## 8.300 HOSPITAL SERVICES

.10 Hospital services are a benefit of the Medicaid Program and Include those items and services which are ordinarily furnished by a hospital for the care and treatment of inpatients provided under the direction of a physician.

Inpatient hospital services are a benefit under the Modified Medical Program.

.11 Inpatient hospital services which are defined as experimental by the Medicare program are not a benefit of the Medicaid Program.

.12 Inpatient hospital services which are not a covered benefit of the Medicare program are not a benefit of the Medicaid Program.

.13 For Medicaid approved benefits, Medicare patients (having Medicaid as secondary coverage) will receive treatment in approved Medicare facilities when the Medicare benefit is limited to treatment in such facilities.

.14 For Medicaid approved benefits, patients (having Medicaid primary coverage) may receive treatment at any participating Colorado Medicaid hospital facility.

.15 The Peer Review Organization (PRO) may evaluate medical data related to benefit coverage for conformance of benefits to community medical standards. The Department may approve PRO recommendations for modifications to benefit coverage.

.16 The published standards of the Department of Health and Human Services which comprise the Medicare benefits and exclusions described above are based upon 42 USC 1395y, 42 CFR Part 409, and the Medicare Intermediary Manual/Claims Processing/Part 3. No amendments or later additions are incorporated. Copies of these standards, or portions thereof, are available at cost at the following addresses:

Colorado Foundation for Medical Care

P.O. Box 173001260 S. Parker Road

Denver, Colorado 80217-0300

or

Manager, Health and Medical Services

Colorado Department of Social Services

1575 Sherman Street

Denver, Colorado 80203

Reimbursement for surgical procedures will be subject to the stipulations set forth in the reimbursement for surgery section.

.20 Acute inpatient hospital psychiatric care is a benefit of the Medicaid Program for eligible recipients when provided as an integral service of a participating Medicaid general hospital. Acute inpatient hospital psychiatric care is a benefit of the Modified Medical Program.

.30 Psychiatric hospital services are reimbursed by the methodology established in 8.374. Such services, except as described herein, are limited to forty-five (45) days per State fiscal year and include:

A. bed and board, including special dietary service, in a semi-private .room to the extent available;

B. professional services, including those of physicians, physical therapists, either voluntary or paid hospital employees, interns, residents, or other physicians in training in the hospital and general nursing services;

C. laboratory services, therapeutic or diagnostic services involving use of x-ray, radium or radioactive isotopes, emergency room, drugs, whole blood or equivalent quantities of packed red cells, medical supplies, equipment and appliances as related to care and treatment of a psychiatric diagnosis in the hospital.

The forty-five (45) day limit shall not apply to clients who are receiving psychiatric hospital services as a result of a court order requiring the psychiatric hospital services.

**8.301 HOSPITAL DEFINITION**

A hospital is an institution which:

A. is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the purpose of medical diagnosis, treatment, and care of an injured, disabled, or sick person;

B. is not primarily established for the care and treatment of mental diseases;

C. is licensed by the Colorado Department of Health, and is approved as meeting the standards established for such licensing;

D. is qualified to participate under Title XVIII of the Social Security Act, or is currently determined to meet the requirements for such participation.

**8.302 MEDICAID PARTICIPATING HOSPITAL: REQUIREMENTS**

To be a participating hospital in the Medicaid Program, an institution must:

A. be certified for participation under the Medicare Program;

B. for non-PPS providers, have in effect a negotiated prospective reimbursement rate with the Department, see 8.350, et seq.;

C. have an approved Application for Participation with the Department;

D. a hospital located outside of Colorado which is more accessible to Medicaid clients who require inpatient hospital services than a hospital within the State, can provide services to Colorado Medicaid clients. The Office of Medical Assistance will be free to make the proximity determination. For inpatient services, these hospitals will be paid the average Colorado urban or rural DRG payment rate. Out-of-state urban hospitals are those hospitals located within the metropolitan statistical area (MSA) as designated by the U.S. Department of Health and Human Services. For outpatient services, these hospitals will be paid 70% of billed charges. Consideration of additional benefit will be made on a case by case basis in accordance with the supporting documentation submitted by the out-of-state hospital; or

E. a Qualified Indian Health Services hospital located outside the State of Colorado may apply for recognition as a provider under Colorado's Medicaid Program. This is pursuant to Public Law No. 94-437, the Indian Health Care Improvement Act, which makes 100% federal financial participation available for payment of inpatient hospital services, outpatient hospital services and emergency transportation to persons who are Indians with a legal tribal affiliation and who are eligible to receive Colorado Medical Assistance benefits. Reimbursement shall be in accordance with the Colorado Title XIX approved State Plan except where insufficient cost data is available in which case payment shall be in accordance with the requirements of the Office of Management and Budget.

Institutions which fail to meet the above requirements shall be eligible to provide emergency hospital services under the Medicaid Program, and shall be classified as non- participating Medicaid Hospitals. Inpatient payment shall be 90% of the Colorado urban or rural DRG payment rate. Outpatient services shall be paid at 60% of billed charges.

**8.303 EMERGENCY CARE**

Emergency care is defined as a medical condition (including active labor and delivery) manifested by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: (a) Placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Emergency care services are exempt from Primary Care Provider referral.

Medical Screening Examination is defined as screening of sick, wounded, or injured persons in the emergency room to determine whether the person has an emergency medical condition. An appropriate medical screening examination (including ancillary services routinely available to an emergency treatment facility) must be available to any individual who comes to the emergency treatment facility for examination or treatment of a medical condition and on whose behalf the examination or treatment is requested.

Disputed Denial: A disputed denial occurs when an authorization for treatment or coordination of care is denied by the primary care provider or a non-physician provider under the PCP's supervision and the emergency physician disagrees with the PCP or non-physician provider's clinical assessment or decision about the recipient's clinical management.

The recipient must return to his/her PCP for further treatment, follow up, referral (if necessary) or other medical services.

Claims submitted for medical screening examination or emergency services, as defined above, do require an emergency indicator code, but do not require a referral from the Primary Care Provider to assure reimbursement.

If an emergency treatment facility or licensed medical professional has made an attempt to contact the primary care provider to coordinate medical care and the primary care provider has not returned the call within 30 minutes, it shall be documented in the patient's medical record, and the Managed Care Hotline shall be notified that the primary care provider failed to return the call.

All claims submitted without the proper primary care physician referral will be denied unless documentation is available demonstrating the primary care physician was unavailable to obtain the proper referral.

Any claim submitted as an emergency care service when non-emergent care was provided is subject to payment recovery.

A claim may be submitted for emergency services when there is a disputed denial. The Managed Care Hotline must be notified when a disputed denial occurs. Any claim submitted as a disputed denial is

subject to review by the Department, the Department's peer review organization and may result in payment recovery.

**8.304 SURGERY BENEFITS**

Reimbursement for surgery will be authorized upon certification by the attending physician that surgical treatment is medically necessary at that time. Surgeries are medically necessary at that time if delay could reasonably result in placing the client's health in jeopardy, deterioration in the person's condition or causing other serious medical consequences and/or serious impairment of bodily functions. This will apply to inpatient and outpatient settings. This regulation is effective for surgeries provided during the time period February 15, through June 30, 1988.

**8.305 NON-PARTICIPATING HOSPITALS**

A non-participating hospital is a hospital which does not meet the requirements of 8.302, above. A non-participating hospital may receive payment for inpatient hospital services if:

A. the services meet the definition of emergency care;

B. the services are covered benefits under the Medicaid Program;

C. the hospital agrees on an individual case basis not to charge the recipient, or the recipient's relatives, for items and services which are covered benefits of the Medicaid Program, and to return any monies improperly collected for such covered items and services.

**8.310 INPATIENT HOSPITAL SERVICES**

**8.311 EXTENT OF INPATIENT HOSPITAL SERVICES**

.10 All Medicaid clients admitted to a participating Medicaid hospital pursuant to the provisions of 8.312, et seq., may receive inpatient hospital services (as described in 8.300) for as many days as determined medically necessary by the client's attending physician and by the PRO for the duration of the client's Medicaid eligibility.

.20 A Colorado non-participating hospital shall be considered a participating hospital only when the services provided to a Medicaid client qualify as emergency services (see 8.303), and they have contacted the Medicaid Program to obtain a provider number.

.30 Hospitals located outside Colorado shall be deemed participating hospitals for purposes of providing services to eligible clients who require emergency services while temporarily absent from Colorado (or in the case of PRO prior authorization approval per Departmental policy), if said hospital meets the definition of a hospital in 8.301.

.40 The primary source of payment for a Medicaid client who has health or other insurance covering all or any part of the costs for inpatient hospital services shall be such insurance. In such instances, Medicaid will be the payor of last resort.

For Medicaid clients who are eligible for Title XVIII (Medicare) benefits, the inpatient hospital services benefit shall run concurrently with Medicare benefits. When Medicare benefits are exhausted and a medical need remains for inpatient hospital services, Medicaid will provide payment for continued inpatient hospital services as a benefit, provided the continuing need for medical services meets criteria for approval.

**8.312 INPATIENT HOSPITAL ADMISSIONS/REVIEW OF MEDICAL NECESSITY OF SERVICES**

.10 To establish administrative controls and procedures on the expenditure of allocated (Medicaid) funds for clients' hospital services, and to meet the requirements of Section 1903(i)(4) of Title XIX of the Social Security Act, the following procedures govern review of medical necessity for hospital services, length of stay for inpatient admissions, and the care delivered in non-hospital settings.

.11 All participating hospitals shall participate in the Hospitalization Review Program administered by a Professional Review Organization (PRO).

.12 The Hospitalization Review Program conducted by the PRO may include (but not be limited to):

A. Preadmission review for inpatient admissions selected by frequency and intensity of services;

B. Admission and Continued stay review for selected Non-Prospective-Payment System (Non-PPS) inpatient admissions;

C. Second opinion review for selected inpatient and outpatient procedures;

D. Prior authorization for selected inpatient and outpatient procedures, and elective out-of-state treatment;

E. Retrospective admission and continued stay review of non-PPS admissions. Retrospective admission, DRG validation, and quality of care review of Prospective Payment System (PPS) admission;

F. A random sample of day outliers, readmissions, and transfers on a retrospective basis; and,

G. Quality review for HMO facilities.

**8.313 REVIEW OF ADMISSION AND CONTINUED STAY**

.10 Effective July 1, 1993, the PRO shall initiate admission and continued stay review in selected non-PPS hospitals subject to departmental approval. The PRO may deny inpatient days, not meeting acute care, rehabilitation care or psychiatric criteria, concurrently or retrospectively.

.11 The hospital, after PRO notification of intent to perform continued stay review, shall be responsible for notifying the PRO of a Medicaid client's admission to the hospital. This notification shall occur on the day of admission, or if the admission is not on a scheduled review day of the PRO, on the first scheduled review day following the client's admission.

.12 The PRO shall examine the medical record and compare the documentation in the record against the appropriate PRO approved hospitalization criteria.

.13 If criteria for hospitalization are not met at any point in the hospitalization (i.e., at the point of admission review or continued stay review) the PRO may cause payment for hospitalization to be denied.

A. When a court-ordered psychiatric inpatient admission does not meet the medical necessity criteria established for Psychiatric Acute Care by the PRO, such stay may be denied by the PRO Physician Advisor (PA).

B. When a court-ordered psychiatric inpatient admission is denied by the PRO PA, the provider shall submit the type of bill as an outpatient claim in order to recover ancillary costs. The billing claim form will reflect the denied admission days as "non-covered days" and will be reimbursed at the prescribed outpatient rate.

.14 During continued stay review prior to issuing a denial of admission or continued hospitalization the PRO shall attempt to contact the attending physician and discuss the need for hospitalization. The PRO decision shall be based on documentation contained in the medical record.

.15 The documentation shall, at a minimum, meet all guidelines required under 42 C.F.R. Part 466, Part 473 and Part 476 (1992). The Department may fulfill these requirements or parts thereof through contract with the designated professional standards review organization as allowed under 42 C.F.R. 431.630, October 1992 edition. No amendments or later editions are incorporated. Copies of these standards, or portions thereof, are available at cost at the following address, or may be examined at any State Publications Depository Library.

Manager, Office of Medical Assistance Colorado Department of Health Care Policy and Financing 1575 Sherman Street, Denver, Colorado 80203.

Documentation shall be sufficient to substantiate the nature and extent of services provided.

**8.314 RETROSPECTIVE REVIEW**

.10 Retrospective review will be performed on a sample basis following the client's discharge from the hospital. Retrospective review will determine if the care provided was medically necessary, of adequate medical quality, and if the billing information provided to the fiscal agent was accurate.

Retrospective review may result in all or part of the stay being denied, and/or may affect the DRG assignment for the hospital stay. Retrospective review may result in recovery of all or part of the payment for a hospital stay. At the time of post-payment retrospective denial, the PRO will inform the provider that the Department will make an adjustment to recover the payment.

In the case of outliers (i.e., hospital stays exceeding a predetermined number of days), retrospective review may result in the denial of all or a portion of outlier days.

.11 Retrospective review may be performed for the purpose of monitoring physician or hospital utilization patterns or it may be performed as as type of corrective action for an identified problem provider or client.

**8.315 PREADMISSION REVIEW**

.10 Preadmission review may be conducted for elective rehabilitation hospital and rehabilitation distinct part unit admissions. The preadmission review process requires that at least 7 days prior to admission to the hospital, the client's attending physician shall contact the PRO and initiate a request for preadmission authorization. The attending physician shall contact the PRO and describe the client's condition. The coordinator shall review the information provided by the attending physician. If criteria for admission are met, the admission shall be approved by the PRO. The PRO shall notify the attending physician, the client, and the hospital in writing regarding the result of the review.

.11 If criteria for hospitalization are not met, the PRO review coordinator shall refer the case to the PRO physician reviewer who shall review the documentation obtained and make a determination as to medical necessity for admission. The physician reviewer may contact the attending physician to discuss the case prior to issuing a denial notification. If an approved PRO preadmission review form is not available in the hospital admission office for any admission requiring preadmission review, and the admission is not specified as an emergency by the attending physician, the client shall be admitted at the financial risk of the hospital and physician.

.12 Preadmission denial, or failure to obtain preadmission approval, may result in recovery of payment(s) made to the hospital and/or physician. Denial of payment may also result if the review did not

occur when specified or if the information provided for review was not accurate.

**8.316 SECOND OPINION REVIEW**

.10 Subject to Departmental approval, the PRO shall provide a second opinion review program for selected procedures. The hospital and/or physician shall be advised in advance of such required review. The second opinion process requires the client's attending physician to obtain a second opinion confirming medical necessity for the selected procedure (on either an inpatient or outpatient basis) in order for payment to be made by Medicaid to the physician and/or the hospital. Providers shall be advised of selected procedures by Medicaid Bulletin. Providers will be notified of changes in selected procedures. Whenever feasible, this notification will occur 60 days prior to the effective date of review.

.11 Second opinion review may be performed in conjunction with preadmission review or independent of preadmission review.

.12 Physicians wishing to schedule one of the selected procedures shall contact the PRO at least 2 weeks prior to the performance of the procedure. A PRO review coordinator shall review documentation from the physician to determine whether criteria for performance of the procedure are met. If criteria are not met then one of the following shall occur:

A. Review coordinator shall contact the client and provide him/her with the name(s) of physicians who shall be willing to provide a second opinion as to the medical necessity of the procedure and shall advise the attending physician of this action; or

B. Review coordinator shall refer the case to a physician reviewer for reviewer for consideration of the medical necessity of the procedure.

.13 If a second confirming opinion is not obtained prior to the procedure being performed, and after review the procedure is found to be medically unnecessary, the Department will recover payment for that procedure and notify the provider. A Notice of Denial shall be provided to the client by PRO.

.14 Documented emergency cases are exempted from this requirement.

**8.317 PRIOR AUTHORIZATION REVIEW**

.10 Effective March 1, 1992, prior authorization review shall be performed by the PRO for all inpatient elective (non-emergent) care occurring out- of- state, all covered transplants (except corneal or kidney) or when extraordinary elective treatment and/or procedures are identified by the department. Hospital treatment and procedures requiring prior authorization are listed in provider bulletins. All documented emergency cases, regardless of location, are exempt from prior authorization, but are subject to PRO retrospective review.

.11 The provider (not the client) shall contact the PRO by telephone, or in writing, and provide information required by the PRO concerning the patient's medical condition. Subsequent to the initial contact with the PRO, the provider shall also submit any additional information required to complete the prior authorization process.

.12 When a request for prior authorization is received by the PRO, the registered nurse review coordinator (RNRC) shall conduct the prior authorization review, utilizing established PRO review screening criteria described in 8.317.15. The RNRC will have one working day to respond to the provider (physician or hospital) if the screening guidelines are met and the requested treatment/procedure is approved. If screening guidelines are not met, the RNRC must refer the case to a PRO physician reviewer (PR), who will conduct an independent medical evaluation,

based on his/her professional medical knowledge and experience, and make a final determination. If PR review is required, the PRO shall have a maximum of five working days to respond to the provider.

.13 When the prior authorization request is for out-of-state elective care or for covered transplants, the PRO shall notify the provider and the client of the determination within the same specifications for timeliness referred to in 8.317.12. For extraordinary elective treatment and/or procedures identified by the Department, the PRO shall send notification to the Department within five working days. The Department will then notify the provider and the client by telephone or by placing written notice in the mail no later than two days after notification is received from the PRO.

.14 The prior authorization reconsideration and formal appeal process for clients is described in 8.318.15. Provider appeals are addressed in 8.318.16 and in 8.050, Provider Appeals.

.15 PRO REVIEW CRITERIA

A state plan for medical assistance shall provide such methods and procedures as are necessary to guard against unnecessary utilization of care. For this purpose, the State is required to contract with a federally-approved utilization and quality control peer review organization (PRO). (Stipulations of the Social Security Act - Section 1902(a)(30((A), (B), (C)). No later amendments to or editions of the Social Security Act are incorporated. Copies of these standards or portions thereof are available for public inspection during normal business hours and will be provided at cost from the Manager, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714, or may be examined at any State Publications Depository Library.

PRO review screening criteria are developed by health professionals relying on professional expertise, prior experience, and the professional literature. These criteria are used to determine the quality, medical necessity, and appropriateness of a health care procedure, treatment or service under review. (Title 42 CFR, Part 466, Subpart A.) No later amendments to or editions of Title 42 CFR are incorporated. Copies of these standards or portions thereof are available for public inspection during normal business hours and will be provided at cost from the Manager, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714, or may be examined at any State Publications Depository Library.

The PRO shall maintain review criteria development committees for the purpose of revising and/or developing review screening criteria to be utilized for the approval or denial of specific Medicaid benefits. Any new or revised criteria must be approved by the PRO Board of Directors, and shall be reviewed on an approximately yearly basis to assure continuing appropriateness. The Department shall also evaluate and approve all criteria used in the review of Medicaid services.

## 8.318 ADMINISTRATIVE DENIAL AND APPEAL PROCEDURES

.10 DENIAL AS A RESULT OF PREADMISSION AND PRIOR AUTHORIZATION REVIEW

A denial notification shall be issued by the PRO if justification for admission is not indicated from the documentation provided by the attending physician. A denial notification shall be provided to the attending physician and the client, which shall include the reason for the determination; a statement informing the parties and their representatives of their right to appeal the denial; the location, procedure, and time frame for filing an appeal request; and, a brief statement concerning the duties and functions of the PRO under the act.

.11 DENIAL AS A RESULT OF CONTINUED STAY REVIEW

During continued stay review a denial decision may not be made unless the PRO has made a reasonable attempt to contact the client's attending physician to discuss the review in question. If the PRO makes the decision to deny medical necessity of either admission or continued stay, the PRO shall provide a written notice of denial of Medicaid payment to the client (or next of kin, guardian, or sponsor, if the client is expected to be unable to comprehend the notice) to the attending physician or other attending health care practitioners, the hospital, and the Department. The notice shall include the reason for the denial, the date after which the stay in the hospital will not be approved as being medically necessary or appropriate, and those items specified under 8.318.10 above.

.12 DENIAL AS A RESULT OF RETROSPECTIVE REVIEW

A. If upon review of the medical record the PRO physician advisor does not find justification for medical necessity for hospitalization, a Notice of Denial shall be issued to the client, attending physician and the hospital. The notice shall include those items specified under 8.318.10 above.

B. The denial of medical necessity may result in denial and recovery of payment to the hospital and/or the physician. In the case of post-payment restrospective denial, the Department will proceed to recover payment upon notification of the denial decision by the PRO. Payment may be denied if review is being performed as a form of corrective action. The hospital and/or the physician shall not pursue collection from the client for the denied payment.

