuals receiving long-term services.
4. In coordination with the resource development efforts of the Area Agency on Aging (AAA) that serves the district, the resource development committee shall develop a local resource development plan during the first year of operation.
  - a. The resource development plan shall include:
    - i. An analysis of the LTSS resources available within the SEP district;
    - ii. Gaps in LTSS resources within the SEP district;
    - iii. Strategies for developing needed resources; and
    - iv. A plan for implementing these strategies, including the identification of potential funding sources, potential in-kind support and a time frame for accomplishing stated objectives.
  - b. The data generated by the SEP Agency's intake, screening and referral, individual assessment, documentation of unmet individual needs, resource development for individuals and data available through the Department shall be used to identify persons most at risk of nursing facility care and to document the need for resources locally.
5. At least annually, the resource development committee shall provide progress reports on the implementation of the resource development plan to the community advisory committee and to the Department.

**8.393.3 DENIALS/DISCONTINUATIONS/ADVERSE ACTIONS**

**8.393.3.A. Denial Reasons and Notification Actions**

1. Individuals seeking or receiving services shall be denied or discontinued from services under publicly funded programs served by the SEP system if they are determined ineligible for any of the reasons below. Individuals shall be notified of any of the adverse actions and appeal rights as follows:
  - a. Financial Eligibility

- i. The eligibility enrollment specialist from the county department of social services shall notify the individual of denial or discontinuation for reasons of financial eligibility and shall inform the individual of appeal rights in accordance with Section 8.057.
  - ii. If the individual is found to be financially ineligible for LTSS programs, the SEP Agency shall notify the individual of the adverse action and inform the individual of their appeal rights in accordance with Section 8.057. The case manager shall not attend the appeal hearing for a denial or discontinuation based on financial eligibility, unless subpoenaed, or unless requested by the Department.
- b. **Functional Eligibility and Target Group**
  - i. The SEP Agency shall notify the individual of the denial or discontinuation and appeal rights by sending the Notice of Services Status (LTC-803) and shall attend the appeal hearing to defend the denial or discontinuation, when:
    - 1) The individual does not meet the functional eligibility threshold for LTSS Programs or nursing facility admissions; or
    - 2) The individual does not meet the target group criteria as specified by the HCBS Program.
- c. **Receipt of Services**
  - i. The SEP Agency shall notify the individual of the denial or discontinuation and appeal rights by sending the Notice of Services Status (LTC-803) and shall attend the appeal hearing to defend the denial or discontinuation, when:
    - 1) The individual has not received long-term services or supports for thirty (30) days;
    - 2) The individual has two (2) times in a thirty-day consecutive period refused to schedule an appointment for assessment, or monitoring required by these regulations;
    - 3) The individual has failed to keep three scheduled assessment appointments within a thirty-day consecutive period; or
    - 4) The SEP Agency does not receive the completed Professional Medical Information Page (PMIP) form, when required.
- d. **Institutional Status**
  - i. The SEP Agency shall notify the individual of denial or discontinuation by sending the Notice of Services Status (LTC-803) when the case manager determines that the individual does not meet the following program eligibility requirements.
    - 1) The individual is not eligible to receive HCBS services while a resident of a nursing facility, hospital, or other institution; or

- 2) The individual who is already a recipient of program services enters a hospital for treatment, and hospitalization continues for thirty (30) days or more.

e. Cost-Effectiveness/Service Limitations

- i. During the Support Planning process in conjunction with the initial assessment or reassessment, the individual seeking or receiving services shall not be eligible for the HCBS program if the case manager determines the individual's needs are more extensive than the HCBS program services are able to support, the individual's health and safety cannot be assured in a community setting, and/or the cost containment review process is not met as outlined in Section 8.393.2.F.

- 1) If the case manager determines that the individual is ineligible for an HCBS Program, the case manager shall:
  - a) Obtain any other documentation necessary to support the determination; and
  - b) Inform the individual of their appeal rights pursuant to Section 8.057.

2. The Long-Term Care Waiver Program Notice Action (LTC-803) shall be completed in the IMS for all applicable programs at the time of initial eligibility, when there is a significant change in the individual's payment or services, an adverse action, and at the time of discontinuation.
3. In the event the individual appeals a denial or discontinuation action, except for reasons related to financial eligibility, the case manager shall attend the appeal hearing to defend the denial or discontinuation action.

**8.393.3.B. Case Management Actions Following a Denial or Discontinuation**

1. In the case of denial or discontinuation, the case manager shall provide appropriate referrals to other community resources, as needed, within one (1) working day of discontinuation.
2. The case manager shall notify all providers on the Support Plan within one (1) working day of discontinuation.
3. The case manager shall follow procedures to close the individual's case in the IMS within one (1) working day of discontinuation for all HCBS Programs.
4. If a case is discontinued before an approved HCBS Prior Authorization Request (PAR) has expired, the case manager shall submit to the Department or its fiscal agent, within five (5) working days of discontinuation, a copy of the current PAR form on which the end date is adjusted (and highlighted in some manner on the form); and the reason for discontinuation shall be written on the form.

