

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Services Board

MEDICAL ASSISTANCE - SECTION 8.300

10 CCR 2505-10 8.300

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

8.300 HOSPITAL SERVICES

8.300.1 Definitions

Abbreviated Client Stay means an Inpatient stay ending in client death or in which the client leaves against medical advice.

Concurrent Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service during the course of treatment.

Continued Stay Review means a review of quality, Medical Necessity and appropriateness of an Inpatient health care procedure, treatment or service.

Department means the Department of Health Care Policy and Financing.

Diagnosis Related Group (DRG) means a cluster of similar conditions within a classification system used for Hospital reimbursement. It reflects clinically cohesive groupings of Inpatient hospitalizations that utilize similar amounts of Hospital resources.

DRG Hospital means a Hospital that is reimbursed by the Colorado Medicaid program based on a system of DRGs. Those Hospitals reimbursed based on a DRG system are: General Hospitals, Critical Access Hospitals, Pediatric Hospitals, Rehabilitation Hospitals, and Long-Term Care Hospitals.

Diagnostic Services means any medical procedures or supplies recommended by a licensed professional within the scope of his/her practice under state law to enable him/her to identify the existence, nature, or extent of illness, injury or other health condition in a client.

Disproportionate Share Hospital (DSH) Factor is a percentage add-on adjustment that qualified Hospitals receive for serving a disproportionate share of low-income clients.

Emergency Care Services, for the purposes of this rule, means services for a medical condition, including active labor and delivery, manifested by acute symptoms of sufficient severity, including severe pain, for which the absence of immediate medical attention could reasonably be expected to result in: (1) placing the client's health in serious jeopardy, (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

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

A General Hospital is licensed and CMS-certified as a General Hospital that, under an organized medical staff, provides Inpatient services, emergency medical and surgical care, continuous nursing services, and necessary ancillary services. A General Hospital may also offer and provide Outpatient services, or any other supportive services for periods of less than twenty-four hours per day.

A Critical Access Hospital (CAH) is licensed and CMS-certified as a Critical Access Hospital. CAHs offer emergency services and limited Inpatient care. CAHs may offer limited surgical services and/or obstetrical services including a delivery room and nursery.

A Pediatric Hospital is licensed as a General Hospital and CMS-certified as a children's Hospital providing care primarily to populations aged seventeen years and under.

A Rehabilitation Hospital is licensed and CMS-certified as a Rehabilitation Hospital which primarily serves an Inpatient population requiring intensive rehabilitative services including but not limited to stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of femur, brain injury, and other disorders or injuries requiring intensive rehabilitation.

A Long-Term Care Hospital is licensed as a General Hospital and CMS-certified as a Long-Term Care Hospital. In general, Long-Term Care Hospitals have an average length of stay of greater than twenty-five (25) days.

A Psychiatric Hospital is licensed and CMS-certified as a Psychiatric Hospital to plan, organize, operate, and maintain facilities, beds, and treatment, including diagnostic, therapeutic and rehabilitation services, over a continuous period exceeding twenty-four (24) hours, to individuals requiring early diagnosis, intensive and continued clinical therapy for mental illness; and mental rehabilitation. A Psychiatric Hospital can qualify to be a state-owned Psychiatric Hospital if it is operated by the Colorado Department of Human Services.

Inpatient means a person who is receiving professional services at a Hospital; the services include a room and are provided on a continuous 24-hour-a-day basis. Generally, a person is considered an Inpatient by a physician's order if formally admitted as an Inpatient with the expectation that the client will remain at least overnight and occupy a bed even though it later develops that the client can be discharged or transferred to another Hospital and does not actually use a bed overnight.

Inpatient Hospital Services means preventive, therapeutic, surgical, diagnostic, medical and rehabilitative services that are furnished by a Hospital for the care and treatment of Inpatients and are provided in the Hospital by or under the direction of a physician.

Medically Necessary, or Medical Necessity, means a Medicaid service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.