**8.318.13 DENIAL AS A RESULT OF ADMINISTRATIVE ERROR**

If a provider does not comply with the PRO request to provide required medical information within 30 calendar days, the claim will be denied and the provider will have an additional 30 calendar days to provide the required information. If after 60 calendar days the required information is not received, the PRO will notify the Department. Upon receiving this notice the Department will initiate recovery of payment and notify the provider.

.14 DENIAL AS A RESULT OF BILLING ERROR

During retrospective review, when the PRO identifies a billing error which has resulted in incorrect payment, the PRO will notify the provider that the Department will correct the billing information and adjust the payment.

.15 APPEALS OF PRO REVIEW DECISIONS

A. PRO Reconsideration Process

1. The reconsideration process available through the PRO is the first step in filing a formal client appeal. The client or his/her representative may initiate the process by contacting the PRO office. The attending physician or the hospital may appeal on the client's behalf. If the request for reconsideration is made within 24 hours or one working day of the issuance of the denial of admission or continued stay, and the client remains hospitalized, the PRO shall complete the reconsideration process within 24 hours of request.

2. The reconsideration process shall consist of an independent review of the medical record by one or more peer physicians who were not involved with the original denial decision.

3. Parties to the denial as stated above shall be notified verbally by PRO of the results of the reconsideration process. This shall be followed by a written notification.

B. Formal Client Appeal

1. A second step is available in the client appeal process, if the patient is dissatisfied with the decision of the PRO reconsideration panel. The patient or his/her representative may appeal to (the State Department of) General Support Services for a fair hearing before an independent State Administrative Law Judge. Appeals of prior authorization, preadmission or continued stay denials may be filed by the attending physician or the hospital only on behalf of the patient, as formal client appeals, and shall not duplicate appeals filed by the patient. A written request must be made to General Support Services of Administration within 60 calendar days of the date of the PRO reconsideration panel notification. This written request may be filed with either:

   a. the PRO following instructions contained in the notification documents; or

   b. directly with General Support Services, Division of Administrative Hearings.

   The PRO shall forward said appeal to General Support Services, Office of Administrative Courts, for hearing pursuant to Section 24-4-105, C.R.S.

2. The Administrative Law Judge shall conduct the hearing as provided in Section 8.058, STATE HEARINGS. S/he shall prepare and enter an Initial Decision which the State Department shall serve upon each party. The Office of Appeals of the State Department, as designee of the Executive Director, shall review the Initial Decision and enter a Final Agency Decision affirming, modifying, reversing, or remanding the Initial Decision.

   If the Final Agency Decision is adverse to the patient, he/she, or his/her representative, shall have a right to judicial review pursuant to Section 24-4-106, C.R.S.

**8.318.16 APPEAL OF RETROSPECTIVE DENIALS (PROVIDER APPEALS)**

If payment to the provider for covered services rendered to an eligible client is denied due to failure to comply with provisions of the Medical Assistance Program, law and/or appropriate rules, the provider is precluded from collecting payment from the Medicaid client (8.012 Prohibition of Charges to Recipients). Federal regulations at Title 42 CFR Section 447.25, Acceptance of State Payment. No later amendments to or editions of 42 CFR Section 447.25 are included. Copies are available for public inspection during normal business hours and will be provided at cost upon request to the Manager, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, Colorado 80203-1714, or may be examined at any State Publications Depository Library.

.17 DISCHARGE PLANNING

The PRO may perform such services as may be appropriate to assist the attending physician and the participating hospital in identifying, at the earliest reasonable opportunity during the eligible person's hospital stay, situations which may require discharge planning, and in planning for the eligible person's health needs after discharge, including but not limited to the recommendation of appropriate post-hospital accommodations.

.18 SELECTION OF REVIEW METHODOLOGY

The PRO, with Department approval, is responsible for determining the review methodology to be used for specific providers or specific procedures, and shall notify providers accordingly.

**8.318.19 CORRECTIVE ACTION**

A. Corrective action shall be recommended when documentation is presented which indicates a chronic problem of inappropriate utilization or questionable quality of care. A decision regarding whether corrective action should be initiated shall then be made.

B. Corrective action may include, but is not limited to: provider education, intensified review, required consultation, mandatory preadmission review, second opinion review, and retrospective review. The provider, and the client, when appropriate, shall be notified when corrective action is to be initiated.

Satisfactory resolution of the identified problem shall result in the corrective action being lifted. If corrective action does not result in resolution of the problem, sanction activity shall be initiated, as defined under the fraud and abuse section of the rules.

.20 AGENCY RECONSIDERATION

The Department may require the PRO to reconsider an initial review decision resulting in either approval or denial. In the case of a request for reconsideration the Department shall communicate the request within 15 working days of the review decision. Upon receipt of the Department's direction to reconsider, the PRO will convene a reconsideration panel to perform an independent review of the medical record by peer physicians who were not involved with the original decision. The PRO will communicate the findings of this reconsideration review to the attending physician, the hospital (if necessary), the client, and the Department within 15 working days of the request.

**8.319 HOSPITALIZATION AND EXTENSIONS CONCERNING NEWBORN INFANTS**

Medical assistance payments on behalf of the newborn shall extend only for the period of the mother's hospitalization with a single exception; that medical necessity exists for the infant to remain hospitalized. In such cases, the hospitalization for the infant certification and approval for additional days of hospital care, and to the infant's own eligibility for medical assistance following the mother's discharge.

Continued stay of healthy newborns for any other reason after the mother's discharge is not a benefit under the medical assistance program.

**8.320 DIALYSIS**

The Colorado Medical Assistance Program will provide payment for dialysis treatments to individuals who have established eligibility for public assistance purposes in Colorado. Such individuals must be eligible in all respects under the provisions of 8.100, et seq.

**8.321 INPATIENT HOSPITAL (ACUTE DIALYSIS)**

Payments may be made to licensed participating hospitals for the provision of dialysis treatments to an eligible recipient who is an inpatient of the hospital only in those cases where hospitalization is required for:

A. An acute medical condition for which dialysis treatments are required; and

B. Any other medical condition for which the Medical Assistance Program provides payment when the eligible recipient receives regular maintenance treatment on an outpatient dialysis program; and

C. Placement or repair of the dialysis route ("shunt", "cannula").

**8.322 OUTPATIENT DIALYSIS**

Outpatient dialysis treatments are a benefit of the Medical Assistance Program when provided by a separate unit within a hospital or a free standing dialysis treatment center approved for participation by the Colorado State Department of Health Care Policy and Financing. A dialysis treatment center is defined as a health institution or a department of a licensed hospital, which is planned, organized, operated and maintained to provide outpatient treatment by means of dialysis and/or training for home use of dialysis equipment. Other conditions of participation are those entered into specifically in the agreement with the Department of Health Care Policy and Financing (Department).

.10 AUTHORIZATION FOR OUTPATIENT DIALYSIS

No payments shall be made on behalf of eligible recipients for the provision of outpatient dialysis treatments unless a physician licensed to practice in the State of Colorado certifies the medical need for regular chronic dialysis treatments exists.

Dialysis treatment centers or free-standing dialysis units shall permit the Department to review any records for Medicaid patients upon request.

.11 Payments for Medicaid outpatient dialysis shall continue when documentation certifies that outpatient dialysis treatment must continue because:

A. training of the eligible recipient to perform self-treatment in the home environment is contraindicated; or,

B. the eligible recipient is not a proper candidate for self-treatment in a home environment; or,

C. the home environment of the eligible recipient contraindicates self-treatment; or,

D. the eligible recipient is awaiting a kidney transplant.

**8.323 HOME (CHRONIC DIALYSIS)**

The high costs of dialysis treatments and the budgetary limitations of the Medicaid program require that all Medicaid patients be considered for the most cost efficient method of dialysis based upon their individual medical diagnosis and condition. Such treatments include home dialysis and peritoneal methods of dialysis.

The participating separate dialysis unit within a hospital or free-standing dialysis treatment center shall be responsible for the maintenance of all equipment and necessary fixtures required for home dialysis and provisions of all supplies.

**8.324 PAYMENT FOR DIALYSIS TREATMENTS**

.10 INPATIENT HOSPITAL

Payment for inpatient hospital dialysis treatment shall be included as part of the DRG rate.

.20 OUTPATIENT AND HOME TREATMENT

Any facility providing regularly scheduled outpatient or chronic dialysis treatments at a free-standing facility or billing for supplies necessary to perform the various types of home dialysis treatments shall apply for a separate Medicaid provider number from the fiscal agent. Such provider number shall be

designated solely for the purpose of claims submission for dialysis services.

The amount of payment for regularly scheduled routine outpatient dialysis or necessary supplies to perform home dialysis treatments, when provided by a separate unit within a hospital or a free standing dialysis treatment center approved for participation by the Colorado State Department of Health Care Policy and Financing, shall be based on the lesser of the unit's specific Medicare rate or the Medicare composite rate ceiling.

The amount of payment for non-routine outpatient dialysis treatments, when provided by a separate unit within a hospital or free standing dialysis treatment center, shall be based upon the Medicaid fee schedule.

There is no reimbursement for home dialysis, only for supplies necessary to accomplish home dialysis.

### 8.325 REIMBURSEMENT FOR ALL ROUTINE AND NON-ROUTINE ANCILLARY DIALYSIS SERVICES

Ancillary services performed as part of the routine dialysis treatment shall be considered as part of the composite rate and billed on the UB-92 claim form.

Non-routine ancillary services performed outside the dialysis treatment shall be reimbursed separately and billed on the Colorado 1500 claim form. This claim form requires the provider use the appropriate HCPCS codes designated for the service provided.

#### 8.325.10 Laboratory Services

All routine laboratory services performed by a dialysis treatment facility, with the designation as a certified clinical laboratory, or as a certified independent laboratory are included as part of the dialysis treatment reimbursement. All routine tests must be performed by the facility, with designation as a certified clinical laboratory, and reimbursed as part of the composite rate or performed by a certified independent outside laboratory and billed to the facility performing the dialysis treatment.

The following required procedures constitute routine laboratory services that are considered medically necessary. These laboratory tests are included as part of the dialysis service reimbursement.

Per Treatment

Hematocrit

**Weekly**

Prothrombin time for patients on anti-coagulant therapy

Serum Creatinine

BUN

**Monthly**

HCT

Hgb

Dialysate Protein

Alkaline Phosphatase Magnesium

CBC Sodium

LDH

Potassium

Serum Albumin

$CO_2$ Serum Bicarbonate

Serum Calcium

Serum Chloride

Specimen Collection

Serum Phosphorous

Serum Potassium

SGOT

Total Protein

All Hematocrit and Clotting time tests

**Drugs considered part of the routine dialysis treatment:**

Heparin

Protamine

Mannitol

Glucose

Saline

Dextrose

Pressor Drugs

Antihistamines

Antiarrhythmics

Antihypertensives

**Drugs considered non-routine:**

Antibiotics

Anabolics

Hematinics

Sedatives

Analgesics

Tranquilizers

Muscle Relaxants

Nonparenteral items may not be billed separately by the dialysis center, but may be billed directly to Medicaid by the supplier. Nonparenteral items administered during the dialysis treatment are reimbursed as part of the composite rate.

**8.330 OUTPATIENT HOSPITAL SERVICES**

Outpatient hospital services are those diagnostic, therapeutic, rehabilitative, preventive, and palliative items and services furnished by or under the direction of a physician to an eligible person who is an outpatient in a participating hospital. Routine and annual physical examinations are not a benefit of the program unless determined necessary based on medical necessity. Psychiatric outpatient services are not a Medicaid benefit in free-standing psychiatric hospitals. Outpatient hospital services are a benefit of the Modified Medical Plan.

**8.331 DEFINITIONS**

"Outpatient" means a patient who is receiving professional services at a participating hospital, which is not providing him/her with room and board and professional services on a continuous 24-hour-a-day basis.

"Diagnostic services" means any medical procedures or supplies recommended by a physician within the scope of his/her practice under state law, to enable him/her to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

"Rehabilitative services" mean any medical or remedial services recommended by a physician within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

"Preventive services" mean services provided by a physician within the scope of his/her practice under state law to: (1) prevent disease, disability, and other health conditions or their progression; (2) prolong life; and, (3) promote physical and mental health and efficiency.

"Palliative services" mean any medical services recommended by a physician within the scope of his/her practice under state law, for the purpose of affording a recipient relief from the symptoms of a condition or disease.

"Therapeutic services" means any medical service provided by a physician within the scope of his/her practice under state law, in the treatment of disease.

**8.332 PAYMENT**

Outpatient hospital services are reimbursed on an interim basis at actual billed charges times the Medicare charge to cost ratio percent less 28 percent (28%). 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%).

Outpatient hospital services which are defined as experimental by the Medicare program are not a benefit of the Medicaid Program. Outpatient hospital services which are not a covered benefit of the Medicare program are not a benefit of the Medicaid program. Extraordinary situations, based upon PRO recommendation and Department approval, will be reviewed for exception to these benefit limitations.

The published standards of the Department of Health and Human Services which comprise the Medicare benefits and exclusions described above are based upon 42 USC 1395y, 42 CFR Part 409, October 1991 edition, and the Medicare Intermediary Manual/Claims Processing/Part 3. No amendments or later editions are incorporated. Copies of these standards, or portions thereof, are available at cost at the following addresses:

Colorado Department of Health Care Policy & Financing

1570 Grant St.

Denver, Colorado 80203

OUTPATIENT CLINICAL LABORATORY TESTS

Medicaid reimbursement for clinical diagnostic laboratory tests performed by certified outpatient hospital clinical laboratories may not exceed 60 percent (60%) of the Medicare prevailing charge fee schedule or the Medicaid fee schedule, whichever is lower.

OUTPATIENT ANATOMICAL LABORATORY TESTS

Outpatient anatomical laboratory tests are reimbursed on an interim basis from the Medicaid fee schedule. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost, or Medicaid fee schedule.

8.332.10 OUTPATIENT PREPROCEDURE AND PRETREATMENT REVIEW

The purpose of preprocedure review and pretreatment review is to confirm the medical necessity and the appropriateness of the selected outpatient procedures and treatments. The PRO shall provide, upon direction from the Department: 1) a preprocedure review program for selected outpatient surgical, medical and radiographic procedures; and 2) a pretreatment review for planned outpatient psychiatric and substance abuse disorder treatments. Physicians and hospitals shall be advised, in advance of selected procedures and treatments requiring PRO review by Medicaid Bulletin.

The purpose of preprocedure review and pretreatment review is to confirm the medical necessity and the appropriateness of the selected outpatient procedures and treatments. The PRO shall provide, upon direction from the Department: 1) a preprocedure review program for selected outpatient surgical, medical and radiographic procedures; and 2) a pretreatment review for planned outpatient psychiatric and substance abuse disorder treatments. Physicians and hospitals shall be advised, in advance of selected procedures and treatments requiring PRO review by Medicaid Bulletin.

.11 OUTPATIENT PREPROCEDURE REVIEW PROCESS

Upon direction from the Department the preprocedure review process shall involve the following procedures: A physician planning to perform one of the selected outpatient surgical medical and radiographic procedures which requires preprocedure review must contact the PRO at least 2 weeks prior to admission and provide the required information relative to the scheduled

procedure. A PRO RN Review Coordinator (RNRC) will review the information from the physician to determine whether or not criteria for the procedure are met. If criteria are met, then the RNRC will confirm the procedure. If criteria are not met, then the following will occur:

A. The RNRC will refer the case to a Physician Reviewer (PR) for consideration of the medical necessity and appropriateness of the planned procedure.

B. If the PR does not confirm the plan of care, then the RNRC will contact the patient and provide him/her with the names of two physicians who are willing to provide a second opinion as to the medical necessity and appropriateness of the planned procedure. If the second opinion physician confirms the procedure, then the review process is complete. The PRO will notify the patient, the attending physician, and the hospital of the outcome of this action.

C. If the second opinion does not confirm the planned procedure, then the patient may request a third opinion. When the request is received, the RNRC facilitates the third opinion as described in the preceding paragraph.

D. If the third opinion confirms the procedure, then the review process is complete. The PRO will notify the patient, attending physician, and the hospital as above. If the third opinion physician does not confirm the procedure, then the review process is complete and the procedure is not confirmed. The PRO will notify the patient, the attending physician, and the hospital.

8.332.12 OUTPATIENT PRETREATMENT REVIEW PROCESS

Upon direction from the Department, the pretreatment review process shall involve the following procedures: A physician planning to treat one of the selected psychiatric or substance abuse disorders in an outpatient setting must contact the PRO within 2 weeks for approval of the treatment plan and to provide the PRO the required information relative to the current patient status. A PRO RN Review Coordinator (RNRC) will review the information provided to determine whether or not criteria for the planned treatment are met. If criteria are met, then the RNRC confirms the plan for care. If the criteria are not met, then the RNRC will refer the case to a PRO Physician Reviewer who will use his/her best medical judgement to decide whether or not the plan of care is appropriate and demonstrates medical necessity. If he/she agrees with the plan of care, then he/she will approve the planned treatment. If he/she does not agree with the plan of care, then the treatment is denied. The PRO will notify the patient and attending physician of the denial, including the procedure for appeal.

.13 Denial and appeal as a result of outpatient pretreatment review shall be processed as described in 8.318.10 through 8.318.18.

.14 It is assumed that emergency care for the selected psychiatric/substance abuse disorders would be treated in the acute care setting.

.15 OUTPATIENT PREPROCEDURE AND PRETREATMENT REVIEW PAYMENT

Unless specifically approved by the Department, providers will receive NO reimbursement for outpatient claims submitted for payment where appropriate PRO review is not obtained by the facility or when the required PRO review is not documented appropriately.

Documented emergency care is exempt from the second opinion and pretreatment review process. All emergency care may be reviewed retrospectively by the PRO to validate the medical necessity and appropriateness of the procedures or the treatments performed.

## 8.333 OUTPATIENT PSYCHIATRIC SERVICES

### 8.333.10 DEFINITION OF OUTPATIENT AND CLINICS

1. Outpatient Psychiatric hospital services mean preventive, diagnostic, therapeutic, rehabilitative, or palliative services that:

   (a) Are furnished to outpatients;

   (b) Are furnished by or under the direction of a physician; and

   (c) Are furnished by an institution that:

      (i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and

      (ii) Meets the requirements for participation in Medicare.

2. Clinic outpatient psychiatric services means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that:

   (a) Are provided to outpatients;

   (b) Are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients; and

   (c) Are furnished by or under the direction of a physician.

### 8.333.20 EVALUATION

1. Effective September 13, 2002, 10 C.C.R. 2505-10, Section 8.333.10 shall not apply to recipients enrolled in and receiving mental health services through the Mental Health Capitation Program.

2. An intake evaluation for any recipient entering an organized program or course of psychiatric treatment shall be completed. Evaluation is defined as a written assessment that evaluated the recipient's mental condition, and based on the patient's diagnosis, determines whether treatment in the outpatient program would be appropriate. The evaluation team shall include a physician and an individual experienced in diagnoses and treatment of mental illness. The evaluation team shall certify that the program is appropriate to meet the recipient's treatment needs and shall be made part of the medical records.

3. The evaluation team shall periodically review and update the recipient's Plan of Care (PoC) (as defined in 8.333.30) in order to determine the recipient's progress toward the treatment objectives, the appropriateness of the services being furnished and the need for the recipient's continued participation in the program. The evaluation team shall perform such reviews every 90 days and the reviews shall be documented in detail in the patient records, kept on file and made available as requested for State or Federal audit purposes.

   Audits for the purpose of medical necessity for the services rendered shall be conducted by the Department of Health Care Policy and Financing or its designee.

### 8.333.30 DOCUMENTATION

1. Each recipient receiving outpatient psychiatric services in an outpatient or clinic setting shall have an individual, written, Plan of Care (PoC), designed to improve the patient's condition to the point

that participation in the program is no longer necessary. Treatment objectives must be included in the PoC and a description of:

a. The treatment regimen: The specific medical and remedial services, therapies, and activities that will be used to meet the treatment objectives;

b. A projected schedule for service delivery: This includes the expected frequency and duration of each type of planned therapeutic session or encounter; the type of personnel that shall be furnishing the services; and a projected schedule for completing re-evaluations of the patient's condition and updating the PoC;

c. Re-evaluations of treatment objectives that shall be scheduled no less than once every six months; and

d. The written PoC which shall be developed and be entered into the patient's record prior to any billings for service being submitted for reimbursement.

2. The outpatient program shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. This documentation, at a minimum, shall consist of material which includes:

a. the specific services rendered;

b. the date and actual time the services were rendered;

c. who rendered the services;

d. the setting in which the services were rendered;

e. the amount of time it took to deliver the services;

f. the relationship of the services to the treatment regimen described in the PoC;

g. updates describing the patient's progress.

