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Introduction

The *Colorado Register* is published pursuant to C.R.S. 24-4-103(11) and is the sole official publication for state agency notices of rule-making, proposed rules, attorney general's opinions relating to such rules, and adopted rules. The register may also include other public notices including annual departmental regulatory agendas submitted by principal departments to the secretary of state.

"Rule" means the whole or any part of every agency statement of general applicability and future effect implementing, interpreting, or declaring law or policy or setting forth the procedure or practice requirements of any agency. "Rule" includes "regulation". C.R.S. 24-4-102(15). Adopted rules are effective twenty days after the publication date of this issue unless otherwise specified.

The *Colorado Register* is published by the office of the Colorado Secretary of State twice monthly on the tenth and the twenty-fifth. Notices of rule-making and adopted rules that are filed from the first through the fifteenth are published on the twenty-fifth of the same month, and those that are filed from the sixteenth through the last day of the month are published on the tenth of the following month. All filings are submitted through the secretary of state's electronic filing system.

For questions regarding the content and application of a particular rule, please contact the state agency responsible for promulgating the rule. For questions about this publication, please contact the Administrative Rules Program at rules@sos.state.co.us.

Notice of Proposed Rulemaking

Tracking number

2020-00966

Department

100,800 - Department of Personnel and Administration

Agency

801 - State Personnel Board and State Personnel Director

CCR number

4 CCR 801-1

Rule title

STATE PERSONNEL BOARD RULES AND PERSONNEL DIRECTOR'S ADMINISTRATIVE PROCEDURES

Rulemaking Hearing

Date

02/05/2021

Time

01:00 PM

Location

Online only - instructions in notice of hearing

Subjects and issues involved

Chapter 5 - Paid Family Medical Leave

Statutory authority

Colo. Constitution, Art. XII

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DEPARTMENT OF PERSONNEL AND ADMINISTRATION

State Personnel Board and State Personnel Director

STATE PERSONNEL BOARD RULES AND PERSONNEL DIRECTOR'S ADMINISTRATIVE PROCEDURES

4 CCR 801-1

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

The purpose of the State Personnel Board Rules and Director's Administrative Procedures is to establish a comprehensive system of rules and procedures for employees within the state personnel system. In order to distinguish the Board from the Director's Procedures, rules promulgated by the State Personnel Board are noted as "Board Rules". Rules adopted by the Board and procedures adopted by the Director require the formal rulemaking process defined in the Administrative Procedures Act.

Pursuant to § 24-50-101(3)(b), C.R.S., it is the duty of the State Personnel Board to provide fair and timely resolution of the cases before it. Pursuant to § 24-50-101(3)(c), C.R.S., it is the duty of the State Personnel Director to establish the general criteria for adherence to the merit principles and for fair treatment of individuals within the state personnel system.

Preamble

Unless otherwise noted in a specific provision, the entire body of State Personnel Board Rules were repealed and new permanent rules were adopted by the State Personnel Board on April 19, 2005, pursuant to a Statement of Basis and Purpose dated April 19, 2005. The entire body of the State Personnel Director's Administrative Procedures were repealed and new permanent procedures were adopted by the State Personnel Director on May 5, 2005, pursuant to a Statement of Basis and Purpose dated May 5, 2005. Such rules and procedures were effective July 1, 2005.

This version reflects emergency changes to Chapter 5, Time Off, that become effective on January 1, 2021 and permanently placed into rule on April 1, 2021.

These changes are created to align the Director's Procedures with the state personnel system's Paid Family Medical Leave (PFML) policies created by the State Personnel Director under the authority of §24-50-104(1)(g), C.R.S. and become effective as of January 1, 2021.~~This version reflects changes to Chapter 1, Organization, Responsibilities, Ethics, Payroll Deduction, and Definitions, Chapter 3, Compensation, Chapter 4, Employment and Status, and Chapter 5, Time Off. This rulemaking by the State Personnel Director became effective on January 1, 2021 and includes: adding Director's Procedures 3-18.F., 4-10., 5-1.D.1., 5-5.E., 5-7.A.(Table), 5-13.A., 5-40.; modifying Director's Procedures 1-38.2., 3-21.A.1.c., 4-8., 4-9., 4-14.C., 4-21., 4-21.A., 4-21.B., 4-21.C., 5-1.C., 5-5., 5-5.A, 5-13.A., 5-13.B.; reorganized layout of Chapter 4, Employment and Status, to align with the order of operations; updated rules for clarification and consistency; and administrative clean-up which included removal of expired emergency rules.~~

Chapter 5 Time Off

Authority for rules promulgated in Chapter 5, Time Off, is found in State of Colorado Constitution Article XII, Section 13, The Family Medical Leave Act (FMLA), Americans with Disabilities Act (ADA), Family Care Act (FCA), Uniformed Services Employment and Reemployment Rights Act (USERRA), The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA), Healthy Families and Workplace Act, the Public Health Emergency Whistleblower Act and 26 U.S.C. 63, State of Colorado Revised Statutes (C.R.S.) §§ 1-6-115, 1-6-122, 1-7-102, 8-40-101, 14-2-101, 14-15-103, 24-11-101, 24-11-112, 24-18-102, 24-33.5-825, 24-50-104, 24-50-109.5, 24-50-401, 28-1-104, 28-3-601, 28-6-602, 28-3-607, 28-3-609, and 28-3-610. (01/01/2021)

General Principles

5-1. Employees are required to work their established work schedule unless on approved leave. Employees are responsible for requesting leave as far in advance as possible. The leave request shall provide sufficient information to determine the type of leave. (5/1/10)

A. The appointing authority shall respect the employee's privacy rights when requesting adequate information to determine the appropriate type of leave. (02/2017)

B. Appointing authorities are responsible for approving all leave requests and for determining the type of leave granted, subject to these rules and any additional departmental leave procedures. Departmental procedures shall be provided to employees. (02/2017)

C. Except for paid sick leave or public health emergency leave, use of any other leave that is not approved by the appointing authority may result in the denial of paid leave and/or corrective or disciplinary action. (01/01/2021)

D. Mandates to maintain a minimum balance of sick or annual leave (or a combination of both) are not permitted except under a leave sharing program or a corrective or disciplinary action. (02/2017)

1. Paid sick leave or public health emergency leave cannot be counted as an absence that may lead to corrective or disciplinary action against an employee, unless the employee uses the leave for purposes other than the allowable reason. (01/01/2021)

5-2. Paid leave is to be exhausted before an employee is placed on unpaid leave, unless the reason for leave does not qualify for the type of leave available, or during a mandatory or voluntary furlough. (02/2017)

5-3. Departments shall keep accurate leave records in compliance with rule and law and be prepared to report the use of any type of leave when requested by the Director. (5/1/10)

Accrued Paid Leave

5-4. Annual leave is for an employee’s personal needs and use is subject to the approval of the appointing authority. The appointing authority may establish periods when annual leave will not

be allowed, or shall be taken, based on business necessity. These periods cannot create a situation where the employee does not have a reasonable opportunity to use requested leave that will be subject to forfeiture. If the department cancels approved leave that results in forfeiture, the forfeited hours shall be paid before the end of the fiscal year. (5/1/10)

A. Due to the declaration of a state of emergency by the Governor, as defined in the Colorado Disaster Emergency Act, if annual leave was denied, cancelled or the employee was not given reasonable opportunity to use the requested annual leave, resulting in annual leave being subject to forfeiture under rule, up to eighty (80) hours of leave over the maximum accrual allotment may be carried over to the next fiscal year in lieu of payment. The over accrued annual leave amount (up to eighty (80) hours) will roll over to the next fiscal year on July 1 and will be available to the employee to use. This amount will not carry over for a second fiscal year. Any annual leave hours over the maximum accrual amount not carried over in this Rule 5-4.(A) and subject to forfeiture shall be paid out to the employee before the end of the fiscal year. (08/01/2020)

5-5. Sick leave is for health reasons only, including mental or physical illness, injury, a health condition, diagnostic and preventative examinations, treatment, and recovery. Accrued sick leave may be used for the health needs of:

A. The employee or the employee's family members (related by blood, adoption, marriage, or civil union) including a child to whom the employee stands in loco parentis or a person who stood in loco parentis to the employee when the employee was a minor, domestic partners, in-laws, step relatives and for a person for whom the employee is responsible for providing or arranging health or safety-related care. Special consideration will also be given to any other person whose association with the employee is similar to a family member. (01/01/2021)

B. An injured military service member as established under Rule 5-20 (F), legal dependent, or a person in the household for whom the employee is the primary caregiver. (04/01/2020)

C. Appointing authorities may use discretion to send employees home for an illness or injury that impacts the employee's ability to perform the job or the safety of others.

1. Sick leave shall be charged first;

2. Annual leave shall be charged if sick leave is exhausted; then

3. Unpaid leave if both annual and sick leave are exhausted. (01/01/2021)

D. Employees shall provide the State's authorized form (or other official document containing the same information) from a health care provider for an absence of more than three (3) consecutive full working days for any health reason or the use of sick leave shall be denied. Appointing authorities have the discretion to require the State's authorized form (or other official document containing the same information) for absences of less than three (3) days when the appointing authority has a reasonable basis for suspecting abuse of sick leave. (02/2017)

1. The completed official form or document shall be returned within fifteen (15) days from the appointing authority's request. (02/2017)

2. Failure to provide the State's authorized form (or other official document containing the same information) may result in corrective/disciplinary action. Appointing authorities have the discretion to approve other forms of leave if sick leave is denied. (02/2017)

E. When an employee or employee’s family member is a victim of domestic abuse, stalking, sexual assault, or any other crime related to domestic violence and needs to seek medical attention, mental health care or other counseling, or victim services including legal services or relocation. See rule 5-17.(C) for unpaid job protection. (01/01/2021)

Exhaustion of Leave and Administrative Discharge

5-6. If an employee has exhausted all credited paid leave and is unable to return to work, unpaid leave may be granted or the employee may be administratively discharged by written notice following a good faith effort to communicate with the employee. Administrative discharge applies only to exhaustion of leave. (11/1/2019)

A. The notice of administrative discharge shall inform the employee of appeal rights and the need to contact the employee's retirement plan on eligibility for retirement.

B. An employee cannot be administratively discharged if FML, state family medical leave, or short-term disability leave (includes the thirty (30) day waiting period) apply, or if the employee is a qualified individual with a disability under the ADA who can reasonably be accommodated without undue hardship. (11/1/2019)

C. A certified employee who has been discharged under this rule and subsequently recovers has reinstatement privileges.

5-7. Table (08/01/2020)

Monthly Leave Earning, Accrual, Payout, and Restoration for Permanent Employees

Annual Leave				Sick Leave****			
Years of Service*	**Hrs. / Mon.**	**Max. Accrual****	**Payout**	**Hrs./Mon.**	**Max. Accrual*****	**Restoration**	**Payout**
Years 1 - 5 (01 - 60 Months)	8	192 hours	Upon termination or death, unused leave is paid out up to the maximum accrual rate.	6.66	360 hours	Previously accrued sick leave up to three hundred and sixty (360) hours is restored when eligible for reinstatement or reemployment.	Upon death or if eligible to retire, one quarter (¼) of unused leave paid out to the maximum accrual rate. PERA's age and service requirements under the Defined Benefit plan are applied regardless of the plan actually enrolled in.
Years 6 - 10 (61 - 120 Months)	10	240 hours					
Years 11 -15 (121 - 180 Months)	12	288 hours					
Year 16 or Greater (181 or more Months)	14	336 hours					

* Years of service is computed from the 1st calendar day of the month following the hire date; except if the employee began work on the 1st working day of a month, include that month in the count. Employees with prior permanent state service, in or out of the state personnel system, earn leave based on the total whole months of service, excluding temporary assignments.

** Over-accrued amounts are forfeited at the beginning of the new fiscal year (July 1st) except when Rule 5-4. A. is applicable.

*** Over-accrued sick leave up to eighty (80) hours is converted to annual leave each new fiscal year (July 1st) at a five to one (5:1) ratio (five (5) hours of sick converts to one (1) hour annual leave). An employee may have an individual maximum accrual that is greater than three hundred and sixty (360) hours if continuously employed in the state personnel system prior to 7/1/88. Maximum accrual for these employees is calculated by adding three hundred and sixty (360) hours to the leave balance on 6/30/88.

**** During the declaration of a state of emergency by the Governor, as defined in the Colorado Disaster Emergency Act, sick leave balances may go negative up to forty (40) hours once all accrued sick, annual leave, and compensatory time is exhausted. Subsequent sick leave accruals will be credited to the negative balance. If an employee separates before the negative balance is recovered, it will be deducted from their final paycheck.

General Provisions

Employees shall be at work or on paid leave to earn monthly leave. Leave is credited on the last day of the month in which it is earned and is available for use on the first day of the next month, subject to any limitations elsewhere in Chapter 5, Time Off. A terminating employee shall be compensated for annual leave earned through the last day of employment.

Part-time employees who work regular, non-fluctuating schedules earn leave on a prorated basis based on the percentage of the regular appointment, rounded to the nearest one, one hundredth (1/100) of an hour. Leave for part-time employees who work irregular, fluctuating schedules and full-time employees who work or are on paid leave less than a full month is calculated by dividing the number of hours paid by the number of work hours in the monthly pay period. The percentage is then multiplied by the employee's leave earning rate to derive the leave earned. Overtime hours are not included in leave calculations.

Leave payouts at separation are calculated using the annualized hourly rate of pay (annual salary divided by two thousand eighty (2080) hours for full-time employees), and employees are only eligible for the sick leave payout one (1) time - initial eligibility for retirement.

Forfeiture of leave as a disciplinary action or a condition of promotion, demotion, or transfer is not allowed.

Borrowing against any leave that may be earned in the future or "buying back" leave already used is not allowed, except during a declaration of a state of emergency by the Governor, as defined in the Colorado Disaster Emergency Act, as indicated above.

Use of annual leave cannot be required for an employee being laid off.

Make Whole: When an employee is receiving workers' compensation payments, accrued paid leave is used to make the employee's salary whole in an amount that is closest to the difference between the temporary compensation payment and the employee's gross base pay, excluding any pay differentials. Leave earning is not prorated when an employee is being made whole.

Short-Term Disability: Employees are required to use accrued paid leave during the thirty (30) day waiting period for short-term disability benefits, including the use of accrued annual leave and/or compensatory time once accrued sick leave has been exhausted. When an employee is receiving short-term disability payments, the employee may choose to use accrued paid leave to make their salary whole in an amount that is closest to the difference between the short-term disability benefit payment and the employee's gross base pay, excluding any pay differentials. Employees who elect to be made whole will use accrued sick leave first, then annual leave or compensatory time as available. Employees shall not use negative sick leave to be made whole. Leave earning is not prorated when an employee is being made whole.

5-7. A. Table (01/01/2021)

Factor Rate Earning, Accrual, Payout, and Restoration for Temporary Employees			
Sick Leave			
Hourly Accrual / Biweekly Pay	**Cap***	**Restoration**	**Payout**
.033/hour 30 hours x .033 = 1 hour Biweekly Pay Period 80 hours x .033 = 2.64 hours	48 Hours	Previously accrued sick leave up to forty-eight (48) hours is restored when eligible for temporary rehire or hired permanently.	Not applicable.
* Up to a cap of 48 hours of paid leave may be accrued in the fiscal year. Leave is no longer accrued once the cap is reached.			
General Provisions: Temporary employees shall be at work or on paid leave to earn paid sick leave. Leave is credited on the last day of the biweekly pay period in which it is earned and is available for use on the first day of the following biweekly pay period. Sick leave may be requested and used, subject to the general principles, sick leave, Family Medical Leave Act, and public health emergency leave rules of this Chapter 5, Time Off.			

Leave Sharing

5-8. Leave sharing allows for the transfer of annual leave between permanent state employees for an unforeseeable life-altering event beyond the employee's control, and is subject to the discretionary approval of a department head. Departments shall develop and communicate their programs prior to use, including criteria for qualifying events. The authority to approve leave sharing shall not be delegated below the department head without advance written approval of the Director. (02/2017)

5-9. Employees shall have at least one (1) year of state service to be eligible. Leave sharing is not an entitlement even if the individual case is qualified. Donated leave is not part of the leave payout upon termination or death. (5/1/10)

A. Donated leave is allowed for a qualifying event for the employee or the employee's immediate family member as defined under Rule 5-5. In order to use donated leave, the employee shall first exhaust all applicable paid leave and compensatory time and shall not be receiving short-term disability or long-term disability benefit payments. If all leave is exhausted, donated leave may be used to cover the leave necessary during the thirty (30) day waiting period for short-term disability benefit payments. The transfer of donated leave between departments is allowed only with the approval of both department heads. (02/2017)

Holiday Leave

5-10. Permanent full-time employees employed by the state when the holiday is observed are granted eight (8) hours of paid holiday leave (prorated for permanent part-time employees) to observe each legal holiday designated by law, the Governor, or the President. Appointing authorities may designate alternative holiday schedules for the fiscal year. If a holiday occurs when an employee is on short or long–term disability and is being paid for the disability benefit, the employee will be paid through those benefits and not be granted eight (8) hours of holiday leave. (04/01/2020)

A. Department heads have the discretion to grant employee requests to observe César Chávez day, March 31, in lieu of another holiday in the same fiscal year. The department shall be open and at least minimally operational for both days and the employee shall have work to perform.

B. Each department shall establish an equitable and consistent policy to ensure that all permanent employees are granted their full complement of holidays. (02/2017)

Other Employer-Provided Leaves

5-11. The types of leave in this section do not accrue, carry over, or pay out. (5/1/10)

5-12. Bereavement leave is for an employee's personal needs and use is subject to the approval of the appointing authority. The appointing authority may provide up to forty (40) hours (prorated for part-time work or unpaid leave in the month) of paid leave to permanent employees for the death of a family member or other person. Employees are responsible for requesting the amount of leave needed. Documentation may be required when deemed necessary by the appointing

authority. (02/2017)

5-13. Military leave provides up to one hundred twenty (120) hours in a fiscal year to permanent employees who are members of the National Guard, military reserves, or National Disaster Medical Service to attend the annual encampment or equivalent training or who are called to active service, including declared emergencies. Unpaid leave is granted in accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA) after exhaustion of the one hundred twenty (120) hours. The employee may request the use of annual leave before being placed on unpaid leave. (04/01/2020)

A. Notice may be written or verbal and should be in advance of the leave unless unreasonable or precluded by military necessity. Required documentation shall be submitted in advance of the leave or upon the return to work in the form of military orders, estimates of military entitlements, military leave earning statements, correspondence from a commanding officer, or other forms that may be verified. (01/01/2021)

B. In the case of a state emergency, the employee shall return upon release from active duty. In the case of federal service, the employee shall notify the appointing authority of the intent to return to work, return to work, or may need to apply to return, and is entitled to the same position or an equivalent position, including the same pay, benefits, location, work schedule, and other working conditions. This leave is not a break in service. (02/2017)

5-14. Jury leave provides paid leave to all employees; however, temporary employees receive paid leave for a maximum of three (3) days of jury leave. Jury pay is not turned over to the department. Proof may be required. (02/2017)

5-15. Administrative leave may be used to grant paid time when the appointing authority wishes to release employees from their official duties for the good of the state. In determining what is for the good of the state, an appointing authority shall consider prudent use of taxpayer and personal services dollars and the business needs of the department. (02/2017)

A. Activities performed in an official employment capacity, including job-related training and meetings, voluntary training, conferences, participation in hearings or settlement conferences at the direction of the Board or Director, and job-related testimony in court or official government hearings required by an appointing authority or subpoena are work time and not administrative leave. Administrative leave is not intended to be a substitute for corrective or disciplinary action or other benefits and leave. (02/2017)

B. Administrative leave may be granted for the following: (02/2017)

1. Up to five (5) days for local or fifteen (15) days for national emergencies per fiscal year to employees who are certified disaster service volunteers of the American Red Cross. (02/2017)

2. One (1) period of administrative leave for the initial call up to active military service in the war against terrorism of which shall not exceed ninety (90) days and applies after exhaustion of paid military leave. Administrative leave is only used to make up the difference between the employee’s base salary (excluding premiums) and total gross military pay and allowances. The employee shall furnish proof of military pay and

allowances. This leave does not apply to regular military obligations such as the annual encampment and training. (02/2017)

3. Volunteering in community or school activities. A department shall adopt and communicate a policy regarding the amount of leave available, employee eligibility, and process for requesting and approving leave. (04/01/2020)

4. Employee recognition for special accomplishments or contributions in accordance with the department's established incentive plan. (02/2017)

C. Administrative leave shall be granted for the following: (02/2017)

1. Two (2) hours to participate in general elections if the employee does not have three (3) hours of unscheduled work time during the hours the polls are open. (02/2017)

2. Up to two (2) days per fiscal year for organ, tissue, or bone donation for transplants. (02/2017)

3. To serve as an uncompensated election judge unless a supervisor determines that the employee's attendance on Election Day is essential. The employee shall provide evidence of service. (02/2017)

4. Up to fifteen (15) days in a fiscal year when qualified volunteers or members of the Civil Air Patrol are directed to serve during a declared local disaster, provided the employee returns the next scheduled workday once relieved from the volunteer service. (02/2017)

D. Administrative leave that exceeds twenty (20) consecutive working days shall be reported to the department head and the Director. (01/01/2021)

5-16. Administrative leave that exceeds twenty (20) consecutive working days shall be reported to the department head and the Director. The exception is the qualifying reasons for victim protection leave as prescribed in D. of this rule. (01/01/2021)~~(02/2017)~~

A. PFML shall be used before accrued paid leave.

B. Employees who work in the same department or division as his or her spouse, partners in a civil union or domestic partnership are each entitled to PFML when they are eligible and qualify for FML.

C. Injury leave, leave under the make whole policy for workers compensation, and emergency public health leave are excluded from PFML.

D. PFML may be used when an employee or an employee's family member is a victim of domestic abuse, stalking, sexual assault, or any other crime related to domestic violence and needs to seek medical attention, mental health care or other counseling, or victim services including legal services or relocation.

1. An employee must meet the eligibility requirements for FML to qualify for PFML for domestic violence related reasons. However, the use of PFML for domestic violence

related reasons does not automatically qualify an employee for FML.

2. All information related to the leave shall be confidential and maintained in separate confidential files with limited access.

E. Retaliation against an employee is prohibited; however, this rule does not prohibit adverse employment action that would have otherwise occurred had the leave not been requested or used.

5-17. Unpaid leave may be approved by the appointing authority unless otherwise prohibited. The appointing authority may also place an employee on unpaid leave for unauthorized absences and may consider corrective and/or disciplinary action. Probationary and trial service periods are extended by the number of days on unpaid leave and may be extended for periods of paid leave. The amount of unpaid leave for employees paid on a monthly pay cycle is calculated based on the monthly salary multiplied by the number of unpaid leave hours divided by the number of hours in the pay period. The amount of unpaid leave for nonexempt employees paid on a biweekly pay cycle is calculated based on the hourly pay rate multiplied by the number of unpaid leave hours. The amount of unpaid leave for exempt employees paid on a biweekly pay cycle is calculated based on the biweekly salary multiplied by the number of unpaid leave hours divided by the number of hours in the pay period. (11/1/2019)

A. Short-term disability (STD) leave is a type of unpaid leave of up to six (6) months while either state or PERA STD benefit payments are being made. To be eligible for this leave, employees shall have one (1) year of service and an application for the STD benefit shall be submitted within thirty (30) days of the beginning of the absence. The employee shall also notify the department at the same time that a benefit application is submitted to the insurance provider. (08/01/2020)

B. Voluntary furlough is unpaid job protection granted for up to seventy two (72) workdays per fiscal year when a department head declares a budget deficit in personal services. The employee may request such absence to avoid more serious position reduction or abolishment. Employees earn sick and annual leave and continue to receive service credit as if the furlough had not occurred.

C. ~~Victim protection leave is unpaid job protection granted for up to twenty four (24) hours (prorated for part-time employees) per fiscal year for victims of stalking, sexual assault, or domestic abuse or violence. An employee shall have one (1) year of state service to be eligible and have exhausted all annual and, if applicable, sick leave. All information related to the leave shall be confidential and maintained in separate confidential files with limited access. Retaliation against an employee is prohibited; however, this rule does not prohibit adverse employment action that would have otherwise occurred had the leave not been requested or used~~Repealed. (01/01/2021)

D. State family medical leave is unpaid job protection granted for up to forty (40) hours subsequent to FML. To be eligible for this leave, the employee shall be eligible for FML, see Rule 5-20. Employees do not need to apply for state family medical leave separately.

5-18. Parental Academic leave. Departments may provide up to eighteen (18) hours (prorated for part-

time) in an academic year for parents or legal guardians to participate in academic-related activities. A department shall adopt and communicate a policy on whether the leave will be unpaid or paid, the amount and type of paid leave, and specifically the substitution of annual leave or use of administrative leave. (02/2017)

Family/Medical Leave (FML)

5-19. The state is considered a single employer under the Family and Medical Leave Act (FMLA) and complies with its requirements, the Family Care Act (FCA), and the following rules for all employees in the state personnel system. Family/medical leave cannot be waived. (02/2017)

A. The FCA provides unpaid leave to eligible employees to care for their partners in a civil union or domestic partnership who have a serious health condition and is administered consistent with FML. (02/2017)

5-20. FML is granted to eligible employees for the following conditions: (02/2017)

A. Birth and care of a child and shall be completed within one (1) year of the birth; (02/2017)

B. Placement and care of an adopted or foster child and shall be completed within one (1) year of the placement; (02/2017)

C. Serious health condition of an employee's parent, child under the age of eighteen (18), an adult child who is disabled at the time of leave, spouse, partner in a civil union, or registered domestic partner for physical care or psychological comfort; see Chapter 1, Organization, Responsibilities, Ethics, Payroll Deduction, and Definitions, for the definition of serious health condition and ADA definition for disability; (02/2017)

D. Employee's own serious health condition; (02/2017)

E. Active duty military leave when a parent, child, or spouse experiences a qualifying event directly related to being deployed to a foreign country; or (02/2017)

F. Military caregiver leave for a parent, child, spouse, or next of kin who suffered a serious injury or illness in the line of duty while on active duty. Military caregiver leave includes time for veterans who are receiving treatment within five (5) years of the beginning of that treatment. (02/2017)

5-21. To be eligible for FML, an employee shall have twelve (12) months of total state service as of the date leave will begin, regardless of employee type. A state temporary employee shall also have worked one thousand two hundred fifty (1250) hours within the twelve (12) months prior to the date leave will begin. Time worked includes overtime hours. (11/1/2019)

A. Full-time employees will be granted up to four hundred eighty (480) hours of FML per rolling twelve (12) month period. Once eligible for FML, the employee is also eligible for up to an additional forty (40) hours of state family medical leave. The amount of leave is determined by the difference of five hundred twenty (520) hours and any FML or state family medical leave taken in the previous twelve (12) month period and is calculated from the date of the most recent leave. The amount of leave is prorated for part-time employees based on the

regular appointment or schedule. Any extension of leave beyond the amount to which the employee is entitled is not FML, or state family medical leave, see Rule 5-1 B. (11/1/2019)

5-22. Military caregiver leave is a one (1) time entitlement of up to one thousand forty (1040) hours (prorated for part-time) in a single twelve (12) month period starting on the date the leave begins. While intermittent leave is permitted, it does not extend beyond the twelve (12) month period. In addition, the combined total for military caregiver, state family medical leave, and all other types of FML shall not exceed one thousand forty (1040) hours. (11/1/2019)

5-23. All other types of leave, compensatory time, and make whole payments under short-term disability and workers' compensation run concurrently with FML and state family medical leave and do not extend the time to which the employee is entitled. The employee shall use all accrued paid leave subject to the conditions for use of such leave before being placed on unpaid leave for the remainder of FML and state family medical leave. An employee on FML or state family medical leave cannot be required to accept a temporary "modified duty" assignment even though workers' compensation benefits may be affected. (08/01/2020)

5-24. Unpaid leave rules apply to any unpaid FML and state family medical leave except the state continues to pay its portion of insurance premiums. An employee's condition that also qualifies for short-term disability benefits shall comply with the requirements of that plan. (11/1/2019)

5-25. Employer Requirements. The appointing authority, human resources director, or FMLA coordinator shall designate and notify the employee whether requested leave qualifies as FML based on the information provided by the employee, regardless of the employee's desires. Departments shall follow all written directives and guidance on designation and notice requirements. (02/2017)

5-26. Employee Requirements. Written notice of the need for leave shall be provided by the employee thirty (30) days in advance. If an employee becomes aware of the need for leave in less than thirty (30) days in advance, the employee shall provide notice either the same day or the next business day. Failure to provide timely notice when the need for leave is foreseeable, and when there is no reasonable excuse, may delay the start of FML for up to thirty (30) days after notice is received as long as it is designated as FML in a timely manner. Advance notice is not required in the case of a medical emergency. In such a case, an adult family member or other responsible party may give notice, by any means, if the employee is unable to do so personally. (5/1/10)

5-27. The employee shall consult with the appointing authority to: establish a mutually satisfactory schedule for intermittent treatments and a periodic check-in schedule; report a change in circumstances; make return to work arrangements, etc. (5/1/10)

5-28. Employees shall provide proper medical certification, including additional medical certificates and fitness-to-return certificates as prescribed in Rules 5-29 through 5-32. If the employee does not provide the required initial and additional medical certificates, the leave will not qualify as FML and shall be denied. (02/2017)

Medical Certificates

5-29. Employees shall provide the State's authorized medical certification form (or other official document containing the same information) when initiating an FML leave request. Appointing

authorities have the discretion to require periodic medical certification to determine if FML continues to apply or when the appointing authority has a reasonable basis for suspecting leave abuse. Medical certification for FML may be required for the first leave request in an employee's rolling twelve (12) month period. Additional medical certification may be required every thirty (30) days or the time period established in the initial certification, whichever is longer, unless circumstances change or new information is received. (02/2017)

A. The medical certification shall be completed by a health care provider as defined in federal law. The completed medical certification shall be returned within fifteen (15) days from the appointing authority's request. If it is not practical under the particular circumstances to provide the requested medical certification within fifteen (15) days despite the employee's diligent, good faith efforts, the employee shall provide the medical certification within a reasonable period of time involved, but no later than thirty (30) calendar days after the initial date the appointing authority requested such medical certification. (02/2017)

B. Failure to provide the medical certification shall result in denial of leave and possible corrective/disciplinary action. (7/1/13)

5-30. When incomplete medical certification is submitted, the employee shall be allowed seven (7) days to obtain complete information, absent reasonable extenuating circumstances. (7/1/13)

A. Following receipt of the information or the seven (7) days from which it was requested, the department's human resources director or FMLA coordinator may, with the employee's written permission, contact the health care provider for purposes only of clarification and authentication of the medical certification. (02/2017)

5-31. When medical certification is submitted to demonstrate that the leave is FML-qualifying, the department has the right to request a second opinion on the initial certification. If the first and second opinion conflict, the department may require a binding third opinion by a mutually agreed upon health care provider. Under both circumstances the cost is paid by the department. Second and third opinions are not permitted on additional certification for recertification purposes. (02/2017)

5-32. If an absence is more than thirty (30) days for the employee's own condition, the employee shall provide a fitness-to-return certificate. The fitness-to-return certificate may be required for absences of thirty (30) days or less based on the nature of the condition in relation to the employee's job. The department may also require a fitness-to-return certificate from employees taking intermittent FML every thirty (30) days if there are reasonable safety concerns regarding the employee's ability to perform his or her job duties. (02/2017)

A. When requested, employees shall present a completed fitness-to-return certificate before they will be allowed to return to work. Failure to provide a fitness-to-return certificate as instructed could result in delay of return, a requirement for new medical certification, or administrative discharge as defined in Rule 5-6. (7/1/13)

B. When an incomplete fitness-to-return certification is submitted, the employee shall be allowed seven (7) days to obtain complete information, absent reasonable extenuating circumstances. Following receipt of the information or the seven (7) days from which it was requested, the department's human resources director or FMLA coordinator may, with the employee's

written permission, contact the health care provider for purposes only of clarification and authentication of the fitness-to-return certification. (02/2017)

5-33. Benefits coverage continues during FML and state family medical leave. If the employee is on paid FML or state family medical leave, premiums will be paid through normal payroll deduction. If the FML or state family medical leave is unpaid, the employee shall pay the employee share of premiums as prescribed by benefits and payroll procedures. (11/1/2019)

5-34. Upon return to work, the employee is restored to the same, or an equivalent, position, including the same pay, benefits, location, work schedule, and other working conditions. If the employee is no longer qualified to perform the job (e.g., unable to renew an expired license), the employee shall be given an opportunity to fulfill the requirement. (11/1/2019)

A. If the employee is no longer able to perform the essential functions of the job due to a continuing or new serious health condition, the employee does not have restoration rights under FML or state family medical leave, and the appointing authority may separate the employee pursuant to Rule 5-6 subject to any applicable ADA provisions. (11/1/2019)

B. The employee does not have restoration rights if the employment would not have otherwise continued had the FML or state family medical leave not been taken, e.g., discharge due to performance, layoff, or the end of the appointment. (11/1/2019)

5-35. FML and state family medical leave do not prohibit adverse action that would have otherwise occurred had the leave not been taken. (11/1/2019)

5-36. The use of FML or state family medical leave cannot be considered in evaluating performance. If the performance plan includes an attendance factor, any time the employee was on FML or state family medical leave cannot be considered. (11/1/19)

5-37. Records. Federal law requires that specified records be kept for all employees taking FML. These records shall be kept for three (3) years. Any medical information shall be maintained in a separate confidential medical file in accordance with ADA requirements and Chapter 1, Organization, Responsibilities, Ethics, Payroll Deduction, and Definitions. (02/2017)

Injury Leave

5-38. Injury Leave. A permanent employee who suffers an injury or illness that is compensable under the Workers' Compensation Act shall be granted injury leave up to ninety (90) occurrences (whole day increments regardless of the actual hours absent during a day) with full pay if the temporary compensation is assigned or endorsed to the employing department. (5/1/10)

A. If after ninety (90) occurrences of injury leave an employee still is unable to work, the employee is placed on leave under the "make whole" policy. The employee will receive temporary disability benefits pursuant to the Colorado Workers' Compensation Act. The employing department will make up the difference between the temporary disability benefits and the employee's full pay using accrued sick leave first, then annual leave or compensatory time as available. Once all paid leave is exhausted, employees may be given unpaid leave. Workers' compensation payments after termination of injury leave shall be made to the employee as required by law. (02/2017)

B. The appointing authority may invoke Rule 5-6 if the employee is unable to return to work after exhausting all accrued paid leave and applicable job protection. Termination of service under that rule will not affect continuation of payments under the Workers' Compensation Act.

C. If the employee's temporary compensation payment is reduced because the injury or occupational disease was caused by willful misconduct or violation of rules or regulations, the employee shall not be entitled to or granted injury leave. Any absence shall be charged using sick leave first, then annual leave or compensatory time on a "make whole basis" or, at the appointing authority's discretion, unpaid leave may be granted and the temporary compensation payments shall be made to the employee. (02/2017)

D. The first three (3) regular working days missed as a result of a compensable work injury will be charged to the employee's sick leave, then annual leave or compensatory time, as available. Injury leave will only be granted once an eligible employee misses more than three (3) regular working days. Sick or annual leave for the first three (3) regular working days will be restored if the employee is off work for more than two (2) weeks. (02/2017)

E. If a holiday occurs while an employee is on injury leave, the employee receives the holiday and the day is not counted as an injury leave occurrence.

Disaster and Public Health Emergency

5--39. Public health emergency leave, as defined in the Healthy Families Workplaces Act, shall be granted to a temporary or permanent employee for the cause of a disaster or public emergency declared by the Governor or a federal, state, or local public health agency. (01/01/2021)

A. Employees are eligible for up to eighty (80) hours of paid leave (prorated for part-time) during the entirety of a public health emergency even if such public health emergency is amended, extended, restated, or prolonged. Public health emergency leave may be used for the following reasons:

1. Needing to self-isolate because the employee is diagnosed or experiencing symptoms of the communicable illness;

2. Seeking or obtaining medical diagnosis, care or treatment, preventative care, or care of such illness;

3. Being exposed to, or experiencing symptoms of, such illness;

4. Being unable to work due to a health condition that may increase susceptibility or risk of such illness;

5. Caring for a child or other family member for reasons 1, 2, or 3 above, or whose school, child care provider, or other care provider is either unavailable, closed, or providing remote instruction due to the public health emergency; or

6. Closure of the temporary employee's work location, and work cannot be performed remotely. (01/01/2021)

B. Permanent employees may receive administrative leave due to closure of work location caused by the disaster or public emergency of work location, and work cannot be performed remotely. (01/01/2021)

C. Public health emergency leave may be used up to four (4) weeks after the suspension of the public health emergency. (01/01/2021)

5-40. During the declaration of a state of emergency by the Governor, as defined in the Colorado Disaster Emergency Act, in the event that daycares, schools or other care services are closed, impacted employees shall first work with their supervisor to determine if working from home or a schedule adjustment will allow them to continue working. If these measures do not allow for the employee to continue to work, then employees may use any accrued leave to care for their family members, including but not limited to domestic partners, in-laws and step relatives. Special consideration will be given to any other person whose association with the employee is similar to that of a family member. (08/01/2020)

C
E s Office
Department of Personnel & Administration
1525 Sherman St. Denver, CO 80203

NOTICE OF HEARING

TO: Secretary of State; All State Government Departments, Agencies, Institutions and Other Interested Parties

FROM: Kara Veitch, State Personnel Director
Department of Personnel & Administration

DATE: December 23, 2020

SUBJECT: NOTICE OF PUBLIC HEARING

The State Personnel Director will hold an online public hearing:

When: Friday, February 5, 2021 at 01:00 PM Mountain Time (US and Canada)
Topic: Zoom Virtual Webinar Public Hearing - DHR Rulemaking – Chapter 5 – Paid Family Medical Leave

Register in advance for this webinar:
https://zoom.us/webinar/register/WN_PeQNztmmSVycyprmG7RRgw

After registering, you will receive a confirmation email containing information about joining the webinar to consider modification of certain administrative procedures rules regarding employee leave related to Paid Family Medical Leave, and to make permanent emergency rules regarding Paid Family Medical Leave.

Due to the State's COVID-19 response this hearing will only be conducted in a virtual setting. All interested persons are urged to attend this public hearing using the instructions above, and to submit written comments in advance if possible for consideration concerning the proposed promulgation of these rules.

The Hearing Officer will take comments as follows:

In order to facilitate review of comments by the Hearing Officer, all interested parties are strongly encouraged to submit their written comments prior to the hearing. Written comments submitted prior to the hearing must be submitted to Doug Platt via email at doug.platt@state.co.us on before 5:00 p.m. on January 29, 2021.

All written comments submitted on or before 5:00 p.m. on January 29, 2021 will be posted on the DPA website on or before 5:00 p.m. on February 1, 2021.

Any comments not received by January 29, 2021 may be submitted via testimony or in writing at the hearing on February 5, 2021.

Oral comment may be provided at the hearing as follows:

- Each speaker who requests an opportunity to, will be allowed to testify;

- All persons wishing to provide oral testimony must identify themselves at the start of their testimony, noting whom they represent and/or if they are ceding any portion of their time to another speaker;

- Any person wishing to provide oral testimony may cede any portion or all of their time to another speaker, however, no speaker may be ceded the time of more than two other speakers; and

- At her discretion, the Hearing Officer may limit or extend the time of any speaker.

After taking public comment the Hearing Officer will commence deliberations regarding these administrative rules.

Reasonable accommodation will be provided upon request for persons with disabilities. If you are a person with a disability who requires an accommodation to participate in this public hearing, please notify Doug Platt at 303-503-9939 by no later than Friday, January 29, 2021.

The proposed rules, notice of hearing and the proposed statement of basis, specific statutory authority and purpose will be available for review by interested persons on or before close of business January 4, 2021, at the State Personnel Director's website (Department of Personnel & Administration) and the Division of Human Resources website, "What's New," at https://dpa.colorado.gov or https://dhr.colorado.gov . The specific authority of the Executive Director of the Department of Personnel & Administration to promulgate these particular rules is found at Colorado Constitution, Article XII, and/or 24-33.5-701 et seq, C.R.S.

Kara Veitch
State Personnel Director
Department of Personnel & Administration

Notice of Proposed Rulemaking

Tracking number

2020-00958

Department

1000 - Department of Public Health and Environment

Agency

1001 - Air Quality Control Commission

CCR number

5 CCR 1001-9

Rule title

REGULATION NUMBER 7 CONTROL OF OZONE VIA OZONE PRECURSORS AND CONTROL OF HYDROCARBONS VIA OIL AND GAS EMISSIONS

Rulemaking Hearing

Date

02/18/2021

Time

09:00 AM

Location

This hearing will be held online only via the Zoom platform; there will be no in-person participation. See Notice for details.

Subjects and issues involved

To consider revisions to Regulation No. 7, Part D, Section III. This hearing is intended to address the issues which were bifurcated from the December 2020 rulemaking hearing. Alternative proposals to extend requirements for non-emitting controllers to existing facilities are within the scope of notice for this hearing. Revisions unrelated to pneumatic controller requirements will not be considered during this hearing.

Statutory authority

Sections 25-7-105(1); 25-7-102; 25-7-106; 25-7-106(6); 25-7-109(1)(a), (2), and (3); 25-7-109(2)(c); 25-7-109(10). Sections 24-4-103 and 25-7-110, 25-7-110.5 and 25-7-110.8 C.R.S., as applicable and amended.

Contact information

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Air Quality Control Commission

REGULATION NUMBER 7

Control of Ozone via Ozone Precursors and Control of Hydrocarbons via Oil and Gas Emissions

(Emissions of Volatile Organic Compounds and Nitrogen Oxides)

5 CCR 1001-9

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

Outline of Regulation

III. Use of Cutback Asphalt

IV. Graphic Arts and Printing

V. Pharmaceutical Synthesis

Appendix D Minimum Cooling Capacities for Refrigerated Freeboard Chillers on Vapor Degreasers

Appendix E Emission Limit Conversion Procedure

Part D Oil and Natural Gas Operations

I. Volatile Organic Compound Emissions from Oil and Gas Operations

II. (State Only) Statewide Controls for Oil and Gas Operations

III. (State Only) Natural Gas-Actuated Pneumatic Controllers Associated with Oil and Gas Operations

IV. (State Only) Control of Emissions from the Natural Gas Transmission and Storage Segment

V. (State Only) Oil and Natural Gas Operations Emissions Inventory

Part E Combustion Equipment and Major Source RACT

I. Control of Emissions from Engines

II. Control of Emissions from Stationary and Portable Combustion Equipment in the 8-Hour Ozone Control Area

III. Control of Emissions from Specific Major Sources of VOC and/or NOx in the 8-Hour Ozone Control Area

IV. Control of Emissions from Breweries in the 8-hour Ozone Control Area

Part F Statements of Basis, Specific Statutory Authority and Purpose

Pursuant to Colorado Revised Statutes Section 24-4-103 (12.5), materials incorporated by reference are available for public inspection during normal business hours, or copies may be obtained at a reasonable cost from the Air Quality Control Commission (the Commission), 4300 Cherry Creek Drive South, Denver, Colorado 80246-1530. The material incorporated by reference is also available through the United States Government Printing Office, online at www.govinfo.gov. Materials incorporated by reference are those editions in existence as of the date indicated and do not include any later amendments.

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PART D Oil and Natural Gas Operations

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III. Natural Gas-Actuated Pneumatic Controllers Associated with Oil and Gas Operations

III.A. Applicability

This section applies to pneumatic controllers that are actuated by natural gas, and located at, or upstream of natural gas processing plants (upstream activities include: oil and gas exploration and production operations and natural gas compressor stations).

III.B. Definitions

III.B.1. “Affected Operations” means pneumatic controllers that are actuated by natural gas, and located at, or upstream of natural gas processing plants (upstream activities include: oil and gas exploration and production operations and natural gas compressor stations).

III.B.2. “Continuous Bleed” means an intentional continuous bleed rate of natural gas from a pneumatic controller.

III.B.3. “Custody Transfer” means the transfer of crude oil or natural gas after processing and/or treatment in the producing operations or from storage vessels or automatic transfer facilities or other such equipment, including product loading racks, to pipelines or any other forms of transportation.

III.B.4. “Enhanced Response” means to return equipment to proper operation and includes but is not limited to, cleaning, tuning, and repairing leaking gaskets, tubing fittings, and seals; tuning to operate over a broader range of proportional band; and eliminating unnecessary valve positioners.

III.B.5. “High-Bleed Pneumatic Controller” means a pneumatic controller that is designed to have a continuous bleed rate that emits in excess of 6 standard cubic feet per hour (scfh) of natural gas to the atmosphere.

III.B.6. (State Only) “Intermittent pneumatic controller” means a pneumatic controller that vents non-continuously.

III.B.7. “Low-Bleed Pneumatic controller” means a pneumatic controller that is designed to have a continuous bleed rate that emits less than or equal to 6 scfh of natural gas to the atmosphere.

III.B.8. “Natural Gas Processing Plant” means any processing site engaged in the extraction of natural gas liquids from field gas, fractionation of mixed natural gas liquids to natural gas products, or both. A Joule-Thompson valve, a dew point depression valve, or an isolated or standalone Joule-Thompson skid is not a natural gas processing plant.

III.B.9. “No-Bleed Pneumatic Controller” means any pneumatic controller that is not using hydrocarbon gas as the valve’s actuating gas.

III.B.10. “Pneumatic Controller” means an instrument that is actuated using pressurized gas and used to control or monitor process parameters such as liquid level, gas level, pressure, valve position, liquid flow, gas flow and temperature.

III.B.11. “Self-contained Pneumatic Controller” means a pneumatic controller that releases gas to a process or sales line instead of to the atmosphere.

III.C. Emission Reduction Requirements

Owners and operators of affected operations shall reduce emissions of volatile organic compounds from pneumatic controllers associated with affected operations as follows:

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III.C.3. (State Only) Statewide:

III.C.3.a. Owners or operators of all pneumatic controllers placed in service on or after May 1, 2014, must:

III.C.3.a.(i) Utilize no-bleed pneumatic controllers where on-site electrical grid power is being used and use of a no-bleed pneumatic controller is technically and economically feasible.

III.C.3.a.(ii) If on-site electrical grid power is not being used or a no-bleed pneumatic controller is not technically and economically feasible, utilize pneumatic controllers that emit natural gas emissions in an amount equal to or less than a low-bleed pneumatic controller, unless allowed pursuant to Section III.C.3.c.

III.C.3.a.(iii) For purposes of Section III.C.3.a.(ii), instead of a low-bleed pneumatic controller, owners or operators may utilize a natural gas-driven intermittent pneumatic controller.

III.C.3.a.(iv) Utilizing self-contained pneumatic controllers satisfies Section III.C.3.a.(i).

III.C.3.b. All high-bleed pneumatic controllers in service prior to May 1, 2014, must be replaced or retrofitted by May 1, 2015, such that natural gas emissions are reduced to an amount equal to or less than a low-bleed pneumatic controller, unless allowed pursuant to Section III.C.3.c.

III.C.3.c. All high-bleed pneumatic controllers that must remain in service due to safety and/or process purposes must comply with Sections III.D. and III.E.

III.C.3.c.(i) For high-bleed pneumatic controllers in service prior to May 1, 2014, the owner/operator must submit justification for high-bleed pneumatic controllers to remain in service due to safety and/or process purposes by March 1, 2015.

III.C.3.c.(ii) For high-bleed pneumatic controllers placed in service on or after May 1, 2014, the owner/operator must submit justification for high-bleed pneumatic controllers to be installed due to safety and/or process purposes thirty (30) days prior to installation.

III.C.3.d. Pneumatic controllers placed in service at a facility with a commencement of operation or modification date on or after May 1, 2021, must not emit natural gas emissions to the atmosphere unless necessary for a safety or process purpose that cannot otherwise be met without emitting natural gas.

III.C.3.d.(i) If the owner or operator requires an emitting pneumatic controller for a safety or process purpose, the owner or operator must submit a justification for the safety or process purposes to the Division for approval forty-five (45) days prior to installation.

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III.F. (State Only) Pneumatic Controller Inspection and Enhanced Response

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III.F.2. Pneumatic controller inspection

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III.F.2.a.(iii) Quarterly at well production facilities with uncontrolled actual volatile organic compound emissions greater than twelve (12) tons per year and less than or equal to ~~twenty (2~~fifty (50) tons per year, based on a rolling twelve-month total, or ~~fifty (5~~twenty (20) tons per year if no storage tanks storing oil or condensate are located at the well production facility, based on a rolling twelve-month total.

III.F.2.a.(iv) Monthly at well production facilities with uncontrolled actual volatile organic compound emissions greater than ~~twenty (2~~fifty (50) tons per year, based on a rolling twelve-month total, or ~~fifty (5~~twenty (20) tons per year if no storage tanks storing oil or condensate are located at the well production facility, based on a rolling twelve-month total.

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III.F.2.b.(iii) Quarterly at well production facilities statewide with uncontrolled actual volatile organic compound emissions greater than twelve (12) tons per year and less than or equal to ~~twenty (2~~fifty (50) tons per year, based on a rolling twelve-month total, or ~~fifty (5~~twenty (20) tons per year if no storage tanks storing oil or condensate are located at the well production facility, based on a rolling twelve-month total.

III.F.2.b.(iv) Monthly at well production facilities statewide with uncontrolled actual volatile organic compound emissions greater than ~~twenty (2~~fifty (50) tons per year, based on a rolling twelve-month total, or ~~fifty (5~~twenty (20) tons per year if no storage tanks storing oil or condensate are located at the well production facility, based on a rolling twelve-month total.

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PART F. Statements of Basis, Specific Statutory Authority and Purpose

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V. February 18, 2021 (Part D, Section III.)

This Statement of Basis, Specific Statutory Authority, and Purpose complies with the requirements of the State Administrative Procedure Act, § 24-4-103(4), C.R.S., the Colorado Air Pollution Prevention and Control Act, §§ 25-7-101, C.R.S., et. seq., and the Air Quality Control Commission's (Commission) Procedural Rules, 5 Code Colo. Reg. §1001-1.

Basis

During the 2019 legislative session, Colorado's General Assembly adopted revisions to several Colorado Revised Statutes in Senate Bill 19-181 (SB 19-181) (Concerning additional public welfare protections regarding the conduct of oil and gas operations) that include directives for both the Oil and Gas Conservation Commission. SB 19-1818 revised the Air Quality Control Commission's directives in § 25-7-109, CRS, to consider pneumatic device requirements.

Further, on December 26, 2019, the Environmental Protection Agency (EPA) reclassified the Denver Metro North Front Range (DMNFR) to Serious, after 2015-2017 ozone data failed to show attainment of the 2008 8-hour Ozone National Ambient Air Quality Standard (NAAQS). See 84 Fed. Reg. 247 (December 26, 2019). As a Serious area, the major source threshold lowers from 100 tons per year (tpy) of VOC or NOx to 50 tpy. EPA has also designated the DMNFR as Marginal nonattainment for the 2015 ozone NAAQS of 70 ppb.

Therefore, to minimize emissions from the oil and gas sector and ensure progress towards attainment of the 2008 and 2015 ozone NAAQS and, the Commission is adopting revisions to Regulation Number 7 to require non-emitting pneumatic controllers.

Statutory Authority

The State Air Act, specifically § 25-7-105(1), directs the Commission to promulgate such rules and regulations as are consistent with the legislative declaration set forth in § 25-7-102 and that are necessary for the proper implementation and administration of Article 7. The Act broadly defines air pollutant to include essentially any gas emitted into the atmosphere (and, as such, includes VOC, NOx, methane and other hydrocarbons) and provides the Commission broad authority to regulate air pollutants.

Section 25-7-106 provides the Commission maximum flexibility in developing an effective air quality program and promulgating such combination of regulations as may be necessary or desirable to carry out that program. Section 25-7-106 also authorizes the Commission to promulgate emission control regulations applicable to the entire state, specified areas or zones, or a specified class of pollution. Section 25-7-106(6) further authorizes the Commission to require owners and operators of any air pollution source to monitor, record, and report information. Sections 25-7-109(1)(a), (2), and (3) of the Act authorize the Commission to promulgate regulations requiring effective and practical air pollution controls for significant sources and categories of sources, emission control regulations pertaining to nitrogen oxides and hydrocarbons, and emissions control regulations pertaining to the storage and transfer of petroleum products and other VOCs. Section 25-7-109(2)(c), in particular, provides broad authority to regulate hydrocarbons. Section 25-7-109(10) directs the Commission to adopt emission control regulations to minimize emissions of methane, other hydrocarbons, VOC, and NOx from oil and gas operations.

Purpose

The following section sets forth the Commission's purpose in adopting the revisions to Regulation Number 7, and includes the technological and scientific rational for the adoption of the revisions.

The revisions also correct typographical, grammatical, and formatting errors found through the regulation.

As discussed above, SB 19-181 identifies specific provisions the Air Quality Control Commission should consider including pneumatic device requirements.

In December 2019, the Commission expanded the pneumatic controller inspection and maintenance requirements, adopted in 2017, from nonattainment area applicability to statewide applicability. As part of that rulemaking, the Commission directed the Statewide Hydrocarbon Emission Reduction (SHER) team and Pneumatic Controller Task Force (PCTF), stakeholder processes directed by the Commission in 2017, to continue their stakeholder processes and bring to the Commission in 2020 their recommendations on the use of zero-bleed pneumatic devices. Both the SHER team and PCTF continued to meet through the spring of 2020. The stakeholder discussions from 2017-2020 informed the Commission's adopted provisions require non-emitting pneumatic controllers at oil and gas facilities constructed or modified on or after May 1, 2020. Non-emitting pneumatic controllers are a broader category of no-bleed pneumatic controllers and can include, but are not limited to, air-driven controllers, mechanical controllers, electric controllers, and self-contained controllers. In applying this requirement to new and modified facilities, the Commission recognizes that additional work needs to be done to determine where and when requiring retrofits of natural-gas driven pneumatic controllers is feasible and appropriate.

In accordance with §§ 25-7-105.1 and 25-7-133(3), CRS, the Commission states the rules in Part D, Section II. of Regulation Number 7 adopted in this rulemaking are state-only requirements and are not intended as additions or revisions to Colorado's SIP at this time.

These revisions do not exceed or differ from the federal act due to state flexibility in determining what control strategies to implement to reduce emissions. However, where the proposal may differ from federal rules under the federal act, in accordance with § 25-7-110.5(5)(b), CRS, the Commission determines:

(I) The revisions to Regulation Number 7 address equipment and operations in the oil and gas sector including pneumatic controllers. NSPS OOOO and NSPS OOOOa may also apply to such oil and gas facilities and operations. The revisions to Regulation Number 7 apply on a broader basis to more pneumatic controllers then the NSPS.

(II) The federal rules discussed in (I) are primarily technology-based in that they largely prescribe the use of specific technologies or work practices to comply. EPA has provided some flexibility in NSPS OOOOa by allowing a company to apply to EPA for an alternative means of emission limitations.

(III) The revisions to Regulation Number 7 strengthen Colorado's state-only provisions. These sections currently address emissions from the oil and gas sector in a cost-effective manner, allowing for continued growth of Colorado's oil and gas industry.

(IV) The revisions to Regulation Number 7 Part D establish reasonable equity for oil and gas owners and operators subject to these rules by providing the same standards for similarly situated and sized sources.

(V) Where necessary, the revisions to Regulation Number 7 include minimal monitoring, recordkeeping, and reporting requirements that correlate, where possible, to similar federal or state requirements.

(VI) Demonstrated technology is available to comply with the revisions to Regulation Number 7. Some of the revisions expand upon requirements already applicable, such as the requirements for pneumatic controllers.

(VII) As set forth in the Economic Impact Analysis, the revisions to Regulation Number 7 will reduce emissions in a cost-effective manner.

(VIII) Alternative rules could also provide reductions in ozone, VOC, methane, and other hydrocarbons to address SB 19-181 and help to attain the NAAQS. SB 19-181 specifically directs the Commission to "consider" revising its rules to adopt more stringent requirements related to pneumatic devices. The Commission determined that the Division's proposal was reasonable and cost-effective.

As part of adopting the revisions to Regulation Number 7, the Commission has taken into consideration each of the factors set forth in CRS § 25-7-109(1)(b).

To the extent that CRS § 25-7-110.8 requirements apply to this rulemaking, and after considering all the information in the record, the Commission hereby makes the determination that:

(I) These rules are based upon reasonably available, validated, reviewed, and sound scientific methodologies, and the Commission has considered all information submitted by interested parties.

(II) Evidence in the record supports the finding that the rules shall result in a demonstrable reduction of methane, VOCs, and other hydrocarbons.

(III) Evidence in the record supports the finding that the rules shall bring about reductions in risks to human health and the environment that justify the costs to implement and comply with the rules.

(IV) The rules are the most cost-effective to achieve the necessary and desired results, provide the regulated community flexibility, and achieve the necessary reduction in air pollution.

(V) The rule will maximize the air quality benefits of regulation in the most cost-effective manner.

COLORADO
Air Quality Control Commission
Department of Public Health & Environment

NOTICE OF RULEMAKING HEARING

Regarding proposed revisions to:

Regulation Number 7
5 CCR 1001-9

SUBJECT:
The Air Quality Control Commission will hold a rulemaking hearing to consider revisions to Regulation No. 7, Part D, Section III. This hearing is intended to address the issues which were bifurcated from the December 2020 rulemaking hearing. Alternative proposals to extend requirements for non-emitting controllers to existing facilities are within the scope of notice for this hearing. Revisions unrelated to pneumatic controller requirements will not be considered during this hearing.

All required documents for this rulemaking can be found on the Commission website at: https://cdphe.colorado.gov/aqcc

PARTY TESTIMONY & DELIBERATIONS
DATE: February 18 (& 19 if necessary), 2021
TIME: To begin at or after 9:00 a.m. on February 18, 2021
PLACE: This part of the hearing will be held online only; there will be no in-person participation. Details related to participation and registration can be found at: https://cdphe.colorado.gov/aqcc

The hearing may be continued at such places and time as the Commission may announce. Any such changes will be noticed on the Commission's website. Interested parties may contact the Commission Office at cdphe.aqcc-comments@state.co.us to confirm meeting details.

PUBLIC COMMENT:
The Commission encourages input from the public, either orally during the public comment session or in writing prior to the hearing. Instructions for registering for the oral public comment session will be posted in the agenda on the Commission's website at https://cdphe.colorado.gov/aqcc on February 5, 2021.

Written comments should be submitted no later than **February 2, 2021** by emailing cdphe.aqcc-comments@state.co.us or mailing to:

Colorado Air Quality Control Commission
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South, EDO-AQCC-A5
Denver, Colorado 80246

IMPORTANT DATES AND DEADLINES:

PROCESS DESCRIPTION	DUE DATE & TIME	NOTES
Request for Party Status	January 13, 2021 by 5:00 p.m.	Additional information below
Status Conference	January 15, 2021 at 9:00 a.m.	Virtual Meeting
Alternate Proposal	January 20, 2021 by 11:59 p.m.	Additional information below
Prehearing Statement	January 20, 2021 by 11:59 p.m.	Additional information below
Prehearing Conference	January 27, 2021 at 2:00 p.m.	Virtual Meeting
Rebuttal Statement	February 2, 2021 by 5:00 p.m.	Additional information below
Written Public Comments	February 2, 2021 by 11:59 p.m.	Additional information above

Submittals for this hearing should be emailed to cdphe.aqcc-comments@state.co.us unless an exception is granted pursuant to Subsection III.I.3. of the Commissions Procedural Rules.

REQUEST FOR PARTY STATUS:
A request for party status must:

1) identify the applicant (this could be a company and/or contact name);
2) provide the name, address, telephone and email address of the applicant's representative or counsel; and
3) briefly summarize what, if any, policy, factual, and legal issues the applicant has with the proposal(s) as of the time of filing the application.

In addition, requests for party status should indicate whether the applicant intends to file an alternate proposal and, if so, briefly describe the scope and nature of the alternate proposal.

The request for party status must be electronically mailed to:

- Air Quality Control Commission staff: theresa.martin@state.co.us
- Air Quality Control Commission attorney: tom.roan@coag.gov
- Air Pollution Control Division staff: jeramy.murray@state.co.us
- Air Pollution Control Division attorney: laura.mehew@coag.gov

Requests received beyond the stated deadline shall only be considered upon a written motion for good cause shown. The Commission reserves the right to deny party status to anyone that does not comply with the Commission's Procedural Rules.

STATUS CONFERENCE:
Attendance at the status conference is mandatory for anyone who has requested party status, though each party need only have one representative present. The status conference is intended to ascertain and discuss the issues involved, and to ensure that parties are making all necessary efforts to discuss and resolve such issues prior to the submission of prehearing statements. Parties will be confirmed and a party list will be generated and distributed. The status conference will be held virtually via video conference. A registration link will be provided by the Commission's office prior to the status conference. Note that if the Hearing Officer deems the status conference unnecessary, the status conference may be cancelled.

ALTERNATE PROPOSAL:
Alternate proposals will be considered by the Commission "only if the subject matter of the alternative proposal is consistent with and fits within the scope of the notice." 5 CCR 1001-1, Section (V)(E)(4)(b). The submittal of an alternate proposal must be accompanied by a separate electronic copy of the alternate proposed rule and statement of basis and purpose language and all other associated documents as required by the Commission's Procedural Rules, including an economic impact analysis. Alternate proposals and associated exhibits must be emailed to all persons listed on the party status list or otherwise provided through an approved method of electronic transmission.

PREHEARING STATEMENTS:
Each party must submit a prehearing statement. Exhibits to a prehearing statement must be submitted in a separate electronic transmission. Prehearing statements and associated exhibits must be emailed to all persons listed on the party status list or otherwise provided through an approved method of electronic transmission. Prehearing statements must contain all the necessary elements described in subsection V.E.6.c of the Commission's Procedural Rules (5 CCR 1001-1).

PREHEARING CONFERENCE:
Attendance at the prehearing conference is mandatory for all parties to this hearing, though each party need only have one representative present. The prehearing conference will be held virtually, and registration information will be provided by the Commission's office prior to the prehearing conference.

REBUTTAL STATEMENTS:
Rebuttal statements may be submitted by the Division and any party to the hearing to respond to issues and arguments identified in prehearing statements. Rebuttal statements may not raise any issues, or be accompanied by alternate propsoals, that could have been raised in the party's prehearing statement. Rebuttal statements and associated exhibits must be emailed to all persons listed on the party status list or otherwise provided through an approved method of electronic transmission. The filing of rebuttal statements is optional.

DELIBERATION AND FINAL ACTION:

The Commission intends to deliberate and take final action on the proposed changes to these Regulations at the conclusion of the testimony.

STATUTORY AUTHORITY FOR THE COMMISSION'S ACTIONS:

The State Air Act, specifically § 25-7-105(1), directs the Commission to promulgate such rules and regulations as are consistent with the legislative declaration set forth in § 25-7-102 and that are necessary for the proper implementation and administration of Article 7. The Act broadly defines air pollutant to include essentially any gas emitted into the atmosphere (and, as such, includes VOC, NOx, methane and other hydrocarbons) and provides the Commission broad authority to regulate air pollutants.

Section 25-7-106 provides the Commission maximum flexibility in developing an effective air quality program and promulgating such combination of regulations as may be necessary or desirable to carry out that program. Section 25-7-106 also authorizes the Commission to promulgate emission control regulations applicable to the entire state, specified areas or zones, or a specified class of pollution. Section 25-7-106(6) further authorizes the Commission to require owners and operators of any air pollution source to monitor, record, and report information. Sections 25-7-109(1)(a), (2), and (3) of the Act authorize the Commission to promulgate regulations requiring effective and practical air pollution controls for significant sources and categories of sources, emission control regulations pertaining to nitrogen oxides and hydrocarbons, and emissions control regulations pertaining to the storage and transfer of petroleum products and other VOCs. Section 25-7-109(2)(c), in particular, provides broad authority to regulate hydrocarbons. Section 25-7-109(10) directs the Commission to adopt emission control regulations to minimize emissions of methane, other hydrocarbons, VOC, and NOx from oil and gas operations.

The rulemaking hearing will be conducted in accordance with Sections 24-4-103 and 25-7-110, 25-7-110.5 and 25-7-110.8 C.R.S., as applicable and amended, the Commission's Procedural Rules, all other applicable rules and regulations, and as otherwise stated in this notice. This list of statutory authority is not intended as an exhaustive list of the Commission's statutory authority to act in this matter.

Dated this 17th day of December 2020 at Denver, Colorado

Colorado Air Quality Control Commission

Trisha Oeth, Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00960

Department

1000 - Department of Public Health and Environment

Agency

1005 - Laboratory Services Division

CCR number

5 CCR 1005-5

Rule title

Hemp Testing Laboratory Certification

Rulemaking Hearing

Date

02/17/2021

Time

10:00 AM

Location

Via Zoom: https://us02web.zoom.us/meeting/register/tZAqd-uqpjwvG9d-KHCYl4VIAXCFrhAfhFI3

Subjects and issues involved

The proposed new rule will establish rules for hemp testing laboratory certification. Laboratory certification will promote accuracy and reproducibility of test results. Accurate testing of hemp and hemp-derived products will allow for the identification of non-compliant hemp, aid in the consistency of products available to consumers, help ensure label claims are accurate, and protect public health and safety by ensuring products are free of contaminants.

Statutory authority

Sections 35-61-105.5(2)(d) and 25-1.5-101(1)(f), C.R.S.

Contact information

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Heather Krug, State Cannabis Sciences Program Manager, Colorado State Public Health Laboratory

Through: Scott Bookman, Interim Director, Division of Disease Control and Public Health Response (DCPHR) ***SB***
Emily Travanty, PhD, Interim Director, Colorado State Public Health Laboratory ***ET***

Date: December 16, 2020

Subject: Request for Rulemaking Hearing concerning New rule 5 CCR 1005-5, *Hemp Testing Laboratory Certification*.

Please find copies of the following documents: Statement of Basis and Purpose and Specific Statutory Authority, Regulatory Analysis, Stakeholder Engagement, and Proposed New Rule, 5 CCR 1005-5, Hemp Testing Laboratory Certification.

The Department is requesting a rulemaking hearing to establish new rules for certification of hemp testing laboratories. The need for these rules is described below.

The Colorado Department of Agriculture (CDA) regulates the cultivation of industrial hemp as authorized through Title 35, Article 61 C.R.S. Hemp cultivators are subject to sampling by the CDA to test for Tetrahydrocannabinol (THC) content before harvest, as established by Rules Pertaining To The Administration And Enforcement Of The Industrial Hemp Regulatory Program Act (8 CCR 1203-23). Industrial hemp with a THC level exceeding 0.3% is not legally considered hemp and is instead considered marijuana, a controlled substance. To date, this testing has been performed exclusively by the CDA laboratory, with the CDA capable of testing approximately 30% of all registered hemp producing areas in Colorado annually.

On October 31, 2019 the United States Department of Agriculture (USDA) released interim final rules on industrial hemp production. A key element of the interim final rule is the requirement to test 100% of registered hemp producers in the state. Thus, with the CDA laboratory limited in the amount of industrial hemp they can test, cultivators will look to private laboratories to complete this testing. Furthermore, Colorado Senate Bill 20-197 requires that hemp samples be submitted to a state certified industrial hemp testing laboratory.

The Department is well positioned to be the agency that certifies laboratories to perform hemp testing because it already has expertise in lab inspection, as it currently inspects and recommends marijuana testing labs for certification and certifies clinical, environmental, and forensic laboratories. The Department also houses the state's cannabis reference lab. As such, the Department possesses unique expertise of both lab certification and the technical aspects of cannabis testing.

In addition to the testing of hemp biomass for THC content, the Department regulates hemp-derived products under the provisions of section 25-5-426, C.R.S. and has a need for testing of these cannabidiol (CBD) oils and foods for THC content and other contaminants of concern in food products, such as

pathogenic bacteria and toxins. Hemp-derived products include foods, tinctures, and oils in various forms such as capsules made by extracting CBD and other components from hemp biomass.

While all hemp and hemp-derived product testing can be performed by state certified marijuana testing facilities, there is a need to establish state-certified hemp testing laboratories that can operate outside of the close-looped marijuana seed-to-sale system. Marijuana testing facilities must track all samples they receive through this system as part of the diversion prevention measures applicable to legal marijuana products in Colorado. While hemp companies can elect to use this system and submit samples to marijuana testing facilities, doing so increases the cost of testing for these companies. Many also want to remain separate from any association with the marijuana industry.

Finally, the Colorado Hemp Advancement and Management Plan (CHAMP) stakeholders have recommended the development of a Hemp Testing Laboratory Certification Program to comply with state and USDA rules to guarantee THC testing of all hemp lots grown in Colorado, and to protect public safety by ensuring human-consumable products meet standards for safety and purity. Further, it is important to establish a state-level testing framework in the absence of federal guidelines from the Food and Drug Administration.

Testing information from certified labs is crucial for:

- Maintaining compliance with the USDA;
- Implementing an important part of the hemp electronic traceability system;
- Assuring potency and purity to consumers and businesses purchasing hemp products; and
- Protecting businesses and the public against inaccurate or misleading product claims and against product impurities and food-borne illnesses.

The Department has contacted a wide variety of stakeholders to solicit input on these proposed amendments. A summary of the feedback received and, if the Department incorporated this feedback, is detailed in the Stakeholder Engagement section.

Thus, in response to the regulatory need and stakeholder recommendations, the Department is requesting a rulemaking hearing to establish rules for hemp testing laboratory certification. In total, laboratory certification will promote accuracy and reproducibility of test results. Accurate testing of hemp and hemp-derived products will allow for the identification of non-compliant hemp, aid in the consistency of products available to consumers, help ensure label claims are accurate, and protect public health and safety by ensuring products are free of contaminants.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for New rule
5 CCR 1005-5, *Hemp Testing Laboratory Certification*

Basis and Purpose.

Colorado became a national leader in industrial hemp cultivation and production when it launched one of the first successful pilot hemp programs in the United States in 2015. The recent passage of the 2018 Agricultural Improvement Act, commonly called the Farm Bill, requires each state department of agriculture to submit a state management plan to the United States Department of Agriculture (USDA), outlining how various aspects of hemp cultivation and processing will be managed within their jurisdiction.

Hemp is an emerging specialty crop that has received considerable attention from agricultural producers, consumers, manufacturing businesses, and policymakers both internationally and in the State of Colorado. Hemp cultivation may provide an alternative enterprise to improve grower profitability and a potential engine of economic development and business creation, while also contributing to the sustainability of Colorado's natural resources as a substitute crop. Hemp can be manufactured and processed into numerous industrial and commercial goods for which there is a national and international demand. On the industrial front, applications range from building materials and textiles to food ingredients and wellness products. As the supply chain grows and matures, Colorado is poised to benefit. For this growth in demand to occur, however, the industry must be proactive about early-stage issues like standardization, unproven use cases and efficacy, and the accuracy of dosing for consumable products.

Colorado citizens voted to pass Amendment 64 to the Colorado Constitution in 2012, which, in part, directed the General Assembly to enact legislation governing the cultivation, processing, and sale of industrial hemp.[1] The legislation enacted in 2013 delegated responsibility for most hemp-related registration and inspection oversight to the Colorado Department of Agriculture (CDA). Statutory authority for Colorado's Industrial Hemp Program appears in Title 35 Article 61 of the Colorado Revised Statutes. In the following years, CDA promulgated a comprehensive set of rules to administer and enforce the Colorado Industrial Hemp Regulatory Program Act ("hemp program"), which is enabled by regulations set forth at 8 CCR 1203-23. Under the Colorado hemp program, CDA regulates the cultivation of industrial hemp. In order to grow industrial hemp in Colorado, cultivators must register annually with the CDA. Colorado has the largest industrial hemp registered land area in the nation with 88,743 acres. Notably, the CDA does not have jurisdiction over the processing, sale, or distribution of industrial hemp products. Any amount of hemp being grown requires a registration with CDA. Even though the 2018 Farm Bill removed hemp from the Controlled Substance Act, it did not de-regulate it. Prior to the 2018 Farm Bill, there was a grey area of hemp being legal at the State level under the 2014 Farm Bill Pilot Program, but yet still considered a "Controlled Substance" and illegal according to Federal laws. The 2018 Farm Bill eliminates the grey area, but still mandates States to maintain information on any land (regardless of size) where hemp is grown (regardless of quantity). The CDA's authority is limited to cultivation; the oversight for processing, sales and distribution is provided by CDPHE, pursuant to section 35-61-108, C.R.S. Hemp product manufacturers must register with the CDPHE to process hemp and produce hemp-derived products.

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[1]. As defined in the Colorado Revised Statutes, and in the 2018 Farm Bill, the term "industrial hemp" means the plant species *Cannabis sativa L.* and any part of that plant, including the seeds thereof and all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers, whether growing or not, with a Δ-9 tetrahydrocannabinol concentration of not more than 0.3 percent on a dry weight basis.

The 2018 Farm Bill changed hemp production in several ways, by 1) clarifying that both hemp and hemp products are legal in the U.S., 2) amending the Controlled Substances Act to remove hemp from the definition of marijuana, and 3) revising language in the 2014 Farm Bill Pilot Program to expressly include products derived from hemp in the legal definition of industrial hemp. Finally, the 2018 Farm Bill also allowed commercial cultivation and manufacturing of hemp outside of the 2014 Farm Bill pilot projects. Under the 2018 Farm Bill, each state must submit a management plan to the USDA for approval that includes a framework outlining how the state will regulate and monitor the various aspects of hemp production. The 2018 Farm Bill also instructs the USDA to promulgate federal rules for commercial hemp production. Importantly, the 2018 Farm Bill does not address regulations for processing and manufacturing of hemp products into food, drugs, and cosmetics, such regulations are still forthcoming from the FDA.

The USDA issued its first set of hemp regulations in October 2019, the Interim Final Rule (IFR), which formally addressed hemp cultivation, harvest, and testing. The IFR established a regulatory framework for USDA oversight of domestic hemp production under the 2018 Farm Bill. The IFR established requirements for approval of state or tribal plans regulating the production of hemp in their territories. Rules addressed the production, sampling, testing, and disposal of hemp plants, and set thresholds for acceptable amounts of Tetrahydrocannabinol (THC).

To respond to the needs and emerging issues of the hemp industry, the state organized a collaborative initiative with a broad group of stakeholders and state agencies known as the Colorado Hemp Advancement and Management Plan (CHAMP) in 2019. The CHAMP initiative represented a broad stakeholder effort that included representatives from:

- CDA
- Governor's Office
- Colorado Department of Public Health and Environment (CDPHE)
- Department of Revenue (DOR)
- Department of Regulatory Agencies (DORA)
- Office of Economic Development and International Trade (OEDIT)
- Department of Public Safety (DPS)
- Department of Education (CDE)
- Ute Mountain Ute Tribe
- Southern Ute Indian Tribe
- Local governments
- State institutions of higher learning
- Industry experts

Through the CHAMP process, stakeholders crafted economic advancement principles for the entire hemp supply chain, including research and development, seed, cultivation, testing, transportation, processing, manufacturing, marketing, and finance and insurance. The CHAMP initiative ensured that a wide range of stakeholders, including members of the public, had the opportunity to comment on and participate in shaping a variety of hemp-related policies the State of Colorado should strive to implement through a series of in-person meetings of eight different stakeholder groups as well as a travelling series of public engagement meetings held across the state. The goals of this collaborative process were to develop a robust and functional hemp supply chain, as well as inform the state’s hemp management plan for submission to the USDA.

A key area of focus of both the CHAMP initiative and the USDA IFR is testing. The new federal rules include regulations on reporting and testing requirements, including the requirement to establish a procedure for accurate and effective sampling and testing of *all* hemp production areas.

Currently, hemp cultivators are subject to sampling by the CDA to test for THC content before harvest, to ensure it does not exceed the allowable threshold of 0.3% THC. In 2019, crops from approximately 30% of the 2,634 registered hemp producing areas were sampled. The CDA currently tests these samples in its laboratory facilities in Broomfield, CO. In addition, hemp product manufacturers must also be able to document that the final product does not contain more than 0.3% THC, but there is not yet an established testing program or approved laboratories to perform this testing. The CDA lab only has capacity to test hemp samples from approximately 30% of registrants at its laboratory. The CDA lab also only tests plant material for THC content; it does not test hemp-derived products for THC or for contaminants. Therefore, hemp products are currently only tested on a voluntary basis.

Certified marijuana testing facilities are allowed to test hemp products, but are required to track all samples received through the marijuana seed-to-sale tracking system. Use of this system is not mandatory for hemp registrants and, if utilized, increases costs, so many elect not to use marijuana testing facilities. As a result new labs have begun offering hemp testing, but these labs currently have no state oversight and are not subject to any accreditation/certification requirements.

Due to the unique testing needs of the nascent and evolving hemp industry, the CHAMP initiative stakeholders established a recommendation that the state develop a certification program that provides guidance and oversight to private analytical laboratories on quality assurance requirements, appropriate analytical methods, and general testing procedures. Establishing a Hemp Testing Laboratory Certification Program would create the foundation for reliable laboratory testing to comply with the USDA rules to ensure THC testing of all hemp lots grown in Colorado, and to protect public safety by ensuring human-consumable products meet standards for safety and purity.

Testing information from certified labs is crucial for:

- Maintaining compliance with the USDA;
- Implementing an important part of the eventual hemp electronic traceability system;
- Assuring potency and purity to consumers and businesses purchasing hemp products; and
- Protecting businesses and the public against inaccurate or misleading product claims and against product impurities and food-borne illnesses.

The recommendation further specified that CDPHE will serve as the certifying agency for labs that test hemp and consumable hemp products. CDPHE is well positioned to certify these laboratories to perform hemp testing because it already has expertise in lab certification, as it currently inspects and recommends marijuana testing labs for certification and certifies clinical, environmental, and forensic laboratories. The Department can adapt its process for certifying these other labs for hemp testing labs; the processes, procedures, and equipment are very similar. The Department also houses the state's cannabis reference lab. As such, the Department possesses unique expertise of both lab certification and the technical aspects of cannabis testing.

Thus, the proposed rule establishes a Hemp Testing Laboratory Certification Program, and specifically includes criteria for:

- Laboratory certification authorizations
- General limitations or prohibited acts
- Certification requirements
- Laboratory personnel qualifications
- Standard operating procedure requirements
- Analytical processes
- Proficiency Testing
- Quality assurance and quality control

- Certificates of Analysis (reporting)
- Chain of custody
- Records retention
- Business records required
- Waste Disposal

Below is an explanation of each set of criteria. It is important to note that this proposed rule is largely consistent with the Department of Revenue certification rules found in Colorado Marijuana Rules (1 CCR 212-3) for marijuana testing facilities. Consistency in state certification requirements for all cannabis testing laboratories is necessary to ensure hemp is tested under equivalent laboratory standards.

Laboratory Certification Authorizations:

This section requires a certified Hemp Testing laboratory to verify the entity submitting samples for testing is a registered hemp cultivator or product manufacturer (i.e., is legally producing industrial hemp). This section also specifies that for any required test, the laboratory must be certified in that testing category in order to perform testing for compliance purposes. The rule allows labs to transfer samples to other certified laboratories which may be necessary in the event a laboratory instrument becomes inoperable.

General Limitations or Prohibited Acts:

This section specifies that Hemp Testing Laboratories are not allowed to transfer hemp to anyone except another certified laboratory and shall destroy any remaining sample after testing is completed as laboratories are not permitted to distribute hemp products. The section prohibits testing of unregistered hemp and requires laboratories to reject any sample that may have been tampered with or otherwise contaminated to help ensure test results are accurate. Conflicts of interest are also prohibited and the laboratory must establish policies to prevent these conflicts; this is also a requirement of International Organization for Standardization (ISO) accreditation to the standard for *General requirements for the competence of testing and calibration laboratories* (ISO/IEC 17025:2017).

Certification Requirements:

The CHAMP stakeholder recommendations included that hemp testing requirements align with marijuana testing requirements. Thus, this section includes the same certification categories: residual solvents, microbials, mycotoxins, pesticides, THC and other cannabinoid potency, and metals and aligns with Colorado Marijuana Rules - Retail Marijuana Testing Facilities: Certification Requirements (1 CCR 212-3 Rule 6-415(A)). This alignment also includes requiring ISO 17025 accreditation for the applicable methods for which the laboratory is seeking certification. The section specifies the allowances for provisional certification while a Hemp Testing Laboratory is seeking accreditation and DEA registration. This section further outlines the components of certification expectations.

Laboratory Personnel Qualifications:

Qualified staff with the appropriate scientific experience are critical to ensuring testing and associated quality assurance practices are performed and documented accurately and consistently. This section outlines the qualification requirements for each level of testing personnel and is consistent with personnel qualification requirements for marijuana testing facilities. This rule also outlines all of the responsibilities of the laboratory director who holds ultimate responsibility for these duties and certification standards are met.

Standard Operating Procedure Requirements:

Standard operating procedures (SOPs) are an essential tool for ensuring that laboratory staff are trained on and consistently perform testing procedures in accordance with the validated methodology. These SOPs also describe pre-analytic and post-analytic lab processes such as sample receipt and retention. The procedural requirements outlined in this section provide clarity to laboratories, including which details must be included in written SOPs to meet certification standards.

Analytical Processes:

In order to have confidence in any testing method, certain performance criteria must be established, met, and shown to be consistent. The application of parameters applied during method validation allow for the general acceptance of data generated during subsequent analyses. This section specifies the performance criteria that must be evaluated and proven satisfactory through method validation, such as accuracy and precision, for a laboratory to be certified to perform that test method. The USDA IFR specified that laboratory methods must meet the standard method performance requirements established by AOAC International (AOAC). AOAC is an organization that develops consensus standards for performing analytical testing. These are agreed upon, reproducible protocols for analytical methods. The AOAC requirements have not yet been established for all possible methodologies, so the rule specifies flexibility in that validation of methods should follow AOAC, United States pharmacopoeia (USP), FDA or other established guidelines as appropriate.

This section also details requirements for the use of specific types of instrumentation used to test cannabis. These requirements create a baseline for consistency across laboratories, as methods may vary slightly from lab to lab.

Proficiency Testing:

Proficiency testing is an assessment of the performance of a Hemp Testing Laboratory's methodology and processes. It is also known as inter-laboratory comparison. The goal of proficiency testing is to ensure results are accurate, reproducible, and consistent. Laboratory standardization is achieved when test results with the same high levels of accuracy and precision can be reproduced across analytical systems, laboratories, and over time. Proficiency testing ensures the production of credible and comparable data across laboratories, and is therefore a critical component of obtaining and maintaining laboratory certification.

Quality Assurance and Quality Control (QA/QC):

Quality assurance programs encompass a range of activities that enable laboratories to achieve and maintain high levels of accuracy and proficiency despite changes in test methods, the volume of specimens tested, or staff turnover. Test results produced by Hemp Testing Laboratories will have a significant influence on public health and industry product acceptability, making QA/QC critical to daily operations. A good QA/QC program does the following:

- Establishes SOPs for each step of the laboratory testing process, ranging from specimen handling to instrument performance validation.
- Defines administrative requirements, such as mandatory recordkeeping, data evaluation, and internal audits to monitor adherence to SOPs.
- Specifies corrective actions, documentation, and the persons responsible for carrying out corrective actions when problems are identified; and
- Sustains high-quality employee performance.

Certificate of Analysis (reporting):

This section specifies the necessary information that must be included on the test result report (certificate of analysis) to ensure the result is traceable to the submitter and sample. It also includes requirements necessary for interpretation of the result such as units of measurement and the methodology's limit of detection. Certificates of Analysis are provided to the submitting cultivator or manufacturer and regulatory agency as required. The section requires total THC concentration to be reported as the measured amount plus the method's uncertainty as required by the USDA IFR, as well as other contaminants required for testing by Colorado Wholesale Food And Shellfish Regulations (6 CCR 1010-21).

Chain of Custody:

Chain of custody is essential to ensure that the end results report by the laboratory correspond to the appropriate sample. Elements of these chain of custody requirements also help ensure that samples are received and stored under appropriate conditions so as to not impact the final result. This section also includes a requirement for the lab to separate and store a retain sample which is necessary for situations where additional testing is required after initial testing and is required by the USDA IFR.

Records Retention:

This section requires Hemp Testing Laboratories to establish processes for preserving records that are essential for verifying the accuracy and traceability of test results. This is necessary for state certification, ISO 17025 accreditation, and at any time a test result is in question.

Business Records Required:

The rule specifies that required records must be maintained for the current year plus three preceding years.

Waste Disposal:

Laboratory waste generated by Hemp Testing Laboratories may include controlled substances (i.e., marijuana), biohazardous waste, and chemical hazardous waste. This section requires compliance with all applicable federal, state, and local statutes, regulations, ordinances, or other requirements when disposing of lab generated waste.

Specific Statutory Authority.

These rules are promulgated pursuant to the following statutes: CRS 35-61-105.5(2)(d) and CRS 25-1.5-101(1)(f)

Is this rulemaking due to a change in state statute?
_____ Yes, the bill number is _____. Rules are ___ authorized ___ required.
_X____ No
Does this rulemaking include proposed rule language that incorporate materials by reference?
_____ Yes ___ URL
_X____ No

Does this rulemaking include proposed rule language to create or modify fines or fees?
_____ Yes
__X____ No

Does the proposed rule language create (or increase) a state mandate on local government?
___X_ No.

- The proposed rule does not require a local government to perform or increase a specific activity for which the local government will not be reimbursed.

REGULATORY ANALYSIS
for New rule
5 CCR 1005-5, *Hemp Testing Laboratory Certification*

1. A description of the classes of persons affected by the proposed rule, including the classes that will bear the costs and the classes that will benefit from the proposed rule.

Group of persons/entities Affected by the Proposed Rule	Size of the Group	Relationship to the Proposed Rule
Hemp Testing Laboratories	~10	C/B
Marijuana Testing Facilities	11	C/B
Hemp Product Manufacturers	~500	S/B
Hemp Cultivators	1279	S/B
Hemp Consumers	~1,400,000	B
State Hemp Registration Programs	2	S

While all are stakeholders, groups of persons/entities connect to the rule and the problem being solved by the rule in different ways. To better understand those different relationships, please use this relationship categorization key:

C = individuals/entities that implement or apply the rule.

S = individuals/entities that do not implement or apply the rule but are interested in others applying the rule.

B = the individuals that are ultimately served, including the customers of our customers. These individuals may benefit, be harmed by or be at-risk because of the standard communicated in the rule or the manner in which the rule is implemented.

More than one category may be appropriate for some stakeholders.

2. To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

The Department already has expertise in lab inspection and certification as it currently performs this work for other types of laboratories. As such, it is believed that this work can be the most cost effective and efficient when performed by the Departement. The Department has received $216,277 appropriated from the Industrial Hemp Registration Program Cash Fund to perform hemp laboratory certification activities. Because this certification program is new and the number of labs who will seek this certification is uncertain, the Department will charge a fee equivalent to those paid to marijuana testing facilities. The Department will evaluate whether these fees are sufficient to sustain the program over time and rely on the cash funds to initiate the program and to provide support until the adequacy of fees is fully assessed.

Economic outcomes

Please describe any anticipated financial costs or benefits to these individuals/entities.

C: The Department expects to charge Hemp Testing Laboratories the same fees as marijuana testing facilities:

Annual Certification Fee (includes one testing method), per category	$500.00
On-site inspection base charge	$250.00
Additional On-Site Charges, per method	$150.00
Desk audits (remedial proficiency testing review, personnel review, new testing method review, etc.)	$150.00
Applicable Travel Costs	Actual Costs

S: There may be an increase in test prices for hemp cultivators and manufacturers submitting samples to Hemp Testing Laboratories due the lab's new costs for certification.

B: Consumers may see an increase in hemp prices due to increased testing costs.

Non-economic outcomes

Summarize the anticipated favorable and non-favorable non-economic outcomes (short-term and long-term), and, if known, the likelihood of the outcomes for each affected class of persons by the relationship category.

Favorable non-economic outcomes:

C: The quality management requirements of lab certification will require hemp testing laboratories to establish documentation of their processes and testing creating defensible data in the event their test results are questioned.

S: Reproducible, accurate testing of hemp and hemp products will increase regulatory compliance and product safety, resulting in fewer enforcement actions against non-compliant hemp registrants and fewer product recalls as contaminated products will be less likely to be in the marketplace.

B: Consumers will have increased confidence in hemp product label claims and fewer adverse health events from contaminated products.

Unfavorable non-economic outcomes: N/A

3. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

A. Anticipated CDPHE personal services, operating costs or other expenditures:

Type of Expenditure	**Year 1**	**Year 2**
Total Personnel	***$197,177***	***$199,177***
• PHY SCI RES/SCIENTIST IV (anticipated hiring by calendar 2021)	$62,787	$115,914
• PHY SCI RES/SCIENTIST I (anticipated hiring by calendar 2021)	$45,101	$83,263
• One-time, Year 1 vacancy savings due to COVID-affected hiring delays	$89,289	$0
Total Operating	***$19,100***	***$17,100***
• Computer and Furniture, FTE one-time costs and any average annual maintenance and license costs	$15,833	$3,000
• Training and new program planning costs	$2,500	$4,000
• Contractual costs	$0	$3,500
• Travel, professional fees, miscellaneous employee operating costs	$767	$6,600
Total	***$216,277***	***$216,277***

Anticipated CDPHE Revenues: Unknown. Hemp is a nascent industry in Colorado and, thus, the need for testing hemp biomass and hemp products is just emerging. At this time, CDPHE cannot reliably estimate how many labs it will certify in the near term, or if the proposed fee structure will be sufficient to generate revenue for the Department.

B. Anticipated personal services, operating costs or other expenditures by another state agency: N/A

Anticipated Revenues for another state agency: N/A

4. A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

Along with the costs and benefits discussed above, the proposed revisions:

___ Comply with a statutory mandate to promulgate rules.
_X_ Comply with federal or state statutory mandates, federal or state regulations, and department funding obligations.
___ Maintain alignment with other states or national standards.
___ Implement a Regulatory Efficiency Review (rule review) result
___ Improve public and environmental health practice.
_X_ Implement stakeholder feedback.
_X_ Advance the following CDPHE Strategic Plan priorities:
Goal 1, Implement public health and environmental priorities
Goal 2, Increase Efficiency, Effectiveness and Elegance
Goal 3, Improve Employee Engagement
Goal 4, Promote health equity and environmental justice
Goal 5, Prepare and respond to emerging issues, and
Comply with statutory mandates and funding obligations

Strategies to support these goals:

___ Substance Abuse (Goal 1)
___ Mental Health (Goal 1, 2, 3 and 4)
___ Obesity (Goal 1)
___ Immunization (Goal 1)
___ Air Quality (Goal 1)
___ Water Quality (Goal 1)
___ Data collection and dissemination (Goal 1, 2, 3, 4, 5)
___ Implement quality improvement/a quality improvement project (Goal 1, 2, 3, 5)
___ Employee Engagement (Goal 1, 2, 3)
___ Decisions incorporate health equity and environmental justice (Goal 1, 3, 4)
_X_ Detect, prepare and respond to emerging issues (Goal 1, 2, 3, 4, 5)
___ Advance CDPHE Division-level strategic priorities.

The costs and benefits of the proposed rule will not be incurred if inaction was chosen. Costs and benefits of inaction not previously discussed include: N/A

5. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

Rulemaking is proposed when it is the least costly method or the only statutorily allowable method for achieving the purpose of the statute. The specific revisions proposed in this rulemaking were developed in conjunctions with stakeholders. The benefits, risks and costs of these proposed revisions were compared to the costs and benefits of other options. The proposed revisions provide the most benefit for the least amount of cost, are the minimum necessary or are the most feasible manner to achieve compliance with statute.

6. Alternative Rules or Alternatives to Rulemaking Considered and Why Rejected.

The only alternative considered was to not require state certification and require only accreditation to the ISO 17025 standard. This idea was not supported by stakeholders who wanted to ensure hemp labs were held to high standards to allow Colorado to continue be a leader in the hemp industry, as well as to ensure that the state could hold labs accountable to any requirements unique to the Colorado Hemp Management Plan and CDA and CDPHE regulations.

7. To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.

Like other models of laboratory accreditation, state certification of hemp testing laboratories is a means of determining the technical competence of laboratories to perform specific types of testing and measurement. It also provides formal recognition to competent laboratories, thus providing a ready means for customers to identify and select reliable testing services to meet their needs.

The following resources informed the Department's proposed rulemaking:

- Colorado Hemp Advancement and Management Plan
- USDA Interim Final Rule 84 FR 58522
- Industrial Hemp Regulatory Program (Title 35, Article 61 C.R.S.)
- Rules Pertaining To The Administration And Enforcement Of The Industrial Hemp Regulatory Program Act (8 CCR 1203-23)
- Colorado Wholesale Food And Shellfish Regulations (6 CCR 1010-21)
- Colorado Marijuana Rules (1 CCR 212-3)
- International Organization for Standardization. (2017). *General Requirements For The Competence Of Testing And Calibration Laboratories* (ISO Stand No. 17025:2017)

STAKEHOLDER ENGAGEMENT
for 5 CCR 1005-5, Hemp Testing Laboratory Certification

State law requires agencies to establish a representative group of participants when considering to adopt or modify new and existing rules. This is commonly referred to as a stakeholder group.

Early Stakeholder Engagement:
The following individuals and/or entities were invited to provide input and included in the development of these proposed rules:

The Department developed the proposed rules and has sought feedback through an early stakeholder engagement process. These early efforts included sending an email notification of upcoming new rules, summarization of draft proposed changes, draft rule text, and a dedicated online survey where staff could collect feedback from stakeholders. An email announcing upcoming rulemaking was sent to 662 individuals who were asked to sign up if they wished to participate in the stakeholder engagement process. Feedback was then solicited from approximately 70 individuals representing: members of the public, hemp testing laboratories, marijuana testing facilities, hemp cultivators, hemp product manufacturers, Colorado Hemp Industries Association, Grow Hemp Colorado, Colorado Department of Agriculture, Colorado Marijuana Enforcement Division, CDPHE Manufactured Food Safety Program.

Stakeholder Group Notification
The stakeholder group was provided notice of the rulemaking hearing and provided a copy of the proposed rules or the internet location where the rules may be viewed. Notice was provided prior to the date the notice of rulemaking was published in the Colorado Register (typically, the 10th of the month following the Request for Rulemaking).

_XX_ Not applicable. This is a Request for Rulemaking Packet. Notification will occur if the Board of Health sets this matter for rulemaking.

__ Yes.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

The Department's outreach to stakeholders has been ongoing with open communication among all stakeholder groups. Stakeholders were sent an email notification about the rulemaking and proposed changes on November 3, 2020. The November email notification contained a draft version of the proposed rule language and a link to an online form where interested individuals could submit informal feedback. From that initial email, the Department received informal feedback from 12 stakeholders out of approximately 70 stakeholders contacted.

The Department received a few questions through the stakeholder feedback process. To the extent possible, the Department responded to stakeholders who asked clarifying questions or referred them to publicly available information on our website.

Below is a summary of feedback received from stakeholders and how the Department is responding to the suggestions.

- There was significant feedback received suggesting changes to several definitions in the proposed rule. However, these definitions are included in other existing and proposed regulations across several agencies (Colorado Department of Public Health and Environment [CDPHE], Colorado Department of Agriculture [CDA], and Marijuana Enforcement Division [MED]). The Department will need to continue discussions with stakeholders to ensure that any changes made are appropriately consistent with these other regulations.

- Stakeholders expressed a lack of clarity regarding the application of certification requirements to compliance testing versus voluntary testing. The Department agrees with this feedback and has modified the proposed rule to include a definition of "Sample" to provide clarity throughout the rule that any sample referred to is a compliance sample.

- The proposed rule includes a requirement for labs to report cannabinoid results to the CDA via email. Several stakeholders expressed concern that reporting via email would be inefficient for both labs and CDA. The Department conferred with CDA to determine if the rule could be modified to exclude this specific manner of reporting. CDA agreed that the rule could reflect mandatory reporting to the agency in a non-specific manner as the agency is currently considering alternative systems for collecting test results. The Department will defer to CDA regarding the specific mechanism for reporting.

- Stakeholders expressed that Drug Enforcement Agency (DEA) registration should be removed from the rule as a certification requirement. However, DEA registration is required by the United States Department of Agriculture (USDA) Interim Final Rule (IFR), thus, DEA registration needs to remain in rule language for now. Stakeholders may note that the USDA has delayed enforcement of this requirement until October 31, 2021. Additionally, the USDA has not yet issued a final rule and the Department will evaluate any necessary change to this proposed rule, including the requirement for DEA registration, at the time USDA implements a final rule.

- The terms "THC" and Total THC" are often used interchangeably, but are not in fact interchangeable. Stakeholders pointed out specific sections of rule where there was opportunity to clarify which term was technically correct. The Department has made these changes throughout the rule.

- Some feedback was not directly applicable to this rule as a result of the overlap between this rule and other hemp regulations. The Department will share this feedback with the appropriate state agency for their consideration.

- Stakeholders suggested that hemp testing laboratories should not report test results as pass or fail, but instead report only the test result, either quantitatively or qualitatively as appropriate. The Department agrees that the responsibility of determining whether a test result is acceptable or unacceptable falls upon the hemp registrant and applicable regulatory body and has therefore incorporated this suggestion.

- Some feedback suggested the rule be modified to more specifically define certain requirements. For example, it was suggested that rather than stating the lab ensure appropriate environmental conditions, the rule should specify the lab must ensure it has appropriate heat and humidity controls, ventilation, etc. However, these specifications can vary depending on the type of testing performed and the requirements specified by instrumentation manufacturers. These details are thoroughly reviewed during laboratory audits. The Department will leave the general requirements in rule and evaluate specific requirements on a case-by-case basis during audits.

Please identify the determinants of health or other health equity and environmental justice considerations, values or outcomes related to this rulemaking. N/A

Overall, after considering the benefits, risks and costs, the proposed rule:

Select all that apply.

	Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.		Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.
	Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.		Reduces occupational hazards; improves an individual's ability to secure or maintain employment; or, increases stability in an employer's workforce.
	Improves access to food and healthy food options.	X	Reduces exposure to toxins, pollutants, contaminants or hazardous substances; or ensures the safe application of radioactive material or chemicals.
X	Improves access to public and environmental health information; improves the readability of the rule; or, increases the shared understanding of roles and responsibilities, or what occurs under a rule.		Supports community partnerships; community planning efforts; community needs for data to inform decisions; community needs to evaluate the effectiveness of its efforts and outcomes.
	Increases a child's ability to participate in early education and educational opportunities through prevention efforts that increase protective factors and decrease risk factors, or stabilizes individual participation in the opportunity.		Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
	Monitors, diagnoses and investigates health problems, and health or environmental hazards in the community.		Ensures a competent public and environmental health workforce or health care workforce.
	Other:_____ _____		Other:_____ _____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Colorado State Public Health Lab, Disease Control and Public Health Response Division

Hemp Testing Laboratory Certification

5 CCR 1005-5

Rule 1: Authority and Definitions

1.1 Authority

This regulation is established under the authority contained in sections 35-61-105.5(2)(d) and 25-1.5-101(1)(f) et seq., C.R.S.

1.2 Scope and Purpose

The purpose of this rule is to establish criteria for the certification of laboratories to test Industrial Hemp and hemp-derived products.

1.3 Definitions

The following terms, whenever used in or referred to in these regulations, shall have the following respective meanings:

1.3.1 “Acceptability Criteria” means the specified limits placed on the characteristics of an item or method that are used to determine data quality.

1.3.2 “Accreditation” means approval by an impartial non-profit organization that operates in conformance with the International Organization for Standardization (ISO) / International Electrotechnical Commission (IEC) standard 17011 and is a signatory to the International Laboratory Accreditation Cooperation (ILAC) Mutual Recognition Arrangement (MRA) for Testing.

1.3.3 “Action Level” means the threshold value that provides the criterion for determining whether a Sample passes or fails an analytical test.

1.3.4 “Analyte” means the substance of interest in the analysis.

1.3.5 “Cannabinoid” means a class of lipophilic molecules that are naturally occurring in cannabis, including Industrial Hemp and marijuana.

1.3.6 “CBD” means cannabidiol.

1.3.7 “CBDA” means cannabidiolic acid.

1.3.8 “Chain of Custody” or “COC” means the chronological documentation that records the sequence of custody, control, transfer, analysis, and disposal of a Sample.

1.3.9 “Corrective Action” means a reactive action implemented to eliminate the root cause of a Nonconformance and to prevent recurrence.

1.3.10 “Certificate of Analysis” means an official document issued by a certified Hemp Testing Laboratory that shows results of scientific tests performed on a product.

1.3.11 “Delta-9 tetrahydrocannabinol” or “delta-9 THC” has the same meaning as "tetrahydrocannabinols" as set forth in section 27-80-203 (24). C.R.S. Delta-9 THC is the primary psychoactive component of cannabis. For the purposes of these regulations, the terms "Delta-9 THC" and "THC" are interchangeable.

1.3.12 “Department” means the Colorado Department of Public Health and Environment.

1.3.13 “Exclusivity” means the specificity of the test method for validating microbial testing methods. It evaluates the ability of the method to distinguish the Target Organisms from similar but genetically distinct non-target organisms.

1.3.14 “Hemp Testing Laboratory” means a public or private laboratory certified, or approved by the Department, to perform compliance testing or research on Industrial Hemp and Industrial Hemp Products.

1.3.15 “Inclusivity” means, related to microbiological method validation, the sensitivity of the test method. It evaluates the ability of the test method to detect a wide range of Target Organisms by a defined relatedness.

1.3.16 “Industrial Hemp” or “hemp” means the plant Cannabis sativa L. and any part of the plant, including the seeds, all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers, whether growing or not, with a Total THC concentration of no more than 0.3% on a dry-weight basis.

1.3.17 “Industrial Hemp Cultivator” means a producer that grows Industrial Hemp under a current registration issued by the Colorado Department of Agriculture.

1.3.18 “Industrial Hemp Extract” means an unfinished industrial hemp product or industrial hemp product produced through a solvent or non-solvent based industrial hemp manufacturing process, including but not limited to oils, distillates, resins, and isolates.

1.3.19 “Industrial Hemp Manufacturer” means a facility that manufactures, produces, packs, processes (extracts), treats, packages, or holds/warehouses Industrial Hemp Products and unfinished Industrial Hemp Products.

1.3.20 “Industrial Hemp Product” means a finished product containing Industrial Hemp that is for human use or consumption and:

a. Is a cosmetic as defined in 25-5-402(6) C.R.S.; or

b. Is a dietary supplement as defined in 25-5-426(2)(d) C.R.S.; or

c. Is a food as defined in 25-5-402(11) C.R.S.;

d. Is a food additive as defined in 25-5-402(12) C.R.S.;

e. Contains any part of the hemp plant, including naturally occurring Cannabinoids, compounds, concentrates, extracts, isolates, resins, or derivatives; and

f. Contains a Delta-9 THC concentration of no more than 0.3% and

g. Is not a drug as defined in 25-5-402(9) C.R.S.

1.3.21 “Limit of Detection” or “LOD” means the lowest quantity of a substance that can be distinguished from the absence of that substance (a blank value) within a stated confidence limit (generally 1%).

1.3.22 “Limit of Quantitation” or “LOQ” means the lowest concentration at which the Analyte can not only be reliably detected but at which some predefined goals for bias and imprecision are met.

1.3.23 “Matrix” means the components of a Sample other than the Analyte(s) of interest (i.e., Sample type).

1.3.24 “Measurement Uncertainty” is defined as a parameter, associated with the result of a measurement, that characterizes the dispersion of the values that could reasonably be attributed to the measurand. The following equation is recommended:

Equation: ˜ = ˜ × ˜-

Where, $u_c u_c = \sqrt{u_r^2 + u_R^2 + u_{bias}^2}\sqrt{u_r^2 + u_R^2 + u_{bias}^2}$

And:

u = standard uncertainty (standard deviation)

u_r = uncertainty due to repeatability

u_R = uncertainty due to reproducibility

u_{bias} = uncertainty due to accuracy (bias)

u_c = combined standard uncertainty

U = Expanded uncertainty = $\frac{u}{Mean} * k_{95\%\ confidence\ level}\frac{u}{Mean} * k_{95\%\ confidence\ level}$, k = 2

k = coverage factor, use 2 for a 95% confidence level

1.3.25 “Moisture Content” means the percentage of water in a Sample, by weight.

1.3.26 “Nonconformance” means a non-fulfillment of a requirement or departure from written procedures, work instructions, or quality system, as defined by the laboratory’s written Corrective Action and Preventive Action procedures.

1.3.27 “Person” means a natural person, an estate, a trust, an entity, or a state or other jurisdiction.

1.3.28 “Preventive Action” means a proactive action implemented to eliminate the cause of a potential Nonconformance or other quality problem before it occurs.

1.3.29 “Proficiency Testing” means an assessment of the performance of a Hemp Testing Laboratory’s methodology and processes. Proficiency Testing is also known as inter-laboratory

comparison. The goal of Proficiency Testing is to ensure results are accurate, reproducible, and consistent.

1.3.30 "Quality Control" means the set of measures implemented within an analytical procedure to ensure that the measurement system is operating in a state of statistical control for which errors have been reduced to acceptable levels.

1.3.31 "Reference Material" means material containing a known concentration of an Analyte of interest that is in solution or in a homogeneous Matrix.

1.3.32 "Reference Method" means the method by which the performance of an alternate method is measured or evaluated.

1.3.33 "Sample" means the Industrial Hemp, Industrial Hemp Product submitted to a Hemp Testing Laboratory for compliance testing.

1.3.34 "Scope of Accreditation" means the tests or types of tests performed, materials or products tested, and the methods used for testing cannabis or cannabis products for which the accreditation has been granted.

1.3.35 "Standard Operating Procedure" (SOP) means a written document that provides detailed instructions for the performance of all aspects of an analysis, operation, or action.

1.3.36 "Target Organism" means an organism that is being tested for in an analytical procedure or test method.

1.3.37 "THC" means tetrahydrocannabinol.

1.3.38 "THCA" means tetrahydrocannabinolic acid.

1.3.39 "Total CBD" means the sum of the percentage by weight of CBDA multiplied by 0.877 plus the percentage by weight of CBD i.e., Total CBD= (%CBDA x 0.877) + % CBD.

1.3.40 "Total THC" means the sum of the percentage by weight of THCA multiplied by 0.877 plus the percentage by weight of THC i.e., Total THC = (%THCA x 0.877) + % THC.

1.3.41 "Unfinished Industrial Hemp Product" means an oil, concentrate or other substance that has a total THC concentration above 0.3% and less than or equal to 5.0%, is not for consumer use or distribution, must be sold or transferred between registered industrial hemp manufacturers, and will undergo further refinement or processing into an industrial hemp product.

Rule 2: Hemp Testing Laboratory Certification Authorizations

2.1 Testing of Industrial Hemp Authorized. A Hemp Testing Laboratory may accept Samples of Industrial Hemp, Industrial Hemp Products, and Unfinished Industrial Hemp Products from Persons registered with the Commissioner of the Colorado Department of Agriculture, pursuant to section 35-61-104, C.R.S. or registered with the Colorado Department of Public Health and Environment pursuant to section 25-5-426, C.R.S. for testing and research purposes only.

2.1.1 Before a Hemp Testing Laboratory accepts a Sample of Industrial Hemp, Industrial Hemp Product or Unfinished Industrial Hemp Product, the laboratory shall verify that the Person submitting the Sample is registered with the Colorado Department of Agriculture or registered with the Colorado Department of Public Health and Environment.

2.2 A Hemp Testing Laboratory shall be permitted to test Industrial Hemp, Industrial Hemp Product, and Unfinished Industrial Hemp Product for required tests pursuant to Colorado Wholesale Food And Shellfish Regulations (6 CCR 1010-21) and section 35-61-105.5(d), C.R.S. only in the category(ies) that the Hemp Testing Laboratory is certified to perform testing in pursuant to Rule 4.1 – Hemp Testing Laboratory: Certification Requirements.

2.3 Transferring Samples to another Certified Hemp Testing Laboratory. A Hemp Testing Laboratory may transfer Samples to another certified Hemp Testing Laboratory for testing. All laboratory reports provided to a Hemp Registrant must identify the Hemp Testing Laboratory that actually conducted the test.

2.4 A Hemp Testing Laboratory shall provide the results of any required compliance testing performed on Industrial Hemp, Industrial Hemp Product and Unfinished Industrial Hemp Product to the Person submitting the Sample. Results for Total THC compliance testing of Industrial Hemp must also be provided to the Colorado Department of Agriculture.

Rule 3: Hemp Testing Laboratories: General Limitations or Prohibited Acts

3.1. Conflicts of Interest. The Hemp Testing Laboratory, including those that are internal departments of hemp registrants, shall establish policies to prevent the existence of or appearance of undue commercial, financial, or other influences that may diminish the competency, impartiality, and integrity of the Hemp Testing Laboratory's testing processes or results, or that may diminish public confidence in the competency, impartiality and integrity of the Hemp Testing Laboratory's testing processes or results. At a minimum, employees, owners or agents of a Hemp Testing Laboratory who participate in any aspect of the analysis, resulting, and/or reporting of a Sample are prohibited from improperly influencing the testing process, improperly manipulating data, or improperly benefiting from any on-going financial, employment, personal or business relationship with the Industrial Hemp Registrant or Industrial Hemp Manufacturer that provided the Sample. The Hemp Testing Laboratory shall provide documentation showing a clear delineation between production and lab testing activities reflected in their quality management system documentation. Any conflicts of interest must be documented and disclosed.

3.2. Transfer of Industrial Hemp and Industrial Hemp Product Prohibited. A Hemp Testing Laboratory shall not transfer Industrial Hemp or Industrial Hemp Product to an Industrial Hemp Registrant or Industrial Hemp Manufacturer or a consumer, except that a Hemp Testing Laboratory may transfer a Sample to another Hemp Testing Laboratory.

3.3. Destruction of Received Samples. A Hemp Testing Laboratory shall properly dispose of all Samples it receives, that are not transferred to another Hemp Testing Laboratory, after all necessary tests have been conducted and any required period of storage. *See* Rule 14 – Waste Disposal.

3.4 Sample Rejection. A Hemp Testing Laboratory shall reject any Sample where the condition of the Sample at receipt indicates that the Sample may have been tampered with or could have become contaminated as a result of damaged or improper packaging.

3.5 Testing of Unregistered Industrial Hemp or Industrial Hemp Products Prohibited.

3.5.1 A Hemp Testing Laboratory is authorized to accept or test Industrial Hemp only if (1) the entity providing the Samples of Industrial Hemp is regulated by Article 61 of Title 35, C.R.S., and (2) the Industrial Hemp is submitted by a registered cultivator.

3.5.2 A Hemp Testing Laboratory is authorized to accept or test Industrial Hemp Product only if the entity providing the Samples of Industrial Hemp Product is registered and regulated pursuant to Title 25, C.R.S.

Rule 4: Hemp Testing Laboratories: Certification Requirements

4.1. Certification Types. For required tests, the Hemp Testing Laboratory must be certified by the Department in the category in order to perform that type of testing.

4.1.1 Residual solvents;

4.1.2 Microbials;

4.1.3 Mycotoxins;

4.1.4 Pesticides;

4.1.5 THC and other Cannabinoid potency; and

4.1.6 Metals.

4.2 Certification Procedures and Principles. The Hemp Testing Laboratory certification program is contingent upon successful on-site inspection, successful participation in proficiency testing, and ongoing compliance with the requirements in this Rule.

4.2.1 Certification Inspection. A Hemp Testing Laboratory must be inspected prior to initial certification and annually thereafter by the Department.

4.2.2 Standards for Certification. A Hemp Testing Laboratory must meet standards of performance, as established by these rules, in order to obtain and maintain certification. Standards of performance include but are not limited to: Personnel Qualifications, Standard Operating Procedures, analytical processes, Proficiency Testing, Quality Control, quality assurance, security, Chain of Custody, Sample retention, Sample disposal, space, records, and results reporting.

4.2.2.1 A Hemp Testing Laboratory must be accredited under the International Organization for Standardization/International Electrotechnical Commission 17025:2017 Standard (ISO/IEC 17025), or any subsequent superseding ISO/IEC 17025 standard, by an accreditation body that is a signatory to the International Laboratory Accreditation Cooperation (ILAC) Mutual Recognition Arrangement (MRA). In order to obtain and maintain certification in a testing category from the Department, the Hemp Testing Laboratory's Scope of Accreditation must specify that particular testing category, including the applicable methods and Analytes. In addition, Hemp Testing Laboratories must be registered with the United State Drug Enforcement Administration.

4.2.2.2 Certification will be granted when laboratories have met all certification requirements, including ISO/IEC 17025 accreditation and DEA registration.

4.2.2.3 The Department may grant provisional certification for a testing category if the laboratory has not yet obtained ISO/IEC 17025 accreditation, but meets all other certification requirements. Such provisional certification shall be for a period not to exceed twelve months.

4.2.2.4 The Department may grant conditional certification to laboratories who have obtained ISO/IEC 17025 accreditation and, and have met all other certification requirements, but are not registered with the DEA.

4.2.3 Personnel Qualifications.

4.2.3.1 Laboratory Director. A Hemp Testing Laboratory must employ, at a minimum, a laboratory director with sufficient education and experience in a regulated laboratory environment in order to obtain and maintain certification. *See* Rule 5 – Hemp Testing Laboratories: Personnel.

4.3.2 Employee Competency. A Hemp Testing Laboratory must have a written and documented system to evaluate and document the competency in performing authorized tests for employees. Prior to independently analyzing Samples, testing personnel must demonstrate acceptable performance on precision, accuracy, specificity, reportable ranges, blanks, and unknown challenge Samples (proficiency Samples or internally generated quality controls). Analysts must, at a minimum, annually (or upon method modification) demonstrate continued acceptable competency.

4.2.4 Standard Operating Procedures. A Hemp Testing Laboratory must have written Standard Operating Procedures meeting the minimum standards set forth in these rules detailing the performance of all methods employed by the facility used to test the Analytes it reports and made available for testing analysts to follow at all times.

4.2.4.1 The current laboratory director must approve, sign and date each procedure. If any modifications are made to those procedures, the laboratory director must approve, sign, and date the revised version prior to use.

4.2.4.2 A Hemp Testing Laboratory must maintain a copy of all Standard Operating Procedures to include any revised copies for a minimum of three years. *See* Rule 11 – Hemp Testing Laboratories: Records Retention and Rule 13 – Hemp Testing Laboratories: Business Records Required.

4.2.4.3 A Hemp Testing Laboratory must inform the Department of any major changes to Standard Operating Procedures pertaining to analytical methods subsequent to initial certification. Major method changes include, but are not limited to: modifications to Sample preparation, changes in column type, changes in enrichment media, changes in solvent(s) used, etc.

4.2.5 Analytical Processes. A Hemp Testing Laboratory must maintain a listing of all analytical methods used and all Analytes tested and reported. The Hemp Testing Laboratory must provide this listing to the Department upon request.

4.2.6 Proficiency Testing. A Hemp Testing Laboratory must successfully participate in a Department approved Proficiency Testing program in order to obtain and maintain certification.

4.2.7 Quality Assurance and Quality Control. A Hemp Testing Laboratory must establish and follow a quality assurance and Quality Control program to ensure sufficient monitoring of laboratory processes and quality of results reported.

4.2.8 Security. A Hemp Testing Laboratory must be located in a secure setting to prevent unauthorized persons from gaining access to the testing and storage areas of the laboratory.

4.2.9 Chain of Custody. A Hemp Testing Laboratory must establish a system to document the complete Chain of Custody for Samples from receipt through disposal.

4.2.10 Space. A Hemp Testing Laboratory must be located in a fixed structure that provides adequate infrastructure to perform analysis in a safe and compliant manner consistent with federal, state, and local requirements.

4.2.11 Records. A Hemp Testing Laboratory must establish a system to retain and maintain records for a period not less than three years. *See* Rules 11 – Hemp Testing Laboratory: Records Retention and Rule 13 – Hemp Testing Laboratories: Business Records Required.

4.2.12 Results Reporting. A Hemp Testing Laboratory must establish processes to ensure results are reported in a timely and accurate manner. A Hemp Testing Laboratory's process may require that the Industrial Hemp Registrant or Industrial Hemp Product Manufacturer remit payment for any test conducted by the laboratory prior to reporting results. A Hemp Testing Laboratory's process established under this subparagraph (12) must be maintained on the premises of the Hemp Testing Laboratory.

4.2.13 Conduct While Seeking Certification. A Hemp Testing Laboratory, and its agents and employees, shall provide all documents and information required or requested by the Department and its employees in a full, faithful, truthful, and fair manner.

Rule 5: Hemp Testing Laboratories: Personnel

5.1 Laboratory Director. The laboratory director is responsible for the overall analytical operation and quality of the results reported by the Hemp Testing Laboratory, including the employment of personnel who are competent to perform test procedures and record and report test results promptly, accurately, and proficiently, and for assuring compliance with the standards set forth in this Rule.

5.1.1 The laboratory director may also serve as a supervisory analyst or testing analyst, or both, for a Hemp Testing Laboratory.

5.1.2 The laboratory director for a Hemp Testing Laboratory must meet one of the following qualification requirements:

5.2.2.1 Be a Medical Doctor (M.D.) licensed to practice medicine in Colorado and have at least three years of full-time laboratory experience in a regulated laboratory environment performing analytical scientific testing in which the testing methods were recognized by an accrediting body; OR

5.2.2.2 Hold a doctoral degree in one of the natural sciences and have at least three years of full-time laboratory experience in a regulated laboratory environment performing analytical scientific testing in which the testing methods were recognized by an accrediting body; OR

5.2.2.3 Hold a master's degree in one of the natural sciences and have at least five years of full-time laboratory experience in a regulated laboratory environment performing analytical scientific testing in which the testing methods were recognized by an accrediting body; OR

5.2.2.4 Hold a bachelor's degree in one of the natural sciences and have at least seven years of full-time laboratory experience in a regulated laboratory environment performing

analytical scientific testing in which the testing methods were recognized by an accrediting body.

5.2 What the Laboratory Director May Delegate. The laboratory director may delegate the responsibilities assigned under this Rule to a qualified supervisory analyst, provided that such delegation is made in writing and a record of the delegation is maintained. *See* Rule 13 - Business Records Required. Despite the designation of a responsibility, the laboratory director remains responsible for ensuring that all duties are properly performed.

5.3 Responsibilities of the Laboratory Director. The laboratory director must:

5.3.1 Ensure that the Hemp Testing Laboratory has adequate space, equipment, materials, and controls available to perform the tests reported;

5.3.2 Establish and ensure adherence to written Standard Operating Procedures used to perform the tests reported;

5.3.3 Ensure that testing systems developed and used for each of the tests performed in the laboratory provide quality laboratory services for all aspects of test performance, which includes the preanalytic, analytic, and postanalytic phases of testing;

5.3.4 Ensure that the physical location and environmental conditions of the laboratory are appropriate for the testing performed and provide a safe environment in which employees are protected from physical, chemical, and biological hazards;

5.3.5 Ensure that the test methodologies selected are fit-for-purpose and appropriate to ensure the quality of results required for the level of testing the laboratory is certified to perform;

5.3.6 Ensure that validation and verification test methods used are adequate to determine the accuracy, precision, and other pertinent performance characteristics of the method;

5.3.7 Ensure that testing analysts perform the test methods as required for accurate and reliable results;

5.3.8 Ensure that the laboratory is enrolled in and successfully participates in a Department approved Proficiency Testing program;

5.3.9 Ensure that the Quality Control and quality assessment programs are established and maintained to assure the quality of laboratory services provided and to identify failures in quality as they occur;

5.3.10 Ensure the establishment and maintenance of acceptable levels of analytical performance for each test system;

5.3.11 Ensure that all necessary remedial actions are taken and documented whenever significant deviations from the laboratory's established performance specifications are identified, and that test results are reported only when the system is functioning properly;

5.3.12 Ensure that reports of test results include pertinent information required for interpretation;

5.3.13 Ensure that consultation is available to the laboratory's clients on matters relating to the quality of the test results reported and their interpretation of said results;

5.3.14 Employ a sufficient number of laboratory personnel who meet the qualification requirements and provide appropriate consultation, properly supervise, and ensure accurate performance of tests and reporting of test results;

5.3.15 Ensure that prior to testing any Samples, all testing analysts receive the appropriate training for the type and complexity of tests performed, and have demonstrated and documented that they can perform all testing operations reliably to provide and report accurate results;

5.3.16 Ensure that policies and procedures are established for monitoring individuals who conduct preanalytical, analytical, and postanalytical phases of testing to assure that they are competent and maintain their competency to process Samples, perform test procedures and report test results promptly and proficiently, avoid actual and apparent conflicts of interests, and whenever necessary, identify needs for remedial training or continuing education to improve skills;

5.3.17 Ensure that an approved Standard Operating Procedure manual is available to all personnel responsible for any aspect of the testing process; and

5.3.18 Specify, in writing, the responsibilities and duties of each person engaged in the performance of the preanalytic, analytic, and postanalytic phases of testing, that identifies which examinations and procedures each individual is authorized to perform, whether supervision is required for Sample processing, test performance or results reporting, and whether consultant or laboratory director review is required prior to reporting test results.

5.4 Change in Laboratory Director. In the event that the laboratory director leaves employment at the Hemp Testing Laboratory, the Hemp Testing Laboratory shall:

5.4.1 Provide written notice to the Department within seven days of the laboratory director's departure; and

5.4.2 Designate an interim laboratory director within seven days of the laboratory director's departure. At a minimum, the interim laboratory director must meet the qualifications of a supervisory analyst.

5.4.3 The Hemp Testing Laboratory must hire a permanent laboratory director within 60 days from the date of the previous laboratory director's departure.

5.4.4 Notwithstanding the requirement of subparagraph 5.4.3, the Hemp Testing Laboratory may submit a waiver request to the Department to receive an additional 60 days to hire a permanent laboratory director provided that the Hemp Testing Laboratory submits a detailed oversight plan along with the waiver request.

5.5. Supervisory Analyst. Supervisory analysts must meet one of the qualifications for a laboratory director or have at least a bachelor's degree in one of the natural sciences and three years of full-time laboratory experience in a regulated laboratory environment performing analytical scientific testing in which the testing methods were recognized by an accrediting body. A combination of education and experience may substitute for the three years of full-time laboratory experience.

5.6. Laboratory Testing Analyst.

5.6.1 Educational Requirements. An individual designated as a testing analyst must meet one of the qualifications for a laboratory director or supervisory analyst or have at least a bachelor's

degree in one of the natural sciences and one year of full-time experience in laboratory testing.

5.6.2 Responsibilities. In order to independently perform any test for a Hemp Testing Laboratory, an individual must at least meet the educational requirements for a testing analyst.