Non-DRG Hospital means a Hospital that is not reimbursed by the Colorado Medicaid program based on a system of DRGs. Psychiatric Hospitals are considered Non-DRG Hospitals since their reimbursement is based on a per diem rate.

Observation Stay means a stay in the Hospital for no more than forty-eight hours for the purpose of (a) evaluating a client for possible Inpatient admission; or (b) treating clients expected to be stabilized and released in no more than 24 hours; or (c) extended recovery following a complication of an Outpatient procedure. Only rarely will an Observation Stay exceed twenty-four hours in length.

Outlier Days mean the days in a Hospital stay that occur after the Trim Point Day.

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

Outpatient Hospital Services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished to Outpatients; and are furnished by or under the direction of a physician or dentist.

Prospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service prior to treatment.

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

Relative Weight (DRG weight) means a numerical value which reflects the relative resource consumption for the DRG to which it is assigned. Modifications to these Relative Weights are made when needed to ensure payments reasonably reflect the average cost of claims for each DRG. Relative Weights are intended to be cost effective, and based upon Colorado data as available.

Retrospective Review means a review of quality, Medical Necessity and/or appropriateness of a health care procedure, treatment or service following treatment. A Retrospective Review can occur before or after reimbursement has been made.

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

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

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

Trim Point Day (Outlier Threshold Day) means the day which would occur 1.94 standard deviations above the mean (average) length of stay (ALOS) for each DRG.

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

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

8.300.2 Requirements for Participation

8.300.2.A In-Network Hospitals

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

8.300.2.B Out-of-Network Hospitals

An out-of-network Hospital, including out-of-state Hospitals, may receive payment for emergency Hospital services if:

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

8.300.2.C Out-of-State Hospitals

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

8.300.2.D Hospitals with Swing-Bed Designation

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

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

8.300.3 Covered Hospital Services

8.300.3.A Covered Hospital Services - Inpatient

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

1. Inpatient Hospital services include:
 - a. bed and board, including special dietary service, in a semi-private room to the extent available;
 - b. professional services of hospital staff;

- c. laboratory services, therapeutic or Diagnostic Services involving use of radiology & radioactive isotopes;
 - d. emergency room services;
 - e. drugs, blood products;
 - f. medical supplies, equipment and appliances as related to care and treatment; and
 - g. associated services provided in a 24-hour period immediately prior to the Hospital admission, during the Hospital stay and 24 hours immediately after discharge. Such services can include, but are not limited to laboratory, radiology and supply services provided on an outpatient basis.
2. Medical treatment for the acute effects and complications of substance abuse toxicity is a covered benefit.
3. Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.
4. Psychiatric Hospital Services

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

- a. Inpatient care in a Psychiatric Hospital is limited to forty-five (45) days per state fiscal year, unless additional services are prior-authorized as medically necessary by the Department's utilization review vendor or other Department representative, and includes physician services, as well as all services identified in 8.300.3.A.1, above.
- b. Inpatient psychiatric care in Psychiatric Hospitals is a Medicaid benefit only when:
 - i. services involve active treatment which a team has determined is necessary on an Inpatient basis and can reasonably be expected to improve the condition or prevent further regression so that the services shall no longer be needed; the team must consist of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof; and
 - ii. services are provided prior to the date the individual attains age 21 or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, the date such individual no longer requires such services or, if earlier, the date such individual attains age 22.
- c. Medicaid clients obtain access to inpatient psychiatric care through the Community Mental Health Services Program defined in 10 CCR 2505-10, Section 8.212.

5. Inpatient Hospital Dialysis

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

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

8.300.3.B Covered Hospital Services – Outpatient

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

1. Observation Stays

Observation stays are a covered benefit as follows:

- a. Clients may be admitted as Outpatients to Observation Stay status.
- b. With appropriate documentation, clients may stay in observation more than 24 hours, but an Observation Stay shall not exceed forty-eight hours in length.
- c. A physician's order must be written prior to initiation of the Observation Stay.
- d. Observation Stays end when the physician orders either Inpatient admission or discharge from observation.
- e. An Inpatient admission cannot be converted to an Outpatient Observation Stay after the client is discharged.

