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43 CR 5

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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

2020-00093

Department

200 - Department of Revenue

Agency

204 - Division of Motor Vehicles

CCR number

1 CCR 204-10

Rule title

VEHICLE SERVICES SECTION

Rulemaking Hearing

Date

04/06/2020

Time

10:00 AM

Location

1881 Pierce Street, Lakewood, CO 80214 Room 110

Subjects and issues involved

The purpose of this rule is to establish criteria for a Registration Agent to register a low-power scooter.

Statutory authority

The statutory bases for this rule are sections 42-1-102(48.5), 42-1-204, 42-2-103(2), 42-3-105(1)(d), 42-3-105(2), 42-3-105(4), 42-3-301, 42-3-311, and 42-3-304(18)(d), C.R.S.

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DEPARTMENT OF REVENUE

Division of Motor Vehicles – Vehicle Services Section

1 CCR-204-10

RULE 40. Low-Power Scooter

Basis: The statutory bases for this rule are sections 42-1-102(48.5), 42-1-204, 42-2-103(2), 42-3-105(1)(d), 42-3-105(2), 42-3-105(4), 42-3-301, 42-3-311, and 42-3-304(18)(d), C.R.S.

Purpose: The purpose of this rule is to establish criteria for a Registration Agent to register a low-power scooter.

1.0 Definitions

1.1 "Dealer" means a motor vehicle dealer, used motor vehicle dealer or power sport dealer licensed under Article 20 of Title 44, C.R.S.

1.2 "Registration Agent" means a Dealer that has been approved by the Department to act as an authorized agent of the Department for the purposes of compliance with 42-3-105(4) and 42-3-311, C.R.S. and the collection of fees required for the registration of a low-power scooter.

2.0 Registration Agent Eligibility

2.1 A Dealer that engages in the selling of low-power scooters that desires to register low-power scooters that the Dealer has sold must apply with the Department to be approved to be a Registration Agent for the Department.

a. A Dealer that is engaged in the selling of low-power scooters that does not desire to be a Registration Agent is not required to be a Registration Agent. A customer purchasing a low-power scooter from a Dealer that is not an authorized Registration Agent should be directed to the Department for the registration of the low-power scooter purchased from the Dealer that is not a Registration Agent.

3.0 Registration Agent Responsibilities

3.1 A Dealer that desires to be a Registration Agent must submit a form DR 2228 Low-Power Scooter Registration Agent Application to the Department for approval.

3.2 Upon approval, the Dealer will be issued a Registration Agent number. The Registration Agent number is in addition to any dealer license number issued to the Dealer and must appear on all correspondence with the Department, monthly reports and all low-power scooter registrations submitted to the Department.

3.3 If a Registration Agent changes their Dealership location address from the location address identified in the original approved form DR 2228 Low-Power Scooter Registration Agent Application, a new form DR 2228 must be submitted within ten (10) business days of the address change from when the Dealer is physically located at the new address to the Department. "Address Change Only" must be indicated at the top of the application. The assigned Registration Agent number will remain the same.

3.4 If a Registration Agent changes their business name, a new form DR 2228 must be submitted within ten (10) business days of the name change to the Department. "Name Change Only" must be indicated at the top of the application. The assigned Registration Agent number may be changed and the Registration Agent may be issued a new Registration Agent number at the discretion of the Department.

3.5 Upon request, of the Department, by any Dealer regulatory agency or governing body, by law enforcement, or by a customer, the Registration Agent must provide a copy of the Department approved form DR 2228 as proof of authorization to register low-power scooters and collect the associated fees on behalf of the Department.

3.6 Authorization to be an approved Registration Agent and register low-power scooters and collect the associated fees on behalf of the Department is immediately revoked if the Registration Agent ceases to be a Dealer, either by its own actions or due to actions taken by a Dealer regulatory agency or governing body or upon negative audit findings initiated by the Department.

3.7 Low-Power Scooter Decals

a. Low-power scooter decals must be purchased by Registration Agent from the Department. Requests for low-power scooter decals must be completed on the form DR 2183 Low-Power Scooter Monthly Report and Request for Decals/Forms. Requests for low-power scooter decals may be processed by mail or in person at the address indicated on the DR 2183.

b. A Registration Agent shall not be permitted to purchase excess low-power scooter decals above their allowable months of supply based on historical issuance trends determined by the Department.

c. No refunds will be granted for returned or expired low-power scooter decals. Damaged low-power scooter decals must be returned to the Department. Damaged low-power scooter decals shall be replaced upon payment of the applicable fees by the Registration Agent.

d. Low-power scooter decals that are lost or stolen must be reported to law enforcement within 72-hours from the date it was determined that the low-power scooter decals were lost or discovered stolen. A copy of the report to law enforcement listing all the serial numbers of the lost or stolen low-power scooter decals must be submitted to the Department. The Department will replace the missing low-power scooter decals upon payment of the applicable fees by the Registration Agent.

e. A low-power scooter decal and registration period is valid for a period of three (3) years from the date of issuance. A license plate will not be issued to a low-power scooter.

f. The Department reserves the right to audit Registration Agent low-power scooter decal inventory at any time. Registration Agent will be provided with audit instructions and details. Failure to follow these rules and procedures may result in revocation of the ability to operate as a Registration Agent.

3.8 Monthly Reports

a. Registration Agent must complete and submit form DR 2183 Low-Power Scooter Monthly Report and Request for Decals/Form to the Department at the address on the form by the 10th of every month. In the event that the 10th is a Saturday, Sunday

or State holiday the DR 2183 must be submitted on the next business day following the Saturday, Sunday or State Holiday. In the event that the Registration Agent did not issue low-power scooter decals for any given month, the DR 2183 shall be submitted indicating zero (0) under the section identified as “Decal Numbers Sold”.

b. A Registration Agent who does not submit the monthly reports, as listed above, shall lose the authority to issue low-power scooter decals on behalf of the Department and authorization to be an approved Registration Agent and to register low-power scooters and collect the associated fees on behalf of the Department will be revoked. Upon revocation notice from the Department, the Dealer must immediately cease acting as a Registration Agent and provide any low-power scooter deals that have not been issued to the Department.

3.9 Upon a Registration Agent completing a low-power scooter registration the Registration Agent must:

a. Submit to the Department:

i. The completed form DR 2579 Low-Power Scooter Registration Agent Temporary Registration form.

ii. Photocopy of the proof of ownership including, but not limited to, a Manufacturer’s Statement of Origin, invoice, notarized bill of sale, or receipt. The owner’s/applicant’s name must be consistent on the proof of ownership.

iii. Appropriate registration fees as indicated on the DR 2579.

iv. Proof that the owner’s/applicant’s secure and verifiable identification has been verified using the Secure and Verifiable Identification section on the form DR 2579 or by using the form DR 2841 Secure and Verifiable ID and form DR 2842 Supplemental Secure and Verifiable Identification Information and Attestation Clause forms.

v. Proof of insurance.

b. Provide to the low-power scooter owner/applicant:

i. A photocopy of the proof of ownership as listed under 3.9 a. ii. Above.

ii. A photocopy of the form DR 2579 Low-Power Scooter Registration Agent Temporary Registration form to evidence the registration of the low-power scooter.

iii. The low-power scooter decal issued to evidence the registration of the low-power scooter listed on the DR 2579. The Registration Agent shall hole punch the expire month and expire year on the low-power scooter decal prior to issuing the low-power scooter decal to the customer. The expire month and expire year must match the expire month and expire year on the DR 2579.

iii. Instructions that upon acceptance of the documents and items provided to the Department from the Registration Agent that the Department will complete the registration transaction in Department systems and upon completion of the registration transaction will mail to the low-power scooter owner/applicant a registration receipt that will replace the copy of the DR 2579 provided.

iv. Instructions that renewal of the low-power scooter registration can only be completed by the Department. Prior to expiration of the current registration period the owner will receive renewal notice with instructions from the Department.

v. Instructions that replacement of a lost, damaged or stolen low-power scooter decal can only be completed by the Department by contacting the Department directly.

3.10 If the Department is unable to validate the low-power scooter or any of the documents or forms provided by the Registration Agent or the Department determines that the vehicle submitted does not meet the definition of low-power scooter or that the insurance provide is not valid the Department will reject the application back to the Registration Agent for resolution with the owner/applicant.

3.11 Insurance

a. A low-power scooter will not be registered until the applicant has a complying motor vehicle insurance policy pursuant to Part 6 of Article 4 of Title 10, C.R.S., or a certificate of self-insurance is in full force and effect as required by sections 10-4-619 and 10-4-624, C.R.S.

b. The applicant must provide the Department or the Registration Agent with the proof of insurance certificate or insurance identification card provided to the applicant by the applicant's insurer pursuant to section 10-4-604.5, C.R.S., or provide proof of insurance in such other media as is authorized by the Department.

3.12 In the event that a Registration Agent chooses to no longer act as a Registration Agent, all low-power scooter decals must be returned to the Department with a notice on the Dealer's letterhead. This notice shall serve as notification to the Department that this Dealer will no longer act as a Registration Agent for the Department. All remaining DR 2579's and DR 2183's that have not been submitted to the Department previously shall be submitted at that time.

3.13 At no time will a Registration Agent register or issue a low-power scooter decal to a vehicle that does not meet the definition of low-power scooter in section 42-1-102(48.5), C.R.S. This includes but is not limited to, a motorcycle defined in section 42-1-102(55), C.R.S., a toy vehicle defined in section 42-1-102(103.5), C.R.S., a bicycle defined in section 42-1-102(10), C.R.S., or an off-highway vehicle defined in section 42-1-102(63), C.R.S.

a. If a Registration Agent is unsure if a vehicle meets the definition of a low-power scooter it should not register the vehicle and direct the owner/applicant to the Department for a determination.

b. A Registration Agent that knowingly registers a vehicle as a low-power scooter that does not meet the definition of a low-power scooter is required to make reasonable efforts to recover the low-power scooter decal and registration from the owner/applicant and at the discretion of the Department may have their authorization to be a Registration Agent revoked.

4.0 Appeals

4.1 If a Dealer is denied application to be a Registration Agent or if a Dealer's Registration Agent status is revoked, the Dealer may request a hearing, in writing, within sixty days

after the date of notice of denial. Written hearing requests shall be submitted to the Department of Revenue, Hearings Division.

4.2 The hearing shall be held at the Department of Revenue, Hearing Division. The presiding hearing officer shall be an authorized representative designated by the Executive Director. The Department's representative need not be present at the hearing unless the presiding hearing officer requires his or her presence or the person requesting the hearing requests his or her presence in writing. If the Department's representative is not present at the hearing, the hearing officer has the discretion to consider any written documents and affidavits submitted by the Department.

DEPARTMENT OF REVENUE

Division of Motor Vehicles – ~~Title and Registration~~ Vehicle Services Section

1 CCR-204-10

RULE 40. Low-Power Scooter

Basis: The statutory bases for this ~~regulation~~ rule are sections 42-1-102(48.5), 42-1-204, 42-2-103(2), 42-3-105(1)(d), 42-3-105(2), 42-3-105(4), 42-3-301, ~~and~~ 42-3-311, and 42-3-304(18)(d), C.R.S.

Purpose: The ~~following rules and regulations are promulgated~~ purpose of this rule is to establish criteria for ~~the issuance~~ a Registration Agent to register a low-power scooter ~~temporary registrations, identify the entities that are authorized to complete the temporary registration process and the process for the registration agent application~~.

1.0 Definitions

~~1.1 "Department" for this regulation means the State Registration Section, Division of Motor Vehicles, Department of Revenue.~~

~~1.2 "Low-Power Scooter" means a self-propelled vehicle designed primarily for use on the roadways with not more than three wheels in contact with the ground, no manual clutch, and either of the following:~~

~~A. A cylinder capacity not exceeding fifty cubic centimeters if powered by internal combustion; or~~

~~B. A wattage not exceeding four thousand four hundred seventy-six if powered by electricity.~~

~~1.3 "Motor vehicle" in pertinent part, means any self-propelled vehicle which is designed primarily for travel on the public highways and which is generated and commonly used to transport persons and property over the public highways, except that the term does not include low-power scooters, wheelchairs, or vehicles moved solely by human power.~~

~~1.4 "Motorcycle" means a motor vehicle that uses handlebars to steer and that is designed to travel on not more than three wheels in contact with the ground; except that the term does not include a farm tractor or low-power scooter.~~

1.1 "Dealer" means a motor vehicle dealer, used motor vehicle dealer or power sport dealer licensed under Article 20 of Title 44, C.R.S.

1.~~5~~2 "Registration Agent" means a ~~motor vehicle dealer or used motor vehicle dealer licensed under article 6 of title 42, of the Colorado Revised Statutes~~ Dealer that has been approved by the Department to act as an authorized agent of the Department for the purposes of compliance with 42-3-105(4)~~(a)~~ and 42-3-311, C.R.S. and the collection of fees required for the registration of a low-power scooter~~s~~.

2.0 ~~Low-Power Scooter~~ Registration Agent Eligibility

2.1 ~~A Upon application and approval, any licensed Colorado motor vehicle dealer, used motor vehicle dealer, or power sport dealer~~ Dealer that engages in the selling of low-power scooters that desires to register low-power scooters that the Dealer has sold ~~may~~ must apply with the Department to ~~act as a registration agent~~ be approved to be a Registration Agent for the Department ~~for the purpose of temporarily registering low-power scooters~~.

~~A. The DR 2228 Low-Power Scooter Registration Agent Application shall be submitted to the Department for approval.~~

~~B~~a. ~~A Motor vehicle dealers, used motor vehicle dealers or power sport dealers~~ Dealer that ~~are~~ is engaged in the selling of low-power scooters that does not desire to be a Registration Agent is ~~are~~ not required to be a ~~low-power scooter registration agent~~ Registration Agent. ~~Customers~~ A customer purchasing a low-power scooter from a Dealer that is not an authorized Registration Agent should be directed to the Department for the registration of the low-power scooter purchased from ~~a dealer~~ the Dealer that is not a ~~low power scooter registration agent~~Registration Agent.

~~C. A valid Colorado motor vehicle dealers license, used motor vehicle dealers license or power sport dealers license is required.~~

3.0 ~~Low-Power Scooter~~ Registration Agent ~~Application and Approval~~ Responsibilities

3.1 A Dealer that desires to be a Registration Agent must submit a form DR 2228 Low-Power Scooter Registration Agent Application ~~shall be submitted~~ to the Department for approval.

3.2 Upon approval ~~by the Department~~, the Dealer will be issued a ~~low-power scooter registration agent~~ Registration Agent number ~~shall be issued~~. The Registration Agent number is in addition to any dealer license number issued to the Dealer and ~~This number~~ must appear on all correspondence with the Department, monthly reports and all low-power scooter ~~temporary~~ registrations submitted to the Department.

~~3.3 Upon issuance of a low-power scooter registration agent number, the Department shall create the following:~~

~~A. An electronic spreadsheet to log and track the dates the monthly reports for each registration agent are received, the amount of payments submitted, a record of all decal numbers issued to that registration agent and a list of all decals that have been returned by the registration agent.~~

3.~~4~~3 If a ~~registration agent~~ Registration Agent changes their Dealership location address from the ~~original~~ location address identified in the original approved form DR 2228 Low-Power Scooter Registration Agent Application ~~application and/or changes their business name~~, a new form DR 2228 ~~Low-Power Scooter Registration Agent Application shall~~ must be submitted within ten (10) business days of the address change from when the Dealer is physically located at the new address to the Department. "Address Change Only" must be indicated at the top of the application. The assigned ~~low-power scooter registration agent~~ Registration Agent number ~~shall~~ will remain the same.

3.4 If a Registration Agent changes their business name, a new form DR 2228 must be submitted within ten (10) business days of the name change to the Department. "Name Change Only" must be indicated at the top of the application. The assigned Registration Agent number may be changed and the Registration Agent may be issued a new Registration Agent number at the discretion of the Department.

3.5 Upon request, of the Department, by any Dealer regulatory agency or governing body, by law enforcement, or by a customer, the ~~registration agent shall~~ Registration Agent must provide a copy of the Department approved form DR 2228 ~~Low-Power Scooter Registration Agent Application~~ as proof of authorization to register low-power scooters and collect the associated fees on behalf of the Department.

3.6 Authorization to be an approved Registration Agent and register low-power scooters and collect the associated fees on behalf of the Department is immediately revoked if the Registration Agent ceases to be a Dealer, either by its own actions or due to actions taken by a Dealer regulatory agency or governing body or upon negative audit findings initiated by the Department.

3.~~6~~7 Low-Power Scooter Decals

~~A~~a. Low-power scooter decals ~~Decals~~ must be purchased by the ~~registration agent~~ Registration Agent from the Department. Requests for low-power scooter decals ~~shall~~ must be completed on the form DR 2183 Low-Power Scooter Monthly Report and Request for Decals/Forms. Requests for low-power scooter decals may be processed by mail or in person at the address indicated on the DR 2183.

~~B~~b. ~~Low-power scooter registration agents~~ A Registration Agent shall not be permitted to purchase excess low-power scooter decals above their allowable months of supply based on historical issuance trends determined by the Department.

~~C~~c. No refunds will be granted for returned or expired low-power scooter decals. Damaged low-power scooter decals must be returned to the Department. Damaged low-power scooter decals shall be replaced upon payment of the applicable ~~low-power scooter decal~~ fees by the Registration Agent.

~~D~~d. Low-power scooter decals ~~Decals~~ that are lost or stolen must be reported to ~~the local, county or state~~ law enforcement within 72-hours from the date it was determined that the low-power scooter decals were lost or discovered stolen. A copy of the ~~police~~ report to law enforcement listing all the serial numbers of the lost or stolen low-power scooter decals must be submitted to the Department. The Department ~~shall~~ will replace the missing low-power scooter decals upon payment of the applicable ~~low-power scooter decal~~ fees by the Registration Agent.

~~E~~e. A low-power scooter decal and registration period is valid for a period of three (3) years from the date of issuance. ~~Standard~~ A license plate~~s shall~~ will not be issued to ~~any vehicle that is defined as~~ a low-power scooter.

f. The Department reserves the right to audit Registration Agent low-power scooter decal inventory at any time. Registration Agent will be provided with audit instructions and details. Failure to follow these rules and procedures may result in revocation of the ability to operate as a Registration Agent.

3.~~7~~8 Monthly Reports

~~A~~a. ~~A registration agent shall~~ Registration Agent must complete and submit form DR 2183 Low-Power Scooter Monthly Report and Request for Decals/Form to the Department at the address on the form by the 10th of every month. In the event that the 10th is a Saturday, Sunday or State holiday the DR 2183 must be submitted on the next business day following the Saturday, Sunday or State Holiday. In the event that the ~~registration agent~~ Registration Agent did not issue low-power scooter decals

for any given month, the DR 2183 shall be submitted indicating zero (0) under the section identified as “Decal Numbers Sold”.

~~B~~b. ~~Any low-power scooter registration agent~~ A Registration Agent who does not submit the~~ir~~ monthly reports, as listed above, shall lose the authority to issue low-power scooter decals on behalf of the Department and authorization to be an approved Registration Agent and to register low-power scooters and collect the associated fees on behalf of the Department will be revoked. Upon revocation notice from the Department, the Dealer must immediately cease acting as a Registration Agent and provide any low-power scooter deals that have not been issued to the Department. ~~This authority may be considered for only when all monthly reports have been submitted and brought current to the Department.~~

~~3.8 Renewal of low-power scooter registrations shall be completed by the Department.~~

3.9 Upon a Registration Agent completing a ~~L~~low-power scooter registration~~s~~ ~~shall~~ the Registration Agent must: ~~be submitted directly to the Department and must include the following:~~

a. Submit to the Department:

~~A~~i. ~~A~~ The completed form DR 2579 Low-Power Scooter Registration Agent Temporary Registration form.

~~B~~ii. Photocopy of the proof of ownership including, but not limited to, a Manufacturer’s Statement of Origin, invoice, notarized bill of sale, or receipt. The owner’s/applicant’s name must be consistent on the proof of ownership.

~~C~~iii. Appropriate registration fees as indicated on the ~~application~~ DR 2579.

~~D~~iv. Proof that the owner’s/applicant’s ~~S~~secure and ~~V~~verifiable ~~I~~identification has been verified using the Secure and Verifiable Identification section on the form DR 2579 or by using the form DR 2841 Secure and Verifiable ID and form DR 2842 Supplemental Secure and Verifiable Identification Information and Attestation Clause forms.

~~E~~v. Proof of insurance ~~as listed in section 3.11 of this regulation~~.

b. Provide to the low-power scooter owner/applicant:

i. A photocopy of the proof of ownership as listed under 3.9 a. ii. Above.

ii. A photocopy of the form DR 2579 Low-Power Scooter Registration Agent Temporary Registration form to evidence the registration of the low-power scooter.

~~F~~iii. The low-power scooter decal issued to evidence the registration of the low-power scooter listed on the DR 2579. The Registration ~~agent~~ Agent shall hole punch the expire month and expire year on the low-power scooter decal prior to issuing the low-power scooter decal to the customer. The expire month and expire year ~~shall~~ must match the expire month and expire year on the DR 2579.

iii. Instructions that upon acceptance of the documents and items provided to the Department from the Registration Agent that the Department will complete the registration transaction in Department systems and upon completion of the

registration transaction will mail to the low-power scooter owner/applicant a registration receipt that will replace the copy of the DR 2579 provided.

iv. Instructions that renewal of the low-power scooter registration can only be completed by the Department. Prior to expiration of the current registration period the owner will receive renewal notice with instructions from the Department.

v. Instructions that replacement of a lost, damaged or stolen low-power scooter decal can only be completed by the Department by contacting the Department directly.

3.10 ~~Upon receipt of the DR 2579 Low-Power Scooter Registration Agent Temporary Registration Application from the registration agent the Department shall validate the form and ensure compliance with statute, rules and regulations. The registration agent shall provide a photocopy of the DR 2579 to the owner to evidence registration. The registration agent shall instruct the owner of the registration process.~~If the Department is unable to validate the low-power scooter or any of the documents or forms provided by the Registration Agent or the Department determines that the vehicle submitted does not meet the definition of low-power scooter or that the insurance provide is not valid the Department will reject the application back to the Registration Agent for resolution with the owner/applicant.

~~A. The Department shall complete the low-power scooter registration in the Colorado State Title and Registration System. Upon finalization of the transaction a DR 2574 Registration Receipt will be printed and mailed directly to the low-power scooter owner. Upon receipt of the DR 2574 the low-power scooter owner shall replace the agent issued DR 2579 with the DR 2574. The DR 2574 shall be the owners' proof of valid registration.~~

~~B. If the vehicle listed on the DR 2579 does not meet the statutory definition of a low-power scooter the registration agent will be notified by the Department. The Department shall also send notice to the applicant requiring return of the decal. The applicant will be instructed to resolve any refund of fees paid with the agent directly.~~

3.11 Insurance

~~A~~a. A low-power scooter ~~shall~~ will not be registered until the applicant has a complying motor vehicle insurance policy pursuant to ~~part~~ Part 6 of ~~article~~ Article 4 of ~~title~~ Title 10, C.R.S., or a certificate of self-insurance is in full force and effect as required by sections 10-4-619 and 10-4-624, C.R.S.

~~B~~b. The applicant ~~shall~~ must provide the ~~department~~ Department or the ~~registration agent~~ Registration Agent with the proof of insurance certificate or insurance identification card provided to the applicant by the applicant's insurer pursuant to section 10-4-604.5, C.R.S., or provide proof of insurance in such other media as is authorized by the Department.

~~C. Any person who knowingly provides fraudulent information or insurance documents to obtain registration of a low-power scooter is guilty of a misdemeanor and is subject to the criminal and civil penalties provided under section 42-6-139(3) and (4) C.R.S.~~

3.12 In the event that a ~~registration agent~~ Registration Agent chooses to no longer act as a ~~registration agent~~ Registration Agent, all low-power scooter decals must be returned to the Department with a notice on the ~~business~~ Dealer's letterhead ~~within ten (10) business~~

~~days from the notice~~. This notice shall serve as notification to the Department that this ~~business~~ Dealer ~~shall~~ will no longer act as a ~~registration agent~~ Registration Agent for the Department ~~in this capacity~~. All remaining DR 2579's and DR 2183's that have not been submitted to the Department previously shall be submitted at that time. ~~No refunds shall be issued. The registration agent shall submit to the Department all retained low-power scooter temporary registrations.~~

3.13 At no time will a Registration Agent register or issue a low-power scooter decal to a vehicle that does not meet the definition of low-power scooter in section 42-1-102(48.5), C.R.S. This includes but is not limited to, a motorcycle defined in section 42-1-102(55), C.R.S., a toy vehicle defined in section 42-1-102(103.5), C.R.S., a bicycle defined in section 42-1-102(10), C.R.S., or an off-highway vehicle defined in section 42-1-102(63), C.R.S.

a. If a Registration Agent is unsure if a vehicle meets the definition of a low-power scooter it should not register the vehicle and direct the owner/applicant to the Department for a determination.

b. A Registration Agent that knowingly registers a vehicle as a low-power scooter that does not meet the definition of a low-power scooter is required to make reasonable efforts to recover the low-power scooter decal and registration from the owner/applicant and at the discretion of the Department may have their authorization to be a Registration Agent revoked.

~~4.0 Low-Power Scooter Record Maintenance~~

~~4.1 Records shall be maintained listing each low-power scooter decal with the names of the person(s) registered to such decal, to be used upon inquiry from law enforcement or the registered owner.~~

~~4.2 Notices of monthly report delinquency shall be sent to the registration agent(s) if the monthly reports are more than two months negligent.~~

~~4.3 If a registration agent fails to respond to a letter of monthly report delinquency, a notice shall be placed in the registration agent's file to discontinue the issuance of decals until all monthly reports have been submitted to the Department at which time the Department will re-evaluate the registration agent's authority to issue low-power scooter temporary registrations and decals on behalf of the Department.~~

4.0 Appeals

4.1 If a Dealer is denied application to be a Registration Agent or if a Dealer's Registration Agent status is revoked, the Dealer may request a hearing, in writing, within sixty days after the date of notice of denial. Written hearing requests shall be submitted to the Department of Revenue, Hearings Division.

4.2 The hearing shall be held at the Department of Revenue, Hearing Division. The presiding hearing officer shall be an authorized representative designated by the Executive Director. The Department's representative need not be present at the hearing unless the presiding hearing officer requires his or her presence or the person requesting the hearing requests his or her presence in writing. If the Department's representative is not present at the hearing, the hearing officer has the discretion to consider any written documents and affidavits submitted by the Department.

Notice of Proposed Rulemaking

Tracking number

2020-00115

Department

200 - Department of Revenue

Agency

212 - Marijuana Enforcement Division

CCR number

1 CCR 212-3

Rule title

COLORADO MARIJUANA RULES

Rulemaking Hearing

Date

03/30/2020

Time

01:00 PM

Location

1707 Cole Blvd., Ste. 300, Lakewood, CO 80401

Subjects and issues involved

The Marijuana Rules at 1 CCR 212-3, will include new and amended rules to implement statutory changes resulting from 2019 legislation, including Senate Bill 19-224 (SB 224), and to clarify prior adopted rules. These rules will include, but may not be limited to, the following subjects:

Rule 1-115 - Definitions (SB 224); Accelerator Endorsements (SB 224); Retail Marijuana Accelerator-Cultivator Licenses (SB 224); Retail Marijuana Accelerator-Manufacturer Licenses (SB 224); Rule 2-205 Fees (Reinstatement of Regulated Marijuana Business License - Emergency Rules adopted February 7, 2020); Rule 2-225 Renewal Application Requirements for All Licensees (Reinstatement of Expired Marijuana Business License - Emergency Rules adopted February 7, 2020); Rule 2-235 - Suitability (HB19-1090 - Amended rules will clarify the time period during which a finding of suitability is considered valid).

Statutory authority

The State Licensing Authority promulgates these rules pursuant to the authority granted in the Colorado Marijuana Code, 44-10-101, C.R.S., et seq., Article XVIII, Section 16 of the Colorado Constitution, and section 24-4-103, C.R.S. of the Administrative Procedure Act.

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DEPARTMENT OF REVENUE

Marijuana Enforcement Division

COLORADO MARIJUANA RULES

1 CCR 212-3

Part 1 – General Applicability

Basis and Purpose – 1-115

The statutory authority for this rule includes but is not limited to sections 44-10-202(1)(c), 44-10-202(1)(j), and 44-10-103, C.R.S., and all of the Marijuana Code. The purpose of this rule is to provide necessary definitions of terms used throughout the rules. Defined terms are capitalized where they appear in the rules, to let the reader know to refer back to these definitions. When a term is used in a conventional sense, and is not intended to be a defined term, it is not capitalized. This Rule 1-115 was previously Rules M and R 103, 1 CCR 212-1 and 1 CCR 212-2.

1-115 – Definitions

Definitions. The following definitions of terms, in addition to those set forth in section 44-10-103, C.R.S., apply to all rules promulgated pursuant to the Marijuana Code, unless the context requires otherwise:

"Accelerator Cultivator" means a natural person qualified as an Accelerator Licensee pursuant to these rules and is licensed to cultivate on the Licensed Premises of a Retail Marijuana Cultivation Facility and to distribute Retail Marijuana to Retail Marijuana Products Manufacturers and Retail Marijuana Stores.

"Accelerator Endorsement" means an endorsement issued by the State Licensing Authority to a Retail Marijuana Cultivation Facility Licensee or Retail Marijuana Products Manufacturer Licensee authorizing the licensee to exercise the privileges of an Accelerator-Endorsed Licensee.

"Accelerator-Endorsed Licensee" means a Retail Marijuana Cultivation Facility Licensee or Retail Marijuana Products Manufacturer Licensee who has, pursuant to these rules, been endorsed to host and offer technical and capital support to an Accelerator Licensee operating on its Licensed Premises.

"Accelerator License" means a license issued by the State Licensing Authority to a natural person authorizing the person to exercise the privileges of an Accelerator Licensee.

"Accelerator Licensee" means a natural person who has resided in a census tract designated by the Office of Economic Development and International Trade as an opportunity zone for five of the ten years prior to application and has not been the Beneficial Owner of a license issued pursuant to the Marijuana Code.

"Accelerator Manufacturer" means a natural person qualified as an Accelerator Licensee pursuant to these rules and is licensed to manufacture and distribute Retail Marijuana Concentrate and Retail Marijuana Product on the Licensed Premises of an Accelerator-Endorsed Manufacturer Licensee.

"Acquire," when used in connection with the acquisition of an Owner's Interest of a Regulated Marijuana Business, means obtaining ownership, Control, power to vote, or sole power of disposition of the Owner's Interest, directly or indirectly through one or more transactions or subsidiaries, through purchase, assignment, transfer, exchange, succession or other means.

"Acting in Concert" means knowing participation in a joint activity or interdependent conscious parallel action toward a common goal, whether or not pursuant to an express agreement.

"Advertising" means the act of providing consideration for the publication, dissemination, solicitation, or circulation, of visual, oral, or written communication, to directly induce any Person to patronize a particular Regulated Marijuana Business, or to purchase particular Regulated Marijuana. "Advertising" includes marketing, but does not include packaging and labeling, Consumer Education Materials, or Branding. "Advertising" proposes a commercial transaction or otherwise constitutes commercial speech.

"Additive" means any non-marijuana derived substance added to Regulated Marijuana to achieve a specific technical and/or functional purpose during processing, storage, or packaging. Additives may be direct or indirect. Direct additives are used to impart specific technological or functional qualities. Indirect additives are not intentionally added but may be present in trace amounts as a result of processing, packaging, shipping, or storage.

"Affiliate" of, or Person affiliated with, a specified Person, means a Person that directly or indirectly through one or more intermediaries, Controls or is Controlled by, or is under common Control with, the Person specified.

"Alarm Installation Company" means a Person engaged in the business of selling, providing, maintaining, servicing, repairing, altering, replacing, moving or installing a Security Alarm System in a Licensed Premises.

"Alternative Use Designation" means a designation approved by the State Licensing Authority, permitting a Medical Marijuana Products Manufacturer or Retail Marijuana Products Manufacturer to manufacture and Transfer Alternative Use Product.

"Alternative Use Product" means Regulated Marijuana that has at least one intended use that is not included in the list of intended uses in Rule 3-1015(B). Alternative Use Product may raise public health concerns that outweigh approval of the Alternative Use Product, or that require additional safeguards and oversight. Alternative Use Product cannot be Transferred except as permitted by Rule 5-325 or Rule 6-325 after obtaining an Alternative Use Designation. Rule 5-325 permits a Medical Marijuana Products Manufacturer to Transfer Alternative Use Product to a Medical Marijuana Testing Facility prior to receiving an Alternative Use Designation. Rule 6-325 permits a Retail Marijuana Products Manufacturer to Transfer Alternative Use Product to a Retail Marijuana Testing Facility prior to receiving an Alternative Use Designation. Except where the context otherwise clearly requires, rules applying to Regulated Marijuana Concentrate or Regulated Marijuana Product apply to Alternative Use Product.

"Applicant" means a Person that has submitted an application for licensure, permit, or registration, or for renewal of licensure, permit, or registration, pursuant to these rules that was accepted by the Division for review but has not been approved or denied by the State Licensing Authority.

"Approved Training Program" means a responsible vendor program that received approval from the Division prior to being offered to a Licensee.

"Audited Product" means a Regulated Marijuana Product with an intended use of: (1) metered dose nasal spray, (2) vaginal administration, or (3) rectal administration. Audited Product types

may raise public health concerns requiring additional safeguards and oversight. These product types may only be manufactured and Transferred by a Medical Marijuana Products Manufacturer in strict compliance with Rule 5-325 or Retail Marijuana Products Manufacturer in strict compliance with Rule 6-325. Prior to the first Transfer of an Audited Product to a Medical Marijuana Store, Medical Marijuana Cultivation Facility that has a Centralized Distribution Permit, Retail Marijuana Store or Retail Marijuana Cultivation Facility that has obtained a Centralized Distribution Permit, the Medical Marijuana Products Manufacturer or Retail Marijuana Products Manufacturer shall submit to the Division and, if applicable, to the Local Licensing Authority or Local Jurisdiction an independent third-party audit verifying compliance with Rule 5-325 or Rule 6-325. All rules regarding Regulated Marijuana Product apply to Audited Product except where Rules 5-325, 6-325, 4-115, 3-1010, and 3-1015 apply different requirements.

"Bad Actor" means a Person who:

a. Has been convicted, within the previous ten years (or five years, in the case of issuers, their predecessors and affiliated issuers), of any felony or misdemeanor:

   i. In connection with the purchase or sale of any Security;

   ii. Involving the making of any false filing with the Federal Securities Exchange Commission; or

   iii. Arising out of the conduct of the business of an underwriter, broker, dealer, municipal securities dealer, investment adviser or paid solicitor of purchasers of Securities;

b. Is subject to any order, judgment or decree of any court of competent jurisdiction, entered within the previous five years, that restrains or enjoins such Person from engaging or continuing to engage in any conduct or practice:

   i. In connection with the purchase or sale of any Security;

   ii. Involving the making of any false filings with the Federal Securities Exchange Commission; or

   iii. Arising out of conduct of the business of an underwriter, broker, dealer, municipal securities dealer, investment adviser or paid solicitor of purchasers of Securities:

c. Is subject to a final order of a state securities commission (or an agency or officer of a state performing like functions); a state authority that supervises or examines banks, savings associations, or credit unions; a state insurance commission (or an agency or officer of a state performing like functions); an appropriate federal banking agency; the U.S. Commodity Futures Trading Commission; or the National Credit Union Administration that:

   i. Bars the Person from:

      A. Association with an Entity regulated by such commission, authority, agency, or officer;

      B. Engaging in the business of Securities, insurance or banking; or

      C. Engaging in savings association or credit union activities; or

ii. Constitutes a final order based on a violation of any law or regulation that prohibits fraudulent, manipulative, or deceptive conduct entered within the previous ten years;

d. Is subject to an order of the Federal Securities Exchange Commission entered pursuant to section 15(b) or 15B(c) of the Securities Exchange Act of 1934, or section 203(e) or (f) of the Investment Advisers Act of 1940 that:

i. Suspends or revokes such Person's registration as a broker, dealer, municipal securities dealer or investment adviser;

ii. Places limitations on the activities, functions or operations of such Person; or

iii. Bars such Person from being associated with any Entity, or from participating in the offering of any Penny Stock;

e. Is subject to any order of the Federal Securities Exchange Commission entered within the previous five years that orders the Person to cease and desist from committing or causing a violation or future violation of:

i. Any scienter-based anti-fraud provision of the federal securities laws, including without limitations section 17(a)(1) of the Securities Act of 1933, section 10(b) of the Securities Exchange Act of 1934 and 17 C.F.R. 240.10b-5, section 15(c)(1) of the Securities Exchange Act of 1934 and section 206(1) of the Investment Advisers Act of 1940, or any other rule or regulation thereunder; or

ii. Section 5 of the Securities Act of 1933.

f. Is suspended or expelled from membership in, or suspended or barred from association with a member of, a registered national securities exchange or a registered national or affiliated securities association for any act or omission to act constituting conduct inconsistent with just and equitable principles of trade;

g. Has filed (as a registrant or issuer), or was named as an underwriter in, any registration statement or Regulation A offering statement filed with the federal Securities Exchange Commission that, within the previous five years, was the subject of a refusal order, stop order, or order suspending the Regulation A exemption, or is the subject of an investigation or proceeding to determine whether a stop order or suspension order should be issued; or

h. Is subject to a United States Postal Service false representation order entered with the previous five years, or is subject to a temporary restraining order or preliminary injunction with respect to conduct alleged by the United States Postal Service to constitute a scheme or device for obtaining money or property through the mail by means of false representations.

"Batch Number" means any distinct group of numbers, letters, or symbols, or any combination thereof, assigned by a Medical Marijuana Cultivation Facility or Medical Marijuana Products Manufacturer to a specific Harvest Batch or Production Batch of Medical Marijuana, or by a Retail Marijuana Cultivation Facility or Retail Marijuana Products Manufacturer to a specific Harvest Batch or Production Batch of Retail Marijuana.

"Beneficial Owner" includes the terms "beneficial ownership", or "beneficially owns" and means:

a. Any Person who, directly or indirectly, through any contract, arrangement, understanding, relationship, or otherwise has or shares:

i. Voting power which includes the power to vote, or to direct the voting of, an Owner's Interest; and/or,

ii. Investment power which includes the power to dispose, or to direct the disposition of, an Owner's Interest.

b. Any Person who, directly or indirectly, creates or uses a trust, proxy, power of attorney, pooling arrangement or any other contract, arrangement, or device with the purpose of effect of divesting such Person of beneficial ownership of an Owner's Interest or preventing the vesting of such beneficial ownership as part of a plan or scheme to evade the reporting requirements of section 13(d) or (g) of the Securities Act of 1933 shall be deemed for purposes of such sections to be the beneficial owner of such Owner's Interest.

c. All Owner's Interests of the same class beneficially owned by a Person, regardless of the form which such beneficial ownership takes, shall be aggregated in calculating the number of shares beneficially owned by such Person.

d. Notwithstanding the provisions of paragraphs (a) and (c) of this rule:

i.

A. A Person shall be deemed to be the beneficial owner of an Owner's Interest, subject to the provisions of paragraph (b) of this rule, if that Person has the right to acquire beneficial ownership of such Owner's Interest, as defined in Rule 13d-3(a) (§ 240.13d-3(a)) within sixty days, including but not limited to any right to acquire: (1) Through the exercise of any option, warrant or right; (2) through the conversion of an Owner's Interest; (3) pursuant to the power to revoke a trust, discretionary account, or similar arrangement; or (4) pursuant to the automatic termination of a trust, discretionary account or similar arrangement; provided, however, any person who acquires an Owner's Interest or power specified in paragraphs (d)(i)(A)(1), (2) or (3), of this section, with the purpose or effect of changing or influencing the control of the issuer, or in connection with or as a participant in any transaction having such purpose or effect, immediately upon such acquisition shall be deemed to be the beneficial owner of the Owner's Interests which may be acquired through the exercise or conversion of such Owner's Interests or power. Any Owner's Interests not outstanding which are subject to such options, warrants, rights or conversion privileges shall be deemed to be outstanding for the purpose of computing the percentage of outstanding Owner's Interests of the class owned by such Person but shall not be deemed to be outstanding for the purpose of computing the percentage of the class by any other Person.

B. Paragraph (d)(i)(A) of this section remains applicable for the purpose of determining the obligation to file with respect to the underlying Owner's Interests even though the option, warrant, right or convertible Owner's Interests is of a class of equity

Owner's Interest, as defined in § 240.13d-1(i), and may therefore give rise to a separate obligation to file.

ii. A member of a national securities exchange shall not be deemed to be a beneficial owner of an Owner's Interest held directly or indirectly by it on behalf of another Person solely because such member is the record holder of such Owner's Interests and, pursuant to the rules of such exchange, may direct the vote of such Owner's Interests, without instruction, on other than contested matters or matters that may affect substantially the rights or privileges of the holders of the Owner's Interests to be voted, but is otherwise precluded by the rules of such exchange from voting without instruction.

iii. A person who in the ordinary course of his business is a pledgee of Owner's Interests under a written pledge agreement shall not be deemed to be the beneficial owner of such pledged Owner's Interests until the pledgee has taken all formal steps necessary which are required to declare a default and determines that the power to vote or to direct the vote or to dispose or to direct the disposition of such pledged Owner's Interests will be exercised, provided, that:

A. The pledgee agreement is bona fide and was not entered into with the purpose nor with the effect of changing or influencing the control of the issuer, nor in connection with any transaction having such purpose or effect, including any transaction subject to Rule 13d-3(b);

B The pledgee is a Person specified in Rule 13d-1(b)(ii), including Persons meeting the conditions set forth in paragraph (G) thereof; and

C The pledgee agreement, prior to default, does not grant to the pledgee;

1. The power to vote or to direct the vote of the pledged Owner's Interests; or

2. The power to dispose or direct the disposition of the pledged Owner's Interests, other than the grant of such power(s) pursuant to a pledge agreement under which credit is extended subject to regulation T (12 CFR 220.1 to 220.8) and in which the pledgee is a broker or dealer registered undersection 15 of the Securities Act of 1933.

iv. A Person engaged in business as an underwriter of Owner's Interests who acquires Owner's Interests through his participation in good faith in a firm commitment underwriting registered under the Securities Act of 1933 shall not be deemed to be the beneficial owner of such Owner's Interests until the expiration of forty days after the date of such acquisition.

"Blank Check Company" means an Entity that:

a. Is a development stage company that has no specific business plan or purpose or has indicated that its business plan is to engage in a merger or acquisition with an unidentified company or companies, or other Entity or Person; and

b. Is issuing Penny Stock.

"Branding" means promotion of a Regulated Marijuana Business's brand through publicizing the Regulated Marijuana Business's name, logo, or distinct design feature of the brand.

"Cannabinoid" means any of the chemical compounds that are the active principles of marijuana.

"Centralized Distribution Permit" means a permit issued to a Medical Marijuana Cultivation Facility pursuant to section 44-10-502, C.R.S., or a Retail Marijuana Cultivation Facility pursuant to section 44-10-602, C.R.S., authorizing temporary storage of Medical Marijuana Concentrate and Medical Marijuana Product received from a Medical Marijuana Products Manufacturer or Retail Marijuana Concentrate and Retail Marijuana Product received from a Retail Marijuana Products Manufacturer for the sole purpose of Transfer to commonly owned Medical Marijuana Stores or Retail Marijuana Stores. For purposes of a Centralized Distribution Permit only, the term "commonly owned" means at least one natural person has a minimum of five percent ownership in both the Medical Marijuana Cultivation Facility possessing the Centralized Distribution Permit and the Medical Marijuana Store, or in both the Retail Marijuana Cultivation Facility possessing the Centralized Distribution Permit and the Retail Marijuana Store.

"Child-Resistant" means special packaging that is:

a. Designed or constructed to be significantly difficult for children under five years of age to open and not difficult for normal adults to use properly as defined by 16 C.F.R. 1700.15 (1995) and 16 C.F.R. 1700.20 (1995). Note that this Rule does not include any later amendments or editions to the Code of Federal Regulations. The Division has maintained a copy of the applicable federal regulations, which is available to the public;

b. Opaque so that the packaging does not allow the product to be seen without opening the packaging material; and

c. Resealable for any product intended for more than a single use or containing multiple servings.

"Commercially Reasonable Royalty" means a right to compensation in the form of a royalty payment for the use of intellectual property with a direct nexus to the cultivation, manufacture, Transfer or testing of Regulated Marijuana. A Commercially Reasonable Royalty must be limited to specific intellectual property the Commercially Reasonable Royalty interest owns or is otherwise authorized to license or to a product or line of products. A Commercially Reasonable Royalty must not cause reasonable consumer confusion or violate any federal copyright, trademark or patent law or regulation will not be approved. To determine whether the Commercially Reasonable Royalty is reasonable, the Division will consider the totality of the circumstances, including but not limited to the following factors:

a. The percentage of royalties received by the recipient for the licensing of the intellectual property.

b. The rates paid by the Licensee for the use of other intellectual property.

c. The nature and scope of the license, as exclusive or non-exclusive; or as restricted or non-restricted in terms of territory or with respect to whom the product may be sold.

d. The licensor's established policy and marketing program to maintain his intellectual property monopoly by not licensing others or by granting licenses under special conditions designed to preserve that monopoly.

e. The commercial relationship between the recipient and Licensee, such as, whether they are competitors in the same territory in the same line of business.

f. The effect of selling the intellectual property in promoting sales of other products of the Licensee; the existing value of the intellectual property to the recipient as a generator of sales of his non-intellectual property items; and the extent of such derivative sales.

g. The duration of the term of the license for use of the intellectual property.

h. The established or projected profitability of the product made using the intellectual property; its commercial success; and its current popularity.

i. The utility and advantages of the intellectual property over products or businesses without the intellectual property.

j. The nature of the intellectual property; the character of the commercial embodiment of it as owned and produced by the licensor; and the benefits to those who have used the intellectual property.

k. The portion of the profit or of the selling price that may be customary in the particular business or in comparable businesses to allow for the use of the intellectual property.

l. The portion of the realizable profit that should be credited to the intellectual property as distinguished from non-intellectual property elements, the manufacturing process, business risks, or significant features or improvements added by the Licensee.

"Consumer Education Materials" means any informational materials that seek to educate consumers about Regulated Marijuana generally, including but not limited to education regarding the safe consumption of marijuana, Regulated Marijuana Concentrate, or Regulated Marijuana Products, provided it is not distributed or made available to individuals under twenty-one years of age.

"Consumption Area" means a designated and secured area within the Licensed Premises of a Licensed Hospitality Business where consumers can use and consume marijuana and where no one under the age of 21 is permitted. A Consumption Area may, but is not required to, be part of a Restricted Access Area.

"Container" means the receptacle directly containing Regulated Marijuana that is labeled according to the requirements in the 3-1000 Series Rules.

"Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management or policies of a Person, whether through the ownership of voting Owner's Interests, by contract, or otherwise. This definition of Control includes Controls, Controlled, Controlling, Controlled by, and under common Control with.

"Controlling Beneficial Owner" means a Person that satisfies one or more of the following criteria:

a. A natural person, an Entity that is organized under the laws of and for which its principal place of business is located in one of the states or territories of the United States or District of Columbia, a Publicly Traded Corporation, or a Qualified Private Fund that is not a Qualified Institutional Investor:

i. Acting alone or Acting In Concert, that owns or Acquires Beneficial Ownership of ten percent or more of the Owner's Interest of a Regulated Marijuana Business;

ii. That is an Affiliate that Controls a Regulated Marijuana Business and includes, without limitation, any Manager; or

iii. That is otherwise in a position to Control the Regulated Marijuana Business except as authorized in section 44-10-506 or 44-10-606, C.R.S.; or

b. A Qualified Institutional Investor acting alone or Acting In Concert that owns or Acquires Beneficial Ownership of more than thirty percent of the Owner's Interest of a Regulated Marijuana Business.

c. Unless the context otherwise requires, the defined term Controlling Beneficial Owner includes Direct Beneficial Interest Owner.

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

"Court Appointee" means a Person appointed by a court as a receiver, personal representative, executor, administrator, guardian, conservator, trustee, or similarly situated Person; acting in accordance with section 44-10-401(3), C.R.S., and these rules; and authorized by court order to take possession of, operate, manage, or control a licensed Regulated Marijuana Business.

"Covered Securities" means:

a. A Security designated as qualified for trading in the national market system pursuant to section 78k-1(a)(2) of the Securities Act of 1933 that is listed, or authorized for listing, on a national securities exchange (or tier or segment thereof); or a Security of the same issuer that is equal in seniority or that is a senior Security to a Security designated as qualified for trading in the national market system.

b. A Security issued by an investment company that is registered, or that has filed a registration statement under the federal Investment Company Act of 1940.

c. A Security as defined by the Federal Securities Exchange Commission by rule pursuant to 15 U.S.C. §77r(b)(3).

d. A Security pursuant to 15 U.S.C. §77r(b)(4).

"Delivery Motor Vehicle" means any self-propelled vehicle that is designed primarily for travel on the public highways, that is generally and commonly used to transport persons and property over the public highways or a low-speed electric vehicle that is used for delivery of Regulated Marijuana to patients or consumers; except that the term does not include electric assisted bicycles, wheelchairs, or vehicles moved solely by human power.

"Denied Applicant" means any Person whose application for licensure, permit, or registration pursuant to the Marijuana Code has been denied, any Person whose application for a responsible vendor program has been denied, or any Licensee whose application for any of the following non-exhaustive list has been denied: An initial license application pursuant to Rule 2-220, a renewal application pursuant to Rule 2-225, the request for a finding of suitability pursuant to Rule 2-235, a change of owner pursuant to Rule 2-245; a change of location of the Licensed Premises pursuant to Rule 2-255; a change, alteration, or modification of the Licensed Premises pursuant to Rule 2-260; or a production management tier increase request pursuant to Rule 5-225 or 6-220.

"Department" means the Colorado Department of Revenue.

"Director" means the Director of the Marijuana Enforcement Division.

"Division" means the Marijuana Enforcement Division.

"Edible Medical Marijuana Product" means any Medical Marijuana Product for which the intended use is oral consumption, including but not limited to, any type of food, drink, or pill.

"Edible Retail Marijuana Product" means any Retail Marijuana Product for which the intended use is oral consumption, including but not limited to, any type of food, drink, or pill.

"Employee License" means a license granted by the State Licensing Authority pursuant to section 44-10-401, C.R.S., to a natural person who is not a Controlling Beneficial Owner. Any person who possesses, cultivates, manufactures, tests, dispenses, sells, serves, transports, or delivers Regulated Marijuana, who is authorized to input data into a Regulated Marijuana Business's Inventory Tracking System or point-of-sale system, or who has unescorted access in the Restricted Access Area or Limited Access Area must hold an Employee License. Employee License includes both Key Licenses and Support Licenses.

"Entity" means a domestic or foreign corporation, cooperative, general partnership, limited liability partnership, limited liability company, limited partnership, limited liability limited partnership, limited partnership association, nonprofit association, nonprofit corporation, or any other organization or association that is formed under a statute or common law of the state of Colorado or any other jurisdiction as to which the laws of this state of Colorado or the laws of any other jurisdiction governs relations among owners and between the owners and the organization or association and that is recognized under the laws of the state of Colorado or the other jurisdiction as a separate legal entity.

"Executive Officer" means the president, any vice president in charge of a principal business unit, division or function (such as sales, administration or finance), any other officer who performs a policy making function, or any other person who performs similar policy making functions for the Regulated Marijuana Business.

"Exit Package" means an Opaque bag or other similar Opaque covering provided at the point of sale, in which Regulated Marijuana already in a Container is placed. If Regulated Marijuana flower, trim or seeds are placed into a Container that is not Child-Resistant, then the Exit Package must be Child-Resistant. The Exit Package is not required to be labeled in accordance with the 3-100 Series Rules.

"Fibrous Waste" means any roots, stalks, and stems from a Regulated Marijuana plant.

"Final Agency Order" means an Order of the State Licensing Authority issued in accordance with the Marijuana Code and the State Administrative Procedure Act. The State Licensing Authority will issue a Final Agency Order following review of the Initial Decision and any exceptions filed

thereto or at the conclusion of the declaratory order process. A Final Agency Order is subject to judicial review.

"Flammable Solvent" means a liquid that has a flash point below 100 degrees Fahrenheit.

"Flowering" means the reproductive state of the cannabis plant in which there are physical signs of flower budding out of the nodes of the stem.

"Food-Based Medical Marijuana Concentrate" means a Medical Marijuana Concentrate that was produced by extracting Cannabinoids from Medical Marijuana through the use of propylene glycol, glycerin, butter, olive oil or other typical cooking fats.

"Food-Based Retail Marijuana Concentrate" means a Retail Marijuana Concentrate that was produced by extracting Cannabinoids from Retail Marijuana through the use of propylene glycol, glycerin, butter, olive oil or other typical cooking fats.

"Foreign Private Issuer" means any foreign issuer other than a foreign government except an issuer meeting the following conditions as of the last business day of its most recently completed second fiscal quarter:

a. More than 50 percent of the outstanding voting Securities of such issuer are directly or indirectly owned of record by residents of the United States; and

b. Any of the following:

   i. The majority of the executive officers or directors are United States citizens or residents;

   ii. More than 50 percent of the assets of the issuer are located in the United States; or

   iii. The business of the issuer is administered principally in the United States.

"Good Cause" for purposes of denial of an initial, renewal, or reinstatement of a license, registration, or permit application, means:

a. The Licensee or Applicant has violated, does not meet, or has failed to comply with any of the terms, conditions, or provisions of the Marijuana Code, any rules promulgated pursuant to the Marijuana Code, or any supplemental relevant state or local law, rule, or regulation;

b. The Licensee or Applicant has failed to comply with any special terms or conditions that were placed upon the license pursuant to an order of the State Licensing Authority or the relevant local jurisdiction; or

c. The Licensee's Licensed Premises have been operated in a manner that adversely affects the public health or welfare or the safety of the immediate neighborhood in which the establishment is located.

"Good Moral Character" means having a criminal history that demonstrates honesty, fairness, and respect for the rights of others and for the law.

"Greenhouse" means a hoop house or other structure with non-rigid walls that utilizes natural light, in whole or in part, for the cultivation of Regulated Marijuana.

"Harvest Batch" means a specifically identified quantity of processed Regulated Marijuana that is uniform in strain, cultivated utilizing the same Pesticide and other agricultural chemicals and harvested at the same time.

"Harvested Marijuana" means Regulated Marijuana flower reported as a package in the Inventory Tracking System or post-harvest Regulated Marijuana not including wet whole plant, trim, concentrate, waste, or Fibrous Waste that remains on the premises of the Medical Marijuana Cultivation Facility or Retail Marijuana Cultivation Facility or its off-premises storage location beyond 90 days from harvest.