Rule 6: Hemp Testing Laboratories: Standard Operating Procedures

6.1 Standard Operating Procedures must include, but need not be limited to, procedures for:

6.1.1 Sample receiving;

6.1.2 Sample accessioning;

6.1.3 Sample storage;

6.1.4 Identifying and rejecting unacceptable Samples;

6.1.5 Recording and reporting discrepancies;

6.1.6 Security and stability of Samples, aliquots and extracts and records;

6.1.7 Sample retention to assure stability, as follows:

6.1.7.1 For Samples submitted for testing other than pesticide contaminant testing, Sample retention for 14 days;

6.1.7.2 For Samples submitted for pesticide contaminant testing, Sample retention for 90 days.

6.1.8 Validating a new or revised method prior to testing Samples to include the performance criteria as stated in Rule 7.1.5;

6.1.9 Aliquoting Samples to avoid contamination and carry-over;

6.1.10 Preparation of Samples;

6.1.11 Disposal of Samples;

6.1.11 The theory and principles behind each assay;

6.1.12 Preparation and identification of reagents, standards, calibrators and controls and ensure all standards are traceable to a certified vendor that meets the accreditation requirements of the laboratory, such as National Institute of Standards of Technology (NIST), ISO 17034, other other similar entities;

6.1.13 Special requirements and safety precautions involved in performing assays;

6.1.14 Frequency and number of control and calibration materials;

6.1.15 Recording and reporting assay results;

6.1.16 Protocol and criteria for accepting or rejecting analytical procedure to verify the accuracy of the final report;

6.1.17 Pertinent literature references for each method;

6.1.18 Current step-by-step instructions with sufficient detail to perform the assay to include equipment operation and any abbreviated versions used by a testing analyst;

6.1.19 Acceptability Criteria for the results of calibration standards and controls as well as between two aliquots, Sample duplicates, new standard lots, or columns;

6.1.20 A documented system for reviewing the results of testing calibrators, controls, standards, and Sample test results, as well as reviewing for clerical errors, analytical errors and any unusual analytical results; and

6.1.21 A documented system for issuing, implementing, and monitoring Corrective Actions, including instructions for the laboratory to contact the requesting entity, when required;

6.1.22 Policies and procedures to follow when Samples are requested for referral and testing by another certified Hemp Testing Laboratory or an approved local or state agency's laboratory;

6.1.23 Protocol and criteria for calculating and applying Measurement Uncertainty;

6.1.24 Policies and procedures including the titles and required training of individuals responsible for the transport of biohazardous materials; and

6.1.25 Procedures and/or protocols for general laboratory upkeep and cleaning, including specific procedures to eliminate or avoid cross-contamination.

Rule 7: Hemp Testing Laboratories: Analytical Processes

7.1 Method Validation and Verification. Analytical method selection, validation, and verification must ensure that the test method used is fit-for-purpose and that the laboratory can successfully perform the testing.

7.1.1 The demonstration of testing validity must ensure consistent, accurate and reproducible analytical performance in the matrices tested by the laboratory.

7.1.2 Method performance specifications must ensure analytical tests are sufficiently sensitive for the purposes of the detectability requirements of Rules Pertaining to the Administration and Enforcement of the Industrial hemp Regulatory Program Act, 8 CCR 1203-23 Part 6.1 and Colorado Wholesale Food, Industrial Hemp and Shellfish Regulations, 6 CCR 1010-21.

7.1.3 To the extent practicable, laboratory test methods must meet AOAC International (AOAC) standard method performance requirements.

7.1.4 The laboratory must implement a performance based measurement system for the selected methodology and validate the method following good laboratory practices in accordance with AOAC, United States Pharmacopeia (USP), United States Food and Drug Administration (FDA), and other reputable validation guidelines and methodology prior to reporting results. Validation, verification, or Matrix extension of methodology must include when applicable, but is not limited to:

7.1.4.1 Verification of Accuracy

7.1.4.2 Verification of Precision

7.1.4.3 Verification of Analytical Sensitivity

7.1.4.4 Verification of Analytical Specificity

7.1.4.5 Verification of the LOD

7.1.4.6 Verification of the LOQ

7.1.4.7 Verification of the Reportable Range

7.1.4.8 Identification of Interfering Substances

7.1.4.9 Verification of Recovery

7.1.4.10 Inclusivity

7.1.4.11 Exclusivity

7.1.4.12 Measurement Uncertainty

7.1.4.12.1 Subsequent to initial validation, Measurement Uncertainty must be re-evaluated at least annually or whenever method modifications are made.

7.1.4.13 For GC cannabinoid methods, experimental determination of actual conversion rate of THCA to THC.

7.1.5 Validation or verification of methodology must be documented in a validation report. The validation report shall include, but is not limited to, the following:

7.1.5.1 Validation plan;

7.1.5.2 Introduction and summary;

7.1.5.3 Materials, to include identification of certified Reference Materials, and preparation methods;

7.1.5.4 Method parameters;

7.1.5.5 Raw data, including instrument raw data such as chromatograms, for each test method and each instrument, if any;

7.1.5.6 Instrument calibration data, if any;

7.1.5.7 Data, calculations, and results;

7.1.5.8 Method Acceptability Criteria performance data;

7.1.5.9 Conclusion and discussion;

7.1.5.10 And References.

7.1.6 Software must be validated prior to testing Samples, including but not limited to: analytical software, application programming interface(s) (APIs), laboratory information management systems (LIMS), etc.

7.1.7 Prior to use, methodology must have a Standard Operating Procedure approved and signed by the laboratory director.

7.1.8 Testing analysts must have documentation of competency assessment prior to testing Samples.

7.1.9 Any changes to the approved methodology must be revalidated and documented prior to testing Samples. The documentation of changes and revalidation must be provided to the Department prior to implementation.

7.2 Gas Chromatography (GC). A Hemp Testing Laboratory using GC must:

7.2.1 Document the conditions of the gas chromatograph, including the detector response;

7.2.2 Perform and document preventive maintenance as required by the manufacturer and SOPs;

7.2.3 Ensure that records are maintained and readily available to the staff operating the equipment;

7.2.4 Document the performance of new columns before use;

7.2.5 Use an internal standard for each qualitative and quantitative analysis that has similar chemical and physical properties to that of the compound identified;

7.2.6 Establish Acceptability Criteria for variances between different aliquots and different columns;

7.2.7 Document the monitoring of the response (area or peak height) of the internal standard to ensure consistency overtime of the analytical system;

7.2.8 Evaluate the performance of the instrument after routine and preventive maintenance prior to analyzing subject Samples; and

7.2.9 Monitor and document the performance of the instrument each day of testing.

7.3 Gas Chromatography Mass Spectrometry (GC/MS). A Hemp Testing Laboratory using GC/MS must:

7.3.1 Perform and document preventive maintenance as required by the manufacturer and SOPs;

7.3.2 Document and maintain records when cleaning or changes in source, source conditions, column, or other routine maintenance are made to the instrument;

7.3.3 Ensure that records are maintained and readily available to the staff operating the equipment;

7.3.4 Maintain records of mass spectrometric tuning;

7.3.5 Establish written criteria for an acceptable mass-spectrometric tune;

7.3.6 Document corrective actions if a mass-spectrometric tune is unacceptable;

7.3.7 Monitor analytic analyses to check for contamination and carry-over;

7.3.8 Use selected ion monitoring within each run to assure that the laboratory compares ion ratios and retention times between calibrators, controls and Samples for identification of an Analyte;

7.3.9 Use an internal standard for qualitative and quantitative analysis that has similar chemical and physical properties to that of the compound identified and is isotopically labeled when available or appropriate for the assay;

7.3.10. Document the monitoring of the response (area or peak height) for the internal standard to ensure consistency overtime of the analytical system;

7.3.11 Define the criteria for designating qualitative results as positive;

7.3.12 When a library is used to qualitatively identify an Analyte, the identity of the Analyte must be confirmed before reporting results by comparing the relative retention time and mass spectrum to that of a known standard or control run on the same system;

7.3.13 Evaluate the performance of the instrument after routine and preventive maintenance (*e.g.* clipping or replacing the column or cleaning the source) prior to analyzing subject Samples; and

7.3.14 Monitor and document the performance of the instrument each day of testing.

7.4 Immunoassays. A Hemp Testing Laboratory using Immunoassays must:

7.4.1 Perform and document preventive maintenance as required by the manufacturer and SOPs;

7.4.2 Ensure that records are maintained and readily available to the staff operating the equipment;

7.4.3 Validate any changes or modifications to a manufacturer's approved assays or testing methods when a Sample is not included within the types of Samples approved by the manufacturer; and

7.4.4 Define acceptable separation or measurement units (absorbance intensity or counts per minute) for each assay, which must be consistent with manufacturer's instructions.

7.5 High Performance Liquid Chromatography (HPLC). A Hemp Testing Laboratory using HPLC must:

7.5.1 Perform and document preventive maintenance as required by the manufacturer and SOPs;

7.5.2 Ensure that records are maintained and readily available to the staff operating the equipment;

7.5.3 Monitor and document the performance of the HPLC instrument each day of testing;

7.5.4 Evaluate the performance of new columns before use;

7.5.5 Create written standards for acceptability when eluting solvents are recycled;

7.5.6 Use an internal standard for each qualitative and quantitative analysis that has similar chemical and physical properties to that of the compound identified when available or appropriate for the assay;

7.5.7 Document the monitoring of the response (area or peak height) of the internal standard to ensure consistency overtime of the analytical system;

7.5.8 Evaluate the performance of the instrument after routine and preventive maintenance prior to analyzing subject Samples; and

7.5.9 Monitor and document the performance of the instrument each day of testing.

7.6 Liquid Chromatography Mass Spectrometry (LC/MS). A Hemp Testing Laboratory using LC/MS must:

7.6.1 Perform and document preventive maintenance as required by the manufacturer and SOPs;

7.6.2 Ensure that records are maintained and readily available to the staff operating the equipment;

7.6.3 Establish written criteria for an acceptable mass-spectrometric tune;

7.6.4 Maintain records of mass spectrometric tuning;

7.6.5 Document Corrective Actions if a mass-spectrometric tune is unacceptable;

7.6.6 Use an internal standard with each qualitative and quantitative analysis that has similar chemical and physical properties to that of the compound identified and is isotopically labeled when available or appropriate for the assay;

7.6.7 Document the monitoring of the response (area or peak height) of the internal standard to ensure consistency overtime of the analytical system;

7.6.8 Compare two transitions and retention times between calibrators, controls and Samples within each run;

7.6.9 Document and maintain records when changes or cleaning in source, source conditions, eluent, or column are made to the instrument;

7.6.10 Evaluate and document the performance of the instrument after routine and preventative maintenance and when changes in: source, source conditions, eluent, or column are made prior to reporting test results; and

7.6.11 Monitor and document the performance of the instrument each day of testing.

7.7 Inductively Coupled Plasma Mass Spectrometry (ICP/MS). A Hemp Testing Laboratory using ICP must:

7.7.1 Perform and document preventive maintenance as required by the manufacturer and SOPs;

7.7.2 Ensure that records are maintained and readily available to the staff operating the equipment;

7.7.3 Establish written criteria for an acceptable mass-spectrometric tune;

7.7.4 Maintain records of mass spectrometric tuning;

7.7.5 Document Corrective Actions if a mass-spectrometric tune is unacceptable;

7.7.6 Use an internal standard with each qualitative and quantitative analysis that has similar chemical and physical properties to that of the compound identified and is isotopically labeled when available or appropriate for the assay;

7.7.7 Document the monitoring of the response (counts per second) of the internal standard to ensure consistency overtime of the analytical system;

7.7.8 Compare mass-to-charge ratios between calibrators, controls and Samples within each run;

7.7.9 Monitor analyses to check for contamination and carry-over;

7.7.10 Evaluate and document the performance of the instrument after routine and preventative maintenance and when changes in: source, conditions, or detector are made prior to reporting test results; and

7.7.11 Monitor and document the performance of the instrument each day of testing.

7.8 Microbial Assays. A Hemp Testing Facility using microbial assays must:

7.8.1 Perform and document preventive maintenance as required by the manufacturer and SOPs;

7.8.2 Ensure that records are maintained and readily available to the staff operating the equipment;

7.8.3 Validate any changes or modifications to a manufacturer's approved assays or testing methods when a Sample is not included within the types of Samples approved by the manufacturer;

7.8.4 Verify the method at the Action Levels for each Analyte. Verification at the qualitative presence/absence limit shall include a fractional recovery study;

7.8.5 The laboratory shall include controls for each set of Samples. Quantitative microbial methods shall use controls of a specific known value or set of values that lies within the quantifiable range of the method;

7.8.6 For molecular methods, the laboratory shall include controls for each individual analytical run. Quantitative molecular methods shall use controls of a specific known value or set of values that lies within the quantifiable range of the method;

7.8.7 PCR-based methods must include validated internal amplification controls; and

7.8.8 Microbial methods must include steps to confirm presumptive positive results; confirmation methods may be molecular or cultural or both. Where applicable, confirmation of viability must be performed.

7.9 Other Analytical Methodology. A Hemp Testing Laboratory using any other analytical methodology must:

7.9.1 Perform and document preventive maintenance as required by the manufacturer or SOP;

7.9.2 Ensure that records are maintained and readily available to the staff operating the equipment;

7.9.3 Ensure that appropriate quality assurance and Quality Control measures are performed and documented as necessary for the specific methodology; and

7.9.4 Evaluate the performance of the instrument after routine and preventive maintenance prior to analyzing subject Samples.

7.10 Cannabinoid Methodology. At a minimum, analytical testing of Samples for delta-9 tetrahydrocannabinol (THC) and cannabidiol (CBD) must use post-decarboxylation or other similarly reliable methods. The testing methodology must consider the potential conversion of delta-9 tetrahydrocannabinolic acid (THCA) and cannabidiolic acid (CBDA) into THC and CBD. The results reported must reflect the Total THC and Total CBD content.

7.10.1 The Cannabinoid concentrations of Industrial Hemp shall be determined and reported on a dry weight basis. Dry weight basis means the Moisture Content does not exceed 15%; and

7.10.2 The Cannabinoid concentrations of Industrial Hemp Products shall be determined and reported on an "as-is" basis (i.e., in the form submitted to the laboratory).

Rule 8: Hemp Testing Laboratories: Proficiency Testing

8.1 Proficiency Testing Required. A Hemp Testing Laboratory must participate in a Proficiency Testing program for each approved category in which it seeks certification under Rule 4 – Hemp Testing Laboratories: Certification Requirements.

8.2. Participation in Designated Proficiency Testing Event. If required by the Department as part of certification, the Hemp Testing Laboratory must have successfully participated in Proficiency Testing in the category for which it seeks certification, within the preceding 12 months.

8.2.1 The laboratory shall request the proficiency testing provider to send results concurrently to the Department, if available, or the laboratory shall provide the proficiency testing results to the Department within 3 business days after the laboratory receives notification of their results.

8.3 Continued Certification. To maintain continued certification, a Hemp Testing Laboratory must participate twice per calendar year in a designated Proficiency Testing program with continued satisfactory performance as determined by the Department as part of certification. The Department may designate a local agency, state agency, or independent third-party to provide Proficiency Testing.

8.4 Analyzing Proficiency Testing Samples. A Hemp Testing Laboratory must analyze Proficiency Test Samples using the same procedures with the same number of replicate analyses, standards, testing analysts, equipment, and data review processes as used in its Standard Operating Procedures.

8.5 Proficiency Testing Attestation. The laboratory director and all testing analysts who participated in Proficiency Testing must sign corresponding attestation statements.

8.6 Laboratory Director Must Review Results. The laboratory director must review and evaluate all Proficiency Testing results after receiving them from the proficiency testing provider.

8.7 Remedial Action. A Hemp Testing Laboratory must take and document remedial action when a score of less than 100% is achieved on any test during Proficiency Testing. Remedial action documentation must include a review of Samples tested and results reported since the last successful Proficiency Testing event. A requirement to take remedial action does not necessarily indicate unsatisfactory participation in a Proficiency Testing event.

8.8 Unsatisfactory Participation in a Proficiency Testing Event. Unless the Hemp Testing Laboratory positively identifies at least 80% of the target Analytes tested, participation in the Proficiency Testing event will be considered unsatisfactory. A positive identification must include accurate

quantitative and qualitative results as applicable. Any false positive result reported will be considered unsatisfactory participation in the Proficiency Testing event.

8.9 Consequence of Unsatisfactory Participation in Proficiency Testing Event. Unsatisfactory participation in a Proficiency Testing event may result in limitation, suspension or revocation of certification. A Hemp Testing Laboratory's certification will be suspended for the relevant testing category if two consecutive unsatisfactory Proficiency Testing events occur, or if two out of three consecutive unsatisfactory Proficiency Testing events occur. Certification may be reinstated after successful participation in the next Proficiency Testing event. Failure to achieve a satisfactory score in the next test event will result in the revocation of the certification and will require two successful consecutive Proficiency Testing events before the laboratory may be eligible to reapply for certification.

Rule 9: Hemp Testing Laboratories: Quality Assurance and Quality Control

9.1 Quality Assurance Program Required. A Hemp Testing Laboratory must establish, monitor, and document the ongoing review of a quality assurance program that is sufficient to identify problems in the laboratory preanalytic, analytic and postanalytic systems when they occur and must include, but is not limited to:

9.1.1 Review of instrument preventive maintenance, repair, and troubleshooting;

9.1.2 Documentation of Nonconformances and implementation of Corrective Actions and Preventative Actions when necessary;

9.1.3 Review of quality assurance documentation must be performed by the laboratory director or designated supervisory analyst on an ongoing basis to ensure the effectiveness of actions taken over time;

9.1.3 Review by the laboratory director or designated supervisory analyst of all ongoing quality assurance; and

9.1.4. Review of the performance of validated methods used by the Hemp Testing Laboratory to include calibration standards, controls and the Standard Operating Procedures used for analysis on an ongoing basis to ensure quality improvements are made when problems are identified or as needed.

9.2 Quality Control Measures Required. A Hemp Testing Laboratory must establish, monitor and document on an ongoing basis the Quality Control measures taken by the laboratory to ensure the proper functioning of equipment, validity of Standard Operating Procedures and accuracy of results reported. The laboratory must ensure that appropriate quality assurance and Quality Control measures are performed and documented as necessary for the specific methodology. Such Quality Control measures must include, but shall not be limited to:

9.2.1 Documentation of instrument preventive maintenance, repair, troubleshooting and Corrective Actions taken when performance does not meet established levels of quality;

9.2.2 Review and documentation of the accuracy of automatic and adjustable pipettes and other measuring devices when placed into service and annually thereafter;

9.2.3 Cleaning, maintaining and calibrating as needed the analytical balances and in addition, verifying the performance of the balance annually using certified weights to include three or more weights bracketing the ranges of measurement used by the laboratory;

9.2.4 Annually verifying working thermometers against a certified reference thermometer. Certified reference thermometers shall be calibrated traceable to the SI (International System of Units) through NIST, or equivalent by an ISO/IEC 17025 accredited calibration laboratory with a listed certification date;

9.2.5 Recording temperatures on all equipment when in use where temperature control is specified in the Standard Operating Procedures, such as water baths, heating blocks, incubators, ovens, refrigerators, and freezers;

9.2.6 Properly labeling reagents as to the identity, the concentration, date of preparation, storage conditions, lot number tracking, expiration date and the identity of the preparer;

9.2.7 Avoiding mixing different lots of reagents in the same analytical run;

9.2.8 Performing and documenting a calibration curve with each analysis using at minimum five calibrators throughout the reporting range;

9.2.9 For qualitative analyses, analyzing, at minimum, a negative and a positive control with each batch of Samples analyzed;

9.2.10 For quantitative analyses, analyzing, at minimum, a negative and two levels of controls that challenge the linearity of the entire curve;

9.2.11 Using a control material or materials that differ in either source or, lot number, or concentration from the calibration material used with each analytical run;

9.2.12 For multi-Analyte assays, performing and documenting calibration curves and controls specific to each Analyte, or at minimum, one with similar chemical properties as reported in the analytical run;

9.2.13 Analyzing an appropriate Matrix blank and control with each analytical run, when available;

9.2.14 Analyzing calibrators and controls in the same manner as unknowns;

9.2.15 Documenting the performance of calibration standards and controls for each analytical run to ensure the Acceptability Criteria as defined in the Standard Operating Procedure is met;

9.2.16 Documenting all Corrective Actions taken when unacceptable calibration, control, and standard or instrument performance does not meet Acceptability Criteria as defined in the Standard Operating Procedure;

9.2.17 Maintaining records of validation data for any new or modified methods to include; accuracy, precision, analytical specificity (interferences), LOD, LOQ, and verification of the linear range; and

9.2.18 Performing testing analysts that follow the current Standard Operating Procedures for the test or tests to be performed.

Rule 10: Hemp Testing Laboratories: Certificate of Analysis

10.1 The laboratory shall generate a Certificate of Analysis (COA) for each Sample that the laboratory analyzes.

10.2 The laboratory shall ensure that the COA contains the results of all requested analyses performed for the Sample.

10.3 The laboratory shall, within 1 business day of completing Total THC analysis of a Sample, provide a copy of the COA to the submitting Industrial Hemp Cultivator or Industrial Hemp Manufacturer and the Colorado Department of Agriculture Hemp Regulatory Program.

10.4 The COA shall contain, at minimum, the following information:

10.4.1 Laboratory's name, address, and contact information;

10.4.2 Industrial Hemp Cultivator's or Industrial Hemp Manufacturer's name and address;

10.4.3 Sample identifying information, including Matrix type and unique Sample identifiers;

10.4.4 Sample received date, and the date(s) of Sample analyses and corresponding testing results;

10.4.5 Units of measure;

10.4.6 The analytical methods, analytical instrumentation used, and corresponding Limits of Detection (LOD) and Limits of Quantitation (LOQ);

10.4.7 For Samples of Industrial Hemp, reported cannabinoid results must include the range of estimated uncertainty shall be reported as a ± value in the same units of measure as the test result, following best practices for significant figures and rounding; and

10.4.7.1 For Samples of Industrial Hemp, reported cannabinoid results must provide a calculated Total THC value + uncertainty on a dry weight basis.

10.4.8 A dedicated area to include any qualifiers or comments needed for interpretation, (when applicable to the test method and results being reported) to include any Identified and documented discrepancies.

10.5 The laboratory shall report test results for each representative Sample on the COA as follows:

10.5.1 When reporting qualitative results for each Analyte, the laboratory shall indicate presence or absence;

10.5.2 When reporting quantitative results for each Analyte, the laboratory shall use the appropriate units of measurement;

10.5.3 When reporting results for any Analytes that were detected below the analytical method LOQ, indicate "<LOQ";

10.5.4 When reporting results for any Analytes that were not detected or detected below the LOD, indicate "ND" or "<LOD"; and

10.6 The laboratory director or supervisory analyst shall validate the accuracy of the information contained on the COA.

Rule 11: Hemp Testing Laboratories: Chain of Custody

11.1 General Requirements. A Hemp Testing Laboratory must establish an adequate Chain of Custody and Sample requirement instructions that must include, but not limited to:

11.1.1 Issue instructions for the minimum Sample requirements and storage requirements;

11.1.1.1 Separate Sample into a test and a retain Sample;

11.1.1.1.1 The Sample shall be fully homogenized prior to dividing into test and retain Samples. The test and retain Samples shall each be sufficient to conduct the required analyses on the Sample;

11.1.1.1.2 The test Sample shall be carried through analysis; and

11.1.1.1.3 Retain Sample shall be packaged and stored in accordance with rule 6.1.7.

11.1.2 Document identifying information of the submitting Industrial Hemp Cultivator or Industrial Hemp Manufacturer, including harvest or production batch identification;

11.1.3 Assign and document a unique Sample identifier;

11.1.4 Document the condition of the external package and integrity seals utilized to prevent contamination of, or tampering with, the Sample;

11.1.5 Document the condition, temperature, Matrix, and amount of Sample provided at the time of receipt;

11.1.6 Document all persons handling the original Samples, aliquots, and extracts;

11.1.7 Document all Transfers of Samples, aliquots, and extracts referred to another certified Hemp Testing Laboratory for additional testing or whenever requested by a client;

11.1.8 Maintain a current list of authorized personnel and restrict entry to the laboratory to only those authorized;

11.1.9 Secure the Laboratory during non-working hours;

11.1.10 Secure short and long-term storage areas when not in use;

11.1.11 Ensure Samples are stored appropriately as defined in the written SOP; and

11.1.12 Document the disposal of Samples, aliquots, and extracts.

Rule 12: Hemp Testing Laboratories: Records Retention

12.1 General Requirements. A Hemp Testing Laboratory must maintain all required business records. *See* Rule 13 - Business Records Required.

12.2 Specific Business Records Required Record Retention. A Hemp Testing Laboratory must establish processes to preserve records in accordance with Rule 13 that includes, but is not limited to;

12.2.1 Test Results, including final and amended reports, and identification of analyst and date of analysis;

12.2.2 Quality Control and quality assurance Records, including accession numbers, Sample type, and acceptable reference range parameters;

1.2.3 Standard Operating Procedures;

12.2.4 Personnel Records;

12.2.5 Chain of Custody Records;

12.2.6 Proficiency Testing Records; and

12.2.7 Analytical Data to include data generated by the instrumentation, raw data of calibration standards and curves.

Rule 13: Hemp Testing Laboratories: Business Records Required

13.1 General Requirements.

13.1.1 A Hemp Testing Laboratory shall retain all records required by this rule for the current year and three preceding calendar years.

13.1.1.1 On premises records: The Hemp Testing Laboratory records for the preceding six months (or complete copies of such records) must be maintained onsite at all times; and

13.1.1.2 On- or off-premises records: Records associated with older periods may be archived onsite or offsite.

13.1.2 The records must include, but shall not be limited to:

13.1.2.1 Current Employee List – This list must provide the full name and job title of each employee who works at the laboratory;

13.1.2.3 Visitor Log – List of all visitors entering any limited or restricted access areas as defined by the laboratory;

13.1.2.4 Waste Log – Comprehensive records regarding all waste that accounts for, reconciles, and evidences all waste activity related to the disposal of any Sample that tests above 0.3% THC with at least 95% confidence and the disposal of any chemically hazardous or biohazardous waste;

13.1.2.5 Testing Records – The laboratory must maintain all testing records, to include calibration records, analytical data, calculations, test reports, and worksheets;

13.1.2.6 Standard Operating Procedures – All Standard Operating Procedures as required by these Rules;

13.1.2.7 Corrective Action and Preventive Action records;

13.1.2.8 Chain of Custody records; and

13.1.2.9 All other records required by these Rules.

13.1.3 Loss of Records and Data. Any loss of electronically-maintained records shall not be considered a mitigating factor for violations of this Rule. Laboratories are required to exercise due diligence in preserving and maintaining all required records.

13.1.4 Provision of Any Requested Record to the Department. A Hemp Testing Laboratory must provide on-demand access to on-premises records following a request from the Department during normal business hours or hours of apparent operation, and must provide access to off-premises records within three business days following a request from the Department.

Rule 14: Waste Disposal

14.1 All Applicable Laws Apply. All waste must be stored, secured, and managed in accordance with all applicable federal, state, and local statutes, regulations, ordinances, or other requirements, including but not limited to the “Regulations Pertaining to Solid Waste Sites and Facilities” (6 CCR

1007-2, Part 1) and "Regulation No. 100 – Water and Wastewater Facility Operations Certification Requirements" (5 CCR 1003-2) established by the Colorado Department of Public Health and Environment pursuant to the Title 25, Article 9, Part 1, C.R.S.

14.2 Liquid Waste. Liquid waste from Hemp Testing Laboratories shall be disposed of in compliance with all applicable federal, state and local laws, regulations, rules, and other requirements.

14.3 Chemical, Dangerous and Hazardous Waste. Disposal of chemical, dangerous, and hazardous waste must be conducted in a manner consistent with federal, state and local laws, statutes, regulations, rules, and other requirements.

COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing
February 17, 2021

NOTICE is hereby given pursuant to the provisions of Section 24-4-103, C.R.S., that the Colorado Board of Health will conduct a public rule-making hearing on February 17, 2021 at 10 a.m. remotely over Zoom at this link, to consider the adoption of new rule 5 CCR 1005-5, Hemp Testing Laboratory Certification. The proposed rule has been developed by the Division of Disease Control and Public Health Response of the Colorado Department of Public Health and Environment pursuant to Sections 35-61-105.5(2)(d) and 25-1.5-101(1)(f), C.R.S.

The agenda for the meeting and the proposed rule will also be available on the Board's website, https://cdphe.colorado.gov/board-of-health at least seven (7) days prior to the meeting. The proposed rules, together with the proposed statement of basis and purpose, specific statutory authority and regulatory analysis will be available for inspection at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South EDO-A5, Denver, Colorado 80246-1530 at least five days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Division of Disease Control and Public Health Response, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-2358.

The Board encourages all interested persons to participate in the hearing by providing written data, views, or comments. Written testimony is encouraged; oral testimony will be received only to the extent the Board finds it necessary. For those that are permitted to provide oral testimony, the time may be limited to 3 minutes or less. Testimony is limited to the scope of the rulemaking hearing. Pursuant to 6 CCR 1014-8, §3.02.1, written testimony must be submitted no later than five (5) calendar days prior to the rulemaking hearing. Written testimony must be received by 5:00 p.m., Thursday, February 11, 2021. Persons wishing to submit written comments should submit them to: Colorado Board of Health, ATTN: Board of Health Program Assistant, Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South EDO-A5, Denver, Colorado 80246-1530 or by e-mail at: cdphe.bohrequests@state.co.us

Dated this 17th day of December, 2020.

Alexandra S. Haas
Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00959

Department

1000 - Department of Public Health and Environment

Agency

1010 - Division of Environmental Health and Sustainability

CCR number

6 CCR 1010-21

Rule title

COLORADO WHOLESALE FOOD AND SHELLFISH REGULATIONS

Rulemaking Hearing

Date

02/17/2021

Time

10:00 AM

Location

Via Zoom: https://us02web.zoom.us/meeting/register/tZAqd-uqpjwvG9d-KHCYl4VIAXCFrhAfhFI3

Subjects and issues involved

The amendments refine and clarify manufacturing and testing requirements for the production of industrial hemp products and unfinished industrial hemp products in the state of Colorado.

Statutory authority

Sections 25-1.5-102(1)(c), 25-4-1810, 25-5-406, and 25-5-420, C.R.S

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Title

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Justin Trubee, Manufactured Food Safety Program Manager, Division of Environmental Health and Sustainability

Cary E. Ruble, Regulation Development Coordinator, Division of Environmental Health and Sustainability

Through: Jeff Lawrence, Director
Division of Environmental Health and Sustainability (JL)

Date: December 16, 2020

Subject: **Request for Rulemaking Hearing**
Proposed Amendments to 6 CCR 1010-21, *Colorado Wholesale Food and Shellfish Regulations* with a request for a rulemaking hearing to be set for February 17, 2021

The Division of Environmental Health and Sustainability ("division") is proposing revisions to 6 CCR 1010-21, *Colorado Wholesale Food and Shellfish Regulations* and is requesting that the Board of Health schedule a rulemaking hearing to consider adoption of the proposed amendments at the February 17, 2021, Board of Health meeting.

In compliance with the State Administrative Procedure Act, §24-4-103.3, C.R.S., the department is proposing amendments to 6 CCR 1010-21, *Colorado Wholesale Food and Shellfish Regulations*. These revisions are based on stakeholder input received during the Department of Agriculture's 2019 Colorado Hemp Advancement & Management Plan (CHAMP) initiative, and the division's stakeholder engagement process. The proposed revisions refine and clarify manufacturing and testing requirements for the production of industrial hemp products and unfinished industrial hemp products in the state of Colorado. 6 CCR 1010-21 was last amended by the Board of Health in August 2018.

This request for rulemaking proposes to maintain the requirements of 21 Code of Federal Regulations (C.F.R.) 100-111, 113-170, and 172-190 (April 1, 2017), as applicable to industrial hemp manufacturers and processors, and incorporate new requirements to define and clarify manufacturing and testing requirements for the production of industrial hemp products in Colorado.

Electronic copies of 21 C.F.R. 100-190 and Colorado's "*Pure Food and Drug Law*" are available for review on the division website and at the Colorado Legal Resources provided by LexisNexis:

- https://cdphe.colorado.gov/industrial-hemp-in-food/industrial-hemp-news-and-announcements
- https://advance.lexis.com/container?config=0345494EJAA5ZjE0MDIyYy1kNzZkLTRkNzktYTkxMS04YmJhNjBlNWUwYzYKAFBvZENhdGFsb2e4CaPI4cak6laXLCWyLBO9&crid=28abbed8-56f4-44da-9671-a4ad25ba0ba4&prid=d441faf3-c6aa-4ddf-ab54-167f1bfc5e2f

Also, federal regulation currently incorporated by reference and applicable law is posted and available for review using the following website:

- 21 C.F.R. 100-190 - https://www.ecfr.gov/cgi-bin/text-idx?SID=2029b930ffb25f468e235e6ec9a86dea&mc=true&tpl=/ecfrbrowse/Title21/21tab_02.tpl

The proposed amendments to 6 CCR 1010-21 do not apply to:

- Retail food establishments governed by the *Colorado Retail Food Establishment Regulations*, 6 CCR 1010-2;
- Facilities or conditions governed by the *Colorado Milk and Dairy Products Regulations*, 6 CCR 1010-4;
- Medical or retail marijuana regulated by the *Colorado Marijuana Rules* 1 CCR 212-3;
- Cultivation of industrial hemp governed by the *Rules Pertaining to the Administration and Enforcement of the Industrial Hemp Regulatory Program Act*, 8 CCR 1203-23;
- Entities that are manufacturing intermediate or finished hemp products from the fibrous material of the plant that are not intended for human consumption;
- Entities that are manufacturing industrial hemp-derived smokable products, inhalable products, over-the-counter drugs or medical devices; and
- Testing performed in accordance with the *Hemp Testing Laboratory Certification*, 5 CCR 1005-5.

The proposed rule applies the definition of relevant terms, ingredient and approved-source standards, potency and purity testing standards and permissible levels of contaminants, and packaging and labeling, record-keeping, transportation, and waste management requirements, which provide clarity and ease of use and reflect current statutory requirements contained in Sections 25-1.5-102(1)(c), 25-5-406, 25-5-420, and 25-5-426, C.R.S.

The continued incorporation by reference of 21 C.F.R., 100-111, 113-170, and 172-190, in state regulation and application and enforcement of new industrial hemp requirements identified through the CHAMP initiative and the division's robust stakeholder engagement process will retain current public health protections while maintaining the efficiency and effectiveness of the rulemaking process. The division has engaged stakeholders and has achieved consensus with respect to the proposed amendments to the *Colorado Wholesale Food and Shellfish Regulations*.

The division appreciates the Board's consideration.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
6 CCR 1010-21, *Colorado Wholesale Food and Shellfish Regulations*

Basis and Purpose.

Revisions to *Colorado Wholesale Food and Shellfish Regulations*, 6 CCR 1010-21 would include amendments to the existing wholesale food regulation based on broad stakeholder input received during the 2019 Colorado Hemp Advancement and Management Plan (CHAMP) initiative and the division's robust early stakeholder engagement process. The proposed revisions are necessary to refine and clarify manufacturing and testing requirements for the production of industrial hemp products and unfinished industrial hemp products in the State of Colorado. 6 CCR 1010-21 was last amended by the Board of Health in 2018.

The passage of the 2018 Agriculture Improvement Act, commonly called the Farm Bill, requires each state department of agriculture to submit a state management plan to the U.S. Department of Agriculture (USDA), outlining how various aspects of hemp cultivation and processing will be managed within their jurisdiction. In response, the Colorado Department of Agriculture (CDA) partnered with leading state, local, and tribal agencies, as well as industry stakeholders possessing expertise in the cultivation, testing, research, processing, finance, and economics to establish a statewide initiative known as the Colorado Hemp Advancement and Management Plan (CHAMP).

The proposed regulatory requirements do not infer conformance with federal laws and the allowance for manufacturing, sale, and distribution of industrial hemp products and unfinished industrial hemp product to other states or countries. U.S. Food and Drug Administration (FDA) does not recognize industrial hemp as an allowable food ingredient; therefore, the proposed regulation does not govern the allowance of interstate commerce. However, Colorado's industrial hemp manufacturers and processors are currently subject to the federal wholesale food requirements incorporated by reference. The incorporation by reference and application of 21 C.F.R. 100-190 (2017), except for 112 and 171, continues public health protections while:

- providing alignment with current and nationally accepted federal standards for wholesale food manufacturers who are also industrial hemp manufacturers and processors; and
- maintaining the efficiency and effectiveness of the rulemaking process and Department services.

Based on the outcomes from the CHAMP initiative and the division's early stakeholder engagement process, proposed revisions to 6 CCR 1010-21 include and clarify:

➢ ***Definition of relevant terms***

The majority of the proposed definitions were based on federal or state statute or existing regulation, revised during the division's early stakeholder engagement process, and represent stakeholder consensus. However, based on discussions during the stakeholder meeting held on July 28, 2020, two independent workgroups were formed to discuss additional revisions to the proposed definitions and testing requirements.

The definitions workgroup met on August 12, 2020, to focus on further refining the definitions of "*Broad spectrum*", *"Full spectrum", Cannabinoid", and "Unfinished industrial hemp product"*. Following evaluation and input, workgroup-proposed revisions to the definition of these relevant terms were incorporated into the proposed redline and presented for review to all stakeholders at the October 20, 2020 stakeholder meeting. Stakeholder consensus was achieved on the proposed definitions.

Subsequently, stakeholders requested further discussion and clarity regarding the definition of "*Industrial hemp*". Specifically, does the department have the authority to regulate specific cannabinoids in the same manner as delta-9 tetrahydrocannabinols (THC)? The definition of industrial hemp includes "*cannabinoids*" and is referenced in Section 25-5-426(2)(g.3), C.R.S., as having the same meaning as presented in 35-61-101(7), C.R.S., that states:

> "*Industrial hemp" or "hemp" means the plant Cannabis sativa L. and any part of the plant, including the seeds of the plant and all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers, whether growing or not, with a delta-9 tetrahydrocannabinol concentration of no more than three-tenths of one percent on a dry-weight basis."*

Furthermore, Section 25-5-426(2)(g.5)(III), C.R.S., provides a definition of "*Industrial hemp product*" that states, in part:

> "*Contains any part of the industrial hemp plant, including naturally occurring cannabinoids…*"

Therefore, state statute and department authority currently only allows for the regulation and limitation of the concentration of THC, the primary psychoactive component of the cannabis and industrial hemp plants. As the science of industrial hemp continues to evolve, additional "*naturally occurring cannabinoids*" have been identified that can create or have a psychoactive component similar to that of THC. It is anticipated more psychoactive cannabinoids will be identified.

While debate continues nationally and at the state level on what the allowable limit should be for THC in an industrial hemp plant, it was clear in both the *Federal Farm Bill* and the *Colorado Industrial Hemp Act* that the allowance of industrial hemp as a crop was because of the utility of the crop and its naturally low non-psychoactive concentration of THC. Neither of these two laws considered the inclusion of hemp and hemp derivatives being allowed in food, supplements, or other products. Consequently, with Colorado allowing for the use of hemp and its derivatives in cosmetics, dietary supplements and foods, the allowable levels of these other "*naturally occurring cannabinoids*" that have psychoactive properties should be established. However, as the statutory requirements are currently constructed, the department does not have the authority to establish limits on these other naturally occurring psychoactive cannabinoids [e.g., delta-8 THC, Cannabinol (CBN), and Cannabigerol (CBG)].

- ***Processing and manufacturing requirements***

Title 21 of the Code of Federal Regulations (C.F.R.) 100-111, 113-170, and 172-190 (2017) provides the basis for the regulation of wholesale foods in the state of

Colorado. The proposed regulation would require all industrial hemp processors and manufacturers to comply with these federal regulations and the additional requirements included in the proposed regulation. The following additional industrial hemp manufacturing requirements were identified as more substantive, vetted through the stakeholder process, and included in the proposed regulation by consensus.

- Section 21.7(A) – "*Oils, concentrates or other substances that are above 5.0% total THC must undergo further refinement or processing by the original registered industrial hemp manufacturer.*"

- Section 21.7(E)(2) – *"All industrial hemp products or unfinished industrial hemp products shall be clearly identified to allow for appropriate traceability…"*

➢ ***Testing requirements and effective date***

In order for a food, food additive, dietary supplement, or cosmetic to contain industrial hemp, the manufacturer shall demonstrate through analytical testing at a department certified laboratory that the product does not contain contaminant levels that exceed the action limits defined in the testing tables proposed in sections 21.7(F)(5)(a)(b)(c)(d) and (e) of the proposed regulation. The proposed analytical testing requirements will be implemented on the effective date of the regulation. The certified laboratory requirement will be delayed until July 1, 2021, to provide the necessary time for CDPHE to certify industrial hemp laboratories. Action limits for the identified and proposed contaminants were based on the following sources and vetted through the stakeholder process:

- Microbials – The American Herbal Product Association (AHPA), *Recommended Microbial Limits for "Finished" Botanical Products* and United States Pharmacopeia (USP), Chapter <2023>, *Microbiological Attributes of Nonsterile Nutritional and Dietary Supplements*, were the basis for the action limits proposed in table 21.7(F)(5)(a), *Microbials*;

- Mycotoxins – The Food and Drug Administration (FDA), *Guidance for Industry: Action Levels for Poisonous or Deleterious Substances in Human Food and Animal Feed*, and European Union (EU) regulation, Commission Regulation (EC) No 1881/2006, *Setting Maximum Levels for Certain Contaminants in Foodstuffs* were the basis for the action limits for Total Aflatoxins (FDA), Aflatoxin B1 (EU), and Ochratoxin A (EU), as defined in proposed table 21.7(F)(5)(b), *Mycotoxins*;

- Pesticides - The Government of Canada, Health Canada, *Mandatory Cannabis Testing for Pesticide Active Ingredients*, was the basis for the action limits defined in proposed table 21.7(F)(5)(c), *Pesticides*;

- Heavy Metals – USP, Chapter <2232>, *Elemental Contaminants in Dietary Supplements,* was the basis for the action limits defined in proposed table 21.7(F)(5)(d), *Heavy metals*; and

- Residual Solvents – USP, Chapter <467>, *Residual Solvents*, and the *Colorado Marijuana Rules*, 1 CCR 212-3, were the basis for the action limits defined in proposed table 21.7(F)(5)(e), *Residual solvents*.

Based on discussions during the stakeholder meeting held on July 28, 2020, the testing workgroup was formed and met on August 4, 2020, to further evaluate appropriate action limits for the identified microbials, mycotoxins, pesticides, heavy metals, and residual solvents. Following evaluation and input, workgroup-proposed revisions to the testing requirements were incorporated into the proposed redline and presented for review to all stakeholders at the October 20, 2020, stakeholder meeting.

Stakeholder consensus was achieved on the proposed testing requirements with noted objections. Some stakeholders were less supportive of the proposed residual solvent action limits. However, a more appropriate resource or proxy rather than the USP that would assist in establishing more defensible and protective action limits was not identified. Those stakeholders in opposition of utilizing the USP desired to establish limits based on the solvents being characterized as direct or indirect food ingredients. However, these limits would vary greatly depending on what food product was chosen as a reasonable proxy. Additionally, several other states have established residual solvent limits based on the USP and while Canada's limits are not based on the USP, their established limits are closely aligned to those established in the USP and within these regulations.

- ***Packaging and labeling, record keeping, recalls, transportation, and waste management requirements***

The basis of the regulation of wholesale foods in Colorado can be found at 21 C.F.R. 100-111, 113-170, and 172-190 (2017). The proposed packaging and labeling requirements in section 21.7(G)(1) of the proposed changes will be delayed until July 1, 2021, to allow industry to transition into compliance. The following additional industrial hemp requirements were identified as the more substantive additions, were vetted through the stakeholder process, and included in the proposed regulation by consensus:

- Section 21.7(G)(2)(d) requires all industrial hemp finished product labels to; *"(1) identify industrial hemp as an ingredient, (2) identify each isolated cannabinoid as an ingredient and the amount labeled in milligrams or when using a broad or full spectrum product, label the total amount in milligrams, and (3)* Identify in milligrams the total THC content per serving and total THC content per finished individual product packaging.";

- Section 21.7(H)(1) requires that the following records be maintained; *"(a) Certificates of analysis, (b) Batch production records; (c) Recalled product information, (d) Source of ingredients, and (e) Other records as required by the department (e.g., ingredient records, corrective action logs, mock recall documents, calibration records, as applicable).*";

- Section 21.7(J)(1) requires that the *"Transfer of industrial hemp or unfinished industrial hemp product shall be conducted in accordance with the law.*", and

- Section 21.7(K) requires that, "*1. Industrial hemp-derived THC shall be diluted to a concentration less than 0.3%, converted, or disposed of in accordance with the department's Hazardous and Waste Management Division's Marijuana and Marijuana-Related Waste Disposal Compliance Bulletin."* and *"2. Facility*

owner/operator is responsible to secure and limit access to industrial hemp-derived THC with a concentration greater than 0.3%."

- ***Formatting and technical edits to improve readability***

  These proposed amendments align non-substantive and formatting revisions with other division regulations and Secretary of State's requirements.

These proposed requirements were identified as areas where elaborating upon the statutory framework added needed clarity and improved ease of use and application. Along with these substantive changes, technical edits and reformatting occurred to improve readability and alignment with other Department rules.

Specific Statutory Authority.

Statutes that require or authorize rulemaking: Sections 25-1.5-102(1)(c), 25-4-1810, 25-5-406, and 25-5-420, C.R.S.

Is this rulemaking due to a change in state statute?

_____ Yes, the bill number is _____. Rules are ___ authorized ___ required.

__X__ No

Does this rulemaking include proposed rule language that incorporates materials by reference?

__X__ Yes ___ URL https://ecfr.io/Title-21/

_____ No

Does this rulemaking include proposed rule language to create or modify fines or fees?

_____ Yes

__X__ No

Does the proposed rule language create (or increase) a state mandate on local government?

__X__ No.

- The proposed rule does not require a local government to perform or increase a specific activity for which the local government will not be reimbursed;
- The proposed rule requires a local government to perform or increase a specific activity because the local government has opted to perform an activity, or;
- The proposed rule reduces or eliminates a state mandate on local government.

__ Yes.

This rule includes a new state mandate or increases the level of service required to comply with an existing state mandate, and local government will not be reimbursed for the costs associated with the new mandate or increase in service. The state mandate is categorized as:

___ Necessitated by federal law, state law, or a court order

___ Caused by the State's participation in an optional federal program

___ Imposed by the sole discretion of a Department

___ Other: _____
(i.e. requested by local governments and consensus was achieved)

Has an elected official or other representatives of local governments disagreed with this categorization of the mandate? ___Yes ___No. If "yes," please explain why there is disagreement in the categorization.

REGULATORY ANALYSIS
for Amendments to
6 CCR 1010-21, *Colorado Wholesale Food and Shellfish Regulations*

1. A description of the classes of persons affected by the proposed rule, including the classes that will bear the costs and the classes that will benefit from the proposed rule.

Group of persons/entities Affected by the Proposed Rule	Size of the Group	Relationship to the Proposed Rule Select category: C/CLG/S/B
Industrial hemp and unfinished industrial hemp product manufacturers, processors, or storage facilities registered with the department.	~486	C
Industrial hemp transporters	~17	C
Medical and retail marijuana dispensaries	~700	S
Colorado Dept. of Public Health & Environment	~1,600	S
Marijuana Enforcement Division	~120	S
Colorado Department of Agriculture	~300	S
Colorado Bureau of Investigation	~300	S
Colorado State University	~1,900	S
Analytical Laboratories / LSD	~21	S
Retail food establishments	~23,000	S
Consulting/engineering firms	Unknown	S
Pharmaceutical companies	Unknown	S
Institutes, unions, associations, advocacy groups	Unknown	S
Legal firms	Unknown	S
Local county government	64	S
Financial institutions	Unknown	S
Tribal agencies	2	C/S
Industrial hemp consumers in Colorado	~1.5M	S/B
Industrial hemp consumers in US	~70M	S/B

While all are stakeholders, groups of persons/entities connect to the rule and the problem being solved by the rule in different ways. To better understand those different relationships, please use this relationship categorization key:

C = individuals/entities that implement or apply the rule.
S = individuals/entities that do not implement or apply the rule but are interested in others applying the rule.
B = the individuals that are ultimately served, including the customers of our customers. These individuals may benefit, be harmed by or be at-risk because of the standard communicated in the rule or the manner in which the rule is implemented.

More than one category may be appropriate for some stakeholders.

2. To the extent practicable, a description of the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

Registered industrial hemp manufacturers and storage facilities represent approximately 486 of the 2,529 department-regulated wholesale food manufacturing and storage facilities throughout the state of Colorado. The department and the regulated community are all affected and will benefit from the proposed amendments. Maintaining the requirements of 21 C.F.R. 100-111, 113-170, and 172-190 (2017), as applicable to industrial hemp manufacturers and processors, and adoption of the proposed amendments ensures that industrial hemp products in the State of Colorado come from an approved sources, are tested for potency and purity, are packaged and labeled in accordance with 21 C.F.R. 101(A-G) (2017) and the department's labeling requirements, are subject to an established recall plan (if necessary), are transported and disposed properly, and that appropriate records are retained. Costs borne by the department are minimal and administrative in nature.

Industrial hemp manufacturers and processors will bear the costs associated with the proposed industrial hemp testing and labeling requirements. Although the proposed laboratory testing of industrial hemp products may represent an economic impact to our industry partners, these anticipated costs were discussed and vetted during the CHAMP initiative and the division's stakeholder processes. Industrial hemp manufacturers recognize that Colorado is one of the first states to apply the requirements of 21 C.F.R. 100-111, 113-170, and 172-190 (2017), as applicable to industrial hemp manufacturers and processors. The surety of the proposed regulation, including the testing standards, provides stability and validity to this novel industry. Manufacturers of industrial hemp products and unfinished industrial hemp products understand that continued alignment with current industry standards and adoption of the proposed amendments are necessary to refine and clarify manufacturing, testing, and labeling requirements for the production of industrial hemp products in the State of Colorado. The department is proposing July 1, 2021, for compliance with laboratory certification requirements proposed in section 21.7(F)(1) and the labeling requirements proposed in section 21.7(G)(1) of the amended regulation.

The ultimate customer of industrial hemp manufacturing, the consumers inside Colorado and worldwide, will benefit from the proposed revisions by ensuring that the sale and distribution of Colorado's industrial hemp product remains consistent with established requirements and that food containing industrial hemp is honestly represented and safe.

Maintaining the requirements of 21 C.F.R. 100-111, 113-170, and 172-190 (2017), as applicable to industrial hemp manufacturers and processors, and inclusion of the proposed manufacturing and testing requirements will continue to safeguard public health and ensure that food and supplements containing industrial hemp that is served in Colorado is unadulterated and honestly presented to all consumers. The proposed regulation revisions will continue to assure uniformity and effectiveness in the implementation of food safety standards and promote the full health potential of all Coloradans.

Economic outcomes

Summarize the financial costs and benefits, include a description of costs that must be incurred, costs that may be incurred, any Department measures taken to reduce or eliminate these costs, any financial benefits.

Please describe any anticipated financial costs or benefits to these individuals/entities.

C: Industrial hemp manufacturers will bear the costs associated with the proposed industrial hemp analytical testing requirements. Although the required laboratory testing may represent an economic impact to our industry partners, these anticipated costs were discussed and vetted during the CHAMP initiative and division's early stakeholder engagement process.

Also, industrial hemp manufacturers will bear some costs associated with the proposed industrial hemp labeling requirements. The department is proposing July 1, 2021, for compliance with the labeling requirements in section 21.7(G)(1). The delayed implementation of the labeling requirements allows manufacturers to exhaust current labeling inventory and complete the reprinting of labels.

S: No anticipated financial costs or benefits to the department or any state regulatory agency were identified.

B: No anticipated financial costs were identified, but the consumer will benefit from proposed amendments by ensuring that food or dietary supplements containing industrial hemp that is manufactured or processed in Colorado is unadulterated, safe, and honestly presented.

Non-economic outcomes

Summarize the anticipated favorable and non-favorable non-economic outcomes (short-term and long-term), and, if known, the likelihood of the outcomes for each affected class of persons by the relationship category.

C: Industrial hemp manufacturers recognize that Colorado is one of the first states to apply the requirements of 21 C.F.R. 100-111, 113-170, and 172-190 (2017) to industrial hemp manufacturers and processors and that the surety of the proposed regulation provides stability and validity to this novel industry. Manufacturers of industrial hemp products and unfinished industrial hemp products in Colorado understand that maintaining alignment with current federal food safety standards and adoption of the proposed state-specific amendments provides the necessary clarity regarding the manufacturing and testing requirements for the production of industrial hemp products in the State of Colorado.

S: The department will benefit from the proposed revisions by ensuring that the sale and distribution of Colorado's industrial hemp product is consistent with established federal food safety requirements, from approved sources, tested for potency and purity at a CDPHE certified laboratory, packaged and labeled in accordance with 21 C.F.R. 101(A-G) (2017) and the departments labeling requirements, subject to an established written recall plan (if necessary), transported and disposed in accordance with the law, and that appropriate records are retained.

B: The ultimate customer of industrial hemp manufacturing and processing, the consumers inside Colorado and worldwide, will benefit from the proposed revisions by ensuring that the sale and distribution of Colorado's industrial hemp products is consistent with established federal food safety requirements, from approved sources, and are honestly represented and safe.

3. The probable costs to the agency and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   A. Anticipated CDPHE personal services, operating costs or other expenditures: None

   Anticipated CDPHE Revenues: None. Registration fees for industrial hemp manufacturers were established in statute in 2018 and revised in 2019 (25-5-426, C.R.S).

   B. Anticipated personal services, operating costs or other expenditures by another state agency: None

   Anticipated Revenues for another state agency: None

4. A comparison of the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Along with the costs and benefits discussed above, the proposed revisions:

   ___ Comply with a statutory mandate to promulgate rules.
   _X_ Comply with federal or state statutory mandates, federal or state regulations, and department funding obligations.
   _X_ Maintain alignment with other states or national standards.
   _X_ Implement a Regulatory Efficiency Review (rule review) result
   _X_ Improve public and environmental health practice.
   _X_ Implement stakeholder feedback.

   Advance the following CDPHE Strategic Plan priorities (select all that apply):

1. Reduce Greenhouse Gas (GHG) emissions economy-wide from 125.716 million metric tons of CO2e (carbon dioxide equivalent) per year to 119.430 million metric tons of CO2e per year by June 30, 2020 and to 113.144 million metric tons of CO2e by June 30, 2023. ___ Contributes to the blueprint for pollution reduction ___ Reduces carbon dioxide from transportation ___ Reduces methane emissions from oil and gas industry ___ Reduces carbon dioxide emissions from electricity sector
2. Reduce ozone from 83 parts per billion (ppb) to 80 ppb by June 30, 2020 and 75 ppb by June 30, 2023. ___ Reduces volatile organic compounds (VOC) and oxides of nitrogen (NOx) from the oil and gas industry. ___ Supports local agencies and COGCC in oil and gas regulations. ___ Reduces VOC and NOx emissions from non-oil and gas contributors
3. Decrease the number of Colorado adults who have obesity by 2,838 by June 30, 2020 and by 12,207 by June 30, 2023. ___ Increases the consumption of healthy food and beverages through education,

policy, practice and environmental changes. ___ Increases physical activity by promoting local and state policies to improve active transportation and access to recreation. ___ Increases the reach of the National Diabetes Prevention Program and Diabetes Self-Management Education and Support by collaborating with the Department of Health Care Policy and Financing.
4. Decrease the number of Colorado children (age 2-4 years) who participate in the WIC Program and have obesity from 2120 to 2115 by June 30, 2020 and to 2100 by June 30, 2023. ___ Ensures access to breastfeeding-friendly environments.
5. Reverse the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023. ___ Reverses the downward trend and increase the percent of kindergartners protected against measles, mumps and rubella (MMR) from 87.4% to 90% (1,669 more kids) by June 30, 2020 and increase to 95% by June 30, 2023. ___ Performs targeted programming to increase immunization rates. ___ Supports legislation and policies that promote complete immunization and exemption data in the Colorado Immunization Information System (CIIS).
6. Colorado will reduce the suicide death rate by 5% by June 30, 2020 and 15% by June 30, 2023. ___ Creates a roadmap to address suicide in Colorado. ___ Improves youth connections to school, positive peers and caring adults, and promotes healthy behaviors and positive school climate. ___ Decreases stigma associated with mental health and suicide, and increases help-seeking behaviors among working-age males, particularly within high-risk industries. ___ Saves health care costs by reducing reliance on emergency departments and connects to responsive community-based resources.
7. The Office of Emergency Preparedness and Response (OEPR) will identify 100% of jurisdictional gaps to inform the required work of the Operational Readiness Review by June 30, 2020. ___ Conducts a gap assessment. ___ Updates existing plans to address identified gaps. ___ Develops and conducts various exercises to close gaps.
8. For each identified threat, increase the competency rating from 0% to 54% for outbreak/incident investigation steps by June 30, 2020 and increase to 92% competency rating by June 30, 2023. ___ Uses an assessment tool to measure competency for CDPHE's response to an outbreak or environmental incident. ___ Works cross-departmentally to update and draft plans to address identified gaps

noted in the assessment. ___ Conducts exercises to measure and increase performance related to identified gaps in the outbreak or incident response plan.
9. 100% of new technology applications will be virtually available to customers, anytime and anywhere, by June 30, 2020 and 90 of the existing applications by June 30, 2023. ___ Implements the CDPHE Digital Transformation Plan. ___ Optimizes processes prior to digitizing them. ___ Improves data dissemination and interoperability methods and timeliness.
10. Reduce CDPHE's Scope 1 & 2 Greenhouse Gas emissions (GHG) from 6,561 metric tons (in FY2015) to 5,249 metric tons (20% reduction) by June 30, 2020 and 4,593 tons (30% reduction) by June 30, 2023. ___ Reduces emissions from employee commuting ___ Reduces emissions from CDPHE operations
11. Fully implement the roadmap to create and pilot using a budget equity assessment by June 30, 2020 and increase the percent of selected budgets using the equity assessment from 0% to 50% by June 30, 2023. ___ Used a budget equity assessment

_X_ Advances CDPHE Division-level strategic priorities.

The DEHS *Strategic Plan Update*, dated February 15, 2019, identified the creation of a program and regulations that adequately regulates industrial hemp products.

The costs and benefits of the proposed rule will not be incurred if inaction was chosen. Costs and benefits of inaction not previously discussed include: NA

5. A determination of whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

Rulemaking is proposed when it is the least costly method or the only statutorily allowable method for achieving the purpose of the statute. The specific revisions proposed in this rulemaking were developed in conjunction with stakeholders. The benefits, risks and costs of these proposed revisions were compared to the costs and benefits of other options. The proposed revisions provide the most benefit for the least amount of cost, are the minimum necessary, or are the most feasible manner to achieve compliance with statute.

Adoption of the proposed industrial hemp manufacturing and testing requirements and maintaining the incorporation by reference and application of 21 C.F.R. 100-111, 113-170, and 172-190 (2017), as applicable to industrial hemp manufacturers and processors, achieves alignment with existing federal wholesale food regulations and continues levels of wholesale food sanitation practices currently in place. No less costly or intrusive method for achieving the purpose of this rule was identified. The

department will update the incorporation by reference as needed to remain current.

6. Alternative Rules or Alternatives to Rulemaking Considered and Why Rejected.

No alternate rules or alternatives to the proposed rulemaking were considered. Current regulations incorporate by reference the 2017 base requirements of the federal wholesale food regulations and are necessary in achieving the safe production of food and dietary supplements. Colorado House Bill HB 18-1295 directed the department to consider industrial hemp and its derivatives as an allowable food and dietary supplement ingredient. Therefore, continued incorporation by reference of federal regulations as applicable to industrial hemp products and application of the proposed requirements clarifying approved sources, testing, packaged and labeling, record keeping, recalls, transportation, and waste management, is the most effective and efficient approach to rulemaking while protecting public health and allowing Colorado's industrial hemp businesses to continue sell their products. Retention of these federal food regulations and adoption of the proposed amendments will ensure long-term consistency in the application of industrial hemp regulatory requirements in Colorado.

7. To the extent practicable, a quantification of the data used in the analysis; the analysis must take into account both short-term and long-term consequences.

The division began preparations for this rulemaking in 2019, as a co-sponsor and participant in CDA's CHAMP initiative. The proposed revisions to the existing regulation incorporate stakeholder input received during the 2019 CHAMP initiative, stakeholder input received during the division's early stakeholder engagement process (July through November 2020), and are necessary to refine and clarify manufacturing and testing requirements for the production of industrial hemp products in the State of Colorado

Maintaining the incorporation by reference of current federal wholesale food regulation 21 C.F.R. 100-111, 113-170, and 172-190 (2017) and application of the proposed requirements clarifying approved sources, testing, packaged and labeling, record keeping, recalls, transportation, and waste management, for the industrial hemp industry will be a benefit to the department, the regulated community, and the public, both in the short-term and long-term.

STAKEHOLDER ENGAGEMENT
for Amendments to
6 CCR 1010-21, *Colorado Wholesale Food and Shellfish Regulations*

State law requires agencies to establish a representative group of participants when considering to adopt or modify new and existing rules. This is commonly referred to as a stakeholder group.

Early Stakeholder Engagement:
The following individuals and/or entities were invited to provide input and included in the development of these proposed rules:

Organization	**Representative Name and Title (if known)**
1287 Enterprises	Jimmy Haberer/CHAMP
13 Trees Coffee Co LLC	
271 Lake Davis Holding	
4 Corners Cannabis	
43 CBD	
5280 Chefs	
Aaron Horwich	
Abe Rahmanizadeh	
Acacia	
Aceso	
Active Botanical Company	
ADM Labs LLC	
Advanced Plant Processing	
Adventure CBD	
Agile CBD	
Ahava Care Labs	
Alan Call	
Alchemy Processing Laboratory, LLC	
All About Minutes Inc.	
Allay Consulting LLC	Kimberly A Stuck/CHAMP
Alliance Nutra	
Allo Blends, LLC	
Altitude Pioneer Industries LLC	
Alyssa Rosenblum	CHAMP
Ambary Gardens, LLC	
American Original Hemp	
America's Finest CBD, LLC	
Amy Charkowski	CHAMP
Anandamide Alchemy LLC	
Antedotum	
Antonio Negroni	CHAMP
APAX USA, Inc.	
Arcanum Sports Performance	
Arendis, LLC	
Arkansas Valley Farms, LLC	
Aspen Grove Tea Co. LLC.	
Authentic Hemp Company	
Axtell Labs	Blake Boehmier
Ayani Botanicals, LLC	
Azuca	
Backyard Soda	
Bainstar	
Balanced Health Botanicals	Sommer Martinez/CHAMP

Balefire Botanicals	
Basecamp Co-Pack	
BE Labs/CBD Luxe	
Bees Knees CBDs	
Bellisimo Botanicals, LLC	
Benjamin Waters	
Bernie Perry	
Better Way CBD	
Bio Herbs And More	
BioLiveit Cannabinoids	
Bjorn's Colorado Honey	
Blister Pack Pro LLC	
Bloomble Inc.	
Blue Forest Farms	
Blue Sky Ventures LLC	
Bluebird Botanicals	Kevin Liebrock/CHAMP
Bluebird Botanicals	Kasey Irwin/CHAMP
Bluegrass State Holdings, LLC	
Bob Sculpt	CHAMP
BoCo Farms, LLC	Grant Orvis/CHAMP
Bonsai Wellness, LLC	
Botana	
Botanex Technologies Ltd	Industry
Botanix Equities, LLC	
Boulder Botanicals & Bioscience Laboratories, Inc.	Robert Dimarco/CHAMP
Boulder Hemp	
Boulder Raw	
Brian Donovan	
Brian Koontz	CHAMP
Brian Lukas	CHAMP
Brian Morrow	CHAMP
Bryan Burke Astral Organica	
Butterfly, LLC	
Cabaniss Group, LLC	
Cactus Valley Hemp Farm LLC	
Canna Brothers Distribution	
Cannabinoid Contract Manufacturing, LLC	
CannaGea	
Cannopy Corporation	
Canopy Growth Corporation	Ken Woodlin/CHAMP
Care Division, LLC	
Caring Creatures LLC	
CBD CliniLabs, LLC	
CBD Global, LLC	
CBD Inc Group	
CBD Janes LLC	
CBD Universe, LLC	
CBD-Ease	
CBuzzD	
CDA	Duane Sinning
CDPHE-DEHS	Aaron Doussett
CDPHE-DEHS	Anjelica Thibault
CDPHE-DEHS	Bonnie Laws
CDPHE-DEHS	Cary Ruble/CHAMP
CDPHE-DEHS	David Kollar
CDPHE-DEHS	Jeff Lawrence/CHAMP
CDPHE-DEHS	Joe Lomeli/CHAMP
CDPHE-DEHS	Justin Trubee
CDPHE-DEHS	Kelly Lancelot
CDPHE-DEHS	Margaret Furlow

CDPHE-DEHS	Sean Scott
CDPHE-DEHS	Jon Strauss/CHAMP
Centered Snacks	
Cepheus Grown LLC	
Chae International	
Charlotte's Web, Inc.	Nathan Gerhardt/CHAMP
Chromo Labs LLC	
Citizens Laboratories LTD	
City of Aurora	Kim Kreimeyer/CHAMP
City of Colorado Springs	Mattie Gullixson/CHAMP
Cloud Co Farms LLC	
Clutch Hemp Co.	
CML	Laurel Witt/CHAMP
CML	Brandy Delange/CHAMP
Color Up Therapeutics	
Colorado Better Days Ltd	
Colorado BioDynamic	
Colorado Bureau of Investigation	Shawn West/CHAMP
Colorado Cannabinoids	
Colorado Chromatograpy	
Colorado Commodities Exporters LLC	
Colorado Cultivars USA	
Colorado Cultivars USA	
Colorado Dept Of Public Health and Environment	Kaitlin Urso/CHAMP
Colorado Farms, LLC	
Colorado Green Films Technology LLC	
Colorado Hemp Institute, LLC	
Colorado Hemp Solutions, LLC	
Colorado Medicine Woman	
Colorado Mountain Jam	
Colorado Processing Company, LLC	
Colorado Processing LLC	
Colorado State University	Kathleen Russell/CHAMP
Common Ground	
Cottonwood Sciences, LLC	
CoziCBD	
Crazy Mountain Brewing Company	
Cured Nutrition LLC	
Curnativ Labs	
CW Hemp	
Dan Arensmeier	
David USAGOV	
Deez Tea / Deez Coffee	
Denver Department of Public Health and Environment	Abby Davidson / CHAMP
Denver's Department of Excise and Licenses	Erica Rogers/CHAMP
Department of Agriculture	Wondirad Gebru/CHAMP
Diesel Haus Extracts	
Dion Oakes	
Director of Hemp Operations.	Preston Whitfield/CHAMP
Discover CBD/ Active CBD Oil	
Doka LLC	
Don Polly, LLC	
Down Range Productions, LLC	
Dr. Woodard's Colorado Cubes Ltd	
Dragonfly Botanicals	
Dram	
DTN, Inc	
e2 Enterprises, LLC	
Eagle Ridge Extractions	
Earth Pharmaceuticals LLC	

EB Transaction Sub 1, LLC	
Ecclesias Extracts	
EcoGen Laboratories, Eco-X Incorporated	
Eco-X Incorporated	
Ed Lehrburger	CHAMP
EdenFlo LLC	
Elena Bragg	
Elevated Elixirs	
Elevated Gains LLC	
Elevated Softgels, LLC	
Elevation Farms CO, LLC	
Elite Botanicals, LLC	
Elite Health Partners, LLC	
Elixinol	
Ellipse Analytics	Sean Callan/CHAMP
Empeiria Subscriptions	
Enerhealth Botanicals	
EP Greens	
Epic Relief LLC	
Erin Spies, Native Roots Dispensary	
ERL, LLC	
Evello Labs	
EVG Extracts, LLC	
Evolved Alchemy	
Extract Labs	
Eye of Ra Beverages, Inc	
Farmhouse Hemp	
Fat Pig Society	
First Crop, Inc.	Michael Bowman/CHAMP
Fishski Provisions LLC	
Flo Hemp Co	
Flora's Mercantile & Hemp Emporium	Chris Bedrosian/CHAMP
Flowerchild	
FM Labs LLC	
Folium Biosciences	
Fountain of Health Supplements, LLC	
FOURPOINTS BAR	
Frangiosa Farms	
Frank Registrato	
Frying Pan Hemp LLC	
Full Metal Canning	
Functional Remedies	Tim Gordon/CHAMP
Galaxy S9+	
General Processing LLC	
Gerald Campbell	
Glacier Pak LLC	
GOHCo Operations LLC	
Gold Care, LLC	
Good Love CBD	
Good Plant Hemp Inc	
Good Vibe CBD	
Good Vibe Tribe Inc	
Goodberry, LLC	
Grand Valley Gourmet, LLC	
Granny's High Altitude Super Hemp, LLC	
Green Cherry Organics	
Green Mart	
Green Oils	
Grover Family Farms	
GrowHempColorado	Veronica Carpio/CHAMP

Gunbarrel Organic Extractions	
H&H Labs LLC	
H&W Holdings LLC	
H.C. Labs, LLC	
H3L Labs, LLC	
Haleighs Hope Inc.	
Hammer Enterprises	Thuy Vu/CHAMP
Hapi Innovations, LLC	
Hass Farms, LLC	
Hau Processing	
Healing Power of Hemp	
HE-Colorado LLC	
Heilen Organics LLC	
Hemp by Tumbleweed	
Hemp Depot	
Hemp Foundry	
Hemp Health	
Hemp Way Foods	
Hemp Xtracts of Colorado	
Hemperor's Choice LLC	
Hempex	
Hempire Oils LLC	
Hempothecary	
HempStead Enterprises LLC	
Henep LLC	
Herbal Fracture	
Herbal Infusions	
Herbal Pharm Rx	
Herb-A-Lites	
High Altitude Wellness	
High Country ENT LLC	
High Country Kombucha, Inc. and Rocky Mountain Cultures	
High Elevation Laboratories LLC	
Hippie Dip Inc	
HM Health, LLC	
Hoban Law Group	Garrett Graff/CHAMP
HonestCeuticals LLC	
Honey Gold Processing, LLC	
Honeyspoon LLC	
HOPE Manufacturing, LLC	Jackson Tine/CHAMP
Hoplite Collective LLC	
Hunter Buffington	
Ideal Organics LLC	
IHP Refinery	Jessica McStravick/CHAMP
Indulge, LLC	
Incorrigible LLC	
Incredible Hemp Oil, Incredible CBD	
IncredMed Inc	
Infinite CBD	
Infinite Interactions LLC	
Infusionz LLC	
Injoy Integration	
James (Jamie), Baumgartner	James (Jamie), Baumgartner
Jeff Markley	CHAMP
Jen's CBD Shop, LLC	
Jessica Alizadeh	CHAMP
Josh Raderman	CHAMP
Joshua Jetton Sacred Body	Joshua Jetton
Joy Organics	
Just Hemp Co. LLC	

Justin Brothers	Justin@properrhino.com
Justin Singer	CHAMP
Kasey Irwin, Bluebird Botanicals	Kasey Irwin
Kara Lavaux	
Katie Wolf	
Kaylx LLC	
Kazmira LLC	Priyanka Sharma/CHAMP
Kelsie Biotech Inc	
Kelsey Hanley	
Kind Roots Botanicals LLC	Kind Roots
Kindred Extracts Inc	
King Pharma and 7Hands	Francis DellaVecchia/CHAMP
King Pharma, LLC	
Kipp Stroden	CHAMP
KM Relief	
KND Labs, LLC	
Laurel Will	
Laura Miller	
L7 AG, LLC	
L7 Labs	
Leafwell Botanicals, Inc.	Leafwell Botanicals
Leanna Organics	Leanna Organics
Lee Hemp	
Lichen Livin LLC	Lichen Livin
Little Flower Colorado Hemp Company	Little Flower
Loco Food Distribution	Loco Food
Lost Range	Lost Range
Loyal Leaf CBD, LLC	Loyal Leaf
Luke Johnson	
MAKA	
Malcomb Boyce	
Mariah Shaw	
Marijuana Enforcement Division	Brandon Jeffery
Marijuana Enforcement Division	Heather Krug
Marijuana Enforcement Division	Steve Clark/CHAMP
Marijuana Enforcement Division	Kim Kreimeyer/CHAMP
Mark Angerhofer	
Marquis Private Label	Marquis Private
Mary's Nutritionals	Mary's Nutritionals
Mary's Pet Shop, Whole Pet, Mary's Tails	Mary's Pet
Masri Ltd.	Masri Ltd.
Master Smith Enterprises	Master Smith
Mavatika Ltd	Mavatika Ltd
Maven Hemp	Maven Hempp
Maverick Natural Oils	Maverick Natural
Med USA CBD	Med USA CBBD
Melda's Essentials LLC	Melda's Essentials
Mesa Lavender Farms, LLC.	Mesa Lavender
Method CBD	Method CBDD
Metta Hemp Company	Metta Hemp
Metta Hemp Company LLC	Metta Hemp
MHL Broomfield Owner LLC	MHL Broomfield
Mile High Analytical LLC	Mile High
Mile High CBD	Mile High
Mile High Labs LLC	Mile High
Mile High WorkShop	Mile High
Mind Body & Soul Medicinals	Mind Body
Mineralife Nutraceuticals LLC	Mineralife Nutraceuticals
Miracles of Health	Miracles of Health
Missy J's	

MJ BioEssentials	MJ BioEssentials
Monarch Purple	Monarch Purple
Moon Mother Hemp Company	Moon Mother
Mota Munchiies LLC	Mota Munchhies
Motherlode Provisions, LLC	Motherlode Provisions
Mountain Flower Botanicals, LLC	Mountain Flower
Mountain Made LLC	Mountain Made
Mountain Palm	Mountain Palm
Mtn Distribution	Mtn Distribution
My Farmer CBD	My Farmer
Mycotechnology	Mycotechnool
MYKU Biosciences LLC	MYKU Biosciences
Nathan Gerhardt Charlotte's Web, Inc.	Nathan Gerhardt
Native Roots Dispensary	Erin Spies/CHAMP
Natural Foodworks Group, LLC	Natural Foodworks
Natural Grocers	Alan Lewis/CHAMP
Natural Leaf CBD	Natural Leaf
Natural Path Botanical, LLC	Natural Path
Nature's Full Spectrum Kitchen	Nature's Full
Nature's Love	Nature's Love
Nature's Root and Nature's Root Lab	Nature's Root
New Herb Health	New Herb Health
Next Frontier Biosciences	Steve Cape/CHAMP
NHC	
Niagara Bottling LLC	Niagara Bottling
Nikkal Farms, LLC	Nikkal Farms
Nimbus Wholesale	Nimbus Wholesale
NOCO Labs LLC	NOCO Labs
North Field Farmacy, LLC	North Field
NuLeaf Naturals	NuLeaf Naturals
Numb Nuts	
NuRange CBD Cold Brew	NuRange CBBD
Nymm CBD	
Oak Creek Hemp Company	Oak Creek
Oh-Hi Beverages Inc	Oh-Hi Beverages
Optiverde Systems, LLC	Optiverde Systems
Palisade Botanicals	Palisade Botanicals
Pamela Baxter	CHAMP
Panacea Life Sciences	Panacea Life
Paragon Processing LLC	Paragon Processing
Peak Labs & Development, LLC	Peak Labs
Peak Performance	Peak Performance
Perez Agricultural	Scott Perez/CHAMP
Phineas CBD	Phineas CBBD
Phoenix Extractions	Phoenix Extractions
Planetarie, LLC	Planetariee, LLC
Point3 Farma LLC	Point3 Farma
Positive Drop	Positive Drop
Potent Pantry LLC	Potent Pantry
Precision Plant Molecules	Precision Plant
Preston Whitfield	Preston Whitfield
Priyanka Sharma Kazmira LLC	Priyanka Sharma
Proper Rhino Packaging	Proper Rhino
Pueblo County	Chris Wiseman/CHAMP
Pulpo LLC	
Pure 5 Nutrients Colorado LLC	Pure 5 Nutrients
Pure Hemp Technology LLC/Pure Kind Botanicals	Pure Hemp
Pure Spectrum CBD	Pure Spectrum
Pure Water, llc	George Rhoades/CHAMP
Purple Monkey LTD	Purple Monkey

QSP Design, LLC	QSP Design
R & R Medicinals, LLC	R & R Medic
Rad Extraction	Rad Extraction
Raising Vibes LLC	Raising Vibes
Receptra Naturals LLC	Receptra Naturals
Redlaw Sauce Co	Redlaw Sauce
Reef Drink Company	Reef Drink
Resilience CBD	Resilience CBD
Resinosa LLC	Jeff Hays/CHAMP
Restorative Botanicals	Restorative Botanicals
Revitalize Inc	Revitalize Inc.
Revive Hemp	Revive Hemp
RFI Ingredients, RFI Extracts	RFI Ingredients
RH Company	RH Company
Rise Relief	Rise Relief
Robin Peterson	
Rockies Agricultural Processing LLC	Rockies Agricultural
Rocky Mountain Bob CBD, LLC	Rocky Mountain
Rocky Mountain Extraction Services, LLC	Rocky Mountain
Rocky Mountain Farmers Union	Nick Levendofsky/CHAMP
Rocky Mountain Soda Company, CO's Best Drinks, and Lifted Libations	Rocky Mountain
Rocky Mountain Supply Co	Rocky Mountain
Rose Bud Ice Cream LLC	Rose Bud LLC
S&C Lab Corp LLC	S&C Lab Corp
Sacred Body	Joshua Jetton/CHAMP
Saint Raphael of the Hills	Saint Raphael
Salad Ground Kitchens	Matthew Arnold/CHAMP
Salt Creek Hemp Co LLC	Salt Creek
San Luis Valley Hemp Company	San Luis Valley Hemp Co
Saving Grace Oils.Inc.	Saving Grace
Sawatch Hemp	Sawatch Hemp
Scott McWhorter	
Seattle Fish Company	Seattle Fish
Selah Organics Natural Healing and Wellness	Selah Organics
Serendipity Farms, LLC	Serendipity Farms
Shanao Chocolate Products LLC	Shanao Chocolate
Sheilah Ophaug	
Simply Hemp LLC	Simply Hemp
Simtech LLC	Simtech LLC
Ska Brewing Co	Ska Brewing
Sky and Wyatt Hemp Company	Sky and Wyatt
Snowball Distribution	Snowball Distribution
SoluScience, LLC	SoluSciencce, LLC
Southern Ute Indian Tribe	Eric Thayer/CHAMP
Southern Ute Indian Tribe	Roger Zalneraitis/CHAMP
Sovine Consulting	Cindy Sovine/CHAMP
Speedy Grow Inc.	Speedy Grow
St. Bernie's	St. Bernie's
SteepFuze	
Stefanie Gilbretj	
Steven Stinson	CHAMP
Steve's Goods	Steve's Goods
Still Point Coffee	Still Point
Stillwater	
Straight Hemp	Straight Hemp
Strasburg Pharms Cannaoil & Aethics	Strasburg Pharms
Strategic Healing Solutions	Strategic Healing
Stratos CBD	Stratos CBBD
Strava Craft Coffee, Inc.	Strava Craft
Strongwater LLC	Strongwater LLC

STRW LLC	
Subtle Relief LLC	Subtle Relief
Sub-Zero Extracts	Sub-Zero Extracts
Summit Extraction Systems	Summit Extraction
Summit Manufacturing Corporation	Summit Manufacturing
Sundown Sparkling	Sundown Sparkling
Sungting Chen	
Sunrise Beverage	Sunrise Beverage
Supergood, LLC	Supergood,, LLC
Supreme Labs	Supreme Labs
Sylva Labs	Sylva Labs
Szm, LLC	
Tailwind Nutrition	Tailwind Nutrition
Tanner Willis	
Terra Gold Plus	Terra Gold
TGC Network	TGC Netwrk
Thar Extracts CO, LLC	Thar Extraacts
The CBD Honey Company	The CBD Honey
The CBDistillery	The CBDisttillery
The Hemp Shoppe	The Hemp Shoppe
The Hibbert Group	The Hibbert
The Tea Spot, Inc.	The Tea Spot
Three Kings Kombucha, LLC	Three Kings
Thunder Mountain Chocolate LLC	Thunder Mountain
Tiffany Moseley	
Topline Management Inc.	Topline Management
Treehouse	
Trill Pills	Trill Pills
Trove, LLC	Trove, LLC
Tru Pura CBD	Tru Pura CCB
Truesdell Manufacturing and Consulting	Truesdell Manufacturing
Turtle House Holdings, LLC	Turtle House
UBIX Processing	UBIX Processing
Uleva Products, Inc.	Uleva Products
UnCanny Wellness	UnCanny Wellness
United Cannabis Corporation	United Cannabis
Upstart Kombucha	Upstart Kombucha
Valley CBDS LLC	Valley CBDDS
Vantage Hemp Co	Vantage Hemp
Vapor Distilled	Dana Shierstone/CHAMP
Vera Herbals LLC	Vera Herbals
Verdant Formulas	Verdant Formulas
Verks Unlimited, Ltd.	Verks Unlimited
VESL Oils	
Vidya LLC	
Violet's Miracle	Violet's Miracle
V-tek Botanicals LLC	V-tek Botanicals
WAAYB Labs, LLC	WAAYB Labs
Wana Wellness, LLC	Wana Wellness
Wasa Development Company LLC	Wasa Development
Weller	
Wellicy Inc	Wellicy Inc.
Welltiva Labs, LLC	Welltiva Labs
Western CBD	Western CBBD
White Buffalo Hemp Company	White Buffalo
WholeMade, Inc.	Jerell Klaver/CHAMP
Wild West Weed and Seed/ Dr Herb-al	Wild West
William Billings	
Windy Hill Hemp	Windy Hill
Wise Bar	

Wise Hemp LLC	Wise Hemp
WL324 LLC	
WOH Consulting	James Reil/CHAMP
World Class Health, LLC	World Class
Wow Organics LLC	Wow Organiics
Yoh F	
Z3 Sciences	Z3 Sciences
Zakah Life	Zakah Liee
Zelios	
Zimgrove LLC	Zimgrove LLLC
zumXR	

The passage of the 2018 Agricultural Improvement Act, commonly called the Farm Bill, requires each state department of agriculture to submit a state management plan to the United States Department of Agriculture (USDA), outlining how various aspects of hemp cultivation and processing will be managed within their jurisdiction. In response, the Colorado Department of Agriculture (CDA) partnered with leading state, local, and tribal agencies, as well as industry experts in cultivation, testing, research, processing, finance and economics to establish a statewide initiative known as the Colorado Hemp Advancement and Management Plan (CHAMP).

The 2018 Farm Bill provided Colorado a unique opportunity to establish a comprehensive blueprint for how the state will not only manage, but also advance this emerging industry by examining the entire supply chain from cultivation to market, and the steps in between. The CHAMP was a broad stakeholder-based effort initiated in 2019, and represented a collaborative effort between CDA, the Governor's Office, Department of Public Health and Environment, Department of Revenue, Department of Regulatory Agencies, Office of Economic Development and International Trade, Department of Public Safety, Colorado Commission of Indian Affairs, Department of Higher Education, local governments, and industry experts. CHAMP stakeholder meetings addressing the industrial hemp supply chain were conducted from July through December 2019, and included stakeholder group discussions related to research and development and seed, cultivation, transportation, testing, processing, manufacturing, marketing, and banking and insurance. On June 18, 2020, Colorado submitted the *Colorado State Hemp Management Plan* and associated appendices to the USDA.

The proposed revisions to the existing wholesale food regulation incorporate pertinent stakeholder input received during the 2019 CHAMP initiative and the division’s stakeholder process conducted from July through November 2020, and are necessary to refine and clarify manufacturing and testing requirements for the production of industrial hemp products in the State of Colorado.

On July 14, July 21, and July 28, and October 20, 2020, the division held four stakeholder meetings to evaluate the proposed changes to the existing wholesale food regulation and receive additional feedback from industrial hemp stakeholders.

Based on discussion during the stakeholder meeting held on July 28, 2020, stakeholders formed two independent workgroups to discuss additional revisions to the proposed definitions and testing requirements. The hemp testing workgroup met on August 4, 2020 and the definitions workgroup on August 12, 2020. Following agency evaluation and input, proposed revisions to definitions and testing requirements resulting from the workgroups were incorporated into the proposed redline and presented for review to all stakeholders at the October 20, 2020 stakeholder meeting.

Consensus was achieved on the proposed regulation, including definitions of relevant terms, industrial hemp manufacturing and testing requirements, and continued application of 21 C.F.R. 100-111, 113-170, and 172-190 (2017). All documents associated with stakeholder engagement were made available on the department's webpage:

https://cdphe.colorado.gov/industrial-hemp-in-food/industrial-hemp-news-and-announcements

Stakeholder Group Notification

The stakeholder group was provided notice of the rulemaking hearing and provided a copy of the proposed rules and the internet location where the amended regulations and associated documents and resources could be viewed. Notice was provided prior to the date the notice of rulemaking was published in the Colorado Register (typically, the 10th of the month following the Request for Rulemaking).

_X_ Not applicable. This is a Request for Rulemaking Packet. Notification will occur if the Board of Health sets this matter for rulemaking

____ Yes.

Summarize Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received. If there is a lack of consensus regarding the proposed rule, please also identify the Department's efforts to address stakeholder feedback or why the Department was unable to accommodate the request.

The division began preparations for this rulemaking in 2019, as co-sponsors and participants in CDA's CHAMP initiative. On July 14, July 21, and July 28, and October 20, 2020, the division held stakeholder meetings to evaluate the proposed changes to the existing rule that resulted from the CHAMP initiative. Stakeholders included industrial hemp and unfinished industrial hemp product manufacturers, processors, or storage facilities registered with the department, industrial hemp transporters, dispensaries, multiple state and local government agencies, educational institutes, analytical laboratories, retail food establishments, consulting firms, pharmaceutical companies, various institutes, unions, associations, and advocacy groups, legal firms, financial institutions, tribal agencies, and consumers of industrial hemp products.

Based on discussion during the stakeholder meeting held on July 28, 2020, stakeholders formed two independent workgroups to discuss and refine revisions to the proposed definitions and testing requirements. The hemp testing workgroup met on August 4, 2020 and the definitions workgroup on August 12, 2020. Following agency evaluation and input, proposed revisions to definitions and testing requirements resulting from the workgroups were incorporated into the proposed redline and presented for review to all stakeholders at the October 20, 2020 stakeholder meeting.

United States Pharmacopeia (USP), Chapter <467> and the *Colorado Marijuana Rules*, 1 CCR 212-3, provided the basis for the action limits defined in table 21.7(F)(5)(e), *Residual solvents, of the proposed rules*. Some stakeholders were less supportive of these proposed residual solvent action limits. However, an appropriate resource or proxy that would establish more defensible and protective action limits was not identified.

Those not in support of utilizing the USP desired to use levels for residual solvents utilized by FDA for indirect or direct food additives. While the approach seems reasonable, the application of this approach presented challenges and conflicts. First, the allowed levels of the solvent varies greatly depending on the food ingredient/product. Levels were based on normal daily intake and required the manufacturer to petition FDA with their proposed levels and their rationale. As we currently stand hemp products are not federally approved and the state does not have the resources or expertise to review the petition. Additionally, several other states have established hemp product regulation and utilize the USP. Canada's cannabis regulations, while not referencing the USP, have limits that are aligned with those established in the USP. Finally, the long-standing requirements for commensurate marijuana products in the state utilize the USP as the action levels for residual solvent.

Consensus was achieved on the proposed regulation, including maintaining the requirements of 21 C.F.R. 100-190 (2017), as applicable to industrial hemp manufacturers, as wells as including new definitions of relevant terms and industrial hemp manufacturing, testing and labeling requirements.

Please identify the determinants of health or other health equity and environmental justice considerations, values or outcomes related to this rulemaking.

Overall, after considering the benefits, risks and costs, the proposed rule:

Select all that apply.

	Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.		Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.
	Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.	X	Reduces occupational hazards; improves an individual's ability to secure or maintain employment; or, increases stability in an employer's workforce.
X	Improves access to food and healthy food options.	X	Reduces exposure to toxins, pollutants, contaminants or hazardous substances; or ensures the safe application of radioactive material or chemicals.
	Improves access to public and environmental health information; improves the readability of the rule; or, increases the shared understanding of roles and responsibilities, or what occurs under a rule.		Supports community partnerships; community planning efforts; community needs for data to inform decisions; community needs to evaluate the effectiveness of its efforts and outcomes.

	Increases a child's ability to participate in early education and educational opportunities through prevention efforts that increase protective factors and decrease risk factors, or stabilizes individual participation in the opportunity.		Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
	Monitors, diagnoses and investigates health problems, and health or environmental hazards in the community.		Ensures a competent public and environmental health workforce or health care workforce.
	Other:_____ _____		Other:_____ _____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Division of Environmental Health and Sustainability

COLORADO WHOLESALE FOOD, INDUSTRIAL HEMP, AND SHELLFISH REGULATIONS

6 CCR 1010-21

Adopted by the Board of Health on ~~August 15, 2018~~_____; effective, ~~October 15, 2018~~_____.

21.1 Authority

This regulation is adopted pursuant to Sections 25-4-1805, 25-5-420(1), and 25-5-426(1), Colorado Revised Statute (C.R.S.) and is consistent with the requirements of the State Administrative Procedure Act, Section 24-4-101, *et seq.*, C.R.S.

21.2 Scope and Purpose

A. This regulation shall be applied for the protection of public health by ensuring that the premises or places wherein manufactured foods and industrial hemp products are produced, manufactured, packed, processed, prepared, treated, packaged, transported, or held for distribution are in accordance with the "Pure Food and Drug Law", Section 25-5-401 *et seq.*, C.R.S. and the "Shellfish Dealer Certification Act," Section 25-4-1801 *et seq.*, C.R.S.

B. This regulation shall govern the registration of wholesale food manufacturers. Along with the powers and duties delineated in Section 25-4-420 *et seq.*, C.R.S., Section 25-5-426(3), C.R.S., provides the department the power and duty:

1. To grant or refuse to grant registration pursuant to ~~s~~Section 25-5-426(4), C.R.S. and to grant or refuse to grant the annual renewal of a registration;

2. To deny, suspend, or revoke a registration;

3. To issue a certificate of free sale; and

4. To review any records of a wholesale food manufacturer or storage facility necessary to verify compliance with the provisions of ~~s~~Section 25-5-426, C.R.S.

C. This regulation does not apply to:

1. Retail food establishments governed by the *Colorado Retail Food Establishment Regulations*, 6 CCR 1010-2~~, and~~;

2. Facilities or conditions governed by the *Colorado Milk and Dairy Products Regulations*, 6 CCR 1010-4~~.~~;

3. Entities engaged in the business of possessing, cultivating, dispensing, transferring, transporting, or testing Medical Marijuana or Retail Marijuana governed by the *Colorado Marijuana Rules*, 1 CCR 212-3;

4. The cultivation of industrial hemp governed by the *Rules Pertaining to the Administration and Enforcement of the Industrial Hemp Regulatory Program Act*, 8 CCR 1203-23;

5. Entities that are manufacturing intermediate or finished hemp products from the fibrous material of the plant that are not intended for human consumption. These products include, but are not limited to, cordage, paper, fuel, textiles, bedding, insulation, construction materials, compost materials, and industrial materials;

6. Entities that are manufacturing industrial hemp-derived smokable products, inhalable products, over-the-counter drugs, drugs, or medical devices; and

7. Testing performed by a certified laboratory in accordance with the *Hemp Testing Laboratory Certification*, 5 CCR 1005-5.

D. Nothing in this rule shall be construed to limit the dDepartment's statutory authority under the "Pure Food and Drug Law", Section 25-5-401 et seq., C.R.S., the "Shellfish Dealer Certification Act," Section 25-4-1801 et seq., C.R.S., or Section 25-1.5-102, C.R.S.

21.3 Applicability

A. This rule establishes registration requirements for wholesale food and industrial hemp product manufacturers, Section 25-5-426, C.R.S., and certification requirements for wholesale food manufacturers who are also shellfish dealers, Section 25-4-1801 *et seq.*, C.R.S.

1. This regulation establishes the allowance that industrial hemp manufacturers [as defined in 21.4(A)(16)] shall adhere to for the production of industrial hemp products and unfinished industrial hemp products in the State of Colorado.

2. These regulatory requirements do not infer conformance with federal laws and the allowance for manufacturing, sale, and distribution of industrial hemp products and unfinished industrial hemp products to other states or countries.

B. This rule incorporates by reference the Code of Federal Regulations addressing Food for Human Consumption and the national shellfish sanitation standards.

C. This rule incorporates by reference 21 Code of Federal Regulations (C.F.R.) 100-111, 113-170, and 172-190 (April 1, 2017), including requirements of the *Current Good Manufacturing Practices, Hazard Analysis, and Risk-Based Preventive Controls for Human Food* (cGMP) 21 C.F.R. 117, and other State or U.S. Department of Health and Human Services, Food & Drug Administration (FDA) guidance regarding food safety and Current Good Manufacturing Practice in Manufacturing, Packaging, Labeling, or Holding Operations for Dietary Supplements.

D. This rule establishes enforcement standards for wholesale food manufacturers pursuant to Sections 25-1.5-102(1)(c), 25-5-406 and 25-5-420, C.R.S., and enforcement standards for wholesale food manufacturers who are also shellfish dealers pursuant to Section 25-4-1810, C.R.S.

21.4 Definitions

A. For the purpose of these rules and regulations, unless otherwise specified herein:

1. Approved Source means:

   a. A product from a wholesale food manufacturer, industrial hemp manufacturer, or a storage facility registered with the department in accordance with Section 25-4-426, C.R.S, or

   b. Generally Recognized As Safe (GRAS), or

   c. Hemp seed, hemp seed co-products, or hemp-seed by-products, or

   d. Industrial hemp or hemp products from a state that has an established and approved industrial hemp program, or

   e. Industrial hemp or hemp products from a country that inspects or regulates hemp under a food safety program or equivalent criteria to ensure safety for human consumption.

2. Broad spectrum means industrial hemp products that contain multiple cannabinoids and no more than 0.01% total THC.

3. Cannabinoids means a class of lipophilic molecules that are naturally occurring in industrial hemp.

4. Certified laboratory means a public or private laboratory or testing facility certified by the department to perform testing on industrial hemp and industrial hemp products or a testing facility licensed by the Marijuana Enforcement Division.

5. Certificate of Analysis means an official document issued by a certified laboratory or testing facility that shows results of scientific tests performed on a product.

6. Cosmetics means articles intended to be rubbed, poured, sprinkled, or sprayed on, introduced into, or otherwise applied to the human body or any part thereof for cleansing, beautifying, promoting attractiveness, or altering the appearance or an article intended for use as a component of any such articles; except that such term does not include soap.

~~2.~~7. Dealer or Shellfish Dealer means a person to whom certification is issued for the activities of shell stock shipper, shucker-packer, repacker, reshipper, depuration processor, or wet storage.

8. Delta-9 tetrahydrocannabinols (THC) or delta-9 THC has the same meaning as "tetrahydrocannabinols" as set forth in Section 27-80-203 (24), C.R.S. Delta-9 THC is the primary psychoactive component of cannabis. For the purposes of these regulations, the terms "Delta-9 THC" and "THC" are interchangeable.

~~3.~~9. Department means the Colorado Department of Public Health and Environment.

10. Dietary supplement means a product taken by mouth that contains a dietary ingredient or a new dietary ingredient intended to supplement the diet.

11. Full spectrum means an industrial hemp product that contains all phytochemicals naturally found in the plant, trace cannabinoids, terpenes, and essential oils, with no more than 0.3% total THC.

12. Generally Recognized As Safe (GRAS) means any substance that is intentionally added to food which is a food additive, that is subject to premarket review by FDA, unless the substance is generally recognized, among qualified experts, as having been adequately shown to be safe under the conditions of its intended use, or unless the use of the substance is otherwise excepted from the definitions of food additive.

13. Herb means any plant with leaves, seeds, or flowers used as a flavoring, food, food additive, or dietary supplement ingredient.

14. Industrial hemp or hemp means the plant Cannabis sativa L. and any part of the plant, including the seeds, all derivatives, extracts, cannabinoids, isomers, acids, salts, and salts of isomers, whether growing or not, with a Delta-9 tetrahydrocannabinol concentration of no more than 0.3% on a dry-weight basis.

15. Industrial hemp extract means an unfinished industrial hemp product or industrial hemp product produced through a solvent or non-solvent based industrial hemp manufacturing process, including but not limited to oils, distillates, resins, and isolates.

16. Industrial hemp manufacturer means a facility that manufactures, produces, packs, processes (extracts), treats, packages, or holds/warehouses industrial hemp products and unfinished industrial hemp products.

17. Industrial hemp product means finished products containing industrial hemp that is for human use or consumption and:

a. Is a cosmetic as defined in 25-5-402(6) C.R.S.; or

b. Is a dietary supplement as defined in 25-5-426(2)(b) C.R.S.; or

c. Is a food as defined in 25-5-402(11) C.R.S.;

d. Is a food additive as defined in 25-5-402(12) C.R.S.;

e. Contains any part of the hemp plant, including naturally occurring cannabinoids, compounds, concentrates, extracts, isolates, resins, or derivatives;

f. Contains a Delta-9 THC concentration of no more than 0.3%, and

g. Is not a drug as defined in 25-5-402(9) C.R.S.

18. Labeling means a display of written, printed, or graphic matter upon a food, food ingredient container, or package and includes product inserts, and other promotional materials including digital communications.

19. Law means applicable local, state, and federal statutes, regulations and ordinances.

20. Packaging means any type of container, wrapping, or other type of vessel intended to protect both food or supplements from damage, contamination, spoilage, pest attacks, and tampering, during transport, storage, and sale.

21. THC means tetrahydrocannabinol.

22. THCA means tetrahydrocannabinolic acid.

23. Total THC means the sum of the percentage by weight of THCA multiplied by 0.877 plus the percentage by weight of THC [i.e., (% THCA x 0.877) + % THC].

24. Unfinished industrial hemp product means an oil, concentrate or other substance that has a total THC concentration above 0.3% and less than or equal to 5.0%, is not for consumer use or distribution, must be sold or transferred between registered industrial hemp manufacturers or certified laboratories, and will undergo further refinement or processing into an industrial hemp product.

~~4.~~25. Wholesale food manufacturer means a facility that manufactures, produces, packs, processes, treats, packages, transports, or holds human food, including dietary supplements. These terms include storage facilities. These terms include shellfish dealers when the wholesale food manufacturer is also a shellfish dealer.

21.5 Wholesale Food Manufacturer and Shellfish Dealer Requirements

A. Wholesale food manufacturing facilities in Colorado must be registered in accordance with Section 25-5-426(4), C.R.S.

1. The owner of any wholesale food manufacturer must submit to the department an application each year for registration, along with applicable application and registration fees, using forms provided by the department.

2. The owner of any wholesale food manufacturer must also submit to the department complete and accurate information about the facility's operation and business size, using forms provided by the department.

B. Wholesale food manufacturers who are also shellfish dealers in Colorado must also be certified in accordance with Section 25-4-1805, C.R.S.

1. Any person desiring to do business as a shellfish dealer must apply for and obtain a valid certification issued by the department.

2. Shellfish dealers must report to the department, in the form and manner required by the department, any change in the information provided in the

dealer's application or in such reports previously submitted, within thirty days of such change.

21.6 Incorporation by Reference

A. The department shall utilize material incorporated by reference as appropriate to assure that wholesale food manufacturers comply with the "Pure Food and Drug Law", and wholesale food manufacturers who are also shellfish dealers comply with the "Shellfish Dealer Certification Act."

1. 21 C.F.R. 100-190 (April 1, 2017) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the reference material.

2. U.S. Department of Health and Human Services, Public Health Service/Food and Drug Administration, *National Shellfish Sanitation Program Guide for the Control of Molluscan Shellfish Model Ordinance* (2015 Revision) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the reference material.

B. Any provision included or incorporated herein by reference which conflicts with the Colorado Revised Statutes, including but not limited to Section 25-5-401 et seq., C.R.S., Section 25-4-1801 *et seq.*, C.R.S., and Section 25-1.5-102, C.R.S., shall be null and void. These regulations do not incorporate by reference:

1. 21 C.F.R. 112, *Standards for the Growing, Harvesting, Packing, and Holding of Produce for Human Consumption*.

2. 21 C.F.R. 171, *Food Additive Petitions*.

C. The incorporated material is available for public inspection during regular business hours at:

Division of Environmental Health and Sustainability
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, Colorado 80246-1530

Pursuant to ~~C.R.S.~~ 24-4-103(12.5)(V)(b), C.R.S., the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

D. The incorporated materials are available at:

https://www.ecfr.gov/cgi-bin/text-idx?SID=2029b930ffb25f468e235e6ec9a86dea&mc=true&tpl=/ecfrbrowse/Title21/21tab_02.tpl

21.7 Industrial Hemp Processing and Manufacturing Requirements

A. Oils, concentrates or other substances that are above 5.0% total THC must undergo further refinement or processing by the original registered industrial hemp manufacturer.

B. Prior to manufacturing, packaging, or distributing an industrial hemp product or an unfinished industrial hemp product, a business shall:

1. Be registered with the department;

2. Obtain any necessary local licenses, registrations, and approvals;

3. Ensure all types of industrial hemp products and unfinished industrial hemp products, packaging, and labeling meet the requirements established within this regulation; and

4. Have conspicuously posted all applicable documentation in accordance with the law.

C. Industrial hemp manufacturing facilities shall maintain physical and operational separation from any marijuana-related facility, including separate entrances and exits.

D. All standard operating procedures and scheduled processes performed in the facility are limited to those approved by the appropriate regulatory authority.

E. Ingredients

1. All ingredients must come from an approved source;

2. All industrial hemp products or unfinished industrial hemp products shall be clearly identified to allow for appropriate traceability. Identification includes:

a. Name of ingredient;

b. Identifying batch or lot number from original package;

c. Date the ingredient was manufactured;

d. Date the ingredient was received at the facility; and

e. Expiration, re-test, or use-by date.

3. Spoiled, unwholesome, adulterated, vermin-infested or insect-infested ingredients are not allowed into the facility and shall be:

a. Removed immediately from the premises and properly disposed; or

b. Placed in a quarantine area temporarily until proper disposal if:

(1) Not practicable to remove immediately; or

(2) Required to be collected by a local or state regulatory agency for examination or testing.

F. Testing

1. Effective July 1, 2021, analytical testing shall be performed by a certified laboratory in accordance with the department's State Public Health Laboratory, Disease Control and Public Health Response Division's, *Hemp Testing Laboratory Certification*, 5 CCR 1005-5.

2. In order for a food, food additive, dietary supplement, or cosmetic to contain industrial hemp, the manufacturer shall be able to demonstrate the following purity and potency:

a. Industrial hemp shall conform to the standard of identity established by the Colorado Department of Agriculture.

b. The use of parts of the industrial hemp plant, other than seed and its derivatives (e.g., hulled hemp seed, hemp seed protein powder, hemp seed oil) shall have laboratory test results indicating conforming levels of THC and total THC.

c. The manufacturer shall be able to document that the industrial hemp product does not contain more than 0.3% total THC.

3. Additional Testing Standards: The testing requirements contained in this regulation are the minimum required and approved testing standards. Industrial hemp manufacturers are responsible for ensuring testing requirements listed in subparagraphs 21.7(F)(5)(a-e) are met and maintaining certificates of analysis on any regulated industrial hemp products they produce or transfer to ensure safety on all lots or batches for human consumption.

4. All certificates of analysis provided as documentation of conformance with the established testing requirements shall be furnished from a certified industrial hemp testing laboratory or a licensed retail marijuana testing laboratory.

a. Any exceedance of the contaminant action limits presented in section 21.7(F)(5)(a-e) shall be reported to the department by the industrial hemp manufacturer within 48 hours of receipt of the analytical testing results.

5. Permissible Levels of Contaminants: If an industrial hemp product is found to have a contaminant in levels exceeding those established as permissible under this regulation, then it shall be considered to have failed contaminant testing. Notwithstanding the permissible levels established in this regulation, the department reserves the right to determine, upon good cause and reasonable grounds that a particular product presents a risk to public health or safety and therefore shall be considered to have failed a contaminant test.

a. Microbials (Bacteria and Fungus)

Substance	Action Limits Per gram (g), unless otherwise indicated
Salmonella spp.	Absent in 25 g
-Shiga-toxin producing Escherichia coli (STEC) - Bacteria	Absent in 25 g
Total coliforms	< 10^2 cfu/g
Total aerobic plate count	< 10^4 cfu/g
Total yeast and mold	< 10^3 cfu/g

b. Mycotoxins

Substance	Action Limits Parts per billion (ppb)
Aflatoxins (B1, B2, G1, and G2)	< 20 (total of B1 + B2 + G1 + G2)
Aflatoxin B1	< 5
Ochratoxin	< 5

c. Pesticides

The following pesticides are not allowed in finished hemp products or unfinished hemp products. The following table establishes the Limits of Quantification (LOQ) for laboratory verification.

Substance (pesticides)	Detection Limit Parts per million (ppm)	
	Product Type	
	Dried Hemp	Hemp Oil
Abamectin	0.1	0.25
Acephate	0.02	0.05
Acequinocyl	0.03	*
Acetamiprid	0.1	0.05
Aldicarb	1	0.5

Substance (pesticides)	Detection Limit Parts per million (ppm)	
	Product Type	
	Dried Hemp	Hemp Oil
Allethrin	0.2	0.1
Atrazine	0.025	*
Azadirachtin	1	0.5
Azoxystrobin	0.02	0.01
Benzovindiflupyr	0.02	0.01
Bifenazate	0.02	0.01
Bifenthrin	1	*
Boscalid	0.02	0.01
Buprofezin	0.02	*
Carbaryl	0.05	0.025
Carbofuran	0.02	0.01
Chlorantraniliprole	0.02	*
Chlorphenapyr	0.05	1.5
Chlorpyrifos	0.04	0.5
Clofentezine	0.02	0.01
Clothianidin	0.05	0.025
Coumaphos	0.02	0.01
Cyantraniliprole	0.02	0.01
Cyfluthrin	0.2	*
Cypermethrin	0.3	*
Cyprodinil	0.25	0.01
Daminozide	0.1	*
Deltamethrin	0.5	*
Diazinon	0.02	*

Substance (pesticides)	Detection Limit Parts per million (ppm)	
	Product Type	
	Dried Hemp	Hemp Oil
Dichlorvos	0.1	0.05
Dimethoate	0.02	0.01
Dimethomorph	0.05	*
Dinotefuran	0.1	0.05
Diuron	0.125	*
Dodemorph	0.05	*
Endosulfan sulfate	0.05	2.5
Endosulfan-alpha	0.2	2.5
Endosulfan-beta	0.05	2.5
Ethoprophos	0.02	0.01
Etofenprox	0.05	*
Etoxazole	0.02	*
Etridiazole	0.03	0.15
Fenhexamid	0.125	*
Fenoxycarb	0.02	0.01
Fenpyroximate	0.02	*
Fensulfothion	0.02	0.01
Fenthion	0.02	0.01
Fenvalerate	0.1	*
Fipronil	0.06	0.01
Flonicamid	0.05	0.025
Fludioxonil	0.02	0.01
Fluopyram	0.02	0.01
Hexythiazox	0.01	*

Substance (pesticides)	Detection Limit Parts per million (ppm)	
	Product Type	
	Dried Hemp	Hemp Oil
Imazalil	0.05	0.01
Imidacloprid	0.02	0.01
Iprodione	1	0.50
Kinoprene	0.50	1.25
Kresoxim-methyl	0.02	0.15
(Lambda) Cyhalothrin	0.25	*
Malathion	0.02	0.01
Metalaxyl	0.02	0.01
Methiocarb	0.02	0.01
Methomyl	0.05	0.025
Methoprene	2	*
Mevinphos	0.05	0.025
MGK-264	0.05	*
Myclobutanil	0.02	0.01
Naled	0.1	*
Novaluron	0.05	0.025
Oxamyl	3.0	1.5
Paclobutrazol	0.02	0.01
Parathion-methyl	0.05	*
Permethrin	0.5	*
Phenothrin	0.05	*
Phosmet	0.02	*
Piperonyl butoxide	0.2	1.25
Pirimicarb	0.02	0.01

Substance (pesticides)	Detection Limit Parts per million (ppm)	
	Product Type	
	Dried Hemp	Hemp Oil
Prallethrin	0.05	*
Propiconazole	0.1	*
Propoxur	0.02	0.01
Pyraclostrobin	0.02	0.01
Pyrethrins	0.05	*
Pyridaben	0.05	0.02
Pyriproxyfen	0.010	*
Quintozene	0.02	*
Resmethrin	0.1	0.05
Spinetoram	0.02	0.01
Spinosad	0.1	0.01
Spirodiclofen	0.25	*
Spiromesifen	3	*
Spirotetramat	0.02	0.01
Spiroxamine	0.1	*
Tebuconazole	0.05	0.01
Tebufenozide	0.02	0.01
Teflubenzuron	0.05	0.025
Tetrachlorvinphos	0.02	0.01
Tetramethrin	0.1	*
Thiabendazole	0.020	*
Thiacloprid	0.02	0.01
Thiamethoxam	0.02	0.01
Thiophanate-methyl	0.05	*

Substance (pesticides)	Detection Limit Parts per million (ppm)	
	Product Type	
	Dried Hemp	Hemp Oil
Trifloxystrobin	0.02	0.01

* Note: LOQ not available or established.

d. Heavy Metals

Substance (heavy metals)	Action Limits (extracts, foods, supplements) Parts per million (ppm)
Arsenic	< 1.5
Cadmium	< 0.5
Lead	< 0.5
Mercury	< 1.5

e. Residual Solvents

Substance	Action Limits (solvent based industrial hemp extracts) Parts per million (ppm)
Acetone	< 1,000
Benzene*	<2
Butanes	< 1,000
Ethanol	< 1,000
Ethyl Acetate	< 1,000
Heptanes	< 1,000
Hexane	< 60
Isopropyl Alcohol	< 1,000
Methanol	< 600
Pentane	< 1,000

Substance (residual solvents)	Action Limits (solvent based industrial hemp extracts) Parts per million (ppm)
Propane	< 1,000
Toluene*	< 180
Total Xylenes (m, p, o-xylenes)*	< 430
Any other solvent not permitted for use	None detected

* Note: These solvents are not approved for use. Due to their possible presence in the solvents approved for use, limits have been listed here accordingly.

G. Packaging and Labeling Requirements

1. Effective July 1, 2021, packaging and labeling shall be performed in accordance with the department's labeling requirements for industrial hemp food products listed in sections 21.7(G)(2-6).

2. Industrial hemp product packaging shall be food-grade or GRAS and labeling shall be performed in accordance with 21 C.F.R. 101, subparts A-G and the department's labeling requirements for hemp food products, which includes:

a. Product Identity Statement (in bold type) which indicates the common or usual name of the food ingredient;

b. Manufacturing address or a qualifying phrase which states the firm's relation to the product (e.g., "manufactured for" or "distributed by");

c. Net Weight Statement placed as a distinct item parallel to the base of the package in the bottom third of the principal display panel; and

d. List of ingredients, in descending order of predominance by weight:

(1) Identify industrial hemp as an ingredient;

(2) Identify each isolated cannabinoid as an ingredient and the amount labeled in milligrams or when using a broad or full spectrum product, label the total amount in milligrams; and

(3) Identify in milligrams the total THC content per serving and total THC content per individual finished product package.

3. Allergens shall be clearly identified and listed separately.

4. A code or numbering system that identifies the date and location of manufacturing and packaging is required for tracking and assisting in recalls or trace forward/trace back efforts.

5. Health Benefit Claims for hemp or hemp-derived ingredients must be substantiated and should follow Federal Trade Commission (FTC) and FDA guidance, including marketing materials and electronic communications.

6. The label of a cosmetic product shall bear a warning statement whenever necessary or appropriate to prevent a health hazard that may be associated with the product. This applies to unsubstantiated claims on products ~~and~~as well as ingredients, aerosol products, deodorant products, foaming detergent bath products, coal tar hair dyes, sun-tanning and sunscreen products. Additional cosmetic labeling requirements are listed in 21 C.F.R. 701, subparts A-C.

H. Record Keeping

1. For all facilities, the following records shall be maintained, as required herein:

a. Certificates of analysis;

b. Batch production records;

c. Recalled product information;

d. Source of ingredients; and

e. Other records as required by the department (e.g., ingredient records, corrective action logs, mock recall documents, calibration records, as applicable).

2. For all facilities, records shall:

a. Be kept as original records, true copies (such as photocopies, pictures, scanned copies, microfilm, microfiche, or other accurate reproductions of the original record(s), or electronic records;

b. Contain the actual values and observations obtained during monitoring and, as appropriate, during verification activities;

c. Be accurate, indelible, and legible;

d. Be created concurrently with performance of the activity documented;

e. Be as detailed as necessary to provide history of work performed; and include:

(1) Information adequate to identify the plant or facility (e.g., the name and, when necessary, location of the plant of facility);

(2) The date and time of the activity documented, when appropriate;

(3) The signature or initials of the person performing the activity; and

(4) The identity of the product and the lot code, when appropriate.

3. Record retention for cGMP facilities

a. Records shall be retained at the plant or facility for at least 2 years after the date they were prepared.

4. Record retention for dietary supplement facilities

a. Records shall be kept for one year past the shelf life date, if the shelf life dating is used, or two years beyond the date of distribution of the last batch of dietary supplements associated with those records.

I. Recalls

1. Industrial hemp product processing and manufacturing facilities shall establish a written recall plan in accordance with 21 C.F.R. 117.139, *Recall Plan*, that includes procedures that describe the steps to be taken, and assign responsibility for taking those steps, to perform the following actions as appropriate to the facility:

a. Directly notify the direct consignees of the food being recalled, including how to return or dispose of the affected product;

b. Notify the public about any hazard presented by the product when appropriate to protect public health;

c. Conduct effectiveness checks to verify that the recall is carried out; and

d. Appropriately dispose of recalled product (e.g., through reprocessing or reworking as appropriate, or diverting to a use that does not present a safety concern, or destroying the product).

J. Transportation

1. Transfer of industrial hemp or unfinished industrial hemp product shall be conducted in accordance with the law.

2. Industrial hemp, unfinished industrial hemp products, and industrial hemp products shall be transported in a manner where they will be protected from adulteration, allergen cross-contact, environmental contamination and any other hazards.

K. Waste Management

1. Industrial hemp-derived THC shall be diluted to a concentration less than 0.3%, converted, or disposed of in accordance with the department's Hazardous and Waste Management Division's *Marijuana and Marijuana-Related Waste Disposal* Compliance Bulletin.

2. Facility owner/operator is responsible to secure and limit access to industrial hemp-derived THC with a concentration greater than 0.3%.

~~21.7~~21.8 Enforcement

A. 1. Wholesale food manufacturers that fail to submit a complete and accurate annual application for registration, or fail to remit fees in accordance with Section 25-5-426(4), C.R.S., are not considered an approved source for introduction of manufactured food into retail commerce.

2. Wholesale food manufacturers who are also shellfish dealers that fail to submit a complete and accurate annual application for certification are not considered an approved source for introduction of shellfish into retail commerce.

B. Adulterated or misbranded food, including food from unapproved sources, may be embargoed in accordance with Section 25-5-406, C.R.S.

C. In accordance with Section 25-1.5-102(1)(c), C.R.S., the department may require wholesale food manufacturers, including wholesale food manufacturers who are also shellfish dealers, to recall adulterated or misbranded food in order to investigate and control the causes of epidemic and communicable diseases affecting public health.

D. Pursuant to Sections 25-4-1810 and 25-5-420, C.R.S., if the department has reasonable cause to believe a violation of this regulation has occurred and immediate enforcement is necessary, it may issue a cease-and-desist order, which shall set forth the provisions alleged to have been violated, the facts constituting the violation, and the requirement that all violating actions immediately cease.

1. At any time after service of the order to cease and desist by certified mail, the person for whom such order was served may request a hearing to determine whether such violation has occurred. Such hearing will be conducted in conformance with the provisions of article 4 of title 24, C.R.S. and shall be determined promptly.

E. To the extent and manner authorized by law, the department may issue letters of admonition or may deny, suspend, refuse to renew, restrict, or revoke any wholesale food manufacturer registration or any shellfish dealer certification if the wholesale food manufacturer or wholesale food manufacturer who is also a shellfish dealer has:

1. Refused or failed to comply with any provision of this regulation or any lawful order of the department;

2. Had an equivalent certification or registration denied, revoked, or suspended by another authority, including but not limited to another state, or the U.S. Food and Drug Administration;

3. Refused to provide the department with reasonable, complete, and accurate information when requested by the department; or

4. Falsified any information submitted to the department.

F. In addition to the requirements herein, when the department determines that a wholesale food manufacturer who is also a shellfish dealer's activity constitutes a

major public health threat, the department shall cooperate with other authorities pursuant to Section 25-4-1805(5), C.R.S

COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing
February 17, 2021

NOTICE is hereby given pursuant to the provisions of Section 24-4-103, C.R.S., that the Colorado Board of Health will conduct a public rule-making hearing on February 17, 2021 at 10 a.m. remotely over Zoom at this link, to consider the revision of 6 CCR 1010-21, Colorado Wholesale Food and Shellfish Regulations. The proposed revisions have been developed by the Division of Environmental Health and Sustainability of the Colorado Department of Public Health and Environment pursuant to Sections 25-1.5-102(1)(c), 25-4-1810, 25-5-406, and 25-5-420, C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://cdphe.colorado.gov/board-of-health at least seven (7) days prior to the meeting. The proposed rules, together with the proposed statement of basis and purpose, specific statutory authority and regulatory analysis will be available for inspection at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South EDO-A5, Denver, Colorado 80246-1530 at least five days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Division of Environmental Health and Sustainability, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-2978.

The Board encourages all interested persons to participate in the hearing by providing written data, views, or comments. Written testimony is encouraged; oral testimony will be received only to the extent the Board finds it necessary. For those that are permitted to provide oral testimony, the time may be limited to 3 minutes or less. Testimony is limited to the scope of the rulemaking hearing. Pursuant to 6 CCR 1014-8, §3.02.1, written testimony must be submitted no later than five (5) calendar days prior to the rulemaking hearing. Written testimony must be received by 5:00 p.m., Thursday, February 11, 2021. Persons wishing to submit written comments should submit them to: Colorado Board of Health, ATTN: Board of Health Program Assistant, Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South EDO-A5, Denver, Colorado 80246-1530 or by e-mail at: cdphe.bohrequests@state.co.us

Dated this 17th day of December, 2020.

Alexandra S. Haas
Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00998

Department

2505,1305 - Department of Health Care Policy and Financing

Agency

2505 - Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

CCR number

10 CCR 2505-10

Rule title

MEDICAL ASSISTANCE - STATEMENTS OF BASIS AND PURPOSE AND RULE HISTORY

Rulemaking Hearing

Date

02/12/2021

Time

09:00 AM

Location

303 East 17th Avenue, 11th Floor, Denver, CO 80203

Subjects and issues involved

see attached

Statutory authority

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020)

Contact information

Name

Chris Sykes

Title

Medical Services Board Coordinator

Telephone

3038664416

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chris.sykes@state.co.us

COLORADO
Department of Health Care Policy & Financing
Medical Services Board

NOTICE OF PROPOSED RULES

The Medical Services Board of the Colorado Department of Health Care Policy and Financing will hold a public meeting on Friday, February 12, 2021, beginning at 9:00 a.m., in the eleventh floor conference room at 303 East 17th Avenue, Denver, CO 80203. Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Board Coordinator at 303-866-4416 or chris.sykes@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting.

A copy of the full text of these proposed rule changes is available for review from the Medical Services Board Office, 1570 Grant Street, Denver, Colorado 80203, (303) 866-4416, fax (303) 866-4411. Written comments may be submitted to the Medical Services Board Office on or before close of business the Wednesday prior to the meeting. Additionally, the full text of all proposed changes will be available approximately one week prior to the meeting on the Department's website at www.colorado.gov/hcpf/medical-services-board.

This notice is submitted pursuant to § 24-4-103(3)(a) and (11)(a), C.R.S.

MSB 20-01-02-A, Revision to the Medical Assistance Rule concerning Family Support Services Program Rule, Section 8.613

Medical Assistance. The purpose of this rule change is to is make it easier for CCBs to implement the Family Support and Services Program (FSSP) by removing the regulatory requirement of only one Family Support Plan (FSP) per family. This change will benefit the CCBs by allowing them to maintain documentation in a way that best meets their needs.

The authority for this rule is contained in Section 25.5-10-303, C.R.S. and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020).

MSB 20-08-27-A, Revision to the Medical Assistance Rule concerning Adult Dental Annual Limit Decrease, Section 8.201

Medical Assistance. The 2020 Long Bill (HB20-1360) passed by the Colorado General Assembly decreases the Colorado Medicaid annual adult dental limit from $1,500 to $1,000, effective April 1, 2021. This rule decreases the adult dental annual limit from $1,500 to $1,000, effective April 1, 2021, to comply with HB20-1360. This bill impacts adult clients and reduces the maximum reimbursable dental services per year by $500.

The authority for this rule is contained in 42 CFR § 440.100 (2020); Sections 25.5-5-202(1)(w), C.R.S. (2020) and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020).

MSB 20-12-18-A, Revision to the Medical Assistance Act Rule concerning Federally Qualified Health Centers, Section 8.700

Medical Assistance. The purpose of this rule revision is to adjust the FQHC rate setting process to consider the changes to utilization and cost due to COVID-19. The pandemic has caused utilization to drop at FQHCs and costs have changed as well. To avoid setting unreasonable rates, this rule revision will set rates for FQHC cost reports with fiscal year ends between May 31, 2020 and March 31, 2021 using the previous year's rates multiplied by the Medicare Economic Index (MEI).

The authority for this rule is contained in Section 1902(bb) of the Social Security Act and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020).

Permanent Rules Adopted

Department

Department of Revenue

Agency

Taxation Division

CCR number

1 CCR 201-4

Rule title

1 CCR 201-4 SALES AND USE TAX 1 - eff 01/30/2021

Effective date

01/30/2021

DEPARTMENT OF REVENUE

Taxation Division

SALES AND USE TAX

1 CCR 201-4

[Publication instruction: Please maintain the 2 spaces between the rule number and title]

Rule 39-26-102(15). Tangible Personal Property.

Basis and Purpose. The statutory bases for this rule are sections 39-21-112(1), 39-26-102(15), and 39-26-122, C.R.S. The purpose of this rule is to provide clarification on the definition of tangible personal property.

(1) Tangible personal property embraces all goods, wares, merchandise, products and commodities, and all tangible or corporeal things and substances which are dealt in, capable of being possessed and exchanged, except newspapers excluded by the law.

(2) Tangible personal property does not include:

(a) real property, such as land and buildings, nor tangible personal property that loses its identity when it becomes an integral and inseparable part of the realty, and is removable only with substantial damage to the premises. Property severed from real estate becomes tangible personal property.

(b) intangible personal property constituting mere rights of action and having no intrinsic value, such as contracts, deeds, mortgages, stocks, bonds, certificates of deposit or membership, or uncancelled United States postage or revenue stamps sold for postage or revenue purposes.

(c) water in pipes, conduits, ditches or reservoirs, but does include water in bottles, wagons, tanks or other containers.

(d) computer software that does not meet the criteria enumerated in section 39-26-102(15)(c), C.R.S.

(3) An advertising supplement included in a newspaper is considered part of the newspaper and is exempt. See Special Rule 32, Newspapers, Magazines and Other Publications.

(4) The method of delivery does not impact the taxability of a sale of tangible personal property. Examples of methods used to deliver tangible personal property under current technology include, but are not limited to, the following: compact disc, electronic download, and internet streaming.

(a) Example 1: Purchaser buys a movie on a VHS tape. Sales tax is due on the purchase price of the movie.

(b) Example 2: Purchaser buys a movie on a compact disc. Sales tax is due on the purchase price of the movie.

(c) Example 3: Purchaser buys a movie through the internet, and then downloads the movie to the purchaser's computer. Sales tax is due on the purchase price of the movie.

(d) Example 4: Purchaser buys a movie, which purchaser accesses through an internet browser. Purchaser does not save a copy of the movie to purchaser's computer. Sales tax is due on the purchase price of the movie.

(e) Example 5: Purchaser pays a monthly subscription fee, which allows purchaser to select and stream movies and television shows from a library of available titles. Sales tax is due on the monthly fee.