2. Outpatient Hospital Psychiatric Services

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

- a. Psychiatric outpatient services are not a Medicaid benefit in free-standing psychiatric hospitals.

3. Emergency Care

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

8.300.3.C. Bariatric Surgery

1. Eligible Clients
 - a. All currently enrolled Medicaid clients over the age of sixteen when:
 - i) The client has clinical obesity; and
 - ii) It is Medically Necessary.
2. Eligible Providers
 - a. Providers must enroll in Colorado Medicaid.
 - b. Surgeons must be trained and credentialed in bariatric surgery procedures.
 - c. Preoperative evaluations and treatment may be performed by:
 - i) Primary care physician,
 - ii) Nurse Practitioner,
 - iii) Physician Assistant,
 - iv) Registered dietician,
 - v) Mental health providers available through the Client's Behavioral Health Organization.
3. Eligible Places of Service
 - a. All surgeries shall be performed at a Hospital, as defined at 8.300.1.
 - i) Facilities must have safety protocols in place specific to the care and treatment of bariatric clients.
 - b. Pre- and Post- operative care may be performed at a physician's office, clinic, or other medically appropriate setting.
4. Covered Services and Limitations
 - a. Colorado Medicaid covers participating providers for one bariatric procedure per client lifetime unless a revision is appropriate based one of the identified complications.
 - i) Appropriate revision procedures are identified at section 8.300.3.C.4.d.
 - b. Covered primary procedures Include:
 - i) Roux-en-Y Gastric Bypass;
 - ii) Adjustable Gastric Banding;
 - iii) Biliopancreatic Diversion with or without Duodenal Switch;

- iv) Vertical-Banded Gastroplasty;
- v) Vertical Sleeve Gastroplasty.

c. Criteria for Primary Procedures

All Clients must meet the first four following criteria, clients under age 18 must meet criteria five:

- i) The client is clinically obese with one of the following:
 - 1) BMI of 40 or higher, or
 - 2) BMI of 35-40 with objective measurements documenting one or more of the following co-morbid conditions:
 - a) Severe cardiac disease;
 - b) Type 2 diabetes mellitus;
 - c) Obstructive sleep apnea or other respiratory disease;
 - d) Pseudo-tumor cerebri;
 - e) Hypertension;
 - f) Hyperlipidemia;
 - g) Severe joint or disc disease that interferes with daily functioning;
 - h) Intertriginous soft-tissue infections, nonalcoholic steatohepatitis, stress urinary incontinence, recurrent or persistent venous stasis disease, or significant impairment in Activities of Daily Living (ADL).
- ii) The BMI level qualifying the client for surgery (>40 or >35 with one of the above co-morbidities) must be of at least two years' duration. A client's BMI may fluctuate around the required levels during this period around the required levels, and will be reviewed on a case-by-case basis.
- iii) The client must have made at least one clinically supervised attempt to lose weight lasting at least six consecutive months or longer within the past eighteen months of the prior authorization request, monitored by a registered dietician that is supervised by a physician, nurse practitioner, or physician's assistant.
- iv) Medical and psychiatric contraindications to the surgical procedure must have been ruled out through:
 - 1) A complete history and physical conducted by or in consultation with the requesting surgeon; and