"Heat/Pressure-Based Medical Marijuana Concentrate" means a Medical Marijuana Concentrate that was produced by extracting Cannabinoids from Medical Marijuana through the use of heat and/or pressure. The method of extraction may be used by only a Medical Marijuana Products Manufacturer and can be used alone or on a Production Batch that also includes Water-Based Medical Marijuana Concentrate or Solvent-Based Medical Marijuana Concentrate.

"Heat/Pressure-Based Retail Marijuana Concentrate" means Retail Marijuana Concentrate that was produced by extracting Cannabinoids from Retail Marijuana through the use of heat and/or pressure. This method of extraction may be used by only a Retail Marijuana Products Manufacturer and can be used alone or on a Production Batch that also includes Water-Based Retail Marijuana Concentrate or Solvent-Based Retail Marijuana Concentrate.

"Identification Badge" means a physical badge issued to any natural person possessing an Owner License or Employee License, used to verify the identity of the natural persons on the Licensed Premises of a Regulated Marijuana Business.

"Identity Statement" means the name of the business as it is commonly known and used in any Advertising.

"Immature plant" means a nonflowering Regulated Marijuana plant that is no taller than eight inches and no wider than eight inches produced from a cutting, clipping or seedling and is in a cultivating container. Plants meeting these requirements are not attributable to a Licensee's maximum allowable plant count, but must be fully accounted for in the Inventory Tracking System.

"Indirect Financial Interest Holder" means a Person that is not an Affiliate, a Controlling Beneficial Owner, or a Passive Beneficial Owner of a Regulated Marijuana Business and that:

a. Holds a Commercially Reasonable Royalty in exchange for a Regulated Marijuana Business's use of the Person's intellectual property;

b. Holds a Permitted Economic Interest that was issued prior to January 1, 2020, and that has not been converted into an Owner's Interest or holds any unsecured convertible debt option, option agreement or warrant that establishes a right for a Person to obtain an interest that might convert to an ownership interest in a Regulated Marijuana Business obtained after January 1, 2020;

c. Is a contract counterparty with a Regulated Marijuana Business, other than a customary employment agreement, that has a direct nexus to the cultivation, manufacture, sale, or testing of Regulated Marijuana, including, but not limited to, a lease of real property on which the Regulated Marijuana Business operates, a lease of equipment used in the cultivation, manufacture, or testing of Regulated Marijuana, a secured or unsecured financing agreement with the Regulated Marijuana Business, a security contract with the Regulated Marijuana Business, or a management agreement with the Regulated Marijuana Business, provided

that no such contract compensates the contract counterparty with a percentage of revenue for profits of the Regulated Marijuana Business.

i. Any secured interest in Regulated Marijuana must expressly provide that it is subject to all required suitability and application requirements.

d. Unless the context otherwise requires, the defined term Indirect Financial Interest Holder includes Indirect Beneficial Interest Owner.

"Industrial Fiber Products" means intermediate or finished products made from Fibrous Waste that are not intended for human or animal consumption and are not usable or recognizable as Regulated Marijuana. Industrial Fiber Products include, but are not limited to, cordage, paper, fuel, textiles, bedding, insulation, construction materials, compost materials, and industrial materials.

"Industrial Fiber Products Producer" means a Person who produces Industrial Fiber Products using Fibrous Waste.

"Industrial Hemp" means a plant of the genus Cannabis and any part of the plant, whether growing or not, containing a delta-9 tetrahydrocannabinol (THC) concentration of no more than three-tenths of one percent (0.3%) on a dry weight basis.

"Industrial Hemp Product" means a finished product containing Industrial Hemp that:

a. Is a cosmetic, food, food additive, or herb;

b. Is for human use or consumption;

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

d. Contains a delta-9 tetrahydrocannabinol concentration of no more than three-tenths of one percent.

"Industrial Hygienist" means a natural person who has obtained a baccalaureate or graduate degree in industrial hygiene, biology, chemistry, engineering, physics, or a closely related physical or biological science from an accredited college or university.

a. The special studies and training of such persons must be sufficient in the cognate sciences to provide the ability and competency to:

i. Anticipate and recognize the environmental factors and stresses associated with work and work operations and to understand their effects on individuals and their well-being;

ii. Evaluate on the basis of training and experience and with the aid of quantitative measurement techniques the magnitude of such environmental factors and stresses in terms of their ability to impair human health and well-being;

iii. Prescribe methods to prevent, eliminate, control, or reduce such factors and stresses and their effects.

b. Any person who has practiced within the scope of the meaning of industrial hygiene for a period of not less than five years immediately prior to July 1, 1997, is exempt from the degree requirements set forth in the definition above.

c. Any person who has a two-year associate of applied science degree in environmental science from an accredited college or university and in addition not less than four years practice immediately prior to July 1, 1997, within the scope of the meaning of industrial hygiene is exempt from the degree requirements set forth in the definition above.

"Ineligible Issuer" means:

a. Any issuer that is required to file reports pursuant to section 13 or 15(d) of the Securities Exchange Act of 1934 that has not filed all reports and other materials required to be filed during the preceding 12 months, other than reports on Form 8-K required solely pursuant to an item specified in General Instruction I.A.3(b) of Form S-3;

b. The issuer is, or during the past three years the issuer or any of its predecessors was:

i. A Blank Check Company;

ii. A Shell Company;

iii. An issuer of an offering of Penny Stock;

c. The issuer is a limited partnership that is offering and selling its Securities other than through a firm commitment underwriting;

d. Within the past three years, a petition under the federal bankruptcy laws or any state insolvency law was filed by or against the issuer, or a court appointed a receiver, fiscal agent or similar officer with respect to the business or property of the issuer subject to the following:

i. In the case of an involuntary bankruptcy in which a petition was filed against the issuer, ineligibility will occur upon the earlier to occur of:

A. 90 days following the date of the filing of the involuntary petition (if the case has not been earlier dismissed); or

B. The conversion of the case to a voluntary proceeding under federal bankruptcy or state insolvency laws; and

ii. Ineligibility will terminate if an issuer has filed an annual report with audited financial statements subsequent to its emergence from that bankruptcy, insolvency, or receivership process;

e. Within the past three years, the issuer or any Entity that at the time was a subsidiary of the issuer was convicted of any felony or misdemeanor described in paragraphs (i) through (iv) of section 15(b)(4)(B) of the Securities Exchange Act of 1934;

f. Within the past three years, the issuer or any Entity that at the time was a subsidiary of the issuer was made the subject of any judicial or administrative decree or order arising out of a governmental action that:

i. Prohibits certain conduct or activities regarding, including future violations of, the anti-fraud provisions of the federal securities laws;

ii. Requires that the Person cease and desist from violating the anti-fraud provisions of the federal securities laws; or

iii. Determines that the Person violated the anti-fraud provisions of the federal securities laws;

g. The issuer has filed a registration statement that is the subject of any pending proceeding or examination under section 8 of the Securities Act of 1933 or has been the subject of any refusal order or stop order under section 8 of the Securities Act of 1933 within the past three years; or

h. The issuer is the subject of any pending proceeding under section 8A of the Securities Act of 1933 in connection with an offering.

"Ingredient" means any non-marijuana derived substance that is added to Regulated Marijuana to achieve a desired effect. The term Ingredient includes all Additives.

"Initial Decision" means a decision of a hearing officer in the Department following a licensing, disciplinary, or other administrative hearing. Either party may file exceptions to the Initial Decision. The State Licensing Authority will review the Initial Decision and any exceptions filed thereto, and will issue a Final Agency Order.

"Inventory Tracking System" means the required seed-to-sale tracking system that tracks Regulated Marijuana from either the seed or immature plant stage until the Regulated Marijuana is sold to a patient at a Medical Marijuana Store or to a consumer at a Retail Marijuana Store, Transferred to a Medical Marijuana Testing Facility or Retail Marijuana Testing Facility, Transferred to a Sampling Manager, Transferred to an Industrial Fiber Products Producer, Transferred to a Medical Research Facility, Transferred to a Pesticide Manufacturer, or destroyed by a Regulated Marijuana Business, or used in a Research Project by a Marijuana Research and Development Facility.

"Inventory Tracking System Trained Administrator" means an Owner Licensee of a Regulated Marijuana Business or an Employee Licensee employed by a Regulated Marijuana Business, each of whom has attended and successfully completed Inventory Tracking System training and has completed any additional training required by the Division.

"Inventory Tracking System User" means an Owner Licensee of a Regulated Marijuana Business or an Employee Licensee employed by a Regulated Marijuana Business, who is granted Inventory Tracking System User account access for the purposes of performing inventory tracking functions in the Inventory Tracking System. Each Inventory Tracking System User must have been successfully trained by an Inventory Tracking System Trained Administrator in the proper and lawful use of Inventory Tracking System.

"Kief" means the resinous crystal-like tricomes that are found on Regulated Marijuana flower and that are accumulated, resulting in a higher concentration of cannabinoids.

"License" means to grant a license, permit, or registration pursuant to the Marijuana Code.

"Licensed Hospitality Business" means a Marijuana Hospitality Business or Retail Marijuana Hospitality and Sales Business.

"Licensed Premises" means the premises specified in an application for a license pursuant to the Marijuana Code that are owned or in possession of the Licensee and within which the Licensee is authorized to cultivate, manufacture, distribute, sell, store, transport, or test Medical Marijuana, or to cultivate, manufacture, distribute, sell, store, transport, test, or allow the use or consumption of Retail Marijuana, in accordance with the provisions of the Marijuana Code, and these rules. Not all areas of the Licensed Premises are Limited Access Areas or Restricted Access Areas.

"Licensee" means any Person licensed, registered, or permitted pursuant to the Marijuana Code including an Owner Licensee and an Employee Licensee.

"Limited Access Area" means a building, room, or other contiguous area upon the Licensed Premises where Regulated Marijuana and Regulated Marijuana Products are grown, cultivated, manufactured, stored, weighed, packaged, sold, possessed for sale, Transferred, or processed for Transfer, under control of the Licensee, with access limited to only those persons licensed by the State Licensing Authority and those visitors Escorted by a person licensed by the State Licensing Authority. All areas of ingress or egress to limited access areas must be clearly identified as such by a sign as designated by the State Licensing Authority.

"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%).

"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.

"Liquid Edible Medical Marijuana Product" means an Edible Medical Marijuana Product that is a liquid beverage or liquid food-based product for which the intended use is oral consumption, such as a soft drink or cooking sauce.

"Liquid Edible Retail Marijuana Product" means an Edible Retail Marijuana Product that is a liquid beverage or liquid food-based product for which the intended use is oral consumption, such as a soft drink or cooking sauce.

"Local Jurisdiction" means a locality as defined in section 16 (2)(e) of article XVIII of the state constitution.

"Local Licensing Authority" means an authority designated by municipal, county, or city and county charter, ordinance, or resolution, or the governing body of a municipality or city and county, or the board of county commissioners of a county if no such authority is designated.

"Manager" means:

a. A member of a limited liability company in which management is not vested in managers rather than members;

b. A manager of a limited liability company in which management is vested in managers rather than members;

c. A member of a limited partnership association in which management is not vested in managers rather than members;

d. A manager of a limited partnership association in which management is vested in managers rather than members;

e. A general partner;

f. An officer or director of a corporation, a nonprofit corporation, a cooperative, or a limited partnership association; or

g. Any Person whose position with respect to an Entity, as determined under the constituent documents and organic statutes of the Entity, without regard to the Person's title, is the functional equivalent of any of the positions described in this definition.

"Marijuana-Based Workforce Development Training Program" means a program designed to train individuals to work in the Regulated Marijuana industry operated by an entity licensed under the Marijuana Code or by a school that is authorized by the Division of Private Occupational Schools.

"Marijuana Code" means the Colorado Marijuana Code found at sections 44-10-101 *et seq.*, C.R.S.

"Marijuana Consumer Waste" means any component left after the consumption of a Regulated Marijuana Product, including but not limited to Containers, packages, cartridges, pods, cups, batteries, all-in-one disposable devices, and any other waste component left after the Regulated Marijuana is consumed.

"Marijuana Hospitality Business" means an entity licensed to permit the use or consumption of marijuana within a Consumption Area.

"Marketing Layer" means packaging in addition to the Container that is the outermost layer visible to the consumer at the point of sale. The Marketing Layer is optional, but if used by a Licensee in addition to the required Container, it must be labeled according to the requirements in the 3-1000 Series Rules.

"Marijuana Research and Development Facility" means a Person that is licensed pursuant to the Marijuana Code to grow, cultivate, manufacture, and possess Medical Marijuana, and to Transfer Medical Marijuana to another Marijuana Research and Development Facility or a Medical Research and Development Facility, all for limited research purposes authorized pursuant to section 44-10-507, C.R.S.

"Material Change" means any change that would require a substantive revision to a Regulated Marijuana Business's standard operating procedures for the cultivation of Regulated Marijuana or the production of Regulated Marijuana Product.

"Medical Marijuana" means marijuana that is grown and sold pursuant to the Marijuana Code and includes seeds and Immature Plants. Unless the context otherwise requires, Medical Marijuana includes Medical Marijuana Concentrate and Medical Marijuana Products.

"Medical Marijuana Business" means a Medical Marijuana Store, a Medical Marijuana Product Manufacturer, a Medical Marijuana Cultivation Facility, a Medical Marijuana Testing Facility, a Medical Marijuana Business Operator, a Medical Marijuana Transporter, or a Marijuana Research and Development Facility.

"Medical Marijuana Business Operator" means an entity that holds a license from the State Licensing Authority to provide professional operational services to one or more Medical Marijuana Businesses, other than a Marijuana Research and Development Facility, for direct remuneration

from the Medical Marijuana Business(es), which may include compensation based upon a percentage of the profits of the Medical Marijuana Business(es) being operated. A Medical Marijuana Business Operator may contract with Medical Marijuana Business(es) to provide operational services. A Medical Marijuana Business Operator's contract with a Medical Marijuana Business does not in and of itself constitute ownership.

"Medical Marijuana Concentrate" means a specific subset of Medical Marijuana that was produced by extracting Cannabinoids from Medical Marijuana. Categories of Medical Marijuana Concentrate include Water-Based Medical Marijuana Concentrate, Food-Based Medical Marijuana Concentrate, Solvent-Based Medical Marijuana Concentrate, and Heat/Pressure-Based Medical Marijuana Concentrate. Medical Marijuana Concentrate includes Medical Marijuana Concentrate consumed using a Vaporizer Delivery Device or Pressurized Metered Dose Inhaler.

"Medical Marijuana Cultivation Facility" means a Person licensed pursuant to the Marijuana Code to operate a business as described in section 44-10-502, C.R.S.

"Medical Marijuana Product" means a product infused with Medical Marijuana and other Ingredients that is intended for use or consumption other than by smoking, including but not limited to edible product, ointments, and tinctures.

"Medical Marijuana Products Manufacturer" means a Person licensed pursuant to the Marijuana Code to operate a business as described in section 44-10-503, C.R.S.

"Medical Marijuana Store" means a Person licensed pursuant to the Marijuana Code to operate a business as described in section 44-10-501, C.R.S., and sells Medical Marijuana to registered patients or primary caregivers as defined in Article XVIII, Section 14 of the Colorado Constitution, but is not a primary caregiver.

"Medical Marijuana Testing Facility" means a public or private laboratory licensed and certified, or approved by the Division, to perform testing and research on Medical Marijuana.

"Medical Marijuana Transporter" means a Person that is licensed to transport Medical Marijuana from one Medical Marijuana Business to another Medical Marijuana Business or to a Medical Research Facility or Pesticide Manufacturer, and to temporarily store the transported Medical Marijuana at its Licensed Premises, but is not authorized to sell, give away, buy, or receive complimentary Medical Marijuana under any circumstances. A Medical Marijuana Transporter does not include a Licensee that transports its own Medical Marijuana.

"Medical Research Facility" means a Person approved and grant-funded by the State Board of Health pursuant to section 25-1.5-106.5, C.R.S., to conduct Medical Marijuana research. A Medical Research Facility is neither a Regulated Marijuana Business, nor a Licensee.

"Mobile Premises" means a Licensed Premises operated by a Marijuana Hospitality Business in a motor vehicle, which includes any self-propelled vehicle that is designed primarily for travel on the public highways and that is generally and commonly used to transport persons and property over the public highways or a low-speed electric vehicle; but does not include electrical assisted bicycles, electric scooters, low-power scooters, wheelchairs, or vehicles moved solely by human power. A Marijuana Hospitality Business operating a Mobile Premises must comply with all requirements in Rule 6-740.

"Monitoring" means the continuous and uninterrupted attention to potential alarm signals that could be transmitted from a Security Alarm System located at a Regulated Marijuana Business Licensed Premises, for the purpose of summoning a law enforcement officer to the premises during alarm conditions.

"Monitoring Company" means a person in the business of providing security system Monitoring services for the Licensed Premises of a Regulated Marijuana Business.

"Multiple-Serving Edible Retail Marijuana Product" means an Edible Retail Marijuana Product unit for sale to consumers containing no more than 10mg of active THC and no more than 100mg of active THC. If the overall Edible Retail Marijuana Product unit for sale to the consumer consists of multiple pieces where each individual piece may contain less than 10mg active THC, yet in total all pieces combined within the unit for sale contain more than 10mg of active THC, then the Edible Retail Marijuana Product shall be considered a Multiple-Serving Edible Retail Marijuana Product.

"Nonconformance" means a non-fulfillment of a requirement or departure from written procedures, work instructions, or quality system, as defined by the Licensee's written Corrective Action and Preventive Action procedures.

"Non-objecting Beneficial Owner" means a Beneficial Owner who gives permission to a financial intermediary to release their name and address to the company(ies) or issuer(s) in which they have bought Securities.

"Notice of Denial" means a written statement from the State Licensing Authority, articulating the reasons or basis for denial of a license application.

"Opaque" means that the packaging does not allow the product to be seen without opening the packaging material.

"Order to Show Cause" means a document from the State Licensing Authority alleging the grounds for imposing discipline against a Licensee's license.

"Owner's Interest" means the shares of stock in a corporation, a membership in a nonprofit corporation, a membership interest in a limited liability company, the interest of a member in a cooperative or in a limited cooperative association, a partnership interest in a limited partnership, a partnership interest in a partnership, and the interest of a member in a limited partnership association.

"Owner License" means a license issued to a natural person who is a Controlling Beneficial Owner of a Regulated Marijuana Business or who is a Passive Beneficial Owner electing to be subject to licensure.

"Passive Beneficial Owner" means any Person Acquiring any Owner's Interest in a Regulated Marijuana Business that is not otherwise a Controlling Beneficial Owner or in Control.

"Penny Stock" means any equity security other than a Security:

a. That is an National Market System stock, provided that:

i. The Security is registered, or approved for registration upon notice of issuance, on a national securities exchange that has been continuously registered as a national securities exchange since April 20, 1992; and the national securities exchange has maintained quantitative listing standards that are substantially similar to or stricter than those listing standards that were in place on that exchange on January 8, 2004; or

ii. The Security is registered, or approved for registration upon notice of issuance, on a national securities exchange, or is listed, or approved for

listing upon notice of issuance on, an automated quotation system sponsored by a registered national securities association, that:

A. Has established initial listing standards that meet or exceed the following criteria:

1. The issuer shall have: (a) stockholders' equity of $5,000,000; (b) market value of listed Securities of $50 million for 90 consecutive days prior to applying for a listing (market value means the closing bid price multiplied by the number of Securities listed); or (c) net income of $750,000 (excluding non-recurring items) in the most recently completed fiscal year or in two of the last three most recently completed fiscal years;

2. The issuer shall have an operating history of at least one year or a market value of listed Securities of $50 million (market value means the closing bid price multiplied by the number of Securities listed);

3. The issuer's stock, common or preferred, shall have a minimum bid price of $4 per share;

4. In the case of common stock, there shall be at least 300 round lot holders of the Security (a round lot holder means a holder of a normal unit of trading);

5. In the case of common stock, there shall be at least 1,000,000 publicly held shares and such shares shall have a market value of at least $5 million (market value means the closing bid price multiplied by the number of publicly held shares, and shares held directly or indirectly by an officer or director of the issuer and by any Person who is the Beneficial Owner of more than 10 percent of the total shares outstanding are not considered to be publicly held);

6. In the case of a convertible debt security, there shall be a principal amount outstanding of at least $10 million;

7. In the case of rights and warrants, there shall be at least 100,000 issued and the underlying security shall be registered on a national securities exchange or listed on an automated quotation system sponsored by a registered national securities association and shall satisfy the requirements of paragraphs (a) or (e) of this definition;

8. In the case of put warrants (that is, instruments that grant the holder the right to sell to the issuing company a specified number of shares of the company's common stock, at a specified price until a specified period of time), there shall be at least 100,000 issued and the underlying Security shall be registered on a national securities exchange or listed on an automated quotation

system sponsored by a registered national securities association and shall satisfy the requirements of paragraphs (a) or (e) of this definition;

9. In the case of units (that is, two or more Securities traded together), all component parts shall be registered on a national securities exchange or listed on an automated quotation system sponsored by a registered national securities association and shall satisfy the requirements of paragraphs (a) or (e) of this definition; and

10. In the case of equity Securities (other than common and preferred stock, convertible debt securities, rights and warrants, put warrants, or units), including hybrid products and derivative products, the national securities exchange or registered national securities association shall establish quantitative listing standards that are substantially similar to those found in paragraph (a)(ii) of this definition; and

B. Has established quantitative continued listing standards that are reasonably related to the initial listing standards set forth in paragraph (a)(ii) of this definition, and that are consistent with the maintenance of fair and orderly markets;

b. That is issued by an investment company registered under the Federal Investment Company Act of 1940;

c. That is a put or call option issued by the Options Clearing Corporation;

d. That has a price of five dollars or more;

i. For purposes of this paragraph (d):

A. A Security has a price of five dollars or more for a particular transaction if the Security is purchased or sold in that transaction at a price of five dollars or more, excluding any broker or dealer commission, commission equivalent, mark-up, or mark-down; and

B. Other than in connection with a particular transaction, a Security has a price of five dollars or more at a given time if the inside bid quotation is five dollars or more; provided, however, that if there is no such inside bid quotation, a Security has a price of five dollars or more at a given time if the average of three or more interdealer bid quotations at specified prices displayed at that time in an interdealer quotation system, by three or more market makers in the Security, is five dollars or more.

C. The term “inside bid quotation” shall mean the highest bid quotation for the Security displayed by a market maker in the Security on an automated interdealer quotation system that has the characteristics set forth in section 17B(b)(2) of the Federal Securities Exchange Act of 1934, or such other automated

interdealer quotation system designated by the Federal Securities Exchange Commission for purposes of this definition, at any time in which at least two market makers are contemporaneously displaying on such system bid and offer quotation for the Security at specified prices.

ii. If a Security is a unit composed of one or more Securities, the unit price divided by the number of shares of the unit that are not warrants, options, rights, or similar Securities must be five dollars or more as determined in accordance with paragraph (d)(i), and any share of the unit that is a warrant, option, right, or similar security, or a convertible security, must have an exercise price or conversion price of five dollars or more;

e. That is registered, or approved for registration upon notice of issuance, on a national securities exchange that makes transaction reports available provided that:

i. Price and volume of information with respect to transactions in that security is required to be reported on a current and continuing basis and is made available to vendors of market information pursuant to the rules of the national securities exchange;

ii. The Security is purchased or sold in a transaction that is effected on or through the facilities of the national securities exchange, or that is part of the distribution of the Security; and

iii. The Security satisfies the requirements of paragraphs (a)(i) or (a)(ii);

f. That is a security futures product listed on a national securities exchange or an automated quotation system sponsored by a registered national securities association; or

g. Whose issuer has:

i. Net tangible assets in excess of $2,000,000, if the issuer has been in continuous operation for at least three years, or $5,000,000 if the issuer has been in continuous operation for less than three years; or

ii. Average revenue of at least $6,000,000 for the last three years.

"Permitted Economic Interest" means any unsecured convertible debt option, option agreement or warrant that establishes a right for a Person to obtain an interest that might convert to an ownership interest in a Regulated Marijuana Business issued prior to January 1, 2020 where the holder is a natural person who is a lawful United States resident and whose right to convert into an ownership interest is contingent on the holder qualifying as a Controlling Beneficial Owner or Passive Beneficial Owner under the Retail Code or Medical Code. This definition is repealed effective January 1, 2020.

"Person" means a natural person, an estate, a trust, an Entity, or a state or other jurisdiction.

"Pesticide" means any substance or mixture of substances intended for preventing, destroying, repelling or mitigating any pest or any substance or mixture of substances intended for use as a plant regulator, defoliant or desiccant; except that the term "pesticide" does not include any article that is a "new animal drug" as designated by the United States Food and Drug Administration.

"Pesticide Manufacturer" means a Person who (1) manufactures, prepares, compounds, propagates, or processes any Pesticide or device or active ingredient used in producing a Pesticide; (2) who possesses an establishment registration number with the U.S. Environmental Protection Agency pursuant to the Federal Insecticide, Fungicide, and Rodenticide Act, 7 U.S.C. §§ 136 *et seq.*; (3) who conducts research to establish safe and effective protocols, including but not limited to establishing efficacy and toxicity, for the use of Pesticides on Regulated Marijuana; (4) who has applied for and received any necessary license, registration, certifications, or permits from the Colorado Department of Agriculture, pursuant to the Pesticide Act, sections 35-9-101 *et seq.*, C.R.S. and/or the Pesticide Applicators' Act, sections 35-10-101 *et seq.*, C.R.S.; (5) who is authorized to conduct business in the State of Colorado; and (6) who has physical possession of the location in the State of Colorado where its research activities occur. A Pesticide Manufacturer is neither a Regulated Marijuana Business, nor a Licensee.

"Pressurized Metered Dose Inhaler" means inhalable Regulated Marijuana Concentrate, which may be comprised of other Ingredients, and a pressurized propellant inside a device that administers a dose of an aerosolized composition.

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

"Private Residence" includes, but is not limited to, a private premises where a person lives such as a private dwelling, place of habitation, a house, a multi-dwelling unit for residential occupants, or an apartment unit. Private residence does not include any premises located at a school, on the campus of an institution of higher education, public property, or any commercial property unit such as offices or retail space.

"Production Batch" means (a) any amount of Regulated Marijuana Concentrate of the same category and produced using the same extraction methods, standard operating procedures and an identical group of Harvest Batch(es) of Medical Marijuana or Retail Marijuana; or (b) any amount of Regulated Marijuana Product of the same exact type, produced using the same Ingredients, standard operating procedures, and the same Production Batch(es) of Regulated Marijuana Concentrate.

"Professional Engineer" means a natural person who is licensed by the State of Colorado as a professional engineer pursuant to sections 12-25-101 *et seq.*, C.R.S.

"Proficiency Testing" means an assessment of the performance of a Medical Marijuana Testing Facility's or Retail Marijuana Testing Facility'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.

"Propagation" means the reproduction of Regulated Marijuana plants by seeds, cuttings, or grafting.

"Public Institution," for purposes of the 5-700 Series Rules, means any entity established or controlled by the federal government, a state government, or a local government or municipality, including but not limited to an institution of higher education or a public higher education research institution.

"Public Money," for purposes of the 5-700 Serie Rules, means any funds or money obtained by the holder from any governmental entity, including but not limited to research grants.

"Publicly Traded Corporation" means any Person other than an individual that is organized under the laws of and for which its principal place of business is located in one of the states or territories

of the United States or District of Columbia or another country that authorizes the sale of marijuana that:

a. Has a class of Securities registered pursuant to section 12 of the Securities Exchange Act of 1934, as amended, that:

i. Constitutes Covered Securities; or

ii. Is qualified and quoted on the OTCQX or OTCQB tier of the OTC markets if:

A. The Person is then required to file reports and is filing reports on a current basis with the Federal Securities Exchange Commission pursuant to the Federal Securities Exchange Act of 1934, as amended, as if the Securities constituted Covered Securities; and

B. The Person has established and is in compliance with corporate governance measures pursuant to corporate governance obligations imposed on Securities qualified and quoted on the OTCQX tier of the OTC markets.

b. Is an Entity that has a class of Securities listed on the Canadian Securities Exchange, Toronto Stock Exchange, TSX Venture Exchange, or NEO Exchange, if:

i. The Entity constitutes a Foreign Private Issuer whose Securities are exempt from registration pursuant to section 12 of the Federal Securities Exchange Act of 1934, as amended, pursuant to Rule 12g3-2(b) promulgated pursuant to the federal Securities Exchange Act of 1934, as amended; and

ii. The Entity has been, for the preceding three hundred sixty-five days or since the formation of the Entity, in compliance with all governance and reporting obligations imposed by the relevant exchange on such Entity; or

c. Publicly Traded Corporation does not include:

i. An Ineligible Issuer, unless such Publicly Traded Corporation satisfies the definition of Ineligible Issuer solely because it is one or more of the following, and the Person is filing reports on a current basis with the Federal Securities and Exchange Commission pursuant to the Federal Securities Exchange Act of 1934, as amended, as if the Securities constituted Covered Securities, and prior to becoming a Publicly Traded Corporation, the Person for at least two years was licensed by the State Licensing Authority as a Regulated Marijuana Business with a demonstrated history of operations in the state of Colorado, and during such time was not subject to suspension or revocation of the business license:

A. a Blank Check Company;

B. an issuer in an offering of Penny Stock; or

C. a Shell Company.

ii. A Person disqualified as a Bad Actor.

"Qualified Institutional Investor" means:

a. A bank as defined in Section 3(a) (6) of the Federal Securities Exchange Act of 1934, as amended, if the bank is current in all applicable reporting and record-keeping requirements under such act and rules promulgated thereunder;

b. A bank holding company as defined in the Federal Bank Holding Company Act of 1956, as amended, if the bank holding company is registered and current in all applicable reporting and record-keeping requirements under such act and rules promulgated thereunder;

c. An insurance company as defined in Section 2(a) (17) of the Investment Company Act of 1940, as amended;

d. An investment company registered under Section 8 of the Investment Company Act of 1940, as amended;

e. An employee benefit plan or pension fund subject to the Federal Employee Retirement Income Security Act of 1974, excluding an employee benefit plan or pension fund sponsored by a licensee or an intermediary or holding company licensee which directly or indirectly owns ten percent or more of a licensee;

f. A state or federal government pension plan; or

g. A group comprised entirely of persons specified in (a) through (g) of this definition.

"Qualified Private Fund" means an issuer that would be an investment company, as defined in section 3 of the Federal Investment Company Act of 1940, but for the exclusions provided under sections 3(c)(1) or 3(c)(7) of that Act, and that:

a. Is advised or managed by an investment adviser as defined and registered under sections 80b-1-21, title 15 of the Federal Investment Advisors Act of 1940, and for which the registered investment adviser is current in all applicable reporting and record-keeping requirements under such act and rules promulgated thereunder; and

b. Satisfies one or more of the following:

i. Is organized under the law of a state or the United States;

ii. Is organized, operated, or sponsored by a U.S. person, as defined under subsection 17 CFR 230.902(k), as amended; or

iii. Sells Securities to a U.S. person, as defined under subsection 17 CFR 230.902(k), as amended.

"R&D Co-Location Permit" means a permit issued to a Marijuana Research and Development Facility authorizing it to co-locate with a commonly owned Medical Marijuana Products Manufacturer, Retail Marijuana Products Manufacturer, Medical Marijuana Cultivation Facility, or Retail Marijuana Cultivation Facility pursuant to Rule 5-705. A separate R&D Co-Location Permit

is required for each location at which a Marijuana Research and Development Facility seeks to share a single Licensed Premises.

"Reasonable Cause" means just or legitimate grounds based in law and in fact to believe that the particular requested action furthers the purposes of the Marijuana Code or protects the public safety.

"Regulated Marijuana" means Medical Marijuana and Retail Marijuana. If the context requires, Regulated Marijuana includes Medical Marijuana Concentrate, Medical Marijuana Product, Retail Marijuana Concentrate, and Retail Marijuana Product.

"Regulated Marijuana Business" means Medical Marijuana Businesses and Retail Marijuana Businesses.

"Regulated Marijuana Concentrate" means Medical Marijuana Concentrate and Retail Marijuana Concentrate.

"Regulated Marijuana Product" means Medical Marijuana Product and Retail Marijuana Product.

"Remediation" means the process by which Regulated Marijuana flower and trim, which has failed microbial testing, is processed into a Solvent-Based Medical Marijuana Concentrate, or into Solvent-Based Retail Marijuana Concentrate and retested as required by these rules.

"Resealable" means that the Container maintains its Child-Resistant effectiveness for multiple openings.

"Research Project" means a discrete scientific endeavor to answer a research question or a set of research questions. A Research Project must include a description of a defined protocol, clearly articulated goal(s), defined methods and outputs, and a defined start and end date. The description must demonstrate that the Research Project will comply with all requirements in the 5-700 Series Rules – Marijuana Research and Development Facility. All research and development conducted by a Marijuana Research and Development Facility must be conducted in furtherance of an approved Research Project.

"Respondent" means a Person who has filed a petition for declaratory order that the State Licensing Authority has determined needs a hearing or legal argument, or a Licensee who is subject to an Order to Show Cause.

"Responsible Vendor Program Provider" means a Person offering an Approved Training Program, in accordance with section 44-10-1201, C.R.S., to Licensees seeking to be designated a responsible vendor.

"Restricted Access Area" means a designated and secure area within a Licensed Premises in a Medical Marijuana Store where Medical Marijuana is sold to patients, possessed for sale, and displayed for sale, and where no one without a valid patient registry card is permitted, and 2) in a Retail Marijuana Store or a Retail Marijuana Hospitality and Sales Business where Retail Marijuana is sold to consumers, possessed for sale, and displayed for sale, and where no one under the age of 21 is permitted.

"Retail Food Establishment" means a retail operation that stores, prepares, or packages food for human consumption or serves or otherwise provides food for human consumption to consumers directly or indirectly through a delivery service, whether such food is consumed on or off the premises or whether there is a charge for such food. "Retail food establishment" does not mean:

a. Any private home;

b. Private boarding house;

c. Hospital and health facility patient feeding operations licensed by the department;

d. Child care centers and other child care facilities licensed by the department of human services;

e. Hunting camps and other outdoor recreation locations where food is prepared in the field rather than at a fixed based of operation;

f. Food or beverage wholesale manufacturing, processing, or packaging plants, or portions thereof, that are subject to regulatory controls under state or federal laws or regulations;

g. Motor vehicles used only for the transport of food;

h. Establishments preparing and serving only hot coffee, hot tea, instant hot beverages, and nonpotentially hazardous doughnuts or pastries obtained from sources complying with all laws related to food and food labeling;

i. Establishments that handle only nonpotentially hazardous prepackaged food and operations serving only commercially prepared, prepackaged foods requiring no preparation other than the heating of the food within its original container or package;

j. Farmers markets and roadside markets that offer only uncut fresh fruit and vegetables for sale;

k. Automated food merchandising enterprises that supply only prepackaged nonpotentially hazardous food or drink in bottles, cans, or cartons only, and operations that dispense only chewing gum or salted nuts in their natural protective covering;

l. The donation, preparation, sale, or service of food by a nonprofit or charitable organization in conjunction with an event or celebration if such donation, preparation, sale, or service of food:

   i. Does not exceed the duration of the event or celebration or a maximum of fifty-two days within a calendar year; and

   ii. Takes place in the county in which such nonprofit or charitable organization resides or is principally located.

m. A home, commercial, private, or public kitchen in which a person produces food products sold directly to consumers pursuant to the “Colorado Cottage Foods Act,” section 25-4-1614, C.R.S.

“Retail Marijuana” means all parts of the plant of the genus cannabis whether growing or not, the seeds thereof, the resin extracted from any part of the plant, and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds, or its resin, including but not limited to Retail Marijuana Concentrate, that is cultivated, manufactured, distributed, or sold by a licensed Retail Marijuana Business. “Retail Marijuana” does not include industrial hemp, nor does it include fiber produced from stalks, oil, or cake made from the seeds of the plant, sterilized seed of the plant which is incapable of germination, or the weight of any other Ingredient combined with

marijuana to prepare topical or oral administrations, food, drink, or other product. If the context requires, Retail Marijuana includes Retail Marijuana Concentrate and Retail Marijuana Product.

"Retail Marijuana Business" means a Retail Marijuana Store, a Retail Marijuana Cultivation Facility, a Retail Marijuana Products Manufacturer, a Retail Marijuana Testing Facility, a Retail Marijuana Business Operator, a Retail Marijuana Transporter, and Licensed Hospitality Businesses.

"Retail Marijuana Business Operator" means an entity that holds a license from the State Licensing Authority to provide professional operational services to one or more Retail Marijuana Businesses for direct remuneration from the Retail Marijuana Business(es), which may include compensation based upon a percentage of the profits of the Retail Marijuana Business(es) being operated. A Retail Marijuana Business Operator contracts with Retail Marijuana Business(es) to provide operational services. A Retail Marijuana Business Operator's contract with a Retail Marijuana Business does not in and of itself constitute ownership.

"Retail Marijuana Concentrate" means a specific subset of Retail Marijuana that was produced by extracting Cannabinoids from Retail Marijuana. Categories of Retail Marijuana Concentrate include Water-Based Retail Marijuana Concentrate, Food-Based Retail Marijuana Concentrate Solvent-Based Retail Marijuana Concentrate, and Heat/Pressure-Based Retail Marijuana Concentrate. Retail Marijuana Concentrate includes Retail Marijuana Concentrate consumed using a Vaporizer Delivery Device or Pressurized Metered Dose Inhaler.

"Retail Marijuana Cultivation Facility" means an entity licensed to cultivate, prepare, and package Retail Marijuana and Transfer Retail Marijuana to Retail Marijuana Businesses, Medical Research Facilities, and Pesticide Manufacturers, but not to consumers.

"Retail Marijuana Hospitality and Sales Business" means an entity licensed to (1) purchase Retail Marijuana from a Retail Marijuana Business, (2) Transfer Retail Marijuana to consumers, and (3) permit the use or consumption of Retail Marijuana Transferred to a consumer within the Restricted Access Area.

"Retail Marijuana Product" means a product that is comprised of Retail Marijuana and other Ingredients and is intended for use or consumption, such as, but not limited to, edible product, ointments and tinctures.

"Retail Marijuana Products Manufacturer" means an entity licensed to purchase Retail Marijuana; manufacture, prepare, and package Retail Marijuana Product; and Transfer Retail Marijuana, Retail Marijuana Concentrate, and Retail Marijuana Product only to other Retail Marijuana Products Manufacturers, Retail Marijuana Stores, Retail Marijuana Hospitality and Sales Businesses, Medical Research Facilities, and Pesticide Manufacturers.

"Retail Marijuana Store" means an entity licensed to purchase Retail Marijuana and Retail Marijuana Concentrate from a Retail Marijuana Cultivation Facility and to purchase Retail Marijuana Product and Retail Marijuana Concentrate from a Retail Marijuana Products Manufacturer, and to Transfer Retail Marijuana to Retail Marijuana Hospitality and Sales Businesses and to consumers.

"Retail Marijuana Testing Facility" means a public or private laboratory licensed and certified, or approved by the Division, to perform testing and research on Retail Marijuana.

"Retail Marijuana Transporter" means a Person that is licensed to transport Retail Marijuana from one Retail Marijuana Business to another Retail Marijuana Business or to a Medical Research Facility or Pesticide Manufacturer, and to temporarily store the transported Retail Marijuana at its Licensed Premises, but is not authorized to sell, give away, buy, or receive complimentary Retail

Marijuana under any circumstances. A Retail Marijuana Transporter does not include a Licensee that transports and distributes its own Retail Marijuana.

"RFID" means Radio Frequency Identification.

"Sample" means any item collected from a Regulated Marijuana Business that is provided to a Medical Marijuana Testing Facility or Retail Marijuana Testing Facility for testing. The following is a non-exhaustive list of types of Samples: Medical Marijuana, Medical Marijuana Concentrate, Medical Marijuana Product, Retail Marijuana, Retail Marijuana Concentrate, Retail Marijuana Product, soil, growing medium, water, solvent or swab of a counter or equipment.

"Sampling Manager" means an Owner Licensee or management personnel holding an Employee Licensee designated by a Medical Marijuana Cultivation Facility, Medical Marijuana Products Manufacturer, Retail Marijuana Cultivation Facility, or Retail Marijuana Products Manufacturer to receive Transfers of Sampling Units pursuant to Rules 5-230, 5-320, 6-225, and 6-320.

"Sampling Unit" means a unit of Regulated Marijuana Transferred to a Sampling Manager for purposes of quality control and product development pursuant to Rules 5-230 and 5-320, sections 44-10-502(4) and 44-10-503(10), C.R.S., and Rules 6-225 and 6-320, and sections 44-10-602(6) and 44-10-603(10), C.R.S.

"Security(ies)" means any note, stock, treasury stock, security future, security-based swap, bond, debenture, evidence of indebtedness, certificate of interest or participation in any profit-sharing agreement, collateral-trust certificate, preorganization certificate or subscription, transferable share, investment contract, voting-trust certificate, certificate of deposit for a security, fractional undivided interest in oil, gas, or other mineral rights, any put, call, straddle, option, or privilege on any security, certificate of deposit, or group index of securities (including any interest therein or based on the value thereof), or any put, call, straddle, option, or privilege entered into on a national securities exchange relating to foreign currency, or, in general, any interest or instrument commonly known as a "security," or any certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase, any of the foregoing.

"Security Alarm System" means a device or series of devices, intended to summon law enforcement personnel during, or as a result of, an alarm condition. Devices may include hard-wired systems and systems interconnected with a radio frequency method such as cellular or private radio signals that emit or transmit a remote or local audible, visual, or electronic signal; motion detectors, pressure switches, duress alarms (a silent system signal generated by the entry of a designated code into the arming station to indicate that the user is disarming under duress); panic alarms (an audible system signal to indicate an emergency situation); and hold-up alarms (a silent system signal to indicate that a robbery is in progress).

"Shell Company" means a registrant, other than an asset-backed issuer as defined in Item 1101(b) of Regulation AB, that has:

a. No or nominal operations; and

b. Either:

   i. No or nominal operations;

   ii. Assets consisting solely of cash and cash equivalents; or

   iii. Assets consisting of any amount of cash and cash equivalents and nominal other assets.

"Shipping Container" means a hard-sided container with a lid or other enclosure that can be secured in place. A Shipping Container is used solely for the transport of Regulated Marijuana between Regulated Marijuana Businesses, a Medical Research Facility, or a Pesticide Manufacturer.

"Single-Serving Edible Retail Marijuana Product" means an Edible Retail Marijuana Product unit for sale to consumers containing no more than 10mg of active THC.

"Solvent-Based Medical Marijuana Concentrate" means a Medical Marijuana Concentrate that was produced by extracting Cannabinoids from Medical Marijuana through the use of a solvent approved by the Division pursuant to Rule 5-315.

"Solvent-Based Retail Marijuana Concentrate" means a Retail Marijuana Concentrate that was produced by extracting Cannabinoids from Retail Marijuana through the use of a solvent approved by the Division pursuant to Rule 6-315.

"Standardized Graphic Symbol" means a graphic image or small design adopted by a Licensee to identify its business.

"Standardized Serving of Marijuana" means a standardized single serving of active THC in Retail Marijuana. The size of a Standardized Serving of Marijuana shall be no more than 10mg of active THC.

"State Licensing Authority" means the authority created for the purpose of regulating and controlling the licensing of the cultivation, manufacture, distribution, sale, and testing of Regulated Marijuana in Colorado, pursuant to section 44-10-201, C.R.S.

"Target Potency" means the potency that a Medical Marijuana Products Manufacturer intends for an individual Medical Marijuana Product, or a Retail Marijuana Products Manufacturer intends for an individual Retail Marijuana Product, prior to testing, which is also outlined in the Licensee's standard operating procedures.

"Temporary Appointee Registration" means a registration issued to a Court Appointee pursuant to section 44-10-401(3)(a), C.R.S.

"THC" means tetrahydrocannabinol.

"THCA" means tetrahydrocannabinolic acid.

"Test Batch" means a group of Samples that are derived from a single Harvest Batch, Production Batch, or Inventory Tracking System package, and that are collectively submitted to a Medical Marijuana Testing Facility or to a Retail Marijuana Testing Facility for testing purposes.

"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.

"Transfer(s)(ed)(ing)" means to grant, convey, hand over, assign, sell, exchange, donate, or barter, in any manner or by any means, with or without consideration, any Regulated Marijuana from one Licensee to another Licensee, to a patient, or to a consumer. A Transfer includes the movement of Regulated Marijuana from one Licensed Premises to another, even if both premises are contiguous, and even if both premises are owned by a single entity or individual or group of individuals and also includes a virtual transfer that is reflected in the Inventory Tracking System, even if no physical movement of the Regulated Marijuana occurs.

"Universal Symbol" means the image established by the Division and made available to Licensees through the Division's website indicating the Regulated Marijuana contains marijuana.

"Unrecognizable" means marijuana or *Cannabis* plant material rendered indistinguishable from any other plant material.

"U.S. Person" means:

a. Any natural person resident in the United States;

b. Any partnership or corporation organized or incorporated under the laws of the United States;

c. Any estate of which any executor or administrator is a U.S. natural person;

d. Any trust of which any trustee is a U.S. natural person;

e. Any agency or branch of a foreign entity located in the United States;

f. Any non-discretionary account or similar account (other than an estate or trust) held by a dealer or other fiduciary for the benefit or account of a U.S. natural person;

g. Any discretionary account or similar account (other than an estate or trust) held by a dealer or other fiduciary organized, incorporated, or (if a natural person) resident in the United States; and

h. Any partnership or corporation if:

i. Organized or incorporated under the laws of any foreign jurisdiction; and

ii. Formed by a U.S. natural person principally for the purpose of investing in Owner's Interests not registered under the Securities Act of 1933, unless it is organized or incorporated, and owned, by accredited investors (as defined in § 230.501(a)) who are not natural persons, estates or trusts.

"Vaporizer Delivery Device" means inhalable Regulated Marijuana Concentrate, which may be comprised of other Ingredients inside a device that uses a heating element to create a vapor including, but not limited to, vaporizer cartridges and vaporizer pens.

"Vegetative" means the state of the *Cannabis* plant during which plants do not produce resin or flowers and are bulking up to a desired production size for Flowering.

"Water-Based Medical Marijuana Concentrate" means a Medical Marijuana Concentrate that was produced by extracting Cannabinoids from Medical Marijuana through the use of only water or ice.

"Water-Based Retail Marijuana Concentrate" means a Retail Marijuana Concentrate that was produced by extracting Cannabinoids from Retail Marijuana through the use of only water or ice.

Part 2 – Applications and Licenses

2-200 Series – Applications and Licenses Rules

Basis and Purpose – 2-205

The statutory basis for this rule includes but is not limited to sections 44-10-103, 44-10-202(1)(b), 44-10-202(1)(c), 44-10-202(1)(e), 44-10-203(1)(j), 44-10-203(1)(i), 44-10-203(2)(b), 44-10-203(2)(h), 44-10-203(2)(q), 44-10-203(2)(w), 44-10-203(2)(dd)(XII), 44-10-303(2)(b), 44-10-310(7), 44-10-313, 44-10-401, 44-10-801, 44-10-802, 44-10-803, 44-10-1201, 44-10-1202, C.R.S. Authority also exists in the Colorado Constitution at Article XVIII, Subsection 16(5)(a)(II). The purpose of this rule is to establish fees required for applications, renewals, licenses fees, permits, and other fees required to accompany applications and submissions to the Division. The Division anticipates evaluating all fees in connection with a fee analysis. Any recommendations from the fee analysis will be considered during subsequent rulemaking proceedings. This Rule 2-205 was previously Rules M 207, 208, 209, 210, 235, and 236, 1 CCR 212-1, and Rules R 207, 208, 209, 210, 234, and 235, 1 CCR 212-2.

2-205 – Fees

A. Regulated Marijuana Business Initial Application and License Fees.

1. Medical Marijuana Businesses.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Medical Marijuana Store	$5,000.00	$2,000.00	$7,000.00
Medical Marijuana Products Manufacturer	$1,000.00	$1,500.00	$2,500.00
Medical Marijuana Cultivation Facility Class 1 (1-500 plants)	$1,000.00	$1,500.00	$2,500.00
Medical Marijuana Testing Facility	$1,000.00	$1,500.00	$2,500.00
Medical Marijuana Transporter	$1,000.00	$4,400.00	$5,400.00
Medical Marijuana Business Operator	$1,000.00	$2,200.00	$3,200.00
Marijuana Research and Development Facility	$1,000.00	$1,500.00	$2,500.00

2. Retail Marijuana Businesses.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Retail Marijuana Store	$5,000.00	$2,000.00	**Separate Checks** $4,500.00 State $2,500.00 Local

Retail Marijuana Products Manufacturer	$5,000.00	$1,500.00	**Separate Checks** $4,000.00 State $2,500.00 Local
Retail Marijuana Cultivation Facility Tier 1 (1-1,800 plants)	$5,000.00	$1,500.00	**Separate Checks** $4,000.00 State $2,500.00 Local
Retail Marijuana Testing Facility	$1,000.00	$1,500.00	**Separate Checks** $2,000.00 State $500.00 Local
Retail Marijuana Transporter	$1,000.00	$4,400.00	**Separate Checks** $4,900.00 State $500.00 Local
Retail Marijuana Business Operator	$1,000.00	$2,200.00	**Separate Checks** $2,700.00 State $500.00 Local
Marijuana Hospitality Business (Eff. Jan. 1, 2020)	$1,000.00	$1,000.00	**Separate Checks** $1,500.00 State $500.00 Local
Retail Marijuana Hospitality and Sales Business (Eff. Jan. 1, 2020)	$5,000.00	$2,000.00	**Separate Checks** $4,500.00 State $2,500.00 Local

B. Regulated Marijuana Business Renewal Application and License Renewal Fees.

1. Medical Marijuana Businesses.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Medical Marijuana Store	$300.00	$1,500.00	$1,800.00
Medical Marijuana Products Manufacturer	$300.00	$1,500.00	$1,800.00

Medical Marijuana Cultivation Facility Class 1 (1-500 plants)	$300.00	$1,500.00	$1,800.00
Class 2 (501-1,500 plants)		$2,300.00	$2,600.00
Class 3 (1,501-3,000 plants)		$3,500.00	$3,800.00
Expanded Production Management (for each class of 3,000 plants over Class 3)		$3,500.00 [Plus $800 for each additional class of 3,000 plants over Class 3]	$3,800.00 [Plus $800 for each additional class of 3,000 plants over Class 3]
Medical Marijuana Testing Facility	$300.00	$1,500.00	$1,800.00
Medical Marijuana Transporter	$300.00	$4,400.00	$4,700.00
Medical Marijuana Business Operator	$300.00	$2,200.00	$2,500.00
Marijuana Research and Development Facility	$300.00	$1,500.00	$1,800.00

2. Retail Marijuana Businesses.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Retail Marijuana Store	$300.00	$1,500.00	$1,800.00
Retail Marijuana Products Manufacturer	$300.00	$1,500.00	$1,800.00
Retail Marijuana Cultivation Facility Tier 1 (1-1,800 plants)	$300.00	$1,500.00	$1,800.00
Tier 2 (1,801-3,600 plants)		$2,300.00	$2,600.00
Tier 3 (3,601-6,000 plants)		$3,000.00	$3,300.00
Tier 4 (6,001-10,200 plants)		$4,500.00	$4,800.00
Tier 5 (10,201-13,800 plants)		$6,500.00	$6,800.00

Expanded Production Management (for each additional tier of 3,600 plants over Tier 5)		$6,500.00 [Plus $800.00 for each additional tier of 3,600 plants over Tier 5]	$6,800.00 [Plus $800.00 for each additional tier of 3,600 plants over Tier 5]
Retail Marijuana Testing Facility	$300.00	$1,500.00	$1,800.00
Retail Marijuana Transporter	$300.00	$4,400.00	$4,700.00
Retail Marijuana Business Operator	$300.00	$2,200.00	$2,500.00
Marijuana Hospitality Business (Eff. Jan. 1, 2020)	$300.00	$750.00	$1,050.00
Retail Marijuana Hospitality and Sales Business (Eff. Jan. 1, 2020)	$300.00	$1,500.00	$1,800.00

C. Owner Request for a Finding of Suitability, Owner License, and Owner Identification Badge – Initial Application and Renewal Fees.

1. Controlling Beneficial Owner Request for a Finding of Suitability Fee.

   a. $800.00 per Natural Person

   b. $800.00 for an Entity that is not a Publicly Traded Corporation, plus the fee in paragraph (C)(1)(a) and (C)(1)(b), for each associated natural person subject to suitability

   c. $5,000.00 for a Publicly Traded Corporation, plus the fee in paragraph (C)(1)(a) and (C)(1)(b), for each associated natural person or Entity subject to suitability.

2. Passive Beneficial Owner Request for Finding of Suitability Fee. A Passive Beneficial Owner may, but is not required to, apply for an Owner License and Identification Badge, and if the Passive Beneficial Owner chooses to do so, must submit the fees required by subparagraph (C)(1).

3. Renewal Fee for an Owner License. All Controlling Beneficial Owners and licensed Passive Beneficial Owners - $500.00.

D. Employee License – Initial Fees and Renewal Fees.

1. Employee License Initial Application and License Fee – $100.00

   a. Of the total Employee License application and license fee, $75.00 is the application fee and $25.00 is the license fee. An individual submitting an application for an Employee License may submit the total fee of $100.00 in one form of payment.

2. Employee License Renewal Fee – $75.00

a. Of the total Employee License Renewal fee, $50.00 is the application fee and $25.00 is the license fee. An individual submitting an application for an Employee License renewal may submit the total fee of $75.00 in one form of payment.

3. All Key Licenses and Support Licenses issued before January 1, 2020 will be converted to an Employee License upon the first license renewal following January 1, 2020.

E. Temporary Appointee Registration – Request for Finding of Suitability Fees.

1. Natural Person – $225.00

2. Entity – $800.00

F. Other Fees. The following other fees apply:

1. Permits.

a. Off Premises Storage Permit – $1,500.00

b. Transporter Off Premises Storage Permit – $2,200.00

c. Centralized Distribution Permit Initial and Renewal Fee – $20.00

d. R&D Co-Location Permit Initial and Renewal Fee – $50.00

e. Delivery Permit:

i. Initial Fee Business License that will expire in 6 months or less - $2,000.00.

ii. Initial Fee Business License that will expire in more than 6 months - $4,000.00.

iii. All Renewals - $2,000.00

f. Transition Permit – $250.00

2. Regulated Marijuana Business Changes. The following fees apply per license:

a. Change of Controlling Beneficial Owner – $1,600.00

b. Changes Exempt from Change of Owner Application Requirement – $800.00

c. Change of Trade Name – $50.00

d. Change of Location – $500.00

e. Modification of Licensed Premises – $100.00

3. Marijuana Research and Development Facility Research Project Proposal – $500.00

4. Responsible Vendor Provider Applications.

a. Responsible Vendor Program Provider Initial Application – $850.00

b. Responsible Vendor Program Provider Renewal Application – $350.00

5. Duplicate License, Identification Badge, ~~or~~ Certificate, Regulated Marijuana Business License Reinstatement.

a. Duplicate Business License – $20.00

b. Duplicate Owner or Employee Identification Badge – $20.00

c. Responsible Vendor Program Provider Duplicate Certificate – $50.00

d. Reinstatement of Regulated Marijuana Business License - $250.00

G. When Fees are Due. All fees in this Rule are due at the time the application or request is submitted.

Basis and Purpose – 2-220

The statutory basis for this rule includes but is not limited to sections 44-10-202(1)(c), 44-10-202(1)(e), 44-10-203(1)(c), 44-10-203(1)(j), 44-10-203(2)(a), 44-10-203(2)(w), 44-10-203(2)(ee), 44-10-203(7), 44-10-301, 44-10-305, 44-10-307, 44-10-308, 44-10-309, 44-10-310, 44-10-311, 44-10-312, 44-10-313, and 44-10-316, C.R.S. The purpose of this rule is to establish the general requirements and processes for submission of an initial application for a Regulated Marijuana Business to the State Licensing Authority.