(5) Whether a purchase that includes tangible personal property and services, and/or other types of property, is subject to tax is determined by application of the true object test. If the true object of the purchase is the tangible personal property, then sales tax is due on the purchase price.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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DEPARTMENT OF LAW

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Office of the Attorney General

Tracking number: 2020-00369

Opinion of the Attorney General rendered in connection with the rules adopted by the

Taxation Division

on 12/01/2020

1 CCR 201-4

SALES AND USE TAX

The above-referenced rules were submitted to this office on 12/01/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 18, 2020 15:27:13

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Revenue

Agency

Division of Motor Vehicles

CCR number

1 CCR 204-30

Rule title

1 CCR 204-30 DRIVER'S LICENSE-DRIVER CONTROL 1 - eff 01/30/2021

Effective date

01/30/2021

DEPARTMENT OF REVENUE

1 CCR 204-30, Rule 02 INTERSTATE DRIVER LICENSE COMPACT

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

Rule 02: Interstate Driver License Compact Rule

Basis: This rule is promulgated pursuant to sections 24-4-104, 24-60-1101 et seq., 42-1-204, 42-2-202, C.R.S.

Purpose: The purpose of this rule is to clarify the administrative procedures related to the Driver License Compact when a driver is applying for a license in Colorado.

1. DEFINITIONS:

1.1 "DMV" means the Department of Revenue, Division of Motor Vehicles for the state of Colorado.

1.2 "Habitual Traffic Offender (HTO)" has the same meaning as set forth in 42-2-202, Colorado Revised Statutes.

1.3 "National Driver Register (NDR)" is a nationwide file of information provided voluntarily by the States on drivers with licensing sanctions for drunk driving and other serious traffic violations, that provides State licensing officials with a central index; administered by the Department of Transportation's National Highway Traffic Safety Administration.

1.4 "Not Eligible Result" is a result transmitted through the Problem Driver Pointer System (PDPS) to inform the inquiring state that an applicant's driver license has been withdrawn in a party state or has active withdrawals on their driving record in another state.

1.5 "Party State" means a state that has enacted the Driver License Compact into law and is recognized by the American Association of Motor Vehicle Administrators as a participating state.

1.6 "Persistent Drunk Driver (PDD)" has the same meaning as set forth in 42-1-102(68.5), Colorado Revised Statutes.

1.7 "Problem Driver Pointer System (PDPS)" is a computerized subsystem of the National Driver Register that allows jurisdictions and other organizations to search an applicant's driver status and history to determine if an individual's privilege to operate a motor vehicle has been revoked, suspended, canceled, or denied, or if the applicant has been convicted of certain serious traffic related offenses. Based on the information in the PDPS, received from the state of record (SOR), the inquiring state decides if the applicant is eligible to receive a new or renewed driver license.

1.8 "Restraint" means any denial, cancellation, revocation, or suspension of a person's license or privilege to drive a motor vehicle.

2. LICENSING OF DRIVERS CURRENTLY SUSPENDED OR REVOKED IN A PARTY STATE

2.1. Whenever the DMV receives a driver license application from a person under restraint in a party state and a "Not Eligible" result is received from the PDPS National Driver Registry, the DMV shall issue a notice of out of state restraint that the application for a Colorado license or

instruction permit cannot be processed until the “Not Eligible” result is cleared. The notice shall identify the state(s) where the applicant's privilege is under restraint and that the applicant may contact the party state for more information, or to request a letter of clearance from the state with the restraint. The applicant may make a written request to review the “Not Eligible” result.

2.2. Upon receipt of a written request for review, the DMV will request the applicant’s party state driving record for analysis. DMV shall calculate the reinstatement eligibility date as if the offense had occurred in Colorado.

a. In calculating reinstatement eligibility, the DMV shall credit the length of time spent under the party state’s restraint to the period of suspension or revocation pursuant to Colorado law.

b. If the calculated reinstatement eligibility date has passed, the applicant shall be eligible to apply for a Colorado driver's license or instruction permit upon the completion of all required reinstatement conditions.

c. If the calculated reinstatement eligibility date is a date in the future, the applicant will not be eligible to apply for the Colorado license or instruction permit until that future date and will be issued a notice of denial.

2.3. If an applicant is not eligible under Colorado law for reinstatement, based on a restraint in a party state, then the applicant is also not eligible for any limited driving privilege, such as a probationary or temporary license and shall be issued a notice of denial.

2.4. In no event shall a Colorado driver's license or instruction permit be issued to any applicant if the period from the imposition of a revocation by a party state is less than one year, nor may a driver license be issued if the period of suspension imposed by a party state has not terminated.

2.5. If the restraint is from a state that does not participate in the Driver’s License Compact, a Colorado driver’s license or instruction permit may only be obtained once the non-party state shows an “eligible” status on the PDPS.

2.6. Any applicant who disagrees with the DMV’s analysis and license requirements based upon the existing revocation or suspension of their license in another party state may request a hearing within 60 days from the date of denial.

3. DEPARTMENT HEARING FOR DENIAL OF LICENSE UNDER RESTRAINT

3.1 An applicant who has received a notice of denial may, within 60 days of the date of the notice of denial, request a hearing on the denial by filing a written request for hearing with the Hearings Section of the Department.

3.2 Hearings shall be held in accordance with the provisions of the State Administrative Procedure Act, and the provisions of Title 42 and 24 of the Colorado Revised Statutes.

3.3 The only issue at a hearing shall be whether the applicant has satisfied federal and state requirements for the issuance of a Driver License.

3.4 The hearing officer shall issue a written decision. If the hearing officer finds that the applicant has not satisfied federal and state requirements for the issuance of a driver license, then the denial shall be sustained. If the hearing officer finds that the applicant has satisfied

requirements for the issuance of a Driver License, the denial shall be rescinded and the Department shall issue a Colorado driver license.

3.5 The hearing officer's decision shall constitute final agency action, and is subject to judicial review as provided by section 24-4-106, C.R.S.

4. CLEARANCE FROM A PARTY STATE

4.1. If at the time of application the applicant presents a reinstatement order, letter of clearance, or a no match letter from the party state for the restraint in question, the application for a Colorado driver license shall be processed.

5. EFFECT OF CONVICTIONS IN OTHER STATES

5.1 Whenever the DMV receives a conviction from another state for a Colorado licensed driver, the conviction will be posted to the driver's record.

5.2 Convictions occurring in another state while licensed as a Colorado driver shall have the same effect as though the conviction had occurred in Colorado except that, there will not be points assessed against the driver's record pursuant to C.R.S. 24-60-1105.

5.3 Drivers moving into Colorado will whenever possible have their previous driving history applied to the Colorado record.

5.4 Subsequent violations occurring after the Colorado record is created will be evaluated against the driver's history for the purpose of determining whether additional action or other designations such as Persistent Drunk Driver or Habitual Traffic Offender statuses should be applied to the driver's record.

Editor's Notes

History

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
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Office of the Attorney General

Tracking number: 2020-00760

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Motor Vehicles

on 12/08/2020

1 CCR 204-30

DRIVER'S LICENSE-DRIVER CONTROL

The above-referenced rules were submitted to this office on 12/11/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 23, 2020 14:41:14

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Colorado Podiatry Board

CCR number

3 CCR 712-18

Rule title

3 CCR 712-18 ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES 1 - eff 01/30/2021

Effective date

01/30/2021

DEPARTMENT OF REGULATORY AGENCIES

Colorado Podiatry Board

RULE 300 – ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES

3 CCR 712-18

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

18.1 STATEMENT OF BASIS AND PURPOSE

The basis for the Board's promulgation of these rules and regulations is sections 12-20-204(1) and 12-290-106(1)(a), C.R.S. The specific statutory authority for the promulgation of this Rule is section 12-30-111(2), C.R.S.

The purpose for the Board's promulgation of this Rule is to define a temporary technological failure, a temporary electrical failure, and an economic hardship for purposes of sections 12-30-111(1)(a)(1) and 12-30-111(1)(a)(XI), C.R.S., as well as to explain the process for a prescriber to demonstrate an exception to the requirement to prescribe controlled substances electronically as required by section 12-30-111(1)(a), C.R.S.

18.2 ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES

A. Effective on July 1, 2021, and pursuant to section 12-30-111(1)(a), C.R.S., a prescriber shall prescribe a controlled substance as set forth in section 12-30-111(1)(a), C.R.S., only by electronic prescription transmitted to a pharmacy unless an exception in section 12-30-111(1)(a), C.R.S., applies.

B. A "temporary technological failure," for purposes of section 12-30-111(1)(a)(I), C.R.S., is when:

   1. A necessary prescribing software program is inaccessible or otherwise not operational;

   2. Required technology fails to start; or

   3. During a period when a virus or cyber security breach is actively putting patient data and transmission at risk.

C. A "temporary electrical failure," for purposes of section 12-30-111(1)(a)(I), C.R.S., is a short-term loss of electrical power at the place of business that lasts no more than forty-eight hours or two consecutive business days unless there is a showing of undue hardship.

D. An "economic hardship," for purposes of section 12-30-111(1)(a)(XI), C.R.S., is a measurement of relative need taking into consideration the individual gross receipts and net profits, cost of compliance, and type of software upgrade required. In order for a prescriber to demonstrate economic hardship, the prescriber must submit to the Board for a final determination:

   1. A written statement explaining the economic hardship, including supporting documentation to demonstrate economic hardship. Supporting documentation may include the most recent tax return or other business records that show gross receipts and net profits. The Board reserves the right to request additional documentation to support

the request, if necessary. The request must also include the requested duration of the economic hardship.

2. If the Board determines there should be an economic hardship exception for the prescriber, then the Board will determine the duration of the economic hardship exception, which shall not exceed one year from the date the exception was granted.

3. In order to renew a request for an economic hardship exception, the prescriber must submit a request to renew the exception in writing to the Board no less than two months prior to the expiration of the economic hardship exception. The prescriber must provide a written statement explaining the need to renew the economic hardship, including supporting documentation.

PHILIP J. WEISER
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Office of the Attorney General

Tracking number: 2020-00854

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Colorado Podiatry Board

on 12/04/2020

3 CCR 712-18

ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES

The above-referenced rules were submitted to this office on 12/04/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 22, 2020 10:25:54

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Colorado Podiatry Board

CCR number

3 CCR 712-19

Rule title

3 CCR 712-19 REQUIRED DISCLOSURE TO PATIENTS CONVICTION OF OR DISCIPLINE BASED ON SEXUAL MISCONDUCT 1 - eff 01/30/2021

Effective date

01/30/2021

DEPARTMENT OF REGULATORY AGENCIES

Colorado Podiatry Board

RULE 310 – REQUIRED DISCLOSURE TO PATIENTS – CONVICTION OF OR DISCIPLINE BASED ON SEXUAL MISCONDUCT

3 CCR 712-19

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

19.1 REQUIRED DISCLOSURE TO PATIENTS – CONVICTION OF OR DISCIPLINE BASED ON SEXUAL MISCONDUCT

A. On or after March 1, 2021, a licensee, shall disclose to a patient, as defined in section 12-30-115(1)(a), C.R.S., instances of sexual misconduct , including a conviction or guilty plea as set forth in section 12-30-115 (2)(a) C.R.S., or final agency action resulting in probation or limitation of the licensee's ability to practice as set forth is section 12-30-115(2)(b), C.R.S.

B. Form of Disclosure: The written disclosure shall include all information specified in section 12-30-115(3), C.R.S., and consistent with the sample model disclosure form as set forth in Appendix A to these rules. The patient must, through his or her signature on the disclosure form, acknowledge the receipt of the disclosure and agree to treatment with the registrant.

C. Timing of Disclosure: This disclosure shall be provided to a patient the same day the patient schedules a professional services appointment with the licensee. If an appointment is scheduled the same day that services will be provided or if an appointment is not necessary, the disclosure must be provided in advance of the treatment.

1. The written disclosure and agreement to treatment must be completed prior to each treatment appointment with a patient unless the treatment will occur in a series over multiple appointments or a patient/patient schedules follow-up treatment appointments.

2. For treatment series or follow-up treatment appointments, one disclosure prior to the first appointment is sufficient, unless the information the licensee is required to disclose pursuant to section 12-30-115, C.R.S., has changed since the most recent disclosure, in which case an updated disclosure must be provided to a patient and signed before treatment may continue.

D. As set forth in section 12-30-115(3)(e), C.R.S., the requirement to disclose the conviction, guilty plea, or agency action ends when the licensee has satisfied the requirements of the probation or other limitation and is no longer on probation or otherwise subject to a limitation on the ability to practice the licensee's profession.

E. A licensee is not required to provide the written disclosure before providing professional services to the patient in the following instances as set forth in section 12-20-115(4), C.R.S.:

1. The patient is unconscious or otherwise unable to comprehend the disclosure and a guardian of the patient is unavailable;

2. The patient visit occurs in an emergency room or freestanding emergency department or the visit is unscheduled, including consultations in inpatient facilities; or

3. The licensee providing the professional service to the patient is not known to the patient until immediately prior to the start of the visit; or

4. The licensee does not have a direct treatment relationship or have direct contact with the patient.

APPENDIX A

MODEL SEXUAL MISCONDUCT DISCLOSURE STATEMENT

DISCLAIMER: This Model Sexual Misconduct Disclosure Statement is to be used as a guide only and is aimed only to assist the practitioner in complying with section 12-30-115, C.R.S., and the rules promulgated pursuant to this statute by the Director. As a licensed, registered, and/or certified health care licensee in the State of Colorado, you are responsible for ensuring that you are in compliance with state statutes and rules. While the information below must be included in your Sexual Misconduct Disclosure Statement pursuant to section 12-30-115, C.R.S., you are welcome to include additional information that specifically applies to your situation and practice.

A. Licensee information, including, at a minimum: name, business address, and business telephone number.

B. A listing of any final convictions of or a guilty plea to a sex offense, as defined in section 16-11.7-102(3), C.R.S.

C. For each such conviction or guilty plea, the licensee shall provide, at a minimum:

1. The date that the final judgment of conviction or guilty plea was entered;

2. The nature of the offense or conduct that led to the final conviction or guilty plea;

3. The type, scope, and duration of the sentence or other penalty imposed, including whether:

a. The provider entered a guilty plea or was convicted pursuant to a criminal adjudication;

b. The provider was placed on probation and, if so, the duration and terms of the probation and the date the probation ends; and

c. The jurisdiction that imposed the final conviction or issued an order approving the guilty plea.

D. A listing of any final agency action by a professional regulatory board or agency that results in probationary status or other limitation on the licensee's ability to practice if the final agency action is based in whole or in part on:

1. a conviction for or a guilty plea to a sex offense, as defined in section 16-11.7-102(3), C.R.S., or a finding by the professional regulatory board or Director that the provider committed a sex offense, as defined in as defined in section 16-11.7-102(3), C.R.S.; OR

2. a finding by a professional regulatory board or agency that the provider engaged in unprofessional conduct or other conduct that is grounds for discipline under the part or

article of Title 12 of the Colorado Revised Statutes that regulates the provider's profession, where the failure or conduct is related to, includes, or involves sexual misconduct that results in harm to a patient or presents a significant risk of public harm to patients.

E. For each such final agency action by a professional regulatory board or agency the provider shall provide, at a minimum:

1. The type, scope, and duration of the agency action imposed, including whether:

   a. the regulator and licensee entered into a stipulation;

   b. the agency action resulted from an adjudicated decision;

   c. the licensee was placed on probation and, if so, the duration and terms of probation; and

   d. the professional regulatory board or agency imposed any limitations on the licensee's practice and, if so, a description of the specific limitations and the duration of the limitations.

2. The nature of the offense or conduct, including the grounds for probation or practice limitations specified in the final agency action;

3. The date the final agency action was issued;

4. The date the probation status or practice limitation ends; and

5. The contact information for the professional regulatory board or agency that imposed the final agency action on the licensee, including information on how to file a complaint.

Sample Signature Block

I have received and read the sexual misconduct disclosure by [Provider Name] and I agree to treatment by [Provider Name].

_____

Print Client Name

_____

Client or Responsible Party's Signature **Date**

If signed by Responsible Party (parent, legal guardian, or custodian), print Responsible Party's name and relationship to client:

_____

Print Responsible Party Name **Print Relationship to Client**

_____

Licensee Signature **Date**

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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Office of the Attorney General

Tracking number: 2020-00855

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Colorado Podiatry Board

on 12/04/2020

3 CCR 712-19

REQUIRED DISCLOSURE TO PATIENTS CONVICTION OF OR DISCIPLINE BASED ON SEXUAL MISCONDUCT

The above-referenced rules were submitted to this office on 12/04/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 22, 2020 10:27:31

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Real Estate

CCR number

4 CCR 725-1

Rule title

4 CCR 725-1 RULES REGARDING REAL ESTATE BROKERS 1 - eff 01/30/2021

Effective date

01/30/2021

DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF REAL ESTATE
REAL ESTATE COMMISSION
4 CCR 725-1

RULES GOVERNING THE PRACTICE OF REAL ESTATE BROKERS OF THE REAL ESTATE COMMISSION

NOTICE OF PROPOSED PERMANENT RULEMAKING HEARING
December 1, 2020 at 9:00 AM MST

Division of Real Estate Office
1560 Broadway
Denver, CO 80202

Chapter 3: Licensure, Renewal, License Status, and Insurance

3.11. Renewal

A. No Renewal Requirement for Brokerage Firms

Brokerage Firms are not required to renew their License; however, the Independent Broker or Employing Broker associated with the Brokerage Firm must renew as set forth in Rule 3.11.B.

B. Renewal Requirements for Brokers

1. Licensing Cycle for Renewal (Renewal Periods)

Brokers will renew a License on a Calendar Year Cycle commencing on January 1 of year one and expiring on December 31 of year three.

2. Notification of Renewal

Notification that a License will expire, unless renewed, will be sent to the electronic mail address on file with the Commission.

3. Renewal Application

a. All Brokers, whether on Active or Inactive status, may renew their License beginning forty-five (45) days prior to the expiration date of their License by use of the renewal application form provided by the Commission.

b. Pay the renewal Fee.

c. Any Broker who has not submitted fingerprints to the Colorado Bureau of Investigation to be used to complete a one-time only criminal history record check must do so prior to renewal of an Active License. Fingerprints must be submitted to the Colorado Bureau of Investigation for processing in a manner acceptable to the Colorado Bureau of Investigation. Fingerprints must be readable and all personal

identification data completed in a manner satisfactory to the Colorado Bureau of Investigation. The Commission may, however, acquire a name-based criminal history record check for an Applicant who has twice submitted to a fingerprint-based criminal history record check and whose fingerprints are unclassifiable. The renewed License will remain on Inactive status until the Commission has received and reviewed the results of a criminal record check.

3.15. License Reinstatement

Brokers who failed to renew a License as set forth in Rule 3.11.B.3 may Reinstate the Expired License as follows:

A. If a proper application is made within thirty-one (31) days after the date of expiration of a License, by payment of the renewal Fee, the License will be issued as set forth in Rule 3.11.B.3.

B. If a proper application is made more than thirty-one (31) days but within one (1) year after the date of expiration of a License, by payment of the renewal Fee and payment of a reinstatement Fee equal to one-half (1/2) the renewal Fee, the reinstated License will be issued with an expiration date of three (3) years beginning from the expiration date of the prior expired License.

C. If a proper application is made more than one (1) year but within three (3) years after the date of expiration of a License, by payment of the renewal Fee and payment of a reinstatement Fee equal to the renewal Fee, the reinstated License will be issued with an expiration date of three (3) years beginning from the expiration date of the prior expired License.

PHILIP J. WEISER
Attorney General

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ERIC R. OLSON
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Office of the Attorney General

Tracking number: 2020-00851

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Real Estate

on 12/01/2020

4 CCR 725-1

RULES REGARDING REAL ESTATE BROKERS

The above-referenced rules were submitted to this office on 12/02/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 18, 2020 15:26:10

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 14 – Fingerprint-Based Criminal History Record Check

Effective January 30, 2021

(a) No person shall be eligible for certification as a Colorado peace officer if they have a disqualifying incident.

(b) Per § 24-31-304, C.R.S. and POST Rules, all persons seeking to enroll in a training academy shall submit their fingerprints to CBI no more than 60 days prior and at least one week before enrolling in the training academy. The academy must notify POST when fingerprints are submitted.

(c) All persons seeking to apply for provisional or renewal certification must submit fingerprints to CBI as part of the application process pursuant to Rule 11 and 13.

(d) POST Applicant Fingerprint results.

(I) The Board recommends that an applicant's fingerprints be submitted electronically by a CBI-authorized vendor or a LEA authorized by CBI to submit fingerprints for POST. When this is not possible, the applicant can submit fingerprints using the POST Applicant Fingerprint Card, obtained directly from POST. Any fees associated with this service are the responsibility of the applicant.

(II) Provisional and renewal applicants may request the POST Applicant Fingerprint Card when they are unable to submit fingerprints electronically. The applicant is responsible for having their fingerprints taken prior to the applicant's participation in the testing process as a provisional or renewal applicant.

(IV) Applicants enrolling in a basic or reserve training academy fingerprinted in accordance with the academy's policies and procedures. The academy is responsible for ensuring that fingerprints are submitted to CBI by a CBI-authorized vendor or that the completed POST Applicant Fingerprint Card and fee are submitted to CBI prior to the applicant's enrollment in the academy.

(V) Fingerprint results are valid throughout the certification process and through the life of certification. If certification expires or is revoked they become invalid. Applicants renewing their certification must submit new fingerprints.

(e) Results from completed criminal history record checks.

(I) The Board shall be the authorized agency to receive the results from all POST Applicant Fingerprint submissions that have been processed for the state and national fingerprint-based criminal history record checks.

(II) All results from the completed criminal history record checks will be provided to the POST Director. Notice of subsequent arrests and convictions resulting in denial of certification will be provided to the Board.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
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Office of the Attorney General

Tracking number: 2020-00867

Opinion of the Attorney General rendered in connection with the rules adopted by the

Peace Officer Standards and Training Board

on 12/11/2020

4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/15/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 11:59:50

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 15 – Certification Examination
Basic, Provisional, Renewal

Effective January 30, 2021

(a) To be eligible to take the certification examination, an applicant must have completed and submitted to POST, as applicable:

(I) Form 1 - Application for Basic Peace Officer Certification; or
Form 3 - Application for Provisional Certification; or
Form 4 - Application for Renewal of Basic Certification; and

(II) A copy of their approved basic training academy diploma, or other evidence of successful completion; and

(III) A copy of their high school diploma, high school equivalency certificate or other evidence of successful completion of high school, including official college transcripts or college degree as evidence that the applicant has met the high school completion requirement; and

(IV) A copy of their current first aid and cardiopulmonary resuscitation certification, or equivalents; and

(V) A copy of their current driver's license or state-issued identification card; and

(VI) If applicable, a copy of their official military discharge documents showing character of service other than dishonorable conditions per § 24-31-301(5), C.R.S.

(VII) A law enforcement agency check, certified check, money order, or electronic payment in the prescribed amount.

(b) Certification examinations will be conducted by POST staff or POST approved designated proctor at academy locations. However, if the number of students sitting for the examination is four (4) or fewer, the students shall be required to take the examination at a location designated by POST. Additional exam dates will be offered periodically at POST for individuals.

(c) Refunds of certification examination fees shall not be provided unless the examination is postponed or canceled or under such other exceptional circumstances as determined by the Director. Otherwise, non-refunded fees may be credited to allow the applicant to take the next administration of the certification examination. Further credits or extensions shall not be permitted.

(d) An applicant has a maximum of three attempts to pass the POST certification examination within two years of graduating the academy, or within one year of beginning the provisional or renewal process. Applicants taking the examination for a second or third time must pay the fee for the additional examination, and such examination shall not

be comprised of the same questions that comprised the prior examinations. If an applicant cannot pass the certification examination after three attempts, the applicant must retake and successfully complete the academic portion of a basic academy in accordance with Rule 10 at the discretion of the academy director and in coordination with POST.

(e) Any protest or challenge to an examination or its administration must be made in writing within ten (10) days of the examination. The Director shall issue his decision in writing within twenty (20) working days. The decisions of the Director shall be final, unless appealed to the Board in accordance with Rule 5(c).

(f) POST sets a passing score that reflects the level of knowledge and skills required for minimally competent performance as an entry-level Peace Officer in the State of Colorado. POST uses national testing standards in setting the passing score which falls on a test score scale that ranges from 0 to 100.

PHILIP J. WEISER
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NATALIE HANLON LEH
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Office of the Attorney General

Tracking number: 2020-00868

Opinion of the Attorney General rendered in connection with the rules adopted by the

Peace Officer Standards and Training Board

on 12/11/2020

4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/15/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 12:00:55

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 16 – Skills Examinations for Provisional and Renewal Applicants

Effective January 30, 2021

(a) To be eligible to take any of the skills examinations, an applicant must complete and submit all applicable POST form(s) as set forth in POST Rule, including POST Form 3 – *Application for Provisional Certification* and/or POST Form 4 – *Application for Renewal of Basic Certification* along with a law enforcement agency check, certified check, money order, or electronic payment in the prescribed amount for each examination to be taken (prior to the day of the exam).

(b) Refunds of skills examination fees shall be provided only if requested more than twenty (20) days prior to the scheduled examination, unless the examination is postponed or canceled, or under such other exceptional circumstances as may be determined by the Director.-

(c) Only SME members, or the Director's designee, may conduct skills examinations.

(d) An applicant will be permitted three formal attempts to successfully complete each skills exam.

(1) Starting any skills exam is considered one attempt.

(2) An applicant may only coordinate additional attempts with POST staff in advance.

(3) Payment for each attempt must be submitted prior to the exam.

(4) Multiple attempts may be permitted at the discretion of the SME member administering the test out. POST may or may not assess an additional exam fee.

(e) If an applicant has failed a skills examination on three (3) formal attempts, the applicant then has two (2) years to complete the basic academy training program for that skill at a Colorado POST-approved basic or reserve academy at the discretion of the academy director and in coordination with POST. If the applicant does not complete the required training within the two (2) years following their last skills examination attempt, they must complete a full basic academy.

(f) Skills examination scores are valid for two (2) years from the date of the last registered score with POST. All skills exams must be taken and successfully completed within two years of the initial application date.

(g) Any protest or challenge to an examination or its administration must be made in writing within ten (10) days of the examination. The Director shall issue a decision in writing within twenty (20) working days. The decision of the Director shall be final, unless appealed to the Board in accordance with Rule 5(c).

PHILIP J. WEISER
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Tracking number: 2020-00869

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Peace Officer Standards and Training Board

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4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/21/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 12:02:02

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 17 – Certification Records

Effective January 30, 2021

(a) Every POST certificate holder shall keep current the POST certificate holder's name, home address, mailing address, email address, home telephone number, or cell phone number to the POST records management system.

(b) When any person is appointed or separated as a certified peace officer the agency shall submit an update to the POST records management system within fifteen (15) days of such appointment or separation.

(c) Employment in the state of Colorado as a Basic peace officer, Provisional peace officer, or Reserve peace officer as defined in section § 16-2.5-102, § 24-31-308 and § 16-2.5-110, C.R.S. requires submission of physical and psychological examinations affirmation (Form 6).

(d) By the 31st of January of each year, each agency shall verify the accuracy of the certified peace officers associated with the law enforcement agency listed on the POST records management system by submitting the Rule 17 form to POST. By submitting the form, each agency is certifying that the agency has confirmed all certified peace officers associated with their law enforcement agency have no decertifying incidents that would prevent the individual from being a certified peace officer in Colorado, and that each certified peace officer has a valid Colorado Driver's License or Colorado ID.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
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Tracking number: 2020-00870

Opinion of the Attorney General rendered in connection with the rules adopted by the

Peace Officer Standards and Training Board

on 12/11/2020

4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/15/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 12:03:22

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 18 – Certification, Suspension, and Revocation; Basic, Provisional, Renewal, and Reserves

Effective January 30, 2021

(a) A suspension temporarily invalidates the subject certification until such time as the defect has been remedied. Any certification shall be suspended by the Board if the holder wrongfully obtained the certificate through misrepresentation, neglect, mistake or otherwise failed to meet the certification requirements established by the Board.

(b) The Board shall suspend a peace officer's certification if the peace officer fails to comply with the training requirements. The POST Director shall reinstate a peace officer's certification that was suspended pursuant to this paragraph (a) upon completion of the training requirements. The reinstatement will be effective immediately.

(c) Failure to comply with POST training requirements may result in certification revocation by the POST Board if a peace officer fails to satisfactorily complete the training required, and fails to remedy such failure by satisfactorily completing the training within 30 calendar days of receiving notification of failure from the POST Board."

(d) A revocation permanently invalidates the subject certification. Any certification shall be revoked by the Board if the holder has a disqualifying incident.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
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Office of the Attorney General

Tracking number: 2020-00871

Opinion of the Attorney General rendered in connection with the rules adopted by the

Peace Officer Standards and Training Board

on 12/11/2020

4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/15/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 12:04:32

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 19 – Vehicle Identification Number Inspectors

Effective January 30, 2021

(a) Any person seeking certification as a Vehicle Identification Number Inspector must meet each of the following requirements:

(I) Currently serving as a peace officer recognized in Title 16, Article 2.5 of the Colorado Revised Statutes or as "Inspector" defined in Title 42 Article 5 of the Colorado Revised Statutes; and

(II) Successfully completes and submits his/her certificate of completion from an approved Vehicle Identification Number course; and

(III) Completes and submits the POST Form 9 – *Application for VIN Inspector Certification*.

(IV) VIN Inspector certifications are valid for three (3) years from the date of issue or from the most recent renewal date.

(b) The following are requirements for renewing a VIN Inspector certification:

(I) The VIN Inspector must successfully complete the approved POST VIN Inspector renewal training either on-line or in-person (if available).

(II) The renewal training must be completed prior to the inspector's current expiration date.

(III) The training must be reported to the POST records management system. This may occur automatically in the case of POST on-line training.

(IV) Once renewal training is successfully completed and submitted to POST, the VIN Inspector certification will be renewed and given an expiration date of three (3) years from the training completion date.

(V) Any inspector who fails to successfully complete the renewal training prior to their expiration date must complete the full VIN Inspector training in order to be re-certified.

(VI) All VIN Inspectors who were certified prior to August 2, 2019 (the effective date of § 42-5-206(4), C.R.S.,) will have until June 30, 2020 to complete the renewal training for the first time.

PHILIP J. WEISER
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Office of the Attorney General

Tracking number: 2020-00872

Opinion of the Attorney General rendered in connection with the rules adopted by the

Peace Officer Standards and Training Board

on 12/11/2020

4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/15/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 12:05:30

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 20 – Vehicle Identification Number Inspector Programs

Effective January 30, 2021

(a) Every vehicle identification number (VIN) inspector program must contain a minimum of seventeen (17) hours, adhere to POST curriculum requirements and be approved prior to the start of instruction.

(b) The program director must submit all of the following documentation to POST staff at least sixty (60) days prior to the start of instruction:

(I) A narrative of performance objectives for the program (new programs only);

(II) A list of courses to be taught and the time allocated for each course (new programs only); and

(III) A completed POST Form 9A, *Application for VIN Inspector Training Program Approval,* and a list of instructors and their qualifications. Instructors shall be approved only for a specific program under this rule (all programs).

(c) To be approved, a program must include all of the following:

(I) Legal aspects of VIN inspection;

(II) Use of the National Insurance Crime Bureau (NICB) *Passenger* and *Commercial Vehicle Identification Manuals*;

(III) How to conduct a VIN inspection; and

(IV) How to meet the reporting requirements of a VIN inspection.

(d) The program director must submit a roster of passing students to POST within thirty (30) days of the end of the program.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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DEPARTMENT OF LAW

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Office of the Attorney General

Tracking number: 2020-00873

Opinion of the Attorney General rendered in connection with the rules adopted by the

Peace Officer Standards and Training Board

on 12/11/2020

4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/15/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 12:06:27

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 22 – Concerning Sunrise Review of Peace Officer Status

Effective January 30, 2021

The Colorado General Assembly and Colorado Peace Officer Standards and Training Board (POST) find that it is necessary to ensure that clear standards exist for obtaining peace officer status in the state of Colorado. The General Assembly and POST Board, during the 2003 legislative session, made statutory changes to end the stratification of peace officers and to ensure that all peace officers receive a consistent level of statutory protection. During the 2004 legislative session, SB04-224 required that the POST Board review any group seeking peace officer status, either for a group or a specific position. These POST Board actions are to be accomplished prior to the group seeking authorization from the General Assembly.

(a) Proposal Submission to POST

(I) No later than July 1 of any year, a group or political subdivision of the state that seeks peace officer status, either for the group or a specific position, shall submit to the POST Board for its review, a completed POST Form 12 and proposal containing the following information.

(A) A complete description of the group or specific position, its enforcement responsibilities and purpose for seeking peace officer status.

(B) An estimate of the number of persons who hold the position or are in the group affected.

(C) A description of the specific need for the authority and protections required for the group or specific position.

(D) The direct benefit to the public that would result from granting the peace officer status to the group or specific position.

(E) The costs associated with granting the status to the applicant group or specific position.

(F) A resolution or letter of support for the proposed change in status from the chief executive officer of the unit of government or political subdivision employing the applicant group or overseeing the proposed position.

(G) All other information requested or required by the POST Director or POST Board Sub-committee for Peace Officer status.

(II) The Director will review item (A) through (G) and will coordinate with the group or specific position on additional information needed for POST Board review. A date will then be set for POST Board Sub-committee hearing.

(b) POST Board Sub-committee Hearing

(I) POST Board Sub-committee for peace officer status

(A) The Sub-committee shall include the following POST Board members – 2 Police Chiefs, 2 Sheriffs, and 1 additional Board member. The Director shall staff the Sub-committee.

(II) After receiving the required information specified in subsections (a)(I) and (II) of this rule, the POST Board sub-committee for Peace Officer status shall conduct a hearing with the group's representatives seeking peace officer status for the group or position.

(III) At the hearing a determination as to whether Peace Officer status is needed shall be based upon the following criteria:

(A) Sufficient need for one or more of the "primary" Peace Officer powers:

1) Authority to enforce all laws in the State of Colorado.

2) Authority to arrest (PC, warrant, restraining order, court order).

3) Authority to use force in effecting arrest or preventing escape.

4) Authority to "stop and frisk."

5) Authority to execute search warrants.

6) Authority to carry concealed without Sheriff's permit.

(B) Employment by a government entity or a political subdivision thereof.

(C) Endorsement by the governing body or bodies of every group or position that the proposed legislation would include.

(D) Copies of letters of notification from the group seeking status to the affected law enforcement agencies with concurrent jurisdiction.

(E) "Draft" copy of the position/group's proposed bill language. The draft shall be completed through the use of a POST provided bill language template. Any specific limitations to Peace Officer authority need to be clearly delineated in the language of the proposed legislation.

(IV) Identification and assessment of the range and scope of authority, limits on authority, and the availability of Peace Officers with concurrent jurisdiction will be considered by the sub-committee regarding POST recommendations and training standards for each group.

(V) The preferred standards for any group or position requesting Peace Officer status are full POST certification (including background standards), and 40 hours annual continuing education.

(VI) The POST Board sub-committee for Peace Officer status shall submit a report and recommendation to the full POST Board for review and action. The applicant group or position will receive a copy of the report and recommendation.

(c) POST Board Review

(I) Upon receipt of the POST Board sub-committee report and recommendation, the POST Board shall review the sub-committee recommendations at a scheduled POST Board meeting.

(II) At the scheduled meeting, the POST Board shall review the report, recommendation(s) and the information submitted by the sub-committee, and shall grant the groups' or positions' representatives a hearing to address the report and recommendations of the sub-committee. The POST Board can approve the recommendations or return the application to the POST sub-committee requiring additional information, requirements, and/or further review. Should the POST Board require the sub-committee to conduct a further review of the

Positions' or Groups' application, the sub-committee's final report and recommendations shall be presented to the full Board at a scheduled POST Board Meeting. The affected group/position will be notified of the meeting at which the final report and recommendations will be considered by the Board.

(III) Upon completion of sections (c)(I) and (II) of this rule, the POST Board shall submit a final report and recommendations to the group seeking Peace Officer status for the group or for a specific position and to the Judiciary Committees of the Senate and House of Representatives. The report will be submitted no later than October 15 of the year following the year in which the proposal was submitted. The report may include legislative recommendations.

(d) Limitations – § 16-2.5-201(6)

(I) The group seeking Peace Officer status for the group or specific position may request members of the General Assembly to present appropriate legislation to the General Assembly during each of the two regular sessions that immediately succeed the date of the report required pursuant to subsection (c)(III) without having to comply again with the provisions of this rule.

(II) Bills introduced pursuant to the statute and this rule shall count against the number of bills to which members of the General Assembly are limited by joint rule of the Senate and House of Representatives. The General Assembly shall not consider Peace Officer status of more than five positions or groups in any one session of the General Assembly.

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(II) Bills introduced pursuant to the statute and this rule shall count against the number of bills to which members of the General Assembly are limited by joint rule of the Senate and House of Representatives. The General Assembly shall not consider Peace Officer status of more than five positions or groups in any one session of the General Assembly.

PHILIP J. WEISER
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Chief Deputy Attorney General

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Office of the Attorney General

Tracking number: 2020-00875

Opinion of the Attorney General rendered in connection with the rules adopted by the

Peace Officer Standards and Training Board

on 12/11/2020

4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/21/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 12:07:20

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 28 – In-Service Training Program

Effective January 30, 2021

The purpose of in-service training is to provide continuing education to certified peace officers to develop their knowledge and/or skills. The POST Board's duties relating to annual in-service training are addressed in Colorado Revised Statutes § 24-31-303(1). The POST Board can "promulgate rules deemed necessary by the Board concerning annual in-service training requirements for certified peace officers, including but not limited to evaluation of the training program and processes to ensure substantial compliance by law enforcement agencies and departments." In-service training is mandatory for certified peace officers who are currently employed in positions requiring certified peace officers as defined in Colorado Revised Statutes section § 16-2.5-102. This includes certified fulltime, part-time and reserve peace officers. Failure to satisfactorily complete training can result in suspension or revocation of an individual's POST certification.

(a) Annual Hour Requirement

The in-service training program requires certified peace officers to complete a minimum of 24 hours of in-service training annually. Of the 24 hours, a minimum of 12 hours shall be perishable skills training as specified below.

(b) Training Period

(I) The training period shall be the calendar year, from January 1 to December 31, of each year. In-service training in excess of 24 hours each year shall not be credited towards any future or prior training period.

(II) Remedial training hours completed after January 1 to gain compliance for a prior calendar year shall not count towards the current year requirement.

(c) Approved Training for POST Credit

The authority and responsibility for training shall be with the chief executive of each law enforcement agency. The chief executive accepts responsibility and liability for the course content and instructor qualification. Legislatively mandated training may also be used for credit towards the training requirement.

The following are examples of training that would qualify for in-service credit:

(I) Training received during the Basic Academic Training Program (Basic Academy).

(II) Computer or web-based courses that have been approved by the chief executive may be used for in-service credit.

(III) The viewing of law enforcement related audiovisual material (DVD, video, etc.) or material related to the viewer's position or rank can be used in conjunction with a facilitated discussion or other presentation. This could include roll call or lineup briefings where the session is dedicated to training and not for the purpose of information exchange.

(IV) For each class hour attended at an accredited college or university in any course related to law enforcement or criminal justice that is required to earn a degree, one hour of in-service credit may be awarded.

(d) Perishable Skills Training

Perishable skills training shall consist of a minimum of 12 hours. The required 12 hours must include a minimum of one hour of training in each of the three perishable skills (Arrest Control, Driving, and Firearms) each calendar year. Examples of perishable skills training could include:

(I) Arrest Control-live or simulator exercises and scenarios, classroom discussion followed by interactive scenario events. Arrest control fundamentals, agency policies and/or legal issues.

(II) Driving-behind-the-wheel or simulator training, classroom discussion regarding judgment/decision making in driving, agency policies and/or legal issues.

(III) Firearms-live or simulator exercises and scenarios, firearms fundamentals, use of force training or discussions, classroom training requiring student interaction and/or decision making, classroom discussion on agency policies and/or legal issue. Firearms qualification alone is insufficient to meet this mandate.

(e) Agency Maintenance of Training Records

The chief executive of each agency is responsible for the true, accurate and verifiable entry of training records into the POST database. -

Agencies are encouraged to enter training as it occurs, but shall enter training no later than the end of each calendar year for the certified peace officers employed at any time during that year, regardless of current employment status. This information shall be entered into the POST database.
For in-person courses, agencies are required to keep records of sign-in sheets, topics covered, and lesson plans (if they exist).

(I) Waiver of In-Service Requirements

All certified peace officers shall meet the minimum annual hours. However, under the circumstances listed below, an agency may request a waiver for a portion of the annual in-service training requirement. Any waiver of the annual training request must be made in writing to the POST Director by January 31st of the following year.

(A) Perishable Skills Waiver
Agency executives may request an exemption from the perishable skills training requirement. This request shall be in writing to the POST Director. This request shall state that either their certified peace officers do not carry firearms, or they infrequently interact with or effect physical arrests, or they do not utilize marked or unmarked emergency vehicles as part of their normal duties.

(B) Partial Year Employment Waiver
The 24 hours of in-service training is required if a certified peace officer is employed for the entire calendar year. Certified peace officers who are employed after the start of the calendar year only need to complete a prorated number of training hours. Therefore, two hours of training per month, with a minimum of one hour of perishable skills training shall be required. (Example: If a certified peace officer is hired in July, 12 hours of training with a minimum of six hours of perishable skills training must be completed for that calendar year).

(C) Long Term Disability, Medical Leave or Restricted Duty
If a certified peace officer is unable to complete the in-service annual hours due to long term disability, medical leave or restricted duty, the agency must obtain a letter from a physician stating that participation in any type of training including audiovisual or online training would be detrimental to the officer's health. The letter should define the time that the officer is unable to attend any training. Those granted a waiver will be on a prorated basis for the time stated in the physician's letter. The agency does not need to forward the physician's letter to POST but only reference it in a waiver request.

(D) Military Leave
Those certified peace officers deployed in military service only need to complete a prorated number of training hours.

(E) Administrative Leave
If a certified peace officer is unable to complete the in-service annual hours due to placement on administrative leave, the officer must complete a prorated number of training hours.

(II) Compliance

(A) Agencies and individual peace officers are required to be in compliance with the in-service training requirements.

(1) Agencies

(a) POST will send out a preliminary compliance report following each training period. The report will provide the compliance status of each agency and its certified peace officers. Agencies shall have thirty (30) days from the date of the preliminary report to dispute the POST data and provide additional training information. Following the thirty-day period, POST will distribute the final compliance reports to all agencies.

(b) POST may declare an agency noncompliant after the final compliance report has been issued if new information is discovered.

(c) Once the final compliance report has been sent to all agencies; an agency seeking to appeal the POST data must do so within thirty (30) days of being notified of failure to comply with Rule 28. Agencies may appeal this by following the process outlined in Rule 5, *Hearings*. Upon conclusion of all appeal hearings POST will issue a final report indicating whether the agency was found in compliance.

(d) If upon the final decision by POST the agency was found not compliant, all POST funding (region grant funds, continuing education funds, and marijuana funds) to that agency will be suspended from July 1st through December 31st of the same calendar year.–

(2) Individual peace officers

(a) POST will send out a preliminary compliance report following each training period. The report will provide an individual peace officer's compliance status. Individuals shall have thirty (30) days from the date of the preliminary report to dispute the POST data and/or complete the training requirements.

(b) Individual peace officers failing to satisfactorily complete the training requirements within the 30 day period shall have their POST-certification suspended by POST staff, until such time as they come into compliance. If an individual peace officer is suspended, the peace officer may appeal the suspension within thirty (30) days, as provided in Rule 5(c).

(c) Failure to satisfactorily complete POST training requirements may result in a recommendation by the Director to the Board for revocation of the individual's POST certification.

(III) The POST Board shall evaluate the program annually following the release of the final compliance reports. Such evaluation will include a review and evaluation of the program. The evaluation may be based on the compliance rate, agency survey and other performance metrics.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

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Solicitor General

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Office of the Attorney General

Tracking number: 2020-00876

Opinion of the Attorney General rendered in connection with the rules adopted by the

Peace Officer Standards and Training Board

on 12/11/2020

4 CCR 901-1

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The above-referenced rules were submitted to this office on 12/15/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 12:08:15

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 1 –Definitions

Effective January 30, 2021

As used in these rules

(a) "Academy director" means that person responsible for the administration and operation of a POST-approved academy.

(b) "Applicant" means any person formally seeking approval by the Board.

(c) "Appointed" means sworn in and serving as a peace officer or reserve peace officer.

(d) "Approved" means formally accepted or authorized by the Board.

(e) "ACT" means Arrest Control Tactics, one of the skills training programs required for the basic, refresher and reserve training academies.

(f) "Assistant skills instructor" means an individual who has successfully completed a relevant approved skills instructor training program and who may instruct the corresponding skills training program in arrest control, law enforcement driving, or firearms under the direction and in the presence of a full skills instructor, and assist in evaluating and coaching trainees at an approved basic, refresher or reserve training academy.

(g) "Authorized emergency vehicle" means such vehicles as further defined in § 42-1-102(6), C.R.S.

(h) "Board" means the Colorado Peace Officer Standards and Training Board.

(i) "Bodily injury" means physical pain, illness, or any impairment of physical or mental condition, per § 18-1-901(3)(c), C.R.S.

(j) "Certification examination" means the written test required, per § 24-31- 305(1)(a)(III), C.R.S.

(k) "Certified peace officer" means any person who has successfully attained POST Certification, as further described in §§ 24-31-305 and 24-31-308, C.R.S.

(l) “Course” means a formal unit of instruction relating to a particular subject.

(m) "C.R.S." means Colorado Revised Statutes, codified laws of the State of Colorado.

(n) "Director" means the director of the POST Board staff.

(o) “Disqualifying incident” means:

a. A finding of guilt following either a verdict of guilty by the court or jury, or a plea of guilty, or a plea of nolo contendere., per § 24-31-305(1.5)(a), C.R.S. Any Colorado juvenile adjudication is not a conviction.

b. Entering into a deferred judgment and sentencing agreement, a deferred prosecution agreement, or a pretrial diversion agreement of any disqualifying offense, whether pending or successfully completed, per § 24-31-305 (1.5)(b), C.R.S.

c. A finding of untruthfulness pursuant to § 24-31-305(2.5), C.R.S.

d. Convicted of or pleads guilty or nolo contendre to a crime involving unlawful use or threatened use of force, per § 24-31-904, C.R.S. Unlawful or excessive force is as further described in § 18-8-803, C.R.S.

e. Convicted of or pleads guilty or nolo contendre to a crime involving the failure to intervene in the use of unlawful force, per § 24-31-904, C.R.S. Failure to intervene is as further described in § 18-8-802 (1.5)(a) and (d), C.R.S.

f. Found civilly liable for the use of unlawful physical force, per § 24-31-904, C.R.S.

g. Found civilly liable for the failure to intervene in the use of unlawful force, per § 24-31-904, C.R.S.

h. A finding by an administrative law judge or internal investigation that the peace officer failed to intervene in the use of unlawful physical force for an incident which resulted in serious bodily injury or death, per § 18-8-802(1.5)(f), C.R.S.

i. Failure to satisfactorily complete peace officer training required by the POST Board, per § 24-31-305(2.7), C.R.S.

j. Making materially false or misleading statements of omissions in the application for certification.

k. Otherwise failing to meet the certification requirements established by the Board.

(p) "Enroll" means that a person has applied to and been accepted for admission into an academy and is physically present at the academy to receive instruction.

(q) "Enrollment date" means the first day of instruction at an approved basic, refresher or reserve training academy, and shall be synonymous with the first day of instruction as reflected on the approved academy schedule.

(r) Fingerprint-based criminal history record check: a search of a person’s fingerprints, provided on a POST applicant fingerprint card or a Colorado bureau

of investigation (CBI) authorized vendor, and processed by CBI and federal bureau of investigation (FBI) for the purpose of determining a person's eligibility for certification as a peace officer in the state of Colorado.

(s) "Full skills instructor" means an individual who has successfully completed the minimum qualifications required by these Rules and who may develop, implement and evaluate a skills training program at an approved basic, refresher or reserve training academy.

(t) "Incident" means a single, distinct event as determined by the POST Director or designee.

(u) "Lead skills instructor" means a full skills instructor at a basic, refresher or reserve training academy who may be designated by the academy director to oversee or coordinate the administration of a specific skills program for a particular academy class.

(v) "Lesson plan" means a document that specifically describes the material presented during a course of instruction, as further described in POST RULE 21.

(w) "Moving training" means training where the academy students are involved in movement with a loaded weapon. It is recognized that during square range drills, academy students may move 1-2 steps laterally or forward/backward. The 1:1 ratio is not required for this drill. For all other drills/exercises involving movement a 1:1 ratio is required.

(x) "Operable firearm" means a firearm that is capable of discharging a bullet if loaded. This does not include firearms designed or modified to discharge marking cartridges or airsoft projectiles during academy scenario/reality-based training.

(y) "Peace officer" means any person, AS recognized in § 16-2.5, Part 1 C.R.S.

(z) "POST certified" means any person possessing a valid, numbered certificate issued by the Board authorizing such person to serve as a peace officer or reserve peace officer.

(aa) "POST fingerprint card" means a fingerprint card provided by POST.

(bb) "POST Identification" (PID) means a number assigned and unique to each active peace officer's certification record. All inquiries and correspondence to POST should contain this number.

(cc) "Practical Exercise" means role playing, table top exercises, or other scenario/reality-based training.

(dd) "Program director" means the person responsible for the administration and operation of a POST-approved training program.

(ee) "Provisional certification" means a signed instrument issued by the POST Board that grants interim certification for qualified out-of-state peace officers seeking Colorado certification that enables the provisional applicant to obtain appointment as a peace officer in Colorado while fulfilling the requirements for basic certification.

(ff) "Recognized disciplines for arrest control training" mean those arrest control/defensive tactics systems that have been reviewed and approved by the Board, or it's designee, in consultation with the Arrest Control Subject Matter Expert Committee for use in an approved law enforcement academy. Such systems may include, but are not limited to, Federal Bureau of Investigation (FBI) system, Koga system and Pressure Point Control Tactics (PPCT) system.

"Refresher academy" means an approved training program that consists of a minimum of 96 hours of instruction and includes POST Board approved academics, arrest control, law enforcement driving and firearms.

(gg) "Relevant approved skills instructor training program" means a basic, not advanced, instructor training program that contains a minimum of forty (40) hours of instruction with instructional content that meets or exceeds the content of the respective instructor training programs for arrest control, law enforcement driving, or firearms, and has been formally accepted or authorized by the Board.

(hh) "Renewal applicant" means an applicant whose Colorado peace officer certificate has expired per § 24-31-305(1.7)(b), C.R.S., and who has applied to renew his/her Colorado peace officer certificate in accordance with § 24-31-305(1.7)(c), C.R.S. and POST Rule 13.

(ii) "Reserve peace officer" means any person described in § 16-2.5-110, C.R.S., and who has not been convicted of a felony or convicted on or after July 1, 2001, of any misdemeanor as described in section 24-31-305 (1.5), or released or discharged from the armed forces of the United States under dishonorable conditions.

(jj) "Serious bodily injury" means bodily injury which, either at the time of the actual injury or at a later time, involves a substantial risk of death, a substantial risk of serious permanent disfigurement, a substantial risk of protracted loss or impairment of the function of any part or organ of the body, or breaks, fractures, or burns of the second or third degree, per § 18-1-901(3)(p), C.R.S.

(kk) "Skills examination" means the approved practical test of an applicant's proficiency in arrest control, law enforcement driving, or firearms.

(ll) "Skills training" means the required approved arrest control, law enforcement driving, and firearms courses.

(mm) "State" means any State in the United States, the District of Columbia, and any territory or possession of the United States.

(nn) "Subject Matter Expert" (SME) means an individual formally recognized by the chair of the Board for his or her extensive knowledge, expertise and/or experience in one of the skills areas or in academics.

(oo) "Successful completion" means a score of seventy (70) percent or greater, or a grade of "C" or better, or a rating of pass, if offered as pass/fail, in a POST approved academy or program. For the certification examination passing score, see Rule 15.

(pp) "Test out" means a POST-scheduled skills examination where proficiency is assessed by ~~a~~ POST Subject Matter Experts (SMEs) in all three perishable skills (Arrest Control, Law Enforcement Driving, and Firearms) and the written POST certification exam is administered.

(qq) "Training academy" means a POST-approved school, agency or other entity that provides POST-approved training programs.

(rr) "Training program" means a POST-approved course of instruction required by statute, or Rule, or for peace officer certification and other peace officer training programs as otherwise recognized and approved by the Board.

PHILIP J. WEISER
Attorney General

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Office of the Attorney General

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4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/15/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 11:50:22

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 30 – Peace Officer Continuing Education Grant Training Program

Effective January 30, 2021

POST funding was created under the authority of SB 03-103 and defined in § 24-31-303 (2) (B) & (3), C.R.S.; § 24-31-310, C.R.S.; and § 42-3-304 (24), C.R.S. for the training of Colorado Peace Officers through awards by the POST Board.

(A) The Grant Sub-Committee Board shall consist of eight members, appointed by the Chair of the Board from the POST Board. They may serve as members of the Grant Sub-Committee Board for one three (3) year term.

(B) Eligible applicants for a grant award are local governments, colleges, universities, or not for profit organizations providing peace officer training programs. State agencies are not eligible applicants, but may apply for funds through their training region.

(C) The Grant Guidelines is a Department of Law-Peace Officer Standards and Training (POST) policy document. Grant applicants and award recipients must adhere to the requirements in the Grant Guidelines, found at the POST website. The current Grant Guidelines are also available through POST staff.

(D) At the discretion of the Director or the Director's designee, failure to adhere to the requirements in the grant guidelines shall constitute a basis for a reduction of future grant awards, or rescission of current grant awards.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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Office of the Attorney General

Tracking number: 2020-00877

Opinion of the Attorney General rendered in connection with the rules adopted by the

Peace Officer Standards and Training Board

on 12/11/2020

4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/21/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 12:10:11

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 3 – Director's Authority

Effective January 30, 2021

(a) The Director's authority shall include:

(I) Making the initial determination as to whether an applicant has met the requirements to sit for the certification examination, or to be certified;

(II) Approving or disapproving program applications;

(III) Issuing remedial action and compliance orders for non-compliance with POST rule;

(IV) Determining the equivalency of first aid and cardiopulmonary resuscitation training;

(V) At the Director's discretion, selecting qualified evaluators to administer the skills examinations described in Rule 16;

(VI) Determining the merit of challenges relating to the administration of examinations pursuant to Rules 15 and 16;

(VII) Determining the merits of variance requests, consistent with the basic purposes and policies of § 24-31-301, et seq., C.R.S., and of the Board, in accordance with Rule 7 and Rule 8;

(VIII) The Director, or their designee, may approve eyewitness identification training per § 16-1-109, C.R.S., or other statutorily mandated training on behalf of the POST Board.

(IX) Discharging such other powers or duties as the Board or the Attorney General may direct.

(b) If any action or determination made by the Director pursuant to this rule is not appealed by the applicant within thirty (30) days as provided in Rule 5(c), the Director's action or determination shall become final agency action.

PHILIP J. WEISER
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NATALIE HANLON LEH
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Tracking number: 2020-00862

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Peace Officer Standards and Training Board

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4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/29/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 31, 2020 14:03:31

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

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4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 5 – Hearings

Effective January 30, 2021

(a) Non-Revocation Hearings

(I) At any time, the Director may direct a respondent to appear at a hearing and show cause why the Board should not issue a remedial order. Not less than forty (40) days prior to the date set for such hearing, the Director shall transmit to the respondent written notice of such hearing, which must include:

(A) The date, time and place of such hearing; and

(B) That the respondent has the right to appear and be heard at such hearing, either in person or through legal counsel; and

(C) That the respondent has the burden of proving all of the facts relevant to their position; and

(D) A concise statement setting forth the subject of the hearing, all facts relevant to the matter, and the statute, rule, or order, to which the matter relates; and

(E) Copies of all documents considered by the Board in setting the hearing; and

(F) The nature of the proposed remedial order.

(II) Not less than ten (10) days prior to the date set for a hearing pursuant to subsection (I) of this rule, the respondent shall file a response, including:

(A) A concise statement setting forth the respondent's position; and

(B) All facts relevant to the matter; and

(C) Copies of all documents the respondent wishes the Board to consider in the matter.

(D) Notification if they intend to appear at the hearing. If no such notification is received, the hearing will be cancelled, and the Director will make a finding on the documents presented.

(III) Any person may request a formal hearing before the Board through the filing of a petition, which must include:

(A) The name and address of the petitioner and whether the petitioner currently possesses Colorado POST certification; and

(B) A concise statement setting forth the subject of the hearing, all facts necessary to the matter, and the statute, rule, or order, to which the petition relates; and

(C) Copies of all documents the petitioner wishes the Board to consider in the matter; and

(D) What action the petitioner wishes the Board to take.

(IV) Not less than thirty (30) days prior to the date set for a hearing on a petition, the Board shall provide a written response to the petitioner, including:

(A) The date, time and place of such hearing; and

(B) That the petitioner has the right to appear and be heard at such hearing, either in person or through legal counsel; and

(C) That the petitioner has the burden of proving all of the facts relevant to their petition; and

(D) A summary of the Director's recommendation to the Board; and

(E) Copies of all documents submitted by the Director for the Board's consideration in the matter.

(V) The Director and any petitioner or respondent may mutually agree to shorten or lengthen any of the time frames set forth in this rule.

(VI) Any final order entered pursuant to this rule shall constitute final agency action subject to judicial review under § 24-4-106, C.R.S.

(b) Revocation Hearings for Criminal Convictions, Deferred Judgment and Sentence, Deferred Prosecution, or Pretrial Diversion Agreements:

(I) Certifications may be revoked based upon conviction of certain offenses; or entry into a deferred judgment and sentence, deferred sentence, deferred prosecution, or pretrial diversion agreement for offenses as identified or referenced in § 24-31-305(1.5), 24-31-904, 18-8-802 (1.5)(d), and 18-8-803 C.R.S.

(II) When the Director learns that a certificate holder has been convicted of the enumerated offenses or has entered into one of the agreements described in

paragraph (a), the Director shall issue an Order to Show Cause why the officer's certification should not be revoked.

(A) At the Show Cause hearing, the court record of the conviction or agreement shall be sufficient evidence to establish the conviction or agreement.

(B) The certificate holder may be represented by counsel.

(C) The certificate holder bears the burden of proving that it would not be in the public interest to revoke the certification.

(III) The Director will consider all information provided at the Show Cause hearing. If the Director determines that revocation is not appropriate, no further action will be taken. If the Director determines that revocation is appropriate, they will make a revocation recommendation to the Board.

(c) Appeals from Director Decisions:

(I) A decision by the Director on any of the above matters is final unless appealed to the Board within thirty (30) days of the date of such decisions.

(II) If a decision is appealed to the Board, the Board will decide whether to hear the appeal. An appeal of the Director's decision must be made in writing and submitted to the POST Director. Upon receipt of the appeal, the POST Director will notify the POST Board members and request a decision be made. If a majority of the POST Board members agree to hear the appeal, a five-member panel of Board members shall proceed to hear the Board appeal. The appeal hearing must commence within thirty (30) days from the date the Board agreed to hear the appeal. The certificate holder will be notified of the Board's action. This decision, whether summarily affirmed or decided by the board subcommittee, shall be deemed final Board action. The applicant will be notified of the Board's action.

(d) Revocation Hearings for Other Disqualifying Incidents

When POST receives appropriate written notification that a peace officer is subject to action against the Peace Officer's POST certificate per § 24-31-305(2.5), (2.7) and/or § 24-31-904 C.R.S. POST shall take the following actions:-

(I) The POST Director shall review the written notification to determine whether the information provided complies with the statutory requirements.

(A) If the POST Director determines that the information provided on the written notification did not comply with statutory requirements, the POST

Director shall notify the LEA of that determination and POST will take no further action.

(B) If the POST Director determines that the information provided in the written notification did comply with the statutory requirements, the POST Director shall notify the peace officer of the right to request a show cause hearing to determine whether the certification should be revoked. The notice must also inform the peace officer that they must request the show cause hearing within 30 days of the date of the notice, which may be extended for good cause shown.

(C) If the peace officer does not request a show cause hearing within the required time frame, the Director will recommend revocation and the POST Board will vote on revoking the certification at its next regular meeting.

(II) If the peace officer requests a show cause hearing, the Director will request the LEA to provide documentation relevant to the information provided in the written notification. The Director will review the documentation provided by the LEA and conduct additional investigation, if necessary and appropriate. Upon the conclusion of the Director's review and investigation, the Director will either recommend no action or refer the matter for hearing.

(III) The Director shall appoint a hearing officer to conduct the hearing pursuant to § 24-4-104 and 105, C.R.S.

(IV) The Director shall notify the LEA in writing that the matter has been set for hearing and that the LEA may submit any documentary evidence or argument that it wishes to provide to the hearing officer, but may not intervene or participate as a party to the hearing. Documentary evidence or argument must be submitted on or before the first day of the hearing.

(V) The hearing officer shall confer with the parties to schedule the hearing and shall issue a Prehearing Order, which shall be served by first-class mail or email to the certificate holder or counsel and POST counsel. The Prehearing Order shall include the following information:

(A) The date, time, and location of the hearing and the legal authority and jurisdiction under which it is to be held;

(B) Any orders relating to prehearing discovery, motions, or briefs;

(C) A protective order maintaining the confidentiality of internal affairs investigation records;

(D) Any other orders necessary or appropriate to guide the hearing

efficiently.

(VI) POST will appear at the show cause hearing through its counsel, and will bear the burden of proving grounds for decertification by a preponderance of the evidence. The peace officer may be represented by counsel of their choice.

(VII) The show cause hearing will be recorded.

(VIII) The hearing officer has the authority to: administer oaths and affirmations; sign and issue subpoenas; receive evidence and rule upon offers of proof; dispose of motions; regulate the course of the hearing, set the time and place for hearings, and set the time for filing briefs and other documents; direct the parties to appear and confer to consider simplifying issues; direct the parties to confer regarding stipulations of fact and exhibits; limit the number of expert witnesses; issue orders; reprimand or exclude from the hearing any person for any improper conduct in the hearing officer's presence; award attorney fees or impose sanctions for abuse of discovery procedures or as otherwise provided under the Colorado rules of civil procedure; and take any other action authorized by agency rule consistent with this statute or in accordance, to the extent practicable, with the procedure in the district courts. The hearing officer may direct the parties to confer about presenting their case by documentary evidence if that will expedite the hearing without substantially prejudicing any party.

(IX) Subpoenas shall be served in the same manner as a subpoena issued by a district court. The party serving the subpoena shall provide the witness the fees and mileage provided for a witness in a court of record.

(X) All parties shall have the right to examine and cross-examine witnesses.

(XI) The rules of evidence and requirements of proof shall conform, to the extent practicable, with those in civil nonjury cases in the district courts. However, when necessary to do so in order to ascertain facts affecting the substantial rights of the parties to the proceeding, the hearing officer may receive and consider evidence not admissible under
such rules if such evidence possesses probative value commonly accepted by reasonable and prudent people in the conduct of their affairs.

(XII) Within 42 days of the conclusion of the hearing, the hearing officer shall prepare and file an initial decision, which the agency shall serve upon the parties. Each decision and initial decision must include a statement of findings and conclusions upon all the material issues of fact, law, or discretion presented by the record and the appropriate order, sanction, relief, or denial. A notice of appeal rights shall be attached to the initial decision.

(XIII) Either party may file an appeal of the initial decision with the POST Board by filing written exceptions and designation of record within 30 days of the date of

service of the initial decision. This deadline is jurisdictional and will not be extended. Timely filing is determined by the date the POST Board receives the appeal.

(XIV) If neither party appeals, the initial decision of the hearing officer becomes the final decision of the POST Board 30 days after the date of the initial decision.

(XV) If a party appeals the initial decision of the hearing officer, the appeal must describe in detail the basis for the appeal, the specific findings of fact and/or conclusions of law to be reviewed, and the remedy being sought.

(XVI) The record shall be certified within 60 days of the appeal. Any party that designates a transcript as part of the record is responsible for obtaining and paying a certified court reporter who shall prepare the transcript and file it with the Board no more than 59 days after the designation of record. If no transcript has been filed within the time limit, the record will be certified and the transcript will not be included in the record or considered on appeal. In the absence of a transcript, the POST Board is bound by the hearing officer's findings of fact.

(XVII) The POST Board will notify the parties when the record is certified. Opening briefs are due 10 days after the notice is served. Answer briefs are due 10 days after the opening brief is filed. Reply briefs are due 10 days after the answer brief is filed. These deadlines may be extended by the POST Board or designee upon motion filed before the deadline upon good cause shown. No brief may exceed 10 pages without leave of the POST Board or designee, which must be requested before the due date for the brief.

(XVIII) In general, no oral argument will be heard and the POST Board will decide the appeal based upon the briefs. A request for oral argument must be made no later than the date the requesting party's brief is due. If oral argument is granted, the parties will be given notice of the time and place. If granted, oral argument will be limited to no more than 10 minutes per side.

PHILIP J. WEISER
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NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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Office of the Attorney General

Tracking number: 2020-00863

Opinion of the Attorney General rendered in connection with the rules adopted by the

Peace Officer Standards and Training Board

on 12/11/2020

4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/15/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 11:53:39

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 10 – Basic Peace Officer Certification

Effective January 30, 2021

(a) The POST Board is authorized to issue POST Basic Peace Officer Certification to any applicant who meets the following requirements:

(I) Possesses and submits a copy of their high school diploma, high school equivalency certificate, or other evidence of successful completion of high school, including official college transcripts or degree;

(II) Possesses and submits a copy of their current first aid and cardiopulmonary resuscitation certification, or equivalents;

(III) Truthfully completes and submits the POST Form 1 - *Application for Basic Peace Officer Certification*;

(A) If previously certified as an officer in another state but is ineligible to apply as a provisional applicant, the applicant must be in good standing with the other certifying state and must complete and submit to POST a POST Form 3 – Application for Provisional Certification and a Release of Information Form within thirty (30) days of starting the academy**.**

(IV) Is in good standing with Colorado POST as determined by the ~~post~~ Director; and

(V) Successfully completes the fingerprint-based criminal history record check required under Rule 14 and meets all of the following requirements:

(A) If applicable, submits a copy of their official military discharge documents showing character of service other than discharge under dishonorable conditions, per § 24-31-301(5), C.R.S.

(B) Successfully completes an approved basic training academy, including skills training, and passes the written certification examination.

(C) Submits a copy of their academy certificate of completion.

(D) Possesses and submits a copy of their current Colorado Driver's License or State-Issued Identification card.

(b) Documentation pertaining to certification requirements must be submitted to POST via the law enforcement training academy, if applicable.

(c) Testing is valid for two years from the date of completion. After this time has elapsed, if full certification was not issued, the applicant must successfully complete an additional basic academy program.

(b) POST Basic Peace Officer Certification qualifies the person to seek employment and serve as a fully authorized peace officer with any Colorado law enforcement agency recognized in Article 2.5 of Title 16, C.R.S.

(c) Upon issuance of a basic certification, if all training requirements under § 24-31-315, C.R.S., have not previously been met, the individual must complete all requirements within six (6) months from date of appointment.

(I) Complete 2 hours of training in each of the following areas: anti-bias; community policing; situational de-escalation; and proper holds and restraints.

(d) If a basic certificate holder has not served as a peace officer or reserve peace officer for a total of at least six (6) months during any consecutive three-year period, the certification automatically expires at the end of such three-year period, unless the certificate holder is then serving as a peace officer or reserve peace officer.

(I) If a basic certificate holder is deployed for military service, the certification automatically expires at the end of a three-year period from the date of certification or the date of separation from a Colorado law enforcement agency. If expired, the basic certificate holder is eligible to complete the certification renewal process. If employed at time of deployment, the certificate holder, at the agency's discretion, may remain on the employment roster and their certification will not expire.

(e) A certified peace officer who has obtained basic certification may maintain current status as a certified peace officer while serving in a reserve peace officer position, recognized in § 16-2.5-110, C.R.S.

(f) A certified reserve peace officer seeking regular basic peace officer certification may apply their successfully completed skills training, obtained through the reserve peace officer certification program at a POST approved reserve academy, towards basic peace officer certification. Acceptance of the
skills training is at the option of the Director of the basic peace officer training academy to which the applicant is seeking enrollment.

PHILIP J. WEISER
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Tracking number: 2020-00864

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Peace Officer Standards and Training Board

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4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/15/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 11:55:31

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 12 – Reserve Certification

Effective January 30, 2021

(a) The Board is authorized to issue a reserve certificate to any applicant who meets the following requirements:

(I) Possesses and submits a copy of their high school diploma, or high school equivalency certificate, or other evidence of successful completion of high school, including official college transcripts or degree; and

(II) Possesses and submits a copy of their current first aid and cardiopulmonary resuscitation certification, or equivalents; and

(III) Truthfully completes and submits the POST Form 2 – Application for Reserve Certification; and

(IV) Is in good standing with Colorado POST as determined by the Director; and

(V) Successfully completes the fingerprint-based criminal history record check required under Rule 14 and meets all of the following requirements:

(A) If applicable, submits a copy of their official military discharge documents showing character of service other than dishonorable conditions, per § 24-31-301(5), C.R.S.

(B) Successfully completes an approved reserve academy including skills training. within two (2) years of the graduation date.

(C) Submits a copy of their academy certificate of completion.

(D) Possesses and submits a copy of their current Colorado driver's license or state-issued identification card.

(VI) Testing is valid for two years from the date of completion. After this time has elapsed, if reserve certification was not issued, the applicant must successfully complete an additional reserve academy program.

(b) Upon issuance of a reserve certification and appointment to an agency the individual must comply with training requirements outlined in § 24-31-315 C.R.S. within six (6) months.

(I) Complete 2 hours of training in each of the following areas: anti-bias, community policing, situational de-escalation, and proper holds and restraints.

(c) Any law enforcement agency assigning duties to a reserve peace officer beyond those included in the approved reserve training shall assume the responsibility for ensuring that such reserve peace officer is adequately trained for such duties.

(d) If a reserve certificate holder has not served as a reserve peace officer for a total of at least six (6) months during any consecutive three-year period, the certification automatically expires at the end of such three-year period, unless the certificate holder is then serving as a reserve peace officer.

(I) If a reserve certificate holder is deployed for military service, the certification automatically expires at the end of a three-year period from the date of certification or the date of separation from a Colorado law enforcement agency. if expired, the reserve certificate holder must complete a new reserve training academy. if employed at time of deployment, the certificate holder, at the agency's discretion, may remain on the employment roster and their certification will not expire.

(e) Reserve certifications may not be renewed.

(f) A certified peace officer may maintain current status as a certified peace officer while serving in a reserve peace officer position, recognized in § 16-2.5- 110, C.R.S.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

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Tracking number: 2020-00865

Opinion of the Attorney General rendered in connection with the rules adopted by the

Peace Officer Standards and Training Board

on 12/11/2020

4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/15/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 11:56:45

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Rule title

4 CCR 901-1 PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION 1 - eff 01/30/2021

Effective date

01/30/2021

Rule 13 – Renewal of Basic Certification

Effective January 30, 2021

The Board is authorized to renew a basic certificate for any applicant who:

(a) Has not served as a peace officer or reserve peace officer within the previous three (3) years; and

(b) Possesses and submits a copy of their current first aid and cardiopulmonary resuscitation certification, or equivalents; and

(c) Truthfully completes and submits the POST Form 4 – Application for Renewal of Basic Certification; and

(I) If an applicant has worked in another state as a certified peace officer after being certified in Colorado, they must truthfully complete and submit the POST Form 3 – Application for Provisional Certification, and a notarized copy of the Release of Information Form; and

(II) Is in good standing with Colorado POST as determined by the Director; and

(e) Successfully completes the fingerprint-based criminal history record check required under Rule 14; and

(f) Passes the certification examination pursuant to Rule 15; and

(g) Satisfies any combination of the following skills proficiency requirements:

(I) Successfully completes skills training at a POST approved basic peace officer training academy;

(II) Successfully completes a POST approved refresher academy, including the arrest control, law enforcement driving, and firearms skills training;

(A) Submits a copy of their refresher academy certificate of completion.

(III) Passes a test out pursuant to Rule 16 with SME committee members or POST approved designees who are not members of the applicant's employing agency.

(h) The POST SME Committee member or POST approved designee must submit the completed *POST Skills Testing Grade Sheet* to POST.

(i) Upon renewal of a Colorado basic peace officer certification and appointment to an agency the individual must comply with training requirements outlined in C.R.S. §24-31-315 within six (6) months.

(I) Complete 2 hours of training in each of the following areas: anti-bias, community policing, situational de-escalation, and proper holds and restraints.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

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Office of the Attorney General

Tracking number: 2020-00866

Opinion of the Attorney General rendered in connection with the rules adopted by the

Peace Officer Standards and Training Board

on 12/11/2020

4 CCR 901-1

PEACE OFFICER TRAINING PROGRAMS AND PEACE OFFICER CERTIFICATION

The above-referenced rules were submitted to this office on 12/15/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 11:58:50

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Public Health and Environment

Agency

Water Quality Control Commission (1002 Series)

CCR number

5 CCR 1002-32

Rule title

5 CCR 1002-32 REGULATION NO. 32 - CLASSIFICATIONS AND NUMERIC STANDARDS FOR ARKANSAS RIVER BASIN 1 - eff 02/14/2021

Effective date

02/14/2021

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Water Quality Control Commission

REGULATION NO. 32 - CLASSIFICATIONS AND NUMERIC STANDARDS FOR ARKANSAS RIVER BASIN

5 CCR 1002-32

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

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32.65 STATEMENT OF BASIS, SPECIFIC STATUTORY AUTHORITY AND PURPOSE; DECEMBER 14, 2020 RULEMAKING; FINAL ACTION DECEMBER 14, 2020; EFFECTIVE DATE FEBRUARY 14, 2021

The provisions of C.R.S. 25-8-202(1)(a), (b) and (2); 25-8-203; 25-8-204; and 25-8-402; provide the specific statutory authority for adoption of these regulatory amendments. The commission also adopted in compliance with 24-4-103(4) C.R.S. the following statement of basis and purpose.

BASIS AND PURPOSE

The commission adopted a temporary modification for chronic arsenic on Upper Arkansas Segment 20b (COARUA20b), with an expiration date of 12/31/2024. An arsenic temporary modification was previously adopted on this segment in the 2013 Regulation No. 32 rulemaking hearing, but was inadvertently deleted during the 2018 Regulation No. 32 rulemaking hearing. The basis, requirements, and expectations for this temporary modification are described at 32.63(B).

*****

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

WATER QUALITY CONTROL COMMISSION

5 CCR 1002-32

REGULATION NO. 32
CLASSIFICATIONS AND NUMERIC STANDARDS
FOR
ARKANSAS RIVER BASIN

APPENDIX 32-1
Stream Classifications and Water Quality Standards Tables

Effective 02/14/2021

REGULATION #32 STREAM CLASSIFICATIONS and WATER QUALITY STANDARDS
Upper Arkansas River Basin

20a. Mainstem of Fourmile Creek, including all tributaries and wetlands, from immediately below the confluence with High Creek to a point immediately above the confluence with Long Gulch, except for the specific listing to segment 23.

COARUA20A	Classifications
Designation	Agriculture
Reviewable	Aq Life Cold 1
	Recreation E

Qualifiers:

Other:

*chlorophyll a (mg/m^2)(chronic) = applies only above the facilities listed at 32.5(4).
*Phosphorus(chronic) = applies only above the facilities listed at 32.5(4).
*Uranium(acute) = See 32.5(3) for details.
*Uranium(chronic) = See 32.5(3) for details.
*Temperature =
DM=14.2 and MWAT=9.7 from 11/1-2/29
DM= 27.1 and MWAT=21 from 3/1-10/31

Physical and Biological

	DM	MWAT
Temperature °C	varies*	varies*
	acute	**chronic**
D.O. (mg/L)	---	6.0
D.O. (spawning)	---	7.0
pH	6.5 - 9.0	---
chlorophyll a (mg/m^2)	---	150*
E. Coli (per 100 mL)	---	126

Inorganic (mg/L)

	acute	chronic
Ammonia	TVS	TVS
Boron	---	0.75
Chloride	---	---
Chlorine	0.019	0.011
Cyanide	0.005	---
Nitrate	100	---
Nitrite	0.05	---
Phosphorus	---	0.11*
Sulfate	---	---
Sulfide	---	0.002

Metals (ug/L)

	acute	chronic
Arsenic	340	---
Arsenic(T)	---	7.6
Cadmium	TVS	TVS
Chromium III	TVS	TVS
Chromium III(T)	---	100
Chromium VI	TVS	TVS
Copper	TVS	TVS
Iron(T)	---	1000
Lead	TVS	TVS
Manganese	TVS	TVS
Mercury(T)	---	0.01
Molybdenum(T)	---	150
Nickel	TVS	TVS
Selenium	TVS	TVS
Silver	TVS	TVS(tr)
Uranium	varies*	varies*
Zinc	TVS	TVS

20b. Mainstem of Fourmile Creek, including all tributaries and wetlands, from the confluence with Long Gulch to the confluence with the Arkansas River.

COARUA20B	Classifications
Designation	Agriculture
Reviewable	Aq Life Cold 1
	Recreation E
	Water Supply

Qualifiers:

Other:

Temporary Modification(s):
Arsenic(chronic) = hybrid
Expiration Date of 12/31/2024

*chlorophyll a (mg/m^2)(chronic) = applies only above the facilities listed at 32.5(4).
*Phosphorus(chronic) = applies only above the facilities listed at 32.5(4).
*Sulfate(chronic) = Dissolved standards applicable at the point of withdraw.
*Manganese(chronic) = Dissolved standards applicable at the point of withdraw.
*Uranium(acute) = See 32.5(3) for details.
*Uranium(chronic) = See 32.5(3) for details.
*Temperature =
DM=13 and MWAT=9.4 from 11/1-2/29
DM= 28.1 and MWAT=22 from 3/1-10/31

Physical and Biological

	DM	MWAT
Temperature °C	varies*	varies*
	acute	**chronic**
D.O. (mg/L)	---	6.0
D.O. (spawning)	---	7.0
pH	6.5 - 9.0	---
chlorophyll a (mg/m^2)	---	150*
E. Coli (per 100 mL)	---	126

Inorganic (mg/L)

	acute	chronic
Ammonia	TVS	TVS
Boron	---	0.75
Chloride	---	250
Chlorine	0.019	0.011
Cyanide	0.005	---
Nitrate	10	---
Nitrite	0.05	---
Phosphorus	---	0.11*
Sulfate	---	WS*
Sulfide	---	0.002

Metals (ug/L)

	acute	chronic
Arsenic	340	---
Arsenic(T)	---	0.02
Cadmium	TVS	TVS
Cadmium(T)	5.0	---
Chromium III	---	TVS
Chromium III(T)	50	---
Chromium VI	TVS	TVS
Copper	TVS	TVS
Iron	---	WS
Iron(T)	---	1000
Lead	TVS	TVS
Lead(T)	50	---
Manganese	TVS	TVS/WS*
Mercury(T)	---	0.01
Molybdenum(T)	---	150
Nickel	TVS	TVS
Nickel(T)	---	100
Selenium	TVS	TVS
Silver	TVS	TVS(tr)
Uranium	varies*	varies*
Zinc	TVS	TVS

All metals are dissolved unless otherwise noted.
T = total recoverable
t = total
tr = trout

D.O. = dissolved oxygen
DM = daily maximum
MWAT = maximum weekly average temperature
See 32.6 for further details on applied standards.

PHILIP J. WEISER
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Office of the Attorney General

Tracking number: 2020-00685

Opinion of the Attorney General rendered in connection with the rules adopted by the

Water Quality Control Commission (1002 Series)

on 12/14/2020

5 CCR 1002-32

REGULATION NO. 32 - CLASSIFICATIONS AND NUMERIC STANDARDS FOR ARKANSAS RIVER BASIN

The above-referenced rules were submitted to this office on 12/17/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 30, 2020 09:44:49

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Public Health and Environment

Agency

Water Quality Control Commission (1002 Series)

CCR number

5 CCR 1002-38

Rule title

5 CCR 1002-38 REGULATION NO. 38 - CLASSIFICATIONS AND NUMERIC STANDARDS SOUTH PLATTE RIVER BASIN LARAMIE RIVER BASIN REPUBLICAN RIVER BASIN SMOKY HILL RIVER BASIN 1 - eff 02/14/2021

Effective date

02/14/2021

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Water Quality Control Commission

REGULATION NO. 38 - CLASSIFICATIONS AND NUMERIC STANDARDS FOR SOUTH PLATTE RIVER BASIN, LARAMIE RIVER BASIN, REPUBLICAN RIVER BASIN, SMOKY HILL RIVER BASIN

5 CCR 1002-38

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

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38.102 STATEMENT OF BASIS, SPECIFIC STATUTORY AUTHORITY AND PURPOSE; DECEMBER 14, 2020 RULEMAKING; FINAL ACTION DECEMBER 14, 2020; EFFECTIVE DATE FEBRUARY 14, 2021

The provisions of C.R.S. 25-8-202(1)(a), (b) and (2); 25-8-203; 25-8-204; and 25-8-402; provide the specific statutory authority for adoption of these regulatory amendments. The commission also adopted in compliance with 24-4-103(4) C.R.S. the following statement of basis and purpose.

BASIS AND PURPOSE

The commission deleted the temporary modification for chronic arsenic on Upper South Platte Segment 11b (COSPUS11b), which had an expiration date of 12/31/2024. An arsenic temporary modification was inadvertently adopted on this segment during the 2020 Regulation No. 38 rulemaking hearing; however, the temporary modification is more stringent than the underlying standard.

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COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

WATER QUALITY CONTROL COMMISSION

5 CCR 1002-38

REGULATION NO. 38
CLASSIFICATIONS AND NUMERIC STANDARDS
FOR
SOUTH PLATTE RIVER BASIN, LARAMIE RIVER BASIN
REPUBLICAN RIVER BASIN, SMOKY HILL RIVER BASIN

APPENDIX 38-1
Stream Classifications and Water Quality Standards Tables

Effective 02/14/2021

REGULATION #38 STREAM CLASSIFICATIONS and WATER QUALITY STANDARDS
Upper South Platte River Basin

11b. All tributaries to the West Plum Creek system, including all wetlands, which are not on national forest lands, except for listings in Segments 9 and 12.

COSPUS11B	Classifications
Designation	Agriculture
UP	Aq Life Warm 2
	Water Supply
	Recreation E

Qualifiers:

Other:

*chlorophyll a (mg/m^2)(chronic) = applies only above the facilities listed at 38.5(4).
*Phosphorus(chronic) = applies only above the facilities listed at 38.5(4).
*Uranium(acute) = See 38.5(3) for details.
*Uranium(chronic) = See 38.5(3) for details.

Physical and Biological	DM	MWAT
Temperature °C	WS-I	WS-I
	acute	**chronic**
D.O. (mg/L)	---	5.0
pH	6.5 - 9.0	---
chlorophyll a (mg/m^2)	---	150*
E. Coli (per 100 mL)	---	126
Inorganic (mg/L)		
	acute	**chronic**
Ammonia	TVS	TVS
Boron	---	0.75
Chloride	---	250
Chlorine	0.019	0.011
Cyanide	0.005	---
Nitrate	10	---
Nitrite	---	0.5
Phosphorus	---	0.17*
Sulfate	---	WS
Sulfide	---	0.002

Metals (ug/L)	acute	chronic
Arsenic	340	---
Arsenic(T)	---	0.02-10 [A]
Cadmium	TVS	TVS
Cadmium(T)	5.0	---
Chromium III	---	TVS
Chromium III(T)	50	---
Chromium VI	TVS	TVS
Copper	TVS	TVS
Iron	---	WS
Iron(T)	---	1000
Lead	TVS	TVS
Lead(T)	50	---
Manganese	TVS	TVS/WS
Mercury(T)	---	0.01
Molybdenum(T)	---	150
Nickel	TVS	TVS
Nickel(T)	---	100
Selenium	TVS	TVS
Silver	TVS	TVS
Uranium	varies*	varies*
Zinc	TVS	TVS

12. Mainstem of Garber Creek and Jackson Creek from the boundary of National Forest lands to the confluence with West Plum Creek; mainstem of Bear Creek from the outlet of Perry Park Reservoir, a.k.a. Waucondah Reservoir, to the confluence with West Plum Creek.

COSPUS12	Classifications
Designation	Agriculture
Reviewable	Aq Life Warm 1
	Recreation E
	Water Supply

Qualifiers:

Other:

Temporary Modification(s):
Arsenic(chronic) = hybrid
Expiration Date of 12/31/2024

*Uranium(acute) = See 38.5(3) for details.
*Uranium(chronic) = See 38.5(3) for details.

Physical and Biological	DM	MWAT
Temperature °C	WS-I	WS-I
	acute	**chronic**
D.O. (mg/L)	---	5.0
pH	6.5 - 9.0	---
chlorophyll a (mg/m^2)	---	150
E. Coli (per 100 mL)	---	126
Inorganic (mg/L)		
	acute	**chronic**
Ammonia	TVS	TVS
Boron	---	0.75
Chloride	---	250
Chlorine	0.019	0.011
Cyanide	0.005	---
Nitrate	10	---
Nitrite	---	0.5
Phosphorus	---	0.17
Sulfate	---	WS
Sulfide	---	0.002

Metals (ug/L)	acute	chronic
Arsenic	340	---
Arsenic(T)	---	0.02
Cadmium	TVS	TVS
Cadmium(T)	5.0	---
Chromium III	---	TVS
Chromium III(T)	50	---
Chromium VI	TVS	TVS
Copper	TVS	TVS
Iron	---	WS
Iron(T)	---	1000
Lead	TVS	TVS
Lead(T)	50	---
Manganese	TVS	TVS/WS
Mercury(T)	---	0.01
Molybdenum(T)	---	150
Nickel	TVS	TVS
Nickel(T)	---	100
Selenium	TVS	TVS
Silver	TVS	TVS
Uranium	varies*	varies*
Zinc	TVS	TVS

All metals are dissolved unless otherwise noted.
T = total recoverable
t = total
tr = trout

D.O. = dissolved oxygen
DM = daily maximum
MWAT = maximum weekly average temperature
See 38.6 for further details on applied standards.

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Water Quality Control Commission (1002 Series)

on 12/14/2020

5 CCR 1002-38

REGULATION NO. 38 - CLASSIFICATIONS AND NUMERIC STANDARDS SOUTH PLATTE RIVER BASIN LARAMIE RIVER BASIN REPUBLICAN RIVER BASIN SMOKY HILL RIVER BASIN

The above-referenced rules were submitted to this office on 12/17/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 30, 2020 09:43:14

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Public Health and Environment

Agency

Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 02

Rule title

6 CCR 1011-1 Chapter 02 CHAPTER 2 - GENERAL LICENSURE STANDARDS 1 - eff 02/14/2021

Effective date

02/14/2021

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES CHAPTER 2 – GENERAL LICENSURE STANDARDS

6 CCR 1011-1 Chapter 2

[Publication Instruction: remove the April 15, 2020, adopted date and replace with December 16, 2020, adoption date. Remove the July 1, 2020 effective date and replace with the February 14, 2021 effective date.]

Adopted by the Board of Health on December 16, 2020. Effective, February 14, 2021.

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PART 2. LICENSURE PROCESS

****

2.6 Change of Ownership/Management

****

[Publication instructions: in regulation 2.6, replace regulation 2.6.2 with the text below.]

2.6.2 The Department shall consider the following criteria in determining whether there is a change of ownership of a facility or agency that requires a new license. The transfer of fifty percent (50%) of the ownership interest referred to in this Part 2.6.2 may occur during the course of one transaction or during a series of transactions occurring over a five year period.

(A) Sole proprietors:

(1) The transfer of at least fifty percent (50%) of the ownership interest in a facility or agency from a sole proprietor to another individual, whether or not the transaction affects the title to real property, shall be considered a change of ownership.

(2) Change of ownership does not include forming a corporation from the sole proprietorship with the proprietor as the sole shareholder.

(B) Partnerships:

(1) Dissolution of the partnership and conversion into any other legal structure shall be considered a change of ownership if the conversion also includes a transfer of at least fifty percent (50%) of the direct or indirect ownership to one or more new owners.

(2) Change of ownership does not include dissolution of the partnership to form a corporation with the same persons retaining the same shares of ownership in the new corporation.

(C) Corporations:

(1) Consolidation of two or more corporations resulting in the creation of a new corporate entity shall be considered a change of ownership if the consolidation includes a transfer of at least fifty percent (50%) of the direct or indirect ownership to one or more new owners.

(2) Formation of a corporation from a partnership, a sole proprietorship, or a limited liability company shall be considered a change of ownership if the change includes a transfer of at least fifty percent (50%) of the direct or indirect ownership to one or more new owners.

(3) The transfer, purchase, or sale of shares in the corporation such that at least fifty percent (50%) of the direct or indirect ownership of the corporation is shifted to one or more new owners shall be considered a change of ownership.

(D) Limited Liability Companies:

(1) The transfer of at least fifty percent (50%) of the direct or indirect ownership interest in the company shall be considered a change of ownership.

(2) The termination or dissolution of the company and the conversion thereof into any other entity shall be considered a change of ownership if the conversion also includes a transfer of at least fifty percent (50%) of the direct or indirect ownership to one or more new owners.

(3) Change of ownership does not include transfers of ownership interest between existing members if the transaction does not involve the acquisition of ownership interest by a new member. For the purposes of this Part, “member” means a person or entity with an ownership interest in the limited liability company.

(E) Non-Profits:

(1) The transfer of at least fifty percent (50%) of the controlling interest in the non-profit is considered a change of ownership.

(F) Management contracts, leases, or other operational arrangements:

(1) If the licensee enters into a lease arrangement or management agreement whereby the owner retains no authority or responsibility for the operation and management of the facility or agency, the action shall be considered a change of ownership that requires a new license.

(G) Legal Structures:

(1) The conversion of a licensee’s legal structure, or the legal structure of a business entity that has a direct or indirect ownership interest in the licensee is a change of ownership if the conversion also includes a transfer of at least fifty percent (50%) of the facility’s or agency’s direct or indirect ownership interest to one or more new owners.

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PART 7. CLIENT RIGHTS

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7.2 Client Grievance Mechanism

[Publication instructions: Replace regulation 7.2.1 with the text below.]

7.2.1 All facilities or agencies that have a client capacity of fifty-one (51) or higher shall have a client grievance mechanism plan that shall be submitted to the Department in the manner and form prescribed by the Department.

****

PART 9. MEDICATIONS, MEDICAL DEVICES, AND MEDICAL SUPPLIES

****

9.2 Donation of Unused Medications, Medical Devices, and Medical Supplies

9.2.1 A facility or agency may accept unused medications or medical supplies, and used or unused medical devices from a client or a client's personal representative.

[Publication instructions: Replace regulation 9.2.1(A) with the text below.]

(A) In accordance with Section 12-280-135, C.R.S., the facility or agency may choose to either:

****

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on 12/16/2020

6 CCR 1011-1 Chapter 02

CHAPTER 2 - GENERAL LICENSURE STANDARDS

The above-referenced rules were submitted to this office on 12/17/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 30, 2020 09:47:21

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Public Health and Environment

Agency

Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 07

Rule title

6 CCR 1011-1 Chapter 07 CHAPTER 7 - ASSISTED LIVING RESIDENCES 1 - eff 06/14/2021

Effective date

06/14/2021

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES

CHAPTER 7 - ASSISTED LIVING RESIDENCES

6 CCR 1011-1 Chapter 7

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

Adopted by the Board of Health on December 16, 2020. Effective, June 14, 2021.

(Publication Instructions: Replace all text in **6 CCR 1011-1, Chapter 7 – Assisted Living Residences** with the following new text.)

TABLE OF CONTENTS

Part 23 – Environmental Pest Control

Part 24 – Waste Disposal

Part 25 – Secure Environment

PART 1 – STATUTORY AUTHORITY AND APPLICABILITY

1.1 Authority to establish minimum standards through regulation and to administer and enforce such regulations is provided by Sections 25-1.5-103, 25-27-101, and 25-27-104, C.R.S.

1.2 Assisted living residences, as defined herein, shall comply with all applicable federal and state statutes and regulations including, but not limited to, the following:

(A) This Chapter 7;

(B) 6 CCR 1011-1, Chapter 2, General Licensure Standards;

(C) 6 CCR 1011-1, Chapter 24, Medication Administration Regulations, and Sections 25-1.5-301 through 25-1.5-303 C.R.S, pertaining to medication administration;

(D) 6 CCR 1010-2, Colorado Retail Food Establishment Regulations, pertaining to food safety, for residences licensed for 20 or more beds;

(E) 6 CCR 1009-1, Epidemic and Communicable Disease Control;

(F) 6 CCR 1007-2, Part 1, Regulations Pertaining to Solid Waste Disposal Sites and Facilities, Section 13, Medical Waste; and

(G) 6 CCR 1007-3, Part 262, Standards Applicable to Generators of Hazardous Waste.

PART 2 – DEFINITIONS

For purposes of this chapter, the following definitions shall apply, unless the context requires otherwise:

2.1 “Abuse” means any of the following acts or omissions:

(A) The non-accidental infliction of bodily injury, serious bodily injury or death,

(B) Confinement or restraint that is unreasonable under generally accepted caretaking standards, or

(C) Subjection to sexual conduct or contact that is classified as a crime.

2.2 “Administrator” means a person who is responsible for the overall operation, daily administration, management and maintenance of the assisted living residence. The term “administrator” is synonymous with “operator” as that term is used in Title 25, Article 27, Part 1.

2.3 “Activities of daily living (ADLs)” means those personal functional activities required by an individual for continued well-being, health and safety. As used in this Chapter 7, activities of daily living include, but are not limited to, accompaniment, eating, dressing, grooming, bathing, personal hygiene (hair care, nail care, mouth care, positioning, shaving, skin care), mobility (ambulation, positioning, transfer), elimination (using the toilet) and respiratory care.

2.4 "Alternative care facility" means an assisted living residence certified by the Colorado Department of Health Care Policy and Financing to receive Medicaid reimbursement for the services provided pursuant to 10 CCR 2505-10, Section 8.495.

2.5 "Appropriately skilled professional" means an individual that has the necessary qualifications and/or training to perform the medical procedures prescribed by a practitioner. This includes, but is not limited to, registered nurse, licensed practical nurse, physical therapist, occupational therapist, respiratory therapist, and dietitian.

2.6 "Assisted living residence" or "ALR" means:

(A) A residential facility that makes available to three or more adults not related to the owner of such facility, either directly or indirectly through a resident agreement with the resident, room and board and at least the following services: personal services; protective oversight; social care due to impaired capacity to live independently; and regular supervision that shall be available on a twenty-four-hour basis, but not to the extent that regular twenty-four hour medical or nursing care is required, or

(B) A Supportive Living Program residence that, in addition to the criteria specified in the above paragraph, is certified by the Colorado Department of Health Care Policy and Financing to also provide health maintenance activities, behavioral management and education, independent living skills training and other related services as set forth in the supportive living program regulations at 10 CCR 2505-10, Section 8.515.

(C) Unless otherwise indicated, the term "assisted living residence" is synonymous with the terms "health care entity," "health facility," or "facility" as used elsewhere in 6 CCR 1011-1, Standards for Hospitals and Health Facilities.

2.7 "At-risk person" means any person who is 70 years of age or older, or any person who is 18 years of age or older and meets one or more of the following criteria:

(A) Is impaired by the loss (or permanent loss of use) of a hand or foot, blindness or permanent impairment of vision sufficient to constitute virtual blindness;

(B) Is unable to walk, see, hear or speak;

(C) Is unable to breathe without mechanical assistance;

(D) Is a person with an intellectual and developmental disability as defined in Section 25.5-10-202, C.R.S.;

(E) Is a person with a mental health disorder as defined in Section 27-65-102(11.5), C.R.S.;

(F) Is mentally impaired as defined in Section 24-34-501(1.3)(b)(II), C.R.S.;

(G) Is blind as defined in SECTION 26-2-103(3), C.R.S.; or

(H) Is receiving care and treatment for a developmental disability under Article 10.5 of Title 27, C.R.S.

2.8 "Auxiliary aid" means any device used by persons to overcome a physical disability and includes but is not limited to a wheelchair, walker or orthopedic appliance.

2.9 "Care plan" means a written description, in lay terminology, of the functional capabilities of an individual, the individual's need for personal assistance, service received from external providers,

and the services to be provided by the facility in order to meet the individual's needs. In order to deliver person-centered care, the care plan shall take into account the resident's preferences and desired outcomes. "Care plan" may also mean a service plan for those facilities which are licensed to provide services specifically for the mentally ill.

2.10 "Caretaker neglect" means neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision or any other service necessary for the health or safety of an at-risk person is not secured for that person or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise, or a caretaker knowingly uses harassment, undue influence or intimidation to create a hostile or fearful environment for an at-risk person.

2.11 "Certified nurse medication aide (CNA-Med)" means a certified nurse aide who meets the qualifications specified in 3 CCR 716-1, Rule 1.19, and who is currently certified as a nurse aide with medication aide authority by the State Board of Nursing.

2.12 "Controlled substance" means any medication that is regulated and classified by the Controlled Substances Act at 21 U.S.C., §812 as being schedule II through V.

2.13 "Deficiency" means a failure to fully comply with any statutory and/or regulatory requirements applicable to a licensed assisted living residence.

2.14 "Deficiency list" means a listing of deficiency citations which contains a statement of the statute or regulation violated, and a statement of the findings, with evidence to support the deficiency.

2.15 "Department" means the Colorado Department of Public Health and Environment or its designee.

2.16 "Disproportionate share facilities" means facilities that serve a disproportionate share of low income residents as evidenced by having qualified for federal or state low income housing assistance; planning to serve low income residents with incomes at or below 80 percent of the area median income; and submitting evidence of such qualification, as required by the Department.

2.17 "Discharge" means termination of the resident agreement and the resident's permanent departure from the facility.

2.18 "Egress alert device" means a device that is affixed to a structure or worn by a resident that triggers a visual or auditory alarm when a resident leaves the building or grounds. Such devices shall only be used to assist staff in redirecting residents back into the facility when staff are alerted to a resident's departure from the facility as opposed to restricting the free movement of residents.

2.19 "Emergency contact" means one of the individuals identified on the face sheet of the resident record to be contacted in the case of an emergency.

2.20 "Exploitation" means an act or omission committed by a person who:

(A) Uses deception, harassment, intimidation or undue influence to permanently or temporarily deprive an at-risk person of the use, benefit or possession of anything of value;

(B) Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the at-risk person;

(C) Forces, compels, coerces or entices an at-risk person to perform services for the profit or advantage of the person or another person against the will of the at-risk person; or

(D) Misuses the property of an at-risk person in a manner that adversely affects the at-risk person's ability to receive health care, health care benefits, or to pay bills for basic needs or obligations.

2.21 "External services" means personal services and protective oversight services provided to a resident by family members or healthcare professionals who are not employees, contractors, or volunteers of the facility. External service providers include, but are not limited to, home health, hospice, private pay caregivers and family members.

2.22 "High Medicaid utilization facility" means a facility that has no less than 35 percent of its licensed beds occupied by Medicaid enrollees as indicated by complete and accurate fiscal year claims data; and served Medicaid clients and submitted claims data for a minimum of nine (9) months of the relevant fiscal year.

2.23 "Hospice care" means a comprehensive set of services identified and coordinated by an external service provider in collaboration with the resident, family and assisted living residence to provide for the physical, psychosocial, spiritual and emotional needs of a terminally ill resident as delineated in a care plan. Hospice care services shall be available 24 hours a day, seven days a week pursuant to the requirements for hospice providers set forth in 6 CCR 1011-1, Chapter 21, Hospices.

2.24 "Licensee" means the person or entity to whom a license is issued by the Department pursuant to Section 25-1.5-103 (1) (a), C.R.S., to operate an assisted living residence within the definition herein provided. For the purposes of this Chapter 7, the term "licensee" is synonymous with the term "owner."

2.25 "Medical waste" means waste that may contain disease causing organisms or chemicals that present potential health hazards such as discarded surgical gloves, sharps, blood, human tissue, prescription or over-the-counter pharmaceutical waste, and laboratory waste.

2.26 "Medication administration" means assisting a person in the ingestion, application, inhalation, or, using universal precautions, rectal or vaginal insertion of medication, including prescription drugs, according to the legibly written or printed directions of the attending physician or other authorized practitioner, or as written on the prescription label, and making a written record thereof with regard to each medication administered, including the time and the amount taken.

(A) Medication administration does not include:

(1) Medication monitoring; or

(2) Self-administration of prescription drugs or the self-injection of medication by a resident.

(B) Medication administration by a qualified medication administration person (QMAP) does not include judgement, evaluation, assessments, or injecting medication (unless otherwise authorized by law in response to an emergent situation.)

2.27 "Medication monitoring" means:

(A) Reminding the resident to take medication(s) at the time ordered by the authorized practitioner;

(B) Handing to a resident a container or package of medication that was lawfully labeled previously by an authorized practitioner for the individual resident;

(C) Visual observation of the resident to ensure compliance;

(D) Making a written record of the resident's compliance with regard to each medication, including the time taken; and

(E) Notifying the authorized practitioner if the resident refuses or is unable to comply with the practitioner's instructions regarding the medication.

2.28 "Mistreatment" means abuse, caretaker neglect, or exploitation.

2.29 "Nurse" means an individual who holds a current unrestricted license to practice pursuant to Article 255 of Title 12, C.R.S., and is acting within the scope of such authority.

2.30 "Nursing services" means support for activities of daily living, the administration of medications, and the provision of treatment by a nurse in accordance with orders from the resident's practitioner.

2.31 "Owner" means the person or business entity that applies for assisted living residence licensure and/or in whose name the license is issued.

2.32 "Palliative care" means specialized medical care for people with serious illnesses. This type of care is focused on providing residents with relief from the symptoms, pain and stress of serious illness, whatever the diagnosis. The goal is to improve quality of life for both the resident and the family. Palliative care is provided by a team of physicians, nurses and other specialists who work with a resident's other health care providers to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided together with curative treatment. Unless otherwise indicated, the term "palliative care" is synonymous with the terms "comfort care," "supportive care," and similar designations.

2.33 "Personal care worker" means an individual who:

(A) Provides personal services for any resident; and

(B) Is not acting in his or her capacity as a health care professional under Articles 240, 255, 270, or 285 of Title 12 of the Colorado Revised Statutes.

2.34 "Personal services" means those services that an assisted living residence and its staff provide for each resident including, but not limited to:

(A) An environment that is sanitary and safe from physical harm,

(B) Individualized social supervision,

(C) Assistance with transportation, and

(D) Assistance with activities of daily living.

2.35 "Plan of correction" means a written plan to be submitted by an assisted living residence to the Department for approval, detailing the measures that shall be taken to correct all cited deficiencies.

2.36 "Practitioner" means a physician, physician assistant or advance practice nurse (i.e., nurse practitioner or clinical nurse specialist) who has a current, unrestricted license to practice and is acting within the scope of such authority.

2.37 "Pressure sore" (also called pressure ulcer, decubitus ulcer, bed-sore or skin breakdown) means an area of the skin or underlying tissue (muscle, bone) that is damaged due to loss of blood flow to the area. Symptoms and medical treatment of pressure sores are based upon the level of severity or "stage" of the pressure sore.

(A) Stage 1 affects only the upper layer of skin. Symptoms include pain, burning, or itching and the affected area may look or feel different from the surrounding skin.

(B) Stage 2 goes below the upper surface of the skin. Symptoms include pain, broken skin, or open wound that is swollen, warm, and/or red, and may be oozing fluid or pus.

(C) Stage 3 involves a sore that looks like a crater and may have a bad odor. It may show signs of infection such as red edges, pus, odor, heat, and/or drainage.

(D) Stage 4 is a deep, large sore. The skin may have turned black and show signs of infection such as red edges, pus, odor, heat and/or drainage. Tendons, muscles, and bone may be visible.

2.38 "Protective oversight" means guidance of a resident as required by the needs of the resident or as reasonably requested by the resident, including the following:

(A) Being aware of a resident's general whereabouts, although the resident may travel independently in the community; and

(B) Monitoring the activities of the resident while on the premises to ensure the resident's health, safety and well-being, including monitoring the resident's needs and ensuring that the resident receives the services and care necessary to protect the resident's health, safety, and well-being.

2.39 "Qualified medication administration person" or "QMAP" means an individual who passed a competency evaluation administered by the Department before July 1, 2017, or passed a competency evaluation administered by an approved training entity on or after July 1, 2017, and whose name appears on the Department's list of persons who have passed the requisite competency evaluation.

2.40 "Renovation" means the moving of walls and reconfiguring of existing floor plans. It includes the rebuilding or upgrading of major systems, including but not limited to: heating, ventilation, and electrical systems. It also means the changing of the functional operation of the space.

(A) Renovations do not include "minor alterations," which are building construction projects which are not additions, which do not affect the structural integrity of the building, which do not change functional operation, and/or which do not add beds or capacity above what the facility is limited to under the existing license.

2.41 "Resident's legal representative" means one of the following:

(A) The legal guardian of the resident, where proof is offered that such guardian has been duly appointed by a court of law, acting within the scope of such guardianship;

(B) An individual named as the agent in a power of attorney (POA) that authorizes the individual to act on the resident's behalf, as enumerated in the POA;

(C) An individual selected as a proxy decision-maker pursuant to Section 15-18.5-101, C.R.S., et seq., to make medical treatment decisions. For the purposes of this regulation, the proxy decision-maker serves as the resident's legal representative for the purposes of medical treatment decisions only; or

(D) A conservator, where proof is offered that such conservator has been duly appointed by a court of law, acting within the scope of such conservatorship.

2.42 "Restraint" means any method or device used to involuntarily limit freedom of movement including, but not limited to, bodily physical force, mechanical devices, chemicals, or confinement.

2.43 "Secure environment" means any grounds, building or part thereof, method, or device that prohibits free egress of residents. An environment is secure when the right of any resident thereof to move outside the environment during any hours is limited.

2.44 "Self-administration" means the ability of a resident to take medication independently without any assistance from another person.

2.45 "Staff" means employees and contracted individuals intended to substitute for or supplement employees who provide personal services. "Staff" does not include individuals providing external services, as defined herein.

2.46 "Therapeutic diet" means a diet ordered by a practitioner or registered dietician as part of a treatment of disease or clinical condition, or to eliminate, decrease, or increase specific nutrients in the diet. Examples include, but are not limited to, a calorie counted diet; a specific sodium gram diet; and a cardiac diet.

2.47 "Transfer" means being able to move from one body position to another. This includes, but is not limited to, moving from a bed to a chair or standing up from a chair to grasp an auxiliary aid.

2.48 "Volunteer" means an unpaid individual providing personal services on behalf of and/or under the control of the assisted living residence. "Volunteer" does not include individuals visiting the assisted living residence for the purposes of resident engagement.

PART 3 – DEPARTMENT OVERSIGHT

Licensure

3.1 Applicants for an initial or renewal license shall follow the licensure procedures outlined in 6 CCR 1011-1, Chapter 2, Part 2.

(A) In addition, each license renewal applicant shall annually submit, in the form and manner prescribed by the Department, information about the facility's operations, resident care, and services.

3.2 The Department may issue a provisional license to an applicant for the purpose of operating an assisted living residence for one period of 90 days if the applicant is temporarily unable to conform to all the minimum standards required under these regulations, except no license shall

be issued to an applicant if the operation of the applicant's facility will adversely affect the health, safety, and welfare of the residents of such facility.

(A) As a condition of obtaining a provisional license, the applicant shall provide the Department with proof that it is attempting to conform and comply with applicable standards. No provisional license shall be granted prior to the submission of a criminal background check in accordance with Section 25-27-105 (2.5), C.R.S.

3.3 Each owner or applicant shall request a criminal history record check.

(A) If an owner or applicant for an initial assisted living residence license has lived in Colorado for more than three (3) years at the time of the initial application, said individual shall request from the Colorado Bureau of Investigation (CBI) a state fingerprint-based criminal history record check with notification of future arrests.

(B) If an owner or applicant for an initial assisted living residence license has lived in Colorado for three (3) years or less at the time of the initial application, said individual shall:-

(1) Request from the Colorado Bureau of Investigation (CBI) a state fingerprint-based criminal history record check with notification of future arrests; and

(2) Obtain a name-based criminal history report for each additional state in which the applicant has lived for the past three years, conducted by the respective states' bureaus of investigation or equivalent state-level law enforcement agency or other name-based report as determined by the Department.

(C) The cost of obtaining such information shall be borne by the individual or individuals who are the subject of such check.

(D) The results of the check shall be forwarded to the Department as follows:

(1) For results from CBI, the information shall be forwarded by CBI to the Department.

(2) For equivalent agencies in other states, the information shall be forwarded by the agency to the Department if authorized by such state. If such authorization does not exist, the results shall be forwarded to the Department by the individual.

(E) When the results of a fingerprint-based criminal history record check of an applicant reveal a record of arrest without a disposition, the applicant shall submit to a name-based criminal history record check.

3.4 No license shall be issued or renewed by the Department if an owner, applicant, and/ or licensee of the assisted living residence has been convicted of a felony or of a misdemeanor, which felony or misdemeanor involves moral turpitude or involves conduct that the Department determines could pose a risk to the health, safety, or welfare of residents of the assisted living residence.

3.5 An assisted living residence shall not care for more residents than the number of beds for which it is currently licensed.

License Fees

Unless otherwise specified, all license fees paid to the Department shall be non-refundable.

3.6 Initial Licenses

The applicable fee, as set forth below, shall accompany the license application.

3 to 8 licensed beds:	$6,300
9 to 19 licensed beds:	$7,300
20 to 49 licensed beds:	$8,750
50 to 99 licensed beds:	$11,550
100 or more licensed beds:	$14,750
Qualifying disproportionate share facility:	$3,000

3.7 Renewal Fees

The applicable fee(s), as set forth below, shall accompany the renewal application:

$360 per facility plus $103 per bed.

$360 per facility plus $38 per bed for a high Medicaid utilization facility.

$350 per secure environment that is separate and distinct from a non-secure environment.

3.8 Provisional Licensure. Any facility approved by the Department for a provisional license, shall submit a fee of $1,000 for the provisional licensure period.

3.9 Change of Ownership

(A) The applicable fee, as set forth below, shall accompany a facility's application for change of ownership.

Three to 19 licensed beds:	$6,250.
20 to 49 licensed beds:	$7,800.
50 to 99 licensed beds:	$10,600
100 licensed beds and more:	$13,700

(B) If the same purchaser buys more than one facility from the same seller in a single business transaction, the change of ownership fee shall be the fee noted above for the largest facility and $4,500 for each additional facility included in the transaction. The appropriate fee total shall be submitted with the application.

3.10 Other License Fees

(A) A facility applying for a change of mailing address~~,~~ shall submit a fee of $75 with the application. For purposes of this subpart, a corporate change of address for multiple facilities shall be considered one change of address.

(B) A facility applying for a change of name shall submit a fee of $75 with the application.

(C) A facility applying for an increased number of licensed beds shall submit a fee of $500 with the application.

(D) A facility applying for a change of administrator shall submit a fee of $500 with the application.

(E) A facility seeking to open a new secure environment shall submit a fee of $1,600 with the first submission of the applicable building plans.

Citing Deficiencies

3.11 The level of the deficiency shall be based upon the number of sample residents affected and the level of harm, as follows:

Level A – isolated potential for harm for one or more residents.

Level B – a pattern of potential for harm for one or more residents.

Level C – isolated actual harm affecting one or more residents.

Level D – a pattern of actual harm affecting one or more residents.

Level E (Immediate Jeopardy) – actual or potential for serious injury or harm for one or more residents.

3.12 When a Level E deficiency is cited, the assisted living residence shall immediately remove the cause of the immediate jeopardy risk and provide the Department with written evidence that the risk has been removed.

Plans of Correction

3.13 Pursuant to Section 25-27-105 (2), C.R.S., an assisted living residence shall submit a written plan detailing the measures that will be taken to correct any deficiencies.

(A) Plans of correction shall be in the format prescribed by the Department and conform to the requirements set forth in 6 CCR 1011-1, Chapter 2, Part 2.10.4(B);

(B) The Department has the discretion to approve, impose, modify, or reject a plan of correction as set forth in 6 CCR 1011-1, Chapter 2, Part 2.10.4(B).

Intermediate Restrictions or Conditions

3.14 Section 25-27-106, C.R.S., allows the Department to impose intermediate restrictions or conditions on a licensee that may include at least one of the following:

(A) Retaining a consultant to address corrective measures including deficient practice resulting from systemic failure;

(B) Monitoring by the Department for a specific period;

(C) Providing additional training to employees, owners, or operators of the residence;

(D) Complying with a directed written plan, to correct the violation; or

(E) Paying a civil fine not to exceed two thousand dollars ($2,000) in a calendar year.

3.15 Intermediate restrictions or conditions may be imposed for Level A, B and C deficiencies when the Department finds the assisted living residence has violated statutory or regulatory requirements. The factors that may be considered include, but are not limited to, the following:

(A) The level of actual or potential harm to a resident(s);

(B) The number of residents affected;

(C) Whether the conduct leading to the imposition of the restriction are isolated or a pattern~~,~~; and

(D) The licensee's prior history of noncompliance in general, and specifically with reference to the cited deficiencies.

3.16 For all cases where the deficiency list includes Levels D or E deficiencies, the assisted living residence shall comply with at least one intermediate restriction or condition. In addition, for all level E deficiencies, the assisted living residence shall:

(A) Pay a civil fine of $500, not to exceed $2,000 in a calendar year;

(B) Immediately correct the circumstances that gave rise to the immediate jeopardy situation; and

(C) Comply with any other restrictions or conditions required by the Department.

Appealing the Imposition of Intermediate Restrictions/Conditions

3.17 A licensee may appeal the imposition of an intermediate restriction or condition pursuant to procedures established by the Department and as provided by Section 25-27-106, C.R.S.

(A) Informal Review

Informal review is an administrative review process conducted by the Department that does not include an evidentiary hearing.

(1) A licensee may submit a written request for informal review of the imposition of an intermediate restriction no later than ten (10) business days after the date notice is received from the Department of the restriction or condition. If an extension of time is needed, the assisted living residence shall request an extension in writing from the Department prior to the submittal due date. An extension of time may be granted by the Department not to exceed seven (7) calendar days. Informal review may be conducted after the plan of correction has been approved.

(2) For civil fines, the licensee may request, in writing that, the informal review be conducted in person, which would allow the licensee to orally address the informal reviewer(s).

(B) Formal Review

A licensee may appeal the imposition of an intermediate restriction or condition in accordance with the Administrative Procedure Act (APA) at Section 24-4-105, C.R.S. A licensee is not required to submit to the Department's informal review before pursuing formal review under the APA.

(1) For life-threatening situations, the licensee shall implement the restriction or condition immediately upon receiving notice of the restriction or condition.

(2) For situations that are not life-threatening, the restriction or condition shall be implemented in accordance with the type of condition as set forth below:

(a) For restriction/conditions other than fines, immediately upon the expiration of the opportunity for appeal or from the date that the

Department's decision is upheld after all administrative appeals have been exhausted.

(b) For fines, within 30 calendar days from the date the Department's decision is upheld after all administrative appeals have been exhausted.

Supported Living Program Oversight

3.18 An assisted living residence that is certified to participate in the Supported Living Program administered by the Department of Healthcare Policy and Financing (HCPF) shall comply with both HCPF's regulations concerning that program and the applicable portions of this chapter. The Department shall coordinate with HCPF in regulatory interpretation of both license and certification requirements to ensure that the intent of similar regulations is congruently met.

PART 4 – LICENSEE RESPONSIBILITIES

4.1 The licensee shall assume responsibility for all services provided by the assisted living residence, including those provided by contract.

4.2 The licensee shall ensure the provision of facilities, personnel, and services necessary for the welfare and safety of residents.

4.3 The licensee shall ensure that all marketing, advertising, and promotional information published or otherwise distributed by the assisted living residence accurately represents the ALR and the care, treatment, and services that it provides.

4.4 The licensee shall establish, and ensure the maintenance of, a system of financial management and accountability for the assisted living residence.

4.5 The licensee shall appoint an administrator who meets the minimum qualifications set forth in these regulations and delegate to that individual the executive authority and responsibility for the administration of the assisted living residence.

PART 5 – REPORTING REQUIREMENTS

At-Risk Persons Mandatory Reporting

5.1 Assisted living residence personnel engaged in the admission, care or treatment of at-risk persons shall report suspected physical or sexual abuse, exploitation and/or caretaker neglect to law enforcement within 24 hours of observation or discovery pursuant to Section 18-6.5-108, C.R.S.

Resident Relocation Reporting

5.2 The assisted living residence shall notify the Department within 48 hours if the relocation of one or more residents occurs due to any portion of the assisted living residence becoming uninhabitable.

Occurrence Reporting

5.3 An assisted living residence shall comply with all occurrence reporting required by state law and shall follow the reporting procedures set forth in 6 CCR 1011-1, Chapter 2, Part 4.2.

(A) An assisted living residence shall investigate an occurrence to determine the circumstances of the event and institute appropriate measures to prevent similar future situations.

(1) Documentation regarding the investigation, including the appropriate measures to be instituted, shall be made available to the Department, upon request.

(B) An assisted living residence shall submit its final investigation report to the Department within five business days after the initial report of the occurrence.

(C) Nothing in this Part 5.3 shall be construed to limit or modify any statutory or common law right, privilege, confidentiality, or immunity.

PART 6 – ADMINISTRATOR

Criminal history record checks

6.1 In order to ensure that the administrator is of good, moral, and responsible character, the assisted living residence shall request a fingerprint-based criminal history record check with notification of future arrests for each prospective administrator prior to hire.

(A) If an administrator applicant has lived in Colorado for more than three (3) years at the time of application, the assisted living residence shall request from the Colorado Bureau of Investigation (CBI) a state fingerprint-based criminal history record check with notification of future arrests.

(B) If an administrator applicant has lived in Colorado for less than three (3) years at the time of application, the assisted living residence shall:

(1) Request from the CBI a state fingerprint-based criminal history record check with notification of future arrests; and

(2) Obtain a name-based criminal history report for each additional state in which the applicant has lived for the past three (3) years, conducted by the respective states' bureaus of investigation or equivalent state-level law enforcement agency or other name-based report as determined by the Department.

(C) The cost of obtaining such information shall be borne by the individual who is the subject of such check. The information shall be forwarded to the department in accordance with Part 3.3(D) of these rules.

(D) When the results of a fingerprint-based criminal history record check of an administrator applicant reveal a record of arrest without a disposition, the administrator applicant shall submit to a name-based criminal history record check.

Qualifications

6.2 An administrator who is recognized by the Department as having been an assisted living residence administrator of record prior to July 1, 2019, shall not be required to meet the criteria in Part 6.3.

6.3 Each newly hired administrator who does not qualify under Part 6.2, shall be at least 21 years of age, possess a high school diploma or equivalent, and at least one year of experience supervising the delivery of personal care services that include activities of daily living. If the administrator does not have the required one year of experience supervising the delivery of

personal care services including activities of daily living, they shall demonstrate they have one or more of the following:

(A) An active, unrestricted Colorado nursing home administrator license;

(B) An active, unrestricted Colorado registered nurse license plus at least six (6) months of work experience in health care during the previous ten (10)-year period;

(C) An active, unrestricted Colorado licensed practical nurse license plus at least one year of work experience in health care during the previous ten (10)-year period;

(D) A bachelor's degree with emphasis in health care or human services plus at least one year of work experience in health care during the previous ten (10)-year period;

(E) An associate's degree with emphasis in health care or human services plus at least two (2) years of work experience in health care during the previous ten (10)-year period;

(F) Thirty (30) credit hours from an accredited college or university with an emphasis in health care or human services plus three (3) years of work experience in health care during the previous ten (10)-year period;

(G) Five (5) or more years of management or supervisory work in the field of geriatrics, human services, or providing care for the physically and/or cognitively disabled during the previous ten (10)-year period; or

(H) A college degree in any field plus two (2) years of health care experience during the previous ten (10)-year period.

6.4 Each administrator of an assisted living residence shall ensure that qualified medication administration persons (QMAPs) comply with the medication administration requirements and limitations in 6 CCR 1011-1, Chapter 24, and Sections 25-1.5-301 through 25-1.5-303, C.R.S.

Training

6.5 Each administrator shall have completed an administrator training program before assuming an administrator position. Written proof regarding the successful completion of such training program shall be maintained in the administrator's personnel file.

6.6 An administrator training program shall meet all of the following requirements:

(A) The program or program components are conducted by an accredited college, university, or vocational school; or an organization, association, corporation, group, or agency with specific expertise in the provision of residential care and services; and

(B) The curriculum includes at least 40 actual hours, 20 of which shall focus on applicable state regulations. The remaining 20 hours shall provide an overview of the following topics:

(1) Business operations including, but not limited to:

(a) Budgeting,

(b) Business plan/service model,

(c) Insurance,

(d) Labor laws,

(e) Marketing, messaging and liability consequences, and

(f) Resident agreement.

(2) Daily business management including, but not limited to,

(a) Coordination with external service providers (i.e., community and support services including case management, referral agencies, mental health resources, ombudsmen, adult protective services, hospice, and home care),

(b) Ethics, and

(c) Grievance and complaint process.

(3) Physical plant

(4) Resident care including, but not limited to:

(a) Admission and discharge criteria,

(b) Behavior expression management,

(c) Care needs assessment,

(d) Fall management,

(e) Nutrition,

(f) Person-centered care,

(g) Personal versus skilled care,

(h) Quality management education,

(i) Resident rights,

(j) Sexuality and aging,

(k) Secure environment, and

(l) Medication Management.

(5) Resident psychosocial needs including, but not limited to,

(a) Cultural competency (ethnicity, race, sexual orientation),

(b) Family involvement and dynamics,

(c) Mental health care (maintaining good mental health and recognizing symptoms of poor mental health),

(d) Palliative care standards, and

(e) Resident engagement.

6.7 Competency testing shall be performed to demonstrate that the individuals trained have a comprehensive, evidence-based understanding of the regulations and topics.

Duties

6.8 The administrator shall be responsible for the overall day-to-day operation of the assisted living residence, including, but not limited to:

(A) Managing the day-to-day delivery of services to ensure residents receive the care that is described in the resident agreement, the comprehensive resident assessment, and the resident care plan;

(B) Organizing and directing the assisted living residence's ongoing functions including physical maintenance;

(C) Ensuring that resident care services conform to the requirements set forth in Part 12 of this chapter;

(D) Employing, training, and supervising qualified personnel~~,~~;

(E) Providing continuing education for all personnel~~,~~;

(F) Establishing and maintaining a written organizational chart to ensure there are well-defined lines of responsibility and adequate supervision of all personnel;

(G) Reviewing the marketing materials and information published by an assisted living residence to ensure consistency with the services actually provided by the ALR;

(H) Managing the business and financial aspects of the assisted living residence which includes working with the licensee to ensure there is an adequate budget to provide necessary resident services;

(I) Completing, maintaining, and submitting all reports and records required by the Department;

(J) Complying with all applicable federal, state, and local laws concerning licensure and certification; and

(K) Appointing and supervising a qualified designee who is capable of satisfactorily fulfilling the administrator's duties when the administrator is unavailable.

(1) The name and contact information for the administrator or qualified designee on duty shall always be readily available to the residents and public.

(2) The administrator or qualified designee shall always, whether on or off site, be readily accessible to staff.

(3) When a qualified designee is acting as administrator in an assisted living residence that is licensed for more than 12 beds, there shall be at least one other staff member on duty whose primary responsibility is the daily care of residents.

PART 7 – PERSONNEL

Criminal History Record Checks

7.1 In order to ensure that staff members and volunteers are of good, moral, and responsible character, the assisted living residence shall request, prior to staff hire or volunteer on-boarding, a name-based criminal history record check for each prospective staff member and volunteer.

