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.

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

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.

Medical Necessity is defined at Section 8.076.1..

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

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 2.58 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 anastamosis 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% of 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%).

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

a. The EAPG Payment will be equal to the EAPG Weight multiplied by the Hospital-specific Medicaid Outpatient base rate for that hospital as calculated in 10 CCR 2505-10 Section 8.300.6.A.1.k. If the EAPG Weight is modified due to any action impacting payment as described in sections 8.300.6.A.1.d-j, the modified EAPG Weight will be referred to as the EAPG Adjusted Weight. EAPG Payment will then be equal to the EAPG Adjusted Weight multiplied by the Hospital-specific Medicaid Outpatient base rate. If the billed amount is less than the EAPG Payment, reimbursement will be the billed amount.

b. The EAPG Payment is calculated for each detail on the claim. Claim details with the same dates of service are grouped into a visit. Claims containing details describing charges for emergency room, treatment room services or patients placed under observation will have all its details grouped into a single visit.

c. Each detail on a claim is assigned an EAPG. EAPGs can have the following types:

    (1) Per Diem

    (2) Significant Procedure. Subtypes of Significant Procedures Are:

        (a) General Significant Procedures

        (b) Physical Therapy and Rehabilitation

        (c) Mental Health and Counseling

        (d) Dental Procedure

        (e) Radiologic Procedure

        (f) Diagnostic Significant Procedure

    (3) Medical Visit

    (4) Ancillary

    (5) Incidental

    (6) Drug

    (7) Durable Medical Equipment

    (8) Unassigned

d. A detail will be subject to EAPG Consolidation when it is assigned the same Significant Procedure EAPG as a detail not already subjected to EAPG Consolidation for that visit. EAPG Consolidation will also occur for details assigned EAPGs considered to be clinically similar to another EAPG during the visit. Details subject to EAPG Consolidation will have an EAPG Payment calculated using an EAPG Weight of 0.

e. A detail will be subject to EAPG Packaging when its assigned EAPG is considered an ancillary service to a Significant Procedure EAPG or Medical Visit EAPG present on the claim for that visit. Details describing additional undifferentiated medical visits and services will be exempt from EAPG Packaging. A detail is also subject to EAPG Packaging when it is assigned a Medical Visit EAPG while a Significant Procedure EAPG is present on the claim for that visit. Details assigned Significant Procedure EAPGs that are of subtypes Physical Therapy and Rehabilitation and Radiologic Significant Procedure do not cause details with Medical Visit EAPGs to be subject to EAPG Packaging. Details subject to EAPG Packaging will be calculated using an EAPG Weight of 0.

f. A detail will qualify for Multiple Significant Procedure Discounting when a Significant Procedure of the same subtype is present on the claim for that visit. Details qualifying for Multiple Significant Procedure Discounting are ordered by their EAPG Weight, by visit. Per visit, the qualifying detail with the greatest EAPG Weight will have its EAPG Payment calculated at 100 percent (100%) of its EAPG Weight. The qualifying detail for that visit with the next greatest EAPG Weight will have its EAPG Payment calculated at 50 percent (50%) of its EAPG Weight. All other qualifying details for that visit will have its EAPG Payment calculated at 25 percent (25%) of its EAPG Weight.

g. Details assigned the same Ancillary EAPG on the same visit will qualify for Repeat Ancillary Discounting. EAPG Payment for the first occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 100 percent (100%) of its EAPG Weight. EAPG Payment for the second occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 50 percent (50%) of its EAPG Weight. EAPG Payment for all other details qualifying for Repeat Ancillary Discounting for that visit and EAPG will be calculated using 25 percent (25%) of their EAPG Weights.

h. Details describing terminated procedures will be subject to Terminated Procedure Discounting. EAPG Payment for a detail subject to Terminated Procedure Discounting is calculated using 50 percent (50%) of the EAPG Weight. Terminated procedures are not subject to other types of discounting.

i. Details describing bilateral services will have EAPG Payment calculated using 150 percent (150%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

j. Details describing 340B Drugs will have an EAPG Payment calculated using 50 percent (50%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

k. The Hospital-specific Medicaid Outpatient base rate for the year of the methodology implementation for each hospital is calculated using the following method.

(1) Assign each hospital to one of the following peer groups based on hospital type and location:

(a) Pediatric Hospitals

(b) Urban Hospitals

(c) Rural Hospitals

(2) Process Medicaid outpatient hospital claims from state fiscal year 2015, known as the Base Year, through the methodology described in 8.300.6.A.1.a-j using Colorado's EAPG Relative Weights. For lines with incomplete data, estimations of EAPG Adjusted Weights will be used.

(3) Calculate costs from hospital charge data using the computation of the ratio of costs to charges from the CMS-2552-10 Cost Report. After the application of inflation factors to account for the difference in cost and caseload from state fiscal year 2015 to the implementation period, costs and EAPG Adjusted Weights are aggregated by peer group and are used to form peer group base rates. Each hospital is assigned the peer group base rate depending on their respective peer group assigned in 8.300.6.A.1.k.(1).

(4) For each hospital, calculate the projected EAPG payment by multiplying its peer group base rate by its hospital-specific EAPG Adjusted Weights as calculated in 8.300.6.A.1.k.(2). If the projected payment exceeds a +/- 10% difference in payment from the prior outpatient hospital reimbursement methodology, the hospital will receive an adjustment to their base rate to cap its resulting gains or losses in projected EAPG payments to 10%.

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.

Effective October 31, 2016, Out-of-Network PPS Hospitals will be reimbursed for Outpatient Hospital Services based the system of Enhanced Ambulatory Patient Grouping described in 10 CCR 2505-10 Section 8.300.6.A.1. Such hospitals will be assigned to a Rural or Urban peer group depending on hospital location and will receive a base rate of 90% of the respective peer group base rate as calculated 8.300.6.A.1.k.(3).

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

8.300.9 Supplemental Inpatient Hospital Payments

8.300.9.A Family Medicine Residency Training Program Payment

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

8.300.9.B State University Teaching Hospital Payment

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

8.300.10 Patient Payment Calculation for Nursing Facility Clients Who are Hospitalized

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

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

8.300.11. Payment for Hospital Beds Designated as Swing Beds

8.300.11.A Swing Bed Payment Rates

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

2. Oxygen provided to swing-bed clients shall be reimbursed as specified in 10 CCR 2505-10, Sections 8.580 and 8.585.

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

8.300.11.B Swing Bed Claim Submission

1. Hospitals shall submit claims for swing-bed routine services as nursing facility claims.

2. Ancillary services (services not required to be provided by nursing facilities participating in the Medicaid program within their per diem rate, but reimbursable under Medicaid, including but not limited to laboratory and radiology) shall be billed separately on the appropriate claim form.