2-220 – Initial Application Requirements for Regulated Marijuana Businesses

A. Documents and Information Requested. Every initial application for a Regulated Marijuana Business license must include all required documents and information including, but not limited to:

1. A copy of the local license application, if required, for a Regulated Marijuana Business.

2. Certificate of Good Standing from the jurisdiction in which the Entity was formed, which must be one of the states of the United States, territories of the United States, District of Columbia, or another country that authorizes the sale of marijuana.

3. If the Applicant is an Entity, the identity and physical address of its registered agent in the state of Colorado.

4. Organizational Documents. Articles of Incorporation, by-laws, and any shareholder agreement for a corporation; articles of organization and operating agreement for a limited liability company; or partnership agreement for a partnership.

5. Corporate Governance Documents.

a. A Regulated Marijuana Business that is a Publicly Traded Corporation must maintain corporate governance documents as required by the securities exchange on which its securities are listed and traded, and section 44-10-103(50), C.R.S., and must provide those corporate governance documents with each initial application.

b. A Regulated Marijuana Business that is not a Publicly Traded Corporation is not required to maintain any corporate governance documents. However, if the Regulated Marijuana Business that is not a Publicly Traded Corporation

voluntarily maintains corporate governance documents, the Division encourages inclusion of such documents with each initial application.

6. The deed, lease, sublease, rental agreement, contract, or any other document(s) establishing the Applicant is, or will be, entitled to possession of the premises for which the application is made.

7. Legible and accurate diagram for the facility. The diagram must include a plan for the Licensed Premises and a separate plan for the security/surveillance plan including camera location, number and direction of coverage. If the diagram is larger than 8.5 x 11 inches, the Applicant must also provide a copy of the diagram in a portable document format (.pdf).

8. All required findings of suitability issued by the Division.

9. If the Applicant is a Publicly Traded Corporation:

   a. Documents establishing the Publicly Traded Corporation qualifies to hold a Regulated Marijuana Business license including but not limited to disclosure of securities exchange(s) on which its Securities are listed and traded, the stock symbol(s), the identity of all regulators with regulatory oversight over its Securities; and

   b. Divestiture plan for any Controlling Beneficial Owner that is a Person prohibited by the Marijuana Code, has had her or his Owner License revoked, or has been found unsuitable.

10. Financial Statements. Consolidated financial statements (which may be prepared on either a calendar or fiscal year basis) that were prepared in the preceding 365 days, and which must include a balance sheet, an income statement, and a cash flow statement. If the Applicant or Regulated Marijuana Business is required to have audited financial statements by another regulator (e.g. United States Securities and Exchange Commission or the Canadian Securities Administrators) the financial statements provided to the Division must be audited and must also include all footnotes, schedules, auditors' report(s), and auditor's opinion(s). If the financial statements are publicly available on a website (e.g. EDGAR or SEDAR), the Applicant or Regulated Marijuana Business may provide notification of the website link where the financial statements can be accessed in lieu of hardcopy submission.

11. Tax Documents. Documentation establishing compliant return filing and payment of taxes related to any Regulated Marijuana Business in which the Person is, or was, required to file and pay taxes.

B. Local Licensing/Approval Required.

1. Regulated Marijuana Business Local Licensing Authority Approval Required.

   a. If the Division grants a license to a Regulated Marijuana Business before the Local Licensing Authority or Local Jurisdiction approves the application or grants a local license, the state license will be conditioned upon local approval. If the Local Licensing Authority denies the application, the state license will be revoked.

   b. An Applicant is prohibited from operating a Regulated Marijuana Business prior to obtaining all necessary licenses, registrations, permits, or approvals from both

the State Licensing Authority and the Local Licensing Authority or Local Jurisdiction.

2. Retail Marijuana Business One Year to Obtain Local Jurisdiction Approval Required.

a. The Applicant has one year from the date of licensing by the State Licensing Authority to obtain approval or licensing from the Local Jurisdiction. If the Applicant fails to obtain Local Jurisdiction approval or licensing within one year from grant of the state license, the state license expires and may not be renewed.

C. Accelerator License Application, Qualification, and Eligibility.

1. License Issuance and Privileges.

a. Beginning July 1, 2020, a natural person may apply for an Accelerator License. The application shall be made on Division forms and in accordance with the 2-200 Series Rules.

b. An Accelerator License may be issued to a person to exercise the privileges of a Retail Marijuana Cultivation Facility on the Licensed Premises of a Retail Marijuana Cultivation Facility Licensee possessing a valid Accelerator Endorsement.

c. An Accelerator License may be issued to a person to exercise the privileges of a Retail Marijuana Products Manufacturer on the Licensed Premises of a Retail Marijuana Products Manufacturer Licensee possessing a valid Accelerator Endorsement.

2. Qualifications and Eligibility.

a. To qualify for an Accelerator License, the applicant must be found suitable for licensure pursuant to Rule 2-235, unless otherwise exempt by these Rules, and must satisfy the following minimum eligibility requirements:

i. The applicant resided in a census tract designated by the Office of Economic Development and International Trade as an “opportunity zone” for at least five of the ten years prior to application;

ii. The applicant has not been the Beneficial Owner of a license issued pursuant to the Marijuana Code; and

iii. The State Licensing Authority may consider additional facts and circumstances for purposes of determining qualifications and eligibility for an Accelerator License.

b. The State Licensing Authority will not deny an Accelerator License on the sole basis of a marijuana-related conviction.

3. Application Requirements. In addition to other application requirements, an application for an Accelerator License must include the following:

a. Information establishing that the applicant resided in a census tract designated by the Office of Economic Development and International Trade as an “opportunity zone” for at least five of the ten years prior to application;

b. Affirmation that the applicant has not been the Beneficial Owner of a license issued pursuant to the Marijuana Code

Basis and Purpose – 2-225

The statutory basis for this rule includes but is not limited to sections 44-10-202(1)(c), 44-10-202(1)(e), 44-10-203(1)(c), 44-10-203(2)(a), 44-10-203(2)(c), 44-10-203(2)(w), 44-10-203(2)(ee), 44-10-203(7), 44-10-307, 44-10-308, 44-10-309, 44-10-313, 44-10-314, and 44-10-316 C.R.S. The purpose of this rule is to establish the requirements and procedures for the license renewal process, including the circumstances under which an expired Regulated Marijuana Business license may be reinstated.

2-225 – Renewal Application Requirements for All Licensees

A. License Periods.

1. Regulated Marijuana Business and Owner Licenses are valid for one year from the date of issuance.

2. Medical Marijuana Transporters, Retail Marijuana Transporters, and Employee Licenses are valid for two years from the date of issuance.

B. Division Notification Prior to Expiration.

1. The Division will send a notice of license renewal 90 days prior to the expiration of an existing license by first class mail to the Licensee's physical address of record.

2. Failure to receive the Division notification does not relieve the Licensee of the obligation to timely renew the license.

C. Renewal Deadline.

1. A Licensee must apply for the renewal of an existing license prior to the License's expiration date.

2. A renewal application submitted to the Division prior to the license's expiration date shall be deemed timely pursuant to subsection 24-4-104(7), C.R.S., and the Licensee may continue to operate until Final Agency Order on the renewal application.

D. If License Not Renewed Before Expiration. A license is immediately invalid upon expiration if the Licensee has not filed a renewal application and remitted all of the required application and license fees prior to the license expiration date. A Regulated Marijuana Business that fails to file a renewal application and remit all required application and license fees prior to the license expiration date must not operate unless it first obtains a new state license and any required local license.

1. Reinstatement of Expired Regulated Marijuana Business License. A Regulated Marijuana Business that fails to file a renewal application and remit all required application and license fees prior to the license expiration date may request that the Division reinstate an expired license only in accordance with the following:

a. The Regulated Marijuana Business License expired within the previous 30 days;

b. The Regulated Marijuana Business has submitted an initial application pursuant to Rule 2-220. The initial application must be submitted prior to, or concurrent with, the request for reinstatement;

c. The Regulated Marijuana Business has paid the reinstatement fee pursuant to Rule 2-205; and

d. Any license or approval from the Local Licensing Authority or Local Jurisdiction is still valid or has been obtained.

2. Reinstatement Not Available for Surrendered or Revoked Licenses. A request for reinstatement cannot be submitted and will not be approved for a Regulated Marijuana Business License that was surrendered or revoked.

3. Reinstatement Not Available for Owner Licenses or Employee Licenses. A request for reinstatement cannot be submitted and will not be approved for expired, surrendered, or revoked Owner Licenses or Employee Licenses.

4. Denial of Request for Reinstatement or Administrative Action. If the Licensee requesting reinstatement of a Regulated Marijuana Business License operated during a period that the license was expired, the request may be subject to denial or subject to an administrative action authorized by the Marijuana Code or these Rules.

5. Approval of Request for Reinstatement. Upon approval of any request for reinstatement of an expired Regulated Marijuana Business License, the Licensee may resume operations until the final agency action on the Licensee's initial application for a Regulated Marijuana Business license.

a. Approval of a request for reinstatement of an expired Regulated Marijuana Business License does not guarantee approval of the Regulated Marijuana Business license initial application.

b. Approval of a request for reinstatement of an expired license does not waive the State Licensing Authority's authority to pursue administrative action on the expired license or initial application for Regulated Marijuana Business license.

6. Final Agency Order on Initial Application for Regulated Marijuana Business.

a. If the initial application for Regulated Marijuana Business license submitted pursuant to this rule is approved, the Regulated Marijuana Business Licensee will replace the reinstated License.

b. If the initial application for a Regulated Marijuana Business License submitted pursuant to this Rule is denied, the Licensee must immediately cease all operations including, but not limited to, Transfer of Regulated Marijuana. See Rule 2-270 – Application Denial and Voluntary Withdrawal; 8-115 – Disposition of Unauthorized Regulated Marijuana; 8-130 – Administrative Warrants.

E. Voluntarily Surrendered or Revoked Licenses Not Eligible for Renewal. Any license that was voluntarily surrendered or that was revoked by a Final Agency Order is not eligible for renewal. Any Licensee who voluntarily surrendered its license or has had its license revoked by a Final Agency Order may only submit an initial application. The State Licensing Authority will consider the voluntary surrender or the Final Agency Order and all related facts and circumstances in determining approval of any subsequent initial application.

F. Licenses Subject to Ongoing Administrative Action. Licenses subject to an administrative action are subject to the requirements of this Rule. Licenses that are not timely renewed expire and cannot be renewed.

G. Documents Required at Renewal. A Regulated Marijuana Business must provide the following documents with every renewal application:

1. Any document required by Rule 2-220(A)(1) through (10) that has changed since the document was last submitted to the Division. It is a license violation affecting public safety to fail to submit any document that changed since the last submission for the purpose of circumventing the requirements of the Marijuana Code, or these Rules;

2. A copy of the Local Licensing Authority or Local Jurisdiction approval, licensure, and/or documentation demonstrating timely submission of pending local license renewal application;

3. A list of any sanctions, penalties, assessments, or cease and desist orders imposed by any securities regulatory agency, including but not limited to the United States Securities and Exchange Commission or the Canadian Securities Administrators;

4. A Regulated Marijuana Business operating under a single Entity name with more than one license may submit the following documents only once each calendar year on the first license renewal in lieu of submission with every license renewal in the same calendar year:

a. Tax documents and financial statements required by Rule 2-220(A)(11) and (12);

b. If the Regulated Marijuana Business is a Publicly Traded Corporation, the most recent list of Non-Objecting Beneficial Owners possessed by the Regulated Marijuana Business;

c. A copy of all management agreement(s) the Regulated Marijuana Business has entered into regardless of whether the Person is licensed or unlicensed.; and

d. Contracts, agreements, royalty agreements, equipment leases, financing agreement, or security contract for any Indirect Financial Interest Holder that is required to be disclosed by Rule 2-230(A)(3).

H. Controlling Beneficial Owner Signature. At least one Controlling Beneficial Owner shall sign the renewal application. However, other Controlling Beneficial Owners may be required to sign authorizations and/or requests to release information.

I. Accelerator License Renewal.

1. An Accelerator License must be renewed annually.

2. At the time of renewal, an Accelerator Licensee must disclose to the Division the following information regarding any Accelerator-Endorsed Licensee under which it operated during the previous year:

a. Copies of any agreements between the Accelerator Licensee and the Accelerator-Endorsed Licensee.

Basis and Purpose – 2-235

The statutory basis for this rule includes but is not limited to sections 44-10-202(1)(e), 44-10-203(2)(c), 44-10-203(2)(ee), 44-10-309, 44-10-310, and 44-10-312(4), C.R.S. Section 44-10-310, C.R.S., requires that persons disclosed or who should have been disclosed to the State Licensing Authority obtain a finding of suitability from the State Licensing Authority. The purpose of this rule is to explain the

conditions under which a Person is subject to either a mandatory finding of suitability or a finding of suitability for reasonable cause, to identify exemptions from an otherwise required finding of suitability and to identify the information and documents that, at a minimum, must be submitted in connection with any Person's request for a finding of suitability.

2-235 – Suitability

A. Persons Subject to a Mandatory Finding of Suitability for Regulated Marijuana Businesses That Are Not Publicly Traded Corporations.

1. Except as provided in subparagraph (A)(1)(a), any Person intending to become a Controlling Beneficial Owner by submitting an initial application for any Regulated Marijuana Business that is not a Publicly Traded Corporation must first submit a request to the State Licensing Authority for a finding of suitability.

a. An individual who is a Controlling Beneficial Owner because he or she is a member of the board of directors or an Executive Officer of a Regulated Marijuana Business or is Controlling a Regulated Marijuana Business but who does not possess ten percent or more of the Owner's Interest in a Regulated Marijuana Business must submit a request for a finding of suitability to the State Licensing Authority within 45 days of becoming such a Controlling Beneficial Owner.

b. Whether an individual is an Executive Officer required to obtain a mandatory finding of suitability is based on the definition in these rules and the facts and circumstances. In determining whether an individual is an Executive Officer, the State Licensing Authority will consider the following, non-exhaustive factors:

i. Title is not dispositive, however, the Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, president, the General Counsel, and any individual with similar policy making authority are Executive Officers;

ii. The level of decision making authority the individual possess;

iii. The Controlling Beneficial Owner and/or Regulated Marijuana Business's organizational chart; and

iv. Any relevant guidance from the United States Securities and Exchange Commission or similar securities regulator, securities rules or securities case law.

2. For a Controlling Beneficial Owner that is an Entity, the Entity's request for finding of suitability must include all information necessary for the State Licensing Authority to determine whether its Executive Officers and any Person that indirectly owns ten percent or more of the Owner's Interest in the Regulated Marijuana Business are suitable.

3. Any Person that has not received a finding of suitability and who intends to become a Controlling Beneficial Owner of a Regulated Marijuana Business that is not a Publicly Traded Corporation must submit their request for a finding of suitability contemporaneously with the change of owner application, unless exempt from the change of owner application requirement under Rule 2-245(C).

B. Persons Subject to a Mandatory Finding of Suitability for Regulated Marijuana Businesses That Are Publicly Traded Corporations.

1. The following Persons must apply to the State Licensing Authority for a finding of suitability:

    a. Any Person that becomes a Controlling Beneficial Owner of any Regulated Marijuana Business that is a Publicly Traded Corporation; and

    b. Any Person that indirectly Beneficially Owns ten percent or more of the Regulated Marijuana Business that is a Publicly Traded Corporation through direct or indirect ownership of its Controlling Beneficial Owner. For example, assuming the scenario depicted below, Licensee PTC Inc. has one-million shares of outstanding Securities and CBO 1 owns 400,000 of those securities. John Doe owns 30% of CBO 1. Therefore, John Doe indirectly owns 12% of the outstanding securities of Licensee PTC Inc., and must apply to the State Licensing Authority for a finding of suitability.

2. For a Controlling Beneficial Owner that is an Entity, the Entity's request for finding of suitability must include all information necessary for the State Licensing Authority to determine whether its Executive Officers and any Person that indirectly owns ten percent or more of the Owner's Interest in the Regulated Marijuana Business are suitable.

3. Timing of Request for Finding of Suitability Involving Publicly Traded Corporation.

    a. Unless exempted under Rule 2-235(E), all Persons that will be a Controlling Beneficial Owner in a Regulated Marijuana Business that is entering into a Publicly Traded Corporation transaction described in Rule 2-245(C)(1) must first obtain a finding of suitability by the State Licensing Authority before the transaction can close or the public offering can occur.

    b. A Person who becomes a Controlling Beneficial Owner in a Regulated Marijuana Business that is a Publicly Traded Corporation must submit a request for a finding of suitability to the State Licensing Authority within 45 days of becoming a Controlling Beneficial Owner.

    c. An individual who is a Controlling Beneficial Owner because he or she is a member of the board of directors or an Executive Officer of a Regulated Marijuana Business or is Controlling a Regulated Marijuana Business but who does not possess ten percent or more of the Owner's Interest in a Regulated Marijuana Business must submit a request for a finding of suitability to the State Licensing Authority within 45 days of becoming such a Controlling Beneficial Owner.

C. Finding of Suitability for Reasonable Cause. For Reasonable Cause, any other Person that was disclosed or should have been disclosed pursuant to subsections 44-10-309(1) or (2) or that was required to be disclosed based on previous notification of Reasonable Cause must submit a request to the State Licensing Authority for a finding of suitability. Any Person required to submit a request for a finding of suitability pursuant to this Rule must submit such request within 45 days from notice of the State Licensing Authority's determination of Reasonable Cause for the finding of suitability.

D. Information Required in Connection with a Request for a Finding of Suitability. When determining whether a Person is suitable or unsuitable for licensure, the State Licensing Authority may consider the Person's criminal character or record, licensing character or record, or financial character or record. To consider a Person's criminal character or record, licensing character or record, and financial character or record, all requests for a finding of suitability must, at a minimum, be accompanied by the following information:

1. Criminal Character or Record:

   a. A set of the natural person's fingerprints for purposes of a fingerprint-based criminal history record check.

2. Licensing Character or Record:

   a. Affirmation that the Person is not prohibited from holding a license under section 44-10-307, C.R.S.

   b. A list of all Colorado Department of Revenue-issued business licenses held in the three years prior to submission of the request for a finding of suitability;

   c. A list of all Department of Regulatory Agencies business, professional, or occupational licenses held in the three years prior to submission of the request for a finding of suitability.

   d. A list of any marijuana business or personal license(s) held in any other state or territory of the United States or District of Columbia or another country, where such license is or was at any time subject to a denial, suspension, revocation, surrender, or equivalent action by the licensing agency, commission, board, or similar authority; and

   e. Disclosure of any civil lawsuits in which the Person was named a party where pleadings included allegations involving any Regulated Marijuana Business.

3. Financial Character or Record:

   a. Disclosure of any sanctions, penalties, assessments, or cease and desist orders imposed by any securities regulatory agency other than the United States Securities Exchange Commission;

   b. If the Person's request for a finding of suitability is for purposes of acquiring ten percent or more of the Owner's Interest in the Regulated Marijuana Business, copies of the Person's financial account statements for the preceding one-hundred eighty days for any accounts serving as a source of funding used to acquire the Owner's Interest in the Regulated Marijuana Business; or, if the Person is contributing one or more asset(s) to the Regulated Marijuana Business in exchange for the Owner's Interests, documents establishing the Person has owned such asset(s) for the preceding one-hundred eighty days.

E. Exemptions from a Finding of Suitability.

1. The following Persons are exempt from an otherwise required finding of suitability:

   a. Any Person that currently possesses an approved Owner License issued by the State Licensing Authority and such Owner License has not, in the preceding 365 days, been subject to suspension or revocation.

2. Exemptions from an otherwise required finding of suitability are limited to those listed in this Rule. The State Licensing Authority will consider other factors that may inform amendments to this Rule through the Department's formal rulemaking session.

F. Timing to Approve or Deny a Request for Finding of Suitability. Absent Reasonable Cause, the State Licensing Authority must approve or deny a request for a finding of suitability within 120

days from the date of submission of the request for such finding, where such request was accompanied by all information required under subsection (D) of this Rule.

G. Finding of Suitability Valid for One Year. A finding of suitability is valid for one year from the date it is issued by the State Licensing Authority. If more than one year has passed since the State Licensing Authority issued a finding of suitability to a Person and such Person has not during that time become a Controlling Beneficial Owner of a Regulated Marijuana Business pursuant to an initial business application or change of owner application, then such Person shall submit a new request for finding of suitability to the State Licensing Authority and obtain a new finding of suitability before submitting any application to become a Controlling Beneficial Owner of a Regulated Marijuana Business.

Basis and Purpose – 2-245

The statutory basis for this rule includes but is not limited to sections44-10-202(1)(e), 44-10-203(1)(d), 44-10-203(1)(j), 44-10-203(2)(ee)(I)(A) and (E), 44-10-203(7), 44-10-308(3)(b), 44-10-309, 44-10-310, 44-10-311, and 44-10-312, C.R.S. The purpose of this rule is define the application process and conditions an Applicant or Licensee must meet when changing Beneficial Ownership in a Regulated Marijuana Business. This rule further describes requirements in the event of a dispute between the Controlling Beneficial Owners of a Regulated Marijuana Business.

2-245 – Change of Controlling Beneficial Owner Application or Notification

A. Application for Change of Controlling Beneficial Owner(s) – Not a Publicly Traded Corporation.

1. Unless excepted pursuant to subparagraph (C) of this Rule, a Regulated Marijuana Business that is not a Publicly Traded Corporation must obtain Division approval before it transfers the Owner's Interests of any Controlling Beneficial Owner(s).

2. All applications for change of Controlling Beneficial Owner(s) must be executed by every Controlling Beneficial Owner whose Owner's Interests are proposed to change and any Person proposed to become a Controlling Beneficial Owner(s). Controlling Beneficial Owners who's Owner's Interest will not change are not required to execute the change of owner application; however, at least one Controlling Beneficial Owner and all Persons proposed to become a Controlling Beneficial Owner must execute every change of owner application.

3. Upon completion of the investigation of a change of owner application, the State Licensing Authority will issue a contingent approval letter. However, the State Licensing Authority will not issue the state license until:

a. Local Approval Required. If local approval is required, the proposed Controlling Beneficial Owner(s) demonstrates to the State Licensing Authority that local approval has been obtained and notifies the State Licensing Authority of the date by which the change of owner will be completed, which must be within thirty days of the notification. The proposed Controlling Beneficial Owner's notification to the Division must be within 365 days of the issuance of the Division's contingent approval letter.

i. If a Local Licensing Authority or Local Jurisdiction requires a change of owner application and that application is denied, the State Licensing Authority will deny the State change of owner application;

b. No Local Approval Required. If local approval is not required, the proposed Controlling Beneficial Owner(s) demonstrates that such approval is not required

and notifies the State Licensing Authority of the date by which the change of owner will be completed, which must be within thirty days of the of the notification. However, the proposed Controlling Beneficial Owner's notification to the Division must be made within 365 days of issuance of the Division's contingent approval letter.

4. Any proposed new Controlling Beneficial Owner cannot operate the Regulated Marijuana Business for which it intends to become a Controlling Beneficial Owner until it receives any required finding of suitability and is issued all approvals and/or license(s) pursuant to any change of owner application required by this Rule. Controlling Beneficial Owners that have already been approved in connection with ownership of the Regulated Marijuana Business may continue to operate the Regulated Marijuana Business. A violation of this requirement is grounds for denial of the change of owner application, may be a violation affecting public safety, and may result in disciplinary action against existing license(s).

5. If a Regulated Marijuana Business or any of its Controlling Beneficial Owner(s) apply for a change of owner and is involved in an administrative investigation or administrative action, the following may apply:

   a. The change of owner application may be delayed or denied until the administrative action is resolved; or

   b. If the change of owner application is approved by the Division, the transferor, the transferee, or both may be responsible for the actions of the Regulated Marijuana Business and its prior Controlling Beneficial Owner(s), and subject to discipline based upon the same.

6. Documents Required. Any change of owner application regarding a Controlling Beneficial Owner of a Regulated Marijuana Business that does not involve a Publicly Traded Corporation must include the following documents:

   a. Asset purchase agreement, merger, sales contract, agreement, or any other document necessary to effectuate the change of owner;

   b. Request for a finding of suitability for each proposed Controlling Beneficial Owner(s);

   c. Operating agreement, by-laws, partnership agreement, or other governing document(s) as will apply to the Regulated Marijuana Business if the change of owner application is approved;

   d. Request for voluntary surrender form of the Owner License of any Controlling Beneficial Owner that will not remain a Controlling Beneficial Owner, or Passive Beneficial Owner electing to hold an Owner License in a Regulated Marijuana Business if the change of owner application is approved.

   e. Copy of current Medical Marijuana or Retail Marijuana State Sales Tax or Wholesale license and any other documents necessary to verify tax compliance; and

   f. Any required finding of suitability for any proposed Controlling Beneficial Owner that does not already hold a valid Owner License.

7. Licensee Initiates Change of Owner for Permitted Economic Interests Issued Prior to January 1, 2020. All natural persons holding a Permitted Economic Interest who seek to

become a Controlling Beneficial Owner are subject to this Rule. The Regulated Marijuana Business must initiate the change of owner process for a natural person holding a Permitted Economic Interest who seeks to convert its interest and become a Controlling Beneficial Owner in a Regulated Marijuana Business. Prior to submitting a change of owner application, the Permitted Economic Interest holder must obtain a finding of suitability pursuant to Rule 2-235 including any required criminal history record check. Permitted Economic Interest holders who fail to obtain a finding of suitability to become a Controlling Beneficial Owner may remain as a Permitted Economic Interest holder.

8. Medical Marijuana Transporters and Retail Marijuana Transporters Not Eligible for Change of Owner. Medical Marijuana Transporters and Retail Marijuana Transporters are not eligible to transfer the entire Beneficial Ownership of their Regulated Marijuana Business.

B. Change of Owner Involving a Publicly Traded Corporation. This Rule applies to transactions involving any Publicly Traded Corporation.

1. Publicly Traded Corporation Transactions. A Regulated Marijuana Business may transact with a Publicly Traded Corporation in the following ways:

a. Merger with a Publicly Traded Corporation. A Regulated Marijuana Business that intends or that has a Controlling Beneficial Owner that intends to receive, directly or indirectly, an investment from, or intends to merge or consolidate with a Publicly Traded Corporation, whether by way of merger, combination, exchange, consolidation, reorganization, sale of assets or otherwise, including but not limited to any shell company merger.

b. Investment by a Publicly Traded Corporation. A Regulated Marijuana Business that intends or that has a Controlling Beneficial Owner that intends to transfer, directly or indirectly, ten percent or more of the Securities in the Regulated Marijuana Business to a Publicly Traded Corporation, whether by sale or other transfer of outstanding Securities, issuance of new Securities, or otherwise.

c. Public Offering. A Regulated Marijuana Business that intends or that has a Controlling Beneficial Owner that intends to become, directly or indirectly, a Publicly Traded Corporation, whether by effecting a primary or secondary offering of its Securities, uplisting of outstanding Securities, or otherwise.

2. Required Finding(s) of Suitability.

a. Pre-Transaction Findings of Suitability Required. Any Person intending to become a Controlling Beneficial Owner in a Regulated Marijuana Business in connection with any transaction identified in subparagraph (B)(1)(a) through (c) above, must obtain a finding of suitability prior to the Publicly Traded Corporation transaction closing or becoming effective

b. Ongoing Suitability Requirements. Any Person who becomes a Controlling Beneficial Owner of a Publicly Traded Corporation that is a Regulated Marijuana Business must apply to the State Licensing Authority for a finding of suitability or an exemption from a finding of a suitability pursuant to Rule 2-235 within forty-five days of becoming a Controlling Beneficial Owner. A Publicly Traded Corporation that is a Regulated Marijuana Business must notify any Person that becomes a Controlling Beneficial Owner of the suitability requirements as soon as the Regulated Marijuana Business becomes aware of the ownership subjecting the Person to this requirement; however, the Controlling Beneficial

Owner's obligation to timely request the required finding of suitability is independent of, and unaffected by, the Regulated Marijuana Business's failure to make the notification.

3. Change of Owner Application Required. A Licensee entering into a transaction permitted in subparagraph (B)(1)(a)-(c) above with Publicly Traded Corporation must submit any required change of owner application to the Division prior to the transaction closing. The change of owner application may be submitted simultaneously with the requests for finding(s) of suitability required by subparagraph (B)(2) or after the or after the request(s) for findings of suitability were submitted to the Division.

4. Mandatory Disclosure of Required, United States Securities and Exchange Commission, Canadian Securities Administrators and/or Securities Exchange Filings. A Regulated Marijuana Business and any Controlling Beneficial Owner that is required to file any document with the United States Securities and Exchange Commission, the Canadian Securities Administrators, any other similar securities regulator or any securities exchange regarding any change of owner in subparagraphs (C)(1)(a) through (c) above must also provide a notice to the Division at the same time as the filing with the United States Securities and Exchange Commission, the Canadian Securities Administrators or the securities exchange.

5. Ordinary Broker Transactions. Resales or transfers of Securities of a Publicly Traded Corporation that is a Regulated Marijuana Business or Controlling Beneficial Owner or Passive Beneficial Owner in ordinary broker transactions through an established trading market do not require a change of owner application or prior approval from the State Licensing Authority.

C. Exemptions to the Change of Owner Application Requirement.

1. Entity Conversions or Change of Legal Name. A Regulated Marijuana Business or a Controlling Beneficial Owner may combine with or convert, including but not limited to under sections 7-90-201 et seq., C.R.S., for the exclusive purpose of changing its Entity jurisdiction to one of the states or territories of the United States or the District of Columbia, its Entity type or change the legal name of an Entity without filing a change of owner application. These exemptions apply only if the Controlling Beneficial Owners and their Owner's Interests will remain the same after the combination, conversion, or change of legal name, and there will not be any new Controlling Beneficial Owners (individuals or Entities). Within fourteen days of the combination, conversion, or change of legal name the Regulated Marijuana Business must submit the following to the Division:

a. A copy of the transaction documents;

b. Documents submitted to the Colorado Secretary of States;

c. Any document submitted to the secretary of state or similar regulator if the Entity is organized under the laws of a state of the United States other than Colorado, a territory of the United States, or the District of Columbia;

d. Identification of the Regulated Marijuana Business's or Controlling Beneficial Owner's registered agent;

e. Identification of any Passive Beneficial Owner and Indirect Financial Interest Holder for which disclosure is required by Rule 2-230; and

f. The fee required by Rule 2-205(F)(2)(b).

2. Reallocation of Owner's Interests Among Controlling Beneficial Owners. A Regulated Marijuana Business may reallocate Owner's Interests among existing Controlling Beneficial Owners holding valid Owner Licenses if it provides notification of the reallocation to the Division with its next application submission as long as there are no new Controlling Beneficial Owners. A reallocation under this rule is subject to the following requirements:

   a. All Owner's Interests of a Controlling Beneficial Owner may be reallocated to other existing Controlling Beneficial Owners;

   b. If any Controlling Beneficial Owner will not hold any Owner's Interest in a Regulated Marijuana Business following the reallocation, that Controlling Beneficial Owner shall voluntarily surrender his or her Owner's License and identification badge within 30 days of the reallocation;

   c. All Controlling Beneficial Owners remain responsible for all actions of the Regulated Marijuana Business while they were a Controlling Beneficial Owner and are subject to administrative action based on the same regardless of the reallocation; and

   d. Disclosure and submission of the fee required by Rule 2-205(F)(2)(b) at the next application submission which shall not be longer than 365 days.

3. Passive Beneficial Owner Licensed Prior to August 1, 2019. A Passive Beneficial Owner who was issued an Owner License prior to August 1, 2019, and who has continuously maintained that license, is not required to submit a change of owner application if he or she becomes a Controlling Beneficial Owner in the business license(s) with which the Owner License is associated but must disclose and submit the fee required by Rule 2-205(F)(2)(b) at the next application submission, which shall not be longer than 365 days.

4. Change of Executive Officer or Member of the Board of Directors. A change of owner application is not required for a change of an Executive Officer or member of the board of directors of a Regulated Marijuana Business or an Entity Controlling Beneficial Owner of a Regulated Marijuana Business so long as the new Executive Officer or member of the board of directors does not possess ten percent or more of the Owner's Interest in the Regulated Marijuana Business or is otherwise Controlling the Regulated Marijuana Business. However, a change of Executive Officer or member of the board of directors is subject to the following requirements:

   a. Any such Executive Officer or member of the board of directors of the Regulated Marijuana Business must submit a request for a finding of suitability as required by Rule 235-1 or, if exempt from a finding of suitability pursuant to Rule 235-1(E), the Regulated Marijuana Business subject to any such change of the Executive Officer or members of their board of directors must provide notice to the Division of the new Controlling Beneficial Owner within forty-five days.

   b. The fee required by Rule 2-205(F)(2)(b).

5. Change of Passive Beneficial Owner. Persons are not required to submit an application or obtain prior approval of their ownership if: (1) the Person will remain a Passive Beneficial Owner after the acquisition of Owner's Interests is complete, and (2) disclosure is not otherwise required by section 44-10-309, C.R.S., or Rule 2-230.

E. Refundable and Nonrefundable Deposits Permitted. A proposed Controlling Beneficial Owner may provide a selling Controlling Beneficial Owner with a refundable or nonrefundable deposit in connection with a change of owner application.

F. Controlling Beneficial Owner Dispute.

1. In the event of a dispute between Controlling Beneficial Owner(s) not involving divestiture under Rule 2-275 and precluding or otherwise impeding the ability to comply with these Rules, a Regulated Marijuana Business that is not a Publicly Traded Corporation must submit a change of owner application, notification pursuant to subparagraph (C) of this Rule, or initiate mediation, arbitration, or a judicial proceeding within 90 days of the dispute. The 90-day period may be extended for an additional 90 days upon a showing of good cause by the Regulated Marijuana Business.

2. A Regulated Marijuana Business that is not a Publicly Traded Corporation must submit a change of owner application or notification pursuant to subparagraph (C) of this Rule within forty-five days of entry of a final court order, final arbitration award, or full execution of a settlement agreement altering the Controlling Beneficial Owner(s) of a Regulated Marijuana Business. Any change of owner application or notification based on a final court order, final arbitration award, or fully executed settlement agreement must include a copy of the order or settlement agreement and remains subject to approval by the Division. In this circumstance, the change of owner application or notification needs to be executed by at least one remaining Controlling Beneficial Owner.

3. If mediation, arbitration, or a judicial proceeding is not timely initiated, or if a change of owner application or notification pursuant to subparagraph (C) of this Rule is not timely submitted following entry of a final court order, final arbitration award, or full execution of a settlement agreement altering the Controlling Beneficial Owner(s) of a Regulated Marijuana Business that is not a Publicly Traded Corporation, the Regulated Marijuana Business and its Owner Licensee(s) may be subject to fine, suspension, or revocation of their license(s).

Basis and Purpose – 2-285

The statutory basis for this rule includes but is not limited to sections 44-10-203(2)(c), 44-10-203(2)(l), 44-10-203(2)(t), 44-10-203(2)(aa), 44-10-307(1)(g)(I), 44-10-309(4)-(5), 44-10-313(8)(a), and 44-10-901, C.R.S. The purpose of this rule is to establish initial and renewal application, qualification, and eligibility requirements for Accelerator-Endorsed Licensees and Accelerator Licensees.

2-285 – Accelerator-Endorsement Application, Qualification and Eligibility.

A. Beginning July 1, 2020, a Retail Marijuana Cultivation Facility and Retail Marijuana Products Manufacturer Licensee may apply for an Accelerator Endorsement. The application shall be made on Division forms and in accordance with the 2-200 Series Rules.

B. Qualifications and Eligibility. The State Licensing Authority may consider the following facts and circumstances for purposes of determining qualifications and eligibility.

1. The applicant has not, in the previous year, been subject to a license revocation, suspension, or fine issued by the State Licensing Authority or any Local Licensing Authority or Local Jurisdiction in which it operated.

2. Information demonstrating the applicant operated its license for at least two years prior to the date of application; or if the applicant is unable to demonstrate operations for a period of at least two years, it must satisfy the following:

a. The applicant possesses a valid commercial marijuana license issued in another state and has operated such license for the preceding two years;

b. For the preceding two years the applicant has participated in an accelerator, incubator or social equity program that may, but is not required to be, associated with the commercial marijuana industry;

c. The applicant has at least two years of cannabis industry experience at a managerial or executive level; or

d. The applicant has at least two years of business experience in a highly regulated industry other than the marijuana industry.

C. Application Requirements. In addition to other application requirements, an application for an Accelerator Endorsement must include the following:

1. Equity Assistance Plan – Required Information. An equity assistance plan detailing the technical, compliance, and/or capital assistance the applicant intends to provide an Accelerator Licensee. The equity assistance plan must, at a minimum, include the following:

a. The types of assistance the applicant intends to provide, which may include but is not limited to the following types of assistance:

i. Accounting

ii. Business Services (e.g. Sales and Marketing)

iii. Financial Support

iv. Human Resources Support

v. Information Technology Support

vi. Legal Services

vii. Regulatory Compliance Support

b. Whether the applicant intends to subcontract with any third parties to provide technical or compliance assistance, and the identity of the prospective third parties, if known;

c. Any applicable timelines associated with the provisions of the assistance the applicant intends to provide;

d. Whether the applicant intends to charge rent for a prospective Accelerator Licensee's use of the applicant's Licensed Premises, and the amount of rent and required deposits, if applicable;

e. How the applicant plans to prevent or minimize negative impacts on a prospective Accelerator License in the event of a change of owner of the applicant's License;

f. How the applicant plans to prevent or minimize negative impacts on a prospective Accelerator Licensee in the event of a change of location of the applicant's Licensed Premises;

g. Whether the applicant has been subject to any administrative action by the State Licensing Authority or the Local Licensing Authority or Local Jurisdiction within the proceeding two years and, if so, whether there are any restrictions on the applicant as a result of such administrative action.

2. Equity Assistance Plan – Voluntary Information. An equity assistance plan may, but is not required to, include additional information about the Accelerator-Endorsement applicant, including but not limited to the following:

a. The applicant's business objectives and organizational values;

b. A description of the applicant's work environment, including employee benefits or incentives;

c. Information regarding the applicant's business profile, including company size, revenue, and distribution capabilities.

D. The Division will maintain a list of Accelerator-Endorsed Licenses on its website.

E. Accelerator Endorsement Renewal.

1. An Accelerator Endorsement must be renewed annually.

2. At the time of renewal, an Accelerator-Endorsed Licensee must submit the following information:

a. The name and license number of any Accelerator Licensee for which it served as an Accelerator-Endorsed Licensee during the previous year;

b. If applicable, an equity assistance plan reflecting any updates or amendments to the prior submitted plan; and

c. Copies of any agreements between the Accelerator-Endorsed Licensee and the Accelerator Licensee(s), including the equity partnership agreement.

3. In addition to any other basis for denial of renewal application, the State Licensing Authority may also consider the following facts and circumstances as an additional basis for denial of an Accelerator Endorsement renewal application:

a. The Accelerator-Endorsed Licensee failed to comply with the terms of any equity partnership agreement it entered into with an Accelerator Licensee;

b. The Accelerator-Endorsed Licensee provided false or misleading statements or produced false or misleading records to an Accelerator Licensee.

Part 3 – Regulated Marijuana Business Operations

3-200 Series – Licensed Premises

Basis and Purpose – ~~302~~ 3-210

The statutory authority for this rule includes but is not limited to sections 44-10-202(1)(c), 44-10-311(1)(b), and 44-10-311(2), C.R.S. The purpose of this rule is to establish and clarify the means by which the Licensee has lawful possession of the Licensed Premises. This Rule 3-210 was previously Rules M and R 302, 1 CCR 212-1 and 1 CCR 212-2.

3-210 – Possession of Licensed Premises

A. Evidence of Lawful Possession. Persons licensed pursuant to sections 44-10-501, 44-10-502, 44-10-503, 44-10-504, 44-10-507, 44-10-601, 44-10-602, 44-10-603, 44-10-604, 44-10-607, 44-10-608, 44-10-609, 44-10-610 C.R.S., or those applying for such licenses, must demonstrate proof of lawful possession of the premises to be licensed or Licensed Premises. Evidence of lawful possession consists of properly executed deeds of trust, leases, or other written documents acceptable to state and local licensing authorities.

B. Relocation Prohibited. The Licensed Premises shall only be those geographical areas that are specifically and accurately described in executed documents verifying lawful possession. Licensees are not authorized to relocate to other areas or units within a building structure without first filing a change of location application and obtaining approval from the Division and the relevant Local Jurisdiction. Licensees shall not add additional contiguous units or areas, thereby altering the initially-approved premises, without filing an application and receiving approval to modify the Licensed Premises on current forms prepared by the Division, including any applicable processing fee. *See* Rule 2-260 - Changing, Altering, or Modifying Licensed Premises

C. Subletting Not Authorized. Licensees are not authorized to sublet any portion of Licensed Premises for any purpose, unless all necessary applications to modify the existing Licensed Premises to accomplish any subletting have been approved by the Division and the relevant Local Licensing Authority or Local Jurisdiction.

Part 6 – Retail Marijuana Business License Types

6-800 Series – Accelerator-Endorsed Licenses and Accelerator License

Basis and Purpose – 6-805

The statutory authority for this rule includes but is not limited to sections 44-10-202(1)(c), 44-10-203(2)(aa), 44-10-311(1)(b), and 44-10-311(2), C.R.S. The purpose of this rule is to establish requirements for Accelerator-Endorsed Licensees and Accelerator Licensees participating in the accelerator program.

6-805 – Accelerator Program Operations

A. Licensed Premises. An Accelerator Licensee may share, and operate at, the same Licensed Premises of a Retail Marijuana Cultivation Facility or Retail Marijuana Products Manufacturer with a valid Accelerator Endorsement.

B. Accelerator Endorsement Equity Assistance Plan.

1. An Accelerator-Endorsed Licensee must disclose its equity assistance plan to the Division and to any prospective Accelerator Licensee.

C. Equity Partnership Agreement.

1. An Accelerator-Endorsed Licensee's equity assistance plan that includes the information required by this Rule may also serve as its equity partnership agreement.

2. Prior to hosting or offering technical and/or capital support to an Accelerator Licensee, an Accelerator-Endorsed Licensee must first enter into an equity partnership agreement with the Accelerator Licensee to which it intends to host or offer technical and/or capital support. The equity partnership agreement must be executed by both the Accelerator-Endorsed Licensee and Accelerator Licensee.

3. The executed equity partnership agreement must represent the full legal and business relationship between the Accelerator-Endorsed Licensee and Accelerator Licensee. There shall not be any agreement(s) or contracts between the Accelerator-Endorsed Licensee and the Accelerator Licensee that are not disclosed to the Division.

4. The executed equity partnership agreement shall at a minimum, include the following:

   a. A description of the types of technical, compliance, and/or capital assistance the Accelerator-Endorsed Licensee is providing to the Accelerator Licensee;

   b. The timeline associated with the provisions of the assistance the Accelerator-Endorsed Licensee is providing;

   c. If the Accelerator-Endorsed Licensee is charging rent for the Accelerator Licensee's use of the Licensed Premises, the rent amount, any required deposits, and length of lease;

   d. How the Accelerator-Endorsed Licensee will prevent or minimize negative impacts on the Accelerator License in the event of a change of owner of the Accelerator-Endorsed Licensee's license;

   e. How the Accelerator-Endorsed Licensee will prevent or minimize negative impacts on the Accelerator License in the event of a change of location of the Accelerator-Endorsed Licensee's Licensed Premises;

   f. Conditions for amendments to the plan; and

   g. Conditions for dissolution of the plan.

5. An Accelerator-Endorsed Licensee must provide technical, compliance, and/or capital assistance to an Accelerator Licensee pursuant to its equity partnership agreement with an Accelerator Licensee. An Accelerator-Endorsed Licensee may provide technical and/or compliance assistance to an Accelerator Licensee through third parties. However, an equity partnership agreement cannot require an Accelerator Licensee to receive such assistance from a specific provider.

D. Division of Liability.

1. Shared Equipment. An Accelerator-Endorsed licensee and Accelerator licensee may share equipment if they have standard operating procedures addressing the following:

   a. Rotational/time schedule for utilizing equipment;

   b. Changes to the schedule; and

   c. Sanitizing equipment.

2. Shared Ingredients and/or Co-Mingling of Inventory. An Accelerator-Endorsed Licensee and Accelerator Licensee may share non-marijuana ingredients such as soil, growing

medium, fertilizers, sugar, flour, etc. If the Accelerator-Endorsed Licensee and the Accelerator Licensee share non-marijuana ingredients, they must have standard operating procedures for the protection, use, and maintenance of such products.

3. Inventory Tracking and Record Keeping. Both the Accelerator-Endorsed Licensee and the Accelerator Licensee are each required to comply with the Inventory Tracking Requirements in the 3-800 Series Rules and the Business Records in the 3-900 Series Rules. Nothing in this rule prohibits an Accelerator-Endorsed Licensee from providing the Accelerator Licensee financial support to comply with these requirements such as purchasing RFID tags for use by the Accelerator Licensee.

4. Security and Surveillance. Both the Accelerator-Endorsed Licensee and the Accelerator Licensee are each required to comply with security and surveillance requirements in the 3-200 Series Rules. Nothing in this rule prohibits an Accelerator-Endorsed Licensee from providing the Accelerator Licensee financial support to comply with these requirements

5. Other. Both the Accelerator-Endorsed Licensee and the Accelerator Licensee will be jointly liable for any violations related to the Licensed Premises, security requirements, video surveillance requirements, health and safety requirements, possession, and waste, unless the licensees have standard operating procedures or agreements establishing severed liability. It may be considered mitigation if the Accelerator-Endorsed Licensee demonstrated the Accelerator Licensee failed to comply with the standard operating procedures.

E. Dissolution of Business Relationship. If the business relationship between the Accelerator-Endorsed Licensee and Accelerator Licensee dissolves, both parties are required to notify the Division within 10 days. The notification of dissolution must include the reasons for the dissolution of the business relationship between the Accelerator-Endorsed Licensee and Accelerator Licensee.

F. Additional License Privileges for Accelerator-Endorsed Licensees.

1. Social Equity Leader Designation. A Retail Marijuana Cultivation Facility and Retail Marijuana Products Manufacturer Licensee holding a valid Accelerator Endorsement and that is operating under an equity partnership agreement with an Accelerator Licensee shall be designated by the Division as a Social Equity Leader during the period of its active endorsement. A Social Equity Leader may use a logo or symbol created or approved by the Division to indicate its leadership status. The Retail Marijuana Cultivation Facility or Retail Marijuana Products Manufacturer shall immediately discontinue using the Social Equity Leader designation and shall cease use of any logo or symbol if its business relationship with the Accelerator Licensee dissolves or the Accelerator-Endorsed Licensee discontinues offering to host or offer technical or capital support to Accelerator Licensees.

2. Mitigation. A Retail Marijuana Cultivation Facility or Retail Marijuana Products Manufacturer Licensee's Accelerator Endorsement shall be considered a mitigating factor by the Division and State Licensing Authority when determining the initiation of administrative action or assessment of penalties.

3. Compliance Assistance and Education Engagement. For an Accelerator-Endorsed Licensee operating under an equity partnership agreement with an Accelerator Licensee, the Division will conduct an on-site compliance assistance and education engagement with the Accelerator-Endorsed Licensee at least once annually for purposes of supporting the licensee's activities as an Accelerator-Endorsed Licensee.

4. Application and License Fee Exemptions. An Accelerator-Endorsed Licensee may submit a request to the State Licensing Authority for an exemption from application and license fees for a change of owner, change of location, or modification of premises that is directly related to its participation in the accelerator program.

   a. The request for an exemption may be included with the submission of the application for which it is requesting an exemption from fees. The request for exemption must include any information demonstrating the application is related to its participation in the accelerator program, including but not limited to, the positive impact to the Accelerator Licensee.

   b. If a request for an exemption is denied, the applicant shall submit required fees within 10 days from notice that the fee exemption request was denied. Failure to submit required fees may result in denial of the application.

COLORADO
Department of Revenue

NOTICE OF RULEMAKING HEARING

The State Licensing Authority of the Colorado Department of Revenue, Marijuana Enforcement Division ("Division"), will consider the promulgation of additions and amendments to the Division's Rules, as authorized by Article XVIII, Section 16 of the Colorado Constitution and the Colorado Marijuana Code, sections 44-10-101 *et seq.*, C.R.S. ("Marijuana Code"). For specific information and language concerning the proposed changes and new rules, please refer to the contents of this Notice and the initial proposed rules which were considered by the stakeholder groups discussed below, and which are, or will be, available on the Division's website.

STATUTORY AUTHORITY FOR RULEMAKING

The State Licensing Authority promulgates these rules pursuant to the authority granted in the Colorado Marijuana Code, 44-10-101, C.R.S., *et seq.*, Article XVIII, Section 16 of the Colorado Constitution, and section 24-4-103, C.R.S. of the Administrative Procedure Act.

SUBJECT OF RULEMAKING

Pursuant to section 24-4-103(2), C.R.S., the State Licensing Authority initiated two (2) public meetings of representative groups of participants with an interest in the subject of the rulemaking ("stakeholder meetings"), which were held on **September 13, 2019** and **February 14, 2020**. More information related to these meetings can be found on the Division's website. Each stakeholder meeting was noticed on the Division's website, and the Division sent notification of each meeting to licensees and other stakeholders subscribed to receive updates from the Division. The written and recorded materials from the stakeholder meetings are available on the Division's website and will be included in the rulemaking record. Initial proposed rules were prepared in conjunction with the stakeholder meetings and are, or will be, available on the Division's website.

The Division will retain a record of the initial proposed rules as part of the rulemaking record. The initial proposed rules available on the Division's website are intended to provide interested persons with the initial proposed drafts of the permanent rules. The State Licensing Authority anticipates the initial proposed rules will be amended during the stakeholder engagement process, written comments from the public, internal review and that additional new rules may be drafted.

The State Licensing Authority will consider the promulgation of new and amended rules on the subjects outlined below. This list is under consideration to implement legislation passed in the 2019 legislative session and to address any other subject matter necessary to implement, interpret, and effectively administer and enforce the Colorado Marijuana Code. This list is not exhaustive, and the State Licensing Authority may consider any additional rule or amendment to any rule.

Please take note that in addition to the subject matters addressed in the initial proposed rules, the State Licensing Authority will consider additional rules consistent with any subject matter needed to implement and interpret the Colorado Marijuana Code, and Article XVIII, Sections 14 and 16 of the Colorado Constitution. The rulemaking hearing will include, but will not be limited to, modifications required due to statutory changes adopted during the 2019 legislative session.

The full set of proposed rules will be posted on the Division's website on or before **Monday, March 23, 2020**. Other relevant information regarding this rulemaking also will be posted on the Division's website.

RULES TO BE CONSIDERED FOR ADOPTION PURSUANT TO THE MARIJUANA CODE

The Marijuana Rules at 1 CCR 212-3, will include new and amended rules to implement statutory changes resulting from 2019 legislation, including Senate Bill 19-224 (SB 224), and to clarify prior adopted rules. These rules will include, but may not be limited to, the following subjects:

Rule 1-115 - Definitions (SB 224)

Accelerator Endorsements (SB 224)

Retail Marijuana Accelerator-Cultivator Licenses (SB 224)

Retail Marijuana Accelerator-Manufacturer Licenses (SB 224)

Rule 2-205 – Fees (Reinstatement of Regulated Marijuana Business License - Emergency Rules adopted February 7, 2020)

Rule 2-225 – Renewal Application Requirements for All Licensees (Reinstatement of Expired Marijuana Business License - Emergency Rules adopted February 7, 2020)

Rule 2-235 - Suitability (HB19-1090 - Amended rules will clarify the time period during which a finding of suitability is considered valid)

Any other rules necessary to implement the Marijuana Code may be adopted.

RULEMAKING RECORD AND PUBLIC PARTICIPATION

1. Official Rulemaking Record. The official record for purposes of the rulemaking hearing to be held on **Monday, March 30, 2020** will include the written and recorded materials from the stakeholder meetings and any written comments or oral testimony submitted or presented.

2. Written Comments. The State Licensing Authority encourages interested parties to submit written comments on the proposed rules, including alternate proposals, by Monday, **March 16, 2020**, so the State Licensing Authority can review comments prior to the rulemaking hearing. Written comments will also be accepted after that date. The deadline to submit written comments is **5:00 P.M. on Monday, March 30, 2020.**

   Written comments may be emailed to dor_medrulecomments@state.co.us or submitted in hard copy to:

   Marijuana Enforcement Division
   Re: Rules
   1707 Cole Boulevard, Ste. 300
   Lakewood, CO 8040

3. Oral Comments. The State Licensing Authority will afford interested parties an opportunity to make brief oral presentations at the rulemaking hearing on March 30, 2020. Oral presentations will likely be limited to two minutes per person. Organized groups of individuals are encouraged to identify one spokesperson to speak on behalf of the organization or group. The State Licensing Authority encourages interested parties to avoid duplicating previously-submitted material and testimony.

HEARING SCHEDULE

Date:	Monday, March 30, 2020
Time:	1:00 p.m. – 4:00 p.m. (proceedings may conclude prior to 4 p.m.)
Place:	Marijuana Enforcement Division 1707 Cole Blvd., Ste. 300 Lakewood, CO 80401

The location of the rulemaking hearing will also be posted on the Division's website and the Secretary of State's website. The hearing may be continued at such place and time as the State Licensing Authority may announce. The State Licensing Authority will deliberate upon the rulemaking record including oral testimony and written submissions presented as well as applicable law. The State Licensing Authority will adopt such rules as in her judgment are justified by the rulemaking record and applicable law.

If you are an individual with a disability who needs a reasonable accommodation in order to participate in this rulemaking hearing, please contact Danielle Henry at Danielle.Henry@state.co.us or at (303) 866-2779 no later than **Monday, March 16, 2020**.

Dated this 28th day of February, 2020.