(A) If the applicant has lived in Colorado for more than three (3) years at the time of application, the assisted living residence shall obtain a name-based criminal history report conducted by the Colorado Bureau of Investigation (CBI).

(B) If the applicant has lived in Colorado for three years or less at the time of application, the assisted living residence shall obtain a name-based criminal history report for each state in which the applicant has lived for the past three years, conducted by the respective states' bureaus of investigation or equivalent state-level law enforcement agency or other name-based report as determined by the Department.

(C) The cost of obtaining such information shall be borne by the assisted living residence, the contract staffing agency or the individual who is the subject of such check, as appropriate.

Background Check Policies and Procedures

7.2 If the assisted living residence becomes aware of information that indicates a current administrator, staff member, or volunteer could pose a risk to the health, safety, and welfare of the residents and/or that such individual is not of good, moral, and responsible character, the assisted living residence shall request an updated criminal history record check for such individual from the CBI and/or other relevant law enforcement agency.

7.3 The assisted living residence shall develop and implement policies and procedures regarding the hiring or continued service of any administrator, staff member, or volunteer whose criminal history records do not reveal good, moral, and responsible character or demonstrate other conduct that could pose a risk to the health, safety, or welfare of the residents.

(A) At a minimum, the assisted living residence shall consider and address the following items:

(1) The history of convictions, pleas of guilty or no contest,

(2) The nature and seriousness of the crime(s),

(3) The time that has elapsed since the convictions,

(4) Whether there are any mitigating circumstances, and

(5) The nature of the position to which the individual will be assigned.

Ability to Perform Job Functions

7.4 Each staff member and volunteer shall be physically and mentally able to adequately and safely perform all functions essential to resident care.

7.5 The assisted living residence shall select direct care staff based on such factors as the ability to read, write, carry out directions, communicate, and demonstrate competency to safely and effectively provide care and services.

7.6 The assisted living residence shall establish written policies concerning pre-employment physical evaluations and employee health. Those policies shall include, at a minimum:

(A) Tuberculin skin testing of each staff member and volunteer prior to direct contact with residents; and

(B) The imposition of work restrictions on direct care staff who are known to be affected with any illness in a communicable stage. At a minimum, such staff shall be barred from direct contact with residents or resident food.

7.7 The assisted living residence shall have policies and procedures restricting on-site access by staff or volunteers with drug or alcohol use that would adversely impact their ability to provide resident care and services.

Staff and Volunteer Orientation and Training

7.8 The assisted living residence shall ensure that each staff member and volunteer receives orientation and training, as follows:

(A) The assisted living residence shall ensure each staff member or volunteer completes an initial orientation prior to providing any care or services to a resident. Such orientation shall include, at a minimum, all of the following topics:

(1) The care and services provided by the assisted living residence; -

(2) Assignment of duties and responsibilities, specific to the staff member or volunteer;

(3) Hand Hygiene and infection control;

(4) Emergency response policies and procedures, including:

(a) Recognizing emergencies,

(b) Relevant emergency contact numbers,

(c) Fire response, including facility evacuation procedures

(d) Basic first aid,

(e) Automated external defibrillator (AED) use, if applicable,

(f) Practitioner assessment, and

(g) Serious illness injury, and/or death of a resident.

(5) Reporting requirements, including occurrence reporting procedures within the facility;

(6) Resident rights;

(7) House rules;

(8) Where to immediately locate a resident's advance directive; and

(9) An overview of the assisted living residence's policies and procedures and how to access them for reference.

(B) The assisted living residence shall provide each staff member or volunteer with training relevant to their specific duties and responsibilities prior to that staff member or volunteer working independently. This training may be provided through formal instruction, self-study courses, or on-the-job training, and shall include, but is not limited to, the following topics:

(1) Overview of state regulatory oversight applicable to the assisted living residence;

(2) Person-centered care;

(3) The role of and communication with external service providers;

(4) Recognizing behavioral expression and management techniques, as appropriate for the population being served;

(5) How to effectively communicate with residents that have hearing loss, limited English proficiency, dementia, or other conditions that impair communication, as appropriate for the population being served;

(6) Training related to fall prevention and ways to monitor residents for signs of heightened fall potential such as deteriorating eyesight, unsteady gait, and increasing limitations that restrict mobility;

(7) How to safely provide lift assistance, accompaniment, and transport of residents;

(8) Maintenance of a clean, safe and healthy environment including appropriate cleaning techniques;

(9) Food safety; and

(10) Understanding the staff or volunteer's role in end of life care including hospice and palliative care.

Personnel Policies

7.9 The assisted living residence shall develop and maintain written personnel policies, job descriptions and other requirements regarding the conditions of employment, management of staff and resident care to be provided, including, but not limited to, the following:

(A) The assisted living residence shall provide a job-specific orientation for each new staff member and volunteer before they independently provide resident services~~.~~;

(B) All staff members and volunteers shall be informed of the purpose and objectives of the assisted living residence;

(C) All staff members and volunteers shall be given access to the ALR's personnel policies and the ALR shall provide evidence that each staff member and volunteer has reviewed them; and

(D) All staff members shall wear name tags or other identification that is visible to residents and visitors.

(1) The requirement for name tags may be waived if a majority of attendees at a regularly scheduled assisted living resident meeting agree to do so.

(a) The assisted living residence shall maintain documentation showing that all residents and family members were provided advance notice regarding the topic and meeting details.

(b) The decision to waive the name tag requirement shall be raised and reviewed at the assisted living resident meeting at least annually.

Personnel Files

7.10 The assisted living residence shall maintain a personnel file for each of its employees and volunteers.

7.11 Personnel files for current employees and volunteers shall be readily available onsite for Department review.

7.12 Each personnel file shall include, but not be limited to, written documentation regarding the following items:

(A) A description of the employee or volunteer duties;

(B) Date of hire or acceptance of volunteer service and date duties commenced;

(C) Orientation and training, including first aid and CPR certification, if applicable;

(D) Verification from the Department of Regulatory Agencies, or other state agency, of an active license or certification, if applicable;

(E) Results of background checks and follow up, as applicable; and

(F) Tuberculin test results, if applicable.

7.13 If the employee or volunteer is a qualified medication administration person, the following shall also be retained in the employee's or volunteer's personnel file:

(A) Documentation that the individual's name appears on the Department's list of individuals who have successfully completed the medication administration competency evaluation; and

(B) A signed disclosure that the individual has not had a professional medical, nursing, or pharmacy license revoked in this or any other state for reasons directly related to the administration of medications.

7.14 Personnel files shall be retained for three years following an employee's separation from employment or a volunteer's separation from service and include the reason(s) for the separation.

Personal Care Worker

7.15 The assisted living residence shall ensure that each personal care worker attends the initial orientation required in Part 7.8(A). The assisted living residence shall also require that each personal care worker receives additional orientation on the following topics before providing care and services to a resident:

(A) Personal care worker duties and responsibilities;

(B) The differences between personal services and skilled care; and

(C) Observation, reporting and documentation regarding a resident's change in functional status along with the assisted living residence's response requirements.

7.16 Orientation and training is not required for a personal care worker who is returning to an assisted living residence after a break in service of three years or less if that individual meets all of the following conditions:

(A) The personal care worker completed the assisted living residence's required orientation, training, and competency assessment at the time of initial employment;

(B) The personal care worker successfully completed the assisted living residence's required competency assessment at the time of rehire or reactivation;

(C) The personal care worker did not have performance issues directly related to resident care and services in the prior active period of employment; and

(D) All orientation, training, and personnel action documentation is retained in the personal care worker's personnel file.

7.17 The assisted living residence shall designate an administrator, nurse or other capable individual to be responsible for the oversight and supervision of each personal care worker. Such supervision shall include, but not be limited to:

(A) Being accessible to respond to personal care worker questions, and

(B) Evaluating each personal care worker at least annually.

(1) Each evaluation shall include observation of the personal care worker's performance of his or her assigned tasks.

7.18 The assisted living residence shall only allow a personal care worker to perform tasks that have a chronic, stable, predictable outcome and do not require routine nurse assessment.

7.19 The potential duties of a personal care worker range from observation and monitoring of residents to ensure their health, safety, and welfare, to companionship and personal services.

7.20 Before a personal care worker independently performs personal services for a resident, the supervisor designated by the assisted living residence shall observe and document that the worker has demonstrated his or her ability to competently perform every personal task assigned. This competency check shall be repeated each time a worker is assigned a new or additional personal care task that he or she has not previously performed.

7.21 Only appropriately skilled professionals may train personal care workers and their supervisors on specialized techniques beyond general personal care and assistance with activities of daily living

as defined in these rules. (Examples include, but are not limited to, transfers requiring specialized equipment and assistance with therapeutic diets). Personal care workers and their supervisors shall be evaluated for competency before the delivery of each personal service requiring a specialized technique.

(A) Documentation regarding competency in specialized techniques shall be included in the personnel files of both personal care workers and supervisors.

(B) A registered nurse who is employed or contracted by the assisted living residence may delegate to a personal care worker in accordance with the Nursing Practice Act if the registered nurse is the supervising nurse for the personal care worker.

7.22 The assisted living residence shall ensure that each personal care worker complies with all assisted living residence policies and procedures and not allow a personal care worker to perform any functions which are outside of his or her job description, written agreements, or a resident's care plan.

PART 8 – STAFFING REQUIREMENTS

Minimum Staffing

8.1 Whenever one or more residents are present in the assisted living residence, there shall be at least one staff member present who meets the criteria in Part 8.7 and is capable of responding to an emergency.

(A) Residents shall not be transferred off site solely for the convenience of the assisted living residence or its staff.

8.2 Between 10 PM and 6 AM, staff shall conduct at least one safety check of all consenting residents.

Staffing Levels

8.3 To determine appropriate routine staffing levels, the assisted living residence shall consider, at a minimum, the following items:

(A) The acuity and needs of the residents,

(B) The services outlined in the care plan, and

(C) The services set forth in the resident agreement.

8.4 Staff shall be sufficient in number to help residents needing or potentially needing assistance, considering individual needs such as the risk of accident, hazards, or other challenging events.

First Aid, Obstructed Airway Technique and Cardiopulmonary Resuscitation Trained Staff

8.5 The assisted living residence shall ensure that it has sufficient staff members who are currently certified in first aid and cardiopulmonary resuscitation to meet the requirements of this part.

8.6 Each assisted living residence shall have at least one staff member onsite at all times who has current certification in first aid from a nationally recognized organization such as the American Red Cross, the American Heart Association, National Safety Council, or American Safety and Health Institute. The certification shall either be in Adult First Aid or include Adult First Aid.

8.7 Each assisted living residence shall have at least one staff member onsite at all times who has current certification in cardiopulmonary resuscitation (CPR) and obstructed airway techniques from a nationally recognized organization such as the American Red Cross, the American Heart Association, the National Safety Council or the American Safety and Health Institute. The certification shall either be in Adult CPR or include Adult CPR.

8.8 Each assisted living residence shall place in a visible location a list of all staff who have current certification in first aid or CPR so that the information is readily available to staff at all times. The list shall be kept up to date and indicate by staff person whether the certification is in first aid or CPR or both.

8.9 Each assisted living residence shall require that all staff who are certified in first aid and/or obstructed airway techniques promptly provide those services in accordance with their training.

8.10 Each assisted living residence shall require that all staff who are certified in CPR promptly provide those services in accordance with their training, unless the affected resident has a do not resuscitate order.

8.11 Each assisted living residence shall require that staff, even if not certified in first aid or CPR, promptly respond to an emergency and follow the instructions of a 911 emergency call operator until a medically trained provider can assume care.

Use of Volunteers and Residents

8.12 Volunteers and residents may assist with the provision of resident care and services, but the assisted living residence shall not consider the use of either volunteers or resident helpers in determining the appropriate staffing level.

Use of Hospice Providers

8.13 When licensed hospice care is provided in an assisted living residence, there shall be a written agreement regarding the provision of that care by a hospice provider. The written agreement shall be signed by authorized representatives of the hospice and assisted living residence prior to the provision of hospice care. The written agreement shall include, at a minimum, the following:

(A) How the assisted living residence and hospice will coordinate and communicate with each other to ensure that the needs of the resident are being fully met;

(B) A provision that the assisted living residence shall immediately notify the hospice if:

(1) There is a significant change in the resident's physical, mental, social or emotional status that may necessitate a change to the resident's care plan;

(2) There is a need to transfer the resident from the assisted living residence, in which case the hospice shall coordinate any necessary care related to the terminal illness and related conditions; or

(3) The resident dies.

(C) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided; and

(D) A provision stating that it is the responsibility of the assisted living residence to provide 24-hour room and board and the other services required by this Chapter 7.

8.14 If a hospice provider fails to provide services when they are necessary, the assisted living residence shall follow the requirements of Part 12.5 regarding a resident's significant change in baseline status and request a practitioner assessment.

Contracted Personnel and Services

8.15 An assisted living residence that uses a separate agency, organization, or individual to provide services for the ALR or residents shall have a written agreement that sets forth the terms of the arrangement. The agreement shall specify, at a minimum, the following items:

(A) The specific services to be provided;

(B) The time frame for the provision of such services;

(C) The contractor's obligation to comply with all applicable assisted living residence policies and procedures, including personnel qualifications;

(D) How such services will be coordinated and overseen by the assisted living residence; and

(E) The procedure for payment of services provided under the contract.

8.16 If contract personnel and/or services are used, the contractor shall meet all applicable requirements of these regulations.

8.17 Notwithstanding the above criteria, the assisted living residence shall retain responsibility for oversight of all contracted personnel and services to ensure the health, safety and welfare of the residents.

PART 9 – POLICIES AND PROCEDURES

9.1 The assisted living residence shall develop and at least annually review, all policies and procedures. At a minimum, the assisted living residence shall have policies and procedures that address the following items:

(A) Admission and discharge criteria in accordance with Parts 11 and 25, if applicable;

(B) Resident rights;

(C) Grievance procedure and complaint resolution;

(D) Investigation of abuse, neglect, and exploitation allegations;

(E) Investigation of injuries of known or unknown source/origin;

(F) House rules;

(G) Emergency preparedness;

(H) Fall management;

(I) Provision of lift assistance, first aid, obstructed airway technique, and cardiopulmonary resuscitation;

(J) Unanticipated illness, injury, significant change of status from baseline, or death of resident;

(K) Infection control;

(L) Practitioner assessment;

(M) Health information management;

(N) Personnel;

(O) Staff Training;

(P) Environmental pest control;

(Q) Medication errors and medication destruction and disposal;

(R) Management of resident funds, if applicable;

(S) Policies and procedures related to secure environment, if applicable; and

(T) Provision of palliative care in accordance with 6 CCR 1011-1, Chapter 2, Part 4.3, if applicable.

PART 10 – EMERGENCY PREPAREDNESS

Emergency Policies and Procedures

10.1 The assisted living residence shall have readily available a roster of current residents, their room assignments and emergency contact information, along with a facility diagram showing room locations.

10.2 The assisted living residence shall complete a risk assessment of all hazards and preparedness measures to address natural and human-caused crises including, but not limited to, fire(s), gas explosion, power outages, tornado, flooding and threatened or actual acts of violence.

10.3 The assisted living residence shall develop and follow written policies and procedures to ensure the continuation of necessary care to all residents for at least 72 hours immediately following any emergency including, but not limited to, a long-term power failure.

10.4 Emergency policies and procedures shall be tailored to the geographic location of the assisted living residence; types of residents served; and unique risks and circumstances identified by the assisted living residence.

10.5 Each assisted living residence shall identify its highest potential risk and hold routine drills to facilitate staff and resident response to that risk. There shall be written documentation of such drills.

10.6 Each assisted living residence's emergency policies shall address, at a minimum, all of the following items:

(A) Written instructions for each identified risk that includes persons to be notified and steps to be taken. The instructions shall be readily available 24 hours a day in more than one location with all staff aware of the locations;

(B) A schematic plan of the building or portions thereof placed visibly in a central location and throughout the building, as needed, showing evacuation routes, smoke stop and fire doors, exit doors, and the location of fire extinguishers and fire alarm boxes;

(C) When to evacuate the premises and the procedure for doing so;

(D) A pre-determined means of communicating with residents, families, staff and other providers;

(E) A plan that ensures the availability of, or access to, emergency power for essential functions and all resident-required medical devices or auxiliary aids;

(F) Storage and preservation of medications;

(G) Assignment of specific tasks and responsibilities to the staff members on each shift including use of a triage system to assess the needs of the most vulnerable residents first;

(H) Protection and transfer of health information as needed to meet the care needs of residents; and

(I) In the event relocation of residents becomes necessary, written agreements with other health facilities and/or community agencies.

Emergency Equipment

10.7 First aid equipment shall be maintained on the premises in a readily available location and staff shall be instructed in its use and location.

10.8 The assisted living residence shall have enough first aid kits to enable staff to immediately respond to emergencies. Each first aid kit shall be checked regularly to ensure that it is fully stocked and that any expiration date is not exceeded.

10.9 Each kit shall include, at a minimum, the following items:

(A) Latex free disposable gloves,

(B) Scissors,

(C) Adhesive bandages,

(D) Bandage tape,

(E) Sterile gauze pads,

(F) Flexible roller gauze,

(G) Triangular bandages with safety pins,

(H) A note pad with a pen or pencil,

(I) A CPR barrier device or mask, and

(J) Soap or waterless hand sanitizer.

10.10 If the assisted living residence has an automated external defibrillator (AED), staff shall be trained in its use and it shall be maintained in accordance with the manufacturer's specifications.

10.11 There shall be at least one telephone, not powered by household electrical current, in the assisted living residence available for immediate emergency use by staff, residents, and visitors. Contact information for police, fire, ambulance [911, if applicable] and poison control center shall be readily accessible to staff.

10.12 Assisted living residences shall have a battery or generator-powered alternative lighting system available in the event of a power failure.

PART 11 – RESIDENT ADMISSION AND DISCHARGE

Move-In Criteria

11.1 The assisted living residence shall accept only those persons whose needs can be fully met by the existing staff, physical environment, and services already being provided. The assisted living residence's ability to meet resident needs shall be based upon a comprehensive pre-admission assessment of a resident's physical, mental, and social needs; cultural, religious and activity needs; preferences; and capacity for self-care.

Move-In Restrictions

11.2 An assisted living residence shall not allow to move in any person who:

(A) Needs regular 24-hour medical or nursing care;

(B) Is incapable of self-administration of medication and the assisted living residence does not have staff who are either licensed or qualified under 6 CCR 1011-1, Chapter 24 to administer medications;

(C) Has an acute physical illness which cannot be managed through medication or prescribed therapy;

(D) Has physical limitations that restrict mobility unless compensated for by available auxiliary aids or intermittent staff assistance;

E) Has incontinence issues that cannot be managed by the resident or staff;

(F) Is profoundly disoriented to time, person, and place with safety concerns that require a secure environment and the assisted living residence does not provide a secure environment;

(G) Has a stage 3 or 4 pressure sore and does not meet the criteria in Part 12.4;

(H) Has a history of conduct that has been disclosed to the assisted living residence that would pose a danger to the resident or others, unless the ALR reasonably believes that the conduct can be managed through therapeutic approaches; or

(I) Needs restraints, as defined herein, of any kind except as statutorily allowed for assisted living residences which are certified to provide services specifically for the mentally ill.

(1) Assisted living residences certified to provide services for the mentally ill shall have policies, procedures, and appropriate staff training regarding the use of restraint and maintain current documentation to show that less restrictive measures were, and continue to be, unsuccessful.

Resident Agreement

11.3 At the time the resident moves in, the assisted living residence shall ensure that the resident and/or the resident's legal representative has received a copy of the written resident agreement and agreed to the terms set forth therein. The assisted living residence shall ensure that the agreement is signed and dated by both parties.

11.4 The terms of a resident agreement shall not alter, or be construed to relieve the assisted living residence of compliance with, any requirement or obligation under relevant federal, state, or local law and regulation.

11.5 The assisted living residence shall review its resident agreements annually and update or amend them as necessary. Amendments to the resident agreement shall also be signed and dated by both parties.

(A) When a change of ownership occurs, the new owner shall either acknowledge and agree to the terms of each existing resident agreement or establish a new agreement with each resident.

11.6 The written resident agreement shall specify the understanding between the parties concerning, at a minimum, the following items:

(A) Assisted living residence charges, refunds, and deposit policies;

(B) The general type of services and activities provided and not provided by the assisted living residence and those which the assisted living residence will assist the resident in obtaining;

(C) A list of specific assisted living residence services included for the agreed upon rates and charges, along with a list of all available optional services and the specified charge for each;

(D) The amount of any fee to hold a place for the resident in the assisted living residence while the resident is absent from the assisted living residence and the circumstances under which it will be charged;

(E) Responsibility for providing and maintaining bed linens, bath and hygiene supplies, room furnishings, communication devices, and auxiliary aids; and

(F) A guarantee that any security deposit will be fully reimbursed if the assisted living residence closes without giving resident(s) written notice at least thirty (30) calendar days before such closure.

Written Disclosure of Information

11.7 The assisted living residence shall ensure that when a new resident moves in, he or she is provided with, and acknowledges receipt of, the following information:

(A) How to obtain access to the assisted living residence policies and procedures listed under Part 9.1;

(B) The resident's right to receive cardiopulmonary resuscitation (CPR) or have a written advance directive refusing CPR;

(C) Minimum staffing levels, whether the assisted living residence has awake staff 24 hours a day and the extent to which certified or licensed health care professionals are available on-site;

(D) Whether the assisted living residence has an automatic fire sprinkler system;

(E) Whether the assisted living residence uses egress alert devices, including details about when and where they are used;

(F) Whether the assisted living residence has resident location monitoring devices (such as video surveillance), when and where they are used, and how the assisted living residence determines that a resident requires monitoring;

(G) Whether the assisted living residence operates a secure environment and what that means;

(H) The resident's individualized care plan that addresses his or her functional capability and needs;

(I) Smoking prohibitions and/or designated areas for smoking;

(J) The readily available on-site location of the assisted living residence's most recent inspection report; and

(K) Upon request, a copy of the most recent version of these Chapter 7 rules.

Management of Resident Funds/Property

11.8 An assisted living residence shall not assume power of attorney or guardianship over a resident unless by court order, nor shall an assisted living residence require a resident to execute or assign a loan, advance, financial interest, mortgage, or other property in exchange for future services.

11.9 An assisted living residence shall not be required to handle resident funds or property.

11.10 An assisted living residence that chooses to handle resident funds or property, shall have a policy regarding the management of such funds and shall comply with the following criteria:

(A) There shall be a written authorization that specifies the terms and duration of the financial management services to be performed by the assisted living residence. Such authorization shall be signed by the resident or resident's legal representative and notarized;

(B) Upon entering into an agreement with a resident for financial management services, the assisted living residence shall exercise fiduciary responsibility for these funds and property, including, but not limited to, maintaining any funds over the amount of five hundred dollars ($500) in an interest-bearing account, separate from the general operating fund of the ALR, which interest shall accrue to the resident;

(C) The assisted living residence shall post a surety bond in an amount sufficient to protect the residents' personal funds;

(D) The assisted living residence shall maintain a continuous, dated record of all financial transactions. The record shall begin with the date of the first handling of the personal funds of the resident and shall be kept on file for at least three years following termination

of the resident's stay in the assisted living residence. Such record shall be available for inspection by the Department; and

(E) The assisted living residence shall provide the resident or legal representative a receipt each time funds are disbursed along with a quarterly report identifying the beginning and ending account balance along with a description of each and every transaction since the last report.

Discharge

11.11 The assisted living residence shall arrange to discharge any resident who:

(A) Has an acute physical illness which cannot be managed through medication or prescribed therapy;

(B) Has physical limitations that restrict mobility, and which cannot be compensated for by available auxiliary aids or intermittent staff assistance;

(C) Has incontinence issues that cannot be managed by the resident or staff;

(D) Has a stage 3 or stage 4 pressure sore and does not meet the criteria in Part 12.4;

(E) Is profoundly disoriented to time, person, and place with safety concerns that require a secure environment, and the assisted living residence does not provide a secure environment;

(F) Exhibits conduct that poses a danger to self or others and the assisted living residence is unable to sufficiently address those issues through therapeutic approach; and/or

(G) Needs more services than can be routinely provided by the assisted living residence or an external service provider.

11.12 The assisted living residence may also discharge a resident for:

(A) Nonpayment of basic services in accordance with the resident agreement; or

(B) The resident's failure to comply with a valid, signed resident agreement.

11.13 Where a resident has demonstrated that he or she has become a danger to self or others, the assisted living residence shall promptly implement the following process pending discharge:

(A) Take all appropriate measures necessary to protect other residents;

(B) Reassess the resident to be discharged and revise his or her care plan to identify the resident's current needs and what services the assisted living residence will provide to meet those needs; and

(C) Ensure all staff are aware of any new directives placed in the care plan and are properly trained to provide supervision and actions consistent with the care plan.

11.14 The assisted living residence shall coordinate a voluntary or involuntary discharge with the resident, the resident's legal representative and/or the appropriate agency. Prior to discharging a resident because of increased care needs, the assisted living residence shall make documented efforts to meet those needs through other means.

11.15 In the event a resident is transferred to another health care entity for additional care, the assisted living residence shall arrange to evaluate the resident prior to re-admission or discharge the resident in accordance with the discharge procedures specified below.

11.16 The assisted living residence shall provide written notice of any discharge to the resident or legal representative 30 calendar days in advance of discharge except in cases of imminent physical harm to or by the resident or medical emergency, whereupon the assisted living residence shall notify the legal representative as soon as possible.

11.17 A copy of any involuntary discharge notice shall be sent to the state ombudsman and the designated local long-term care ombudsman, within five (5) calendar days of the date that it is provided to the resident or the resident's legal representative.

PART 12 – RESIDENT CARE SERVICES

Minimum Services

12.1 The assisted living residence shall make available, either directly or indirectly through a resident agreement, the following services, sufficient to meet the needs of the residents:

(A) A physically safe and sanitary environment including, but not limited to, measures to reduce the risk of potential hazards in the physical environment related to the unique characteristics of the population;

(B) Room and board;

(C) Personal services including, but not limited to, a system for identifying and reporting resident concerns that require either an immediate individualized approach or on-going monitoring and possible re-assessment;

(D) Protective oversight including, but not limited to, taking appropriate measures when confronted with an unanticipated situation or event involving one or more residents and the identification of urgent issues or concerns that require an immediate individualized approach; and

(E) Social care and resident engagement.

Nursing Services

12.2 Nurses may provide nursing services to support the personal services provided to residents of the assisted living residence, except that such services shall not rise to the level that requires resident discharge as described in Part 11.11 or becomes regular 24-hour medical or nursing care.

(A) Other staff may assist with nursing services if they are trained and evaluated for competency prior to assignment.

(B) Staff assisting with nursing services shall be supervised by a nurse.

(C) Only staff employed or contracted by the assisted living residence shall provide or assist with nursing services on behalf of the assisted living residence.

12.3 The following occasionally required services may only be provided by an external service provider or the nurse of the assisted living residence:

(A) Syringe or tube feeding,

(B) Intravenous medication,

(C) Catheter care that involves changing the catheter, irrigation of the catheter and/or total assistance with catheter,

(D) Ostomy care where the ostomy site is new or unstable, and

(E) Care for a stage 1 or stage 2 pressure sore if the condition is stable and resolving.

12.4 An assisted living residence shall not admit or keep a resident with a stage 3 or stage 4 pressure sore unless the resident has a terminal condition and is receiving continuing care from an external service provider.

Practitioner Assessment

12.5 The assisted living residence shall have a policy and procedure regarding when a practitioner's assessment of a resident is appropriate. At a minimum, the assisted living residence shall contact the resident's primary practitioner when any of the following circumstances occur and follow the practitioner's recommendation regarding further action.

(A) The resident experiences a significant change in their baseline status,

(B) The resident has physical signs of possible infection (open sores, etc.),

(C) The resident sustains an injury or accident,

(D) The resident has known exposure to a communicable disease, and/or

(E) The resident develops any condition which would have initially precluded admission to the assisted living residence.

Comprehensive Resident Assessment

12.6 At the time a new resident moves in, the assisted living residence shall complete a comprehensive assessment that reflects information requested and received from the resident, the resident's representative if requested by the resident, and a practitioner. Information from the comprehensive assessment shall be used to establish an individualized care plan.

12.7 The comprehensive assessment shall include all the following items:

(A) Information from the comprehensive pre-admission assessment described in Part 11.1;

(B) Information regarding the resident's overall health and physical functioning ability;

(C) Information regarding the resident's advance directives;

(D) Communication ability and any specific needs to facilitate effective communication;

(E) Current diagnoses and any known or anticipated need or impact related to the diagnoses;

(F) Food and dining preferences, unique needs and restrictions;

(G) Individual bathroom routines, sleep and awake patterns;

(H) Reactions to the environment and others, including changes that may occur at certain times or in certain circumstances;

(I) Routines and interests;

(J) History and circumstances of recent falls and any known approaches to prevent future falls;

(K) Safety awareness;

(L) Types of physical, mental, and social support required; and

(M) Personal background, including information regarding any other individuals who are supportive of the resident, cultural preferences, and spiritual needs.

12.8 The comprehensive assessment shall be documented in writing and kept in the resident's health information record.

12.9 The comprehensive assessment shall be updated for each resident at least annually and whenever the resident's condition changes from baseline status.

Resident Care Plan

12.10 Each resident care plan shall:

(A) Be developed with input from the resident and the resident's representative;

(B) Reflect the most current assessment information;

(C) Promote resident choice, mobility, independence and safety;

(D) Detail specific personal service needs and preferences along with the staff tasks necessary to meet those needs;

(E) Identify all external service providers along with care coordination arrangements; and

(F) Identify formal, planned, and informal spontaneous engagement opportunities that match the resident's personal choices and needs.

Care Coordination

12.11 The assisted living residence shall be responsible for the coordination of resident care services with known external service providers.

12.12 The assisted living residence shall notify the resident's representative whenever the resident experiences a significant change from baseline status.

Restraint

12.13 An assisted living residence shall not use restraints of any kind or deprive a resident of his or her liberty for purposes of care or safety except as allowed by Part 11.2(I), Part 25, or as set forth below.

12.14 A device that facilitates a resident's well-being and/or independence may be used only if all of the following criteria are met:

(A) The resident has the functional ability to alter his or her position;

(B) The resident is able to remove the device to allow for normal movement;

(C) The device improves the resident's physical or emotional state and allows the resident to participate in activities that would otherwise be difficult or impossible; and

(D) There is an order from a practitioner for its use.

(1) There shall also be interdisciplinary documentation from both the practitioner and a therapist describing the benefits and hazards associated with the device and information on its appropriate use.

(2) A resident's continued use of such device shall be re-evaluated by both therapist and practitioner at least annually or whenever the resident experiences a significant change in status.

(3) Documentation of compliance with this subpart (D) shall be retained in the resident's care plan.

Fall Management Program

12.15 The assisted living residence shall develop policies and procedures to establish a fall management program. The program shall include the following:

(A) Providing fall management education and materials to residents and family members;

(B) Detailing in each resident's care plan the individualized approach necessary to address fall risk related to deficits in strength, balance, and eyesight, or effects of medication as identified during the comprehensive resident assessment;

(C) Providing resident engagement activities to improve strength and balance as specified in Part 12.22(C);

(D) Routinely inspecting and maintaining a safe exterior and interior environment as specified in Parts 21 and 22; and

(E) Providing staff training related to fall prevention as specified in Part 7.8(B)(6).

Lift Assistance

12.16 Each assisted living residence shall direct staff to assist residents who have fallen or are otherwise unable to independently get up off the floor. The assisted living residence's policy on staff providing lift assistance shall be made available to its local emergency medical responders.

12.17 The assisted living residence shall ensure that it has trained staff available to evaluate residents who have fallen or are otherwise unable to independently get up off the floor and provide lift assistance when determined appropriate instead of relying on emergency medical responders.

(A) Each situation shall be evaluated to determine if the resident can be assisted in a safe manner such as when the resident has no pain and/or there is no change from baseline, the resident's mental status is unchanged from baseline, and there is no, or minor, bleeding.

(B) Once the situation has been evaluated, assisted living residence policy shall require staff to take the following actions:

(1) Physically perform the lift assistance using techniques provided in staff training and monitor the resident; or

(2) Not lift and call 911 when the resident is unconscious, the resident's physical or mental status has declined from baseline, the resident experiences an increase in pain when lifting is attempted, the resident wants 9-1-1 called, and/or the resident either can't assist in any way or refuses to assist because of pain, injury, or other physical complications.

(C) The assisted living residence shall promptly notify the resident's practitioner, family and/or legal representative of the occurrence of either circumstance identified in Part 12.17(B)(1) or (2), along with information regarding the ALR's response.

12.18 The assisted living residence's policy shall also require documentation of the action taken by staff and ongoing efforts to prevent a reoccurrence of the situation in the future.

Resident Engagement

12.19 The assisted living residence shall encourage residents to maintain and develop their fullest potential for independent living through individual and group engagement opportunities.

12.20 The assisted living residence shall provide all residents with regular opportunities to participate in structured engagement and shall support the pursuit of each resident's interests.

12.21 If requested, the assisted living residence shall assist a resident with identifying and accessing outside services and community events.

12.22 Examples of resident engagement include, but are not limited to, the following:

(A) Individual or group conversation, recreation, art, crafts, music, and pet care;

(B) Use of daily living skills that foster and maintain a sense of purpose and significance;

(C) Physical pursuits such as games, sports, and exercise that develop and maintain strength, coordination, and range of motion;

(D) Educational opportunities such as special classes or community events;

(E) Cultivation of personal interests and pursuits; and

(F) Encouraging engagement with others.

12.23 The assisted living residence shall encourage residents to contribute to the planning, preparation, conduct, clean-up, and critique of any structured engagement offering.

12.24 The assisted living residence shall evaluate its resident engagement program at least every three months to ascertain whether the opportunities offered to residents are relevant and well-received and/or if changes are appropriate in response to resident feed-back.

12.25 The assisted living residence shall, whenever feasible, coordinate with local agencies and organizations to promote resident participation in community centered activities including, but not limited to:

(A) Public service endeavors;

(B) Community events such as concerts, exhibits, and plays;

(C) Community organized group engagement such as senior citizen groups, sports leagues, and service clubs; and

(D) Attendance at the place of worship of the resident's choice.

12.26 Each assisted living residence shall place notices of planned resident engagement offerings in a central location readily accessible to residents, relatives, and the public. Copies shall be retained for at least six months.

Resident Engagement Management

19 or fewer residents

12.27 In assisted living residences that are licensed for 19 or fewer residents, the administrator shall be primarily responsible for organizing, conducting, and evaluating resident engagement. If an assisted living residence can demonstrate that its residents are self-directed to the extent that they are able to plan, organize, and conduct the ALR's resident engagement activities themselves, the ALR may request a waiver of this requirement.

20 to 49 residents

12.28 In assisted living residences that are licensed for 20 to 49 residents, the administrator shall designate one staff member to be responsible for organizing, conducting, and evaluating resident engagement. The designated staff member shall have had at least six months experience in providing structured resident engagement offerings or have completed or be enrolled in an equivalent education and/or training program.

50 or more residents

12.29 In assisted living residences that are licensed for 50 or more residents, there shall be at least one staff member whose sole responsibility is to organize, conduct, and evaluate resident engagement. The ALR shall provide such staff member with as much accommodation and staff support as necessary to ensure that all residents have on-going opportunities to participate in resident engagement activities that are planned in advance, documented in writing, kept up to date, and made available to all residents. The responsible staff member shall have had at least one year of experience or equivalent education and/or training in providing structured resident engagement offerings and be knowledgeable in evaluating resident needs, supervising other staff and in training volunteers.

Use of Volunteers

12.30 Each assisted living residence shall encourage participation of volunteers in resident engagement opportunities. All such volunteers shall be supervised and directed by the administrator or staff member primarily responsible for resident engagement.

Physical Space and Equipment:

12.31 Each assisted living residence shall have sufficient physical space to accommodate both indoor and outdoor resident engagement. Such accommodations shall include, at a minimum:

(A) A comfortable, appropriately furnished area such as a living room, family room, or great room available to all residents for their relaxation and for socializing with friends and relatives; and

(B) An outdoor activity area which is easily accessible to residents and protected from traffic. Outdoor spaces shall be sufficient in size to comfortably accommodate all residents participating in an activity.

12.32 Each assisted living residence shall provide sufficient recreational equipment and supplies to meet the needs of the resident engagement program. Special equipment and supplies necessary to accommodate persons with special needs shall be made available as appropriate. When not in use, recreational equipment and supplies shall be stored in such a way that they do not create a safety hazard.

12.33 Each assisted living residence shall ensure that staff who accompany residents away from the assisted living residence have ready access to the pertinent personal information of those residents in the event of an emergency.

PART 13 – RESIDENT RIGHTS

13.1 The assisted living residence shall adopt, and place in a publically visible location, a statement regarding the rights and responsibilities of its residents. The assisted living residence and staff shall observe these rights in the care, treatment, and oversight of the residents. The statement of rights shall include, at a minimum, the following items:

(A) The right to privacy and confidentiality, including:

(1) The right to have private and unrestricted communications with any person of choice;

(2) The right to private telephone calls or use of electronic communication;

(3) The right to receive mail unopened;

(4) The right to have visitors at any time; and

(5) The right to private, consensual sexual activity.

(B) The right to civil and religious liberties, including:

(1) The right to be treated with dignity and respect;

(2) The right to be free from sexual, verbal, physical or emotional abuse, humiliation, intimidation, or punishment;

(3) The right to be free from neglect;

(4) The right to live free from financial exploitation, restraint as defined in this chapter, and involuntary confinement except as allowed by the secure environment requirements of this chapter;

(5) The right to vote;

(6) The right to exercise choice in attending and participating in religious activities;

(7) The right to wear clothing of choice unless otherwise indicated in the care plan; and

(8) The right to care and services that are not conditioned or limited because of a resident's disability, sexual orientation, ethnicity, and/or personal preferences.

(C) The right to personal and community engagement, including:

(1) The right to socialize with other residents and participate in assisted living residence activities, in accordance with the applicable care plan;

(2) The right to full use of the assisted living residence common areas in compliance with written house rules;

(3) The right to participate in resident meetings, voice grievances, and recommend changes in policies and services without fear of reprisal;

(4) The right to participate in activities outside the assisted living residence and request assistance with transportation; and

(5) The right to use of the telephone including access to operator assistance for placing collect telephone calls.

(a) At least one telephone accessible to residents utilizing an auxiliary aid shall be available if the assisted living residence is occupied by one or more residents utilizing such an aid.

(D) The right to choice and personal involvement regarding care and services, including:

(1) The right to be informed and participate in decision making regarding care and services, in coordination with family members who may have different opinions;

(2) The right to be informed about and formulate advance directives;

(3) The right to freedom of choice in selecting a health care service or provider;

(4) The right to expect the cooperation of the assisted living residence in achieving the maximum degree of benefit from those services which are made available by the assisted living residence;

(a) For residents with limited English proficiency or impairments that inhibit communication, the assisted living residence shall find a way to facilitate communication of care needs.

(5) The right to make decisions and choices in the management of personal affairs, funds, and property in accordance with resident ability;

(6) The right to refuse to perform tasks requested by the assisted living residence or staff in exchange for room, board, other goods or services;

(7) The right to have advocates, including members of community organizations whose purposes include rendering assistance to the residents;

(8) The right to receive services in accordance with the resident agreement and the care plan; and

(9) The right to thirty (30) calendar days written notice of changes in services provided by the assisted living residence including, but not limited to, involuntarily change of room or changes in charges for a service. Exceptions to this notice are:

(a) Changes in the resident's medical acuity that result in a documented decline in condition and that constitute an increase in care necessary to protect the health and safety of the resident; and

(b) Requests by the resident or the family for additional services to be added to the care plan.

Ombudsman Access

13.2 In accordance with the Supporting Older Americans Act of 2020 (P.L. 116-131), and Sections 26-11.5-108 and 25-27-104(2)(d), C.R.S., an assisted living residence shall permit access to the premises and residents by the state ombudsman and the designated local long-term care ombudsman at any time during an ALR's regular business hours or regular visiting hours, and at any other time when access may be required by the circumstances to be investigated.

(A) For the purposes of complying with this Part 13.2, access to residents shall include access to the assisted living residence's contact information for the resident and the resident's representative.

House Rules

13.3 The assisted living residence shall establish written house rules and place them in a publically visible location so that they are always available to residents and visitors.

13.4 The house rules shall list all possible actions which may be taken by the assisted living residence if any rule is knowingly violated by a resident. House rules shall not supersede or contradict any regulation herein, or in any way discourage or hinder a resident's exercise of his or her rights. House rules shall address, at a minimum, the following items:

(A) Smoking, including the use of electronic cigarettes and vaporizers;

(B) Cooking;

(C) Protection of valuables on premises;

(D) Visitors;

(E) Telephone usage, including frequency and duration of calls;

(F) Use of common areas and devices, such as television, radio, and computer;

(G) Consumption of alcohol and marijuana; and

(H) Pets.

Resident Meetings

13.5 Each assisted living residence shall hold regular meetings with residents, staff, family, and friends of residents so that all have the opportunity to voice concerns and make recommendations concerning assisted living residence care, services, activities, policies, and procedures.

13.6 Meetings shall be held at least quarterly with an opportunity for more frequent meetings if requested.

13.7 Written minutes of such meetings shall be maintained and made readily available for review by residents or family members.

13.8 Before the next regularly scheduled meeting, assisted living residence staff shall respond in writing to any suggestions or issues raised at the prior meeting.

13.9 Residents and family members shall also have the opportunity to meet without the presence of assisted living residence staff.

Internal Grievance and Complaint Resolution Process

13.10 Each assisted living residence shall develop and implement an internal process to ensure the routine and prompt handling of grievances or complaints brought by residents, family members, or advocates. The process for raising and addressing grievances and complaints shall be placed in a visible on-site location along with full contact information for the following agencies:

(A) The state and local long-term care ombudsman;

(B) The Adult Protection Services of the appropriate county Department of Social Services;

(C) The advocacy services of the area's agency on aging;

(D) The Colorado Department of Public Health and Environment; and

(E) The Colorado Department of Health Care Policy and Financing, in those cases where the assisted living residence is licensed to provide services specifically for persons with intellectual and developmental disabilities.

Investigation of Abuse and Neglect Allegations or injuries of unknown origin

13.11 The assisted living residence shall investigate all allegations of abuse, neglect, or exploitation of residents in accordance with Part 5.3 and its written policy which shall include, but not be limited to, the following:

(A) Reporting requirements to the appropriate agencies such as the adult protection services of the appropriate county Department of Social Services, and to the assisted living residence administrator;

(B) A requirement that the assisted living residence notify the legal representative about the allegation within 24 hours of the assisted living residence becoming aware of the allegation;

(C) The process for investigating such allegations;

(D) How the assisted living residence will document the investigation process to evidence the required reporting and that a thorough investigation was conducted;

(E) A requirement that the resident shall be protected from potential future abuse and neglect, and/or exploitation while the investigation is being conducted;

(F) A requirement that if the alleged neglect or abuse is verified, the assisted living residence shall take appropriate corrective action; and

(G) A requirement that a copy of the report with the investigation findings shall be retained by the facility and available for Department review.

13.12 The assisted living residence shall develop and implement policies and procedures for the identification, reporting, and investigation of injuries of unknown origin. Such policies and procedures shall include, but not be limited to, the following requirements:

(A) The assisted living residence shall identify and document resident injuries for which the origin of the injury was not observed by or otherwise known by staff, and either:

(1) The resident cannot explain how the injury occurred; or

(2) The resident can explain the source of the injury, but the source could be addressed to prevent future injuries.

(B) The assisted living residence shall document the following:

(1) The investigation and identification of any injury identified in (A), above.

(2) The implementation and outcome of the following for injuries for which the investigation determines the source/origin:

(a) Compliance with Part 13.11, when the source/origin of the injury is suspected to be abuse, neglect, or exploitation; or

(b) The steps taken to prevent or mitigate future injuries of like nature for both the injured resident and other residents when the source/origin of the injury is not suspected abuse, neglect, or exploitation. Such steps may include, but not be limited to:

(i) Staff or volunteer corrective action and/or additional training; or

(ii) Modification of the assisted living residence's policies, procedures or physical environment.

(3) When the source of the injury remains undetermined, the steps taken to monitor the resident in an effort identify and prevent similar injuries.

(C) All documentation of the investigation, outcomes, and steps taken shall be retained by the assisted living residence, including, but not limited to, details of any interviews and/or records used in the investigation. Such documentation shall be made available for review at the Department's request.

(1) Documentation on the investigation, outcomes, and steps taken may be maintained separately from the resident record, in which case a summary of the investigation and steps taken shall be included in the resident's care plan and progress notes.

(D) The assisted living residence shall notify the resident's representative of the outcome of the investigation and steps taken.

PART 14 – MEDICATION AND MEDICATION ADMINISTRATION

General Requirements:

14.1 An assisted living residence shall not allow an employee or volunteer to administer or assist with administering medication to a resident unless such individual is a practitioner, nurse, qualified medication administration person (QMAP), or certified nurse medication aide (CNA-Med) acting within his or her scope of practice.

14.2 For purposes of this Part 14, a practitioner is "authorized" if state law allows the practitioner to prescribe treatment, medication, or medical devices.

14.3 An assisted living residence shall not allow a QMAP or a CNA-Med to assist a resident with medication administration unless the resident is able to consent and participate in the consumption of the medication.

14.4 If a CNA-Med is used to administer or assist with administering medication to a resident, the assisted living residence shall ensure that the CNA-Med complies with the medication administration procedures listed in this Part 14, except that a CNA-Med may perform additional tasks associated with medication administration as authorized by his or her certification.

14.5 An assisted living residence that utilizes qualified medication administration persons shall comply with the requirements of 6 CCR 1011-1, Chapter 24, Medication Administration Regulations, in addition to the requirements set forth in this Part 14.

14.6 The assisted living residence shall comply with all federal and state laws and regulations relating to procurement, storage, administration, and disposal of controlled substances.

14.7 The assisted living residence shall ensure that each resident receives proper administration and/or monitoring of medications.

14.8 The assisted living residence shall be responsible for ensuring compliance with all safety requirements regarding oxygen use, handling, and storage as set forth in Parts 22.29 through 22.34 of this chapter.

14.9 No medication shall be administered by a qualified medication administration person on a pro re nata (PRN) or "as needed" basis except:

(A) In a residential treatment facility that is licensed to provide services for the mentally ill;

(B) Where the resident understands the purpose of the medication, is capable of voluntarily requesting the medication, and the assisted living residence has documentation from an authorized practitioner that the use of such medication in this manner is appropriate; or

(C) Where specifically allowed by statute.

14.10 Unless otherwise allowed by statute, the assisted living residence shall not permit a qualified medication administration person to perform any of the following tasks:

(A) Intravenous, intramuscular, or subcutaneous injections;

(B) Gastrostomy or jejunostomy tube feeding;

(C) Chemical debridement;

(D) Administration of medication for purposes of restraint;

(E) Titration of oxygen;

(F) Decision making regarding PRN or "as needed" medication administration;

(G) Assessment of residents or use of judgment including, but not limited to, medication effect;

(H) Pre-pouring of medication; or

(I) Masking or deceiving administration of medication including, but not limited to, concealing in food or liquid.

14.11 Only medication that has been ordered by an authorized practitioner shall be prepared for or administered to residents.

Training, Competency and Supervision

14.12 The assisted living residence shall ensure that all qualified medication administration persons are trained in and adhere to the following medication administration procedures:

(A) Identification of the right resident for each medication administration or monitoring by asking for the resident's name or comparing the resident to a photograph maintained specifically for medication administration identification;

(B) Providing the correct medication by the correct route at the correct time and in the correct dose as ordered by the authorized practitioner; and

(C) Implementing any changes in medication orders upon receipt.

14.13 The assisted living residence shall designate a QMAP supervisor who is a nurse, practitioner, or meets the requirements of a qualified medication administration person.

(A) The QMAP supervisor shall, before initial assignment of each qualified medication administration person, conduct a competency assessment with direct observation of all medication administration tasks that the QMAP will be assigned to perform.

(1) Whenever a QMAP is assigned additional medication administration tasks, the QMAP supervisor shall conduct a competency assessment with direct observation of each new task that the QMAP will be assigned.

Resident Rights

14.14 All personal medication is the property of the resident and no resident shall be required to surrender the right to possess or self-administer any personal medication unless an authorized practitioner has determined that the resident lacks the decisional capacity to possess or self-administer such medication safely.

14.15 The assisted living residence shall ensure each resident's right to privacy and dignity with respect to medication monitoring and administration.

14.16 Each resident shall have the right to refuse medications.

Orders

14.17 The assisted living residence shall ensure that each authorized practitioner's order for medication includes the correct name of the resident, date of the order, medication name, strength of medication, dosage to administer, route of administration along with timing and/or frequency of administration, any specific considerations, if substitutions are allowed or restricted, and the signature of the practitioner.

14.18 All medication orders shall be documented in writing by the authorized prescribing practitioner. Verbal orders for medication shall not be valid unless received by a licensed staff member who is authorized to receive and transcribe such orders.

14.19 Any orders received from medical staff on behalf of an authorized practitioner must be countersigned by said practitioner as soon as possible.

14.20 The assisted living residence shall contact the authorized practitioner for clarification of any orders which are incomplete or unclear and obtain new orders in writing.

14.21 The assisted living residence shall be responsible for complying with authorized practitioner orders associated with medication administration except for those medications which a resident self-administers.

14.22 The assisted living residence shall coordinate care and medication administration with external providers.

Medication Reminder Boxes

14.23 For medication reminder boxes that the assisted living residence is responsible for, the assisted living residence shall ensure that the box contains:

(A) No more than a 14 calendar day supply of medications at a time;

(B) No PRN medications, including PRN controlled substances;

(C) Only medication intended for oral ingestion; and

(D) No medications that require administration within specific timeframes unless the medication reminder box is specifically designed and labeled with specific instructions to address this situation.

14.24 Medication reminder boxes shall be stored in a manner that ensures access for the designated resident and prevents access from unauthorized persons.

Medication Preparation and Handling

14.25 The assisted living residence shall maintain medication storage and preparation areas which are clean and free of clutter.

14.26 All reusable medical devices shall be cleaned according to the manufacturer instructions and appropriately stored.

14.27 No stock medications shall be stored or administered by qualified medication administration persons.

A) All over-the-counter medication prescribed for administration shall be labeled or marked with the individual resident's full name.

14.28 The assisted living residence shall ensure that qualified medication administration persons are trained in and apply nationally recognized protocols for basic infection control and prevention when preparing and administering medications.

Record Keeping

14.29 All prescribed and PRN medications shall be listed and recorded on a medication administration record (MAR) which contains the name and date of birth of the resident, the resident's room location, any known allergies, and the name and telephone number of the resident's authorized practitioner.

(A) The medication administration record shall reflect the name, strength, dosage, and mode of administration of each medication, the date the order was received, the date and time of administration, any special considerations related to administration, and the signature or initial of the person administering the medication.

(B) As part of the medication administration record, the assisted living residence shall maintain a legible list of the names of the persons utilizing the record for medication administration, along with each of their signatures and, if used, their initials.

(C) Each qualified medication administration person, nurse, or practitioner shall accurately document each medication administration or monitoring event at the time the event is completed for each resident.

(D) Each qualified medication administration person, nurse, or authorized practitioner shall document accurate information in the medication administration record including any medication omissions, refusals, and resident reported responses to medications.

14.30 The assisted living residence shall maintain a record on a separate sheet for each resident receiving a controlled substance which contains the name of the controlled substance, strength and dosage, date and time administered, resident name, name of authorized practitioner, and the quantity of the controlled substance remaining.

14.31 The administrator and the QMAP supervisor shall, on a quarterly basis, audit the accuracy and completeness of the medication administration records, controlled substance list, medication error reports, and medication disposal records. Any irregularities shall be investigated and resolved. The results of the audits shall be documented and routinely included as part of the assisted living residence's Quality Management Program assessment and review.

Reporting

14.32 The assisted living residence shall have policies and procedures for documenting, investigating, reporting, and responding to any errors related to accurate accounting of controlled substances and/or medication administration.

14.33 The assisted living residence shall ensure that the resident's authorized practitioner and resident's legal representative are promptly notified of:

(A) A decline from a resident's baseline status;

(B) A resident's pattern of refusal;

(C) A resident's repetitive request for and use of PRN medication;

(D) Any observed or reported unfavorable reactions to medications;

(E) The administration of medications used to emergently treat angina; and

(F) Medication errors that affect the resident.

Self-Administration

14.34 The assisted living residence shall compile a list of all resident medications, along with any known allergies, and verify the accuracy and completeness of the list with the resident and authorized practitioner at the time of admission.

14.35 The assisted living residence shall review this list with the resident and authorized practitioner at least once a year and maintain documentation of such review.

14.36 The assisted living residence shall report non-compliance, misuse, or inappropriate use of known medications by a resident who is self-administering to that resident's authorized practitioner.

Medication Storage

14.37 All medications shall be stored in the original prescribed/manufacturer containers with the exception of medications placed in medication reminder boxes pursuant to Part 14.23.

14.38 All medications shall be stored in a locked cabinet, cart, or storage area when unattended by qualified medication administration persons or other licensed staff.

14.39 Controlled substances shall be kept in double lock storage.

(A) Two individuals who are either qualified medication administration persons, nurses, or practitioners shall jointly count all controlled substances at the end of each shift and sign documentation regarding the results of the count at the time it occurs. Any discrepancy in the controlled substance count shall be immediately reported to the administrator.

14.40 All refrigerated medications shall be stored in a refrigerator that does not contain food and that is not accessible to residents.

(A) All medication stored in a refrigerator shall be clearly labeled with the resident's name and prescribing information.

14.41 Outdated, discontinued, and/or expired medications that are not returned to the resident or legal representative shall be stored in a locked storage area until properly disposed of.

(A) Any controlled substance medications which are designated for destruction shall be kept in a separate locked container within the locked storage area until they are destroyed.

14.42 The assisted living residence shall conduct, on a monthly basis, a joint two person audit of medications designated for disposal.

(A) At least one of the persons conducting the audit shall be a qualified medication administration person.

(B) The results of the audit shall be documented and signed by both staff members conducting the audit.

(C) Audit records shall be maintained for a minimum of three years. Any discrepancy in the list and count of medications designated for disposal shall be immediately reported to the administrator.

Medication Destruction and Disposal

14.43 Medication shall be returned to the resident or resident's legal representative, upon discharge or death, except that return of medication to the resident may be withheld if specified in the care plan of a resident of a facility which is licensed to provide services specifically for the mentally ill, or if a practitioner has determined that the resident lacks the decisional capacity to possess or administer such medication safely.

(A) The assisted living residence shall request and maintain signed documentation from the resident or resident's legal representative regarding the disposition of all medications, medical supplies, or devices.

14.44 The assisted living residence shall have policies and procedures regarding the destruction and disposal of outdated, unused, discontinued, and/or expired medications which are not returned to the resident or legal representative. At a minimum, the policies and procedures shall include the following requirements:

(A) Outdated, discontinued, and/or expired medications shall be destroyed in accordance with federal, state, and local regulations within thirty (30) days.

(1) Medication shall be destroyed in the presence of two individuals, each of whom are either a qualified medication administration person, nurse, or practitioner;

(2) All medications shall be destroyed in a manner that renders the substances totally non-retrievable to prevent diversion of the medication; and

(3) There shall be documentation which identifies the medications, the date, and the method of destruction, and the signatures of the witnesses performing the medication destruction.

(B) All destroyed medications shall be disposed of in compliance with Parts 24.2 and 24.3 regarding medical waste disposal.

PART 15 – LAUNDRY SERVICES

General Requirements:

15.1 The assisted living residence shall make laundry services available in one or more of the following ways:

(A) Providing laundry service for the residents,

(B) Providing access to laundry equipment so that the residents may do their own laundry,

(C) Making arrangements with a commercial laundry, or

(D) Coordinating with friends or family members who choose to provide laundry services for a resident.

15.2 There shall be separate storage areas for soiled linen and clothing.

15.3 The assisted living residence shall address resident sensitivities or allergies with regard to laundry detergents or methods.

Assisted Living Residence Laundry Service

15.4 If providing laundry service for residents, the assisted living residence shall ensure the following:

(A) Washing machines and dryers are properly maintained according to the manufacturer's instructions;

(B) Bed and bath linens are cleaned at least weekly or more frequently to meet individual resident needs while blankets are cleaned as necessary;

(C) Laundry personnel or designated staff handle, store, process, transport, and return laundry in a way that prevents the spread of infection or cross contamination;

(D) Personal clothing is returned to the appropriate resident in a presentable, ready-to-wear manner in order to promote resident respect and dignity; and

(E) The appropriate resident representative is notified if a resident needs additional clothing or linens.

Resident Access

15.5 If a resident independently uses the assisted living residence laundry area, the assisted living residence shall ensure that:

(A) The resident is instructed in the proper use of the equipment,

(B) There is a readily available schedule showing when resident use is permitted, and

(C) The resident has the means to independently access the area during the permitted times.

PART 16 – FOOD SAFETY

All Assisted Living Residences

16.1 Residents handling or preparing food for other residents shall have access to a hand-sink, soap, and disposable paper towels. The assisted living residence shall ensure that such residents understand when to wash hands and the proper procedure for doing so. Supplies for cleaning and a pre-made solution for sanitizing food contact surfaces shall be readily available. The ingredients used shall be allowable foods from approved sources and within the "use-by" date.

16.2 The food safety requirements specified in this chapter do not preclude residents from consuming foods not procured by the assisted living residence.

20 or More Beds

16.3 An assisted living residence that is licensed for 20 beds or more shall comply with the Department's regulations concerning Colorado Retail Food Establishments at 6 CCR 1010-2.

19 or Fewer Beds

16.4 An assisted living residence that is licensed for 19 beds or fewer shall comply with all of the requirements in Parts 16.5 through 16.37. A commercial kitchen is not a requirement for an assisted living residence with fewer than 20 beds.

Employee Training

16.5 Staff preparing or serving food shall complete recognized food safety training and maintain evidence of completion on site. Food safety training shall be provided by recognized food safety experts or agencies, such as the Department's Division of Environmental Health and Sustainability, local public health agencies, or Colorado State University Extension Services. At a minimum, a certificate of completion of the available online modules is sufficient to comply with this part. The successful completion of other accredited food safety courses is also acceptable.

Personal Health

16.6 Staff shall be in good health and free of communicable disease while handling, preparing or serving food, or handling utensils.

16.7 Staff are prohibited from handling, preparing or serving food, or handling utensils for residents or other staff while experiencing any of the following symptoms: Vomiting, diarrhea, fever, jaundice, or a lesion containing pus on the hands or wrists.

(A) Staff members experiencing these symptoms are permitted to return to handling food and utensils only when they have been symptom-free for at least 24 hours and/or the lesions on their hands are bandaged and completely covered with an impervious glove or finger cot.

Handwashing

16.8 The assisted living residence shall ensure that food handlers, cooks, and servers properly wash their hands using the following procedure:

(A) Wash hands in warm soapy water by vigorously scrubbing all surfaces of the hands and wrists for at least 20 seconds. Rinse hands clean. Thoroughly dry hands with a disposable paper towel. Use the paper towel to turn off sink faucets before disposing.

16.9 The assisted living residence shall ensure that food handlers, cooks, and servers always wash their hands at the following times:

(A) Before leaving the restroom, and again before returning to food or beverage preparation, food and food equipment storage areas, or dishwashing;

(B) After coughing, sneezing, using a handkerchief or tissue, using tobacco products, or eating;

(C) When switching between working with raw animal derived foods and ready-to-eat foods;

(D) After touching the hair, face, or body;

(E) During food preparation, as often as necessary to remove soil and contamination, and to prevent cross contamination when changing tasks;

(F) Before handling or putting on single use gloves for food handling, and between removing soiled gloves and putting on new, clean gloves;

(G) After handling soiled dishes or utensils, such as clearing tables or loading a dishwashing machine;

(H) After feeding or caring for a resident;

(I) After caring for pets or other animals; and

(J) After engaging in any activity that contaminates the hands such as handling garbage, mopping, working with chemicals, and/or other cleaning activities.

Employee Hygiene

16.10 The assisted living residence shall ensure that all staff members have good hygienic practices and wear clean clothing or protective coverings while handling food or utensils.

16.11 The assisted living residence shall prohibit staff members from using common towels and other multiple use linens or clothing to wipe or dry their hands. When hands become soiled, the ALR shall ensure that staff wash their hands in accordance with Part 16.8(A).

16.12 The assisted living residence shall ensure that staff members refrain from eating or smoking in the area used for food preparation or storage while food is being prepared.

16.13 Tasting food during preparation shall be done with a utensil that is clean and sanitized. The same utensil must be washed, rinsed, and sanitized before it is reused.

16.14 Utensils used to dispense food shall have handles. Utensil handles shall be kept out of food and ice. For example, scooping ice with a glass is prohibited.

Bare Hand Contact

16.15 Ready-to-eat foods shall not be handled with bare hands. Instead gloves or utensils must be used to handle, prepare, and serve these foods.

Proper Glove Use

16.16 When used, disposable food service gloves shall be used in a manner that prevents contamination of food and food contact surfaces. Gloves shall be changed whenever switching from handling raw animal products to ready-to-eat foods and when changing tasks or touching soiled surfaces. When gloves are changed, hands shall be washed in accordance with Part 16.8(A).

Approved Source

16.17 All foods, including raw ingredients and prepared foods, shall be obtained from approved, licensed, or registered sources or food manufacturers. Raw uncut produce can be obtained from other sources, including grown onsite, as long as good agricultural are used. Guidance for produce grown by a supplier or at an assisted living residence may be obtained from the Department of Public Health and Environment, Division of Environmental Health and Sustainability.

Prohibited Foods

16.18 Prohibited foods shall not be served by the assisted living residence. Prohibited foods include raw or undercooked meat, poultry, fish, and molluscan shellfish; raw unpasteurized eggs; raw milk and raw seed sprouts. Unpasteurized juice is also prohibited unless it is freshly squeezed and made to order.

16.19 Foods that pose a greater risk for the long-term care population include deli meats, hot dogs, and soft cheeses. These foods are allowed, but it is strongly recommended that they be heated before service to control Listeria monocytogenes, a particularly dangerous bacteria for older adults and immune compromised populations.

16.20 An assisted living residence shall not distribute or dispense raw milk products of any kind.

Date Marking

16.21 Refrigerated foods opened or prepared and not used within twenty-four (24) hours must be marked with a “use by” or “discard by” date. The “use by” or “discard by” date is seven (7) calendar days following opening or preparation. The seven (7) days cannot surpass the manufacturer’s expiration date for the product or its ingredients or seven (7) days since the date any of the ingredients in the food were opened or prepared. This requirement does not apply to commercially prepared condiments and dressings.

Required Cooking Temperatures

16.22 Animal derived foods; meat, poultry, fish, and unpasteurized eggs must be cooked to the minimum internal temperatures in the following table before being served or held hot.

Poultry (ground or intact), stuffed meats	165°F
Eggs, pork, lamb, fish	145°F
Ground beef, fish, pork, lamb, veal	155°F
Whole muscle beef steaks	145°F
Whole roasts (beef, lamb, pork)	135°F

Required Holding Temperatures

16.23 Potentially hazardous foods shall be maintained at the proper temperatures at all times. Potentially hazardous foods that are stored cold shall be held at or below 41°F. Assisted living residences can achieve this by keeping potentially hazardous foods in refrigerators maintained and running at 41°F or below.

16.24 Potentially hazardous foods that are stored hot shall be held at or above 135°F. Assisted living residences can achieve this by keeping soups, sauce, and other hot foods warm on a stove burner, in the oven, or on a warming plate at a temperature above 135°F until they are served, stored, or discarded.

16.25 When potentially hazardous foods are being prepared, cooled, or reheated, they shall not be held below 135°F or above 41°F for extended time to control the growth of harmful bacteria. Assisted

living residences can achieve this by not leaving these types of food out for long periods of time once they are purchased, while they are being prepared, or waiting to be served.

Rapid Reheating

16.26 Potentially hazardous foods that are being reheated from room temperature, such as opening a can, or from cold storage before hot holding shall be rapidly heated within two (2) hours to 165°F. Rapid heating can be accomplished on a stove top, in an oven, microwave, or another approved reheating device.

Rapid Cooling

16.27 Potentially hazardous foods that are being cooled from room temperature, such as after opening a can or preparing food from room temperature ingredients, shall be cooled to 41°F within four (4) hours.

16. 28 Following cooking or removal from hot storage, foods must be cooled within six (6) hours to 41°F. Begin active cooling foods when foods are 135°F. Cool to 70°F within two (2) hours or less. Then cool from 70°F to 41°F within four (4) hours or less. Active cooling means using uncovered shallow pans, ice as an ingredient, ice wands, breaking foods down into small portions and fully submerging containers in ice baths or a combination of these methods.

Food Preparation

16.29 When foods are being assembled or prepared outside of temperature control, the process should be completed as quickly as possible and no more than two (2) hours.

Thawing

16.30 Frozen foods shall be thawed under refrigeration, under cool, running water between 60-70°F, in a microwave oven, or as part of the cooking process.

16.31 Leaving food out to thaw without temperature control is prohibited.

Equipment

16.32 Equipment shall be maintained in working order and cleanable. Refrigeration equipment shall maintain foods below 41°F. Hot holding equipment must hold food at or above 135°F.

Cleaning and Sanitizing

16.33 Food contact surfaces of equipment shall be washed, rinsed, and sanitized before use or at least every four (4) hours of continual use. Dish detergent shall be labeled for the intended purpose. Sanitizer shall be approved for use as a no-rinse food contact sanitizer. Sanitizers shall be registered with EPA and used in accordance with labeled instructions.

Plumbing

16.34 A handwashing sink supplied with soap and disposable paper towels shall be available in all food handling areas.

16.35 Sinks shall be washed, rinsed, and sanitized when switching between food preparation or produce washing and thawing animal derived foods.

Dish Washing

16.36 Dishes, utensils, and cookware shall be washed using one of the following methods:

(A) In a single or multiple compartment sink using a dish detergent that is labeled for that intended purpose. Once washed, dishes and utensils shall be rinsed clean, and then submerged in an approved no-rinse food contact sanitizer and allowed to air dry. Sanitizer shall be registered with EPA and used in accordance with labeled instructions; or

(B) A domestic or commercial dishwashing machine with a wash water temperature that reaches the operating temperature prescribed by the manufacturer.

Mop Water

16.37 Mop water shall only be filled in a dedicated utility sink, a bath tub, or using a quick release hose attachment on another sink that is immediately removed and stored away from the sink after filling. Mop water shall be disposed in the sanitary sewer (e.g., toilet, bathtub, or utility sink). Mop water shall not be discarded on the ground outside or in a storm drain.

PART 17 – FOOD AND DINING SERVICES

Meals, Drinks and Snacks

17.1 The assisted living residence shall provide at least three meals daily, at regular times comparable to normal mealtimes in the community, or in accordance with resident needs, preferences, and plans of care.

(A) Nourishing meal substitutes and between-meal snacks shall be provided, in accordance with plans of care, to residents who want to eat at non-traditional times or outside of scheduled meal service times.

17.2 Meals shall include a variety of foods, be nutritionally balanced, and sufficient in amount to satisfy resident appetites.

(A) Appealing substitutes of similar nutritive value shall be available for residents who choose not to eat food that is initially served or who request an alternative meal.

17.3 The assisted living residence shall offer drinks, including water and other liquids, to residents with every meal and between meals throughout the day. The assisted living residence shall also ensure that residents have independent access to drinks at all times.

17.4 Assisted living residence staff shall observe resident food consumption on a regular basis in order to detect unplanned changes such as weight gain, weight loss, or dehydration. Changes in consumption that may indicate the need for assistance with eating shall be reported to the resident's practitioner and case manager, if applicable.

17.5 If a resident repeatedly chooses not to follow the dietary recommendations of his or her practitioner, the assisted living residence shall document such in the record or care plan and notify the resident's practitioner and case manager, if applicable.

Menus

17.6 Menus shall vary daily and incorporate seasonal and/or holiday foods.

17.7 Weekly menus shall be readily available for residents and public viewing no less than 24 hours prior to serving.

17.8 Residents shall be encouraged to participate in planning menus and the assisted living residence shall make reasonable efforts to accommodate resident suggestions.

Food Supply

17.9 Each assisted living residence shall have sufficient food on hand to prepare three nutritionally balanced meals per day for three (3) calendar days.

Therapeutic Diets

17.10 An assisted living residence may provide therapeutic diets when the following conditions are met:

(A) The diet is prescribed by the resident's practitioner, and

(B) The assisted living residence has trained staff to prepare the food in accordance with the diet and ensure it is being served to the appropriate resident.

Assistance with Dining and Feeding

17.11 If a resident demonstrates difficulty opening, reaching, or accessing food and beverage items at meal time, staff shall promptly assist that resident in doing so regardless of the resident's dining location.

17.12 Staff may assist residents by cueing and prompting them to eat and drink so long as that assistance is not undertaken for the convenience of staff.

17.13 Staff may assist feeding a resident only if the resident is able to maintain an upright position and chew and swallow without difficulty.

17.14 Staff who assist feeding a resident shall be trained in the proper techniques for supporting nutrition and hydration by a licensed or registered professional qualified by education and training to assess choking risks, such as a registered nurse, speech language pathologist, or registered dietitian.

(A) The assisted living residence shall not allow staff to assist feeding a resident if the resident has difficulty chewing and swallowing, or has a history of chronic choking or coughing while eating or drinking.

(B) If a resident who is receiving feeding assistance experiences a change in eating and swallowing that is a decline from baseline as identified in the individualized resident care plan, staff shall stop providing assistance, document the issue in the resident's record and ensure that the resident's practitioner is notified.

(1) Unless temporary measures are ordered by the practitioner, feeding assistance shall not be resumed until a medical evaluation has been performed and the assisted living residence has documentation from the practitioner that it is safe to resume.

Dining Area and Equipment

17.15 Each assisted living residence shall have a designated dining area with tables and chairs that all residents are able to access and that is sufficient in size to comfortably accommodate all residents. Residents shall be given the opportunity to choose where and with whom to sit.

17.16 No resident or group of residents shall be excluded from the designated dining area during meal time unless otherwise indicated in the resident's individualized care plan.

17.17 Meals shall not be routinely served in resident rooms unless otherwise indicated in the resident's individualized care plan. The assisted living residence shall, however, make reasonable efforts to accommodate residents that choose to dine somewhere other than the dining room.

17.18 The location of resident dining shall not be chosen solely for staff convenience.

17.19 Paper or disposable plastic ware shall not be used for regular meals with the exception of emergencies and outdoor dining.

PART 18 – RESIDENT HEALTH INFORMATION RECORDS

General

18.1 Each assisted living residence shall have a confidential health information record for each resident and maintain it in a manner that ensures accuracy of information.

18.2 Health information records for current residents shall be kept on site at all times.

18.3 Each assisted living residence shall implement a policy and procedure for an effective information management system that is either paper-based or electronic. If the ALR maintains both paper-based and electronic records, there shall be a method for integration of those records that allows effective continuity of care. Processes shall include effective management for capturing reporting, processing, storing and retrieving care/service data and information.

18.4 At the time of admission, the resident record shall contain, at a minimum, the following items:

(A) Face sheet,

(B) Practitioner orders,

(C) Individualized resident care plan,

(D) Copies of any advance directives, and

(E) A signed copy of the resident agreement.

Confidentiality and Access

18.5 The assisted living residence shall have a means of securing resident records that preserves their confidentiality and provides protection from loss, damage, and unauthorized access.

18.6 The confidentiality of the resident record including all medical, psychological, and sociological information shall be protected in accordance with all applicable federal and state laws and regulations.

18.7 Each resident or legal representative of a resident shall be allowed to inspect that resident's own record in accordance with Section 25-1-801, C.R.S. Upon request, resident records shall also be made available for inspection by the state and local long-term care ombudsman pursuant to Section 26-11.5-108, C.R.S., Department representatives and other lawfully authorized individuals.

Content

18.8 Resident records shall contain, but not be limited to, the following items:

(A) Face Sheet;

(B) Practitioner order;

(C) Individualized resident care plan;

(D) Progress notes which shall include information on resident status and wellbeing, as well as documentation regarding any out of the ordinary event or issue that affects a resident's physical, behavioral, cognitive and/or functional condition, along with the action taken by staff to address that resident's changing needs;

(1) The assisted living residence shall require staff members to document, before the end of their shift, any out of the ordinary event or issue regarding a resident that they personally observed, or was reported to them.

(E) Medication Administration Record;

(F) Documentation of on-going services provided by external service providers including, but not limited to, family members, aides, podiatrists, physical therapists, hospice and home care services, and other practitioners, assistants, and caregivers;

(G) Advance directives, if applicable, with extra copies; and

(H) Final disposition of resident including, if applicable, date, time, and circumstances of a resident's death, along with the name of the person to whom the body is released.

18.9 The face sheet shall be updated at least annually and contain the following information:

(A) Resident's full name, including maiden name, if applicable;

(B) Resident's sex, date of birth, and marital status;

(C) Resident's most recent former address;

(D) Resident's medical insurance information and Medicaid number, if applicable;

(E) Date of admission and readmission, if applicable;

(F) Name, address and contact information for family members, legal representatives, and/or other persons to be notified in case of emergency;

(G) Name, address, and contact information for resident's practitioner and case manager, if applicable;

(H) Resident's primary spoken language and any issues with oral communication;

(I) Indication of resident's religious preference, if any;

(J) Resident's current diagnoses; and

(K) Notation of resident's allergies, if any.

Record Transfer and Retention

18.10 If a resident's care is transferred to another health facility or agency, a copy of the face sheet, individualized resident care plan, and medication administration record for the current month shall be transferred with the resident.

18.11 If an assisted living residence ceases operation, each resident's records must be transferred to the licensed health facility or agency that assumes that resident's care.

18.12 Records of former residents shall be complete and maintained for at least three (3) years following the termination of the resident's stay in the assisted living residence.

18.13 Such records shall be maintained and readily available at the assisted living residence location for a minimum of six (6) months following termination of the resident's stay.

PART 19 – INFECTION CONTROL

Education

19.1 The assisted living residence shall have an infection control program that provides initial and annual staff training on infection prevention and control. Such training shall cover, at a minimum, the following items:

(A) Modes of infection transmission;

(B) The importance of hand washing and proper techniques;

(C) Use of personal protective equipment, including proper use of disposable gloves; and

(D) Cleaning and disinfection techniques.

Policies and Procedures

19.2 The assisted living residence shall have and follow written policies and procedures that address the transmission of communicable diseases with a significant risk of transmission to other persons and for reporting diseases to the state and/or local health department, pursuant to 6 CCR 1009-1, Epidemic and Communicable Disease Control.

(A) The policies and procedures shall be based on nationally recognized guidelines, such as those promulgated by the Centers for Disease Control (CDC), World Health Organization (WHO), or the Association for Professionals in Infection Control and Epidemiology (APIC), and comply with guidance from the Colorado Department of Public Health and Environment, as applicable.

(1) The policies shall identify the nationally recognized guidelines and Department guidance upon which the policies are based.

19.3 The policies and procedures shall include at a minimum, all of the following criteria:

(A) The method for monitoring and encouraging employee wellness,

(B) The method for tracking infection patterns and trends and initiating a response,

(C) The method for determining when to seek assistance from a medical professional and/or the local health department,

(D) Isolation techniques, and

(E) Appropriate handling of linen and clothing of residents with communicable infections.

Infectious Waste Management

19.4 Any item containing blood, body fluid, or body waste from a resident with a contagious condition shall be presumed to be infectious waste and shall be disposed of in the room where it is used into a sturdy plastic bag, then re-bagged outside the room and disposed of consistent with the medical waste disposal requirements at Parts 24.2 and 24.3.

PART 20– PHYSICAL PLANT STANDARDS

20.1 An assisted living residence shall conform to the standards in Part 3 of 6 CCR 1011-1, Chapter 2, unless otherwise modified in this Chapter 7.

20.2 An assisted living residence seeking an initial license, or a licensed assisted living residence undergoing an addition, renovation, or construction that triggers a compliance review in accordance with Part 3 of 6 CCR 1011-1, Chapter 2, shall comply with the FGI requirements in that Part 3, except as follows:

(A) Assisted living residences are subject only to Part 1, any cross-referenced Part 2 systems, and Part 4.1 of the Guidelines for Design and Construction of Residential Health, Care and Support Facilities, Facility Guidelines Institute (FGI).

(B) The number of parking spaces to be provided by the assisted living residence shall be based solely on local requirements and the functional need of the resident population.

(C) Assisted living residences that are located in single-family residential neighborhoods and are operating in structures designed to be single-family homes shall be exempt from compliance with FGI Guidelines that each resident have access to a bathroom without entering a corridor and that the building have an elevator that is sized to accommodate a gurney and/or medical carts.

PART 21 – EXTERIOR ENVIRONMENT

21.1 The assisted living residence grounds shall be kept free of high weeds, garbage, and rubbish.

21.2 The assisted living residence grounds shall be maintained to protect residents from slopes, holes or other hazards, and shall be consistent with any landscape plan approved by the local jurisdiction.

21.3 Exterior stairs shall be lighted at night.

21.4 Porches, stairs, handrails, and ramps shall be maintained in good repair.

21.5 For new construction or renovation, porches and exterior areas with more than one step within a six-foot linear run shall have a handrail in addition to the requirements of Part 20.2.

PART 22 – INTERIOR ENVIRONMENT

General

22.1 All interior areas including attics, basements, and garages shall be free from accumulations of extraneous material such as refuse, unused or discarded furniture, and potential combustible materials.

22.2 Combustibles such as cleaning rags and compounds shall be kept in closed metal containers.

22.3 Cleaning compounds and other hazardous substances (including products labeled "Keep out of reach of children" on their original containers) shall be clearly labeled to indicate contents and (except when a staff member is present) shall be stored in a location sufficiently secure to deny access to confused residents.

(A) The ALR shall maintain a readily available list and the safety data sheet of potentially hazardous substances used by housekeeping and other staff.

(B) Utility rooms used for storing disinfectants and detergent concentrates, caustic bowl and tile cleaners, and insecticides shall be locked.

22.4 Designated areas where smoking is allowed shall be equipped with fire resistant wastebaskets. Resident rooms occupied by smokers, even when house rules prohibit smoking in resident rooms, shall have fire resistant wastebaskets.

Heating, Lighting and Ventilation

22.5 Each room shall have heat, lighting, and ventilation sufficient to meet the use of the room and the needs of the residents.

22.6 All interior stairs and corridors shall be adequately lighted.

Water

22.7 There shall be an adequate supply of safe, potable water available for domestic purposes.

22.8 There shall be a sufficient supply of hot water during peak usage demand.

22.9 Hot water shall not measure more than 120 degrees Fahrenheit at taps which are accessible by residents.

Common Areas

22.10 Common areas shall be sufficient in size to reasonably accommodate all residents.

22.11 All common and dining areas shall be accessible to a resident using an auxiliary aid without requiring transfer from a wheelchair to walker or from a wheelchair to a stationary chair for use in the dining area. All doors to those rooms requiring access shall be at least 32 inches wide.

22.12 An assisted living residence that has one or more residents using an auxiliary aid shall have a minimum of two means of access and egress from the building unless local code requires otherwise.

Sleeping Room

22.13 No resident shall be assigned to reside in any room other than one regularly designated for sleeping.

22.14 No more than two residents shall occupy a sleeping room.

(A) An assisted living residence initially licensed prior to July 1, 1986, is permitted to have up to four residents per room unless the ALR undertakes renovation or changes ownership, at which time the newer, more stringent requirement shall apply.

22.15 Sleeping rooms, exclusive of bathroom areas and closets, shall have the following minimum square footage:

(A) 100 square feet for single occupancy, and

(B) 60 square feet per person for double occupancy.

22.16 Each resident shall have storage space, such as a closet, for clothing and personal articles.

22.17 Each sleeping room shall have at least one window of 8 square feet which shall have opening capability.

(A) An assisted living residence initially licensed prior to January 1, 1992, is permitted to have a window of smaller dimensions unless the ALR undertakes renovation or changes ownership, at which time the newer, more stringent requirement shall apply.

22.18 In assisted living residences that provide furnishings for residents pursuant to a resident agreement, each resident shall be provided, at a minimum, with the following items:

(A) A standard-sized bed with a comfortable, clean mattress~~,~~; mattress protector, pad, and pillow (Rollaway type beds, cots, folding beds, futons, or bunk beds are prohibited); and

(B) A standard-sized chair in good condition.

Bathroom

22.19 There shall be at least one full bathroom for every six residents.

22.20 A full bathroom shall contain the following:

(A) Toilet,

(B) Hand-washing station,

(C) Mirror,

(D) Private individual storage for resident personal effects, and

(E) Shower.

22.21 All bathtubs and shower floors shall have proper safety features to prevent slips and falls.

22.22 Toilet seats shall be constructed of non-absorbent material and free of cracks.

22.23 Each assisted living residence shall provide toilet paper in each resident bathroom, except where a resident has a specific preference and agrees to supply it.

22.24 Toilet paper in a dispenser, liquid soap, and paper towels or hand drying devices shall be available at all times in each common bathroom.

22.25 In an assisted living residence that has one or more residents using auxiliary aids, the assisted living residence shall provide at least one full bathroom with fixtures positioned so that they are fully accessible to any resident utilizing an auxiliary aid.

22.26 Grab bars shall be properly installed at each tub and shower, and adjacent to at least one toilet in every multi-stall toilet room in an assisted living residence if any resident uses an auxiliary aid or as otherwise indicated by the needs of the resident population.

(A) When residents can undertake independent transfers, alternative grab bar configurations are permitted.

Heating Devices

22.27 The assisted living residence shall prohibit the use of portable heaters in resident rooms. The use of fireplaces, space heaters, and like units that generate heat shall be prohibited in the common areas of the assisted living residence unless the ALR is able to ensure that such devices have a UL (Underwriters Laboratory) or similar certification label, do not present a resident burn risk, and are used in accordance with manufacturer instructions.

22.28 The assisted living residence shall prohibit the use of electric blankets and/or heating pads in resident rooms unless there is staff supervision or written documentation that the administrator has assessed the resident and determined he or she is capable of using such device in a safe and appropriate manner.

Oxygen Use, Handling and Storage

22.29 The assisted living residence's handling and storage of oxygen shall comply with all applicable local, state, and federal requirements.

22.30 The assisted living residence shall prohibit smoking in areas where oxygen is stored and/or used and shall post a conspicuous "No Smoking" sign in those areas.

22.31 The assisted living residence shall ensure that oxygen tanks are not rolled on their side or dragged.

22.32 The assisted living residence shall ensure that oxygen tanks are secured upright at all times in a manner that prevents tanks from falling over, being dropped, or striking each other.

22.33 Oxygen tank valves shall be closed except when in use.

22.34 The assisted living residence shall ensure that oxygen tanks are not placed against electrical panels, live electrical cords, or near radiators or heat sources. If stored outdoors, tanks shall be protected from weather extremes and damp ground to prevent corrosion.

Smoking

22.35 Assisted living residences shall comply with the Colorado Clean Indoor Air Act at Sections 25-14-201 through 25-14-209, C.R.S.

22.36 Designated outdoor smoking areas shall be monitored whenever residents are present.

22.37 Designated outdoor smoking areas shall have fire resistant waste disposal containers.

Cooking

22.38 Cooking shall not be permitted in sleeping rooms.

22.39 Residents shall have access to an alternative area where minimal food preparation is permitted.

22.40 In assisted living residences where residents have dwelling units rather than simply sleeping rooms, cooking may be allowed in accordance with house rules.

(A) Only residents who are capable of cooking safely shall be allowed to do so and the assisted living residence shall document such assessment.

(B) If cooking equipment is present in dwelling units, the assisted living residence shall have a definitive way of disabling such equipment if they become unsafe for residents to use.

Electrical Equipment

22.41 Electrical socket adaptors or connectors designed to multiply outlet capacity shall be prohibited.

22.42 Extension cords are permitted for temporary use only.

22.43 Power strip surge protectors are permitted throughout the assisted living residence with the following limitations:

(A) The power strip shall have overcurrent protection in the form of a circuit breaker or fuse,

(B) The power strip shall have a UL (underwriters laboratories) or similar certification label, and

(C) Power strips shall not be linked together.

Personal Electric Appliances

22.44 Personal electric appliances are allowed in resident rooms only if the following criteria are met:

(A) Such appliances do not require the use of an extension cord or multiple use electrical sockets,

(B) Such appliance is in good repair as evaluated by the administrator or designee, and

(C) There is written documentation that the resident has been assessed and determined to be capable of using such appliance in a safe and appropriate manner.

PART 23 – ENVIRONMENTAL PEST CONTROL

23.1 The assisted living residence shall have written policies and procedures that provide for effective control and eradication of insects, rodents, and other pests.

23.2 The assisted living residence shall have a contract with a licensed pest control company or an effective means for pest control using the least toxic and least flammable effective pesticides. The

pesticides shall not be stored in resident or food areas and shall be kept under lock and only properly trained responsible personnel shall be allowed to apply them.

23.3 Screens or other pest control measures shall be provided on all exterior openings except where prohibited by fire regulations. Assisted living residence doors, door screens, and window screens shall fit with sufficient tightness at their perimeters to exclude pests.

PART 24 – WASTE DISPOSAL

Sewage and Sewer Systems

24.1 All sewage shall be discharged into a public sewer system, or if such is not available, disposed of in a manner approved by the State and local health authorities and the Colorado Water Quality Control Commission.

(A) When private sewage disposal systems are in use, records of maintenance and the system design plans shall be kept on the premises.

(B) No unprotected exposed sewer line shall be located directly above working, storage, or eating surfaces in kitchens, dining rooms, pantries, food storage rooms, or where medical or nursing supplies are prepared, processed, or stored.

Medical Waste

24.2 Assisted living residences shall not transport, manage, or dispose of medical waste unless in accordance with the 6 CCR 1007-2, Part 1, Regulations Pertaining to Solid Waste Disposal Sites and Facilities, Section 13, Medical Waste.

24.3 Assisted living residences that generate waste including medical waste shall make a hazardous waste determination in accordance with Part 262 of the state hazardous waste regulations at 6 CCR 1007-3. If the facility generates hazardous waste, it shall manage, transport and dispose of such waste in accordance with 6 CCR 1007-3.

Refuse

24.4 All garbage and rubbish that is not disposed of as sewage shall be collected in impervious containers in such manner as not to become a nuisance or a health hazard and shall be removed to an outside storage area at least once a day.

(A) The refuse storage area shall be kept clean, and free from nuisance.

(B) A sufficient number of impervious containers with tight fitting lids shall be provided, and kept clean and in good repair.

(C) Carts used to transport refuse shall be constructed of impervious materials, enclosed, used solely for refuse and maintained in a sanitary manner.

PART 25 – SECURE ENVIRONMENT

25.1 An assisted living residence may choose to provide a secure environment as that term is defined in Part 2. A secure environment, which may be provided throughout an entire assisted living residence, or in a distinct part of an assisted living residence, shall comply with Parts 1 through 24 of this chapter, in addition to the requirements in this Part 25.

25.2 An assisted living residence that uses any methods or devices to limit, restrict, or prohibit free egress of one or more residents to move unsupervised outside of the ALR or any separate and distinct part of the ALR shall comply with this section regarding secure environment.

25.3 An assisted living residence with a secure environment shall include all the services provided in an unsecured environment plus any additional services specified in this Part 25.

Written Disclosure

25.4 In addition to the information listed in Part 11.7(A) through (K), an assisted living residence shall also disclose the following information to each potential resident and his or her legal representative before such individual moves into a secure environment:

(A) The criteria for admission including the types of required assessments used to determine unique resident needs,

(B) The location of the secure environment and the methods of restrictions that are used,

(C) How the safety of residents is monitored within the building and the outdoor area, and

(D) Information on any specialty services such as memory care and/or special care services, including, but not limited to, a description of daily engagement opportunities.

Pre-Admission Assessment

25.5 Before an individual moves in, the assisted living residence shall complete a pre-admission assessment to determine the appropriateness and need for secure environment residency. The pre-admission assessment shall include all the items required for the comprehensive assessment in Part 12.7(A) through (M), plus the following:

(A) An evaluation by a licensed practitioner which has occurred within the previous ninety (90) calendar days and which describes the resident's medical condition and any cognitive deficits that contribute to wandering, compromised safety awareness, and other types of conduct; and

(B) Detailed information from the resident's family and/or representative concerning the resident's recent relevant history and patterns of reduced safety awareness and wandering, along with any strategies used to prevent unsafe wandering or successful exiting, and any other known types of conduct.

Resident Admission

25.6 No individual shall be required to move into a secure environment against their will unless legal authority for the admission of the individual has been established by guardianship, court order, medical durable power of attorney, health care proxy, or other means allowed by Colorado law.

25.7 An individual may voluntarily agree to reside in a secure environment even though his or her physical or psychosocial status does not require such placement. In such circumstances, the assisted living residence shall assure that the resident has freedom of movement inside and outside of the secure environment at all times and that there is a signed resident agreement to that effect.

25.8 Once a resident moves into a secure environment, the assisted living residence shall comply with the following:

(A) The assisted living residence shall evaluate a resident when the resident expresses the desire to move out of a secure environment, and contact the resident's legal representative, practitioner, and the state and local long-term care ombudsman, when appropriate;

(B) The assisted living residence shall ensure that admission to and continuing residence in a secure environment is the least restrictive alternative available and is necessary for the physical and psychosocial well-being of the resident; and

(C) If at any time a resident is determined to be a danger to self or others, the assisted living residence shall be responsible for developing and implementing a temporary plan to monitor the resident's safety along with the protection of others until the issue is appropriately resolved and/or the resident is discharged from the assisted living residence.

Re-Assessment

25.9 Each resident shall be re-assessed to determine his or her continued need for a secure environment every six (6) months and whenever the resident's condition changes from baseline status.

(A) As part of the secure environment re-assessment, the assisted living residence shall consult with the resident's attending practitioner, family, and/or resident's representative and review service documentation dating back to the most recent comprehensive assessment.

Enhanced Resident Care Plan

25.10 In addition to the information required for a resident care plan at Part 12.10, the care plan for each resident in a secure environment shall include the following:

(A) A description of the resident's wandering patterns and known behavioral expressions, along with individualized approaches to be implemented by staff to protect the resident and other residents with whom they have contact;

(B) A description of how the resident will have continuous independent access to his or her individual room, along with the ALR's plan to protect the resident from unwanted visitation by other residents;

(C) Identification of the type and level of staff oversight, monitoring, and/or accompaniment that the ALR deems necessary to meet the needs of the resident within the secure environment and secure outdoor area; and

(D) Documentation describing the personal grooming and hygiene items that are determined safe for the resident to have in their own possession for self-care, and how those items are stored to prevent unauthorized access by other residents.

25.11 The enhanced resident care plan shall be updated to reflect changes in the staff approach to meeting resident needs and when any medical assessment, appraisal, or observations indicate the resident's care needs have changed.

Staff Training

25.12 The assisted living residence shall have a policy and procedure regarding the training of staff who provide services in a secure environment. The policy shall include, at a minimum, information on

the appropriate staff response when there is a missing resident or resident incident/altercation, along with distribution of staff when responding to such an event to ensure that there is sufficient staff presence for the continued supervision of other residents.

25.13 In addition to the training requirements in Part 7.9, staff assigned to a secure environment shall receive training and education on assisted living residence policies and procedures specific to the secure environment resident care, services, and protections. Such training shall include, at a minimum, the following:

(A) Information on the secure environment that identifies and describes the areas where residents have free passage, where passage may be restricted, and where passage is prohibited;

(B) Information regarding the current mobility status of all residents so that staff are prepared to successfully evacuate all residents in the event of an emergency;

(C) Information on the location of the storage area which is not accessible to residents including a description of what items or contents are required to be kept in the storage area; and

(D) Information on the equipment and devices used to secure the environment, including how to override or disarm such devices, along with expectations for response if staff are alerted to an alarm.

25.14 Before a staff member is allowed to work independently in the secure environment, the assisted living residence shall provide each staff member with training and education on the provision of care and services for the specific population in the assisted living residence.

(A) At a minimum, the individual shall be trained on the care plan for each resident to which the individual could provide care given the staff member's assigned duties and responsibilities. Such training shall be documented.

25.15 Within sixty (60) days, the assisted living residence shall provide each staff member a minimum of six (6) hours of general training and education on providing care and services for residents with dementia/cognitive impairment.

(A) The training may be provided over several sessions.

(B) The training shall be provided through structured, formalized classes, correspondence courses, competency-based computer courses, training videos, or distance learning programs.

(C) The training content shall be provided or recognized by an academic institution, a recognized state or national organization or association, or an independent contractor or group that emphasizes dementia/cognitive impairment care.

(D) The training shall cover, at a minimum, the following topics:

(1) Information on disease processes associated with dementia and cognitive impairment, including progression of the diseases, types and stages of memory loss, family dynamics, behavioral symptoms and limitations to normal activities of daily living;

(2) Information on non-pharmacological techniques and approaches used to guide and support residents with dementia/cognitive impairment, wandering, and socially challenging behavioral expressions of need or distress;

(3) Information on communication techniques that facilitate supportive and interactive staff-resident relations;

(4) Positive therapeutic approaches and activities such as exercise, sensory stimulation, activities of daily living and social, recreation, and rehabilitative activities;

(5) Information on recognizing physical symptoms that may cause a change in dementia/cognitive impairment such as dehydration, infection, and swallowing difficulty; along with individualized approaches to assist or address associated symptoms such as pain, decreased appetite and fluid intake, and/or isolation; and

(6) Benefits and importance of person-centered care planning and collaborative approaches to delivery of care.

25.16 The assisted living residence shall ensure that each staff member assigned to the secure environment is trained on the care plan for each new resident that is part of the individual's assigned duties and responsibilities.

Staffing

25.17 The assisted living residence shall have a sufficient number of trained staff members on duty in the secure environment to ensure each resident's physical, social, and emotional health care and safety needs are met in accordance with their individualized care plan.

25.~~7~~8 The assisted living residence shall consider the day to day resident needs and activity, including the intensity of staff assistance, on an individual resident basis to determine the appropriate level of staffing. At a minimum, there shall be one trained, awake staff member on duty at all times.

25.19 Staff members shall be familiar with each resident's specific care-planned needs and the unique approaches for assisting with care and safety.

Care and Services

25.20 In addition to the requirements for resident care services in Part 12, each assisted living residence with a secure environment shall establish policies and procedures for the delivery of resident care and services that include, at a minimum, the following:

(A) A system or method of accounting for the whereabouts of each resident;

(B) The system or method staff members are to use for observation, identification, evaluation, individualized approach to and documentation of resident behavioral expression; and

(C) Assistance with the transition of residents to and from the secure environment and when changing rooms within a secure environment.

25.21 Residents who indicate a desire to go outside the secured area shall be permitted to do so with staff supervision except in those situations where it would be detrimental to the resident's health, safety or welfare.

(A) If the assisted living residence is aware of an ongoing issue or pattern of behavioral expression that would be exacerbated by allowing a resident to go outside the secure area, it shall be documented in the resident's enhanced, individualized care plan.

Family Council

25.22 The assisted living residence shall meet the requirements of Part 13.10 regarding the internal grievance and complaint resolution process. In addition, the assisted living residence shall hold regular meetings to allow residents, their family members, friends, and representatives to provide mutual support and share concerns and/or recommendations about the care and services within each separate secure environment.

(A) Such meetings shall be held at least quarterly, at a place and time that reasonably accommodates participation; and

(B) The assisted living residence shall provide adequate advance notice of the meeting and ensure that details regarding any meeting are readily available in a common area within the secure environment.

Resident Rights

25.23 The assisted living residence shall ensure that residents in a secure environment have all the same resident rights as set forth in Part 13 of this chapter including, but not limited to, the right to privacy and confidentiality.

Discharge

25.24 The assisted living residence shall follow the requirements of Parts 11.11 through 11.17 regarding resident discharge when moving a resident out of a secure environment unless the move is voluntarily initiated by the resident's legal representative.

Physical Design, Environment and Safety

25.25 The assisted living residence shall ensure that residents have freedom of movement to common areas and resident personal spaces.

25.26 A secure environment shall meet the following criteria:

(A) There shall be a multipurpose room for dining, group and individual activities, and family visits;

(B) Resident access to appliances shall only be allowed with staff supervision;

(C) There shall be a storage area which is inaccessible to residents for storage of items that could pose a risk or danger such as chemicals, toxic materials, and sharp objects;

(D) The corridors and passageways shall be free of objects or obstacles that could pose a hazard;

(E) There shall be documentation of routine monthly testing of all equipment and devices used to secure the environment; and

(F) There shall be a secure outdoor area that is available for resident use year-round that:

(1) Is directly supervised by staff,

(2) Is independently accessible to residents without staff assistance for entrance or exit,

(3) Has comfortable seating areas,

(4) Has one or more areas that provide protection from weather elements, and

(5) Has a fence or enclosure around the perimeter of the outdoor area that is no less than six (6) feet in height and constructed to reduce the risk of resident wandering or elopement from the area.

(a) If the fence or enclosure has gated access which is locked, all staff assigned to the secure environment shall have a readily available means of unlocking the gate in case of emergency.

PHILIP J. WEISER
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Office of the Attorney General

Tracking number: 2020-00849

Opinion of the Attorney General rendered in connection with the rules adopted by the

State Board of Health

on 12/16/2020

6 CCR 1011-1 Chapter 07

CHAPTER 7 - ASSISTED LIVING RESIDENCES

The above-referenced rules were submitted to this office on 12/18/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 30, 2020 09:49:04

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of State

Agency

Secretary of State

CCR number

8 CCR 1505-11

Rule title

8 CCR 1505-11 NOTARY PROGRAM RULES 1 - eff 01/30/2021

Effective date

01/30/2021

COLORADO SECRETARY OF STATE

[8 CCR 1505-11]

NOTARY PROGRAM RULES

Rules as Adopted - Clean

December 1, 2020

(*Publication instructions/notes* may be included):

Amendments to 8 CCR 1505-11:

[New Rule 2.1.1]

2.1.1 An applicant must put his or her legal name on applications and renewals. The first and last name must match the name on the applicant's government-issued identification. If the last name on the identification contains more than one name, the applicant must include all of those names in the last name field on the application and not abbreviate any part.

[Not shown: current Rules 2.1.1 through 2.1.6 are renumbered as Rules 2.1.2 through 2.1.7]

[New Rule 2.3]

2.3 Communication

2.3.1 A notary public must be able to communicate directly with, be understood by, and understand the individual for whom the notary public is performing a notarial act.

2.3.2 A notary public may not use a translator or translator services to communicate with the individual for whom the notary public is performing a notarial act. This prohibition applies to all methods of notarization, including electronic and remote notarization, authorized by The Revised Uniform Law on Notarial Acts (Title 24, Article 24, Part 5, C.R.S.).

[Current Rule 3.3.2 is amended.]

3.3.2 A certificate of successful completion of an approved course of instruction expires 90 days from the date of issuance.

[Current Rule 3.3.3 is amended.]

3.3.3 The certificate of proof of successful completion of an approved course of

instruction must contain:

(a) The name of the vendor or course provider who provided the course;

(b) The name of the person who completed the course;

(c) The date of completion of the course;

(d) The statement, “This certificate of proof of completion is valid for a period of 90 days from the date of issuance.”; and

(e) For vendors, the seal of accreditation.

[New Rule 5]

Rule 5. Remote Notarization

5.1 Definitions

As used in the Revised Uniform Law on Notarial Acts (Title 24, Article 21, Part 5, C.R.S.) and this Rule 5, unless otherwise stated:

5.1.1 “Personal information” means any information or data that is collected or used in order to complete the transaction subject to remote notarization or in the remote notarization itself. The term includes but is not limited to data included in the electronic record that is being remotely notarized.

5.1.2 “Provider” refers collectively to both remote notarization system providers and remote notarization storage providers.

5.1.3 “Remote notarization system provider” means a business entity that provides a remote notarization system, as defined in section 24-21-502(11.7), C.R.S., that includes storage of both the notarized electronic records and the audio-video recordings required by section 24-21-514.5(9)(a), C.R.S.

5.1.4 “Remote notarization storage provider” means a business entity that solely provides storage of notarized electronic records and the audio-video recordings required by section 24-21-514.5(9)(a), C.R.S.

5.2 Requirements for Remote Notaries

5.2.1 Application

(a) A notary public must submit a notice of intent on the approved application form and receive approval from the Secretary of State before the notary can remotely notarize a document. The notary must submit proof of successful completion of remote notarization training and examination and the required fee.

(b) A notary public must already be commissioned as a Colorado notary public with Active status to be approved as a remote notary.

(c) An individual may file the notice of intent when initially applying to become a Colorado notary public but may only remotely notarize a document after being commissioned and approved.

(d) A remote notary public must renew every four years or until his or her regular notary public commission requires renewal, whichever date comes first. No more than 90 days before renewing his or her remote notary status, the remote notary public must successfully complete the renewal training, pass the required exam, and pay the required fee.

(e) In applying to become a remote notary public or upon renewal, the individual must select at least one approved remote notarization system provider. An applicant may select multiple approved system providers.

5.2.2 Approved Course of Instruction/Examination

(a) The Secretary will provide a remote notarization training course and examination.

(b) If the Secretary determines that there is a need for additional instructors, the Secretary may designate a third-party training course or appoint certified notary public instructors to administer the remote training course and testing for applicants.

5.2.3 Requirements for Remote Notary Public Seal and Electronic Signature

(a) Form of remote notary public seal and electronic signature

(1) A remote notary public must affix to an electronic record a seal that in both appearance and content matches the manually applied official stamp required by section 24-21-517, C.R.S.

(2) The electronic signature used by the remote notary public for remote notarizations must match in appearance the image of the signature that the remote notary public submitted to the Secretary of State for and is on file as the notary's most recent underlying commission as a Colorado notary public. This is the signature identified as the notary public's "official signature" on the notary's most recent affirmation form or on the notary's most recent signature change form, whichever was filed later. A remote notary public may not use the remote notarization application or any update form to change the notary's official signature.

(b) Use of and access to remote notary public's seal and electronic signature

(1) The remote notary's seal and electronic signature must:

(A) Be retained under the remote notary public's sole control and access through the authentication required by Rule 5.3.3 (a)(4).

(B) Appear as images on any visual or printed representation of a remote notarial certificate regardless of the technology being used to affix the images; and

(C) Be attached or logically associated with both the electronic record being notarized and the certificate of notarial act being affixed and linked such that any subsequent alteration to either item is observable through visual examination, i.e., the document must be rendered tamper-evident.

(2) A remote notary public's employer, including the employer's employees and agents, must not use or permit the use of a remote notary's seal or electronic signature by anyone except the remote notary public.

(3) On resignation from or the revocation of the notary public's commission or on the death or adjudication of incompetency of the notary public, the notary or that notary's personal representative or guardian must delete the notary's seal and electronic signature from the remote notary system provider's system.

5.2.4 Journal to record remote notarizations

(a) In addition to the journal information required by section 24-21-519(3), C.R.S., the remote notary public must record the name of the remote notarization system provider used for each remote notarization.

(b) The remote notary public must retain his or her electronic journal under the remote notary public's sole control and access and all other requirements of section 24-21-519, C.R.S. apply.

(c) The electronic journal must be securely backed up and be tamper-evident.

(d) On resignation from or the revocation of the notary public's commission or on the death or adjudication of incompetency of the notary public, the notary or that notary's personal representative or guardian with knowledge of the existence of or knowingly in possession of the remote notarization journal and recordings must retain or dispose of the journal and the audio-video recordings in accordance with sections 24-21-514.5(9)(c) and 24-21-519, C.R.S. Only remote notarization system

providers and remote notarization storage providers that have been approved by the Secretary of State may store audio-video recordings.

5.2.5 A remote notary public must stop and restart the remote notarization process from the beginning if:

(a) The remotely located individual or the remote notary public must exit the remote notarization system before completion of the notarial act;

(b) The audio or visual feed is interrupted or terminated; or

(c) The resolution or quality of the transmission becomes such that the remote notary public believes the process has been compromised and cannot be completed.

5.2.6 A remote notary public has an ongoing duty to verify that each remote notary provider used has Active status with the Secretary of State's office before using that provider's remote notarization system to perform a remote notarization. This duty extends to each remote notarization.

5.2.7 In accordance with section 24-21-529(2), C.R.S., a remote notary may charge a fee, not to exceed ten dollars, for the notary's electronic signature.

5.2.8 A remote notary public must notify the Secretary of State in writing through the Secretary of State's online system within 30 days after changing a remote notarization system provider or remote notarization storage provider.

5.2.9 Expiration of the Secretary of State's approval to perform remote notarizations:

(a) Approval automatically expires:

(1) Upon revocation, expiration, or resignation of the notary's commission;

(2) 30 days after the notary's name changes unless the notary previously submitted a name change.

(3) Upon conviction of a felony;

(4) Upon conviction of a misdemeanor involving dishonesty;

(5) If the notary no longer has a place of employment or practice or a residential address in the state of Colorado; or

(6) Upon the revocation of approval of the remote notarization system provider or the remote notarization storage provider used by the remote notary public unless the remote notary public either notified the Secretary of State of another provider or already has alternative providers on file with the Secretary of

State as authorized by Rule 5.2.1(e).

(b) If approval expires, the remote notary public or the notary's authorized representative must delete the notary's seal and electronic signature from the remote notary provider's system and dispose of the journal and the audio-video recordings in accordance with sections 24-21-514.5(9)(c) and 24-21-519, C.R.S. unless within 30 days of the expiration, the Secretary of State reapproves the notary.

5.3 Requirements for providers

5.3.1 Provider Protocols

(a) The Colorado Secretary of State's Provider Protocols (December 1, 2020) are hereby incorporated by reference.

(1) Material incorporated by reference in the Notary Rules does not include later amendments or editions of the incorporated material.

(2) Copies of the material incorporated by reference may be obtained by contacting the Colorado Department of State, 1700 Broadway, Suite 550, Denver, CO 80290, (303) 894-2200. Copies are also available online at https://www.sos.state.co.us/pubs/notary/home.html

(b) All providers must meet the requirements of the Provider Protocols.

5.3.2 Application

(a) A provider must submit the approved application form and receive approval from the Secretary of State before the provider can provide services to a Colorado remote notary public.

(b) The applicant must provide to the Secretary of State in its application:

(1) The certification required by section 24-21-514.5 (11)(a), C.R.S.

(2) The following information:

(A) The names of all business entities and any of their affiliates that will have access to either personally identifying information and any non-personally identifying data gathered during the remote notarization process and procedures; and

(B) A copy of the data privacy policy provided to users, which clearly specifies the permissible uses for both personally identifying and non-personally identifying

data.

(3) All data and technology specifics required in the application and set forth in the Provider Protocols under Rule 5.3.1.

(c) At the time of application, the applicant must be in Good Standing status as a business entity registered to do business in Colorado and must continue to maintain that status while providing remote notarization services to Colorado remote notaries public.

(d) The Secretary of State may require an applicant to supplement its application with additional information, including an in-person demonstration or electronic demonstration of the applicant's system.

(e) The applicant must pay the required application fee.

5.3.3 Criteria and standards for approval of remote notarization system providers.

(a) In order to be approved and maintain continuing eligibility, a remote notarization system provider must:

(1) Provide a remote notarization system that complies with the technical specifications of these rules and the standards, including data security and integrity requirements, set forth in the Secretary of State's Provider Protocols under Rule 5.3.1;

(2) Verify the authorization of a Colorado notary public to perform remote notarial acts before each remote notarization;

(3) Suspend the use of its remote notarization system for any remote notary public if the notary's underlying commission or the Secretary of State's approval of the notary public to perform remote notarizations has been denied, suspended, or revoked by the Secretary or when the notary has resigned; and

(4) Ensure that access to a remote notary public's electronic signature and seal is limited solely to the remote notary public and protected by the use of a password authentication, token authentication, biometric authentication, or other form of authentication that is described in the remote notarization system provider's application.

(5) Verify that a Colorado remote notary public has Active status with the Secretary of State's office at the time of each remote notarization.

(b) Communication technology provided by the remote notarization system provider must:

(1) Provide for continuous, synchronous audio-visual feeds;

(2) Provide sufficient video resolution and audio clarity to enable the remote notary public and the remotely located individual to see and speak to one another simultaneously through live, real time transmission;

(3) Provide sufficient captured image resolution for credential analysis to be performed in accordance with section 24-21-514.5(6)(b)(II), C.R.S., and this Rule 5;

(4) Include a means of authentication that reasonably ensures only the proper parties have access to the audio-video communication;

(5) Be capable of securely creating and storing or transmitting securely to be stored an electronic recording of the audio-video communication, keeping confidential the questions asked as part of any identity proofing assessment, and the means and methods used to generate the credential analysis output; and

(6) Provide reasonable security measures to prevent unauthorized access to:

(A) The live transmission of the audio-video communication;

(B) A recording of the audio-video communication;

(C) The verification methods and credentials used to verify the identity of the principal; and

(D) The electronic records presented for remote notarization.

(c) Credential analysis provided by a remote notarization system provider must satisfy the requirements of the Secretary of State's Provider Protocols under Rule 5.3.1.

(d) Dynamic, knowledge-based authentication assessment, if selected by a remote notarization system provider as the method of verifying the identity of the remotely located individual per section 24-21-514.5(6)(b)(II)(A), C.R.S., must satisfy the requirements of the Secretary of State's Provider Protocols under Rule 5.3.1.

(e) Public Key Certificate or an identity verification method by a trusted third party. A remote notarization system provider may satisfy section 24-21-514.5(6)(b)(II)(B) or (c), C.R.S., by providing a method of identification of the remotely located individual that satisfies the requirements of the Secretary of State's Provider Protocols under Rule 5.3.1.

(f) Data Storage and security

A remote notarization system provider must provide a storage system that complies with the technical specifications of these rules and the standards, including data security and integrity protocols, set forth in the secretary of state's Provider Protocols under Rule 5.3.1.

5.3.4 Criteria and standards for approval of remote notarization storage providers

In order to be approved and maintain continuing eligibility, a remote notarization storage provider must provide a storage system that complies with the technical specifications of these rules and the standards, including data security and integrity protocols, set forth in the Secretary of State's Provider Protocols under Rule 5.3.1.

5.3.5 Notifications

(a) If a remote notarization system provider or storage provider becomes aware of a possible security breach involving its data, the provider must give notice to both the Secretary of State and each Colorado remote notary public using its services no later than 30 days after the date of determination that a security breach occurred. The provider must comply with any other notification requirements of Colorado's data privacy laws.

(b) No later than 30 days before making any changes to the remote notarization system or storage system used by Colorado remote notaries that would impact any previously provided answer in its application about its system that would affect the provider's eligibility for approval, a provider must both request approval from the Secretary of State and notify each Colorado remote notary public using its services. Changes to the system or storage must conform to statutory and rule requirements.

(c) For non-system or storage-related changes to the provider's information on file with the Secretary of State, the provider must notify and update information provided to the Secretary of State no later than 30 days after changes to the provider's previously supplied information. This requirement includes changes to the disclosures required by Rule 5.3.2(b)(2).

5.3.6 Complaints. A person may file a complaint with the Secretary of State against an approved provider. The complaint must allege a specific violation of Colorado's Revised Uniform Law on Notarial Acts or these rules. The person must submit the signed and dated complaint on the Secretary of State's standard form.

5.3.7 Grounds for termination of approval. The Secretary of State may terminate approval of a provider for any of the following reasons:

(a) Violation of any provision of Colorado's Revised Uniform Law on Notarial Act or these rules;

(b) Making representations that the Secretary of State endorses, recommends, or mandates use of any of the provider's products, goods, or services;

(c) If the provider sustains a data breach; and

(d) Failure to timely respond to the Secretary of State's request for information or otherwise cooperate with an investigation, including providing requested information.

5.3.8 Right to appeal denial or termination of approval. If the Secretary of State denies or proposes to terminate an approved provider's status, the provider has the right to request a hearing as provided in the State Administrative Procedure Act, (Article 4 of Title 24, C.R.S.)

(a) If the provider does not request a hearing, termination of approval will be effective 30 days after the mailing date of the termination notice.

(b) Termination does not bar the Secretary of State from beginning or continuing an investigation concerning the provider.

5.4 Use of personal information

5.4.1 The limited exceptions in section 24-21-514.5(11)(c)(I) through (IV), C.R.S., do not include or authorize the use of personal information for the purpose of generating additional business or marketing opportunities by or for:

(a) The remote notary;

(b) The remote notary's employer or any business for whom the remote notary may be providing contracted services; or

(c) The provider or any of its affiliates.

5.4.2 Such use is prohibited and cannot be waived by the explicit consent required section 24-21-514.5(9)(a)(II), C.R.S., or otherwise.

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NATALIE HANLON LEH
Chief Deputy Attorney General

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Office of the Attorney General

Tracking number: 2020-00819

Opinion of the Attorney General rendered in connection with the rules adopted by the

Secretary of State

on 12/01/2020

8 CCR 1505-11

NOTARY PROGRAM RULES

The above-referenced rules were submitted to this office on 12/01/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 18, 2020 15:28:01

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

CCR number

10 CCR 2505-10

Rule title

10 CCR 2505-10 MEDICAL ASSISTANCE - STATEMENTS OF BASIS AND PURPOSE AND RULE HISTORY 1 - eff 02/15/2021

Effective date

02/15/2021

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Inpatient Hospital Services Substance Use Disorder Treatment Services, Section 8.300.4, Section 8.300.4
Rule Number: MSB 20-08-24-A
Division / Contact / Phone: Health Programs Office / Whitney McOwen/303-866-4441 / Kim McConnell/303-866-2687

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 20-08-24-A, Revision to the Medical Assistance Act Rule concerning Inpatient Hospital Services Substance Use Disorder Treatment Services, Section 8.300.4, Section 8.300.4

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.300.4, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.300.4 with the proposed text beginning at 8.300.4 through the end of 8.300.4. This rule is effective February 15, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Inpatient Hospital Services Substance Use Disorder Treatment Services, Section 8.300.4, Section 8.300.4
Rule Number: MSB 20-08-24-A
Division / Contact / Phone: Health Programs Office / Whitney McOwen/303-866-4441 / Kim McConnell/303-866-2687

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule revision removes the age limitation on SUD services at 8.300.4 to expand access to inpatient substance use disorder (SUD) treatment and withdrawal management services. The effective date for this revision is January 1, 2021.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);
   Section 25.5-5-325, C.R.S. (2020)

Initial Review	**11/13/2020**	Final Adoption	**12/11/2020**
Proposed Effective Date	**02/15/2021**	Emergency Adoption	

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Inpatient Hospital Services Substance Use Disorder Treatment Services, Section 8.300.4, Section 8.300.4
Rule Number: MSB 20-08-24-A
Division / Contact / Phone: Health Programs Office / Whitney McOwen/303-866-4441 / Kim McConnell/303-866-2687

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Members aged 21 and over in need of SUD treatment services will benefit from this rule revision. The increased cost associated with the expansion of these services is expected to be at least partially offset by a decrease in emergency services and other healthcare costs related to SUD.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   There will be an increase in the population of members receiving needed SUD treatment services, with a corresponding increase in expenditure on these services. The Department expects that this increase will be at least partially offset by a decrease in emergency services and other healthcare costs related to SUD.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   As noted, the Department expects an increase in utilization with a corresponding increase in expenditure on these services, but also expects this increase to be offset at least partially with a decrease in emergency services and other healthcare costs related to SUD.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The Department is obligated by 25.5-5-325, C.R.S. (2020) to expand SUD treatment services and one cost of inaction would be noncompliance with state statute. There are also healthcare and other costs associated with

the current coverage limitations that would be alleviated through this rulemaking. The benefit of this rulemaking will be members receiving needed services, improving health overall. There are no probable benefits of inaction.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or intrusive methods for achieving the purposes of the proposed rule revisions.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for aligning the rule with state statute and making the proposed change to delivery services reimbursement.

8.300 HOSPITAL SERVICES

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.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to Healthcare Affordability and Sustainability fee Collection and Disbursement, Section 8.3000
Rule Number: MSB 20-10-01-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 20-10-01-A, Revisions to Healthcare Affordability and Sustainability fee Collection and Disbursement

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.3000, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.3000 with the proposed text beginning at 8.3000 unnumbered paragraph 7 through the end of unnumbered paragraph 7. Replace the current text at 8.3003 with the proposed text beginning at 8.3003.A through the end of 8.3003.C. Replace the current text at 8.3004.B with the proposed text beginning at 8.3004.B through the end of 8.3004.G. This rule is effective February 15, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to Healthcare Affordability and Sustainability fee Collection and Disbursement, Section 8.3000
Rule Number: MSB 20-10-01-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The rule change makes necessary revisions for the federal fiscal year (FFY) 2019-20 Healthcare Affordability and Sustainability (HAS) fee and supplemental payment amounts. Inpatient per-diem fees and Outpatient percentage fees are updated to account for changes to estimated Medicaid expansion costs, estimated administration costs, and HAS supplemental payments. Without the rule change there will not be enough HAS fee to fund Colorado Medicaid and CHP+ expansions and HAS supplemental payments.

   The Rule change includes the creation of the Inpatient supplemental payment and Essential Access supplemental payment.

   The Inpatient Base Rate supplemental payment is now the Inpatient supplemental payment. The new Inpatient supplemental payment is calculated using a hospital's Medicaid patient days not their Medicaid Base Rate, allowing for greater fluctuation in payments based on changing Medicaid utilization. The Uncompensated Care Cost (UCC) Medicaid payment is now the Essential Access supplemental payment. The new Essential Access supplemental payment was one of two parts creating the UCC supplemental payment in prior years. The Essential Access part continues while the non-Essential access part is removed with its funding being absorbed into the Inpatient supplemental payment.

   The Rule also includes revisions to the Disproportionate Share Hospital (DSH) supplemental payment for the FFY 2021 DSH allotment reduction, revisions to the Hospital Quality Incentive Payment (HQIP) supplemental payment for changes recommended by the HQIP sub-committee and approved by the Colorado Healthcare Affordability and Sustainably Enterprise (CHASE) Board, and revisions to language used throughout to increase transparency and understanding.

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

2. Federal authority for the Rule, if any:

   42 CFR 433.68 and 42 U.S.C. § 1396b(w)

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

   25.5-4-402.4(4)(b), (g), C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to Healthcare Affordability and Sustainability fee Collection and Disbursement, Section 8.3000
Rule Number: MSB 20-10-01-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Colorado hospitals benefit from increased Medicaid reimbursement made possible through HAS supplemental payments and the reduced number of uninsured Coloradans from expanded Medicaid and CHP+ eligibility. Low-income persons benefit from having healthcare coverage through the expanded Medicaid and CHP+ eligibility. The state also benefits with HAS fee revenue now used to offset General Fund expenditures due to the budget shortfall created by the COVID-19 pandemic.

   Colorado hospitals bear the costs of the proposed rule due to paying the HAS fee to fund HAS supplemental payments and expanded Medicaid and CHP+ eligibility expenditures before federal matching funds.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The HAS fee, with federal matching funds, will result in approximately $2 billion in annual health care expenditures for more than 400,000 Coloradans and will provide more than $50 million new federal funds to Colorado hospitals. Has Fee will offset $114 million in General Fund expenditures.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   While there are administrative costs, such costs are funded with HAS fees and federal matching funds. No state General Fund is used. The proposed rule will offset $114 million in General Fund expenditures.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The benefits of the proposed rule are the funding of approximately $2 billion in annual health care expenditures for more than 400,000 Coloradoans and more than $500 million in new federal funds to Colorado hospitals. The cost of the proposed

rule is the HAS fee paid by Colorado hospitals to fund the expanded Medicaid and CHP+ eligibility, General Fund expenditures, and HAS supplemental payments.

If no action is taken, there will not be enough HAS fee to fund Colorado Medicaid and CHP+ expansions, affecting over 400,000 currently enrolled persons or the ability to fund the HAS supplemental payments. HAS Fee revenue cannot be allocated to offset General Fund expenditures pursuant to H.B. 1386.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no alternative resources to fund HAS supplemental payments or health coverage for Medicaid and CHP+ expansion populations. No other methods are available to achieve the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The CHASE Act directs the Medical Services Board to promulgate rules for the implementation of the HAS fee and supplemental payments. No other alternatives to rule making are available.

"POS" or "Point of Service" means a type of managed care health plan that charges patients less to receive services from providers in the plan's network and requires a referral from a primary care provider to receive services from a specialist.

"PPO" or "Preferred Provider Organization" means a type of managed care health plan that contracts with providers to create a network of participating providers. Patients are charged less to receive services from providers that belong to the network and may receive services from providers outside the network at an additional cost.

"Privately-Owned Hospital" means a hospital that is privately owned and operated.

"Psychiatric Hospital" means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

"Rehabilitation Hospital" means an inpatient rehabilitation facility.

"Respiratory Hospital" means a hospital that primarily specializes in respiratory related diseases.

"Rural Area" means a county outside a Metropolitan Statistical Area designated by the United States Office of Management and Budget.

"State-Owned Government Hospital" means a hospital that is either owned or operated by the State.

"State University Teaching Hospital" means a High Volume Medicaid and CICP 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.

"Supplemental Medicaid Payment" means any of the payments described in 10 CCR 2505-10, Sections 8.3004.B., 8.3004.C., 8.3004.E., and 8.3004.F.

"Uninsured Cost" means uninsured days and charges allocated to routine and ancillary cost centers and multiplied by the most recent provider-specific per diem cost and cost-to-charge ratio from the Medicare Cost Report.

"Urban Center Safety Net Specialty Hospital" means a hospital located in a Metropolitan Statistical Area designated by the United States Office of Management and Budget where its Medicaid Days plus CICP Days relative to total inpatient hospital days, rounded to the nearest percent, equals or exceeds 65%.

8.3002: RESPONSIBILITIES OF THE ENTERPRISE AND HOSPITALS

8.3002.A. DATA REPORTING

1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the distribution of supplemental payments, the Enterprise shall distribute a data reporting template to all hospitals. The Enterprise shall include instructions for completing the data reporting template, including definitions and descriptions of each data element to be reported. Hospitals shall submit the requested data to the Enterprise within thirty (30) calendar days after receiving the data reporting template or on the stated due date, whichever is later. The Enterprise may estimate any data element not provided directly by the hospital.

    a. For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the collection of fees, payments to hospitals shall be processed by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

    b. For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the disbursement of payments, payments to hospitals shall be processed through a warrant (paper check) by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

8.3003: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

8.3003.A. OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.8664% of total hospital outpatient charges with the following exception.

    a. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted to 1.8507% of total hospital outpatient charges.

8.3003.B. INPATIENT SERVICES FEE

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $91.39 per day for Managed Care Days and $408.56 per day for all Non-Managed Care Days with the following exceptions:

a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $47.71 per day for Managed Care Days and $213.31 per day for all Non-Managed Care Days, and.

b. Essential Access Hospitals' Inpatient Services Fee is discounted to $36.56 per day for Managed Care Days and $163.42 per day for Non-Managed Care Days.

8.3003.C. ASSESSMENT OF HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

1. The Enterprise shall calculate the Inpatient Services Fee and Outpatient Services Fee under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Enterprise Board, the Inpatient Services Fee and Outpatient Services Fee shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Enterprise shall notify hospitals, in writing or by electronic notice, of the annual fee to be collected each year, the methodology to calculate such fee, and the fee assessment be retroactively distributed to other qualified hospitals by each hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals not exceeding their Hospital-Specific DSH Limit.

3. In order to receive a Supplemental Medicaid Payment or DSH Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.3004.B. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing outpatient hospital services to Medicaid clients are qualified to receive this payment except as provided below.