**8.393.3.C. Notification**

1. The SEP Agency shall notify the county eligibility enrollment specialist of the appropriate county department of social services:

- a. At the same time it notifies the individual seeking or receiving services of the adverse action;
  - b. When the individual has filed a written appeal with the SEP Agency; and
  - c. When the individual has withdrawn the appeal or a final Agency decision has been entered.
2. The SEP Agency shall provide information to individuals seeking and receiving services regarding their appeal rights when individuals apply for publicly funded LTSS and whenever the individual requests such information, whether or not adverse action has been taken by the SEP Agency.

**8.393.4. COMMUNICATION**

- A. In addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:
  1. The case manager shall inform the eligibility enrollment specialist of any and all changes affecting the participation of an individual receiving services in SEP Agency-served programs, including changes in income, within one (1) working day after the case manager learns of the change. The case manager shall provide the eligibility enrollment specialist with copies of the certification page of the approved ULTC-100.2 form.
  2. If the individual has an open adult protective services (APS) case at the county department of social services, the case manager shall keep the individual's APS worker informed of the individual's status and shall participate in mutual staffing of the individual's case.
  3. The case manager shall inform the individual's physician of any significant changes in the individual's condition or needs.
  4. The case manager shall report to the Colorado Department of Public Health and Environment (CDPHE) any congregate facility which is not licensed.

**8.393.5 LEVEL OF CARE ELIGIBILITY DETERMINATION**

- A. The SEP Agency shall be responsible for the following:
  1. Ensuring that the Level of Care Screen is completed in the IMS in accordance with Section 8.401.1 and justifies that the individual seeking or receiving services is eligible or ineligible for admission to or continued stay in an applicable LTSS program.
  2. Once the assessment is complete in the IMS, the case manager shall generate a Level of Care Eligibility Determination in the IMS within three (3) business days for hospital discharge to a Nursing Facility, within six (6) business days for Nursing Facility discharge and within eleven (11) business days of receipt of referral.
  3. If the assessment indicates approval, the SEP Agency shall notify the appropriate parties.
  4. If the assessment indicates denial, the SEP Agency shall notify the appropriate parties in accordance with 8.393.3.A.2.
  5. If the individual or individual's legally authorized representative appeals, the SEP Agency shall process the appeal request, according to Section 8.057.

**8.393.6. INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES**

**8.393.6.A. Intercounty Transfers**

1. SEP agencies shall complete the following procedures to transfer individuals receiving case management services to another county within the same SEP district:
  - a. Notify the current county department of social services eligibility enrollment specialist of the individual's plans to relocate to another county and the date of transfer, with financial transfer details at Section 8.100.3.C.
  - b. If the individual's current service providers do not provide services in the area where the individual is relocating, make arrangements, in consultation with the individual, for new service providers.
  - c. In order to assure quality of services and supports and health and welfare of the individual, the case manager must observe and evaluate the condition of the individual's residence. Upon Department approval, observation may be completed using virtual technology methods. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).
  - d. If the individual is moving from one county to another to enter an Alternative Care Facility (ACF), forward copies of the following individual records to the ACF prior to the individual's admission to the facility:
    - i. Level of Care Eligibility Determination.
    - ii. The individual's updated draft Prior Authorization Request (PAR) and/or Post Eligibility Treatment of Income (PETI) form; and
    - iii. Verification of Medicaid eligibility status.

**8.393.6.B. Inter-district Transfers**

1. SEP Agencies shall complete the following procedures in the event an individual receiving services transfers from one SEP district to another SEP district:
  - a. The transferring SEP Agency shall contact the receiving SEP Agency by telephone and give notification that the individual is planning to transfer, negotiate a transfer date and provide all necessary information.
  - b. The transferring SEP Agency shall notify the original county department of social services eligibility enrollment specialist of the individual's plan to transfer and the transfer date, and eligibility enrollment specialist shall follow rules described in Section 8.100.3.C. The receiving SEP Agency shall coordinate the transfer with the eligibility enrollment specialist of the new county.
  - c. The transferring SEP Agency shall make available in the IMS the individual's case records to the receiving SEP Agency prior to the relocation.
  - d. If the individual is moving from one SEP District to another SEP District to enter an ACF, the transferring SEP Agency shall forward copies of the individual's records to the ACF prior to the individual's admission to the facility, in accordance with section 8.393.6.A.

- e. To ensure continuity of services and supports, the transferring SEP Agency and the receiving SEP Agency shall coordinate the arrangement of services prior to the individual's relocation to the receiving SEP Agency's district and within ten (10) working days after notification of the individual's relocation.
- f. The receiving SEP Agency shall complete an in person meeting with the individual in the individual's residence and a case summary update within ten (10) working days after the individual's relocation, in accordance with assessment procedures for individuals served by SEP Agencies. Upon Department approval, meeting may be completed using virtual technology methods or may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.)
- g. The receiving SEP Agency shall review the PCSP and the LOC Screen and change or coordinate services and providers as necessary.
- h. If indicated by changes in the PCSP, the receiving SEP Agency shall revise the PCSP and prior authorization forms as required by the publicly funded program.
- i. Within thirty (30) calendar days of the individual's relocation, the receiving SEP Agency shall forward to the Department, or its fiscal agent, revised forms as required by the publicly funded program.

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### **Editor's Notes**

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 3/4/07, 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 3/4/07, 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]*