THE COLORADO DEPARTMENT OF REVENUE, STATE LICENSING AUTHORITY,
MARIJUANA ENFORCEMENT DIVISION

Heidi Humphreys (Feb 28, 2020)

Heidi Humphreys, COO/Deputy Executive Director
State Licensing Authority
Colorado Department of Revenue

Notice of Proposed Rulemaking

Tracking number

2020-00112

Department

500,1008,2500 - Department of Human Services

Agency

502 - Behavioral Health

CCR number

2 CCR 502-1

Rule title

BEHAVIORAL HEALTH

Rulemaking Hearing

Date

04/03/2020

Time

08:30 AM

Location

405 W 9th St, Pueblo, CO 81003

Subjects and issues involved

The Office of Behavioral Health licenses substance use disorder programs to provide treatment services across levels of care. These levels of care are established by the American Society of Addiction Medicine (ASAM). The Office of Behavioral Healths level of care rules do not consistently align with the levels of care established by ASAM. The federal government requires Colorado to update substance use disorder program licensing standards to align consistently with the ASAM Levels of Care in order for Colorado to be approved to add residential substance use disorder treatment and withdrawal management services to Colorados Medicaid benefit.

Statutory authority

26-1-107, C.R.S. (2019); 26-1-109, C.R.S. (2019); 26-1-111, C.R.S. (2019); 27-80-108, C.R.S. (2019); 27-81-106, C.R.S. (2019); 27-82-103, C.R.S. (2019)

Contact information

Name

Ryan Templeton

Title

Policy Advisor

Telephone

303.866.7405

Email

ryan.templeton@state.co.us

Title of Proposed Rule:	**ASAM Levels of Care Update**	
CDHS Tracking #:	**20-02-21-01**	
Office, Division, & Program:	Rule Author: Ryan Templeton, Policy Advisor	Phone: 303-866-7405
OBH-CBH, Licensing and Designation		E-Mail: ryan.templeton@state.co.us

RULEMAKING PACKET

Type of Rule: *(complete a and b, below)*

a. [X] Board [ ] Executive Director

b. [X] Regular [ ] 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	
6	Amended Rules
23	New Rules
19	Repealed Rules
28	Reviewed Rules

What month is being requested for this rule to first go before the State Board?	April 2020

What date is being requested for this rule to be effective?	July 1, 2020
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 4/3/2020 2nd Board 5/8/2020 Effective Date 7/1/2020

Title of Proposed Rule:	**ASAM Levels of Care Update**	
CDHS Tracking #:	**20-02-21-01**	
Office, Division, & Program:	Rule Author: Ryan Templeton, Policy Advisor	Phone: 303-866-7405
OBH-CBH, Licensing and Designation		E-Mail: ryan.templeton@state.co.us

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***

The Office of Behavioral Health licenses substance use disorder programs to provide treatment services across levels of care. These levels of care are established by the American Society of Addiction Medicine (ASAM). The Office of Behavioral Health's level of care rules do not consistently align with the levels of care established by ASAM. The federal government requires Colorado to update substance use disorder program licensing standards to align consistently with the ASAM Levels of Care in order for Colorado to be approved to add residential substance use disorder treatment and withdrawal management services to Colorado's Medicaid benefit.

An emergency rule-making (which waives the initial Administrative Procedure Act noticing requirements) is necessary:

- [ ] to comply with state/federal law and/or
- [ ] to preserve public health, safety and welfare

Justification for emergency:

Not applicable

State Board Authority for Rule:

Code	Description
26-1-107, C.R.S. (2019)	State Board to promulgate rules
26-1-109, C.R.S. (2019)	State department rules to coordinate with federal programs
26-1-111, C.R.S. (2019)	State department to promulgate rules for public assistance and welfare activities.

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
27-80-108, C.R.S. (2019)	State Board to promulgate rules governing the provisions of substance use disorder programs and services.
27-81-106, C.R.S. (2019)	OBH shall establish standards for approved treatment facilities that receive public funds.
27-82-103, C.R.S. (2019)	OBH shall establish standards for approved treatment facilities that receive public funds.

Does the rule incorporate material by reference?	[X]	Yes	[ ]	No
Does this rule repeat language found in statute?	[ ]	Yes	[X]	No

If yes, please explain.

This rule update proposal references The ASAM Criteria, which is incorporated by reference in this Rule Volume 2 CCR 502-1.

Title of Proposed Rule:	**ASAM Levels of Care Update**	
CDHS Tracking #:	**20-02-21-01**	
Office, Division, & Program:	Rule Author: Ryan Templeton, Policy Advisor	Phone: 303-866-7405
OBH-CBH, Licensing and Designation		E-Mail: ryan.templeton@state.co.us

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?

Individuals in need of or receiving substance use disorder services and family of individuals in need of or receiving substance use disorder services, and the entities responsible for the payment of substance use disorder services should benefit from this rule update.
Providers will bear the burden of this rule update.

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?

Individuals in need of or receiving substance use disorder services and family of individuals in need of or receiving substance use disorder services should benefit from this rule update as substance use disorder programs will be required to follow nationally-recognized evidence-based level of care criteria. The entities responsible for the payment of substance use disorder services, included the Managed Service Organizations, and Regional Accountable Entities, should also benefits from the update as substance use disorder providers whose services being are purchased will be required to meet the rule updates that align with national standards.
Providers will bear the burden of this rule update because programs may need to provide additional staffing and service provisions to comply with the updates that align with the national standards. The impact is expected to be offset by adding the inpatient and residential components, including withdrawal management, to the continuum of outpatient SUD services currently available as part of Colorado's Medicaid Program, allowing for additional treatment service reimbursement.
The Office of Behavioral Health licenses approximately 300 agencies that provide substance use disorder services at roughly 700 sites across Colorado.

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 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 fiscal impact to the state regarding this rule update is expected to be minimal, as the Office of Behavioral Health currently licenses Substance Use Disorder providers based on the level of care each program providers. This rule update aligns OBH's levels of care with the nationally-recognized American Society of Addiction Medicine Criteria.

County Fiscal Impact

County fiscal impact is not expected because the Office of Behavioral Health licenses and contracts with individual providers not Counties.

Title of Proposed Rule:	**ASAM Levels of Care Update**	
CDHS Tracking #:	**20-02-21-01**	
Office, Division, & Program:	Rule Author: Ryan Templeton, Policy Advisor	Phone: 303-866-7405
OBH-CBH, Licensing and Designation		E-Mail: ryan.templeton@state.co.us

Federal Fiscal Impact

The federal government requires Colorado to update substance use disorder program licensing standards to align consistently with the ASAM Levels of Care in order for Colorado to be approved to add residential substance use disorder treatment and withdrawal management treatment to Colorado's Medicaid benefit.

Other Fiscal Impact *(such as providers, local governments, etc.)*

Updates may impact providers, as additional staffing and service provision may be required. This fiscal impact is expected to be offset by adding the inpatient and residential components, including withdrawal management, to the continuum of outpatient SUD services currently available as part of Colorado's Medicaid Program, allowing for additional treatment service reimbursement.

4. Data Description

List and explain any data, such as studies, federal announcements, or questionnaires, which were relied upon when developing this rule?

In accordance with House Bill 18-1136, the Department of Health Care Policy and Financing (HCPF) will be providing the full continuum of Substance Use Disorder (SUD) benefits as part of the Colorado Medicaid Program. HCPF will be adding the inpatient and residential components, including withdrawal management, to the continuum of outpatient SUD services currently available. HCPF's objective is to make these services available for individuals who meet nationally-recognized evidence-based level of care criteria without shifting care from outpatient settings when they are more appropriate. The Office of Behavioral Health is the state entity that establishes standards that substance use disorder programs must meet in order to be approved to receive public funds to provide substance use disorder services.

In order to be approved by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services to provide this expanded Medicaid benefit in Colorado. The Federal Government requires the Colorado standards of approval for substance use disorder programs to receive public funds to provide substance use disorder services be updated to align directly with a nationally-recognized level of care framework.

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…"**

The Department of Health Care Policy and Financing considered requiring each regional accountable entity provide the accreditation of providers within each of their regions. This could have led to providers needing to be accredited or licensed by up to five entities in order to be reimbursed for substance use disorder services. In attempt to streamline the licensing/accreditation process an update to OBH's rule-making was pursued.

Title of Proposed Rule:	**ASAM Levels of Care Update**	
CDHS Tracking #:	**20-02-21-01**	
Office, Division, & Program:	Rule Author: Ryan Templeton, Policy Advisor	Phone: 303-866-7405
OBH-CBH, Licensing and Designation		E-Mail: ryan.templeton@state.co.us

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
7.000	*Incorrect Statutory Reference*	*Section 26.5.103 C.R.S.*	*Section 26.5-101(3) C.R.S.*		
21.100	No definition of "youth"	Not applicable	"Youth" means under the age of twenty-one (21), unless otherwise noted.	Establish clear standards	No
21.210	Incorrect reference	21.210.53	21.210.924	Cover the whole section of rule being referenced	No
21.210.1	Workforce issues created by arbitrary standards	A. Qualifications referred to in this section, including education, professional credentials, training and supervision, and work experience shall be in accordance with Addiction Counselor Certification and Licensure Standards (Section 21.330). B. At least fifty percent (50%) of all treatment staff in substance use disorder programs within each licensed site, excluding non-hospital residential withdrawal management, shall be certified as a Certified Addiction Counselor II (CAC II), Certified Addiction Counselor III (CAC III) or Licensed Addiction Counselor (LAC). C. Counselors-in-training or Certified Addiction Counselor I (CAC I) shall not independently counsel, sign clinical documentation or carry out other duties relegated solely to Certified Addiction Counselor II, Certified Addiction Counselor III or Licensed Addiction Counselors. The Counselor in-training or CAC I must have all clinical documentation reviewed and co-signed by their clinical supervisor. Counselors-in-training and CAC I's shall not comprise more than twenty-five percent (25%) of total treatment staff. D. All staff who are providing psychotherapy services as defined in the Colorado Mental Health Practice Act (Section 12-43-201(9), C.R.S.) must be regulated by the Colorado Department of Regulatory Agencies (DORA), either by	A. Agencies shall ensure treatment staff are appropriately trained and properly credentialed to provide substance use disorder services in Colorado and are in good standing with their credentialing body. B. Agencies shall ensure treatment staff providing independent treatment services in substance use disorder programs within each licensed site, excluding clinically managed residential withdrawal management, are credential by the department of regulatory agencies as followed: 1. Certified as a CAC II, CAC III or licensed as an addiction counselor pursuant to Part 8 of Article 245 of Title 12, C.R.S.; 2. A physician licensed pursuant to article 240 of title 12, C.R.S.; 3. A psychologist licensed pursuant to Part 3 of article 245 of title 12, C.R.S.; 4. An advanced practice nurse licensed pursuant to Section 12-255-111, C.R.S.; or, 5. A Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, or Licensed Professional Counselor licensed under Part 4, 5, or 6 of Article 245 of Title 12, C.R.S. C. Peer support professionals, counselors-in-training or certified addiction counselor I (CAC I) shall not independently counsel, sign clinical documentation or carry out other duties relegated solely to the	Create rules that better address requirements	No

		credentialing as a CAC I, CAC II OR CAC III or becoming licensed as a mental health professional, including Licensed Addiction Counselor, or by registering in the registered psychotherapist database with DORA. Addiction counselor certifications and licenses shall be current and in good standing. E. Treatment staff licensed as behavioral healthcare practitioners in Colorado shall meet one of the following criteria: 1. Licensed physicians who are also: a. Certified in addiction medicine by the American Society of Addiction Medicine; or, b. Certified Addiction Counselor (CAC) II or III, or Licensed Addiction Counselor by the Colorado Department of Regulatory Agencies (DORA), Division of Professions and Occupations; or, c. Certified by the National Association of Alcohol and Drug Abuse Counselors (NAADAC) as an NCAC II or MAC; or, d. Certified in Addiction Psychiatry by the American Board of Psychiatry and Neurology (ABPN). 2. Licensed addiction counselors (LAC) 3. Licensed behavioral health non-physician practitioners are any of the following: a. Psychologist b. Nurse Practitioner c. Licensed Clinical Social Worker (LCSW) d. Licensed Marriage and Family Therapist (LMFT) e. Licensed Professional Counselor (LPC)	treatment staff identified in 21.210.1(b). Peer support professionals, counselor in-training or CAC I must have all clinical documentation reviewed and co-signed by their clinical supervisor. Peer support professionals, counselors-in-training and CAC I's shall not comprise more than twenty-five percent (25%) of total treatment staff.		
21.210.43	Level of care general provision section need clarifications	A. Agencies shall use The ASAM Criteria as a guide for assessing and placing individuals in the appropriate level of care. B. All levels of care shall give special consideration to the individuals' identified medical and psychiatric needs in planning treatment. C. Different levels of care shall offer a range of treatment approaches and support services based	A. In addition to meeting the requirements established in 21.190, Agencies shall: 1. Use the ASAM Criteria as a guide for assessing and placing individuals in the appropriate level of care; 2. Assessments shall include information gathered on all six (6) dimensions outlined in the ASAM Criteria; and, 3. Level of care shall be determined utilizing the	Create one level of care general provision section that contains provisions at all programs must follow	No

		on individual readiness to change and focus on identified substance use disorder education and treatment needs. Treatment approaches and support services may include: 1. Group and individual therapy and education; 2. Relapse prevention; 3. Building support systems; 4. Developing coping skills; 5. Education on substance use disorders; 6. Vocational counseling; 7. Life skills training; 8. Self-help groups; and, 9. Milieu therapy.	decisional flow process as outlined in the ASAM criteria. B. Agencies shall specify the specific level of care services the agency plans to provide, including the population the agency plans to serve. C. Each levels of care shall offer a range of treatment approaches and support services based on the assessment of the individual's treatment needs. Treatment services may include, but are not limited to: 1. Group and individual counseling; 2. Motivational enhancement; 3. Family therapy; 4. Educational groups; 5. Occupational and recreational therapy; 6. Psychotherapy; 7. Addiction pharmacology; 8. Medication management; 9. Peer, social and recovery support; 10.ase management or service coordination; 11. Assessment; and 12. Support for development of life skills. D. In addition to meeting the staff qualification and training requirements established in 21.210, Agencies shall document that staff are appropriately credentialed and qualified to provide treatment services in the levels of care described in this section and to the individual populations they serve. E. Agencies shall apply sliding fee scales equally to all prospective persons seeking services. F. Agencies shall be responsible for monitoring and routinely reporting to referring courts and the criminal justice system the individual's progress within treatment, including any ancillary services. G.in addition to meeting the requirements established in 21.200, agencies shall ensure all staff working with youth at each level of care are trained and knowledgeable of youth development and engaging youth in care. H. Agencies shall obtain a controlled substance license from the office of behavioral health if the program plans to dispense, compound, or administer a		

			controlled substance in order to treat a substance use disorder or to treat the withdrawal symptoms of a substance use disorder. I. Agencies shall continue individuals on their medication assisted treatment regimen when available and will only detox individuals from medications treating opioid use disorders at the individual's request or if it is deemed medically necessary. J. Agencies shall inform individuals receiving services about access to medication assisted treatment. Upon the individual's consent, agencies shall provide medication assisted treatment directly, if the agency or provider is appropriately licensed to do so, or through referral.		
Currently 21.210.44	Second general provision section	A. Agencies shall document that counselors are appropriately credentialed and qualified to provide treatment services in the levels of care described in this section and the individual populations they serve. B. Level I education groups shall not regularly exceed twenty (20) people. C. Therapeutic groups and level II therapeutic education groups shall not regularly exceed twelve (12) people. D. Outpatient licensed sites shall make emergency services accessible during non-business hours to individuals receiving services by providing pager or emergency room contact information on voice mail or through voice messaging services, twenty-four (24)hours per day, seven (7) days per week. Residential sites shall provide for emergency medical services available to clients twenty four (24) hours per day, seven (7) days per week. E. Sliding fee scales shall be applied equally to all prospective persons seeking services. F. Agencies shall be responsible for monitoring and routinely reporting to referring courts and the criminal justice system the individual's progress within treatment, including any ancillary services.	Current section content updated and included in 21.210.43 above.	Second general provision section content added to 21.210.43	No
21.210.5	Title Only	Title Only	Each level of care is based on a specific level of care	Clarify that each level of	No

			outlined in the ASAM Criteria.	care is based on an ASAM level of care	
21.210.6 (currently 21.210.51)	Outpatient Services rules do not currently align with the ASAM Criteria Level 1.	A. Outpatient services shall generally be intended for individuals who may or may not have supportive resources during the course of treatment in the form of family, friends, employment or housing but are assessed as not appropriate for more intensive levels of treatment. Traditional outpatient treatment may also be a transition from more intensive treatment settings. B. Outpatient services shall be conducted with a frequency of nine (9) or less substance use disorder education/treatment contact hours per week for adults, and six (6) or less substance use disorder education/treatment contact hours per week for youth. C. Minimum frequency of treatment contact shall be one time per thirty (30) consecutive calendar days. D. The ASAM Criteria Level 1 services are appropriate for individuals with co-occurring mental and substance-related disorders if, the disorders are of moderate severity, or have been resolved to an extent addiction treatment services are assessed as potentially beneficial.	A. Level 1 services shall generally be intended for individuals who are assessed as not appropriate for more intensive levels of care. Level 1 may also be a step-down from a higher level of care or offered when an individual is in early stages of change and not willing to participate in the higher level of care indicated by the assessment. B. Level 1 services are appropriate for individuals with co-occurring mental and substance-related disorders if the mental health disorders are of moderate severity, or are of high severity but have been stabilized.	Create outpatient services rules that align with ASAM level 1.	No
21.210.61	Service Provisions for Outpatient Services rules do not align with ASAM Criteria Level 1.	No current rules for Outpatient (Level 1) Service Provision Section.	A. Level 1 services shall be conducted in regularly scheduled sessions of fewer than nine (9) treatment contact hours per week for adults, and fewer than six (6) treatment contact hours per week for youth. B. Agencies providing level 1 services shall inform individuals receiving services how to access medical and psychiatric emergency services by telephone twenty-four (24) hours per day, seven (7) days per, including but not limited to services provided by the behavioral health crisis response system created pursuant to 27-60-103, C.R.S. C. Agencies providing level 1 services shall have direct affiliation or close coordination through referral to more intense levels of care. D. Agencies providing level 1 services shall ensure staff has psychiatric and medical consultation available	Create outpatient services rules that align with ASAM level 1.	No

			within twenty-four (24) hours by telephone.		
21.210.7	No established ASAM Level 2 rule Section	No current rule section for ASAM Level 2.	Title only	Create a section specific to ASAM level 2 services.	No
21.210.71 (currently 21.210.52)	Intensive Outpatient Services rules do not currently align with the ASAM Criteria Level 2.1.	A. Intensive outpatient services shall generally be intended for individuals who require a more structured substance use disorder outpatient treatment experience than can be received from traditional outpatient treatment. Individuals may or may not have resources in the form of family, friends, employment or housing that provides support during the course of treatment. Intensive outpatient treatment may reflect an increase in treatment intensity, such as outpatient to intensive outpatient, or a decrease in treatment intensity, such as residential to intensive outpatient treatment. B. Intensive outpatient services shall be conducted with a minimum frequency of nine (9) treatment contact hours per week for adults and a minimum frequency of six (6) treatment contact hours per week for youth. C. The ASAM Criteria Level 2 services are appropriate for individuals with co-occurring mental and substance-related disorders if, the disorders are of moderate severity, or have been resolved to an extent addiction treatment services are assessed as potentially beneficial.	A. Level 2.1 services shall generally be intended for individuals who require a more structured substance use disorder outpatient treatment experience than can be received in Level 1 outpatient treatment. B. Level 2.1 services are appropriate for individuals with co-occurring mental and substance-related disorders if the disorders are of moderate severity, or are of higher severity but have been stabilized.	Create intensive outpatient services rules that align with ASAM level 2.1.	No
21.210.711	Service Provisions for Intensive Outpatient Services rules do not align with ASAM Criteria Level 2.1.	No current rules for Intensive Outpatient (Level 2.1) Service Provision Section.	A. Level 2.1 services shall be conducted in regularly scheduled sessions that follow a planned format of treatment services of nine (9) to nineteen (19) contact hours per week for adults and a six (6) to nineteen (19) contact hours per week for youth. B. Agencies providing level 2.1 services shall inform individuals receiving services how to access medical and psychiatric emergency services by telephone twenty-four (24) hours per day, seven (7) days per week, including but not limited to services provided by the behavioral health crisis response system created pursuant to 27-60-103, C.R.S.	Create intensive outpatient services rules that align with ASAM level 2.1.	No

			C. Agencies providing level 2.1 services shall have direct affiliation or close coordination through referral to more and less intense levels of care. D. Agencies providing level 2.1 services shall ensure staff has psychiatric and medical consultation available within twenty-four (24) hours by telephone and within seventy-two (72) hours in person.		
21.210.72 (currently 21.210.53)	Partial Hospitalization Services rules do not currently align with the ASAM Criteria Level 2.5.	A. Partial hospitalization shall generally be intended for individuals who require more structured treatment for substance use disorders than can be provided by intensive outpatient treatment, but are not assessed as needing treatment in a residential setting. Individuals may or may not have resources in the form of family, friends, employment or housing that provides support during the course of treatment. Partial hospitalization may be a transition to or from more intensive residential settings. B. Partial Hospitalization shall be conducted with a minimum frequency of twenty (20) treatment contact hours per week. C. The ASAM Criteria Level 2 services are appropriate for individuals with co-occurring mental and substance-related disorders if, the disorders are of moderate severity, or have been resolved to an extent addiction treatment services are assessed as potentially beneficial.	A. Level 2.5 services shall generally be intended for individuals who require daily monitoring or management to treat substance use disorders that can be provided in a structured outpatient setting. Services include direct access to medical, psychiatric, and laboratory services level 2.5 service sites for youth include access to educational services and coordination with a school system, as appropriate. B. Level 2.5 services are appropriate for individuals with co-occurring mental and substance-related disorders if the disorders are of moderate severity, or are of higher severity but have been stabilized. Staff of level 2.5 services shall understand the signs and symptoms of mental health disorders and the uses of psychotropic medications and their interactions with substance use disorders.	Create partial hospitalization services rules that align with ASAM level 2.5.	No
21.210.721	Service Provisions for Partial Hospitalization Services rules do not align with ASAM Criteria Level 2.5.	No current rules for Partial Hospitalization (Level 2.5) Service Provision Section.	A. Level 2.5 services shall be conducted with a minimum frequency of twenty (20) regularly scheduled treatment contact hours per week. B. Agencies providing level 2.5 services shall inform individuals receiving services how to access medical and psychiatric emergency services by telephone twenty-four (24) hours per day, seven (7) days per week when the program is not in session, including but not limited to services provided by the behavioral health crisis response system created pursuant to 27-60-103, C.R.S. C. Agencies providing level 2.5 services shall have direct affiliation or close coordination through referral to	Create partial hospitalization services rules that align with ASAM level 2.5.	No

			more and less intense levels of care. D. Agencies providing level 2.5 services shall ensure staff has psychiatric and medical consultation available within eight (8) hours by telephone and within forty-eight (48) hours in person.		
21.210.8	No established ASAM Level 3 rule Section	No current rule section for ASAM Level 3.	Agencies providing residential/inpatient substance use disorder services (level 3) shall construct and maintain sound and sight barriers between male and female individuals and between adult and youth in bathrooms and sleeping quarters.	Create a section specific to ASAM level 3 services.	No
21.210.81 (currently 21.210.54)	Clinically Managed Low-Intensity Residential Services rules do not currently align with the ASAM Criteria Level 3.1.	A. This level of treatment shall generally be intended for individuals who are transitioning to higher intensity or lower-intensity levels of care and/or are reintegrating with the community, and whose history of chronic substance use disorders, lack of functional and supportive living situations, possible unemployment, levels of social or psychological dysfunction and lack of housing necessitate low-intensity residential treatment. B. Clinically managed low-intensity residential services shall be conducted with a minimum frequency of five (5) hours of planned clinical treatment activities per week. C. Resident to staff ratios shall not exceed twenty to one (20:1) during nighttime hours, per agency site. D. Residential facilities delivering The ASAM Criteria Level 3 services shall construct and maintain sound and sight barriers between male and female	A. Level 3.1 services shall generally be intended for individuals whose history of chronic substance use disorders, lack of supportive living situations, unemployment, levels of social or psychological dysfunction and/or lack of housing necessitates twenty-four (24) hour structure and support. Level 3.1 services are generally provided in settings such as a halfway house, group home or other supportive living environment providing twenty-four (24) hour staff and close integration with treatment services. B. Level 3.1 services shall have staff who are able to identify the signs and symptoms of acute psychiatric conditions and understand the signs and symptoms of mental disorders, the uses of psychotropic medication and their interaction with substance use disorders. Level 3.1 services shall have the capacity to arrange for psychiatric or addiction medications.	Create Clinically Managed Low-Intensity Residential Services rules that align with ASAM level 3.1.	No
21.210.811	Service Provisions and Staffing for Clinically Managed Low-Intensity Residential Services rules do not align with ASAM Criteria Level 3.1.	No current rules for Clinically Managed Low-Intensity Residential (Level 3.1) Service Provision Section and Staffing.	A. Level 3.1 services shall be regularly scheduled and include a minimum of five (5) hours of planned-treatment activities per week. B. Agencies providing level 3.1 services shall maintain an individual to staff ratios not exceeding twenty to one (20:1) during nighttime hours, per agency site. C. Agencies providing level 3.1 services shall provide twenty-four (24) hour per day seven (7) days per week on-site staff. 24 hour on-site staff shall be trained and knowledgeable of substance use disorders and the treatment of substance use disorders and may include: 1. Credentialed peer support specialists; or,	Create Clinically Managed Low-Intensity Residential Services rules that align with ASAM level 3.1.	No

			2. Addiction counselors level I or II (CAC I or CAC II) certified pursuant to Part 8 OF Article 245 OF Title 12, C.R.S. D. Agencies providing level 3.1 services shall have at least one (1) clinical staff trained and knowledgeable of substance use disorders, the treatment of substance use disorders and able to monitor and identify psychiatric conditions available by telephone twenty-four (24) hours a day seven (7) days per week and available to be on-site within 30 minutes. Trained clinical staff shall be: 1. Certified as a CAC III or licensed as an addiction counselor pursuant to Part 8 of Article 245 of Title 12, C.R.S.; 2. A physician licensed pursuant to Article 240 of Title 12, C.R.S.; 3. A psychologist licensed pursuant to Part 3 of Article 245 of Title 12, C.R.S.; 4. An advanced practice nurse licensed pursuant to section 12-255-111, C.R.S.; or, 5. A licensed clinical social worker, licensed marriage and family therapist, or licensed professional counselor licensed under Part 4, 5, or 6 of Article 245 of Title 12, C.R.S. E. Agencies providing level 3.1 services shall have direct affiliation or close coordination through referral to more and less intense levels of care. F. Agencies providing level 3.1 services shall ensure staff have telephone or in-person consultation with a physician and emergency services available twenty-four (24) hours a day, seven (7) days a week.		
Currently 21.210.55	Duplicative with current section 21.250	A. A non-hospital (non-medical) residential withdrawal management unit is an organized service that may be delivered by trained staff, who provide twenty-four (24) hour supervision, observation and support for individuals who are intoxicated or experiencing withdrawal. B. Individual to staff ratios shall not exceed ten to one (10:1); and, 1. Procedures for responding to periods of high client-traffic and/or emergency situations shall	Section removed	This section is duplicative with section 21.250, new Clinically Managed Residential Withdrawal Management section created as 21.210.9	No

		be conspicuously posted. 2. Each shift shall have a minimum of two (2) staff members, whenever one (1) or more consumers are present. C. This level provides care for individuals whose intoxication/withdrawal signs and symptoms are sufficiently severe to require twenty four (24) hour structure and support. However the full resources of a Level 3.7-WM medically monitored inpatient withdrawal management service are not necessary. D. This level is staffed to supervise self-administered medications for the management of withdrawal. All programs at this level rely on established clinical protocols to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to more appropriate levels of care.			
21.210.82 (currently 21.210.56)	Clinically Managed Population-Specific High-Intensity Residential Services rules do not currently align with the ASAM Criteria Level 3.3.	A. Frequently referred to as extended or long-term care, this level of care provides a structured recovery environment in combination with high-intensity clinical services to support recovery from substance-related disorders. B. The functional deficits seen in individuals who are appropriate for this level of care are primarily cognitive and can be either temporary or permanent. C. Some individuals have such severe deficits in interpersonal and coping skills that the treatment process is one of “habilitation” rather than “rehabilitation”. D. Services may be provided in a deliberately repetitive fashion to address the special cognitive needs of individuals for whom this level of care is considered a medical necessity. E. Treatment is focused on preventing relapse, continued problems and/or continued use, and promoting the eventual reintegration of the individual into the community. F. Clinically managed population-specific high-intensity Residential Services shall be conducted	A. Level 3.3 services a structured recovery environment in combination with high-intensity clinical services to support recovery from substance-related disorders. B. Level 3.3 is appropriate for individuals who are unable to benefit from outpatient services or services in general settings because of cognitive impairments that result in functional limitations. Treatment is focused on preventing relapse, continued problems and/or continued use, and promoting the eventual reintegration of the individual into the community. Therapeutic rehabilitation facilities or traumatic brain injury programs are examples of this level of care.	Create Clinically Managed Population-Specific High-Intensity Residential Services rules that align with ASAM level 3.3.	No

		with a minimum frequency of nine (9) hours of planned clinical treatment activities per week. G. A nursing home is widely identified as an example of this level of care. H. Resident to staff ratios shall not exceed twenty to one (20:1) during nighttime hours, per agency site. I. Residential facilities delivering The ASAM Criteria Level 3 services shall construct and maintain sound and sight barriers between male and female individuals, and between adult and adolescents in bathrooms and sleeping quarters.			
21.210.821	Service Provisions and Staffing for Clinically Managed Population-Specific High-Intensity Residential Services rules do not align with ASAM Criteria Level 3.3.	No current rules for Clinically Managed Population-Specific High-Intensity Residential (Level 3.3) Service Provision Section and Staffing.	A. Agencies providing level 3.3 services shall deliver treatment services in a manner that is matched to the individual's functioning and may be provided in a deliberately repetitive fashion to address the special cognitive needs of individuals for whom this level of care is considered a medical necessity. B. Agencies shall provide daily scheduled level 3.3 services and include minimum of nine (9) hours of planned treatment services per week. C. Agencies providing level 3.3 services shall maintain individual to staff ratios not exceeding twenty to one (20:1) during nighttime hours, per agency site. Staff shall include: 1. At least one (1) clinical staff trained and knowledgeable of substance use disorders, the treatment substance use disorders and able to monitor and identify psychiatric conditions available by telephone twenty-four (24) hours a day seven (7) days per week and available to be on-site within 30 minutes. Trained clinical staff shall be: a. Certified as a CAC III or licensed as an addiction counselor pursuant to Part 8 of Article 245 of Title 12, C.R.S.; b. A physician licensed pursuant to Article 240 of Title 12, C.R.S.; c. A psychologist licensed pursuant to Part 3 of Article 245 of Title 12, C.R.S.; d. An advanced practice nurse licensed pursuant to section 12-255-111, C.R.S.; or,	Create Clinically Managed Population-Specific High-Intensity Residential Services rules that align with ASAM level 3.3.	No

			e. A licensed clinical social worker, licensed marriage and family therapist, or licensed professional counselor licensed under Part 4, 5, or 6 of Article 245 of Title 12, C.R.S. 2. Peer support professionals appropriately credentialed in Colorado or addiction counselors level I or II (CAC I or CAC II) certified pursuant to Part 8 of Article 245 of Title 12, C.R.S. 3. A physician, physician assistant or nurse practitioner available by telephone or in-person twenty-four (24) hours a day, seven (7) days a week to provide medical evaluation and consultation. D. Agencies providing level 3.3 services shall have direct affiliation or close coordination through referral to more and less intense levels of care.		
21.210.83 (currently 21.210.57)	Clinically Managed High-Intensity Residential Services rules do not currently align with the ASAM Criteria Level 3.5.	A. Individuals who are appropriately placed in this level of care typically have multiple deficits, which may include substance-related disorders and criminal activity. B. Such individuals generally can be characterized as having chaotic, non-supportive and often abusive interpersonal relationships; extensive treatment or criminal justice histories; chronic substance use disorders; limited work histories and educational experiences; and antisocial value systems. C. Standard rehabilitation methods are inadequate to treat these individuals effectively. Effective treatment approaches are primarily habilitative in focus, addressing the individual's educational and vocational deficits, as well as his or her socially dysfunctional behavior. D. This level of care may represent a step-down from Level 3.7 and the therapeutic community is also identified as an example of this level of care. E. Clinically Managed High-Intensity Residential Services shall be a minimum frequency of five (5) hours of planned clinical treatment activities per week. F. Resident to staff ratios shall not exceed twenty to one (20:1) during nighttime hours, per agency site.	A. Level 3.5 services provide a safe and stable living environment with treatment focused on promoting skills needed to avoid relapse or continued use. Level 3.5 is appropriate for individuals with multiple limitations including criminal activity, psychological problems, impaired social and vocational functioning. B. Treatment is directed toward reducing relapse risk, enhancing prosocial behaviors and reintegration into the community. A variable length therapeutic community or residential treatment center are examples of this level of care.	Create Clinically Managed High-Intensity Residential Services rules that align with ASAM level 3.5.	No

		G. Residential facilities delivering The ASAM Criteria Level 3 services shall construct and maintain sound and sight barriers between male and female individuals, and between adult and adolescents in bathrooms and sleeping quarters.			
21.210.831	Service Provisions and Staffing for Clinically Managed High-Intensity Residential Services rules do not align with ASAM Criteria Level 3.5.	No current rules for Clinically Managed High-Intensity Residential (Level 3.5) Service Provision Section and Staffing.	A. Agencies shall provide daily level 3.5 services and include a minimum of ten (10) hours of planned treatment services per week. B. Agencies providing level 3.5 services shall maintain individual to staff ratios not exceeding twenty to one (20:1) during nighttime hours, per agency site and each shift shall have a minimum of two (2) staff members, whenever one (1) or more individuals are present. Staff shall include: 1. At least one (1) clinical staff trained and knowledgeable of substance use disorders, the treatment substance use disorders and able to monitor and identify psychiatric conditions available twenty-four (24) hours a day seven (7) days per week. Trained clinical staff shall be: a. Certified as a CAC III or licensed as an addiction counselor pursuant to Part 8 of Article 245 of Title 12, C.R.S.; b. A physician licensed pursuant to Article 240 of Title 12, C.R.S.; c. A psychologist licensed pursuant to Part 3 of Article 245 of Title 12, C.R.S.; d. An advanced practice nurse licensed pursuant to section 12-255-111, C.R.S.; or, e. A licensed clinical social worker, licensed marriage and family therapist, or licensed professional licensed under Part 4, 5, or 6 of Article 245 of Title 12, C.R.S. 2. Peer support professionals appropriately credentialed in Colorado or addiction counselors level I or II (CACI or CAC II) certified pursuant to Part 8 of Article 245 of Title 12, C.R.S. 3. A physician, physician assistant or nurse practitioner available to provide medical evaluation and consultation and assess and treat co-	Create Clinically Managed High-Intensity Residential Services rules that align with ASAM level 3.5.	No

			occurring biomedical disorders, as well as prescribe and monitor the administration of medications. C. Agencies providing level 3.5 services shall have direct affiliation or close coordination through referral to more and less intense levels of care.		
21.210.84 (currently 21.210.58)	Medically Monitored Intensive Inpatient Services rules do not currently align with the ASAM Criteria Level 3.7.	A. Medically monitored treatment shall generally be intended for individuals with significant substance use disorders who may also have extensive criminal and treatment histories, treatment failures in less intensive settings, psychological problems and impaired functioning meriting short-term, high-intensity residential treatment that may include a community re-entry phase. B. Medically monitored intensive residential treatment shall be conducted with a minimum frequency of twenty (20) treatment contact hours per week. C. Resident to staff ratios shall not exceed twenty to one (20:1) during nighttime hours per agency site. D. Residential facilities delivering The ASAM Criteria Level 3 services shall construct and maintain sound and sight barriers between male and female individuals, and between adult and adolescents in bathrooms and sleeping quarters.	A. Level 3.7 services provide a planned and structured regimen of twenty-four (24) hour evaluation, observation, medical monitoring and addiction treatment. B. Level 3.7 services are appropriate for individuals whose medical, emotional, behavioral or cognitive problems are so severe that they require twenty-four (24) hour medical monitoring but do not need the full resources of an acute care general hospital or medically managed inpatient treatment program (level 4). Treatment is designed for individuals who have functional limitations in the areas of intoxication/withdrawal potential; biomedical conditions; or emotional, behavioral or cognitive conditions.	Create Medically Monitored Intensive Inpatient Services rules that align with ASAM level 3.7.	No
21.210.841	Service Provisions and Staffing for Medically Monitored Intensive Inpatient Services rules do not align with ASAM Criteria Level 3.7.	No current rules for Medically Monitored Intensive Inpatient (Level 3.7) Service Provision Section and Staffing.	A. Level 3.7 services shall be scheduled daily and include a minimum of twenty (20) hours of planned treatment activities per week. B. Agencies providing level 3.7 services shall maintain individual to staff ratios not exceeding twenty to one (20:1) during nighttime hours, per agency site and each shift shall have a minimum of two (2) staff members, whenever one (1) or more individuals are present. C. Level 3.7 services shall be staffed with a team that that includes physicians, nurses and behavioral health professional licensed pursuant to Article 245 of Title 12, C.R.S. that provide 24-hour professionally directed evaluation, care and treatment services including administration of prescribed medications, withdrawal management and integrated treatment of co-occurring	Create Medically Monitored Intensive Inpatient Services rules that align with ASAM level 3.7.	No

			medical, emotional, behavioral or cognitive conditions. D. A licensed physician shall oversee treatment and assure quality of care in level 3.7 services. A physician, physician assistant or nurse practitioner shall perform physical examinations for all individuals admitted. Examinations shall occur within 24 hours of admission and thereafter as necessary. E. A registered nurse conducts an alcohol or other drug-focused nursing assessment at the time of admission. F. A licensed nurse is responsible for monitoring the individual's progress and or medication administration twenty-four (24) hours a day seven (7) days a week. G. Additional medical specialty consultation, psychological, laboratory and toxicology services are available on-site through consultation or referral. Psychiatric services are available on-site through consultation or referral within eight (8) hours by telephone or twenty-four (24) hours in person.		
Currently 21.210.59	Duplicative with current section 21.310	This level of care is an organized service delivered by medical and nursing professionals, which provides for twenty-four (24) hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds.	Section removed	This section is duplicative with section 21.310, new Medically-Monitored Withdrawal Management section created as 21.210.92	No
21.210.9	No established ASAM Withdrawal Management rule Section	No current rule section specific to Withdrawal Management	Title only	Create a section specific to withdrawal management services, which combine current sections 21.210.55; 21.210.59; 21.250; and 21.310.	No
21.210.91	No centralized general provision section exists for Clinically Managed Residential Withdrawal Management Services (ASAM Level 3.2-WM)	Not applicable (new)	A. Level 3.2-WM programs shall provide twenty-four (24) hour supervised withdrawal from alcohol and/or other drugs in a residential setting. B. Level 3.2-WM programs shall provide collaboration and coordination with emergency mental health services as needed. C. Level 3.2-WM programs shall obtain a controlled substance license from the Office of Behavioral Health if the program plans to dispense, compound, or administer a controlled substance in order to treat a	New section that combines the content of 21.210.55 and 21.250 and updates to align with ASAM level 3.2-WM.	No

			substance use disorder or to treat the withdrawal symptoms of a substance use disorder. D. Level 3.2-WM programs shall develop and implement policies and procedures in accordance with federal and state regulations, department rules, and in consultation with medical professionals qualified in substance use disorders. Policies and procedures must address but are not limited to: 1. Handling individuals who are assessed as being a current threat to themselves or others and shall include appropriate uses of law enforcement and monitor any use of individual restraint and/or seclusion. 2. Communication with intoxicated individuals leaving treatment against staff recommendations, including the use of emergency commitments. 3. Circumstances under which individuals shall be discharged, other than completing withdrawal management or leaving against staff recommendations.		
21.210.911	No centralized Admission and Monitoring section exists for Clinically Managed Residential Withdrawal Management Services (ASAM Level 3.2-WM)	Not applicable (new)	A. Individuals admitted to level 3.2-WM services shall be intoxicated, under the influence, or in any stage of withdrawal from alcohol and/or other drugs. B. Level 3.2-WM admission procedures shall include at a minimum: 1. Degree of alcohol and other drug intoxication as evidenced by breathalyzer, urinalysis, self-report, observation or other evidence-based or best practices; 2. Initial vital signs; 3. Need for emergency medical and/or psychiatric services; 4. Inventorying and securing personal belongings; 5. Substance use disorder history and the degree to which the use of substance affects personal and social functioning, as soon as clinically feasible following admission; 6. Pregnancy screening; 7. Administration of a validated clinical withdrawal assessment tool. C. Withdrawal management monitoring of individuals	New section that combines the content of 21.210.55 and 21.250 and updates to align with ASAM level 3.2-WM.	No

			shall include: 1. Routine monitoring of physical and mental status including observation of individual; 2. Vital signs taken at least every two (2) hours until they remain at the person's baseline for at least four (4) hours, and then taken every eight (8) hours thereafter until discharge. 3. Documentation per shift to include all individual monitoring activities.		
21.210.912	No centralized Service Planning section exists for Clinically Managed Residential Withdrawal Management Services (ASAM Level 3.2-WM)	Not applicable (new)	A. Level 3.2-WM programs shall develop and implement service plans in accordance with section 21.190.4 and address safe withdrawal, motivational counseling, and referral for treatment. B. Level 3.2-WM programs shall provide additional service planning for managing individuals with medical conditions, suicidal ideation, pregnancy, psychiatric conditions, and other conditions, which place individuals at additional risk during withdrawal management. C. Level 3.2-WM programs shall provide assessments of individual readiness for treatment and interventions based on the service plan and the assessments shall be documented in the individual's record.	New section that combines the content of 21.210.55 and 21.250 and updates to align with ASAM level 3.2-WM.	No
21.210.913	No centralized Discharge section exists for Clinically Managed Residential Withdrawal Management Services (ASAM Level 3.2-WM)	Not applicable (new)	A. Level 3.2-WM programs shall provide discharge information to individuals and documented in the individual's records the requirements established in section 21.190.6, and: 1. Effects of alcohol and other drugs; 2. Risk factors associated with alcohol and other drug abuse for acquiring and transmitting HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome), Tuberculosis, and other infectious diseases, and for pregnancy. 3. Availability of testing and pre/post-test counseling for HIV/AIDS, TB, Hepatitis c and other infectious diseases, and pregnancy; 4. Availability of alcohol and other drug abuse treatment services.	New section that combines the content of 21.210.55 and 21.250 and updates to align with ASAM level 3.2-WM.	No
21.210.914	No centralized Staff Requirements	Not applicable (new)	A. At least fifty percent (50%) of withdrawal management staff including on-call staff shall consist of certified	New section that combines the content of	No

	section exists for Clinically Managed Residential Withdrawal Management Services (ASAM Level 3.2-WM)		addiction counselors or staff in the process of obtaining certification. Plans for certification shall be available for review. Full-time staff shall obtain at least a CAC I within eighteen (18) months of employment. B. Uncertified staff or staff without a plan for certification shall not comprise more than fifty percent (50%) of total withdrawal management staff. C. Level 3.2-wm programs' individual to staff ratios shall not exceed ten to one (10:1); and, 1. Procedures for responding to periods of high census and/or emergency situations shall be conspicuously posted. 2. Each shift shall have a minimum of two (2) staff members, whenever one (1) or more individuals are present. D. The staff person overseeing day-to-day operations shall be: 1. Certified as a CAC III or licensed as an addiction counselor pursuant to Part 8 of Article 245 of Title 12, C.R.S.; 2. A physician licensed pursuant to Article 240 of Title 12, C.R.S.; 3. A psychologist licensed pursuant to Part 3 of Article 245 of Title 12, C.R.S.; 4. An advanced practice nurse licensed pursuant to section 12-255-111, C.R.S.; or, 5. A licensed clinical social worker, licensed marriage and family therapist, or licensed professional counselor licensed under Part 4, 5, or 6 of Article 245 of Title 12, C.R.S. E. Level 3.2-WM programs shall provide twenty-four (24) hour per day seven (7) days per week on-site staff. 24 hour on-site staff shall be trained and knowledgeable of substance use disorders and the treatment of substance use disorders and may include: 1. Credentialed peer support specialists; or, 2. Addiction counselors level I or II (CAC I or CAC II) certified pursuant to Part 8 of Article 245 of Title 12, C.R.S. F. Programs shall maintain documentation that all direct care staff have training in, and/or be evaluated as	21.210.55 and 21.250 and updates to align with ASAM level 3.2-WM.	

			having knowledge of, the following before providing independent services: 1. Withdrawal management; 2. Infectious diseases (AIDS/HIV, Hepatitis C, TB), including universal precautions against becoming infected; 3. Administering cardiopulmonary resuscitation (CPR) and first aid; 4. Monitoring vital signs; 5. Conducting assessment and triage, including identifying suicidal ideation; 6. Emergency procedures and their implementation; 7. Collecting urine, and breath samples; 8. Cultural factors that impact withdrawal management; 9. Ethics and confidentiality; 10. Individual records systems; 11. De-escalating potentially dangerous situations; and, 12. Basic counseling and motivational interviewing skills.		
21.210.92	No centralized general provision section exists for Medically Monitored Inpatient Withdrawal Management Services (ASAM Level 3.7-WM)	Not applicable (new)	Level 3.7-WM services shall be provided by licensed medical staff qualified to supervise withdrawal from alcohol and other drugs through use of medication and/or medical procedures in residential settings which possess controlled substances licenses in compliance with Title 27, Article 80, Part 2, C.R.S.	New section that combines the content of 21.210.59 and 21.2310 and updates to align with ASAM level 3.7-WM.	No
21.210.921	No centralized admission and evaluation section exists for Medically Monitored Inpatient Withdrawal Management Services (ASAM Level 3.7-WM)	Not applicable (new)	A. Level 3.7-WM programs shall develop and implement specific admission criteria detail for which drugs, including alcohol, medical withdrawal management is provided. B. In addition to the consent requirements established in 21.170.2, Level 3.7-WM programs shall provide informed consent to medical withdrawal management that include: 1. Medications to be used; 2. Need to consult with primary care physicians. C. Level 3.7-wWM programs shall provide medical evaluations by physicians licensed pursuant to Article	New section that combines the content of 21.210.59 and 21.2310 and updates to align with ASAM level 3.7-WM.	No

			240 of Title 12, C.R.S. or authorized health-care professionals under the supervision of authorized physicians shall be required and shall consist of, at minimum: 1. Medical histories including detailed chronologies of substance use disorders; 2. Identification of current physical addiction including drug types; 3. Physical examinations to determine appropriateness for outpatient or inpatient medical withdrawal management; 4. Appropriate laboratory tests including pregnancy tests, and other evaluations as indicated. D. Level 3.7-WM service protocols for usual and customary withdrawal management from each drug delineated in the admission criteria shall be developed in consultation with licensed physicians and other allied health-care professionals and shall be implemented in the form of individualized withdrawal management plans under direct supervision of program medical directors. Protocols shall include: 1. Types of intoxication; 2. Tolerance levels for the individual's drug of choice; 3. Degrees of withdrawal; 4. Possible withdrawal and/or intoxication complications; 5. Other conditions affecting medical withdrawal management procedures; 6. Types of medications used; 7. Recommended dosage levels; 8. Frequency of visits (outpatient settings); 9. Procedures to follow in the event of withdrawal management complications; 10. Daily assessments including expected improvements as well as potential problems; 11. Expected duration of withdrawal management. E. Medical withdrawal management programs using any controlled substances are required to have controlled substance licenses issued by the department. Buprenorphine is the only medication that can be		

			used for opioid dependent individuals unless the medical withdrawal management program is licensed as an opioid treatment program and it has been verified through the program and coordinated with the CSA. F. Authorized physicians may prescribe buprenorphine under his/her own Drug Enforcement Administration (DEA) registration number for individuals admitted to hospital for inpatient withdrawal management or addiction treatment. G. Withdrawal management programs must continue patients on their medication assisted treatment regimen when available and will only detox individuals from medications treating opioid use disorders at the patient's request or if it is deemed medically necessary.		
21.210.922	No centralized clinical staff section exists for Medically Monitored Inpatient Withdrawal Management Services (ASAM Level 3.7-WM)	Not applicable (new)	A. Level 3.7-WM programs shall provide, at minimum, the following clinical staff: 1. One medical director; 2. One registered nurse or licensed practical nurse (R.N. or L.P.N..) with at least one year of withdrawal management experience; 3. Behavioral health professionals, behavioral health professionals shall be: a. An addiction counselor certified as CAC II, CAC III or licensed pursuant to Part 8 of Article 245 of Title 12, C.R.S.; b. A physician licensed pursuant to Article 240 of Title 12, C.R.S.; c. A psychologist licensed pursuant to part 3 of Article 245 of Title 12, C.R.S.; d. An advanced practice nurse licensed pursuant to section 12-255-111, C.R.S.; or, e. A licensed clinical social worker, licensed marriage and family therapist, or licensed professional counselor licensed under Part 4, 5, or 6 of Article 245 of Title 12, C.R.S. B. Level 3.7-WM program medical directors' responsibilities shall include, at minimum: 1. Quarterly reviews and revisions of drug withdrawal management categories and protocols;	New section that combines the content of 21.210.59 and 21.2310 and updates to align with ASAM level 3.7-WM.	No

			2. Reviews of individual withdrawal management plans; 3. Reviews of individual prescriptions that deviate from standard withdrawal management protocols; 4. Five hours minimum of monthly supervision of and consultation with staff providing withdrawal management services; 5. Direct supervision of individual withdrawal management cases that deviate from standard protocols and/or experience complications; 6. Developing and implementing back-up systems for physician coverage when medical directors are unavailable and/or for emergencies. C. Level 3.7-WM programs shall ensure twenty four (24) hour access to clinical staff by telephone and accommodation for unscheduled visits for crises or problem situations.		
21.210.923	No centralized treatment services section exists for Medically Monitored Inpatient Withdrawal Management Services (ASAM Level 3.7-WM)	Not applicable (new)	A. Level 3.7-WM programs shall provide the following treatment services in addition to medication dosing contacts: 1. Motivational counseling and support; 2. Continuous evaluation and behavioral health intervention; and, 3. Development and monitoring of a service plan per section 21.190.4. B. Level 3.7-WM programs shall ensure a minimum of one (1) daily clinical supportive services contact, which shall be documented in individual records.	New section that combines the content of 21.210.59 and 21.2310 and updates to align with ASAM level 3.7-WM.	No
21.210.924	No centralized dispensing and administration procedures section exists for Medically Monitored Inpatient Withdrawal Management Services (ASAM Level 3.7-WM)	Not applicable (new)	A. Level 3.7-WM programs shall develop and implement policies and procedures for dispensing medications per standard withdrawal management protocols that are in accordance with applicable state and federal statutes and for the following: 1. Individual prescriptions filled and dispensed by a registered pharmacist at a designated pharmacy location; 2. Individual prescriptions from medical directors that are filled from stock quantities. B. Level 3.7-WM programs shall develop a implement policies and procedures in accordance with applicable federal and state statutes for storing and accounting	New section that combines the content of 21.210.59 and 21.2310 and updates to align with ASAM level 3.7-WM.	No

			for all drugs including controlled substances.		
21.250 through 21.250.5	Unclear section alignment within rule volume	Non-Hospital Residential Withdrawal Management	Section 21.250 repealed	Created new clinically managed substance use disorder withdrawal management as section 21.210.91	No
21.260	Incorrect reference	21.250.5(c)	21.210.914(B)		
21.310 through 21.310.5	Unclear section alignment within rule volume	Medically Monitored Inpatient Detoxification	Section 21.310 repealed	Created new medically monitored inpatient withdrawal management as section 21.210.92	No

Title of Proposed Rule:	**ASAM Levels of Care Update**	
CDHS Tracking #:	**20-02-21-01**	
Office, Division, & Program:	Rule Author: Ryan Templeton, Policy Advisor	Phone: 303-866-7405
OBH-CBH, Licensing and Designation		E-Mail: ryan.templeton@state.co.us

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):

Individuals and entities involved in the creation of the rule proposal include: individuals with lived experience, behavioral health provider organizations, substance use disorder providers, managed service organizations, the Department of Health Care Policy and Financing, the Department of Public Health and Environment, and experts on the nationally-recognized ASAM Criteria.

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:

The proposed rule draft, along with a feedback survey was posted on Colorado Department of Human Services website. The Office of Behavioral Health informed behavioral health stakeholders through direct contact and through the OBH monthly newsletter that the rule draft was available for review and feedback. Stakeholders who receive the monthly newsletter include: Colorado Behavioral Healthcare Council; Colorado Hospital Association; Mental Health Colorado; Behavioral Health Planning and Advisory Council; Department of Public Health and Environment; Department of Regulatory Agencies; Department of Health Care Policy and Financing; Department of Public Safety; substance use disorder providers; community mental health centers; community mental health clinics; hospitals; patient advocacy agencies; individuals and families with lived experience; and, law enforcement.

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?

[X] Yes [ ] No

If yes, who was contacted and what was their input?

Health Care Policy and Financing has provided guidance and expertise in this proposed rule update to ensure the update aligns with the requirements need by the Federal Government to approve the expanded Colorado Medicaid benefits.

The Department of Public Health and Environment (CDHPE) was involved in the rule drafting process as CDHPE will be taking over the licensing of substance use disorder facilities in less than four years due to the Behavioral Health Entity License created by HB 19-1237.

Sub-PAC

Have these rules been reviewed by the appropriate Sub-PAC Committee?

[ ] Yes [X] No

Name of Sub-PAC	Not applicable		
Date presented	Not applicable		
What issues were raised?	Not applicable		
Vote Count	*For*	*Against*	*Abstain*
	n/a	n/a	n/a
If not presented, explain why.	There is not a Behavioral Health Sub-PAC		

PAC

Title of Proposed Rule:	**ASAM Levels of Care Update**	
CDHS Tracking #:	**20-02-21-01**	
Office, Division, & Program:	Rule Author: Ryan Templeton, Policy Advisor	Phone: 303-866-7405
OBH-CBH, Licensing and Designation		E-Mail: ryan.templeton@state.co.us

Have these rules been approved by PAC?

☐ Yes ☒ No

Date presented	Not applicable		
What issues were raised?	Not applicable		
Vote Count	*For*	*Against*	*Abstain*
	n/a	n/a	n/a
If not presented, explain why.	Pursuant to PAC Bylaws, Office of Behavioral Health rules are not required to go through PAC.		