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor. Outpatient billed costs equal outpatient billed charges multiplied by the Medicare cost-to-charge ratio. The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. Total payments to qualified hospitals shall not exceed the Outpatient Upper Payment Limit. The percentage adjustment factor for each qualified hospital shall be published annually in the Colorado Medicaid Provider Bulletin.

8.3004.C. INPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing inpatient hospital services to Medicaid clients are qualified to receive this payment, except as provided below.

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal Medicaid Days multiplied by an adjustment factor. The adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Pediatric Specialty Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. Total payments to qualified hospitals shall not exceed the Inpatient Upper

Payment Limit. The adjustment factor for each qualified hospital shall be published annually in the Colorado Medicaid Provider Bulletin.

8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals.

   a. Hospitals that are Colorado Indigent Care Program providers and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.

   b. Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment.

   c. Critical Access Hospital with at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or are exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(A) are qualified to receive this payment

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment.

   a. Total funds for the payment shall equal $216,338,548.

   b. All qualified hospitals with CICP write-off costs greater than 1,000.00% of the state-wide average shall receive a payment equal to 96.00% of their Hospital-Specific DSH Limit. A qualified Critical Access Hospital shall receive a payment equal to 96% of their Hospital Specific DSH Limit.

   c. All remaining qualified hospitals shall receive a payment calculated as the percentage of uninsured costs to total uninsured costs for all remaining qualified hospitals, multiplied by the remaining funds.

   d. No qualified hospital shall receive a payment exceeding 96.00% of their Hospital-Specific DSH Limit as specified in federal regulation. If a qualified hospital's payment exceeds 96.00% of their Hospital-Specific DSH Limit, the payment shall be reduced to 96.00% of the Hospital-Specific DSH Limit. The amount of the reduction shall then be redistributed to other qualified hospitals not exceeding 96.00% of their Hospital-Specific DSH Limit based on the percentage of uninsured costs to total uninsured costs for all qualified hospitals not exceeding 96.00% of their Hospital-Specific DSH Limit.

   e. A new CICP hospital shall have their Hospital-Specific DSH Limit equal to 10.00%. A Low MIUR hospital shall have their Hospital-Specific DSH Limit equal 10.00%.

      i. A new CICP hospital is a hospital approved as a CICP provider after October 1, 2018.

      ii. A low MIUR hospital is a hospital with a MIUR less than or equal to 15.00%.

8.3004.E. ESSENTIAL ACCESS HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Essential Access Hospitals are qualified receive this payment.

2. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal the percentage of beds to total beds for all qualified hospitals, multiplied by the available Essential Access funds.

8.3004.F. HOSPITAL QUALITY INCENTIVE PAYMENT

1. Qualified hospitals. Hospitals providing hospital services to Medicaid clients are qualified to receive this payment except as provided below.

2. Excluded hospitals. Psychiatric Hospitals are not qualified to receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment shall equal adjusted discharge points multiplied by dollars per-adjusted discharge point.

   a. Adjusted discharge points equal normalized points awarded multiplied by adjusted Medicaid discharges. Normalized points awarded equals the sum of points awarded, normalized to 100 points for measures a hospital is not eligible to complete. There are fifteen measures separated into six measure groups. The measures and measure groups are:

      Maternal Health and Perinatal Care Measure Group
      1. Exclusive Breast Feeding
      2. Cesarean Section
      3. Perinatal Depression and Anxiety
      4. Maternal Emergencies
      5. Reproductive Life/Family Planning

      Patient Safety Measure Group
      6. Clostridium Difficile
      7. Adverse Event
      8. Falls with Injury
      9. Culture of Safety Survey

      Patient Experience Measure Group
      10. Hospital Consumer Assessment of Healthcare Providers and Systems
      11. Advance Care Plan

      Regional Accountable Entity (RAE) Engagement Measure Group
      12. RAE engagement on Physical and Behavioral Health

      Substance Abuse Measure Group
      13. Substance Use Disorder Composite
      14. Alternatives to Opioids

      Addressing Cost of Care Measure Group
      15. Hospital Index

      Adjusted Medicaid Discharges equal inpatient Medicaid discharges multiplied by a discharge adjustment factor.

      i. The discharge adjustment factor equals total Medicaid charges divided by inpatient Medicaid charges. The discharge adjustment factor is limited to 5.

      ii. For qualified hospitals with less than 200 inpatient Medicaid discharges, inpatient Medicaid discharges shall be multiplied by 125%.

   b. Dollars per-adjusted discharge point is determined using a qualified hospital's normalized points awarded. Dollars per-adjusted discharge

point are tiered so that qualified hospitals with more normalized points awarded receive more dollars per-adjusted discharge point. There are five tiers delineating the dollars per-adjusted discharge point with each tier assigned a certain normalized points awarded range. For each tier the dollars per-adjusted discharge point increase by a multiplier.
The multiplier and normalized points awarded for each tier are:

Tier	Normalized Points Awarded	Dollars Per-Adjusted Discharge Point
1	1-19	0(x)
2	20-39	1(x)
3	40-59	2(x)
4	60-79	3(x)
5	80-100	4(x)

The dollars per discharge point (x) shall equal an amount such that the total quality incentive payments made to all qualified hospitals shall equal seven percent (7.00%) of total hospital payments in the previous state fiscal year.

8.3004.G. REIMBURSEMENT OF SUPPLEMENTAL MEDICAID PAYMENT AND DISPROPORTIONATE SHARE HOSPITAL PAYMENT

1. The Enterprise shall calculate the Supplemental Medicaid Payment and DSH Payment under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Enterprise Board, the Supplemental Medicaid Payment and DSH Payment shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Enterprise shall notify hospitals, in writing or by electronic notice, of the annual payment made each year, the methodology to calculate such payment, and the payment reimbursement schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days prior to any change in the dollar amount of the Supplemental Medicaid Payment or the DSH Payment to be reimbursed.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Rule Concerning Nursing Facility Per Diem Rates, Section 8.443
Rule Number: MSB 20-10-01-B
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 20-10-01-B, Revision to Medical Assistance Rule Concerning Nursing Facility Per Diem Rates

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.443.1.B, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.443 with the proposed text beginning at 8.443.1.B through the end of 8.443.1.B. This rule is effective February 15, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Rule Concerning Nursing Facility Per Diem Rates, Section 8.443
Rule Number: MSB 20-10-01-B
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   House Bill (H.B.) 20-1362 limits the annual increase in the General Fund share of the per diem rates for nursing homes from 3.00% to 2.00% in SFY 2020-21 and SFY 201-22. The rule change makes necessary revisions to be compliant with state statute.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 433.68 and 42 U.S.C. § 1396b(w)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

   Sections 25.5-6-202 & 25.5-6-203, C.R.S

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to Medical Assistance Rule Concerning Nursing Facility Per Diem Rates, Section 8.443
Rule Number: MSB 20-10-01-B
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Nursing homes will bear the costs of the proposed rule. Nursing home claims based reimbursement rates will increase less with the proposed rule. Nursing homes will now be reimbursed a smaller portion of their Core Component per diem rate (cost based rate) through the Colorado interChange (iC). The state will benefit from the proposed rule. The state will generate savings by limiting the increase in nursing home reimbursement rates

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The projected decrease in claims based reimbursement to nursing homes equals approximately $7 million in SFY 2020-21. The state will generate savings equal to approximately $3.3 million, after subtracting for federal matching dollars.

   The projected decrease in claims based reimbursement to nursing homes equals approximately $16.6 million in SFY 2021-22. The state will generate savings equal to approximately $8.3 million, after subtracting for federal matching dollars.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs to the Department or any other agency to implement/enforce the proposed rule. The proposed rule will generate approximately $3.3 million in savings for the state in SFY 2020-21 and $8.3 million in SFY 2021-22.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Benefits of proposed rule is being compliant with state statute and generating savings to state. Costs of proposed rule is a reduction to nursing home claims based reimbursement. Costs of inaction is not being compliant with state statute and not generating savings for the state.

DO NOT PUBLISH THIS PAGE

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no other methods that are less costly or intrusive that still achieve the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   No alternative methods were seriously considered by the Department to achieve the desired goal of the proposed rule.

8.443 NURSING FACILITY REIMBURSEMENT

8.443.1.A Where no specific Medicaid authority exists, the sources listed below shall be considered in reaching a rate determination:

1. Medicare statutes.

2. Medicare regulations.

3. Medicaid and Medicare guidelines.

4. Generally accepted accounting principles.

8.443.1.B Effective July 1 of each year, a MMIS per diem reimbursement rate for Class I nursing facility providers shall be established for reimbursement of billed claims.

1. The MMIS per diem reimbursement rate shall equal the July 1 Core Component per diem rate multiplied by a percent factor. The percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by the statutory limit pursuant to C.R.S 25.5-6-202(9)(b)(VII)(2020) for SFY 2020-21 and SFY 2021-22. The increase for all subsequent years shall be limited pursuant to C.R.S 25.5-6-202(9)(b)(I)(2020).

2. For state fiscal year (SFY) 2019-20, if the MMIS per diem reimbursement rate is less than ninety-five percent (95%) of the SFY 2018-19 MMIS per diem reimbursement rate, the SFY 2019-20 MMIS per diem reimbursement rate shall be the lesser of 95% of the SFY 2018-19 MMIS per diem reimbursement rate or the SFY 2019-20 Core Component per diem rate.

3. In the event that MMIS per diem reimbursement rate is greater than the Core Component per diem rate, the Department shall reduce the rate to no greater than the Core Component per diem rate.

The Core Component per diem rate shall be determined using information on the MED-13, the Minimum Data Set (MDS) resident assessment information and information obtained by the Department or its designee retained for cost auditing purposes.

The Core Component per diem rate shall be the sum of the following per diem rates:

1. Health care per diem rate described in Section 8.443.7.D,

2. Administrative and general per diem rate described in Section 8.443.8.E, and

3. Fair rental allowance per diem rate described in Section 8.443.9.B.

In addition to the MMIS claims reimbursement, a Class 1 nursing facility provider may be reimbursed supplemental payments. Supplemental payments are funded using available provider fee dollars collected as described in Section 8.443.17. Supplemental payments shall be funded in the subsequent order based upon the statutory hierarchy pursuant to C.R.S § 25.5-6-203(2)(b).

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

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

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

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

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

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

7. Core Component supplemental payment described in Section 8.443.11.A.

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Tracking number: 2020-00852

Opinion of the Attorney General rendered in connection with the rules adopted by the

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

on 12/11/2020

10 CCR 2505-10

MEDICAL ASSISTANCE - STATEMENTS OF BASIS AND PURPOSE AND RULE HISTORY

The above-referenced rules were submitted to this office on 12/11/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 12:11:26

Philip J. Weiser
Attorney General
by Eric R. Olson
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Permanent Rules Adopted

Department

Department of Human Services

Agency

Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)

CCR number

12 CCR 2509-1

Rule title

12 CCR 2509-1 OVERVIEW OF CHILD WELFARE SERVICES 1 - eff 01/30/2021

Effective date

01/30/2021

(12 CCR 2509-1)

7.000 OVERVIEW OF CHILD WELFARE SERVICES - PROGRAM AREAS AND TARGET GROUPS FOR 3, 4, 5, 6 AND 7

Child Welfare Services constitutes a specialized set of services defined at Section 26-5-101(3), C.R.S., that are intended to strengthen the ability of families to protect and care for their own children, prevent involvement or continued involvement in the child welfare system, minimize harm to children and youth, and ensure permanency planning. The goal of the treatment/prevention plan shall be to support the intactness of families, when appropriate, through the provision of services aimed at stabilizing the family situation and strengthening the parents/guardians in fulfilling their parental responsibilities to their children. Intervention shall be guided by respect for the family's integrity, knowledge of the legal bases for action, and sound social work practice.

The following principles shall underlie the provision of Child Welfare Services:

A. Children and youth, including youth who have run away, are experiencing homelessness, or who are unaccompanied, shall have the right to be raised in an environment free from abuse or neglect preferably by their families of origin by providing reasonable efforts to maintain the family unit through the provision of in-home services.

B. Placement shall be considered when there is evidence that leaving the child in the home would jeopardize the safety of the child or the community. Reasonable efforts shall be made to prevent placement or to reunite the family as soon as safely possible if removal is necessary. In determining reasonable efforts to be made, and in making such reasonable efforts, the child's health and safety shall be the paramount concern. A court may determine that reasonable efforts shall not be required; otherwise, reasonable efforts shall be made to preserve and reunify families.

C. Appropriate and culturally competent and trauma informed services that promote safety shall be provided to families, children, and youth in their own homes and in out-of-home placements.

D. Children and youth who have been removed from the care of their parents shall have the right to a diligent search according to Section 7.304.52 (12 CCR 2509-4) for extended family members who can be considered as placement resources, to be placed in a safe environment, to not be moved indiscriminately from one placement to another, and to have the assurance of a permanency plan.

   It is the responsibility of all adults involved in a child/youth's life, including but not limited to county department personnel, parents, foster parents, adoptive parent/s, Guardians Ad Litem, Court-Appointed Special Advocates, next of kin, treatment providers, and others, to seek opportunities to foster sibling relationships, to promote continuity, and to help sustain family relationships.

E. Consideration of the child's age, culture, language, religion, and other needs shall guide the choice of all services provided. Race, color, and national origin of the child and the prospective parents are considered in foster and adoptive placements only in extraordinary circumstances.

F. Case planning shall involve the parents so that relevant services can be provided to permit timely rehabilitation and reunification.

G. Child Welfare Services shall be provided in collaboration with other community agencies on behalf of children, youth, and their families. Assessment tools or resources available through these community agencies shall be incorporated in the assessment, based on the culture and other needs of the family.

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7.000.2 Definitions

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"Youth who are Experiencing Homelessness" has the same meaning as "Homeless Youth," which is defined at section 24-32-723(2)(b), C.R.S. (2020) and 26-5.7-102(2), C.R.S. (2020).

"Youth who have Run Away" means a child/youth who has become homeless or who left and remains away from home without the permission of their parent(s), caregiver(s), or legal guardian(s).

"Youth who are Unaccompanied" means a child/youth who is at risk of or is experiencing abuse, neglect, or is a youth in conflict and who is living without financial, physical, and/or housing support from family, or whose parent(s), caregiver(s), and/or legal guardian(s) whereabouts are unknown.

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on 12/04/2020

12 CCR 2509-1

OVERVIEW OF CHILD WELFARE SERVICES

The above-referenced rules were submitted to this office on 12/07/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 22, 2020 10:22:56

Philip J. Weiser
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by Eric R. Olson
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Permanent Rules Adopted

Department

Department of Human Services

Agency

Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)

CCR number

12 CCR 2509-2

Rule title

12 CCR 2509-2 REFERRAL AND ASSESSMENT 1 - eff 01/30/2021

Effective date

01/30/2021

(12 CCR 2509-2)

<Title2**7.103 Receipt Of Referral Alleging Intrafamilial Or Third Party Abuse And/Or Neglect And/Or A Youth In Conflict– Information To Be Gathered**

A. Upon receipt of a report alleging intrafamilial or third party abuse and/or neglect, and/or a youth in conflict, the county departments or the Hotline County Connection Center shall gather and document the following information, when available.

1. Reporting party's:

a. Name;

b. Address;

c. Telephone number;

d. Reporter type; and

e. Relationship to the alleged victim child(ren)/youth and/or a youth in conflict.

2. Alleged victim child(ren)/youth's and/or a youth in conflict:

a. Name;

b. Address;

c. Current specific location;

d. School or child care (if applicable);

e. Birth date(s) or estimated age(s);

f. Information as to whether or not the child(ren)/youth have American Indian or native Alaskan heritage, and if so, the tribal affiliation; and

g. Any developmental delays, physical disabilities, competency or cultural considerations.

3. Family and household members:

a. Names;

b. Birth date(s) or estimated age(s);

c. Relationship to each other;

d. Relationship to the alleged victim child(ren)/youth and/or a youth in conflict; and

e. Any developmental delays, physical disabilities, competency or cultural considerations.

4. Person(s) alleged to be responsible for the abuse and/or neglect:

a. Name;

b. Birth date(s) or estimated age(s);

c. Present location;

d. Current or last known address;

e. Relationship to the alleged victim child(ren)/youth; and

f. Any developmental delays, physical disabilities, competency or cultural considerations.

5. Narrative describing the presenting problems and specific allegations of the abuse and/or neglect, including but not limited to:

a. When it occurred;

b. Location;

c. Witness(es) of the incident; and

d. Description of any injury that was sustained.

6. The date, time, and location the alleged victim child(ren)/youth and/or a youth in conflict were last seen by the reporting party.

7. The nature of any other environmental hazards in the home which may impact child(ren)/youth or worker safety.

8. The name and contact information of any individuals who may have information about the referral, and/or the identity and contact information of collateral agencies and individuals involved with the family.

9. Date and time referral received.

10. Family strengths and supports, and/or other protective factors or actions taken.

B. If at any point during the referral process, a county department becomes aware of an allegation that a child(ren)/youth is, or may be, a victim of sex trafficking, the county department shall:

1. Report immediately, and no later than twenty-four (24) hours from when the county department becomes aware, to the local law enforcement agency; and,

2. Document the details of the report to law enforcement in the state automated case management system.

C. If at any point during the referral process, a county department becomes aware that a youth is experiencing homelessness, has run away, or is unaccompanied and is seeking shelter, the county department shall gather and document the following information:

1. Does the provider believe there is a reasonable plan in place to keep the child or youth free from harm, and, if not, what the provider believes would prevent harm,

2. Has the shelter provider notified parent(s)/guardian(s) and, if so, what is their response; and

3. When did intake of the child or youth occur and how many days are left in the 21 day shelter period allowable pursuant to section 26-5.7-107, C.R.S.

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12 CCR 2509-2

REFERRAL AND ASSESSMENT

The above-referenced rules were submitted to this office on 12/07/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 22, 2020 10:24:12

Philip J. Weiser
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Permanent Rules Adopted

Department

Department of Human Services

Agency

Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)

CCR number

12 CCR 2509-8

Rule title

12 CCR 2509-8 CHILD CARE FACILITY LICENSING 1 - eff 01/30/2021

Effective date

01/30/2021

<Title2**7.701.21 Homeless Youth Services - Definitions**

“Homeless Youth” is defined at Sections 24-32-723(2)(b), C.R.S. (2020) and 26-5.7-102(2), C.R.S. (2020).

“Homeless Youth Shelter” is defined at Sections 26-5.7-102(3), C.R.S. (2020) and 26-6-102(17), C.R.S. (2020).

“Licensed Host Family Home” is a home that is certified by the county department or a child placement agency as meeting the requirements for providing shelter to homeless youth.

“Youth Who Have Runaway” is defined IN 12 CCR 2509-01; 7.000.2

“Youth Who Are Unaccompanied” is defined in 12 CCR 2509-01; 7.000.2

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7.705.81 Shelter Care for Placements [Rev. eff. 9/15/12]

A. Applicability of Rules

1. Any residential child care facility may provide shelter or twenty-four (24) hour emergency care for children and homeless youth, defined in general rules at Section 7.701.21, in need of short-term placement resulting from such circumstances as child abuse or running away from home for up to twenty-one (21) consecutive days. Some facilities accept only children for emergency care and are known as shelter care facilities.

2. The acceptance of children for emergency care must be stated in the written purpose of the facility and the admission policy.

3. Residential child care facilities shall make every effort to assure that shelter care placements do not exceed sixty days. Exceptional circumstances shall be documented in the case file. No child shall remain in a shelter care facility for longer than ninety days. Review of placement will be required as appropriate.

4. These rules are specifically for shelter care facilities. The following rules are in addition to corresponding regulations in Sections 7.705.1 through 7.705.6. However, if there is a conflict between those rules and these shelter care rules, these rules shall apply.

B. Admission to Shelter Care and Orientation

1. At the time of emergency shelter care placement of a child, the facility shall obtain at least the following information: name, birth date, if available, physical description of the child, date and time of the admission, name and authority of person bringing child to the facility, and reason for placement. On the next working day following emergency shelter care placement of the child, the facility shall obtain from the county department of social services or the parent of guardian a signed, written authorization to obtain medical care for the child. The county department is authorized to give this authorization pursuant to this staff manual.

a. A youth who has reached the age of 15 or older may consent to shelter and services for a period not to exceed 21 days when the following criteria are met:

.1 The youth shall voluntarily and knowingly sign a consent form that includes:

A. All services the youth may receive during their stay at the shelter and the total number of days the youth may consent to remain in the shelter.

B. Legal limits to confidentiality.

C. How and when parent(s), legal guardian(s), and/or child welfare agencies will be notified of the youth's stay.

D. An explanation that services provided by the shelter are provided free of charge to the youth without exchange of any goods, services, or sexual acts.

2. The consent form shall be explained in the child's dominant language or mode of communication, including augmented or facilitated communication, if necessary, and shall take into consideration the child's age, disability, and cultural and religious background.

3. The consent form shall be signed within 12 hours of admission.

2. The facility shall ensure that each newly admitted child is checked by facility staff or physician for signs of illness, symptoms of abuse, and the presence of vermin.

The facility shall have a medical plan, including staff training, which includes the screening of the child for child abuse and signs of illness requiring immediate medical attention.

3. If a child remains in shelter care for longer than thirty days, a medical examination must be completed in compliance with Section 7.705.31, B.

4. The facility shall provide orientation for the new child. Orientation shall include:

a. Tour of the facility.

b. Introduction to staff.

c. Description of rules, regulations, and discipline policies of the facility.

d. Discussion of tasks and behaviors the child is expected to perform.

e. Discussion regarding personal possessions the child is permitted to bring and obtain while in shelter care.

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7.705.82 Homeless Youth Shelter Care

A. Applicability of Rules

1. Any residential child care facility may provide shelter to homeless youth age eighteen and under for up to twenty-one (21) consecutive days. A residential child care facility may provide shelter to a homeless youth between the ages of eighteen (18) and twenty-one

(21), if such services will not negatively impact the health, safety and welfare of the other children in care. The facility shall obtain approval from the department prior to accepting a homeless youth between the ages of eighteen (18) and twenty-one (21).

2. The acceptance of homeless youth must be stated in the written purpose of the facility and the admission policy.

3. These rules are specifically for shelter care of homeless youth. The following rules are in addition to corresponding regulations in Sections 7.705.1 through 7.705.6. However, if there is a conflict between those rules and these shelter care rules, these rules shall apply.

B. Admission to Homeless Youth Shelter Care and Orientation

1. At the time of entering the facility, the facility shall obtain at least the following information: name, birth date, physical description of the child, date and time of the admission, and reason for needing admission.

2. The facility shall ensure that each newly admitted child is checked by facility staff or physician for signs of illness, symptoms of abuse, and the presence of vermin.

   The facility shall have a medical plan, including staff training, which includes the screening of the child for child abuse and signs of illness requiring immediate medical attention.

3. A youth who has reached the age of 15 or older may consent to shelter and services for a period not to exceed 21 days when the following criteria are met:

   a. The youth shall voluntarily and knowingly willingly sign a consent form that includes:

      1. All services the youth may receive during their stay at the shelter and the total number of days the youth may consent to remain in the shelter.

      2. Legal limits to confidentiality.

      3. How and when parent(s), legal guardian(s), and/or child welfare agencies will be notified of the youth's stay.

      4 an explanation that services provided by the shelter are provided free of charge to the youth without exchange of any goods, services, or sexual acts.

   C. The consent form shall be explained in the child's dominant language or mode of communication, including augmented or facilitated communication, if necessary, and shall take into consideration the child's age, disability, and cultural and religious background.

   D. The consent form shall be signed within 12 hours of admission.

~~3~~4. The facility shall provide orientation for the new child/youth. Orientation shall include:

   a. Tour of the facility.

   b. Introduction to staff.

   c. Description of rules, regulations, and discipline policies of the facility.

d. Discussion of tasks and behaviors the child is expected to perform.

e. Discussion regarding personal possessions the child is permitted to bring and obtain while in shelter care.

C. Notifications and Referrals

1. Pursuant to Section 26-5.7-105(4), C.R.S., if the facility determines that a referral for additional services needs to be made, it shall make the referral to county department of residence of the parents of the youth.

2. Pursuant to Section 26-5.7-105(7), C.R.S., When a youth under fifteen years of age is admitted to the facility, the facility shall notify the county department of residence of the parents of the youth within seventy-two (72) hours of the youth's admission.

3. Pursuant to Section 26-5.7-105(5), C.R.S., if the facility determines that a referral for additional services needs to be made, it shall make the referral to the appropriate county department of human/social services, notify the county department of the facility's relationship to the youth pursuant to section 19-1-307(2)(e.5)(I), and notify the county department of the date when the twenty-one-day shelter time period will expire.

4. For youth under the age of eighteen (18), if reconciliation with the youth's family has not occurred within seventy-two (72) hours following admission to the shelter, and the director of the shelter or other person in charge does not anticipate that reconciliation will be achieved within twenty-one (21) consecutive days, the director or other person in charge shall provide the youth and the youth's parent(s) or legal guardian(s) with a written statement identifying:

A. The availability of counseling services;

B. The availability of longer term residential arrangements; and,

C. The possibility of referral to the county department.

5. If the facility staff know the youth is away from home without permission, the shelter shall notify the youth's parent(s)/legal guardian(s), the county department, or law enforcement pursuant to Section 26-5.7-106, C.R.S. if notifying the parent(s) or legal guardian(s) would not be in the youth's best interest due to an imminent risk of abuse or neglect by the parent(s) or legal guardian(s), the shelter shall notify the appropriate county department of human/social services instead of the parent(s)/legal guardian(s).

6. Documentation of all required notifications and consents shall be kept in the youth's file.

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7.715.43 Admission Policy and Procedures [Rev. eff. 9/15/12]

A. Admission of a youth shall be in keeping with the stated purpose of the homeless youth shelter and shall be limited to those youth for whom the shelter is qualified by staff, program, equipment, and needs of youth already in residence to provide care deemed necessary. Care must be provided in the least restrictive, most appropriate setting in order to meet the youth's needs.

B. Each shelter shall have a written admission policy which at a minimum must include:

1. The policies and procedures related to intake.

2. The age range and sex of youth accepted for care.

3. The needs, problems, situations or patterns best addressed by the shelter's program.

4. The anticipated criteria, problems, situations, and patterns that would result in the shelter requesting removal of a youth.

5. A statement regarding the religious orientation or affiliation of the shelter, and of the religious activities at the shelter, if any.

6. A statement regarding any charges or costs for services that may be expected from the youth, the youth's family or others who may be responsible for the youth.

C. The shelter shall accept a youth into care only after a preliminary assessment and screening of presenting problems in areas such as social, physical health, mental health.

D. Upon admission of a youth to a shelter:

1. The shelter shall provide all necessary services pursuant to section 26-5.7-106(2), C.R.S.

2. A youth who has reached the age of 15 or older may consent to shelter and services for a period not to exceed 21 days when the following criteria are met:

A. The youth shall voluntarily and knowingly sign a consent form that includes:

1. All services the youth may receive during their stay at the shelter and the total number of days the youth may consent.

2. Legal limits to confidentiality.

3. How and when parent(s), legal guardian(s), and/or child welfare agencies will be notified of the youth’s stay.

4. An explanation that services provided by the shelter are provided free of charge to the youth without exchange of any goods, services, or sexual acts.

B. The consent form shall be explained in the child's dominant language or mode of communication, including augmented or facilitated communication, if necessary, and shall take into consideration the child's age, disability, and cultural and religious background.

C. The consent form shall be signed within 12 hours of admission.

E. Within 24 hours of arrival at the shelter, a youth shall be given an orientation to the shelter, consistent with the youth's age and ability to participate, which includes at least the following:

1. Tour of the shelter and instruction on fire alarm and fire evacuation procedures, escape routes and exits.

2. The rules/regulations of the shelter.

3. Procedures affecting the youth's behavior, including limiting or restricting a youth's rights where allowed, the type of discipline used in the shelter, and consequences for certain behaviors.

4. The complete youth's rights and youth's grievance procedures as developed by the shelter or by the certifying authority.

F. For youth under the age of eighteen (18), if reconciliation with the youth's family has not occurred within seventy-two (72) hours following admission to the shelter, and the director of the shelter or other person in charge does not anticipate that reconciliation will be achieved within twenty-one (21) consecutive days, the director or other person in charge shall provide the youth and the youth's parent(s) or legal guardian(s) with a written statement identifying:

1. The availability of counseling services;

2. The availability of longer term residential arrangements; and

3. The possibility of referral to the county department.

G. Youth may reside at a shelter for a period not to exceed twenty-one (21) consecutive days unless the youth is paced in a voluntary alternative residential placement pursuant to Section 26-5.7-107 or 26-5.7-108, C.R.S.

For youth under the age of eighteen (18), a voluntary residential agreement shall be developed with the involvement of the youth and, if possible, the youth's parent or the legal guardian(s). Where the involvement of any of these is not feasible or desirable, the reasons for the exclusion shall be recorded by the shelter. If the youth and the youth's parent cannot agree on an initial voluntary alternative residence within twenty-one (21) days, the shelter may make a referral to the county department. If an agreement can be reached, the placement agreement shall include at least the following information:

1. Discussion of the youth's and the parent's or guardian's expectations regarding: family contact, reconciliation and involvement; how family contact and involvement are to occur, the nature and goals of care, the anticipated planned discharge date and the plan for the youth following discharge.

2. A delineation of the respective roles and responsibilities of all agencies and persons involved with the youth and his/her family.

3. Legal status or custody of the youth.

4. If a youth is placed by a Colorado county department of social services, the appropriate state form or contract shall be completed. This form or contract may provide some of the required authorizations.

For youth between the age of eighteen (18) and twenty-one (21), the voluntary residential agreement shall be developed with the involvement of the youth. Other individuals may participate in the development of the agreement at the youth and shelter's discretion The agreement shall include at least the following information: the nature and goals of care, the anticipated planned discharge date, and the plan for the youth following discharge.

H. Pursuant to Section 26-5.7-105(5), C.R.S., if the facility determines that a referral for additional services needs to be made, it shall make the referral to the appropriate county department of human/social services, notify the county department of the facility's relationship to the youth pursuant to section 19-1-307 (2)(e.5)(I), and notify the county department of the date when the twenty-one-day shelter time period will expire.

For youth under the age of eighteen (18), the shelter will contact the county department of residence of the parents(S) of the youth for the limited purpose of determining whether a county department is serving the youth.

I. Pursuant to Section 26-5.7-105(4), C.R.S., when a youth under fifteen years of age is admitted to a licensed homeless youth shelter, the director of the shelter or other person in charge shall notify the county department of residence of the parents of the youth within seventy-two (72) hours of the youth's admission.

J. Pursuant to Section 26-5.7-105(7), C.R.S., if a youth who is at least eleven (11) years of age but less than fifteen (15) years of age has been served up to twenty-one (21) consecutive days and returns again to the licensed homeless youth shelter after leaving the shelter, the director of the shelter or other person in charge shall notify the county department of residence of the parents of the youth within seventy-two (72) hours of the youth's admission.

K. If the shelter staff know the youth is away from home without permission, the shelter shall notify the youth's parent or law enforcement pursuant to Section 26-5.7-106, C.R.S.

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7.721.43 Admission Policy and Procedures

A. Admission of a runaway/homeless youth to a host family home shall be in keeping with the stated purpose of the program.

B. Notification and contacts:

1. Pursuant to Section 26-5.7-105(4), C.R.S., when a youth under fifteen years of age is admitted to a licensed host family home, the director of the facility, shelter, or other person in charge shall notify the county department of the county of residence of the parents of the youth within seventy-two (72) hours of the youth's admission.

2. Pursuant to Section 26-5.7-105(5), C.R.S., if the facility determines that a referral for additional services needs to be made, it shall make the referral to THE APPROPRIATE county department of human/social services, notify the county department of the facility's relationship to the youth pursuant to section 19-1-307 (2)(e.5)(I), and notify the county department of the date when the twenty-one-day shelter time period will expire.

3. Pursuant to Section 26-5.7-105(7), C.R.S., if a youth who is at least eleven (11) years of age but less than fifteen (15) years of age has been served up to twenty-one (21) days and returns again to the licensed host family home after leaving the host family home, the child placement agency or county certifying the host family home shall make a referral for services to the county of residence of the parents of the youth.

C. Child placement agency or county shall place youth in host family homes where the provider of the host family home is qualified and taking into account the needs of children already in residence to provide the care necessary. Care must be provided in the least restrictive, most appropriate setting in order to meet the youth's needs.

D. Each host family home and its certifying authority shall have a written admission policy that at a minimum must include:

1. The policies and procedures related to intake.

2. The age range and sex of youth accepted/admitted for care.

3. The needs, problems, situations or patterns best addressed by the host family home.

E. Any pre-placement requirements for the youth, the parent(s) or guardian, and/or the placing agency.

F. The anticipated problems or situations that would result in the host family home or certifying authority requesting removal of a youth from the host family home.

G. The written description of admission policies and criteria shall be provided to referring agencies.

H. The child placement agency or county shall accept a youth into temporary/emergency shelter only after a preliminary intake assessment and screening of immediate needs. Further assessments of areas such as social, physical health, mental health shall be conducted within three days of admission.

I. Pursuant to Section 26-5.7-106(2), C.R.S., upon admission of a youth to a host family home, the child placement agency or county shall:

1. Notify the youth's parent(s) or county department of human/social services of the youth's whereabouts, physical and emotional condition, and the circumstances surrounding the youth's placement within 24 hours;

2. Notify the youth's parent that it is the paramount concern of the facility or shelter to achieve reconciliation between the parent and the youth, to reunify the family, and to inform the parent about the alternatives that are available;

3. Arrange transportation for the youth to the residence of the youth's parent when the youth and the parent agree that the youth shall return to the home of the youth's parent. The parent shall reimburse the party who paid for the transportation costs to the extent of the parent's ability.

4. Arrange transportation for the youth to an alternative residential placement facility when the youth and the youth's parent agree to such placement. The parent shall reimburse the appropriate person for transportation costs to the extent of the parent's ability.

J. Within 24 hours of admission the child placement agency or county is responsible to contact parent(s)/legal guardians(S) of youth under the age of eighteen and document their permission to serve or attempts made to contact parents/legal guardians. If notifying the parent(s) or legal guardian(s) would not be in the youth's best interest due to an imminent risk of abuse or neglect by the parent(s) or legal guardian(s), the shelter shall notify the appropriate county department of human/social services instead of the parent(s)/legal guardian(s).

K. Within 24 hours of arrival at the host family home, a youth shall be given an orientation to the host family home, consistent with the youth’s age and ability to participate, which includes at least the following:

1. Tour of the host family home and instruction on fire alarm and fire evacuation procedures, escape routes and exits.

2. The rules of the host family home.

3. Procedures affecting the youth's behavior, including limiting or restricting a youth's rights where allowed, the type of discipline used in the host family home, and consequences for certain behaviors.

4. The complete youth’s rights and youth’s grievance procedures as developed by the host family home or by the certifying authority.

L. If reconciliation with the family and voluntary return of the youth has not been achieved within 48 hours following admission to the host family home, excluding Saturdays, Sundays and legal holidays, and the child placement agency or county department does not anticipate reconciliation occurring within twenty-one (21) consecutive days, the child placement agency or county shall provide the youth and the youth’s parent with a written statement identifying:

1. The availability of counseling services;

2. The availability of longer term residential arrangements; and,

3. The possibility of referral to the county department.

M. The case plan shall be developed with the involvement of the youth, the parent(s) or guardian(s) of the youth, the representative of the child placement agency or county, and when possible, the host family home provider. Where the involvement of any of these is not feasible or desirable, the certifying authority shall record the reasons for the exclusion. The case plan shall include by reference or attachment at a minimum the following:

1. Discussion of the youth's and the parent's or guardian's expectations regarding: family contact and involvement; how family contact and involvement are to occur; the nature and goals of care, including any specialized services or specialized treatment to be provided; the religious orientation and practices of the host family home; and, the anticipated planned discharge date and plan for the youth following discharge.

2. Written authorization for care and treatment of the youth.

N. A youth who has reached the age of 15 or older may consent to shelter and services for a period not to exceed 21 days when the following criteria are met:

.1 The youth shall voluntarily, knowingly, and willingly sign a consent form that includes:

A. All services the youth may receive during their stay at the shelter and the total number of days the youth may consent to stay in the host home.

B. Legal limits to confidentiality.

C. How and when parent(s), legal guardian(s), and/or child welfare agencies will be notified of the youth's stay.

D. An explanation that services provided by the shelter are provided free of charge to the youth without exchange of any goods, services, or sexual acts.

2. The consent form shall be explained in the child's dominant language or mode of communication, including augmented or facilitated communication, if necessary, and shall take into consideration the child's age, disability, and cultural and religious background.

3. The consent form shall be signed within 12 hours of admission.

O. Documentation of all required notifications and consents shall be kept in the youth's file.

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Opinion of the Attorney General rendered in connection with the rules adopted by the

Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)

on 12/04/2020

12 CCR 2509-8

CHILD CARE FACILITY LICENSING

The above-referenced rules were submitted to this office on 12/07/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 22, 2020 10:21:57

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Insurance

CCR number

3 CCR 702-4 Series 4-2

Rule title

3 CCR 702-4 Series 4-2 LIFE, ACCIDENT AND HEALTH 1 - eff 12/15/2020

Effective date

12/15/2020

Expiration date

04/14/2021

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Emergency Regulation 20-E-16

CONCERNING COVERAGE AND REIMBURSEMENT FOR TELEHEALTH SERVICES DURING THE COVID-19 DISASTER EMERGENCY

Section 1 Authority

This emergency regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109, 10-16-109, 10-16-123 and 10-16-708, C.R.S.

Section 2 Scope and Purpose

The purpose of this emergency regulation is to require carriers offering health benefit plans to reimburse providers for provision of telehealth services using non-public facing audio or video communication products during the COVID-19 nationwide public health emergency.

The Department of Health and Human Services (HHS) issued a declaration on January 31, 2020 of the existence of a national public health emergency due to COVID-19. The National Emergency Order was extended, effective October 23, 2020, through January 20, 2021. On March 11, 2020, Governor Polis issued Executive Order D 2020 003 declaring a disaster emergency due to the presence of COVID-19 in Colorado and has extended that declaration, on December 3, 2020, with Executive Order D 2020 268.

On March 17, 2020, the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) announced that it will waive potential Health Insurance Portability and Accountability Act (HIPAA) penalties for good faith use of telehealth during the nationwide public health emergency due to COVID-19. OCR is exercising its enforcement discretion to not impose penalties for noncompliance with the

HIPAA Rules in connection with the good faith provision of telehealth using such non-public facing audio or video communication products during the COVID-19 nationwide public health emergency. This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19. This regulation shall remain in effect for 120 days or during any period in which a disaster declaration is in effect in the state of Colorado or nationally due to the presence of COVID-19, whichever is shorter.

The use of non-public facing remote communication products, including but not limited to audio only telephone calls, shall be considered HIPAA compliant for purposes of § 10-16-123, C.R.S. during the nationwide public health emergency period when OCR has enforcement discretion regarding HIPAA compliance and providers in Colorado are making a good faith provision of telehealth services.

The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary for the preservation of public health, safety, or welfare as allowing individuals broader access to telehealth services during the COVID-19 public emergency is imperative to preserve the health of the citizens of Colorado. Therefore, compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interest.

Section 3 Applicability

This regulation shall apply to all carriers offering individual, small group, and large group health benefit plans, managed care plans, and student health insurance coverage subject to the insurance laws of Colorado and the requirements of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), together referred to as the "Affordable Care Act" (ACA). This regulation does not apply to stand-alone dental plans.

Section 4 Definitions

A. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S.

B. "Commissioner" means, for the purposes of this regulation, the Commissioner of Insurance or his or her designee.

C. "Health benefit plan" shall have the same meaning as found at § 10-16-102(32), C.R.S.

D. "Health care services" shall have the same meaning as found at § 10-16-102(33), C.R.S.

E. "HIPAA" means, for the purposes of this regulation, the Health Insurance Portability and Accountability Act of 1996, which protects the privacy and security of certain health information.

F. Based on U.S. Department of Health and Human Services Office for Civil Rights FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency, as provided on the adopted date of this regulation and available at https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf, a "non-public facing remote communication product" shall mean an audio or video communication product that, as a default, allows only the intended parties to participate in the communication. Non-public facing remote communication products would include platforms such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Whatsapp video chat, Zoom, or Skype and commonly used texting applications such as Signal, Jabber, Facebook Messenger, Google Hangouts, Whatsapp, or iMessage. In contrast, public-facing products such as TikTok, Facebook Live, Twitch, or a public chat room are not acceptable forms of remote communication for telehealth because they are designed to be open to the public or allow wide or indiscriminate access to the communication.

G. "Provider" shall have the same meaning as found at § 10-16-102(56), C.R.S.

H. “Remote monitoring” shall have the same meaning as found at § 10-16-123(4)(b.5), C.R.S.

I. “Telehealth” shall have the same meaning as found at § 10-16-123(4)(e), C.R.S.

Section 5 Reimbursement for Telehealth Services

A. A carrier offering a health benefit plan in this state shall:

1. Reimburse providers for the provision of medically necessary covered health care services that are appropriately provided through telehealth, including but not limited to behavioral health, mental health, substance use disorder, occupational therapy, speech therapy, physical therapy services, dental services that are included in a health benefit plan, and remote monitoring of patients; and

2. Consistent with the guidance issued by HHS on March 17, 2020 on HIPAA enforcement discretion, provision of telehealth services using audio only telephone calls and non-public facing remote communication products shall be considered HIPAA compliant for purposes of § 10-16-123, C.R.S.

B. Telehealth services delivered by providers shall be reimbursed at rates not lower than in-person services delivered by providers and in compliance with state behavioral health parity laws.

C. Carriers shall not impose specific requirements or limitations on the technologies used to deliver telehealth services, including any limitations on audio only or live video technologies.

D. Carriers shall not require a covered person have a previously established patient/provider relationship with a specific provider in order for that covered person to receive medically necessary health care services via telehealth from that provider.

E. Carriers shall not impose additional certification, location, or training requirements as a condition of reimbursing providers for using telehealth services.

F. Carriers shall notify providers of any instructions necessary to facilitate billing for telehealth. Carriers shall ensure this information is prominently displayed on a public-facing website. For purposes of processing payment of a claim, a carrier shall not require a health professional to provide documentation of a health care service or procedure delivered as a telehealth service beyond what is required for the same service or procedure in an in-person setting.

D. If a carrier’s providers are unable to use telehealth to provide medically necessary health care services, carriers shall cover such telehealth services by a nonparticipating provider pursuant to § 10-16-704(2)(a), C.R.S.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Incorporated Materials

The U.S. Department of Health and Human Services Office of Civil Rights’ Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency (Notification) as published on the effective date of this regulation and does not include later amendments or editions of the Notification. A copy of the Notification may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of the Notification may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy

may also be obtained online at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This emergency regulation shall be effective December 15, 2020.

Section 9 History

The Emergency Regulation replaces Emergency Regulation 20-E-11 effective August 14, 2020.

20-E-16 Emergency Justification

The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary for the preservation of public health, safety, or welfare as allowing individuals broader access to telehealth services during the COVID-19 public emergency is imperative to preserve the health of the citizens of Colorado. Therefore, compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interest.

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Tracking number: 2020-00955

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Insurance

on 12/15/2020

3 CCR 702-4 Series 4-2

LIFE, ACCIDENT AND HEALTH

The above-referenced rules were submitted to this office on 12/16/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 30, 2020 09:45:58

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Board of Nursing

CCR number

3 CCR 716-1

Rule title

3 CCR 716-1 NURSING RULES AND REGULATIONS 1 - eff 12/07/2020

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12/07/2020

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04/06/2021

DEPARTMENT OF REGULATORY AGENCIES

Division of Professions and Occupations - Board of Nursing

NURSING RULES AND REGULATIONS

3 CCR 716-1

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

1.26 TEMPORARY LICENSURE OF PRACTICAL NURSES, PROFESSIONAL NURSES, ADVANCED PRACTICE NURSES, AND CERTIFIED NURSE ASSISTANTS AND TEMPORARY SUSPENSION OF CERTAIN NURSE AND NURSE AIDE EDUCATION REQUIREMENTS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2020 271

A. Basis. Through Executive Order D 2020 271, Governor Jared Polis governor temporarily suspended the emergency rulemaking authorities for the State Board of Nursing ("Board") set forth in section 24-1- 122(3)(gg), C.R.S, and directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2020 271 issued by Governor Jared Polis pursuant to the State of Emergency Declaration found in Executive Orders D 2020 003, D 2020 018, D 2020 032, D 2020 058, D 2020 076, D 2020 109 D 2020 125, , D 2020 152, D 2020 176, D 2020 205, D 2020 234, D 2020 258, D 2020 264, and D 2020 268, Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of the Department of Regulatory Agencies, through the Division Director, to effectuate Executive Order D 2020 271 directing the immediate expansion of the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. TEMPORARY LICENSURE

1. The Board may issue a temporary license to an applicant that is a new graduate of an approved practical nursing program who meets all qualifications for licensure with the exception of successful completion of the required examination as set forth in section 12-255-109, C.R.S.

    a. Practical Nursing new graduates must submit an application for temporary licensure.

    b. A temporary license issued from May 1, 2020, through August 29, 2020, is effective from the date of issuance through December 31, 2020.

        (1) New graduates issued a temporary license between May 1, 2020 through August 29, 2020 may apply for a second temporary license to expire 60 days after the applicant is scheduled to sit for the examination subject to the following terms:

            (a) The applicant shall submit documentation of registration for the required examination and a statement by the examination vendor affirming the applicant is registered for the next available examination; and

(b) The applicant shall attest that the scheduled examination in section (C)(1)(b)(1)(a) of this rule is the applicants first attempt to successfully complete the examination.

(2) On January 1, 2021, if a full license to practice practical nursing in Colorado has not been issued, the temporary licensee shall cease practice immediately and until such time as full licensure to practice practical nursing in Colorado has been granted or another temporary license has been issued pursuant to this Rule 1.26.

c. An initial temporary license issued to a new graduate on or after August 30, 2020 is effective from the date of issuance through March 31, 2021.

(1) New graduates issued a temporary license between August 30, 2020 and December 7, 2020 may apply for a second temporary license to expire 60 days after the applicant is scheduled to sit for the examination subject to the following terms:

(a) The applicant shall submit documentation of registration for the required examination and a statement by the examination vendor affirming the applicant is registered for the next available examination; and,

(b) The applicant shall attest that the scheduled examination in section (C)(1)(b)(1)(a) of this rule is the applicants first attempt to successfully complete the examination.

(2) On April 1, 2021, if a full license to practice practical nursing in Colorado has not been issued, the temporary licensee shall cease practice immediately and until such time as full licensure to practice practical nursing in Colorado has been granted or another temporary license has been issued pursuant to this Rule 1.26.

d. An initial temporary license issued to a new graduate on or after December 7, 2020 is effective from the date of issuance through June 30, 2021.

(1) On July 1 2021, if a full license to practice practical nursing in Colorado has not been issued, the temporary licensee shall cease practice immediately and until such time as full licensure to practice practical nursing in Colorado has been granted.

e. Practical Nurse applicants granted this temporary licensure shall practice under the direct supervision of a Colorado licensed professional nurse in good standing during the entire term of the temporary licensure.

(1) For the purpose of this emergency rule, “direct supervision” means the Colorado licensed professional nurse must be on the premises with the temporary practical nurse licensee and immediately available to respond to an emergency or provide assistance.

(2) For the purpose of this emergency rule, “premises” means within the same building, office or facility and within the physical proximity to establish direct contact with the patient should the need arise.

f. Once the temporary licensee successfully completes the statutorily required examination, the temporary licensee must immediately submit an application and the required fee for full licensure.

g. This temporary license is not renewable and does not create a property interest for the holder of the temporary license.

h. The temporary licensee may be subject to discipline by the Board as defined in section 12-255-101, *et seq.*, C.R.S.

2. The Board may issue a temporary license to an applicant that is a new graduate of an approved professional nursing program who meets all qualifications for licensure with the exception of successful completion of the required examination as set forth in section 12-255-109, C.R.S.

a. Professional Nursing new graduates must submit an application for temporary licensure.

b. A temporary license issued from May 1, 2020, through August 29, 2020, is effective from the date of issuance through December 31, 2020.

(1) New graduates issued a temporary license between May 1, 2020 through August 29, 2020 may apply for a second temporary license to expire 60 days after the applicant is scheduled to sit for the examination subject to the following terms:

(a) The applicant shall submit documentation of registration for the required examination and a statement by the examination vendor affirming the applicant is registered for the next available examination; and,

(b) The applicant shall attest that the scheduled examination in section (C)(2)(b)(1)(a) of this rule is the applicants first attempt to successfully complete the examination.

(2) On January 1, 2021, if a full license to practice professional nursing in Colorado has not been issued, the temporary licensee shall cease practice immediately and until such time as full licensure to practice professional nursing in Colorado has been granted or another temporary license has been issued pursuant to this Rule 1.26.

c. An initial temporary license issued to a new graduate on or after August 30, 2020, is effective from the date of issuance through March 31, 2021.

(1) New graduates issued a temporary license between August 30, 2020, and December 7, 2020, may apply for a second temporary license to expire 60 days after the applicant is scheduled to sit for the examination subject to the following terms:

(a) The applicant shall submit documentation of registration for the required examination and a statement by the examination vendor affirming the applicant is registered for the next available examination; and,

(b) The applicant shall attest that the scheduled examination in section (C)(1)(b)(1)(a) of this rule is the applicants first attempt to successfully complete the examination.

(2) On April 1, 2021, if a full license to practice professional nursing in Colorado has not been issued, the temporary licensee shall cease practice immediately and until such time as full licensure to practice professional nursing in Colorado has been granted or another temporary license has been issued pursuant to this Rule 1.26.

d. An initial temporary license issued to a new graduate on or after December 7, 2020, is effective from the date of issuance through June 30, 2021.

(1) On July 1 2021, if a full license to practice professional nursing in Colorado has not been issued, the temporary licensee shall cease practice immediately and until such time as full licensure to practice professional nursing in Colorado has been granted.

e. Professional Nurse applicants granted this temporary licensure shall practice under the direct supervision of a Colorado licensed professional nurse in good standing during the entire term of the temporary licensure.

(1) For the purpose of this emergency rule, “direct supervision” means the Colorado licensed professional nurse must be on the premises with the temporary professional nurse licensee and immediately available to respond to an emergency or provide assistance.

(2) For the purpose of this emergency rule, “premises” means within the same building, office or facility and within the physical proximity to establish direct contact with the patient should the need arise.

f. Once the temporary licensee successfully completes the statutorily required examination, the temporary licensee must immediately submit an application and the required fee for full licensure.

g. This temporary license is not renewable and does not create a property interest for the holder of the temporary license.

h. The temporary licensee may be subject to discipline by the Board as defined in section 12-255-101, C.R.S.*, et seq.*

4. The Board may issue a temporary license to a professional nurse or a practical nurse that holds an active, unrestricted professional or practical nurse license in good standing in a non-compact state.

a. Professional or Practical Nurses holding an active, unrestricted license in good standing in a non-compact state must submit an application for temporary licensure.

(1) The applicant must submit evidence of an active, unrestricted license, in good standing, to practice professional or practical nursing in a non-compact state.

b. An initial temporary license issued under this section C(4) of this rule is effective from the date of issuance through June 30, 2021.

c. This temporary license may be renewable beginning June 1, 2021, subject to the extension of the State of Emergency Declaration and Executive Order D 2020 271.

d. This temporary license does not create a property interest for the holder of the temporary license.

e. The temporary licensee may be subject to discipline by the Board as defined in section 12-255-101, C.R.S.*, et seq.*

D. TEMPORARY EMERGENCY NURSE AIDE CERTIFICATION

1. The Board may issue a temporary emergency certification to an applicant that is a new graduate of an approved nurse aide training program who meets all qualifications for certification with the exception of successful completion of the required examinations as set forth in section 12-260-108, C.R.S.

a. Nurse aide new graduates must submit an application for temporary certification.

b. A temporary certificate issued from May 1, 2020, through August 29, 2020, is effective from the date of issuance through December 31, 2020.

(1) New graduates issued a temporary certificate between May 1, 2020, through August 29, 2020, may apply for a second temporary certificate to expire 60 days after the applicant is scheduled to sit for the examination subject to the following terms:

(a) The applicant shall submit documentation of registration for the required written examination and a statement by the examination vendor affirming the applicant is registered for the next available examination; and,

(b) The applicant shall attest that the scheduled examination in section (D)(1)(b)(1)(a) of this rule is the applicants first attempt to successfully complete the written examination.

(c) The applicant shall attest that the applicant will register for the required skills examination within 60 days of availability in the applicant's regional area.

(1) For the purpose of this rule, "regional area" means within 250 miles of the applicant's residence.

(2) On January 1, 2021, if a full certificate to practice as a nurse aide in Colorado has not been issued, the temporary certificate holder shall cease practice immediately and until such time as full certification to practice as a nurse aide in Colorado has been granted or another temporary certificate has been issued pursuant to this Rule 1.26.

c. An initial temporary certificate issued to a new graduate on or after August 30, 2020, is effective from the date of issuance through March 31, 2021.

(1) New graduates issued a temporary license between August 30, 2020, and December 7, 2020, may apply for a second temporary license to expire

60 days after the applicant is scheduled to sit for the examination subject to the following terms:

(a) The applicant shall submit documentation of registration for the required written examination and a statement by the examination vendor affirming the applicant is registered for the next available written examination; and,

(b) The applicant shall attest that the scheduled examination in section (D)(1)(b)(1)(a) of this rule is the applicants first attempt to successfully complete the written examination.

(c) The applicant shall attest that the applicant will register for the required skills examination within 60 days of availability in the applicant's regional area.

(1) For the purpose of this rule, "regional area" means within 250 miles of the applicant's residence.

(2) On April 1, 2021, if a full certificate to practice as a nurse aide in Colorado has not been issued, the temporary certificate holder shall cease practice immediately and until such time as full certification to practice as a nurse aide in Colorado has been granted or another temporary certificate has been issued pursuant to this Rule 1.26.

d. An initial temporary emergency certificate issued to a new graduate on or after December 7, 2020, is effective from the date of issuance through June 30, 2021.

(1) On July 1 2021, if a full certificate to practice as a nurse aide in Colorado has not been issued, the temporary certificate holder shall cease practice immediately and until such time as full certification to practice as a nurse aide in Colorado has been granted.

e. Nurse aide applicants granted this temporary emergency certification shall practice under the direct supervision of a Colorado licensed professional nurse in good standing during the entire term of the temporary emergency certification.

(1) For the purpose of this emergency rule, "premises" means within the same building, office or facility and within the physical proximity to establish direct contact with the patient should the need arise.

(2) For the purpose of this emergency rule, "direct supervision" means the Colorado licensed professional nurse must be on the premises, in-person, with the temporary emergency certified nurse aide and immediately available to respond to an emergency or provide assistance with the following exception:

(a) For home-health or home-hospice settings, "direct supervision" of the temporary emergency certified nurse may include video telesupervision by a professional nurse, provided the nurse supervises the entire visit via video telesupervision and the professional nurse is within proximity of the home site to promptly respond to provide non-emergent assistance and immediately available to respond to an emergency by activating EMS to respond to the home site.

f. Once the temporary emergency certificate holder successfully completes the statutorily required examinations, the temporary emergency certificate must immediately submit an application and the required fee for full certification.

g. This temporary emergency certificate is not renewable and does not create a property interest for the holder of the temporary emergency certificate.

h.. The temporary emergency certificate holder may be subject to discipline by the Board as defined in section 12-255-101, *et seq.,* C.R.S.

2. The Board may issue a temporary emergency certification to a reinstatement applicant who meets all qualifications for certification with the exception of successful completion of the required skills examinations as set forth in Rule 1.10 (F).

a. An initial temporary emergency certificate issued to a new graduate on or after December 7, 2020, is effective from the date of issuance through June 30, 2021.

(1) On July 1 2021, if a full certificate to practice as a nurse aide in Colorado has not been issued, the temporary certificate holder shall cease practice immediately and until such time as full certification to practice as a nurse aide in Colorado has been granted.

b. Nurse aide applicants granted this temporary emergency certification shall practice under the direct supervision of a Colorado licensed professional nurse in good standing during the entire term of the temporary emergency certification.

(1) For the purpose of this emergency rule, “premises” means within the same building, office or facility and within the physical proximity to establish direct contact with the patient should the need arise.

(2) For the purpose of this emergency rule, “direct supervision” means the Colorado licensed professional nurse must be on the premises, in-person, with the temporary emergency certified nurse aide and immediately available to respond to an emergency or provide assistance with the following exception:

(a) For home-health or home-hospice settings, “direct supervision” of the temporary emergency certified nurse may include video telesupervision by a professional nurse, provided the nurse supervises the entire visit via video telesupervision and the professional nurse is within proximity of the home site to promptly respond to provide non-emergent assistance and immediately available to respond to an emergency by activating EMS to respond to the home site.

f. Once the temporary emergency certificate holder successfully completes the statutorily required examinations, the temporary emergency certificate must immediately submit an application and the required fee for full certification.

g. This temporary emergency certificate is not renewable and does not create a property interest for the holder of the temporary emergency certificate.

h. The temporary emergency certificate holder may be subject to discipline by the Board as defined in section 12-255-101, *et seq.,* C.R.S.

E. TEMPORARY REGISTRY ON THE ADVANCED PRACTICE REGISTRY

1. The Board may temporarily register on the advanced practice registry an applicant that is a new graduate of an approved advanced practice nurse program who meets all qualifications for registry with the exception of national certification as set forth in section 12-255-111(3)(b), C.R.S., provided the lack of national certification is due to unavailability of the examination required for such certification.

   a. Advanced practice nurse graduates must submit an application for temporary registration on the advanced practice registry.

   b. A temporary registration issued from May 1, 2020, through August 29, 2020, is effective from the date of issuance through December 31, 2020.

      (1) New graduates issued a temporary registration between May 1, 2020, through August 29, 2020, may apply for a second temporary registration to expire 60 days after the applicant is scheduled to sit for the examination subject to the following terms:

         (a) The applicant shall submit documentation of registration for the required examination and a statement by the examination vendor affirming the applicant is registered for the next available examination; and

         (b) The applicant shall attest that the scheduled examination in section (E)(1)(b)(1)(a) of this rule is the applicants first attempt to successfully complete the examination.

      (2) On January 1, 2021, if a full registration to practice as an advanced practice registered nurse in Colorado has not been issued, the temporary registration holder shall cease practice immediately and until such time as full registration to practice as an advanced practice registered nurse in Colorado has been granted or another temporary registration has been issued pursuant to this Rule 1.26.

   c. An initial temporary registration issued to a new graduate on or after August 30, 2020, is effective from the date of issuance through March 31, 2021.

      (1) New graduates issued a temporary license between August 30, 2020, and December 7, 2020, may apply for a second temporary license to expire 60 days after the applicant is scheduled to sit for the examination subject to the following terms:

         (a) The applicant shall submit documentation of registration for the required written examination and a statement by the examination vendor affirming the applicant is registered for the next available written examination;

         (b) The applicant shall attest that the scheduled examination in section (E)(1)(b)(1)(a) of this rule is the applicants first attempt to successfully complete the written examination; and

         (c) The applicant shall attest that the applicant will register for the required skills examination within 60 days of availability in the applicant's regional area.

(1) For the purpose of this rule, “regional area” means within 250 miles of the applicant’s residence.

(2) On April 1, 2021, if a full registration to practice as an advanced practice registered nurse in Colorado has not been issued, the temporary registrant shall cease practice immediately and until such time as full registration to practice as an advanced practice registered nurse in Colorado has been granted or another temporary registration has been issued pursuant to this Rule 1.26.

d. An initial temporary emergency registration issued to a new graduate on or after December 7, 2020, is effective from the date of issuance through June 30, 2021.

(1) On July 1 2021, if a full registration to practice as an advanced practice registered nurse in Colorado has not been issued, the temporary registrant holder shall cease practice immediately and until such time as full registration to practice as an advanced practice registered nurse in Colorado has been granted.

e. Advanced practice nurse applicants granted this temporary registration on the advanced practice registry shall practice under the direct supervision of an Advanced Practice Nurse registered on the Colorado advanced practice registry in good standing during the entire term of the temporary licensure.

(1) For the purpose of this emergency rule, “direct supervision” means the Advanced Practice Nurse registered on the Colorado advanced practice registry must be on the premises with the temporarily registered advanced practice nurse and immediately available to respond to an emergency or provide assistance.

(2) For the purpose of this emergency rule, “premises” means within the same building, office or facility and within the physical proximity to establish direct contact with the patient should the need arise.

f. Once the temporarily registered advanced practice nurse successfully completes the required examination, the temporarily registered advanced practice nurse must immediately submit an application and the required fee for full registration on the advanced practice registry.

g. This temporary registration on the advanced practice registry is not renewable and does not create a property interest for the holder of the temporary registration on the advanced practice registry.

h. The temporarily registered advanced practice nurse may be subject to discipline by the Board as defined in section 12-255-101, C.R.S., *et seq.,* and shall be subject to professional liability requirements set forth in 12-255-113, C.R.S.

F. TEMPORARY SUSPENSION OF CERTAIN NURSE AND NURSE AIDE EDUCATION REQUIREMENTS RELATED TO COVID-19

1. Pursuant to this emergency rule, promulgated in compliance with Executive Order D 2020 271 the following State Board of Nursing Rules are temporarily suspended effective December 7, 2020, for a period of no longer than 120 days:

a. Rule 1.2 C.11 (requiring concurrent clinical and theory experiences to allow clinical hours to be completed beyond six (6) months of relevant theory content);

b. Rule 1.2 E.15.c.(4)(a) (requiring a minimum of four hundred (400) clinical hours graduation from a practical nursing education program);

c. Rule 1.2 E.15.c.(4)(b) (requiring a minimum of seven hundred fifty (750) clinical hours for graduation from a professional nursing education program);

d. Rule 1.2 E.15.c.(4)(c) (requiring fifty percent of clinical hours in the Medical Surgical Nursing II, Community Health and Capstone (practicum) courses, pediatrics, obstetrics, psychiatric and medical surgical nursing, including those clinical hours required for nurse refresher courses, be completed in a clinical setting);

e. Rule 1.2 E.15.c.(13)(d) (requiring faculty supervision for healthcare related volunteer experiences);

f. Rule 1.10.D.12.a (requiring successful completion of a written and skills-based examination prior to certification); and,

g. Rule 1.11.E.2.a (requiring a minimum of sixteen (16) hours of clinical instruction be performed in a clinical setting).

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

Colorado Governor Jared Polis declared a state of emergency on March 10, 2020, through Executive Order D 2020 003, which was subsequently extended through Executive Orders D 2020 018, D 2020 032, D 2020 058, D 2020 076, D 2020 109, D 2020 125, D 2020 176, D 2020 205, D 2020 234, D 2020 258, D 2020 264, and D 2020 268 to meet the challenges of the COVID-19 pandemic by mitigating the harm caused by the spread of the disease. Executive Order D 2020 038 was issued on April 15, 2020, extended through Executive Orders D 2020 063, D 2020 097, D 2020 131, D 2020 158, D 2020 182, D 2020 212, and D 2020 240, and amended, restated and extended through Executive Order 2020-271 to address the immediate need for trained medical personnel available to provide healthcare services during the COVID-19 pandemic.

Basis

The basis for these emergency rules is Executive Order D 2020 271, which amended, restated and extended Executive Orders D 2020 038, D 2020 063, D 2020 097, and D 2020 131, D 2020 158, D 2020 182, D 2020 212, and D 2020 240 issued by Governor Jared Polis pursuant to the State of Emergency Declaration found in Executive Orders D 2020-003, D 2020-018, D 2020 032, D 2020 058, D 2020 076, D 2020 109, D 2020 125, D 2020 152, D 2020 176, D 2020 205, D 2020 234, D 2020 258, D 2020 264, and D 2020 268, Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq.*, C.R.S.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2020 271, amending, restating and extending Executive Orders D 2020 038, directing the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

Due to the COVID-19 pandemic, nurse and nurse aid educational programs are unable to secure clinical education placements for its students to complete the requisite education in clinical settings, leaving nursing and nurse aide students unable to progress through their education, including graduation, leaving thousands of trained nursing personnel unable to enter the workforce.

In addition, the COVID-19 pandemic has resulted in the indefinite postponement of examinations required for licensure across the United States, including Colorado, Even as the testing centers re-open, the number of seats available for each scheduled examination have been drastically reduced in order to comply with Social Distancing requirements, leaving thousands of otherwise qualified nursing and nurse aide graduates unable to enter the workforce.

Through this emergency rulemaking, the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Profession and Occupations (Division Director), is extending the suspension of State Board of Nursing Rules related to nurse and nurse aide education and nurse aide examinations, as set forth in Executive Order 2020 271; and granting temporary licensure for nurse and nurse aide graduates who are eligible for licensure but for successful completion of the requisite examination, in order to expand the available healthcare workforce.

Justification

As set forth in Executive Order 2020 271, the need exists to immediately expand the available healthcare workforce. The Executive Director of the Department of Regulatory Agencies, through the Division Director, is promulgating these emergency rules governing temporary licensure for new graduate applicants who meet the qualifications for licensures but for the required examination that is not immediately available due to the COVID-19 pandemic.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order 2020 271 and, that due to threat posed by the COVID-19 pandemic, the adoption of emergency rules to expand the available healthcare workforce is imperatively necessary for the preservation of the public health, safety and welfare.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect December 7, 2020, and remain in effect for the longer of (A) 30 days after adoption, or (B) the duration of the State of Disaster Emergency declared by the Governor, up to a maximum of 120 days after adoption of these temporary/emergency rules.

Dated this 7th day of December, 2020.

Ronne Hines, Director
Division of Professions and Occupations

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

STATE OF COLORADO
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Office of the Attorney General

Tracking number: 2020-00934

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Board of Nursing

on 12/07/2020

3 CCR 716-1

NURSING RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 12/18/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 23, 2020 14:40:08

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of State

Agency

Secretary of State

CCR number

8 CCR 1505-11

Rule title

8 CCR 1505-11 NOTARY PROGRAM RULES 1 - eff 12/31/2020

Effective date

12/31/2020

Expiration date

03/31/2021

COLORADO SECRETARY OF STATE

[8 CCR 1505-11]

NOTARY PROGRAM RULES

Rules as Adopted - Clean

December 1, 2020

(*Publication instructions/notes* may be included):

Amendments to 8 CCR 1505-11:

[New Rule 2.1.1]

2.1.1 An applicant must put his or her legal name on applications and renewals. The first and last name must match the name on the applicant's government-issued identification. If the last name on the identification contains more than one name, the applicant must include all of those names in the last name field on the application and not abbreviate any part.

[Not shown: current Rules 2.1.1 through 2.1.6 are renumbered as Rules 2.1.2 through 2.1.7]

[New Rule 2.3]

2.3 Communication

2.3.1 A notary public must be able to communicate directly with, be understood by, and understand the individual for whom the notary public is performing a notarial act.

2.3.2 A notary public may not use a translator or translator services to communicate with the individual for whom the notary public is performing a notarial act. This prohibition applies to all methods of notarization, including electronic and remote notarization, authorized by The Revised Uniform Law on Notarial Acts (Title 24, Article 24, Part 5, C.R.S.).

[Current Rule 3.3.2 is amended.]

3.3.2 A certificate of successful completion of an approved course of instruction expires 90 days from the date of issuance.

[Current Rule 3.3.3 is amended.]

3.3.3 The certificate of proof of successful completion of an approved course of

instruction must contain:

(a) The name of the vendor or course provider who provided the course;

(b) The name of the person who completed the course;

(c) The date of completion of the course;

(d) The statement, “This certificate of proof of completion is valid for a period of 90 days from the date of issuance.”; and

(e) For vendors, the seal of accreditation.

[New Rule 5]

Rule 5. Remote Notarization

5.1 Definitions

As used in the Revised Uniform Law on Notarial Acts (Title 24, Article 21, Part 5, C.R.S.) and this Rule 5, unless otherwise stated:

5.1.1 “Personal information” means any information or data that is collected or used in order to complete the transaction subject to remote notarization or in the remote notarization itself. The term includes but is not limited to data included in the electronic record that is being remotely notarized.

5.1.2 “Provider” refers collectively to both remote notarization system providers and remote notarization storage providers.

5.1.3 “Remote notarization system provider” means a business entity that provides a remote notarization system, as defined in section 24-21-502(11.7), C.R.S., that includes storage of both the notarized electronic records and the audio-video recordings required by section 24-21-514.5(9)(a), C.R.S.

5.1.4 “Remote notarization storage provider” means a business entity that solely provides storage of notarized electronic records and the audio-video recordings required by section 24-21-514.5(9)(a), C.R.S.

5.2 Requirements for Remote Notaries

5.2.1 Application

(a) A notary public must submit a notice of intent on the approved application form and receive approval from the Secretary of State before the notary can remotely notarize a document. The notary must submit proof of successful completion of remote notarization training and examination and the required fee.

(b) A notary public must already be commissioned as a Colorado notary public with Active status to be approved as a remote notary.

(c) An individual may file the notice of intent when initially applying to become a Colorado notary public but may only remotely notarize a document after being commissioned and approved.

(d) A remote notary public must renew every four years or until his or her regular notary public commission requires renewal, whichever date comes first. No more than 90 days before renewing his or her remote notary status, the remote notary public must successfully complete the renewal training, pass the required exam, and pay the required fee.

(e) In applying to become a remote notary public or upon renewal, the individual must select at least one approved remote notarization system provider. An applicant may select multiple approved system providers.

5.2.2 Approved Course of Instruction/Examination

(a) The Secretary will provide a remote notarization training course and examination.

(b) If the Secretary determines that there is a need for additional instructors, the Secretary may designate a third-party training course or appoint certified notary public instructors to administer the remote training course and testing for applicants.

5.2.3 Requirements for Remote Notary Public Seal and Electronic Signature

(a) Form of remote notary public seal and electronic signature

(1) A remote notary public must affix to an electronic record a seal that in both appearance and content matches the manually applied official stamp required by section 24-21-517, C.R.S.

(2) The electronic signature used by the remote notary public for remote notarizations must match in appearance the image of the signature that the remote notary public submitted to the Secretary of State for and is on file as the notary's most recent underlying commission as a Colorado notary public. This is the signature identified as the notary public's "official signature" on the notary's most recent affirmation form or on the notary's most recent signature change form, whichever was filed later. A remote notary public may not use the remote notarization application or any update form to change the notary's official signature.

(b) Use of and access to remote notary public's seal and electronic signature

(1) The remote notary's seal and electronic signature must:

(A) Be retained under the remote notary public's sole control and access through the authentication required by Rule 5.3.3 (a)(4).

(B) Appear as images on any visual or printed representation of a remote notarial certificate regardless of the technology being used to affix the images; and

(C) Be attached or logically associated with both the electronic record being notarized and the certificate of notarial act being affixed and linked such that any subsequent alteration to either item is observable through visual examination, i.e., the document must be rendered tamper-evident.

(2) A remote notary public's employer, including the employer's employees and agents, must not use or permit the use of a remote notary's seal or electronic signature by anyone except the remote notary public.

(3) On resignation from or the revocation of the notary public's commission or on the death or adjudication of incompetency of the notary public, the notary or that notary's personal representative or guardian must delete the notary's seal and electronic signature from the remote notary system provider's system.

5.2.4 Journal to record remote notarizations

(a) In addition to the journal information required by section 24-21-519(3), C.R.S., the remote notary public must record the name of the remote notarization system provider used for each remote notarization.

(b) The remote notary public must retain his or her electronic journal under the remote notary public's sole control and access and all other requirements of section 24-21-519, C.R.S. apply.

(c) The electronic journal must be securely backed up and be tamper-evident.

(d) On resignation from or the revocation of the notary public's commission or on the death or adjudication of incompetency of the notary public, the notary or that notary's personal representative or guardian with knowledge of the existence of or knowingly in possession of the remote notarization journal and recordings must retain or dispose of the journal and the audio-video recordings in accordance with sections 24-21-514.5(9)(c) and 24-21-519, C.R.S. Only remote notarization system

providers and remote notarization storage providers that have been approved by the Secretary of State may store audio-video recordings.

5.2.5 A remote notary public must stop and restart the remote notarization process from the beginning if:

(a) The remotely located individual or the remote notary public must exit the remote notarization system before completion of the notarial act;

(b) The audio or visual feed is interrupted or terminated; or

(c) The resolution or quality of the transmission becomes such that the remote notary public believes the process has been compromised and cannot be completed.

5.2.6 A remote notary public has an ongoing duty to verify that each remote notary provider used has Active status with the Secretary of State's office before using that provider's remote notarization system to perform a remote notarization. This duty extends to each remote notarization.

5.2.7 In accordance with section 24-21-529(2), C.R.S., a remote notary may charge a fee, not to exceed ten dollars, for the notary's electronic signature.

5.2.8 A remote notary public must notify the Secretary of State in writing through the Secretary of State's online system within 30 days after changing a remote notarization system provider or remote notarization storage provider.

5.2.9 Expiration of the Secretary of State's approval to perform remote notarizations:

(a) Approval automatically expires:

(1) Upon revocation, expiration, or resignation of the notary's commission;

(2) 30 days after the notary's name changes unless the notary previously submitted a name change.

(3) Upon conviction of a felony;

(4) Upon conviction of a misdemeanor involving dishonesty;

(5) If the notary no longer has a place of employment or practice or a residential address in the state of Colorado; or

(6) Upon the revocation of approval of the remote notarization system provider or the remote notarization storage provider used by the remote notary public unless the remote notary public either notified the Secretary of State of another provider or already has alternative providers on file with the Secretary of

State as authorized by Rule 5.2.1(e).

(b) If approval expires, the remote notary public or the notary's authorized representative must delete the notary's seal and electronic signature from the remote notary provider's system and dispose of the journal and the audio-video recordings in accordance with sections 24-21-514.5(9)(c) and 24-21-519, C.R.S. unless within 30 days of the expiration, the Secretary of State reapproves the notary.

5.3 Requirements for providers

5.3.1 Provider Protocols

(a) The Colorado Secretary of State's Provider Protocols (December 1, 2020) are hereby incorporated by reference.

(1) Material incorporated by reference in the Notary Rules does not include later amendments or editions of the incorporated material.

(2) Copies of the material incorporated by reference may be obtained by contacting the Colorado Department of State, 1700 Broadway, Suite 550, Denver, CO 80290, (303) 894-2200. Copies are also available online at https://www.sos.state.co.us/pubs/notary/home.html

(b) All providers must meet the requirements of the Provider Protocols.

5.3.2 Application

(a) A provider must submit the approved application form and receive approval from the Secretary of State before the provider can provide services to a Colorado remote notary public.

(b) The applicant must provide to the Secretary of State in its application:

(1) The certification required by section 24-21-514.5 (11)(a), C.R.S.

(2) The following information:

(A) The names of all business entities and any of their affiliates that will have access to either personally identifying information and any non-personally identifying data gathered during the remote notarization process and procedures; and

(B) A copy of the data privacy policy provided to users, which clearly specifies the permissible uses for both personally identifying and non-personally identifying

data.

(3) All data and technology specifics required in the application and set forth in the Provider Protocols under Rule 5.3.1.

(c) At the time of application, the applicant must be in Good Standing status as a business entity registered to do business in Colorado and must continue to maintain that status while providing remote notarization services to Colorado remote notaries public.

(d) The Secretary of State may require an applicant to supplement its application with additional information, including an in-person demonstration or electronic demonstration of the applicant's system.

(e) The applicant must pay the required application fee.

5.3.3 Criteria and standards for approval of remote notarization system providers.

(a) In order to be approved and maintain continuing eligibility, a remote notarization system provider must:

(1) Provide a remote notarization system that complies with the technical specifications of these rules and the standards, including data security and integrity requirements, set forth in the Secretary of State's Provider Protocols under Rule 5.3.1;

(2) Verify the authorization of a Colorado notary public to perform remote notarial acts before each remote notarization;

(3) Suspend the use of its remote notarization system for any remote notary public if the notary's underlying commission or the Secretary of State's approval of the notary public to perform remote notarizations has been denied, suspended, or revoked by the Secretary or when the notary has resigned; and

(4) Ensure that access to a remote notary public's electronic signature and seal is limited solely to the remote notary public and protected by the use of a password authentication, token authentication, biometric authentication, or other form of authentication that is described in the remote notarization system provider's application.

(5) Verify that a Colorado remote notary public has Active status with the Secretary of State's office at the time of each remote notarization.

(b) Communication technology provided by the remote notarization system provider must:

(1) Provide for continuous, synchronous audio-visual feeds;

(2) Provide sufficient video resolution and audio clarity to enable the remote notary public and the remotely located individual to see and speak to one another simultaneously through live, real time transmission;

(3) Provide sufficient captured image resolution for credential analysis to be performed in accordance with section 24-21-514.5(6)(b)(II), C.R.S., and this Rule 5;

(4) Include a means of authentication that reasonably ensures only the proper parties have access to the audio-video communication;

(5) Be capable of securely creating and storing or transmitting securely to be stored an electronic recording of the audio-video communication, keeping confidential the questions asked as part of any identity proofing assessment, and the means and methods used to generate the credential analysis output; and

(6) Provide reasonable security measures to prevent unauthorized access to:

(A) The live transmission of the audio-video communication;

(B) A recording of the audio-video communication;

(C) The verification methods and credentials used to verify the identity of the principal; and

(D) The electronic records presented for remote notarization.

(c) Credential analysis provided by a remote notarization system provider must satisfy the requirements of the Secretary of State's Provider Protocols under Rule 5.3.1.

(d) Dynamic, knowledge-based authentication assessment, if selected by a remote notarization system provider as the method of verifying the identity of the remotely located individual per section 24-21-514.5(6)(b)(II)(A), C.R.S., must satisfy the requirements of the Secretary of State's Provider Protocols under Rule 5.3.1.

(e) Public Key Certificate or an identity verification method by a trusted third party. A remote notarization system provider may satisfy section 24-21-514.5(6)(b)(II)(B) or (c), C.R.S., by providing a method of identification of the remotely located individual that satisfies the requirements of the Secretary of State's Provider Protocols under Rule 5.3.1.

(f) Data Storage and security

A remote notarization system provider must provide a storage system that complies with the technical specifications of these rules and the standards, including data security and integrity protocols, set forth in the secretary of state's Provider Protocols under Rule 5.3.1.

5.3.4 Criteria and standards for approval of remote notarization storage providers

In order to be approved and maintain continuing eligibility, a remote notarization storage provider must provide a storage system that complies with the technical specifications of these rules and the standards, including data security and integrity protocols, set forth in the Secretary of State's Provider Protocols under Rule 5.3.1.

5.3.5 Notifications

(a) If a remote notarization system provider or storage provider becomes aware of a possible security breach involving its data, the provider must give notice to both the Secretary of State and each Colorado remote notary public using its services no later than 30 days after the date of determination that a security breach occurred. The provider must comply with any other notification requirements of Colorado's data privacy laws.

(b) No later than 30 days before making any changes to the remote notarization system or storage system used by Colorado remote notaries that would impact any previously provided answer in its application about its system that would affect the provider's eligibility for approval, a provider must both request approval from the Secretary of State and notify each Colorado remote notary public using its services. Changes to the system or storage must conform to statutory and rule requirements.

(c) For non-system or storage-related changes to the provider's information on file with the Secretary of State, the provider must notify and update information provided to the Secretary of State no later than 30 days after changes to the provider's previously supplied information. This requirement includes changes to the disclosures required by Rule 5.3.2(b)(2).

5.3.6 Complaints. A person may file a complaint with the Secretary of State against an approved provider. The complaint must allege a specific violation of Colorado's Revised Uniform Law on Notarial Acts or these rules. The person must submit the signed and dated complaint on the Secretary of State's standard form.

5.3.7 Grounds for termination of approval. The Secretary of State may terminate approval of a provider for any of the following reasons:

(a) Violation of any provision of Colorado's Revised Uniform Law on Notarial Act or these rules;

(b) Making representations that the Secretary of State endorses, recommends, or mandates use of any of the provider's products, goods, or services;

(c) If the provider sustains a data breach; and

(d) Failure to timely respond to the Secretary of State's request for information or otherwise cooperate with an investigation, including providing requested information.

5.3.8 Right to appeal denial or termination of approval. If the Secretary of State denies or proposes to terminate an approved provider's status, the provider has the right to request a hearing as provided in the State Administrative Procedure Act, (Article 4 of Title 24, C.R.S.)

(a) If the provider does not request a hearing, termination of approval will be effective 30 days after the mailing date of the termination notice.

(b) Termination does not bar the Secretary of State from beginning or continuing an investigation concerning the provider.

5.4 Use of personal information

5.4.1 The limited exceptions in section 24-21-514.5(11)(c)(I) through (IV), C.R.S., do not include or authorize the use of personal information for the purpose of generating additional business or marketing opportunities by or for:

(a) The remote notary;

(b) The remote notary's employer or any business for whom the remote notary may be providing contracted services; or

(c) The provider or any of its affiliates.

5.4.2 Such use is prohibited and cannot be waived by the explicit consent required section 24-21-514.5(9)(a)(II), C.R.S., or otherwise.

STATE OF COLORADO
Department of State
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Suite 200
Denver, CO 80290

Jena Griswold
Secretary of State

Ian Rayder
Deputy Secretary of State

Statement of Justification and Reasons for Adoption of Temporary Rules

Office of the Secretary of State
Notary Program Rules
8 CCR 1505-11

December 1, 2020

New Rules: 2.1.1, 2.3, and 5 (replaces 10/15/2020 emergency rule)
Amended Rules: 3.3.2 and 3.3.3
Renumbered Rules: Rules 2.1.1 through 2.1.6 are renumbered as Rules 2.1.2 through 2.1.7

The Secretary of State finds that certain amendments to the existing notary program rules must be adopted and effective December 31, 2020, to ensure the uniform and proper administration, implementation, and enforcement of the Colorado Revised Uniform Law on Notarial Acts (RULONA)[1].

On October 15, 2020, the Secretary issued a notice of permanent rulemaking. Simultaneously, the Secretary readopted temporary Rule 5 as necessary to extend authorization and minimum standards for remote notarizations until permanent rules may be established. Today, December 1, 2020, the Secretary of State temporarily and permanently adopted New Rule 5 and other rule amendments. Temporary adoption, with a December 31, 2020 effective date, is necessary to implement Senate Bill 20-096. (For reference: the rules are permanently adopted under CCR Tracking # 2020-00819.)

For these reasons, and in accordance with the State Administrative Procedure Act, the Secretary of State finds that temporary adoption of the amendments to existing notary program rules is imperatively necessary to comply with state and federal law and to promote public interests.[2]

[1] Article 24, Title 21 of the Colorado Revised Statutes.
[2] Section 24-4-103(3) (6), C.R.S. (2020).

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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Office of the Attorney General

Tracking number: 2020-00932

Opinion of the Attorney General rendered in connection with the rules adopted by the

Secretary of State

on 12/01/2020

8 CCR 1505-11

NOTARY PROGRAM RULES

The above-referenced rules were submitted to this office on 12/01/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 18, 2020 15:28:58

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Human Services

Agency

Income Maintenance (Volume 3)

CCR number

9 CCR 2503-5

Rule title

9 CCR 2503-5 ADULT FINANCIAL PROGRAMS 1 - eff 01/01/2021

Effective date

01/01/2021

Expiration date

04/03/2021

9 CCR 2503-5

3.530 OLD AGE PENSION (OAP) PROGRAM

The Old Age Pension (OAP) program provides financial assistance and may provide health care benefits for low-income Colorado residents who are sixty (60) years of age or older who meet all financial and non-financial eligibility requirements.

A. The total monthly OAP grant standard, as set by the State Board of Human Services, is $832.00, effective January 1, 2021.

B. Effective January 1, 2021, the maximum monthly In-Kind Support and Maintenance (ISM) deduction amount for shelter costs is $284.00.

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9 CCR 2503-5

3.546 AID TO THE NEEDY DISABLED-COLORADO SUPPLEMENT (AND-CS) PROGRAM

The Aid to the Needy Disabled-Colorado Supplement (AND-CS) program provides a supplemental payment for client's age zero (0) to fifty-nine (59) who are receiving SSI due to a disability or blindness, but are not receiving the full SSI benefit standard, as defined in Section 3.510.

A. The total AND-CS grant standard is $794.00, effective January 1, 2021.

****

D. Effective January 1, 2021, the maximum ISM amount for shelter costs is $284.00.

Title of Proposed Rule:	Old Age Pension and Aid to the Needy Disabled Colorado Supplement Cost of Living Adjustment (COLA) Increase for 2021	
CDHS Tracking #:	20-10-16-01	
Office, Division, & Program: Office of Economic Security, Employment & Benefits Division, Adult Financial Programs	Rule Author: Erin Barajas	Phone: 720-955-1957 E-Mail: erin.barajas@state.co.us

RULEMAKING PACKET

Type of Rule: *(complete a and b, below)*

a. [X] Board [ ] Executive Director

b. [ ] Regular [X] Emergency

This package is submitted to State Board Administration as: *(check all that apply)*

[x] AG Initial Review	[x] Initial Board Reading	[ ] AG 2nd Review	[ ] Second Board Reading / Adoption

This package contains the following types of rules: *(check all that apply)*

Number	
X	Amended Rules
	New Rules
	Repealed Rules
	Reviewed Rules

What month is being requested for this rule to first go before the State Board?	December

What date is being requested for this rule to be effective?	January 1, 2021
Is this date legislatively required?	No

I hereby certify that I am aware of this rule-making and that any necessary consultation with the Executive Director's Office, Budget and Policy Unit, and Office of Information Technology has occurred.

Office Director Approval: _____ Date: _____

REVIEW TO BE COMPLETED BY STATE BOARD ADMINISTRATION

Comments:

Estimated Dates:	1st Board	12/04/2020	2nd Board	01/08/2021	Effective Date	01/01/2021 (Emergency) 03/02/2021 (Permanent)

Title of Proposed Rule:	Old Age Pension and Aid to the Needy Disabled Colorado Supplement Cost of Living Adjustment (COLA) Increase for 2021	
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STATEMENT OF BASIS AND PURPOSE

Summary of the basis and purpose for new rule or rule change.
Explain why the rule or rule change is necessary and what the program hopes to accomplish through this rule. ***1500 Char max***

On October 13, 2020, the U.S. Social Security Administration (SSA) announced a 1.3% Cost of Living Adjustment (COLA) for all Social Security and Supplemental Security Income recipients effective December 31, 2020. Colorado has a Maintenance of Effort requirement with the U.S. Social Security Administration that requires the State to "pass through" the COLA to recipients in order to spend at least the same amount in the current year as in the year prior. This means an increase in the Adult Financial assistance to program recipients. The SSA COLA will increase the Supplemental Security Income (SSI) maximum payment to program recipients by eleven dollars ($11) ($783 x 1.3% = $11) to $794 per month.

This rule will revise the Colorado Department of Human Services rules to increase the Old Age Pension (OAP) grant standard to $832 and the Aid to the Needy Disabled Colorado Supplement (AND-CS) grant standard to $794 in order to pass along the $11 COLA increase.

An emergency rule-making (which waives the initial Administrative Procedure Act noticing requirements) is necessary:

x	to comply with state/federal law and/or
	to preserve public health, safety and welfare

Justification for emergency:

20 CFR 416 et seq. requires a Maintenance of Effort (MOE) between the State of Colorado and the Social Security Administration (SSA). This MOE requires that Colorado spend at least the same amount in the current year as they did in the previous year for specific categories of assistance, which includes OAP and AND-CS recipients who receive SSI. Failure to pass along the COLA could impact the MOE agreement with the SSA. Failure to comply with the terms of the MOE could jeopardize Medicaid Federal Financial Participation (FFP) funds as the SSA could impose a sanction of no less than one full quarter FFP match (approximately $300-350 million) for every month Colorado does not meet the MOE requirement.

This COLA increase will be completed in the Colorado Benefits Management System (CBMS). The aforementioned recipients live at 77% of the Federal poverty level. Adoption of these rules will allow these individuals to improve income levels by granting an increase for their daily living expenses, positively impacting the health, safety, and welfare of recipients.

State Board Authority for Rule:

Code	Description
26-1-107, C.R.S. (2020)	State Board to promulgate rules
26-1-109, C.R.S. (2020)	State department rules to coordinate with federal programs
26-1-111, C.R.S. (2020)	State department to promulgate rules for public assistance and welfare activities.

Title of Proposed Rule:	Old Age Pension and Aid to the Needy Disabled Colorado Supplement Cost of Living Adjustment (COLA) Increase for 2021	
CDHS Tracking #:	20-10-16-01	
Office, Division, & Program: Office of Economic Security, Employment & Benefits Division, Adult Financial Programs	Rule Author: Erin Barajas	Phone: 720-955-1957 E-Mail: erin.barajas@state.co.us

Program Authority for Rule: *Give federal and/or state citations and a summary of the language authorizing the rule-making function AND authority.*

Code	Description
24-4-103, C.R.S. (2020)	Provides for emergency adoption of rules
26-2-111, C.R.S. (2020)	Describes eligibility for Old Age Pension and Aid to the Needy Disabled
26-2-114, C.R.S. (2020)	Provides state board authority to adjust the minimum award of Old Age Pension if living costs have changed sufficiently to justify such adjustment
Colorado Constitution, Article XXIV, Section 6	Provides the state board of public welfare, or such other agency as may be authorized by law power to adjust the basic minimum award for Old Age Pensions if living costs have changed sufficiently to justify that action.
26-2-119, C.R.S. (2020)	Provides the state department authority and encourages it to adjust the aid to the needy disabled assistance payment to reflect increases in the cost of living.
20 CFR 416.2095 et seq.	Requires a maintenance of effort with SSA

Does the rule incorporate material by reference? [ ] Yes [X] No

Does this rule repeat language found in statute? [ ] Yes [X] No

If yes, please explain.

Title of Proposed Rule:	Old Age Pension and Aid to the Needy Disabled Colorado Supplement Cost of Living Adjustment (COLA) Increase for 2021	
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REGULATORY ANALYSIS

1. List of groups impacted by this rule.

Which groups of persons will benefit, bear the burdens or be adversely impacted by this rule?

This rule change will impact all OAP and AND-CS recipients. All OAP and AND-CS recipients will receive an eleven dollar ($11) increase to their monthly grant. OAP recipients maximum grant will increase to $832 ($821 + $11 = $832). AND-CS recipients maximum grant will increase to $794 ($783 + $11 = $794).

This rule change will also impact OAP and AND-CS recipients that have an In-kind Support Maintenance (ISM) calculation because they are not paying their fair share of shelter and utility costs. The ISM is applied as in-kind income in the calculation of benefits. The new maximum ISM amount is $284. ($794 x 33.33% = $264 + $20 = $284)

2. Describe the qualitative and quantitative impact.

How will this rule-making impact those groups listed above? How many people will be impacted? What are the short-term and long-term consequences of this rule?

The rule will result in an increase of $11 to the OAP Grant Standard $832 ($821 + $11 = $832) and will impact all OAP recipients, approximately 19,507 individuals. The rule will result in an increase of $11 to the AND-CS Grant Standard $794 ($783 + $11 = $794) and will impact all AND-CS recipients, approximately 519 individuals.

This increase will ensure that the recipients do not go below 77% of the federal poverty level and will provide them with increased means to meet their basic living needs. This change may impact the food assistance benefits received by these clients. Approximately for every three dollars ($3) additional cash assistance received could result in a decrease of the Food Assistance amount by one dollar ($1). If an individual receives the full increase of eleven dollars ($11), his/her Food Assistance amount may decrease by three dollars ($3).

Long-term, increasing the grant standard will assist the State in meeting the SSA MOE. If the State fails to meet the provisions of the MOE, Medicaid Federal Financial Participation (FFP) funds will be placed in jeopardy.

The ISM adjustment only impacts those individuals who are not currently paying their fair share of shelter costs. Less than two percent (2%) of the combined OAP and AND-CS caseload has any type of in-kind income, and not all of those will have the ISM deduction. In simplified terms, we will assume that the client has no income or resources and, up to this point, would qualify for the full OAP or AND-CS grant. However, the county then looks to see if the client is paying his/her fair share for shelter, which includes utilities. The total shelter cost is then divided by the number of people living in the home to determine each person's fair share for shelter costs. If the client is not paying a fair share, the ISM deduction may apply. The amount the client is charged as income for unpaid shelter costs is never more than the ISM amount set in rule.

3. Fiscal Impact

For each of the categories listed below explain the distribution of dollars; please identify the costs, revenues, matches or any changes in the distribution of funds even if such change has a total zero effect

Title of Proposed Rule:	Old Age Pension and Aid to the Needy Disabled Colorado Supplement Cost of Living Adjustment (COLA) Increase for 2021	
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for any entity that falls within the category. If this rule-making requires one of the categories listed below to devote resources without receiving additional funding, please explain why the rule-making is required and what consultation has occurred with those who will need to devote resources. ***Answer should NEVER be just "no impact" answer should include "no impact because…."***

State Fiscal Impact *(Identify all state agencies with a fiscal impact, including any Colorado Benefits Management System (CBMS) change request costs required to implement this rule change)*

The cost to the State for the increase for non-SSI OAP recipients (approximately 9,140) will be $11/recipient/month. This cost will be paid using 100% OAP cash funds. These increased expenditures by the State to non-SSI OAP recipients are estimated at $1,206,480 (plus caseload growth) for 2021 and beyond.

The cost to the State for the increase to OAP recipients that are also receiving SSI (approximately 10,367) is estimated at $1,368,444 (plus caseload growth) for 2021 and beyond.

The total estimated cost to the State through the OAP cash fund for SSI and non-SSI OAP recipients is estimated at $2,574,924 (plus caseload growth) for 2021 and beyond.

The cost to the State for the increase for AND-CS recipients (approximately 519) will be $11/recipient/month. These increased expenditures by the State to AND-CS recipients are estimated at $68,508 (plus caseload growth) for 2021 and beyond.

The cost to the State will not increase as a result of changing the ISM calculation. The maximum ISM amount is tied directly to the SSI grant.

County Fiscal Impact

No additional appropriation is required as it is included within existing appropriations for the programs impacted by this grant increase.

Federal Fiscal Impact

No impact because there are no federal funds utilized.

Other Fiscal Impact *(such as providers, local governments, etc.)*

No impact because there are no other providers or local governments involved.

4. Data Description

List and explain any data, such as studies, federal announcements, or questionnaires, which were relied upon when developing this rule?

The Social Security Administration issued a press release on October 13, 2020 announcing the 1.3% cost of living adjustment (COLA). This information can be found at https://www.ssa.gov/news/press/releases/2020/#10-2020-1

Title of Proposed Rule:	Old Age Pension and Aid to the Needy Disabled Colorado Supplement Cost of Living Adjustment (COLA) Increase for 2021	
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5. Alternatives to this Rule-making

Describe any alternatives that were seriously considered. Are there any less costly or less intrusive ways to accomplish the purpose(s) of this rule? Explain why the program chose this rule-making rather than taking no action or using another alternative. **Answer should NEVER be just "no alternative" answer should include "no alternative because…"**

Taking no action could adversely impact the health, safety, and welfare of OAP and AND-CS recipients and could potentially cause the State to be unable to meet the MOE requirements as well with the Social Security Administration. Because of the penalties associated with not meeting the MOE, there are no other viable options.

Title of Proposed Rule:	Old Age Pension and Aid to the Needy Disabled Colorado Supplement Cost of Living Adjustment (COLA) Increase for 2021	
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OVERVIEW OF PROPOSED RULE

Compare and/or contrast the content of the current regulation and the proposed change.

Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
3.530 A B	Update amounts of components to reflect the increased grant standard and ISM amount effective January 1, 2021.	The Old Age Pension (OAP) program provides financial assistance and may provide health care benefits for low-income Colorado residents who are sixty (60) years of age or older who meet all financial and non-financial eligibility requirements. A. The total monthly OAP grant standard, as set by the State Board of Human Services, is $821.00, effective January 1, 2020. B. Effective January 1, 2020, the maximum monthly In-Kind Support and Maintenance (ISM) deduction amount for shelter costs is $281.00.	The Old Age Pension (OAP) program provides financial assistance and may provide health care benefits for low-income Colorado residents who are sixty (60) years of age or older who meet all financial and non-financial eligibility requirements. A. The total monthly OAP grant standard, as set by the State Board of Human Services, is $~~821.00~~832.00, effective January 1, ~~2020~~2021. B. Effective January 1, ~~2020~~2021, the maximum monthly In-Kind Support and Maintenance (ISM) deduction amount for shelter costs is $~~281.00~~284.00.	To implement the $11 COLA increase and adjust the ISM amount	
3.546 A & D	Update amounts of components to reflect the increased grant standard and ISM amount effective January 1, 2021	The Aid to the Needy Disabled-Colorado Supplement (AND-CS) program provides a supplemental payment for client's age zero (0) to fifty-nine (59) who are receiving SSI due to a disability or blindness, but are not receiving the full SSI benefit standard, as defined in Section 3.510. A. The total AND-CS grant standard is $783.00, effective January 1, 2020. D. Effective January 1, 2020, the maximum ISM amount for shelter costs is $281.00.	The Aid to the Needy Disabled-Colorado Supplement (AND-CS) program provides a supplemental payment for client's age zero (0) to fifty-nine (59) who are receiving SSI due to a disability or blindness, but are not receiving the full SSI benefit standard, as defined in Section 3.510. A. The total AND-CS grant standard is $~~783.00~~794.00, effective January 1, ~~2020~~2021. D. Effective January 1, ~~2020~~2021, the maximum ISM amount for shelter costs is $~~281.00~~284.00.	To implement the $11 COLA increase and adjust the ISM amount	

Title of Proposed Rule:	Old Age Pension and Aid to the Needy Disabled Colorado Supplement Cost of Living Adjustment (COLA) Increase for 2021	
CDHS Tracking #:	20-10-16-01	
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STAKEHOLDER COMMENT SUMMARY

Development

The following individuals and/or entities were included in the development of these proposed rules (such as other Program Areas, Legislative Liaison, and Sub-PAC):

This Rule-Making Package

The following individuals and/or entities were contacted and informed that this rule-making was proposed for consideration by the State Board of Human Services:

County Human Services Directors Association; Colorado Commission on Aging; Colorado Legal Services; Disability Law Colorado; Colorado Senior Lobby; Single Entry Point agencies; PAC & Economic Security Sub-PAC; Colorado Gerontological Society; Area Agencies on Aging; Colorado Center on Law and Policy; Colorado Department of Human Services Food & Energy Assistance Division; and, Colorado Department of Health Care Policy and Financing

Other State Agencies

Are other State Agencies (such as HCPF or CDPHE) impacted by these rules? If so, have they been contacted and provided input on the proposed rules?

[ ] Yes [X] No

If yes, who was contacted and what was their input?

Sub-PAC

Have these rules been reviewed by the appropriate Sub-PAC Committee?

[X] Yes [ ] No

Name of Sub-PAC	Economic Security		
Date presented	November 5, 2020		
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
	Unanimous		
If not presented, explain why.			

PAC

Have these rules been approved by PAC?

[ ] Yes [ ] No

Date presented	Scheduled for December 3, 2020		
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.			

Other Comments

Title of Proposed Rule:	Old Age Pension and Aid to the Needy Disabled Colorado Supplement Cost of Living Adjustment (COLA) Increase for 2021	
CDHS Tracking #:	20-10-16-01	
Office, Division, & Program: Office of Economic Security, Employment & Benefits Division, Adult Financial Programs	Rule Author: Erin Barajas	Phone: 720-955-1957 E-Mail: erin.barajas@state.co.us

Comments were received from stakeholders on the proposed rules:

☐ Yes ☒ No

If "yes" to any of the above questions, summarize and/or attach the feedback received, including requests made by the State Board of Human Services, by specifying the section and including the Department/Office/Division response. Provide proof of agreement or ongoing issues with a letter or public testimony by the stakeholder.

9 CCR 2503-5

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3.530 OLD AGE PENSION (OAP) PROGRAM

The Old Age Pension (OAP) program provides financial assistance and may provide health care benefits for low-income Colorado residents who are sixty (60) years of age or older who meet all financial and non-financial eligibility requirements.

A. The total monthly OAP grant standard, as set by the State Board of Human Services, is ~~$821.00~~832.00, effective January 1, ~~2020~~2021.

B. Effective January 1, ~~2020~~2021, the maximum monthly In-Kind Support and Maintenance (ISM) deduction amount for shelter costs is ~~$281.00~~284.00.

****

3.546 AID TO THE NEEDY DISABLED-COLORADO SUPPLEMENT (AND-CS) PROGRAM

The Aid to the Needy Disabled-Colorado Supplement (AND-CS) program provides a supplemental payment for client's age zero (0) to fifty-nine (59) who are receiving SSI due to a disability or blindness, but are not receiving the full SSI benefit standard, as defined in Section 3.510.

A. The total AND-CS grant standard is ~~$783.00~~794.00, effective January 1, ~~2020~~2021.

B. The grant standard for AND-CS shall be adjusted as needed to remain within available appropriations. Appeals shall not be allowed for grant standard adjustments necessary to stay within available appropriations.

C. In addition to the regular monthly AND-CS grant payments, supplemental payments necessary to comply with the Federal MOE requirements, as incorporated by reference in Section 3.531.D, may be provided. These payments are supplements to regular grant payments, are not entitlements, and do not affect grant standards. Appeals shall not be allowed for MOE payment adjustments.

D. Effective January 1, ~~2020~~2021 the maximum ISM amount for shelter costs is ~~$281.00~~284.00.

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PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

STATE OF COLORADO
DEPARTMENT OF LAW

RALPH L. CARR
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Denver, Colorado 80203
Phone (720) 508-6000

Office of the Attorney General

Tracking number: 2020-00935

Opinion of the Attorney General rendered in connection with the rules adopted by the

Income Maintenance (Volume 3)

on 12/04/2020

9 CCR 2503-5

ADULT FINANCIAL PROGRAMS

The above-referenced rules were submitted to this office on 12/08/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 22, 2020 10:20:06

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

CCR number

10 CCR 2505-3

Rule title

10 CCR 2505-3 FINANCIAL MANAGEMENT OF THE CHILDREN'S BASIC HEALTH PLAN 1 - eff 12/11/2020

Effective date

12/11/2020

Expiration date

04/10/2021

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Child Health Plan Plus program rule updates, Sections 110,140, 310 and 320
Rule Number: CHP 20-12-02-C
Division / Contact / Phone: Office of Medicaid Operations / Ana Bordallo / 3558

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: CHP 20-12-02-C, Revision to the Medical Assistance Rule concerning Child Health Plan Plus program rule updates, Sections 110,140, 310 and 320
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 110,140, 310 and 320, Colorado Department of Health Care Policy and Financing, Child Health Plan *Plus* (10 CCR 2505-3).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 12/11/2020
   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text with the proposed text beginning at Section 50 through the end of Section 600.5. This rule is effective December 11, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Child Health Plan Plus program rule updates, Sections 110,140, 310 and 320
Rule Number: CHP 20-12-02-C
Division / Contact / Phone: Office of Medicaid Operations / Ana Bordallo / 3558

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The proposed rule change will amend 10 CCR 2505-3 sections 110,140,310 and 320 based on the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Families First Coronavirus Response Act (FFCRA) and the Affordable Care Act (ACA), which includes the Maintenance of Effort (MOE) provision. All policy revisions will align with federal regulations for the state to be in compliance during this Coronavirus (COVID-19) Public Health Emergency. These changes will impact all Medical Assistance categories which includes the Child Health Plan Plus (CHP+) category. These policy changes will stay in place until the end of the Coronavirus (COVID-19) Public Health Emergency. The following policy changes are: Members who were evacuated from or unable to return to Colorado and are temporarily absent will maintain enrollment in the CHP+ program. Enrollment fees will be waived for members who are being redetermined and eligible for CHP+. required through the Federal CARES Act for the Maintenance of Effort (MOE), the Department will continue eligibility for all the CHP+ categories regardless of changes made for a redetermination or additional documentation for current CHP+ enrollee and allow them to continue eligibility through the end of the Public Health Emergency. At the end of emergency, the Department will process the redetermination and /or changes for all members whose eligibility was maintained during the emergency period.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   Due to the Coronavirus (COVID-19) public health emergency rules need to be updated for the state to be in compliance with federal regulations.

3. Federal authority for the Rule, if any:

   Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127 and Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136. The Affordable Care Act(ACA), which includes the Maintenance of Effort (MOE) provision.

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

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4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2020);
   25.5-8-107.(b)

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Title of Rule: Revision to the Medical Assistance Rule concerning Child Health Plan Plus program rule updates, Sections 110,140, 310 and 320
Rule Number: CHP 20-12-02-C
Division / Contact / Phone: Office of Medicaid Operations / Ana Bordallo / 3558

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The proposed rules will impact members enrolled in the CHP+ programs. The rule updates will benefit members enrolled in CHP+ by remaining eligible during this Coronavirus (COVID-19) public health emergency.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The proposed rule will help to determine eligibility correctly by applying regulations appropriately to help members remain eligible for the CHP+ programs during this Coronavirus (COVID-19) public health emergency.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The Department expects that eligibility could potentially increase as members who are outside the state for the duration of the emergency will not be disenrolled. This will lead to an increase in expenditure for the Department as the member will be included in the monthly capitation payment. The Department also assumes that the waiving of enrollment fees for the CHP+ program will reduce revenues to the Department which will result in the increase of expenditures to the CHP+ Trust fund, Healthcare Affordability and Sustainability Fee (HAS) Cash Fund, and federal funds in order to fill the gap in revenue lost from the premiums. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

DO NOT PUBLISH THIS PAGE

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The Department expects that inaction to the proposal to allow CHP+ member to retain eligibility outside the state will result in lack of care to those members who are outside the state during the emergency period who will need those services. The Department sees no benefit to inaction.

   In addition, the Department expects that inaction to the proposal to waive enrollment fees will cause potential members to not qualify because they are unable to pay the premiums due to the severity of the economic shock. The Department also sees no benefit to inaction.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are currently no less costly measures to the Department that will allow the Department to service members more effectively during the emergency period.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for the proposed rule that were considered

50 DEFINITIONS

50.1 "Applicant" shall mean a person applying or re-applying for benefits on behalf of a child and/or themselves.

50.2 "CBMS" shall mean Colorado Benefits Management System is the computer system that determines an applicant's eligibility for public assistance in the state of Colorado.

50.3 "Child" means a person who is less than nineteen years of age.

50.4 "Cost sharing" shall mean payments, such as copayments or enrollment fees that are due on behalf of the enrollee.

50.5 "Department" shall mean the Colorado Department of Health Care Policy and Financing which is responsible for administering the Colorado Medical Assistance Program and Children's Basic Health Plan as well as other State-funded health care programs.

50.6 "Dependent child" shall mean a child who lives with a parent, legal guardian, caretaker relative or foster parent and is under the age of 18, or, is age 18 and a full-time student, and expected to graduate by age 19

50.7 "Effective Date" shall mean the first day of eligibility which is the date the application is received and date-stamped by the Eligibility site or the date the application was received and date-stamped by an Application Assistance site or Presumptive Eligibility site. In the absence of a date-stamp, the application date is the date that the application was signed by the client.

50.8 "Eligibility Site" shall mean a location outside of the Department that has been deemed by the Department as eligible to accept applications and determine eligibility for applicants.

50.9 "Enrollee" shall mean an eligible person who is enrolled in the Children's Basic Health Plan.

50.10 "Essential Community Provider" means a healthcare provider that:

A. Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population, or in the case of a sole community provider, serves medically indigent patients within its medical capability; and

B. Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations.

50.11 "Evidence of Coverage" or "EOC" shall mean any certificate, agreement, or contract issued to an enrollee from time-to-time by a Managed Care Organization (MCO) setting out the coverage to which the enrollee is or was entitled under the Children's Basic Health Plan.

50.12 "Grievance Committee" shall mean a conference with the Department or its Designee in which a contested decision regarding an applicant or enrollee is reexamined.

50.13 "Household" shall be determined by relationships to the tax filer as declared on the Single Streamlined Application and as required in 10 CCR 2505-10-8.100.4.E.

50.14 "Income" shall be any compensation from participation in a business, including wages, salary, tips, commissions and bonuses. The Modified Adjusted Gross Income is a methodology used to determine eligibility as required in 10 CCR 2505-10-8.100.4.C.

50.15 "Managed Care Organization" or "MCO" shall mean:

A. A carrier which meets the definition in §10-16-102 (8), C.R.S. with which the Department contracts to provide health care or dental services covered by the Children's Basic Health Plan; or,

B. Essential community providers and other health care and dental service providers with whom the Department contracted to provide health care services under the Children's Basic Health Plan using a managed care model.

50.16 "Presumptive Eligibility" shall mean children and pregnant women who have applied and appear to be eligible for the Children's Basic Health Plan shall be presumed eligible and may receive immediate temporary medical coverage.

50.17 "Unearned Income" shall be the gross amount received in cash or kind that is not earned from employment or self-employment.

50.18 "Woman" shall mean a female who is 19 years in age or older.

100 ELIGIBILITY

110 INDIVIDUALS ASSISTED UNDER THE PROGRAM

110.1 To be eligible for the Children's Basic Health Plan, an eligible person shall:

A.

1. Be less than 19 years of age; or

2. Be a pregnant woman

B. Fall into one of the following categories:

1. Be a citizen or national of the United States, the District of Columbia, Puerto Rico, Guam, the United States Virgin Islands, the Northern Mariana Islands, American Samoa, or Swain's Island; or

2. Be a lawfully admitted non-citizen who entered the United States prior to August 22, 1996, or

3. Be a non-citizen who entered the United States on or after August 22, 1996 and is applying for Medical Assistance who falls into one of the following categories:

a. Lawfully admitted for permanent residence under the U.S. Immigration and Nationality Act (hereafter referred to as the "INA"); or

b. Paroled into the United States for at least one year under 8 U.S.C § 1182(d)(5); or

c. Granted conditional entry under Section 203(a)(7) of the INA, as in effect prior to April 1, 1980; or

d. determined by the Eligibility site, in accordance with guidelines issued by the U.S. Attorney General, to be a spouse, child, parent of a child, or child of a parent who, in circumstances specifically described in 8 U.S.C. §1641(c), has been battered or subjected to extreme cruelty which necessitates the provision of Medical Assistance (Children's Basic Health Plan); or

4. Be a non-citizen who arrived in the United States on any date, who falls into one of the following categories:

a. Lawfully residing in Colorado and is an honorably discharged military veteran; or

1. A spouse of such military veteran; or

2. An unremarried surviving spouse of such military veteran; or

3. An unmarried dependent child of such military veteran.7

b. Lawfully residing in Colorado and is on active duty in the United States Armed Forces, excluding military training; or

1. A spouse of such individual; or

2. An unremarried surviving spouse of such individual; or

3. An unmarried dependent child of such individual.

c. Granted asylum under Section 208 of the INA; or

d. Refugee under Section 207 of the INA; or

e. An individual with deportation withheld:

1. Under Section 243(h) of the INA, as in effect prior to September 30, 1996; or

2. Under Section 241(b)(3), as amended by P.L. 104-208 of the INA.

f. A Cuban or Haitian entrant, as defined under Section 501(e) of the U.S. Refugee Education Assistance Act of 1980; or

g. An individual who:

1. Was born in Canada and possesses at least 50 percent American Indian blood; or

2. Is a member of an Indian tribe, as defined in 25 U.S.C. Section 450(b)e.

h. Admitted into the United States as an Amerasian immigrant under Section 584 of the U.S. Foreign Operations, Export Financing, and Related Programs Appropriation Act of 1988, as amended by P.L. 100-461; or

i. A lawfully admitted, permanent resident, who is a Hmong or Highland Lao veteran of the Vietnam conflict; or

j. An alien who was admitted in the United States on or after December 26, 2007 who is an Iraqi Special Immigrant under section 101(a)(27) of the INA; or

k. An alien who was admitted in the United States on or after December 26,2007 who is an Afghan Special Immigrant under section 101(a)(27) of the INA; and

5. Be a lawfully admitted non-citizen in the United States who falls into one of the categories:

a. granted temporary resident status in accordance with section 8 U.S.C. 1160 or 1255a; or

b. granted Temporary Protected Status (TPS) in accordance with section 8 U.S.C 1254a and pending applicants for TPS granted employment authorization;

c. granted employment authorization under section 8 CFR 274a.12(c);or

d. Family Unity beneficiary in accordance with section 301 of Pub. L. 101-649, as amended.

e. Deferred Enforced Departure (DED), pursuant to a decision made by the President

f. Granted Deferred Action status (excluding Deferred Action for Childhood Arrivals (DACA)) as described in the Secretary of Homeland Security's June 15,2012 memorandum;

g. Granted an administrative stay of removal under section 8 CFR 241; or

h. Beneficiary of approved visa petition who has a pending application for adjustment of status.

i. Pending an application for asylum under section 8 U.S.C. 1158, or for withholding of removal under section 8 U.S.C. 1231, or under the Convention Against Torture who-

1. as been granted employment authorization; or

2. Is under the age of 14 and has had an application pending for at least 180 days.

j. Granted withholding of removal under the Convention Against Torture;

k. Citizens of Micronesia, the Marshall Islands, and Palau; or

l. Is lawfully present American Samoa under the immigration of laws of American Samoa.

m. A non-citizen in a valid nonimmigrant status, as defined in section 8 U.S.C. 1101(a)(15) or under section 8 U.S.C. 1101(a)(17); or

n. A non-citizen who has been paroled into the United States for less than one year under section U.S.C. 1182(d)(5), except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings; or

o. A child who has a pending application for Special Immigrant Juvenile status under 8 U.S.C 1101(a)(27)(J).

C. For determinations of eligibility for the Children's Basic Health Plan, legal immigration status must be verified. This requirement applies to a non-citizen individual who meets the criteria of any category defined at 110.1.B and has declared that he or she has a legal immigration status.

1. The Verify Lawful Presence (VLP) interface will be used to verify immigration status as required in 10 CCR 2505-10-8.100.3.G.2

2. If the state cannot verify immigration status the individual will receive a Reasonable Opportunity Period as required in 10 CCR 2505-10-8.100.3.G.3

D. Be a resident of Colorado; and residence shall be retained until abandoned. A person temporarily absent from the state, inside or outside the United States, retains Colorado residence. Temporarily absent means that at the time he/she leaves, the person intends to return.

E. Have a household income greater than 133% but not exceeding 250% of the Federal Poverty Level (MAGI-equivalent), adjusted for household size for children under the age of 19; or

F. Have a household income greater than 185% but not exceeding 250% of the Federal Poverty Level (MAGI-equivalent), adjusted for household size for pregnant women.

G. Failure to complete an application or to provide required documentation in Section 130 will result in the denial of the incomplete application or individual applicant (s).

120 INSUFFICIENT ACCESS TO OTHER HEALTH COVERAGE

120.1 To be eligible for the Children's Basic Health Plan, an eligible person shall not:

A. Be covered under a group health plan or under health insurance coverage excluding Consolidated Omnibus Budget Reconciliation Act (COBRA); or

B. Be eligible to receive assistance under Title XIX of the Social Security Act; or

C. Be an inmate of a public institution or a patient in an institution for mental diseases.

120.2 The Department shall not require that applicants be uninsured for any period of time prior to becoming eligible for the Children's Basic Health Plan.

130 VERIFICATION REQUIREMENTS

130.1 To be eligible for the Children's Basic Health Plan, an applicant shall provide minimal verification as required in 10 CCR 2505-10-8.100.4.B.

140 REDETERMINATION

140.1 A redetermination of eligibility shall mean a case review and necessary verification to determine whether the client continues to be eligible to receive Medical Assistance. Eligibility shall be redetermined twelve (12) months since the last eligibility determination. An Eligibility site may redetermine eligibility through telephone, mail, or electronic means. The use of telephone or electronic redeterminations should be noted in the case record and in CBMS case comments.

A. A redetermination form is not required to be sent to the client if all current eligibility requirements can be verified by reviewing information from another assistance program or if this information can be verified through an electronic data source. When applicable, the eligibility site shall redetermine eligibility based solely on information already available. If verification or information is available for any of the three months prior to redetermination month, no request shall be made of the client and a notice of the outcome will go to the client. If not all verification or information is available, the eligibility site shall only request the additional minimum verification from the client. This procedure is referenced as Ex Parte Review.

B. A redetermination form, approved by the Department, shall be mailed to the client at least 30 days prior to the first of the month in which completion of eligibility redetermination is due. The redetermination form shall be used to inform the client of the redetermination and verification needed. The client shall not be required to return the form to the eligibility site. The only verification that may be required at redetermination is the minimum verification needed to complete a redetermination of eligibility.

The redetermination form shall direct clients to review current information and to take no action if there are no changes to report in the household. Eligibility sites and CBMS shall view the absence of reported changes from the client at this redetermination period as confirmation that there have been no changes in the household. This procedure is referenced as automatic reenrollment.

C. Due to the Coronavirus COVID-19 Public Health Emergency, required through the Federal CARES Act for the Maintenance of Effort (MOE), the Department will continue eligibility for all Medical Assistance categories regardless of changes made for a redetermination or additional documentation for current CHP+ enrollee and allow them to continue eligibility through the emergency declaration. Once the emergency declaration has concluded, the Department will process the redetermination and /or changes for all members whose eligibility was maintained during the emergency declaration.

150 CALCULATION OF HOUSEHOLD INCOME

150.1 Calculation of income for the Children's Basic Health Plan shall be determined as required in 10 CCR 2505-10-8.100.4.C

150.2 Income disregards for the Children's Basic Health Plan shall be determined as required in 10 CCR 2505-10-8.100.4.D

160 [Repealed eff. 12/30/2012]

170 PRESUMPTIVE ELIGIBILITY

170.1 A pregnant applicant or a child under the age of 19 may apply for presumptive eligibility for immediate temporary medical services through designated presumptive eligibility sites.

A. To qualify for presumptive eligibility, a child under the age of 19 shall have a declared household income that shall be greater than 133% but not exceed 250% of Federal Poverty Level (MAGI-equivalent); or

B. To qualify for presumptive eligibility, a pregnant women shall have an attested pregnancy, declare that her household's income shall be greater than 185% but not exceed 250% of the Federal Poverty Level (MAGI-equivalent); and

C. He/she shall be a United States citizen or a documented immigrant as defined in Section 110.

170.2 Presumptive eligibility sites shall be certified by the Department of Health Care Policy and Financing to make presumptive eligibility determinations. Sites shall be re-certified by the Department of Health Care Policy and Financing every 2 years to remain approved presumptive eligibility sites.

A. The presumptive eligibility site shall forward the application to the county within five business days of the received date.

170.3 The presumptive eligibility period begins on the date the applicant is determined eligible and ends with the earlier of:

A. The day an eligibility determination for Medical Assistance is made for the applicant(s); or

B. The last day of the month following the month in which a determination for presumptive eligibility was made.

170.4 The county or Medical Assistance site shall make an eligibility determination within 45 days from the date of application.

A. Presumptively eligible clients may appeal the county or Medical Assistance site's failure to act on an application within 45 days from date of application or the denial of an application. Appeal procedures are outlined in Section 600.

B. A presumptively eligible client may not appeal the end of a presumptive eligibility period.

180 Express Lane Eligibility

Express Lane Eligibility shall allow for automatic initiation of Medical Assistance enrollment by using available data and findings from other programs as listed below.

180.1 Free/Reduced Lunch Program

A. Recipients of the Free/Reduced Lunch Program who have submitted a Free/Reduced Lunch application at a participating school district

1. Families will be given the option to opt into Medical Assistance coverage for their potentially eligible child.

2. Children who meet all necessary eligibility requirements as outlined in this volume will be automatically enrolled.

3. Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity will receive 90 days of eligibility while awaiting this verification.

4. Any additionally required verification will be requested from the client through CBMS prior to being automatically enrolled.

5. Eligibility is based on income declared on the Free/Reduced Lunch application as well as eligibility requirements outlined in section 150.

6. If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility will be evaluated using the application for Medical Assistance.

B. Recipients of the Free/Reduced Lunch Program who were not required to submit a Free/Reduced Lunch application at a participating school district

1. Families who are automatically enrolled Free/Reduced Lunch recipient children will not be forwarded to the Department for Express Lane Eligibility in compliance USDA confidentiality guidelines.

2. These families must apply for Medical Assistance in order to give consent for request of benefits.

180.2 Direct Certification

A. When an application for Food Stamps or Colorado Works has been submitted, families will be given the option to opt into Medical Assistance coverage for their potentially eligible children.

1. Children who meet all necessary eligibility requirements as outlined throughout sections 100 through 180 will be automatically enrolled,

2. Children who are only missing verification of U.S. citizenship and identity will receive 90 days of coverage while waiting for this verification.

3. Any additionally required verification will be requested from the client through CBMS prior to being automatically enrolled.

4. Eligibility is determined based on income declared on the Food Stamp or Colorado Works application as well as eligibility requirements outlined throughout this volume.

5. If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility will be evaluated using the Single Streamlined application for Medical Assistance.

6. Individuals whose eligibility is not determined through Express Lane Eligibility may also submit a separate Single Streamlined Application for Medical Assistance to determine eligibility.

200 BENEFITS PACKAGE

210 The following are covered benefits including any applicable limitations:

A. Emergency Care and Urgent/After Hours Care;

B. Emergency Transport/Ambulance Services;

C. Hospital/Other Facility Services Including:

1. Inpatient;

2. Physician;

3. Outpatient/Ambulatory;

D. Medical Office Visits Including:

1. Physician;

2. Mid-Level Practitioner;

3. Specialist;

E. Diagnostic Services;

F. Preventative, Routine and Family Planning Services Including:

1. Immunizations;

2. Well-child visits;

3. Health maintenance visits;

G. Maternity Care Including:

1. Prenatal;

2. Delivery and inpatient well-baby care;

3. Postpartum care

H. Mental Illness Treatments such as:

1. Neurobiologically-based mental illness including:

a. Schizophrenia;

b. Schizoaffective disorder;

c. Bipolar affective disorder;

d. Major depressive disorder;

e. Specific obsessive compulsive disorder;

f. Panic disorder;

2. Mental disorders including:

a. Post traumatic stress disorder

b. Drug and alcohol disorders

c. Dysthymia

d. Cyclothymia

e. Social phobia

f. Agoraphobia with panic disorder

g. General anxiety

h. Anorexia Nervosa exclusive of residential treatment

i. Bulimia exclusive of residential treatment

3. All other mental illness;

a. Inpatient coverage;

b. Outpatient coverage;

I. Physical Therapy, Speech Therapy and Occupational Therapy shall be limited to 30 visits per diagnosis per year. Effective November 1, 2007, Physical, Speech and Occupational Therapy services shall be unlimited for children from birth up to the child's third birthday.

J. Durable Medical Equipment shall be limited to the lesser of the purchase price or rental price for medically necessary durable medical equipment that shall not exceed two thousand dollars per year.

K. Transplants must be medically necessary and are limited to:

1. Liver;

2. Heart;

3. Heart/lung;

4. Cornea;

5. Kidney;

6. Bone marrow which shall be limited to the following conditions:

    a. Aplastic anemia;

    b. Leukemia;

    c. Immunodeficiency disease;

    d. Neuroblastoma;

    e. Lymphoma;

    f. High risk stage ii and iii breast cancer;

    g. Wiskott aldrich syndrome;

7. Peripheral stem cell support which shall be limited to the following conditions:

    a. Aplastic anemia;

    b. Leukemia;

    c. Immunodeficiency disease;

    d. Neuroblastoma;

    e. Lymphoma;

    f. High risk stage II and III breast cancer;

    g. Wiskott aldrich syndrome;

L. Home health care;

M. Hospice care;

N. Prescription medication;

O. Kidney dialysis shall be excluded only if the member is also eligible for Medicare;

P. Skilled nursing facility care must be provided only when there is a reasonable expectation of measurable improvement in the members' health status.