- 2) A psychiatric or psychological assessment, conducted by a licensed mental health professional, no more than three months prior to the requested authorization. The assessment must address both potential psychiatric contraindications and client's ability to comply with the long-term postoperative care plan.
- v) For clients under the age of eighteen, the following must be documented:
 - 1) The exclusion or diagnosis of genetic or syndromic obesity, such as Prader-Willi Syndrome;
 - 2) Whether female clients have attained Tanner stage IV breast development; and
 - 3) Whether bone age studies estimate the attainment of 95% of projected adult height.
 - 4) Mental health evaluations for clients age 17 must address issues specific to these clients' maturity as it relates to compliance with postoperative instructions.
- d. Revision Procedures
 - i) Colorado Medicaid covers Revisions of a surgery for clinical obesity if it is used to correct complications such as slippage of an adjustable gastric band, intestinal obstruction, or stricture, following a primary procedure.
 - ii) Indications for surgical revision:
 - 1) Weight loss to 20% below the ideal body weight;
 - 2) Esophagitis, unresponsive to nonsurgical treatment;
 - 3) Hemorrhage or hematoma complicating a procedure;
 - 4) Excessive bilious vomiting following gastrointestinal surgery;
 - 5) Complications of the intestinal anastomosis and bypass;
 - 6) Stomal dilation, documented by endoscopy;
 - 7) Documented slippage of the adjustable gastric band;
 - 8) Pouch dilation documented by upper gastrointestinal examination or endoscopy producing weight gain of 20% or more, provided that:
 - a) The primary procedure was successful in inducing weight loss prior to the pouch dilation; and

- b) The client has been compliant with a prescribed nutrition and exercise program following the procedure (weight and BMI prior to surgery, at lowest stable point, and at current time must be submitted along with surgeon's statement to document compliance with diet and exercise);
 - 9) Other and unspecified post-surgical non-absorption complications.
 - e. Non-Covered Services:
 - i) For Clients with clinically diagnosed COPD (Chronic Obstructive Pulmonary Disease), including Chronic Bronchitis or Emphysema.
 - ii) Repeat procedures not associated with surgical complications.
 - iii) Cosmetic Follow-up: Weight loss following surgery for clinical obesity can result in skin and fat folds in locations such as the medial upper arms, lower abdominal area, and medial thighs. Surgical removal of this skin and fat for solely cosmetic purposes is not a covered benefit.
 - iv) During pregnancy.
5. Prior Authorization Requirements

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

- a) The Client's height, weight, BMI with duration.
- b) A list and description of each co-morbid condition, with attention to any contraindication which might affect the surgery including all objective measurements.
- c) A detailed account of the Client's clinically supervised weight loss attempt(s), including duration, medical records of attempts, identification of the supervising clinician, and evidence of successful completion and compliance.
- d) A current psychiatric or psychological assessment regarding contraindications for bariatric surgery, as described in 8.300.3.C.4.c(iv)(2).
- e) A statement written or agreed to by the client, detailing for the interdisciplinary team the client's:
 - i) Commitment to lose weight;
 - ii) Expectations of the surgical outcome;
 - iii) Willingness to make permanent life-style changes;
 - iv) Be willing to participate in the long-term postoperative care plan offered by the surgery program, including education and support, diet therapy, behavior modification, and activity/exercise components; and

- v) If female, client's statement that she is not pregnant or breast-feeding and does not plan to become pregnant within two years of surgery.
- f) A description of the post-surgical follow-up program.
- g) For clients under the age of eighteen, documentation of the physical criteria requirements at 8.300.3.C.4.c(v).

8.300.4 Non-Covered Services

The following services are not covered benefits:

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

8.300.5 Payment for Inpatient Hospital Services

8.300.5.A Payments to DRG Hospitals for Inpatient Hospital Services

1. Peer Groups

For the purposes of Inpatient reimbursement, DRG Hospitals are assigned to one of the following peer groups:

- a. Pediatric Hospitals
- b. Rehabilitation Hospitals and Long-Term Care Hospitals
- c. Urban Safety Net Hospitals
- d. Rural Hospitals
- e. Urban Hospitals
- f. Hospitals which do not fall into the peer groups described in a through c above shall default to the peer groups described in d and e based on geographic location.

2. Base Payment and Outlier Payment

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

- a. The DRG base payment shall be equal to the DRG Relative Weight multiplied by the Medicaid Inpatient base rate as calculated in 10 CCR 2505-10 Section 8.300.5.A.3 – 6.
- b. Outlier days shall be reimbursed at 80% of the DRG per diem rate. The DRG per diem rate shall be the DRG base payment divided by the DRG average length of stay.
- c. The DRG base payment plus any corresponding outlier payment is considered the full reimbursement for an Inpatient Hospital stay where the client was Medicaid-eligible for the entire stay.
- d. When a client was not Medicaid-eligible for an entire Inpatient Hospital stay, reimbursement shall be equal to the DRG per diem rate for every eligible day, with payment up to the full DRG base payment. If applicable, the Hospital shall receive outlier reimbursement.