Other Comments

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.

The proposed rule has been disseminated statewide and the feedback deadline is open until March 11, 2020. Any feedback received will be addressed by the Office of Behavioral Health at the first reading at the State Board of Human Services on April 3, 2020.

(2 CCR 502-1)

21.100 DEFINITIONS

"The ASAM Criteria" means the publication from the American Society of Addiction Medicine, Mee-Lee, D., Shulman, G.D., Fishman, M.J., Gastfriend, D.R., Miller, M.M., EDS. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed. Carson City, NV: The Change Companies®; 2013, which is hereby incorporated by reference. No later editions or amendments are incorporated. Mee-Lee, D., Shulman, G.D., Fishman, M.J., Gastfriend, D.R., Miller, M.M., EDS. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed. Carson City, NV: The Change Companies®; 2013, is available for a reasonable charge at http://www.asam.org/resources/the-asam-criteria. Mee-Lee, D., Shulman, G.D., Fishman, M.J., Gastfriend, D.R., Miller, M.M., EDS. The ASAM Criteria: Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions, 3rd ed. Carson City, NV: The Change Companies®; 2013, is also available for public inspection at the Colorado Department of Human Services, Office of Behavioral Health, 3824 West Princeton Circle, Denver, Colorado 80236, during regular business hours.

"YOUTH" MEANS UNDER THE AGE OF TWENTY-ONE (21), UNLESS OTHERWISE NOTED.

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21.210 AGENCIES LICENSED TO PROVIDE SUBSTANCE USE DISORDER SERVICES

In addition to the rules provided in Sections 21.000 through 21.190, all agencies licensed to provide substance use disorder services shall comply with the following rule Sections 21.210.1 through 21.210.924. ~~21.210.59.~~

21.210.1 Agency Staff Qualifications and Training

A. AGENCIES SHALL ENSURE TREATMENT STAFF ARE APPROPRIATELY TRAINED AND PROPERLY CREDENTIALED TO PROVIDE SUBSTANCE USE DISORDER SERVICES IN COLORADO AND ARE IN GOOD STANDING WITH THEIR CREDENTIALING BODY. ~~Qualifications referred to in this section, including education, professional credentials, training and supervision, and work experience shall be in accordance with Addiction Counselor Certification and Licensure Standards (Section 21.330).~~

B. AGENCIES SHALL ENSURE ~~At least fifty percent (50%) of all~~ treatment staff PROVIDING INDEPENDENT TREATMENT SERVICES in substance use disorder programs within each licensed site, excluding ~~non-hospital~~ CLINICALLY MANAGED residential withdrawal management, ARE CREDENTIAL BY THE DEPARTMENT OF REGULATORY AGENCIES AS FOLLOWED: ~~shall be certified as a Certified Addiction Counselor II (CAC II), Certified Addiction Counselor III (CAC III) or Licensed Addiction Counselor (LAC).~~

1. CERTIFIED AS A CAC II, CAC III OR LICENSED AS AN ADDICTION COUNSELOR PURSUANT TO PART 8 OF ARTICLE 245 OF TITLE 12, C.R.S.;

2. A PHYSICIAN LICENSED PURSUANT TO ARTICLE 240 OF TITLE 12, C.R.S.;

3. A PSYCHOLOGIST LICENSED PURSUANT TO PART 3 OF ARTICLE 245 OF TITLE 12, C.R.S.;

4. AN ADVANCED PRACTICE NURSE LICENSED PURSUANT TO SECTION 12-255-111, C.R.S.; OR,

5. A LICENSED CLINICAL SOCIAL WORKER, LICENSED MARRIAGE AND FAMILY THERAPIST, OR LICENSED PROFESSIONAL COUNSELOR LICENSED UNDER PART 4, 5, OR 6 OF ARTICLE 245 OF TITLE 12, C.R.S.

C. PEER SUPPORT PROFESSIONALS, Counselors-in-training or Certified Addiction Counselor I (CAC I) shall not independently counsel, sign clinical documentation or carry out other duties relegated solely to THE TREATMENT STAFF IDENTIFIED IN 21.210.1(B). ~~Certified Addiction Counselor II, Certified Addiction Counselor III or Licensed Addiction Counselors. The~~ PEER SUPPORT PROFESSIONALS, Counselor in-training or CAC I must have all clinical documentation reviewed and co-signed by their clinical supervisor. PEER SUPPORT PROFESSIONALS, Counselors-in-training and CAC I's shall not comprise more than twenty-five percent (25%) of total treatment staff.

~~D. All staff who are providing psychotherapy services as defined in the Colorado Mental Health Practice Act (Section 12-43-201(9), C.R.S.) must be regulated by the Colorado Department of Regulatory Agencies (DORA), either by credentialing as a CAC I, CAC II OR CAC III or becoming licensed as a mental health professional, including Licensed Addiction Counselor, or by registering in the registered psychotherapist database with DORA. Addiction counselor certifications and licenses shall be current and in good standing.~~

~~E. Treatment staff licensed as behavioral healthcare practitioners in Colorado shall meet one of the following criteria:~~

~~1. Licensed physicians who are also:~~

~~a. Certified in addiction medicine by the American Society of Addiction Medicine; or,~~

~~b. Certified Addiction Counselor (CAC) II or III, or Licensed Addiction Counselor by the Colorado Department of Regulatory Agencies (DORA), Division of Professions and Occupations; or,~~

~~c. Certified by the National Association of Alcohol and Drug Abuse Counselors (NAADAC) as an NCAC II or MAC; or,~~

~~d. Certified in Addiction Psychiatry by the American Board of Psychiatry and Neurology (ABPN).~~

~~2. Licensed addiction counselors (LAC)~~

~~3. Licensed behavioral health non-physician practitioners are any of the following:~~

~~a. Psychologist~~

~~b. Nurse Practitioner~~

~~c. Licensed Clinical Social Worker (LCSW)~~

~~d. Licensed Marriage and Family Therapist~~ (LMFT)

~~e. Licensed Professional Counselor (LPC)~~

D. ~~F.~~ All agencies shall provide and document initial training in methods of preventing and controlling infectious diseases and in universal precautions providing protection from possible infection when handling blood and other body fluids. Annual refresher training, including updates, shall be provided and documented.

E. ~~G.~~ Staff collecting samples for drug or alcohol testing shall be knowledgeable of collection, handling, recording and storing procedures assuring sample viability for evidentiary and therapeutic purposes.

F. ~~H.~~ Agencies administering and/or monitoring individual medications shall maintain at least one staff person per shift who is currently qualified by certification and/or training to perform those functions in accordance with applicable Department rules and state and federal regulations.

G. ~~I.~~ Agencies shall document that at least one residential treatment staff person per shift is currently certified in cardiopulmonary resuscitation and basic First Aid.

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21.210.43 LEVEL OF CARE <u>GENERAL PROVISIONS</u>

A. IN ADDITION TO MEETING THE REQUIREMENTS ESTABLISHED IN 21.190, Agencies shall:

1. Use the ASAM Criteria as a guide for assessing and placing individuals in the appropriate level of care;

2. ASSESSMENTS SHALL INCLUDE INFORMATION GATHERED ON ALL SIX (6) DIMENSIONS OUTLINED IN THE ASAM CRITERIA; AND,

3. LEVEL OF CARE SHALL BE DETERMINED UTILIZING THE DECISIONAL FLOW PROCESS AS OUTLINED IN THE ASAM CRITERIA.

B. ~~All levels of care shall give special consideration to the individuals' identified medical and psychiatric needs in planning treatment.~~ AGENCIES SHALL SPECIFY THE SPECIFIC LEVEL OF CARE SERVICES THE AGENCY PLANS TO PROVIDE, INCLUDING THE POPULATION THE AGENCY PLANS TO SERVE.

C. EACH ~~Different~~ level~~s~~ of care shall offer a range of treatment approaches and support services based on THE ASSESSMENT OF THE INDIVIDUAL'S ~~individual readiness to change and focus on identified substance use disorder education and~~ treatment needs. Treatment ~~approaches and support~~ services may include, BUT ARE NOT LIMITED TO:

1. Group and individual ~~therapy and education~~ COUNSELING;

2. ~~Relapse prevention~~ MOTIVATIONAL ENHANCEMENT;

3. ~~Building support systems~~ FAMILY THERAPY;

4. ~~Developing coping skills~~ EDUCATIONAL GROUPS;

5. ~~Education on substance use disorders~~ OCCUPATIONAL AND RECREATIONAL THERAPY;

6. ~~Vocational counseling~~ PSYCHOTHERAPY;

7. ~~Life skills training~~ ADDICTION PHARMACOLOGY;

8. ~~Self-help groups~~ MEDICATION MANAGEMENT; ~~and,~~

9. ~~Milieu therapy.~~ PEER, SOCIAL AND RECOVERY SUPPORT;

<u>10.</u> CASE MANAGEMENT OR SERVICE COORDINATION;

11. ASSESSMENT; AND,

12. SUPPORT FOR DEVELOPMENT OF LIFE SKILLS.

~~**21.210.44 General Provisions**~~

D. ~~A.~~ IN ADDITION TO MEETING THE STAFF QUALIFICATION AND TRAINING REQUIREMENTS ESTABLISHED IN 21.210, Agencies shall document that ~~counselors~~ STAFF are appropriately credentialed and qualified to provide treatment services in the levels of care described in this section and TO the individual populations they serve.

E. ~~B. Level I education groups shall not regularly exceed twenty (20) people.~~ AGENCIES SHALL APPLY SLIDING FEE SCALES EQUALLY TO ALL PROSPECTIVE PERSONS SEEKING SERVICES.

F. ~~C. Therapeutic groups and level II therapeutic education groups shall not regularly exceed twelve (12) people.~~ AGENCIES SHALL BE RESPONSIBLE FOR MONITORING AND ROUTINELY REPORTING TO REFERRING COURTS AND THE CRIMINAL JUSTICE SYSTEM THE INDIVIDUAL'S PROGRESS WITHIN TREATMENT, INCLUDING ANY ANCILLARY SERVICES.

G. ~~D. Outpatient licensed sites shall make emergency services accessible during non-business hours to individuals receiving services by providing pager or emergency room contact information on voice mail or through voice messaging services, twenty-four (24)hours per day, seven (7) days per week. Residential sites shall provide for emergency medical services available to clients twenty four (24) hours per day, seven (7) days per week.~~ IN ADDITION TO MEETING THE REQUIREMENTS ESTABLISHED IN 21.200, AGENCIES SHALL ENSURE ALL STAFF WORKING WITH YOUTH AT EACH LEVEL OF CARE ARE TRAINED AND KNOWLEDGEABLE OF YOUTH DEVELOPMENT AND ENGAGING YOUTH IN CARE.

H. AGENCIES SHALL OBTAIN A CONTROLLED SUBSTANCE LICENSE FROM THE OFFICE OF BEHAVIORAL HEALTH IF THE PROGRAM PLANS TO DISPENSE, COMPOUND, OR ADMINISTER A CONTROLLED SUBSTANCE IN ORDER TO TREAT A SUBSTANCE USE DISORDER OR TO TREAT THE WITHDRAWAL SYMPTOMS OF A SUBSTANCE USE DISORDER.

I. AGENCIES SHALL CONTINUE INDIVIDUALS ON THEIR MEDICATION ASSISTED TREATMENT REGIMEN WHEN AVAILABLE AND WILL ONLY DETOX INDIVIDUALS FROM MEDICATIONS TREATING OPIOID USE DISORDERS AT THE INDIVIDUAL'S REQUEST OR IF IT IS DEEMED MEDICALLY NECESSARY.

J. AGENCIES SHALL INFORM INDIVIDUALS RECEIVING SERVICES ABOUT ACCESS TO MEDICATION ASSISTED TREATMENT. UPON THE INDIVIDUAL'S CONSENT, AGENCIES SHALL PROVIDE MEDICATION ASSISTED TREATMENT DIRECTLY, IF THE AGENCY OR PROVIDER IS APPROPRIATELY LICENSED TO DO SO, OR THROUGH REFERRAL.

~~E. Sliding fee scales shall be applied equally to all prospective persons seeking services.~~

~~F. Agencies shall be responsible for monitoring and routinely reporting to referring courts and the criminal justice system the individual's progress within treatment, including any ancillary services.~~

21.210.5 LEVELS OF CARE Specific Requirements

EACH LEVEL OF CARE IS BASED ON A SPECIFIC LEVEL OF CARE OUTLINED IN THE ASAM CRITERIA.

~~21.210.51~~ 21.210.6 OUTPATIENT SUBSTANCE USE DISORDER SERVICES (~~THE ASAM CRITERIA~~ Level 1) ~~(Outpatient Services)~~

A. ~~Outpatient~~ LEVEL 1 services shall generally be intended for individuals who ~~may or may not have supportive resources during the course of treatment in the form of family, friends, employment or housing but~~ are assessed as not appropriate for more intensive levels of ~~treatment~~ CARE. LEVEL 1 MAY ALSO BE A STEP-DOWN FROM A HIGHER LEVEL OF CARE OR OFFERED WHEN AN INDIVIDUAL IS IN EARLY STAGES OF CHANGE AND NOT WILLING TO PARTICIPATE IN THE HIGHER LEVEL OF CARE INDICATED BY THE ASSESSMENT. ~~Traditional outpatient treatment may also be a transition from more intensive treatment settings.~~

B. LEVEL 1 SERVICES ARE APPROPRIATE FOR INDIVIDUALS WITH CO-OCCURRING MENTAL AND SUBSTANCE-RELATED DISORDERS IF THE MENTAL HEALTH DISORDERS ARE OF MODERATE SEVERITY, OR ARE OF HIGH SEVERITY BUT HAVE BEEN STABILIZED.

21.210.61 LEVEL 1 SERVICE PROVISIONS

A. ~~B. Outpatient~~ LEVEL 1 services shall be conducted IN REGULARLY SCHEDULED SESSIONS OF ~~with a frequency of~~ FEWER THAN nine (9) ~~or less substance use disorder education~~ treatment contact hours per week for adults, and FEWER THAN six (6) ~~or less substance use disorder education/~~treatment contact hours per week for youth.

~~C. Minimum frequency of treatment contact shall be one time per thirty (30) consecutive calendar days.~~

B.~~D.~~ AGENCIES PROVIDING LEVEL 1 SERVICES SHALL INFORM INDIVIDUALS RECEIVING SERVICES HOW TO ACCESS MEDICAL AND PSYCHIATRIC EMERGENCY SERVICES BY TELEPHONE TWENTY-FOUR (24) HOURS PER DAY, SEVEN (7) DAYS PER, INCLUDING BUT NOT LIMITED TO SERVICES PROVIDED BY THE BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM CREATED PURSUANT TO 27-60-103, C.R.S. ~~The ASAM Criteria Level 1 services are appropriate for individuals with co-occurring mental and substance-related disorders if, the disorders are of moderate severity, or have been resolved to an extent addiction treatment services are assessed as potentially beneficial.~~

C. AGENCIES PROVIDING LEVEL 1 SERVICES SHALL HAVE DIRECT AFFILIATION OR CLOSE COORDINATION THROUGH REFERRAL TO MORE INTENSE LEVELS OF CARE.

D. AGENCIES PROVIDING LEVEL 1 SERVICES SHALL ENSURE STAFF HAS PSYCHIATRIC AND MEDICAL CONSULTATION AVAILABLE WITHIN TWENTY-FOUR (24) HOURS BY TELEPHONE.

21.210.7 INTENSIVE OUTPATIENT/PARTIAL HOSPITALIZATION SUBSTANCE USE DISORDER SERVICES (LEVEL 2)

~~21.210.52~~ 21.210.71 INTENSIVE OUTPATIENT SUBSTANCE USE DISORDER SERVICES (~~THE ASAM CRITERIA~~ level 2.1) ~~(Intensive Outpatient Services)~~

A. LEVEL 2.1 ~~Intensive outpatient~~ services shall generally be intended for individuals who require a more structured substance use disorder outpatient treatment experience than can be received ~~from traditional~~ IN LEVEL 1 outpatient treatment. ~~Individuals may or may not have resources in the form of family, friends, employment or housing that provides support during the course of treatment. Intensive outpatient treatment may reflect an increase in treatment intensity, such as~~

~~outpatient to intensive outpatient, or a decrease in treatment intensity, such as residential to intensive outpatient treatment.~~

B. LEVEL 2.1 SERVICES ARE APPROPRIATE FOR INDIVIDUALS WITH CO-OCCURRING MENTAL AND SUBSTANCE-RELATED DISORDERS IF THE DISORDERS ARE OF MODERATE SEVERITY, OR ARE OF HIGHER SEVERITY BUT HAVE BEEN STABILIZED.

21.210.711 LEVEL 2.1 SERVICE PROVISIONS

A. ~~B. Intensive outpatient~~ LEVEL 2.1 services shall be conducted IN REGULARLY SCHEDULED SESSIONS THAT FOLLOW A PLANNED FORMAT OF TREATMENT SERVICES OF ~~with a minimum frequency of~~ nine (9) TO NINETEEN (19) ~~treatment~~ contact hours per week for adults and a ~~minimum frequency of~~ six (6) TO NINETEEN (19) ~~treatment~~ contact hours per week for youth.

B. ~~C. The ASAM Criteria Level 2 services are appropriate for individuals with co-occurring mental and substance-related disorders if, the disorders are of moderate severity, or have been resolved to an extent addiction treatment services are assessed as potentially beneficial.~~ AGENCIES PROVIDING LEVEL 2.1 SERVICES SHALL INFORM INDIVIDUALS RECEIVING SERVICES HOW TO ACCESS MEDICAL AND PSYCHIATRIC EMERGENCY SERVICES BY TELEPHONE TWENTY-FOUR (24) HOURS PER DAY, SEVEN (7) DAYS PER WEEK, INCLUDING BUT NOT LIMITED TO SERVICES PROVIDED BY THE BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM CREATED PURSUANT TO 27-60-103, C.R.S.

C. AGENCIES PROVIDING LEVEL 2.1 SERVICES SHALL HAVE DIRECT AFFILIATION OR CLOSE COORDINATION THROUGH REFERRAL TO MORE AND LESS INTENSE LEVELS OF CARE.

D. AGENCIES PROVIDING LEVEL 2.1 SERVICES SHALL ENSURE STAFF HAS PSYCHIATRIC AND MEDICAL CONSULTATION AVAILABLE WITHIN TWENTY-FOUR (24) HOURS BY TELEPHONE AND WITHIN SEVENTY-TWO (72) HOURS IN PERSON.

~~21.210.53~~ 2.210.72 PARTIAL HOSPITALIZATION SUBSTANCE USE DISORDER SERVICES (~~THE ASAM CRITERIA~~ Level 2.5) ~~(Partial Hospitalization Services)~~

A. ~~Partial hospitalization~~ LEVEL 2.5 SERVICES shall generally be intended for individuals who require DAILY MONITORING OR MANAGEMENT TO TREAT SUBSTANCE USE DISORDERS THAT CAN BE PROVIDED IN A STRUCTURED OUTPATIENT SETTING. SERVICES INCLUDE DIRECT ACCESS TO MEDICAL, PSYCHIATRIC, AND LABORATORY SERVICES. ~~more structured treatment for substance use disorders than can be provided by intensive outpatient treatment, but are not assessed as needing treatment in a residential setting. Individuals may or may not have resources in the form of family, friends, employment or housing that provides support during the course of treatment. Partial hospitalization may be a transition to or from more intensive residential settings.~~ LEVEL 2.5 SERVICE SITES FOR YOUTH INCLUDE ACCESS TO EDUCATIONAL SERVICES AND COORDINATION WITH A SCHOOL SYSTEM, AS APPROPRIATE.

B. LEVEL 2.5 SERVICES ARE APPROPRIATE FOR INDIVIDUALS WITH CO-OCCURRING MENTAL AND SUBSTANCE-RELATED DISORDERS IF THE DISORDERS ARE OF MODERATE SEVERITY, OR ARE OF HIGHER SEVERITY BUT HAVE BEEN STABILIZED. STAFF OF LEVEL 2.5 SERVICES SHALL UNDERSTAND THE SIGNS AND SYMPTOMS OF MENTAL HEALTH DISORDERS AND THE USES OF PSYCHOTROPIC MEDICATIONS AND THEIR INTERACTIONS WITH SUBSTANCE USE DISORDERS.

21.210.721 LEVEL 2.5 SERVICE PROVISIONS

A. ~~B.~~ ~~Partial Hospitalization~~ LEVEL 2.5 SERVICES shall be conducted with a minimum frequency of twenty (20) REGULARLY SCHEDULED treatment contact hours per week.

B. ~~C.~~ AGENCIES PROVIDING LEVEL 2.5 SERVICES SHALL INFORM INDIVIDUALS RECEIVING SERVICES HOW TO ACCESS MEDICAL AND PSYCHIATRIC EMERGENCY SERVICES BY TELEPHONE TWENTY-FOUR (24) HOURS PER DAY, SEVEN (7) DAYS PER WEEK WHEN THE PROGRAM IS NOT IN SESSION, INCLUDING BUT NOT LIMITED TO SERVICES PROVIDED BY THE BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM CREATED PURSUANT TO 27-60-103, C.R.S. ~~The ASAM Criteria Level 2 services are appropriate for individuals with co-occurring mental and substance-related disorders if, the disorders are of moderate severity, or have been resolved to an extent addiction treatment services are assessed as potentially beneficial.~~

C. AGENCIES PROVIDING LEVEL 2.5 SERVICES SHALL HAVE DIRECT AFFILIATION OR CLOSE COORDINATION THROUGH REFERRAL TO MORE AND LESS INTENSE LEVELS OF CARE.

D. AGENCIES PROVIDING LEVEL 2.5 SERVICES SHALL ENSURE STAFF HAS PSYCHIATRIC AND MEDICAL CONSULTATION AVAILABLE WITHIN EIGHT (8) HOURS BY TELEPHONE AND WITHIN FORTY-EIGHT (48) HOURS IN PERSON.

21.210.8 RESIDENTIAL/INPATIENT SUBSTANCE USE DISORDER SERVICES (LEVEL 3)

AGENCIES PROVIDING RESIDENTIAL/INPATIENT SUBSTANCE USE DISORDER SERVICES (LEVEL 3) SHALL CONSTRUCT AND MAINTAIN SOUND AND SIGHT BARRIERS BETWEEN MALE AND FEMALE INDIVIDUALS AND BETWEEN ADULT AND YOUTH IN BATHROOMS AND SLEEPING QUARTERS.

~~21.210.54~~ 21.210.81 ~~THE ASAM CRITERIA Level 3.1~~ (Clinically Managed Low-Intensity Residential SUBSTANCE USE DISORDER Services (LEVEL 3.1)

A. ~~This level of treatment~~ LEVEL 3.1 SERVICES shall generally be intended for individuals ~~who are transitioning to higher-intensity or lower-intensity levels of care and/or are reintegrating with the community, and~~ whose history of chronic substance use disorders, lack of ~~functional and~~ supportive living situations, ~~possible~~ unemployment, levels of social or psychological dysfunction and/OR lack of housing necessitates TWENTY-FOUR (24) HOUR STRUCTURE AND SUPPORT. ~~low-intensity residential treatment.~~ LEVEL 3.1 SERVICES ARE GENERALLY PROVIDED IN SETTINGS SUCH AS A HALFWAY HOUSE, GROUP HOME OR OTHER SUPPORTIVE LIVING ENVIRONMENT PROVIDING TWENTY-FOUR (24) HOUR STAFF AND CLOSE INTEGRATION WITH TREATMENT SERVICES.

B. LEVEL 3.1 SERVICES SHALL HAVE STAFF WHO ARE ABLE TO IDENTIFY THE SIGNS AND SYMPTOMS OF ACUTE PSYCHIATRIC CONDITIONS AND UNDERSTAND THE SIGNS AND SYMPTOMS OF MENTAL DISORDERS, THE USES OF PSYCHOTROPIC MEDICATION AND THEIR INTERACTION WITH SUBSTANCE USE DISORDERS. LEVEL 3.1 SERVICES SHALL HAVE THE CAPACITY TO ARRANGE FOR PSYCHIATRIC OR ADDICTION MEDICATIONS.

21.210.811 LEVEL 3.1 SERVICE PROVISIONS AND STAFFING

A. ~~B.~~ LEVEL 3.1 SERVICES SHALL BE REGULARLY SCHEDULED AND INCLUDE A MINIMUM ~~Clinically managed low-intensity residential services shall be conducted with a minimum frequency~~ of five (5) hours of planned ~~clinical~~ treatment activities per week.

B. ~~C.~~ AGENCIES PROVIDING LEVEL 3.1 SERVICES SHALL MAINTAIN AN ~~Resident~~ INDIVIDUAL to staff ratios ~~shall~~ not exceeding twenty to one (20:1) during nighttime hours, per agency site.

C. AGENCIES PROVIDING LEVEL 3.1 SERVICES SHALL PROVIDE TWENTY-FOUR (24) HOUR PER DAY SEVEN (7) DAYS PER WEEK ON-SITE STAFF. 24 HOUR ON-SITE STAFF SHALL BE TRAINED AND KNOWLEDGEABLE OF SUBSTANCE USE DISORDERS AND THE TREATMENT OF SUBSTANCE USE DISORDERS AND MAY INCLUDE:

1. CREDENTIALED PEER SUPPORT SPECIALISTS; OR,

2. ADDICTION COUNSELORS LEVEL I OR II (CAC I OR CAC II) CERTIFIED PURSUANT TO PART 8 OF ARTICLE 245 OF TITLE 12, C.R.S.

D. AGENCIES PROVIDING LEVEL 3.1 SERVICES SHALL HAVE AT LEAST ONE (1) CLINICAL STAFF TRAINED AND KNOWLEDGEABLE OF SUBSTANCE USE DISORDERS, THE TREATMENT OF SUBSTANCE USE DISORDERS AND ABLE TO MONITOR AND IDENTIFY PSYCHIATRIC CONDITIONS AVAILABLE BY TELEPHONE TWENTY-FOUR (24) HOURS A DAY SEVEN (7) DAYS PER WEEK AND AVAILABLE TO BE ON-SITE WITHIN 30 MINUTES. TRAINED CLINICAL STAFF SHALL BE:

1. CERTIFIED AS A CAC III OR LICENSED AS AN ADDICTION COUNSELOR PURSUANT TO PART 8 OF ARTICLE 245 OF TITLE 12, C.R.S.;

2. A PHYSICIAN LICENSED PURSUANT TO ARTICLE 240 OF TITLE 12, C.R.S.;

3. A PSYCHOLOGIST LICENSED PURSUANT TO PART 3 OF ARTICLE 245 OF TITLE 12, C.R.S.;

4. AN ADVANCED PRACTICE NURSE LICENSED PURSUANT TO SECTION 12-255-111, C.R.S.; OR,

5. A LICENSED CLINICAL SOCIAL WORKER, LICENSED MARRIAGE AND FAMILY THERAPIST, OR LICENSED PROFESSIONAL COUNSELOR LICENSED UNDER PART 4, 5, OR 6 OF ARTICLE 245 OF TITLE 12, C.R.S.

~~D. Residential facilities delivering The ASAM Criteria Level 3 services shall construct and maintain sound and sight barriers between male and female individuals, and between adult and adolescents in bathrooms and sleeping quarters.~~

E. AGENCIES PROVIDING LEVEL 3.1 SERVICES SHALL HAVE DIRECT AFFILIATION OR CLOSE COORDINATION THROUGH REFERRAL TO MORE AND LESS INTENSE LEVELS OF CARE.

F. AGENCIES PROVIDING LEVEL 3.1 SERVICES SHALL ENSURE STAFF HAVE TELEPHONE OR IN-PERSON CONSULTATION WITH A PHYSICIAN AND EMERGENCY SERVICES AVAILABLE TWENTY-FOUR (24) HOURS A DAY, SEVEN (7) DAYS A WEEK.

~~21.210.55 THE ASAM CRITERIA Level 3.2-WM (Clinically Managed Residential Withdrawal Management)~~

~~A. A non-hospital (non-medical) residential withdrawal management unit is an organized service that may be delivered by trained staff, who provide twenty-four (24) hour supervision, observation and support for individuals who are intoxicated or experiencing withdrawal.~~

~~B. Individual to staff ratios shall not exceed ten to one (10:1); and,~~

~~1. Procedures for responding to periods of high client-traffic and/or emergency situations shall be conspicuously posted.~~

~~2. Each shift shall have a minimum of two (2) staff members, whenever one (1) or more consumers are present.~~

~~C. This level provides care for individuals whose intoxication/withdrawal signs and symptoms are sufficiently severe to require twenty four (24) hour structure and support. However the full resources of a Level 3.7-WM medically monitored inpatient withdrawal management service are not necessary.~~

~~D. This level is staffed to supervise self-administered medications for the management of withdrawal. All programs at this level rely on established clinical protocols to identify individuals who are in need of medical services beyond the capacity of the facility and to transfer such individuals to more appropriate levels of care.~~

~~21.210.56~~ 21.210.82 ~~THE ASAM CRITERIA Level 3.3 (~~Clinically Managed Population-Specific High-Intensity Residential SUBSTANCE USE DISORDER Services (LEVEL 3.3)

A. LEVEL 3.3 SERVICES ARE ~~Frequently referred to as extended or long-term care, this level of care provides~~ a structured recovery environment in combination with high-intensity clinical services to support recovery from substance-related disorders.

B. LEVEL 3.3 IS APPROPRIATE FOR INDIVIDUALS WHO ARE UNABLE TO BENEFIT FROM OUTPATIENT SERVICES OR SERVICES IN GENERAL SETTINGS BECAUSE OF COGNITIVE IMPAIRMENTS THAT RESULT IN FUNCTIONAL LIMITATIONS. ~~The functional deficits seen in individuals who are appropriate for this level of care are primarily cognitive and can be either temporary or permanent.~~ TREATMENT IS FOCUSED ON PREVENTING RELAPSE, CONTINUED PROBLEMS AND/OR CONTINUED USE, AND PROMOTING THE EVENTUAL REINTEGRATION OF THE INDIVIDUAL INTO THE COMMUNITY. THERAPEUTIC REHABILITATION FACILITIES OR TRAUMATIC BRAIN INJURY PROGRAMS ARE EXAMPLES OF THIS LEVEL OF CARE.

21.210.821 LEVEL 3.3 SERVICE PROVISIONS AND STAFFING

A. ~~C.~~ AGENCIES PROVIDING LEVEL 3.3 SERVICES SHALL DELIVER TREATMENT SERVICES IN A MANNER THAT IS MATCHED TO THE INDIVIDUAL'S FUNCTIONING AND MAY BE PROVIDED IN A DELIBERATELY REPETITIVE FASHION TO ADDRESS THE SPECIAL COGNITIVE NEEDS OF INDIVIDUALS FOR WHOM THIS LEVEL OF CARE IS CONSIDERED A MEDICAL NECESSITY. ~~Some individuals have such severe deficits in interpersonal and coping skills that the treatment process is one of "habilitation" rather than "rehabilitation".~~

~~D. Services may be provided in a deliberately repetitive fashion to address the special cognitive needs of individuals for whom this level of care is considered a medical necessity.~~

~~E. Treatment is focused on preventing relapse, continued problems and/or continued use, and promoting the eventual reintegration of the individual into the community.~~

B. ~~F.~~ AGENCIES SHALL PROVIDE DAILY SCHEDULED LEVEL 3.3 SERVICES AND INCLUDE ~~Clinically managed population-specific high-intensity Residential Services shall be conducted with~~ a minimum ~~frequency~~ of nine (9) hours of planned ~~clinical~~ treatment ~~activities~~ SERVICES per week.

~~G. A nursing home is widely identified as an example of this level of care.~~

C. ~~H.~~ AGENCIES PROVIDING LEVEL 3.3 SERVICES SHALL MAINTAIN ~~Resident~~ INDIVIDUAL to staff ratios ~~shall~~ not ~~exceed~~ EXCEEDING twenty to one (20:1) during nighttime hours, per agency site. STAFF SHALL INCLUDE:

1. AT LEAST ONE (1) CLINICAL STAFF TRAINED AND KNOWLEDGEABLE OF SUBSTANCE USE DISORDERS, THE TREATMENT SUBSTANCE USE DISORDERS AND ABLE TO MONITOR AND IDENTIFY PSYCHIATRIC CONDITIONS AVAILABLE BY TELEPHONE TWENTY-FOUR (24) HOURS A DAY SEVEN (7) DAYS PER WEEK AND AVAILABLE TO BE ON-SITE WITHIN 30 MINUTES. TRAINED CLINICAL STAFF SHALL BE:

    a. CERTIFIED AS A CAC III OR LICENSED AS AN ADDICTION COUNSELOR PURSUANT TO PART 8 OF ARTICLE 245 OF TITLE 12, C.R.S.;

    b. A PHYSICIAN LICENSED PURSUANT TO ARTICLE 240 OF TITLE 12, C.R.S.;

    c. A PSYCHOLOGIST LICENSED PURSUANT TO PART 3 OF ARTICLE 245 OF TITLE 12, C.R.S.;

    d. AN ADVANCED PRACTICE NURSE LICENSED PURSUANT TO SECTION 12-255-111, C.R.S.; OR,

    e. A LICENSED CLINICAL SOCIAL WORKER, LICENSED MARRIAGE AND FAMILY THERAPIST, OR LICENSED PROFESSIONAL COUNSELOR LICENSED UNDER PART 4, 5, OR 6 OF ARTICLE 245 OF TITLE 12, C.R.S.

2. PEER SUPPORT PROFESSIONALS APPROPRIATELY CREDENTIALED IN COLORADO OR ADDICTION COUNSELORS LEVEL I OR II (CAC I OR CAC II) CERTIFIED PURSUANT TO PART 8 OF ARTICLE 245 OF TITLE 12, C.R.S.

3. A PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER AVAILABLE BY TELEPHONE OR IN-PERSON TWENTY-FOUR (24) HOURS A DAY, SEVEN (7) DAYS A WEEK TO PROVIDE MEDICAL EVALUATION AND CONSULTATION.

D. AGENCIES PROVIDING LEVEL 3.3 SERVICES SHALL HAVE DIRECT AFFILIATION OR CLOSE COORDINATION THROUGH REFERRAL TO MORE AND LESS INTENSE LEVELS OF CARE.

~~I. Residential facilities delivering The ASAM Criteria Level 3 services shall construct and maintain sound and sight barriers between male and female individuals, and between adult and adolescents in bathrooms and sleeping quarters.~~

~~21.210.57~~ 21.210.83 ~~THE ASAM CRITERIA Level 3.5~~ (Clinically Managed High-Intensity Residential SUBSTANCE USE DISORDER Services (LEVEL 3.5)

A. LEVEL 3.5 SERVICES PROVIDE A SAFE AND STABLE LIVING ENVIRONMENT WITH TREATMENT FOCUSED ON PROMOTING SKILLS NEEDED TO AVOID RELAPSE OR

CONTINUED USE. LEVEL 3.5 IS APPROPRIATE FOR INDIVIDUALS WITH MULTIPLE LIMITATIONS INCLUDING CRIMINAL ACTIVITY, PSYCHOLOGICAL PROBLEMS, IMPAIRED SOCIAL AND VOCATIONAL FUNCTIONING. ~~Individuals who are appropriately placed in this level of care typically have multiple deficits, which may include substance-related disorders and criminal activity.~~

B. TREATMENT IS DIRECTED TOWARD REDUCING RELAPSE RISK, ENHANCING PROSOCIAL BEHAVIORS AND REINTEGRATION INTO THE COMMUNITY. A VARIABLE LENGTH THERAPEUTIC COMMUNITY OR RESIDENTIAL TREATMENT CENTER ARE EXAMPLES OF THIS LEVEL OF CARE. ~~Such individuals generally can be characterized as having chaotic, non-supportive and often abusive interpersonal relationships; extensive treatment or criminal justice histories; chronic substance use disorders; limited work histories and educational experiences; and antisocial value systems.~~

~~C. Standard rehabilitation methods are inadequate to treat these individuals effectively. Effective treatment approaches are primarily habilitative in focus, addressing the individual's educational and vocational deficits, as well as his or her socially dysfunctional behavior.~~

~~D. This level of care may represent a step-down from Level 3.7 and the therapeutic community is also identified as an example of this level of care.~~

21.210.831 LEVEL 3.5 SERVICE PROVISIONS AND STAFFING

A. ~~E.~~ ~~Clinically Managed High-Intensity Residential Services~~ AGENCIES SHALL PROVIDE DAILY LEVEL 3.5 SERVICES ~~shall be~~ AND INCLUDE a minimum ~~frequency~~ of ~~five (5)~~ TEN (10) hours of planned ~~clinical~~ treatment ~~activities~~ SERVICES per week.

B. ~~F.~~ AGENCIES PROVIDING LEVEL 3.5 SERVICES SHALL MAINTAIN ~~Resident~~ INDIVIDUAL to staff ratios ~~shall~~ not ~~exceed~~ EXCEEDING twenty to one (20:1) during nighttime hours, per agency site AND EACH SHIFT SHALL HAVE A MINIMUM OF TWO (2) STAFF MEMBERS, WHENEVER ONE (1) OR MORE INDIVIDUALS ARE PRESENT. STAFF SHALL INCLUDE:

1. AT LEAST ONE (1) CLINICAL STAFF TRAINED AND KNOWLEDGEABLE OF SUBSTANCE USE DISORDERS, THE TREATMENT SUBSTANCE USE DISORDERS AND ABLE TO MONITOR AND IDENTIFY PSYCHIATRIC CONDITIONS AVAILABLE TWENTY-FOUR (24) HOURS A DAY SEVEN (7) DAYS PER WEEK. TRAINED CLINICAL STAFF SHALL BE:

    a. CERTIFIED AS A CAC III OR LICENSED AS AN ADDICTION COUNSELOR PURSUANT TO PART 8 OF ARTICLE 245 OF TITLE 12, C.R.S.;

    b. A PHYSICIAN LICENSED PURSUANT TO ARTICLE 240 OF TITLE 12, C.R.S.;

    c. A PSYCHOLOGIST LICENSED PURSUANT TO PART 3 OF ARTICLE 245 OF TITLE 12, C.R.S.;

    d. AN ADVANCED PRACTICE NURSE LICENSED PURSUANT TO SECTION 12-255-111, C.R.S.; OR,

    e. A LICENSED CLINICAL SOCIAL WORKER, LICENSED MARRIAGE AND FAMILY THERAPIST, OR LICENSED PROFESSIONAL LICENSED UNDER PART 4, 5, OR 6 OF ARTICLE 245 OF TITLE 12, C.R.S.

2. PEER SUPPORT PROFESSIONALS APPROPRIATELY CREDENTIALED IN COLORADO OR ADDICTION COUNSELORS LEVEL I OR II (CAC I OR CAC II) CERTIFIED PURSUANT TO PART 8 OF ARTICLE 245 OF TITLE 12, C.R.S.

3. A PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER AVAILABLE TO PROVIDE MEDICAL EVALUATION AND CONSULTATION AND ASSESS AND TREAT CO-OCCURRING BIOMEDICAL DISORDERS, AS WELL AS PRESCRIBE AND MONITOR THE ADMINISTRATION OF MEDICATIONS.

C. AGENCIES PROVIDING LEVEL 3.5 SERVICES SHALL HAVE DIRECT AFFILIATION OR CLOSE COORDINATION THROUGH REFERRAL TO MORE AND LESS INTENSE LEVELS OF CARE.

~~G. Residential facilities delivering The ASAM Criteria Level 3 services shall construct and maintain sound and sight barriers between male and female individuals, and between adult and adolescents in bathrooms and sleeping quarters.~~

~~21.210.58~~ 21.210.84 ~~THE ASAM CRITERIA Level 3.7 (~~Medically Monitored Intensive Inpatient SUBSTANCE USE DISORDER Services (LEVEL 3.7)

A. LEVEL 3.7 SERVICES PROVIDE A PLANNED AND STRUCTURED REGIMEN OF TWENTY-FOUR (24) HOUR EVALUATION, OBSERVATION, MEDICAL MONITORING AND ADDICTION TREATMENT. ~~Medically monitored treatment shall generally be intended for individuals with significant substance use disorders who may also have extensive criminal and treatment histories, treatment failures in less intensive settings, psychological problems and impaired functioning meriting short-term, high-intensity residential treatment that may include a community re-entry phase.~~

B. LEVEL 3.7 SERVICES ARE APPROPRIATE FOR INDIVIDUALS WHOSE MEDICAL, EMOTIONAL, BEHAVIORAL OR COGNITIVE PROBLEMS ARE SO SEVERE THAT THEY REQUIRE TWENTY-FOUR (24) HOUR MEDICAL MONITORING BUT DO NOT NEED THE FULL RESOURCES OF AN ACUTE CARE GENERAL HOSPITAL OR MEDICALLY MANAGED INPATIENT TREATMENT PROGRAM (LEVEL 4). TREATMENT IS DESIGNED FOR INDIVIDUALS WHO HAVE FUNCTIONAL LIMITATIONS IN THE AREAS OF INTOXICATION/WITHDRAWAL POTENTIAL; BIOMEDICAL CONDITIONS; OR EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS.

21.210.841 LEVEL 3.7 SERVICE PROVISIONS AND STAFFING

A. ~~B.~~ LEVEL 3.7 SERVICES SHALL BE SCHEDULED DAILY AND INCLUDE A MINIMUM OF TWENTY (20) HOURS OF PLANNED TREATMENT ACTIVITIES PER WEEK. ~~Medically monitored intensive residential treatment shall be conducted with a minimum frequency of twenty (20) treatment contact hours per week.~~

B. ~~C.~~ AGENCIES PROVIDING LEVEL 3.7 SERVICES SHALL MAINTAIN ~~Resident~~ INDIVIDUAL to staff ratios ~~shall~~ not ~~exceed~~ EXCEEDING twenty to one (20:1) during nighttime hours, per agency site AND EACH SHIFT SHALL HAVE A MINIMUM OF TWO (2) STAFF MEMBERS, WHENEVER ONE (1) OR MORE INDIVIDUALS ARE PRESENT.

C. ~~D.~~ LEVEL 3.7 SERVICES SHALL BE STAFFED WITH A TEAM THAT THAT INCLUDES PHYSICIANS, NURSES AND BEHAVIORAL HEALTH PROFESSIONAL LICENSED PURSUANT TO ARTICLE 245 OF TITLE 12, C.R.S. THAT PROVIDE 24-HOUR PROFESSIONALLY DIRECTED EVALUATION, CARE AND TREATMENT SERVICES INCLUDING

ADMINISTRATION OF PRESCRIBED MEDICATIONS, WITHDRAWAL MANAGEMENT AND INTEGRATED TREATMENT OF CO-OCCURRING MEDICAL, EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS. ~~Residential facilities delivering The ASAM Criteria Level 3 services shall construct and maintain sound and sight barriers between male and female individuals, and between adult and adolescents in bathrooms and sleeping quarters.~~

D. A LICENSED PHYSICIAN SHALL OVERSEE TREATMENT AND ASSURE QUALITY OF CARE IN LEVEL 3.7 SERVICES. A PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER SHALL PERFORM PHYSICAL EXAMINATIONS FOR ALL INDIVIDUALS ADMITTED. EXAMINATIONS SHALL OCCUR WITHIN 24 HOURS OF ADMISSION AND THEREAFTER AS NECESSARY.

E. A REGISTERED NURSE CONDUCTS AN ALCOHOL OR OTHER DRUG-FOCUSED NURSING ASSESSMENT AT THE TIME OF ADMISSION.

F. A LICENSED NURSE IS RESPONSIBLE FOR MONITORING THE INDIVIDUAL'S PROGRESS AND OR MEDICATION ADMINISTRATION TWENTY-FOUR (24) HOURS A DAY SEVEN (7) DAYS A WEEK.

G. ADDITIONAL MEDICAL SPECIALTY CONSULTATION, PSYCHOLOGICAL, LABORATORY AND TOXICOLOGY SERVICES ARE AVAILABLE ON-SITE THROUGH CONSULTATION OR REFERRAL. PSYCHIATRIC SERVICES ARE AVAILABLE ON-SITE THROUGH CONSULTATION OR REFERRAL WITHIN EIGHT (8) HOURS BY TELEPHONE OR TWENTY-FOUR (24) HOURS IN PERSON.

~~21.210.59 THE ASAM CRITERIA Level 3.7-WM (Medically Monitored Inpatient Withdrawal Management)~~

~~This level of care is an organized service delivered by medical and nursing professionals, which provides for twenty-four (24) hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds.~~

21.210.9 WITHDRAWAL MANAGEMENT SERVICES

21.210.91 CLINICALLY MANAGED RESIDENTIAL WITHDRAWAL MANAGEMENT (LEVEL 3.2-WM)

A. LEVEL 3.2-WM PROGRAMS SHALL PROVIDE TWENTY-FOUR (24) HOUR SUPERVISED WITHDRAWAL FROM ALCOHOL AND/OR OTHER DRUGS IN A RESIDENTIAL SETTING.

B. LEVEL 3.2-WM PROGRAMS SHALL PROVIDE COLLABORATION AND COORDINATION WITH EMERGENCY MENTAL HEALTH SERVICES AS NEEDED.

C. LEVEL 3.2-WM PROGRAMS SHALL OBTAIN A CONTROLLED SUBSTANCE LICENSE FROM THE OFFICE OF BEHAVIORAL HEALTH IF THE PROGRAM PLANS TO DISPENSE, COMPOUND, OR ADMINISTER A CONTROLLED SUBSTANCE IN ORDER TO TREAT A SUBSTANCE USE DISORDER OR TO TREAT THE WITHDRAWAL SYMPTOMS OF A SUBSTANCE USE DISORDER.

D. LEVEL 3.2-WM PROGRAMS SHALL DEVELOP AND IMPLEMENT POLICIES AND PROCEDURES IN ACCORDANCE WITH FEDERAL AND STATE REGULATIONS, DEPARTMENT RULES, AND IN CONSULTATION WITH MEDICAL PROFESSIONALS QUALIFIED IN SUBSTANCE USE DISORDERS. POLICIES AND PROCEDURES MUST ADDRESS BUT ARE NOT LIMITED TO:

1. HANDLING INDIVIDUALS WHO ARE ASSESSED AS BEING A CURRENT THREAT TO THEMSELVES OR OTHERS AND SHALL INCLUDE APPROPRIATE USES OF LAW ENFORCEMENT AND MONITOR ANY USE OF INDIVIDUAL RESTRAINT AND/OR SECLUSION.

2. COMMUNICATION WITH INTOXICATED INDIVIDUALS LEAVING TREATMENT AGAINST STAFF RECOMMENDATIONS, INCLUDING THE USE OF EMERGENCY COMMITMENTS.

3. CIRCUMSTANCES UNDER WHICH INDIVIDUALS SHALL BE DISCHARGED, OTHER THAN COMPLETING WITHDRAWAL MANAGEMENT OR LEAVING AGAINST STAFF RECOMMENDATIONS.

21.210.911 LEVEL 3.2-WM ADMISSION AND MONITORING

A. INDIVIDUALS ADMITTED TO LEVEL 3.2-WM SERVICES SHALL BE INTOXICATED, UNDER THE INFLUENCE, OR IN ANY STAGE OF WITHDRAWAL FROM ALCOHOL AND/OR OTHER DRUGS.

B. LEVEL 3.2-WM ADMISSION PROCEDURES SHALL INCLUDE AT A MINIMUM:

1. DEGREE OF ALCOHOL AND OTHER DRUG INTOXICATION AS EVIDENCED BY BREATHALYZER, URINALYSIS, SELF-REPORT, OBSERVATION OR OTHER EVIDENCE-BASED OR BEST PRACTICES;

2. INITIAL VITAL SIGNS;

3. NEED FOR EMERGENCY MEDICAL AND/OR PSYCHIATRIC SERVICES;

4. INVENTORYING AND SECURING PERSONAL BELONGINGS;

5. SUBSTANCE USE DISORDER HISTORY AND THE DEGREE TO WHICH THE USE OF SUBSTANCE AFFECTS PERSONAL AND SOCIAL FUNCTIONING, AS SOON AS CLINICALLY FEASIBLE FOLLOWING ADMISSION;

6. PREGNANCY SCREENING;

7. ADMINISTRATION OF A VALIDATED CLINICAL WITHDRAWAL ASSESSMENT TOOL.

C. WITHDRAWAL MANAGEMENT MONITORING OF INDIVIDUALS SHALL INCLUDE:

1. ROUTINE MONITORING OF PHYSICAL AND MENTAL STATUS INCLUDING OBSERVATION OF INDIVIDUAL;

2. VITAL SIGNS TAKEN AT LEAST EVERY TWO (2) HOURS UNTIL THEY REMAIN AT THE PERSON'S BASELINE FOR AT LEAST FOUR (4) HOURS, AND THEN TAKEN EVERY EIGHT (8) HOURS THEREAFTER UNTIL DISCHARGE.

3. DOCUMENTATION PER SHIFT TO INCLUDE ALL INDIVIDUAL MONITORING ACTIVITIES.

21.210.912 LEVEL 3.2-WM SERVICE PLANNING

A. LEVEL 3.2-WM PROGRAMS SHALL DEVELOP AND IMPLEMENT SERVICE PLANS IN ACCORDANCE WITH SECTION 21.190.4 AND ADDRESS SAFE WITHDRAWAL, MOTIVATIONAL COUNSELING, AND REFERRAL FOR TREATMENT.

B. LEVEL 3.2-WM PROGRAMS SHALL PROVIDE ADDITIONAL SERVICE PLANNING FOR MANAGING INDIVIDUALS WITH MEDICAL CONDITIONS, SUICIDAL IDEATION, PREGNANCY, PSYCHIATRIC CONDITIONS, AND OTHER CONDITIONS, WHICH PLACE INDIVIDUALS AT ADDITIONAL RISK DURING WITHDRAWAL MANAGEMENT.

C. LEVEL 3.2-WM PROGRAMS SHALL PROVIDE ASSESSMENTS OF INDIVIDUAL READINESS FOR TREATMENT AND INTERVENTIONS BASED ON THE SERVICE PLAN AND THE ASSESSMENTS SHALL BE DOCUMENTED IN THE INDIVIDUAL'S RECORD.

21.210.913 LEVEL 3.2-WM DISCHARGE

A. LEVEL 3.2-WM PROGRAMS SHALL PROVIDE DISCHARGE INFORMATION TO INDIVIDUALS AND DOCUMENTED IN THE INDIVIDUAL'S RECORDS THE REQUIREMENTS ESTABLISHED IN SECTION 21.190.6, AND:

1. EFFECTS OF ALCOHOL AND OTHER DRUGS;

2. RISK FACTORS ASSOCIATED WITH ALCOHOL AND OTHER DRUG ABUSE FOR ACQUIRING AND TRANSMITTING HIV/AIDS (HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME), TUBERCULOSIS, AND OTHER INFECTIOUS DISEASES, AND FOR PREGNANCY;

3. AVAILABILITY OF TESTING AND PRE/POST-TEST COUNSELING FOR HIV/AIDS, TB, HEPATITIS C AND OTHER INFECTIOUS DISEASES, AND PREGNANCY;

4. AVAILABILITY OF ALCOHOL AND OTHER DRUG ABUSE TREATMENT SERVICES.

21.210.914 LEVEL 3.2-WM STAFF REQUIREMENTS

A. AT LEAST FIFTY PERCENT (50%) OF WITHDRAWAL MANAGEMENT STAFF INCLUDING ON-CALL STAFF SHALL CONSIST OF CERTIFIED ADDICTION COUNSELORS OR STAFF IN THE PROCESS OF OBTAINING CERTIFICATION. PLANS FOR CERTIFICATION SHALL BE AVAILABLE FOR REVIEW. FULL-TIME STAFF SHALL OBTAIN AT LEAST A CAC I WITHIN EIGHTEEN (18) MONTHS OF EMPLOYMENT.

B. UNCERTIFIED STAFF OR STAFF WITHOUT A PLAN FOR CERTIFICATION SHALL NOT COMPRISE MORE THAN FIFTY PERCENT (50%) OF TOTAL WITHDRAWAL MANAGEMENT STAFF.

C. LEVEL 3.2-WM PROGRAMS' INDIVIDUAL TO STAFF RATIOS SHALL NOT EXCEED TEN TO ONE (10:1); AND,

1. PROCEDURES FOR RESPONDING TO PERIODS OF HIGH CENSUS AND/OR EMERGENCY SITUATIONS SHALL BE CONSPICUOUSLY POSTED.

2. EACH SHIFT SHALL HAVE A MINIMUM OF TWO (2) STAFF MEMBERS, WHENEVER ONE (1) OR MORE INDIVIDUALS ARE PRESENT.

D. THE STAFF PERSON OVERSEEING DAY-TO-DAY OPERATIONS SHALL BE:

1. CERTIFIED AS A CAC III OR LICENSED AS AN ADDICTION COUNSELOR PURSUANT TO PART 8 OF ARTICLE 245 OF TITLE 12, C.R.S.;

2. A PHYSICIAN LICENSED PURSUANT TO ARTICLE 240 OF TITLE 12, C.R.S.;

3. A PSYCHOLOGIST LICENSED PURSUANT TO PART 3 OF ARTICLE 245 OF TITLE 12, C.R.S.;

4. AN ADVANCED PRACTICE NURSE LICENSED PURSUANT TO SECTION 12-255-111, C.R.S.; OR,

5. A LICENSED CLINICAL SOCIAL WORKER, LICENSED MARRIAGE AND FAMILY THERAPIST, OR LICENSED PROFESSIONAL COUNSELOR LICENSED UNDER PART 4, 5, OR 6 OF ARTICLE 245 OF TITLE 12, C.R.S.

E. LEVEL 3.2-WM PROGRAMS SHALL PROVIDE TWENTY-FOUR (24) HOUR PER DAY SEVEN (7) DAYS PER WEEK ON-SITE STAFF. 24 HOUR ON-SITE STAFF SHALL BE TRAINED AND KNOWLEDGEABLE OF SUBSTANCE USE DISORDERS AND THE TREATMENT OF SUBSTANCE USE DISORDERS AND MAY INCLUDE:

1. CREDENTIALED PEER SUPPORT SPECIALISTS; OR,

2. ADDICTION COUNSELORS LEVEL I OR II (CAC I OR CAC II) CERTIFIED PURSUANT TO PART 8 OF ARTICLE 245 OF TITLE 12, C.R.S.

F. PROGRAMS SHALL MAINTAIN DOCUMENTATION THAT ALL DIRECT CARE STAFF HAVE TRAINING IN, AND/OR BE EVALUATED AS HAVING KNOWLEDGE OF, THE FOLLOWING BEFORE PROVIDING INDEPENDENT SERVICES:

1. WITHDRAWAL MANAGEMENT;

2. INFECTIOUS DISEASES (AIDS/HIV, HEPATITIS C, TB), INCLUDING UNIVERSAL PRECAUTIONS AGAINST BECOMING INFECTED;

3. ADMINISTERING CARDIOPULMONARY RESUSCITATION (CPR) AND FIRST AID;

4. MONITORING VITAL SIGNS;

5. CONDUCTING ASSESSMENT AND TRIAGE, INCLUDING IDENTIFYING SUICIDAL IDEATION;

6. EMERGENCY PROCEDURES AND THEIR IMPLEMENTATION;

7. COLLECTING URINE, AND BREATH SAMPLES;

8. CULTURAL FACTORS THAT IMPACT WITHDRAWAL MANAGEMENT;

9. ETHICS AND CONFIDENTIALITY;

10. INDIVIDUAL RECORDS SYSTEMS;

11. DE-ESCALATING POTENTIALLY DANGEROUS SITUATIONS; AND,

12. BASIC COUNSELING AND MOTIVATIONAL INTERVIEWING SKILLS.

21.210.92 MEDICALLY MONITORED INPATIENT WITHDRAWAL MANAGEMENT (LEVEL 3.7-WM)

LEVEL 3.7-WM SERVICES SHALL BE PROVIDED BY LICENSED MEDICAL STAFF QUALIFIED TO SUPERVISE WITHDRAWAL FROM ALCOHOL AND OTHER DRUGS THROUGH USE OF MEDICATION AND/OR MEDICAL PROCEDURES IN RESIDENTIAL SETTINGS WHICH POSSESS CONTROLLED SUBSTANCES LICENSES IN COMPLIANCE WITH TITLE 27, ARTICLE 80, PART 2, C.R.S.