Q. Vision services shall be limited to:

1. Vision screenings for age appropriate preventative care;

2. Referral required for refraction services;

3. Minimum fifty dollar benefit for eyeglasses;

R. Audiology services shall be limited to:

1. Hearing screenings for age appropriate preventative care;

2. Hearing aids without financial limitation for enrollees age 18 and under no more than once every five years unless medically necessary including:

    a. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child

    b. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

S. Intractable pain;

T. Autism;

U. Case management is covered only when medically necessary;

V. Dietary counseling/nutritional services shall be limited to:

1. Formula for metabolic disorders;

2. Total parenteral nutrition;

3. Enterals and nutrition products;

4. Formulas for gastrostomy tubes;

W. Dental services are limited to:

1. Those dental services described in the Children's Basic Health Plan dental Evidence of Coverage booklet provided to enrollees, who are less than nineteen years of age. Beginning October 1, 2019, the dental services listed below are covered benefits for enrolled pregnant women of any age, excepting Limited Orthodontic services under Section 210.W.1.h for pregnant women age nineteen and above. Children's Basic Health Plan dental services are provided by the dental MCO (or its designee) with which the Department has contracted for the applicable plan year to provide the following dental services;

    a. Diagnostic

    b. Preventive

    c. Restorative

    d. Endodontic

    e. Periodontic

    f. Prosthodontic

    g. Oral and Maxillofacial Surgery

    h. Limited Orthodontic, excepting pregnant women age nineteen and above.

    i. Adjunctive General Services

2. Orthodontic and prosthodontic treatment for cleft lip or cleft palate in newborns (covered as a medical service in accordance with section 10-16-104, C.R.S.); and

3. Treatment of teeth or periodontium required due to accidental injury to naturally sound teeth (covered as a medical service in accordance with section 10-16-104, C.R.S.). A physician or legally licensed dentist must perform treatment within 72 hours of the accident.

X. Therapies covered shall include:

1. Chemotherapy;

2. Radiation;

Y. The following are not covered benefits:

1. Acupuncture;

2. Artificial conception;

3. Biofeedback;

4. Storage Costs for umbilical blood;

5. Chiropractic care;

6. Convalescent care or rest cures;

7. Cosmetic surgery;

8. Custodial care;

9. Domiciliary care;

10. Duplicate coverage;

11. Government institution or facility services;

12. Hair loss treatments;

13. Hypnosis;

14. Infertility services;

15. Maintenance therapy;

16. Nutritional therapy unless specified otherwise;

17. Elective termination of pregnancy, unless the elective termination is to save the life of the mother or if the pregnancy is the result of an act of rape or incest;

18. Personal comfort items;

19. Physical exams for employment or insurance;

20. Private duty nursing services;

21. Routine foot care;

22. Sex change operations;

23. Sexual disorder treatments;

24. Taxes;

25. Temporomandibular joint (TMJ) treatment, unless it has a medical basis;

26. Other therapies and treatments which are not medically necessary;

27. Vision services unless specified otherwise;

28. Vision therapy;

29. War-related conditions;

30. Weight-loss programs;

31. Work-related conditions;

300 ENROLLMENT FEES AND COPAYMENTS

310 ANNUAL ENROLLMENT FEES AND DUE DATE

310.1 For eligible children, the following annual enrollment fees shall be due prior to enrollment in the Children's Basic Health Plan:

A. For families with income, at the time of eligibility determination, less than 151% of the Federal Poverty Level, the annual enrollment fee shall be waived.

B. For families with income, at the time of eligibility determination, between 151% and 205% of the Federal Poverty Level (MAGI-equivalent), the annual enrollment fee shall be:

1. $25.00 for a single eligible child; and

2. $35.00 for two or more eligible children.

3. Waived for families who include an eligible pregnant woman.

C. For families with income, at the time of eligibility determination, greater than 205% and up to 250% of the Federal Poverty Level, the annual enrollment fee shall be:

1. $75.00 for a single eligible child; and

2. $105.00 for two or more eligible children.

3. Waived for families who include an eligible pregnant woman

310.2 If the required enrollment fee is not received with the application for the Children's Basic Health Plan, the Department or its designee shall notify the applicant:

A. That applicable enrollment fees are a requirement for enrollment;

B. That fees shall be due within thirty (30) days of the date of notification;

C. Of effective date of enrollment if payment is received; and

D. That the application shall be denied if payment is not received by the due date indicated.

310.3 The application shall be denied if payment is not received by the due date indicated on the notification.

310.5 Once enrollment has occurred, the annual enrollment fee is non-refundable.

310.6 Due to the Coronavirus COVID-19 Public Health Emergency, an eligible applicant will be charged an enrollment fee. Existing members who are being re-enrolled will not be charged enrollment fees until after the Public Health Emergency has ended.

320 COPAYMENTS

320.1 The following copayments shall be due for enrollees at the time of service:

A. For families with income, at the time of eligibility determination, less than 101% of the Federal Poverty Level (MAGI-equivalent), all copayments shall be waived, except for emergency and care, which shall be $3.00 per use and urgent/after hours care, which shall be $1.00 per use.

B. For families with income, at the time of eligibility determination, between 101% and 150% of the Federal Poverty Level (MAGI-equivalent), the copayment shall be:

1. Effective until June 30, 2012:

a. $2.00 per office visit;

b. $2.00 per outpatient mental health or substance abuse visit;

c. $1.00 per generic or brand name prescription;

d. $2.00 per physical therapy, occupational therapy or speech therapy visit;

e. $2.00 per vision visit;

f. $3.00 per use of emergency care and urgent/after hours care;

2. Effective July 1, 2012:

a. $2.00 per office visit;

b. $2.00 per outpatient mental health or substance abuse visit;

c. $1.00 per generic or brand name prescription;

d. $2.00 per physical therapy, occupational therapy or speech therapy visit;

e. $2.00 per vision visit;

f. $3.00 per use of emergency care (co-payment is waived if client is admitted to the hospital);

g. $1.00 per use of urgent/after hours care;

h. $2.00 per trip for emergency transport/ambulance services;

i. $2.00 per inpatient hospital visit;

j. $2.00 per inpatient hospital visit for physician services in the hospital;

k. $2.00 per outpatient hospital or ambulatory surgery center visit.

C. For families with income, at the time of eligibility determination, between 151% and 200% of Federal Poverty Level (MAGI-equivalent), the copayment shall be:

1. Effective until June 30, 2012:

a. $5.00 per office visit;

b. $5.00 per outpatient mental health or substance abuse visit;

c. $3.00 per generic prescription;

d. $5.00 per brand name prescription;

e. $5.00 per physical therapy, occupational therapy or speech therapy visit;

f. $5.00 per vision visit;

g. $15.00 per use of emergency care and urgent/after hours care

2. Effective July 1, 2012:

a. $5.00 per office visit;

b. $5.00 per outpatient mental health or substance abuse visit;

c. $3.00 per generic prescription;

d. $10.00 per brand name prescription;

e. $5.00 per physical therapy, occupational therapy or speech therapy visit;

f. $5.00 per vision visit;

g. $30.00 per use of emergency care ((co-payment is waived if client is admitted to the hospital)

h. $20.00 per use of urgent/after hours care;

i. $5.00 per date of service for laboratory and radiology/imaging services

j. $15.00 per trip for emergency transport/ambulance services;

k. $20.00 per inpatient hospital visit;

l. $5.00 per inpatient hospital visit for physician services;

m. $5.00 per outpatient hospital or ambulatory surgery center visit.

3. Due to the Coronavirus COVID-19 Public Health Emergency, members who are eligible for Children's Basic Health Plan will have waived laboratory copayments, specifically as it relates to laboratory copayments associated with COVID-19 testing.

D. For families with income, at the time of eligibility determination, between 201% and 250% of Federal Poverty Level (MAGI-equivalent), the copayment shall be:

1. Effective until June 30, 2012:

a. $10.00 per office visit;

b. $10.00 per outpatient mental health or substance abuse visit;

c. $5.00 per generic prescription;

d. $10.00 per brand name prescription;

e. $10.00 per physical therapy, occupational therapy or speech therapy visit;

f. $10.00 per vision visit;

g. $20.00 per use of emergency care and urgent/after hours care.

2. Effective July 1, 2012:

a. $10.00 per office visit;

b. $10.00 per outpatient mental health or substance abuse visit;

c. $5.00 per generic prescription;

d. $15.00 per brand name prescription;

e. $10.00 per physical therapy, occupational therapy or speech therapy visit;

f. $10.00 per vision visit;

g. $50.00 per use of emergency care (co-payment is waived if client is admitted to the hospital);

h. $30.00 per use of urgent/after hours care;

i. $10.00 per date of service for laboratory and radiology/imaging services

j. $25.00 per trip for emergency transport/ambulance services;

k. $50.00 per inpatient hospital visit;

l. $10.00 per inpatient hospital visit for physician services;

m. $10.00 per outpatient hospital or ambulatory surgery center visit.

3, Due to the Coronavirus COVID-19 Public Health Emergency, members who are eligible for Children's Basic Health Plan will have waived laboratory copayments, specifically as it relates to laboratory copayments associated with COVID-19 testing.330 COST SHARING LIMITATIONS

330.1 American Indians and Alaskan Natives shall be exempt from cost sharing requirements. American Indian shall mean a member of a federally recognized Indian tribe, band, or group, or a descendant in the first or second degree of any such member. Alaskan Native shall mean an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior.

330.2 The maximum yearly cost sharing requirements for families of enrollees shall be 5% of income.

330.3 No copayments shall apply to preventive services. For the purpose of this section, preventive services shall mean:

A. All healthy newborn and newborn inpatient visits, including routine screening whether provided on an inpatient or outpatient basis;

B. Routine examinations;

C. Immunizations and related office visits; and

D. Routine preventive and diagnostic dental services.

330.4 Prenatal Care Program clients shall be exempt from cost sharing requirements.

400 ENROLLMENT

400.1 An applicant found eligible for Children's Basic Health Plan can elect to be enrolled the Children's Basic Health Plan.

410 SELECTION OF A MANAGED CARE ORGANIZATION

410.1

A. Once eligibility has been determined, an eligible person shall have the opportunity to select a participating MCO in the county of the eligible person's residence. If there is only one participating MCO available in the county of the eligible person's residence, the eligible person shall be enrolled in that MCO.

B. In the event the Department contracts with an MCO to provide dental services to Children's Basic Health Plan enrollees, an enrollee automatically will be enrolled with such MCO. No separate MCO election will be required.

410.2 MCO SELECTION

A. Upon determination of eligibility for the Children's Basic Health Plan program, if the eligible person has notified the Department or its designee of his/her chosen MCO prior to the last business day of the month in which eligibility was determined, the Department or its designee shall enroll the eligible person in that MCO.

B. Upon determination of eligibility for the Children's Basic Health Plan program, if the eligible person has not chosen an MCO, the Department or its designee shall enroll the eligible person in an MCO selected by the Department or its designee. In areas of the state where there is only one participating MCO available, the Department or its designee shall select that MCO and enroll the eligible person.

C. The Department or its designee shall notify the enrollee of the MCO selected. If the enrollee wants to change MCOs, the enrollee shall contact the Department or its designee within 90 days from the effective date of the MCO enrollment. An enrollee may also change a pending MCO enrollment before the effective date.

D. For renewal applications, the Department or its designee shall reassign the eligible person to the participating MCO the applicant approved for the previous enrollment period. If the eligible person wishes to change MCO enrollment, he/she shall notify the Department or its designee within his/her re-enrollment period.

410.3 In counties in which a participating MCO as defined in section 50.14.A is not available, the eligible person shall be enrolled in an MCO as defined in section 50.14.B.

410.4 Once an enrollee has selected an MCO or upon expiration of the timeframe to change, the enrollee shall remain enrolled in that MCO for the remainder of his/her eligibility period, unless the eligible person meets any of the disenrollment criteria set forth in section 440.

410.5 An eligible person shall have an opportunity to change to a different MCO serving the eligible person's geographic region, if one is available, during the applicant's annual redetermination period.

420 ENROLLMENT OF ALL ELIGIBLE PERSONS IN A FAMILY

420.1 If one eligible child from a family is enrolled in the Children's Basic Health Plan, all eligible children in that family must be enrolled in the Children's Basic Health Plan.

420.2 All eligible children in a family must be enrolled in the same MCO.

430 ENROLLMENT DATE

430.1 Eligibility for the Children's Basic Health Plan shall be effective on the latter of:

A. The first day of the month of application for Medical Assistance; or

B. The first day of the month the person becomes eligible for the Children's Basic Health Plan program.

430.2 Upon being enrolled in the Children's Basic Health Plan, continuous eligibility applies to children under the age of 19, who through an eligibility determination, reassessment or redetermination are found eligible for the Children's Basic Health Plan program. The continuous eligibility period

may last for up to 12 months and will begin on the month of application or from the authorization date.

A. The continuous eligibility period applies without regard to changes in income or other factors that would otherwise cause the child to be ineligible.

i) A 14-day no fault period shall begin on the date the child is determined eligible for Medical Assistance. During the 14-day period, updates or corrections may be made to the child's case. Any changes to the child's case made during the 14-day no fault period may impact his or her eligibility for Medical Assistance.

B. A child's continuous eligibility period will end effective the earliest possible month, if any of the following occur:

i) Child is deceased

ii) Becomes an inmate of a public institutio

iii) The child states that she/he has moved out of the household permanently

iv) Is no longer a Colorado resident

v) Is unable to be located based on evidence or reasonable assumption

vi) Requests to be withdrawn from continuous eligibility

vii) Fails to provide documentation during a reasonable opportunity period as specified in section 8.100.3.H.9

viii) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90-day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

ix) An eligible person shall not be enrolled in other health insurance coverage

430.3. If determined eligible, the enrollment date of a pregnant woman shall be effective as of the first of the month of the date of application or the first day of the month the pregnant woman becomes eligible. The enrollment span shall end at the end of the month following 60 days after the birth of the child or termination of the pregnancy. Once eligibility has been approved, coverage must be provided regardless of changes in the woman's financial circumstances, once the income verification requirements are met.

A. A pregnant women's eligibility period will end effective the earliest possible month, if any of the following occur:

i) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90-day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

430.4 An eligible person's enrollment date in the selected MCO shall be no later than:

A. The first of the month following eligibility determination and MCO selection if eligibility is determined before the 17th of the month.

B. The first of the second month following eligibility determination and MCO selection if eligibility is determined on or after the 17th of the month.

430.5 A child born to a mother who is enrolled in the Children's Basic Health Plan at the time of the child's birth is guaranteed coverage for one year.

A. To receive Medical Assistance under the Children's Basic Health Plan, the birth must be reported verbally or in writing to the County Department of Human Services or Eligibility site. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time by any person. Once reported, a newborn meeting the above criteria shall be added to the mother's Medical Assistance case, or his or her own case if the newborn does not reside with the mother, according to timelines defined by the Department. If adopted, the newborn's agent does not need to file an application or provide a Social Security Number or proof of application for a Social Security Number for the newborn.

440 DISENROLLMENT

440.1 An enrollee shall be disenrolled from an MCO for the following reasons:

A. Administrative error on the part of the Department, the Department's designee, or the MCO, including but not limited to enrollment of a person who does not reside in the MCO's service area; or,

B. A change in the enrollee's residence to an area not in the MCO's service area; or,

C. When an enrollee's coverage is terminated as described in section 440.1A.

440.2 If an enrollee is disenrolled from an MCO for any of the reasons stated in section440.1 and there is another participating MCO available in the enrollee's county of residence, the enrollee shall be allowed to select a new MCO.

440.3 If the enrollee is enrolled in a MCO as defined in section 50.15B and a MCO as defined in section 50.15A becomes available in the child's county of residence, the enrollee will be disenrolled from the MCO as defined in section 50.15 B and enrolled in the MCO as defined in section 50.15A.

440.4 An enrollee may be disenrolled from both an MCO and/or the Children's Basic Health Plan for the following reasons:

A. Fraud or intentional misconduct, including but not limited to knowing misuse of covered services, knowing misrepresentation of membership status; or,

B. An enrollee's receipt of other health care coverage; or,

C. The admission of an enrollee into any federal, state, or county institution for the treatment of mental illness, narcoticism, or alcoholism, or into any correctional facility; or,

D. Ineligibility for the program, based on the guidelines set forth in the Children's Basic Health Plan eligibility rules; or,

E. Failure to comply with cost sharing requirements (annual enrollment fees and copayments) set forth in the Children's Basic Health Plan cost sharing rules; or,

F. There is not another participating MCO as defined in section 50.14 available in the enrollee's county of residence.

440.5 If an eligible person or an eligible person's family displays an ongoing pattern of behavior that is abusive to provider(s), staff or other patients; or, disruptive to the extent that the provider's ability to furnish services to the child or other patients is impaired, the eligible person may be disenrolled from his/her managed care organization. If there is another participating MCO available in the eligible person's county of residence, the Department may allow the eligible person to select a new MCO. If there is not another MCO available in the eligible person's county, the eligible person may be disenrolled from the Children's Basic Health Plan.

500 FINANCIAL MANAGEMENT

The Children's Basic Health Plan, being a non-entitlement program, must manage to its legislative appropriation. The Department shall track expenditures, caseload, and other financial information to make informed decisions on spending its appropriation. Expenditures may exceed State appropriations with approval of the Governor, but any General Fund over expenditure shall be limited to $250,000.

510 The Department shall make quarterly assessments of projected expenditures. If it appears the program may overspend its appropriation due to changes in enrollment, health care costs, funding, legislation, or other factors, the Department shall consider if adjustments to the program are necessary. The program may use, but is not limited to, any of the following financial management tools: waiting lists, adjustments of eligibility criteria and/or levels, instituting open enrollment periods, or temporary closure of the program.

600 APPEALS PROCESS

600.1 Applicants shall be notified of any action regarding the eligibility and enrollment status and cost sharing requirements for the enrollees' participation in the Children's Basic Health Plan and appeal rights regarding those actions by the Department or its designee.

600.2 The Department or its designee shall notify the applicant within ten (10) business days of a decision regarding eligibility, enrollment and cost sharing. The notice shall:

A. Be in writing;

B. Be in his/her primary language, to the extent practicable;

C. Describe to the applicant the reasons for the decision;

D. Document the authority for the decision (e.g. rule citation); and

E. Inform the applicant of his/her rights and responsibilities regarding the decision.

600.3 An applicant who disagrees with a denial regarding eligibility, enrollment, or cost sharing requirements may appeal in writing to the Children's Basic Health Plan Eligibility Vendor within thirty (30) calendar days of the date of the notification of denial of eligibility, enrollment, or cost sharing. The appeal shall be reviewed and processed within thirty (30) calendar days of receipt and the results of the appeal shall be communicated to the applicant within ten (10) business days of the review. The following guidelines shall apply to the appeal process:

A. The Children's Basic Health Plan Eligibility Vendor will coordinate the appeals process with the county or Eligibility site that determined the initial eligibility, enrollment, or cost sharing decision within ten (10) business days after receipt of the appeal.

B. The county or Eligibility site that determined the initial eligibility, enrollment, or cost sharing decision shall:

1. Review the data entry of the application in the Department's eligibility system for accuracy and completeness within ten (10) business days after receipt of the appeal from the Children's Basic Health Plan Eligibility Vendor;

2. Correct or complete information in the Department's eligibility system if it is found to be incomplete or incorrect and re-run eligibility;

3. Maintain the original denial, if the information in the Department's eligibility system is complete and correct; and

4. Notify the applicant and the Children's Basic Health Plan Eligibility Vendor in writing once the review is complete with the results of the data entry review and the option of forwarding the appeal to the Grievance Committee.

600.4 If the applicant disagrees with the results of the appeal, the applicant may have their appeal reviewed by the Grievance Committee. The Grievance Committee's decision shall be final.

A. The Grievance Committee shall be conducted by an independent panel appointed by the Executive Director of the Department. The panel shall include at least three people from the Department or its designee not previously involved with the grievance. A person previously involved with the grievance may be present at the conference and appear before the panel to present information and answer questions, but shall not have a vote. The Department shall ensure that those appointed to the panel have sufficient experience to make an informed decision regarding the grievance under review.

B. The applicant may attend the Grievance Committee in person or by telephone.

C. The applicant may be represented by the person of the applicant's choice (i.e. legal counsel, friend, family member, etc.) during the Grievance Committee.

D. The applicant may have access to documents that were used by the Department or its designee in making the decision under appeal.

600.5 An enrollee who disagrees with a denial of benefits shall submit an appeal to the MCO he/she is enrolled in and shall follow the MCO's appeal process.

610 [Repealed eff.12/30/2012]

COLORADO
Department of Health Care Policy & Financing
Medical Services Board

December 2020 EMERGENCY JUSTIFICATION FOR MEDICAL ASSISTANCE RULES ADOPTED AT THE December 11, 2020 MEDICAL SERVICES BOARD MEETING

Document 09, CHP 20-12-02-C, Revision to the Medical Assistance Rule concerning Child Health Plan Plus program rule updates, Sections 110,140, 310 and 320

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. The proposed rule change will amend 10 CCR 2505-3 sections 110,140,310 and 320 based on the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Families First Coronavirus Response Act (FFCRA) and the Affordable Care Act (ACA), which includes the Maintenance of Effort (MOE) provision. All policy revisions will align with federal regulations for the state to be in compliance during this Coronavirus (COVID-19) Public Health Emergency. These changes will impact all Medical Assistance categories which includes the Child Health Plan Plus (CHP+) category. These policy changes will stay in place until the end of the Coronavirus (COVID-19) Public Health Emergency. The following policy changes are: Members who were evacuated from or unable to return to Colorado and are temporarily absent will maintain enrollment in the CHP+ program. Enrollment fees will be waived for members who are being redetermined and eligible for CHP+. required through the Federal CARES Act for the Maintenance of Effort (MOE), the Department will continue eligibility for all the CHP+ categories regardless of changes made for a redetermination or additional documentation for current CHP+ enrollee and allow them to continue eligibility through the end of the Public Health Emergency. At the end of emergency, the Department will process the redetermination and /or changes for all members whose eligibility was maintained during the emergency period. And the timeframe, depending on prevailing conditions and current guidance at that time.

This rule change is crucial for the preservation of public health, safety, and welfare.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

STATE OF COLORADO
DEPARTMENT OF LAW

RALPH L. CARR
COLORADO JUDICIAL CENTER
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Phone (720) 508-6000

Office of the Attorney General

Tracking number: 2020-00937

Opinion of the Attorney General rendered in connection with the rules adopted by the

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

on 12/11/2020

10 CCR 2505-3

FINANCIAL MANAGEMENT OF THE CHILDREN'S BASIC HEALTH PLAN

The above-referenced rules were submitted to this office on 12/15/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 12:13:25

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

CCR number

10 CCR 2505-10

Rule title

10 CCR 2505-10 MEDICAL ASSISTANCE - STATEMENTS OF BASIS AND PURPOSE AND RULE HISTORY 1 - eff 12/11/2020

Effective date

12/11/2020

Expiration date

04/10/2021

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13

Rule Number: MSB 20-12-01-A

Division / Contact / Phone: Medicaid Operations Office / Clint Eatmon / 720-819-6409

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 20-12-01-A, Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.125.11, 8.125.12, 8.125.13, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 12/11/2020
   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Remove the current text at 8.125.11 through the end of 8.125.13. This rule is effective December 11, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13

Rule Number: MSB 20-12-01-A

Division / Contact / Phone: Medicaid Operations Office / Clint Eatmon / 720-819-6409

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule revision will temporarily remove current requirements for providers to comply with: Fingerprint Criminal Background Checks (10 CCR 2505-10 8.125.12), Site-Visits (10 CCR 2505-10 8.125.11) and payment of Application Fee's (10 CCR 2505-10 8.125.13), during the provider enrollment process. Alleviating these requirements will expedite the processing of provider-enrollment applications.

   These proposed changes bring Colorado regulations into alignment with the approved 1135 waiver which was granted by CMS, temporarily waiving these requirements at the Federal Level. If passed, the rule will become effective on the date the board adopts it and it will expire after 120 days. However, the Department has the option to bring the rule to MSB a second time within the 120 days to reinstate or further extend the timeframe, depending on prevailing conditions and current guidance at that time.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

Removing these requirements will expedite the processing of provider enrollment applications during the COVID-19 pandemic, thereby increasing the number of approved providers during this emergency period.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13

Rule Number: MSB 20-12-01-A

Division / Contact / Phone: Medicaid Operations Office / Clint Eatmon / 720-819-6409

REGULATORY ANALYSIS

5. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Those seeking to be approved Medicaid providers and our member population will benefit from this proposed rule.

6. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Those seeking to become approved providers will benefit from a streamlined provider enrollment process. Members will benefit from increased access to care as more providers are enrolled and available to offer treatment and services.

7. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs to the Department or to an other agency to implement and enforce the proposed rule.

8. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   There are no probable costs to providers.

9. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

There are no less costly or less intrusive methods for achieving the purpose of the proposed rule.

10. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

    There are no alternative methods for achieving the purpose of the proposed rule.

8.125 PROVIDER SCREENING

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Sections 8.300.3 & 8.300.5
Rule Number: MSB 20-12-01-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 20-12-01-B, Revision to the Medical Assistance Act Rule concerning Subacute Care

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Sections 8.300.3 and 8.300.5, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 12/11/2020
   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.300.3.A.6 with the proposed text beginning at 8.300.6 through the end of 8.300.3.A.6. Replace the current text at 8.300.4 with the proposed text beginning at 8.300.4 through the end of 8.300.4. Replace the current text at 8.300.5.E with the proposed text beginning at 8.300.5.E through the end of 8.300.5.E. This rule is effective December 11, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Sections 8.300.3 & 8.300.5
Rule Number: MSB 20-12-01-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   During the Coronavirus Disease 2019 (COVID-19) public health emergency, subacute care may be administered by an enrolled hospital in its inpatient hospital or alternate care facilities. Subacute care in a hospital setting shall be equivalent to the level of care administered by a skilled nursing facility for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409. Patients may be admitted to subacute care after an inpatient admission, or directly from an emergency department, observation status, or primary care referral to the administering hospital. Subacute care will be paid at the rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State Plan. Adding subacute care to the covered hospital services in an inpatient hospital, or an associated alternate care facility, increases access to such services for the duration of the COVID-19 public health emergency.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☒ for the preservation of public health, safety and welfare.

   Explain:

   Addition of subacute care to the list of the covered services for inpatient hospitals, and associated alternate care facilities, increases access to such care for the duration of the COVID-19 public health emergency and is imperatively necessary for the preservation of public health, safety, and welfare.

3. Federal authority for the Rule, if any:

   42 CFR §447, Subpart C (2020)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);
   C.R.S. 25.5-5-102(1)(a) (2019)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Sections 8.300.3 & 8.300.5
Rule Number: MSB 20-12-01-B
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Inpatient hospitals, and associated alternate care facilities (ACF), will be affected by, and benefit from, the proposed rule with the addition of subacute care as a covered treatment modality for the duration of the COVID-19 public health emergency. Clients receiving subacute care in an inpatient hospital, or in an ACF, for the duration of the COVID-19 public health emergency will also be affected by, and benefit from, the proposed rule. The Department will bear the cost of reimbursement for subacute care services authorized under the proposed rule.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The qualitative impact of the proposed rule is adding the subacute care treatment modality to the inpatient hospital, and associated ACF, covered services for the duration of the COVID-19 public health emergency. The proposed rule increases access to such services during the COVID-19 public health emergency by allowing hospitals to treat clients that would normally be discharged from the hospital in order to receive a lower level of care. It may be difficult for hospitals to discharge and place such clients in a skilled nursing facility during the COVID-19 public health emergency due to COVID-19 positive or presumptive status. The proposed rule allows hospitals to treat such clients on-site and be reimbursed for such care. Because the clients are being treated at an inpatient hospital or alternate care facility for the same care they would have otherwise received at a skilled nursing facility, the proposed rule is budget neutral.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   Because the clients treated at an inpatient hospital or alternate care facility for the subacute care under the authority of this rule would have otherwise received such care at a skilled nursing facility, the proposed rule is budget neutral. There are no

probable implementation or enforcement costs to the Department or to any other agency. There is no anticipated effect on state revenues.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The probable cost of the proposed rule is reimbursement for subacute care at inpatient hospitals and associated ACFs. The probable benefit of the proposed rule is increased access to subacute care for the duration of the COVID-19 public health emergency. There are no benefits to inaction. Diminished access to subacute care, as described in question two above, for the duration of the COVID-19 public health emergency could be a cost of inaction.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or less intrusive methods for adding subacute care to the covered services for inpatient hospitals and associated ACFs for the duration of the COVID-19 public health emergency.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for adding subacute care to the covered services for inpatient hospitals and associated ACFs for the duration of the COVID-19 public health emergency.

8.300 HOSPITAL SERVICES

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”).

6. Inpatient Subacute Care

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

8.300.4 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. 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.

3. 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.E Payment for Inpatient Subacute Care

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000

Rule Number: MSB 20-08-12-A

Division / Contact / Phone: Office of Community Living / Colin Laughlin / 303-866-2549

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 20-12-02-A, Novel Coronavirus Disease (COVID-19) Rules
3. This action is an adoption of:	new rules

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.6000, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	December 11, 2020
Is rule to be made permanent? (If yes, please attach notice of hearing).	No

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text at 8.6000. This rule is effective December 11, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000

Rule Number: MSB 20-12-02-A

Division / Contact / Phone: Office of Community Living / Colin Laughlin / 303-866-2549

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this emergency rule is to temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

   The temporary changes to regulatory requirements in order to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic is imperatively necessary fo the preservation of public health safety, and welfare.

3. Federal authority for the Rule, if any:

   Social Security Act Section 1135, Social Security Act 1115 (Pending), and Social Security Act 1915(c), Appendix K.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2020); 25.5 Article 6, C.R.S.

DO NOT PUBLISH THIS PAGE

REGULATORY ANALYSIS

5. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Individual's receiving services in community-based settings, provider-owned community-based residential settings, provider-owned facility settings, and case management will all be benefitting from an increase in available funding to respond to the COVID-19 crisis.

6. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Those rendering services in facilities, the community, or even remotely from their office or home may receive additional payment to do so during this critical time. Those receiving services are likely to continue with more likely to experience uninterrupted services as direct care workers/direct support professionals will be incentivized to continue to provide these services.

7. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   Many of the changes the Department is asking for are cost neutral. Additionally, the Department has sought, and in some cases, received approval from the Centers for Medicare and Medicaid to increase payments or rates. However, the Department also must work with its partners at the Office for State Planning and Budget as well as prioritize the many different areas of Medicaid that are impacted by COVID-19. Accordingly, the Department continues to estimate potential costs.

8. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The comparison between direct cost and cost of inaction is hard to quantify. However, it is highly likely that the cost of doing nothing could be higher costs

associated with more costly forms of care, significant impact to member's quality of life, and, in some cases – the loss of life or limb.

9. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   At this time, the Department is also pursuing additional alternatives to ensure health, safety, and welfare but a key component of this effort is to ensure providers, agencies, and direct support professionals have the money they need to continue to go out in a time of crisis and provide services.

10. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

    As mentioned above, the Department is also partnering with community organizations, non-profits, advocacy organizations, other executive agencies, and the governor's office to work towards prioritizing Colorado's most vulnerable citizens receiving long-term care health, safety, and welfare.

8.6000 COVID-19 EMERGENCY RULES

PURPOSE: To temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduced programmatic limitations, and alignment with existing federal guidance related to the COVID-19 pandemic.

8.6001 REGULATORY CHANGES

The following regulations require, as applicable, that funds be made available for payment, federal approval is received, and any conflicting state statutory requirements are suspended by Executive Order. Each regulation below is effective once the applicable prerequisites are satisfied and shall continue to be in effect as long as those prerequisites continue to be satisfied.

8.6001.1 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Section 8.420

> Temporarily waive the requirement that payments for ICF-IID are only allowed for facilities licensed by the Colorado Department of Public Health and Environment (CDPHE) to allow for potential inclusion of existing HCBS Group Homes.

Sections 8.404.3; 8.404.1; 8.405.2.22; 8.405.2.23; 8.405.2.24; 8.405.2.25.

> Temporarily allow emergency placement of eligible individuals into an ICF-IID. Individual would still need to be fully eligible in meeting placement requirements but would allow for Department to expedite process through existing layers of review.

Sections 8.443.16.A; 8.443.1.C-D.

> Temporarily allow payment beyond current limitation not to exceed COVID-19 emergency supplement payments.

8.6001.2 Nursing Facilities

Sections 8.443.10.B; 8.443.10.a; 8.443.11.A

> Temporarily allow Nursing Facilities to receive a supplemental payment for COVID-19 related activities, provided the Nursing Facility organization follows Departmental guidance and benchmarks for the assurance of the member's health, safety, and welfare and adherence to published guidelines for safety.

Section 8.443.12.B – Inclusion of the Following Language:

> COVID-19 Mitigation Emergency Supplemental Payment
>
> > Subject to available non-provider fee funding and Upper Payment Limit restrictions, the Department shall pay an additional supplemental payment to nursing facilities increasing measures to protect residents during the COVID-19 public health emergency.
> >
> > 1. In order to be eligible for this payment facilities must be:
> >
> > a. Compliant with all emergency related reported measures required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

b. Implementing enhanced operational guidelines required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

c. Cooperative with State or National efforts to mitigate the emergency

2. The Department will use historical Medicaid patient data to calculate and issue supplemental payments.

3. All payments issued as an emergency supplemental payment due to COVID-19 must be reported as a revenue in the cost reporting period in which it is received.

Section 8.443.1.B Addition of the Following Language

In addition to the MMIS claims reimbursement and provider fee funded supplemental payments, the Department may issue additional supplemental payments necessary to protect the health, safety and welfare of nursing facility residents when additional state or federal funding is available.

Establishment of Section 8.430.6 – Temporary Medicaid Nursing Facility Expansion

1. 8.430.6.A The Department may issue temporary enrollments for the purposes of increasing bed capacity during a public health emergency.

2. Facilities seeking temporary enrollments must submit plans to discharge residents within 60 days of the emergency end date.

3. Facilities with temporary Medicaid beds will be reimbursed statewide average rate for nursing facilities.

4. The enrollment will be effective until 60 days after the COVID-19 emergency is lifted.

5. After the 60 days has expired, the facility will receive no further reimbursement.

8.6001.3 Case Management

Sections 8.763.C; 8.761.46

Authorize providers of targeted case management services to increase, supplement, exceed, or provide additional authorization of units and correlating payments to all long-term care case management entities including transitional services for individuals needing community-placement due to COVID-19.

8.6001.4 Level of Care Assessment

Sections 8.393.2.c.5.a; 8.393.2.D.3.a; 8.393.3.A.1.c.i.3; 8.401.183.B; 8.497; 8.401; 8.491.2.B.2; 8.500.1; 8.500.90; 8.503; 8.504.1; 8.504.5.D; 8.506.3; 8.506.4.e.ii; 8.508.20; 8.515.5.B.1; 8.517.5.A.2; 8.519.1;

Remove the Professional Medical Information Page (PMIP) from the level of care determination for HCBS waivers, Long-Term Care-Home Health, PACE, NF, and ICF/IID programs to enable additional capacity and expedite enrollment.

Sections 8.390.3.A.2; 8.393.1.M.1.C; 8.393.2.C.5.; 8.393.2.D.1-3; 8.401.11 through 8.401.15; 8.485.61.B; 8.485.71.C; 8.486.201; 8.603.5.D; 8.500.18.B.3; 8.500.108.B.1; 8.503.70.3; 8.503.80.A; 8.506.3; 8.506.4.B; 8.509.14; 8.508.121; 8.503.70.A.1; 8.503.80.A.4; 8.506.4.B; 8.506.12.F; 8.508.20; 8.509.14; 8.509.31.A; 8.515.6.A.3; 8.517.7.A.3; 8.603.5.D; 8.503.30.A; 8.503.30.A.8; 8.508.121.A

Modify the requirements for initial and continued stay review assessments:

1. For initial assessments, upon Department direction to case management agencies, members pursuing a Home and Community Based Services (HCBS) waiver enrollment will be issued a start date based on the date of referral to the Case Management Agency, with the Level of Care to be completed with the member thereafter via telephonic or virtual modality.

2. For yearly re-assessments, the members existing eligibility will continue through the duration of federal authority for the Public Health Emergency. The yearly re-assessment may be postponed up to one year to allow the member to continue to receive services during the pandemic.

3. Changes to transfers from nursing facility to nursing facility by not requiring an entirely new assessment be conducted

8.6001.5 Termination from Waiver Eligibility - Adverse Action

Sections 8.393.3.A.1.a through 8.393.A.1.d; 8.485.61.A through 8.485.61.D.3.b; 8.500.16.A.1 through 8.500.16.A.4; 8.500.16.E.1 and E.2; 8.503.160.A.1 through 8.500.160.A.4; 8.503.160.E.1 through 8.503.160.E.9; 8.508.190.A.1-4; 8.508.190.E.1 and E.2 ; 8.508.190.H.1-4; 8.508.190.I.3 and I.4; 8.509.15.A.1 through 8.509.15.A.4.c.1; 8.555.5.D.2

Remove requirement to involuntarily terminate a member from their selected HCBS waiver program

8.6001.6 Preadmission Screening and Resident Review (PASRR)

Section 8.401.18.181.A

PASRR Level I Screening and Level II Evaluations will be suspended for 30 days in accordance with Section 1919(e)(7) for new admissions.

8.6001.7 Personal Care

Sections 8.485.61.D.2-3; 8.489.10.11; 8.510.4.A

Temporarily waive the restriction of personal care services provided in Hospital, Nursing Facility, or other acute-like setting.

Sections 8.510.18; 8.552.1.B

Temporarily allow legally responsible person to provide services using participant directed models (Consumer Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS)).

8.6001.8 Guidelines for Institutions for Mental Diseases (IMDs)

Section 8.401.4

Temporarily waive the IMD requirements for nursing facilities that exceed 50% of patient-census with a primary diagnosis of major mental illness.

8.6001.9 Retainer Payments

Sections 8.515.80.F; 8.500.14.B.3

Temporarily allow specified Brain Injury waiver providers to bill retainer payments for services not rendered.

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Title of Rule: Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6
Rule Number: MSB 20-12-02-B
Division / Contact / Phone: Eligibility / Ana Bordallo / 3558

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

a

2. Title of Rule: MSB 20-12-02-B, Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

Sections(s) 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
If yes, state effective date: 12/11/2020
Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100 with the proposed text beginning at 8.100.1 through the end of 8.100.7.V.6. This rule is effective December 11, 2020.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6
Rule Number: MSB 20-12-02-B
Division / Contact / Phone: Eligibility / Ana Bordallo / 3558

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The proposed rule change will amend 10 CCR 2505-10 sections 8.100.1,8.100.3, 8.100.4, 8.100.5 and 8.100.6 based on the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Families First Coronavirus Response Act (FFCRA) and the Affordable Care Act(ACA), which includes the Maintenance of Effort (MOE) provision. All policy revisions will align with federal regulations for the state to be in compliance during the federal Coronavirus (COVID-19) Public Health Emergency. These changes will impact all Medical Assistance categories and these policy changes will stay in place until the end of the federal Coronavirus (COVID-19) Public Health Emergency. The following policy changes are: Self-attestation for most verifications will be acceptable to be in compliance with the Maintenance of Effort (MOE) provision to ensure the continuance of health coverage for all eligible members. When a member is not reasonable compatible based off income a member self-attests, documentation will not be required, and the member will remain eligible for Medical Assistance. Self-attestation of resources will be acceptable for Non-MAGI programs. Premiums for the Buy-In program will be waived. Required through the Federal CARES Act for the Maintenance of Effort (MOE), members who had a loss of employment will remain in the Buy-In program. Newly enrolled members will still need to meet the work requirements. For applicants who are not eligible for Medical Assistance but have been exposed or who are potentially infected by the COVID-19, will be eligible for Medical Assistance for related COVID testing. The economic stimulus relief package designed to provide direct assistance to individuals to help offset the financial impacts of the COVID-19 Public Health Emergency will be exempt for MAGI and Non-MAGI eligibility determinations. The economic stimulus will *not* be a countable resource for 12 months for any Non-MAGI financial eligibility determinations that include a resource test. Lastly, the Federal Pandemic Unemployment Compensation (FPUC) program which provides an extra $600.00 a week is not countable unearned income for Medical Assistance categories

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

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Due to the Coronavirus (COVID-19) Public Health Emergency the state rules need to be updated to comply with federal regulations.

3. Federal authority for the Rule, if any:

   Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127 and Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 and the Affordable Care Act (ACA), which includes the Maintenance of Effort (MOE) provision.

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   25.5-4-205(3)(II)(b)(A), 25.5-5-105, 25.5-5-206(1)(II)(B), 25.5-6-1404(1)(b) and(3)(a)(b), 25.5-6-1405(1),25.5.-6-1405(2)

Title of Rule: Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6
Rule Number: MSB 20-12-02-B
Division / Contact / Phone: Eligibility / Ana Bordallo / 3558

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The proposed rules will impact applicants and members who are applying or enrolled in a MAGI and Non-MAGI Medical Assistance program. The rule updates will benefit both an applicant and member who becomes eligible for Medical Assistance by remaining eligible during this Coronavirus (COVID-19) Public Health Emergency.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The proposed rule will help to determine eligibility correctly by applying regulations based on the CARES Act to help applicants and members remain eligible for MAGI and Non-MAGI Medical Assistance programs during this Coronavirus (COVID-19) Public Health Emergency.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   Self-attestation of all eligibility requirements, including resources, is likely to increase the number of individuals who will be eligible to enroll in Medicaid, therefore the Department expects its expenditures to increase as a result of this policy change. The Department expects that the waiving of premiums for the Disabled Buy-In program will reduce the revenues to the Department, which will result in an increase in expenditures from the Healthcare Affordability and Sustainability Fee (HAS) Cash Fund and federal funds, in order to fill the gap in revenue lost from the premiums.

   The Department expects that the provision of COVID testing to applicants will increase expenditures to the Department, but these expenditures will be covered with 100% federal funds and will not impact expenditures from state fund sources.

The exemptions to counting the economic relief provided to individuals from the federal government towards eligibility for Medical Assistance is likely to not affect eligibility, and therefore not impact costs to the Department.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The allowance of self-attestation of eligibility criteria is mandated by the Families First Coronavirus Response Act in order for states to qualify for an enhanced FMAP of 6.2%. If the Department does not act in accordance with this policy, the costs to the Department will increase beyond what is necessary. The benefit of implementing this policy will allow the Department to secure a higher FMAP, which will allow the Department to operate with less administrative burden and serve more members during the emergency period. With respect to the proposal to waive the premiums for the Disabled Buy-In program, the Department expects that inaction will cause potential members to not qualify for buy-in because they will be unable to pay the premiums due to the severity of the economic shock. Therefore, the Department sees no benefit to inaction of the rule changes.

   In addition, the Families First Coronavirus Response Act allows state Medicaid and CHP+ programs to fund the cost of COVID-19 diagnostic testing for residents who do not qualify for Medical Assistance through 100% federal funds. Thus, inaction will lead to less testing of individual during the emergency and more uncertainty of the status of the emergency in Colorado. Again, the Department sees no benefit to inaction as the costs will be covered by federal funds.

   The exemptions to counting the economic relief provided to individuals from the federal government towards eligibility for Medical Assistance are mandated by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. If the Department does not act it will be in violation of the law.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly methods available to the Department to comply with the Families First Coronavirus Response Act and the CARES Act. The purposes of the proposed rule changes are to allow the Department to better serve Medicaid members and the people of Colorado during this emergency period and the Department sees no other method to accomplish this goal.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.
   There are no alternative methods for the proposed rule that were considered

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.1 Definitions

300% Institutionalized Special Income Group is a Medical Assistance category that provides Long-Term Care Services to aged or disabled individuals.

1619b is section 1619b of the Social Security Act which allows individuals who are eligible for Supplemental Security Income (SSI) to continue to be eligible for Medical Assistance coverage after they return to work.

AB - Aid to the Blind is a program which provides financial assistance to low-income blind persons.

ABD - Aged, Blind and Disabled Medical Assistance is a group of Medical Assistance categories for individuals that have been deemed to be aged, blind, or disabled by the Social Security Administration or the Department.

Achieving a Better Life Experience (ABLE) accounts – Special savings accounts that are set up by (or for) certain individuals with disabilities in a qualified ABLE program that are exempt for eligibility. They can be established by any state's qualified ABLE Program. Colorado's ABLE program is administered by the Department of Higher Education.

Adjusted Gross Income (AGI)-means" gross income", as defined in federal tax rules, minus certain adjustments prescribed in the federal tax rules to derive the "Adjusted Gross Income" line on the tax return. These adjustments from gross income are taken before the taxpayer takes his or her Schedule A deductions or Standard Deduction.

Adult MAGI Medical Assistance Group provides Medical Assistance to eligible adults from the age of 19 through the end of the month that the individual turns 65, who do not receive or who are ineligible for Medicare.

AND - Aid to Needy Disabled is a program which provides financial assistance to low-income persons over age 18 who have a total disability which is expected to last six months or longer and prevents them from working.

AFDC - Aid to Families with Dependent Children is the Title IV federal assistance program in effect from 1935 to 1997 which was administered by the United States Department of Health and Human Services. This program provided financial assistance to children whose families had low or no income.

AP-5615 is the form used to determine the patient payment for clients in nursing facilities receiving Long Term Care.

Alien is a person who was not born in the United States and who is not a naturalized citizen.

Ambulatory Services is any medical care delivered on an outpatient basis.

Annuity is an investment vehicle whereby an individual establishes a right to receive fixed periodic payments, either for life or a term of years.

Applicant is an individual who is seeking an eligibility determination for Medical Assistance through the submission of an application.

Application Date is the date the application is received and date-stamped by the eligibility site or the date the application was received and date-stamped by an Application Assistance site or Presumptive

Eligibility site. In the absence of a date-stamp, the application date is the date that the application was signed by the client.

Application for Public Assistance is the designated application used to determine eligibility for financial assistance. It can also be used to determine eligibility for Medical Assistance.

Blindness is defined in this volume as the total lack of vision or vision in the better eye of 20/200 or less with the use of a correcting lens and/or tunnel vision to the extent that the field of vision is no greater than 20 degrees.

Burial Spaces are burial plots, gravesites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the individual or are held for his or her use, including necessary and reasonable improvements or additions to or upon such burial spaces such as: vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

Burial Trusts are irrevocable pre-need funeral agreements with a funeral director or other entity to meet the expenses associated with burial for Medical Assistance applicants/recipients. The agreement can include burial spaces as well as the services of the funeral director.

Caretaker Relative is a person who is related to the dependent child or any adult with whom the dependent child is living and who assumes responsibility for the dependent child’s care.

Case Management Services are services provided by community mental health centers, clinics, community centered boards, and EPSDT case managers to assist in providing services to Medical Assistance clients in gaining access to needed medical, social, educational and other services.

Cash Surrender Value is the amount the insurer will pay to the owner upon cancellation of the policy before the death of the insured or before maturity of the policy.

Categorically Eligible means persons who are eligible for Medical Assistance due to their eligibility for one or more Federal categories of public assistance.

CBMS - Colorado Benefits Management System is the computer system that determines an applicant’s eligibility for public assistance in the state of Colorado.

CDHS -Colorado Department of Human Services is the state department responsible for administering the social service and financial assistance programs for Colorado.

Children MAGI Medical Assistance group provides Medical Assistance coverage to tax dependents or otherwise eligible applicants through the end of the month that the individual turns 19 years old.

Child Support Services is a CDHS program that assures that all children receive financial and medical support from each parent. This is accomplished by locating each parent, establishing paternity and support obligations, and enforcing those obligations.

Citizen is a person who was born in the United States or who has been naturalized.

Client is a person who is eligible for the Medical Assistance Program. “Client” is used interchangeably with “recipient” when the person is eligible for the program.

CMS - Centers for Medicare and Medicaid Services is the Federal agency within the US Department of Health and Human Services that partners with the states to administer Medicaid and CHP+ via State Plans in effect for each State. Colorado is in Region VIII.

CHP+ - Child Health Plan Plus is low-cost health insurance for Colorado's uninsured children and pregnant women. CHP+ is public health insurance for children and pregnant women who earn too much to qualify for The Medical Assistance Program, but cannot afford private health insurance.

COLA - Cost of Living Adjustment is an annual increase in the dollar value of benefits made automatically by the United States Department of Health and Human Services or the state in OASDI, SSI and OAP cases to account for rises in the cost of living due to inflation.

Colorado State Plan is a written statement which describes the purpose, nature, and scope of the Colorado's Medical Assistance Program. The Plan is submitted to the CMS and assures that the program is administered consistently within specific requirements set forth in both the Social Security Act and the Code of Federal Regulations (CFR) in order for a state to be eligible for Federal Financial Participation (FFP).

Common Law Marriage is legally recognized as a marriage in the State of Colorado under certain circumstances even though no legally recognized marriage ceremony is performed or civil marriage contract is executed. Individuals declaring or publicly holding themselves out as a married couple through verbal or written methods may be recognized as legally married under state law. C.R.S. § 14-2-104(3).

Community Centered Boards are private non-profit organizations designated in statute as the single entry point into the long-term service and support system for persons with developmental disabilities.

Community Spouse is the spouse of an institutionalized spouse.

Community Spouse Resource Allowance is the amount of resources that the Medical Assistance regulations permit the spouse staying at home to retain.

Complete Application means an application in which all questions have been answered, which is signed, and for which all required verifications have been submitted.The Department is defined in this volume as the Colorado Department of Health Care Policy and Financing which is responsible for administering the Colorado Medical Assistance Program and Child Health Plan Plus programs as well as other State-funded health care programs.

Dependent Child is a child who lives with a parent, legal guardian, caretaker relative or foster parent and is under the age of 18, or, is age 18 and a full-time student, and expected to graduate by age 19.

Dependent Relative for purposes of this rule is defined as one who is claimed as a dependent by an applicant for federal income tax purposes.

Difficulty of Care Payments is a payment to an applicant or member as compensation for providing live-in home care to an individual who qualifies for foster care or Home and Community Based Services (HCBS) waiver program and lives in the home of the care recipient. This additional care must be required due to a physical, mental, or emotional handicap.

Disability means the inability to do any substantial gainful activity (or, in the case of a child, having marked and severe functional limitations) by reason of a medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of l2 months or more.

Dual Eligible clients are Medicare beneficiaries who are also eligible for Medical Assistance.

Earned Income is defined for purposes of this volume as any compensation from participation in a business, including wages, salary, tips, commissions and bonuses.

Earned Income Disregards are the allowable deductions and exclusions subtracted from the gross earnings. Income disregards vary in amount and type, depending on the category of assistance.

Electronic Data Source is an interface established with a federal or state agency, commercial entity, or other data sources obtained through data sharing agreements to verify data used in determining eligibility. The active interfaces are identified in the Department's verification plan submitted to CMS.

Eligibility Site is defined in this volume as a location outside of the Department that has been deemed by the Department as eligible to accept applications and determine eligibility for applicants.

Employed means that an individual has earned income and is working part time, full time or is self-employed, and has proof of employment. Volunteer or in-kind work is not considered employment.

EPSDT- Early Periodic Screening, Diagnosis and Treatment is the child health component of the Medical Assistance Program. It is required in every state and is designed to improve the health of low-income children by financing appropriate, medically necessary services and providing outreach and case management services for all eligible individuals.

Equity Value is the fair market value of land or other asset less any encumbrances.

Ex Parte Review is an administrative review of eligibility during a redetermination period in lieu of performing a redetermination from the client. This administrative review is performed by verifying current information obtained from another current aid program.

Face Value of a Life Insurance Policy is the basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or other special provisions.

Fair Market Value is the average price a similar property will sell for on the open market to a private individual in the particular geographic area involved. Also, the price at which the property would change hands between a willing buyer and a willing seller, neither being under any pressure to buy or to sell and both having reasonable knowledge of relevant facts.

FBR - The Federal Benefit Rate is the monthly Supplemental Security Income payment amount for a single individual or a couple. The FBR is used by the Aged, Blind and Disabled Medical Assistance Programs as the eligibility income limits.

FFP - Federal Financial Participation as defined in this volume is the amount or percentage of funds provided by the Federal Government to administer the Colorado Medical Assistance Program.

FPL - Federal Poverty Level is a simplified version of the federal poverty thresholds used to determine financial eligibility for assistance programs. The thresholds are issued each year in the Federal Register by the Department of Health and Human Services (HHS).

Good Cause is the client's justification for needing additional time due to extenuating circumstances, usually used when extending deadlines for submittal of required documentation.

Good Cause for Child Support is the specific process and criteria that can be applied when a client is refusing to cooperate in the establishment of paternity or establishment and enforcement of a child support order due to extenuating circumstances.

HCBS are Home and Community Based Services are also referred to as "waiver programs". HCBS provides services beyond those covered by the Medical Assistance Program that enable individuals to remain in a community setting rather than being admitted to a Long-Term Care institution.

In-Kind Income is income a person receives in a form other than money. It may be received in exchange for work or service (earned income) or a non-cash gift or contribution (unearned income).

Inpatient is an individual who has been admitted to a medical institution on recommendation of a physician or dentist and who receives room, board and professional services for 24 hours or longer, or is expected to receive these services for 24 hours or longer.

Institution is an establishment that furnishes, in single or multiple facilities, food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

Institutionalization is the commitment of a patient to a health care facility for treatment.

Institutionalized Individual is a person who is institutionalized in a medical facility, a Long-Term Care institution, or applying for or receiving Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).

Institutionalized Spouse is a Medicaid eligible client who begins a stay in a medical institution or nursing facility on or after September 30, 1989, or is first enrolled as a Medical Assistance client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or receives Home and Community Based Services (HCBS) on or after July 1, 1999; and is married to a spouse who is not in a medical institution or nursing facility. An institutionalized spouse does not include any such individual who is not likely to be in a medical institution or nursing facility or to receive HCBS or PACE for at least 30 consecutive days. Irrevocable means that the contract, trust, or other arrangement cannot be terminated, and that the funds cannot be used for any purpose other than outlined in the document.

Insurance Affordability Program (IAP) refers to Medicaid, Child Health Plan *Plus* (CHP+), and premium and cost-sharing assistance for purchasing private health insurance through state insurance marketplace.

Legal Immigrant is an individual who is not a citizen or national and has been permitted to remain in the United States by the United States Citizenship and Immigration Services (USCIS) either temporarily or as an actual or prospective permanent resident or whose extended physical presence in the United States is known to and allowed by USCIS.

Legal Immigrant Prenatal is a medical program that provides medical coverage for pregnant legal immigrants who have been legal immigrants for less than five years.

Limited Disability for the Medicaid Buy-In Program for Working Adults with Disabilities means that an individual has a disability that would meet the definition of disability under SSA without regard to Substantial Gainful Activity (SGA).

Long-Term Care is Medical Assistance services that provides nursing-home care, home-health care, personal or adult day care for individuals aged at least 65 years or with a chronic or disabling condition.

Long-Term Care Institution means class I nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR) and swing bed facilities. Long-Term Care institutions can include hospitals.

Managed care system is a system for providing health care services which integrates both the delivery and the financing of health care services in an attempt to provide access to medical services while containing the cost and use of medical care.

Medical Assistance is defined as all medical programs administered by the Department of Health Care Policy and Financing. Medical Assistance/Medicaid is the joint state/federal health benefits program for individuals and families with low income and resources. It is an entitlement program that is jointly funded by the states and federal government and administered by the state. This program provides for payment of all or part of the cost of care for medical services.

Medical Assistance Required Household is defined for purposes of this volume as all parents or caretaker relatives, spouses, and dependent children residing in the same home.

Minimal Verification is defined in this volume as the minimum amount of information needed to process an application for benefits. No other verification can be requested from clients unless the information provided is questionable or inconsistent.

Minimum Essential Coverage is the type of coverage one must maintain to be in compliance with the Affordable Care Act in order to avoid paying a penalty for being uninsured. Minimum essential coverage may include but not limited to: Medicaid; CHP+; private health plans through Connect for Health Colorado; Medicare; job-based insurance, and certain other coverage.

MMMNA - Minimum Monthly Maintenance Needs Allowance is the calculation used to determine the amount of institutionalized spouse's income that the community spouse is allowed to retain to meet their monthly living needs.

MAGI - Modified Adjusted Gross Income refers to the methodology by which income and household composition are determined for the MAGI Medical Assistance groups under the Affordable Care Act. These MAGI groups include Parents and Caretaker Relatives, Pregnant Women, Children, and Adults. For a more complete description of the MAGI categories and pursuant rules, please refer to section 8.100.4.

MAGI-Equivalent is the resulting standard identified through a process that converts a state's net-income standard to equivalent MAGI standards.

MIA - Monthly Income Allowance is the amount of institutionalized spouse's income that the community spouse is allowed to retain to meet their monthly living needs.

MSP - Medicare Savings Program is a Medical Assistance Program to assist in the payment of Medicare premium, coinsurance and deductible amounts. There are four groups that are eligible for payment or part-payment of Medicare premiums, coinsurance and deductibles: Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLIMBs), Qualified Disabled and Working Individuals (QDWIs), and Qualifying Individuals – 1 (QI-1s).

Non-Filer is an individual who neither files a tax return nor is claimed as a tax dependent. For a more complete description of how household composition is determined for the MAGI Medical Assistance groups, please refer to the MAGI household composition section at 8.100.4.E.

Nursing Facility is a facility or distinct part of a facility which is maintained primarily for the care and treatment of inpatients under the direction of a physician. The patients in such a facility require supportive, therapeutic, or compensating services and the availability of a licensed nurse for observation or treatment on a twenty-four-hour basis.

OAP - Old Age Pension is a financial assistance program for low income adults age 60 or older.

OASDI - Old Age, Survivors and Disability Insurance is the official term Social Security uses for Social Security Act Title II benefits including retirement, survivors, and disability. This does not include SSI payments.

Outpatient is a patient who is not hospitalized overnight but who visits a hospital, clinic, or associated facility for diagnosis or treatment. Is a patient who does not require admittance to a facility to receive medical services.

PACE - Program of All-inclusive Care for the Elderly is a unique, capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. The PACE program features a comprehensive

medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

Parent and Caretaker Relative is a MAGI Medical Assistance group that provides Medical Assistance to adults who are parents or Caretaker Relatives of dependent children.

Patient is an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

PEAK – the Colorado Program Eligibility and Application Kit is a web-based portal used to apply for public assistance benefits in the State of Colorado, including Medical Assistance.

PNA - Personal Needs Allowance means moneys received by any person admitted to a nursing care facility or Long-Term Care Institution which are received by said person to purchase necessary clothing, incidentals, or other personal needs items which are not reimbursed by a Federal or state program.

Pregnant Women is a MAGI Medical Assistance group that provides Medical Assistance coverage to pregnant women whose MAGI-based income calculation is less than 185% FPL, including women who are 60 days post-partum.

Premium means the monthly amount an individual pays to participate in a Medicaid Buy-In Program.

Provider is any person, public or private institution, agency, or business concern enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding a current valid license or certificate to provide such services or to dispense such goods.

Psychiatric Facility is a facility that is licensed as a residential care facility or hospital and that provides inpatient psychiatric services for individuals under the direction of a licensed physician.

Public Institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

Questionable is defined as inconsistent or contradictory tangible information, statements, documents, or file records.

Reasonable Compatibility refers to an allowable difference or discrepancy between the income an applicant self attests and the amount of income reported by an electronic data source. For a more complete description of how reasonable compatibility is used to determine an applicant’s financial eligibility for Medical Assistance, please refer to the MAGI Income section at 8.100.4.C

Reasonable Explanation refers to the opportunity afforded an applicant to explain a discrepancy between self-attested income and income as reported by an electronic data source, when the difference is above the threshold percentage for reasonable compatibility.

Recipient is any person who has been determined eligible to receive benefits.

Resident is any individual who is living within the state and considers the state as their place of residence. Residents include any unemancipated child whose parent or other person exercising custody lives within the state.

RRB - Railroad Retirement Benefits is a benefit program under Federal law 45 U.S.C. § 231 et seq that became effective in 1935. It provides retirement benefits to retired railroad workers and families from a special fund, which is separate from the Social Security fund.

Secondary School is a school or educational program that provides instruction or training towards a high school diploma or an equivalent degree such as a High School Equivalency Diploma (HSED).

SGA – Substantial Gainful Activity is defined by the Social Security Administration. SGA is the term used to describe a level of work activity and earnings. Work is “substantial” if it involves performance of significant physical or mental activities or a combination of both, which are productive in nature. For work activity to be substantial, it does not need to be performed on a full-time basis. Work activity performed on a part-time basis may also be substantial gainful activity. “Gainful” work activity is work performed for pay or profit; or work of a nature generally performed for pay or profit; or work intended for profit, whether or not a profit is realized.

Single Entry Point Agency means the organization selected to provide case management functions for persons in need of Long-Term Care services within a Single Entry Point District.

Single Streamlined Application or “SSAp” is the general application for health assistance benefits through which applicants will be screened for Medical Assistance programs including Medicaid, CHP+, or premium and cost-sharing assistance for purchasing private health insurance through a state insurance marketplace.

SISC- Supplemental Income Status Codes are system codes used to distinguish the different types of state supplementary benefits (such as OAP) a recipient may receive. Supplemental Income Status Codes determine the FFP for benefits paid on behalf of groups covered under the Medical Assistance program.

SSA - Social Security Administration is an agency of the United States federal government that administers Social Security, a social insurance program consisting of retirement, disability, and survivors' benefits.

SSI - Supplemental Security Income is a Federal income supplement program funded by general tax revenues (not Social Security taxes) that provides income to aged, blind or disabled individuals with little or no income and resources.

SSI Eligible means an individual who is eligible to receive Supplemental Security Income under Title XVI of the Social Security Act, and may or may not be receiving the monetary payment.

TANF - Temporary Assistance to Needy Families is the Federal assistance program which provides supportive services and federal benefits to families with little or no income or resources. It is the Block Grant that was established under the Personal Responsibility and Work Opportunity Reconciliation Act in Title IV of the Social Security Act.

Tax Dependent is anyone expected to be claimed as a dependent by a Tax-Filer.

Tax-Filer is an individual, head of household or married couple who is required to and who files a personal income tax return.

Third Party is an individual, institution, corporation, or public or private agency which is or may be liable to pay all or any part of the medical cost of an injury, a disease, or the disability of an applicant for or recipient of Medical Assistance.

Title XIX is the portion of the federal Social Security Act which authorizes a joint federal/state Medicaid program. Title XIX contains federal regulations governing the Medicaid program.

TMA - Transitional Medical Assistance is a Medical Assistance category for families that lost Medical Assistance coverage due to increased earned income or loss of earned income disregards.

ULTC 100.2 is an assessment tool used to determine level of functional limitation and eligibility for Long-Term Care services in Colorado.

Unearned Income is the gross amount received in cash or kind that is not earned from employment or self-employment.

VA - Veterans Affairs is The Department of Veterans Affairs which provides patient care and Federal benefits to veterans and their dependents.

8.100.2 Legal Basis

Constitution of Colorado, Article XXIV, Old Age Pensions, section 7, established a health and medical care fund for persons who qualify to receive old age pensions.

Colorado Revised Statutes, Title 25.5, Article 4, Colorado Medical Assistance Act, section 102, provides for a program of Medical Assistance for individuals and families, whose income and resources are insufficient to meet the costs of necessary medical care and services, to be administered in cooperation with the federal government.

The Social Security Act, Title XIX, Grants to States for Medical Assistance Programs, and the consequent Federal regulations, Title 42, CFR (Code of Federal Regulations), Chapter IV, Subchapter C, set forth the conditions for states to obtain Federal Financial Participation in Medical Assistance expenditures.

Under the Colorado Medical Assistance Program, the Medicaid program provides coverage of certain groups specified in Title XIX of the Social Security Act. The OAP State Only Medical Assistance Program provides coverage to certain old age pension clients entitled to health and medical care under the Colorado Constitution.

The Department of Health Care Policy and Financing is the single State agency designated to administer the Colorado Medical Assistance Program under Title XIX of the Social Security Act and Colorado statutes. The Office of Medical Assistance of the Department is delegated the duties and responsibilities for administration of the Colorado Medical Assistance Program.

8.100.3. Medical Assistance General Eligibility Requirements

8.100.3.A. Application Requirements

1. The eligibility site shall advise individuals concerning the benefits of the Medical Assistance Program and determine or redetermine eligibility for Medical Assistance in accordance with rules and regulations of the Department. A person who is applying for the Medical Assistance Program or a client who is determined ineligible for the Medical Assistance Program in one category shall be evaluated under all other categories of eligibility. There is no time limit for Medical Assistance coverage as long as the client remains categorically eligible.

2. If the applicant applied for Medical Assistance on the Single Streamlined Application and was found ineligible, this application shall be reviewed for all other Medical Assistance eligibility programs, the Child Health Plan Plus (CHP+) program and premium and cost-sharing assistance for purchasing private health insurance through the state insurance marketplace.

    a. The application data and verifications shall be automatically transferred to the state insurance marketplace through a system interface when applicants are found ineligible for Medical Assistance eligibility programs. If an individual is pending for a Non-MAGI Medical Assistance eligibility program but has been found financially ineligible for MAGI

Medical Assistance eligibility programs, the application data and verifications shall be transferred to the state insurance marketplace.

3. Persons applying for assistance need complete only one application form to apply for both Medical Assistance and Financial Assistance under the Federal or State Financial Assistance Programs administered in the county. The application will be the Application for Public Assistance.

4. If an applicant is found to be ineligible for a particular program, the Application for Public Assistance shall be reviewed and processed for other financial programs the household has requested on the Application for Public Assistance and all other Medical Assistance Programs. Referrals to other community agencies and organizations shall be made for the applicant whenever available or requested.

5. The applicant must sign the application form, give declaration in lieu of a signature by telephone, or may opt to use an electronic signature in order to receive Medical Assistance.

6. A family member, adult in the applicant's Medical Assistance Required Household or authorized representative may submit an application and request assistance on behalf of an applicant.

7. If the applicant is not able to participate in the completion of the application forms because they are a minor (as defined in C.R.S. § 13-22-101) or due to physical or mental incapacity, the spouse, other relative, friend, or representative acting responsibly on behalf of the applicant may complete the forms. When no such person is available to assist in these situations, the eligibility site shall assist the applicant in the completion of the necessary forms. This type of situation should be identified clearly in the case record.

8. For the purpose of Medical Assistance, when an applicant is incompetent or incapacitated and unable to sign an application, or in case of death of the applicant, the application shall be signed, under penalty of perjury, by someone acting responsibly on behalf of the applicant either:

    a. A parent, or other specified relative, or legally appointed guardian or conservator, or

    b. For a person in a medical institution for whom none of the above in 8.a. are available, an authorized official of the institution may sign the application.

9. Application interviews or requested visits to the eligibility site for Medical Assistance shall not be required. All correspondence may occur by mail, email or telephone.

10. During normal business hours, eligibility sites shall not restrict the hours in which applicants may file an application. The eligibility site must afford any individual wishing to do so the opportunity to apply for Medical Assistance without delay.

11. The applicant has the right to withdraw his or her application at any time.

8.100.3.B. Residency Requirements

1. Individuals shall make application in the county in which they live. Individuals who reside in a county but who do not reside in a permanent dwelling nor have a fixed mailing address shall be considered eligible for the Medical Assistance Program, provided all other eligibility requirements are met. In no instance shall there be a durational residency requirement imposed upon the applicant, nor shall there be a requirement for the applicant to reside in a permanent dwelling or have a fixed mailing address. If an individual without a permanent dwelling or fixed mailing address is hospitalized, the county where the hospital is located shall be responsible for processing the application to completion. If the individual moves prior to completion of the

eligibility determination the origination eligibility site completes the determination and transfers the case as applicable.

a. For applicants in Long Term Care institutions - The county of domicile for all Long Term Care clients is the county in which they are physically located and receiving services.

2. A resident of Colorado is defined as a person that is living within the state of Colorado and considers Colorado to be their place of residence at the time of application. For institutionalized individuals who are incapable of indicating intent as to their state of residence, the state of residence shall be where the institution is located unless that state determines that the individual is a resident of another state, by applying the following criteria:

a. for any institutionalized individual who is under age 21 or who is age 21 or older and incapable of indicating intent before age 21, the state of residence is that of the individual's parent(s) or legally appointed guardian at the time of placement;

b. for any institutionalized individual who became incapable of indicating intent at or after age 21, (1) the state of residence is the state in which the person was living when he or she became incapable of indicating intent, or (2) if this cannot be determined, the state of residence is the state in which the person was living when he or she was first determined to be incapable of indicating intent;

c. upon placement in another state, the new state is the state of residence unless the current state of residence is involved in the placement. If a current state arranged for an individual to be placed in an institution located in another state, the current state shall be the individual's state of residence, irrespective of the individual's indicated intent or ability to indicate intent;

d. in the case of conflicting opinions between states, the state of residence is the state where the individual is physically located.

3. For purposes of this section on establishing an individual's state of residence, an individual is considered incapable of indicating intent if:

a. the person has an I.Q. of 49 or less or has a mental age of 7 or less, based on standardized tests as specified in the persons in medical facilities section of this volume;

b. the person is judged legally incompetent; or

c. medical documentation, or other documentation acceptable to the eligibility site, supports a finding that the person is incapable of indicating intent.

4. Residence shall be retained until abandoned. A person temporarily absent from the state, inside or outside the United States, retains Colorado residence. Temporarily absent means that at the time he/she leaves, the person intends to return.

5. A non-resident shall mean a person who considers his/her place of residence to be other than Colorado. Any person who enters the state to receive Medical Assistance or for any other reason is a non-resident, so long as they consider their permanent place of residence to be outside of the state of Colorado.

8.100.3.C. Transferring Requirements

1. When a family or individual moves from one county to another within Colorado, the client shall report the change of address to the eligibility site responsible for the current active Medical

Assistance Program case(s). If a household applies in the county in which they live and then moves out of that county during the application determination process, the originating eligibility site shall complete the processing of that application before transferring the case. The originating eligibility site shall electronically transfer the case to the new county of residence in CBMS.

2. The originating eligibility site must notify the receiving eligibility site of the client's transfer of Medical Assistance. The originating eligibility site may notify the receiving eligibility site by telephone that a client has moved to the receiving county. If the family or individual wishes to apply for other types of assistance, they shall submit a new application to the receiving eligibility site.

3. If the household is transferring the current Medical Assistance case, the receiving eligibility site cannot mandate a new application, verification, or an office visit to authorize the transfer. The receiving eligibility site can request copies of specific case documents to be forwarded from the originating eligibility site to verify the data contained in CBMS.

4. If the originating eligibility site closes a case for the discontinuation reason of “unable to locate,” the applicant shall reapply at the receiving eligibility site for the Medical Assistance Program.

5. If a case is closed for any other discontinuation reason than “unable to locate” and the client provides appropriate information to overturn the discontinuation with the originating eligibility site, then, upon transfer, the receiving eligibility site shall reopen the case with case comments in CBMS. These actions shall be performed according to timeframes defined by the Department.

6. When a recipient moves from his/her home to a nursing facility in another county or when a recipient moves from one nursing facility to another in a different county:

    a. the initiating eligibility site will transfer the case electronically in the eligibility system to the eligibility site in which the nursing facility is located when the individual is determined eligible; and

    b. The following items shall be furnished by the initiating eligibility site to the new eligibility site in hard copy format:

        i) 5615 that was sent to the nursing facility indicating the case transfer; and

        ii) Identification and citizenship documents; and

        iii) The ULTC 100.2.

7. When transferring a case, the initiating eligibility site will send an AP-5615 form to the nursing facility administrator of the new nursing facility showing the date of case closure and the current patient payment at the time of transfer. Should the Medical Assistance Program reimbursement be interrupted, the receiving eligibility site will have the responsibility to process the application and back date the Medical Assistance eligibility date to cover the period of ineligibility.

8.100.3.D. Processing Requirements

1. The eligibility site shall process a Single Streamlined Application for Medical Assistance Program benefits within the following deadlines:

    a. 90 days for persons who apply for the Medical Assistance Program and a disability determination is required.

    b. 45 days for all other Medical Assistance Program applicants.

c. The above deadlines cover the period from the date of receipt of a complete application to the date the eligibility site mails a notice of its decision to the applicant.

d. In unusual circumstances, documented in the case record and in CBMS case comments, the eligibility site may delay its decision on the application beyond the applicable deadline at its discretion. Examples of such unusual circumstances are a delay or failure by the applicant or an examining physician to take a required action such as submitting required documentation, or an administrative or other emergency beyond the agency's control.

e. Due to the Coronavirus COVID-19 Public Health Emergency, required by the Federal Families First Coronavirus Response Act for the Maintenance of Effort (MOE), the Department will continue eligibility for all Medical Assistance categories for any individual enrolled in Health First Colorado prior to the Public Health Emergency or who is enrolled in Health First Colorado during the Public Health Emergency but before the last day of the month in which the Public Health Emergency period ends, unless the individual requests a voluntary termination of eligibility or the individual ceases to be a resident of the state. The Department will allow these individuals to continue eligibility through the last day of the month in which the Public Health Emergency period ends. Once the federal emergency declaration has concluded, the Department will process eligibility redeterminations and /or changes for all members whose eligibility was maintained during the emergency declaration.

2. Upon request, applicants will be given an extension of time within the application processing timeframe to submit requested verification. Applicants may request an extension of time beyond the application processing timeframe to obtain necessary verification. The extension may be granted at the eligibility site's discretion. The amount of time given should be determined on a case-by-case basis and should be based on the amount of time the individual needs to obtain the required documentation.

3. The eligibility site shall not use the above timeframes as a waiting period before determining eligibility or as a reason for denying eligibility.

4. For clients who apply for the Medical Assistance Program and a disability determination is required, the eligibility site shall send a notice informing the applicant of the reason for a delay beyond the applicable deadline, and of the applicant's right to appeal if dissatisfied with the delay. The eligibility site shall send this notice no later than 91 days following the application for the Medical Assistance Program.

5. For information regarding continuation of benefits during the pendency of an appeal to the Social Security Administration (SSA) based upon termination of disability benefits see section 8.057.5.C.

6. Effective July 1, 1997, as a condition of eligibility for the Medical Assistance Program, any legal immigrant who is applying for or receiving Medical Assistance shall agree in writing that, during the time period the client is receiving Medical Assistance, he or she will not sign an affidavit of support for the purpose of sponsoring an alien who is seeking permission from the United States Immigration and Citizenship Services to enter or remain in the United States. A legal immigrant's eligibility for Medical Assistance shall not be affected by the fact that he or she has signed an affidavit of support for an alien before July 1, 1997.

7. Eligibility sites at which an individual is able to apply for Medical Assistance benefits shall also provide the applicant the opportunity to register to vote.

a. The eligibility site shall provide to the applicant the prescribed voter registration application.

b. The eligibility site shall not:

i) Seek to influence the applicant's political preference or party registration;

ii) Display any political preference or party allegiance;

iii) Make any statement to the applicant or take any action, the purpose or effect of which is to discourage the applicant from registering to vote; and

iv) Make any statement to an applicant which is to lead the applicant to believe that a decision to register or not to register has any bearing on the availability of services or benefits.

c. The eligibility site shall ensure the confidentiality of individuals registering and declining to register to vote.

d. Records concerning registration and declination to register to vote shall be maintained for two years by the eligibility site. These records shall not be part of the public assistance case record.

e. A completed voter registration application shall be transmitted to the county clerk and recorder for the county in which the eligibility site is located not later than ten (10) days after the date of acceptance; except that if a registration application is accepted within five (5) days before the last day for registration to vote in an election, the application shall be transmitted to the county clerk and recorder for the county not later than five (5) days after the date of acceptance.

8. Individuals who transfer from one Colorado county to another shall be provided the same opportunity to register to vote in the new county of residence. The new county of residence shall follow the above procedure. The new county of residence shall notify its county clerk and recorder of the client's change in address within five (5) days of receiving the information from the client.

8.100.3.E. Retroactive Medical Assistance Coverage

1. An applicant for Medical Assistance shall be provided such assistance any time during the three months preceding the date of application, or as of the date the person became eligible for Medical Assistance, whichever is later. That person shall have received medical services at any time during that period and met all applicable eligibility requirements.

2. An explanation of the conditions for retroactive Medical Assistance shall be given to all applicants. Those applicants who within the three months period prior to the date of application or as of the date the person became eligible for Medical Assistance, whichever is later, have received medical services which would be a benefit under the Colorado State Plan, can request retroactive coverage on the application form. The determination of eligibility for retroactive Medical Assistance shall be made as part of the application process. An applicant does not have to be eligible in the month of application to be eligible for retroactive Medical Assistance. The applicant or client may verbally request retroactive coverage at any time following the completion of an application. Verification required to determine Medical Assistance Program eligibility for the retroactive period shall be secured by the eligibility site to determine retroactive eligibility. Proof of the declared medical service shall not be required.

8.100.3.F. Groups Assisted Under the Program

1. The Medical Assistance Program provides benefits to the following persons who meet the federal definition of categorically needy at the time they apply for benefits:

a. Parents and Caretaker Relatives, Pregnant Women, Children, and Adults as defined under the Modified Adjusted Gross Income (MAGI)Medical Assistance section 8.100.4.

b. Persons who meet legal immigrant requirements as outlined in this volume, who were or would have been eligible for SSI but for their alien status, if such persons meet the resource, income and disability requirements for SSI eligibility.

c. Persons who are receiving financial assistance; and who are eligible for a SISC Code of A or B. See section 8.100.3.M for more information on SISC Codes.

d. Persons who are eligible for financial assistance under Old Age Pension (OAP) and SSI, but are not receiving the money payment.

e. Persons who would be eligible for financial assistance from OAP or SSI, except for the receipt of Social Security Cost of Living Adjustment (COLA) increases, or other retirement, survivors, or disability benefit increases to their own or a spouse's income. This group also includes persons who lost OAP or SSI due to the receipt of Social Security Benefits and who would still be eligible for the Medical Assistance Program except for the cost of living adjustments (COLA's) received. These populations are referenced as Pickle and Disabled Widow(er)s.

f. Persons who are blind, disabled, or aged individuals residing in the medical institution or Long Term Care Institution whose income does not exceed 300% of SSI.

g. Persons who are blind, disabled or aged receiving HCBS whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment.

h. A disabled adult child who is at least 18 years of age and who was receiving SSI as a disabled child prior to the age of 22, and for whom SSI was discontinued on or after May 1, 1987, due to having received of OASDI drawn from a parent(s) Social Security Number, and who would continue to be eligible for SSI if the above OASDI and all subsequent cost of living adjustments were disregarded. This population is referenced as Disabled Adult Child (DAC).

i. Children age 18 and under who would otherwise require institutionalization in an Long Term Care Institution, Nursing Facility (NF), or a hospital but for which it is appropriate to provide care outside of an institution as described in 1902(e)(3) of the Act Public Law No. 97-248 (Section 134).

j. Persons receiving OAP-A, OAP-B, and OAP Refugees who do not meet SSI eligibility criteria but do meet the state eligibility criteria for the OAP State Only Medical Assistance Program. These persons qualify for a SISC Code C.

k. Persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but do not meet the criteria of citizenship shall receive Medical Assistance benefits for emergencies only.

l. Persons with a disability or limited disability who are at least 16 but less than 65 years of age, with income less than or equal to 450% of FPL after income disregards, regardless of resources, and who are employed.

m. Children with a disability who are age 18 and under, with household income less than or equal to 300% of FPL after income disregards, regardless of resources.

n. Due to the Coronavirus COVID-19 public health emergency, an applicant who is not eligible for Medical Assistance but has been impacted through exposure to or potential infection of COVID-19 may be eligible to receive services for COVID-19 testing only. To qualify for this limited benefit, the Applicant must satisfy residency and immigration or citizenship status and not be enrolled in other health insurance.

8.100.3.G. General and Citizenship Eligibility Requirements

1. To be eligible to receive Medical Assistance, an eligible person shall:

a. Be a resident of Colorado;

b. Meet the following requirements while being an inmate, in-patient or resident of a public institution:

i). The following individuals, if eligible, may be enrolled for Medical Assistance

1. Patients in a public medical institution

2. Residents of a Long-Term Care Institution

3. Prior inmates who have been paroled

4. Resident of a publicly operated community residence which serves no more than 16 residents

5. Individuals participating in community corrections programs or residents in community corrections facilities (“halfway houses”) who have freedom of movement and association which includes individuals who:

a) are not precluded from working outside the facility in employment available to individuals who are not under justice system supervision;

b) can use community resources (e.g., libraries, grocery stores, recreation, and education) at will;

c) can seek health care treatment in the broader community to the same or similar extent as other Medicaid enrollees in the state; and/or

d) are residing at their home, such as house arrest, or another location

ii). Inmates who are incarcerated in a correctional institution such as a city, county, state or federal prison may be enrolled, if eligible, with benefits limited to an in-patient stay of 24 hours or longer in a medical institution.

c. Not be a patient in an institution for tuberculosis or mental disease, unless the person is under 21 years of age or has attained 65 years of age and is eligible for the Medical Assistance Program and is receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement. See section 8.100.4.H for special provisions extending Medical Assistance coverage for certain patients who attain age 21 while receiving such inpatient psychiatric services;

d. Meet all financial eligibility requirements of the Medical Assistance Program for which application is being made;

e. Meet the definition of disability or blindness, when applicable. Those definitions appear in this volume at 8.100.1 under Definitions;

f. Meet all other requirements of the Medical Assistance Program for which application is being made; and

g. Fall into one of the following categories:

i) Be a citizen or national of the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa or Swain's Island; or

ii) Be a lawfully admitted non-citizen who entered the United States prior to August 22, 1996, or

iii) Be a non-citizen who entered the United States on or after August 22, 1996 and is applying for Medical Assistance benefits to begin no earlier than five years after the non-citizen's date of entry into the United States who falls into one of the following categories:

1) lawfully admitted for permanent residence under the Immigration and Nationality Act (hereafter referred to as the "INA");

2) paroled into the United States for at least one year under 8 U.S.C. § 1182(d)(5); or

3) granted conditional entry under section 203(a)(7) of the INA, as in effect prior to April 1, 1980; or

4) determined by the eligibility site, in accordance with guidelines issued by the U.S. Attorney General, to be a spouse, child, parent of a child, or child of a parent who, in circumstances specifically described in 8 U.S.C. §1641(c), has been battered or subjected to extreme cruelty which necessitates the provision of Medical Assistance (Medicaid); or

iv) Be a non-citizen who arrived in the United States on any date, who falls into one of the following categories:

1) lawfully residing in Colorado and is an honorably discharged military veteran (also includes spouse, unremarried surviving spouse and unmarried, dependent children), or

2) lawfully residing in Colorado and is on active duty (excluding training) in the U.S. Armed Forces (also includes spouse, unremarried surviving spouse and unmarried, dependent children), or

3) granted asylum under section 208 of the INA, or

4) refugee under section 207 of the INA, or

5) deportation withheld under section 243(h) (as in effect prior to September 30, 1996) or section 241(b)(3) (as amended by P.L. 104-208) of the INA, or

6) Cuban or Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980, or

7) an individual who (1) was born in Canada and possesses at least 50 percent American Indian blood, or is a member of an Indian tribe as defined in 25 U.S.C. sec. 5304(e)(2016), or

8) admitted to the U.S. as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988 (as amended by P.L. 100-461), or

9) lawfully admitted permanent resident who is a Hmong or Highland Lao veteran of the Vietnam conflict, or

10) a victim of a severe form of trafficking in persons, as defined in section 103 of the Victims of Trafficking and Violence Protection Act of 2000, Pub. L.106-386, as amended (22 U.S.C. § 7105(b) (2016)), or

11) An alien who arrived in the United States on or after December 26, 2007 who is an Iraqi special immigrant under section 101(a)(27) of the INA, or

12) An alien who arrived in the United States on or after December 26, 2007 who is an Afghan Special Immigrant under section 101(a)(27) of the INA.

v) The statutes listed at sections 8.100.3.G.1.g.iii.1-5 and at 8.100.3.G.1.g.iv.3-11 are incorporated herein by reference. No amendments or later editions are incorporated. These regulations are available for public inspection at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Pursuant to C.R.S. 24-4-103(12.5)(b)(2016), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

vi) Be a lawfully admitted non-citizen who is a pregnant women or a child under the age of 19 years in the United States who falls into one of the categories listed in 8.100.3.G.1.g.iii or into one of the following categories listed below. These individuals are exempt from the 5-year waiting period:

1) granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a,or

2) granted Temporary Protected Status (TPS) in accordance with 8 U.S.C 1254a and pending applicants for TPS granted employment authorization,

3) granted employment authorization under 8 CFR 274a.12(c),or

4) Family Unity beneficiary in accordance with section 301 of Pub. L. 101-649, as amended.

5) Deferred Enforced Departure (DED), pursuant to a decision made by the President,

6) granted Deferred Action status (excluding Deferred Action for Childhood Arrivals (DACA)) as described in the Secretary of Homeland Security's June 15,2012 memorandum,

7) granted an administrative stay of removal under 8 CFR 241.6(2016), or

8) Beneficiary of approved visa petition who has a pending application for adjustment of status.

9) Pending an application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who-

a) as been granted employment authorization; or

b) Is under the age of 14 and has had an application pending for at least 180 days.

10) granted withholding of removal under the Convention Against Torture,

11) A child who has a pending application for Special Immigrant Juvenile status under 8 U.S.C. 1101(a)(27)(J), or

12) Citizens of Micronesia, the Marshall Islands, and Palau, or

13) is lawfully present American Samoa under the immigration of laws of American Samoa.

14) A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or under 8 U.S.C. 1101(a)(17), or

15) A non-citizen who has been paroled into the United States for less than one year under 8 U.S.C. § 1182(d)(5), except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings.

vii) Exception: The exception to these requirements is that persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but who are not citizens, and are not eligible non-citizens, according to the criteria set forth in 8.100.3.G.1.g, shall receive Medical Assistance benefits for emergency medical care only. The rules on confidentiality prevent the Department or eligibility site from reporting to the United States Citizenship and Immigration Services persons who have applied for or are receiving assistance. These persons need not select a primary care physician as they are eligible only for emergency medical services.

For non-qualified aliens receiving Medical Assistance emergency only benefits, the following medical conditions will be covered:

An emergency medical condition (including labor and delivery) which manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1) placing the patient's health in serious jeopardy;

2) serious impairment of bodily function; or

3) serious dysfunction of any bodily organ or part.

A physician shall make a written statement certifying the presence of an emergency medical condition when services are provided and shall indicate that services were for a medical emergency on the claim form. Coverage is limited to care and services that are necessary to treat immediate emergency medical conditions. Coverage does not include prenatal care or follow-up care.

2. For determinations of eligibility for Medical Assistance, legal immigration status must be verified. This requirement applies to a non-citizen individual who meets the criteria of any category defined at 8.100.3.G(1)(g)(ii) (iii) (iv) or (vi) and has declared that he or she has a legal immigration status.

a. The Verify Lawful Presence (VLP) interface will be used to verify immigration status. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) Program to verify legal immigration status.

i) If an automated response from VLP confirms that the information submitted is consistent with VLP data for immigration status verification requirements, no further action is required for the individual and no additional documentation of immigration status is required.

ii) If the VLP cannot automatically confirm the information submitted, the individual will be contacted with a request for additional documents and/or information needed to verify their legal immigration status through the VLP interface. If a response from the VLP interface confirms that the additional documents and/or information received from the individual verifies their legal immigration status, no further action is required for the individual and no additional documentation of immigration status is required.

3. Reasonable Opportunity Period

a. If the verification through the electronic interface is unsuccessful then the applicant will be provided a reasonable opportunity period, of 90 days, to submit documents indicating a legal immigration status, as listed in 8.100.3.G.1.g. The reasonable opportunity period will begin as of the date of the Notice of Action. The required documentation must be received within the reasonable opportunity period.

b If the applicant does not provide the necessary documents within the reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated.

c. The reasonable opportunity period applies to MAGI, Adult and Buy-In Programs.

i) For the purpose of this section only, MAGI Programs for persons covered pursuant to 8.100.4.G or 8.100.4.I. include the following:

Commonly Used Program Name	Rule Citation
Children's Medical Assistance	8.100.4.G.2
Parent and Caretaker Relative Medical	8.100.4.G.3

Assistance	
Adult Medical Assistance	8.100.4.G.4
Pregnant Women Medical Assistance	8.100.4.G.5
Legal Immigrant Prenatal Medical Assistance	8.100.4.G.6
Transitional Medical Assistance	8.100.4.I.1-5

ii) For the purpose of this section only, Adult and Buy-In Programs for persons covered pursuant to 8.100.3.F, 8.100.6.P, 8.100.6.Q, or 8.715. include the following:

Commonly Used Program Name	Rule Citation
Old Age Pension A (OAP-A)	8.100.3.F.1.c
Old Age Pension B (OAP-B)	8.100.3.F.1.c
Qualified Disabled Widow/Widower	8.100.3.F.1.e
Pickle	8.100.3.F.1.e
Long-Term Care	8.100.3.F.1.f-h
Medicaid Buy-In Program for Working Adults with Disabilities	8.100.6.P
Medicaid Buy-In Program for Children with Disabilities	8.100.6.Q
Breast and Cervical Cancer Program (BCCP)	8.715

8.100.3.H. Citizenship and Identity Documentation Requirements

1. For determinations of initial eligibility and redeterminations of eligibility for Medical Assistance made on or after July 1, 2006, citizenship or nationality and identity status must be verified unless such satisfactory documentary evidence has already been provided, as described in 8.100.3.H.4.b. This requirement applies to an individual who declares or who has previously declared that he or she is a citizen or national of the United States.

   a. The following electronic interfaces shall be accepted as proof of citizenship and/or identity as listed and should be used prior to requesting documentary evidence from applicants/clients:

      i) SSA Interface is an acceptable interface to verify citizenship and identity. An automated response from SSA that confirms that the data submitted is consistent with SSA data, including citizenship or nationality, meets citizenship and identity verification requirements. No further action is required for the individual and no additional documentation of either citizenship or identity is required.

      ii) Department of Motor Vehicles (DMV) Interface is an acceptable interface to verify identity. An automated response from DMV confirms that the data submitted is consistent with DMV data for identity verification requirements. No further action is required for the individual and no additional documentation of identity is required.

b. This requirement does not apply to the following groups:

i) Individuals who are entitled to or who are enrolled in any part of Medicare.

ii) Individuals who receive Supplemental Security Income (SSI).

iii) Individuals who receive child welfare services under Title IV-B of the Social Security Act on the basis of being a child in foster care.

iv) Individuals who receive adoption or foster care assistance under Title IV-E of the Social Security Act.

v) Individuals who receive Social Security Disability Insurance (SSDI).

vi) Children born to a woman who has applied for, has been determined eligible, and is receiving Medical Assistance on the date of the child's birth, as described in 8.100.4.G.5. This includes instances where the labor and delivery services were provided before the date of application and were covered by the Medical Assistance Program as an emergency service based on retroactive eligibility.

1) A child meeting the criteria described in 8.100.3.H.1.b.vi shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence at any time in the future, regardless of any subsequent changes in the child's eligibility for Medical Assistance.

2) Special Provisions for Retroactive Reversal of a Previous Denial

a) If a child described at 8.100.3.H.1.b.vi was previously determined to be ineligible for Medical Assistance solely for failure to meet the citizenship and identity documentation requirements, the denial shall be reversed. Eligibility shall be effective retroactively to the date of the child's birth provided all of the following criteria are met:

(1) The child was determined to be ineligible for Medical Assistance during the period between July 1, 2006 and October 1, 2009 solely for failure to meet the citizenship and identity documentation requirements as they existed during that period;

(2) The child would have been determined to be eligible for Medical Assistance had 8.100.3.H.1.b.vi and/or 8.100.3.H.1.b.vi.2.a been in effect during the period from July 1, 2006 through October 1, 2009; and

(3) The child's parent, caretaker relative, or legally appointed guardian or conservator requests that the denial of eligibility for Medical Assistance be reversed. The request may be verbal or in writing.

b) A child for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at 8.100.3.P.1. Such

redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed pursuant to this subsection 1.

c) A child granted retroactive eligibility for Medical Assistance shall be subject to the requirements described at 8.100.4.G.2. for continued eligibility.

vii) Individuals receiving Medical Assistance during a period of presumptive eligibility.

2. Satisfactory documentary evidence of citizenship or nationality includes the following:

a. Stand-alone documents for evidence of citizenship and identity. The following evidence shall be accepted as satisfactory documentary evidence of both identity and citizenship:

i) A U.S. passport issued by the U.S. Department of State that:

1) includes the applicant or recipient, and

2) was issued without limitation. A passport issued with a limitation may be used as proof of identity, as outlined in 8.100.3.H.3.

ii) A Certificate of Naturalization (DHS Forms N-550 or N-570) issued by the Department of Homeland Security (DHS) for naturalized citizens.

iii) A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561) issued by the Department of Homeland Security for individuals who derive citizenship through a parent.

iv) A document issued by a federally recognized Indian tribe, evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

1) Special Provisions for Retroactive Reversal of a Previous Denial

a) For a member of a federally recognized Indian tribe who was determined to be ineligible for Medical Assistance solely for failure to meet the citizenship and identity documentation requirements, the denial of eligibility shall be reversed and eligibility shall be effective as of the date on which the individual was determined to be ineligible provided all of the following criteria are met:

(1) The individual was determined to be ineligible for Medical Assistance on or after July 1, 2006 solely on the basis of not meeting the citizenship and identity documentation requirements as they existed during that period;

(2) The individual would have been determined to be eligible for Medical Assistance had 8.100.3.H.2.a.iv) been in effect on or after July 1, 2006; and

(3) The individual or a legally appointed guardian or conservator of the individual requests that the denial of

eligibility for Medical Assistance be reversed. The request may be verbal or in writing.

b) A member of a federally recognized Indian tribe for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at 8.100.3.P.1. Such redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed as provided in this subsection 2.

b. Evidence of citizenship. If evidence from the list in 8.100.3.H.2.a. is not provided, an applicant or recipient shall provide satisfactory documentary evidence of citizenship from the list specified in this section to establish citizenship AND satisfactory documentary evidence from the documents listed in section 8.100.3.H. 3. to establish identity. Evidence of citizenship includes:

i) A U.S. public birth certificate.

1) The birth certificate shall show birth in any one of the following:

a) One of the 50 States,

b) The District of Columbia,

c) Puerto Rico (if born on or after January 13, 1941),

d) Guam (if born on or after April 10, 1899),

e) The Virgin Islands of the U.S. (if born on or after January 17, 1917),

f) American Samoa,

g) Swain's Island, or

h) The Northern Mariana Islands (NMI) (if born after November 4, 1986 (NMI local time)).

2) The birth record document shall have been issued by the State, Commonwealth, Territory or local jurisdiction.

3) The birth record document shall have been recorded before the person was 5 years of age. A delayed birth record document that is recorded at or after 5 years of age is considered fourth level evidence of citizenship, as described in 8.100.3.H.2.d.

ii) A Certification of Report of Birth (DS-1350) issued by the U.S. Department of State to U.S. citizens who were born outside the U.S. and acquired U.S. citizenship at birth.

iii) A Report of Birth Abroad of a U.S. Citizen (Form FS-240) issued by the U.S. Department of State consular office overseas for children under age 18 at the time of issuance. Children born outside the U.S. to U.S. military personnel usually have one of these.

iv) A Certification of birth issued by the U.S. Department of State (Form FS-545 or DS-1350) before November 1,1990.

v) A U.S. Citizen I.D. card issued by the U.S. Immigration and Naturalization Services (INS):

1) Form I-179 issued from 1960 until 1973, or

2) Form I-197 issued from 1973 until April 7, 1983.

vi) A Northern Mariana Identification Card (I-873) issued by INS to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986.

vii) An American Indian Card (I-872) issued by the Department of Homeland Security with the classification code “KIC.”

viii) A final adoption decree that:

1) shows the child's name and U.S. place of birth, or

2) a statement from a State approved adoption agency that shows the child's name and U.S. place of birth. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

ix) Evidence of U.S. Civil Service employment before June 1, 1976. The document shall show employment by the U.S. government before June 1, 1976.

x) U.S. Military Record that shows a U.S. place of birth such as a DD-214 or similar official document showing a U.S. place of birth.

xi) Data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens.

xii) Child Citizenship Act. Adopted or biological children born outside the United States may establish citizenship obtained automatically under section 320 of the Immigration and Nationality Act (8 USC § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000). section 320 of the Immigration and Nationality Act (8 USC § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

Documentary evidence must be provided at any time on or after February 27, 2001, if the following conditions have been met:

1) At least one parent of the child is a United States citizen by either birth or naturalization (as verified under the requirements of this part);

2) The child is under the age of 18;

3) The child is residing in the United States in the legal and physical custody of the U.S. citizen parent;

4) The child was admitted to the United States for lawful permanent residence (as verified through the Systematic Alien Verification for Entitlements (SAVE) Program); and

5) If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 USC § 1101(b)(1)) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred. 8 USC § 1101(b)(1) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

xiii) Extract of a hospital record on hospital letterhead.

1) The record shall have been established at the time of the person's birth;

2) The record shall have been created at least 5 years before the initial application date; and

3) The record shall indicate a U.S. place of birth;

4) For children under 16 the document shall have been created near the time of birth or at least 5 years before the date of application.

5) Souvenir “birth certificates” issued by a hospital are not acceptable.

xiv) Life, health, or other insurance record.

1) The record shall show a U.S. place of birth; and

2) The record shall have been created at least 5 years before the initial application date.

3) For children under 16 the document must have been created near the time of birth or at least 5 years before the date of application.

xv) Religious record.

1) The record shall have been recorded in the U.S. within 3 months of the date of the individual's birth;

2) The record shall show that the birth occurred in the U.S.;

3) The record shall show either the date of birth or the individual's age at the time the record was made; and

4) The record shall be an official record recorded with the religious organization.

xvi) Early school record that meets the following criteria:

1) The school record shows the name of the child;

2) The school record shows the child's date of admission to the school;

3) The school record shows the child's date of birth;

4) The school record shows a U.S. place of birth for the child; and

5) The school record shows the name(s) and place(s) of birth of the applicant's parents.

xvii) Federal or State census record showing U.S. citizenship or a U.S. place of birth and the applicant's age.

xviii) One of the following documents that shows a U.S. place of birth and was created at least 5 years before the application for The Medical Assistance Program. For children under 16 the document must have been created near the time of birth or at least 5 years before the date of application.

1) Seneca Indian tribal census record;

2) Bureau of Indian Affairs tribal census records of the Navajo Indians;

3) U.S. State Vital Statistics official notification of birth registration;

4) A delayed U.S. public birth record that is recorded more than 5 years after the person's birth;

5) Statement signed by the physician or midwife who was in attendance at the time of birth; or

6) The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.

xix) Institutional admission papers from a nursing facility, skilled care facility or other institution created at least 5 years before the initial application date that indicate a U.S. place of birth.

xx) Medical (clinic, doctor, or hospital) record.

1) The record shall have been created at least 5 years before the initial application date; and

2) The record shall indicate a U.S. place of birth.

3) An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.

4) For children under 16 the document shall have been created near the time of birth or at least 5 years before the date of application.

xxi) Written affidavit. Affidavits shall only be used in rare circumstances. They may be used by U.S. citizens or nationals born inside or outside the U.S. If documentation is by affidavit, the following rules apply:

1) There shall be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship (the two affidavits could be combined in a joint affidavit);

2) At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient;

3) In order for the affidavit to be acceptable the persons making them shall provide proof of their own U.S. citizenship and identity.

4) If the individual(s) making the affidavit has (have) information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit shall contain this information as well;

5) The applicant/recipient or other knowledgeable individual (guardian or representative) shall provide a separate affidavit explaining why the evidence does not exist or cannot be obtained; and

6) The affidavits shall be signed under penalty of perjury pursuant to 18 U.S.C. §1641 and Title 18 of the Criminal Code article 8 part 5 and need not be notarized.

c. Evidence of citizenship for collectively naturalized individuals. If a document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. A second document from 8.100.3.H.3. to establish identity shall also be presented.

i) Puerto Rico:

1) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; OR

2) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

ii) US Virgin Islands:

1) Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; OR

2) The applicant's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; OR

3) Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or Territory or the Canal Zone on June 28, 1932.

iii) Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

1) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); OR

2) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); OR

3) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

4) If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile, and the individual is not a U.S. citizen.

d) Referrals for Colorado Birth Certificates

i) An applicant or client who was born in the State of Colorado who does not possess a Colorado birth certificate shall receive a referral to the Department of Public Health and Environment by the county department to obtain a birth certificate at no charge, pursuant to C.R.S. § 25-2-117(2)(a)(I)(C).

ii) The referral shall be provided on county department letterhead and shall include the following:

1) The name and address of the applicant or client;

2) A statement that the county department requests that the Department of Public Health and Environment waive the birth certificate fee, pursuant to C.R.S. § 25-2-117(2)(a)(I)(C); and

3) The name and contact telephone number for the county caseworker responsible for the referral.

iii) An applicant or client who has been referred to the Department of Public Health and Environment to obtain a birth certificate shall not be required to present a birth certificate to satisfy the citizenship documentation requirement at 8.100.3.H.2. The applicant or client shall have the right to use any of the documents listed under 8.100.3.H.2. to satisfy the citizenship documentation requirement.

3. The following documents shall be accepted as proof of identity and shall accompany a document establishing citizenship from the groups of documentary evidence outlined in 8.100.3.H.2.b. through d.

a) A driver's license issued by a State or Territory either with a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;

b) School identification card with a photograph of the individual;

c) U.S. military card or draft record;

d) Identification card issued by the Federal, State, or local government with the same information included on driver's licenses;

e) Military dependent's identification card;

f) U.S. Coast Guard Merchant Mariner card;

g) Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. The document is acceptable if it carries a photograph of the individual or has other personal identifying information relating to the individual such as age, weight, height, race, sex, and eye color; or

h) Three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the individual's citizenship and the individual submitted evidence of citizenship listed under 8.100.3.H.2.b. or 8.100.3.H.2.c. The following requirements must be met:

i) No other evidence of identity is available to the individual;

ii) The documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity; and

iii) All documents used must contain consistent identifying information.

iv) These documents include, but are not limited to, employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees, and property deeds/titles.

i) Special identity rules for children. For children under 16, the following records are acceptable:

i) Clinic, doctor, or hospital records; or

ii) School records.

1) The school record may include nursery or daycare records and report cards; and

2) The school, nursery, or daycare record must be verified with the issuing school, nursery, or daycare.

3) If clinic, doctor, hospital, or school records are not available, an affidavit may be used if it meets the following requirements:

a) It shall be signed under penalty of perjury by a parent or guardian;

b) It shall state the date and place of birth of the child; and

c) It cannot be used if an affidavit for citizenship was provided.

d) The affidavit is not required to be notarized.

e) An affidavit may be accepted on behalf of a child under the age of 18 in instances when school ID cards and drivers' licenses are not available to the individual until that age.

j) Special identity rules for disabled individuals in institutional care facilities.

i) An affidavit may be used for disabled individuals in institutional care facilities if the following requirements are met:

1) It shall be signed under penalty of perjury by a residential care facility director or administrator on behalf of an institutionalized individual in the facility; and

2) No other evidence of identity is available to the individual.

3) The affidavit is not required to be notarized.

k) Expired identity documents.

i) Identity documents do not need to be current to be acceptable. An expired identity document shall be accepted as long as there is no reason to believe that the document does not match the individual.

l) Referrals for Colorado Identification Cards

i) An applicant or client who does not possess a Colorado driver’s license or identification card shall be referred to the Department of Revenue Division of Motor Vehicles by the county department to obtain an identification card at no charge, pursuant to C.R.S. § 42-2-306(1)(a)(II).

ii) The referral shall be provided on county department letterhead and shall include the following:

1) The name and address of the applicant or client;

2) A statement that the county department requests that the Department of Revenue Division of Motor Vehicles waive the identification card fee, pursuant to C.R.S § 42-2-306(1)(a)(II).; and

3) The name and contact telephone number for the county caseworker responsible for the referral.

iii) An applicant or client who has been referred to the Division of Motor Vehicles to obtain an identification card shall not be required to present a Colorado identification card to satisfy the identity documentation requirement at 8.100.3.H.3. The applicant or client shall have the right to use any of the documents listed under 8.100.3.H.3. to satisfy the identity documentation requirement.

4. Documentation Requirements

a. Citizenship and identity documents may be submitted as originals, certified copies, photocopies, facsimiles, scans or other copies.

b. Individuals who submitted notarized copies of citizenship and identity documents as part of an application or redetermination before January 1, 2008 shall not be required to submit originals or copies certified by the issuing agency for any application or redetermination processed on or after January 1, 2008.

c. All citizenship and identity documents shall be presumed to be genuine unless the authenticity of the document is questionable.

d. Individuals shall not be required to submit citizenship and identity documentation in person. Documents shall be accepted from a Medical Assistance applicant or client or from his or her guardian or authorized representative in person or by mail.

i) Individuals are strongly encouraged to use alternatives to mailing original documents to counties, such as those described in 8.100.3.H.4.e.

e. Individuals may present original citizenship and identity documents or copies certified by the issuing agency to Medical Assistance (MA) sites, School-based Medical Assistance sites, Presumptive Eligibility (PE) sites, Federally Qualified Health Centers (FQHCs), Disproportionate Share Hospitals (DSHs), or any other location designated by the Department by published agency letter.

i) Staff at these locations shall make a copy of the original documents and shall complete a “Citizenship and Identity Documentation Received” form, stamp the copy, or provide other verification that identifies that the documents presented were originals. The verification shall include the name, telephone number, organization name and address, and signature of the individual who reviewed the document(s). This form, stamp, or other verification shall be attached to or directly applied to the copy.

ii) Upon request by the client or eligibility site, the copy of the original document with the “Citizenship and Identity Documentation Received” form, stamp, or other verification as described in 8.100.3.H.4.e. i) shall be mailed or delivered directly to the eligibility site within five business days.

f. Counties shall accept photocopies of citizenship and identity documents from any location described in 8.100.3.H.4.e provided the photocopies include the form, stamp, or verification described in 8.100.3.H.4.e.i).

g. Counties shall develop procedures for handling original citizenship and identity documents to ensure that these documents are not lost, damaged, or destroyed.

i) Upon receiving the original documents, eligibility site staff shall make a copy of the original documents and shall complete a “Citizenship and Identity Documentation Received” form, stamp the copy, or provide other verification that identifies that the documents presented were originals, as described in 8.100.3.H.4.e. i). This form, stamp, or other verification shall be attached to or directly applied to the copy.

ii) The original documents shall be sent by mail or returned to the individual in person within five business days of the date on which they were received.

iii) To limit the risk of original documents being lost, damaged, or destroyed, counties are strongly encouraged to make copies of documents immediately upon receipt and to return original documents to the individual while he or she is present.

h. Once an individual has provided the required citizenship and identity documentation, he or she shall not be required to submit the documentation again unless:

i) Later evidence raises a question about the individual's citizenship or identity; or

ii) There is a gap of more than five years between the ending date of the individual's last period of eligibility and a subsequent application for The Medical Assistance Program and the eligibility site has not retained the citizenship and identity documentation the individual previously provided.

5. Record Retention Requirements

a. The eligibility site shall retain a paper or electronically scanned copy of an individual's citizenship and identity documentation, including any verification described in 8.100.3.H.4.e.i), for at least five years from the ending date of the individual's last period of Medical Assistance eligibility.

6. Name Change Provisions

a. An individual who has changed his or her last name for reasons including, but not limited to, marriage, divorce, or court order shall not be required to produce any additional documentation concerning the name change unless:

i) With the exception of the last name, the personal information in the citizenship and identity documentation provided by the individual does not match in every way;

ii) In addition to changing his or her last name, the individual also changed his or her first name and/or middle name; or

iii) There is a reasonable basis for questioning whether the citizenship and identity documents belong to the same individual.

7. Reasonable Level of Assistance

a. The eligibility site shall provide a reasonable level of assistance to applicants and clients in obtaining the required citizenship and identity documentation.

b. Examples of a reasonable level of assistance include, but are not limited to:

i) Providing contact information for the appropriate agencies that issue the required documents;

ii) Explaining the documentation requirements and how the client or applicant may provide the documentation; or

iii) Referring the applicant or client to other agencies or organizations which may be able to provide further assistance.

c. The eligibility site shall not be required to pay for the cost of obtaining required documentation.

8. Individuals Requiring Additional Assistance

a. The eligibility site shall provide additional assistance beyond the level described in 8.100.3.H.7 to applicants and clients in obtaining the required citizenship and identity documentation if the client or applicant:

i) Is unable to comply with the requirements due to physical or mental impairments or homelessness; and

ii) The individual lacks a guardian or representative who can provide assistance.

b. Examples of additional assistance include, but are not limited to:

i) Contacting any known family members who may have the required documentation;

ii) Contacting any known current or past health care providers who may have the required documentation; or

iii) Contacting other social services agencies that are known to have provided assistance to the individual.

c. The eligibility site shall document its efforts to provide additional assistance to the client or applicant. Such documentation shall be subject to the record retention requirements described in 8.100.3.H.5.a.

9. Reasonable Opportunity Period

a. If a Medical Assistance applicant does not have the required documentation, he or she must be given a reasonable opportunity period to provide the required documentation. The reasonable opportunity period will begin as of the date of the Notice of Action. The required documentation must be received within the reasonable opportunity period. If the

applicant does not provide the required documentation within the reasonable opportunity period, then the applicant's Medical Assistance benefits shall be terminated.

b. The reasonable opportunity period is 90 calendar days and applies to MAGI, Adult, and Buy-In Programs:

i) For the purpose of this section only, MAGI Programs for persons covered pursuant to 8.100.4.G or 8.100.4.I, include the following:

Commonly Used Program Name	Rule Citation
Children's Medical Assistance	8.100.4.G.2
Parent and Caretaker Relative Medical Assistance	8.100.4.G.3
Adult Medical Assistance	8.100.4.G.4
Pregnant Women Medical Assistance	8.100.4.G.5
Transitional Medical Assistance	8.100.4.I.1-5

ii) For the purpose of this section only, Adult and Buy-In Programs for persons covered pursuant to 8.100.3.F, 8.100.6.P, 8.100.6.Q, or 8.715 include the following:

Commonly Used Program Name	Rule Citation
Old Age Pension A (OAP-A)	8.100.3.F.1.c
Old Age Pension B (OAP-B)	8.100.3.F.1.c
Qualified Disabled Widow/Widower	8.100.3.F.1.e
Pickle	8.100.3.F.1.e
Long-Term Care	8.100.3.F.1.f-h
Medicaid Buy-In Program for Working Adults with Disabilities	8.100.6.P
Medicaid Buy-In Program for Children with Disabilities	8.100.6.Q
Breast and Cervical Cancer Program (BCCP)	8.715

10. Good Faith Effort

a. In some cases, a Medical Assistance client or applicant may not be able to obtain the required documentation within the applicable reasonable opportunity period. If the client or applicant is making a good faith effort to obtain the required documentation, then the reasonable opportunity period should be extended. The amount of time given should be determined on a case-by-case basis and should be based on the amount of time the individual needs to obtain the required documentation.

Examples of good faith effort include, but are not limited to:

i) Providing verbal or written statements describing the individual's effort at obtaining the required documentation;

ii) Providing copies of emails, letters, applications, checks, receipts, or other materials sent or received in connection with a request for documentation; or

iii) Providing verbal or written statements of the individuals' efforts at identifying people who could attest to the individual's citizenship or identity, if citizenship and/or identity are included in missing documentation.

An individual's verbal statement describing his or her efforts at securing the required documentation should be accepted without further verification unless the accuracy or truthfulness of the statement is questionable. The individual's good faith efforts should be documented in the case file and are subject to all record retention requirements.

8.100.3.I. Additional General Eligibility Requirements

1. Each person for whom Medical Assistance is being requested shall furnish a Social Security Number (SSN); or, if one has not been issued or is unknown, shall apply for the number and submit verification of the application, unless an exception below applies. The application for an SSN shall be documented in the case record by the eligibility site. Upon receipt of the assigned SSN, the client shall provide the number to the eligibility site. This requirement does not apply to those individuals who are not requesting Medical Assistance yet appear on the application, nor does it apply to individuals applying for emergency medical services or eligible newborns born to a Medical Assistance eligible mother.

   a. An applicant's or client's refusal to furnish or apply for a Social Security Number affects the family's eligibility for assistance as follows:

      i) that person cannot be determined eligible for the Medical Assistance Program; and/or

      ii) if the person with no SSN or proof of application for SSN is the only dependent child on whose behalf assistance is requested or received, assistance shall be denied or terminated.

   b. Exception: An individual who qualifies for any of the following exceptions must not be required to provide an SSN:

      i.) The individual is not eligible to receive an SSN; or

      ii) The individual does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104; or

      iii) The individual refuses to obtain an SSN because of a well-established religious objection.

   c. Due to the COVID-19 Public Health Emergency, the Department will accept self-attestations for SSN verification. At the end of the COVID-19 Public Health Emergency, verification for eligibility criteria will be required as specified prior to the public health emergency.

2. A person who is applying for or receiving Medical Assistance shall assign to the State all rights against any other person (including but not limited to the sponsor of an alien) for medical support or payments for medical expenses paid on the applicant's or client's behalf or on the behalf of any other person for whom application is made or assistance is received.

   All appropriate clients of the Medical Assistance Program shall have the option to be referred for child support enforcement services using the form as specified by the Department.

3. A person who is applying for or receiving Medical Assistance shall provide information regarding any third party resources available to any member of the assistance unit. Third party resources are any health coverage or insurance other than the Medical Assistance Program. A client's refusal to supply information regarding third party resources may result in loss of Medical Assistance Program eligibility.

4. A person who is eligible for Medical Assistance shall be free to choose any qualified and approved participating institution, agency, or person offering care and services which are benefits of the program unless that person is enrolled in a managed care program operating under Federal waiver authority.

8.100.3.J. Supplemental Security Income (SSI) And Aid To The Needy Disabled (AND) Recipients

1. Persons who may be eligible for benefits under either MAGI Medical Assistance or SSI:

   a. shall be advised of the benefits available under each program;

   b. may apply for a determination of eligibility under either or both programs;

   c. have the option to receive benefits under the program of their choice, but may not receive benefits under both programs at the same time; and

   d. may change their selection if their circumstances change or if they decide later that it would be more advantageous to receive benefits from the other program.

2. Any family member who is receiving financial assistance from SSI or OAP-A is not considered a member of the Medical Assistance required household, is not counted as a member of the household, and the individual's income and resources are disregarded in making the determination of need for Medical Assistance.

   a. Exception: For MAGI Medical Assistance a family member who is receiving SSI, when appropriate can be counted as a member of the household and their income when appropriate can be considered in making the determination of eligibility for MAGI Medical Assistance. For treatment of income and household construction for MAGI Medical Assistance cases, see section 8.100.4.

3. An individual receiving Aid to the Needy Disabled (AND) may also receive MAGI Medical Assistance, if the recipient meets the eligibility requirements for MAGI Medical Assistance. For these individuals, eligibility sites shall not include the applicant's AND payment when calculating income to determine the household's financial eligibility for MAGI Medical Assistance.

8.100.3.K. Consideration of Income

1. Income or resources of an alien sponsor or an alien sponsor's spouse shall be countable to the sponsored alien effective December 19, 1997. Forms used prior to December 19, 1997, including but not limited to forms I-134 or I-136 are legally unenforceable affidavits of support. The

attribution of the income and resources of the sponsor and the sponsor's spouse to the alien will continue until the alien becomes a U.S. citizen or has worked or can be credited with 40 qualifying quarters of work, provided that an alien crediting the quarters to the applicant/client has not received any public benefit during any creditable quarter for any period after December 31, 1996.

a. Exception: When the sponsored alien is a pregnant woman or a child the income or resources of an alien sponsor or an alien sponsor's spouse will not be countable to the sponsored alien.

2. Income, in general, is the receipt by an individual of a gain or benefit in cash or in kind during a calendar month. Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, interest, etc., that are received by an individual or family.

3. Earned income is payment in cash or in kind for services performed as an employee or from self-employment.

4. Earned in kind income shall be income produced as a result of the performance of services by the applicant/client, for which he/she is compensated in shelter or other items in lieu of wages.

5. Received means "actually" received or legally becomes available, whichever occurs first; the point at which the income first is available to the individual for use. For example, interest income on a savings account is counted when it is credited to the account.

6. All Home Care Allowance (HCA) income paid to a Medical Assistance applicant or member by the HCA recipient to provide home care services is countable earned income.

7. An applicant or member who is a live-In home care provider to a care recipient receiving a Difficulty of Care Payment and who is being determined for a MAGI Medical Assistance program, must meet the following requirements for Difficulty of Care payments to be excluded as countable income:

   a. The care provider receiving payments for personal care or supportive services provided to a care recipient must live full-time in the same home with the care recipient; and

   b. The care recipient must either

      i) receiving personal care or supportive services must be enrolled in Long Term Service Supports (LTSS), with additional services through a Home-Based Services (HCBS) waiver program; or

      ii) The care recipient must be enrolled in the Buy-In Program for Working Adults with Disabilities, and receive additional services through the Home and Community Based Services (HCBS) waiver program.

   c. Exception: Difficulty of Care Payments are not excluded if the payments are for more than 10 qualified foster individuals under the age of 19 or 5 qualified foster individuals who are over the age of 19

8. Participation in the Workforce Investment Act (WIA) affects eligibility for Medical Assistance as follows:

   a. Wages derived from participation in a program carried out under WIA (work experience or on-the-job training) and paid to a caretaker relative is considered countable earned income.

b. Training allowances granted by WIA to a dependent child or a caretaker relative of a dependent child to participate in a training program is exempt.

c. Wages derived from participation in a program carried out the under Workforce Investment Act (WIA) and paid to any dependent child who is applying for or receiving Medical Assistance are exempt in determining eligibility for a period not to exceed six months in each calendar year.

9. An individual involved in a profit-making activity as a sole proprietor, partner in a partnership, independent contractor, or consultant shall be classified as self-employed.

a. To determine the net profit of a self-employed applicant/client deduct the cost of doing business from the gross income. These business expenses include, but are not limited to:

i) the rent of business premises,

ii) wholesale cost of merchandise,

iii) utilities,

iv) taxes,

v) labor, and

vi) upkeep of necessary equipment.

b. The following are not allowed as business expenses:

i) Depreciation of equipment;

1) Exception: For the purpose of calculating MAGI-based income, depreciation of equipment is an allowable business expense if the equipment is not used for capital improvements.

ii) The cost of and payment on the principal of loans for capital asset or durable goods;

iii) Personal expenses such as personal income tax payments, lunches, and transportation to and from work.

c. Appropriate allowances for cost of doing business for Medical Assistance clients who are licensed, certified or approved day care providers are (1) $ 55 for the first child for whom day care is provided, and (2) $ 22 for each additional child. If the client can document a cost of doing business which is greater than the amounts above set forth, the procedure described in A, shall be used.

d. When determining self-employment expenses and distinguishing personal expenses from business expenses it is a requirement to only allow the percentage of the expense that is business related.

10. Self-employment income includes, but is not limited to, the following:

a. Farm income - shall be considered as income in the month it is received. When an individual ceases to farm the land, the self-employment deductions are no longer allowable.

b. Rental income - shall be considered as self-employment income only if the Medical Assistance client actively manages the property at least an average of 20 hours per week.

c. Board (to provide a person with regular meals only) payment shall be considered earned income in the month received to the extent that the board payment exceeds the maximum food stamp allotment for one-person household per boarder and other documentable expenses directly related to the provision of board.

d. Room (to provide a person with lodging only) payments shall be considered earned income in the month received to the extent that the room payment exceeds documentable expenses directly related to the provision of the room.

e. Room and board payments shall be considered earned income in the month received to the extent that the payment for room and board exceeds the food stamp allotment for a one-person household per room and boarder and documentable expenses directly related to the provision of room and board.

11. Unearned income is the gross amount received in cash or kind that is not earned from employment or self-employment. Unearned income includes, but is not limited to, the following:

a. Pensions and other period payments, such as:

i) Private pensions or disability benefits

1) Exception: Refer to section 8.100.4 for treatment of private disability benefits for MAGI Medical Assistance.

ii) Social Security benefits (Retirement, survivors, and disability)

iii) Workers' Compensation payments

iv) Railroad retirement annuities

v) Unemployment insurance payments

vi) Veterans benefits other than Aid and Attendance (A&A) and Unusual Medical Expenses (UME).

vii) Alimony and support payments

viii) Interest, dividends and certain royalties on countable resources

12. For all Medical Assistance categories, the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act Recovery Rebate, known as the COVID-19 Economic Stimulus, shall be exempt from consideration as income.

13. Federal Pandemic Unemployment Compensation (FPUC) program, which provides an extra $600.00 a week for qualifying individuals, is exempt as countable unearned income for all Medical Assistance categories.

8.100.3.L Consideration of Resources

Consideration of Resources

1. Resources are counted in determining eligibility for the Aged, Blind and Disabled, and Long-Term Care institutionalized and Home and Community Based Services categories of Medical Assistance. Resources are not counted in determining eligibility for the MAGI Medical Assistance programs, the Medicaid Buy-in Program for Working Adults with Disabilities, or the Medicaid Buy-In Program for Children with Disabilities, See section 8.100.5 for rules regarding consideration of resources.

2. The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act Recovery Rebate, known as COVID-19 Economic Stimulus, shall be an exempt resource for the first 12 months following the receipt of the Recovery Rebate, after which the remaining balance will be considered a countable resource for all Medical Assistance categories which include an asset test.

8.100.3.M. Federal Financial Participation (FFP)

1. The state is entitled to claim federal financial participation (FFP) for benefits paid on behalf of groups covered under the Colorado Medical Assistance Program and also for the Medicare supplementary medical insurance benefits (SMIB) premium payments made on behalf of certain groups of categorically needy persons.

2. The SISC codes are as follows:

    a. Code A - for institutionalized persons whose income is under 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; and non-institutionalized persons receiving Home and Community Based Services, whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; code A signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program but not for SMIB premium payments;

    b. Code B - for persons eligible to receive financial assistance under SSI; persons eligible to receive financial assistance under OAP “A” who, except for the level of their income, would be eligible for an SSI payment; persons who are receiving mandatory State supplementary payments; and persons who continue to be eligible for Medical Assistance after disregarding certain Social Security increases; code B signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program and also for SMIB premium payments;

    c. Code C - for persons eligible to receive assistance under OAP “A”, OAP “B”, or OAP Refugee Assistance for financial assistance only; who do not receive SSI payment and do not otherwise qualify under SISC code B as described in item B. above; code C signifies that no FFP is available in Medical Assistance program expenditures.

    d. Code D1 – for persons eligible to receive assistance under AwDC from program implementation through 12/31/2013; Code D1 signifies 50% FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program.

    e. Code E1 - for persons eligible to receive assistance under the Medicaid Buy-In Program for Working Adults with Disabilities and whose annual adjusted gross income, as defined under IRS statute, is less than or equal to 450% of FPL – after SSI earned income deductions; as well as for children eligible to receive assistance under the Medicaid Buy-In Program for Children with Disabilities and whose household income is less than or equal to 300% of FPL after income disregards. Code E1 signifies that FFP is available in

expenditures for medical care and services which are benefits of the Medical Assistance program but not for SMIB premium payments.

3. Recipients of financial assistance under State AND, State AB, or OAP “C” are not automatically eligible for Medical Assistance and the SISC code which shall be entered on the eligibility reporting form is C.

8.100.3.N. Confidentiality

1. All information obtained by the eligibility site concerning an applicant for or a recipient of Medical Assistance is confidential information.