Clinics that are licensed by Department of Human Services, Mental Health Services are exempt from the above specific documentation standards and shall be required to adhere to the documentation standards required by the licensing authority. But deviations shall be documented in the medical record. For services that are not specifically included in the recipient's treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's PoC shall be documented in the patient's record. Similarly, a detailed explanation, shall be documented for a medical or remedial therapy session, or encounter that departs from the PoC in terms of need, scheduling, frequency, or duration of services furnished (e.g., unscheduled emergency services furnished during an acute psychotic episode), explaining why this departure from the established treatment regimen is necessary in order to achieve the treatment objectives.

If the documentation standards required above are not met, that service is subject to recoupment and/or State and Federal administrative or civil action.

**8.333.40 REIMBURSEMENT**

Outpatient hospitals and clinics shall bill on the appropriate claim forms to receive reimbursement.

**8.340 GRADUATE MEDICAL EDUCATION (GME) AND DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS TO HOSPITALS FOR MEDICAID MANAGED CARE**

Effective for inpatient discharges and outpatient dates of service after October 1, 1997. graduate medical education (GME) costs for Medicaid managed care clients shall be paid directly to qualifying hospitals. rather than to managed care organizations (MCOs).

**8.341 GME for Medicaid Managed Care - Inpatient Services**

.10 The hospital cost report used for the most recent rebasing shall be used to determine the Medicaid inpatient GME cost per day for each hospital that has graduate medical education costs in its fee-for-service base rate. Each hospital's GME cost per day shall be computed when hospital rates are recalculated each year.

.20 MCOs shall provide to the Department inpatient days. by hospital. for discharges (net of adjustments) during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.

.30 The Medicaid managed care inpatient days for each hospital shall be the total of the inpatient days for each hospital received from the MCOs for each quarter. That total shall be multiplied by the GME cost per day to determine the inpatient GME reimbursement for each hospital per quarter. The GME reimbursement will be paid at least annually through a gross adjustment process to each hospital by June 30th of each year.

.40 MCOs other than Mental Health Assessment and Services Agencies (MHASAs) shall provide to the Department inpatient days, by hospital, for discharges from October 1, 1997 through December 31, 1997. This data shall be used for the purpose of calculating the GME reimbursement for the first partial year covered under this new methodology. (MHASA days are not included for this partial period since GME was still included in the payment to MHASAs.) If the MCOs are unable to provide this data by April 30, 1998, the reimbursement will be calculated using one quarter of the MCO inpatient hospital days at each hospital for the 1997 calendar year. This initial inpatient GME payment to hospitals shall be made by June 30, 1998.

**8.342 GME for Medicaid Managed Care - Outpatient Services**

.10 The hospital cost report used for the most recent rebasing shall be used to determine the outpatient GME cost to charge ratio for each hospital that has a graduate medical education program. Each hospital's GME cost per day shall be computed when hospital rates are recalculated each year.

.20 MCOs shall provide to the Department outpatient charges for Medicaid clients. by hospital. for outpatient dates of service during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.

.30 The Medicaid managed care outpatient charges for each hospital shall be the total of the outpatient charges for each hospital received from the MCOs for each quarter. That total shall be multiplied by 72 percent of outpatient charges to determine the outpatient GME reimbursement for each hospital per quarter. The GME reimbursement shall be paid at least annually through a gross adjustment process to each hospital by June 30th of each year.

.40 MCOs other than MHASAs shall provide to the Department outpatient charges. by hospital. for outpatient dates of service from October 1, 1997 through December 31, 1997. This data shall be used for the purpose of calculating the GME reimbursement for the first partial year covered under this new methodology. (MHASA charges are not included for this partial period since GME was still included in the payment to MHASAs.) If the MCOs are unable to provide this data by April 30, 1998. the reimbursement shall be calculated using one quarter of the outpatient hospital charges at each hospital for the 1997 calendar year. This initial inpatient GME payment to hospitals shall be made by June 30, 1998.

## 8.350 PAYMENT OF HOSPITAL COSTS FOR NON-PPS PROVIDERS AND UNITS

This section provides the method by which the payment rate for costs of medical care provided by exempt providers to eligible clients shall be determined. This method shall be referred to as "The Hospital Rate System."

In summary, these rules provide that:

a. For exempt (non-PPS) providers, the rate of payment for services rendered during the twelve month period corresponding with the State's fiscal year (7/1 ? 6/30) shall be determined and agreed upon by both the provider and the Department of Health Care Policy and Financing.

b. For exempt (non-PPS) providers, the prospective rates may be established in accordance with the established accounting principles and regulations utilized for the determination of reimbursement to providers as provided for by Title XVIII, with the exception that prospective rather than historic expenses will provide the basis for payment. Title XVIII regulations shall be utilized as guidelines. This method of payment will not exceed that produced under available Title XVIII methods of apportionment of such costs.

c. The establishment of prospective rates shall be supported by current and predicted costs derived through an appropriate budget and accounting system.

d. Absolute and comparative performance measurements shall be based upon the direct costs of patient care which shall include approved research projects and educational activities only. In addition, any comparative evaluations shall reflect the provider's size, geographic location, and scope of services.

e. In order to provide incentives for the efficient and economical utilization of provider resources, the payment rate agreed upon by provider and the Department of Health Care Policy and Financing shall be neither retroactively increased to reflect unforeseen patient costs nor retroactively decreased as a result of efficient provider operation. However, gains accruing to the provider as a result of a suspension of those patient services which were included in the setting of the prospective rate may be subject to a reduced adjustment.

f. Provision is made for the Department to consider establishing a mechanism for determining emergency adjustments of prospectively determined rates.

g. Provision is made for the Department to consider establishing a mechanism of administrative review of any prospective rate which cannot be agreed upon by the Department of Health Care Policy and Financing and provider.

## 8.351 METHODS FOR DETERMINING RATES FOR EXEMPT PROVIDERS

.10 As used in this section, 8.351, unless the context otherwise requires, the following definitions shall apply:

(1) "Add-ons" - This consists of a significant increase in a budgeted departmental cost that exceeds the consumer price index (CPI) and which can be justified on the basis of being a new or expanded service, a price increase, or case mix change. It is understood that rate modifiers, as described in the consent decree, are considered to be synonymous with add-ons. Further details regarding add-ons are found in the consent decree.

(2) "Consent Decree" - Settlement of Colorado Hospital Association, et al. v. State of Colorado, et al., D.C. Colorado, 76-F, 140, December 13, 1977. These rules, as modified by the consent decree, are applied in determining rates for Medicaid provider hospital.

(3) "Retroactive" - Increases incurred in years prior to the budget year. Exception: the Department may consider add-ons incurred in the current (most recent contract) year if such expenses were unforeseen and therefore not budgeted. Increases which were budgeted but not requested will not be considered as retrospective add-ons.

(4) "Significant Increase" - An increase in he cost of goods and services over the CPI which results in a minimum increase of $.20 per diem or $2,000 per year in total inpatient Medicaid payment, based on the most recent annual Medicaid days.

.20 The provider shall submit an approved budget which provides the basis for any add-ons requested prior to the submission of same to the Department of Health Care Policy and Financing. All information supplied by provider is deemed to be confidential.

a. The provider's proposed budget shall be submitted 60 days prior to the beginning of the State's fiscal year and shall be accompanied by the add-on request, where applicable. If an approved budget is not available May 1, the provider shall not submit an interim budget. No penalty is imposed for late budget submittal other than a possible delay in the effective date of a new rate. No per diem can be offered until an approved budget is received. The add-on request shall be accompanied by all required documentation. Documentation shall be sufficient to prove the merits of the add-on, including its relation to patient care as defined by Medicare. The Department reserves the right to request any additional information considered necessary to justify the add-on request. Provider shall propose a prospective payment rate for the next operating period. No add-ons requests shall be accepted after August 1.

b. If no add-on requests accompany the approved budget, the Department shall offer the hospital a rate computed by applying the appropriate CPI to the provider's previous contract rate.

The participation agreement shall become effective on the date of receipt by the Department or the beginning of the State's fiscal year, whichever is later.

c. The CPI used shall be the CPI W-U.S. for the 12 month period ending 90 days prior to the beginning of the State's new fiscal year.

d. If add-ons are requested, the two parties can begin negotiations. Should it appear that no agreement can be reached before the beginning of the State's fiscal year, the CPI rate will be offered. When accepted, then a participation agreement for the CPI increase only shall be signed to become effective on the date of signature or the State's fiscal year, whichever is later, and shall remain effective until such time as it is replaced by a participation agreement for a final rate based upon approved add-on requests.

e. Negotiations with respect to add-ons may continue as follows: If there is no agreement with respect to the add-ons within 60 days from the beginning of the State's fiscal year (July 1), the provider shall receive written notice from the Department that it is required to proceed within the scope of the following four options.

(1) Sign a participation agreement for the Department's offer;

(2) File a request for a rate review board hearing. Whatever rate is then decided upon would become effective the date the contract is signed, or such other date, as recommended by the rate review board and approved by the Executive Director.

(3) Continue to negotiate for an additional 20 days (to Sept. 18). A final offer shall be issued by the Department on or before 10 days (to September 28). The provider shall either sign a contract or request rate review. Rate review shall be requested

within fifteen (15) days (to October 13). If rate review is requested after October 13 it shall be denied; or

(4) Withdraw from participation in the Medicaid Program.

f. A provider and/or the Department of Health Care Policy and Financing shall be able to request changes in rates when major events that have a fiscal impact occur which were unpredictable or were uncontrollable by the provider and which would require a rate change to meet the financial requirements of the provider.

The Department of Health Care Policy and Financing shall act upon such a request within a thirty-day period after receipt of the request.

g. A possible basis for denial of add-ons includes, but is not limited to: projects which do not foster cost containment and which do not improve patient care, in accordance with Medicare regulations, or projects which would significantly increase a hospital's per diem in excess of that of its peers, or projects which are not required as a medical necessity. Return on equity and increases in hospital property costs caused by re-evaluation of assets are not allowable add-ons. Retroactive issues shall not be considered for add-ons in the prospective budget year.

**8.352 REVIEW PROCEDURES CARRIED OUT BY THE DEPARTMENT**

Upon receipt of materials from providers, the Department of Health Care Policy and Financing shall:

Review submitted material for completeness and request additional information if necessary.

Review cost components of the rate to determine significant changes, i.e., addition or deletion of departments determine changes in rates resulting from such additions or deletions.

Equate the proposed expenses/rate with prior rate by removing or adding the expenses of the departments in question.

Review the components of the proposed rate. Salary, other supplies and expense, professional fees shall be evaluated for their change as related to appropriate wage and price indices.

Approve the rate if the changes fall within limits defined above.

Review additional information as provided. Approve as a result of extenuating circumstances or disapprove request.

Calculate a counter proposed rate on all rates which are disapproved.

**8.353 RATE REVIEW BOARD**

.10 The Rate Review Board shall consist of six (6) members who shall be appointed by the Executive Director, Department of Health Care Policy and Financing, and shall serve thereon at the pleasure of said Executive Director. Three of the said six (and three alternate members) members shall be members of the staff of the Department of Health Care Policy and Financing. Three of the said six (and three alternate members) members shall be selected from the membership of the Colorado Hospital Association. The total membership of the Board shall be seven (7) members. Such seventh member (and one alternate for said seventh member) shall be selected by the six above said and duly appointed members from candidates submitted by any such member or any other person making known his desire for such membership.

.20 The principle function of the Rate Review Board shall be to assist the Department of Health Care Policy and Financing in determination of rates to be paid individual hospitals as described and set forth in these rules.

.30 The board also shall function in performing administrative reviews as set forth in 8.354.

**8.354 ADMINISTRATIVE REVIEW**

A request for rate review board hearing (see 8.351.20) shall necessitate the following steps:

a. The Department of Health Care Policy and Financing shall designate, within a period of thirty (30) days, a date upon which provider may appear before the Department of Health Care Policy and Financing Hospital Rate Administrative Review Board. Such appearance date shall not be later than sixty (60) days following the request for hearing unless otherwise agreed to by the hospital and the Department.

b. The Board shall not consider any evidence of add-on requests that were denied because of noncompliance with the rules of the Department. The Board shall be bound by the rules and regulations of the Department in its deliberations and recommendations to the Executive Director.

c. Provider shall place before the Board evidence it deems to be good and sufficient to warrant purchaser's acceptance of the proposed rate. Department of Health Care Policy and Financing shall, at the same time, state evidence it deems good and sufficient to warrant acceptance of the counter proposal. All review shall be open to the public and shall be conducted informally insofar as an orderly presentation will permit. The Board shall only consider evidence presented or introduced at the review which is within the scope of the rules of the Department. A full and complete record shall be kept of the proceedings. Cost of attendance shall be borne by the provider.

d. For purposes of conducting reviews, five (5) members of the Board constitute a quorum, one of whom must be the chairman or vice chairman. No Board member shall hear any matter in which he has an interest, nor shall he represent either party at the review. Either Department of Health Care Policy and Financing or the subject provider may challenge any Board member in writing, served upon the Board Chairman five (5) days in advance of any schedule review, and if the Board shall find merit in the challenge, it shall excuse the challenged member.

e. Within hirty (30) days after the review, the Review Board shall render its decision, in writing, to both parties. The rate designated by the Review Board shall be recommended to the Executive Director for his consideration. The Executive Director shall issue a final decision to the provider within thirty (30) days after receiving the Rate Review Board's recommendations. A final offer based on this decision shall be made to the provider within seven (7) days after the decision has been issued. Copies of such decision shall be kept on file by the Board.

f. Department has exclusive right to set rates for hospital vendors. Department may allow vendors to request adjustments in rates as provided herein. The Medical Services Board may, in its discretion, review rates. A vendor has no vested right to participate in the Medicaid program. Any vendor by applying to participate agrees to accept the rate determined after the procedures set out herein, and should he not be able to accept the rates so determined, shall withdraw from participating.. In such an event, if the negotiations have extended into the vendor's new fiscal period, final settlement for services provided during such new fiscal period shall be on the basis of 90 percent of allowed charges.

**8.355 FORMS TO BE USED CONCERNING THE PAYMENT RATE FOR HOSPITALS**

The instructions set forth in 8.350 - 8.355.10 et seq. are designed to allow Colorado hospitals to prepare

an estimate of per diem patient costs in their next fiscal year in accordance with Section 8.351 through 8.355.80.

These instructions are designed to be used by those hospitals which currently do not prepare budgets. They are not complete, in the sense that they do not provide for the budgeting of either patient revenue or capital expenditures, but instead concentrate only upon hospital expenses and adjustment to expenses.

.10 PATIENT DAY STATISTICS

.11 The purpose of this form is to establish a level of service for the hospital's budget year. Specifically, the level of service shall be considered as the number of patient days that are anticipated in the next year.

.12 The form provides for the patient days by month for the current and budget years for up to seven patient categories and nursery. The categories of patient type are neither meant to be all inclusive nor are they meant to be mandatory. No doubt many hospitals do not have their patient statistics kept in this manner. A minimum breakdown of patient days, however, shall be by Nursery and Other.

.13 In the space provided in "Current Year", enter by month the patient days, broken down into as many categories as possible. This information should be available from medical records for the current year through the end of last month. Then, using knowledge of existing medical trends, and both recent and anticipated changes in the community, changes in the hospital facilities, or other items which would affect the level of hospital service, such as seasonal trends, predict by month the number of patient days for the remainder of the current year and for the budget year. The estimate shall be broken into the same categories as the existing statistics.

.14 Total each column and row ("foot" and "crossfoot").

8.355.20 PAYROLL BUDGET WORKSHEET

.21 This form may be used, if desired, to estimate the amount of the salaries to be paid in the budget year. This form need not be returned to the Department. By Department, list each full-time employee and then each part-time employee. Leave several spaces after each department.

.22 From each employee's earnings record, enter in column 4 the earnings paid to date. From the number of pay periods remaining in the year, estimate each employee's earnings for the rest of the year and enter this in column 5. Be certain to reflect that each employee may have been given a raise or will soon receive one in the calculation of the remaining wages.

.23 If additional employees are to be added before year end, enter their position description in column 2, and in column 3 enter their start date, the number of pay periods they are expected to be employed through the rest of the year, and their expected annual earnings. In column 4, enter the wages to be paid that employee. Place an asterisk by those positions which are new. The cross total of columns 4 and 5 should be placed in column 6.

.24 Total columns 4, 5 and 6.

.25 For each position listed at year end, determine the increases, if any, that will be paid in the budget year. For example, recognize that a $100 merit increase which is due halfway through the year will only cause a $50 increase in earnings. For all positions which have

not been newly created this year, add columns 6, 7 and 8 across to determine the budget year wages (column 9). For those positions which have been added this year (not new employees filling existing positions), add the estimated annual wages entered in column 3 to columns 7 and 8 to obtain budget year wages.

.26 For each new position, if any, to be created in the budget year, enter the position description in column 2, and in column 3, enter the start date, number of pay periods, and estimated annual earnings for the position. Enter the anticipated wages to be paid the employee in column 9.

.27 Total columns 7, 8 and 9.

.28 In columns 10 and 11 respectively, enter 5.2% of column 9 not to exceed $468, and enter 3.1% of column 9 not to exceed $130. Total columns 10 and 11.

8.355.30 PAYROLL SUMMARY

From the Payroll Budget Worksheet, enter the estimated wages to be paid in the current year and the wages expected in the budget year. Also enter the number of employees expected at the end of both the current and budget year.

Total columns 2 through 5.

8.355.40 SUPPLIES AND SERVICES

.41 This form shall be used for all expenses other than payroll and payroll taxes, and medical professional fees.

.42 In column 2, enter the expenses corresponding to the description in column 1 for the year to date. In column 3, estimate the expenses for the remainder of the year. This may be done in either of two ways. If the first portion of the year has been representative of the year's activity, annualize the rest of the year, i.e., if nine months of actual expenses have been recorded, place the figure 1.33 (12/9) in column 3 and multiply column 2 by 3 to obtain the year's expense (column 4). If activity in the first portion of the year has not been representative, either because expenses have been too high or there is an unusual expense still to be incurred, estimate the remaining expense based upon the particular situation. Add columns 2 and 3 for those expenses which were not annualized and place the total in column 4.

.43 Based upon historic trends and upon the forecast of patient days, estimate the expenses for the budget year, and place them in column 5.

8.355.50 MEDICAL PROFESSIONAL FEES

Procedures for completion of this form should correspond to those for completing Worksheet C - Supplies and Services.

8.355.60 ADJUSTMENTS TO EXPENSES

The captions and the intent of this form correspond to the captions and the intent of schedules A-5 of Form SSA-1562. The procedure for completing this form is the same procedure used in Worksheet C and Worksheet D.

8.355.70 YEAR EXPENSE SUMMARY

Two forms should be submitted, one for the current year, and one for the budget year, identify by lining out "budget" or "current" as applicable. Enter by department, in Columns 2 through 5, the expenses calculated for the applicable year. These expenses come forward from Schedules B-1, C, and D. Enter the total of Columns 2 through 5 in Column 6. Enter the adjustments from Worksheet E in Column 7 and subtract Column 7 from Column 6 to obtain net expenses.

8.355.80 HOSPITAL EXPENSE SUMMARY

Figures for the current year and the budget year carry forward from Columns 8 of Schedules F.

8.355.90 Modification of payment to exempt non-prospective payment (non-PPS) hospitals (including free-standing psychiatric hospitals) effective with dates of services on or after December 15, 1989.

1. For purposes of payment, exempt hospitals will not be considered to be in any of the peer group categories developed for prospective payment system (PPS) hospitals. Exempt hospitals (including free standing psychiatric hospitals) will be paid a per diem for inpatient hospital services. Exempt hospitals and exempt units are also eligible for the major teaching hospital and disproportionate share payments as described in 8.356.20.

2. Effective for dates of service on or after July 1, 1991, exempt hospitals will receive modifications to per diem rates via the add-on development process described in 8.351 through 8.355. The maximum amount of any rate increase granted to a facility's per diem rate shall be a 7% annual limit.

3. In July 1993, the maximum amount of any add-on granted to a facility's per diem rate shall be no more than the weighted average increase in the base rates of participating PPS hospitals. This exemption from the 7% annual limit shall be in effect only for state fiscal year 1994 and for every third year thereafter when PPS base rates are recalculated.

4. An exempt hospital advisory committee will be convened by the department, consisting of representatives of the department and the hospital industry, to include but not be limited to:

   a. representatives of psychiatric facilities,

   b. representatives of state facilities,

   c. the Colorado Hospital Association.

   The purpose of this committee is to advise the department on issues related to future modification to the rate structure and other issues of relevance to non-PPS inpatient hospital financing and delivery of health care services. The department will attempt to assure statewide geographic representation in the selection of committee members.

**8.356 PAYMENTS FOR INPATIENT HOSPITAL SERVICES**

.10 General Provisions

The payment method described in this section will apply to all Colorado participating hospitals, effective with dates of service on or after December 15,1989 (unless otherwise specified).