8.300.12 Utilization Management

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 services and supports to access appropriate services and supports.

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 individual seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources. Case Managers shall use the ULTC 100.2 to complete assessments.

C. Case Management means the assessment of an individual receiving long-term services and supports' needs, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness, and the periodic reassessment of such individual's needs.

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

E. Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; and it may endanger or negatively impact the mental and/or physical well-being of an individual. Critical Incidents include, but are not limited to: Injury/illness; abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death.

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 Eligibility means an individual meets functional criteria for a Long Term Services and Supports (LTSS) Program as determined by the Department.

J. Functional Needs Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, friends and/or caregivers) and a written evaluation by the case manager utilizing the ULTC 100.2, with supporting diagnostic information from the individual's medical provider, to determine the individual's level of functioning, service needs, available resources, potential funding resources and medical necessity for admission or continued stay in certain Long Term Services and Supports (LTSS) Programs.

K. Home and Community Based Services (HCBS) Programs means the specific HCBS programs for which Single Entry Point agencies shall provide case management services, including Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons with a Spinal Cord Injury (HCBS-SCI) (where applicable), Home and Community-Based Services for Persons with a Brain Injury (HCBS-BI), Home and Community-Based Services Community Mental Health Supports (HCBS-CMHS), Home and Community-Based Services for Children with a Life Limiting Illness (HCBS-CLLI).

L. Information Management System (IMS) means an automated data management system approved by the Department to enter case management information for each individual seeking or receiving long term services as well as to compile and generate standardized or custom summary reports.

M. 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 services and supports; 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 functional assessment of the individual seeking services.

N. Long Term Services and Supports (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

O. LTSS Program means a publicly funded program including, but not limited to, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons with a Spinal Cord Injury (HCBS-SCI) (where applicable), Home and Community-Based Services for Persons with a Brain Injury (HCBS-BI), Home and Community-Based Services Community Mental Health Supports (HCBS-CMHS), Home and Community-Based Services for Children with a Life Limiting Illness (HCBS-CLLI), Medicaid Nursing Facility Care, Program for All Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU) and Adult Long Term Home Health (LTHH).

P. Pre-Admission Screening and Resident Review (PASRR) means the pre-screening of individuals seeking nursing facility admission to identify individuals with mental illness (MI) and/or intellectual disability (ID), to ensure that individuals are placed appropriately, whether in the community or in a NF and to ensure that individuals receive the services they require for their MI or ID.

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

R. Professional Medical Information Page (PMIP) means the medical information signed by a licensed medical professional used as a component of the Assessment (ULTC-100.2) to determine the client's need for institutional care.

S. Reassessment means a periodic comprehensive reevaluation with the individual receiving services, appropriate collaterals and case manager, with supporting diagnostic information from the individual's medical provider to re-determine the individual's level of functioning, service needs, available resources and potential funding resources.

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

U. Single Entry Point (SEP) means the availability of a single access or entry point within a local area where an individual seeking or currently receiving LTSS can obtain LTSS information, screening, assessment of need and referral to appropriate LTSS programs and case management services.

V. Single Entry Point Agency means the organization selected to provide intake, screening, referral, eligibility determination, and case management functions for persons in need of LTSS within a Single Entry Point District.

W. 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 LTSS.

X. 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.

Y. Support Planning means the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. Support planning informs the individual seeking or receiving services of his or her rights and responsibilities.

Z. Target Group Criteria means the specific population to be served through an HCBS waiver. Target Group criteria includes physical or behavioral disabilities, chronic conditions, age or diagnosis and can include other criteria such as demonstrating an exceptional need.

8.390.2 LEGAL AUTHORITY

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

8.390.3 CHARACTERISTICS OF INDIVIDUALS RECEIVING SERVICES IN LTSS PROGRAMS

A. An individual served by the SEP Agency shall meet the following criteria:

1. The individual requires skilled, maintenance and/or supportive services long term;

2. The individual has functional impairment in activities of daily living (ADL) and/or a need for supervision, necessitating LTSS provided in a nursing facility, an alternative residential setting, the individual's home or other services and supports in the community;

3. The individual receives or is eligible to receive medical assistance (Medicaid) and/or financial assistance under one or more of the following programs: Old Age Pension, Aid to Blind, Aid to Needy Disabled, Supplemental Security Income, or Colorado Supplemental, or as a 300% eligible, as defined at 8.485.50.T, receiving LTSS in a nursing facility or through one of the HCBS Programs.

8.391 SINGLE ENTRY POINT DISTRICT DESIGNATION

8.391.1.A. District Designation Requirements

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

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

2. A single county may be designated a district provided the county serves a monthly average of 200 or more individuals for LTSS programs.

3. Multi-county districts shall not be required to serve a minimum number of individuals receiving services.

4. Each district shall assure adequate staffing and infrastructure by the district's SEP agency, including at least one full-time case manager employed by the SEP agency, to provide coverage for all case management functions and administrative support, in accordance with rules at Section 8.393.

8.391.1.B. Changes in Single Entry Point District Designation

1. In order to change SEP district designation, a county or district shall submit an application to the Department, six (6) months prior to commencement date of the proposed change. The application shall include the following information:

   a. The geographic boundaries of the proposed SEP district;

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

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

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

2. The application shall be approved provided the proposed district meets the SEP district designation requirements.

8.391.2 Single Entry Point Agency Selection

A. Except as otherwise provided herein, upon a change in SEP district designation or upon expiration of the district's existing SEP agency contract, a SEP district may select a county agency, including a county department of social/human services, a county nursing service, an area agency on aging or a multicounty agency to serve as the SEP agency for the district. Once the SEP functions in a district are provided through a contract between the Department and an

entity other than as listed above, the SEP agency for that district shall thereafter be selected by the Department pursuant to applicable state statutes and regulations.

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

C. The SEP district's selection shall be delivered to the Department no less than six (6) months prior to the effective date of the change in district designation or expiration of the contract with the district's existing SEP agency.