21.210.921 LEVEL 3.7-WM ADMISSION AND EVALUATION

A. LEVEL 3.7-WM PROGRAMS SHALL DEVELOP AND IMPLEMENT SPECIFIC ADMISSION CRITERIA DETAIL FOR WHICH DRUGS, INCLUDING ALCOHOL, MEDICAL WITHDRAWAL MANAGEMENT IS PROVIDED.

B. IN ADDITION TO THE CONSENT REQUIREMENTS ESTABLISHED IN 21.170.2, LEVEL 3.7-WM PROGRAMS SHALL PROVIDE INFORMED CONSENT TO MEDICAL WITHDRAWAL MANAGEMENT THAT INCLUDE:

1. MEDICATIONS TO BE USED;

2. NEED TO CONSULT WITH PRIMARY CARE PHYSICIANS.

C. LEVEL 3.7-WM PROGRAMS SHALL PROVIDE MEDICAL EVALUATIONS BY PHYSICIANS LICENSED PURSUANT TO ARTICLE 240 OF TITLE 12, C.R.S. OR AUTHORIZED HEALTH-CARE PROFESSIONALS UNDER THE SUPERVISION OF AUTHORIZED PHYSICIANS SHALL BE REQUIRED AND SHALL CONSIST OF, AT MINIMUM:

1. MEDICAL HISTORIES INCLUDING DETAILED CHRONOLOGIES OF SUBSTANCE USE DISORDERS;

2. IDENTIFICATION OF CURRENT PHYSICAL ADDICTION INCLUDING DRUG TYPES;

3. PHYSICAL EXAMINATIONS TO DETERMINE APPROPRIATENESS FOR OUTPATIENT OR INPATIENT MEDICAL WITHDRAWAL MANAGEMENT;

4. APPROPRIATE LABORATORY TESTS INCLUDING PREGNANCY TESTS, AND OTHER EVALUATIONS AS INDICATED.

D. LEVEL 3.7-WM SERVICE PROTOCOLS FOR USUAL AND CUSTOMARY WITHDRAWAL MANAGEMENT FROM EACH DRUG DELINEATED IN THE ADMISSION CRITERIA SHALL BE DEVELOPED IN CONSULTATION WITH LICENSED PHYSICIANS AND OTHER ALLIED HEALTH-CARE PROFESSIONALS AND SHALL BE IMPLEMENTED IN THE FORM OF INDIVIDUALIZED WITHDRAWAL MANAGEMENT PLANS UNDER DIRECT SUPERVISION OF PROGRAM MEDICAL DIRECTORS. PROTOCOLS SHALL INCLUDE:

1. TYPES OF INTOXICATION;

2. TOLERANCE LEVELS FOR THE INDIVIDUAL'S DRUG OF CHOICE;

3. DEGREES OF WITHDRAWAL;

4. POSSIBLE WITHDRAWAL AND/OR INTOXICATION COMPLICATIONS;

5. OTHER CONDITIONS AFFECTING MEDICAL WITHDRAWAL MANAGEMENT PROCEDURES;

6. TYPES OF MEDICATIONS USED;

7. RECOMMENDED DOSAGE LEVELS;

8. FREQUENCY OF VISITS (OUTPATIENT SETTINGS);

9. PROCEDURES TO FOLLOW IN THE EVENT OF WITHDRAWAL MANAGEMENT COMPLICATIONS;

10. DAILY ASSESSMENTS INCLUDING EXPECTED IMPROVEMENTS AS WELL AS POTENTIAL PROBLEMS;

11. EXPECTED DURATION OF WITHDRAWAL MANAGEMENT.

E. MEDICAL WITHDRAWAL MANAGEMENT PROGRAMS USING ANY CONTROLLED SUBSTANCES ARE REQUIRED TO HAVE CONTROLLED SUBSTANCE LICENSES ISSUED BY THE DEPARTMENT. BUPRENORPHINE IS THE ONLY MEDICATION THAT CAN BE USED FOR OPIOID DEPENDENT INDIVIDUALS UNLESS THE MEDICAL WITHDRAWAL MANAGEMENT PROGRAM IS LICENSED AS AN OPIOID TREATMENT PROGRAM AND IT HAS BEEN VERIFIED THROUGH THE PROGRAM AND COORDINATED WITH THE CSA.

F. AUTHORIZED PHYSICIANS MAY PRESCRIBE BUPRENORPHINE UNDER HIS/HER OWN DRUG ENFORCEMENT ADMINISTRATION (DEA) REGISTRATION NUMBER FOR INDIVIDUALS ADMITTED TO HOSPITAL FOR INPATIENT WITHDRAWAL MANAGEMENT OR ADDICTION TREATMENT.

G. WITHDRAWAL MANAGEMENT PROGRAMS MUST CONTINUE PATIENTS ON THEIR MEDICATION ASSISTED TREATMENT REGIMEN WHEN AVAILABLE AND WILL ONLY DETOX INDIVIDUALS FROM MEDICATIONS TREATING OPIOID USE DISORDERS AT THE PATIENT'S REQUEST OR IF IT IS DEEMED MEDICALLY NECESSARY.

21.210.922 LEVEL 3.7-WM CLINICAL STAFF

A. LEVEL 3.7-WM PROGRAMS SHALL PROVIDE, AT MINIMUM, THE FOLLOWING CLINICAL STAFF:

1. ONE MEDICAL DIRECTOR;

2. ONE REGISTERED NURSE OR LICENSED PRACTICAL NURSE (R.N. OR L.P.N.) WITH AT LEAST ONE YEAR OF WITHDRAWAL MANAGEMENT EXPERIENCE;

3. BEHAVIORAL HEALTH PROFESSIONALS, BEHAVIORAL HEALTH PROFESSIONALS SHALL BE:

a. AN ADDICTION COUNSELOR CERTIFIED AS CAC II, CAC III OR LICENSED PURSUANT TO PART 8 OF ARTICLE 245 OF TITLE 12, C.R.S.;

b. A PHYSICIAN LICENSED PURSUANT TO ARTICLE 240 OF TITLE 12, C.R.S.;

c. A PSYCHOLOGIST LICENSED PURSUANT TO PART 3 OF ARTICLE 245 OF TITLE 12, C.R.S.;

d. AN ADVANCED PRACTICE NURSE LICENSED PURSUANT TO SECTION 12-255-111, C.R.S.; OR,

e. A LICENSED CLINICAL SOCIAL WORKER, LICENSED MARRIAGE AND FAMILY THERAPIST, OR LICENSED PROFESSIONAL COUNSELOR LICENSED UNDER PART 4, 5, OR 6 OF ARTICLE 245 OF TITLE 12, C.R.S.

B. LEVEL 3.7-WM PROGRAM MEDICAL DIRECTORS' RESPONSIBILITIES SHALL INCLUDE, AT MINIMUM:

1. QUARTERLY REVIEWS AND REVISIONS OF DRUG WITHDRAWAL MANAGEMENT CATEGORIES AND PROTOCOLS;

2. REVIEWS OF INDIVIDUAL WITHDRAWAL MANAGEMENT PLANS;

3. REVIEWS OF INDIVIDUAL PRESCRIPTIONS THAT DEVIATE FROM STANDARD WITHDRAWAL MANAGEMENT PROTOCOLS;

4. FIVE HOURS MINIMUM OF MONTHLY SUPERVISION OF AND CONSULTATION WITH STAFF PROVIDING WITHDRAWAL MANAGEMENT SERVICES;

5. DIRECT SUPERVISION OF INDIVIDUAL WITHDRAWAL MANAGEMENT CASES THAT DEVIATE FROM STANDARD PROTOCOLS AND/OR EXPERIENCE COMPLICATIONS;

6. DEVELOPING AND IMPLEMENTING BACK-UP SYSTEMS FOR PHYSICIAN COVERAGE WHEN MEDICAL DIRECTORS ARE UNAVAILABLE AND/OR FOR EMERGENCIES.

C. LEVEL 3.7-WM PROGRAMS SHALL ENSURE TWENTY FOUR (24) HOUR ACCESS TO CLINICAL STAFF BY TELEPHONE AND ACCOMMODATION FOR UNSCHEDULED VISITS FOR CRISES OR PROBLEM SITUATIONS.

21.210.923 LEVEL 3.7-WM TREATMENT SERVICES

A. LEVEL 3.7-WM PROGRAMS SHALL PROVIDE THE FOLLOWING TREATMENT SERVICES IN ADDITION TO MEDICATION DOSING CONTACTS:

1. MOTIVATIONAL COUNSELING AND SUPPORT;

2. CONTINUOUS EVALUATION AND BEHAVIORAL HEALTH INTERVENTION; AND,

3. DEVELOPMENT AND MONITORING OF A SERVICE PLAN PER SECTION 21.190.4.

B. LEVEL 3.7-WM PROGRAMS SHALL ENSURE A MINIMUM OF ONE (1) DAILY CLINICAL SUPPORTIVE SERVICES CONTACT, WHICH SHALL BE DOCUMENTED IN INDIVIDUAL RECORDS.

21.210.924 LEVEL 3.7-WM DISPENSING AND ADMINISTRATION PROCEDURES

A. LEVEL 3.7-WM PROGRAMS SHALL DEVELOP AND IMPLEMENT POLICIES AND PROCEDURES FOR DISPENSING MEDICATIONS PER STANDARD WITHDRAWAL MANAGEMENT PROTOCOLS THAT ARE IN ACCORDANCE WITH APPLICABLE STATE AND FEDERAL STATUTES AND FOR THE FOLLOWING:

1. INDIVIDUAL PRESCRIPTIONS FILLED AND DISPENSED BY A REGISTERED PHARMACIST AT A DESIGNATED PHARMACY LOCATION;

2. INDIVIDUAL PRESCRIPTIONS FROM MEDICAL DIRECTORS THAT ARE FILLED FROM STOCK QUANTITIES.

B. LEVEL 3.7-WM PROGRAMS SHALL DEVELOP AND IMPLEMENT POLICIES AND PROCEDURES IN ACCORDANCE WITH APPLICABLE FEDERAL AND STATE STATUTES FOR STORING AND ACCOUNTING FOR ALL DRUGS INCLUDING CONTROLLED SUBSTANCES.

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~~**21.250 NON-HOSPITAL RESIDENTIAL Withdrawal Management**~~

~~**21.250.1 GENERAL PROVISIONS**~~

A. Non-hospital withdrawal management services shall provide twenty-four (24) hour supervised withdrawal from alcohol and/or other drugs in a residential setting.

B. Withdrawal management policies and procedures shall be developed and implemented in accordance with federal and state regulations, Department rules, and in consultation with medical professionals qualified in substance use disorders.

C. Programs shall provide collaboration and coordination with emergency mental health services as needed.

D. Individual to staff ratios shall not exceed ten to one (10:1); and,

1. Procedures for responding to periods of high client-traffic and/or emergency situations shall be conspicuously posted.

2. Each shift shall have a minimum of two (2) staff members, whenever one (1) or more consumers are present.

E. Policies and procedures shall be developed and implemented for handling individuals who are assessed as being a current threat to themselves or others and shall include appropriate uses of law enforcement and monitor any use of individual restraint and/or seclusion.

21.250.2 ADMISSION AND MONITORING

A. Individuals admitted to withdrawal management services shall be intoxicated, under the influence, or in any stage of withdrawal from alcohol and/or other drugs.

B. Withdrawal management admission procedures shall include at a minimum:

1. Degree of alcohol and other drug intoxication as evidenced by breathalyzer, urinalysis, self-report, observation or other evidence-based or best practices;

2. Initial vital signs;

3. Need for emergency medical and/or psychiatric services;

4. Inventorying and securing personal belongings;

5. Substance use disorder history and the degree to which the use of substance affects personal and social functioning, as soon as clinically feasible following admission;

6. Pregnancy screening;

7. Administration of a validated clinical withdrawal assessment tool.

C. Withdrawal management monitoring of individuals shall include:

1. Routine monitoring of physical and mental status including observation of individual;

2. Vital signs taken at least every two (2) hours until they remain at the person's baseline for at least four (4) hours, and then taken every eight (8) hours thereafter until discharge.

3. Documentation per shift to include all individual monitoring activities.

21.250.3 SERVICE PLANNING

A. Withdrawal management agencies shall develop and implement service plans in accordance with Section 21.190.4 and address safe withdrawal, motivational counseling, and referral for treatment.

B. Additional service planning shall be required for managing individuals with medical conditions, suicidal ideation, pregnancy, psychiatric conditions, and other conditions, which place individuals at additional risk during withdrawal management.

C. Assessments of individual readiness for treatment and interventions based on the service plan shall be documented in the record.

21.250.4 DISCHARGE

A. Discharge information provided to individuals and documented in records shall include Section 21.190.6 and:

1. Effects of alcohol and other drugs;

2. Risk factors associated with alcohol and other drug abuse for acquiring and transmitting HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome), tuberculosis, and other infectious diseases, and for pregnancy.

3. Availability of testing and pre/post-test counseling for HIV/AIDS, TB, Hepatitis C and other infectious diseases, and pregnancy;

4. Availability of alcohol and other drug abuse treatment services.

B. Discharge policies and procedures shall be developed and implemented including:

1. Assurance that blood alcohol levels no greater than 0.00 prior to discharge and vital signs within normal range;

2. Communication with intoxicated individuals leaving treatment against staff recommendations, including the use of emergency commitments.

3. Circumstances under which individuals shall be discharged, other than completing withdrawal management or leaving against staff recommendations.

21.250.5 STAFF REQUIREMENTS

A. At least fifty percent (50%) of withdrawal management staff including on-call staff shall consist of certified addiction counselors or staff in the process of obtaining certification. Plans for certification shall be available for review. Full-time staff shall obtain at least a CAC I within eighteen (18) months of employment.

B. Uncertified staff or staff without a plan for certification shall not comprise more than fifty percent (50%) of total withdrawal management staff.

C. The staff person overseeing day-to-day operations shall be:

1. Certified as a CAC III or licensed as an addiction counselor pursuant to Part 8 of Article 245 of Title 12, C.R.S.;

2. A physician licensed pursuant to Article 240 of Title 12, C.R.S.;

3. A psychologist licensed pursuant to Part 3 of Article 245 of Title 12, C.R.S.;

4. An advanced practice nurse licensed pursuant to Section 12-255-111, C.R.S.; or,

5. A licensed clinical social worker, licensed marriage and family therapist, or licensed professional counselor licensed under Part 4, 5, or 6 of Article 245 of Title 12, C.R.S. who by reason of postgraduate education and additional preparation has gained knowledge, judgement, and skill in substance use counseling, psychotherapy, or evaluation of substance use disorders.

D. There shall be documentation that all staff within ninety (90) consecutive calendar days of employment shall have training in, and/or be evaluated as having knowledge of, the following:

1. Infectious diseases (AIDS HIV, Hepatitis C, TB), including universal precautions against becoming infected;

2. Administering cardiopulmonary resuscitation (CPR) and First Aid;

3. Monitoring vital signs;

4. Conducting assessment and triage, including identifying suicidal ideation;

5. Emergency procedures and their implementation;

6. Collecting urine, and breath samples;

7. Cultural factors that impact withdrawal management;

8. Ethics and confidentiality;

9. Individual records systems;

10. De-escalating potentially dangerous situations;

11. Basic counseling and motivational interviewing skills.

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21.260 ALCOHOL AND DRUG EMERGENCY COMMITMENTS

B. The treatment facility administrator shall designate, in writing, qualified staff, who meet the criteria established in Section 21.210.914(B) 21.250.5(c), to assume responsibility for accepting, evaluating, informing, and providing treatment to individuals on emergency commitment.

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21.310 MEDICALLY MONITORED INPATIENT DETOXIFICATION

21.310.1 GENERAL PROVISIONS

Medical detoxification services shall be provided by licensed medical staff qualified to supervise withdrawal from alcohol and other drugs through use of medication and/or medical procedures in residential or outpatient settings which possess controlled substances licenses in compliance with Colorado Revised Statutes Title 12, Article 42.5, Part 1.

21.310.2 ADMISSION AND EVALUATION

A. Specific admission criteria shall be developed and implemented that detail for which drugs, including alcohol, medical detoxification is provided.

B. Informed consent to medical detoxification shall include:

1. Medications to be used;

2. Need to consult with primary care physicians.

C. Medical evaluations by physicians licensed pursuant to Article 36, Title 12, Colorado Revised Statutes Medical Practice Act, or authorized health-care professionals under the supervision of authorized physicians shall be required and shall consist of, at minimum:

1. Medical histories including detailed chronologies of substance use disorders;

2. Identification of current physical addiction including drug types;

3. Physical examinations to determine appropriateness for outpatient or inpatient medical detoxification;

4. Appropriate laboratory tests including pregnancy tests, and other evaluations as indicated.

D. Protocols for usual and customary detoxification from each drug delineated in admission criteria shall be developed in consultation with licensed physicians and other allied health-care professionals and shall be implemented in the form of individualized detoxification plans under direct supervision of program medical directors. Protocols shall include:

1. Types of intoxication;

2. Tolerance levels for the individual's drug of choice;

3. Degrees of withdrawal;

4. Possible withdrawal and/or intoxication complications;

5. Other conditions affecting medical detoxification procedures;

6. Types of medications used;

7. Recommended dosage levels;

8. Frequency of visits (outpatient settings);

9. Procedures to follow in the event of detoxification complications;

10. Daily assessments including expected improvements as well as potential problems;

11. Expected duration of detoxification.

E. Medical detoxification programs using any controlled substances are required to have controlled substance licenses issued by the Department. Buprenorphine is the only medication that can be used for opioid dependent individuals unless the medical detoxification program is licensed as an opioid treatment program and it has been verified through the program and coordinated with the CSA.

F. Authorized physicians may prescribe buprenorphine under his/her own Drug Enforcement Administration (DEA) registration number for individuals admitted to hospital for inpatient detoxification or addiction treatment.

21.310.3 CLINICAL STAFF

A. The following minimum clinical staff shall be provided:

1. One medical director;

2. One R.N. or L.P.N. with at least one year of detoxification experience;

3. Clinicians holding Colorado addiction counselor certifications at Levels II or III, or Colorado addiction counselor licenses, or appropriately credentialed per Section 21.330.

B. Medical directors' responsibilities shall include, at minimum:

1. Quarterly reviews and revisions of drug detoxification categories and protocols;

2. Reviews of individual detoxification plans;

3. Reviews of individual prescriptions that deviate from standard detoxification protocols;

4. Five hours minimum of monthly supervision of and consultation with staff providing detoxification services;

5. Direct supervision of individual detoxification cases that deviate from standard protocols and/or experience complications;

6. Developing and implementing back-up systems for physician coverage when medical directors are unavailable and/or for emergencies.

C. There shall be twenty four (24) hour access to clinical staff by telephone and accommodation for unscheduled visits for crises or problem situations.

21.310.4 TREATMENT SERVICES

A. The following treatment services shall be provided in addition to medication dosing contacts:

1. Motivational counseling and support;

2. Continuous evaluation and behavioral health intervention.

3. Development and monitoring of a service plan per Section 21.190.4.

B. There shall be a minimum of one (1) daily clinical supportive services contact, which shall be documented in individual records.

21.310.5 DISPENSING AND ADMINISTRATION PROCEDURES

A. There shall be procedures for dispensing medications per standard detoxification protocols that are in accordance with applicable state and federal statutes and for the following:

1. Individual prescriptions filled and dispensed by a registered pharmacist at a designated pharmacy location;

2. Individual prescriptions from medical directors that are filled from stock quantities.

B. There shall be procedures in accordance with applicable federal and state statutes for storing and accounting for all drugs including controlled substances.

Notice of Proposed Rulemaking

Tracking number

2020-00088

Department

1000 - Department of Public Health and Environment

Agency

1001 - Air Quality Control Commission

CCR number

5 CCR 1001-8

Rule title

REGULATION NUMBER 6 STANDARDS OF PERFORMANCE FOR NEW STATIONARY SOURCES

Rulemaking Hearing

Date

05/21/2020

Time

09:00 AM

Location

Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Sabin Conference Room

Subjects and issues involved

To consider revisions to incorporate by reference additions and changes to the U.S. Environmental Protection Agencys (EPA) New Source Performance Standards (NSPS), Emission Guidelines, and performance specifications in 40 C.F.R. Part 60. Specifically, the Division proposes to update the citation dates of the NSPS, Emissions Guidelines and Compliance Times, and performance specifications in Regulation Number 6, Part A.

Statutory authority

Sections 25-7-105(1)(b) and 25-7-109; 25-7-106(6); 24-4-103 and 25-7-110, 110.5 and 110.8 C.R.S., as applicable and amended.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Air Quality Control Commission

REGULATION NUMBER 6

Standards of Performance for New Stationary Sources

5 CCR 1001-8

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

PART A

Federal Register Regulations Adopted by Reference

The regulations promulgated by the United States Environmental Protection Agency (EPA) listed below, found in Part 60, Chapter I, Title 40 and Part 75, Chapter 1, Title 40 of the Code of Federal Regulations (CFR) and in effect as of the dates indicated, but not including later amendments, were adopted by the Colorado Air Quality Control Commission and are hereby incorporated by reference. Copies of the material incorporated by reference are available for public inspection during regular business hours at the Office of the Commission, located at 4300 Cherry Creek Drive South, Denver, Colorado 80246-1530. Parties wishing to inspect these materials should contact the Technical Secretary of the Commission, located at the Office of the Commission. The material incorporated by reference is also available through the United States Government Printing Office, online at www.gpo.gov/fdsys.

All new sources of air pollution and all modified or reconstructed sources of air pollution shall comply with the standards, criteria, and requirements set forth herein. For the purpose of this regulation, the word "Administrator" as used in Part 60, Chapter I, Title 40, of the CFR shall mean the Colorado Air Pollution Control Division, except that in the sections in Table 1, "Administrator" shall mean both the Administrator of the Environmental Protection Agency or his authorized representative and the Colorado Air Pollution Control Division. For the purpose of this regulation, the word "Administrator" as used in Part 75, Chapter 1, Title 40, shall mean the Administrator of the Environmental Protection Agency or his authorized representative for everything except mercury monitoring, recordkeeping and reporting requirements (separately addressed in Part B, Section VIII. of this Regulation Number 6. Other deviations from these federal standards, as presented in the CFR and which the Colorado Air Quality Control Commission ordered, are noted in the affected Subpart, and/or included in Part B of the Regulation. Table 2 identifies Part 75, Chapter I, Title 40 of the CFR requirements incorporated by reference.

TABLE 1

40 CFR Part 60 Subpart*	Section(s)
A	60.8(b)(2) and (b)(3) and those sections throughout the standards that reference 60.8(b)(2) and (b)(3), 60.11(b) and (e).
Da	60.45a.
Ka	60.114a.
Kb	60.111b(f)(4), 60.114b, 60.116b (e)(3)(iii) and (e)(3)(iv), 60.116b(f)(2)(iii).

40 CFR Part 60 Subpart*	Section(s)
S	60.195(b).
DD	60.302(d)(3).
GG	60.332(a)(3), 60.335(a).
VV	60.482-1(c)(2), 60.484.
WW	60.493(b)(2)(i)(A), 60.496(a)(1).
XX	60.502(e)(6).
GGG	60.592(c).
JJJ	60.623.
KKK	60.634.

*And any other section which 40 CFR Part 60 specifically states will not be delegated to the States.

Subpart A General Provisions. 40 CFR Part 60, Subpart A (July 1, ~~2018~~2019).

(See Part B of this Regulation Number 6 for Additional Requirements Regarding Modifications)

Subpart Cb Emission Guidelines and Compliance Times for Existing Sources: Municipal Waste Combustors That Are Constructed On or Before September 20, 1994. 40 CFR Part 60, Subpart Cb (July 1, ~~2018~~2019).

Subpart Cc Emission Guidelines and Compliance Times for Municipal Solid Waste Landfills. 40 CFR Part 60, Subpart Cc (July 1, ~~2018~~2019).

For clarification regarding requirements applicable to existing municipal solid waste landfills, designated facilities as defined in 40 CFR Part 60, Section 60.32c which meet the condition in 40 CFR Part 60, Section 60.33c(a)(1) shall submit to the Division an initial design capacity report and an initial emission rate report in accordance with 40 CFR Part 60, Section 60.757 within 90 days of the effective date of this regulation. If the design capacity report reflects that the facility meets the condition in 40 CFR Part 60, Section 60.33c(a)(2) and the initial NMOC emission rate report reflects that the facility meets the condition in 40 CFR Part 60, Section 60.33c(a)(3), the facility shall comply with the collection and control system requirements in 40 CFR Part 60, Section 60.752(b)(2)(ii), applicable control device requirements in 40 CFR Part 60, Section 60.33c(c)(1), (2) and (3), test methods and procedures requirements in 40 CFR 60.754, operational standards in 40 CFR Part 60, Section 60.753, compliance provisions in 40 CFR Part 60, Section 60.755, monitoring provisions in 40 CFR Part 60, Section 60.756 and reporting and recordkeeping provisions in 40 CFR Part 60, Sections 60.757 and 60.758, respectively. Such facilities must complete installation of air emission collection and control equipment capable of meeting the requirements of this subpart no later than 30 months from the effective date of these requirements or the date on which the source becomes subject to this subpart pursuant to 40 CFR Part 60, Section 60.36c(b) (the date on which the condition in 60.33c(a)(3) is met (i.e., the date of the first annual report in which the non-methane organic compounds emission rate equals or exceeds 50 megagrams per year)), whichever occurs later. These facilities must submit a final collection and control system design plan pursuant to 40 CFR Part 60, Section 60.757(c) within one year of the effective date of these requirements, which must be reviewed and approved by

the state. The final collection and control system design plan must specify: (1) the date by which contracts for control systems/process modifications shall be awarded, (which shall be no later than 20 months after the effective date); (2) the date by which on-site construction or installation of the air pollution control device(s) or process changes will begin, (which shall be no later than 24 months after the effective date); and (3) the date by which the construction or installation of the air pollution control device(s) or process changes will be complete (which shall be no later than 30 months after the effective date).

In addition, the plan shall include site-specific design plans for the gas collection and control system(s). These facilities shall comply with the approved final collection and control system design plan and shall demonstrate compliance with these emission standards in accordance with 40 CFR Part 60, Section 60.8 not later than 180 days following initial startup of the collection and control system.

~~The Commission designates the effective date of Colorado's 111(d) plan, including the state emission standard for existing municipal solid waste landfills, as the date on which the EPA promulgates a final rule approving the state plan under Section 111(d) of the Clean Air Act.~~On July 29, 1998, EPA approved Colorado's 111(d) plan that established performance standards for existing MSW landfills under 40 CFR Part 60, Subpart Cc. On May 21, 2020, the Commission adopted an updated 111(d) plan for existing MSW landfills. Upon approval by EPA, all landfills for which construction, reconstruction, or modification was commenced on or before July 17, 2014 ('existing' designated facilities) will be subject to the requirements of the updated 111(d) state plan. Sources previously subject to 40 CFR Subpart Cc will be subject instead to Subpart Cf on the effective date of the EPA approved 111(d) state plan.

Subpart Ce Emission Guidelines and Compliance Times for Hospital/Medical/Infectious Waste Incinerators. 40 CFR Part 60, Subpart Ce (July 1, ~~2018~~2019).

Designated facilities to which this subpart applies must comply with the minimum requirements in Subpart Ce, as provided in Colorado's 111(d) plan for Existing Hospital/Medical/Infectious Waste Incinerators. Colorado's 111(d) plan for Hospital/Medical/Infectious Waste Incinerators will be submitted to EPA once approved by the Commission and is effective once approved by EPA in 40 CFR Part 62, Subpart G.

Specifically, designated facilities are defined in Section 60.32e and additional definitions are specified in Section 60.31e. Designated facilities must comply with applicable emission limits as provided in Sections 60.33e(a)(1)-(3), (b)(1)-(2), and (c)(1)-(2). Designated facilities must comply with applicable operating training and qualification requirements as specified in Section 60.34e (referencing 40 CFR Part 60 Subpart Ec Section 60.53c). Designated facilities must comply with applicable waste management plan requirements as specified in Section 60.35e (referencing 40 CFR Part 60 Subpart Ec Section 60.55c). Designated facilities must comply with applicable inspection requirements as specified in Section 60.36e(a)(1)-(2), (b), (c)(1)-(2), and (d). Designated facilities must comply with applicable compliance and performance testing requirements as specified in Sections 60.37e(a) (referencing 40 CFR Part 60 Subpart Ec Section 60.56c) or (a)(1)-(2), (b) (referencing 40 CFR Part 60 Subpart Ec Section 60.56c) or (b)(1)-(2), and (c)(1)-(4). Designated facilities must comply with applicable monitoring requirements as specified in Sections 60.37e(d) (referencing 40 CFR Part 60 Subpart Ec Section 60.57c), (e)(1)-(3), and (f). Designated facilities must comply with applicable notification and recordkeeping requirements as specified in Sections 60.32e(b)(1)-(2) and (c)(1)-(3). Designated facilities must comply with applicable reporting and recordkeeping requirements as specified in Sections 60.38e(a) (referencing 40 CFR Part 60 Subpart Ec Section 60.58c(b)-(g)) or (a)(1)-(2) and (b)(1)-(2). Designated facilities must comply with applicable compliance times as specified in Section 60.39e.

The Commission designates the effective date of Colorado's 111(d) plan as the date on which the EPA promulgates a final rule in 40 CFR Part 62, Subpart G approving the state plan under Section 111(d) of the Clean Air Act. The compliance schedule for designated facilities can be found in Colorado's 111(d) plan for Existing Hospital/Medical/Infectious Waste Incinerators. Colorado's 111(d) plan for Existing Hospital/Medical/Infectious Waste Incinerators was adopted May 18, 2017, and is obtainable from the Commission Office.

Subpart Cf Emission Guidelines and Compliance Times for Municipal Solid Waste Landfills. 40 CFR Part 60, Subpart Cf (July 1, ~~2018~~2019).

Designated facilities to which this subpart applies must comply with the minimum requirements in Subpart Cf as provided in Colorado's 111(d) plan for Municipal Solid Waste Landfills. Colorado's 111(d) plan for Existing Municipal Solid Waste Landfills will be submitted to EPA once approved by the Commission and is effective once approved by EPA in 40 CFR Part 62, Subpart G. Upon approval, all landfills for which construction, reconstruction, or modification was commenced on or before July 17, 2014 ('existing' designated facilities) will be subject to the requirements of the 111(d) state plan. Sources previously subject to either 40 CFR Subpart Cc or WWW will be subject instead to Subpart Cf on the effective date of the EPA approved 111(d) state plan.

Specifically, designated facilities are defined in Section 60.31f and additional definitions are specified in Section 60.41f. Designated facilities must comply with applicable emission limits for designated facilities specified in Section 60.33f. Designated facilities must comply with applicable operational standards for collection and control systems as specified in Section 60.34f. Designated facilities must comply with applicable test methods and procedures and compliance requirements as specified in Sections 60.35f-60.36f. Designated facilities must comply with applicable monitoring requirements as specified in Section 60.37f. Designated facilities must comply with applicable reporting and recordkeeping requirements as specified in Sections 60.38f-60.39f. Designated facilities must comply with applicable requirements for active collective systems as specified in Section 60.40f.

The Commission designates the effective date of Colorado's 111(d) plan as the date on which the EPA promulgates a final rule in 40 CFR Part 62, Subpart G approving the state plan under Section 111(d) of the Clean Air Act. The compliance schedule for designated facilities can be found in Colorado's 111(d) plan for Existing Municipal Solid Waste Landfills. Colorado's 111(d) plan for Existing Municipal Solid Waste Landfills was adopted May ~~18, 2017~~21, 2020, and is obtainable from Commission Office.

Subpart D Standards of Performance for Fossil-Fuel-Fired Steam Generators for which Construction is Commenced after August 17, 1971. 40 CFR Part 60, Subpart D (July 1, ~~2018~~2019).

Subpart Da Standards of Performance for Electric Utility Steam Generators for which Construction is Commenced after September 18, 1978. 40 CFR Part 60, Subpart Da (July 1, ~~2018~~2019).

(See Regulation Number 6, Part B, Section VIII. and Regulation Number 8, Part E, Subpart UUUUU for additional requirements regarding Electric Utility Steam Generating Units)

Subpart Db Standards of Performance for Industrial-Commercial-Institutional Steam Generating Units. 40 CFR Part 60, Subpart Db (July 1, ~~2018~~2019).

(See Part B, Section III.D. of this Regulation Number 6 for Additional Requirements)

Subpart Dc Standards of Performance for Small Industrial-Commercial- Institutional Steam Generating Units. 40 CFR Part 60, Subpart Dc (July 1, ~~2018~~2019).

Subpart E Standards of Performance for Incinerators. 40 CFR Part 60, Subpart E (July 1, ~~2018~~2019).

(See Part B, Sections V, VI and VII of this Regulation Number 6 for Additional Requirements)

Subpart Ea Standards of Performance for Municipal Waste Combustors For Which Construction Is Commenced After December 20, 1989 and On or Before September 20, 1994. 40 CFR Part 60, Subpart Ea (July 1, ~~2018~~2019).

Subpart Eb Standards of Performance for Municipal Waste Combustors For Which Construction Is Commenced After September 20, 1994. 40 CFR Part 60, Subpart Eb (July 1, ~~2018~~2019).

(See Part B, Section VI of this Regulation Number 6 for Additional Requirements)

Subpart Ec Standards of Performance for Hospital/Medical/Infectious Waste Incinerators for Which Construction is Commenced After June 20, 1996. 40 CFR Part 60, Subpart Ec (July 1, ~~2018~~2019).

(See Part B, Section V of this Regulation Number 6 for Additional Requirements)

Subpart F Standards of Performance for Portland Cement Plants. 40 CFR Part 60, Subpart F (July 1, ~~2018~~2019).

Subpart G Standards of Performance for Nitric Acid Plants. 40 CFR Part 60, Subpart G (July 1, ~~2018~~2019).

Subpart Ga Standards of Performance for Nitric Acid Plants for Which Construction, Reconstruction, or Modification Commenced After October 14, 2011. 40 CFR Part 60, Subpart Ga (July 1, ~~2018~~2019).

Subpart H Standards of Performance for Sulfuric Acid Plants. 40 CFR Part 60, Subpart H (July 1, ~~2018~~2019).

Subpart I Standards of Performance for Hot Mix Asphalt Facilities. 40 CFR Part 60, Subpart I (July 1, ~~2018~~2019).

Subpart J Standards of Performance for Petroleum Refineries. 40 CFR Part 60, Subpart J (July 1, ~~2018~~2019).

Subpart Ja Standards of Performance for Petroleum Refineries for Which Construction, Reconstruction, or Modification Commenced After May 14, 2007. 40 CFR Part 60, Subpart Ja (July 1, ~~2018~~2019)~~, as amended November 11, 2018 *(83 FR 60696)*~~.

Subpart K Standards of Performance for Storage Vessels for Petroleum Liquids Constructed after June 11, 1973 and prior to May 19, 1978. 40 CFR Part 60, Subpart K (July 1, ~~2018~~2019).

Subpart Ka Standards of Performance for Storage Vessels for Petroleum Liquids Constructed after May 18, 1978, and prior to July 23, 1984. 40 CFR Part 60, Subpart Ka (July 1, ~~2018~~2019).

Subpart Kb Standards of Performance for Volatile Organic Liquid Storage Vessels (Including Petroleum Liquid Storage Vessels) for which Construction, Reconstruction, or Modification Commenced after July 23, 1984. 40 CFR Part 60, Subpart Kb (July 1, ~~2018~~2019).

Subpart L Standards of Performance for Secondary Lead Smelters. 40 CFR Part 60, Subpart L (July 1, ~~2018~~2019).

Subpart M Standards of Performance for Secondary Brass and Bronze Production Plants. 40 CFR Part 60, Subpart M (July 1, ~~2018~~2019).

Subpart N Standards of Performance for Iron and Steel Plants. 40 CFR Part 60, Subpart N (July 1, ~~2018~~2019).

Subpart Na Standards of Performance for Basic Oxygen Process Furnaces. 40 CFR Part 60, Subpart Na (July 1, ~~2018~~2019).

Subpart O Standards of Performance for Sewage Treatment Plants. 40 CFR Part 60, Subpart O (July 1, ~~2018~~2019).

Subpart P Standards of Performance for Primary Copper Smelters. 40 CFR Part 60, Subpart P (July 1, ~~2018~~2019).

Subpart Q Standards of Performance for Primary Zinc Smelters. 40 CFR Part 60, Subpart Q (July 1, ~~2018~~2019).

Subpart R Standards of Performance for Primary Lead Smelters. 40 CFR Part 60, Subpart R (July 1, ~~2018~~2019).

Subpart S Standards of Performance for Primary Aluminum Reduction Plants. 40 CFR Part 60, Subpart S (July 1, ~~2018~~2019).

Subpart T Standards of Performance for the Phosphate Fertilizer Industry: Wet-Process Phosphoric Acid Plants. 40 CFR Part 60, Subpart T (July 1, ~~2018~~2019).

Subpart U Standards of Performance for the Phosphate Fertilizer Industry: Superphosphoric Acid Plants. 40 CFR Part 60, Subpart U (July 1, ~~2018~~2019).

Subpart V Standards of Performance for the Phosphate Fertilizer Industry: Diammonium Phosphate Plants. 40 CFR Part 60, Subpart V (July 1, ~~2018~~2019).

Subpart W Standards of Performance for the Phosphate Fertilizer Industry: Triple Superphosphate Plants. 40 CFR Part 60, Subpart W (July 1, ~~2018~~2019).

Subpart X Standards of Performance for the Phosphate Fertilizer Industry: Granular Triple Superphosphate Storage Facilities. 40 CFR Part 60, Subpart X (July 1, ~~2018~~2019).

Subpart Y Standards of Performance for Coal Preparation Plants. 40 CFR Part 60, Subpart Y (July 1, ~~2018~~2019).

Subpart Z Standards of Performance for Ferroalloy Production Facilities. 40 CFR Part 60, Subpart Z (July 1, ~~2018~~2019).

Subpart AA Standards of Performance for Steel Plants: Electric Arc Furnaces Constructed after October 21, 1974, and on or before August 17, 1983. 40 CFR Part 60, Subpart AA (July 1, ~~2018~~2019).

Subpart AAa Standards of Performance for Steel Plants: Electric Arc Furnaces and Argon-Oxygen Decarburization Vessels Constructed after August 17, 1983. 40 CFR Part 60, Subpart AAa (July 1, ~~2018~~2019).

Subpart BB Standards of Performance for Kraft Pulp Mills. 40 CFR Part 60, Subpart BB (July 1, ~~2018~~2019).

Subpart BBa Standards of Performance for Kraft Pulp Mill Affected Sources for Which Construction, Reconstruction, or Modification Commenced After May 23, 2013. 40 CFR Part 60, Subpart BBa (July 1, ~~2018~~2019)

Subpart CC Standards of Performance for Glass Manufacturing Plants. 40 CFR Part 60, Subpart CC (July 1, ~~2018~~2019).

Subpart DD Standards of Performance for Grain Elevators. 40 CFR Part 60, Subpart DD (July 1, ~~2018~~2019).

Subpart EE Standards of Performance for Surface Coating of Metal Furniture. 40 CFR Part 60, Subpart EE (July 1, ~~2018~~2019).

Subpart GG Standards of Performance for Stationary Gas Turbines. 40 CFR Part 60, Subpart GG (July 1, ~~2018~~2019).

(See Subpart KKKK of this Regulation Number 6 for additional requirements for Stationary Combustion Turbines)

Subpart HH Standards of Performance for Lime Manufacturing Plants. 40 CFR Part 60, Subpart HH (July 1, ~~2018~~2019).

Subpart KK Standards of Performance for Lead-Acid Battery Manufacturing Plants. 40 CFR Part 60, Subpart KK (July 1, ~~2018~~2019).

Subpart LL Standards of Performance for Metallic Mineral Processing Plants. 40 CFR Part 60, Subpart LL (July 1, ~~2018~~2019).

Subpart MM Standards of Performance for Automobile and Light-Duty Truck Surface Coating Operations. 40 CFR Part 60, Subpart MM (July 1, ~~2018~~2019).

Subpart NN Standards of Performance for Phosphate Rock Plants. 40 CFR Part 60, Subpart NN (July 1, ~~2018~~2019).

Subpart PP Standards of Performance for Ammonium Sulfate Manufacture. 40 CFR Part 60, Subpart PP (July 1, ~~2018~~2019).

Subpart QQ Standards of Performance for the Graphic Arts Industry: Publication Rotogravure Printing. 40 CFR Part 60, Subpart QQ (July 1, ~~2018~~2019).

Subpart RR Standards of Performance for Pressure Sensitive Tape and Label Surface Coating Operations. 40 CFR Part 60, Subpart RR (July 1, ~~2018~~2019).

Subpart SS Standards of Performance for Industrial Surface Coating: Large Appliances. 40 CFR Part 60, Subpart SS (July 1, ~~2018~~2019).

Subpart TT Standards of Performance for Metal Coil Surface Coating. 40 CFR Part 60, Subpart TT (July 1, ~~2018~~2019).

Subpart UU Standards of Performance for Asphalt Processing and Asphalt Roofing Manufacture. 40 CFR Part 60, Subpart UU (July 1, ~~2018~~2019).

Subpart VV Standards of Performance for Equipment Leaks of VOC in the Synthetic Organic Chemicals Manufacturing Industry for which Construction, Reconstruction or Modification Commenced after January 5, 1981, and on or Before November 7, 2006. 40 CFR Part 60, Subpart VV (July 1, ~~2018~~2019).

Subpart VVa Standards of Performance for Equipment Leaks of VOC in the Synthetic Organic Chemicals Manufacturing Industry for which Construction, Reconstruction or Modification Commenced after November 7, 2006. 40 CFR Part 60, Subpart VVa (July 1, ~~2018~~2019).

Subpart WW Standards of Performance for the Beverage Can Surface Coating Industry. 40 CFR Part 60, Subpart WW (July 1, ~~2018~~2019).

Subpart XX Standards of Performance for Bulk Gasoline Terminals. 40 CFR Part 60, Subpart XX (July 1, ~~2018~~2019).

Subpart BBB Standards of Performance for the Rubber Tire Manufacturing Industry. 40 CFR Part 60, Subpart BBB (July 1, ~~2018~~2019).

Subpart DDD Standards of Performance for Volatile Organic Compound (VOC) Emissions from the Polymer Manufacturing Industry. 40 CFR Part 60, Subpart DDD (July 1, ~~2018~~2019).

Subpart FFF Standards of Performance for Flexible Vinyl and Urethane Coating and Printing. 40 CFR Part 60, Subpart FFF (July 1, ~~2018~~2019).

Subpart GGG Standards of Performance for Equipment Leaks of VOC in Petroleum Refineries for which Construction, Reconstruction, or Modification Commenced After January 4, 1983, and On or Before November 7, 2006. 40 CFR Part 60, Subpart GGG (July 1, ~~2018~~2019).

Subpart GGGa Standards of Performance for Equipment Leaks of VOC in Petroleum Refineries for which Construction, Reconstruction, or Modification Commences After November 7, 2006. 40 CFR Part 60, Subpart GGGa (July 1, ~~2018~~2019).

Subpart HHH Standards of Performance for Synthetic Fiber Production Facilities. 40 CFR Part 60, Subpart HHH (July 1, ~~2018~~2019).

Subpart III Standards of Performance for Volatile Organic Compound (VOC) Emissions From Synthetic Organic Chemical Manufacturing Industry (SOCMI) Air Oxidation Unit Processes. 40 CFR Part 60, Subpart III (July 1, ~~2018~~2019).

Subpart JJJ Standards of Performance for Petroleum Dry Cleaners. 40 CFR Part 60, Subpart JJJ (July 1, ~~2018~~2019).

Subpart KKK Standards of Performance for Equipment Leaks of VOC from Onshore Natural Gas Processing Plants. 40 CFR Part 60, Subpart KKK (July 1, ~~2018~~2019).

Subpart LLL Standards of Performance for Onshore Natural Gas Processing: SO2 Emissions. 40 CFR Part 60, Subpart LLL (July 1, ~~2018~~2019).

Subpart NNN Standards of Performance for Volatile Organic Compound Emissions from Synthetic Organic Chemical Manufacturing Industry Distillation Operations. 40 CFR Part 60, Subpart NNN (July 1, ~~2018~~2019).

Subpart OOO Standards of Performance for Nonmetallic Mineral Processing Plants. 40 CFR Part 60, Subpart OOO (July 1, ~~2018~~2019).

Subpart PPP Standards of Performance for Wool Fiberglass Insulation Manufacturing Plants. 40 CFR Part 60, Subpart PPP (July 1, ~~2018~~2019).

Subpart QQQ Standards of Performance for VOC Emissions from Petroleum Refinery Wastewater Systems. 40 CFR Part 60, Subpart QQQ (July 1, ~~2018~~2019).

Subpart RRR Standards of Performance for Volatile Organic Compounds (VOC) Emissions from Synthetic Organic Chemical Manufacturing Industry (SOCMI) Reactor Processes. 40 CFR Part 60, Subpart RRR (July 1, ~~2018~~2019).

Subpart SSS Standards of Performance for the Magnetic Tape Manufacturing Industry. 40 CFR Part 60, Subpart SSS (July 1, ~~2018~~2019).

Subpart TTT Standards of Performance for Industrial Surface Coating of Plastic Parts for Business Machines. 40 CFR Part 60, Subpart TTT (July 1, ~~2018~~2019).

Subpart UUU Standards of Performance for Calciners and Dryers in Mineral Industries. 40 CFR Part 60, Subpart UUU (July 1, ~~2018~~2019).

Subpart VVV Standards of Performance for Polymeric Coating of Supporting Substrates. 40 CFR Part 60, Subpart VVV (July 1, ~~2018~~2019).

Subpart WWW Standards of Performance for Municipal Solid Waste Landfills. 40 CFR Part 60, Subpart WWW (July 1, ~~2018~~2019).

On May 21, 2020, the Commission adopted an updated 111(d) plan for existing MSW landfills. Upon approval by EPA, all landfills for which construction, reconstruction, or modification was commenced on or before July 17, 2014 ('existing' designated facilities) will be subject to the requirements of the updated 111(d) state plan. Sources previously subject to 40 CFR Subpart WWW will be subject instead to Subpart Cf on the effective date of the EPA approved 111(d) state plan.

Subpart XXX Standards of Performance for Municipal Solid Waste Landfills that Commenced Construction Reconstruction or Modification after July 17, 2014. 40 CFR Part 60, Subpart XXX (July 1, 2019),

Subpart AAAA Standards of Performance for Small Municipal Waste Combustion Units for which Construction is Commenced after August 30, 1999 or for which Modification or Reconstruction is Commenced after June 6, 2001. 40 CFR Part 60, Subpart AAAA (July 1, ~~2018~~2019).

Subpart CCCC Standards of Performance for Commercial and Industrial Solid Waste Incineration Units for which Construction is Commenced after November 30, 1999 or for which Modification or Reconstruction is Commenced on or after June 1, 2001. 40 CFR Part 60, Subpart CCCC (July 1, ~~2018~~2019), as amended April 16, 2019 (84 FR 15846).

Subpart DDDD Emissions Guidelines and Compliance Times for Commercial and Industrial Solid Waste Incineration Units that Commenced Construction On or Before November 30, 1999. 40 CFR Part 60, Subpart DDDD (July 1, ~~2018~~2019), as amended April 16, 2019 (84 FR 15846).

Designated facilities to which this subpart applies must comply with the minimum requirements in Subpart DDDD as provided in Colorado's 111(d) plan for Existing Commercial and Industrial Solid Waste Incineration Units. Colorado's 111(d) plan for Existing Commercial and Industrial Solid Waste Incineration Units will be submitted to EPA once approved by the Commission and is effective once approved by EPA in 40 CFR Part 62, Subpart G.

Specifically, designated facilities are defined in Sections 60.2550 and 60.2555 and additional definitions are specified in Section 60.2875. Designated facilities must comply with applicable emission and operating limits for designated facilities as specified in Sections 60.2670-60.2680. Designated facilities must comply with applicable operator training and qualification requirements are specified in Sections 60.2635-60.2665. Designated facilities must comply with applicable waste management plan requirements as specified in Section 60.2620 and specified in Sections 60.2625 and 60.2630. Designated facilities must comply with applicable performance testing requirements as specified in Sections 60.2690-60.2695. Designated facilities must comply with applicable compliance requirements as specified in Sections 60.2700-60.2725 Designated facilities must comply with applicable monitoring requirements as specified in Sections 60.2730-60.2735. Designated facilities must comply with applicable notification and recordkeeping requirements as specified in Sections 60.2555(a)(1)-(2), (e)(1)-(4), and (f)(1)-(4). Designated facilities must comply with applicable reporting and recordkeeping requirements as specified in Sections 60.2740-60.2800. Designated facilities must comply with applicable air curtain incinerator requirements as specified in Sections 60.2810-60.2870. Designated facilities must comply with applicable compliance times as specified in Section 60.2535.

The Commission designates the effective date of Colorado's 111(d) plan as the date on which the EPA promulgates a final rule in 40 CFR Part 62, Subpart G approving the state plan under Section 111(d) of the Clean Air Act. The compliance schedule for designated facilities can be found in Colorado's 111(d) plan for Existing Commercial and Industrial Solid Waste Incineration Units. Colorado's 111(d) plan for Existing Commercial and Industrial Solid Waste Incineration Units was adopted May 18, 2017, and is obtainable from the Commission Office).

Subpart EEEE Standards of Performance for Other Solid Waste Incineration Units for which Construction is Commenced after December 9, 2004 or for which Modification or Reconstruction is Commenced on or after June 16, 2006. 40 CFR Part 60, Subpart EEEE (July 1, ~~2018~~2019).

Subpart FFFF Emission Guidelines and Compliance Times for Other Solid Waste Incineration Units that Commenced Construction on or before December 9, 2004. 40 CFR Part 60, Subpart FFFF, Sections 60.2991 through 60.2994, 60.3000 through 60.3078, and Tables 1-5 (July 1, ~~2018~~2019).

Subpart HHHH Emission Guidelines and Compliance Times for Coal-Fired Electric Steam Generating Units. Repealed: This rule was vacated by the February 8, 2008 D.C. Circuit Court of Appeals decision.

Subpart IIII Standards of Performance for Stationary Compression Ignition Internal Combustion Engines. 40 CFR Part 60, Subpart IIII, excluding the 100-hour emergency exemption in subsection 60.4211(f)(2)(ii)-(iii) pursuant to the court's decision in *Delaware Dept. of Natural Res. & Envt'l Control, et al. v. EPA*, 785 F. 3d 1 (DC Cir. 2015) (July 1, ~~2018~~2019), as amended November 1, 2019 (84 FR 32084).

Subpart KKKK Standards of Performance for Stationary Combustion Turbines. 40 CFR Part 60, Subpart KKKK (July 1, ~~2018~~2019).

(See Subpart GG for additional requirements for Stationary Gas Turbines)

Subpart LLLL Standards of Performance for New Sewage Sludge Incineration Unit. 40 CFR Part 60, Subpart LLLL (July 1, ~~2018~~2019).

Subpart MMMM Emission Guidelines and Compliance Times for Existing Sewage Sludge Incineration Units. 40 CFR Part 60, Subpart MMMM (July 1, ~~2018~~2019).

Subpart OOOO Standards of Performance for Crude Oil and Natural Gas Production, Transmission and Distribution. 40 CFR Part 60, Subpart OOOO, (July 1, ~~2018~~2019).

APPENDIX A to Part 60 Test Methods. 40 CFR Part 60 (July 1, ~~2018~~2019).

APPENDIX B to Part 60 Performance Specifications. 40 CFR Part 60 (July 1, ~~2018~~2019).

APPENDIX C to Part 60 Determination of Emission Rate Change. 40 CFR Part 60 (July 1, ~~2018~~2019).

APPENDIX D to Part 60 Required Emission Inventory Information. 40 CFR Part 60 (July 1, ~~2018~~2019).

APPENDIX F to Part 60 Quality Assurance Procedures. 40 CFR Part 60 (July 1, ~~2018~~2019).

APPENDIX I to Part 60 Removable Label and Owner's Manual. 40 CFR Part 60 (July 1, ~~2018~~2019).

TABLE 2

40 CFR Part 75 Subpart**	Section(s)
A	75.1-75.8
B	75.10-75.19
C	75.20-75.24
D	75.30-75.39
E	75.40-75.48
F	75.50-75.59
G	75.60-75.67
H	75.70-75.75

** 40 CFR Part 75, Subparts A through H (July 1, ~~2018~~2019).

APPENDIX A to Part 75 Specifications and Test Procedures, 40 CFR Part 75 (July 1, ~~2018~~2019).

APPENDIX B to Part 75 Quality Assurance and Quality Control Procedures, 40 CFR Part 75 (July 1, ~~2018~~2019).

APPENDIX C to Part 75 Missing Data Estimation Procedures, 40 CFR Part 75 (July 1, ~~2018~~2019).

APPENDIX D to Part 75 Optional SO2 Emissions Data Protocol for Gas-Fired Peaking Units and Oil-Fired Peaking Units, 40 CFR Part 75 (July 1, ~~2018~~2019).

APPENDIX E to Part 75 Optional NOx Emissions Data Protocol for Gas-Fired Peaking Units and Oil-Fired Peaking Units, 40 CFR Part 75 (July 1, ~~2018~~2019).

APPENDIX F to Part 75 Conversion Procedures, 40 CFR Part 75 (July 1, ~~2018~~2019).

APPENDIX G to Part 75 Determination of CO2 Emissions, 40 CFR Part 75 (July 1, ~~2018~~2019).