2. A signature on the Single Streamlined Application and the Application for Public Assistance allows an eligibility site worker to consult banks, employers, or any other agency or person to obtain information or verification to determine eligibility. The identification of the worker as an eligibility site employee will, in itself, disclose that an application for the Medical Assistance Program has been made by an individual. In this type of contact, as well as other community contacts, the eligibility site should strive to maintain confidentiality. The signature on the Single Streamlined Application and the Application for Public Assistance also provides permission for the release of the client's medical information to be provided by health care providers to the State and its agents for purpose of administration of the Medical Assistance Program.

3. Eligibility site staff may release a client's Medical Assistance state identification number and approval eligibility spans to a Medical Assistance provider for billing purposes.

   Eligibility site staff may inform a Medical Assistance provider that an application has been denied but may not inform them of the reason why.

4. Access to information concerning applicants or recipients must be restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the State and the eligibility site.

5. The eligibility site must obtain permission from a family, individual, or authorized representative, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of Medical Assistance payment. This permission must be obtained unless the request is from State authorities, federal authorities, or State contractors acting within the scope of their contract. If, because of an emergency situation, time does not permit obtaining consent before release, the eligibility site must notify the family or individual immediately after supplying the information.

6. The eligibility site policies must apply to all requests for information from outside sources, including government bodies, the courts, or law enforcement officials. If a court issues a subpoena for a case record or for any eligibility site representative to testify concerning an applicant or recipient, the eligibility site must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

7. The following types of information are confidential and shall be safeguarded:

   a. Names and addresses of applicants for and recipients of the Medical Assistance Program;

   b. Medical services provided;

   c. Social and economic conditions or circumstances;

d. Agency evaluation of personal information;

e. Medical data, including diagnosis and past history of disease or disability;

f. All information obtained through the Income and Eligibility Verification System (IEVS), Colorado Department of Labor and Employment, SSA or Internal Revenue Service;

g. Any information received in connection with identification of legally liable third party resources;

h. Any information received for verifying income and resources if applicable, or other eligibility and the amount of Medical Assistance payments;

i. Social Security Numbers.

8. The confidential information listed above may be released to persons outside the eligibility site only as follows:

a. In response to a valid subpoena or court order;

b. To State or Federal auditors, investigators or others designated by the Federal or State departments on a need-to-know basis;

c. To individuals executing Income and Eligibility Verification System;

d. Child Support enforcement officials;

e. To a recipient or applicant themselves or their designated representative.

f. To a Long Term Care institution on the AP-5615 form.

9. The applicant/recipient may give a formal written release for disclosure of information to other agencies, such as hospitals, or the permission may be implied by the action of the other agency in rendering service to the client. Before information is released, the eligibility site should be reasonably certain the confidential nature of information will be preserved, the information will be used only for purposes related to the function of the inquiring agency, and the standards of protection established by the inquiring agency are equal to those established by the State Department. If the standards for protection of information are unknown, a written consent from the recipient shall be obtained.

8.100.3.O. Protection Against Discrimination

1. Eligibility sites are to administer the Medical Assistance Program in such a manner that no person will, on the basis of race, color, sex, age, religion, political belief, national origin, or handicap, be excluded from participation, be denied any aid, care, services, or other benefits of, or be otherwise subjected to discrimination in such program.

2. The eligibility site shall not, directly or through contractual or other arrangements, on the grounds of race, color, sex, age, religion, political belief, national origin, or handicap:

a. Provide aid, care, services, or other benefits to an individual which is different, or provided in a different manner, from that of others;

b. Subject an individual to segregation barriers or separate treatment in any manner related to access to or receipt of assistance, care services, or other benefits;

c. Restrict an individual in any way in the enjoyment or any advantage or privilege enjoyed by others receiving aid, care, services, or other benefits provided under the Medical Assistance Program;

d. Treat an individual differently from others in determining whether he/she satisfies any eligibility or other requirements or conditions which individuals shall meet in order to receive aid, care, services, or other benefits provided under the Medical Assistance Programs;

e. Deny an individual an opportunity to participate in programs of assistance through the provision of services or otherwise, or afford him/her an opportunity to do so which is different from that afforded others under the Medical Assistance Program.

3. No distinction on the grounds of race, color, sex, age, religion, political belief, national origin, or handicap is permitted in relation to the use of physical facilities, intake and application procedures, caseload assignments, determination of eligibility, and the amount and type of benefits extended by the eligibility site to Medical Assistance recipients.

4. An individual who believes he/she is being discriminated against may file a complaint with the eligibility site, the Department, or directly with the Federal government. When a complaint is filed with the eligibility site, the county director is responsible for an immediate investigation of the matter and taking necessary corrective action to eliminate any discriminatory activities found. If such activities are not found, the individual is given an explanation. If the person is not satisfied, he/she is requested to direct his/her complaint, in writing, to the State Department, Complaint Section, which will be responsible for further investigation and other necessary action consistent with the provisions of Title VI of the 1963 Civil Rights Act, as amended 42 U.S.C. §2000e et seq. and section 504 of the Rehabilitation Act of 1973, as amended 29 U.S.C. §791.

8.100.3.P. Redetermination of Eligibility

1. A redetermination of eligibility shall mean a case review and necessary verification to determine whether the Medical Assistance Program client continues to be eligible to receive Medical Assistance. Beginning as of the case approval date, a redetermination shall be accomplished each 12 months for Title XIX Medical Assistance only cases. An eligibility site may redetermine eligibility through telephone, mail, or electronic means. The use of telephone or electronic redeterminations should be noted in the case record and in CBMS case comments.

2. The eligibility site shall promptly redetermine eligibility when:

   a. it receives and verifies information which indicates a change in a client's circumstances which may affect continued eligibility for Medical Assistance; or

   b. it receives direction to do so from the Department.

   The eligibility site shall redetermine eligibility according to timelines defined by the Department.

3. A redetermination form is not required to be sent to the client if all current eligibility requirements can be verified by reviewing information from another assistance program, verification system, and/or CBMS. When applicable, the eligibility site shall redetermine eligibility based solely on information already available. If verification or information is available for any of the three months prior to redetermination month, no request shall be made of the client and a notice of the findings of the review will go to the client. If not all verification or information is available, the eligibility site shall only request the additional minimum verification from the client. This procedure is referenced as Ex Parte Review.

4. A redetermination form, approved by the Department, shall be mailed to the person at least 30 days prior to the first of the month in which completion of eligibility redetermination is due. The redetermination form shall be used to inform the client of the redetermination and verification needed, but the form itself cannot be required to be returned. The only verification that can be required at redetermination is the minimum verification needed to complete a redetermination of eligibility.

   The redetermination form shall direct clients to review current information and to take no action if there are no changes to report in the household. Eligibility sites and CBMS shall view the absence of reported changes from the client at this redetermination period as confirmation that there have been no changes in the household. This procedure is referenced as automatic reenrollment.

   The following procedures relate to mail-out redetermination:

   a. A Redetermination Form shall be mailed to the client together with any other forms to be completed;

   b. Required verification shall be returned by the client to the eligibility site no later than ten working days after receipt of request;

   c. When the individual is unable to complete the forms due to physical, mental or emotional disabilities, or other good cause, and has no one to help him/her, the eligibility site shall either assist the client or refer him/her to a legal or other resource. When initial arrangements or a change in arrangements are being made, an extension of up to thirty days shall be allowed. The action of the eligibility site in assistance or referral shall be recorded in the case record and CBMS case comments.

   d. The redetermination form shall require that a recipient and community spouse of a recipient of HCBS, PACE or institutional services disclose a description of any interest the individual or community spouse has in an annuity or similar financial instrument regardless of whether the annuity is irrevocable or treated as an asset. The redetermination form shall include a statement that the Department shall be a remainder beneficiary for any annuity or similar financial instrument purchased on or after February 8, 2006 for the total amount of Medical Assistance provided to the individual.

   e. The eligibility site shall notify in writing the issuer of any annuity or financial instrument that the Department is a preferred remainder beneficiary in the annuity or similar financial instrument for the total amount of Medical Assistance provided to the individual. This notice shall require the issuer to notify the eligibility site when there is a change in the amount of income or principal that is being withdrawn from the annuity.

5. When the redetermination verification information is received by the eligibility site, it shall be date stamped. Within ten working days, the verification information shall be thoroughly reviewed for completeness, accuracy, and consistency. All factors shall be evaluated as to their effect on eligibility at that time. Verifications shall be documented in the case file and CBMS case comments. The case file shall be used as a checklist in the redetermination process, and shall be used to keep track of matters requiring further action. When additional information is needed:

   a. due to incomplete information, the request form shall be mailed back to the client with a letter specifying the items that require completion;

   b. due to incomplete, inaccurate or inconsistent data, the Medical Assistance client shall be contacted by telephone or in writing so that the worker may secure the proper information according to timelines defined by the Department.

6. Due to the federal Coronavirus COVID-19 Public Health Emergency, the Department will continue eligibility for all Medical Assistance categories, regardless of a redetermination and/or reported change for these individuals to ensure continuity of eligibility for Medical Assistance coverage.

8.100.3.Q. Continuous Eligibility (CE) for Medical Assistance programs

1. Continuous eligibility applies to children under age 19, who through an eligibility determination, reassessment or redetermination, are found eligible for a Medical Assistance program. The continuous eligibility period may last for up to 12 months.

    a. The continuous eligibility period applies without regard to changes in income or other factors that would otherwise cause the child to be ineligible.

        i) A 14-day no fault period shall begin on the date the child is determined eligible for Medical Assistance. During the 14-day period, any changes to income or other factors made to the child's case during the 14-day no fault period may change his or her eligibility for Medical Assistance.

    b. Exception: A child's continuous eligibility period will end effective the earliest possible month if any of the following occur:

        i) Child is deceased

        ii) Becomes an inmate of a public institution

        iii) The child is no longer part of the Medical Assistance required household

        iv) Is no longer a Colorado resident

        v) Is unable to be located based on evidence or reasonable assumption

        vi) Requests to be withdrawn from continuous eligibility

        vii) Fails to provide documentation during a reasonable opportunity period as specified in section 8.100.3.H.9

        viii) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90-day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

2. The continuous eligibility period will begin on the first day of the month the application is received or from the date all criteria is met. Continuous eligibility is applicable to children enrolled in the following Medical Assistance programs:

    a. MAGI-Medical Assistance, program as specified in section 8.100.4.G.2

    b. SSI Mandatory, as specified in section 8.100.6.C

        i.) When a child is no longer eligible for SSI Mandatory they will be categorized as eligible within the MAGI-Child category for the remainder of the eligibility period.

    c. Long- Term Care services

i.) When a child is no longer eligible for Long-Term Care services they will be categorized as eligible within the MAGI- Child category for the remainder of the eligibility period.

d. Medicaid Buy-In program specified in section 8.100.6.Q

i) Exception: Enrollment will be discontinued if there is a failure to pay premiums

e. Pickle

f. Disabled Adult Child DAC)

3. Children, under the age of 19, no longer enrolled in Foster Care Medicaid will be eligible for the MAGI-Medical Assistance program. The continuous eligibility period will begin the month the child is no longer enrolled in Foster Care Medicaid as long as they meet one of the following conditions:

a. Begin living with other Relatives

b. Are reunited with Parents

c. Have received guardianship

8.100.4 MAGI Medical Assistance Eligibility [Eff. 01/01/2014]

8.100.4.A. MAGI Application Requirements

1. Persons requesting a MAGI Medical Assistance category need only to complete the Single Streamlined Application.

2. Parents and Caretaker Relatives, Pregnant Women, Children, and Adults may apply for Medical Assistance at sites other than the County Department of Social Services, including eligibility sites and Certified Application Assistance Sites (CAAS). The Department shall approve these sites to receive and initially process these applications. The application used shall be the Single Streamlined Application. The eligibility site shall determine eligibility.

3. The eligibility sites shall refer Medical Assistance clients who are pregnant and/or age 20 and under to EPSDT offices (designated by the Department) by:

a. Copying the page of the Single Streamlined Application that includes the EPSDT benefit questions. The eligibility site will then forward this page to the EPSDT office within five working days from the date of application approval; or by:

b. Means of secure, electronic data transfer approved by the Department

8.100.4.B. MAGI Category Verification Requirements

1. Minimal Verification – At minimum, applicants seeking Medical Assistance shall provide all of the following:

a. Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number (SSN), or each shall submit proof of an application to obtain an SSN, unless they qualify for an exception listed in 8.100.3.I.1.b. Individuals who qualify for an exception must not be required to provide an SSN.

i) Due to the COVID-19 Public Health Emergency, at the time of application, self-attestation is acceptable for SSN criteria, with the exception of verification of citizenship and immigration status. At the end of the federally-declared COVID-19 Public Health Emergency, verification for SSN eligibility criteria will be required.

1)Applicants who meet the criteria for any categorical Medical Assistance programs, but do not meet federal and state citizenship and immigration status requirements, are only eligible to receive emergency medical services.

b. Verification of citizenship and identity as outlined in section 8.100.3.H under Citizenship and Identity Documentation Requirements.

c. Earned Income: Income shall be self-attested by an applicant and verified through an electronic data source. Individuals who provide self-attestation of income must also provide a Social Security Number for wage verification purposes.

If earned income is not or cannot be self-attested, it shall be verified by wage stubs, tax documents, written documentation from the employer stating the employee's gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

Estimated earned income shall be used to determine eligibility if the applicant/client provides less than a full calendar month of wage stubs for the application month. A single recent wage stub shall be sufficient if the applicant's income is expected to be the same amount for the month of application. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month verification is not yet available. Actual earned income shall be used to determine eligibility if the client provides verification for the full calendar month.

Due to the Coronavirus COVID -19 Public Health Emergency, the Department will not take action on any electronic interfaces that notify that the individual's income has changed for all Medical Assistance programs in which the individual is currently enrolled. The Department will take action and require documentation from the individual once the federal emergency declaration has concluded.

d. Unearned income: Unearned income can be self-attested by an applicant. Certain types of unearned income, such as unemployment and survivor benefits may be verified through electronic data sources. Due to the Coronavirus COVID -19 Public Health Emergency, the Department will not take action on any electronic interfaces that notify that the individual's income has changed for all Medical Assistance programs in which the individual is currently enrolled. The Department will take action and require documentation from the individual once the federal emergency declaration has concluded, for all people whose eligibility was maintained during the emergency declaration, for these individuals to maintain eligibility.

e. Verification of Legal Immigrant Status: Immigration status can be self-declared by an applicant applying for Medical Assistance, to determine eligibility for full Medical Assistance benefits. This declaration of legal immigration status will be verified through the Verify Lawful Presence (VLP) interface. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) program to verify legal immigration status. See section 8.100.3.G for a description of the VLP interface. If status cannot be verified, or if the applicant does not provide the necessary documents within the

reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated.

2. Additional Verification: No other verification shall be required of the client unless information is found to be questionable on the basis of fact.

3. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.

4. Information that exists in another case record or in CBMS shall be used by the eligibility site to verify those factors that are not subject to change, if the information is reasonably accessible.

5. The criteria of age and relationship can be declared by the client unless questionable. If questionable, these criteria can be established with information provided from:

   a. official papers such as: a birth certificate, order of adoption, marriage license, immigration or naturalization papers; or

   b. records or statements from sources such as: a court, school, government agency, hospital, or physician.

6. Establishing that a dependent child meets the eligibility criteria of:

   a. age, if questionable requires (1) viewing the birth certificate or comparably reliable document at eligibility site discretion, and (2) documenting the source of verification in the case file and CBMS case comments;

   b. living in the home of the caretaker relative, if questionable requires (1) viewing the appropriate documents which identify the relationship, (2) documenting these sources of verification in the case file and CBMS case comments.

8.100.4.C. MAGI Methodology for Income Calculation

1. For an in depth treatment of gross income, refer to 26 U.S.C. § 61, which is hereby incorporated by reference. The incorporation of 26 U.S.C. § 61 (2014) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request. Except as otherwise provided, pursuant to 26 U.S.C. § 61 gross income means all income from all derived sources, The Modified Adjusted Gross Income calculation for the purposes of determining a household's financial eligibility for Medical Assistance shall consist of, but is not limited to, the following:

   a. Earned Income:

      i) Wages, salaries, tips;

      ii) Gross income derived from business;

      iii) Gains derived from dealings in property;

      iv) Distributive share of partnership gross income (not a limited partner);

v) Compensation for services, including fees, commissions, fringe benefits and similar items; and

vi) Taxable private disability income.

b. Unearned Income:

i) Interest (includes tax exempt interest);

ii) Rents;

iii) Royalties;

iv) Dividends;

v) Alimony received counts as unearned income if the divorce or legal separation is executed on or before December 31, 2018. Alimony received will not be countable income if the divorce or legal separation is modified or executed on or after January 1, 2019;

vi) Pensions and annuities;

vii) Income from life insurance and endowment contracts;

viii) Income from discharge of indebtedness;

ix) Income in respect of a decedent;

x) Income from an interest in an estate or trust;

xi) Social Security (SSA) income; and

xii) Distributive share of partnership gross income (limited partner).

c. Additional Income: In addition to the types of income identified in section 8.100.4.C.1.a-b., the following income is included in the MAGI calculation.

i) Any tax exempt interest income.

ii) Untaxed foreign wages and salaries.

iii) Social Security Title II Benefits (Old Age, Disability and Survivor's benefits).

d. The following are Income exclusions:

i) An amount received as a lump sum is counted as income only in the month received;

ii) Scholarships, awards, or fellowship grants used for educational purposes and not for living expenses;

iii) Child support received;

iv) Worker's Compensation;

v) Supplemental Security Income (SSI);

vi) Veteran's Benefits;

vii) The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act Recovery Rebate, also known as the COVID-19 Economic Stimulus, shall be exempt from consideration as income.

viii) Federal Pandemic Unemployment Compensation (FPUC) program, which provides an extra $600.00 a week for qualified individuals, is exempt as countable unearned income.

ix) American Indian/Alaskan Native income exceptions listed at 42 C.F.R. § 435.603(e) (2012) is hereby incorporated by reference. The incorporation of 42 C.F.R. § 435.603(e) (2012) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

e. Allowable Deductions: For an in-depth treatment of allowable deductions from gross income, please refer to 26 U.S.C. 62, which is hereby incorporated by reference. The incorporation of 26 U.S.C. 62 (2014) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

The following deductions can be subtracted from an individual's taxable gross income, in order to calculate the Adjusted Gross Income (AGI) including (but not limited to):

i) Student loan interest deductions;

ii) Certain Self- employment expenses SEP, SIMPLE and qualified plans, and health insurance deductions;

iii) Deductible part of self-employment tax;

iv) Health savings account deduction;

v) Certain business expenses of reservists, performing artist, and fee-basis government officials;

vi) Reimbursed expenses of employees;

vii) Moving expenses for active duty military who are moving due to a permanent change of station;

viii) IRA deduction: Regular Individual Retirement Account (IRA) contributions claimed on a federal income tax return and which does not exceed the IRA contributions limits;

ix) Penalty on early withdrawal of savings;

x) Domestic production activities deduction;

xi) Alimony paid can be deducted only if the divorce or legal separation is executed on or before December 31, 2018. It cannot be deducted if the divorce or separation is modified or executed on or after January 1, 20019. ;

xii) Certain educator expenses; and

xiii) Certain pre-tax contributions.

f. Income of children and tax dependents:

i) The income of a child who is included in the household of their natural, adopted, or step parent will not be included in the household income unless that child has income above the tax filing threshold..

1) Income from Title II Social Security benefits and Tier I Railroad benefits are excluded when determining if a child is required to file taxes.

ii) The income of a person, other than a child or spouse, who expects to be claimed as a tax dependent will not be included in the household income of the taxpayer unless that tax dependent has income above the tax filing threshold.

1) Income from Title II Social Security benefits and Tier I Railroad benefits are excluded when determining if a tax dependent is required to file taxes.

ii) The income of a child or tax dependent who does not live with their natural, adopted, or step parent will always count towards the determination of their own eligibility, even if the child's or tax dependent's income is below the tax filing threshold.

2. Income verifications: When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive every reasonable opportunity to establish his/her financial eligibility through the test for reasonable compatibility, by providing a reasonable explanation of the discrepancy, or by providing paper documentation in accordance with this section. For Reasonable Opportunity Period please see section 8.100.3.H.9.

a. Income information obtained through an electronic data source shall be considered reasonably compatible with income information provided by or on behalf of an applicant in the following circumstances:

i) If the amount attested by the applicant and the amount reported by an electronic data source are both below the applicable income standard for the requested program, that income shall be determined reasonably compatible and the applicant shall be determined eligible.

ii) If the amount attested by the applicant is below the applicable income standard for that program, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 20%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

iii) If both amounts are above the applicable income standard for that program, the income shall be determined reasonably compatible, and the applicant shall

continue to be determined eligible during the federal Coronavirus COVID-19 Public Health Emergency.

b. If income information provided by or on behalf of an applicant is not determined reasonably compatible with income information obtained through an electronic data source, a reasonable explanation of the discrepancy will not be requested during the federal Coronavirus COVID-19 Public Health Emergency. When the federal COVID-19 Public Health Emergency has ended, a reasonable explanation will be requested from the member..

i) During the federal Coronavirus COVID-19 public health emergency the Department may request paper documentation when the Department does not find income to be reasonably compatible. If the member does or does not provide paper documentation they will remain eligible during the public health emergency period.

3. Self-Employment – If the applicant is self-employed the ledger included in the Single Streamlined Application shall be sufficient verification of earnings, unless questionable.

4. Budget Periods for MAGI-based Income determination – The financial eligibility of applicants for Medical Assistance shall be determined based on current or previous monthly household income and family size.

a. Applicants who are found financially ineligible based on current or previous monthly household income and family size, and whose household has earned income from self-employment, seasonal employment, and/or commission-based employment, shall have their financial eligibility determined using annualized self-employment, seasonal employment, and commission-based employment income.

5. If an applicant does not meet the financial eligibility requirements for Medical Assistance based on MAGI, but meets all other eligibility requirements, the applicant shall be found eligible for MAGI Medical Assistance if the applicant's income, as calculated using the methodology for determining eligibility for Advanced Premium Tax Credits or Cost Sharing Reductions through the marketplace, is below 100% of the federal poverty level.

8.100.4.D. Income Disregard

1. An income disregard equivalent to five percentage points of the Federal Poverty Level for the applicable family size will be subtracted from MAGI-based income.

a. If an individual's MAGI-based countable income is above the income threshold for the applicable MAGI program under title XIX (Medicaid) or title XXI (CHP+) of the Social Security Act, the five percent (5%) disregard will be applied for each qualifying MAGI program as the last step to determine eligibility.

b. If the countable income is below the income threshold for the applicable MAGI program, the individual is income eligible and the five percent (5%) disregard will not be applied to determine eligibility.

8.100.4.E. Determining MAGI Household Composition.

1. MAGI household composition is similar to, but not necessarily the same as a tax household. To determine MAGI household composition, the individual's relationship to the tax filer must be established as declared on the Single Streamlined Application.

a. In the case of an applicant who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and does not expect to be claimed as a tax dependent by anyone else, then the applicant's MAGI household shall consist of the following:

   i) The Tax-Filer;

   ii) The Tax-Filer's spouse if living in the home;

   iii) All persons whom the Tax-Filer expects to claim as a tax dependent on their personal income tax return

b. In the case of an applicant who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the applicant's MAGI household shall be:

   i) The Tax Dependent;

   ii) The Tax-Filer and their spouse if living in the home;

   iii) The Tax-Filer's other tax dependents;

   iv) The Tax Dependent's spouse, if living with the Tax Dependent.

c. The MAGI household of an applicant who expects to be claimed as a tax dependent is as outlined in 8.100.4.E.b above, except in the following circumstances:

   i) The applicant expects to be claimed as a tax dependent by someone other than a spouse, biological, adoptive or step parent.

   ii) The applicant is a child under 19 who is expected to be claimed by one parent as a tax dependent and is living with both parents, but the parents do not expect to file a joint tax return.

   iii) The applicant is a child under 19 and who expects to be claimed as a tax dependent by anon-custodial parent.

d. If the applicant meets one of the exceptions in 8.100.4.E.c above or is a non-filer, household composition shall be determined using the following non-filer rules and the applicant's household shall consist of the following:

   i) The applicant;

   ii) The applicant's spouse who lives in the household;

   iii) The applicant's natural, adopted, and step children under the age of 19, who live in the household; and

   iv) In the case of applicants under the age of 19, the applicant's natural, adoptive, and step parents and natural, adoptive, and step siblings under age 19, who live in the household.

2. When a household includes a pregnant woman, regardless of the Medical Assistance category, the pregnant woman is counted as herself plus the number of children she is expected to deliver.

3. Married couples living together will each be included in the other's MAGI household regardless of whether or not they expect to file taxes jointly, separately or if one expects to be claimed as a tax dependent of the other.

4. If a child is claimed as a tax dependent by both parents who are married and who will file taxes jointly but one parent lives outside of the household due to separation or pending divorce, the child's household composition is determined by non-filer rules. The parent living outside of the household will not be counted as part of the household.

5. An individual who is both a tax dependent and a tax filer will be considered a tax dependent for the purpose of determining eligibility for Medical Assistance.

8.100.4.F. MAGI Category Presumptive Eligibility

1. A pregnant applicant may apply for presumptive eligibility for ambulatory services through Medical Assistance presumptive eligibility sites. A child under the age of 19may apply or have an adult apply on their behalf for presumptive eligibility for State Plan approved medical services through presumptive eligibility sites.

2. To be eligible for presumptive eligibility:

    a. a pregnant woman shall have an attested pregnancy, declare that her household's income shall not exceed 185% of the federal poverty level (MAGI-equivalent) and declare that she is a United States citizen or a documented immigrant. Refer to the MAGI-Medicaid income guidelines chart available on the Department's website

    b. a child under the age of 19 shall have a declared household income that does not exceed 133% of federal poverty level (MAGI-equivalent) and declare that the child is a United States citizen or a documented immigrant.

3. Presumptive eligibility sites shall be certified by the Department to make presumptive eligibility determinations. Sites shall be re-certified by the Department every 2 years to remain approved presumptive eligibility sites.

4. The presumptive eligibility site shall forward the application to the county within five business days.

5. The presumptive eligibility period begins on the date the applicant is determined eligible and ends with the earlier of:

    a. The day an eligibility determination for Medical Assistance is made for the applicant(s); or

    b. The last day of the month following the month in which a determination for presumptive eligibility was made.

6. A presumptive eligible client may not appeal the end of a presumptive eligibility period.

7. Presumptively eligible women and Medical Assistance clients may appeal the county department's failure to act on an application within 45 days from date of application or the denial of an application. Appeal procedures are outlined in the State Hearings section of this volume.

8.100.4.G. MAGI Covered Groups

1. For MAGI Medical Assistance, any person who is determined to be eligible for Medical Assistance based on MAGI at any time during a calendar month shall be eligible for benefits during the entire month.

2. Children applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Refer to the MAGI-Medicaid income guidelines chart available on the Department's website.

    a. Children are eligible for Children's MAGI Medical Assistance through the end of the month in which they turn 19 years old. After turning 19, the individual may be eligible for a different Medical Assistance category.

3. Parents and Caretaker Relatives applying for Medical Assistance whose total household income does not exceed 60% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Parents or Caretaker Relatives eligible for this category shall have a dependent child in the household.

    a. A dependent child is considered to be living in the home of the parent or caretaker relative as long as the parent or specified relative exercises responsibility for the care and control of the child even if:

        i) The child is under the jurisdiction of the court (for example, receiving probation services);

        ii) Legal custody is held by an agency that does not have physical possession of the child;

        iii) The child is in regular attendance at a school away from home;

        iv) Either the child or the relative is away from the home to receive medical treatment;

        v) Either the child or the relative is temporarily absent from the home;

        vi) The child is in voluntary foster care placement for a period not expected to exceed three months. Should the foster care plan change within the three months and the placement become court ordered, the child is no longer considered to be living in the home as of the time the foster care plan is changed.

4. Adults applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance. This category includes adults who are parents or caretaker relatives of dependent children whose income exceeds the income threshold to qualify for the Parents and Caretaker Relatives MAGI category and who meet all other eligibility criteria.

    a. A dependent child living in the household of a parent or caretaker relative shall have minimum essential coverage, in order for the parent or caretaker relative to be eligible for Medical Assistance under this category. Refer to section 8.100.4.G.3.a on who is considered a dependent child.

    b. Due to the COVID-19 Public Health Emergency an applicant who is not eligible for Medical Assistance but has been impacted through exposure to or potential infection with COVID-19 may be eligible to receive services for COVID-19 testing only. To qualify for

this limited benefit, the Applicant must satisfy residency and immigration or citizenship status and not be enrolled in other health insurance.

5. Pregnant Women whose household income does not exceed 185% of the federal poverty level (MAGI-equivalent) are eligible for the Pregnant Women MAGI Medical Assistance program. Medical Assistance shall be provided to a pregnant woman for a period beginning with the date of application for Medical Assistance through the last day of the month following 60 days from the date the pregnancy ends. Once eligibility has been approved, Medical Assistance coverage will be provided regardless of changes in the woman's financial circumstances once the income verification requirements are met.

    a. A pregnant women's eligibility period will end effective the earliest possible month, if the following occurs:

        i) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90 day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

6. A lawfully admitted non-citizen who is pregnant and who has been in the United States for less than five years is eligible for Medical Assistance if she meets all of the other eligibility requirements specified at 8.100.4.G.5 and fits into one of the immigration categories listed in 8.100.3.G.1.g.iii.1-5 and 8.100.3.G.1.g.vi.1-15. This population is referenced as Legal Immigrant Prenatal.

7. A child whose mother is receiving Medical Assistance at the time of the child's birth is continuously eligible for one year. This population is referred to as "Eligible Needy Newborn". This coverage also applies in instances where the mother received Medical Assistance to cover the child's birth through retroactive Medical Assistance. The child is not required to live with the mother receiving Medical Assistance to qualify as an Eligible Needy Newborn.

    a. To receive Medical Assistance under this category, the birth must be reported verbally or in writing to the County Department of Human Services or eligibility site. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time by any person. Once reported, a newborn meeting the above criteria shall be added to the mother's Medical Assistance case, or his or her own case if the newborn does not reside with the mother, according to timelines defined by the Department. If adopted, the newborn's agent does not need to file an application or provide a Social Security Number or proof of application for a Social Security Number for the newborn

8.100.4.H. Needy Persons

1. Medical Assistance shall be provided to certain needy persons under 21 years of age, including the following:

    a. Those receiving care in a Long Term Care Institution eligible for Medical Assistance reimbursement or receiving active treatment as inpatients in a psychiatric facility eligible for Medical Assistance reimbursement and whose household income is less than the MAGI needs standard for his/her family size when the client applies for assistance. Clients that are receiving benefits under this category and are still receiving active inpatient treatment in the facility at age 21 shall be eligible to age 22. This population is referenced as Psych <21.

b. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in foster care, in homes or private institutions or in subsidized adoptive homes. A child shall be the responsibility of the county, even if the child may be in a medical institution at that time. See Colorado Department of Human Services "Social Services Staff Manual" section 7 for specific eligibility requirements (12 CCR § 2509-1). 12 CCR § 2509-1 (2013) is hereby incorporated by reference. The incorporation of 12 CCR § 2509-1 excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

c. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in independent living situations subsequent to being in foster care.

d. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's Alternatives to Foster Care Program and would be in foster care except for this program and whose household income is less than the MAGI needs standard for his/her family size.

e. Those for whom the Department of Human Services is assuming full or partial responsibility and who are removed from their home either with or without (court ordered) parental consent, placed in the custody of the county and residing in a county approved foster home.

f. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's subsidized adoption program, including a clause in the subsidized adoption agreement to provide Medical Assistance for the child.

g. Those for whom the Department of Human Services is assuming full or partial financial responsibility on their 18th birthday or at the time of emancipation. These individuals also must have received foster care maintenance payments or subsidized adoption payments from the State of Colorado pursuant to article 7 of title 26, C.R.S. immediately prior to the date the individual attained 18 years of age or was emancipated. Eligibility shall be extended until the individual's 21st birthday for these individuals with the exception of those receiving subsidized adoption payments.

2. Medical Assistance shall be extended to certain needy persons until the end of the month of the individual's 26th birthday, including the following:

a. Those individuals that were formerly in foster care under the responsibility of the State or Tribe on their 18th, 19th, 20th or up to their 21st birthday and were receiving Medical Assistance.

i) This extension does not apply to youth that are receiving subsidized adoption payments or

ii) To youth that are enrolled in mandatory Medical Assistance.

b) Former Foster Care youth are not subject to either an income or resource test.

c) Former Foster Care youth's newborn shall be considered a needy newborn.

8.100.4.I. Transitional Medical Assistance and 4 Month Extended Medical Assistance

1. Eligibility for Transitional Medical Assistance shall be granted for twelve months (beginning with the first month of ineligibility) to individuals who are no longer eligible for the Parent/Caretaker Relative category due to a change in income.

   The extension shall be applied to individuals who:

   a. Were eligible for the Parent/Caretaker Relative category in at least three of the six months preceding the month in which the individual would have become ineligible, and

   b. Are no longer eligible for coverage under the Parent/Caretaker Relative category because of new or increased income from employment or hours of employment

      i) At least one Parent/Caretaker Relative must continue to be employed and cannot terminate employment without good cause. This does not need to be the same person for the whole period the family is receiving Transitional Medical Assistance.

2. Any dependent child or Parent/Caretaker Relative who was or becomes part of the Medical Assistance household after the individual has begun receiving Transitional Medical Assistance is eligible for the remaining months of Transitional Medical Assistance.

   a. A dependent child in the household who received Medical Assistance through continuous eligibility, but is no longer eligible for Medical Assistance based on a redetermination, is eligible for the family's remaining months of Transitional Medical Assistance.

   b. An individual in the household who received Medical Assistance, but is no longer eligible for Medical Assistance based on a redetermination, is eligible for the family's remaining months of Transitional Medical Assistance

3. To become or remain eligible for Transitional Medical Assistance:

   a. The household must include a dependent child. If it is determined that the household no longer has a child living in the home, Transitional Medicaid Assistance shall discontinue at the end of the month in which the household does not include a dependent child.

   b. If health insurance is available from the employer to the employee, at no cost to the Medical Assistance recipient, the client shall enroll in the insurance program.

4. When Transitional Medical Assistance ends the case will be reassessed for all other categories of Medical Assistance for which the family members may be eligible. A new application shall not be required for this process.

5. Eligibility for Medical Assistance shall be extended for four months (beginning with the first month of ineligibility) for certain families who become ineligible for Medical Assistance due solely or partially to the receipt of support income, such as alimony. The extension shall be applied for a family which receives assistance under Medical Assistance in at least three of the six months immediately preceding the month in which the family becomes ineligible for assistance. To be eligible for the four month Medical Assistance extension, the family shall meet all other eligibility criteria for Medical Assistance before the alimony income is applied.

   a. Alimony received will be countable income only if the divorce or legal separation is executed on or before December 31, 2018. Alimony will not be countable income if the divorce or legal separation is modified or executed on or after January 1, 2019.

8.100.4.J. Express Lane Eligibility

Express Lane Eligibility shall allow for automatic initiation of Medical Assistance enrollment by using available data and findings from other programs as listed below.

1. Free/Reduced Lunch Program

    a. Recipients of the Free/Reduced Lunch Program who have submitted a Free/Reduced Lunch application at a participating school district-

        i) Families shall be given the option to opt into Medical Assistance coverage for their potentially eligible child.

        ii) Children who meet all necessary eligibility requirements as outlined in this volume shall be automatically enrolled.

        iii) Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity shall receive 90days of eligibility while awaiting this verification.

        iv) Any additionally required verification shall be requested from the client through CBMS prior to being automatically enrolled.

        v) Eligibility is based on income declared on the Free/Reduced Lunch application as well as eligibility requirements outlined in this volume.

        vi) If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility will be evaluated using the Single Streamlined Application for Medical Assistance.

    b. Recipients of the Free/Reduced Lunch Program who were not required to submit a Free/Reduced Lunch application at a participating school district-

        i) Families who are automatically enrolled Free/Reduced Lunch recipient children shall not be forwarded to the Department for Express Lane Eligibility in compliance USDA confidentiality guidelines.

        ii) These families must apply for Medical Assistance in order to give consent for request of benefits.

2. Direct Certification

    a. Individuals who have submitted a Food Assistance or Colorado Works application

        i) Families shall be given the option to opt into Medical Assistance coverage for their potentially eligible child.

        ii) Children who meet all necessary eligibility requirements as outlined throughout 8.100.4 shall be automatically enrolled

        iii) Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity will receive 90 days of eligibility while awaiting this verification.

iv) Any additionally required verification shall be requested from the client through CBMS prior to being automatically enrolled.

v) Eligibility is based on income declared on the Food Assistance or Colorado Works application as well as eligibility requirements outlined throughout this volume.

vi) If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility shall be evaluated using the Single Streamlined Application for Medical Assistance.

vii) Individuals whose eligibility is not determined through Express Lane Eligibility can also submit a separate Single Streamlined Application for Medical Assistance to determine eligibility.

8.100.5. Aged, Blind, and Disabled, Long Term Care, and Medicare Savings Plan Medical Assistance General Eligibility

8.100.5.A. Application Requirements

1. When an individual applies for Medical Assistance on the basis of disability or blindness, the eligibility sites shall take the application and determine whether the individual is eligible for Long Term Care or any of the Aged, Blind, and Disabled categories of assistance described in section 8.100.6. If the applicant does not qualify for Medical Assistance on one of those bases, he/she shall be referred to the local Social Security office to apply for SSI.

    a. Applicants who apply for Long-Term Care Medical Assistance on the basis of disability or blindness, or who apply for the Medicaid Buy-In Program for Working Adults with Disabilities or the Medicaid Buy-In Program for Children with Disabilities without a current disability determination, shall complete a Medical Assistance disability determination application in addition to the required Single Streamlined Application. The disability determination application is not required for individuals that have already been determined disabled by the Social Security Administration.

    b. The Medical Assistance disability determination application shall be collected by a designated eligibility site representative and shall be forwarded to the state disability determination contractor upon completion. The state disability determination contractor shall conduct a client disability determination and shall forward the determination to the designated eligibility site representative.

    c. For the Medicaid Buy-In Program for Working Adults with Disabilities, if an individual does not meet the Social Security Administration definition of disability, the state disability determination contractor can review the individual's circumstances to determine if the individual meets limited disability.

    d. Due to the Coronavirus COVID-19 Public Health Emergency, if a person's existing disability determination has expired, the person shall remain enrolled in Medical Assistance until the emergency has ended and the state has processed the verification of eligibility, unless the individual requests a voluntary termination of eligibility.

2. Persons requesting Aged, Blind, and Disabled Medical Assistance need only to complete the Single Streamlined Application.

8.100.5.B. Verification Requirements

1. The particular circumstances of an applicant will dictate the appropriate documentation needed for a complete application. The following items shall be verified for individuals applying for Medical Assistance:

   a. Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number (SSN), or each shall submit proof of an application to obtain an SSN, unless they qualify for an exception listed in 8.100.3.I.1.b. Individuals who qualify for an exception must not be required to provide an SSN.

      i) Due to the Coronavirus COVID-19 Public Health Emergency, at application, self-attestation is acceptable for SSN criteria, with the exception of verification of citizenship and immigration status. At the end of the COVID-19 Public Health Emergency, verification for SSN eligibility criteria will be required.

         1) Applicants who meet the criteria for any categorical Medical Assistance programs, but do not meet the federal and state criteria of citizenship and immigration status are only eligible to receive emergency medical services.

   b. Verification of citizenship and identity as outlined in the section 8.100.3.H under Citizenship and Identity Documentation Requirements.

   c. Earned income may be self-declared by an individual and verified by the Income and Eligibility Verification System (IEVS). Individuals who provide self-declaration of earned income must also provide a Social Security Number for wage verification purposes. If a discrepancy occurs between self-declared income and IEVS wage data reports, IEVS wage data will be used to determine eligibility. An individual may dispute IEVS wage data by submitting all wage verification for all months in which there is a wage discrepancy.

      When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive every reasonable opportunity to establish his/her financial eligibility through the test for reasonable compatibility, by providing a reasonable explanation of the discrepancy, or by providing paper documentation in accordance with this section. For Reasonable Opportunity Period please see section 8.100.3.H.9.

      Income information obtained through an electronic data source shall be considered reasonably compatible with income information provided by or on behalf of an applicant in the following circumstances:

      i) If the amount attested by the applicant and the amount reported by an electronic data source are both below the applicable income standard for the requested program, that income shall be determined reasonably compatible and the applicant shall be determined eligible.

      ii) If the amount attested by the applicant is below the applicable income standard for that program, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 20%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

      iii) If both amounts are above the applicable income standard for that program, the income shall be determined reasonably compatible, and the applicant shall continue to be determined eligible during the federal Coronavirus COVID-19 Public Health Emergency.

If income information provided by or on behalf of an applicant is not determined reasonably compatible with income information obtained through an electronic data source, a reasonable explanation of the discrepancy will not be requested due to the federal COVID-19 Public Health Emergency. When the federal Public Health Emergency has ended, a reasonable explanation will be requested from the member.

iv) During the federal Coronavirus COVID-19 public health emergency the Department may request paper documentation when the Department does not find income to be reasonably compatible. If the member does or does not provide paper documentation they will remain eligible during the public health emergency period.

If the applicant is self-employed, ledgers are sufficient for verification of earnings, if a ledger is not available, receipts are acceptable. The ledger included in the Medical Assistance application is sufficient verification of earnings, unless questionable. If an individual cannot provide verification through self-declaration, income shall be verified by wage stubs, written documentation from the employer stating the employees' gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

As of CBMS implementation, estimated earned income shall be used to determine eligibility if the applicant/client provides less than a full calendar month of wage stubs for the application month. A single recent wage stub shall be sufficient if the applicant's income is expected to be the same amount for the month of application. Written documentation from the employer stating the employees' gross income or a telephone call to an employer, if the applicant authorizes the telephone call shall also be acceptable verification of earned income. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month verification is not yet available. Actual earned income shall be used to determine eligibility if the client provides verification for the full calendar month.

v) During the federal COVID-19 Public Health Emergency, all earned income and self-employment may be reported by self-attestation. At the end of the federal COVID-19 Public Health Emergency, proof of any unverified income shall be provided.

d. Verification of all unearned income shall be provided if the unearned income was received in the month for which eligibility is being determined or during the previous month. If available, information that exists in another case record or verification system shall be used to verify unearned income.

i) During the federal COVID-19 Public Health Emergency, all unearned income may be reported by self-attestation. At the end of the federal COVID-19 Public Health Emergency, proof of any unverified income shall be provided.

e. Verification of all resources shall be provided if the resources were available to the applicant in the month for which eligibility is being determined.

Resource information that is verified through an electronic data source, such as the Asset Verification Program, shall be a valid verification. Supplemental physical verifications for the same resource is not required unless further information is needed for clarification.

i) During the federal COVID-19 Public Health Emergency, all resources may be reported by self-attestation. At the end of the federal COVID-19 Public Health Emergency, proof of any unverified resources shall be provided.

f. Immigrant registration cards or papers, if applicable, to determine if the client is eligible for full Medical Assistance benefits. If an applicant does not provide this, he/she shall only be eligible for emergency Medical Assistance if they meet all other eligibility requirements.

g. Additional verification-If the requested verification is submitted by the applicant, no other additional verification shall be required unless the submitted verification is found to be questionable on the basis of fact.

h. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.

8.100.5.C. Effective Date of Eligibility

1. Eligibility for the Aged, Blind and Disabled categories shall be approved effective on the later of:

   a. The first day of the month of the Single Streamlined Application for Medical Assistance; or

   b. The first day of the month the person becomes eligible for Medical Assistance.

2. The date that eligibility begins for Long-Term Care Medical Assistance is defined in section 8.100.7.A and B.

3. For the Medicaid Buy-In Program for Children with Disabilities, any child who is determined to be eligible for Medical Assistance at any time during a calendar month shall be eligible for benefits during the entire month.

4. Clients applying for Medical Assistance under the Aged, Blind and Disabled category shall be reviewed for retroactive eligibility as described at 8.100.3.E. When reviewing for retroactive eligibility for an individual who is SSI eligible or applied and became SSI eligible in each of the retroactive months, the applicant must:

   a. Be aged at least 65 years; or

   b. Meet the Social Security Administration definition of disability by:

      i) Being approved as eligible to receive either SSI or SSDI, on or prior to the date of a medical service; or

      ii) Having a disability onset date determined on or prior to the date of a medical service; and

   c. Meet the financial requirements as described at 8.100.5.E.

8.100.5.D. Medical Assistance Estate Recovery Program

1. The eligibility site shall provide written information from the Department to the following people explaining the provisions of the Medical Assistance Estate Recovery Program and how those provisions may pertain to the applicant/client:

   a. Applicants age 55 and older who are institutionalized.

   b. Applicants/clients who will turn age 55 before their next eligibility re-determination who are institutionalized.

c. Clients age 55 and older who are approved for admittance to an institution

8.100.5.E. Availability of Resources and Income

Consistent with the legislative declaration outlined at C.R.S. § 25.5-4-300.4, Medicaid should be the payer of last resort for payment of medically necessary goods and services furnished to clients. All other sources of payment, including an individual's own countable income and resources, should be utilized to the fullest extent possible before Medicaid is accessed.

1. Income, which includes earned and unearned income, shall be calculated on a monthly basis regardless of whether it is received annually, semi-annually, quarterly or weekly.

2. For married couples, the income and resources of both spouses are counted in determining eligibility for either or both spouses. Refer to section 8.100.7.C for exceptions.

3. Resources and income shall be considered available when actually available; or, shall be deemed available when all of the following apply to the resources or income of the individual or individual's spouse:

    a. has any ownership interest in income or resources or equity value of a resource;

    b. has the right, authority, or power to convert the resource or income to cash or to cause the resource or income to be converted to cash; and

    c. is not legally restricted from using the resource or income for his or her support and maintenance.

4. Resources and income shall not be considered unavailable merely because the individual or individual's spouse may need to initiate legal proceedings to access the resources or income.

5. If the applicant or client demonstrates with clear and convincing evidence that appropriate steps are being taken to secure the resources, Medical Assistance shall not be delayed or terminated. Verification of efforts to secure the resources must be provided at regular intervals as requested by the Eligibility Site.

6. Resources will be considered available and Medical Assistance shall be denied or terminated if the applicant or client refuses or fails to make a reasonable effort to secure potential resources or income.

7. Timely and adequate notice must be given regarding a proposed action to deny, reduce, or terminate assistance due to failure to make reasonable efforts to secure resources or income. If upon receipt of the prior notice, the individual acts to secure the potential resource, the proposed action to deny, reduce, or terminate assistance must be withdrawn, and assistance must be approved or continued until the resource or income is, in fact, available.

8. If the resources or income has been transferred to a trust, the trust shall be submitted for review to the Department to determine the effect of the trust on eligibility in accordance with section 8.100.7.E.

9. A resource may not necessarily be unavailable by virtue that an individual may be unaware of his or her ownership of an asset. The Department will not treat the unknown asset as a resource

during the period in which the individual was unaware of his/her ownership. However, the value of the previously unknown asset, including any monies such as interest that have accumulated on the asset through the month of discovery, is evaluated under regular income-counting rules in the month of discovery, and the asset is a resource subject to the resource-counting rules following the month of discovery.

a. The burden is on the individual to prove by clear and convincing evidence that the asset was unavailable by virtue of being unknown by the recipient.

b. Unknown assets shall not be deemed an overpayment pursuant to Section 8.065 of the Department's regulations where the asset was unknown through no fault of the individual.

c. If the previously unknown asset causes the individual to be ineligible, the individual may repay the Department from the excess resources to retain Medicaid eligibility.

8.100.5.F. Income Requirements

1. This section reviews how income is looked at for the ABD and Long Term Care Medical Programs and determining premiums for the Medicaid Buy-In Program for Working Adults with Disabilities. For more general income information and income types refer to the Medical Assistance General Eligibility Requirements section 8.100.3.

2. Income for the ABD Medical Programs eligibility is income which is received by an individual or family in the month in which they are applying for or receiving Medical Assistance, or the previous month if income for the current month is not yet available to determine eligibility.

3. A self-declared common law spouse retains the same financial responsibility as a legally married spouse. Once self-declared as married under the common law, financial responsibility remains unless legal separation or divorce occurs. If two persons live together, but are not married to each other, neither one has the legal responsibility to support the other. This is not changed by the fact that the unmarried individuals may share a common child.

4. Earned income is countable as income in the month received and a countable resource the following month. Earned Income includes the following:

   a. Wages, which include salaries, commissions, bonuses, severance pay, and any other special payments received because of employment.

   b. Net earnings from self-employment

   c. Payments for services performed in a sheltered workshop or work activities center

   d. Certain Royalties and honoraria

5. Unearned income is the gross amount received in cash or kind that is not earned from employment or self-employment.

   Unearned income is countable as income in the month received and any unspent amount is a countable resource the following month. Unearned income includes, but is not limited to, the following:

   a. Death benefits, reduced by the cost of last illness and burial

   b. Prizes and awards

c. Gifts and inheritances

d. Interest payments on promissory notes established on or after March 1, 2007.

e. Interest or dividend payments received from any resources

f. Lump sum payments from workers' compensation, insurance settlements, etc.

g. Dividends, royalties or other payments from mineral rights or other resources listed for sale within the resource limits

h. Income from annuities that meet requirements for exclusion as a resource

i. Pensions and other period payments, such as:

i) Private pensions or disability benefits

ii) Social Security benefits (Retirement, survivors, and disability)

iii) Workers' Compensation payments

iv) Railroad retirement annuities

v) Unemployment insurance payments

vi) Veterans benefits other than Aid and Attendance (A&A) and Unusual Medical Expenses (UME).

vii) Alimony and support payments

j. Support and maintenance in kind - The support and maintenance in kind amount should not be greater than one third of the Federal Benefit Rate (FBR). Use the Presumed Maximum Value (PMV) of 1/3 of the recipient's portion of the rent to determine the support and maintenance in kind amount. Use one third of the FBR if an amount is not declared by the client.

6. For the purpose of determining eligibility for the Long Term Care and Aged, Blind, and Disabled Medical Assistance categories the following shall be exempt from consideration as either income or resources:

a. A bona fide loan. Bona fide loans are loans, either private or commercial, which have a repayment agreement. Declaration of such loans is sufficient verification.

b. Benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act.

c. Title XVI (SSI) or Title II (Retirement Survivors or Disability Insurance) retroactive payments (lump sum) for nine months following receipt and the remainder countable as a resource thereafter.

d. The value of supplemental food assistance received under the special food services program for children provided for in the National School Lunch Act and under the Child Nutrition Act, including benefits received from the special supplemental food program for women, infants and children (WIC).

e. Home produce utilized for personal consumption.

f. Payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act; relocation payments to a displaced homeowner toward the purchase of a replacement dwelling are considered exempt for up to 6 months.

g. The value of any assistance paid with respect to a dwelling unit is excluded from income and resources if paid under:

i) Experimental Housing Allowance Program (EHAP) payments made by HUD under section 23 of the U.S. Housing Act.

ii) The United States Housing Act of 1937 (§ 1437 et seq. of 42 U.S.C.)

iii) The National Housing Act (§ 1701 et seq. of 12 U.S.C.)

iv) Section 101 of the Housing and Urban Development Act of 1965 (§ 1701s of 12 U.S.C., § 1451 of 42 U.S.C.);

v) Title V of the Housing Act of 1949 (§ 1471 et seq. of 42 U.S.C.); or

vi) Section 202(h) of the Housing Act of 1959.

h. Payments made from Indian judgment funds and tribal funds held in trust by the Secretary of the Interior and/or distributed per capita; and initial purchases made with such funds. (Public Law No 98-64 and Public Law No. 97-458).

i. Distributions from a native corporation formed pursuant to the Alaska Native Claims Settlement Act (ANCSA) which are in the form of: cash payments up to an amount not to exceed $ 2000 per individual per calendar year; stock; a partnership interest; or an interest in a settlement trust. Cash payments, up to $ 2000, received by a client in one calendar year which is retained into subsequent years is excluded as income and resources; however, cash payments up to $ 2000 received in the subsequent year would be excluded from income in the month(s) received but counted as a resource if retained beyond that month(s).

j. Assistance from other agencies and organizations.

k. Major disaster and emergency assistance provided to individuals and families, and comparable disaster assistance provided to states, local governments and disaster assistance organizations shall be exempt as income and resources in determining eligibility for Medical Assistance.

l. Payments received for providing foster care.

m. Payments to volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other program under Title I (VISTA) when the value of all such payments adjusted to reflect the number of hours such volunteers are serving is not equivalent to or greater than the minimum wage, and Title II and Title III of the Domestic Volunteer Services Act.

n. The benefits provided to eligible persons or households through the Low Income Energy Assistance (LEAP) Program.

o. Training allowances granted by the Workforce Investment Act (WIA) to enable any individual whether dependent child or caretaker relative, to participate in a training program

p. Payments received from the youth incentive entitlement pilot projects, the youth community conservation and improvement projects, and the youth employment and training programs under the Youth Employment and Demonstration Project Act.

q. Social Security benefit payments and the accrued amount thereof to a client when an individual plan for self-care and/or self-support has been developed. In order to disregard such income and resources, it shall be determined that (1) SSI permits such disregard under such developed plan for self-care-support goal, and (2) assurance exists that the funds involved will not be for purposes other than those intended.

r. Monies received pursuant to the “Civil Liberties Act of 1988” P.L. No. 100-383, (by eligible persons of Japanese ancestry or certain specified survivors, and certain eligible Aleuts).

s. Payments made from the Agent Orange Settlement Fund or any fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No 381 (E.D.N.Y).

t. A child receiving subsidized adoption funds shall be excluded from the Medical Assistance budget unit and his income shall be exempt from consideration in determining eligibility, unless such exclusion results in ineligibility for the other members of the household.

u. The Earned Income Tax Credit (EIC). EIC shall also be exempt as resources for the month it is received and for the following month.

v. Any money received from the Radiation Exposure Compensation Trust Fund, Including the Energy Employees Occupational Illness Compensation Program Act, pursuant to P.L. No. 101-426 as amended by P.L. No. 101-510.

w. Reimbursement or restoration of out-of-pocket expenses. Out-of-pocket expenses are actual expenses for food, housing, medical items, clothing, transportation, or personal needs items.

x. Payments to individuals because of their status as victims of Nazi persecution pursuant to Public Law No. 103-286.

y. General Assistance, SSI, OAP-A and cash assistance under the Temporary Assistance to Needy Families (TANF) funds.

z. All wages paid by the United States Census Bureau for temporary employment related to the decennial Census.

aa. Any grant or loan to an undergraduate student for educational purposes made or insured under any programs administered by the Commissioner of Education (Basic Education Opportunity Grants, Supplementary Education Opportunity Grants, National Direct Student Loans and Guaranteed Student Loans), Pell Grant Program, the PLUS Program, the BYRD Honor Scholarship programs and the College Work Study Program.

bb. Any portion of educational loans and grants obtained and used under conditions that preclude their use for current living cost (need-based).

cc. Financial assistance received under the Carl D. Perkins Vocational and Applied Technology Education Act that is made available for attendance cost shall not be considered as income or resources. Attendance cost includes tuition, fees, rental or purchase of equipment, materials or supplies required of all students in the same course of study, books, supplies, transportation, dependent care and miscellaneous personal expenses of students attending the institution on at least a half-time basis, as determined by the institution.

dd. The additional unemployment compensation of $25 a week enacted through the American Recovery and Reinvestment Act of 2009.

8.100.5.G. Deeming Of Income And Resources For The OAP Program

1. All aliens who apply for OAP on or after April 16, 1988, for three years after the date of admission into the United States, shall have the income and resources of their sponsors other than relatives deemed for their care. Refer to the Medical Assistance General Eligibility Requirements section 8.100.3.K for specific information on deeming of income and resources.

8.100.5.H. Income Allocations and Disregards

1. The following income allocations and disregards are only applicable to SSI related, OAP, Medicare Savings Programs (MSP), and the Medicaid Buy-In Program for Working Adults with Disabilities.

   These allocations and disregards are not applicable to the HCBS waivers or the LTC programs.

   For the Medicaid Buy-In Program for Working Adults with Disabilities, the applicant's spouse's income does not count toward the applicant.

   a. Income of spouses living together is considered mutually available for SSI related, OAP, and Medicare Savings Programs (MSP).

   b. For a person living in the household of another and not paying shelter costs, one third of the Federal Benefit Rate (FBR) is counted as in-kind income and is added to the countable income. This does not apply to unemancipated children.

2. For the purposes of this rule, the following definitions apply:

   a. unemancipated child is:

      i) a child under age 18 who is living in the same household with a parent or spouse of a parent, or

      ii) a child under age 21 who is living in the same household with a parent or spouse of a parent, if the child is regularly attending a school, college, or university, or is receiving technical training designed to prepare the child for gainful employment.

   b. Ineligible child is a child who is not applying or eligible for SSI.

   c. Ineligible parent/spouse is a parent or spouse who is not applying or eligible for SSI.

3. Countable income is calculated by reducing the gross income by the following allocations and disregards.

    a. Income allocations are the part of the gross income that is allocated to individuals in the home who are not eligible for Supplemental Security Income or Old Age Pension. The allocation reduces the gross income that is deemed available to the applicant/client. The allocation is deducted from the gross income prior to applying the other disregards.

    The allocations are:

        i) An Ineligible Child Allocation is an amount equal to one half the current year's SSI FBR that is disregarded from the ineligible parents' gross income. This allocation is used to meet the needs of ineligible children in the household. This allocation is available for each ineligible child in the home. The amount of the allocation is reduced by any of the ineligible child's own income.

        ii) An Ineligible Parent(s) Allocation is an amount equal to the current year's SSI FBR for a single individual or a couple, as applicable. This amount is used to meet the needs of the ineligible parent(s) in the home with an applicant/client child.

        iii) No allocations are allowed for applicant/recipient spouses who do not have children in the home.

    b. Allocations are applied to the income in the following manner:

        i) Allocation disregards are deducted from unearned income before earned income.

        ii) Ineligible child allocation disregards are deducted from parents' income before any standard disregards are applied.

        iii) Ineligible parent(s) allocation disregards are deducted after any ineligible child allocation disregards and after the standard income disregards.

4. Income disregards

    a. $20 General Income Disregard

        If there is unearned income left after the Ineligible Child and Parent(s) Allocation Disregards are applied, a General Income Disregard of $20 shall be applied as follows:

        i) The first $20 of total available unearned income (except for SSI income) must be disregarded. The remaining amount of unearned income is countable.

        ii) If the client has less than $20 of unearned income, the difference between the gross unearned income and the $20 deduction shall be applied as an earned income disregard, if applicable.

        iii) Only one $20 general income disregard is allowed per couple and is divided between the two spouses. If one of the spouses has no income the other spouse shall get the full $20 disregard.

    b. $65 Plus One Half Remainder Earned Income Disregard

i) If there is earned income left after the Ineligible Child and Parent(s) Allocation Disregards are applied:

1) Deduct the first $65 of all earned income.

2) Divide the remaining income in half.

3) The result is the amount of earned income used for determining eligibility.

c. Child support received by an applicant/recipient child is reduced by one third of the total child support payment. This reduction does not apply to ineligible children when calculating the ineligible child allocation disregard.

d. The first $400 of the gross monthly earned income is exempt for a blind or disabled child who is a student that is regularly attending school. The exemption cannot exceed $1,620 in a calendar year.

e. Title 20 of the Code of Federal Regulations, § 416.1112 (2012) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.100.5.I. Determining Ownership of Income

1. If payment is made solely to one individual, the income shall be considered available income to that individual.

2. If payment is made to more than one individual, the income shall be considered available to each individual in proportion to their interests.

3. In case of a married couple in which there is no document establishing specific ownership interests, one-half of the income shall be considered available to each spouse.

4. Income from the Community Spouse's Monthly Income Allowance, as defined in the spousal protection rules in this volume at 8.100.7.R, is income to the community spouse.

8.100.5.J. Income-Producing Property

1. Net rental income from an exempt home or a life estate interest in an exempt home is countable after the following allowable deductions:

a. Property taxes and insurance

b. Necessary reasonable routine maintenance expenses

c. Reasonable management fee for a professional property manager.

2. Non-business property that is necessary to produce goods or services essential to self- support is excluded up to $6,000.

3. Property used in a trade or business which is essential to self-support is excluded up to a limit of $6,000 if it produces 6% return of the $6,000 excluded value.

8.100.5.K. Department of Veterans Affairs (VA) Payments

The portion of the pension payments for Aid and Attendance (A&A) and Unusual Medical Expenses (UME), as determined by the VA, shall not be considered as income when determining eligibility.

1. The portion of the pension payments for Aid and Attendance (A&A) and Unusual Medical Expenses (UME), as determined by the VA, shall not be used as patient payment to the medical facility:

    a. for a veteran or surviving spouse of a veteran in a medical facility other than State Veterans Home; or

    b. for a veteran or surviving spouse of a veteran in a State Veterans Home with dependents.

2. For a veteran or surviving spouse of a veteran in a State Veterans Home with no dependents the portion of the pension payments for Aid and Attendance (A&A) and Unusual Medical Expenses (UME), as determined by the VA, shall be used as patient payment to the medical facility.

8.100.5.L. Reverse Mortgages

1. In accordance with C.R.S. § 11-38-110, reverse mortgages payments made to a borrower shall not be treated as income for eligibility purposes.

2. Funds remaining the following month after the payment is made will be countable as a resource.

3. Any payments from a reverse mortgage that are transferred to another individual without fair consideration shall be analyzed in accordance with the rules on transfers without fair consideration in the Long-Term Care section and may result in a penalty period of ineligibility.

8.100.5.M. Resource Requirements

1. Consideration of resources: Resources are defined as cash or other assets or any real or personal property that an individual or spouse owns. The resource limit for an individual is $2,000. For a married couple, the resource limit is $3,000. If one spouse is institutionalized, refer to Spousal Protection-Treatment of Income and Resources for Institutionalized Spouses. Effective January 1, 2011, the resource limits for the Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), and Qualified Individuals 1 (QI-1) programs are $8,180 for a single individual and $13,020 for a married individual living with a spouse and no other dependents. The resource limits for the QMB, SLMB, and QI programs shall be adjusted annually by the Centers for Medicare and Medicaid Services on January 1 of each year. These resource limits are based upon the change in the annual consumer price index (CPI) as of September of the previous year. Resources are not counted for the Medicaid Buy-In Program for Working Adults with Disabilities or the Medicaid Buy-In Program for Children with Disabilities.

2. The following resources are exempt in determining eligibility:

    a. A home, which is any property in which an individual or spouse of an individual has an ownership interest and which serves as the individual's principal place of residence. The property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings.

        i) Only one principal place of residence is excluded for a single individual or a married couple.

ii) The individual's ownership interest in the home must have an equity value that:

1) From January 1, 2006 thru December 31, 2010 is $500,000 or less, or;

2) Is less than the amount that results from the year to year percentage increase to the $500,000 limit. The increase is based upon the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

iii) If an individual or spouse of an individual owns a home of any value located outside Colorado, and if the individual intends to return to that home, then the individual does not meet the residency requirement for Colorado Medicaid eligibility.

iv) If an individual or spouse of an individual owns a home of any value located outside Colorado, and if the individual does not intend to return to that home, then the home is a countable resource unless the individual's spouse or dependent relative lives in the home.

v) If an individual or spouse of an individual owns a home located inside Colorado with an equity value lower than the limit in subparagraph (1), above, and if the individual intends to return to that home, then the home is considered an exempt resource if:

1) The individual is institutionalized; and

2) The intent to return home is documented in writing.

vi) If an individual or spouse of an individual owns a home with an equity value greater than the limit that is located inside Colorado, and if the individual intends to return to that home, then the home is considered to be a countable resource unless spouse or dependent relative lives in the home.

vii) If an individual or spouse of an individual owns a home of any value located inside Colorado, and if the individual does not intend to return to that home, then the home is a countable resource unless spouse or dependent relative lives in the home.

viii) If an individual or spouse moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence.

ix) If an individual leaves his or her home to live in an institution, the home shall still be considered the principal place of residence, irrespective of the individual's intent to return as long as the individual's spouse or dependent relative continues to live there.

x) The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

xi) The intent to return home applies to the home in which the individual or spouse of the individual was living prior to being institutionalized or to a replacement home as long as the individual's spouse or dependent relative continues to live in the home.

xii) The intent to return home also applies if the individual is living in an assisted living facility or alternative care facility and receives HCBS while in that facility or transfers into a Long-Term Care institution to receive services.

xiii) For an individual in a Long-Term Care institution, receiving HCBS, or enrolled in PACE, the exemption for the principal place of residence does not apply to a residence which has been transferred to a trust or other entity, such as a partnership or corporation.

1) The exemption shall be regained if the residence is transferred back into the name of the individual.

xiv) The principal place of residence, which is subject to estate recovery, becomes a countable resource upon the execution and recording of a beneficiary deed.

The exemption can be regained if a revocation of the beneficiary deed is executed and recorded.

b. Excess property will not be included in countable resources as long as reasonable efforts to sell it have been unsuccessful. Reasonable efforts to sell means:

i.) The property is listed with a professional such as a real estate agent, broker, dealer, auction house, etc., at current market value.

ii) If owner listed, the property must be for sale at current market value, advertised and shown to the public.

iii) Any reasonable offer must be accepted.

iv) If an offer is received that is at least two-thirds of the current market value, that offer is presumed reasonable.

v) The client must continue reasonable efforts to sell and must submit verification of these efforts to the Eligibility Site on a quarterly basis. Reasonable effort is at Eligibility Site discretion.

vi) If the exemption is used to become eligible under the Spousal Protection rules, the property shall continue to be viewed according to 8.100.7.L while efforts to sell it are being made.

vii) Eligibility under this exemption is conditional. Once the property sells, the client shall be ineligible until the resources are below the prescribed limit.

c. One automobile is totally excluded regardless of its value if it is used for transportation for the individual or a member of the individual's household. An automobile includes, in addition to passenger cars, other vehicles used to provide necessary transportation.

d. Household goods are not counted as a resource to an individual (and spouse, if any) if they are:

i) Items of personal property, found in or near the home, that are used on a regular basis; or

ii) Items needed by the household for maintenance, use and occupancy of the premises as a home.

iii) Such items include but are not limited to: furniture, appliances, electronic equipment such as personal computers and television sets, carpets, cooking and eating utensils, and dishes.

e. Personal effects are not counted as a resource to an individual (and spouse, if any) if they are:

i) Items of personal property ordinarily worn or carried by the individual; or

ii) Articles otherwise having an intimate relation to the individual.

iii) Such items include but are not limited to: personal jewelry including wedding and engagement rings, personal care items, prosthetic devices, and educational or recreational items such as books or musical instruments.

iv) Items of cultural or religious significance to the individual and items required because of an individual's impairment are also not counted as a resource.

f. The cash surrender value of all life insurance policies owned by an individual and spouse, if any, is exempt if the total face value of all life insurance policies does not exceed $1,500 on any person. If the total face value of all the life insurance policies exceeds $1,500 on one person, the cash surrender value of those policies will be counted.

g. Term life insurance having no cash surrender value, and burial insurance, the proceeds of which can be used only for burial expenses, are not countable toward the resource limit.

h. The total value of burial spaces for the applicant/recipient, his/her spouse and any other members of his/her immediate family is exempt as a resource. If any interest is earned on the value of an agreement for the purchase of a burial space, such interest is also exempt.

i. An applicant or recipient may own burial funds through an irrevocable trust or other irrevocable arrangement which are available for burial and are held in an irrevocable burial contract, an irrevocable burial trust, or in an irrevocable trust which is specifically identified as available for burial expenses without such funds affecting the person's eligibility for assistance.

j. An applicant or recipient may also own up to $1,500 in burial funds through a revocable account, trust, or other arrangement for burial expenses, without such funds affecting the person's eligibility for assistance. This exclusion only applies if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual or spouse's burial expenses. Interest on the burial funds is also excluded if left to accumulate in the burial fund. For a married couple, a separate $1,500 exemption applies to each spouse.

The $1,500 exemption is reduced by:

i) the amount of any irrevocable burial funds such as are described in the preceding subparagraph, and

ii) the face value of any life insurance policy whose cash surrender value is exempt.

k. Achieving a Better Life Experience (ABLE) Accounts.

3. Countable resources include the following:

   a. Cash;

   b. Funds held by a financial institution in a checking or savings account, certificate of deposit or money market account;

   c. Current market value of stocks, bonds, and mutual funds;

   d. All funds in a joint account are presumed to be a resource of the applicant or client. If there is more than one applicant or client account holder, it is presumed that the funds in the account belong to those individuals in equal shares. To rebut this presumption, evidence must be furnished that proves that some or all of the funds in a jointly held account do not belong to him or her. To rebut the sole ownership presumption, the following procedure must be followed:

      i) Submit statements from all of the account holders regarding who owns the funds, why there is a joint account, who has made deposits and withdrawals, and how withdrawals have been spent.

      ii) Submit account records showing deposits, withdrawals and interest in the months for which ownership of funds is at issue.

      iii) Correct the account title and submit revised account records showing that the applicant or client is no longer an account holder or separate the funds to show they are solely owned by the individual within 45 days.

   e. Any real property that is subject to a recorded beneficiary deed and on which an estate recovery claim can be made.

   f. For applications filed on or after January 1, 2006, an individual's home if the individual's equity interest in the home exceeds the equity value limit described at 8.100.5.M.2.a.i)1).

   g. Real property not exempt as the principal place of residence and not exempt as income producing property with a value of $6,000 or less, as described at 8.100.5.J.

   h. When the applicant alleges that the sale of real property would cause undue hardship to the co-owner due to loss of housing, all of the following information must be obtained:

      i) The applicant or client's signed statement to that effect.

      ii) Verification of joint ownership.

      iii) A statement from the co-owner verifying the following:

         1) The property is used as his principal place of residence.

         2) The co-owner would have to move if the property were sold.

         3) The co-owner would be unable to buy the applicant or client's interest in the property.

         4) There is no other readily available residence because there is no other affordable housing available or no other housing with the necessary modifications for the co-owner if he is a person with disabilities.

i. Personal property such as a mobile home or trailer or the like, that is not exempt as a principal place of residence or that is not income producing.

j. Personal effects acquired or held for their value or as an investment. Such items can include but are not limited to: gems, jewelry that is not worn or held for family significance, or collectibles.

k. The equity value of all automobiles that are in addition to one exempt vehicle.

l. The cash surrender value of all life insurance policies owned by an individual and spouse is counted if the total face value of all the policies combined exceeds $1,500 on any person.

m. Promissory notes established before April 1, 2006 are treated as follows:

i) The fair market value of a promissory note, mortgage, installment contract or similar instrument is an available countable resource.

ii) In order to determine the fair market value, the applicant shall obtain three estimates of fair market value from a private note broker, who is engaged in the business of purchasing such notes. In order to obtain the estimates and locate willing buyers, the note shall be advertised in a newspaper with state wide circulation under business or investment opportunities.

iii) A note or similar instrument which transferred funds or assets for less than fair consideration shall be considered as a transfer for less than fair consideration and a period of ineligibility shall be imposed.

n. Promissory notes established on or after April 1, 2006 and before March 1, 2007 are treated as follows:

i) The value of a promissory note, loan or mortgage is an available countable resource unless the note, loan or mortgage:

1) Has a repayment term that is actuarially sound based on the individual's life expectancy, found in the tables at 8.100.7.J, for annuities purchased on or after February 8, 2006;

2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

3) Prohibits the cancellation of the balance upon the death of the lender.

ii) The value of a promissory note, loan or mortgage which does not meet the criteria in outlined in 8.100.5.M.3.n.i)1)-3) is the outstanding balance due as of the date of the individual's application for HCBS, PACE or institutional services and is subject to the transfer of assets without fair consideration provisions as outlined in section 8.100.7.F.

o. Promissory notes established on or after March 1, 2007 are treated as follows:

i) The value of a promissory note, loan or mortgage is the outstanding balance due as of the date of the individual's application for HCBS, PACE or institutional services and is an available countable resource, and

ii) A promissory note, loan or mortgage which does not meet the following criteria shall be considered to be a transfer without fair consideration and shall be subject to the provisions outlined at 8.100.7.F.

1) Has a repayment term that is actuarially sound based on the individual's life expectancy as found in the tables in section 8.100.7.J for annuities purchased on or after February 8, 2006;

2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

3) Prohibits the cancellation of the balance upon the death of the lender.

p. Mineral rights represent ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.

i) Ownership of land and mineral rights. If the individual owns the land to which the mineral rights pertain, the current market value of the land generally includes the value of the mineral rights.

ii) If the individual does not own the land to which the mineral rights pertain, the individual should obtain a current market value estimate from a knowledgeable source. Such sources may include:

1) any mining company that holds leases;

2) the Bureau of Land Management;

3) the U.S. Geological Survey.

8.100.5.N. Treatment of Self-Funded Retirement Accounts

1. The following regulations apply to self-funded retirement accounts such as an Individual Retirement Account (IRA), Keogh Plan, 401(k), 403(b) and any other self-funded retirement account.

2. Self-funded retirement accounts in the name of the applicant are countable as a resource to the applicant.

3. Self-funded retirement accounts in the name of the applicant's spouse who is living with the applicant are exempt in determining eligibility for the applicant, except as set forth in 4. below.

4. Self-funded retirement accounts in the name of a community spouse who is married to an applicant who is applying for Long Term Care in a Long Term Care institution, HCBS or PACE, are countable as a resource to the applicant and may be included in the Community Spouse Resource Allowance (CSRA) up to the maximum amount allowable. The terms community spouse and CSRA are further defined in the regulations on Spousal Protection in this volume.

5. The value of a self-funded retirement account is determined as follows:

a. The gross value of the account, less any taxes due, is the amount that is countable as a resource, regardless of whether any monthly income is being received from the account.

b. If the applicant is not able to provide the amount of taxes that are due, the value shall be determined by deducting 20% from the gross value of the account.

8.100.5.O. Treatment of Inheritances

1. An inheritance is cash, other liquid resources, non-cash items, or any right in real or personal property received at the death of another.

2. If an Individual or individual's spouse is the beneficiary of a will, the inheritance is presumed to be available at the conclusion of the probate process or within 6 months if the estate is not in probate.

3. If an individual or individual's spouse is eligible for a family allowance in a probate proceeding, that allowance will be considered available three months after death or when actually available, whichever is sooner.

4. Evidence demonstrating that the inheritance is not available due to probate or other legal restrictions must be provided to rebut the presumption.

8.100.5.P. Treatment of Proceeds from Disposition of Resources

Treatment of proceeds from disposition of resources is determined as follows:

1. The net proceeds from the sale of exempt or non-exempt resources are considered available resources.

2. The net proceeds are the selling price less any valid encumbrances and costs of sale.

3. After deducting any amount necessary to raise the individual's and spouse's resources to the applicable limits, the balance of the net proceeds, in excess of the resource limits, shall be considered available resources. In lieu of terminating eligibility due to excess resources, the client may request that the proceeds be used to reimburse the Medical Assistance Program for previous payments for Medical Assistance.

4. The proceeds from the sale of an exempt home will be excluded to the extent they are intended to be used and are, in fact, used to purchase another home in which the individual, a spouse or dependent child resides, within three months of the date of the sale of the home.

8.100.6 Aged, Blind, and Disabled Medical Assistance Eligibility

8.100.6.A. Aged, Blind, and Disabled (ABD) General Information

1. Medical Assistance for ABD includes SSI eligible individuals, OAP recipients, and the Medicare Savings Program (MSP) individuals. Refer to section 8.100.5 of this volume for income and resource criteria for these categories of assistance.

8.100.6.B. Disability Determinations

1. Beginning on July 1, 2001, the Department or its contractor shall determine whether the client is disabled or blind in accordance with the requirements and procedures set forth elsewhere in this volume and according to Federal regulations regarding disability determinations.

2. A client who disagrees with the decision on disability or blindness shall have the right to appeal that decision to a state-level fair hearing in accordance with the procedures at 8.057.

8.100.6.C. SSI Eligibles

1. Benefits of the Colorado Medical Assistance Program must be provided to the following:

    a. persons receiving financial assistance under SSI;

    b. persons who are eligible for financial assistance under SSI, but are not receiving SSI;

    c. persons receiving SSI payments based on presumptive eligibility for SSI pending final determination of disability or blindness; and persons receiving SSI payments based on conditional eligibility for SSI pending disposal of excess resources.

2. The Department has entered into an agreement with SSA in which SSA shall determine Medical Assistance for all SSI applicants. Medical Assistance shall be provided to all individuals receiving SSI benefits as determined by SSA to be eligible for Medical Assistance.

3. The eligibility sites shall have access to a weekly unmatched listing of all individuals newly approved and a weekly SSI-Cases Denied or Discontinued listing. These lists shall include the necessary information for the eligibility site to authorize Medical Assistance.

4. Medical Assistance shall not be delayed due to the necessity to contact the SSI recipient and obtain third party medical resources.

5. Notification shall be sent to the SSI recipient advising him/her of the approval of Medical Assistance.

6. The SISC Code for this type of assistance is B.

7. Denied or terminated Medical Assistance based on a denial or termination of SSI which is later overturned, must be approved from the original SSI eligibility date.

8. Individuals who remain eligible as SSI recipients but are not receiving SSI payments shall receive Medical Assistance benefits. This group includes persons whose SSI payments are being withheld as a means of recovering an overpayment, whose checks are undeliverable due to change of address or representative payee, and persons who lost SSI financial assistance due to earned income.

9. If the eligibility site obtains information affecting the eligibility of these SSI recipients, they shall forward such information to the local Social Security office.

10. For individuals under 21 years of age who are eligible for or who are receiving SSI, the effective date of Medicaid eligibility shall be the date on which the individual applied for SSI or the date on which the individual became eligible for SSI, whichever is later.

    a. Special Provisions for Infants

        i) For an infant who is eligible for or who is receiving SSI, the effective date of Medicaid eligibility shall be the infant's date of birth if:

            1) the infant was born in a hospital;

            2) the disability onset date, as reported by the Social Security Administration, occurred during the infant's hospital stay; and

3) the infant's date of birth is within three (3) months of the date on which the infant became eligible for SSI

8.100.6.D. Pickle Amendment

1. Beginning July 1977, Medical Assistance must be provided to an individual if their countable income is below the current years SSI standard after a cost of living adjustment (COLA) disregard is applied to their OASDI (excluding Railroad Retirement Benefits) and they meet all other eligibility criteria. This is referred to as Pickle Disregard.

2. The Pickle Disregard applies to an individual who:

   a. lost SSI and/or OAP because of a cost of living adjustment to his/her own OASDI benefits.

   b. lost SSI and/or OAP because a cost of living adjustment to OASDI income deemed from a parent or spouse.

   c. lost OAP and/or SSI due to the receipt of, or increase to, OASDI, and would be eligible for OAP and/or SSI if all COLA'S on the amount that caused them to lose eligibility is disregarded from their current OASDI amount.

8.100.6.E. Pickle Determination

1. To determine eligibility of Medical Assistance recipients to whom the Pickle disregards apply, the eligibility site must:

   a. establish whether the person was eligible for SSI or OAP and, for the same month, was entitled to OASDI;

   b. determine the previous amount of the OASDI that caused them to lose SSI and/or OAP;

   c. determine the current OASDI income;

   d. subtract the previous OASDI income from the current OASDI income to find the cumulative OASDI COLAs since SSI and/or OAP was lost. This is the Pickle Disregard amount;

   e. subtract the Pickle Disregard amount from the current OASDI income to get the countable OASDI income.

2. If the countable OASDI income and all other countable income is less than the current SSI or OAP standard, and the individual meets all other eligibility criteria then medical eligibility must continue or be reinstated.

3. This disregard must also be applied to any OASDI cost of living increases paid to any financially responsible individual such as a parent or spouse whose income is considered in determining the person's continued eligibility for Medical Assistance.

4. The cost of living increase disregard specified in the preceding action must continue to be applied at each eligibility redetermination.

5. An SSI medical only individual who loses SSI due to an OASDI cost-of-living increase shall be contacted by the eligibility site to determine if the individual would continue to remain eligible for

Medical Assistance under the provisions for SSI related cases. The individual must complete an application for assistance to continue receiving benefits.

8.100.6.F. 1972 Disregard Individuals

1. Medical Assistance must be provided to a person who was receiving financial assistance under AND or Aid to the Blind (AB) for August 1972 and who – except for the October 1972 Social Security (includes RRB) 20% increase amount would currently be eligible for financial assistance. This disregard must also be applied to a person receiving Medical Assistance in August 1972 who was eligible for financial assistance but was not receiving the money payment and to a person receiving Medical Assistance as a resident in a medical institution in August 1972.

2. To redetermine the eligibility of Medical Assistance recipients to whom the 1972 disregard applies, the eligibility site must:

    a. review the case against the current applicable program definitions and requirements;

    b. apply the resource and income criteria specified in section 8.100.5;

    c. subtract the 1972 disregard amount from the income;

    d. consider the remainder against the current appropriate SSI benefit level.

8.100.6.G. Individuals Eligible in 1973

1. Medical Assistance must be provided to ABD persons who are receiving mandatory state supplementary payments (SSP). Such persons are those with income below their December 1973 minimum income level (MIL).

2. Medical Assistance must be provided to a person who was eligible for Medical Assistance in December 1973 as an inpatient of a medical facility, who continues to meet the December 1973 eligibility criteria for institutionalized persons and who remains institutionalized.

3. Medical Assistance must be provided to a person who was eligible for Medical Assistance in December 1973 as an “essential spouse” of an AND or AB financial assistance recipient, and who continues to be in the grant and continues to meet the December 1973 eligibility criteria. Except for such persons who were grandfathered-in for continued assistance, essential spouses included in assistance grants after December 1973 are not eligible for Medical Assistance.

8.100.6.H. Eligibility for Certain Disabled Widow(er)s

1. Medical Assistance shall be provided retroactive to July 1, 1986, to qualified disabled widow(er)s who lost SSI and/or state supplementation due to the 1983 change in the actuarial reduction formula prescribed in section 134 of P.L. No. 98 21.

    In order for these widow(er)s to qualify, these individuals must:

    a. have been continuously entitled to Title II benefits since December 1983;

    b. have been disabled widow(er)s in January 1984;

    c. have established entitlement to Title II benefits prior to age 60;

    d. have been eligible for SSI/SSP benefits prior to application of the revised actuarial reduction formula;

e. have subsequently lost eligibility for SSI/SSP as a result of the change in the actuarial table; and

f. reapply for assistance prior to July 1, 1987.

8.100.6.I. Eligibility for Disabled Widow(er)s

1. Effective January 1, 1991, Medical Assistance shall be provided to disabled widow(er)s age 50 through 64 who lost SSI and/or OAP due to the receipt of Social Security benefits as a disabled widow(er). The individual shall remain eligible for Medical Assistance until he/she becomes eligible for Part A of Medicare (hospital insurance).

   To qualify these individuals must:

   a. be a widow(er);

   b. have received SSI in the past;

   c. be at least 50 years old but not 65 years old;

   d. no longer receive SSI payments because of Social Security payments;

   e. not have hospital insurance under Medicare; and,

   f. meet all other Medical Assistance requirements.

8.100.6.J. Disabled Adult Children

1. Medical Assistance shall be provided to an individual aged 18 or older who loses SSI due to the receipt of OASDI drawn from his/her parents' Social Security Number; and:

   a. who was determined disabled prior to the age of 22; and

   b. who is currently receiving OASDI income as a Disabled Adult Child; and

   c. who would continue to be eligible for SSI if:

      i) the current OASDI income of the applicant is disregarded; and

      ii) the resources are below the applicable limit as listed at 8.100.5.M; and

      iii) other countable income is below the current years SSI FBR.

2. Disabled Adult Children are identified by the OASDI Beneficiary Identification Code (BIC) of “C”.

8.100.6.K. Old Age Pension (OAP) Eligibles

1. Individuals that are 65 and over are defined as the OAP-A category. Individuals who attain the age of 60 but not yet 65 are defined as the OAP-B category.

2. Medical Assistance must be provided to persons receiving OAP-A or OAP-B and SSI (SISC B).

3. Medical Assistance must be provided to all OAP-A and OAP-B persons who also meet SSI eligibility criteria but are not receiving a money payment (SISC-B).

4. Medical Assistance must be provided to all OAP-A and OAP-B persons who also meet SSI eligibility criteria except for the level of their income (SISC-B).

5. Medical Assistance must be provided to persons in a facility eligible for Medical Assistance reimbursement whose income is under 300% of the SSI benefit level and who, but for the level of their income, would be eligible for OAP “A” or OAP “B” and SSI financial assistance. This group includes persons 65 years of age or older receiving active treatment as inpatients in a psychiatric facility eligible for Medical Assistance reimbursement (SISC A). This population is referenced as Psych >65.

6. The OAP B individual included in AFDC assistance unit shall receive Medical Assistance as a member of the AFDC household (SISC B).

7. The OAP State Only Medical Assistance Program provides Medical Assistance to OAP-A, OAP-B or OAP Refugees who lost their OAP financial assistance because of a cost of living adjustment other than OASDI. Examples of other sources of income are VA, RRB, PERA, etc. (SISC C).

8. For the purpose of identifying the proper SISC code for persons receiving assistance under OAP “A” or OAP “B”, if the person:

    a. receives an SSI payment (SISC B);

    b. does not receive an SSI payment but is receiving assistance under OAP “A”, a second evaluation of resources must be made using the same resource criteria as specified in section 8.100.5.M for those who meet this criteria the SISC code is B for money payment and “disregard” case, A for institutional cases;

    c. does not receive an SSI payment and does not otherwise qualify under SISC code B or A as described in item b. above (SISC C).

8.100.6.L. Qualified Medicare Beneficiaries (QMB)

1. Medical Assistance coverage for QMB clients is payment of Medicare part B premiums, co-insurance and deductibles.

2. Effective July 1, 1989, a Qualified Medicare Beneficiary is an individual who:

    a. is entitled to Part A Medicare; and

    b. resources may not exceed the standard for an individual or couple who have resources, as described in section 8.100.5.M; and

    c. has income at or below the percentage of the federal poverty level for the size family as mandated for QMB by federal regulations. Poverty level is established by the Executive Office of Management and Budget.

3. For QMB purposes, couples shall have their income compared against the federal poverty level couples income maximum. This procedure shall be applied whether one or both members apply for QMB.

4. For QMB purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.

5. Medicare cost sharing expenses must be provided to qualified Medicare beneficiaries. This limited Medical Assistance package of Medicare cost sharing expenses only includes:

   a. payment of Part A Medicare premiums where applicable;

   b. payment of Part B Medicare premiums; and

   c. payment of coinsurance and deductibles for Medicare services whether or not a benefit of Medical Assistance up to the full Medicare rate or reasonable rates as established in the State Plan.

6. Individuals may be QMB recipients only or the individual may be classified as a dual eligible. A dual eligible is a Medicare recipient who is otherwise eligible for Medical Assistance.

7. A QMB-only recipient is an individual who is not eligible for other categorical assistance program due to their income and/or resources but who meets the eligibility criteria for QMB described above.

8. Individuals who apply for QMB assistance have the right to have their eligibility determined under all categories of assistance for which they may qualify.

9. All other general non-financial requirements or conditions of eligibility must also be met such as age, citizenship, residency requirements as well as reporting and redetermination requirements. These criteria are defined in section 8.100.3 of this volume.

10. Eligibility for QMB benefits shall be effective the month following the month of determination. Beneficiaries who submit and complete an application within the 45-day standard shall be eligible for benefits no later than the first of the month following the 45th day of application. Administrative delays shall not postpone the effective date of eligibility.

11. QMB benefits are not retroactive and the three month retroactive Medical Assistance rule does not apply to QMB benefits.

12. Clients who would lose their QMB entitlement due to annual social security COLA will remain eligible for QMB coverage under Medical Assistance, as income disregard cases, until the next year's federal poverty guidelines are published.

8.100.6.M. Specified Low Income Medicare Beneficiaries

1. Medical Assistance coverage for SLMB clients is limited to payment of monthly Medicare Part B (Supplemental Medical Insurance Benefits) premiums.

2. Effective January 1, 1993, a Specified Low Income Medicare Beneficiary (SLMB) is an individual who:

   a. is entitled to Medicare Part A;

   b. resources may not exceed the standard for an individual or couple who has resources as described in section 8.100.5.M of this volume.

   c. has income at or below a percentage of the federal poverty level for the family size as mandated by federal regulations for SLMB. Income limits have been defined through CY 1995, as follows: CY 1993 and 1994 100-110% of FPL, CY 1995 100-120% of FPL.

3. For SLMB purposes, couples shall have their income compared against the federal poverty level couples income maximum. This procedure shall be applied whether one or both members apply for SLMB.

4. For SLMB purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.

5. SLMB eligibility starts on the date of application or up to three month prior to the application date for retroactive Medical Assistance.

6. Eligibility may be made retroactive up to 90 days, but may not be effective prior to 1/1/93.

7. Clients who would lose their SLMB entitlement due to annual SSA COLA will remain eligible for SLMB coverage, as income disregard cases, through the month following the month in which the annual federal poverty levels (FPL) update is published.

8.100.6.N. Medicare Qualifying Individuals 1 (QI1)

1. Medical Assistance coverage is limited to monthly payment of Medicare Part B premiums. Payment of the premium shall be made by the Department on behalf of the individual.

2. Eligibility for this benefit is limited by the availability of the allocation set by CMS. Once the state allocation is met, no further benefits under this category shall be paid and a waiting list of eligible individuals shall be maintained.

3. Eligibility for QI1 benefits shall be effective the month in which application is made and the individual is eligible for benefits. Eligibility may be retroactive up to three months from the date of application, but not prior to January 1, 1998.

4. In order to qualify as a Medicare Qualifying Individual 1, the individual must meet the following:

    a. be entitled to Part A of Medicare,

    b. income of at least 120%, but less than 135% of the FPL.

    c. resources may not exceed the standard as described in section 8.100.5.M, and

    d. he/she cannot otherwise be eligible for Medical Assistance.

5. For QI1 purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.

6. Clients who would lose QI-1 entitlement due to annual social security COLA will remain eligible for QI-1 coverage under Medical Assistance, as an income disregard case, until the next year's federal poverty guidelines are published.

8.100.6.O. Qualified Disabled And Working Individuals

1. Medical Assistance coverage is limited to monthly payment of Medicare Part A premiums, and any other Medicare cost sharing expenses determined necessary by CMS.

2. Effective July 1, 1990, a Qualified Disabled and Working Individual (QDWI) is an individual who:

   a. was a recipient of federal Social Security Disability Insurance (SSDI) benefits, who continues to be disabled but lost SSDI entitlement due to earned income in excess of the Social Security Administration's Substantial Gainful Activity (SGA) threshold, and;

   b. has exhausted SSA's allowed extension of “premium free” Medicare Part A coverage under SSDI, and;

   c. has resources at or below twice the SSI resource limit as described in section 8.100.5., and;

   d. has income less than 200% of FPL.

3. For QDWI purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.

4. An individual may be eligible under this section only if he/she is not otherwise eligible under another Medical Assistance category of eligibility.

5. Eligibility for QDWI benefits shall be effective the month of determination of entitlement.

6. Eligibility may be retroactive only to the date as of which SSA approves an individual's application for coverage as a “Qualified Disabled and Working Individual”. However, eligibility may not begin prior to 07/01/90.

8.100.6.P. Medicaid Buy-In Program for Working Adults with Disabilities.

1. To be eligible for the Medicaid Buy-In Program for Working Adults with Disabilities:

   a. Applicants must be at least age 16 but less than 65 years of age.

   b. Income must be less than or equal to 450% of FPL after income allocations and disregards. See 8.100.5.F for Income Requirements and 8.100.5.H for Income allocations and disregards. Only the applicant’s income will be considered.

   c. Resources are not counted in determining eligibility.

   d. Individuals must have a disability as defined by Social Security Administration medical listing or a limited disability as determined by a state contractor.

   e. Individuals must be employed. Please see Verification Requirements at 8.100.5.B.1.c.

      i) Due to the federal COVID-19 Public Health Emergency, and required by the Federal CARES Act for the Maintenance of Effort (MOE), members who had a loss of employment will remain in the Buy-In program until the end of the federal Public Health Emergency. At the end of the federal Public Health Emergency, members will be redetermined based on their current employment status. New applicants enrolled will still need to meet the work requirement.

   f. Individuals will be required to pay monthly premiums on a sliding scale based on income.

i) The amount of premiums cannot exceed 7.5% of the individual's income.

ii) Premiums are charged beginning the month after determination of eligibility. Any premiums for the months prior to the determination of eligibility will be waived.

iii) Premium amounts are as follows:

1) There is no monthly premium for individuals with income at or below 40% FPL.

2) A monthly premium of $25 is applied to individuals with income above 40% of FPL but at or below 133% of FPL.

3) A monthly premium of $90 is applied to individuals with income above 133% of FPL but at or below 200% of FPL.

4) A monthly premium of $130 is applied to individuals with income above 200% of FPL but at or below 300% of FPL.

5) A monthly premium of $200 is applied to individuals with income above 300% of FPL but at or below 450% of FPL./

iv) The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause the premium amount (based on percentage of income) to increase by $10 or more.

v) A change in client net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in client's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due.

vi) Due to the federal COVID-19 Public Health Emergency, the Department will waive premiums for the Medicaid Buy-In for Working Adults with Disability Program during the federal COVID-19 emergency declaration. Once the federal emergency declaration has concluded, the Department will notify all members as to when required premiums will resume.

2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation

3. Individuals have the option to request to be disenrolled if they have been enrolled into the Medicaid Buy-In Program for Working Adults with Disabilities. This is also called "opt out."

8.100.6.Q. Medicaid Buy-In Program for Children with Disabilities

1. To be eligible for the Medicaid Buy-In Program for Children with Disabilities:

a. Applicants must be age 18 or younger.

b. Household income will be considered and must be less than or equal to 300% of FPL after income disregards. The following rules apply:

i) 8.100.4.E - MAGI Household Requirements

ii) 8.100.5.F - Income Requirements

iii) 8.100.5.F.6 - Income Exemptions

iv) An earned income of $90 shall be disregarded from the gross wages of each individual who is employed

v) A disregard of a 33% (.3333) reduction will be applied to the household's net income.

c. Resources are not counted in determining eligibility.

d. Individuals must have a disability as defined by Social Security Administration medical listing.

e. Children age 16 through 18 cannot be employed. If employed, children age 16 through 18 shall be determined for eligibility through the Medicaid Buy-In Program for Working Adults with Disabilities.

f. Families will be required to pay monthly premiums on a sliding scale based on household size and income.

i) For families whose income does not exceed 200% of FPL, the amount of premiums and cost-sharing charges cannot exceed 5% of the family's adjusted gross income. For families whose income exceeds 200% of FPL but does not exceed 300% of FPL, the amount of premiums and cost-sharing charges cannot exceed 7.5% of the family's adjusted gross income.

ii) Premiums are charged beginning the month after determination of eligibility. Any premiums for the months prior to the determination of eligibility will be waived.

iii) For households with two or more children eligible for the Medicaid Buy-In Program for Children with Disabilities, the total premium shall be the amount due for one eligible child.

iv) Premium amounts are as follows:

1) There is no monthly premium for households with income at or below 133% of FPL.

2) A monthly premium of $70 is applied to households with income above 133% of FPL but at or below 185% of FPL.

3) A monthly premium of $90 is applied to individuals with income above 185% of FPL but at or below 250% of FPL.

4) A monthly premium of $120 is applied to individuals with income above 250% of FPL but at or below 300% of FPL.

v) The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause the premium amount (based on percentage of income) to increase by $10 or more.

vi) A change in household net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium

due date will result in client's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due.

vii) Due to the federal COVID-19 Public Health Emergency, the Department will waive premiums for the Department's Children with Disabilities Program during the federal emergency declaration. Once the federal emergency declaration has concluded, the Department will notify all members as to when required premiums will resume.

2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation.

3. Verification requirements will follow the MAGI Category Verification Requirements found at 8.100.4.B.

4, Individuals have the option to request to be disenrolled if they have been enrolled into the Medicaid Buy-In Program for Children with Disabilities. This is also called "opt out."

8.100.7 Long-Term Care Medical Assistance Eligibility

8.100.7.A. Persons in Long-Term Care Institutions or Other Residential Placement

1. For Long-Term Care services to be covered in a Long-Term Care institution, a client must be determined eligible under the 300% Institutionalized Special Income category. If the client is already Medicaid eligible, a new application is not required but the client must be determined to meet the eligibility criteria.

   For a client entering a Long-Term Care Institution from the community, the Eligibility Site must notify the Single Entry Point/Case Management Agency, upon receipt of the application or client request, to schedule the institutional level of care assessment. This is not applicable to a client being discharged from a hospital, nursing facility or Long-Term Home Health.

   For purposes of applying the special income standard for the aged, disabled or blind persons in Long-Term Care Institutions, gross income means income before application of deductions, exemptions or disregards appropriate to the SSI program.

   Medical Assistance will be provided beginning the first day of the month following the month during which a child under the age of 18 ceases to live with his or her parent(s). Once determined to meet the institutional requirement, parental income and resources will cease to be deemed available to the child because the child is institutionalized and not living in the parents' home.

2. Eligibility under the 300% Institutionalized Special Income category will be provided to applicants who:

   a. Have attained the age of 65 years or;

   b. Have met the requirements according to the definition of disability or blindness applicable to the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)

   c. Have been institutionalized for at least 30 consecutive full days in a Long-Term Care institution. The 30 consecutive full day stay may be a combination of days in a hospital, Long-Term Care institution, or receiving services from a Home and Community Based Services (HCBS) program or Program of All Inclusive Care for the Elderly (PACE).

Supporting documentation must be provided which verifies the 30 consecutive full days. This documentation shall include the ULTC 100.2 and/or medical records which must be verified by a physician or case manager.

If a client dies prior to the 30th consecutive full day, the client shall be determined to have met the 30 consecutive full day requirement if:

i) There is a statement from a physician, or case manager that declares if the client had not died, he/she would have been institutionalized for 30 consecutive full days, and;

ii) The statement is verified by supporting documentation from the beginning of the institutionalized period, which is the first 15 days, or prior to the death of the client, whichever is earliest.

iii) Once the 30 consecutive days of institutionalization requirement has been met, Medical Assistance benefits start as of the first day when institutionalization began if all other eligibility requirements were met as of that date.

d. Are in a facility eligible for Medical Assistance Program reimbursement if the individual is in a hospital or Long-Term Care institution; and

e. Have gross income that does not exceed 300% of the current individual SSI benefit level or;

Are in a Long-Term Care institution (excluding hospital) whose gross income exceeds the 300% level and who establishes an income trust in accordance with the rules on income trusts in section 8.100.7 of this volume;

i) This special income standard must be applied for:

1) A person 65 years of age or older, or disabled or blind receiving care in a hospital, nursing facility; or

2) A person who is not SSI eligible needing Long-Term Care from HCBS or PACE; or

3) A person 65 years of age or older receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement; and

f. Have resources that conform with the regulations regarding resource limits and exemptions set forth in section 8.100.5 of this volume; and

g. If married, Income and resources conform to rules set forth at 8.100.7.C and 8.100.7.K; and

h. Have not transferred assets without fair consideration on or after the look-back date defined in section 8.100.7.F.2.d. which would incur a penalty period of ineligibility in accordance with the regulations on transfers without fair consideration in section 8.100.7 of this volume; and

i. Have submitted trust documents to the Department if the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of trust. The Department shall determine the effect of the trust on Medical Assistance Program eligibility.

j. Have submitted documents verifying that an annuity conforms to the regulations regarding Annuities at 8.100.7.I.

3. An appeal process is available to children identified by C.R.S. 27-10.3-101 to 108, The Child Mental Health Treatment Act, who are denied residential treatment. The appeal process is outlined in the Income Maintenance Staff Manual of the Department of Human Services (9 CCR 2503-1). A determination made in connection with this appeal shall not be the final agency action with regard to Medical Assistance eligibility

8.100.7.B. Persons Requesting Long-term Care through Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE)

1. HCBS or PACE shall be provided to persons who have been assessed by the Single Entry Point/Case Management Agency to have met the functional level of care and will remain in the community by receiving HCBS or PACE; and

   a. are SSI (including 1619b) or OAP Medicaid eligible; or

   b. are eligible under the Institutionalized 300% Special Income category described at 8.100.7.A; or

   c. are eligible under the Medicaid Buy-In Program for Working Adults with Disabilities described at 8.100.6.P. For this group, access to HCBS:

      i) Is limited to the Elderly, Blind and Disabled (EBD), Community Mental Health Supports (CMHS), Brain Injury (BI), Spinal Cord Injury (SCI) and Supported Living Services (SLS) waivers; and

      ii) Is contingent on the Department receiving all necessary federal approval for the waiver amendments that extend access to HCBS to the Working Adults with Disabilities population described at 8.100.6.P.

2. A client who is already Medicaid eligible does not need to submit a new application. The client must request the need for Long-Term Care services and the Eligibility Site must redetermine the client's eligibility.

   a. All individuals applying for or requesting Long-Term Care services must disclose and provide documentation of:

      i) any transfer of assets without fair consideration as described at 8.100.7.F; and

      ii) any interest in an annuity as described at 8.100.7.I; and

      iii) any interest in a trust as described at 8.100.7.E.

   b. Failure to disclose and provide documentation of the assets described at 8.100.7.B.2.a may result in the denial of Long-Term Care services.

   c. The requirements at 8.100.7.B.2.a and 8.100.7.B.2.b do not apply to individuals who have been determined eligible under the Medicaid Buy-In Program for Working Adults with Disabilities described at 8.100.6.P.

3. For individuals served in Alternative Care Facilities (ACF), income in excess of the personal needs allowance and room and board amount for the ACF shall be applied to the Medical

Assistance charges for ACF services. The total amount allowed for personal need and room and board cannot exceed the State's Old Age Pension Standard.

8.100.7.C. Treatment of Income and Resources for Married Couples

1. The income of a community spouse is not deemed to the institutionalized spouse in determining eligibility. If both spouses are institutionalized, their individual income is counted in determining their own eligibility. The income of one institutionalized spouse is not deemed to the other institutionalized spouse when determining eligibility.

2. The income and resources of both spouses are counted in determining eligibility for either or both spouses with the following exceptions:

    a. If spouses share the same room in an institution, the income of the individual spouse is counted in determining his or her eligibility, and each spouse is allowed the $2000 limit for resources.

    b. Beginning the first month following the month the couple ceases to live together, only the income of the individual spouse is counted in determining his or her eligibility.

    c. If one spouse is applying for Long-Term Care in a Long-Term Care institution or Home and Community Based Services (HCBS), refer to the rules on Treatment of Income and Resources for Institutionalized Spouses.

3. Long term care insurance benefits are not countable as income, but are payable as part of the patient payment to the Long-Term Care institution.

4. For living expense purposes, income and resources of spouses living in the same household for a full calendar month or more must be considered as available to each other, whether or not they are actually contributed, and must be evaluated in accordance with rules contained in 8.100.7.Q.

Long-Term Care

8.100.7.D. Other Medical Assistance Clients Requesting Long-Term Care in an Institution or through HCBS or PACE

Clients who need Long-Term Care services who are eligible for the State Only Health Care Program shall submit an application because they are not already Medicaid eligible.

8.100.7.E Consideration of Trusts in Determining Medical Assistance Eligibility

1. Trusts established before August 11, 1993:

    a. Medical Assistance Qualifying Trust (MQT)

        i) In the case of a Medical Assistance qualifying trust, as defined in 42 U.S.C. Sec. 1396a(k), the amount of the trust property that is considered available to the applicant/recipient who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual assuming the full exercise of discretion by the trustee(s) for the distribution of the maximum amount to the applicant/recipient. This amount of property is deemed available resources to the individual, whether or not is actually received.

ii) 42 U.S.C. Sec. 1396a(k) was repealed in 1993 and is reprinted here exclusively for purposes of trusts established before August 11, 1993. 42 U.S.C. Sec. 1396a(k) defines a Medical Assistance qualifying trust as “a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.”

b. This provision does not apply to any trust or initial decrees established before April 7, 1986, solely for the benefit of a developmentally disabled individual who resides in an Long Term Care Institution for the developmentally disabled.

c. This provision does not apply to individuals who are receiving SSI.

2. Trusts established on or after July 1, 1994:

Assets include all income and resources of the individual and the individual's spouse, including all income and resources which the individual or the individual's spouse is entitled to but does not receive because of action by any of the following:

a. The individual or the individual's spouse,

b. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual’s spouse, or

c. Any person court or administrative body acting at the direction of or upon the request of the individual or the individual's spouse.

3. In determining an individual's eligibility for Medical Assistance, the following regulations apply to a trust established by an individual:

a. An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust, and if any of the following individuals established the trust, other than by will:

i) The individual or the individual's spouse

ii) A person, including a court or administrative body, with legal authority to act in place of, or on the behalf of, the individual or the individual's spouse;

iii) A person, including a court or administrative body acting at the direction or upon the request of the individual or the individual's spouse.

b. In the case of a trust, the corpus of which includes assets of an individual and the assets of any other person(s), this regulation shall apply to the portion of the trust attributable to the assets of the individual.

c. These regulations apply without regard to the following:

i) The purposes for which a trust is established;

ii) Whether the trustees have or exercise any discretion under the trust;

iii) Any restrictions on when or whether distributions may be made from the trust; or

iv) Any restrictions on the use of distributions from the trust.

4. Revocable Trusts are considered as follows:

a. The corpus of the trust shall be considered resources available to the individual.

b. Payments from the trust to or for the benefit of the individual shall be considered income to the individual, and

c. Any other payments from the trust shall be considered assets transferred by the individual for less than fair market value and are subject to a 60 month look back period and a penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume.

5. Irrevocable Trusts

If there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the following shall apply:

a) The portion of the corpus of the trust, or the income on the corpus, from which payment to the individual could be made, shall be considered as resources available to the individual.

b) Payments from that portion of the corpus, or income to or for the benefit of the individual, shall be considered income to the individual.

c) Payments from that portion of the corpus or income for any other purpose shall be considered as a transfer of assets by the individual for less than fair market value and are subject to a 60 month look back period and a penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume.

d) Any portion of the trust from which, or any income on the corpus from which no payment could be made to the individual under any circumstances, shall be considered as a transfer of assets for less than fair market value and shall be subject to a 60 month look back period and penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume. The transfer will be effective as of the date of the establishment of the trust, or the date on which payment to the individual from the trust was foreclosed, if later. The value of the trust shall be determined by including the amount of any payments made from such portion of the trust after such date.

6. The preceding regulations for trusts established on or after July 1, 1994, do not apply to the following:

a. Income Trusts

i) A trust consisting only of the individual's pension income, social security income and other monthly income that is established for the purpose of establishing income eligibility for Long Term Care institution care or Home and Community Based Services (HCBS). To be valid, the trust must meet the following criteria:

a) The individual's gross monthly income must be above the 300%-SSI limit but below the average cost of private Long Term Care institution care in the geographic region in which the individual resides and intends to remain. The Colorado Department of Health Care Policy and Financing shall calculate the average rates for such regions on an annual, calendar-year basis. The geographic regions which are used for calculating the average private pay rate for Long Term Care institution care shall be based on the Bureau of Economic Analysis Regions and consist of the following counties:

REGION I: (Adams, Arapahoe, Boulder, Broomfield, Denver, Jefferson)

REGION II: (Cheyenne, Clear Creek, Douglas, Elbert, Gilpin, Grand, Jackson, Kit Carson, Larimer, Logan, Morgan, Park, Phillips, Sedgwick, Summit, Washington, Weld, Yuma)

REGION III: (Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, El Paso, Fremont, Huerfano, Kiowa, Lake, Las Animas, Lincoln, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache, Teller)

REGION IV: (Archuleta, Delta, Dolores, Eagle, Garfield, Gunnison, Hinsdale, La Plata, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel)

b) For Long Term Care institution clients, each month the trustee shall distribute the entire amount of income which is transferred into the trust. An amount not to exceed $20.00 may be retained for trust expenses such as bank charges if such charges are expected to be incurred by the trust.

c) The only deductions from the monthly trust distribution to the Long Term Care institution are the allowable deductions which are permitted for Medical Assistance-eligible persons who do not have income trusts. Allowable deductions include only the following:

i) Personal need allowance

ii) Spousal income payments

iii) Approved PETI payments

d) Any funds remaining after the allowable deductions shall be paid solely to the cost of the Long Term Care institution care in an amount not to exceed the Medical Assistance reimbursement rate. Any excess income which is not distributed shall accumulate in the trust.

e) No other deductions or expenses may be paid from the trust. Expenses which cannot be paid from the trust include, but are not limited to, trustee fees, attorney fees and costs (including attorney fees and costs incurred in establishing the trust), accountant fees, court fees and costs, fees for guardians ad litem, funeral expenses, past-due medical bills and other

debts. Trustee fees which were ordered prior to April 1, 1996 may continue until the trust terminates.

f) For HCBS clients, the amount distributed each month shall be limited to the 300% of the SSI limit. Any monthly income above that amount shall remain in the trust. An amount not to exceed $20.00 may be retained for trust expenses such as bank charges if such charges are expected to be incurred by the trust. No other trust expenses or deductions may be paid from the trust. For the purpose of calculating Individual Cost Containment or client payment (PETI), the client's monthly income will be 300% of the SSI limit. Upon termination, the funds which have accumulated in the trust shall be paid to the Department up to the total amount of Medical Assistance paid on behalf of the individual.

g) For a court-approved trust, notice of the time and place of the hearing, with the petition and trust attached, shall be given to the eligibility site and the Department in the manner prescribed by law.

h) The sole beneficiaries of the trust are the individual for whose benefit the trust is established and the Department. The trust terminates upon the death of the individual or if the trust is not required for Medical Assistance eligibility in Colorado.

i) The trust must provide that upon the death of the individual or termination of the trust, whichever occurs sooner, the Department shall receive all amounts remaining in the trust up to the total amount of Medical Assistance paid on behalf of the individual.

j) The trust must include the name and mailing address of the trustee. The trustee must notify the Department of any trustee address changes or change of trustee(s) within 30 calendar days.

k) The trust must provide that an annual accounting of trust income and expenditures and an annual statement of trust assets shall be submitted to the eligibility site or to the Department upon reasonable request or upon any change of trustee.

l) The amount remaining in the trust and an accounting of the trust shall be due to the Department within three months after the death of the individual or termination of the trust, whichever is sooner. An extension of time may be granted by the Department if a written request is submitted within two months of the termination of the trust.

m) The regulations in this section for income trusts shall also apply to income trusts established after January 1, 1992, under the undue hardship provisions in 26-4-506.3(3),C.R.S. and 15-14-412.5,C.R.S.

b. Disability Trusts

i) A trust that is established solely for the benefit of a disabled individual under the age of 65, which consists of the assets of the individual, and is established for the purpose or with the effect of establishing or maintaining the individual's resource eligibility for Medical Assistance and which meets the following criteria:

a) The individual for whom the trust is established must meet the disability criteria of Social Security.

b) The only assets used to fund the trust are (1) the proceeds from any personal injury case brought on behalf of the disabled individual, or (2) retroactive payments of SSI benefits under Sullivan v. Zebley. (This provision is applicable to disability trusts established from July 1, 1994 to December 31, 2000.)

c) The trust is established solely for the benefit of the disabled individual by the individual, the individual's parent, the individual's grandparent, the individual's legal guardian, or by the court.

d) The sole lifetime beneficiaries of the trust are the individual for whose benefit the trust is established and the Colorado Department of Health Care Policy and Financing

e) The trust terminates upon the death of the individual or if the trust is no longer required for Medical Assistance eligibility in Colorado.

f) Any statutory lien pursuant to section 25.5-4-301(5), C.R.S. must be satisfied prior to funding of the trust and approval of the trust.

g) If the trust is funded with an annuity or other periodic payments, the Department shall be named on the contract or settlement as the remainder beneficiary up to the amount of Medical Assistance paid on behalf of the individual.

h) The trust shall provide that, upon the death of the beneficiary or termination of the trust, the Department shall receive all amounts remaining in the trust up to the amount of total Medical Assistance paid on behalf of the individual.

i) No expenditures may be made after the death of the beneficiary, except for federal and state taxes. However, prior to the death of the individual beneficiary, trust funds may be used to purchase a burial fund for the beneficiary.

j) The amount remaining in the trust and an accounting of the trust shall be due to the Department within three months after the death of the individual or termination of the trust, whichever is sooner. An extension of time may be granted by the Department if a written request is submitted within two months of the termination of the trust.

k) The trust fund shall not be considered as a countable resource in determining eligibility for Medical Assistance.

l) [Rule 8.110.52 B 5. b. 1) l), adopted or amended on or after November 1, 2000 and before November 1, 2001 was not extended by HB 02-1203, and therefore expired May 15, 2002.]

m) Distributions from the trust may be made only to or for the benefit of the individual beneficiary. Cash distributions from the trust shall be considered income to the individual. Distributions for food or shelter are considered in-kind income and are countable toward income eligibility.

n) If exempt resources are purchased with trust funds, those resources continue to be exempt. If non-exempt resources are purchased, those resources are countable toward eligibility.

o) The trust must include the name and mailing address of the trustee. The Department must be notified of any trustee address changes or change of trustee(s) within 30 calendar days.

p) The trust must provide that an annual accounting of trust income and expenditures and an annual statement of trust assets shall be submitted to the eligibility site or to the Department upon reasonable request or upon any change of trustee.

q) Prior to the establishment or funding of a disability trust, the trust shall be submitted for review to the Department, along with proof that the individual beneficiary is disabled according to Social Security criteria. No disability trust shall be valid unless the Department has reviewed the trust and determined that the trust conforms to the requirements of 15-14-412.8,C.R.S., as amended, and any rules adopted by the Medical Services Board.

c. Pooled Trusts

i) A trust consisting of individual accounts established for disabled individuals for the purpose of establishing resource eligibility for Medical Assistance. A valid pooled trust shall meet the following criteria:

a) The individual for whom the trust is established must meet the disability criteria of Social Security.

b) The trust is established and managed by a non-profit association which has been approved by the Internal Revenue Service.

c) A separate account is maintained for each beneficiary; however, the trust pools the accounts for the purposes of investment and management of the funds.

d) The sole lifetime beneficiaries of each trust account are the individual for whom the trust is established and the Department.

e) If the trust is funded with an annuity or other periodic payments, the Department or the pooled trust shall be named as remainder beneficiary.

f) The trust account shall be established by the disabled individual, parent, grandparent, legal guardian, or the court.

g) The only assets used to fund each trust account are (1) the proceeds from any personal injury case brought on behalf of the disabled individual, or (2) retroactive payments of SSI benefits under Sullivan v. Zeblev . (This provision is applicable to pooled trusts established from July 1, 1994 to December 31, 2000.)

h) Any statutory lien pursuant to section 25.5-4-301(5), C.R.S. must be satisfied prior to funding of the individual's trust account and approval of the joinder agreement.

i) Following the disabled individual's death or termination of the trust account, whichever occurs sooner, to the extent that the remaining funds in the trust account are not retained by the pooled trust, the Department shall receive any amount remaining in the individual's trust account up to the total amount of Medical Assistance paid on behalf of the individual.

j) The pooled trust account shall not be considered as a countable resource in determining Medical Assistance eligibility.

k) Distributions from the trust account may be made only to or for the benefit of the individual. Cash distributions to the individual from the trust shall be considered as income to the individual. Distributions for food or shelter are considered in-kind income and are countable toward income eligibility.

l) If exempt resources are purchased with trust funds, those resources continue to be exempt. If non-exempt resources are purchased, those resources are countable toward resource eligibility.

ii) If an institutionalized individual for whom a pooled trust is established is 65 years of age or older, the transfer of assets into the pooled trust creates a rebuttable resumption that the assets were transferred without fair consideration and shall be analyzed in accordance with the rules on transfers without fair consideration in this volume. This regulation is effective for transfers to pooled trusts after January 1, 2001.

iii) When the individual beneficiary of an income, disability or pooled trust dies or the trust is terminated, the trustee shall promptly notify the eligibility site and the Department. To the extent required by these rules the trustee shall promptly forward the remainder of the trust property to the Department, up to the amount of Medical Assistance paid on behalf of the individual beneficiary.

d. Third Party Trusts

i) Third party trusts are trusts which are established with assets which are contributed by individuals other than the applicant or the applicant's spouse for the benefit of an applicant or client

ii) The terms of the trust will determine whether the trust fund is countable as a resource or income for Medical Assistance eligibility.

iii) Trusts which limit distributions to non-support or supplemental needs will not be considered as a countable resource. If distributions are made for income or resources, such distributions are countable as such for eligibility.

iv) If the trust requires income distributions, the amount of the income shall be countable as income in determining eligibility.

v) If the trust requires principal distributions, that amount shall be considered as a countable resource.

vi) If the trustee may exercise discretion in distributing income or resources, the income or resources are not countable in determining eligibility. If distributions are made for income or resources, such distributions are countable as such for eligibility.

e. Federally Approved Trusts

i) If an SSI recipient has a trust which has been approved by the Social Security Administration, eligibility for Medical Assistance cannot be delayed or denied. Individuals on SSI are automatically eligible for Medical Assistance despite the existence of a federally approved trust.

ii) If the eligibility site has a copy of a federally approved trust, the eligibility site must send a copy to the Department.

7. Submission of Trust Documents and Records

a. The trustee of a trust which was established by or which benefits a Medical Assistance Applicant or client shall submit trust documents and records to the eligibility site and to the Department.

b. This requirement includes documents and records for income trusts, disability trusts and the joinder agreement for each pooled trust account.

c. The eligibility site shall submit any trust which is submitted with an application or at redetermination to The Department. The eligibility site shall determine Medical Assistance eligibility based on the determination of The Department as to the effect of the trust on eligibility.

8.100.7.F. Transfers of Assets Without Fair Consideration

1. Definitions. The following definitions apply to transfers of assets without fair considerations:

a. “Assets” include all income and resources of the individual and such individual's spouse, including any interest in income or a resource as well as all income or resources which the individual or such individual's spouse is entitled to but does not receive because of action by any of the following:

i) The individual or such individual's spouse,

ii) A person, a court, or administrative body with legal authority to act on behalf of the individual or such individual's spouse, or

iii) Any person, court or administrative body acting at the direction of or upon the request of the individual or such individual's spouse.

b. “Fair market value” is the value of the asset if sold at the prevailing price at the time it was transferred.

c. “Fair consideration” is the amount the individual receives in exchange for the asset that is transferred, which is equal to or greater than the value of the transferred asset.

d. “Look-back period” means the number of months prior to the month of application for long-term care services that the Department will consider for transfer of assets.

e. “Penalty period” means a period of time for which an applicant or client will not be eligible to receive long-term care services.

f. “Uncompensated value” shall mean the fair market value of an asset at the time of the transfer minus the value of compensation the individual receives in exchange for the asset.

g. “Valuable consideration” shall mean what an individual receives in exchange for his or her right or interest in an asset which has a tangible and/or intrinsic value to the individual that is equivalent to or greater than the value of the transferred asset.

2. General Provisions

If an institutionalized individual or the spouse of such individual disposes of assets without fair consideration on or after the look-back period, the individual shall be subject to a period of ineligibility for Long-Term Care services, including Long-Term Care institution care, Home and Community Based Services (HCBS), and the Program of All Inclusive Care for the Elderly (PACE).

a. For transfers made before February 8, 2006, the look-back period is 36 months prior to the date of application. For transfers made on or after February 8, 2006, the look-back date is 60 months prior to the date of application.

b. An institutionalized individual is one who is institutionalized in a medical facility, a Long-Term Care institution, or applying for or receiving Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).

c. If an institutionalized individual or such individual's spouse transfers assets without fair consideration on or after the look-back period, the transfer shall be evaluated as follows:

i) The fair market value of the transferred asset, less the actual amount received, if any, shall be divided by the average of the regions, defined at 8.100.7.E, monthly private pay cost for Long-Term Care institution care in the state of Colorado at the time of application.

ii) The resulting number is the number of months that the individual shall be ineligible for Medical Assistance. For transfers made before February 8, 2006, the period of ineligibility shall begin with the first day of the month following the month in which the transfer occurred. For transfers made on or after February 8, 2006, the period of ineligibility shall begin on the later of the following dates:

a) The first day of the month following the month in which the transfer occurred or is discovered. For transfers discovered after the date the transfer occurred, the date of transfer shall be the discovery date.

Or;

b) The date on which the individual would initially be eligible for HCBS, PACE or institutional services based on an approved application for such assistance that were it not for the imposition of the penalty period, would be covered by Medical Assistance;

And;

c) Which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

d. The period of ineligibility shall also include partial months, which shall be calculated by multiplying 30 days by the decimal fractional share of the partial month. The result is the number of days of ineligibility. For transfers occurring on or after April 1, 2006, the result shall be rounded up to the nearest whole number.

e. There is no maximum period of ineligibility.

f. For transfers prior to February 8, 2006, the total amount of all of the transfers are added together and the period of ineligibility begins the first day of the month following the month in which the resources are transferred.

    i) If the previous penalty period has completely expired, the transfers are not added together.

    ii) If the previous penalty period has not completely expired and the first day of the month following the month in which the resources are transferred is part of a prior penalty period, the new penalty period begins the first day after the prior penalty period expires.

g. For transfers on or after February 8, 2006, the total amounts of all of the transfers are added together and the penalty period is assessed as outlined in section 8.100.7.F.2.c-dabove.

    i) If the previous penalty period has completely expired, the transfers are not added together.

    ii) If the previous penalty period has not completely expired and the first day of the month following the month in which the resources are transferred is part of a prior penalty period, the new penalty period begins the first day after the prior penalty period expires.

h. The institutionalized individual may continue to be eligible for Supplemental Security Income (SSI) and basic Medical Assistance services, but shall not be eligible for Medical Assistance for Long-Term Care institution services, Home and Community Based Services or the Program of All Inclusive Care for the Elderly due to the transfer without fair consideration.

i. If a transfer without fair consideration is made during a period of eligibility, a period of ineligibility shall be assessed in the same manner as stated above.

j. Actions that prevent income or resources from being received, or reduce an individual’s ownership, right or interest in an asset such that the individual does not receive valuable consideration as set forth on the following list, which is not exclusive, shall create a rebuttable presumption that the transfer was without fair consideration:

    i) Waiving pension income.

    ii) Waiving a right to receive an inheritance.

    iii) Preventing access to assets to which an individual is entitled by diverting them to a trust or similar device. This is not applicable to valid income trusts, disability trusts and pooled trusts for individuals under the age of 65 years.

    iv) Failure of a surviving spouse to elect a share of a spouse's estate or failure to open an estate within 6 months after a spouse’s death.

v) Failure to obtain a family allowance or exempt property allowance from an estate of a deceased spouse or parent. Such allowances are presumed to be available 3 months after death.

vi) Not accepting or accessing a personal injury settlement.

vii) Transferring assets into an irrevocable private annuity which was not purchased from a commercial company.

viii) Transferring assets into an irrevocable entity such as a Family Limited Partnership which eliminates or restricts the individual's access to the assets.

ix) Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony, if the benefit outweighs the cost.

x) Failure to exercise rights in a Dissolution of Marriage case, which insure an equitable distribution of marital property and income.

xi) Purchasing a single-premium life insurance policy, endowment policy or similar instrument within the look-back period, which has no cash value, and for which the individual receives no valuable consideration shall be considered an uncompensated transfer. The total amount of the purchase price shall be considered a transfer without fair consideration.

8.100.7.G. Treatment of Certain Assets as Transfers Without Fair Consideration

1. Promissory notes established before April 1, 2006:

a. The fair market value of promissory notes is a countable resource and must be evaluated in accordance with the regulations on consideration of resources in this volume.

b. Promissory notes with one or more of the following provisions, indicating they have little or no market value, shall create a rebuttable presumption of a transfer without fair consideration:

i) An interest rate lower than the prevailing market rate.

ii) A term for repayment longer than the life expectancy of the holder of the note, as determined by the tables at 8.100.7.J.for annuities purchased on or after February 8, 2006.

iii) Low payments.

iv) Cancellation at the death of the note holder.

c. Promissory notes which have been appraised by a note broker as having little or no value shall create a rebuttable presumption of a transfer without fair consideration.