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

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

- i For in-network Colorado DRG Hospitals, excluding Rehabilitation Hospitals, Long-Term Care Hospitals, CAHs, Pediatric Hospitals, and those Hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the starting point shall be the hospital-specific Medicare Federal base rate minus any DSH factors. For the purpose of rate setting effective on July 1 of each fiscal year, the Medicare base rate used shall be the Medicare base rate effective on October 1 of the previous fiscal year.
- ii For Pediatric Hospitals, the starting point shall be equal to the cost per Medicaid discharge derived from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1 for rates effective July 1 of the same calendar year.
- iii For Rehabilitation Hospitals and Long-Term Care Hospitals, the starting point shall 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.
- iv For CAHs and those Hospitals with less than twenty-one Medicaid discharges in the previous fiscal year, the starting point shall be the average Medicare base rate minus DSH factors for their respective peer group. The average calculation shall exclude CAHs and those Hospitals with less than twenty Medicaid discharges in the previous fiscal year.

b. Application of Adjustment Based on General Assembly Funding

For all in-network, Colorado DRG Hospitals, excluding Urban Safety Net Hospitals, the starting point for the Medicaid Inpatient base rate, as determined in 10 CCR 2505-10 Section 8.300.5.A.3.a, shall be adjusted by an equal percentage. This percentage shall be determined by the Department as required by the available funds appropriated by the General Assembly. Urban Safety Net Hospitals' starting point shall be adjusted by the percentage applied to all other Hospitals plus 10 percent. The percentage applied to Urban Safety Net Hospitals' starting point shall not exceed 100 percent.

c. Application of Cost Add-ons to Determine Medicaid Inpatient Base Rate

i The Medicaid Inpatient base rate shall be equal to the rate as calculated in 10 CCR 2505-10 Sections 8.300.5.A.3.a and 8.300.5.A.3.b, plus any Medicaid hospital-specific cost add-ons. The Medicaid hospital-specific cost add-ons are calculated from the most recently audited Medicare/Medicaid cost report (CMS 2552) available as of March 1. Partial year cost reports shall not be used to calculate the cost add-ons.

ii The Medicaid hospital-specific cost add-ons shall be an estimate of the cost per discharge for nursery, neo-natal intensive care units, and Graduate Medical Education (GME). The GME cost add-on information shall be obtained from the audited Medicare/Medicaid cost report, worksheet B, part I; discharges from worksheet S-3, part I, nursery and neo-natal costs, shall be obtained from the audited Medicare/Medicaid cost report, Title XIX in worksheet D-1, part II. The GME cost add-on shall not be applied to the Medicaid Inpatient base rates for State University Teaching Hospitals. State University Teaching Hospitals shall receive reimbursement for GME costs as described in 10 CCR 2505-10 Section 8.300.9.2.

iii Ten percent of the Medicaid hospital-specific cost add-ons shall be applied.

d. Application of Adjustments for Certain Hospitals

For Pediatric Hospitals, Rehabilitation Hospitals, and Long-Term Care Hospitals, the Medicaid Inpatient base rate 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.

e. Annual Adjustments

The Medicaid Inpatient base rates are adjusted annually (rebased) and are effective each July 1. The Medicaid base rate shall be adjusted during the fiscal year, if necessary, based on appropriations available to the Department.