APPENDIX H to Part 75 Revised Traceability Protocol Number 1 (Reserved), 40 CFR Part 75 (July 1, ~~2018~~2019).

APPENDIX I to Part 75 Optional F--Factor/Fuel Flow Method (Reserved), 40 CFR Part 75 (July 1, ~~2018~~2019).

APPENDIX J to Part 75 Compliance Dates for Revised Recordkeeping Requirements and Missing Data Procedures (Reserved), 40 CFR Part 75 (July 1, ~~2018~~2019).

STATEMENTS OF BASIS, SPECIFIC STATUTORY AUTHORITY AND PURPOSE (For Part A)

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XXVII. Adopted May 21, 2020

Background

This Statement of Basis, Specific Statutory Authority, and Purpose complies with the requirements of the Colorado Administrative Procedures Act, Section 24-4-103, C.R.S., the Colorado Air Pollution Prevention and Control Act, Sections 25-7-110 and 25-7-110.5, C.R.S., and the Air Quality Control Commission's ("Commission") Procedural Rules.

Basis

The Commission has incorporated by reference New Source Performance Standards ("NSPS"), Emission Guidelines, and performance specifications amendments of 40 C.F.R. Part 60 into Regulation Number 6, Part A. These references need updated citations to ensure that the corresponding federal rules are enforceable under Colorado law. The Commission also updated references to the amended NSPS and performance specifications in 40 C.F.R. Part 60, Subparts XXX, CCCC, DDDD, and IIII.

The Commission approved a Section 111(d) plan for Municipal Solid Waste ("MSW") landfills, in accordance with the EPA's Model Rule set forth in the Emission Guidelines and Compliance Times for Municipal Solid Waste Landfills at 40 C.F.R. Part 60, Subpart Cf specific to MSW landfills that Commenced Construction On or Before July 17, 2014, and the Clean Air Act Section 111(d).

Specific Statutory Authority

The Colorado Air Pollution Prevention and Control Act, Sections 25-7-105(1)(b) and 25-7-109, C.R.S. authorize the Commission to adopt emission control regulations, including emission control regulations relating to new stationary sources, for the development of an effective air quality control program. Further, Section 25-7-106(6) authorizes the Commission to require testing, monitoring, and recordkeeping. Colorado's updated 111(d) state plan for MSW landfills will also achieve GHG emission reductions.

Purpose

Updating citation references of 40 C.F.R. Part 60 allows the Division to implement and enforce the Emission Guidelines and Compliance Times for applicable source categories.

Adoption of the rules will not impose additional requirements upon sources beyond the minimum required by federal law and may benefit the regulated community by providing sources with up-to-date information and regulatory certainty.

Further, these revisions will correct any typographical, grammatical and formatting errors found within the regulation.

COLORADO
Air Quality Control Commission
Department of Public Health & Environment

NOTICE OF WRITTEN COMMENT ONLY RULEMAKING HEARING

Regarding proposed revisions to:

Regulation Number 6, Part A

SUBJECT:
The Air Quality Control Commission will hold a rulemaking hearing to consider revisions to incorporate by reference additions and changes to the U.S. Environmental Protection Agency's ("EPA") New Source Performance Standards ("NSPS"), Emission Guidelines, and performance specifications in 40 C.F.R. Part 60. Specifically, the Division proposes to update the citation dates of the NSPS, Emissions Guidelines and Compliance Times, and performance specifications in Regulation Number 6, Part A.

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

HEARING SCHEDULE:

DATE: May 21, 2020
TIME: 9:00 AM
PLACE: Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South, Sabin Conference Room
Denver, CO 80246

PUBLIC COMMENT:
This is a written comment only rulemaking hearing. The Commission encourages all interested persons to provide their views in writing prior to or at the hearing. The Commission encourages that written comments be submitted by **May 1, 2020** so that Commissioners have the opportunity to review the information prior to the hearing.

Electronic submissions are preferred and should be emailed to:
cdphe.aqcc-comments@state.co.us

Written submissions should be mailed to:
Colorado Air Quality Control Commission
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South, EDO-AQCC-A5
Denver, Colorado 80246

All submissions should include: your name, address, phone number, email address, and the name of the group that you are representing (if applicable).

STATUTORY AUTHORITY FOR THE COMMISSION'S ACTIONS:

The Colorado Air Pollution Prevention and Control Act, Sections 25-7-105(1)(b) and 25-7-109, C.R.S. authorize the Commission to adopt emission control regulations, including emission control regulations relating to new stationary sources, for the development of an effective air quality control program. Further, Section 25-7-106(6) authorizes the Commission to require testing, monitoring, and recordkeeping.

The rulemaking hearing will be conducted in accordance with Sections 24-4-103 and 25-7-110, 110.5 and 110.8 C.R.S., as applicable and amended, the Commission's Procedural Rules, 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 21st day of February 2020 at Denver, Colorado

Colorado Air Quality Control Commission

Trisha Oeth, Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00089

Department

1000 - Department of Public Health and Environment

Agency

1001 - Air Quality Control Commission

CCR number

5 CCR 1001-10

Rule title

REGULATION NUMBER 8 CONTROL OF HAZARDOUS AIR POLLUTANTS

Rulemaking Hearing

Date

05/21/2020

Time

09:00 AM

Location

Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Sabin Conference Room

Subjects and issues involved

To consider revisions to Regulation Number 8, Parts A and E to incorporate by reference additions and changes that the U.S. Environmental Protection Agency made to its National Emission Standards for Hazardous Air Pollutants (NESHAP) in 40 C.F.R. Part 61 and Maximum Achievable Control Technology (MACT) standards in 40 C.F.R. Part 63. Specifically, the Division proposes to update the citation dates and incorporate by reference in full new and revised NESHAP and MACT standards.

Statutory authority

Sections 25-7-105(1)(b) and 25-7-109(2)(h) and 109(4); Sections 24-4-103 and 25-7-110, 110.5 and 110.8 C.R.S., as applicable and amended.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Air Quality Control Commission

REGULATION NUMBER 8 CONTROL OF HAZARDOUS AIR POLLUTANTS

5 CCR 1001-10

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

PART A Federal NESHAPs

I. Federal NESHAPs

The provisions of Part 61, Chapter I, Title 40, of the Code of Federal Regulations (CFR), promulgated by the U.S. Environmental Protection Agency listed in this section are hereby incorporated by reference by the Air Quality Control Commission and made a part of the Colorado Air Quality Control Commission Regulations. Materials incorporated by reference are those in existence as of the dates indicated and do not include later amendments. The material incorporated by reference is available for public inspection during regular business hours at the Office of the Commission, located at 4300 Cherry Creek Drive South, Denver, Colorado 80246. Parties wishing to inspect these materials should contact the Technical Secretary of the Commission, located at the Office of the Commission. The material incorporated by reference is also available through the United States Government Printing Office, online at www.gpo.gov/fdsys.

All new sources of air pollution and all modified or reconstructed sources of air pollution shall comply with the standards, criteria, and requirements set forth herein. For the purpose of this regulation "Administrator" shall mean both the Administrator of the Environmental Protection Agency or his/her authorized representative and the Colorado Air Pollution Control Division.

Subpart A General Provisions 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

Subpart B Repealed – Reserved for National Emission Standards for Radon Emissions from Underground Uranium Mines 40 C.F.R. Part 61.

Subpart C National Emission Standard for Beryllium 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

Subpart D National Emission Standard for Beryllium Rocket Motor Firing 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

Subpart E National Emission Standard for Mercury 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

Subpart F National Emission Standard for Vinyl Chloride 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

Subpart H Repealed – Reserved for National Emission Standards for Emissions of Radionuclides Other Than Radon From Department of Energy Facilities 40 C.F.R. Part 61.

Subpart J National Emission Standard for Equipment leaks (fugitive Emission sources) of Benzene 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

Subpart K Repealed – Reserved for National Emission Standards for Radionuclide Emissions from Elemental Phosphorous Plants 40 C.F.R. Part 61.

Subpart L National Emission Standard for Benzene Emissions from Coke By-Product Recovery Plants 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

Subpart N National Emission Standard for Inorganic Arsenic Emissions from Glass Manufacturing Plants 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

Subpart O National Emission Standard for Inorganic Arsenic Emissions from Primary Copper Smelters 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

Subpart P National Emission Standard for Inorganic Arsenic Emissions from Arsenic Trioside and Metallic Arsenic Production Facilities 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

Subpart Q Repealed – Reserved for National Emission Standards for Radon Emissions From Department of Energy Facilities 40 C.F.R. Part 61.

Subpart R Repealed – Reserved for National Emission Standards for Radon Emissions from Phosphogypsum Stacks, 40 C.F.R. Part 61.

Subpart T Repealed – Reserved for National Emission Standards for Radon Emissions from the Disposal of Uranium Mill Tailings 40 C.F.R. Part 61.

Subpart V National Emission Standard for Equipment Leaks (Fugitive Emission Sources) 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

Subpart W Repealed – Reserved for National Emission Standards for Radon Emissions from Operating Mill Tailings 40 C.F.R. Part 61.

Subpart Y National Emission Standard for Benzene Emissions from Benzene Storage Vessels 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

Subpart BB National Emission Standard for Benzene Emissions from Benzene Transfer Operations 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

Subpart FF National Emission Standard for Benzene Waste Operations 40 C.F.R. Part 61 (July 1, ~~2018~~2019).

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II. Statements of Basis, Specific Statutory Authority and Purpose for Part A

II.R. Adopted May 21, 2020

Incorporation by reference of federal standards in 40 C.F.R. Part 61 into Regulation Number 8, Part A.

Background

This Statement of Basis, Specific Statutory Authority, and Purpose complies with the requirements of the Colorado Administrative Procedures Act, C.R.S., Sections 24-4-103(4) and -103(12.5) for adopted or modified regulations, and with the requirements of regulations incorporated by reference; the Colorado Air Pollution Prevention and Control Act, Sections 25-7-110 and 25-7-110.5, C.R.S.; and the Air Quality Control Commission's ("Commission") Procedural Rules.

Basis

The State of Colorado is required under Section 112 of the Clean Air Act to adopt revisions to and new standards under 40 C.F.R. Part 61 into its regulations. This rulemaking amends the incorporation dates of subparts already incorporated by reference.

Specific Statutory Authority

Sections 25-7-105(1)(b) and 25-7-109(2)(h) and 109(4), C.R.S. authorize the Commission to adopt emission control regulations and emission control regulations relating to hazardous air pollutants, specifically.

Purpose

Adoption of federal amendments to standards in 40 C.F.R. Part 61 make revisions enforceable under Colorado law. Further, these revisions may include corrections of any typographical, grammatical, and formatting errors throughout the regulation.

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PART E Federal Maximum Achievable Control Technology (MACT)

I. General Provisions

The provisions of Part 63, Chapter I, Title 40, of the Code of Federal Regulations (CFR), promulgated by the U.S. Environmental Protection Agency listed in this section are hereby incorporated by reference by the Air Quality Control Commission and made a part of the Colorado Air Quality Control Commission Regulations. Materials incorporated by reference are those in existence as of the dates indicated and do not include later amendments. The material incorporated by reference is available for public inspection during regular business hours at the Office of the Commission, located at 4300 Cherry Creek Drive South, Denver, Colorado 80246. Parties wishing to inspect these materials should contact the Technical Secretary of the Commission, located at the Office of the Commission. The material incorporated by reference is also available through the United States Government Printing Office, online at www.gpo.gov/fdsys.

For the purpose of this section of this regulation, the word "Administrator" as used in the C.F.R. shall mean the Colorado Air Pollution Control Division. References to 40 CFR part 70 or operating permit issuance shall relate to the Colorado Operating Permit program contained in Colorado Regulation No. 3, Parts A and C. Operating permits issued under these general provisions shall be issued by the Colorado Air Pollution Control Division under Colorado Regulation No. 3, Parts A and C. The phrases "HAP", "HAPs" or "listed HAPs" shall mean those substances listed in Colorado Regulation No. 3, Appendix B.

Subpart A National Emission Standards for Hazardous Air Pollutants for Source Categories: General Provisions, 40 CFR Part 63 (July 1, ~~2018~~2019).

For the purpose of this subpart A, the term "performance track member" shall mean a stationary source that is a member of both the U.S. Environmental Protection Agency's National Environmental Performance Track and the Colorado Department of Public Health and Environment's Environmental Leadership Program at the gold-level or higher.

II. Reserved

III. Federal Maximum Achievable Control Technology

The regulations promulgated by the U. S. Environmental Protection Agency listed in this section are hereby incorporated by reference by the Air Quality Control Commission and made a part of the Colorado Air Quality Control Commission Regulations. Materials incorporated by reference are those in existence

as of the dates indicated and do not include later amendments. The material incorporated by reference is available for public inspection during regular business hours at the Office of the Commission, located at 4300 Cherry Creek Drive South, Denver, Colorado 80246, or may be examined at any state publications depository library. Parties wishing to inspect these materials should contact the Technical Secretary of the Commission, located at the Office of the Commission.

"Administrator" as used in the C. F. R. shall mean the Colorado Air Pollution Control Division.

Subpart F National Emission Standards for Organic Hazardous Air Pollutants From the Synthetic Organic Chemical Manufacturing Industry, 40 C. F. R. Part 63, Subparts F (July 1, ~~2018~~2019).

Subpart G National Emission Standards for Organic Hazardous Air Pollutants From the Synthetic Organic Chemical Manufacturing Industry for Process Vents, Storage Vessels, Transfer Operations, and Wastewater, 40 C. F. R. Part 63, Subparts G (July 1, ~~2018~~2019).

Subpart H National Emission Standards for Organic Hazardous Air Pollutants for Equipment Leaks, 40 C. F. R. Part 63, Subparts H (July 1, ~~2018~~2019).

Subpart I National Emission Standards for Organic Hazardous Air Pollutants for Certain Processes Subject to the Negotiated Regulation for Equipment Leaks, 40 C. F. R. Part 63, Subparts I (July 1, ~~2018~~2019).

Subpart J National Emission Standards for Hazardous Air Pollutants for Polyvinyl Chloride and Copolymers Production, 40 C.F.R. Part 63, Subpart J (July 1, ~~2018~~2019).

Subpart M National Perchloroethylene Air Emission Standards for Dry Cleaning Facilities, 40 C. F. R. Part 63, Subpart M (July 1, ~~2018~~2019). The owner or operator of any source required pursuant to 40 C.F.R. Part 63, Subpart M to obtain a Regulation No. 3, Part C Operating Permit, if not a major source or located at a major source as that term is defined at 40 C.F.R. Part 70.2, is permanently exempted from submitting an application for such permit as of December 19, 2005 (70 FR 75319).

Subpart N National Emission Standards for Chromium Emissions from Hard and Decorative Chromium Electroplating and Chromium Anodizing Tanks, 40 C.F.R. Part 63, Subpart N (July 1, ~~2018~~2019). The owner or operator of any source required pursuant to 40 C.F.R. Part 63, Subpart N to obtain a Regulation No. 3, Part C Operating Permit, if not a major source or located at a major source as that term is defined at 40 C.F.R. Part 70.2, is permanently exempted from submitting an application for such permit as of December 19, 2005 (70 FR 75319).

Subpart O National Emission Standards for Hazardous Air Pollutants for Ethylene Oxide Sterilization and Fumigation Operations, 40 C.F.R. Part 63, Subpart O (July 1, ~~2018~~2019). The owner or operator of any source required pursuant to 40 C.F.R. Part 63, Subpart O to obtain a Regulation No. 3, Part C Operating Permit, if not a major source or located at a major source as that term is defined at 40 C.F.R. Part 70.2, is permanently exempted from submitting an application for such permit as of December 19, 2005 (70 FR 75319).

Subpart Q National Emissions Standards for Hazardous Air Pollutants for Industrial Process Cooling Towers, 40 C.F.R. Part 63, Subpart Q (July 1, ~~2018~~2019).

Subpart R National Emission Standards for Hazardous Air Pollutants for Source Categories: Gasoline Distribution Facilities (Bulk Gasoline Terminals and Pipeline Breakout Stations), 40 C.F.R. Part 63, Subpart R (July 1, ~~2018~~2019).

Subpart S National Emission Standards for Hazardous Air Pollutants for Source Category: Pulp and Paper Production, 40 C.F.R. Part 63, Subpart S (July 1, ~~2018~~2019).

Subpart T National Emission Standards for Hazardous Air Pollutants: Halogenated Solvent Cleaning, 40 C.F.R. Part 63, Subpart T (July 1, ~~2018~~2019). The owner or operator of any source required pursuant to 40 C.F.R. Part 63, Subpart T to obtain a Regulation No. 3, Part C Operating Permit, if not a major source or located at a major source as that term is defined at 40 C.F.R. Part 70.2, is permanently exempted from submitting an application for such permit as of December 19, 2005 (70 FR 75319).

Subpart U National Emission Standards for Hazardous Air Pollutants: Group 1 Polymers and Resins, 40 C.F.R. Part 63, Subpart U (July 1, ~~2018~~2019).

Subpart W National Emissions Standards for Hazardous Air Pollutants: Epoxy Resins Production and Non-Nylon Polyamides Production, 40 C.F.R. Part 63, Subpart W (July 1, ~~2018~~2019).

Subpart X National Emissions Standards for Hazardous Air Pollutants from Secondary Lead Smelting, 40 C.F.R. Part 63, Subpart X (July 1, ~~2018~~2019). The owner or operator of any source required pursuant to 40 C.F.R. Part 63, Subpart X to obtain a Regulation No. 3, Part C Operating Permit, if not a major source or located at a major source as that term is defined at 40 C.F.R. Part 70.2, is deferred from submitting an application for such permit until December 9, 2005.

Subpart AA National Emission Standards for Hazardous Air Pollutants for Source Category: Phosphoric Acid Manufacturing, 40 C.F.R. Part 63, Subpart AA (July 1, ~~2018~~2019).

Subpart BB National Emission Standards for Hazardous Air Pollutants for Phosphate Fertilizers Production, 40 C.F.R. Part 63, Subpart BB (July 1, ~~2018~~2019).

Subpart CC National Emission Standards for Hazardous Air Pollutants: Petroleum Refineries, 40 C.F.R. Part 63, Subpart CC (July 1, ~~2018~~2019)~~, as amended November 26, 2018 (83 FR 60696)~~.

Subpart DD National Emission Standards for Hazardous Air Pollutants: Off-Site Waste and Recovery Operations, 40 C.F.R. Part 63, Subpart DD (July 1, ~~2018~~2019).

Subpart EE National Emission Standards for Hazardous Air Pollutants Final Standards for Hazardous Air Pollutant Emissions from Magnetic Tape Manufacturing Operations, 40 C.F.R. Part 63, Subpart EE (July 1, ~~2018~~2019).

Subpart GG National Emission Standards for Hazardous Air Pollutants for Source Categories: Aerospace Manufacturing and Rework Facilities, 40 C.F.R. Part 63, Subpart GG (July 1, ~~2018~~2019).

Subpart HH National Emission Standards for Hazardous Air Pollutants for Source Category: Oil and Natural Gas Production and Natural Gas Transmission and Storage, 40 C.F.R. Part 63, Subparts HH (July 1, ~~2018~~2019).

Subpart II National Emission Standards for Hazardous Air Pollutants: Shipbuilding and Ship Repair, 40 C.F.R. Part 63, Subpart II (July 1, ~~2018~~2019).

Subpart JJ National Emission Standards for Hazardous Air Pollutants: Wood Furniture Manufacturing Operations, 40 C.F.R. Part 63, Subpart JJ (July 1, ~~2018~~2019).

Subpart KK National Emission Standards for Hazardous Air Pollutants: Printing and Publishing Industry, 40 C.F.R. Part 63, Subpart KK (July 1, ~~2018~~2019).

Subpart LL National Emission Standards for Hazardous Air Pollutants for Source Category: Primary Aluminum Reduction Plants, 40 C.F.R. Part 63, Subpart LL (July 1, ~~2018~~2019).

Subpart MM National Emission Standards for Hazardous Air Pollutants for Source Category: Chemical Recovery Combustion Sources at Kraft, Soda, Sulfite, and Stand-alone Semi-chemical Pulp Mills, 40 C.F.R. Part 63, Subpart MM (July 1, ~~2018~~2019).

Subpart OO National Emission Standards for Tanks - Level 1, 40 C.F.R., Part 63, Subpart OO (July 1, ~~2018~~2019).

Subpart PP National Emission Standards for Containers, 40 C.F.R., Part 63, Subpart PP (July 1, ~~2018~~2019).

Subpart XX National Emission Standards for Ethylene Manufacturing Process Units: Heat Exchange Systems and Waste Operations, 40 C.F.R. Part 63, Subpart XX (July 1, ~~2018~~2019).

Subpart YY National Emission Standards for Hazardous Air Pollutants for Source Category: Generic Maximum Achievable Control Technology Standard for Acetal Resins Production, Acrylic and Modacrylic Fiber Production, Hydrogen Fluoride Production, and Polycarbonate(s) Production, 40 C.F.R. Part 63, Subpart YY (July 1, ~~2018~~2019).

Subpart CCC National Emission Standards for Hazardous Air Pollutants for Source Category: Steel Pickling-HCL Process Facilities and Hydrochloric Acid Regeneration Plants, 40 C.F.R. Part 63, Subpart CCC (July 1, ~~2018~~2019).

Subpart DDD National Emission Standards for Hazardous Air Pollutants for Source Category: Mineral Wool Production, 40 C.F.R. Part 63, Subpart DDD (July 1, ~~2018~~2019).

Subpart EEE National Emission Standards for Hazardous Air Pollutants for Source Category: Hazardous Waste Combustors, 40 C.F.R. Part 63, Subpart EEE (July 1, ~~2018~~2019).

Subpart GGG National Emission Standards for Hazardous Air Pollutants for Source Category: Pharmaceuticals Production, 40 C.F.R. Part 63, Subpart GGG (July 1, ~~2018~~2019).

Subpart HHH National Emission Standards for Hazardous Air Pollutants for Source Category: Oil and Natural Gas Production and Natural Gas Transmission and Storage, 40 C.F.R. Part 63, Subparts HHH (July 1, ~~2018~~2019).

Subpart III National Emission Standards for Hazardous Air Pollutants for Source Category: Flexible Polyurethane Foam Production, 40 C.F.R. Part 63, Subpart III (July 1, ~~2018~~2019).

Subpart JJJ National Emission Standards for Hazardous Air Pollutants: Group IV Polymers and Resins, 40 C.F.R. Part 63, Subpart JJJ (July 1, ~~2018~~2019).

Subpart LLL National Emission Standards for Hazardous Air Pollutants for Source Category: Portland Cement Manufacturing, 40 C.F.R. Part 63, Subpart LLL (July 1, ~~2018~~2019).~~, as amended July 25, 2018 (83 FR 35122).~~

Subpart MMM National Emission Standards for Hazardous Air Pollutants for Source Category: Pesticide Active Ingredient Production, 40 C.F.R. Part 63, Subpart MMM (July 1, ~~2018~~2019).

Subpart NNN National Emission Standards for Hazardous Air Pollutants for Source Category: Wool Fiberglass Manufacturing, 40 C.F.R. Part 63, Subpart NNN (July 1, ~~2018~~2019).

Subpart OOO National Emission Standards for Hazardous Air Pollutants for Source Category: Amino/Phenolic Resins Production, 40 C.F.R. Part 63, Subpart OOO (July 1, ~~2018~~2019).

Subpart PPP National Emission Standards for Hazardous Air Pollutants for Source Category: Polyether Polyols Production, 40 C.F.R. Part 63, Subpart PPP (July 1, ~~2018~~2019).

Subpart QQQ National Emission Standards for Hazardous Air Pollutants for Primary Copper, 40 C.F.R. Part 63, Subpart QQQ (July 1, ~~2018~~2019).

Subpart RRR National Emission Standards for Hazardous Air Pollutants for Source Category: Secondary Aluminum Production, 40 C.F.R. Part 63, Subpart RRR (July 1, 2007). The owner or operator of any source required pursuant to 40 C.F.R. Part 63, Subpart RRR to obtain a Regulation No. 3., Part C Operating Permit, if not a major source or located at a major source as that term is defined at 40 C.F.R. Part 70.2, is permanently exempted from submitting an application for such permit as of December 19, 2005 (70 FR 75319).

Subpart TTT National Emission Standards for Hazardous Air Pollutants for Source Category: Primary Lead Smelting, 40 C.F.R. Part 63, Subpart TTT (July 1, ~~2018~~2019).

Subpart UUU National Emission Standards for Hazardous Air Pollutants for Catalytic Cracking Units, Catalytic Reforming Units and Sulfur Plants at Petroleum Refineries, 40 C.F.R. Part 63, Subpart UUU (July 1, ~~2018~~2019).

Subpart VVV National Emission Standards for Hazardous Air Pollutants for Source Category: Publicly Owned Treatment Works, 40 C.F.R. Part 63, Subpart VVV (July 1, ~~2018~~2019).

Subpart XXX National Emission Standards for Hazardous Air Pollutants for Source Category: Ferroalloys Production: Ferromanganese and Silicomanganese, 40 C.F.R. Part 63, Subpart XXX (July 1, ~~2018~~2019).

Subpart AAAA National Emission Standards for Hazardous Air Pollutants for Municipal Solid Waste Landfills, 40 C.F.R. Part 63, Subpart AAAA (July 1, ~~2018~~2019).

Subpart CCCC National Emission Standards for Hazardous Air Pollutants for Source Category: Manufacturing of Nutritional Yeast, 40 C.F.R. Part 63, Subpart CCCC (July 1, ~~2018~~2019).

Subpart DDDD National Emissions Standards for Hazardous Air Pollutants: Plywood and Composite Wood Products, 40 C.F.R. Part 63, Subpart DDDD (July 1, ~~2018~~2019).

Subpart EEEE National Emissions Standards for Hazardous Air Pollutants: Organic Liquids Distribution (Non-Gasoline), 40 C.F.R. Part 63, Subpart EEEE (July 1, ~~2018~~2019).

Subpart FFFF National Emissions Standards for Hazardous Air Pollutants: Miscellaneous Organic Chemical Manufacturing, 40 C.F.R. Part 63, Subpart FFFF (July 1, ~~2018~~2019).

Subpart GGGG National Emission Standards for Hazardous Air Pollutants for Source Category: Solvent Extraction for Vegetable Oil Production, 40 C.F.R. Part 63, Subpart GGGG (July 1, ~~2018~~2019).

Subpart HHHH National Emission Standards for Hazardous Air Pollutants for Wet Formed Fiberglass Mat Production, 40 C.F.R. Part 63, Subpart HHHH (July 1, ~~2018~~2019), as amended February 28, 2019 (84 FR 6676).

Subpart IIII National Emissions Standards for Hazardous Air Pollutants: Surface Coating of Automobiles and Light-Duty Trucks, 40 C.F.R. Part 63, Subpart IIII (July 1, ~~2018~~2019).

Subpart JJJJ National Emission Standards for Hazardous Air Pollutants for Paper and Other Web Coating, 40 C.F.R. Part 63, Subpart JJJJ (July 1, ~~2018~~2019).

Subpart KKKK National Emissions Standards for Hazardous Air Pollutants: Surface Coating of Metal Cans, 40 C.F.R. Part 63, Subpart KKKK (July 1, ~~2018~~2019).

Subpart MMMM National Emissions Standards for Hazardous Air Pollutants: Surface Coating of Miscellaneous Metal Parts and Products, 40 C.F.R. Part 63, Subpart MMMM (July 1, ~~2018~~2019).

Subpart NNNN National Emission Standards for Hazardous Air Pollutants for Large Appliance Manufacturing, 40 C.F.R. Part 63, Subpart NNNN (July 1, ~~2018~~2019), as amended March 15, 2019 (84 FR 9590).

Subpart OOOO National Emission Standards for Hazardous Air Pollutants for Printing, Coating, and Dyeing of Fabrics and Other Textiles, 40 C.F.R. Part 63, Subpart OOOO (July 1, ~~2018~~2019), as amended March 15, 2019 (84 FR 9590).

Subpart PPPP National Emissions Standards for Hazardous Air Pollutants: Surface Coating of Plastic Parts and Products, 40 C.F.R. Part 63, Subpart PPPP (July 1, ~~2018~~2019).

Subpart QQQQ National Emission Standards for Hazardous Air Pollutants for Surface Coating of Wood Building Products, 40 C.F.R. Part 63, Subpart QQQQ (July 1, ~~2018~~2019), as amended March 4, 2019 (84 FR 7682).

Subpart RRRR National Emission Standards for Hazardous Air Pollutants for Surface Coating of Metal Furniture, 40 C.F.R. Part 63, Subpart RRRR (July 1, ~~2018~~2019), as amended March 15, 2019 (84 FR 9590).

Subpart SSSS National Emission Standards for Hazardous Air Pollutants for Surface Coating of Metal Coil, 40 C.F.R. Part 63, Subpart SSSS (July 1, ~~2018~~2019).

Subpart TTTT National Emission Standards for Hazardous Air Pollutants for Leather Finishing Operations, 40 C.F.R. Part 63, Subpart TTTT (July 1, ~~2018~~2019).

Subpart UUUU National Emission Standards for Hazardous Air Pollutants for Cellulose Production Manufacturing, 40 C.F.R. Part 63, Subpart UUUU (July 1, ~~2018~~2019).

Subpart VVVV National Emission Standards for Hazardous Air Pollutants for Boat Manufacturing, 40 C.F.R. Part 63, Subpart VVVV (July 1, ~~2018~~2019).

Subpart WWWW National Emission Standards for Hazardous Air Pollutants for Reinforced Plastic Composites Production, 40 C.F.R. Part 63, Subpart WWWW (July 1, ~~2018~~2019).

Subpart XXXX National Emission Standards for Hazardous Air Pollutants for Tire Manufacturing, 40 C.F.R. Part 63, Subpart XXXX (July 1, ~~2018~~2019).

Subpart YYYY National Emissions Standards for Hazardous Air Pollutants for Stationary Combustion Turbines, 40 C.F.R. Part 63, Subpart YYYY (July 1, ~~2018~~2019).

Subpart ZZZZ National Emissions Standards for Hazardous Air Pollutants for Stationary Reciprocating Internal Combustion Engines, 40 C.F.R. Part 63, Subpart ZZZZ (July 1, 2007).

Subpart AAAAA National Emissions Standards for Hazardous Air Pollutants for Lime Manufacturing Plants, 40 C.F.R. Part 63, Subpart AAAAA (July 1, ~~2018~~2019).

Subpart BBBBB National Emission Standards for Hazardous Air Pollutants for Semiconductor Manufacturing, 40 C.F.R. Part 63, Subpart BBBBB (July 1, ~~2018~~2019).

Subpart CCCCC National Emission Standards for Hazardous Air Pollutants for Coke Ovens: Pushing, Quenching, and Battery Stacks, 40 C.F.R. Part 63, Subpart CCCCC (July 1, ~~2018~~2019).

Subpart DDDDD National Emission Standards for Hazardous Air Pollutants for Major Sources: Industrial, Commercial, and Institutional Boilers and Process Heaters, 40 C.F.R. Part 63, Subpart DDDDD (July 1, ~~2018~~2019).

Subpart EEEEE National Emissions Standards for Hazardous Air Pollutants for Iron and Steel Foundries, 40 C.F.R. Part 63, Subpart EEEEE (July 1, ~~2018~~2019).

Subpart FFFFF National Emission Standards for Hazardous Air Pollutants for Integrated Iron and Steel Manufacturing, 40 C.F.R. Part 63, Subpart FFFFF (July 1, ~~2018~~2019).

Subpart GGGGG National Emission Standards for Hazardous Air Pollutants: Site Remediation, 40 C.F.R. Part 63, Subpart GGGGG (July 1, ~~2018~~2019).

Subpart HHHHH National Emissions Standards for Hazardous Air Pollutants: Miscellaneous Coating Manufacturing, 40 C.F.R. Part 63, Subpart HHHHH (July 1, ~~2018~~2019).

Subpart IIIII National Emissions Standards for Hazardous Air Pollutants: Mercury Emissions from Mercury Cell Chlor-Alkali Plants, 40 C.F.R. Part 63, Subpart IIIII (July 1, ~~2018~~2019).

Subpart JJJJJ National Emission Standards for Hazardous Air Pollutants for Brick and Structural Clay Manufacturing, 40 C.F.R. Part 63, Subpart JJJJJ (July 1, ~~2018~~2019).

Subpart KKKKK National Emission Standards for Hazardous Air Pollutants for Clay Ceramics Manufacturing, 40 C.F.R. Part 63, Subpart KKKKK (July 1, ~~2018~~2019), as amended November 1, 2019 (84 FR 58601).

Subpart LLLLL National Emission Standards for Hazardous Air Pollutants for Asphalt Processing and Asphalt Roofing Manufacturing, 40 C.F.R. Part 63, Subpart LLLLL (July 1, ~~2018~~2019).

Subpart MMMMM National Emission Standards for Hazardous Air Pollutants for Flexible Polyurethane Foam Fabrication, 40 C.F.R. Part 63, Subpart MMMMM (July 1, ~~2018~~2019).

Subpart NNNNN National Emission Standards for Hazardous Air Pollutants for Hydrochloric Acid Production, 40 C.F.R. Part 63, Subpart NNNNN (July 1, ~~2018~~2019).

Subpart PPPPP National Emission Standards for Hazardous Air Pollutants for Engine Test Cells/Stands, 40 C.F.R. Part 63, Subpart PPPPP (July 1, ~~2018~~2019).

Subpart QQQQQ National Emission Standards for Hazardous Air Pollutants for Friction Materials Manufacturing Facilities, 40 C.F.R. Part 63, Subpart QQQQQ (July 1, ~~2018~~2019)~~, as amended February 2, 2019 (84 FR 2742)~~.

Subpart RRRRR National Emission Standards for Hazardous Air Pollutants: Taconite Iron Ore Processing, 40 C.F.R. Part 63, Subpart RRRRR (July 1, ~~2018~~2019).

Subpart SSSSS National Emission Standards for Hazardous Air Pollutants for Refractory Products Manufacturing, 40 C.F.R. Part 63, Subpart SSSSS (July 1, ~~2018~~2019).

Subpart TTTTT National Emissions Standards for Hazardous Air Pollutants for Primary Magnesium Refining, 40 C.F.R. Part 63, Subpart TTTTT (July 1, ~~2018~~2019).

Subpart UUUUU National Emission Standards for Hazardous Air Pollutants: Coal- and Oil-Fired Electric Utility Steam Generating Units, 40 C.F.R. Part 63, Subpart UUUUU (July 1, ~~2018~~2019).

(See Regulation Number 6, Part A, Subpart Da and Part B, Section VIII. for additional requirements regarding Electric Utility Steam Generating Units)

Subpart WWWWW National Emission Standards for Hospital Ethylene Oxide Sterilizers, 40 C.F.R. Part 63, Subpart WWWWW (July 1, ~~2018~~2019).

Subpart YYYYY National Emission Standards for Hazardous Air Pollutants for Area Sources: Electric Arc Furnace Steelmaking Facilities, 40 C.F.R. Part 63, Subpart YYYYY (July 1, ~~2018~~2019).

Subpart ZZZZZ National Emission Standards for Hazardous Air Pollutants for Iron and Steel Foundries Area Sources, 40 C.F.R. Part 63, Subpart ZZZZZ (July 1, ~~2018~~2019).

Subpart DDDDDD National Emission Standards for Hazardous Air Pollutants for Polyvinyl Chloride and Copolymers Production Area Sources, 40 C.F.R. Part 63, Subpart DDDDDD (July 1, ~~2018~~2019).

Subpart EEEEEE National Emission Standards for Hazardous Air Pollutants for Primary Copper Smelting Area Sources, 40 C.F.R. Part 63, Subpart EEEEEE (July 1, ~~2018~~2019).

Subpart FFFFFF National Emission Standards for Hazardous Air Pollutants: Secondary Copper Smelting, 40 C.F.R. Part 63, Subpart FFFFFF (July 1, ~~2018~~2019).

Subpart GGGGGG National Emission Standards for Hazardous Air Pollutants for Area Sources: Primary Nonferrous Metals: Zinc, Cadmium, and Berylium, 40 C.F.R. Part 63, Subpart GGGGGG (July 1, ~~2018~~2019).

Subpart LLLLLL National Emission Standards for Hazardous Air Pollutants for area sources: Acrylic and Modacrylic Fibers Production, 40 C.F.R. Part 63, Subpart LLLLLL (July 1, ~~2018~~2019).

Subpart MMMMMM National Emission Standards for Hazardous Air Pollutants for area sources: Carbon Black Production, 40 C.F.R. Part 63, Subpart MMMMMM (July 1, ~~2018~~2019).

Subpart NNNNNN National Emission Standards for Hazardous Air Pollutants for Chemical Manufacturing area sources: Chromium Compounds, 40 C.F.R. Part 63, Subpart NNNNNN (July 1, ~~2018~~2019).

Subpart OOOOOO National Emission Standards for Hazardous Air Pollutants for area sources: Flexible Polyurethane Foam Production and Fabrication, 40 C.F.R. Part 63, Subpart OOOOOO (July 1, ~~2018~~2019).

Subpart PPPPPP National Emission Standards for Hazardous Air Pollutants for area sources: Lead Acid Battery Manufacturing, 40 C.F.R. Part 63, Subpart PPPPPP (July 1, ~~2018~~2019).

Subpart QQQQQQ National Emission Standards for Hazardous Air Pollutants for area sources: Wood Preserving, 40 C.F.R. Part 63, Subpart QQQQQQ (July 1, ~~2018~~2019).

Subpart TTTTTT National Emission Standards for Hazardous Air Pollutants for Secondary Nonferrous Metals Processing Area Sources, 40 C.F.R. Part 63, Subpart TTTTTT (July 1, ~~2018~~2019).

Subpart ZZZZZZ National Emission Standards for Hazardous Air Pollutants: Area Source Standards for Aluminum, Copper and Other Nonferrous Foundries, 40 C.F.R. Part 63, Subpart ZZZZZZ (July 1, ~~2018~~2019).

Subpart EEEEEEE National Emission Standards for Hazardous Air Pollutants: Gold Mine Ore Processing and Production Area Source Category, 40 C.F.R. Part 63, Subpart EEEEEEE (July 1, ~~2018~~2019).

Subpart HHHHHHH National Emission Standards for Hazardous Air Pollutant Emissions for Polyvinyl Chloride and Copolymers Production, 40 C.F.R. Part 63, Subpart HHHHHHH (July 1, ~~2018~~2019).

>>>>>>>>>>>>>>

VI. Statements of Basis, Specific Statutory Authority and Purpose for Part E

VI.LL. Adopted May 21, 2020

Incorporation by reference of federal rules and amendments to federal standards in 40 C.F.R. Part 63 into Regulation Number 8, Part E.

This Statement of Basis, Specific Statutory Authority, and Purpose complies with the requirements of the Colorado Administrative Procedure Act Sections 24-4-103, C.R.S. and the Colorado Air Pollution Prevention and Control Act Sections 25-7-110 and 25-7-110.5, C.R.S., and the Air Quality Control Commission's ("Commission") Procedural Rules.

Basis

The EPA promulgated new standards in 40 C.F.R. Part 63, Subparts OOOO, RRRR, NNNN, and KKKKK. The State of Colorado is required under Section 112 of the Clean Air Act to adopt such revisions and new standards into its regulations.

Authority

Sections 25-7-105(1)(b) and 25-7-109(2)(h) and 25-7-109(4), C.R.S. authorize the Commission to adopt emission control regulations and emission control regulations relating to hazardous air pollutants, respectively.

Purpose

Adoption of the federal rules and amendments to federal standards in 40 C.F.R. Part 63, Subparts OOOO, RRRR, NNNN, and KKKKK make these rules and revisions enforceable under Colorado law.

Further, these revisions may correct typographical, grammatical, and formatting errors throughout the regulation.

COLORADO
Air Quality Control Commission
Department of Public Health & Environment

NOTICE OF WRITTEN COMMENT ONLY RULEMAKING HEARING

Regarding proposed revisions to:

Regulation Number 8, Parts A and E

SUBJECT:

The Air Quality Control Commission will hold a rulemaking hearing to consider revisions to Regulation Number 8, Parts A and E to incorporate by reference additions and changes that the U.S. Environmental Protection Agency made to its National Emission Standards for Hazardous Air Pollutants (NESHAP) in 40 C.F.R. Part 61 and Maximum Achievable Control Technology (MACT) standards in 40 C.F.R. Part 63. Specifically, the Division proposes to update the citation dates and incorporate by reference in full new and revised NESHAP and MACT standards.

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

HEARING SCHEDULE:

DATE: May 21, 2020
TIME: 9:00 AM
PLACE: Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South, Sabin Conference Room
Denver, CO 80246

PUBLIC COMMENT:

This is a written comment only rulemaking hearing. The Commission encourages all interested persons to provide their views in writing prior to or at the hearing. The Commission encourages that written comments be submitted by **May 1, 2020** so that Commissioners have the opportunity to review the information prior to the hearing.

Electronic submissions are preferred and should be emailed to:
cdphe.aqcc-comments@state.co.us

Written submissions should be mailed to:
Colorado Air Quality Control Commission
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South, EDO-AQCC-A5
Denver, Colorado 80246

All submissions should include: your name, address, phone number, email address, and the name of the group that you are representing (if applicable).

STATUTORY AUTHORITY FOR THE COMMISSION'S ACTIONS:

Sections 25-7-105(1)(b) and 25-7-109(2)(h) and 109(4), C.R.S. authorize the Commission to adopt emission control regulations and emission control regulations relating to hazardous air pollutants, specifically.

The rulemaking hearing will be conducted in accordance with Sections 24-4-103 and 25-7-110, 110.5 and 110.8 C.R.S., as applicable and amended, the Commission's Procedural Rules, 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 21st day of February 2020 at Denver, Colorado

Colorado Air Quality Control Commission

Trisha Oeth, Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00090

Department

1000 - Department of Public Health and Environment

Agency

1001 - Air Quality Control Commission

CCR number

5 CCR 1001-11

Rule title

REGULATION NUMBER 9 OPEN BURNING, PRESCRIBED FIRE, AND PERMITTING

Rulemaking Hearing

Date

05/21/2020

Time

09:00 AM

Location

Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Sabin Conference Room

Subjects and issues involved

To consider revisions to Regulation Number 9 to clarify the requirements for Prescribed Fires and Open Burning. The revisions consist of five parts: 1) Remove language that is no longer applicable or appropriate; 2) Remove the specific dynamic Smoke Management Program (SMP) scores related to prescribed fire burning; 3) Remove the requirement for inaccurate modeling in the prescribed fire permitting process; 4) Expand the timing for public notification regarding prescribed burns; 5) Incorporate additional best smoke management techniques into the regulation and add/clarify definitions to ensure better air quality and transparency. Also includes changes to correct typographical errors.

Statutory authority

Section 25-7-101, C.R.S., et seq, and specifically Sections 25-7-102, 25-7-105, 25-7-105.1, 25-7-106, 25-7-109, 25-7-114.1, 25-7-114.2, and 114.7; 24-4-103 and 25-7-110, 25-7-110.5 and 25-7-110.8 C.R.S., as applicable and amended.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Air Quality Control Commission

REGULATION NUMBER 9 OPEN BURNING, PRESCRIBED FIRE, AND PERMITTING

5 CCR 1001-11

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

I. Scope

This regulation applies to all open burning activity throughout the state.

II. Definitions

The following definitions apply for the purposes of this Regulation Number 9.

A. Agricultural Open Burning

The open burning of cover vegetation for the purpose of preparing the soil for crop production, weed control, maintenance of water conveyance structures related to agricultural operations, and other agricultural cultivation purposes.

B. Air Curtain Destructor (ACD)

An open burning device that operates by forcefully projecting a curtain of air across an open chamber or pit in which combustion occurs. Devices of this type can be constructed above or below ground and with or without refractory walls and floor. (Air Curtain devices are not conventional combustion devices with enclosed fireboxes and controlled air technology such as mass burn, modular and fluidized bed combustors.) Also referred to as air curtain burners and air curtain incinerators.

C. Authorized Local Agency

A local air pollution control authority to which the Division has delegated authority to issue general open burning permits and/or prescribed fire permits.

D. Broadcast Burn

A broadcast burn is the controlled application of fire to wildland fuels in their natural or modified state over a predetermined area. Broadcast burns do not include the burning of wildland fuels that have been concentrated in piles by manual or mechanical methods.

E. Class I Area and Mandatory Federal Class I Area

A class I area is an area listed in Regulation Number 3, Part B, Section V.A.

F. Clean Lumber

Wood or wood products that have been cut or shaped and include wet, air-dried, and kiln-dried wood products. Clean lumber does not include wood products that have been painted, pigment-stained, or pressure-treated by compounds such as, but not limited to, chromium copper arsenate, pentachlorophenol, and creosote. Clean lumber that is dry may only be burned with an ACD.

G. Fuel Treatment

Manipulation, including combustion, or removal of wildland fuels to reduce the likelihood of ignition and/or to lessen potential damage and resistance to control of wildfire.

H. General Open Burn

A planned fire below the prescribed fire de minimis emissions and smoke threshold pursuant to Appendix A.

~~H~~I. Land Manager

Any federal, state, local or private person or entity that administers, directs, oversees or controls the use of public or private land, including the application of fire to the land.

~~I~~J. Monitoring

Monitoring includes all methods to observe and record smoke from prescribed fire, including tracking of smoke through visual observation.

K. Natural Wood

Natural wood is wood which was grown as a tree or shrub and which has not been treated. Treated wood may include, but is not limited to: dimensional shaping, kiln drying, chemical drying, painting, pressure treating, or any other modification to the wood beyond cutting.

~~J~~L. Open Burning

Burning of rubbish, wastepaper, natural wood, vegetative material or any other flammable material on any open premises, or on any public street, alley, or other land adjacent to such premises.

~~K~~M. Pile Burning

Burning of vegetative material that has been concentrated by manual or mechanical methods and separated into piles.

N. Planned Ignition Fire

A prescribed fire ignited by a specific man-made action intended for the purpose of using the fire for grassland or forest management~~.~~ in which the emissions and smoke levels have the potential to exceed the de minimis threshold pursuant to Appendix A.

~~L~~O. Planning Document

A document that summarizes the use of prescribed fire as a grassland or forest management tool and the associated discharge or release of air pollution.

~~M~~P. Prescribed Fire

Fire that is intentionally used for grassland or forest management, including vegetative, habitat or fuel management, regardless of whether the fire is ignited by natural or human means. Prescribed fire does not include open burning in the course of agricultural operations and does not include open burning for the purpose of maintaining water conveyance structures.

Q. Private Household Trash

Private household trash consists of paper and cardboard. Private household trash does not include food waste, plastic, coated or treated wood, tires and/or rubber, appliances, aerosol/paint cans, insulation or any other non-paper or non-cardboard items.

~~N~~ ~~Planned Ignition Fire~~

~~A prescribed fire ignited by a specific man-made action intended for the purpose of using the fire for grassland or forest management in which the emissions and smoke levels have the potential to exceed the de minimis threshold pursuant to Appendix A.~~

~~O~~R. Prescribed Fire Plan, Wildland Fire Use Plan or Burn Plan

A plan that establishes parameters or conditions for conducting a prescribed fire.

~~P~~S. Significant User of Prescribed Fire

A federal, state or local agency or significant management unit thereof or person that, within any given calendar year:

1. Collectively manages or owns more than 10,000 acres of grassland and/or forest land within the state of Colorado; and

2. Plans to use prescribed fire to broadcast burn and/or pile burn, where the prescribed fires planned for a calendar year will generate more than ten tons of PM10. See Appendix B of this regulation for information to estimate PM10 emissions from prescribed fires.

   The adoption of a fire management plan by a local or county unit of government pursuant to Section 30-11-124, C.R.S., does not constitute management for purposes of this regulation unless the county or local unit of government owns or manages more than ten thousand acres (10,000) and is a significant user of prescribed fire.

~~Q~~T. Smoke Management

Use of techniques to reduce smoke emissions, dilute smoke, identification and reduction of the impact of smoke on smoke-sensitive areas, monitoring and evaluation of smoke impacts from individual and collective burns and coordination among land managers for these purposes.

~~R~~U. Smoke Sensitive Areas or Receptors

Class I areas and other locations of scenic and/or important vistas, especially during periods of significant public use, urban and rural population centers, schools, hospitals, nursing homes, ~~transportation facilities such as roads and airports~~, recreational areas, and other locations that may be sensitive to smoke impacts for health, ~~safety,~~ and/or aesthetic reasons.

~~S~~V. Suppression Action or Activities

Any activity in which the land manager or responsible fire agency personnel take appropriate fire management actions intended to actively confine, contain or control a fire. Suppression action may include the use of natural fire barriers such as cliffs, rocks, or rivers as part of a suppression strategy.

~~T~~W. Unplanned Ignition Fire

A prescribed fire ignited by natural phenomena or by military munitions. Unplanned ignition fires include wildland fires used for resource benefits and wildland fires ignited by military munitions.

~~U~~X. Wildfire

Any fire that is not intended for use for grassland or forest management, regardless of whether the fire is ignited by natural or human means.

~~V~~Y. Wildlands

An area where development is generally limited to roads, railroads, power lines and widely scattered structures. The land is not cultivated (i.e., the soil is disturbed less frequently than once in ten years), is not fallow, and is not in the United States Department of Agriculture Conservation Reserve Program. The land may be neglected altogether or managed for such purposes as wood or forage production, wildlife, recreation, wetlands or protective plant cover.

~~W~~Z. Wildland Fuels

Combustible vegetative materials located on wildlands that can be consumed by fire, including naturally occurring live and dead vegetation, such as grass, leaves, ground litter, plants, shrubs, and trees, as well as excessive buildups of these materials resulting from resource management and other land use activities, as well as from natural plant growth and succession.

~~X~~AA. Wood Waste

Untreated wood and untreated wood products, including tree stumps (chipped only), trees, tree limbs (whole or chipped), bark, sawdust, chips, scraps, slabs, millings, and shavings.

~~Y~~BB. Yard Waste

Conifer needles, bushes, shrubs, and clippings from bushes and shrubs, are resulting from maintenance of yards or other private or public lands.

III. Open Burning Permit Requirements

A. No person shall conduct any open burning activity not exempted from this regulation without first obtaining an open burning permit from the Division or from an authorized local agency. No person shall burn or allow the burning of rubbish, wastepaper, natural wood, vegetative material, or any

other flammable material on any open premises, or on any public street, alley, or other land adjacent to such premises without first obtaining an open burning permit from the Division or authorized local agency.

B. The following activities are exempt from the requirement to obtain an open burning permit:

1. Noncommercial burning of private household trash in particulate matter (PM10) attainment areas unless local ordinances or rules prohibit such burning.

2. Fires used for noncommercial cooking of food for human consumption~~,~~ or recreational purposes;

3. Fires used for instructional or training ~~purposed~~purposes, except instructional or training wildland pile or broadcast fires larger than the de ~~minimus~~minimis thresholds of a low-smoke impact burn pursuant to Appendix A of Regulation Number 9;

   a. Training or instructional fires must comply with all applicable federal, state and local laws, including the demolition notification requirements in Regulation Number 8, Part B, Section III.E.1 for intentional structural fires.

4. Safety flares used to signal danger to the public;

5. Agricultural open burning~~; and~~

   The open burning of animal parts or carcasses is not included in this exemption. Except that, if the State Agricultural Commission declares a public health emergency or a contagious or infectious disease outbreak that imperils the livestock of the state that requires the burning of diseased animal carcasses on weekends or holidays, the owner or operator may conduct open burning of the diseased carcasses after providing telephone notice to the Division and the relevant local health department office by leaving a voice-mail message. All necessary safeguards shall be utilized during such non-permitted open burning to minimize any public health or welfare impacts. In addition, the owner or operator shall take steps to ensure that all surrounding and potentially impacted residents, businesses, schools, and churches are notified prior to beginning the open burn;~~.~~ and

6. Noncommercial burning of trash in the unincorporated areas of counties of less than 25,000 population according to the latest federal census provided such open burning is subject to regulations of the Board of County Commissioners for such county adopted by resolution and such regulations include, among other things, permit provisions and prohibit any such burning that would result in the exceedance of any National Ambient Air Quality Standards applicable to that portion of the atmosphere to which the general public has access.

C. Nothing in this regulation shall be construed as relieving any person conducting open burning from meeting the requirements of any applicable federal, state or local requirements concerning disposal of waste materials.

IV. General Open Burning Permit

A. General Open Burning Permit Applications

1. Any person seeking authority for open burning or to conduct prescribed fires below the de ~~minimus~~minimis emissions and smoke threshold pursuant to Appendix A to this regulation may apply for and obtain a general open burning permit subject to the conditions set forth in this section. Significant users of prescribed fire may apply for and obtain a general open burning permit if they also satisfy the requirements of Section VII of this regulation.

2. Persons seeking a general open burning permit must ~~shall~~ submit to the Division, or the authorized local agency, an application on a Division-approved form ~~form for each separate burn~~. The application must demonstrate that the open burn can and will be conducted in a manner that minimizes the emissions from the burn and the impacts of the smoke on the health and welfare of the public. For prescribed fires under the d~~D~~e ~~Minimus~~minimis threshold, the application must demonstrate the potential for smoke impacts is low as determined by the Division ~~or Authorized Local Agency~~.

B. Rules Specific to General Open Burning Permits

1. Burning in barrels is prohibited; burning may only be conducted in open burn piles;

2. The maximum acreage for a broadcast burn is 10 acres or less of grass and 5 acres or less of other vegetation;

3. Only natural wood, leaves, dry prairie grass, slash and weeds may be burned;

4. Prohibited items include, but are not limited to, clean lumber, pallets, tree stumps, tires, chemicals, plastic, construction debris, and furniture;

5. All burns must have fire suppression ready at all times.

C~~B~~. ~~General~~ Open Burning Permit Criteria

1. The Division or authorized local agency shall consider the following factors in determining whether, and upon what conditions, to issue a general open burning permit;

   a. The location and proximity of the proposed burning to any building or other structure;

   b. Meteorological conditions on the day or days of such the proposed burning; and

   c. Compliance by the applicant for the permit with applicable fire protection and safety requirements of the local authority;

   d. Whether there is any practical alternative method for the disposal of the material to be burned;

   e. The potential contribution of the proposed burning to air pollution in the area; whether the burning will be conducted using best smoke management techniques so as to minimize emissions and the impacts from the smoke on the health and welfare of the public; and

   f. The smoke impact potential for prescribed fires pursuant to Appendix A of this regulation.

2. Methods to minimize emissions and smoke impacts may include, but are not limited to:

   a. The use of permitted air curtain destructors pursuant to Section IV.CB.4 of this regulation;

   b. The use of clean auxiliary fuel;

   c. Drying the material prior to ignition; and

   d. Separation for alternative disposal of materials that produce higher levels of emissions and smoke during the combustion process.

3. Any device defined as an incinerator under the Common Provisions is not subject to the permitting requirements under open burning.