2. Promissory notes established on or after April 1, 2006 but before March 1, 2007

a. Subject to the look-back date described in section 8.100.7.F.2.b for the purpose of calculating the penalty period of ineligibility for a transfer without fair consideration, the value of a promissory note, loan or mortgage which does not meet the criteria in section 8.100.5.M.3.n. is the outstanding balance due as of the date of the individual’s application for Medical Assistance for services, described in section 8.100.7.F.2.c.

3. Promissory notes established on or after March 1, 2007

   a. Subject to the look-back date described in section 8.100.7.F.2.b, for the purpose of calculating the penalty period of ineligibility for a transfer without fair consideration, the value of a promissory note, loan or mortgage which does not meet the criteria in section 8.100.5.M.3.o. is the outstanding balance due as of the date of the individual's application for Medical Assistance for services, described in section 8.100.7.F.2.c..

4. Personal care services

   a. Effective for agreements that were signed and notarized prior to March 1, 2007, family members who provide assistance or services are presumed to do so for love and affection, and compensation for past assistance or services shall create a rebuttable presumption of a transfer without fair consideration unless the compensation is in accordance with the following:

      i) A written agreement must be executed prior to the delivery of services.

      ii) The agreement must be signed by the applicant, or a legally authorized representative, such as agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative may not be a beneficiary of the agreement.

      iii) The agreement must be dated and the signature must be notarized; and

      iv) Compensation for services rendered must be comparable to what is received in the open market.

   b. Effective for agreements that are signed and notarized on or after March 1, 2007, compensation under personal service agreements will be deemed to be a transfer without fair consideration unless the following requirements are met:

      i) A written agreement was executed prior to the delivery of services; and

         a) The agreement must be signed by the applicant, or a legally authorized representative, such as agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative may not be a beneficiary of the agreement; and

         b) The legally authorized representative, agent, guardian, conservator, or other representative of the applicant's estate may not be a beneficiary of a care agreement; and

         c) The agreement specifies the type, frequency and time to be spent providing the services agreed to in exchange for the payment or transferred item; and

         d) The agreement provides for payment of services on a regular basis, no less frequently than monthly, while the services are being provided; and

      ii) Compensation for services rendered must be comparable to what is received in the open market. The burden is on the applicant to prove that the compensation is reasonable and comparable; and

iii) A record or log is provided which details the actual services rendered. The services cannot be services that duplicate services that another party is being paid to provide or which another party is responsible to provide.

c. Payment for services, which were rendered previously and for which no compensation was made, shall be considered as a transfer without fair consideration.

d. Assets transferred in exchange for a contract for personal services for future assistance after the date of application are considered available resources.

e. A care agreement must be entered into, signed, and notarized prior to providing any services for which a beneficiary will be compensated.

5. Transfers of real property into joint tenancy without fair consideration

a. If real property is transferred into joint tenancy with right of survivorship with one or more joint tenants, the amount transferred depends on the number of joint tenants to whom the property is transferred. The following are examples:

i) If the transfer is to one joint tenant, the amount transferred is equal to one-half of the value of the property at the time of the transfer.

ii) If the transfer is to two joint tenants, the amount transferred is equal to two-thirds of the value.

iii) If the transfer is to three joint tenants, the amount transferred is equal to three-fourths of the value of the property at the time of the transfer.

b. If the transfer is completed with two deeds or transactions, the first of which transfers a fractional share of the property into tenancy in common, and the second into joint tenancy, the amount transferred shall be determined in the same manner as set forth above.

6. No period of ineligibility will be imposed if the individual transferred the assets under any of following circumstances:

a. The asset transferred was a home and title to the home was transferred to:

i) The spouse of such individual;

ii) A child of such individual who is either

1) Under the age of 21 years, or

2) Is blind or totally and permanently disabled as determined by the Social Security Administration.

iii) A brother or sister

1) Who has an equity interest in the home and

2) Who was residing in such individual's home for at least one year immediately before the date that the individual becomes institutionalized.

iv) A son or a daughter of such individual

1) Who was residing in the home for a period of at least two years immediately before the date the individual becomes institutionalized and

2) Who provided care to such individual by objective evidence, that permitted such individual to reside at home rather than in an institution.

3) Documentation shall be submitted proving that the son or daughter's sole residence was the home of the parent. The parent's attending physician(s) or professional health provider(s) during the past two years must substantiate in writing that the care was provided, and that the care prevented the parent from requiring placement in a Long-Term Care institution.

b. The assets were transferred:

i) To the individual's spouse or to another for the sole benefit of the individual's spouse.

ii) From the individual's spouse to another for the sole benefit of the individual's spouse.

iii) To a trust which is established solely for benefit of the individual's child who is determined to be blind or totally disabled by the Social Security Administration or to that child directly for the sole benefit of the child.

iv) To a trust established solely for the benefit of an individual under 65 years of age who is determined to be blind or totally disabled by the Social Security Administration.

c. Definition of the term “for the sole benefit of,” as used in the preceding exceptions to the transfer penalty rules:

i). A transfer or a trust is considered to be for the sole benefit of the spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

ii). To insure that the asset transferred is for the sole benefit of the spouse, blind or disabled child or disabled individual, the following criteria must be met:

1) The transfer must be accomplished by a written instrument which legally binds the parties to a specified course of action and sets forth:

a) The conditions under which the transfer was made, and

b) A statement as to whom can benefit from the transfer.

2) The written instrument must provide for the spending of funds or use of the transferred assets for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual.

3) Disability trusts and income trusts, which designate the Colorado Department of Health Care Policy and Financing as the remainder

beneficiary up to the amount of Medical Assistance paid on behalf of the individual, are exempt from this requirement.

4) A community spouse to whom a Community Spouse Resource Allowance has been transferred does not have to provide a written document or comply with the requirement that the transfer is actuarially sound. However, the Community Spouse Resource Allowance must be for the sole benefit of the community spouse to whom it is transferred. Upon the death of the community spouse, those resources shall be made available to the surviving spouse, at least up to the amount of the elective share of the augmented estate, the family allowance and the exempt property allowance.

7. There is a rebuttable presumption the transfer without fair consideration was made for purposes of Medical Assistance eligibility or avoiding the medical assistance estate recovery program.

a. The presumption that an asset was transferred to establish or maintain Medicaid eligibility or to avoid the medical assistance estate recovery program is rebutted only if the individual or individual’s spouse demonstrates by providing convincing evidence that the asset was transferred exclusively for some other purpose and the reason for the transfer did not include Medical Assistance eligibility or avoidance of medical assistance estate recovery..

b. A subjective statement of intent or ignorance of the transfer penalty or verbal assurances that the individual was not considering Medical Assistance eligibility when the transfer was made are not sufficient.

c. There is a rebuttable presumption that transfers without fair consideration were made for the purpose of Medical Assistance eligibility in the following cases:

i) In any case in which the individual's assets and the assets of the individual's spouse remaining after the transfer total an amount insufficient to meet all living expenses and medical expenses reasonably expected to be incurred by the individual or the individual's spouse in the sixty (60) months following the transfer. Medical expenses include the cost of Long-Term Care unless the future necessity of such care could have been absolutely precluded because of the particular circumstances.

ii) In any case where:

1) the transfer was made on behalf of the individual or the individual's spouse;

2) the transfer was made by:

a) the individual or individual’s spouse

b) a guardian,

c) a conservator, or

d) agent under a power of attorney; and

3) the transfer was made to:

a) anyone related to the individual or individual's spouse by birth, adoption or marriage, other than between the individual and the individual's spouse; or to

b) anyone related to the guardian, conservator, or agent under a power of attorney by birth, adoption or marriage.

d. Convincing evidence may include, but is not limited to, verification which establishes:

i) That at the time of the transfer the individual could not have anticipated needing long term Medical Assistance due to the existence of other circumstances which would have precluded the need.

ii) Other assets were available at the time of the transfer to meet current and future needs of the individual, including the cost of Long-Term Care institution or other institutionalized care for a period of sixty (60) months.

iii) The specific purpose for which the assets were transferred and the reason the transfer was necessary and the reason there was no alternative but to transfer the assets without fair consideration.

8. Apportionment of penalty period between spouses

a. If a transfer results in a period of ineligibility for an individual, and the individual's spouse becomes institutionalized and is otherwise eligible for Medical Assistance, the period of ineligibility shall be apportioned equally between the spouses.

b. If one spouse dies or is no longer institutionalized, any months remaining in the period of ineligibility shall be assigned to the spouse who remains institutionalized.

9. If the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of a trust, the trust document shall be submitted to the Colorado Department of Health Care Policy and Financing to determine the effect of the trust on Medical Assistance eligibility.

10. Notice

a. The Colorado Department of Health Care Policy and Financing is an interested person according to 15-14-406, C.R.S. or a successor statute.

b. As an interested party, the department shall be given notice of a hearing in cases in which Medical Assistance planning or Medical Assistance eligibility is set forth in the petition as a factor for requesting court authority to transfer property.

11. Undue Hardship

a. The period of ineligibility resulting from the imposition of the transfer or the trust provisions may be waived if denial of eligibility would create an undue hardship for an individual who is otherwise eligible. Undue hardship can be established if application of the transfer penalty would:

i) deprive the individual of medical care such that the individual's health or life would be endangered; or

ii) deprive the individual of food, clothing, shelter or other necessities of life.

b. Undue hardship shall not exist when the application of the trust or transfer rules merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

c. Notice of an undue hardship exception shall be given to the applicant or client. The Eligibility Site shall make a determination on the request within 15 working days from when the request is received. The Eligibility Site shall issue a notice of action on the determination of hardship. An adverse determination may be appealed in accordance with the appeal process as described at Section 8.057 of this volume.

d. The facility in which an institutionalized individual is residing may file an undue hardship waiver application on behalf of the individual with the individual's or his or her personal representative's consent. Where the individual is unable to give consent and where the personal representative of the individual has a conflict of interest concerning the particular circumstance giving rise to the period of ineligibility, the facility may request an undue hardship on behalf of the individual. An example of such a conflict of interest would be a situation where the personal representative who is also an agent under a power of attorney transfers property to himself or herself. The facility shall submit the undue hardship request to the Eligibility Site and give sufficient detail of the circumstance surrounding the conflict of interest and the information required below to the Eligibility Site. These provisions are not intended to change the Department’s requirements under Section 8.057 of the Department’s regulations as to who has standing to file an appeal.

e. An individual or representative may request that the Eligibility Site waive a transfer penalty on the basis of undue hardship. The request shall be made in writing to the applicant’s or client’s Eligibility Site case worker. The individual making the request has the burden of proof and must provide clear and convincing evidence to substantiate the circumstances surrounding the transfer, attempts to recover the assets, and the impact of the denial of Medicaid payments for Long-Term Care services. The request and documentation shall include all of the following:

   i) the reason(s) for the transfer including the individual’s participation in the transfer or grant of legal authority to another that gave rise to the transfer, and the relationship between the transferor and transferee;

   ii) evidence to prove that the assets have been irretrievably lost and that all reasonable attempts made to recover the asset(s), including any legal actions and the results of the attempts, including but not limited to a request for an adult protection investigation (such as in a case of financial exploitation), filing a police report, or filing a civil action have been exhausted or have been or are being pursued; and,

   iii) documentation such as a notice of discharge or pending discharge from the facility and a physician’s statement detailing how the inability to receive nursing facility or community based services would result in the individual’s inability to obtain life-sustaining medical care or that the individual would not be able to obtain food, clothing or shelter.

f. To the extent that the transferred assets are recovered pursuant to the attempts in (e)(ii) above, the individual shall reimburse Medicaid for the funds expended as a result of an approved undue hardship request.

g. If the transferee and the transferor of the assets for which the transfer penalty is being imposed are related parties there shall be a rebuttable presumption that the transferred

assets are not irretrievably lost as required under (e)(ii) above. Related parties are described in Section 8.100.7.G.7.c.ii of these regulations.

12. No period of ineligibility shall be assessed in any of the following circumstances:

a. Convincing and objective evidence is provided that the individual intended to dispose of the resources either at fair market value or for other fair consideration.

b. Convincing and objective evidence is presented proving that the resources were transferred exclusively for a purpose other than to qualify or remain eligible for Medical Assistance.

c. All of the resources transferred without fair consideration have been returned to the individual.

d. For assets transferred before February 8, 2006, the assets were transferred more than 36 months prior to the date of application.

e. For assets transferred before February 8, 2006, the penalty period has expired based on the following formula: The fair market value of the transferred asset is divided by the average cost of Long Term Care institution care in the state at the time of application and the resulting number of months of ineligibility has ended prior to the date of application.

8.100.7.H. Life Estates

1. Definitions

a. “Fair Market Value” means the amount for which a property or interest in a property could reasonably be expected to sell on the open market.

b. “Life Estate.” A life estate conveys upon a grantee certain rights in property measured by the life of the life estate holder or of some other person. The owner of a life estate has the right to possess the property, the right to use the property, the right to obtain profits from the property, and the right to sell the life estate interest in the property. The establishment of a life estate on a property results in the creation of two interests: a life estate interest and a remainder interest.

c. “Remainder Interest” means an interest in property created at the time a life estate is established which gives the holder of the interest the right to ownership of the property upon the death of the life estate holder. An individual holding a remainder interest is free to sell his or her interest in the property unless the sale is restricted by the terms of the instrument which established the remainder interest.

2. General Provisions

a. Life Estates Established before July 1, 1995

i) Transfer without fair consideration Treatment

1) The establishment of a life estate before July 1, 1995 by an individual or individual’s spouse shall not be considered a transfer without fair consideration.

ii) Resource Treatment

1) A life estate owned by an individual or individual's spouse that was established on exempt property shall be considered to be an exempt resource.

2) A life estate owned by an individual or individual's spouse that was established on countable property shall be considered a countable resource.

i) The value of the life estate shall be determined by using the methodology described at 8.100.7.H.3.

3) A remainder interest held by an individual or individual's spouse on exempt property shall be considered an exempt resource.

4) A remainder interest held by an individual or individual's spouse on countable property shall be considered a countable resource

i) The value of the remainder interest shall be determined by using the methodology described at 8.100.7.H.4.a.

b. Life Estates Established on or after July 1, 1995

i) Transfer without fair consideration Treatment

1) The establishment of a life estate on or after July 1, 1995 on property owned by an individual or individual's spouse shall be considered a transfer without fair consideration if the life estate was established within the look-back period described at 8.100.7.F.2.b.

a) For the purpose of determining the transfer without fair consideration penalty period, the amount of the transfer shall be based on the value of the remainder interest, as calculated using the methodology described at 8.100.7.H.4.a.

2) The purchase of a life estate interest in a home not owned by an individual or individual's spouse on or after April 1, 2006 within the look-back period described at 8.100.7.F.2.b. shall be considered a transfer without fair consideration unless the purchaser lives in the home for a period of at least twelve (12) consecutive months after the date of the purchase.

a) For the purpose of determining the transfer without fair consideration penalty period, the amount of the transfer shall be the entire amount used to purchase the life estate.

b) If the payment for the life estate exceeds the value of the life estate, as calculated using the methodology described at 8.100.7.H.3, then the difference between the amount paid and the value of the life estate shall be considered to be a transfer without fair consideration.

ii) Resource Treatment

1) A life estate owned by an individual or individual's spouse that was established on exempt property shall be considered an exempt resource.

2) A life estate owned by an individual or individual's spouse that was established on countable property shall be considered a countable resource.

a) The value of the life estate shall be determined by using the methodology described at 8.100.7.H.3.a.

3) A remainder interest held by an individual or individual's spouse on exempt property shall be considered an exempt resource.

5) A remainder interest held by an individual or individual's spouse on countable property shall be considered a countable resource

a) The value of the remainder interest shall be determined by using the methodology described at 8.100.7.H.4.

3. Determining the Value of a Life Estate

a. The value of a life estate interest is calculated using the following method:

i) Determine the fair market value of the property on which the life estate was established. The fair market value shall be obtained by using the most recent actual value reported by the county assessor or from the most recent property assessment notice. If the actual value is not shown on the property assessment notice, the assessed value shall be divided by the appropriate property assessment rate to obtain the market value.

ii) Multiply the fair market value of the property by the "Life Estate" factor in Column 1 from the Life Estate Table at 8.100.7.H.5, in this section, that corresponds to the life estate holder's age as of his or her last birthday. The result is the value of the life estate interest.

b. If a life estate was established on property held by spouses in joint tenancy, then the age of the youngest individual shall be used to calculate the value of the life estate.

4. Determining the Value of a Remainder Interest

a. The value of a remainder interest is calculated using the following method:

i) Determine the fair market value of the property on which the remainder interest was established. The fair market value shall be obtained by using the most recent actual value reported by the county assessor or from the most recent property assessment notice. If the market value is not shown on the property assessment notice, the assessed value shall be divided by the appropriate property assessment rate to obtain the market value.

ii) Multiply the fair market value of the property by the "Remainder" factor in Column 2 from the Life Estate Table at 8.100.7.H.5, in this section, that corresponds to the life estate holder's age as of his or her last birthday. The result is the value of the remainder interest.

b. If a life estate was established on property held by spouses in joint tenancy, then the age of the youngest individual shall be used to calculate the value of the remainder interest.

5. Life Estate Table

This rule incorporates by reference the Social Security life estate and remainder interest table effective April 1999 to the present. The incorporation of the table excludes later amendments, or editions of, the referenced material.

The Social Security life estate and remainder interest tables are available at http://policy.ssa.gov/poms.nsf/lnx/0501140120

Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.100.7.I. Annuities

1. DEFINITIONS

a. “Annuity” means a contract between an individual and a commercial company in which the individual invests funds and in return receives installments for life or for a specified number of years.

b. “Annuitant” means an individual who is entitled to receive payments from an annuity.

c. “Annuitization Period” means the period of time during which an annuity makes payments to an annuitant.

d. “Annuitized” means an annuity that has become irrevocable and is making payments to an annuitant.

e. “Assignable” means an annuity that can have its owner and/or annuitant changed.

f. “Balloon Payment” means a lump sum equal to the initial annuity premium less any distributions paid out before the end of an annuitization period.

g. “Beneficiary” means an individual or individuals entitled to receive any remaining payments from an annuity upon the death of the annuitant.

h. “Department” means the Department of Health Care Policy and Financing, its successor(s), or its designee(s).

i. “Irrevocable” means an annuity that cannot be canceled, revoked, terminated, or surrendered under any circumstances.

j. “Non-assignable” means an annuity that cannot have its owner and/or annuitant changed under any circumstances.

k. “Owner” means the person who may exercise the rights provided in an annuity contract during the life of the annuitant. An owner can generally name himself or herself or another person as the annuitant.

l. “Revocable” means an annuity that can be canceled, revoked, terminated, or surrendered.

m. “Transaction” means:

i) The purchase of an annuity;

ii) The addition of principal to an annuity;

iii) Elective withdrawals from an annuity;

iv) Requests to change the distributions from an annuity;

v) Elections to annuitize an annuity contract; or

vi) Any other action taken by an individual that changes the course of payments made by an annuity or the treatment of income or principal of an annuity.

2. Annuities purchased on or before June 30, 1995

a. A revocable or irrevocable annuity established on or before June 30, 1995 is not a countable resource if it is annuitized and regular returns are being received by the annuitant.

i) Payments from the annuity to the individual or individual’s spouse are income in the month received.

b. A revocable or irrevocable annuity established on or before June 30, 1995 is a countable resource if it has not been annuitized.

3. Annuities Established on or after July 1, 1995 but before February 8, 2006

a. The purchase of an annuity shall be considered to be a transfer without fair consideration unless the following criteria are met:

i) The annuity is purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business;

ii) The annuity is annuitized for the individual or individual’s spouse;

iii) The annuity is purchased on the life of the individual or individual’s spouse; and

iv) The annuity provides payments for a period not exceeding the annuitant’s projected life expectancy based on life expectancy tables described at 8.100.7.J.

b. To determine if a transfer without fair consideration has occurred in the purchase of an annuity, the Eligibility Site shall:

i) Determine the date on which the annuity was purchased;

ii) Determine the amount of money used to purchase the annuity and the length of the annuitization period;

iii) Determine the age of the annuitant at the time the annuity was purchased; and

iv) Determine the life expectancy of the annuitant at the time the annuity was purchased using the appropriate life expectancy table described at 8.100.7.J.

1) If the length of the annuitization period exceeds the annuitant's life expectancy, then a transfer without fair consideration exists for the portion of the annuitization period that exceeds the annuitant's life expectancy.

2) If the total value of the annuity's payments during the annuitization period is less than the original purchase price of the annuity, then the difference shall be considered to be a transfer without fair consideration.

3) If the total value of the annuity's payments during the annuitization period is equal to or greater than the original purchase price of the annuity, then the purchase of the annuity shall not be considered to be a transfer without fair consideration. However, any payments made by the annuity shall be considered to be countable income in the month received.

4) If the annuity was purchased more than 36 months before the date of application for Medicaid, then there is no transfer without fair consideration penalty period. However, any payments made by the annuity shall be considered to be countable income in the month received.

4. Annuities Established on or after April 1, 1998 but before February 8, 2006

a. The Eligibility Site shall determine the Minimum Monthly Maintenance Needs Allowance (MMMNA) of the community spouse, if applicable.

i) If the monthly payment amount provided by the annuity to the community spouse exceeds the MMMNA, then the amount of the annuity which causes the monthly annuity payment to exceed the MMMNA shall be considered to be a transfer without fair consideration in determining the institutionalized spouse's eligibility. This applies only to the extent that the transferred amount causes the Community Spouse Resource Allowance to exceed the maximum.

b. The Eligibility Site shall determine if the Individual is receiving substantially equal installments from the annuity for the annuitization period of the annuity.

i) If the annuity is not paid in substantially equal installments, then the original purchase price of the annuity shall be considered to be a transfer without fair consideration.

c. If the annuity was purchased more than 36 months before the date of application for Medicaid, then there is no transfer without fair consideration penalty period.

i) Any payments made by the annuity shall be considered to be countable income in the month received.

5. Annuities Purchased on or after February 8, 2006

a. As a condition of Medicaid eligibility, at the time of application or redetermination, an applicant or his or her spouse for Medicaid Long-Term Care services shall disclose any interest that the Medicaid applicant or his or her spouse has in an annuity.

i) A complete copy of the annuity contract, including the most recent beneficiary designation, shall be provided to the eligibility site.

b. By providing Medicaid Long-Term Care services, the Department shall be a remainder beneficiary of any annuity in which an individual or individual's spouse has an interest. The purchase of the annuity shall not be considered to be a transfer without fair consideration if:

i) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the individual; or

ii) The Department is named as the remainder beneficiary in the next position after the community spouse or minor or disabled child.

iii) This provision shall not apply to annuities that are revocable and/or assignable.

c. The Eligibility Site shall notify the issuer of the annuity that the Department is a preferred remainder beneficiary in the annuity for medical assistance provided to the institutionalized individual. This notice shall include a statement requiring the issuer to notify the Eligibility Site of any changes in the amount of income or principal that is being withdrawn from the annuity or any other transactions, as defined at 8.100.7.I.1., regardless of when the annuity was purchased.

d. If the Department is not named on the annuity as a remainder beneficiary, then the value of funds used to purchase the annuity shall be deemed a transfer without fair consideration and shall be subject to the penalty period provisions described at 8.100.7.F.

i) This provision shall not apply to annuities that are revocable and/or assignable.

e. Revocable Annuities

i) A revocable annuity is a countable resource. The value of the annuity is the total value of the annuity principal plus any accumulated interest.

a) If the annuity includes a surrender charge or other financial penalty (other than tax withholding or a tax penalty) for withdrawing funds from the annuity, then the value of the annuity is the net amount the individual would receive upon full surrender of the annuity.

ii) Payments from a revocable annuity are not countable as income.

f. Irrevocable Assignable Annuities

i) An irrevocable assignable annuity is a countable resource. The value of the annuity is presumed to be the total value of the annuity principal plus any accumulated interest.

a) An individual or individual's spouse can rebut the presumption by providing documented offers from at least three companies who are active in the market for buying and selling annuities an annuity income streams. The value of the annuity shall then be the highest of the offers.

b) Any payments from an irrevocable assignable annuity that is considered to be a countable resource are not considered to be countable income.

ii) An individual or individual's spouse can rebut the presumption that an irrevocable assignable annuity is not a countable resource by providing documented offers from at least three companies who are active in the market for buying and selling annuities and annuity income streams stating their unwillingness or inability to purchase the annuity or annuity income stream.

a) Any payments from an irrevocable assignable annuity that is not considered to be a countable resource are considered to be countable income in the month received.

g. Irrevocable Non-Assignable Annuities

i) An irrevocable non-assignable annuity is not considered to be a countable resource.

ii) Payments from an irrevocable non-assignable annuity are considered countable income in the month received.

iii) An irrevocable non-assignable annuity purchased by or for the benefit of a community spouse shall not be considered to be a transfer without fair consideration if:

1) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the institutionalized individual; or

2) The Department is named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder without fair consideration.

iv) An irrevocable non-assignable annuity purchased by or for the benefit of an institutionalized individual shall not be considered to be a transfer without fair consideration if:

1) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the institutionalized individual; or

2) The Department is named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder without fair consideration.

v) In addition to the requirements listed at 8.100.7.I.5.g.iv) for naming the Department as remainder beneficiary, an irrevocable non-assignable annuity purchased by or for the benefit of an institutionalized individual shall not be considered to be a transfer without fair consideration if the annuity meets any one of the following conditions:

1) The annuity is considered either:

a) An Individual Retirement Annuity as described in Section 408(b) of the Internal Revenue Code of 1986; or

b) A deemed Individual Retirement Account under a qualified employer plan described in Section 408(q) of the Internal Revenue Code of 1986; or

2) The annuity is purchased with proceeds from one of the following:

a) An Individual Retirement Account as described in Section 408(a) of the Internal Revenue Code of 1986; or

b) An account established by an employer or association of employers as described in Section 408(c) of the Internal Revenue Code of 1986; or

c) A simple retirement account as described in Section 408(p) of the Internal Revenue Code of 1986; or

d) A simplified employee pension plan as described in Section 408(k) of the Internal Revenue Code of 1986; or

e) A Roth IRA as described in Section 408A of the Internal Revenue Code of 1986; or

3) The annuity meets all of the following requirements:

a) The annuity is irrevocable and non-assignable; and

b) The annuity is actuarially sound based on the life expectancy tables described at 8.100.7.J.; and

c) The annuity provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

vi) If an irrevocable non-assignable annuity is considered to be a transfer without fair consideration, then, for the purpose of calculating the transfer without fair consideration penalty period, the value that was transferred shall be the amount of funds used to purchase the annuity.

h. Annuity Transactions

i) If an Individual or individual's spouse undertakes any transaction, as defined at 8.100.7.I.1. which has the effect of changing the course of payments to be made by an annuity or the treatment of income or principal of the annuity, such a transaction shall be deemed to be a transfer without fair consideration, regardless of when the annuity was originally purchased. For the purpose of calculating the transfer without fair consideration penalty period, the value that was transferred shall be the amount used to purchase the annuity.

a) Routine changes such as a notification of an address change or death or divorce of a remainder beneficiary are excluded from treatment as a transfer without fair consideration.

b) Changes which occur based on the terms of the annuity which existed before February 8, 2006 and which do not require a decision, election, or

action to take effect are excluded from treatment as a transfer without fair consideration.

c) Changes which are beyond the control of the individual, such as a change in law, a change in the policies of the annuity issuer, or a change in terms based on other factors, such as the annuity issuer's financial condition, are excluded from treatment as a transfer without fair consideration.

8.100.7.J. Life Expectancy Tables

This rule incorporates by reference the Social Security Office of the Chief Actuary Period Life Table 2011 for both males and females. The incorporation of the table excludes later amendments, or editions of, the referenced material.

The Social Security Office of the Chief Actuary Period Life Table 2011 is available at www.ssa.gov/oact/STATS/table4c6.html.

Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.100.7.K. Spousal Protection - Treatment of Income and Resources for Institutionalized Spouses

1. The spousal protection regulations apply to married couples where one spouse is institutionalized or likely to be institutionalized for at least 30 consecutive days and the other spouse remains in the community. Being a community spouse does not prohibit Medicaid eligibility if all criteria are met. The community spouse resource allowance does not supersede the Medicaid eligibility criteria.

2. For purposes of spousal protection, an institutionalized spouse is an individual who:

   a. Begins a stay in a medical institution or nursing facility on or after September 30, 1989, or

   b. Is first enrolled as a Medical Assistance client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or

   c. Receives Home and Community Based Services on or after July 1, 1999; and

   d. Is married to a spouse who is not in a medical institution or nursing facility; but does not include any such individual who is not likely to meet the requirements of subparagraphs 8.100.7.K.2.a thru c for at least 30 consecutive days.

3. A community spouse is defined as the spouse of an institutionalized spouse.

8.100.7.L. Assessment and Documentation of The Couple's Resources

An assessment of the total value of the couple's resources shall be completed at the time of initial Medical Assistance application or when requested by either spouse of a married couple. All non-

exempt resources owned by a married couple are counted, whether owned jointly or individually. There are no exceptions for legal separation, pre-nuptial, or post-nuptial agreements. Once the applicant is approved, the Community Spouses' resources are not reviewed again unless the Community Spouse applies for Medical Assistance.

8.100.7.M. Calculation of the Community Spouse Resource Allowance

1. A Community Spouse Resource Allowance (CSRA) shall be allocated based on the total resources owned by the couple as of the time of Medical Assistance application. The CSRA is established at intake only, and; once approved the community spouse's resources are not considered again until the community spouse applies for Medical Assistance. This is true even if the community spouse becomes institutionalized but does not apply for Medical Assistance. In calculating the amount of the CSRA, resources shall not be attributed to the community spouse based upon state laws relating to community property or the division of marital property.

   For persons whose Medical Assistance application is for an individual who meets the definition of an institutionalized spouse, the CSRA is the largest of the following amounts:

   a. The total resources of the couple but no more than the current maximum allowance which, changes each year beginning January 1st.; or

   b. The increased CSRA calculated pursuant to section 8.100.7.S; or

   c. The amount a court has ordered the institutionalized spouse to transfer to the community spouse for monthly support of the community spouse or a dependent family member.

2. The resources allotted to the community spouse as the CSRA shall be transferred into the name of the community spouse and shall not be considered available to the institutionalized spouse. After the transfer of the CSRA to the community spouse, the income from these resources shall be attributed to the community spouse.

3. The transfer of the CSRA shall be completed as soon as possible, but no later than the next redetermination when the community spouse becomes institutionalizes; whichever is earlier. If the transfer is not completed within this time period, the resources shall be attributed to the institutionalized spouse and shall affect his/her Medical Assistance eligibility. Verification of the transfer of assets to the community spouse shall be provided to the eligibility site.

   The institutionalized spouse may transfer the resources allotted to the community spouse as the CSRA to another person for the sole benefit of the community spouse.

4. If the community spouse is in control of resources attributed to the institutionalized spouse, but fails to make such resources available for his/her cost of care, this fact shall not make the institutionalized spouse ineligible for Medical Assistance, where:

   a. The institutionalized spouse has assigned The Department any rights to support from the community spouse; or

   b. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but The Department has the right to bring a support proceeding against the community spouse without such assignment; or

   c. The eligibility site determines that the denial of eligibility would work an undue hardship upon the institutionalized spouse. For the purposes of this subparagraph, undue hardship means that an institutionalized spouse, who meets all the Medical Assistance eligibility

criteria except for resource eligibility, has no alternative living arrangement other than the medical institution or Long Term Care institution.

8.100.7.N. Treatment of the Home and Other Exempt Resources

The CSRA shall not include the value of exempt resources including the home. It is not necessary for the home to be transferred to the community spouse. The rules regarding countable and exempt resources can be found in the section 8.100.5. However, for Spousal Protection there is no limit to the value of household goods and personal effects and one automobile.

8.100.7.O. Determination of the Institutionalized Spouse's Income and Resource Eligibility

1. The institutionalized spouse is resource eligible for Medical Assistance when the total resources owned by the couple are at or below the amount of the Community Spouse Resource Allowance plus the Medical Assistance resource allowance for an individual of $2,000.

2. The eligibility site shall determine whether the institutionalized spouse is income eligible for Medical Assistance. The institutionalized spouse shall be income eligible if his/her gross income is at or below the Medical Assistance income limit for recipients of long-term care. If an income trust is used the trust must be established before the MIA is calculated.

8.100.7.P. Attribution of Income

During any month in which a spouse is institutionalized, the income of the community spouse shall not be deemed available to the institutionalized spouse except as follows:

1. If payment of income from resources is made solely in the name of either the institutionalized spouse or the community spouse, the income shall be considered available only to the named spouse.

2. If payment of income from resources is made in the names of both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each spouse.

3. If payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest.

4. The above regulations of attribution of income are superseded if the institutionalized spouse can establish by a preponderance of the evidence that the ownership interests in the income are other than that provided in the regulations.

8.100.7.Q. Calculating the Community Spouse's Monthly Income Needs

1. The community spouse's total minimum monthly needs shall be determined as follows:

    a. The current minimum monthly maintenance needs allowance (MMMNA), which is equal to 150% of the federal poverty level for a family of two and is adjusted in July of each year;

    b. An excess shelter allowance, in cases where the community spouse's expenses for shelter exceed 30% of the MMMNA. The excess shelter allowance is computed by adding (a) and (b) together:

        i) The community spouse's expenses for rent or mortgage payment including principal and interest, taxes and insurance, and, in the case of a condominium or

cooperative, any required maintenance fee, for the community spouse's principal residence; and

ii) The larger of the following amounts: the standard utility allowance used by Colorado under U.S.C. 2014(e) of Title 7; or the community spouse's actual, verified, utility expenses. A utility allowance shall not be allowed if the utility expenses are included in the rent or maintenance charge, which is paid by the community spouse.

iii) The excess shelter allowance is the amount, if any, that exceeds 30% of the MMMNA.

2. An additional amount may be approved for the following expenses:

a. Medical expenses of the community spouse or dependent family member for necessary medical or remedial care. Each medical or remedial care expense claimed for deduction must be documented in a manner that describes the service, the date of the service, the amount of the cost incurred, and the name of the service provider. An expense may be deducted only if it is:

i) Provided by a medical practitioner licensed to furnish the care;

ii) Not subject to payment by any third party, including Medical Assistance and Medicare;

b. The cost of Medicare, Long Term Care insurance, and health insurance premiums. A health insurance premium may be allowed in the month the premium is paid or may be prorated and allowed for the months the premium covers. This allowance does not include payments made for coverage which is:

i) Limited to disability or income protection coverage;

ii) Automobile medical payment coverage;

iii) Supplemental to liability insurance;

iv) Designed solely to provide payments on a per diem basis, daily indemnity or non-expense-incurred basis; or

v) Credit life and/or accident and health insurance.

3. If either spouse establishes that the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance due to exceptional circumstances, which result in significant financial duress, such as loss of home and possessions due to fire, flood, or tornado, an additional amount may be substituted for the MMMNA if established through a fair hearing.

4. The total that results from adding the current MMMNA and the excess shelter allowance shall not exceed the current maximum MMMNA which is $2,175.00 for the year 2001 and is adjusted by the Health Care Financing Administration in January of each year.

8.100.7.R. Calculating the Amount of Income to be Contributed by the Institutionalized Spouse for the Community Spouse's Monthly Needs

1. The Monthly Income Allowance (MIA) is the amount of money necessary to raise the community spouse's income to the level of his/her monthly needs, and shall be obtained from the monthly income of the institutionalized spouse. For individuals who become institutionalized on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse must be considered to have been made available to the community spouse before an MIA is allocated to the community spouse.

2. The MIA shall be the amount by which the community spouse's minimum monthly needs, which is the MMMNA, exceed his/her income from sources other than the institutionalized spouse. The community spouse's income shall be calculated by using the gross income less mandatory deduct ions for FICA and Medicare tax.

3. If a court has entered an order against the institutionalized spouse for monthly support of the community spouse, the MIA shall not be less than the monthly amount ordered by the court.

4. The eligibility site shall make adjustments to the MMMNA and/or the MIA on a monthly basis for any continuing change in circumstances that exceeds $50 a month. Continuing changes of less than $50 in a month, and any infrequent or irregular changes, shall be considered at redetermination.

8.100.7.S. Increasing the Community Spouse Resource Allowance

1. The CSRA shall be increased above the maximum amount if additional resources are needed to raise the community spouse's monthly income to the level of the Minimum Monthly Maintenance Needs Allowance (MMMNA). In making this determination the items listed below are calculated in the following order:

    a. The community spouse's MMMNA;

    b. The community spouse's own income; and

    c. The Monthly Income Allowance (MIA) contribution that the community spouse is eligible to receive from the institutionalized spouse.

    d. If the community spouse's own income, and the Monthly Income Allowance contribution from the institutionalized spouse's income is less than the Minimum Monthly Maintenance Needs Allowance, additional available resources shall be shifted to the community spouse to bring his/her income up to the level of the MMMNA. The additional resources necessary to raise the community spouse's monthly income to the level of the MMMNA shall be based upon the cost of a single-premium lifetime annuity with monthly payments equal to the difference between the MMMNA and the community spouse's income. The following steps shall be followed to determine the amount of resources to be shifted:

        i) The applicant shall obtain three estimates of the cost of an annuity that would generate enough income to make up the difference between the MMMNA and the combined community spouse's income as described above.

        ii) The amount of the lowest estimate shall be used as the amount of resources to increase the CSRA.

        iii) The applicant shall not be required to purchase the annuity in order to have the CSRA increased.

    e. The CSRA shall not be increased if the institutionalized spouse refuses to make the monthly income allowance (MIA) available to the community spouse.

8.100.7.T. Deductions from Monthly Income of the Institutionalized Spouse

1. During each month after the institutionalized spouse becomes Medical Assistance eligible, deductions shall be made from the institutionalized spouse's monthly income in the following order.

    a. A personal needs allowance or the client maintenance allowance as allowed by program eligibility.

    b. A Monthly Income Allowance (MIA) for the community spouse, but only to the extent that income of the institutionalized spouse is actually made available to, or for the benefit of, the community spouse;

    c. A family allowance for each dependent family member who lives with the community spouse.

        i) The allowance for each dependent family member shall be equal to one third of the amount of the MMMNA and shall be reduced by the monthly income of that family member.

        ii) Family member means dependent children (minor or adult), dependent parents or dependent siblings of either spouse that are residing with the community spouse and can be claimed by either the institutionalized or community spouse as a dependent for federal income tax purposes.

    d. Allowable deductions identified in section 8.100.7.V.

    e. If the institutionalized spouse fails to make his/her income available to the community spouse or eligible dependent family members in accordance with these regulations, that income shall be applied to the cost of care for the institutionalized spouse.

    f. No other deductions shall be allowed.

8.100.7.U. Right to Appeal

1. Both spouses shall be informed of the following:

    a. The amount and method by which the eligibility site calculated the community spouse resource allowance (CSRA), community spouse monthly income allowance (MIA), and any family allowance;

    b. The spouses' right to a fair hearing concerning these calculations;

    c. The eligibility site conclusions with respect to the spouses' ownership and availability of income and resources, and the spouses' right to a fair hearing concerning these conclusions.

2. If either spouse establishes that the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance due to exceptional circumstances, which result in significant financial duress, such as loss of home and possessions due to fire, flood, or tornado, an additional amount may be substituted for the MMMNA if established through a fair hearing.

3. Appeals from decisions made by the eligibility site shall be governed by the provisions under Recipient Appeals Protocols/Process at 8.058.

8.100.7.V. Long-Term Care Institution Recipient Income

1. Determination of Income and Communication between the Long-Term Care institution and the Eligibility Site Using the AP-5615 Form for Patient Payment

    a. Sections I, II and IV of the AP-5615 form are to be completed by the Long-Term Care institution for all admissions, readmissions, transfers to and from another payer source, including private pay and Medicare, discharges, deaths, changes in income and/or patient payment, medical leaves of absence and non-medical/programmatic leave in excess of 42 days combined per calendar year.

    b. The initial determination of resident income for patient payment shall be made by the Eligibility Site. The Eligibility Site shall notify the Long-Term Care institution of current resident income.

    c. On receipt of AP-5615 form, the Eligibility Site will, within five working days:

        i) For an admission, a readmission or a transfer from/to private pay, Medicare, or another payer source:

            1) Verify and correct, if necessary, data entered by the Long-Term Care institution.

            2) List and/or verify the resident's monthly income adjustments and/or Long-Term Care Insurance benefit payments; and compute patient payment. Provide the completed AP-5615 to the Long-Term Care institution.

            3) Correct the automated system to indicate the Long-Term Care institution name and provider number and to reflect the current distribution of income. Submit the AP-5615 form to the Department.

    d. For change in patient payment with respect to changes in resident income:

        i) Verify changes in resident income, and correct if necessary. All such corrections must be initialed,

        ii) Compute patient payment and provide the completed AP-5615 to the Long-Term Care institution.

    e. For change in patient payment with respect to the post-eligibility treatment of income, the Eligibility Site shall:

        i) Review the AP-5615 form for Medicare part B premium deduction allowances for the first two months of admission.

        ii) If client is already on the Medicare Buy-In program for Medicare part B, do not adjust patient payment on AP-5615 form for the Medicare premium deduction. If client is not on the Buy-In program, adjust AP-5615 form for the Medicare premium deduction for the first two months of Long-Term Care institution eligibility.

        iii) If the client has a Medicare D premium, the Eligibility Site shall use the amount as an income adjustment/deduction in the patient payment calculation and complete the AP-5615 form.

f. For resident leave of absence:

i) Non-Medical/Programmatic Leave. When combined non-medical/programmatic days in excess of 42 days are reported, verify adherence to the restrictions and conditions of section 8.482.44.

ii) Medical Leave/Hospitalization. Verify that the patient payment is apportioned correctly between the nursing facility and the hospital so that no Medicaid payment is requested for the period. See also section 8.482.43.

iii) The nursing facility may wait until the end of the month to complete the AP-5615 form for an ongoing hospitalization.

g. For change in payer status:

i) If Medicare or insurance is a primary payer during the month, verify the nursing facility's calculation of the patient payment.

ii) Complete and provide the AP-5615 to the nursing facility.

h. For discharge or death of resident:

i) Verify the date of death or discharge, and verify the correct patient payment including the resident's monthly income for the discharged month, and the amount calculated by per diem. All corrections must be initialed.

ii) Note if the resident entered another Long-Term Care institution and, if so, enter the name of the new Long-Term Care institution in the system.

iii) In the event the resident may return to the same facility, the AP-5615 form may be completed at the end of the month for discharges due to hospitalization.

i. For discontinuation of Long-Term Care eligibility:

i) Initiate and send an AP-5615 form to the Long-Term Care institution within 5 working days of the date of determination that the client's eligibility will be discontinued. Indicate the date the discontinuation will be effective.

j. Failure to provide a correct and timely AP-5615 to the Long-Term Care institution may result in the refusal of the Department to reimburse such Long-Term Care institution care. The AP-5615 form is required in order for a Prior Authorization Request (PAR) to be issued for Long-Term Care institution claim reimbursement.

k. General Instructions:

i) The AP-5615 form must be verified and a signed AP-5615 form returned to the Long-Term Care institution.

ii) The AP-5615 form must be signed and dated by the director of the Eligibility Site or by his/her designee.

iii) AP-5615 forms may be initiated by either the Long-Term Care institution or Eligibility Site. If the Eligibility Site is aware of information requiring a change in financial arrangements of a resident, and a new AP-5615 form is not forthcoming from the Long-Term Care institution, the Eligibility Site may initiate the revision to

the AP-5615 form. In such case, one copy of the AP-5615 form showing the changes will be sent to the Long-Term Care institution.

l. The Department may deduct excess payments from the Eligibility Site administrative reimbursement as stated in the Colorado Department of Human Services Finance Staff Manual, Volume 5 if the Eligibility Site fails to:

i) Perform the duties as detailed in this section; or

ii) Adhere to the limitations on a reduced patient payment; as detailed in section 8.100.7.V.4; or

iii) Notify the Long-Term Care institution within 5 working days of any changes in resident income, provided the Long-Term Care institution is not authorized to receive the resident's income; and excessive Medicaid funds are paid to the Long-Term Care institution as a result of this negligence.

2. Collection of Patient Payment

a. It shall be the responsibility of the Long-Term Care institution to collect from the client, or from the client's family, conservator or administrator, the patient payment, which is to be applied to the cost of client care. The Department is not responsible for any deficiency in patient payment accounts, due to failure of the Long-Term Care institution to collect such income.

b. If, however, the Long-Term Care institution is unable to collect such funds, through refusal of the resident or the resident's family, conservator, administrator or responsible party to release such income, the Long-Term Care institution shall immediately notify the Eligibility Site.

c. When notified by the Long-Term Care institution of the refusal of the client or the client's family, conservator administrator or responsible party to pay the patient payment due, the Eligibility Site shall immediately contact the refusing party. If, after such contact, the party still refuses to release such income, the action shall be deemed a failure to cooperate, and the Eligibility Site shall proceed to discontinue Medicaid benefits for the resident.

3. Calculation of Patient Payment

a. Specific instructions for computing the patient payment amount are contained in this volume under The “Status of Long-Term Care institution Care” Form, AP-5615

b. Once an applicant for Nursing Facility Medical Assistance has been determined eligible for Medical Assistance, the Eligibility Site shall determine the patient payment due to the Nursing Facility which is to be applied to the Medicaid reimbursement for the cost of care. That patient payment is calculated by:

i) Determining all applicable income of the recipient

ii) Deducting all applicable allowable monthly income adjustments, which include:

1) Personal Needs Allowance

2) If applicable, Monthly Income Allowance for the community spouse.

3) If applicable, Family Dependent Allowance

4) If applicable, Home Maintenance Allowance

5) If applicable, Trustee/Maintenance Fees: actual fees, with a maximum of $20 per month

6) If applicable, Mandatory Income Tax Withheld

7) Mandatory garnishments repaying Federal assistance overpayment

8) Medical or remedial care expenses that are not subject to payment by a third party:

a) Medicare Part B Premium expenses, if applicable, are deductible only for the first and second month in the Nursing Facility.

b) Medicare Part D Premium expenses, if applicable, are ongoing deductions.

c) Other medical and remedial expenses covered under the Nursing Facility PETI (NF PETI) program are not deductible. NF PETI-approved expenses are allowed only for residents with a patient payment, but do not change the patient payment amount. For NF PETI, see the Section 8.482.33 in this volume “Post Eligibility Treatment of Income”.

c. Long-Term Care Insurance

Long-Term Care insurance payments are not counted as income for eligibility purposes. However, they are income available for a patient payment. The patient payment shall include the client’s income after the allowable deductions and any Long-Term Care insurance payments for the month. In the event that the patient payment is greater than the cost of care, the Long-Term Care insurance payment shall be applied before the client’s income.

i) If Long-Term Care insurance is received for the month, and:

1) If, after all deductions, the client has income available for a patient payment, add this to the amount of the Long-Term Care insurance to determine the total patient payment.

a) If the total amount is greater that the allowable cost of care, the Long-Term Care insurance is applied before the client’s income, or;

b If after all deductions, the client does not have income available for the patient payment, only the Long-Term Care insurance payment is used.

d. Personal Needs Allowances

i) Non-Veteran related personal needs allowance

1) Prior to January 1, 2015 the personal needs allowance base amount is $50 per month.

2) Effective January 1, 2015 the personal needs allowance base amount is $75 per month and will be adjusted annually at the same rate as the statewide average of the nursing facility per diem rate net of patient payment pursuant to C.R.S. § 25.5-6-202(9)(b)(I). Each yearly adjustment will set a new base amount.

a) The first annual rate adjustment to the new $75 base amount will occur on January 1, 2015.

ii) Veterans-related personal needs allowance

Effective 07/01/91, the personal needs allowance shall be $90 per month for a veteran in a Long-Term Care institution who has no spouse or dependent child and who receives a non-service connected disability pension from the U.S. Veterans Administration. The personal needs allowance shall also be $90 per month for the widow(er) of a veteran with no dependent children.

1) Public Law requires that a veteran, without a spouse or dependent child, who enters a Long-Term Care institution have their veteran's pension reduced to $90 which is to be reserved for their personal needs. This reduction in pension is not applicable to veteran's who reside in a State Veteran's Nursing facility. If a veteran, who does not reside in a State Veteran's Nursing facility, receives a pension reduction of $90 he/she is allowed to apply this $90 to his/her personal needs allowance. It is not considered income toward the patient payment. The same regulation applies to a widow of a veteran without any dependent children.

2) To verify if those veterans residing in State Veteran's Nursing facilities are receiving a non-service connected pension you may request their award letter from the Department of Veterans Affairs or call the Department of Veterans Affairs and verify through contact. If they are receiving any amount in a non-service connected pension they are entitled to a $90 personal needs allowance so long as they do not have a spouse or dependent child. The same regulation applies to a widow of a veteran without any dependent children.

iii) For aged, disabled, or blind Long-Term Care institution recipients engaged in income-producing activities, an additional amount of $65 per month plus one-half of the remaining gross income may be retained by the individual.

iv) Effective September 15, 1994, aged, disabled, or blind Long-Term Care institution residents, HCBS or PACE recipients with mandatory withholdings from earned or unearned income to cover federal state, and local taxes may have an additional amount included as a deduction from the patient payment. The patient payment deduction must be for a specific accounting period when the taxes are owed and expected to be withheld from income or paid by the individual in the accounting period. The Eligibility Site must verify that the taxes were withheld. If the taxes are not paid, the Eligibility Site must establish a recovery. The

deduction is also applicable for any Federal pensions with mandated tax withholdings from unearned income despite the individual earner being institutionalized. All other pensions will discontinue the tax withholding once notified that the recipient is receiving institutionalized care through Medicaid, thus signifying that the withholding was not mandatory. This deduction does not apply to individuals who have elected to have taxes withheld from their earnings as a means to receiving a greater tax refund.

e. The reserve specified in section 8.100.7.V.3.d.iii. of this volume shall apply to Long-Term Care institution residents who are engaged in income-producing activities on a regular basis. Types of income-producing activities include:

i) work in a sheltered workshop or work activity center;

ii) “protected employment” which means the employer gives special privileges to the individual;

iii) an activity that produced income in connection with a course of vocational rehabilitation;

iv) employment training sessions;

v) activities within the facility such as crafts products and facility employment.

f. In determining the personal needs reserve amount for Long-Term Care institution residents engaged in income-producing activities:

i) The personal needs allowance is reserved from earned income only when the person has insufficient unearned income to meet this need;

ii) In determining countable earned income of a Long-Term Care institution resident, the following rules shall apply:

1) $65 shall be subtracted from the gross earned income.

2) The result shall be divided in half.

3) The remaining income is the countable earned income and shall be considered in determining the patient payment.

iii) When the personal needs allowance is reserved from unearned income, the additional reserve is computed based on the total gross earned income.

g. Other Deductions Reserved from Recipient's Income:

i) In the case of a married, long-term care recipient who is institutionalized in a Long-Term Care institution and who has a spouse (and, in some cases, other dependent family members) living in the community, there are “spousal protection” rules which permit the contribution of the institutionalized spouse's income toward their living expenses. See section 8.100.7.K.

ii) For a Long-Term Care institution recipient with no family at home, an amount in addition to the personal needs allowance may be reserved for maintenance of the recipient's home for a temporary period, not to exceed 6 months, if a physician has certified that the person is likely to return to his/her home within that period.

This additional reserve from recipient income is referred to as Home Maintenance Allowance and the amount of the deduction must be based on actual and verified shelter expenses such as mortgage payments, taxes, utilities to prevent freeze, etc.

The Home Maintenance Allowance:

1) Prior to July 1, 2018 shall not exceed the total of the current shelter and utilities components of the applicable standard of assistance (OAP for aged recipients; AND/SSI-CS or AB/SSI-CS for disabled or blind recipients).

2) Beginning July 1, 2018

a) The Home Maintenance Allowance shall not exceed the Home Maintenance Allowance Maximum described in this section.

Claimable utility costs will be limited to the lessor of the following amounts:

The standard utility allowance used by Colorado under 7 U.S.C. 2014(e) (2018), which is hereby incorporated by reference.

The incorporation of 7 U.S.C. 2014(e) (2018) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

Or;

The individual’s actual, verified, utility expenses.

b) The Maximum Home Maintenance Allowance is The Individual Needs Standard minus 105% Federal Poverty Limit (FPL) for a household of 1, rounded to the nearest whole dollar, and is determined as follows:

(1) The Department will calculate the Individual Needs Standard by dividing the Federal Minimum Monthly Maintenance Needs Allowance maximum by the Federal Minimum Monthly Maintenance Needs Allowance (MMMNA), described at 8.100.7.Q, which is in place on January 1st of each calendar year. The result of this division will be multiplied by 150% of FPL for a household of 1.

(2) The Home Maintenance Maximum is determined by subtracting 150% FPL for a household of 1 from the Individual Needs Standard and adding 30% of 150% FPL for a household of 1. The result will be rounded to the nearest whole dollar.

h. The necessity for the deduction from a recipient's income specified in section 8.100.7.V.3 shall be fully explained in the case record. Such additional reserve amount must be entered on the eligibility reporting form.

i. As of July 1, 1988, an SSI cash recipient may continue to receive SSI benefits when he/she is expected to be institutionalized for three months or less. This provision is intended to allow temporarily institutionalized recipients to pay the necessary expenses to maintain the principal place of residence.

i) Payments made under this continued benefit provision are not considered over-payments of SSI benefits if the recipient's stay is more than 90 days.

ii) The amount of Supplemental Security Income (SSI) benefit paid to an institutionalized individual is deducted from gross income when computing the patient payment.

j. When a nursing facility resident’s SSI is reduced due to institutionalization, the difference between the reduced SSI payment and the personal needs allowance amount shall be provided through the Adult Financial program so that the resident receives the full personal needs allowance.

4. Reduction of the Patient Payment

a. Patient payment may be reduced only under the following conditions:

i) A resident's income is equal to or less than the personal needs allowance and there is no long term care insurance payment, in which case the patient payment is zero; or

ii) A resident's income is equal to or less than the sum of all allowable and appropriate deductions, and there is no long term care insurance payment; or

iii) A resident is admitted to the Long Term Care institution from his/her home and the resident's funds are committed elsewhere for that month; or

iv) The resident is admitted from his/her home, where his/her funds were previously committed, to the hospital, and subsequently to the Long Term Care institution, in the same calendar month; or

v) The resident is discharged to his/her home, and the Eligibility Site determines that the income is necessary for living expenses; or

vi) The resident is admitted from another Long Term Care institution or from private pay within the facility and has committed the entire patient payment for the month for payment of care already provided in the month of admission.

vii) Medicare assesses a co-insurance payment for a QMB recipient; the recipient’s patient payment cannot be used for payment of Medicare co-insurance.

b. Patient payment may not be waived in the following instances:

i) Transfers between nursing facilities, except that the patient payment for the receiving facility may be waived if the patient payment has already been committed to the former nursing facility; or

ii) Discharges from nursing facility to a hospital or other medical institution when Medicaid is paying for services in the medical institution; or

iii) Changes from private pay within the facility and the patient payment is not already committed for care provided under private pay status; or

iv) The death of the resident.

c. The Eligibility Site shall verify and approve partial month patient payments due to transfers, discharges or death when calculated by the nursing facility based upon the nursing facility's per diem rate.

d. The amount of SSI benefits received by a person who is institutionalized is not considered when calculating patient payment.

5. Responsibilities of the Eligibility Site Regarding the Personal Needs Fund

a. It shall be the responsibility of the Eligibility Site to explain to the resident the various options for handling the personal needs monies, as well as the resident's rights to such funds. The resident has the option to allow the Long Term Care institution to hold such funds in trust.

b. It shall be the responsibility of the Eligibility Site to assure that the Long Term Care institution properly transfers or disposes of the resident's personal needs funds within 30 days of discharge from the Long Term Care institution, or transfer to another Long Term Care institution.

c. The Eligibility Site shall notify the State Department if they become aware that a Long Term Care institution has retained personal needs funds more than 30 days after the death of a resident.

6. For rules regarding post eligibility treatment of income, see the section in this volume titled "Post Eligibility Treatment of Income"

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1
Rule Number: MSB 20-12-03-A
Division / Contact / Phone: Health Programs Office / Ryan Dwyer / 303-866-6163

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 20-12-03-A, Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.018.1.F and 8.018.4.D.1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 12/11/2020
   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.018.1.F with the proposed text beginning at 8.018.1.F through the end of 8.018.1.F. Replace the current text at 8.018.4.D with the proposed text beginning at 8.018.4.D through the end of 8.018.4.D. This rule is effective December 11, 2020.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1
Rule Number: MSB 20-12-03-A
Division / Contact / Phone: Health Programs Office / Ryan Dwyer / 303-866-6163

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule revision expands the definition of Facility in the existing EMT rule. The expanded definition will allow for ambulance transports to a wider range of care locations during the COVID-19 public health emergency, including alternative hospital sites and temporary facilities. The rule also allows for transports between facilities without requiring basic or advanced life support services.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☒ for the preservation of public health, safety and welfare.

   Explain:

   Under the Department's current rule, ambulance trips may only be taken to a limited set of medical facilities, the "closest, most appropriate Facility." CMS recently issued an expanded list of allowable destinations for ambulance trips that qualify for Medicare reimbursement during the COVID-19 public health emergency. This rule will align the Department with that new CMS Medicare guidance by expanding our definition of Facility. The goal is to allow EMT providers to take members to a wider range of medical facilities that are appropriate to the member's condition but that are not necessarily hospitals. This will help prevent hospital overcrowding while also getting members the most appropriate medical care, and will allow utilization of temporary and alternative care sites.

   The second change relates to interfacility transportation, which is ambulance transportation from one facility to another, provided the member requires basic or advanced life support en route. This revision suspends the life support requirement. This will allow for members to be moved from one facility to another if they need continued COVID-19-related care, but do not require life support en route.

3. Federal authority for the Rule, if any:

   State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1
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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Members utilizing or eligible for EMT services (nearly all members are eligible), EMT providers, and facilities treating COVID-19 patients will all benefit from the proposed revisions.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Affected members will benefit from increased access to care, and transportation providers will benefit from greater flexibility in their ability to transport patients. Medical providers and facilities will benefit from an increased ability to transport patients to prevent any one facility from becoming overloaded.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs to the Department or to any other agency to implement and enforce the proposed rule.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The probable benefits of implementation are greater flexibility for EMT providers and the avoidance of overcrowding at hospitals. The benefit to members is that they can receive care in the most appropriate setting. The potential costs are an increase in EMT trips, however EMT trips occur as they are needed. The costs of inaction are potential overcrowding at hospitals and a reduction in willing EMT providers.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

There are no less costly or less intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose for the proposed rule.

8.018 EMERGENCY MEDICAL TRANSPORTATION

8.018.1. DEFINITIONS

8.018.1.A. Air Ambulance means a Fixed-Wing or Rotor-Wing Air Ambulance equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.018.1.B. Client means a person enrolled in the Medical Assistance Program.

8.018.1.C. Emergency Medical Services (EMS) Provider means an individual who has a current and valid emergency medical service provider certificate issued by the Department of Public Health and Environment (CDPHE) and includes Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), Emergency Medical Technician Intermediate (EMT-I), and Paramedic, in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two.

8.018.1.D. Emergency Medical Technician (EMT) means an individual who has a current and valid EMT certificate issued by CDPHE and who is authorized to provide basic emergency medical care in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two.

8.018.1.E. Emergency Medical Transportation means Ground Ambulance or Air Ambulance transportation during which Clients who are ill, injured, or otherwise mentally or physically incapacitated receive needed emergency medical services en route.

8.018.1.F. Facility means a general hospital, hospital unit, psychiatric hospital, rehabilitation hospital, Acute Treatment Unit (ATU), or Crisis Stabilization Unit (CSU), as well as any location that is an alternative site determined to be part of a hospital, Critical Access Hospital (CAH) or Skilled Nursing Facility (SNF), community mental health centers, federally qualified health centers (FQHCs), physician's offices, urgent care facilities, ambulatory surgery centers (ASCs), any other location furnishing dialysis services outside of the End Stage Renal Disease (ESRD) facility, and the beneficiary's home..

8.018.1.G. Fixed-Wing Air Ambulance means a fixed-wing aircraft that is certified as a Fixed-Wing Air Ambulance by the Federal Aviation Administration.

8.018.1.H. Ground Ambulance means a ground vehicle, including a water ambulance, equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.018.1.I. Interfacility Transportation means transportation of a Client from one Facility to another Facility.

8.018.1.J. Life-Sustaining Supplies means oxygen and oxygen supplies required for life-sustaining treatment during transport via ambulance.

8.018.1.K. Mileage means the number of miles the Client is transported in the ambulance.

8.018.1.L. Non-Emergent Medical Transportation (NEMT) means transportation to or from medically necessary non-emergency treatment that is covered by the Colorado Medical Assistance Program under Section 8.014. Non-emergency care may be scheduled or unscheduled. This may include urgent care transportation and hospital discharge transportation.

8.018.1.M. Paramedic means an individual who has a current and valid Paramedic certificate issued by CDPHE and who is authorized to provide acts of advanced emergency medical care in

accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two. For the purposes of these rules, Paramedic includes the historic Emergency Medical Service Provider level of EMT-Paramedic (EMT-P).

8.018.1.N. Paramedic with Critical Care Endorsement means an individual who has a current and valid Paramedic certificate issued by CDPHE and who has met the requirements in CDPHE rule to obtain a critical care endorsement from CDPHE and is authorized to provide acts in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight relating to critical care, as set forth in C.R.S. § 25-3.5-206.

8.018.1.O. Rotor-Wing Air Ambulance means a helicopter that is certified as an ambulance by the Federal Aviation Administration.

8.018.1.P. Specialty Care Transport (SCT) means interfacility Ground Ambulance transportation of a critically injured or ill Client from a stabilizing hospital to a hospital with full capabilities to treat the Client's case. SCT is necessary when a Client's condition requires ongoing care during transport at a level of service beyond the scope of the EMT, that must be furnished by one or more health professionals in an appropriate specialty area including, but not limited to, nursing, emergency medicine, respiratory care, cardiovascular care, or a Paramedic with Critical Care Endorsement.

8.018.2. CLIENT ELIGIBILITY

8.018.2.A. Emergency Medical Transportation is a benefit for all Colorado Medical Assistance Program Clients who are ill, injured, or otherwise mentally or physically incapacitated and in need of immediate medical attention to prevent permanent injury or loss of life.

8.018.3. PROVIDER ELIGIBILITY

8.018.3.A. Providers must enroll with the Colorado Medical Assistance Program as an Emergency Medical Transportation provider to be eligible for reimbursement. Enrolled Emergency Medical Transportation providers must:

1. Meet all provider screening requirements in Section 8.125.

2. Comply with commercial liability insurance requirements.

3. Maintain and comply with the appropriate licensure:

    a. Ground Ambulance license as required by CDPHE statute at C.R.S. § 25-3.5-301 and 6 CCR 1015-3, Chapter Four.

    b. Air Ambulance license as required by CDPHE statute at C.R.S. § 25-3.5-307 and 6 CCR 1015-3, Chapter Five.

4. License, operate, and equip Ground and Air Ambulances in accordance with federal and state regulations.

8.018.4. COVERED SERVICES

8.018.4.A. Emergency Medical Transportation is a covered service when medically necessary, as defined in Section 8.076.1.8., and in accordance with this Section 8.018.4.

8.018.4.B. Ground Ambulance

1. The following Ground Ambulance Emergency Medical Transportation services are covered:

    a. Transportation to the closest, most appropriate Facility.

    b. Basic life support (BLS) or advanced life support (ALS) required to maintain life during transport from the Client's pickup point to the treating Facility.

        i. BLS includes:

            1. Cardiopulmonary resuscitation, without cardiac/hemodynamic monitoring or other invasive techniques;

            2. Suctioning en route (not deep suctioning); and

            3. Airway control/positioning.

        ii. ALS includes ALS Levels 1 and 2 in accordance with 42 CFR § 414.605 (2019), which is hereby incorporated by reference. This incorporation by reference excludes later amendments to, or editions of, the referenced materials. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours, at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

            1. ALS Level 1 includes the provision of at least one ALS intervention required to be furnished by ALS personnel.

            2. ALS Level 2 includes:

                a. Administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or

                b. The provision of at least one of the following ALS procedures:

                i. Manual defibrillation/cardioversion.

                ii. Endotracheal intubation.

                iii. Central venous line.

                iv. Cardiac pacing.

                v. Chest decompression.

                vi. Surgical airway.

                vii. Intraosseous line.

c. Specialty Care Transport when medically necessary to reach the closest, most appropriate Facility.

d. Department-approved supplies used during Emergency Medical Transportation, including Life-Sustaining Supplies, are separately reimbursable when medically necessary.

8.018.4.C. Air Ambulance

1. Air Ambulance Emergency Medical Transportation services are covered when:

a. They meet the criteria at Section 8.018.4.B.1.a.-b.; and

b. The point of pick up is inaccessible by a Ground Ambulance, or great distances or other obstacles prohibit transporting the Client by land to the nearest appropriate medical Facility.

8.018.4.D. Interfacility Transportation

1. Interfacility Transportation is covered when:

a. The Client requires a transfer from one Facility to another.

2. Interfacility Transportation can be provided via Ground or Air Ambulance.

8.018.5. NON-COVERED SERVICES AND GENERAL LIMITATIONS

8.018.5.A. The following services are not covered or reimbursable to Emergency Medical Transportation providers as part of an Emergency Medical Transportation service:

1. Waiting time and cancellations.

2. Transportation of additional passengers.

3. Response calls when determined no transportation is needed or approved.

4. Charges when the Client is not in the vehicle.

5. Non-benefit services (e.g., first aid) provided at the scene when transportation is not necessary.

6. Transportation which is covered by another entity.

7. Transportation to local treatment programs not enrolled in Colorado Medical Assistance Program.

8. Transportation of a Client who is deceased prior to transport.

9. Pick up or delivery of prescriptions or supplies.

10. Transportation arranged for a Client’s convenience when there is no reasonable risk of permanent injury or loss of life.

11. Transportation to non-emergency medical appointments or services. See Section 8.014 for NEMT services.

8.018.6. PRIOR AUTHORIZATION

8.018.6.A. Prior Authorization is not required for Emergency Medical Transportation.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3
Rule Number: MSB 20-12-03-B
Division / Contact / Phone: Health Programs Office / Ryan Dwyer / 303-866-6163

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 12/11/2020
   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.014 with the proposed text beginning at 8.014.1 through the end of 8.014.8. This rule is effective December 11, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3
Rule Number: MSB 20-12-03-B
Division / Contact / Phone: Health Programs Office / Ryan Dwyer / 303-866-6163

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule revision permits NEMT services for covered Medicaid services to locations that are not enrolled with the Colorado Medical Assistance Program. The purpose of this rule is to expand the list of allowable NEMT destinations to include alternative care sites (e.g., the Colorado Convention Center) that are not covered places of service. By temporarily waiving the covered place of service requirement, members can receive treatment for COVID-19 at a wider range of locations. This will potentially increase hospital capacity by shifting patients to sites that are not enrolled with the Colorado Medical Assistance Program.

   In addition, the revision suspends the ability for NEMT providers to transport more than one member at a time, unless the additional passenger is an approved Escort.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☒ for the preservation of public health, safety and welfare.

   Explain:

   Permitting NEMT trips to non-covered places of service will prevent hospital overcrowding while ensuring that members receive treatment for COVID-19. The change allows flexibility and takes advantage of newly established alternative care sites that may be temporary in nature and thus not enrolled in the Colorado Medical Assistance Program. If members with COVID-19 can only receive care at covered places of service, those sites may become overcrowded and may see a shortage of available beds.

   Suspending multi-loading will ensure compliance with social distancing guidelines by limiting a vehicle's occupants.

3. Federal authority for the Rule, if any:

   42 CFR 440.170 (2020)

4. State Authority for the Rule:

Initial Review
Proposed Effective Date
Final Adoption
Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);
25.5-5-324, C.R.S. (2019)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3
Rule Number: MSB 20-12-03-B
Division / Contact / Phone: Health Programs Office / Ryan Dwyer / 303-866-6163

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Members utilizing or eligible for NEMT services (nearly all members with State Plan/Title XIX are eligible), NEMT providers, and facilities treating COVID-19 patients will all benefit from the proposed revisions.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Affected members will benefit from increased access to care, and transportation providers will benefit from a slight uptick in utilization when trip volumes have fallen. Medical providers and facilities will benefit from an increased ability to transport patients to prevent any one facility from becoming overloaded.

   For the multi-loading revision, members and drivers will benefit from a reduction in potential exposure to COVID-19. Drivers will not see a reduction in trip volume because the Department previously issued guidance that suspended multi-loading during the public health emergency. This rule simply formalizes that guidance.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no costs to the Department or to any other agency to implement and enforce the proposed rule.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   For the covered place of service requirement, the probable cost of the proposed rule is a potential minimal increase in utilization, which is more than offset by the reduction in NEMT utilization during the stay at home order. The benefits of the proposed rule are increased access to care and the ability to move members to different sites as they recover, which frees up hospital beds.

The cost of inaction is that members in a hospital for COVID-19 will continue to tie up beds if they cannot be moved to an alternate location as they recover. This will potentially strain hospital resources.

For multi-loading, the cost of the revision is a small increase in claims. One driver will have to take one patient at a time rather than multiple patients on the same route. As a result, the Department will need to dispatch more drivers. The cost will be offset by the substantial reduction in NEMT utilization for March and April. The benefit to implementation is that drivers and passengers will maintain social distancing standards and reduce the spread of COVID-19.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or less intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose for the proposed rule.

8.014 NON-EMERGENT MEDICAL TRANSPORTATION

8.014.1. DEFINITIONS

8.014.1.A. Access means the ability to make use of.

8.014.1.B. Air Ambulance means a Fixed-Wing or Rotor-Wing Air Ambulance equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.014.1.C. Ambulatory Vehicle means a passenger-carrying vehicle available for those clients able to walk and who do not rely on wheelchairs or other mobility devices, during boarding or transportation, which would necessitate a vehicle with a lift or other accommodations.

8.014.1.D. Ancillary Services mean services incurred indirectly when a client authorized to receive NEMT also requires the assistance of an Escort or financial assistance for meals or lodging.

8.014.1.E. At-Risk Adult means an adult who is unable to make personal or medical determinations, provide necessary self-care, or travel independently.

8.014.1.F. Child means a minor under the age of 18.

8.014.1.G. Day Treatment means facility-based services designed for Children with complex medical needs. Services include educational or day care services when the school or day care system is unable to provide skilled care in a school setting, or when the Child's medical needs put them at risk when around other Children.

8.014.1.H. Emergency Medical Transportation means Ground Ambulance or Air Ambulance transportation under Section 8.018 during which clients who are ill, injured, or otherwise mentally or physically incapacitated receive needed emergency medical services en route

8.014.1.I. Escort means a person who accompanies an At-Risk Adult or minor client.

8.014.1.J. Fixed-Wing Air Ambulance means a fixed wing aircraft that is certified as a Fixed-Wing Air Ambulance by the Federal Aviation Administration.

8.014.1.K. Ground Ambulance means a ground vehicle, including a water ambulance, equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.014.1.L. Medicaid Client Transport (MCT) Permit means a permit issued by the Colorado Department of Regulatory Agencies Public Utilities Commission (PUC) in accordance with the PUC statute at Section 40-10.1-302, C.R.S.

8.014.1.M. Mode means the method of transportation.

8.014.1.N. Non-Emergent Medical Transportation (NEMT) means transportation to or from medically necessary non-emergency treatment. Non-emergency care may be scheduled or unscheduled. This may include Urgent Care transportation and hospital discharge transportation.

8.014.1.O. Program of All Inclusive Care for the Elderly (PACE) is a capitated rate benefit which provides all-inclusive long-term care to certain individuals as defined in Section 8.497.

8.014.1.P. Rotor-Wing Air Ambulance means a helicopter that is certified as an ambulance by the Federal Aviation Administration.

8.014.1.Q. State Designated Entity (SDE) means the organization responsible for administering NEMT. For the purposes of this rule, the responsible SDE is determined by the client's county of residence.

8.014.1.R. Stretcher Van means a vehicle that can legally transport a client in a prone or supine position when the client does not require medical attention en route. This may be by stretcher, board, gurney, or another appropriate device.

8.014.1.S. Taxicab means a motor vehicle operating in Taxicab Service, as defined in 4 CCR 723-6, § 6001(yyy) (2019), which is hereby incorporated by reference.

8.014.1.T. Taxicab Service has the same meaning as defined in 4 CCR 723-6, § 6001(yyy) (2019), which is hereby incorporated by reference.

8.014.1.U. Trip means one-way transportation from the point of origin to the point of destination.

8.014.1.V. Urgent Care means an appointment for a covered medical service with verification from an attending physician or facility that the client must be seen or picked up from a discharged appointment within 48 hours.

8.014.1.W. Wheelchair Vehicle means a motor vehicle designed and used for the non-emergent transportation of individuals with disabilities who use a wheelchair. These vehicles include vans modified for wheelchair Access or wheelchair accessible minivans.

8.014.2. CLIENT ELIGIBILITY AND RESPONSIBILITIES

8.014.2.A. All Colorado Medical Assistance Program clients are eligible for NEMT services unless the client falls within the following eligibility groups on the date of the Trip:

1. Qualified Medicaid Beneficiary (QMB) Only

2. Special Low Income Medicare Beneficiary (SLMB) Only

3. Medicare Qualifying Individual-1 (QI-1) Only

4. Old Age Pension- State Only (OAP-state only)

8.014.2.B. Child Health Plan Plus clients are not eligible for NEMT.

8.014.2.C. PACE clients receive transportation provided by their PACE organization and are not eligible for NEMT.

8.014.2.D. NEMT services may be denied if clients do not observe the following responsibilities:

1. Comply with applicable state, local, and federal laws during transport.

2. Comply with the rules, procedures and policies of the SDE.

3. Obtain authorization from their SDE.

4. Clients must not engage in violent or illegal conduct while utilizing NEMT services.

5. Clients must not pose a direct threat to the health or safety of themselves or others, including drivers.

6. Clients must cancel their previously scheduled NEMT Trip if the ride is no longer needed, except in emergency situations or when the client is otherwise unable to cancel.

8.014.3. PROVIDER ELIGIBILITY AND RESPONSIBILITIES

8.014.3.A. Providers must enroll with the Colorado Medical Assistance Program as an NEMT provider.

8.014.3.B. Enrolled NEMT providers must:

1. Meet all provider screening requirements in Section 8.125;

2. Comply with commercial liability insurance requirements and, if applicable, PUC financial responsibility requirements established in the PUC statute at C.R.S. § 40-10.1-107;

3. Refrain from attempting to solicit clients known to have already established NEMT service with another provider;

4. Maintain and comply with the following appropriate licensure, or exemption from licensure, requirements:

   a. PUC common carrier certificate as a Taxicab;

   b. PUC MCT Permit as required by the PUC statute at C.R.S. § 40-10.1-302;

   c. Ground Ambulance license as required by Department of Public Health and Environment (CDPHE) rule at 6 CCR 1015-3, Chapter Four;

   d. Air Ambulance license as required by CDPHE rule at 6 CCR 1015-3, Chapter Five; or

   e. Exemption from licensure requirements in accordance with PUC statute at C.R.S. § 40-10.1-105.

5. Only provide NEMT services appropriate to their current licensure(s) and within the geographic limitations applicable to the licensure; and

6. Ensure that all vehicles and auxiliary equipment used to transport clients meet federal, state, and local safety inspection and maintenance requirements.

PUC statute at C.R.S. §§ 40-10.1-105, 40-10.1-107 and 40-10.1-302 (2019) and CDPHE rule at 6 CCR 1015-3, Chapters Four and Five (2019), are hereby incorporated by reference.

8.014.3.C. NEMT transportation providers must maintain a Trip report for each NEMT Trip provided and must, at a minimum, include:

1. The pick-up address;

2. The destination address;

3. Date and time of the Trip;

4. Client’s name or identifier;

5. Confirmation that the driver verified the client’s identity;

6. Confirmation by the client, Escort, or medical facility that the Trip occurred;

7. The actual pick-up and drop off time;

8. The driver's name; and

9. Identification of the vehicle in which the Trip was provided.

8.014.3.D. Multiple Loading

1. NEMT providers may not transport more than one client at the same time, unless the additional passenger is an Escort.

2. NEMT providers may transport more than one client at the same time if the trip occurs in a bus. Each client must agree to be transported with other clients and clients must sit at least six feet apart.

8.014.3.E. The Section 8.014.3 requirements do not apply to client reimbursement or bus or rail systems.

8.014.4. COVERED PLACES OF SERVICE

8.014.4.A. NEMT must be provided to the closest provider available qualified to provide the service the client is traveling to receive. Exceptions may be made by the SDE in the following circumstances:

1. If the closest provider is not willing to accept the client, the client may use NEMT to access the next closest qualified provider.

2. If the client has complex medical conditions that restrict the closest medical provider from accepting the patient, the SDE may authorize NEMT to be used to travel to the next closest qualified provider. The treating medical provider must send the SDE written documentation indicating why the client cannot be treated by the closest provider.

3. If a client has moved within the three (3) months preceding an NEMT transport, the client may use NEMT to their established medical provider seen in their previous locale. During these three (3) months, the client and medical provider must transfer care to the closest provider as defined at Section 8.014.4.B. or determine transportation options other than NEMT.

8.014.5. COVERED SERVICES

8.014.5.A. Transportation Modes

1. Covered Modes of transportation include:

a. Bus and public rail systems

i. Transit passes may be issued by the SDE when the cumulative cost of bus tickets exceeds the cost of a pass.

b. Personal vehicle mileage reimbursement

c. Ambulatory Vehicles

d. Wheelchair Vehicles

e. Taxicab Service

f. Stretcher Van

g. Ground Ambulance

h. Air Ambulance

i. Commercial plane

j. Train

8.014.5.B. NEMT Services

1. NEMT is a covered service when:

a. The client does not have Access to other means of transportation, including free transportation;

b. Transportation is required to obtain a non-emergency service(s) that is medically necessary, as defined in Section 8.076.1.8.; and

c. The client is receiving a service covered by the Colorado Medical Assistance Program.

2. NEMT services may be covered for clients even if the medical procedure is paid for by an entity other than the Colorado Medical Assistance Program.

3. Non-emergent ambulance service (Ground and Air Ambulance), from the client's pickup point to the treating facility, is covered when:

a. Transportation by any other means would endanger the client's life; or

b. The client requires basic life support (BLS) or advanced life support (ALS) to maintain life and to be transported safely.

i. BLS includes:

1. Cardiopulmonary resuscitation, without cardiac/hemodynamic monitoring or other invasive techniques;

2. Suctioning en route (not deep suctioning); and

3. Airway control/positioning.

ii. ALS includes ALS Levels 1 and 2 in accordance with 42 CFR § 414.605 (2019), which is hereby incorporated by reference.

1. ALS Level 1 includes the provision of at least one ALS intervention required to be furnished by ALS personnel.

2. ALS Level 2 includes:

a. Administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or

b. The provision of at least one of the following ALS procedures:

i. Manual defibrillation/cardioversion.

ii. Endotracheal intubation.

iii. Central venous line.

iv. Cardiac pacing.

v. Chest decompression.

vi. Surgical airway.

vii. Intraosseous line.

4. NEMT may be provided to an Urgent Care appointment under the following circumstances:

a. A provider is available;

b. The appointment is for a covered medical service with verification from an attending physician that the client must be seen within 48 hours; and

c. The client is transported to an Urgent Care facility, which may include a trauma center if it is the nearest and most appropriate facility.

8.014.5.C. Personal Vehicle Mileage Reimbursement

1. Personal vehicle mileage reimbursement is covered for a privately owned, non-commercial vehicle when used to provide NEMT services in accordance with Section 8.014.5.B and owned by:

a. A client, a client’s relative, or an acquaintance; or

b. A volunteer or organization with no vested interest in the client.

2. Personal vehicle mileage reimbursement will only be made for the shortest Trip length in miles as determined by an internet-based map, Trip planner, or other Global Positioning System (GPS).

a. Exceptions can be made by the SDE if the shortest distance is impassable due to:

i. Severe weather;

ii. Road closure; or

iii. Other unforeseen circumstances outside of the client's control that severely limit using the shortest route.

b. If an exception is made under Section 8.014.5.C.2.a., the SDE must document the reason and pay mileage for the actual route traveled.

3. To be reimbursed for personal vehicle mileage, the client must provide the following information to the SDE within forty-five (45) calendar days of the final leg of the Trip:

a. Name and address of vehicle owner and driver (if different from owner);

b. Name of the insurance company and policy number for the vehicle; and

c. Driver's license number and expiration date.

8.014.5.D. Ancillary Services

1. Escort

a. The Colorado Medical Assistance Program may cover the cost of transporting one Escort when the client is:

i. A Child.

1. An Escort is required to accompany a client if the client is under thirteen (13) years old, unless the Child:

a. Is traveling to a Day Treatment program (Children are not eligible for NEMT travel to and from school-funded day treatment programs);

b. The parent or guardian signs a written release;

c. An adult will be present to receive the Child at the destination and return location; and

d. The Day Treatment program and the parents approve of the NEMT provider used.

2. Clients who are at least thirteen (13) years old, but younger than eighteen (18) years old, may travel without an Escort if:

a. The parent or guardian signs a written release; andAn adult will be present to receive the Child at the destination and return location.

ii. An At-Risk Adult unable to make personal or medical determinations, or to provide necessary self-care, as certified in writing by the client's attending Colorado Medical Assistance Program enrolled NEMT provider.

b. The Escort must be physically and cognitively capable of providing the needed services for the client.

i. If a client's primary caregiver has a disability that precludes the caregiver from providing all of the client's needs during transport or extended stay, a second Escort may be covered under Section 8.014.5.D.1.c.ii.

c. The Colorado Medical Assistance Program may cover the cost of transporting a second Escort for the client, if prior authorized under Section 8.014.7. A second Escort will only be approved if:

i. The client has a behavioral or medical condition which may cause the client to be a threat to self or to others if only one Escort is provided; or

ii. The client's primary caregiver Escort has a disability that precludes the caregiver from providing all of the client's needs during transport or extended stay.

2. Meals and Lodging

a. Meals and lodging for in-state treatment may be reimbursed when:

i. Travel cannot be completed in one calendar day; or

ii. The client requires ongoing, continuous treatment and:

1. The cost of meals and lodging is less than or equal to the cost of traveling to and from the treatment facility and the client's residence; or

2. The client's treating medical professional determines that traveling to and from the client's residence would put the client's health at risk.

b. Meals and lodging may be covered for the Escort(s) when the client is a Child or an At-Risk Adult who requires the Escort's continued stay under Section 8.014.5.D.1.

c. Reimbursement will only be made for meals and lodging for which clients and Escorts are actually charged, up to the per diem rate established by the Colorado Medical Assistance Program.

d. Meals and lodging will not be paid or reimbursed when those services are included as part of an inpatient stay.

8.014.6. NON-COVERED NEMT SERVICES AND GENERAL LIMITATIONS

8.014.6.A. The following services are not covered or reimbursable to NEMT providers as part of a NEMT service:

1. Services provided only as a convenience to the client.

2. Charges incurred while client is not in the vehicle, except for lodging and meals in accordance with Section 8.014.5.D.2.

3. Transportation to or from non-covered medical services, including services that do not qualify due to coverage limitations..

4. Waiting time.

5. Cancellations.

6. Transportation which is covered by another entity.

7. Metered taxi services.

8. Charges for additional passengers, including siblings or Children, not receiving a medical service, except when acting as an Escort under Section 8.014.5.D.1.

9. Transportation for nursing facility or group home residents to medical or rehabilitative services required in the facility's program, unless the facility does not have an available vehicle.

10. Transportation to emergency departments to receive emergency services. See Section 8.018 for Emergency Medical Transportation services.

11. Providing Escorts or the Escort's wages.

12. Trips to receive Home and Community Based Services

    a. Non-medical transportation should be utilized if other transportation options are not available to the client.

8.014.6.B. General Limitations

1. The SDE is responsible for ensuring that the client utilizes the least costly Mode of transportation available that is suitable to the client's condition.

8.014.7. AUTHORIZATION

8.014.7.A. All NEMT services must be authorized as required by the SDE.

1. Authorization requests submitted more than three months after an NEMT service is rendered will be denied.

2. NEMT services may be denied if proper documentation is not provided to the SDE.

8.014.7.B. If a client requests transportation via Wheelchair Vehicle, Stretcher Van, or ambulance, the SDE must verify the service is medically necessary with the client's medical provider

1. Medical or safety requirements must be the basis for transporting a client in the prone or supine position.

8.014.7.C. Out-of-State NEMT

1. NEMT to receive out of state treatment is permissible only if treatment is not available in the state of Colorado.

2. The following border towns are not considered out of state for the purposes of NEMT prior authorization:

    a. Arizona: Flagstaff and Teec Nos Pos.

b. Kansas: Elkhart, Goodland, Johnson, Sharon Springs, St. Francis, Syracuse, Tribune.

c. Nebraska: Benkelman, Cambridge, Chappell, Grant, Imperial, Kimball, Ogallala, and Sidney.

d. New Mexico: Aztec, Chama, Farmington, Raton, and Shiprock.

e. Oklahoma: Boise City.

f. Utah: Monticello and Vernal.

g. Wyoming: Cheyenne and Laramie.

8.014.7.D. Prior Authorization

1. The following services require prior authorization by Colorado Medical Assistance Program:

a. Out-of-state travel, except to the border towns identified at section 8.014.7.C.2.

b. Air travel, both commercial air and Air Ambulance.

c. Train travel via commercial railway.

d. Second Escort.

2. Prior authorization requests require the following information:

a. NEMT prior authorization request form completed by SDE and member's physician and submitted to Colorado Medical Assistance Program according to form instructions.

i. The Colorado Medical Assistance Program will return requests completed by non-physicians and incomplete requests to the SDE.

ii. The Colorado Medical Assistance Program's determination will be communicated to the SDE. If additional information is requested, the SDE must obtain the information and submit to the Colorado Medical Assistance Program. If the request is denied, the SDE must send the client a denial notice.

8.014.8. INCORPORATIONS BY REFERENCE

The incorporation by reference of materials throughout section 8.014 excludes later amendments to, or editions of, the referenced materials. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours, at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Federally Qualified Health Centers, Section 8.700
Rule Number: MSB 20-11-09-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 20-11-09-A, Revision to the Medical Assistance Act Rule concerning Federally Qualified Health Centers, Section 8.700

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.700, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 12/11/2020
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.700.6.D with the proposed text beginning at 8.700.6.D.4 through the end of 8.700.6.D.4. This rule is effective December 11, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Federally Qualified Health Centers, Section 8.700
Rule Number: MSB 20-11-09-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this rule revision is to adjust the FQHC rate setting process to consider the changes to utilization and cost due to COVID-19. The pandemic has caused utilization to drop at FQHCs and costs have changed as well. To avoid setting unreasonable rates, this rule revision will set rates for FQHC cost reports with fiscal year ends between May 31, 2020 and March 31, 2021 using the previous year's rates multiplied by the Medicare Economic Index (MEI).

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☒ for the preservation of public health, safety and welfare.

   Explain:

   Without the emergency adoption of this rule revision, FQHC rates could skyrocket causing a serious budget on the Department's budget. This could create issues with our programs and prompt service delivery for our members.

3. Federal authority for the Rule, if any:

   1902(bb) SSA

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

Initial Review Final Adoption
Proposed Effective Date **12/11/2020** Emergency Adoption **12/11/2020**

DOCUMENT #12

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Federally Qualified Health Centers, Section 8.700
Rule Number: MSB 20-11-09-A
Division / Contact / Phone: Fee-For-Service Rates / Erin Johnson /4370

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Federally Qualified Health Centers will be impacted by this rule. This rule revision will set reasonable FQHC rates for time periods where costs and visits were dramatically impacted by the COVID-19 pandemic. FQHCs will benefit from this rule because their rates will neither skyrocket nor drop due to the extreme changes caused by the pandemic.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   FQHC rates will increase by 1.9%. FQHC rates usually increase annually by overall average of 4.0% per year. However, the rate change varies by year and is sometimes negative. Therefore, the Department believes the MEI is a good estimate of how FQHC rates should increase. The MEI is currently used to inflate FQHC's annual cost per visit rate, base rate, and Prospective Payment System (PPS) rate.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   This rule revision will impact the Department and state revenues. Instead of having unpredictable and potentially very high FQHC rates, we will have predictable and reasonable FQHC rates for the near future. The Department will be better able to budget FQHC payments and not see an alarming increase in FQHC payments.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   If the Department does not adopt this rule change FQHC rates will be more unstable and less predictable. It is likely FQHC rates will increase greatly, causing the Department to spend more on FQHCs than expected.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

DO NOT PUBLISH THIS PAGE

There are no other methods that are less costly or less intrusive to achieve the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.
   The Department has considered other ways of setting FQHC rates such as using estimates for pandemic months or another inflationary factor. The MEI was chosen due to its familiarity with FQHCs and by the ease of use.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

A. Federally Qualified Health Center (FQHC) means a hospital-based or freestanding center that meets the FQHC definition found in Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015). Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. 24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule:

B. Visit means a one-on-one, face-to-face, interactive audio, interactive video, or interactive data communication encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor providing the services set forth in Section 8.700.3.A. Group sessions do not generate a billable encounter for any FQHC services.

1. A visit includes a one-on-one, face-to-face, interactive audio, interactive video, or interactive data communication encounter between a center client and a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado providing services set forth in Section 8.700.3.A. The supervised person must hold a candidate permit as a licensed professional counselor or a candidate permit as a licensed marriage and family therapist, or a candidate permit as a psychologist, or a be a licensed social worker. Group sessions do not generate a billable encounter for any FQHC services.

C. The visit definition includes interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) encounters.

1. Any health benefits provided through interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) must meet the same standard of care as in-person care.

8.700.2 CLIENT CARE POLICIES

8.700.2.A The FQHCs health care services shall be furnished in accordance with written policies that are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member of the group shall not be a member of the FQHC staff.

8.700.2.B The policies shall include:

1. A description of the services the FQHC furnishes directly and those furnished through agreement or arrangement. See Section 8.700.3.A.3.

2. Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or client referral, the maintenance of health care records and procedures for the periodic review and evaluation of the services furnished by the FQHC.

3. Rules for the storage, handling and administration of drugs and biologicals.

8.700.3 SERVICES

8.700.3.A The following services may be provided by a certified FQHC:

1. General services

a. Outpatient primary care services that are furnished by a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse midwife visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, licensed addiction counselor or supervised person pursuing mental health licensure as defined in their respective practice acts.

i. Outpatient primary care services that are furnished by a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado as defined in their respective practice acts.

b. Part-time or intermittent visiting nurse care.

c. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under Section 8.700.3.A.1.a and b.

2. Emergency services. FQHCs furnish medical emergency procedures as a first response to common life-threatening injuries and acute illness and must have available the drugs and biologicals commonly used in life saving procedures.

3. Services provided through agreements or arrangements. The FQHC has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to clients, including physician services (whether furnished in the hospital, the office, the client's home, a skilled nursing facility, or elsewhere) and additional and specialized diagnostic and laboratory services that are not available at the FQHC.

8.700.3.B A certified FQHC may also provide any service authorized for payment outside the per visit encounter rate by Section 8.700.6.B.

8.700.4 PHYSICIAN RESPONSIBILITIES

8.700.4.A A physician shall provide medical supervision and guidance for physician assistants and nurse practitioners, prepare medical orders, and periodically review the services furnished by the clinic. A physician shall be present at the clinic for sufficient periods of time to fulfill these responsibilities and must be available at all times by direct means of communications for advice and assistance on patient referrals and medical emergencies. A clinic operated by a nurse

practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians.

8.700.5 ALLOWABLE COST

8.700.5.A The following types and items of cost for primary care services are included in allowable costs to the extent that they are covered and reasonable:

1. Compensation for the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor and licensed addiction counselor and licensure candidates for clinical psychologist, clinical social worker, licensed marriage and family therapist, and licensed professional counselor who owns, is employed by, or furnishes services under contract to an FQHC.

2. Compensation for the duties that a supervising physician is required to perform.

3. Costs of services and supplies related to the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor or licensed addiction counselor.

4. Overhead cost, including clinic or center administration, costs applicable to use and maintenance of the entity, and depreciation costs.

5. Costs of services purchased by the clinic or center.

8.700.5.B Unallowable costs include but are not limited to expenses that are incurred by an FQHC and that are not for the provision of covered services, according to applicable laws, rules, and standards applicable to the Medical Assistance Program in Colorado. An FQHC may expend funds on unallowable cost items, but these costs may not be used in calculating the per visit encounter rate for Medicaid clients.

Unallowable costs, include, but are not necessarily limited to, the following:

1. Offsite Laboratory/X-Ray;

2. Costs associated with clinics or cost centers which do not provide services to Medicaid clients; and,

3. Costs of services reimbursed separately from the FQHC encounter rate as described in Section 8.700.6.B.

8.700.6 REIMBURSEMENT

8.700.6.A FQHCs shall be reimbursed separate per visit encounter rates based on 100% of reasonable cost for physical health services, dental services, and specialty behavioral health services. An FQHC may be reimbursed for up to three separate encounters with the same client occurring in one day and at the same location, so long as the encounters submitted for reimbursement are any combination of the following: physical health encounter, dental encounter, or specialty behavioral health encounter. Distinct dental encounters are allowable only when rendered services are covered and paid by the Department’s dental Administrative Service Organization (ASO). Distinct specialty behavioral health encounters are allowable only when

rendered services are covered and paid by either the Regional Accountable Entity (RAE) or through the short-term behavioral health services in the primary care setting policy.

8.700.6.B The following services are reimbursed separately from the FQHC encounter rate. These services shall be reimbursed in accordance with the following:

1. Long-Acting Reversible Contraception (LARC) devices shall be reimbursed separately from the FQHC encounter rate. In addition to payment of the encounter rate for the insertion of the device(s), the LARC device(s) must be billed in accordance with Section 8.730 and shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

2. Services provided in an inpatient hospital setting shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

3. The provision of complete dentures and partial dentures must be billed in accordance with Section 8.201. and Section 8.202. and shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

4. Dental services provided in an outpatient hospital setting shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

5. The Prenatal Plus Program shall be billed and reimbursed in accordance with Section 8.748.

6. The Nurse Home Visitor Program shall be billed and reimbursed in accordance with Section 8.749.

7. An FQHC that operates its own pharmacy that serves Medicaid clients must obtain a separate Medicaid billing number for pharmacy and bill all prescriptions utilizing this number in accordance with Section 8.800.

8. Antagonist injections for substance use disorders provided at the FQHC shall be reimbursed the lower of:

    a. Submitted charges; or

    b. Fee schedule as determined by the Department.

8.700.6.C A physical health encounter, a dental encounter, and a specialty behavioral health encounter on the same day and at the same location shall count as three separate visits.

1. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

8.700.6.D Encounter rates calculations

Effective July 1, 2018, FQHCs will be paid three separate encounter rates for three separate services: physical health services, dental services, and specialty behavioral health services. Physical health services are covered services reimbursed through the Department's MMIS, except the short-term behavioral health services in the primary care setting policy. Dental services are services provided by a dentist or dental hygienist that are reimbursed by the Department's dental ASO. Specialty behavioral health services are behavioral health services covered and reimbursed by either the RAE or by the MMIS through the short-term behavioral health services in the primary care setting policy. The Department will perform an annual reconciliation to ensure each FQHC has been paid at least their per visit Prospective Payment System (PPS) rate. If an FQHC has been paid below their per visit PPS rate, the Department shall make a one-time payment to make up for the difference.

1. The PPS rate is defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554, Dec. 21, 2000. BIPA is incorporated herein by reference. No amendments or later editions are incorporated.

   Copies are available for a reasonable charge and for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

2. Each alternative payment rate shall be the lower of the service specific annual rate or the service specific base rate. The annual rate and the base rate shall be calculated as follows:

   a. The annual rate for the physical health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for physical health services and visits. The annual rate for the dental rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for dental services and visits provided by a dentist or dental hygienist. The annual rate for the specialty behavioral health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for behavioral health services and visits either covered and reimbursed by the RAE or by the short-term behavioral health services in the primary care setting policy.

   b. The new base rates shall be the audited, calculated, inflated, and weighted average encounter rate for each separate rate, for the past three years. Base rates are recalculated (rebased) annually. Initial Base rates shall be calculated when the Department has two year's data of costs and visits.

   c. Beginning July 1, 2020, a portion of the FQHCs physical health alternative payment methodology rates are at-risk based on the FQHC's

quality modifier. An FQHC's quality modifier is determined by the FQHC's performance on quality indicators in the previous Calendar Year.

3. New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set reimbursement base rates for the first year. The base rates shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as an FQHC. These shall be the FQHCs base rates until the FQHC's final base rates are set.

    a. New base rates may be calculated using the most recent audited Medicaid FQHC cost report for those FQHCs that have received their first federal Public Health Service grant with the three years prior to rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates.

4. The Department shall audit the FQHC cost report and calculate the new annual and base reimbursement rates. If the cost report does not contain adequate supporting documentation, the FQHC shall provide requested documentation within ten (10) business days of request. Unsupported costs shall be unallowable for the calculation of the FQHCs new encounter rate.

    a. Freestanding and hospital-based FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. An extension of up to 75 days may be granted based upon circumstances. Failure to submit a cost report within 180 days after the end of a freestanding FQHCs' fiscal year shall result in suspension of payments.

    b. The new reimbursement encounter rates for FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement encounter rates (if less than the new audited rate) shall remain in effect for an additional day above the 120-day limit for each day the required information is late; if the old reimbursement encounter rates are more than the new rate, the new rates shall be effective the 120th day after the FQHCs fiscal year end.

    c. Effective December 11, 2020, FQHC cost reports with fiscal year ends between May 31, 2020 and March 31, 2021 will be set using the previous year's rates multiplied by the Medicare Economic Index (MEI).

5. If an FQHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the FQHC's PPS rate in accordance with section 1902(bb) of the Social Security Act.

    a. An FQHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the FQHC. The documented change in the scope of service of the FQHC must meet all of the following conditions:

        i. The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as

described in Section 1905(a)(2)(C) of the Social Security Act, and is furnished by the FQHC.

ii. The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.5.

iii. The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.

iv. The net change in the FQHC's per-visit encounter rate equals or exceeds 3% for the affected FQHC site. For FQHCs that file consolidated cost reports for multiple sites in order to establish the initial PPS rate, the 3% threshold will be applied to the average per-visit encounter rate of all sites for the purposes of calculating the cost associated with a scope-of-service change.

v. The change in scope of service must have existed for at least a full six (6) months.

b. A change in the cost of a service is not considered in and of itself a change in scope of service. The change in cost must meet the conditions set forth in Section 8.700.6.D.5.b and the change in scope of service must include at least one of the following to prompt a scope-of-service rate adjustment. If the change in scope of service does not include at least one of the following, the change in the cost of services will not prompt a scope-of-service rate adjustment.

i. The addition of a new service not incorporated in the baseline PPS rate, or deletion of a service incorporated in the baseline PPS rate;

ii. The addition or deletion of a covered Medicaid service under the State Plan;

iii. Changes necessary to maintain compliance with amended state or federal regulations or regulatory requirements;

iv. Changes in service due to a change in applicable technology and/or medical practices utilized by the FQHC;

v. Changes resulting from the changes in types of patients served, including, but not limited to, populations with HIV/AIDS, populations with other chronic diseases, or homeless, elderly, migrant, or other special populations that require more intensive and frequent care;

vi. Changes resulting from a change in the provider mix, including, but not limited to:

a. A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in the services provided by the FQHC;

b. The addition or removal of specialty providers (e.g. pediatric, geriatric, or obstetric specialists) with a

corresponding change in the services provided by the FQHC (e.g. delivery services);

c. Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and/or residents; or,

d. Changes in operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or medical practices at the FQHC, provided that those expenditures result in a change in the services provided by the FQHC.

c. The following items do not prompt a scope-of-service rate adjustment:

i. An increase or decrease in the cost of supplies or existing services;

ii. An increase or decrease in the number of encounters;

iii. Changes in office hours or location not directly related to a change in scope of service;

iv. Changes in equipment or supplies not directly related to a change in scope of service;

v. Expansion or remodel not directly related to a change in scope of service;

vi. The addition of a new site, or removal of an existing site, that offers the same Medicaid-covered services;

vii. The addition or removal of administrative staff;

viii. The addition or removal of staff members to or from an existing service;

ix. Changes in salaries and benefits not directly related to a change in scope of service;

x. Change in patient type and volume without changes in type, duration, or intensity of services;

xi. Capital expenditures for losses covered by insurance; or,

xii. A change in ownership.

d. An FQHC must apply to the Department by written notice within ninety (90) days of the end of the FQHCs fiscal year in which the change in scope of service occurred, in conjunction with the submission of the FQHC’s annual cost report. Only one scope-of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.

e. Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.700.6.D.5.b.4, the FQHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid change in scope of service that occurred in FY 2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may submit a scope-of-service rate adjustment application that captures both of those changes. An FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment, either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

f. The documentation for the scope-of-service rate adjustment is the responsibility of the FQHC. Any FQHC requesting a scope-of-service rate adjustment must submit the following to the Department:

    i. The Department's application form for a scope-of-service rate adjustment, which includes:

        a. The provider number(s) that is/are affected by the change(s) in scope of service;

        b. A date on which the change(s) in scope of service was/were implemented;

        c. A brief narrative description of each change in scope of service, including how services were provided both before and after the change;

        d. Detailed documentation such as cost reports that substantiate the change in total costs, total health care costs, and total visits associated with the change(s) in scope; and

        e. An attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the FQHC;

    ii. Any additional documentation requested by the Department. If the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the FQHC must provide the additional documentation within thirty (30) days. If the FQHC does not submit the additional documentation within the specified timeframe, the Department, at its discretion, may postpone the implementation of the scope-of-service rate adjustment.

g. The reimbursement rate for a scope-of-service change applied for January 30, 2017 or afterwards will be calculated as follows:

i. The Department will first verify the total costs, the total covered health care costs, and the total number of visits before and after the change in scope of service. The Department will also calculate the Adjustment Factor (AF = covered health care costs/total cost of FQHC services) associated with the change in scope of service of the FQHC. If the AF is 80% or greater, the Department will accept the total costs as filed by the FQHC. If the AF is less than 80%, the Department will reduce the costs other than covered health care costs (thus reducing the total costs filed by the FQHC) until the AF calculation reaches 80%. These revised total costs will then be the costs used in the scope-of-service rate adjustment calculation.

ii. The Department will then use the appropriate costs and visits data to calculate the adjusted PPS rate. The adjusted PPS rate will be the average of the costs/visits rate before and after the change in scope of service, weighted by visits.

iii. The Department will calculate the difference between the current PPS rate and the adjusted PPS rate. The “current PPS rate” means the PPS rate in effect on the last day of the reporting period during which the most recent scope-of-service change occurred.

iv. The Department will check that the adjusted PPS rate meets the 3% threshold described above. If it does not meet the 3% threshold, no scope-of-service rate adjustment will be implemented.

v. Once the Department has determined that the adjusted PPS rate has met the 3% threshold, the adjusted PPS rate will then be increased by the Medicare Economic Index (MEI) to become the new PPS rate

h. The Department will review the submitted documentation and will notify the FQHC in writing within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable. The new PPS rate will take effect one hundred twenty (120) days after the FQHC’s fiscal year end.

i. Changes in scope of service, and subsequent scope-of-service rate adjustments, may also be identified by the Department through an audit or review process.

i. If the Department identifies a change in scope of services, the Department may request the documentation as described in Section 8.700.6.D.5.g from the FQHC. The FQHC must submit the documentation within ninety (90) days from the date of the request.

ii. The rate adjustment methodology will be the same as described in Section 8.700.6.D.5.h.

iii. The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable.

iv. The effective date of the scope-of-service rate adjustment will be one hundred twenty (120) days after the end of the fiscal year in which the change in scope of service occurred.

j. An FQHC may request a written informal reconsideration of the Department's decision of the PPS rate change regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department's notification letter. The informal reconsideration must be mailed to the Department of Health Care Policy and Financing, 1570 Grant St, Denver, CO 80203. To request an informal reconsideration of the decision, an FQHC must file a written request that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The FQHC should also include any documentation that supports its position. A provider dissatisfied with the Department's decision after the informal reconsideration may appeal that decision through the Office of Administrative Courts according to the procedures set forth in 10 CCR 2505-10 Section 8.050.3, PROVIDER APPEALS.

6. The performance of physician and mid-level medical staff shall be evaluated through application of productivity standards established by the Centers for Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503; "Medicare Rural Health Clinic and FQHC Manual". If an FQHC does not meet the minimum productivity standards, the productivity standards established by CMS shall be used in the FQHCs' rate calculation.

7. Pending federal approval, the Department will offer a second Alternative Payment Methodology (APM 2) that will reimburse FQHCs a Per Member Per Month (PMPM) rate. FQHCs may opt into APM 2 annually. This reimbursement methodology will convert the FQHC's current Physical Health cost per visit rate into an equivalent PMPM rate using historical patient utilization, member designated attribution, and the Physical Health cost per visit rate for the specific FQHC. Physical health services rendered to patients not attributed to the FQHC, or attributed based on geographic location, will pay at the appropriate encounter rate. Dental and specialty behavioral health services for all patients will be paid at the appropriate encounter rate. Year 2 rates for FQHCs participating in APM 2 will be set using trended data. Year 3 rates will be set using actual data.

8. The Department will perform an annual reconciliation to ensure the PMPM reimbursement compensates APM 2 providers in an amount that is no less than their PPS per visit rate. The Department shall perform PPS reconciliations should the FQHC participating in APM 2 realize additional cost, not otherwise reimbursed under the PMPM, incurred as a result of extraordinary circumstances that cause traditional encounters to increase to a level where PMPM reimbursement is not sufficient for the operation of the FQHC.

9. PMPM and encounter rates for FQHC participating in APM 2 shall be effective on the 1st day of the month that falls at least 120 days after an FQHC's fiscal year end.

8.700.6.E The Department shall notify the FQHC of its rates.

8.700.8 REIMBURSEMENT FOR OUTSTATIONING ADMINISTRATIVE COSTS

8.700.8.A The Department shall reimburse freestanding FQHCs for reasonable costs associated with assisting clients in the Medicaid application process. Beginning with the 2019 Cost Report Cycle, this outstationing payment shall be made based upon actual cost and is included as an allowable cost in an FQHC cost report.

8.700.8.B

1. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. For any hospital-based FQHC Medicaid cost report audited and finalized after July 1, 2005, Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

2. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. Effective with the hospital cost report year 2010 and forward, the Department will make an interim payment to Denver Health Medical Center for estimated reasonable costs associated with outstationing activities based on the costs included in the as-filed Medicare cost report. This interim payment will be reconciled to actual costs after the cost report is audited. Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the interim estimated administrative costs and the final audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Immunization Services.
Rule Number: MSB 20-11-25-A
Division / Contact / Phone: Health Program Office / Whitney McOwen/303-866-4441 / Christina Winship/303-866-5578

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 20-11-25-A, Revision to the Medical Assistance Act Rule concerning Immunization Services.

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.815, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 12/11/2020
   Is rule to be made permanent? (If yes, please attach notice of hearing). No<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.815 with the proposed text beginning at 8.815.1 through the end of 8.815.6.A. This rule is effective December 11, 2020.

*to be completed by MSB Board Coordinator

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Rule Number: MSB 20-11-25-A
Division / Contact / Phone: Health Program Office / Whitney McOwen/303-866-4441 / Christina Winship/303-866-5578

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule revision is required for the Department to comply with section 6008(b)(4) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), P.L. 116-136. Specifically, the Department must reimburse providers for COVID-19 testing services and treatments, including vaccines and the administration of such vaccines, provided to Medicaid enrollees. The Department will otherwise no longer qualify for the temporary 6.2 percentage point increase to the Federal Medical Assistance Percentage (FMAP) (the federal government's contribution toward Colorado's Medicaid expenditure) and will be subject to clawback. Current Department policy limits reimbursement for vaccine administration to members 18 and under exclusively through the Vaccines for Children (VFC) program. This revision will allow the Department to reimburse providers for pediatric administration of any and all vaccines provided free of cost by the federal government.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   This revision is necessary to comply with section 6008(b)(4) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), P.L. 116-136. This provision requires the Department to be able to reimburse for administration of the COVID-19 vaccine currently being developed.

3. Federal authority for the Rule, if any:

   Section 6008(b)(4) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), P.L. 116-136

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);

Initial Review
Proposed Effective Date **12/11/2020**
Final Adoption
Emergency Adoption **12/11/2020**

DOCUMENT #13

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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Health First Colorado members aged 18 and under, and providers licensed to administer vaccines, will benefit from the flexibility provided by this rule revision for providers to administer the COVID-19 vaccine regardless of whether it's distributed specifically through the Vaccines for Children (VFC) program. Current policy limits reimbursement to pediatric vaccines provided through VFC. There are no actual costs anticipated due to this change to members, providers, or the Department.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   The impact to the Department is the avoidance of federal noncompliance and clawback of the increased FMAP percentage. For members aged 18 and under, this revision ensures timely access to the COVID-19 vaccine. This will also expand the number of providers eligible for reimbursement for administration of the COVID-19 vaccine.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no associated costs to the Department or any other agency for the implementation and enforcement of the proposed rule. This revision is anticipated to be budget neutral.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The benefit of the proposed rule is federal compliance and expansion of COVID-19 vaccine administration to the pediatric population. The cost of inaction would be exposure to the risk of clawback of the enhanced FMAP claimed by the Department during the Public Health Emergency and a smaller pool of providers eligible to administer the COVID-19 vaccine to the pediatric population.

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5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or intrusive methods to achieve the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose of the proposed rule because the current rule language is explicit in restricting eligible providers for the pediatric population to those participating in the VFC program.

8.815 IMMUNIZATION SERVICES

8.815.1 Definitions

8.815.1.A. Advisory Committee on Immunization Practices (ACIP) means the group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States. ACIP was established under Section 222 of the Public Health Service Act (42 U.S.C. § 2l7a).

8.815.1.B. Immunization means the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine.

8.815.1.C. School District means any board of cooperative services established pursuant to article 5 of title 22, C.R.S., any state educational institution that serves students in kindergarten through twelfth grade including, but not limited to, the Colorado School for the Deaf and Blind, created in article 80 of title 22, C.R.S., and any public School District organized under the laws of Colorado except a junior college district.

8.815.1.D. Vaccine means a biological preparation that improves immunity to a particular disease.

8.815.1.E. Vaccine Administration Services means the provision of an injection, nasal absorption, or oral administration of a vaccine product.

8.815.1.F. Vaccines for Children (VFC) means the federally funded program administered through the Centers for Disease Control for the purchase and distribution of pediatric vaccines to program-registered providers for the Immunization of vaccine-eligible children 18 years of age and younger.

8.815.2 Client Eligibility

8.815.2.A. All Colorado Medicaid clients are eligible for Immunization and Vaccine Administration Services.

8.815.3 Provider Eligibility

8.815.3.A. Rendering Providers

1. Colorado Medicaid enrolled providers are eligible to administer Vaccines and Vaccine Administration Services as follows:

    a. If it is within the scope of the provider’s practice;

    b. In accordance with the requirements at 10 CCR 2505-10, Section 8.200.2.; and

    c. If the provider is administering Vaccines and Vaccine Administration Services to a client 18 years of age or younger, the provider is using Vaccines provided free of cost by the federal government, including through the VFC program.

8.815.3.B. Prescribing Providers

1. Colorado Medicaid enrolled providers are eligible to prescribe Vaccines and Vaccine Administration Services in accordance with Section 8.815.3.A.1.a.-b.

8.815.4 Covered Services

8.815.4.A. Vaccines identified in the ACIP Vaccine Recommendations and Guidelines are updated routinely and are covered as follows:

1. For clients 18 years of age and younger, Vaccines are either provided through the VFC program or are otherwise provided without cost by the federal government.

2. For clients 19 years of age and older, Vaccines are covered by Colorado Medicaid.

8.815.4.B. Administration of Vaccines identified in the ACIP Vaccine Recommendations and Guidelines is a covered service for all clients.

8.815.4.C. Immunization and Vaccine Administration Services that are provided by home health agencies, physicians, or other non-physician practitioners to clients at nursing facilities, group homes, or residential treatment centers are covered only as follows:

1. Immunization services for clients who are residents of nursing facilities and clients receiving home health services are covered only if ordered by their physician. The skilled nursing component for Immunization administration provided at a nursing facility is included in the facility's rate or part of a regularly scheduled home health service for clients receiving home health services.

2. Clients who are residents of an Alternative Care Facility, as defined at Section 8.495.1, may receive Immunization services from their own physician. They may also receive Immunization services as part of a home health service in accordance with Section 8.815.4.C.1.

8.815.5 Prior Authorization Requirements

8.815.5.A. Prior authorization is not required for this benefit.

8.815.6 Non-covered Services

8.815.6.A. The following services are not covered by Colorado Medicaid:

1. For clients 18 years of age and younger, Vaccines that have been obtained from a source other than the federal government;

2. Immunization and Vaccine Administration Services provided by a School District provider; and

3. Travel-related Immunization and Vaccine Administration Services.

COLORADO
Department of Health Care Policy & Financing
Medical Services Board

DECEMBER 2020 EMERGENCY JUSTIFICATION FOR MEDICAL ASSISTANCE RULES ADOPTED AT THE DECEMBER 11, 2020 MEDICAL SERVICES BOARD MEETING

Document 05, MSB 20-12-01-A, Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. This rule revision will temporarily remove current requirements for providers to comply with: Fingerprint Criminal Background Checks (10 CCR 2505-10 8.125.12), Site-Visits (10 CCR 2505-10 8.125.11) and payment of Application Fee's (10 CCR 2505-10 8.125.13), during the provider enrollment process. Alleviating these requirements will expedite the processing of provider-enrollment applications.

These proposed changes bring Colorado regulations into alignment with the approved 1135 waiver which was granted by CMS, temporarily waiving these requirements at the Federal Level. If passed, the rule will become effective on the date the board adopts it and it will expire after 120 days. However, the Department has the option to bring the rule to MSB a second time within the 120 days to reinstate or further extend the timeframe, depending on prevailing conditions and current guidance at that time.

This rule change is crucial for the preservation of public health, safety, and welfare.

Document 06, MSB 20-12-01-B - Revision to the Medical Assistance Act Rule concerning Subacute Care, Sections 8.300.3 & 8.300.5

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. Due to the COVID19 pandemic, the Department must ensure that member's access to care. Therefore, the addition of subacute care to the list of the covered services for inpatient hospitals, and associated alternate care facilities, increases access to such care for the duration of the COVID-19 public health emergency and is imperatively necessary for the preservation of public health, safety, and welfare.

Document 07, MSB 20-12-02-A - Revision to the Medical Assistance Act Rule concerning Novel Corona Virus Disease (COVID-19) Rules, Section 8.6000

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. The purpose of this emergency rule is to temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic. The temporary changes to regulatory requirements in order to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic is imperatively necessary fo the preservation of public health safety, and welfare.

Document 08, MSB 20-12-02-B, Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. The proposed rule change will amend 10 CCR 2505-10 sections 8.100.1,8.100.3, 8.100.4, 8.100.5 and 8.100.6 based on the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Families First Coronavirus Response Act (FFCRA) and the Affordable Care Act (ACA), which includes the Maintenance of Effort (MOE) provision. All policy revisions will align with federal regulations for the state to be in compliance during the federal Coronavirus (COVID-19) Public Health Emergency. These changes will impact all Medical Assistance categories and these policy changes will stay in place until the end of the federal Coronavirus (COVID-19) Public Health Emergency. The following policy changes are: Self-attestation for most verifications will be acceptable to be in compliance with the Maintenance of Effort (MOE) provision to ensure the continuance of health coverage for all eligible members. When a member is not reasonable compatible based off income a member self-attests, documentation will not be required, and the member will remain eligible for Medical Assistance. Self-attestation of resources will be acceptable for Non-MAGI programs. Premiums for the Buy-In program will be waived. Required through the Federal CARES Act for the Maintenance of Effort (MOE), members who had a loss of employment will remain in the Buy-In program. Newly enrolled members will still need to meet the work requirements. For applicants who are not eligible for Medical Assistance but have been exposed or who are potentially infected by the COVID-19, will be eligible for Medical Assistance for related COVID testing. The economic stimulus relief package designed to provide direct assistance to individuals to help offset the financial impacts of the COVID-19 Public Health Emergency will be exempt for MAGI and Non-MAGI eligibility determinations. The economic stimulus will not be a countable resource for 12 months for any Non-MAGI financial eligibility determinations that include a resource test. Lastly, the Federal Pandemic Unemployment Compensation (FPUC) program which provides an extra $600.00 a week is not countable unearned income for Medical Assistance categories

This rule change is crucial for the preservation of public health, safety, and welfare.

Document 10, MSB 20-12-03-A, Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1.

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. Under the Department's current rule, ambulance trips may only be taken to a limited set of medical facilities, the "closest, most appropriate Facility." CMS recently issued an expanded list of allowable destinations for ambulance trips that qualify for Medicare reimbursement during the COVID-19 public health emergency. This rule will align the Department with that new CMS Medicare guidance by expanding our definition of Facility. The goal is to allow EMT providers to take members to a wider range of medical facilities that are appropriate to the member's condition but that are not necessarily hospitals. This will help prevent hospital overcrowding while also getting members the most appropriate medical care, and will allow utilization of temporary and alternative care sites.
The second change relates to interfacility transportation, which is ambulance transportation from one facility to another, provided the member requires basic or advanced life support en route. This revision suspends the life support requirement. This will allow for members to be moved from one facility to another if they need continued COVID-19-related care, but do not require life support en route.

This rule change is crucial for the preservation of public health, safety, and welfare.

Document 11, MSB 20-12-03-B, Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. Permitting NEMT trips to non-covered places of service will prevent hospital overcrowding while ensuring that members receive treatment for COVID-19. The change allows flexibility and takes advantage of newly established alternative care sites that may be temporary in nature and thus not enrolled in the Colorado Medical Assistance Program. If members with COVID-19 can only receive care at covered places of service, those sites may become overcrowded and may see a shortage of available beds. Suspending multi-loading will ensure compliance with social distancing guidelines by limiting a vehicle's occupants.

This rule change is crucial for the preservation of public health, safety, and welfare.

Document 12, MSB 20-11-09-A, Revision to the Medical Assistance Act Rule concerning Federally Qualified Health Centers, Section 8.700

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. The purpose of this rule revision is to adjust the FQHC rate setting process to consider the changes to utilization and cost due to COVID-19. The pandemic has caused utilization to drop at FQHCs and costs have changed as well. To avoid setting unreasonable rates, this rule revision will set rates for FQHC cost reports with fiscal year ends between May 31, 2020 and May 31, 2021 using the previous year's rates multiplied by the Medicare Economic Index (MEI). Without the emergency adoption of this rule revision, FQHC rates could skyrocket causing a serious budget on the Department's budget. This could create issues with our programs and prompt service delivery for our members.

This rule change is crucial for the preservation of public health, safety, and welfare.

Document 13, MSB 20-11-25-A, Revision to the Medical Assistance Act Rule concerning Immunization Services, Section 8.815

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. This rule revision is required for the Department to comply with section 6008(b)(4) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), P.L. 116-136. Specifically, the Department must reimburse providers for COVID-19 testing services and treatments, including vaccines and the administration of such vaccines, provided to Medicaid enrollees. The Department will otherwise no longer qualify for the temporary 6.2 percentage point increase to the Federal Medical Assistance Percentage (FMAP) (the federal government's contribution toward Colorado's Medicaid expenditure) and will be subject to claw back. Current Department policy limits reimbursement for vaccine administration to members 18 and under exclusively through the Vaccines for Children (VFC) program. This revision will allow the Department to reimburse providers for pediatric administration of any and all vaccines provided free of cost by the federal government.

This rule change is crucial for the preservation of public health, safety, and welfare.

PHILIP J. WEISER
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Office of the Attorney General

Tracking number: 2020-00936

Opinion of the Attorney General rendered in connection with the rules adopted by the

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

on 12/11/2020

10 CCR 2505-10

MEDICAL ASSISTANCE - STATEMENTS OF BASIS AND PURPOSE AND RULE HISTORY

The above-referenced rules were submitted to this office on 12/11/2020 as required by section 24-4-103, C.R.S. This office has reviewed them and finds no apparent constitutional or legal deficiency in their form or substance.

December 28, 2020 12:12:24

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Terminated Rulemaking

Department

Department of Law

Agency

Peace Officer Standards and Training Board

CCR number

4 CCR 901-1

Tracking number

2020-00874

Termination date

12/18/2020

Reason for termination

Failed to meet the requirements of § 24-4-103(2.5):

(2.5)(a) At the time of filing a notice of proposed rule-making with the secretary of state [10/30/20] as the secretary may require, an agency shall submit a draft of the proposed rule or the proposed amendment to an existing rule and a statement, in plain language, concerning the subject matter or purpose of the proposed rule or amendment to the office of the executive director in the department of regulatory agencies.

Nonrulemaking Public Notices and other Miscellaneous Rulemaking Notices

Filed on 01/05/2021

Department

Department of Natural Resources

Agency

Division of Water Resources

COLORADO
Division of Water Resources
Department of Natural Resources

January 10, 2021

MISCELLANEOUS RULEMAKING PUBLIC NOTICE

RULES AND REGULATIONS APPLYING TO WELL PERMITS TO WITHDRAW GROUNDWATER PURSUANT TO SECTION 37-90-137(4), C.R.S.
(2 CCR 402-7)

CODE OF COLORADO REGULATIONS eDOCKET
TRACKING NUMBER 2020-00879

The Hearing in this matter originally scheduled for January 20, 2021 is hereby vacated and rescheduled to commence at 9:00 am on Wednesday, March 3, 2021. The public rulemaking hearing, pursuant to section 24-4-103(4)(a), C.R.S., will occur before the Hearing Officer for the State Engineer ("Hearing Officer") via Zoom conferencing. At the hearing, the Hearing Officer will afford interested parties an opportunity to submit and present written or oral data, views, or arguments for consideration by the Hearing Officer. This Notice contains information on how to attend the hearing virtually. Please note, the deadline to request party status has passed, but written comments may still be submitted to the Hearing Officer.

Additional information regarding the Hearing can be obtained on the Division of Water Resources webpage, https://dwr.colorado.gov/rulemaking-hearing-statewide-nontributary-rules, and by viewing all documents filed in the matter, https://dnrftp.state.co.us/#/DWR/Hearings/Nontributary%20Rule%20Amendments%2020SE05/.

Calendar of Hearings

Hearing Date/Time	Agency	Location
02/05/2021 01:00 PM	State Personnel Board and State Personnel Director	Online only - instructions in notice of hearing
02/18/2021 09:00 AM	Air Quality Control Commission	This hearing will be held online only via the Zoom platform; there will be no in-person participation. See Notice for details.
02/17/2021 10:00 AM	Laboratory Services Division	Via Zoom: https://us02web.zoom.us/meeting/register/tZAqd-uqpjwvG9d-KHCYI4VIAXCFrhAfhFI3
02/17/2021 10:00 AM	Division of Environmental Health and Sustainability	Via Zoom: https://us02web.zoom.us/meeting/register/tZAqd-uqpjwvG9d-KHCYI4VIAXCFrhAfhFI3
02/12/2021 09:00 AM	Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)	303 East 17th Avenue, 11th Floor, Denver, CO 80203