.20 Definitions

1. Diagnosis Related Group (DRG): A patient classification that reflects clinically cohesive

groupings of inpatient hospitalizations that utilize similar amounts of hospital resources. The Medicare grouping methodology will be used as a base for the DRG payment system. The Department has the authority to make changes to the Medicare grouper methodology to address issues specific to Medicaid.

2. Principal Diagnosis: The diagnosis established after study to be chiefly responsible for causing the client's admission to the hospital.

3. Relative Weight: A numerical value which reflects the relative resource consumption for the DRG to which it is assigned. A specific Colorado case mix index is calculated by adding the relative weights of all DRG cases for a specific period of time and dividing by the total number of cases: Modifications to these relative weights will be made when needed. Relative weights are intended to be cost effective, and based upon Colorado data as available. The Department shall rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG. Criteria for establishing new relative weights will include, but not be limited to, changes in the following: new medical technology (including associated capital equipment costs), practice patterns, changes in grouper methodology, and other changes in hospital cost that may impact upon a specific DRG relative weight.

4. Base Rate:

   An estimated cost per Medicaid discharge.

   For PPS Hospitals, excluding Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate is derived from the hospital specific Medicare base rate minus any Disproportionate Share Hospital factors. The hospital specific Medicaid base rate will be calculated by reducing the Medicare base rate by a set percentage equally to all PPS Hospitals. This percentage will be determined by the Department based on the available funds appropriated by the General Assembly.

   For the purpose of rate setting effective on July 1 of each fiscal year, the Medicare base rate used will be the Medicare base rate effective on October 1 of the previous fiscal year adjusted for inflation. For Critical Access Hospitals, as defined by Medicare, and for those hospitals with less than twenty Medicaid discharges in the previous fiscal year, the Medicare base rate used will be the average Medicare base rate of their respective peer group, excluding the Critical Access Hospitals and those hospitals with less than twenty Medicaid discharges in the previous fiscal year. The inflation factor will be the CMS hospital market basket index used to inflate the Medicare base rates relative to the fiscal year for which the Medicaid base rates are effective.

   Medicaid hospital specific cost add-ons are added to the adjusted Medicare base rate to determine the Medicaid base rate. The Medicaid specific add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal year. Ten percent of the Medicaid cost add-ons will be applied to determine the Medicaid base rate. The hospital specific Medicaid cost add-ons will be an estimate of the cost per discharge for Nursery, Neo-Natal Intensive Care Units, and Graduate Medical Education.

   Urban Center Safety Net Specialty Hospitals may receive an additional adjustment factor for the specialty care provided. This adjustment factor shall be determined by the Department during the rate setting process. To qualify as an Urban Center Safety Net Specialty Hospital, the urban hospital’s Medicaid days plus Colorado Indigent Care Program (CICP) days relative to total days, rounded to the nearest percent, shall be equal to or exceed sixty-seven percent. Medicaid and total days shall be Medicaid eligible inpatient days and total inpatient days from the most recent survey requested by

the Department prior to March 1 of each year for July 1 rates. If the provider fails to report the requested days, the days used shall be collected from data published by the Colorado Hospital Association in its most recent annual report available on March 1 of each year. The CICP days shall be those reported in the most recently available CICP Annual Report as of March 1 of each year.

Pediatric Specialty Hospitals may receive an additional adjustment factor to account for the specialty care provided. This adjustment factor will be determined by the Department during the rate setting process.

For PPS Rehabilitation and Specialty-Acute Hospitals, the hospital specific Medicaid base rate will be set as a cost per Medicaid discharge derived from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 of each fiscal year. This Medicaid base rate may be adjusted by an equal percent for all hospitals within the peer group. This percentage will be determined by the Department as required by the available funds appropriated by the General Assembly.

Beginning April 1, 2004, acute rehabilitation centers that specialize in spinal cord and traumatic brain injuries shall receive an additional adjustment factor for the specialty care provided. This adjustment factor shall be determined by the Department during the rate setting process.

5. Exempt Providers and Units: Those hospitals and units within hospitals which are designated by the Department to be exempt from the DRG-based prospective payment system (PPS).

   The Department may designate facilities as exempt or non-exempt providers. . Non-exempt providers shall be reimbursed using the DRG-based prospective payment system (PPS).

6. Hospital Peer Groups: The grouping of hospitals for the purpose of cost comparison and determination of efficiency and economy. The peer groups are defined as follows:

   a. Pediatric Specialty Hospitals: All hospitals providing care exclusively to pediatric populations.

   b. Rehabilitation and Specialty-Acute Hospitals: All hospitals providing rehabilitation or specialty-acute care (hospitals with average lengths of stay greater than 25 days).

   c. Rural Hospitals: Colorado hospitals not located within a federally designated metropolitan statistical area (MSA).

   d. Urban Hospitals: All Colorado hospitals in MSAs, including those in the Denver MSA. Also included would be the rural referral centers in Colorado, as defined by HCFA. 42 U.S.C. Section 1395 WW(D)(5)(C)(I), 42 C.F.R. Sections 412.90(C) and 412.96.

   Facilities which do not fall into the peer groups described in a will default to the peer groups described in b. through d. based on geographic location.

7. Outlier Days: The days in a hospital stay which occur after the trim point day. The trim point day is that day which would occur 1.94 standard deviations above the mean length of stay for the DRG at June 30, 1996. For periods beginning on or after July 1, 1996, the number of standard deviations will be adjusted to maintain budget neutrality when

changes are made to the DRG payment system. Trim points shall be periodically adjusted when the Department determines it is necessary to ensure that payments reasonably reflect the average cost of claims for each DRG. Outlier days will be reimbursed at 80% of the DRG per diem rate, which is the DRG base payment divided by the DRG average length of stay.

8. Major Teaching Hospital Allocations: Effective October 1, 1993, hospitals shall qualify for additional payment when they meet the criteria for being a major teaching hospital, and when their Medicaid days combined with indigent care days (days of care provided under Colorado's indigent care program) equal or exceed 30 percent of their total patient days for the prior state fiscal year, or the most recent year for which data are available.

   a. Criteria

      A major teaching hospital is defined as a Colorado hospital which meets the following criteria:

      1. maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.'s.

      2. maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.'s per licensed bed.

      3. meets the department's eligibility requirement for disproportionate share payment.

   b. Payment Formula

      The additional major teaching payment rate is calculated as follows:

      MTHR = ((ICD + MD)/TPD) X MIAF

      where:

      MTHR = major teaching hospital rate

      ICD = indigent care days

      MD = Medicaid days

      MIAF = medically indigent adjustment factor

| I/R FTE's (7/1/91 to 6/30/92) | MIAF |
|---|---|
| 110 to 150 | 1.1590 |
| 151 to 190 | 1.4909 |

Payment calculation for hospitals which qualify for the additional major teaching hospital payment shall be as follows:

a. Based upon data available at the beginning of each fiscal year, Colorado shall determine each hospital's ICD, MD and TPD. ICD will be extracted from the most recent available Colorado Indigent Care Program interim report to the Colorado General Assembly, submitted by the University of Colorado Health Sciences Center. MD and TPD will be extracted from the most recently available Colorado

Acute and Rehabilitation Hospital Utilization Data Report of the Colorado Hospital Association. In addition, each hospital's Medicaid payment for the previous fiscal year shall be estimated.

b. Multiply the Medicaid payment by the calculated MTHR to determine the additional major teaching hospital payment.

c. Payment shall be made monthly.

9. Disproportionate Share Hospital Adjustment:

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

1) Have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent; and

2) A hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan.

In the case where a hospital is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

3) Number 2) above does not apply to a hospital in which:

a) the inpatients are predominantly under 18 years of age; or

b) does not offer non-emergency obstetric services as of December 21, 1987.

The Medicaid inpatient utilization rate for a hospital shall be computed as the total number of Medicaid inpatient days for a hospital in a cost reporting period, divided by the total number of inpatient days in the same period.

The low income utilization rate shall be computed as follows:

a) The fraction (expressed as a percentage)

(I) the numerator of which is the sum (for a period) of (i) total revenues paid the hospital for patient services under a State Plan under this title and (ii) the amount of the cash subsidies for patient services received directly from state and local governments, and (II) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

b) A fraction (expressed as a percentage)

(I) the numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (I) (ii) of subparagraph a) (of Section 1923 of the Social Security Act) in the period reasonably attributable to inpatient hospital services, and (II) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (b)(I) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a state plan approach under this title).

b. Colorado Determination of Individual Hospital Disproportionate Payment Adjustment

Hospitals deemed eligible for minimum disproportionate share payment and which participate in the Colorado Indigent Care Program will receive a Low Income Payment defined in section 8.903 of these regulations.

Hospitals deemed eligible for a minimum disproportionate share payment and which do not participate in the Colorado Indigent Care Program will receive a Low Income Shortfall payment.

The total available funds for the Low Income Shortfall payment equals the percentage of Self Pay Days plus Other Paid Days of those providers who qualify for the Low income Shortfall payment compared to all other Medicaid Inpatient Hospital providers multiplied by the General Fund appropriated by the General Assembly to Safety-Net Provider Payments. The amount of total available funds is distributed by the facility specific Self Pay Days plus Other Paid Days and Medicaid Days (fee-for-service and managed care). The total available funds is multiplied by the hospital specific Self Pay Days plus Other Paid Days and Medicaid Days divided by the summation of Self Pay Days plus Other Paid Days and Medicaid Days for qualified providers to calculate the Low-Income Shortfall payment for the specific provider.

c. Disproportionate share amounts shall be based upon the recalculated base rate for affected facilities (prospectively determined annually in conjunction with base rate changes). The percentage of Medicaid patients in each facility used to calculate the appropriate disproportionate share payments (if any) shall be based upon the most recent Colorado Hospital Association Data Bank information available, information from hospitals not participating in the Data Bank, and from Health Maintenance Organizations and/or Prepaid Health Plans describing total patient days and Medicaid days. Data will be subject to validation through the use of data from the Department and the Colorado Foundation for Medical Care.

d. Effective January 1, 1991, an additional Disproportionate Share Adjustment payment method shall apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula. These hospitals are defined as those hospitals which meet the Disproportionate Share Hospital criterion of Medicaid inpatient hospital services utilization rate of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State (as described above in this subsection, Disproportionate Share Hospital Adjustment, paragraph (A)). Hospitals meeting these criteria shall be eligible for an additional Disproportionate Share payment adjustment as follows:

Each facility will receive a payment proportional to the level of low income care

services provided, as measured by 94% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for third party payments), less Colorado Indigent Care Programs patient payments and Colorado Indigent Care Programs reimbursements.

For each hospital which qualifies under this section D, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. The basis for this calculation will be information published by the Colorado Indigent Care Programs in its most recent annual report available before rate setting by the Department for each upcoming state fiscal year. The Colorado Indigent Care Programs costs, patient payments, and program reimbursements will also be based upon information to be collected by the Colorado Indigent Care Programs, subject to validation through the use of data from the Department, the Colorado Foundation for Medical Care, and/or independent audit.

Effective July 1, 1993. Component 1 shall be superseded by a Disproportionate Share Adjustment payment method (herein described as Component la) under which the above cost data will be inflated forward from the year of the most recent available Colorado Indigent Care Program report available before rate setting (using the CPI-W. Medical Care for Denver) through June 30 of the fiscal year payment period.

Effective for the period from June 1, 1994 to June 30, 1994, each facility will receive a Component la payment proportional to the level of low income care services provided, as measured by the percent of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements, that will allow the State to approach but not exceed the State's Federal Fiscal Year 1994 Disproportionate Share Hospital allotment as published in the May 2, 1994 Federal Register. If these reimbursements exceed the federal allotment limits, they will be recovered proportionately from all participating hospitals.

Effective for the period from July 1, 1994 to June 30, 1995, each facility will receive a Component 1a payment proportional to the level of low income care services provided, as measured by 200% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

Effective June 1 through June 30, 1995, each facility will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 200% of the hospital's reported Colorado Hospital Association bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report available before rate setting by the Department, inflated from the year of the annual report to June, 1995 using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, and reduced by estimated patient payments. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean

Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

Effective from July 1, 1998, through September 30, 1998, and from October 1, 1998 through September 30, 1999, each facility will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report before rate setting by the Department, inflated from the year of the annual report to the current year using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, reduced by Medicare and CHAMPUS payments, and reduced by estimated patient payments. The payments will be such that the total of all Disproportionate Share Adjustment payments do not exceed the Federal Funds limits as published in the Balanced Budget Act of 1997, of $93 million in Federal Fiscal Year 1998, and $85 million in Federal Fiscal Year 1999. A reconciliation to the Balanced Budget Act of 1997 will be done based on the aggregate of all Disproportionate Share Adjustment payments. This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

Effective from September 1, 2000, through September 30, 2000, each government hospital will receive a Disproportionate Share Adjustment payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's bad debt costs. The basis for this calculation will be bad debt cost data published by the Colorado Hospital Association in its most recent available annual report before rate setting by the Department, inflated from the year of the annual report to the current year using the Consumer Price Index-W for Denver Medical Care, reduced by the ratio of cost to charges from the most recent Colorado Indigent Care Program Annual Report, reduced by Medicare and CHAMPUS payments, and reduced by estimated patient payments. These payments will be such that the total of all Disproportionate Share Adjustment payments do not exceed the Federal Funds limits as published in the Balanced Budget Act of 1997, of $79 million in Federal Fiscal Year 2000. A reconciliation to the Balanced Budget Act of 1997 will be done based on the aggregate of all Disproportionate Share payments. This payment will apply to any government disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State. Effective June 1, 2001, this bad debt Disproportionate Share Adjustment payment to government hospitals is extended to an annual basis, and is subject to the Federal Funds limits of the Balanced Budget Act of 1997, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. The limit for 2001 is $81.765 million. These payments are subject to approval and appropriation by the General Assembly.

Effective July 1, 1995, each facility will receive a Component 1a payment proportional to the level of low income care services provided, as measured by up to 100% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for Third Party payments), less Colorado Indigent Care Program patient payments and Colorado Indigent Care Program reimbursements. The basis for this calculation will be cost data published by the Colorado Indigent Care Program in its most recent available annual report available before rate setting by the Department.

This payment will apply to any disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the State.

e. Effective retroactively to July 1, 1991, the department will reimburse disproportionate share hospitals for the reasonable costs associated with administrative outstationing eligibility functions. The reimbursement will occur in the following manner:

Disproportionate share hospitals will submit on an extra line on the Medicaid Cost Report (related to Worksheet A - Trial Balance) the Administrative and General pass through direct costs associated with outstationing activities. This additional retrospective reimbursement will be separately identified on the Medicaid Settlement Sheet.

Payment, for taking of the initial applications and initiating the process of determining Medicaid eligibility, shall be made to recognize these provider administrative costs. This outstationing payment shall be made based upon actual cost with a reasonable cost per application limit to be established by the Department, based upon the lower of the amount allocated to county departments of social services for comparable functions or a provider-specific workload standard. In no case shall reimbursement exceed a maximum cap of $60,000 per facility per year for all administrative costs associated with outstationing activities.

f. Effective October 1, 1991 through September 30, 1992, a separate separate Component 2 Disproportionate Share Adjustment payment method shall apply for all hospitals eligible to receive reimbursement for services provided to Colorado Medicaid patients. These payments shall be made in addition to all other Medicaid payments. Hospitals which serve a higher proportion of low income care will receive a higher disproportionate share adjustment. The additional disproportionate share payments are based upon and are proportional to historical Medicaid Program payments and Colorado Indigent Program payments. The calculation shall be based upon the most recent Colorado Hospital Association Data Bank information available regarding the amount of uncompensated care provided, excluding discounts for contractual allowances made to third party payers, and the most recently published Colorado Indigent Care Program Annual Report.

To provide funding for this payment adjustment, all Colorado hospitals will be assessed 10% of their own specific Medicaid revenues for the previous state fiscal year. Failure of the provider to pay the assessment shall result in the Department withholding Component 2 disproportionate share payment. The disproportionate share payment for Component 2 is based upon the amount of previous year's historical Medicaid and Medically Indigent payment. This is expressed in the following formula and payment schedule:

| | | |
|---|---|---|
| Uncompensated Inpatient Care Ratio | = | UICR |
| Uncompensated I/P care revenue* | . | . |
| _____ | = | UICR |
| Total I/P care revenue | . | . |

* The total of bad debt and charity care revenue

The UICR is used to array facilities to determine the level of uncompensated care. Based upon the level of uncompensated care, facilities will receive from 10% to 60% of their uncompensated care historical cost base (which is defined as .50 of Medically Indigent payment and .10 of Medicaid payment for the previous fiscal year).

| Increased Historical UICR | . | Cost Base (HCB) |
|---|---|---|
| 0.00 - 0.029 | Level 1 | 10% |
| 0.30 - 0.049 | Level 2 | 10% |
| 0.050 - 0.079 | Level 3 | 30% |
| 0.080 - 0.109 | Level 4 | 40% |
| 0.110 - 0.169 | Level 5 | 50% |
| 0.170+ | Level 6 | 60% |

Component 2 Payment is determined as follows:

HCB = Increased Historical Cost Base

X = .10 x Medicaid Payment

Y = .50 x Medically Indigent Payment

Component 2 Payment = HCB x X + Y

Hospitals qualifying under both the Component 1 and Component 2 disproportionate share methodology, as described in Sections D and # above, may receive only the greater of the Component 1 or Component 2 payment adjustments.

g. Based upon historical data for the period July 1, 1986 through June 30, 1989. an additional Disproportionate Share Adjustment payment (herein described as Component 3) will be made effective on October 1, 1991, to any disproportionate share hospitals meeting the current Medicaid inpatient utilization rate formula. These hospitals are defined as those hospitals which meet the Disproportionate Share Hospital criterion of Medicaid inpatient hospital services utilization rate of one or more standard deviations above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payment in the state (as described above in this subsection. Disproportionate Share Hospital Adjustment, paragraph (A)). Hospitals meeting this criterion shall be eligible for an additional Disproportionate Share payment adjustment as follows:

Each facility will receive a payment proportional to the level of low income care services provided, as measured by 94% of the hospital's reported Colorado Indigent Care Program costs (as adjusted for third party payments), less Colorado Indigent Care Programs patient payments and Colorado Indigent Care Programs reimbursements.

For each hospital which qualifies under Component 3, these amounts will be

calculated based upon historical data (for the period July 1, 1986 to June 30, 1989) and paid in a single payment. The basis for this calculation will be information published by the Colorado Indigent Care Programs in its annual reports, which would have been available before each applicable state fiscal year period. The Colorado Indigent Care Programs costs, patient payments, and program reimbursements will also be based upon information to be collected by the Colorado Indigent Care Programs, subject to validation through the use of data from the Department and the Colorado Foundation for Medical Care, and/or independent audit.

h. Effective July 1, 1994, an additional disproportionate share payment adjustment method will apply to any outstate disproportionate share hospitals meeting the Medicaid inpatient utilization rate formula.

1) Eligibility for Outstate Disproportionate Share Hospital Payments.

These hospitals are defined as those hospitals which meet the disproportionate share hospital criterion of having a Medicaid inpatient hospital services patient days utilization rate of at least one percent of total patient days. Providers who are not participating in the Colorado Indigent Care Program are excluded from receiving this adjustment. Also excluded are Specialty Indigent Care Program providers, which are defined by the Colorado Indigent Care Program as those providers which either offer unique specialized services or serve a unique population. Outstate hospitals are defined by the Colorado Indigent Care Program as those Colorado hospitals that are outside the City and County of Denver, and who participate in the Colorado Indigent Care Program.

Effective July 1, 2001, Outstate Disproportionate Share hospitals which do not qualify for disproportionate share under the one standard deviation above the mean Medicaid utilization definition will be separated into the Government Outstate Disproportionate Share hospitals and Non-Government Outstate Disproportionate Share hospitals. Government Outstate Disproportionate Share hospitals are defined as those Colorado hospitals that are located outside the City and County of Denver, who participate in the Colorado Indigent Care Program and are owned by a state, county or local government entity. Non-Government Outstate Disproportionate Share hospitals are defined as those Colorado hospitals that are located outside the City and County of Denver, who participate in the Colorado Indigent Care Program and are not owned by a state, county or local government entity.

These hospitals must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. The obstetrics requirement does not apply to a hospital in which the patients are predominantly under 18 years of age; or which does not offer non-emergency obstetric services as of December 21, 1987.

Hospitals must participate in the Colorado Indigent Care Program, and must meet the separate annual audit requirements of the Colorado

Indigent Care Program; and must supply data per the Colorado Indigent Care Program guidelines on total charges, total third party collections, total patient liability, and write-off charges to the Colorado Indigent Care Program. Hospitals meeting these criteria shall be eligible for an additional disproportionate share payment adjustment as follows:

2) Reimbursement.

a) Percent of Uncompensated Care.