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

The Medicaid Inpatient base rate for new in-network Colorado DRG Hospitals shall be the average Colorado Medicaid Inpatient base rate for their corresponding peer group. A Hospital is considered "new" until the next Inpatient rate rebasing period after the Hospital's contract effective date. For the next Inpatient rate rebasing period, the Hospital's Medicaid Inpatient base rate shall be equal to the rate as determined in 10 CCR 2505-10 Section 8.300.5.A.3. If the Hospital does not have a Medicare Inpatient base rate or an audited Medicare/Medicaid cost report to compute a starting point as described in 10 CCR 2505-10 Section 8.300.5.A.3.a, their initial rate shall be equal to the average Colorado Medicaid Inpatient base rate for their corresponding peer group.

5. Medicaid Inpatient Base Rate for Border-state Hospitals

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

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

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

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

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

8.300.5.B Abbreviated Client Stays

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

8.300.5.C Transfer Pricing

1. Reimbursement for a client who is transferred from one DRG Hospital to another DRG Hospital is calculated at a DRG per diem rate for each Hospital with payment up to the DRG base payment to each DRG Hospital. If applicable, both Hospitals may receive outlier reimbursement.

2. Reimbursement for a client who is transferred from one DRG Hospital to a Non-DRG Hospital, or the reverse, is calculated at the DRG per diem rate for the DRG Hospital with payment up to the DRG base payment. Reimbursement for the Non-DRG Hospital shall be calculated based on the assigned per diem rate. If applicable, the DRG Hospital may receive outlier reimbursement.

3. For transfers within the DRG Hospital, the Hospital is required to submit one claim for the entire stay, regardless of whether or not the client has been transferred to different parts of the Hospital. Since the Colorado Medicaid program does not recognize distinct part units, Hospitals may not submit two claims for a client who is admitted to the Hospital and then transferred to the distinct part unit or vice versa.
4. Rehabilitation Hospitals and Long-Term Care Hospitals shall not be subject to DRG transfer pricing.

8.300.5.D Payments to Non-DRG Hospitals for Inpatient Services

1. Payments to Psychiatric Hospitals
 - a. Inpatient services provided to Medicaid clients in Psychiatric Hospitals shall be reimbursed on a per diem basis. The per diem rates shall follow a step-down methodology. Each step has a corresponding per diem rate based on historical Medicaid payment rates and evaluation of Hospital data concerning the relationship between Hospital costs and client length of stay. Criteria for each step are described below:
 - i Step 1: day 1 through day 7
 - ii Step 2: day 8 through remainder of care at acute level
 - b. Hospital rates may be adjusted annually on July 1 to account for changes in funding by the General Assembly and inflationary adjustments as determined by the Medicare Economic Index.
2. Payment to State-Owned Psychiatric Hospitals

State-owned Psychiatric Hospitals shall receive reimbursement on an interim basis according to a per diem rate. The per diem rate shall be determined based on an estimate of 100% of Medicaid costs from the Hospital's Medicare cost report. A periodic cost audit is conducted and any necessary cost settlement is done to bring reimbursement to 100% of actual audited Medicaid costs.

8.300.6 Payments For Outpatient Hospital Services

8.300.6.A Payments to DRG Hospitals for Outpatient Services

1. Payments to In-Network Colorado DRG Hospitals

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

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

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

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

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

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

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

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

2. Payments to Out-of-Network DRG Hospitals

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

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

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

8.300.7.A GME for Medicaid Managed Care – Inpatient Services

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

8.300.7.B GME for Medicaid Managed Care – Outpatient Services

1. The Hospital cost report used for the most recent rebasing shall be used to determine the Outpatient GME cost-to-charge ratio for each Hospital that has a graduate medical education program. Each Hospital's GME cost-to-charge ratio shall be computed when Hospital rates are recalculated each year.
2. MCOs shall provide to the Department Outpatient charges for Medicaid clients by Hospital for Outpatient dates of service during each quarter of the calendar year. This information shall be provided within 120 days after the close of each calendar year quarter.
3. The Medicaid managed care Outpatient charges for each Hospital shall be the total of the Outpatient charges for each Hospital received from the MCOs for each quarter. That total shall be multiplied by the cost-to-charge ratio and reduced by 28 percent to determine the Outpatient GME reimbursement for each Hospital per quarter. The GME reimbursement shall be paid at least annually through a gross adjustment process to each Hospital by June 30th of each year.