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

8.391.3 Single Entry Point Contract

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

8391.4 Certification of Single Entry Point Agencies

1. A SEP agency shall be certified annually in accordance with quality assurance standards and requirements set forth in the Department's rules and in the contract between the agency and the Department.

    a. Certification as a SEP agency shall be based on an evaluation of the agency's performance in the following areas:

        i. The quality of the services provided by the agency;

        ii. The agency's compliance with program requirements, including compliance with case management standards adopted by the Department;

        iii. The agency's performance of administrative functions, including reasonable costs per individual receiving services, timely reporting, managing programs in one consolidated unit, on-site visits to individuals, community coordination and outreach and individual monitoring;

        iv. Whether targeted populations are being identified and served;

        v. Financial accountability; and

        vi. The maintenance of qualified personnel to perform the contracted duties.

    b. The Department or its designee shall conduct reviews of the SEP agency.

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

8.391.4.A. Provisional Approval of Certification

1. In the event a SEP agency does not meet all of the quality assurance standards established by the Department, the agency may receive provisional approval of certification for a period not to exceed sixty (60) days, provided the deficiencies do not constitute a threat to the health and safety of individuals receiving services.

2. The agency will receive notification of the deficiencies, a request to submit a corrective action plan to be approved by the Department and upon receipt and review of the corrective action plan, at the Department's option, a second sixty-day (60) provisional certification may be approved.

3. The Department or its designee shall provide technical assistance to facilitate corrective action.

8.391.4.B. Denial of Certification

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

8.392 FINANCING OF THE SINGLE ENTRY POINT SYSTEM

8.392.1.A Reimbursement Methodology

1. Reimbursement for SEP functions shall be determined by the number of counties included in a district and by the number of individuals served, subject to the availability of funds in the Department’s annual appropriation for each SEP Agency.

   a. A SEP 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 individual served, to be determined annually by the Department.

   b. A SEP agency that serves a district composed of only one county shall not receive the base amount, but shall receive an amount for each individual served each year.

   c. The amount for each individual shall be based on the number of individuals served in LTSS programs.

8.392.1.B Cost Allocation

1. The Department shall make monthly payments to each designated SEP agency using a methodology which shall be specified in the contract between the state and the agency.

2. Each fiscal year, the Department allocates funds for services provided by SEP agencies from the Department’s appropriation. Payments to SEP agencies shall not exceed this allocation unless additional funds are appropriated by the General Assembly.

3. At the end of the contract year, actual individual and activity counts are reconciled against projected individual 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.

4. 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 2 CFR Part 200 Super Circular, January 2014; 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).

    a. These federal regulations are subject to change, and any change in regulations shall be instructed by the Department.

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

6. Payments are audited by the Department and may result in adjustments to reimbursement.

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

8. For case management functions, the Department shall make monthly payments to each designated SEP agency using a methodology which shall be specified in the contract between the Department and the agency.

8.392.1.C Private Pay Individuals

SEP agencies may provide case management services to private pay individuals seeking or receiving services at the agency's discretion.

8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.1.A Administration of a Single Entry Point

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

    a. The SEP agency shall serve persons in need of LTSS programs defined in Section 8.390.3;

    b. The SEP agency shall have the capacity to accept multiple funding source public dollars;

    c. The SEP agency may contract with individuals, for-profit entities and not-for-profit entities to provide some or all SEP functions;

    d. The SEP agency may receive funds from public or private foundations and corporations; and

    e. The SEP agency shall be required to publicly disclose all sources and amounts of revenue.

2. For individuals with intellectual or developmental disabilities seeking or receiving services, the SEP will refer to the appropriate Community Center Board (CCB) for

programs that serve this population. In the event that the individual is eligible for both a program administered by the SEP and by the CCB, the individual will have the right to choose in which program that he or she will participate.

8.393.1.B. Community Advisory Committee

1. The SEP agency shall, within thirty (30) days of designation, establish a community advisory committee for the purpose of providing public input and guidance for SEP agency operation.

    a. The membership of the Community Advisory Committee shall include, but not be limited to, regional representation from the district's county commissioners, area agencies on aging, medical professionals, LTSS providers, LTSS ombudsman, human service agencies, county government officials and individuals receiving LTSS.

    b. The Community Advisory Committee shall provide public input and guidance to the SEP agency in the review of service delivery policies and procedures, marketing strategies, resource development, overall SEP agency operations, service quality, individual satisfaction and other related professional problems or issues.

8.393.1.C. Personnel System

1. The SEP agency shall have a system for recruiting, hiring, evaluating and terminating employees.

    a. SEP agency employment policies and practices shall comply with all federal and state affirmative action and civil rights requirements.

    b. The SEP agency shall maintain current written job descriptions for all positions.

8.393.1.D. Accounting System

1. The SEP 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 SEP agency shall assure the following:

        i. Funds are used solely for authorized purposes;

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

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

        iv. 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 SEP agency shall be audited annually and shall submit the final report of the audit to the Department within six (6) months after the end of the state's fiscal year. The SEP agency shall assure timely and appropriate resolution of audit findings and recommendations.

c. SEPs are subrecipients of federal funding and therefor are subject to federal subrecipient requirements. See the Office of Management and Budget Super Circular, 2 C.F.R. 200.330-32 (2013).

i. Subrecipient (the SEP agency) means a non-Federal entity that receives a Subaward from a Recipient (the Department) to carry out part of a Federal program, but does not include an individual that is a beneficiary of such program. A Subrecipient may also be a recipient of other Federal Awards directly from a Federal Awarding Agency.

8.393.1.E. Liability Insurance Coverage

The SEP 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.

8.393.1.F. Information Management

1. The SEP agency shall, in a format specified by the Department, be responsible for the collection and reporting of summary and individual-specific data including but not limited to information and referral services provided by the agency, program eligibility determination, financial eligibility determination, support planning, service authorization, critical incident reporting, monitoring of health and welfare, monitoring of services, resource development and fiscal accountability.

a. The SEP agency shall have computer hardware and software, compatible with the Department's computer systems, and with such capacity and capabilities as prescribed by the Department.

b. The SEP agency shall have adequate staff support to maintain a computerized information system in accordance with the Department's requirements.

c. The SEP agency shall have adequate phone and IMSs to manage the administrative requirements necessary to fulfill the responsibilities of the SEP.

8.393.1.G. Recordkeeping

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

a. The case manager shall use the Department-prescribed IMS for purposes of documentation of all case activities, monitoring of service delivery, and service effectiveness. If applicable, the individual's designated representative (such as guardian, conservator, or person given power of attorney) shall be identified in the case record, with a copy of appropriate documentation.