Each facility will receive a payment proportional to its uncompensated medically indigent costs, as calculated by the Colorado Indigent Care Program. The percent of uncompensated care that will be reimbursed depends on the annual amount appropriated by the State Legislature to the Colorado Medically Indigent Program for Outstate hospitals. Government Outstate Disproportionate Share hospitals and Non-Government Outstate Disproportionate Share hospitals may have a different calculated total reimbursement percentage of uncompensated costs.

b) Calculation of Uncompensated Costs.

These uncompensated costs will be calculated by taking total medically indigent charges, subtracting total third party collections and total patient liability to obtain write-off charges, and then multiplying write-off charges by the cost-to-charge ratio as defined by the Colorado Indigent Care Program, to calculate medically indigent write-off costs. The cost-to-charge ratio is defined by the Colorado Indigent Care Program as that cost-to-charge ratio calculated using the most recently submitted Medicare Cost Report for each hospital.

3) Method of Payment.

a) Basis of Payment.

For each hospital which qualifies under this section, these payments for indigent care costs will be calculated based upon prospective data provided by the Colorado Indigent Care Program. The basis for this calculation will be the projected reimbursement for the current fiscal year as calculated by the Colorado Indigent Care Program.

b) Payment Limits

The DSH payment will not exceed uncompensated costs as defined in the Social Security Act, Section 1923(g)(1)(A). Adjustments will be made to the monthly payments based on interim recalculations performed by the Colorado Indigent Care Program.

c) Frequency of Payment.

Payment will be made on a monthly basis.

11. Family Medicine Residency Training Program: A hospital qualifies as a teaching hospital when it has a Family Medicine Program meeting the Medicaid inpatient utilization rate formula. These Family Medicine programs must be recognized by the Commission on

Family Medicine and are defined as those programs having at least 10 residents and interns. The Family Medicine program must be affiliated with a Medicaid participating hospital that has a Medicaid utilization rate of at least one percent. If a Family Medicine program is affiliated with a facility that participates in the major teaching hospital program, it is not eligible for this program, unless the facility is a university hospital. Family Medicine programs meeting these criteria shall be eligible for an additional primary care payment adjustment as follows:

For each program which qualifies under this section, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. In each State fiscal year, the annual payment for each Family Medicine Residency Training Program will be $213,195. Effective July 1, 1999, the annual payment for each Family Medicine Residency Training Program will be $228,379. The annual payment will change based on requests for annual inflation increases by the Commission on Family Medicine, subject to approval by the General Assembly.

8.356.30 Subject to the fiscal agent's implementation of the DRG payment system, PPS hospitals will receive DRG-based payment for inpatient hospital stays no sooner than April 1, 1988.

.31 The DRG will be assigned to an inpatient claim on the basis of the principal diagnosis for which the client was treated, surgical procedures involved, and complication of the illness. Every DRG is assigned a relative weight, average length of stay, and trim point, based upon data obtained from states operating Medicaid DRG systems and upon Colorado-specific data as they become available. The DRG relative weight will be multiplied by the base rate for the each hospital to generate the base payment amount.

.32 Abbreviated patient stays will be paid as follows:

A. The hospital will receive the full DRG payment for all patient deaths and cases in which the patient left against medical advice.

B. Subject to Department approval, in cases involving transfers to, from or between PPS hospitals, PPS facilities excluding rehabilitation and specialty-acute hospitals will be paid a DRG per diem for each day based upon the full DRG payment, divided by the average length of stay for the DRG (up to a maximum of the full DRG payment). These discharges may also qualify for outlier payment when the length of stay exceeds the DRG trim point.

C. The Department may direct the PRO to review hospital transfers. After review, the PRO may recommend that preauthorization be required for transfers from a facility if it finds that transfers have been made for reasons other than when services are unavailable at the transferring hospital, or when it is determined that the client's medical needs are best met at another PPS facility.

8.356.40 ADJUSTMENTS FOR OUT OF STATE PROVIDERS

A. Payment for out-of-state and non-participating Colorado hospital inpatient services shall be at a rate equal to 90% of the average Colorado urban or rural DRG payment rate. Out-of-state urban hospitals are those hospitals located within the metropolitan statistical area (MSA) as designated by the U.S. Department of Health and Human Services.

B. The state agency may reimburse a higher payment rate (than 90% of the average Colorado other urban or rural DRG payment rate) for non-emergent services when needed services are not available in Colorado hospitals. Non-emergent inpatient medical care rendered at an out-of-state hospital to a Colorado Medicaid client must be prior

authorized by the State Department of Health Care Policy and Financing, based upon review and recommendation by the PRO. For non-DRG payment, the out-of-state hospital will be paid at a rate mutually agreed upon by the parties involved.

Payment shall in no case exceed 100% audited Medicaid costs as determined by the Department and/or its agent.

In no case shall payment exceed $1,000,000 per admission.

Prior to authorization for payment, the PRO will review to determine the medical necessity of the treatment. Payment will be made only for the specific treatment(s) approved by the PRO as medically necessary and for complications occurring during the hospital stay which are directly related to the illness under treatment. All subsequent readmissions must be independently reviewed by the PRO and receive separate authorization for payment. The out-of-state hospital will be responsible for providing the PRO (on a bimonthly basis) medical records necessary for PRO review. Non-compliance with a PRO request for medical records will result in denial of reimbursement.

8.356.50 BASE RATES FOR NEW PPS FACILITIES

A. Beginning July 1, 1996, claims for clients admitted to pediatric specialty hospitals will be reimbursed under the DRG payment system.

B. Claims for clients admitted to rehabilitation and specialty-acute hospitals which are designated as non-exempt providers beginning July 1, 1997 shall be reimbursed using the DRG payment system.

C. The Department shall assign any new PPS facilities which become providers during the year to the appropriate peer group. The new facility shall submit budgeted cost data to the Department for consideration. The Department shall consider this data and/or cost and rate data for similar facilities in determining the initial reimbursement rate for new PPS facilities. If a new facility does not submit adequate budgeted cost data, the Department may assign a new PPS facility a rate equal to the lowest rate in the peer group to which the facility is assigned.

D. When changes occur at a Medicaid provider which affect the health facility license or scope of operations attributed to that provider number, the Department shall determine whether a rate adjustment is necessary based on the resulting impact on costs. Examples of such changes include but are not limited to mergers and consolidations, acquisitions, expansions of services to existing facilities, and changes in ownership involving multi-campus hospitals. The Department may use hospital cost report data and may require the provider to submit additional historical and/or budgeted costs for the operating locations involved in order to determine the rate adjustment. If the provider does not submit adequate historical or budgeted cost data, the Department may adjust the rate to the lowest rate in the peer group to which the provider is assigned.

The Department shall adjust rates for the changes described in this section only to the extent that such changes improve efficiency. The rate resulting from the changes shall be no higher than the rate paid prior to the change. The Department may reflect anticipated efficiencies of changes by discounting existing rates for the cost savings.

Changes which are limited to inpatient hospital services shall not be considered significant if the change in total beds is less than 5 (five) percent of the facility's certified beds prior to the change. If the change involved outpatient hospital services, the provider shall submit budgeted cost information for the Department to use in determining whether

the change will significantly impact costs. The Department will determine the necessary rate adjustment for significant changes based on this data.

8.356.60 MEDICAID DATA

All hospitals participating in the Medicaid program will submit Medicaid and total hospital utilization, statistical and financial data to the Colorado Hospital Association Data Bank Program. If a hospital does not report to the Colorado Hospital Association data base, the Department will send the required format for reporting this data.

8.356.70 DRG ADVISORY COMMITTEE

The DRG Advisory Committee shall meet periodically, but no less frequently than annually, to provide advisory input to the department on the DRG payment system. This input shall include, but not be limited to:

1. Base Rate Determination

2. Relative weight adjustment

3. Changes in basic grouping methodology

4. Other aspects of the DRG payment system.

**8.358 PATIENT PAYMENT CALCULATION FOR NURSING FACILITY CLIENTS WHO ARE HOSPITALIZED**

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

.10 When a patient, who is not a transfer from a nursing facility, is admitted to the hospital and it appears the patient may be eligible for medical assistance, the hospital shall notify the county department. If the patient subsequently qualifies for assistance on the basis of institutionalization (see 8.110.31(B)) the county department will compute the income available to the individual. Except for deductions as allowed under the section Nursing Facility/Hospitalized Recipient Income, all income available to the individual must be applied to the cost of medical care. The hospital will show this as third party payment when submitting a claim to the Medicaid Program.

.20 The hospital is responsible for collecting the correct amount of patient payment due from the client, his family, or representatives. Failure to collect patient pay, in whole or in part, does not allow the hospital to bill the Medical Assistance Program.

.30 The hospital shall advise the responsible county department when the client is ready for discharge.

**8.373 INPATIENT PSYCHIATRIC CARE FOR INDIVIDUALS UNDER THE AGE OF 21**

Inpatient psychiatric care is a benefit of the Medicaid Program for individuals eligible for Medicaid benefits

under the age of 21 only when (A) provided in an institution which is accredited as a psychiatric hospital by the Joint Commission on Accreditation of Hospitals, or in a facility or program accredited by the Joint Commission of Accreditation of Hospitals; (B) services are provided under the direction of a physician and involve active treatment which a team, consisting of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof, has determined are necessary on an inpatient basis and can reasonably be expected to improve the condition, by reason of which such services are necessary, or prevent further regression so that the services will no longer be needed; and (C) are provided prior to the date such individual attains age 21, or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, (i) the date such individual no longer requires such services or (ii) if earlier, the date such individual attains 22.

In addition to these requirements, these facilities shall comply with all the federal federal requirements for inpatient psychiatric services for individuals under age 21 in psychiatric facilities or programs as specified in 42 C.F.R. 441.150, et seq., October 1992 edition. No amendments or later editions are incorporated. Copies are available for inspection and available at cost at the following address: Manager, Health and Medical Services, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, CO 80203-1714. The Department may fulfill these requirements or parts thereof through contract with the designated professional standards review organization as allowed under 42 C.F.R. 431.630, October 1992 edition. Copies of these standards, or portions thereof, are available at cost at the following addresses:

Colorado Foundation for Medical Care

P.O. Box 173001260 So. Parker Road

Denver, CO 80217-0300

or

Manager, Health and Medical Services

Colorado Department of Health Care Policy and Financing

1575 Sherman Street

Denver, CO 80203

**8.373.05 COMMUNITY MENTAL HEALTH SYSTEM REFERRAL FOR INPATIENT PSYCHIATRIC CARE RENDERED TO PATIENTS UNDER AGE 21**

When inpatient psychiatric care is provided to Medicaid clients under age 21 at a hospital (other than a state institution) reimbursed by per-diem rates, the Community Mental Health Center (CMHC) referral system shall apply:

A. Admission Notification Assessment

When a Medicaid enrolled individual under age 21 is admitted to an inpatient hospital for psychiatric care, the hospital shall notify the PRO, by telephone, of the admission within 24 hours. The PRO shall notify the CMHC in the patient's service area of responsibility by telephone and writing within 48 hours of notification.

1. The CMHC will determine if the client's condition warrants assessment, and what alternative services are available. If, after notification, the CMHC staff determines an assessment is necessary, such assessment shall occur within 10 working days from the date of

notification. The CMHC staff will assess the client's medical condition/service needs, document the assessment in the hospital medical record, and participate in development of the disposition plan.

2. Exception: If the Medicaid client admitted to the hospital is enrolled in the Mental Health Assessment and Service Agency (MHASA) program, procedures established by that program for notification and coordination of care shall be followed.

B. In hospitals where inpatient psychiatric care is provided to Medicaid clients under age 21 at a hospital (other than a state institution) reimbursed by per-diem rates, PRO retrospective review shall assess the medical necessity for admission and for the number of paid days, in accordance with 8.314.10.

C. In the event of denial of any or all of the client's stay, the appeal process for clients and/or providers is described at 8.318.12.

**8.373.20 ELIGIBILITY**

With the exception of determination that a child is deprived of parental support or care and school attendance, a person's eligibility for this program shall be determined under AFDC rules. See the Medical Assistance Eligibility section regarding needy persons under 21.

Determining eligibility for the "Under 21 Psychiatric Program" must include a determination of whether the person, individually or through his family, is covered by medical insurance or has other "third party" medical resources which must be used prior to benefit coverage under Medicaid. Except for an amount reserved for personal needs, all income available to the individual must be applied to the costs of medical care. When such individual has no income, a personal needs payment may be made if the individual is eligible as an eligible member of an AFDC household.

**8.373.30 ELIGIBILITY AND INITIAL CERTIFICATION PROCESS**

1. The admitting facility shall refer those persons deemed potentially eligible for benefits to the county department of social services of the county in which the facility is located or the county of jurisdiction for the client if different and known to the facility. The referral shall include medical data: diagnosis, prognosis, treatment plan, and long and short-range treatment goals. Such referral should contain as much personal and financial data as possible to enable the county department quickly to undertake and complete eligibility determination.

2. The referral information concerning medical data shall immediately be forwarded by the county department to the Peer Review Organization for purposes of securing certification of the need for inpatient psychiatric care.

3. At the time of such submittal, the county department shall initiate application and eligibility determination process. County departments shall work cooperatively with the facility concerning the securing of application.

4. The State Department promptly shall furnish the county department with the result of its review, certifying, as applicable, the child's need for care. See Section - Extension Certification concerning extensions.

5. The county department shall complete its eligibility determination process and notify the applicant, in accordance with standard procedures therefor (Form PA-75 or PA-78). If the Peer Review Organization fails to certify the child as requiring inpatient care, this reason shall be set forth as the primary reason for denial in the recipient notice.

6. The facility shall advise the responsible county department of any changes in income or circumstances affecting eligibility or payment by the individual client in care. The client (parent or guardian if client is a minor) also has responsibility to provide such information to the county department.

7. Procedures and entries concerning reporting are set forth in the Financial and Medical Eligibility Reporting Manual.

**8.373.40 EXTENSION CERTIFICATION**

Such individuals admitted to a long - term inpatient psychiatric facility with a psychiatric diagnosis are limited to an initial length of stay of up to 30 days. The attending physician (psychiatrist) may request authorization for additional inpatient treatment if, in his opinion, additional active psychiatric treatment in a long-term inpatient psychiatric facility can be expected to result in amelioration of the diagnosed condition.

Such extensions beyond the initial 30 days must be certified by the Office of Medical Assistance, Department of Social Services. Signature is required on each Extension Form MED-177 which states the current medical records have been reviewed and the client's psychiatric condition warrants continued inpatient active treatment. Certification shall be made on the 25th day of care and every 30 days thereafter. Extensions of psychiatric diagnosis(es) beyond the initial 30 days shall be granted only in those cases where the attending physician (psychiatrist) determines that the client can be expected to make a satisfactory recovery through the application of active treatment. Failure to maintain properly signed Certification Form MED-177 for current period of care on client's chart will result in recovery of Medicaid funds.

Medicaid records are subject to audit by staff of the Department of Health Care Policy and Financing or its authorized representative.

Extension certification shall be made before the patient enters into each succeeding period of inpatient care. This applies to all persons eligible for Medicaid regardless of status of application until eligibility is denied or the client is discharged, whichever occurs first. Appropriate prior notice rules are applicable.

**8.373.50 INSPECTION OF CARE**

These facilities shall be surveyed under the Colorado Department of Public Health and Environment's Inspection of Care Program. Failure to satisfy the Inspection of Care requirements shall cause the Department to institute corrective action as it deems necessary.

**8.373.60 BILLING PROCEDURES**

Billing procedures for the Under 21 Psychiatric Program shall be issued by the Medicaid Fiscal Agent. Such billing procedures shall be approved by the Office of Medical Assistance and, as a minimum, shall include the following provisions:

1. All necessary client identification and statistical data as required to maintain necessary and proper medical records.

2. The billing form shall certify that extension certification was made as described under Extension Certification above.

3. Any income the client receives while an inpatient in a long-term care psychiatric facility shall be shown as another resource. Such income shall be applied toward the payment of the client's hospital care.

4. For a facility licensed as a psychiatric hospital, the rate of payment shall be that rate as determined in accordance with procedures contained in the PAYMENT OF HOSPITAL COSTS Section of this

staff manual less any third-party resources, including patient payments.

5. For facilities not licensed as a psychiatric hospital, the initial payment shall be $2710, until such time as a Medicaid cost report is filed according to procedures defined in FORM MED-13: GENERAL INFORMATION, MED-13: DEPARTMENT RESPONSIBILITIES AND FORM MED-13: NURSING FACILITY RESPONSIBILITIES.

   Reimbursement for subsequent periods shall be determined according to procedures described in Computation of Individual Reimbursement Rate and Determination of Maximum Reimbursement Rate of the LONG TERM CARE - REIMBURSEMENT Section of these regulations. For purposes of reimbursement, all psychiatric facilities included under the Under 21 Psychiatric Program which are not licensed as hospitals shall constitute a single class of facilities.

6. Third-party payments are made first. Medicaid payment is made after other resources are exhausted.

Modification to billing procedures necessitated by new or additional requirements of the Medicaid Program shall be authorized by the Office of Medical Assistance of the Department of Health Care Policy and Financing.

**8.374 PAYMENT FOR INPATIENT SERVICES AT FREE STANDING PSYCHIATRIC HOSPITALS**

.10 Payment for inpatient care provided to Medicaid clients under age 21 in free standing psychiatric hospitals (excluding state institutions) shall be limited to the following institutions:

   Centennial Peaks Hospital

   Cleo Wallace Center

   La Plata Psychiatric Hospital

   This limitation applies to the licensed beds available at each institution as of October 10, 1988. Effective June 1, 1991, for the facilities listed in this section, the Department may impose contractual limits on beds by means of the hospital participation agreements subject to the provisions of 8.374.30.

.20 Effective October 10, 1988, payment rates for these institutions have been established by the Department on the basis of historical Medicaid payment rates and Medicaid payment rates and evaluation of hospital information concerning the relationship between hospital costs and patient length of stay. The following per diem rates will be in effect as of October 10, 1988:

| | |
|---|---|
| Day 1 through Day 7: | $330 |
| Day 8 through remainder of care at acute level: | $239 |
| Days certified awaiting appropriate transfer: | $ 67 |

   These rates will be increased initially on July 1, 1989, by the CPI-W. However, when the weighted average of base rates for participating prospective payment system (PPS) hospitals decreases due to a decrease in appropriations available to the Department, the rates for free-standing psychiatric hospitals shall not be increased by an inflation factor and shall be decreased by the same percentage as the base rates for the PPS hospitals. Effective December 15, 1989, these free standing psychiatric hospital rates will be updated annually by the methodology described in 8.355.90. The annual inflator may be adjusted by the Department.

.30 The Department shall conduct an annual assessment to include:

A. The appropriateness of the geographic location of these beds relative to patient needs for access.

B. The appropriateness of the number of beds available, relative to patient needs and accessibility.

Based upon results of this annual assessment the Department shall determine the appropriateness of maintaining the contractual relationships in effect 10/30/88 with psychiatric hospitals (excluding state institutions) providing care for persons under 21 years of age, and if necessary, modify these contractual relationships relative to the number of beds eligible for reimbursement.

Based upon results of this assessment the Department may also issue a Request for Proposal in order to obtain provider contracts for the number and geographic location of beds deemed appropriate.

.31 Federal statute requires that Certification of Need (CON) be performed for all hospital inpatient care provided to Medicaid clients in Colorado Free Standing Psychiatric Hospitals. Payment for inpatient claims submitted by Free Standing Psychiatric Hospitals will be denied if the Colorado Foundation for Medical Care (CFMC) determines that the facility has not complied with Departmental CON documentation.

The CON is performed by the hospital's internal review team. The CFMC denial will be administrative and not subject to appeal.

**8.375 SWING-BED HOSPITALS**

.10 DEFINITIONS

"Swing-Bed Hospital" is a hospital participating in Medicare and Medicaid that has an approval from the federal government to provide skilled and/or intermediate care services.

"Routine SNF Services" and "Routine ICF Services" are those services required to be provided by nursing facilities participating in the Medicaid program as part of their per diem rate.

"Ancillary Services" are services which are not required to be provided by nursing facilities participating in the Medicaid program within their per diem rate, but which are reimbursable services under the Medicaid program. These include but are not limited to: laboratory and x-ray services, and prescription drugs.

.20 APPLICATION PROCESS

Hospitals which intend to designate swing-beds for the Medicaid program must program must apply to the Colorado Department of Public Health and Environment for certification of swing-beds and to the Colorado Department of Health Care Policy and Financing for participation as a provider of skilled and/or intermediate nursing facility services.