8.300.8 Disproportionate Share Hospital Adjustment

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

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

8.300.8.B Colorado Determination of Individual Hospital Disproportionate Payment Adjustment

1. Hospitals deemed eligible for minimum disproportionate share payment and which participate in the Colorado Indigent Care Program will receive a CICP Disproportionate Share Hospital Payment defined in 10 CCR 2505-10 section 8.2000.
2. Hospitals deemed eligible for a minimum disproportionate share payment and which do not participate in the Colorado Indigent Care Program will receive an Uninsured Disproportionate Share Hospital Payment defined in 10-CCR 2505-10 section 8.2000.

8.300.9 Supplemental Inpatient Hospital Payments

8.300.9.A Family Medicine Residency Training Program Payment

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

8.300.9.B State University Teaching Hospital Payment

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

8.300.10 Patient Payment Calculation for Nursing Facility Clients Who are Hospitalized

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

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

8.300.11. Payment for Hospital Beds Designated as Swing Beds

8.300.11.A Swing Bed Payment Rates

1. Payment for swing-bed services will be made at the average rate per client day paid to Class I nursing facilities for services furnished during the previous calendar year.
2. Oxygen provided to swing-bed clients shall be reimbursed as specified in 10 CCR 2505-10, Sections 8.580 and 8.585.
3. Clients shall be required to contribute their patient payment to the cost of their nursing care. Collection as well as determination of the patient payment amount shall be in accordance with 10 CCR 2505-10, Section 8.482.

8.300.11.B Swing Bed Claim Submission

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

8.300.12 Utilization Management

All participating in-network Hospitals are required to comply with utilization management and review, program integrity and quality improvement activities administered by the Department's utilization review vendor, external quality review organization or other representative.

8.300.12.A Conduct of Reviews

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

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

8.300.12.B Corrective Action

- 1. Corrective action may be recommended when documentation indicates a pattern of inappropriate utilization or questionable quality of care.
- 2. If corrective action does not resolve the problem, the Department shall initiate sanctions, as set forth in 10 CCR 2505-10, Section 8.076.
- 3. Retrospective Review may be performed as a type of corrective action for an identified Hospital or client.

8.300.12.C Prior Authorization of Swing-Bed Care

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

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

8.310 DIALYSIS TREATMENT CENTERS

8.310.1 Definitions

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

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

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

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

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

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

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

8.310.2. Eligibility

8.310.2.A. Client Eligibility

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

8.310.2.B. Provider Eligibility

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

8.310.2.C. Prior Authorization

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

8.310.3. General Services

8.310.3.A. Provider Requirements

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

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

8.310.3.B. Covered Dialysis Services

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

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

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

8.310.3.C. Non-Covered Services

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

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

8.390 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.

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- 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.
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- 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 the beginning of each fiscal year, the Department allocates funds for services provided by Single Entry Point agencies from the Department's appropriation. Payments to Single Entry Point agencies shall not exceed this allocation unless additional funding is appropriated by the General Assembly.
- C. At the end of the contract year, actual client and activity counts are reconciled against projected client and activity counts. This process may result in either funds owed to the Department for payments made in excess of services delivered, or funds owed to SEP agencies for services delivered in excess of funds received. At the conclusion of the reconciliation process the Department issues reconciliation statements to collect for overpayments or adjusts for underpayments up to the aggregate amount allocated.
- D. 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 Controller Division, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO; or may be examined at any State Publications Depository Library.
- E. 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.
- F. 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.

- G. 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.
- H. 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.

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- .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 Utilization 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.

Editor's Notes

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 3/4/07, Statements of Basis and Purpose, and rule history are located in the first section, 10 CCR 2505-10. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 3/4/07, select the desired section of the rule, for example 10 CCR 2505-10 8.100, or 10 CCR 2505-10 8.500.

History

[For history of this section, see Editor's Notes in the first section, 10 CCR 2505-10]