2. If the individual is unable to sign a form requiring his/her signature due to a medical condition, any mark that the individual is capable of making will be accepted in lieu of a signature. If the individual is not capable of making a mark, the signature of a family member or other person designated to represent the individual will be accepted.

8**.393.1.H. Confidentiality of Information**

The SEP agency shall protect the confidentiality of all records of individuals seeking and receiving services in accordance with State statute (CRS 26-1-114 as amended). Release of information forms

obtained from the individual must be signed, dated, and kept in the clients record. Release of information forms shall be renewed at least annually, or sooner if there is a change of provider. Fiscal data, budgets, financial statements and reports which do not identify individuals by name or Medicaid ID number are open records.

8.393.1.I. Individual Rights

1. The SEP agency shall assure the protection of the rights individual receiving services' as defined by the Department under applicable programs.

    a. The SEP agency shall assure that the following rights are preserved for all individuals of the SEP agency, whether the individual is a recipient of a state administered program or a private pay individual:

        i. The individual and/or the individual's personal representative is fully informed of the individual's rights and responsibilities;

        ii. The individual and/or the individual's personal representative participates in the development and approval, and is provided a copy of the individual's Support Plan;

        iii. The individual and/or the individual's personal representative selects service providers from among available qualified and willing providers;

        iv. The individual and/or the individual's personal representative has access to a uniform complaint system provided for all individuals of the SEP agency; and

        v. The individual who applies for or receives publicly funded benefits and/or the individual's personal representative has access to a uniform appeal process, which meets the requirements of Section 8.057, when benefits or services are denied or reduced and the issue is appealable.

2. At least annually, the SEP agency shall survey a random sample of individuals receiving services to determine their level of satisfaction with services provided by the agency.

    a. The random sample of individuals shall constitute ten (10) individuals or ten percent (10%) of the SEP agency's average monthly caseload, whichever is higher.

    b. If the SEP agency's average monthly caseload is less than ten (10) individuals, all individuals shall be included in the survey.

    c. The individual satisfaction survey shall conform to guidelines provided by the Department.

    d. The results of the individual satisfaction survey shall be made available to the Department and shall be utilized for the SEP agency's quality assurance and resource development efforts.

    e. The SEP agency shall assure that consumer information regarding LTSS is available for all individuals at the local level.

8.**393.1.J. Access**

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

    a. The SEP agency shall not require individuals receiving services to come to the agency's office in order to receive SEP services.

    b. The SEP agency shall comply with anti-discriminatory provisions, as defined by federal and Department rules.

    c. The functions to be performed by a SEP agency shall be based on a case management model of service delivery.

8.393.1.K. Staffing Patterns

1. 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 SEP agency staff with clerical duties

    b. The administrative/ supervisory function of the SEP agency shall include, but not be limited to, supervision of staff, training and development of agency staff, fiscal management, operational management, quality assurance, case record reviews on at least a sample basis, resource development, marketing, liaison with the Department, and, as needed, providing case management services in lieu of the case manager.

    c. The case management function shall include, but not be limited to, all of the case management functions previously defined in Section 8.393.1.M. for SEP case management services, as well as resource development, and attendance at staff development and training sessions.

    d. Medical consultant services functions shall include, but not be limited to, an employed or contracted physician and/or registered nurse who shall provide consultation to SEP agency staff regarding medical and diagnostic concerns and Adult Long Term Home Health prior authorizations.

8.393.1.L. Qualifications of Staff

1. The SEP 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:

i. Experience as a caseworker or case manager with LTSS population, in a private or public social services agency may substitute for the required education on a year for year basis.

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

iii. The SEP Agency shall request a waiver/memo from the Department in the event that the case manager does not meet minimum educational requirements. A copy of this waiver/ memo stating Department approval will be kept in the case manager's personnel file that justifies the hiring of a case manager who does not meet the minimum educational requirements.

c. The case manager must demonstrate competency in all of the following areas:

i. Application of a person centered approach to planning and practice;

ii. Knowledge of and experience working with populations served by the SEP Agency;

iii. Interviewing and assessment skills;

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

v. Ability to develop support plans and service agreements;

vi. Knowledge of LTSS and other community resources; and

vii. 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 LTSS.

8.393.1.M. Functions of the Case Manager.

1. The Single Entry Point agency's case manager(s) shall be responsible for: intake/screening/referral, assessment/reassessment, development of support plans, on-going case management, monitoring of the individuals health and welfare, documentation of contacts and case management activities in the Department-prescribed IMS, resource development, and case closure.

a. The case manager shall contact the individual at least once within each quarterly period, or more frequently if warranted by the individual's condition /or as determined by the rules of the LTSS Program in which the individual is enrolled.

b. The case manager shall have a face-to-face contact with the individual at least every six (6) months, or more frequently if warranted by the individual's condition or the rules of the LTSS Program in which the individual is enrolled, and shall update the ULTC 100.2 and Support Plan in the IMS to reflect any changes in condition or services.

c. The case manager shall complete a new ULTC-100.2 during a face-to-face reassessment annually, or more frequently if warranted by the individual's condition or if required by the rules of the LTSS Program in which the individual is enrolled.

d. The case manager shall monitor the delivery of services and supports identified within the Support Plan and the Prior Authorization Request (PAR). This includes monitoring:

i. The quality of services and supports provided;

ii. The health and safety of the individual; and

iii. The utilization of services with respect to the Support Plan and the Prior Authorization Request (PAR).

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

i. Availability of family, volunteer, or other support;

ii. Overall level of functioning;

iii. Mental status or cognitive functioning;

iv. Duration of disabilities;

v. Whether the individual is in a crisis or acute situation;

vi. The individual's perception of need and dependency on services;

vii. The individual's move to a new housing alternative; and

viii. Whether the individual was discharged from a hospital or Nursing Facility.

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

1. SEP agencies shall provide adequate supervisory staff who shall be responsible for:

a. Supervisory case conferences with case managers, on a regular basis;

b. Approval of indefinite lengths of stay, pursuant to 8.402.15;

c. Regular, systematic review and remediation of case records and other case management documentation, on at least a sample basis;

d. Communication with the Department when technical assistance is required by case managers, and the supervisor is unable to provide answers after reviewing the regulations;

e. Allocation and monitoring of staff to assure that all standards and time frames are met; and

f. Assumption of case management duties when necessary.