The following requirements must be met for participation as a swing-bed hospital:

1. Hospitals must meet state regulations with respect to certificates of need.

2. Hospitals must have fewer than 50 inpatient acute care beds excluding newborn bassinets and beds in special care units: i.e., ICU, CCU, EDRD, etc. (does not apply to hospitals approved on a demonstration basis by the U.S. Department of Health and Human Services.)

3. Hospitals are not located in an area of the state designated as "urbanized" by the most recent official census published by the Federal Bureau of the Census. (Does not apply to hospitals approved on a demonstration basis by the U.S. Department of Health and Human Services.)

4. Hospitals must have a current valid Medicare agreement. Hospitals on "deferred termination" status are not eligible nor are hospitals with a waiver of 24-hour RN coverage.

**8.375.30 PAYMENT RATES**

Payment for swing-bed services will be made at the average rate per patient day paid to Class I nursing facilities for services furnished during the previous calendar year.

Payment for routine skilled nursing facility and intermediate care facility services may not exceed the rates charged for the same services to private pay residents or residents with other sources of income.

Oxygen provided to swing-bed patients will be paid at the same rate currently paid to skilled nursing facilities and intermediate care facilities in addition to payments made for routine services.

Clients shall be required to contribute all patient income minus the personal needs amount to the cost of their skilled or intermediate nursing care. Collection as well as determination of the patient income amount shall be in accordance with the section of this manual entitled "Patient Income and Possessions."

.40 CLAIM SUBMISSION

Hospitals shall submit claims for swing-bed routine services and oxygen on nursing facility claim forms provided by the fiscal agent.

Ancillary services shall be billed separately on the appropriate claim form.

.50 SERVICES FURNISHED WITHIN THE PER DIEM RATE

Hospitals providing skilled nursing facility and/or intermediate care facility services in swing-beds must furnish the same services, supplies and equipment within the per diem rate which skilled nursing facilities and intermediate care facilities, excluding intermediate care facilities/mentally retarded, are required to provide.

Clients and/or their families or guardians shall not be charged for any of these required items or services.

**8.375.60 PATIENTS' RIGHTS**

Hospitals providing skilled nursing facility or intermediate care facility services to swing-bed patients shall adhere to the patient's rights requirements for skilled nursing facilities and intermediate care facilities contained in the Department of Public Health and Environment regulations including:

> The right to be transferred or discharged only for medical reasons or his/her welfare, or that of other patients, or for nonpayment for his/her stay and the right to be given reasonable advance notice of any transfer or discharge, except in the case of an emergency as determined by professional staff.

However, if the hospital wishes to establish limited lengths of stay in its swing-beds, it will be considered to have protected this patient right if the patient signs a notice of the conditions of such stay at the onset of his/her intermediate care facility or skilled nursing facility care.

.70 PERSONAL NEEDS FUNDS AND PATIENT PAYMENTS

Swing-bed hospitals shall maintain personal needs accounts, submit AP-5615 forms, and be responsible for collecting patient payment amounts in accordance with the requirements established for nursing facilities in the section entitled "Patient Income and Possessions."

.80 PRIOR AUTHORIZATION OF SWING-BED CARE BY THE PEER REVIEW ORGANIZATION

All Medicaid patients shall be prior authorized and subject to the continued stay review processes of the Peer Review Organization in accordance with the criteria and procedures found in the section of this manual entitled "Long Term Care - General."

## 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 care to access appropriate long term care services.

Legal Authority

Pursuant to C.R.S. 26-4-522, the state department is authorized to provide for a statewide Single Entry Point system.

### 8.390.1 DEFINITIONS

A. Agency Applicant means a legal entity seeking designation as the provider of Single Entry Point agency functions within a Single Entry Point district.

B. Assessment means a comprehensive *evaluation* with the client and appropriate collaterals (such as family members, advocates, friends and/or caregivers) and an evaluation by the case manager, with supporting diagnostic information from the client's medical provider to determine the client's level of functioning, service needs, available resources, and potential funding resources.

C. Care Planning means the process of identifying with the client and appropriate collaterals, goals and client choices for the care needed, services needed, appropriate service providers, and client co-payment, based on the client assessment and knowledge of the client and of community resources.

D. Case Management means the assessment of a long-term care client's needs, the development and implementation of a care plan for such client, the coordination and monitoring of long-term care service delivery, the evaluation of service effectiveness, and the periodic reassessment of such client's needs.

E. Corrective Action Plan means a written plan which includes the specific actions the agency shall take to correct non-compliance with standards, and which stipulates the date by which each action shall be completed.

F. Department shall mean the Colorado Department of Health Care Policy and Financing.

G. Failure To Satisfy The Scope Of Work means incorrect or improper activities or inactions by the Single Entry Point agency in terms of its contract with the Department.

H. Financial Eligibility means an individual meets the eligibility criteria for a publicly funded program, based on the individual's financial circumstances, including income and resources.

I. Functional Needs Assessment means a comprehensive *evaluation* with the client and appropriate

collaterals (such as family members, friends and/or caregivers) and a written evaluation on a state prescribed form by the case manager, with supporting diagnostic information from the client's medical provider, to determine the client's level of functioning, service needs, available resources, potential funding resources, and medical necessity for admission or continued stay in certain long term care programs.

J. Intake/Screening/Referral means the initial contact with individuals by the Single Entry Point agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term care services; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive long term care client assessment.

K. On-Going Case Management means the evaluation of the effectiveness and appropriateness of services, on an on-going basis, through contacts with the client, appropriate collaterals, and service providers.

L. Private Pay Client means an individual for whom reimbursement for case management services is received from sources other than a state administered program, including the individual's own financial resources.

M. Program means a publicly funded program including, but not limited to, Adult Foster Care, Home Care Allowance, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People with Brain Injury (HCBS-BI), Medicaid nursing facility care, and case management services funded through the Older Americans Act (Title III-B)

N. Reassessment means a comprehensive *evaluation* with the client and appropriate collaterals and an evaluation by the case manager, with supporting diagnostic information from the client's medical provider to determine the client's level of functioning, service needs, available resources, and potential funding resources.

O. Resource Development means the study, establishment, and implementation of additional resources or services which will extend the capabilities of community long-term care systems to better serve long-term care clients and clients likely to need long-term care in the future.

P. Single Entry Point means the availability of a single access or entry point within a local area where a current or potential long-term care client can obtain long-term care information, screening, assessment of need, and referral to appropriate long-term care programs and case management services.

Q. Single Entry Point District means two or more counties, or a single county, that have been designated as a geographic region in which one agency serves as the Single Entry Point for persons in need of long term care services.

R. Single Entry Point Agency means the organization selected to provide case management functions for persons in need of long term care services within a Single Entry Point District. Single Entry Point agencies may function as a Utilization Review Contractor.

S. State Designated Agency means a single entry point agency designated to perform specified functions that would otherwise be performed by the county department(s) of social services.

T. Utilization Review Contractor shall mean an entity or entities contracted with the Department of Health Care Policy and Financing to provide assessment, case management, training, monitoring, and/or utilization control for the following programs: Home and Community-Based

Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People with Brain Injury (HCBS-BI), Home and Community-Based Services for Persons with Mental Illness (HCBS-MI), Children's Home and Community Based Services, Medicaid nursing facility care, Program for All Inclusive Care for the Elderly (PACE), Estate Recovery, Private Duty Nursing (PDN), Children's Extensive Support, Hospital Back-up and PASARR. Single Entry Points are one type of Utilization Review Contractor.

U. Utilization Management shall mean the use of techniques designed to approve or deny admission or continued stay in selected long term care programs, based on the clinical necessity, amount and scope, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques applicable to this Section 8.390 include prospective review/prior authorization, certification, concurrent review, or retrospective review.

**8.390.2 SINGLE ENTRY POINT CLIENTS**

Persons shall access the above listed long term care programs through the single entry point agency that serves the single district in which they reside.

.21 Client characteristics . An individual who desires access to long term care services shall meet the following criteria:

A. The individual shall require skilled, maintenance and/or supportive services; and

B. The individual has functional impairment in activities of daily living *(ADL)* , and/or a need for supervision, necessitating long term care services provided in a nursing facility, a residential alternative, or the individual's home; and

C. If the individual has a primary diagnosis of developmental disability or mental illness, the individual's needs are primarily for long term care services, in accordance with specific program eligibility criteria; and

D. The individual receives or is eligible to receive medical assistance (Medicaid) and/or financial assistance under one or more of the following programs: Old Age Pension, Aid to Blind, Aid to Needy Disabled, Supplemental Security Income, or Colorado Supplemental, or as a 300% eligible, as defined at 8.485.50 below, receiving long term care services in a nursing facility or through one of the Home and Community-Based Services programs listed below at 8.390.22.

.22 Clients of publicly funded programs . Single Entry Point agencies shall provide case management to clients of publicly funded long term care programs including, but not limited to, Medicaid nursing facility care, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People with Brain Injury (HCBS-BI), Home Care Allowance, Adult Foster Care, and Older American's Act case management services.

.23 Utilization Review Contractors shall be authorized to provide Utilization Management to clients of publicly-funded long term care including, but not limited to, Medicaid nursing facility care, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People with Brain Injury (HCBS-BI), Program for All-Inclusive Care for the Elderly (PACE), Children's Home and Community Based Services, Estate Recovery, Home and Community-Based Services for People with Mental Illness (HCBS-MI), Private Duty Nursing (PDN), PASARR, Hospital Back-up and Children's Extensive

Support Waiver.

.24 Program-specific eligibility criteria . Authorization to receive services through a publicly funded program shall be in accordance with the program's eligibility criteria.

**8.391 SINGLE ENTRY POINT DISTRICT DESIGNATION**

.10 Changes in Single Entry Point District Designation

A. In order to change Single Entry Point designation, a county or district shall submit an application to the Department, six months prior to commencement date of the proposed change. The application shall include the following information:

a. The geographic boundaries of the proposed Single Entry Point district;

b. Assurances that the proposed district meets all criteria set forth in Department rules for Single Entry Point district designation;

c. The designation of a contact person for the proposed district; and

d. A resolution supporting the application passed by the county commissioners of each county or parts of counties in the proposed district.

B. The application shall be approved provided the proposed district meets the Single Entry Point district designation requirements.

.11 District Designation Requirements

Single Entry Point districts shall meet the following requirements:

A. Counties composing a multi-county district shall be contiguous.

B. A single county may be designated a district provided the county serves a monthly average of 200 or more clients from the following community-based programs: Adult Foster Care, Home Care Allowance, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living With Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People with Brain Injury (HCBS-BI), and/or Older American's Act case management services.

C. Multi-county districts shall not be required to serve a minimum number of clients.

D. Each district shall have at least one full-time case manager employed by the Single Entry Point agency that serves the district.

E. Each district shall assure adequate staffing by the district's Single Entry Point agency to provide coverage for all case management functions and administrative support, in accordance with rules at Section 8.393.

**NOTE:** Section 8.391.12 was deleted effective December 2, 2002.

**8.391.20 SINGLE ENTRY POINT AGENCY SELECTION**

A. Except as otherwise provided herein, upon a change in Single Entry Point district designation or upon expiration of the district's existing Single Entry Point agency contract, a Single Entry Point district

may select a county agency, including a county department of social/human services, a county nursing service, an area agency on aging or a multicounty agency to serve as the Single Entry Point agency for the district. Once the Single Entry Point functions in a district are provided through a contract between the Department and an entity other than as listed above, the Single Entry Point agency for that district shall thereafter be selected by the Department pursuant to applicable state statutes and regulations.

B. The agency selected by the Single Entry Point district shall serve as the Single Entry Point agency for the district unless the agency selected by the district has previously had its Single Entry Point agency contract terminated by the Department.

C. The Single Entry Point district's selection shall be delivered to the Department no less than sixty (60) days prior to the effective date of the change in district designation or expiration of the contract with the district's existing Single Entry Point agency.

D. If the Single Entry Point district has not delivered to the Department its selection within the timeframe specified in subsection (3) of this rule, the Single Entry Point agency for the district shall be selected by the Department pursuant to applicable state statutes and regulations.

NOTE: Sections 8.391.21 - 8.391.38 were deleted effective December 2, 2002.

**8.392 FINANCING OF THE SINGLE ENTRY POINT SYSTEM**

8.392.1 Single Entry Point agencies shall be established as separate administrative units for the purpose of providing case management services.

8.392.2 REIMBURSEMENT METHODOLOGY

A. Reimbursement for Single Entry Point functions shall be determined by the number of counties included in a district and by the number of clients served, subject to the availability of funds.

1. A Single Entry Point agency that serves a multi-county district shall annually receive a base amount for each county included in the district, plus an amount for each client served, to be determined annually by the Department.

2. A Single Entry Point agency that serves a district composed of only one county shall not receive the base amount, but shall receive an amount for each client served each year.

3. The amount for each client shall be based on the number of clients served in one or more of the following programs: Adult Foster Care, Home Care Allowance, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living With Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People With Brain Injury (HCBS-BI), and Older American's Act case management services.

8.392.3 COST ALLOCATION

A. The Department shall make monthly payments to each designated Single Entry Point agency using a methodology which shall be specified in the contract between the state and the agency.

B. At year end, each Single Entry Point agency's allowable costs shall be reconciled with the

agency's allocation. Reimbursement for allowable expenditures shall be made to the extent of the district's allocation. In the event a district's allocation is greater than its allowable expenditures, the district shall remit any overpayment.

C. Allowable agency expenditures are those which the Department deems allowed or required, in accordance with the following federal rules: CFR Title 45, Part 74, Appendix C; Office of Management and Budget Circular A-87, January 1981; and U.S. Department of Health and Welfare, December 1976, Cost Principles and Procedures for Establishing Cost Allocation Plans and Indirect Cost Rates for Grants and Contracts with the Federal Government (OASC-10). This rule does not include later amendments to or editions of the incorporated material. Copies are available for public inspection during regular business hours, and may be obtained at cost or examined from the Director of the Office of Accounting and Purchasing, Colorado Department of Health Care Policy and Financing, 1575 Sherman Street, Denver, CO; or may be examined at any State Publications Depository Library.

D. Single Entry Point agencies may be audited by representatives of the Department, its designee, and/or independent audit firms, in accordance with state and federal rules.

E. Pre-audits made in the Department may result in reducing the Single Entry Point agency's reimbursement by the amount of any incorrect payments. Post audits made by the field audit staff verify the correctness of payments and may result in additional adjustments in reimbursement.

F. Single Entry Point agencies shall maintain documentation to support the actual costs of operation. Quarterly reports submitted to the Department shall document time expended by employees on specified programs, in accordance with a state prescribed time analysis method.

G. For Utilization Management functions, the Department shall make monthly payments to each designated Single Entry Point agency using a methodology which shall be specified in the contract between the Department and the agency.

8.392.4 PRIVATE PAY CLIENTS

Single Entry Point agencies shall provide case management services to private pay clients within two years from agency start-up.

A. The Single Entry Point agency must serve private pay clients who are able to make payment in full on a fee-for-service basis and may serve private pay clients on a sliding fee basis.

B. If the Single Entry Point agency chooses to serve private pay clients on a sliding fee basis, the Single Entry Point agency shall be responsible for obtaining supplemental funds to cover the cost of case management services for these clients.

C. The Single Entry Point agency shall establish separate accounting cost centers for the reporting of private pay clients as separate and distinct from clients of publicly funded programs.

D. The services provided to private pay clients shall be subject to the same standards as apply to clients who are recipients or applicants for state administered programs, including the collection of comparable client specific data.

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

**8.393.1 ADMINISTRATION OF A SINGLE ENTRY POINT AGENCY**

The single entry point agency shall be required by federal or state statute, or by mission statement, by-laws, articles of incorporation, contracts, or rules and regulations which govern the agency, to comply with the following standards:

A. The Single Entry Point agency shall serve persons in need of long term care services, regardless of impairment or disability, in accordance with program criteria, except that persons in need of specialized assistance such as services for developmental disabilities or mental illness may be referred by a Single Entry Point agency to programs under the Colorado Department of Human Services;

B. The Single Entry Point agency shall have the capacity to accept multiple funding source public dollars;

C. The Single Entry Point agency shall have the capacity to file for and receive payment from private insurance carriers, and charge and collect fees for services from clients;

D. The Single Entry Point agency shall have the capacity to contract with individuals, with for-profit entities, and with not-for-profit entities to provide some or all Single Entry Point functions;

E. The Single Entry Point agency shall have the capacity to receive funds from public or private foundations and corporations; and

F. The Single Entry Point agency shall be required to publicly disclose all sources and amounts of revenue.

.11 Community advisory committee . The Single Entry Point agency shall, within thirty (30) days of designation, establish a community advisory committee for the purpose of providing public input and guidance for Single Entry Point agency operation.

A. The membership of the community advisory committee shall include, but not be limited to, regional representation from the district's county commissioners, area agencies on aging, medical professionals, long term care service providers, long term care ombudsman, human service agencies, county government officials, and long term care consumers.

B. The community advisory committee shall provide public input and guidance to the Single Entry Point agency in the review of service delivery policies and procedures, marketing strategies, resource development, overall Single Entry Point agency operations, service quality, client satisfaction, and other related professional problems or issues.

.12 Personnel system . The Single Entry Point agency shall have a system for recruiting, hiring, evaluating, and terminating employees.

A. Single Entry Point agency employment policies and practices shall comply with all federal and state affirmative action and civil rights requirements.

B. The Single Entry Point agency shall maintain written job descriptions for all positions.

.13 Accounting system . The Single Entry Point agency shall follow generally accepted accounting practices and comply with all rules and regulations for accounting practices set forth by the State.

A. In addition, the Single Entry Point agency shall assure the following:

1. Funds are used solely for authorized purposes;

2. All financial documents are filed in a systematic manner to facilitate audits;

3. All prior years' expenditure documents are maintained for use in the budgeting process and for audits; and

4. Records and source documents are made available to the Department, its representative, or an independent auditor for inspection, audit, or reproduction during normal business hours.

B. The Single Entry Point agency shall be audited annually and shall submit the final report of the audit to the Department within six months after the end of the state's fiscal year. The Single Entry Point agency shall assure timely and appropriate resolution of audit findings and recommendations.

.14 Liability insurance coverage . The Single Entry Point agency shall maintain adequate liability insurance (including automobile insurance, professional liability insurance and general liability insurance) to meet the Department's minimum requirements for contract agencies.

.15 Information management . The Single Entry Point agency shall, in a format specified by the State, be responsible for the collection and reporting of summary and client-specific data including but not limited to information and referral services provided by the agency, program eligibility determination, financial eligibility determination, care planning, service authorization, resource development, fiscal accountability, and, if applicable, utilization management.

A. The Single Entry Point agency shall have computer hardware and software, compatible with the Department's computer systems, and with such capacity and capabilities as prescribed by the Department.

B. The Single Entry Point agency shall have adequate staff support to maintain a computerized information system in accordance with the Department's requirements.

.16 Recordkeeping. The Single Entry Point agency shall maintain client records in accordance with program requirements, including the documentation of all case activities, the monitoring of service delivery, and service effectiveness. If applicable, the client's designated representative (such as guardian, conservator, or person given power of attorney) shall be identified in the case record, with a copy of appropriate documentation. If the client is unable to sign a form requiring his/her signature due to a medical condition, any mark that the client is capable of making will be accepted in lieu of a signature. If the client is not capable of making a mark, the signature of a family member or other person designated to represent the client will be accepted.

.17 Confidentiality of information . The Single Entry Point agency shall protect the confidentiality of all applicant and recipient records in accordance with State statute (CRS 26-1-114 as amended). Release of information forms obtained from the client must be signed and dated, and shall be renewed at least annually, or sooner if providers change. Fiscal data, budgets, financial statements and reports which do not identify clients by name or number are open records.

.18 Client rights . The Single Entry Point agency shall assure the protection of the client's rights as defined by the Department under applicable programs.

A. The Single Entry Point agency shall assure that the following rights are preserved for all clients of the Single Entry Point agency, whether the client is a recipient of a state administered program or a private pay client:

1. The client and/or the client's designated representative is fully informed of the client's rights and responsibilities;

2. The client and/or the client's designated representative participates in the development and approval, and is provided a copy, of the client's care plan;

3. The client and/or the client's designated representative selects service providers from among available and appropriate providers in the client's Single Entry Point district;

4. The client and/or the client's designated representative has access to a uniform complaint system provided for all clients of the Single Entry Point agency; and

5. The applicant or client who applies for or receives publicly funded benefits and/or the applicant's or client's designated representative has access to a uniform appeal process, which meets the requirements of Section 8.393.26, when benefits or services are denied or reduced and the issue is appealable.

B. At least annually, the Single Entry Point agency shall survey a random sample of clients to determine their level of satisfaction with services provided by the agency.

1. The random sample of clients shall constitute ten (10) clients or ten percent (10%) of the Single Entry Point agency's average monthly caseload, whichever is higher.

2. If the Single Entry Point agency's average monthly caseload is less than ten (10) clients, all clients shall be included in the survey.

3. The client satisfaction survey shall conform to guidelines provided by the Department.

4. The results of the client satisfaction survey shall be made available to the Department and shall be utilized for the Single Entry Point agency's quality assurance and resource development efforts.

C. The Single Entry Point agency shall assure that consumer information regarding long term care services is available for all clients at the local level.

.19 Access

There shall be no physical barriers which prohibit client participation, in accordance with the Americans with Disabilities Act (ADA), 42 U.S.C. 12101 et seq.

A. The Single Entry Point agency shall not require clients to come to the agency's office in order to receive assessments, utilization management services, or case management services.

B. The Single Entry Point agency shall comply with anti-discriminatory provisions, as defined by federal and Department rules.

C. The functions to be performed by a Single Entry Point (SEP) agency shall be based on a case management model of service delivery.

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

A. The Single Entry Point agency shall provide case management and, if applicable, Utilization Management services in compliance with standards established by the Department.

B. The Single Entry Point agency shall provide sufficient staff to meet all performance standards. In the event a Single Entry Point agency sub-contracts with an individual or entity to provide some or all service functions of the Single Entry Point agency, the sub-contractor shall serve the full range of Single Entry Point programs. Subcontractors must abide by the terms of the Single Entry Point agency's contract with the Department, and are obligated to follow all applicable federal and state rules and regulations. The Single Entry Point agency is responsible for subcontractor performance.

C. Protective services. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence and/or the local law enforcement agency.

D. Pilot Projects. Effective July 1, 2001, the Single Entry Points shall be permitted under a pilot project administered by the Department to perform the following activities as negotiated under agreement with the Department:

1. Approve authorizations for admission and continued stay into the Home and Community Based Services - Elderly, Blind, and Disabled (HCBS-EBD) and Home and Community Based Services - Persons Living with AIDS (HCBS-PLWA) Programs.

2. Approve authorizations for admission and continued stay into nursing facilities, Program of All-Inclusive Care for the Elderly, the Brain Injury Program, and the Home and Community Based Services - Mentally Ill program. Such authorization shall only be permitted when both the SEP and the provider submitting the request for authorization agree to voluntarily participate in the pilot. Such agreement from the provider shall be indicated on the provider's official letterhead, signed by a representative of the provider legally authorized to act on behalf of the provider, and submitted to the SEP and the Department.

3. Approvals made pursuant to §8.393.2 D (1) and (2) shall follow 8.401.15 A.

4. Submit data as necessary to support the structure of long term care data systems.

.21 Intake/screening/referral

A. The intake/screening/referral function of a Single Entry Point agency shall include, but not be limited to, the following activities:

1. The completion of Part A of the Department prescribed Long Term Care Single Entry Point Intake Form;

2. The provision of information and referral to other agencies as needed;

3. The determination of the appropriateness of a referral for a comprehensive long term care client assessment;

4. The identification of potential payment source(s), including the availability of private funding resources; and

5. The implementation of a Single Entry Point agency procedure for prioritizing urgent inquiries.

B. If a referral to Single Entry Point long term care services is determined to be appropriate, Part B of the Intake Form shall be completed with the applicant or applicant's representative, within two (2) working days of the completion date on the screening form (Part A).

C. When long term care services are to be reimbursed through one or more of the publicly-funded long term care programs administered by the Single Entry Point system, the Single Entry Point staff shall:

1. Verify the applicant's current financial eligibility status, or

2. Refer the applicant to the county department of social services of the client's county of residence for application, or

3. Provide the applicant with financial eligibility application form(s) for submission, with required attachments, to the county department of social services for the county in which the individual resides, and

4. Document follow-up on return of forms.

D. The determination of the applicant's financial eligibility shall be completed by the county department of social services for the county in which the applicant resides.

E. The notification of applicants at the time of their application for publicly funded long term care services that they have the right to appeal actions of the Single Entry Point agency, the Department of Health Care Policy and Financing, or contractors acting on behalf of the Department. The notification shall include the right to request a fair hearing before an Administrative Law Judge.

F. Single Entry Point staff shall obtain the client's or representative's signature on the Intake Form.

.22 Assessment

A. The county department shall notify the Utilization Review Contractor/Single Entry Point (URC/SEP) case manager of the Medicaid application date for the client upon receipt of the Part I and II of the Medicaid application. The county shall not notify the SEP/URC for clients being discharged from a hospital or nursing facility or Long Term Home Health. The URC/SEP case manager shall complete the ULTC 100.2 assessment within the following time frames:

1. For an individual who is not being discharged from a hospital or a nursing facility, the client evaluation shall be completed within ten (10) working days.

2. For a resident who is changing pay source (Medicare/private pay to Medicaid) in the nursing facility, the URC/SEP case manager shall complete the evaluation within five (5) working days after notification by the nursing facility.

3. For a resident who is being admitted to the nursing facility from the hospital, the URC/SEP case manager shall complete the evaluation within two (2) working days after notification.

4. For a client who is being transferred from a nursing facility to an HCBS program or between nursing facilities, the URC/SEP case manager shall complete the evaluation within five (5) working days after notification.

5. For a client who that is being transferred from a hospital to an HCBS program, the URC/SEP case manager shall complete the evaluation within two (2) working days after notification.

B. The URC/SEP case manager shall complete the ULTC 100.2 assessment. Assessment instrument shall be completed for individuals eligible to receive services through the following programs:

1. Medicaid nursing facility care

2. Home and Community-Based Services for the Elderly, Blind, and Disabled (HCBS-EBD);

3. Home and Community-Based Services for Persons Living With Acquired Immune Deficiency Syndrome (HCBS-PLWA);

4. Adult Foster Care;

5. Home and Community Based Services - Brain Injury

6. Home and Community Based Services - Mentally Ill

7. Home and Community Based Services - Children's

8. Consumer Directed Attendant Support (CDAS)

9. Long term home health

10. In-home services provided by the Older American's Act when the individual is in need of case management services

C. The ULTC-100.2 may be completed for clients who are able to pay for case management services with private resources. Any completed ULTC 100.2 shall be kept on file at the URC/SEP agency, but copies need not be sent to the Department unless specifically requested.

D. The URC/SEP case manager shall conduct the following activities for a comprehensive client assessment:

1. Obtain diagnostic information from the client's medical provider for clients in nursing facilities, HCBS Programs for mentally ill, Persons Living With Aids (PLWA) and brain injured.

2. Determine the client's functional capacity during an evaluation, with observation of the client and family, if appropriate, in his or her residential setting and determine the functional capacity score in each of the areas identified in Section 10 C.C.R. 2505.10 §8.484.20 C.

3. Determine the length of stay for nursing facility clients using the Nursing Facility Length of Stay Assignment Form in accordance with 10.C.C.R. 2505.10 §8.402.15.

4. Determine the need for paid care on the ULTC 100.2 during the evaluation. For HCA clients, the need for paid care score shall be used to determine the monthly HCA authorized amount in accordance with Section 10 C.C.R.-2505-10 §8.484.2.

5. Determine if the HCA services provided by the caregiver living with the client are above and beyond the workload of the normal family/household routine. If services are not beyond normal family/household routine, the client may not be scored as needing paid care for that service. Examples of normal family/household routine are cooking a meal for the members of the household with no special prescribed diet for the client; housekeeping for the members of the household with no heavy housekeeping for the client; washing the client's laundry with the laundry of other members of the household when there is no incontinence or illness which precludes washing household and client clothing together, shopping and running errands for the household when there is no article which has been prescribed for the health or personal care of the client and which necessitates a separate trip.

6. For HCA, score children age zero (0) through thirteen (13) years in both functional capacity and need for paid care according to the following age appropriate criteria:

    a. Toileting: A child age 0 to 36 months will not be scored for bowel and bladder incontinence.

    b. Mobility and Positioning: A child age 0 to 36 months will not be scored for mobility and positioning.

    c. Dressing: A child age 0 to 60 months will not be scored for dressing.

    d. Bathing and hygiene: A child 0 to 60 months will not be scored for bathing and hygiene.

    e. Eating: A child 0 to 48 months will not be scored for eating.

    f. Transfers: A child 0 to 48 months will not be scored for transfers. A child 0 to 60 months will not be scored for car seat, highchair, or crib transfers.

7. Determine the ability and appropriateness of the client's caregiver(s) and family to provide the client assistance in activities of daily living;

8. Determine the client's service needs, taking into consideration services available, or already being received, from all funding sources;

9. If the client is a resident of a nursing facility, determine the feasibility of de-institutionalization;

10. If an out-of-home placement is required, review placement options based on the client's needs, the potential funding sources, and the availability of resources within the district including, but not limited to, an adult foster care facility, an alternative care facility, a nursing facility, or another residential alternative;

11. Determine and document, on the Care Plan, client preferences in program selection;

12. Assist the client in the completion of applications for Single Entry Point administered long term care programs, if appropriate;

13. Maintain appropriate documentation for certification of program eligibility, if required for entrance into a program; or to submit such documentation to the Utilization Review Contractor, if applicable, and

14. Refer the client to alternative services, if the client does not meet the eligibility requirements for a long term care program administered by the Department.

D. The case manager shall complete the following activities for discharges from nursing facilities:

1. For all discharges from nursing facilities to community placements through Single Entry Point agencies:

    a. The nursing facility shall contact the Single Entry Point agency in the district where the nursing facility is located to inform the Single Entry Point agency of the discharge if placement into community services is being considered.

    b. The nursing facility and the Single Entry Point case manager shall coordinate the discharge date, and where placement into the Home Care Allowance or Adult Foster Care programs are being considered, the completion of a new ULTC-100 to use for assessment and care planning. The case manager shall be responsible for completion of the form.

2. When placement into the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program, or the Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA) program is being considered, the Utilization Review Contractor shall determine the remaining length of stay.

    a. The Utilization Review Contractor/, in accordance with 8.486.35, ASSESSMENT-DEINSTITUTIONALIZATION, shall send the Single Entry Point agency a copy of page 1 of the current nursing facility ULTC-100 indicating discharge to HCBS with an assigned length of stay using the end date that was assigned to the nursing facility.

    b. The nursing facility and the URC/SEP agency case manager shall coordinate the discharge date, and where placement into the Home Care Allowance or Adult Foster Care programs are being considered, the completion of a new ULTC 100.2 to use for assessment and care planning. The case manager shall be responsible for completion of the form.

3. When placement into the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program, or the Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA) program is being considered, the URC/SEP agency shall . complete a new ULTC-100.2 if the current ULTC 100's completion date is older than six (6) months. The assessment results shall be used to determine level of care and the new length of stay.

    a. The URC/SEP agency shall send the Statewide Utililzation Review Contractor a copy of the current nursing facility ULTC 100.2 indicating discharge to HCBS with an assigned length of stay and new end date.

    b. The nursing facility ULTC 100.2 used by the URC/SEP agency to certify HCBS eligibility shall be kept in the case record. In addition, a copy must be sent to the income maintenance technician at the county department of social services, and a copy must be sent to the Department or its agent with the HCBS prior authorization request.

4. If placement into the Home Care Allowance program or the Adult Foster Care program is being considered, notification shall be sent to the income maintenance technician at the county department of social services.

5. For referrals to other programs or services, the URC/SEP case manager shall use the ULTC 100.2 for eligibility, care planning, Utilization Management, or referral, as appropriate.

E. For HCBS-EBD or HCBS-PLWA clients already determined to be at the nursing facility level of care and seeking admission into a nursing facility, the URC/SEP case manager shall coordinate the admission date with the facility. . The case manager shall contact the Statewide Utilization Review Contractor to conduct a PASARR screening. If appropriate, the URC/SEP agency shall assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the ULTC 100 is not older than six (6) months..

.23 Care planning

A. The URC/SEP case manager shall develop the care plan after completing the client assessment and prior to the arrangement for services. The URC/SEP case manager shall complete the care plan (including all required paperwork) within fifteen (15) working days after determination of program eligibility.

B. The nursing facility shall be responsible for developing a care plan for the nursing facility client.

C Care planning shall include, but not be limited to, the following tasks:

1. The identification and documentation of care plan goals and client choices;

2. The identification and documentation of services needed, including type of service, specific functions to be performed, duration and frequency of service, type of provider, and services needed but not available;

3. The determination of client co-payment and documentation of client choices, in accordance with program requirements;

4. The formalization of the care plan agreement, including appropriate signatures, in accordance with program requirements;

5. The authorization for services, in accordance with program directives, including cost containment requirements;

6. The prior authorization of Long Term Home Health Services, pursuant to 8.527.11.

7. The arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the client regarding service provision, and formalizing provider agreements in accordance with program rules;

8. The completion of program requirements for authorization of services;

9. Referral to community resources as needed and development of resources for individual clients if a resource is not available within the client's community;

10. The explanation of complaint procedures to the client;

11. The explanation of appeals process to the client.

D. Prudent purchase of services:

1. The case manager shall meet the client's needs, with consideration of the client's choices, using the most cost effective methods available.

2. When services are available to the client at no cost from family, friends, volunteers, or others, these services shall be utilized before the purchase of services, providing these services adequately meet the client's needs.

3. When public dollars must be used to purchase services, the case manager shall encourage the client to select the lowest cost provider of service when quality of service is comparable.

4. The case manager shall assure there is no duplication in services provided by single entry point programs and any other public or privately funded services.

.24 On-going case management

A. The major goals of on-going case management shall be to:

1. Monitor the quality of care provided to clients;

2. Identify changes in the client's needs that may require a full reassessment or a change in the care plan;

3. Identify and resolve any problems with service delivery; and

4. Make changes in service plans as appropriate to client needs.

B. The case manager shall assure quality of care by monitoring service providers, the appropriateness of services provided, the amount of care, the timeliness of service delivery, client satisfaction, and the safety of the client, and by taking corrective actions as needed.

C. On-going case management shall include, but not be limited to, the following tasks:

1. Review of the client's care plan and service agreements;

2. Contact with the client concerning the client's satisfaction with services provided;

3. Contact with service providers concerning service coordination, effectiveness and appropriateness, as well as concerning any complaints raised by the client or others;

4. Contact with appropriate individuals and/or agencies in the event any issues or complaints have been presented by the client or others;

5. Conflict resolution and/or crisis intervention, as needed;

6. Informal assessment of changes in client functioning, service effectiveness, service appropriateness, and service cost-effectiveness;

7. Notification of appropriate enforcement agencies, as needed; and

8. Referral to community resources as needed.

D. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment, or misutilization of any public assistance benefit, and shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with Department of Human Services rules (Staff Manual Volume 3, Section 3.810) and Department of Health Care Policy and Financing (Staff Manual Volume 8, Section 8.076).

E. The case manager shall contact the client at least quarterly, or more frequently as determined by the client's needs or as required by the program.

F. The case manager shall review the ULTC100 and the Care Plan with the client every six months. The review shall be conducted by telephone or at the client's place of residence, place of service or other appropriate setting as determined by the client's needs.

G. The case manager shall contact the service providers to monitor service delivery as determined by the client's needs or as required by the specific service requirements.

.25 Reassessment

A. The case manager shall commence a regularly scheduled reassessment at least one (1) but no more than three (3) months before the required completion date. The case manager shall complete a reassessment of a client within twelve (12) months of the initial client assessment or the previous reassessment. A reassessment shall be completed sooner if the client's condition changes or if required by program criteria.

B. The case manager shall update the information provided at the previous assessment or reassessment, utilizing the ULTC 100.2. When a new ULTC 100.2 is completed for a HCA or AFC client, a copy shall be sent to the county department of social services and to the Department within thirty (30) days of the reassessment.

C. Reassessment shall include, but not be limited to, the following activities:

1. Obtain diagnoses from the client's medical provider at least annually, or sooner if the client's condition changes or if required by program criteria;

2. Assess client's functional status face-to-face at the client's place of residence.

3. Review care plan, service agreements, and provider contracts or agreements;

4. Evaluate service effectiveness, quality of care, and appropriateness of services;

5. Verify continuing Medicaid eligibility, other financial and program eligibility;

5. Annually, or more often if indicated, complete new care plan and service agreements;

7. Inform the client's medical provider of any changes in the client's needs;

8. Maintain appropriate documentation, including type and frequency of long term care services the client is receiving for certification of continued program eligibility, if required by the program for a continued stay review.

9. Refer client to community resources as needed and develop resources for the client if the resource is not available within the client's community; and

10. Submit appropriate documentation for authorization of services, in accordance with program requirements.

D. The URC/SEP agency shall be responsible for completing reassessments of nursing facility clients. A reassessment shall be completed if the nursing facility determines there has been a significant change in the resident's physical/medical status or if the client requests a reassessment.

.26 Case Recording/Documentation

A. The Single Entry Point agency shall maintain records, including a copy of the intake form, on every individual for whom an intake was completed. The records must indicate the dates on which the referral was first received, and the dates of all actions taken by the Single Entry Point agency. Reasons for all assessment decisions and program targeting decisions must be clearly stated in the records.

B. The Single Entry Point agency shall maintain client case records on each Single Entry Point client.

C. The case record shall include:

1. Identifying information, including the client's state identification (Medicaid) number and social security number (SSN);

2. All State-required forms; and

3. Documentation of all case management activity required by these regulations.

D. Case management documentation shall meet all the following standards:

1. Documentation must be legible;

2. Entries must be written at the time of the activity or shortly thereafter;

3. Entries must be dated according to the date of the activity, including the year;

4. Entries must be made in permanent ink;

5. The client must be identified on every page;

6. The person making each entry must be identified;

7. Entries must be concise, but must include all pertinent information;

8. All information regarding a client must be kept together, in a logical organized sequence, for easy access and review by case managers, supervisors, program monitors and auditors; and

9. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact, or is a judgment or conclusion on the part of anyone.

10. All persons and agencies referenced in the documentation must be identified by name and by relationship to the client.

11. All forms prescribed by the Department shall be completely and accurately filled out by the case manager.

12. Whenever the case manager is unable to comply with any of the regulations specifying the time frames within which case management activities are to be completed, due to circumstances outside the Single Entry Point agency's control, the circumstances shall be documented in the case record. These circumstances shall be taken into consideration upon monitoring of Single Entry Point agency performance. However, under no circumstances shall continued stay review ULTC-100 forms be backdated by the utilization review contractor, according to Section 8.486.33, ASSESSMENT, or late PAR revisions be approved by the State or its agent, according to Section 8.485.93, STATE PRIOR AUTHORIZATION OF SERVICES.

E. Summary recording to update a case record shall be done at least every six months or whenever a case is transferred from one Single Entry Point agency to another, or when a case is closed. The location of the six-month summary within the case file may be determined by the Single Entry Point agency, however, the location must be consistent across client files.

.27 Completion of Single Entry Point Forms

A. The Notice of Services Status (LTC-803) form, or an Advisement Letter, shall be sent for all applicable programs at the time of initial eligibility, when there is a significant change in the client's payment or services, an adverse action, or at the time of discontinuation. The Single Entry Point client shall receive a copy of the LTC-803, or Advisement Letter, and a copy shall be placed in the client's case record.

B. The ULTC-100 shall be completed at the time of initial assessment and when there is a significant change in the client's condition, and shall be updated at each six-month summary recording.

For the AFC and HCA Programs, the original ULTC-100 shall be sent to the Department at the time of the initial assessment and each annual reassessment. For HCBS Programs, and admissions to nursing facilities from the community, the original ULTC-100 copy shall be sent to the Utilization Review Contractor, as applicable, or kept by the Single Entry Point agency. A copy shall be placed in the client's case record. At the six-month record update, if there are changes in the client's condition which significantly change the payment or services amount, a copy of the ULTC-100 must be sent to the Department or the Utilization Review Contractor, as applicable or kept by the Single Entry Point agency.

C. When receiving a ULTC-100 from other entities, including but not limited to nursing facilities and hospitals, for utilization management activities, the Utilization Review Contractor shall review the completeness of the ULTC-100. If such ULTC-100 is not sufficiently complete, according to Department-approved criteria, to conduct the utilization management review, then the Utilization Review Contractor shall notify the originating entity within two business days of receipt that the ULTC-100 is incomplete and that a review will not be completed without the requested additional information.

8.393.28 A. DENIALS/DISCONTINUATIONS

Clients shall be denied or discontinued from services under publicly funded programs administered by the Single Entry Point system if they are determined ineligible due to any of the reasons below. Clients shall be notified of the action and appeal rights as follows:

1. Financial Eligibility

   The income maintenance technician shall notify the client of denial for reasons of financial eligibility, and shall inform the client of appeal rights in accordance with Section 8.057. The case manager shall not attend the appeal hearing for a denial or discontinuation based on financial eligibility, unless subpoenaed, or unless requested by the State.