8.393.1.O. Training of Single Entry Point Agency Staff

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

    a. Prior to agency start-up, the SEP agency staff shall receive training provided by the Department or its designee, which will include, but not be limited to, the following content areas:

        i. Background information on the development and implementation of the SEP system;

        ii. Mission, goals, and objectives of the SEP system;

        iii. Regulatory requirements and changes or modifications in federal and state programs;

        iv. Contracting guidelines, quality assurance mechanisms, and certification requirements; and

        v. Federal and state requirements for the SEP agency.

    b. During the first year of agency operation, in addition to an agency's own training, the Department or its designee will provide in-service and skill development training for SEP agency staff. Thereafter, the SEP agency will be responsible for in-service and staff development training.

8.393.1.P. Provision of Direct Services

1. The SEP agency may be granted a waiver by the Department to provide direct services provided the agency complies with the following:

    a. The SEP agency shall document at least one of the following in a formal letter of application for the waiver:

        i. The service is not otherwise available within the SEP district or within a sub-region of the district; and/or

        ii. The service can be provided more cost effectively by the SEP agency, as documented in a detailed cost comparison of its proposed service with all other service providers in the district or sub-region of the district.

    b. The SEP agency that is granted a waiver to provide direct services due to its ability to provide the service cost effectively shall provide an annual report, at such time and on a form as prescribed by the Department, which includes a cost comparison of the service with other service providers in the area in order to document continuing cost effectiveness.

    c. The SEP agency shall assure the Department that efforts have been made, and will continue to be made, to develop the needed service within the SEP district or within the sub-region of the district, as a service external to the SEP agency. The SEP agency shall submit an annual progress report, at such time as prescribed by the Department, on the development of the needed service within the district.

d. The direct service provider functions and the SEP agency functions shall be administratively separate.

e. In the event other service providers are available within the district or sub-region of the district, the SEP agency case manager shall document in the individual's case record that the individual has been offered a choice of providers.

8.393.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

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

8.393.2.A. Protective Services

1. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of 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.

8.393.2.B. Intake/Screening/Referral

1. The intake/screening/referral function of a SEP agency shall include, but not be limited to, the following activities:

    a. The completion of the intake/screening/referral function using the Department's IMS;

        i. SEPs may ask referring agencies to complete and submit an intake and screening form to initiate the process;

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

    d. A screening to determine whether or not a functional eligibility assessment is needed;

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

    f. The implementation of a SEP agency procedure for prioritizing urgent inquiries.

2. When LTSS are to be reimbursed through one or more of the publicly-funded LTSS programs administered by the SEP system, the SEP staff shall:

    a. Verify the individual's demographic information collected during the intake;

    b. Coordinate the completion of financial eligibility determination:

        i. Verify the individual's current financial eligibility status; or

ii. Refer the individual to the county department of social services of the individual's county of residence for application; or

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

iv. Conduct and document follow-up activities to complete the functional eligibility determination and coordinate the completion of the financial eligibility determination.

c. The determination of the individual's financial eligibility shall be completed by the county department of social services for the county in which the individual resides, pursuant to Section 8.100.7 A-U.

d. Individuals shall be notified at the time of their application for publicly funded long term services and supports that they have the right to appeal actions of the SEP 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.

e. The county department shall notify the SEP agency of the Medicaid application date for the individual seeking services upon receipt of the Medicaid application.

f. The county shall not notify the SEP agency for individuals being discharged from a hospital or nursing facility or Adult Long Term Home Health.

8.393.2.C. Initial Assessment

1. For additional guidance on the ULTC-100.2, as well as the actual tool itself, please see Section 8.401.1. GUIDELINES FOR LONG TERM CARE SERVICES

a. The SEP agency shall complete the ULTC 100.2 assessment within the following time frames:

i. For an individual who is not being discharged from a hospital or a nursing facility, the individual assessment shall be completed within ten (10) working days after receiving confirmation that the Medicaid application has been received by the county department of social services.

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

iii. For a resident who is being admitted to the nursing facility from the hospital, the SEP agency shall complete the assessment, including a PASRR Level 1 Screen within two (2) working days after notification.

1) For PASRR Level 1 Screen regulations, refer to 8.401.18, PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND SPECIALIZED SERIVCES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

b. For an individual who is being transferred from a nursing facility to an HCBS program or between nursing facilities, the SEP agency shall complete the assessment within five (5) working days after notification by the nursing facility.

c. For an individual who that is being transferred from a hospital to an HCBS program, the SEP agency shall complete the assessment within two (2) working days after notification from the hospital.

2. Under no circumstances shall the start date for functional eligibility based on the ULTC 100.2 be backdated by the SEP. See section 8.486.30, ASSESSMENT, Under no circumstances shall late PAR revisions be approved by the State or its agent. See Section 8.485.90, STATE PRIOR AUTHORIZATION OF SERVICES.

3. The SEP agency shall complete the ULTC 100.2 for LTSS Programs, in accordance with Section 8.401.1.

a. If enrolled as a provider of case management services for Children's Home and Community Based Services (CHCBS), SEP agencies may complete the ULTC 100.2 for CHCBS.

4. The SEP Agency shall assess the individual's functional status face-to-face at a time and location convenient to the individual.

5. The SEP agency shall conduct the following activities for a comprehensive assessment of an individual seeking services:

a. Obtain diagnostic information through the Professional Medical Information Page (PMIP) form, from the individual's medical provider for individuals in nursing facilities, HCBS Programs for Community Mental Health Supports (HCBS-CMHS), Persons with a Brain Injury (HCBS-BI), Elderly, Blind and Disabled (HCBS-EBD), Persons with a Spinal Cord Injury (HCBS-SCI) and Children with a Life Limiting Illness (HCBS-CLLI).

i. If enrolled as a provider of case management services for Children's Home and Community Based Services (CHCBS), SEP agencies may obtain diagnosis(es) information from the individual's medical provider.

b. Determine the individual's functional capacity during an evaluation, with observation of the individual and family, if appropriate, in his or her residential setting and determine the functional capacity score in each of the areas identified in Section 8.401.1.

c. Determine the length of stay for nursing facility individuals using the Nursing Facility Length of Stay Assignment Form in accordance with Section 8.402.15.

d. Determine the need for long term services and supports on the ULTC 100.2 during the evaluation.

e. For HCBS Programs and admissions to nursing facilities from the community, the original ULTC-100.2 copy shall be sent to the provider agencies, and a copy shall be placed in the individual's case record. At the six-month reassessment, if there are changes in the individual's condition which significantly change the payment or services amount, a copy of the ULTC-100.2 must be sent to the provider agency and a copy is to be maintained.

f. When the SEP Agency conducts an assessment of the individual's functional capacity on the ULTC-100.2, the assessment is not an adverse action which is directly appealable. The individual's right to appeal arises only when an individual is denied enrollment into a LTSS Program by the SEP based on the ULTC-100.2 thresholds for functional eligibility. The appeal process is governed by the provisions of Section 8.057

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

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

   b. The nursing facility and the SEP case manager shall coordinate the discharge date.

   c. When placement into HCBS Programs are being considered, the SEP shall determine the remaining length of stay.

      i. If the end date for the nursing facility is indefinite, the SEP agency shall assign an end date not greater than one (1) year from the date of most recent assessment.

      ii. If the ULTC 100.2 is less than six (6) months, the SEP agency shall generate a new certification page that reflects the end date that was assigned to the nursing facility.

      iii. The SEP agency shall complete a new ULTC 100.2 if the current 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.

      iv. The SEP Agency shall send a copy of the ULTC-100.2 certification page to the eligibility enrollment specialist at the county department of social services.

      v. The SEP agency shall submit the HCBS prior authorization request to the Department or its fiscal agent.

7. For individuals receiving services in HCBS Programs who are already determined to be at the nursing facility level of care and seeking admission into a nursing facility, the SEP shall:

   a. Coordinate the admission date with the facility;

   b. Complete the PASRR Level 1 Screen, and if there is an indication of a mental illness or developmental disability, submit to the Department or its agent to determine if a PASRR Level 2 evaluation is required;

   c. Maintain the Level 1 Screen in the individual's case file regardless of the outcome of the Level 1 Screen; and

   d. If appropriate, assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the ULTC 100.2 is not older than six (6) months.

8.393.2.D. Reassessment

1. 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 an individual receiving services within twelve (12) months of the initial individual assessment or the previous reassessment. A reassessment shall be completed sooner if the individual's condition changes or if required by program criteria.

2. The case manager shall update the information provided at the previous assessment or reassessment, utilizing the ULTC 100.2.

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

    a. Obtain diagnostic information through the Professional Medical Information Page (PMIP) form, from the individual's medical provider at least annually, or sooner if the individual's condition changes or is required by program criteria;

    b. Assess the individual's functional status face-to-face at a time and location convenient to the individual;

    c. Review support plan, service agreements and provider contracts or agreements;

    d. Evaluate effectiveness, appropriateness and quality of services and supports;

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

    f. Annually, or more often if indicated, complete new support plan and service agreements;

    g. Inform the individual's medical provider of any changes in the individual's needs;

    h. Maintain appropriate documentation, including type and frequency of LTSS the individual is receiving for certification of continued program eligibility, if required by the program;

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

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

4. The SEP shall be responsible for completing reassessments of nursing facility individuals. A reassessment shall be completed if the nursing facility determines there has been a significant change in the resident's physical/medical status, if the individual requests a reassessment or if the case manager assigns a definite end date. The nursing facility shall be responsible to send the SEP agency a referral for a new assessment as needed.

5. The ULTC-100.2 shall be reviewed during each six (6) month contact and updated due to any change in the individual's condition or status. If there is no change in the individual's status, the case manager shall document in the Department-prescribed IMS that the ULTC-100.2 has been reviewed but not updated.

6. In order to assure quality of services and supports and the health and welfare of the individual, the case manager shall ask for permission from the individual to observe the individual's residence as part of the reassessment process, but this shall not be compulsory of the individual.

8.393.2.E. Support Plan

1. The nursing facility shall be responsible for developing a support plan for individuals residing in nursing facilities.

2. The SEP agency shall develop the Support Plan (SP) within fifteen (15) working days after determination of program eligibility.

3. The SEP shall:

   a. Address the functional needs identified through the individual assessment;

   b. Offer informed choices to the individual regarding the services and supports they receive and from whom, as well as the documentation of services needed, including type of service, specific functions to be performed, duration and frequency of service, type of provider and services needed but that may not be available;

   c. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;

   d. Reflect cultural considerations of the individual and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient;

   e. Formalize the support plan agreement, including appropriate signatures, in accordance with program requirements;

   f. Contain prior authorization for services, in accordance with program directives, including cost containment requirements;

   g. Contain prior authorization of Adult Long Term Home Health Services, pursuant to Section 8.520-8.527;

   h. Include a method for the individual to request updates to the plan as needed;

   i. Include an explanation of complaint procedures to the individual;

   j. Include an explanation of critical incident procedures to the individual; and

   k. Explain the appeals process to the individual.

4. The case manager shall provide necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions and ensure that the development of the Support Plan:

   a. Occurs at a time and location convenient to the individual receiving services;

   b. Is led by the individual, family members and/or individual's representative with the case manager;

c. Includes people chosen by the individual;

d. Addresses the goals, needs and preferences identified by the individual throughout the planning process;

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

f. Includes referral to community resources as needed and development of resources for individual individuals if a resource is not available within the individual's community.

5. Prudent purchase of services:

a. The case manager shall arrange services and supports using the most cost effective methods available in considering of the individual's needs and preferences.

b. When family, friends, volunteers or others are available, willing and able to support the individual at no cost, these supports shall be utilized before the purchase of services, providing these services adequately meet the individual's needs.

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

d. The case manager shall assure there is no duplication in services provided by SEP programs and any other public or privately funded services.

6. In order to assure quality of services and supports and health and welfare of the individual, the case manager shall observe the individual's residence prior to completing and submitting the individual's support plan.

8.393.2.F. Cost Containment

1. If the case manager expects that the services required to support the individual receiving services' needs will exceed the Department-determined Cost Containment Review Amount, the Department or its agent will review the support plan to determine if the individual's request for services is appropriate and justifiable based on the individual's condition and quality of life and sign the Prior Authorization Request.

a. The individual may request of the case manager that existing services remain intact during this review process.

b. In the event that the request for services is denied by the Department or its agent, the case manager shall provide the individual with:

i. The individual's appeal rights pursuant to Section 8.057; and

ii. Alternative options to meet the individual's needs that may include, but are not limited to, nursing facility placement.