2. Level of Care and Target Group

   a. Home and Community-Based Services Programs, and nursing facility admissions from the community:

      The Utilization Review Contractor shall notify the client of denial for reasons related to determination of level of care and target group eligibility, and shall inform the client of appeal rights in accordance with Section 8.057. The case manager shall not make judgments as to eligibility regarding level of care or target group, and shall refer all clients who request a utilization review to the utilization review contractor

   b. Home Care Allowance and Adult Foster Care Programs:

      The Single Entry Point agency shall notify the applicant on the State-prescribed form [LTC-803] of the denial and appeal rights, and the case manager shall attend the appeal hearing to defend a denial or discontinuation, when:

      1) Home Care Allowance functional capacity and/or Need For Paid Care scores do not meet minimum requirements.

      2) The applicant does not meet the Appropriateness for Placement Criteria for Adult Foster Care

3. Receipt of Services

   The Single Entry Point agency shall notify the client, via the LTC-803, of the denial and appeals rights, and shall attend the appeal hearing to defend the denial or discontinuation, when:

   a. The client has not received services for one month;

   b. The applicant has two (2) times in a thirty (30) day consecutive period, refused to schedule an appointment for assessment, 6 month visit or after an inter-district transfer, or, has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period;

   c. The client or authorized representative refuses to use the Home Care Allowance or Adult Foster Care payment to pay for services, or uses the payment for services not identified in the service agreement; or

   d. The client or authorized representative refuses to sign the Intake form, Care Plan form, Release of Information form, or other forms as required to receive services.

4. Institutional Status

   The Single Entry Point agency shall notify the client of denial or discontinuation, via the

LTC-803, when the case manager determines that the client does not meet the following program eligibility requirements. The case manager shall attend the appeal hearing to defend the denial or discontinuation, when:

a. The client is not eligible to receive services while a resident of a nursing facility, hospital, or other institution.

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

c. An applicant for Home Care Allowance (HCA) is residing in an Adult Foster Care or Alternative Care Facility; or a client receiving HCA has resided in such a facility more than thirty (30) days.

5. Cost-Effectiveness/Service Limitations

The Single Entry Point agency shall notify the client of denial or discontinuation, via the LTC-803 form, when the case manager determines that the client cannot be safely served given the type and/or amount of services available, or, if applicable, is not eligible due to the cost of Home Health and HCBS services exceeding the individual cost containment amount determined at 8.485.61 E. The case manager shall attend the appeal hearing to defend the denial or discontinuation action.

To support a denial or discontinuation for safety reasons related to cost-effectiveness or insufficient services being available, the case manager must document the results of an Adult Protective Services assessment, a statement from the client's physician attesting to the client's mental competency status, and all other available information which will support the determination that the client is unsafe and incompetent to make a decision to live in an unsafe situation; and which will satisfy the burden of proof required of the case manager making the denial.

8.393.28 B. 1. In the case of denial or discontinuation, the case manager shall provide appropriate referrals to other community resources, as needed, within one (1) working day of discontinuation.

2. The case manager shall notify all providers on the case plan within one (1) working day of discontinuation.

3. The case manager shall notify the Utilization Review Contractor on a Department-prescribed form within thirty (30) calendar days of discontinuation for all HCBS Programs.

4. If a case is discontinued before an approved HCBS Prior Authorization Request (PAR) has expired, the case manager shall submit to the Department or its fiscal agent, within five (5) working days of discontinuation, a copy of the current PAR form on which the end date is adjusted (and highlighted in some manner on the form); and the reason for discontinuation shall be written on the form.

8.393.28 C. ADVISEMENT LETTERS

When clients are denied or discontinued from publicly funded programs administered by the Single Entry Point agency, for reasons not related to the eligibility requirements at Section 8.393.28 D, the Single Entry Point agency shall follow the procedures below:

1. Death

Clients who die shall be discontinued from the program, effective upon the day after the

date of death. No advisement letter shall be sent when the basis for discontinuation is death of the client.

2. Move Out of State

Clients who move out of Colorado shall be discontinued effective upon the day after the date of the move. The case manager shall send the client a State-prescribed Advisement Letter advising the client that the case has been closed. Clients who leave the state on a temporary basis, with intent to return to Colorado, according to Income Maintenance Staff Manual Section 3.140.2, RESIDENCE, shall not be discontinued unless one or more of the other eligibility criteria are no longer met.

3. Voluntary Withdrawal from the Program

Clients who voluntarily withdraw from a program shall be discontinued from the program effective upon the day after the date on which the client's request is documented, or the date on which the client enters a nursing facility, other long term care institution, or another HCBS program. The case manager shall send the client a State-prescribed Advisement Letter advising the client that the case has been closed.

4. Residing in an Unlicensed Personal Care Boarding Home

When a client is residing in an unlicensed personal care boarding home, the case manager after confirming with the Colorado Department of Public Health and Environment that the facility is unlicensed, shall inform the client and client's designated representative, if any, of the need to relocate within thirty (30) days in order to continue to receive services. The case manager shall deny or discontinue the client from the publicly funded program effective the thirty-first (31st) day after advising the client of the need to relocate, by sending the client an Advisement Letter advising the client that the case has been closed.

8.393.28 D. The Single Entry Point agency shall notify the income eligibility section of the appropriate county department of social services:

1. At the same time that it notifies the applicant or client of the adverse action;

2. When the applicant or client has filed a written appeal with the Single Entry Point agency; and

3. When the applicant or client has withdrawn the appeal or a final agency decision has been entered.

8.393.28 E. When the Single Entry Point agency conducts an assessment of the applicant's or client's functional capacity on the Uniform Long Term Care Client Assessment Instrument for review by the utilization review contractor, the assessment is not an adverse action which is directly appealable. The applicant's or client's right to appeal arises only when notice of adverse action is given by the Utilization Review Contractor regarding denial of certification for applicable long term care programs. The appeal process is governed by the provisions of Section 8.059.12, titled "Appeals Related to the Utilization Review Contractors" in this Staff Manual.

8.393.28 F. The Single Entry Point agency shall provide information to applicants and clients regarding their appeal rights when applicants apply for publicly funded long term care services or whenever the client requests such information, whether or not adverse action has been taken by the Single Entry Point agency.

**8.393.29 COMMUNICATION**

In addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:

A. The case manager shall inform the income maintenance technician of any and all changes effecting the client's participation in Single Entry Point agency-administered programs, including changes in income, within one working day after the case manager learns of the change. The case manager shall provide the technician with copies of the first page of all (utilization review contractor) approved ULTC-100 forms within one working day after receipt from (utilization review contractor).

B. If the client has an open adult protective services case at the county department of social services, the case manager shall keep the client's caseworker informed of the client's status and shall participate in mutual staffing of the client's case.

C. The case manager shall inform the client's physician of any significant changes in the client's condition or needs.

D. The case manager shall report to the Colorado Department of Public Health and Environment any congregate facility which is not licensed.

E. The Single Entry Point agency.

**8.393.295 UTILIZATION MANAGEMENT**

In addition to any utilization management requirements specified elsewhere in these rules, the Single Entry Point Agency, if assuming utilization management duties, or another Utilization Review Contractor, as applicable, shall be responsible for the following:

A. For Utilization Management Activities Using a Functional Needs Assessment

1. The Utilization Review Contractor logs in Functional Needs Assessment Reviews completed by the Single Entry Point agency and Functional Needs Assessments Reviews received from other entities on the same day as completion/receipt on the Department approved log form.

2. If *a ULTC 100.2* is complete, scoring must be completed with in three (3) business days for hospital discharge and brain injury reviews, all other reviews must be completed within ten (10) business days of receipt.

3. The Utilization Review Contractor determines if the score indicates that client should be approved or disapproved for admission or continued stay to an applicable long term care program and notes recommendation in case file.

4. If *the assessment* indicates approval, the Utilization Review Contractor assures that approval is noted and that the appropriate parties are notified, including requesting client, client's designated representative, if applicable, and requesting provider.

5. If *the assessment* indicates denial, the Utilization Review Contractor shall notify the appropriate parties. Such notification shall include directions for filing an appeal with the Office of Administrative Courts pursuant to Section 8.057.

If the client or client's designated representative appeals, the Utilization Review Contractor shall process such request, according to Recipient Appeals 8.057.

**8.393.3 INTERCOUNTY AND INTERDISTRICT TRANSFER PROCEDURES**

.31 Intercounty transfers . Single Entry Point agencies shall complete the following procedures to transfer case management clients to another county within the same Single Entry Point district:

A. Notify the income maintenance technician of the client's plans to relocate to another county and the date of transfer, and instruct the technician to follow the procedures for intercounty transfers (Department of Human Services, Staff Manual, Volume 3, Section 3.140.3).

B. If the client's current service providers do not provide services in the area where the client is relocating, make arrangements in consultation with the client for new service providers.

C. If the client is moving from one county to another county to enter an Alternative Care Facility, forward copies of the following client records to the Alternative Care Facility, prior to the client's admission to the facility:

1. Uniform Client Assessment Instrument (ULTC-100), certified by a Utilization Review Contractor,

2. Client Payment Form for Alternative Care Facility clients; and

3. Verification of Medicaid eligibility status.

.32 Interdistrict transfers . Single Entry Point agencies shall complete the following procedure in the event a client transfers from one Single Entry Point district to another Single Entry Point district:

A. The transferring Single Entry Point agency shall contact the receiving Single Entry Point agency by telephone and give notification that the client is planning to transfer, negotiate a transfer date, and provide information.

B. If the transfer is from one county to another county, the transferring Single Entry Point agency shall notify the income maintenance technician of the client's plan to transfer and the transfer date, and instruct the technician to follow procedures for intercounty transfers (Section 3.140.3, Volume 3; and Section 8.110.39, Volume 8). The receiving Single Entry Point agency shall coordinate the transfer with the income maintenance technician of the new county.

C. The transferring Single Entry Point agency shall forward copies of the client's case records, including forms required by the publicly funded program, to the receiving Single Entry Point agency prior to the relocation, if possible, or in no case later than five (5) working days after the client's relocation.

D. If the client is moving from one Single Entry Point district to another Single Entry Point district to enter an Alternative Care Facility, the transferring Single Entry Point agency shall forward copies of client records to the Alternative Care Facility, prior to the client's admission to the facility, in accordance with the procedures for intercounty transfers.

E. The receiving Single Entry Point agency shall complete a face-to-face meeting with the client and a case summary update within ten (10) working days after notification of the client's relocation, in accordance with assessment procedures for Single Entry Point agency clients.

F. The receiving single entry point agency shall review the care plan and ULTC-100, and change or coordinate services and providers as necessary.

G. If indicated by changes in the care plan, the receiving Single Entry Point agency shall revise

the care plan and service authorization forms as required by the publicly funded program.

H. Within thirty (30) calendar days of the client's relocation, the receiving Single Entry Point agency shall forward to the Department, or its designee, revised forms as required by the publicly funded program.

**8.393.4 STAFFING OF A SINGLE ENTRY POINT AGENCY**

.41 Staffing patterns . The Single Entry Point agency shall provide staff for the following functions: receptionist/clerical, administrative/ supervisory, case management, and medical consulting services.

A. The receptionist/clerical function shall include, but not be limited to, answering incoming telephone calls, providing information and referral, assisting Single Entry Point agency staff with clerical duties, and entering data into an information management system.

B. The administrative/supervisory function of the Single Entry Point agency shall include, but not be limited to, supervision of staff, training and development of agency staff, fiscal management, operational management, quality assurance, case record reviews on at least a sample basis, review and signing of all HCA and AFC ULTC-100s, resource development, marketing, liaison with the Department, and, as needed, providing case management services in lieu of the case manager.

C. The case management function shall include, but not be limited to, all of the case management functions previously defined for Single Entry Point case management services, as well as resource development, and attendance at staff development and training sessions.

D. Effective October 1, 2001, the contracted medical consultant services functions shall include, but not be limited to, an employed or contracted physician and/or registered nurse who shall provide consultation to Single Entry Point agency staff regarding medical and diagnostic concerns and long term home health prior authorizations.

.42 Qualifications of staff. The Single Entry Point agency's supervisor(s) and case manager(s) shall meet minimum standards for education and/or experience and shall be able to demonstrate competency in pertinent case management knowledge and skills.

A. Case managers shall have at least a bachelor's degree in one of the human behavioral science fields (such as human services, nursing, social work, psychology, etc.).

B. An individual who does not meet the minimum educational requirement may qualify as a Single Entry Point agency case manager under the following conditions:

1. The determination as to the qualification as a case manager shall be made jointly by the Single Entry Point agency and the Department;

2. Experience as a caseworker or case manager with the long term care client population, in a private or public social services agency may substitute for the required education on a year for year basis; and

3. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.

C. The case manager shall be required to demonstrate competency in all of the following areas:

1. Knowledge of and ability to relate to populations served by the Single Entry Point agency;

2. Client interviewing and assessment skills;

3. Knowledge of the policies and procedures regarding public assistance programs;

4. Ability to develop care plans and service agreements;

5. Knowledge of long term care community resources; and

6. Negotiation, intervention, and interpersonal communication skills.

D. The Single Entry Point agency supervisor(s) shall meet all qualifications for case managers and have a minimum of two years of experience in the field of long term care.

.43 Functions of the case manager . The Single Entry Point agency's case manager(s) shall be responsible for all case management services provided by the Single Entry Point agency including: information and referral, intake/screening/referral, assessment of clients, development of care plans, on-going case management, monitoring of clients, reassessments, resource development for individual clients, and case closure.

A. The case manager shall contact the client at least once within each quarterly period, or more frequently if warranted by the client's condition.

B. The case manager shall have a face-to-face contact with the client at least every six months, or more frequently if warranted by the client's condition, updating the Uniform Long Term Care Client Assessment Instrument and placing a copy in the client file.

C. The case manager shall reassess the client annually, or more frequently if warranted by the client's condition or if required by program criteria, completing a new Uniform Long Term Care Client Assessment Instrument.

D. The case manager shall monitor the services provided to the client, and shall monitor the contract between the client and the provider when required by the publicly funded program.

1. The case manager shall monitor the quality of care provided, and

2. The case manager shall monitor the health and safety of the client.

E. The following criteria may be used by the case manager to determine the client's level of need for case management services:

1. Availability of family, volunteer, or other support,

2. Overall level of functioning,

3. Mental status or cognitive functioning,

4. Duration of disabilities,

5. Whether the client is in a crisis or acute situation,

6. The client's perception of need and dependency on services, and

7. The client's move to a new housing alternative, if applicable,

.44 Functions of the Single Entry Point agency supervisor

Single Entry Point agencies shall provide adequate supervisory staff who shall be responsible for:

A. Supervisory case conferences with case managers, on a regular basis;

B. Review and signing of all HCA and AFC ULTC-100s: and regular, systematic review of case records and other case management documentation, on at least a sample basis;

C. Communication with the Department when technical assistance is required by case managers, and the supervisor is unable to provide answers after reviewing the regulations;

D. Allocation and monitoring of staff to assure that all standards and time frames are met in a reasonable percentage of cases; and

E. Assumption of case management duties when necessary.

.45 Training of Single Entry Point agency staff . Single entry point agency staff, including supervisors, shall attend training sessions as directed and/or provided by the Department for Single Entry Point agencies.

A. Prior to agency start-up, the Single Entry Point agency staff shall receive training provided by the Department or its designee, which will include, but not be limited to, the following content areas:

1. Background information on the development and implementation of the Single Entry Point system;

2. Mission, goals, and objectives of the Single Entry Point system;

3. Regulatory requirements and changes or modifications in federal and state programs;

4. Contracting guidelines, quality assurance mechanisms, and certification requirements; and

5. Federal and state requirements for the Single Entry Point agency.

B. During the first three years of agency operation, in addition to an agency's own training, the Department or its designee will provide in-service and skill development training for Single Entry Point agency staff on an annual basis. Thereafter, the Single Entry Point agency will be responsible for in-service and staff development training.

**8.393.5 RESOURCE DEVELOPMENT**

.51 Resource development committee . The Single Entry Point agency shall assume a leadership role in facilitating the development of local resources to meet the long term care needs of clients who reside within the Single Entry Point district served by the Single Entry Point agency.

A. Within 90 days of the effective date of the initial contract, the Single Entry Point agency's community advisory committee shall appoint a resource development committee.

B. The membership of the resource development committee shall include, but not be limited to,

representation from the following local entities: area agencies on aging, county departments of social services, county health departments, home health agencies, nursing facilities, hospitals, physicians, community mental health centers, community centered boards for the developmentally disabled, vocational rehabilitation agencies, and long term care consumers.

C. In coordination with the resource development efforts of the area agency(ies) on aging that serves the district, the resource development committee shall develop a local resource development plan during the first year of operation.

1. The resource development plan shall include:

a. An analysis of the long term care resources available within the Single Entry Point district;

b. Gaps in long term care resources within the Single Entry Point district;

c. Strategies for developing needed resources: and

d. A plan for implementing these strategies, including the identification of potential funding sources, potential in-kind support, and a time frame for accomplishing stated objectives.

2. The data generated by the Single Entry Point agency's information and referral, intake/screening/referral, client assessment, documentation of unmet client needs, resource development for individual clients, and data available through the Department shall be used to identify persons most at risk of nursing facility care and to document the need for resources locally.

D. At least annually, the resource development committee shall provide progress reports on the implementation of the resource development plan to the community advisory committee and to the Department.

.52 Certification of service providers . The Single Entry Point agency shall be responsible for the certification of adult foster care facilities within the Single Entry Point district, in accordance with Department rules for adult foster care (Section 8.483, et seq., of this Staff Manual).

**8.393.6 PROVISION OF DIRECT SERVICES**

.61 Waiver criteria . The Single Entry Point agency may be granted a waiver by the Department to provide direct services provided the agency complies with the following:

A. The Single Entry Point agency shall document at least one of the following in a formal letter of application for the waiver:

1. The service is not otherwise available within the Single Entry Point district or within a sub-region of the district; and/or

2. The service can be provided more cost effectively by the Single Entry Point agency, as documented in a detailed cost comparison of its proposed service with all other service providers in the district or subregion of the district.

B. The Single Entry Point agency that is granted a waiver to provide direct services due to its ability to provide the service cost effectively shall provide an annual report, at such time and on a form as prescribed by the Department, which includes a cost comparison of the

service with other service providers in the area in order to document continuing cost effectiveness.

C. The Single Entry Point agency shall assure the Department that efforts have been made, and will continue to be made, to develop the needed service within the Single Entry Point district or within the sub-region of the district, as a service external to the Single Entry Point agency. The Single Entry Point agency shall submit an annual progress report, at such time as prescribed by the Department, on the development of the needed service within the district.

D. The direct service provider functions and the Single Entry Point agency functions shall be administratively separate.

E. In the event other service providers are available within the district or sub-region of the district, the Single Entry Point agency case manager shall document in the client's case record that the client has been offered a choice of providers.

**8.394 ACCOUNTABILITY MECHANISMS FOR SINGLE ENTRY POINT AGENCIES**

**8.394.1 PERFORMANCE BASED CONTRACT**

A Single Entry Point agency shall be bound to the terms of the contract between the agency and the Department, including quality assurance standards and compliance with the Department's rules for Single Entry Point agencies and for publicly funded programs.

**8.394.2 CERTIFICATION OF SINGLE ENTRY POINT AGENCIES**

A Single Entry Point agency shall be certified annually in accordance with quality assurance standards and requirements set forth in the Department's rules and in the contract between the agency and the Department.

A. Certification as a Single Entry Point agency shall be based on an evaluation of the agency's performance in the following areas:

1. The quality of the services provided by the agency;

2. The agency's compliance with program requirements, including compliance with case management standards adopted by the Department;

3. The agency's performance of administrative functions, including reasonable costs per client, timely reporting, managing programs in one consolidated unit, on-site visits to clients, community coordination and outreach, and client monitoring;

4. Whether targeted populations are being identified and served;

5. Financial accountability, and

6. The maintenance of qualified personnel to perform the contracted duties.

B. The Department or its designee shall conduct reviews of the Single Entry Point agency.

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

.21 Provisional approval of certification. In the event a Single Entry Point agency does not meet all of the quality assurance standards established by the Department, the agency may receive provisional approval of certification for a period not to exceed sixty (60) days, provided the deficiencies do not constitute a threat to the health and safety of clients.

A. The agency will receive notification of the deficiencies and a request to submit a corrective action plan to be approved by the Department, Upon receipt and review of the corrective action plan, at the Department's option, a second sixty-day provisional certification may be approved.

B. The Department or its designee shall provide technical assistance to facilitate corrective action.

.22 Denial of certification . In the event certification as a Single Entry Point agency is denied, the procedure for Single Entry Point agency termination or non-renewal of contract shall apply (Section 8.391.22).

NOTE: Sections 8.394.3 - 8.394.4 were deleted effective December 2, 2002.