8.393.2.G. On-Going Case Management

1. The functions of the on-going case manager shall be:

   a. Assessment/Reassessment: The case manager shall continually identify individuals' strengths, needs, and preferences for services and supports as they change or as indicated by the occurrence of critical incidents;

   b. Support Plan Development: The case manager shall work with individuals to design and update Support Plans that address individuals' goals and assessed needs and preferences;

   c. Referral: The case manager shall provide information to help individuals choose qualified providers and make arrangements to assure providers follow the support plan, including any subsequent revisions based on the changing needs of individuals;

   d. Monitoring: The case manager shall ensure that individuals get the authorized services in accordance with their Support Plan and monitor the quality of the services and supports provided to individuals enrolled in LTSS Programs; and

   e. Remediation: The case manager shall identify, resolve, and to the extent possible, establish strategies to prevent Critical Incidents and problems with the delivery of services and supports.

2. The case manager shall assure quality of services and supports and the health and welfare of the individual by monitoring service providers to ensure, the appropriateness, timeliness and amount of services provided and to promote individual safety, satisfaction and quality of life. The case manager shall take, and the safety of the client, and by taking corrective actions as needed.

3. The SEP Agency must also observe the individual's residence with the individual present to establish the residence is a safe environment at least annually.

   a. If the case manager does not observe the individual's residence at the annual face-to-face reassessment, the case manager to shall align the annual visit to the individual's residence with a six (6) month face-to-face contact.

   b. If the case manager makes an observation in the individual's residence that is inconsistent with the ULTC-100.2 and/or Support Plan, the case manager shall update the assessment and/or Support Plan to reflect the observation.

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

   a. Review of the individual's support plan and service agreements;

   b. Contact with the individual concerning individuals' safety, quality of life and satisfaction with services provided;

   c. Contact with service providers to coordinate, arrange or adjust services, to address quality issues or concerns and to resolve any complaints raised by individuals or others;

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

e. Informal assessment of changes in individual functioning, service effectiveness, service appropriateness and service cost-effectiveness;

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

g. Referral to community resources as needed.

5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment or mis-utilization of any public assistance benefit, and shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with Department of Human Services Section 3.810 and Department of Health Care Policy and Financing Section 8.076.

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

7. The case manager shall review the ULTC 100.2 and the Support Plan with the individual every six (6) months. The review shall be conducted by telephone or at the individual's place of residence, place of service or other appropriate setting as determined by the individual's needs or preferences.

8. The case manager shall complete a new ULTC 100.2 when there is a significant change in the individual's condition or when the individual changes LTSS programs.

9. The case manager shall contact the service providers, as well as, the individual to monitor service delivery as determined by the individual's needs or as required by the specific service requirements.

10. Case Manager shall report critical incident within 24 hours of notification within the State Approved IMS. This report must include:

a. Individual's name;

b. Individual's identification number;

c. HCBS Program;

d. Incident type;

e. Date and time of incident;

f. Location of incident, including name of facility, if applicable;

g. Individuals involved; and

h. Description of Resolution.

8.393.2.H. Case Recording/Documentation

1. The SEP agency shall complete and maintain all required records included in the State approved IMS, and shall maintain individual case records at the agency level for any additional documents associated with the individual applying for or enrolled in a LTSS Program.

2. The case record and/or IMS shall include:

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

   b. All State-required forms; and

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

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

   a. Documentation must be objective and understandable for review by case managers, supervisors, program monitors and auditors;

   b. Entries must be written at the time of the activity or no later than five (5) business days from the time of the activity;

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

   d. Entries must be entered into Department's IMS;

   e. The person making each entry must be identified;

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

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

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

   i. All persons and agencies referenced in the documentation must be identified by name and by relationship to the individual;

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

   k. Whenever the case manager is unable to comply with any of the regulations specifying the time frames within which case management activities are to be completed, due to circumstances outside the SEP agency's control, the circumstances shall be documented in the case record. These circumstances shall be taken into consideration upon monitoring of SEP agency performance.

4. Summary recording to update a case record shall be entered into the IMS at least every six (6) months or whenever a case is transferred from one SEP agency to another, or when a case is closed.

8.393.2.I. Resource Development Committee

1. The SEP agency shall assume a leadership role in facilitating the development of local resources to meet the LTSS needs of individuals receiving services who reside within the SEP district served by the SEP agency.

2. Within 90 days of the effective date of the initial contract, the SEP agency's community advisory committee shall appoint a resource development committee.

3. The membership of the resource development committee shall include, but not be limited to, representation from the following local entities: Area Agency on Aging (AAA), county departments of social services, county health departments, home health agencies, nursing facilities, hospitals, physicians, community mental health centers, community centered boards, vocational rehabilitation agencies, and individuals receiving long-term services.

4. In coordination with the resource development efforts of the Area Agency on Aging (AAA) that serves the district, the resource development committee shall develop a local resource development plan during the first year of operation.

    a. The resource development plan shall include:

        i. An analysis of the LTSS resources available within the SEP district;

        ii. Gaps in LTSS resources within the SEP district;

        iii. Strategies for developing needed resources; and

        iv. A plan for implementing these strategies, including the identification of potential funding sources, potential in-kind support and a time frame for accomplishing stated objectives.

    b. The data generated by the SEP agency's intake/screening/referral, individual assessment, documentation of unmet individual needs, resource development for individuals and data available through the Department shall be used to identify persons most at risk of nursing facility care and to document the need for resources locally.

5. At least annually, the resource development committee shall provide progress reports on the implementation of the resource development plan to the community advisory committee and to the Department.

8.393.3 DENIALS/DISCONTINUATIONS/ADVERSE ACTIONS

8.393.3.A. Denial Reasons and Notification Actions

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

    a. Financial Eligibility

        i. The eligibility enrollment specialist from the county department of social services shall notify the individual of denial for reasons of financial eligibility, and shall inform the individual 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 Department.

1) If the individual is found to be financially ineligible for LTSS programs, the SEP shall notify the individuals of the adverse action and inform the individual of their appeal rights in accordance with Section 8.057.

b. Functional Eligibility and Target Group

i. The SEP agency shall notify the individual of the denial and appeal rights by sending the Notice of Services Status (LTC-803) and shall attend the appeal hearing to defend the denial or discontinuation, when:

1) The individual does not meet the functional eligibility threshold for LTSS Programs or nursing facility admissions; or

2) The individual does not meet the target group criteria as specified by the HCBS Program.

c. Receipt of Services

i. The SEP agency shall notify the individual of the denial and appeals rights by sending the Notice of Services Status (LTC-803) and shall attend the appeal hearing to defend the denial or discontinuation, when:

1) The individual has not received services for thirty (30) days;

2) The individual has two (2) times in a thirty (30) day consecutive period, refused to schedule an appointment for assessment, six (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; or

3) The individual or individual's representative refuses to sign the Intake form, Support Plan form, Release of Information form, or other forms as required to receive services or if the SEP agency does not receive the completed Professional Medical Information Page (PMIP) form.

d. Institutional Status

i. The SEP agency shall notify the individual of denial or discontinuation by sending the Notice of Services Status (LTC-803) when the case manager determines that the individual does not meet the following program eligibility requirements.

1) The individual is not eligible to receive services while a resident of a nursing facility, hospital, or other institution; or

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

e. Cost-Effectiveness/Service Limitations

i. During the Support Planning process in conjunction with the initial assessment or reassessment, the individual seeking or receiving

services shall not be eligible for the HCBS program if the case manager determines the individual's needs are more extensive than the HCBS program services are able to support, that the individual's health and safety cannot be assured in a community setting and/or if the cost containment review process is met as outlined in Section 8.393.2.F.

1) If the case manager determines that the individual is ineligible for an HCBS Program, the case manager shall:

a) Obtain any other documentation necessary to support the determination; and

b) Inform induvial of their appeal rights pursuant to Section 8.057.

2. The Notice Services Status (LTC-803) shall be completed in the IMS for all applicable programs at the time of initial eligibility, when there is a significant change in the individual's payment or services, an adverse action, or at the time of discontinuation.

3. In the event the individual appeals a denial or discontinuation action, with the exception of reasons related to financial eligibility, the case manager shall attend the appeal hearing to defend the denial or discontinuation action.

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

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

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

3. The case manager shall follow procedures to close the individual's case in the IMS within one (1) working day of discontinuation for all HCBS Programs.

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

8.393.3.C. Notification

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

a. At the same time that it notifies the individual seeking or receiving services of the adverse action;

b. When the individual has filed a written appeal with the SEP agency; and

c. When the individual has withdrawn the appeal or if a final agency decision has been entered.

2. The SEP agency shall provide information to individuals seeking and receiving services regarding their appeal rights when individuals apply for publicly funded LTSS or whenever the individual requests such information, whether or not adverse action has been taken by the SEP agency.

8.393.4. COMMUNICATION

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

1. The case manager shall inform the eligibility enrollment specialist of any and all changes effecting the individual receiving services' participation in SEP agency-administered programs, including changes in income, within one (1) working day after the case manager learns of the change. The case manager shall provide the eligibility enrollment specialist with copies of the certification page of the approved ULTC-100.2 form.

2. If the individual has an open adult protective services (APS) case at the county department of social services, the case manager shall keep the individual's APS worker informed of the individual's status and shall participate in mutual staffing of the individual's case.

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

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

8.393.5 FUNCTIONAL ELIGIBILITY DETERMINATION

A. The SEP Agency shall be responsible for the following:

1. Ensuring that the ULTC 100.2 is completed in the IMS in accordance with Section 8.401.1 and justifies that the individual seeking or receiving services should be approved or disapproved for admission or continued stay to an applicable LTSS program.

2. Once the assessment is complete in the IMS, the case manager shall generate a certification page in the IMS within three (3) business days for hospital discharge to a Nursing Facility, within six (6) days for Nursing Facility discharge and within eleven (11) business days of receipt of referral.

3. If the assessment indicates approval, SEP agency shall notify the appropriate parties in accordance with Section 8.393.3.A.2 and 8.383.4.4.

4. If the assessment indicates denial, the SEP agency shall notify the appropriate parties in accordance with 8.393.3.A.2 and 8.383.4.

5. If the individual or individual's designated representative appeals, the SEP shall process the request, according to Section 8.057.

8.393.6. INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES

8.393.6.A. Intercounty Transfers

1. SEP agencies shall complete the following procedures to transfer individuals receiving case management services to another county within the same SEP district:

a. Notify the county department of social services eligibility enrollment specialist of the individual's plans to relocate to another county and the date of transfer, with financial transfer details at Section 8.100.3.C.

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

c. In order to assure quality of services and supports and health and welfare of the individual, the case manager must observe and evaluate the condition of the individuals residence.

d. If the individual is moving from one county to another county to enter an Alternative Care Facility (ACF), forward copies of the following individual records to the Alternative Care Facility (ACF), prior to the individual's admission to the facility:

i. ULTC 100.2, certified by the SEP;

ii. The individual's updated draft Prior Authorization Request (PAR) and/or Post Eligibility Treatment of Income (PETI) form; and

iii. Verification of Medicaid eligibility status.

8.393.6.B. Inter-district Transfers

1. SEP agencies shall complete the following procedure in the event an individual receiving services transfers from one SEP district to another SEP district:

a. The transferring SEP agency shall contact the receiving SEP agency by telephone and give notification that the individual is planning to transfer, negotiate a transfer date and provide all necessary information.

b. The transferring SEP agency shall notify the county department of social services eligibility enrollment specialist of the individual's plan to transfer and the transfer date, and eligibility enrollment specialist shall follow rules described in Section 8.100.3.C. The receiving SEP agency shall coordinate the transfer with the eligibility enrollment specialist of the new county.

c. The transferring SEP agency shall make available in the IMS the individual's case records to the receiving SEP agency prior to the relocation.

d. If the individual is moving from one SEP district to another SEP district to enter an Alternative Care Facility (ACF), the transferring SEP agency shall forward copies of individual records to the Alternative Care Facility (ACF), prior to the individual's admission to the facility, in accordance with section 8.393.6.A.

e. To ensure continuity of services and supports, the transferring SEP agency and the receiving SEP agency shall coordinate the arrangement of services prior to the individual's relocation to the receiving SEP agency's district within ten (10) working days after notification of the individual's relocation,

f. The receiving SEP agency shall complete a face-to-face meeting with the individual in the individual's residence and a case summary update within ten

(10) working days after the individual's relocation, in accordance with assessment procedures for SEP agency individuals.

g. The receiving SEP agency shall review the support plan and the ULTC 100.2 and change or coordinate services and providers as necessary.

h. If indicated by changes in the support plan, the receiving SEP agency shall revise the support plan and prior authorization forms as required by the publicly funded program.

i. Within thirty (30) calendar days of the individual's relocation, the receiving SEP agency shall forward to the Department, or its fiscal agent, revised forms as required by the publicly funded program.

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]