4. The Division shall consider the following in determining whether, and upon what conditions, to issue an air curtain destructor (ACD) Permit.

   a. Device shall burn only yard waste, wood waste, clean lumber, or any mixture thereof generated as a result of projects to reduce the risk of wildfire;

   b. Whether there is any practical alternative disposal method for the proposed burning;

   c. Whether the applicant will conduct any particular burn in accordance with permit conditions in the general open burning permit application pursuant to Section IV.C. of this regulation;

   d. ACD permit conditions may include, but are not limited to, the following:

      i. Shall demonstrate within 60 days after beginning operation the device meets the following emission limits:

         (A) Opacity limit is 10 percent, averaged over 6 minutes, except during startup and malfunctions;

         (B) Opacity limit is 35 percent, averaged over 6 minutes; during startup period within first 30 minutes of operation;

         (C) No more than one startup period per day, not to exceed 30 minutes;

         (D) These limits apply at all times except during malfunctions;

         (E) Malfunctions shall not exceed a total of one hour per day; and

         (F) Excess emissions during malfunctions shall be reported in accordance with Common Provisions Regulation, Section II.E.

      ii. Shall not be co-located with another ACD or any other facility that is required to have an air quality permit or any commercial or industrial facility;

iii. Shall be erected and operated in accordance with the manufacturer's recommendation;

iv. Shall meet the following if a trench device:

(A) Trench dimensions must follow manufacturer's recommendations;

(B) Trenches must be maintained with a rectangular opening and vertical sidewalls;

(C) Bottom of trench must be above water table and not collect groundwater seepage;

(D) Trench must be protected from surface runoff by a berm or other barrier; and

(E) Trench cannot be in land filled material containing any solid waste, including construction and demolition debris.

v. Shall not exceed the manufacturer's recommended throughput or 20 tons per hour, whichever is less;

vi. Shall be operated during daylight hours and not to exceed 13 hours per day;

vii. Shall emit less than 100 tons of any criteria pollutant per calendar year;

viii. Shall ensure the fire is extinguished prior to departure from the project site or a fire watch patrol will remain behind to ensure there is no risk of ~~to~~ escape or nighttime smoke production.~~,~~ An extinguished fire shall produce no visible smoke;

ix. Shall be setback from occupied structure on other property, and from perimeter of restricted public access shall be:

(A) Minimum 300 ft., for any location where an ACD is operated 14 days or more per year; or

(B) Minimum 150 ft., for any location where an ACD is operated for less than 14 days per year.

x. Shall meet Division's reporting and record keeping requirements; and

xi. Shall notify the public in smoke-sensitive areas regarding the location, expected duration and projected smoke impacts from the operation.

D~~C~~. General Open Burning Permit Conditions

General open burning permits will include, but not be limited to, the following conditions, as appropriate:

1. Air pollution emergencies and alerts

   General open burning permits are not valid during periods of publicly announced air pollution emergencies or alerts in the area of the proposed burn. Open burning during such periods may be conducted only with direct written permission from the authority that granted the permit.

2. Smoke management

   In order to minimize emissions and smoke impacts, each permittee shall use the best smoke management techniques appropriate to the proposed burn. The permit may allow the use of auxiliary fuels as reasonably necessary to induce proper ignition.

3. To the degree practical, all burning shall be conducted during periods conducive to smoke dispersal.

4. For burns of piled material, all piles shall be reasonably dry and free of dirt.

5. Wind speed

   The authority granting the permit may impose conditions on wind speed at the time of the burn to minimize smoke impacts on smoke-sensitive areas.

6. Wind direction

   The authority granting the permit may impose conditions on wind direction at the time of the burn to minimize smoke impacts on smoke-sensitive areas.

7. Burn supervision

   Open burns must ~~shall~~ be supervised by a responsible person who must ~~shall~~ have available the means to suppress the burn if the fire does not comply with the terms and conditions of the permit. Precautions shall be taken to ensure that the burning is restricted to the items and location identified in the permit. ~~and to avoid all fire hazards to persons or property within or adjacent to the area in which the permit allows an open burn.~~

8. Inspection

   All open burning operations shall be subject to inspection by the Division and/or the local agency. The permittee shall maintain at the burn site the original or a copy of the permit that shall be made available without unreasonable delay to the inspector.

9. The permit shall state that the permit is for compliance with state air pollution control requirements only and is not a permit to violate any existing local laws, rules, regulations, or ordinances regarding fire, zoning, or building. The permittee will notify the appropriate local agencies as required by local regulations and/or ordinances. Permittees also shall ensure that their actions comply with all procedural and substantive requirements contained in state and local air pollution control regulations.

10. The permit is valid only for the date or period specified in the permit.

11. The Division or local agency may include in the permit other conditions necessary to protect public health and welfare from emissions and smoke impacts.

12. Revocation of permit

If at any time the Division or the local agency granting the permit determines that the permittee has not complied with any term or condition of the permit, the permit is subject to partial or complete suspension or revocation or imposition of additional conditions. All burning activity subject to the permit shall be terminated immediately upon notice of suspension or revocation. In addition to suspension or revocation of the permit, the Division or local agency may take any other enforcement action authorized under state or local law.

V. Planned Ignition Fire Permits

A. No person shall initiate a planned ignition fire without first obtaining a prescribed fire permit from the Division or authorized local agency unless the potential for smoke impacts are low pursuant to the factors in Appendix A to this regulation. Persons seeking authority to conduct prescribed fires with a low potential for smoke impacts pursuant to Appendix A shall apply for a general open burning permit. Significant users of prescribed fire shall apply for and may obtain a planned ignition fire permit if they also satisfy the requirements of Section VII of this regulation.

B. Any person seeking authority to conduct a prescribed fire for which the emissions and smoke levels have the potential to exceed the de minimus threshold of a low smoke impact pursuant to Appendix A to this regulation shall apply for and may obtain a planned ignition fire permit on the conditions set forth in this Section V.

C. Persons seeking a planned ignition fire permit shall submit to the Division or authorized local agency an application on a form approved by the Division for each separate burn. The application must demonstrate that the planned ignition fire can and will be conducted in a manner that minimizes the emissions from the burn and the impacts of the smoke on visibility and on the health and welfare of the public.

D. The Division or authorized local agency shall consider the following factors in determining whether, and upon what conditions, to issue a planned ignition fire permit:

1. Whether all conditions required for general open burning permit applications pursuant to Section IV of this regulation has been met;

2. Whether the applicant evaluated the use of non-burning fuel treatments in place of the proposed burn;

3. The location of the proposed burn and smoke-sensitive areas and class I areas that might be impacted by the smoke and emissions from the burn;

4. The meteorological conditions under which the applicant proposes to conduct the burn and the measures that the applicant will take to ensure that the burn will be conducted only during those identified meteorological conditions, including coordination with appropriate sources of meteorological information on the day preceding ignition;

5. The smoke risk rating for the proposed burn;

6. The smoke mitigation techniques proposed;

7. Whether the applicant has demonstrated~~, through an emissions and smoke generation projection based on a model approved by the Division, the conditions under which the proposed prescribed fire will be conducted and~~ that the applicant will protect scenic and/or important vistas and visibility in class I areas, will minimize the impacts of emissions and smoke on the public, ~~and will not cause a violation of any ambient air quality standards~~ and will minimize the potential for a violation of any ambient air quality standards.

8. Whether the applicant will conduct the burn in accordance with a smoke management plan or narrative that requires:

   a. That best smoke management methods will be used to minimize or eliminate smoke impacts at smoke-sensitive receptors;

   b. That the burn will be scheduled outside times of significant visitor use in smoke-sensitive receptor areas that may be impacted by smoke and emissions from the fire;

   c. A monitoring plan to allow appropriate evaluation of smoke impacts at smoke-sensitive receptors;

   d. That smoke management contingency measures will be taken if unacceptable smoke impacts occur at smoke-sensitive receptors; and

   e. That measures will be taken to notify the public in smoke-sensitive areas at least twenty-four hours~~, and not more than 120 hours,~~ in advance of the planned ignition of the fire regarding the location, expected duration and projected smoke impacts from the fire.

9. Whether the applicant has demonstrated that the proposed burn will conform to all requirements of the state implementation plan; and

10. Whether the actual burn activity that occurs will be reported to the Division or authorized local agency on forms approved by the Division.

E. Planned Ignition Fire Permit Conditions

Planned ignition fire permits shall include, but not be limited to, the following conditions, as appropriate:

1. All conditions required for issuance of a general open burning permit pursuant to Section IV of this regulation and all conditions necessary to meet the requirements of this Section V.

2. All permit conditions necessary to ensure that the burn will be conducted so as to minimize the impacts of the fire on visibility and on public health and welfare.

3. The Division or authorized local agency may allow the applicant to conduct a test fire to evaluate dispersal conditions.

F. Public Comment

1. The Division will evaluate fires proposed in permit applications to determine whether the fire will pose a high smoke risk. The evaluation will include consideration of the size of the fire area, the type and density of fuel, whether or not the fire is a pile burn, expected duration, and the proximity of the fire to smoke sensitive receptors, such as communities and class I areas.

2. If the Division determines that the fire poses a high smoke risk, the Division will provide appropriate notice to the public, such as by making the information available through the internet and by email, and will issue a draft permit for public comment. The notice will include information about location of the fire, expected burn dates, expected duration, potential emissions, potential air quality and visibility impacts at smoke sensitive receptors and the opportunity for public comment. The procedures in the Commission's Procedural Rules apply to any draft permit subject to the public comment provisions of this paragraph. If the Division receives public comment, it will consider those comments in determining whether to issue a permit and what conditions to impose upon the permittee and within thirty days of the close of the comment period or within thirty days following the close of any public comment hearing, whichever is later, shall either grant or deny the permit.

3. Draft permits for high smoke risk burns that have been subject to the public notice provisions of paragraph V.F.2 and for which a permit has been issued, but which have not been completed within the period for which the permit is valid are not subject to the public comment provisions of paragraph V.F.2. This exception to the public comment requirements applies only: for the geographical unit for which a permit that has been subject to the public comment provisions was issued; if less than ten percent of the area originally permitted has been burned; and for a maximum of five years from the date of issuance of the original permit. The Division may amend the permit, based on a case-by-case analysis, to accommodate minor changes in the permit area without triggering the public comment provisions of paragraph V.F.2.

VI. Unplanned Ignition Fire Permits

A. Any person may apply for an unplanned ignition fire permit. A permit allows the use of fire for grassland or forestland management although the applicant did not plan the specific time and location of the ignition. Wildfires do not require a permit if the land manager undertakes appropriate suppression activities. Significant users of prescribed fire may apply for and obtain an unplanned ignition fire permit if they also satisfy the requirements of Section VII of this regulation.

B. Applications for unplanned ignition fire permits shall be submitted to the Division on forms approved by the Division for each area for which a permit is sought. The application submitted by any person shall include a plan and map depicting the area proposed for the permit. The Division may grant unplanned ignition prescribed fire permits for a period of up to five years provided that the information contained in the application remains valid. The Division may amend the permit, based on a case-by-case analysis, to accommodate minor changes in the permit area.

C. The Division shall consider the following factors in determining whether to grant an unplanned ignition fire permit:

1. Whether the applicant evaluated the use of non-burning fuel treatments in place of allowing unplanned ignition fires to continue burning;

2. The location of the proposed burns and smoke-sensitive areas and class I areas that might be impacted by the smoke and emissions from the burns;

3. The smoke risk rating for proposed burns;

4. The sources of meteorological information that the applicant will use to evaluate potential visibility and smoke and emission impacts from each fire;

5. The meteorological conditions under which the applicant proposes to allow unplanned ignition fires to continue burning without suppression efforts and the suppression measures that the applicant will take if weather at the time of the burn does not meet those identified meteorological conditions;

6. Whether the application demonstrates that the Division will be notified by telephone or by another Division-approved method as soon as possible, but no later than two hours after the start of the next working day, and daily thereafter, of the occurrence of an unplanned ignition fire greater than five acres in size that the applicant intends to use for grassland or forest land management;

7. Whether the application demonstrates that the applicant will evaluate the fire conditions daily to determine whether the fire meets the terms of the permit, including an evaluation based on appropriate information to ensure that ambient air quality standards are not being violated nor visibility goals exceeded;

8. Whether the applicant will conduct the burn in accordance with a smoke management plan or narrative that requires:

    a. A monitoring plan, including visual observation, to allow appropriate evaluation of smoke impacts at smoke-sensitive receptors;

    b. That suppression activities will be taken if unacceptable smoke impacts occur at smoke-sensitive receptors;

    c. That measures will be taken to notify the public, within twenty-four hours of discovery of the unplanned ignition, that the applicant intends to use the fire for grassland or forest land management and of the location and expected smoke impacts from the fire; and

9. Whether the actual burn activity that occurs will be reported to the Division on forms approved by the Division.

D. Unplanned Ignition Fire Permit Conditions

Each unplanned ignition fire permit shall contain, but not be limited to, the following conditions, as appropriate:

1. All permit conditions necessary to ensure that the burn will be conducted so as to minimize the impacts of the fire on visibility and on public health and welfare and all conditions necessary to meet the requirements of this Section VI;

2. The applicant must ~~shall~~ promptly initiate suppression action if the fire fails to comply with the permit terms or other activities to ensure that the fire remains within the terms of the permit;

3. The applicant must ~~shall~~ evaluate the fire with appropriate resources to determine whether the fire remains within the permit terms. Appropriate evaluations may include daily monitoring and appropriate modeling to determine whether the fire will minimize the potential for ~~cause~~ a violation of any ambient air quality standard or otherwise ~~will~~ cause unacceptable impacts to human health or welfare, visibility or the environment.

E. Public Comment

1. The Division will evaluate fires proposed in permit applications to determine whether the fire will pose a high smoke risk. The evaluation will include consideration of size of the fire area, the type and density of fuel, and the proximity of the fire to smoke sensitive receptors, such as communities and class I areas.

2. If the Division determines that the fire poses a high smoke risk, the Division will provide appropriate notice to the public, such as by making the information available through the internet and by email, and will issue a draft permit for public comment. The notice will include information about location of the fire, expected range of time when a burn may occur and potential air quality and visibility impacts at smoke sensitive receptors. The procedures in the Commission's Procedural Rules apply to any draft permit subject to the public comment provisions of this paragraph. If the Division receives public comment, it will consider those comments in determining whether to issue a permit and what conditions to impose upon the permittee and within thirty days of the close of the comment period or within thirty days following the close of any public comment hearing shall either grant or deny the permit.

VII. Additional Requirements ~~F~~for Significant Users o~~O~~f Prescribed Fire

A. Applicability

This Section VII applies to activities throughout the state of all significant users of prescribed fire, as defined in Section II.N of this regulation, not specifically exempted by this regulation. The Commission may exempt from the requirements of this Section VII any significant user of prescribed fire upon finding that specific activities of the user will have an insignificant impact on visibility and air quality.

B. Planning Documents.

1. Significant users of prescribed fire as a grassland or forest management tool shall submit plan’s addressing the use and role of prescribed fire and the air quality impacts resulting there from.

2. Planning documents shall:

a. Specify the area to which they apply, which should be relevant to as large an organizational unit of land as is administratively reasonable;

b. Specify the time period to which they apply;

c. Be relevant to vegetative, habitat, and/or fuel management of grassland and/or forest land; and

d. Explain the decision process and criteria considered or applied to show:

i. How the significant user of prescribed fire identifies fuel treatment alternatives to achieve the fuel, habitat, and/or vegetative land management goals;

ii. How the significant user of prescribed fire selects among fuel treatment alternatives;

e. Include a discussion of the alternatives to prescribed fire considered and a discussion of how prescribed fire, if selected, minimizes the risk of wildfire; and

f. Demonstrate, for land selected for fuel treatment, how the significant user of prescribed fire considered the state standard set forth in Section VII.C and how the user will achieve compliance with that standard.

3. Planning documents may summarize the elements of other larger and more general documents.

4. Addition of land subject to planning document review

a. Significant users of prescribed fire that acquire ownership or jurisdiction over lands after a planning document is submitted shall identify the new land areas to the Division and describe how the new lands will be managed in relation to the requirements of this Section VII.

b. New lands that will be managed in the same manner as current lands in the organizational unit described in the planning document will be subject to the same restrictions on permit issuance and conditions as lands already included within the planning document. New lands that will be managed differently than lands already included within the planning document must be addressed in a separate or subsequent planning document submitted to the Commission.

5. Change in Ownership

a. If a change in majority ownership or agency jurisdiction over lands occur that are subject to this Section VII. and that have an approved planning document, the new owner(s) or authorized agency representative shall, in writing to the Division, identify the new owner(s) or agency and describe whether the new owner(s) or agency will manage the lands as per the approved planning document in relation to the requirements of this Section VII.

b. If the land will be managed in the same manner as under the previous owner(s) or management agency as described in the approved planning document, written notice to the Division is sufficient. If the land will not be managed per the approved planning document, as determined by the new owner/manager or the Division, the new owner or agency manager must address the requirements of

this Section VII in a separate or subsequent planning document submitted to the Commission.

C. Compliance ~~W~~with the State Standard

All prescribed fire activities of significant users of prescribed fire in grassland and forest land management, including activities directly conducted by or on behalf of such users on their lands, shall conform to the state standard to minimize emissions using all available, practicable methods that are technologically feasible and economically reasonable in order to minimize the impact or reduce the potential for such impact on both the attainment and maintenance of national ambient air quality standards and achievement of federal and state visibility goals.

D. Planning Document Review Process

1. Significant users of prescribed fire shall submit to the Commission planning documents for each area in which the user intends to use prescribed fire for grassland or forest land management.

2. The Division shall review the planning documents submitted to the Commission and shall present its comments and recommendations to the Commission.

3. The Commission shall hold a public hearing to review each planning document. The Commission shall hold the hearing and complete its review of the planning document within forty-five calendar days of receipt of the document unless the significant user of prescribed fire agrees to a longer review period. Only one hearing shall be held for each planning document during the time it is considered applicable unless an additional hearing is requested by the significant user of prescribed fire for an updated or amended planning document.

4. Following the hearing and consideration of the comments and recommendations of the Division and any other information received relative to the planning document, the Commission shall comment and make recommendations to the significant user regarding any changes to the planning document relating to the discharge or release of air pollutants that the Commission finds necessary to comply with the state standard identified in Section VII.C.

E. Open Burning Permits for Significant Users of Prescribed Fire

1. The Division shall not issue any type of open burning permit to a significant user of prescribed fire or entities acting on its behalf after July 1, 2002, unless a planning document for the area to be burned has been submitted to the Commission for review, public hearing, and comment in accordance with Section VII.D.

2. The Division shall not issue a permit for open burning to a significant user of prescribed fire or entities acting on its behalf after July 1, 2002, unless the permit is consistent with the comments and recommendations made by the Commission concerning the user's planning document pursuant to Section VII.D.

a. Permit conditions imposed pursuant to this subsection may be excluded from the permit if a federal land manager asserts that the condition is specifically prohibited by federal statute and the Division determines that the assertion is correct.

b. The Division shall report all such exclusions to the Commission, the Governor and the Director of the Legislative Council within 30 days after the Division grants the exclusion.

3. The Division may grant a permit regardless of the prohibition of this subsection if it determines that issuance of the permit is necessary to protect public health and safety.

4. For the purposes of this Subsection VII.E, a permit for open burning includes permits for general open burning, planned ignition fires and unplanned ignition fires and related suppression activities, but does not include wildfire or suppression activities associated with wildfire.

5. The Division shall not issue a prescribed fire permit to a significant user of prescribed fire for areas with outdated planning documents. For the purposes of this subsection, planning documents shall be considered outdated upon expiration of the time period for which the document is applicable as stated in the document, but in no event longer than 10 years after submission of the planning document to the Commission.

VIII. Fees ~~F~~for Open Burning and Prescribed Fire

A. Fees for General Open Burning Permittees

The Division shall charge no fees under this regulation to general open burning permit applicants or permit holders.

B. Planning Document Evaluation Fees for Significant Users of Prescribed Fire

1. Every significant user of prescribed fire submitting a planning document to the Commission as required in Section VII of this regulation shall pay a fee for the direct and indirect cost of evaluating such documents.

2. If the Division requires more than thirty hours to evaluate the planning documents, the fee paid by the significant user of prescribed fire shall not exceed $3,000, unless the Division has informed the significant user that the billing may exceed $3,000 and has provided the significant user of prescribed fire with an estimate of what the actual charges may be prior to commencing the work.

3. The planning document review fee shall be calculated at the rate stated in C.R.S. Section 25-7-114.7(2)(a)(III).

4. The Division shall prepare and send a bill at least annually to each significant user of prescribed fire if the Division has spent one or more hours reviewing planning documents from the significant user of prescribed fire. The bill will specify the number of hours spent and the total fee amount. All fees assessed must be received within 30 days of the date of receipt of the written bill. All fees collected under this regulation shall be made payable to the Colorado Department of Public Health and Environment.

C. Prescribed Fire Fees

1. The Division shall charge no flat fee to an applicant for a planned ignition fire permit who applies to an authorized local agency for that permit. Permitting activity and actual

burning activity for such permits shall not be counted into SMP scores pursuant to this regulation's Appendix C, "Distribution of Cost" section.

2. Except as provided for in VIII.C.1. every permittee pursuant to Section V and VI of this regulation shall pay fees as set forth in the following paragraphs to cover the cost of the smoke management program.

3. Fees shall be charged to recover the direct and indirect costs incurred by the Division to operate and administer the smoke management program. Such costs include, but are not limited to: process permit applications; issue permits; compile emission inventory and monitoring information; prepare generally applicable regulations or guidance; model, analyze, and make demonstrations; conduct a compliance assistance and enforcement program; track wildfire activity as needed; operate the fee program; and review plans.

4. The Division shall prepare and send a bill at least annually to each permittee specifying each fee type and the total fee amount for the previous calendar year. All fees assessed must be paid within 30 days of the date of receipt of the written bill. All fees collected under this regulation shall be made payable to the Colorado Department of Public Health and Environment.

    a. Every permit applicant shall pay annual fees regardless of:

        i. Whether a permit is issued, ~~denied~~, suspended, withdrawn, or revoked; and

        ii. Whether actual burning activity occurred.

5. The fee will be calculated in accordance with the Program Cost and Distribution Methodology contained in Appendix C of this regulation.

APPENDIX A DE ~~MINIMUS~~MINIMIS PRESCRIBED FIRE PROJECTS

Some proposed planned ignition prescribed fire projects for grassland and forest management may emit relatively low amounts of smoke and emissions and be below the de ~~minimus~~minimis threshold of a low potential for smoke impacts. If so, such projects may apply for a general open burning permit. Alternatively, if a project is above the de ~~minimus~~minimis threshold, then such projects must apply for and may obtain a planned ignition fire permit. To determine whether a proposed planned ignition prescribed fire is above or below the threshold for low potential smoke impacts, the Division must ~~shall~~ consider the following factors:

1. Size of the project;

2. Fuel type

3. Duration of the project including smoldering and potential for nighttime smoke; and

4. Proximity of the project to smoke sensitive areas

Projects meeting the following guidelines will be considered to have low potential for smoke impacts for the first three factors:

De~~Minimus~~ Minimis Threshold for Open Burning Permits

Type of Project	Thresholds
Broadcast Burn	< 10 acres of grass OR < 5 acres of other vegetation
Pile Burn	All piles out cold before sunset, AND No more than 50 piles total in the project

The final factor, proximity of the project to smoke sensitive areas will be addressed with project permit conditions. The Division may apply the factors and approve different De~~Minimus~~ Minimis Thresholds for good cause shown.

APPENDIX B ESTIMATING PM10 EMISSIONS FOR THE PURPOSE OF DETERMINING WHETHER A LANDOWNER/MANAGER IS A SIGNIFICANT USER OF PRESCRIBED FIRE

TABLE I EXAMPLE BURNS Estimated to Potentially Produce 10 Tons of PM10 Emissions

FUEL TYPE	**SIZE OF BURN**	**FUEL LOADING ASSUMED**	**FUEL CONSUMPTION ASSUMED** (%)	**EMISSION FACTOR** (pounds/ton)
Grass	575 acres	2 tons/acre	87	20
Sagebrush	191 acres	5 tons/acre	70	30
Oakbrush or Aspen	556 acres	4 tons/acre	50	18
Pine/Conifer	23 acres	30 tons/acre	48	60
Pinon/Juniper	476 acres	3 tons/acre	59	24
Piled Slash	144,000 ft3	38 pounds/ ft3	92	8

Example Calculations:

Example 1

A grass burn of 575 acres that is estimated to have a fuel loading of 2 tons per acre and 98% of the acreage burned (black acreage) is estimated to produce:

([(575 acres x .98) x 2 tons/acre] x 20 pounds/ton)÷ 2000 pounds/ton=11.27 tons of PM10

A landowner/manager completing this burn is a “significant user of prescribed fire” as defined in Regulation Number 9.

Example 2

A manager is proposing to treat 140 acres of mixed conifer in this calendar year. It is estimated the fuel loading is 5 tons per acre and 48% of the area is to be burned. This burn is estimated to produce the following particulate matter emissions:

140 acres x 48% fuel consumption=67.2 black acres

67.2 acres x 5 tons/acre=312 tons of fuel consumed

(312 tons x 60 pounds PM10/ton)÷ 2000 pounds/ton=9.36 tons of PM10

The PM10 emissions are below 10 tons. Based on this single burn, the manager is not defined as a "significant user of prescribed fire" in Regulation Number 9. If additional projects are to be completed in the same calendar year, the manager may be defined as a "significant user of prescribed fire" due to cumulative total PM10 emissions exceeding 10 tons.

TABLE II SOURCES OF INFORMATION/DATA USED IN TABLE I

FUEL TYPE	**REFERENCE**	**REFERENCE**
.	**FUEL LOADING**	**EMISSION FACTOR**
Grass	Aids to Determining Fuel Models for Estimating Fire Behavior, US Forest Service, 1982 and historical activity data	AP-42, EPA, 1996, Rocky Mountain Grasslands
Sagebrush	Average of historical activity data reported to the Division	US Forest Service, Fire and Air Research Station memo to the Division, 1990
Oakbrush or Aspen	Average of historical activity data reported to the Division	AP-42, EPA, 1996, Pacific SW Chaparral
Pine/Conifer	AP-42, EPA, 1996, Wildfires and Prescribed Burning, Rocky Mountain. Avg.	AP-42, EPA, 1996, Rocky Mountain Underburning Pine
Pinon/Juniper	Average of historical activity data reported to the Division	AP-42, EPA, 1996, Pacific SW Pinon/Juniper
Piled Slash	Guidelines for Estimating Volume, Biomass, and Smoke Production for Piled Slash, US Forest Service, 1996	AP-42, EPA, 1996, Rocky Mountain Logging Slash

APPENDIX C PROGRAM COST AND DISTRIBUTION METHODOLOGY

Fees that are levied by the Department to cover the costs of the Smoke Management Program are determined using the following methodology.

Cost of the Smoke Management Program

The Colorado Air Pollution Prevention and Control Act requires that the ~~s~~Smoke M~~m~~anagement ~~p~~Program (SMP) fees cover the cost of the program. Section 25-7-106(7)(a), C.R.S. The Air Pollution Control Division's Fiscal Officer determined the cost of the SMP ~~program~~ as implemented by this Regulation Number 9. The program cost is built upon estimates of the percent of each position devoted to all aspects of the ~~Smoke Management Program (~~SMP~~)~~. This percentage is applied to each position's salary and benefits. Operating costs and indirect costs are also included. The total cost of the SMP is $174,585.08 for calendar year 2008 and $199,305.13 for calendar year 2009 and succeeding years.

Fee Use

Functions of the SMP include but are not limited to: management, administration, permitting operations, modeling support, training of users of prescribed fire regarding air quality concerns and the SMP program, database management and reporting, fee program administration (including database management, invoicing, and/or customer service), regulatory development, guidance development, web page management/maintenance, compliance assistance, enforcement, field work, tracking of, and if necessary, involvement in wildfire monitoring, review of plans and involvement in public hearings, data entry, meteorological forecasting, and consultation on high smoke risk burns.

Fee Calculation

The annual cost of the SMP ~~program~~ will be the ~~smoke management program~~ SMP fee. The Division's cost of the SMP will be recalculated annually and reported to the Commission each August. If the Division's annual SMP ~~program~~ cost calculation exceeds five percent of the ~~smoke management program~~ SMP fee reflected in the regulation, the Division will seek a fee change through a Commission rulemaking.

The annual ~~program~~ SMP cost calculation must ~~shall~~ utilize the "total cumulative dollar difference" between the regulatory fee and the annual cost. It will be calculated by first computing a total projected ~~smoke management program~~ SMP cost considering the projected salary and benefits for personnel associated with the program (apportioned according to the percentage of time assigned to the program for each position), indirect costs, travel costs, Division operating costs, Department operating costs and Department indirect costs. That sum will be adjusted by the difference between salary and travel expenses and the previous year's projected salary and travel costs. The Division will complete the calculation of the total cumulative dollar difference by summing: the difference between the adjusted program cost and the previous regulatory fee; and the total cumulative dollar difference from the previous year.

Distribution of Cost

The Division will distribute the cost of the program to permittees as follows:

1. The fee for an unplanned ignition prescribed fire permit in effect for an area is $1000 per permitted area each year the permit is valid. Unplanned ignition prescribed fire permits are valid for up to 5 years.

2. The fee for a planned ignition prescribed fire permit for any permittee with a 3-year block average SMP score (see 3 below) under 1.00% is $100 per permit.

3. The fees for planned ignition fire permits for permittees with 3-year block average SMP score of 1.00% or greater shall be determined as follows:

    a. To distribute the cost of planned ignition prescribed permits for larger users of the SMP, each year the Division shall compute a Smoke Management Program Score (SMP score). The SMP score shall be calculated by averaging the percent of total planned ignition prescribed fire permits requested by that permittee in a calendar year; and the percent of total PM10 emissions generated by actual planned ignition prescribed fire burning activity by that entity.

    b. Every three years the Division must ~~shall~~ compute a 3-year block average SMP score based on the most recent three years SMP scores. The computed 3-year block average

SMP score must be applied to the next year's billing cycle, and for the following 2 years. For example, the 3-year block average SMP score for Year 1, Year 2, and Year 3 will be calculated in Year 4. This 3-year block average will be applied to planned ignition prescribed fire fees for activity conducted in Year 5, Year 6, and Year 7. The next calculation would occur in Year 7. Any entity ~~who's~~ whose SMP score is less than 1.00% shall be removed from the 3-year block average. The SMP scores for remaining users must ~~shall~~ be re-scaled to 100% after small users have been removed. Upcoming 3-year block average scores are scheduled for 2020, 2023, 2026, etc.

~~i. The 3-year block average shall be 2011-2013 to be used for planned ignition prescribed fire fees from activity conducted in 2015-2017.~~

~~ii. The percents to distribute the fees for the following entities for planned ignition prescribed fire activity conducted in 2012-2014 are: U.S.D.A. Forest Service 62.23%, U.S.D.I. Bureau of Land Management 17.45%, U.S.D.I. National Park Service 3.76%, Colorado Division of Wildlife and Parks 2.87%, Colorado State Trust Board 1.38%, U.S.D.O.D. Fort Carson 3.00%, Boulder County Open Space 1.32%, U.S.D.I. Fish and Wildlife Service 2.11%, Blue Valley Ranch 1.88%, and Trinchera Ranch 4.00%. The percents to distribute the fees for the following entities for planned ignition prescribed fire activity conducted in 2015-2017 are: U.S.D.A. Forest Service 66.36%, U.S.D.I. Bureau of Land Management 16.66%, U.S.D.I. National Park Service 4.45%, U.S.D.O.D. Fort Carson 3.22%, U.S.D.I. Fish and Wildlife Service 2.77%, Blue Valley Ranch 1.69%, and Trinchera Ranch 4.85%.~~

c. The resulting 3-year block average percent for each entity shall determine how the cost of the program will be distributed. The cost of the program shall have all unplanned ignition fees and small user fees subtracted from it before it is applied to the 3-year block average to determine the fee for planned ignition prescribed fire users with 3-year block average SMP scores at or greater than 1.00%.

IX. Statement of Basis, Specific Statutory Authority and Purpose

A. Adopted January 17, 2002

This Statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, Section 24-4-103, C.R.S. and the Colorado Air Pollution Prevention and Control Act, Sections 25-7-110 and 25-7-110.5 and implements parts of Sections 25-7-106(7) and (8), 25-7-114.7 and 25-7-123, C.R.S.

Basis

These rule revisions implement the provisions of Senate Bill 01-214 and relocate, update and reorganize existing provisions of Regulation Number 1 relating to open burning into Regulation Number 9. Regulation Number 9 deals solely with open burning activities. This new regulation contains permitting, monitoring, reporting and fee provisions, as well as requirements particular to significant users of prescribed fire.

Specific Statutory Authority

The Colorado Air Pollution Prevention and Control Act, Sections 25-7-109(2)(e) and 25-7-123, C.R.S., provides the authority for the Commission to adopt and modify a program including emissions control regulations to control burning activities. Sections 25-7-106(7) and (8), 25-7-114.7(2)(a)(III) and 25-7-123, C.R.S., set forth specific requirements relating to activities by significant users of prescribed fire, including

open burning activities by federal land managers. The Commission's action is taken pursuant to procedures set forth in Sections 25-7-105, 25-7-110 and 25-7-110.5, C.R.S.

Purpose

Open Burning

The focus of SB 01-214 is on open burning activities by significant users of prescribed fire. Addressing open burning issues is necessary in order to address emissions from natural and prescribed fires. The Grand Canyon Visibility Transport Commission identified these fires as having enough episodic impact on visibility at class I areas to overwhelm progress made through other emission control measures. The Commission views reduction of visibility impairment from fires as an important component in achieving federal and state visibility goals. This regulation should ensure that users of prescribed fire consider air pollution impacts in making determinations whether, and under what conditions, to use fire for grassland or forest management.

Permitting

The regulation continues the existing prohibition on open burning absent a permit from the Division or a local agency. The exemptions from this requirement also remain largely the same. In particular, agricultural open burning activity does not require a permit.

The regulation specifies factors that the Division must consider in deciding whether, and under what conditions, to issue a burning permit. These factors differ depending on the type of permit applicable to the proposed activity.

General open burning permits are the basic permits for most burning activities. General permits require that an applicant use best smoke management techniques to reduce or eliminate smoke impacts on the health and welfare of the public. Although the regulation includes a partial listing of methods to minimize fire emissions and smoke impacts, the Commission intends that the Division will exercise its discretion to achieve the goals of this regulation without imposing unreasonable conditions. The Division to local counties may delegate general open burning.

The next category of fire addressed by this regulation is planned ignition fires, which are a subset of prescribed fires for grassland and forestland management. The Commission decided to establish emissions and smoke de minimus threshold below which a permit applicant must only obtain a general open burning permit. For fires that will exceed that threshold, applicants intending to initiate a fire must obtain a permit for a planned ignition fire. Permits for this type of fire must address additional concerns beyond those applicable to general open burning activities. The Commission listed factors for Division consideration in determining whether, and under what conditions, to issue a permit. This list is not exclusive and the Division may incorporate in permits additional conditions if it finds them necessary to minimize the impacts of fire on visibility and on public health and welfare. These factors focus on identifying and minimizing impacts to smoke-sensitive receptors. In addition, planned ignition permit conditions should ensure that the permittee would take appropriate action to ensure that the fire remains within the terms of the permit or is managed so as to return it within those terms, or that the permittee will suppress the fire if compliance with permit terms cannot otherwise be achieved.

Unplanned ignition fire permits offer persons a mechanism to use fire for grassland or forest management even though the precise time and location of a particular prescribed fire cannot be anticipated. These permits generally will apply to larger parcels of land, in some portion of which unplanned ignition may occur. The purpose of this permit type is to determine before ignition the conditions under which the fire may be used for resource benefit. As with planned ignition fires, permit conditions should ensure that the

permittee will take appropriate action to ensure that the fire remains within the terms of the permit or is managed so as to return it within those terms, or that the permittee will suppress the fire if compliance with permit terms cannot otherwise be achieved.

This regulation focuses on fires that a person intends to use for a beneficial purpose, such as grassland or forest management. The Commission distinguished between those fires and wildfires. Wildfires are beyond the scope of this regulation and no permitting requirements apply to a land manager within whose jurisdiction a wildfire occurs.

The Commission also concluded that a public comment opportunity should be available regarding fires with a high smoke risk. The Commission intends that a high smoke risk rating be equivalent to a rating of 41 or greater from the draft Smoke Risk Rating Worksheet prepared by the Division in conjunction with some users of prescribed fire and attached to this Statement of Basis and Purpose as Attachment A. The Commission recognizes that the Division and users of prescribed fire may find it appropriate to revise the smoke risk rating methodology in the future. If this is done, the Commission intends that what constitutes a high smoke risk burn will consider at least the same factors as in Attachment A, and the point at which a fire becomes a high smoke risk should be equivalent to a rating of 41 on Attachment A.

The Division will determine which fires have a high smoke risk through consideration of the factors reflected in Attachment A. If, after considering these factors, the Division concludes that the fire has a high smoke risk, it will allow the public thirty days in which to submit comments regarding whether a permit should be issued and what conditions are appropriate for inclusion in the permit. For planned ignition prescribed fires, the notice will include information about location of the fire, expected burn dates, expected duration of the fire, potential emissions, and potential air quality and visibility impacts at smoke sensitive receptors. The Commission intends that the Division either add appropriate conditions or combine permits to prevent circumvention of the public comment requirement, should a permit applicant submit separate applications that may have the effect of dividing burns that are more appropriately considered together. This comment opportunity is subject to the Commission's Procedural Rules and includes the rights to a public comment hearing provided in those Rules. The comment opportunity does not include a right to an adjudicatory hearing to appeal issuance of a permit, as only the permit applicant may request such a hearing. Persons would still have recourse to seek judicial review of permits pursuant to the Administrative Procedures Act.

Significant users of prescribed fire

Senate Bill 01-214 imposes on significant users of prescribed fire additional requirements to ensure that that those users consider air quality impacts in making decisions about when, and under what conditions, they will use fire for grassland or forest management. Senate Bill 01-214 defined a significant user of prescribed fire as a person or agency that collectively manages or owns more than 10,000 acres of land and that use prescribed fire. The Commission enlarged on the part of this definition dealing with use of prescribed fire by establishing a minimum activity level based on PM10 emissions during a calendar year. The Commission concludes that users of prescribed fire at levels below this threshold do not have significant enough an impact on visibility and air quality to justify their inclusion in this part of the smoke management program. This provision will focus the regulatory requirements and the resources of the Division and others on the prescribed fires with the greatest potential impact on visibility and human health and welfare. The Commission did not establish a de minimus threshold for other open burns, as even small fires intended to dispose of trash, rubbish and similar materials may have disproportionate impacts on local air quality.

The regulation imposes additional duties on significant users of prescribed fire, consistent with specific requirements in SB 01-214. Section 25-7-106(8)(b), C.R.S., requires that significant users submit planning documents to the Commission for comment and recommendations. This section also

anticipates a hearing on the plans to allow public input. This public hearing requirement is similar to public hearing options applicable to major stationary source permitting. Public input on regulatory compliance and permits for major sources is important to public confidence in air pollution control efforts, particularly for long-term planning documents.

The Commission will hold public hearings to review the planning documents and may make comments and recommendations regarding the plans. Open burning permits for general, planned and unplanned ignition fires can only be issued to significant users of prescribed fire if the permit is consistent with the comments and recommendations of the Commission. The Commission intends that, wherever possible, the Division will issue a permit with appropriate conditions in order to meet this requirement, rather than denying the permit altogether. This approach recognizes the value of prescribed fire in grassland and forestland management, but ensures that the air quality goals of SB 01-214 and this regulation are adequately protected.

The Commission defined planning documents and tailored the applicable regulatory requirements to focus submittals and Commission review on the process used by a significant user of prescribed fire, rather than on the results of that process in a specific instance. The Commission does not intend to challenge land use decisions made by the land manager. The purpose of the Commission comments and recommendations will be to ensure that the land manager adequately considers air quality impacts when making decisions whether, and under what conditions, to use prescribed fire. The Commission planning document review will focus on how a significant user of prescribed fire will meet the state air quality protection standard expressed in Section 25-7-106(7)(e), C.R.S.

Planning documents should summarize the decision process by which the land manager identifies and selects among alternative treatment methods for fuel reduction. The documents should provide a specific description relevant to accomplishment of the state air quality goal expressed in Section 25-7-106(7)(e), C.R.S. This requirement will focus the land manager decision-making process on the goals of Senate Bill 01-214.

The Commission recognizes that planning documents will vary in their level of detail and sophistication in describing decision mechanisms used by land managers, particularly during the initial set of Commission reviews. Commission comments and recommendations may extend to beneficial changes in planning documents as well as improvements in the land manager planning process related to consideration of the state air quality goal.

Specific permit conditions may be excluded from a permit if a federal land manager asserts that a federal statute specifically prohibits the compliance with the condition. In adopting this regulation, the Commission made no evaluation whether any particular federal statute or permit condition may justify exclusion of a permit condition. Nevertheless, Section 118 of the federal Clean Air Act, 42 U.S.C. Section7418, subjects federal agencies engaging in activities resulting, or which may result, in discharge of air pollutants to state requirements on control and abatement of air pollution "in the same manner, and to the same extent as any nongovernmental entity." This waiver of federal sovereign immunity allows states to subject federal agencies to any substantive, procedural, permitting, fee or any other requirement. The Colorado General Assembly enacted Section25-7-106(7), C.R.S., pursuant to Section118 and directed that this subsection be construed to exercise the full extent of the state's authority regarding pollution from federal facilities. The Commission intends these revisions to comport with Section118 and to exercise the state's authority to its full extent. The Division should consider this intent in deciding whether a federal statute specifically prohibits imposition of a particular permit condition.

The rule also establishes a means for dealing with outdated plans or documents. The Commission chose to view a plan as being outdated upon expiration of the period for which the plan itself states it is applicable, up to ten years. The Commission may make comments or recommendations in the review

process that urge a shorter applicable period than anticipated in the planning document. Any such comments will recognize applicable constraints on preparation of updated documents, such as the provisions of the National Environmental Policy Act.

The regulation establishes a means for dealing with lands acquired by a significant user of prescribed fire after the Commission reviews an initial or later version of a planning document. The Commission concluded that requiring changes and further review of planning documents whenever a significant user acquires land would unduly increase the burdens of the review process on the Commission, the Division and the land managers. In general, the Commission anticipates addressing planning documents for these lands at the next regular review, so long as the acquired lands will be managed in largely the same way as those already addressed by the Commission. Where there will be a substantial difference in management of the acquired lands, the Commission concluded that the land manager must submit planning documents to address the anticipated management.

Fees and Monitoring

Senate Bill 01-214 directed the Commission to include within its smoke management program provisions for fees necessary to pay for administration of the program. Since the General Assembly granted the direct authority to develop a fee program for the smoke management program, the Commission is not required to utilize the fee mechanism applicable to traditional stationary sources. The Commission chose to apportion the cost of administering the program among users of prescribed fire rather than relying on traditional emissions fees. In part, this conclusion was due to the unique characteristics of this emission source category including highly variable emissions from one year to the next. Therefore, the Commission concluded that the traditional emission fee approach would result in substantially greater administrative burdens for both the Division and for users of prescribed fire. The methodology adopted combines the proportion of the total number of permits and total PM10 emissions of a particular user to determine the appropriate fraction of the program cost payable by that user. This approach will provide an equitable distribution of the costs of administering the common elements of the program. The Commission intends that fees paid by stationary sources will not be used to pay any portion of the smoke management program costs.

The total administrative cost of $129,646.45 at the outset is specified in an appendix to the regulation and the Commission intends that any change to it or the distribution methodology occur only through a properly noticed public rule-making hearing before the Commission. To that end, the cost is included in the regulation as the regulatory "fee." The Division cost for program administration will be recalculated annually and reported to the Commission each August. If the total cumulative dollar difference between the cost reflected in the regulation and the Division's annual calculation exceeds five percent, the Division will seek a fee change through a Commission rulemaking. The "total cumulative dollar difference" between the regulatory fee and the annual cost will be calculated considering personnel and indirect and operating costs associated with the program, and the cumulative dollar difference from the previous year. This calculation will be performed substantially in accordance with the Colorado Smoke Management Program Cost and Fee Calculation Template (Attachment B). The Commission also intends that the actual revenue collected be reported annually. If collections are consistently below projections, the Division shall seek an appropriate fee adjustment consistent with the shortfall in revenue.

In addition, the Commission imposed a fee pursuant to Section 25-7-114.7(2)(A)(III), C.R.S., to cover the direct and indirect costs of evaluating planning documents submitted to the Commission. In order to reduce the administrative burden on the Division and permittees, both the evaluation fees and the administration fee will be billed annually.

The rule revisions adopted address the procedural mechanisms for accomplishing the mandatory requirements of Senate Bill 01-214. The general structure of the smoke management program has been

established by statute. The Commission's rule implements that legislative prescription; the revisions adopted set a de minimus level for significant users of prescribed fire, establish a fee mechanism and delineate the specifics of the program anticipated by the statute. The Commission concludes that these rule revisions are adopted to implement prescriptive state statutory requirements, where the Commission is allowed no significant policy-making options, for the purposes of Section 25-7-110.5, C.R.S. The Commission also concludes it has no discretion under state law to adopt alternative rules that differ significantly from these revisions, for the purposes of Section 25-7-110.8(1), C.R.S. Accordingly, the Commission did not include in the record some of the portions of the rulemaking prerequisites addressed in Section 25-7-110.5, C.R.S., and did not make specific determinations regarding the factors listed in Section 25-7-110.8(1), C.R.S.

The Commission took into consideration the appropriate items enumerated in Section 25-7-109(1)(b), C.R.S.

B. Adopted December 19, 2002

This Statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, Section 24-4-103, C.R.S., and the Colorado Air Pollution Prevention and Control Act, Sections 25-7-110 and 25-7-110.5, C.R.S., and implements parts of Sections 25-7-106(7) and (8), 25-7-114.7 and 25-7-123, C.R.S.

Basis

This rule revision updates the fee provisions of Regulation Number9. Regulation Number 9 anticipates that the Commission will review and, as necessary, change the fee charged for program administration.

Specific Statutory Authority

The Colorado Air Pollution Prevention and Control Act, Sections 25-7-109(2)(e) and 25-7-123, C.R.S., provides the authority for the Commission to adopt and modify a program including emissions control regulations to control burning activities. Pursuant to Section 25-7-106(7)(a), C.R.S., the Commission program for significant users of prescribed fire includes fees necessary to administer the program. The Commission's action is taken pursuant to procedures set forth in Sections 25-7-105, 25-7-110 and 25-7-110,5, C.R.S.

Purpose

When it adopted Regulation Number 9 in order to implement Senate Bill 01-214, the Commission elected to treat the program costs, as the program "fee" required by the legislation. In the regulation, the Commission required the Division to recalculate the program cost annually and to provide a briefing to the Commission each August. Based on the Program Cost and Distribution Methodology contained in Appendix C, the Division calculated the initial cost for the program. The Commission included the total administrative cost of $129,646.45 for calendar year 2002 in Appendix C to the regulation. In this proceeding, the Commission considered and adopted a change to the projected 2003 program cost and corrected an error in Appendix C. As a result, the "fee" in Appendix C is "$144,309.85 for calendar year 2003 and succeeding years." The fee amount of $144,309.85 is intended to apply beginning calendar year 2003. The Division will bill users of the fire program for activity during 2002 using the $129,646.45 amount. Users of the fire program during 2003, and thereafter if the fee is not adjusted subsequently, will be subject to the $144,309.85 amount.

The Division calculated the projected program cost for calendar year 2003 as $144,309.85, representing an increase of 11% over the 2002 fee. This increase largely results from a position within the program

that was hired in 2002 and worked only 2 months of that calendar year but will be filled for all of 2003. The calculation is based on the methodology contained in Appendix C. The Commission reviewed the calculation of the changes between the 2002 cost projection and the 2003 cost projection and concluded that the fee amount proposed by the Division represents the program cost for calendar year 2003.

Accordingly, the Commission adopted $144,309.85 as the program cost and fee to begin in calendar year 2003.

C. Adopted February 19, 2004

This Statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, Section 24-4-103, C.R.S., and the Colorado Air Pollution Prevention and Control Act, Sections 25-7-110 and 25-7-110.5, C.R.S.

Basis

The rule revisions adopted change the method used to distribute the fees for users of planned and unplanned ignition prescribed fire permits utilizing the Division's Smoke Management Program.

Specific Statutory Authority

The Colorado Air Pollution Prevention and Control Act, Section 25-7-109(2)(e), C.R.S., provides the authority for the Commission to adopt and modify emissions control regulations pertaining to open burning activities.

The Commission's action is taken pursuant to procedures set forth in Sections 25-7-105, 25-7-110 and 25-7-110.5, C.R.S. The Commission took into consideration the appropriate items enumerated in Section 25-7-109(1)(b), C.R.S.

Purpose

In 2002, the Commission adopted regulations to implement the requirements of Senate Bill 99-145 and Senate Bill 01-214 relating to open burning activities by public and private land managers and other significant users of fire for range and forest management. The regulation included a mechanism intended to distribute equitably the cost of the program among the users and to provide revenue certainty to the Division. In practice, fire users subject to the program have experienced substantial uncertainty in their budgeting process because the fee assessments are not determined until the spring following the year for that fee.

The revisions adopted restructure the fee distribution system into the following components. The first is a flat fee of $1000 per year for all unplanned ignition fire permits. Such permits are valid for up to 5 years. The second is a flat fee for small users of planned ignition prescribed fire, which will be charged $100 for each permit. Rather than recalculating the program cost share each year for larger users, the Division will determine the three-year average of proportion of permits and actual PM10 emissions for the user. That proportion will be used to divide the program cost among the large users. Although there may be some variations in fees from year to year, they will be smaller than those occurring under the present system. These proportions will be recalculated every three years to accommodate program participation changes among large users.

D. Adopted February 19, 2004

This Statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, Section 24-4-103, C.R.S. and the Colorado Air Pollution Prevention and Control Act, Sections 25-7-110 and 25-7-110.5.

Basis

The rule revisions adopted change the evaluation method used to distinguish between the permit requirements for prescribed fires above and below a threshold depending on the potential for smoke impacts from the fire.

Specific Statutory Authority

The Colorado Air Pollution Prevention and Control Act, Section 25-7-109(2)(e), C.R.S., provides the authority for the Commission to adopt and modify emissions control regulations pertaining to open burning activities.

The Commission's action is taken pursuant to procedures set forth in Sections 25-7-105, 25-7-110 and 25-7-110.5, C.R.S. The Commission took into consideration the appropriate items enumerated in Section 25-7-109(1)(b), C.R.S.

Purpose

In 2002, the Commission adopted regulations to implement the requirements of Senate Bill 99-145 and Senate Bill 01-214 relating to open burning activities by public and private land managers and other significant users of fire for range and forest management. Those regulations included in Appendix A, a rating table for the Division to use to identify fires with a low enough potential for smoke impact that use of a general open burning permit sufficed to prevent undue air quality impacts. Division experience since that time indicates that the rating table failed to allow sufficient evaluation of the potential impacts from specific fires. In this proceeding, the Commission substituted for the table a more flexible mechanism for the Division to make its determinations. The Commission chose the project size, fuel type, duration and proximity to smoke-sensitive receptors as the most important factors in these evaluations. The Commission has provided guidelines in the Appendix regarding the application of the first 3 factors to identify low smoke risk burns. The final factor shall be addressed in permit conditions. The Commission has also provided that the Division may apply the factors to arrive at somewhat different thresholds as compared to the guideline table in Appendix A as long as the Division provides evidence how the factors are still adequately addressed to ensure the burn is indeed low or no smoke risk. The Commission intends by this change only to simplify and improve the process for assessing smoke impact potential. The purpose of the revisions is not to allow fire users to avoid the more substantial requirements associated with prescribed fire permits unless the potential for smoke impacts is found to be low. The Division is to issue guidance regarding the application of the identified factors to reflect Commission intent.

E. Adopted February 19, 2004

This Statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, Section 24-4-103, C.R.S. and the Colorado Air Pollution Prevention and Control Act, Sections 25-7-110 and 25-7-110.5.

Basis

The rule revisions adopted remove a requirement for an unplanned ignition permit renewal where more than 500 acres burn within a permitted burn area during a calendar year. That requirement prompted unnecessary renewals where the terms of the permit in general remained substantially unchanged.

Specific Statutory Authority

The Colorado Air Pollution Prevention and Control Act, Section 25-7-109(2)(e), C.R.S., provides the authority for the Commission to adopt and modify emissions control regulations pertaining to open burning activities.

The Commission's action is taken pursuant to procedures set forth in Sections 25-7-105, 25-7-110 and 25-7-110.5, C.R.S. The Commission took into consideration the appropriate items enumerated in Section 25-7-109(1)(b), C.R.S.

Purpose

In 2002, the Commission adopted regulations to implement the requirements of Senate Bill 99-145 and Senate Bill 01-214 relating to open burning activities by public and private land managers and other significant users of fire for range and forest management. Section VI.B of Regulation Number 9 allows the Division to issue unplanned ignition fire permits for up to five years if no more than 500 acres burn within the burn area during any calendar year. The expectation in adopting this provision was that large fires would drive significant changes in the fire use plan. Experience in the interim demonstrates that even large fires have not in most cases required significant changes in the permit. The existing regulation created an undue burden on both permittees and the Division by requiring new applications, proposed permits and public comment processes. This revision reduces that burden in the recognition that the permits remain substantially similar and that the renewal did not serve a significant public interest.

F. Adopted March 12, 2004

This statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, Section 24-4-103, C.R.S. and the Colorado Air Pollution Prevention and Control Act, Sections 25-7-110 and 25-7-110.5.

Basis

The rule revisions adopted address the use of air curtain destructors for burning materials generated as a result of projects conducted to reduce the risk of wildfire. Regulation 9 deals with open burning activities and Regulation 3 contains emission notice requirements. The Common Provisions Regulation contains a definition related to these devices.

Specific Statutory Authority

The Colorado Air Pollution Prevention and Control Act, Section 25-7-109(2)(e), C.R.S., provides the authority for the Commission to adopt and modify emissions control regulations pertaining to open burning activities. These regulatory changes implement the provisions of the Colorado Air Pollution Prevention and Control Act, 25-7-101, et. seq., that prohibits anyone from operating an air pollution source such as an air curtain destructor without first obtaining a permit.

The Commission's action is taken pursuant to procedures set forth in Sections 25-7-105, 25-7-110 and 25-7-110.5, C.R.S. The Commission took into consideration the appropriate items enumerated in Section 25-7-109(1)(b), C.R.S.

Purpose

In 2002, the Commission adopted regulations to implement the requirements of Senate Bill 99-145 and Senate Bill 01-214 relating to open burning activities by public and private land managers and other significant users of fire for range and forest management. Since that action, the public and both state and federal agencies have focused on the risks associated with wildfires, particularly in the forest/urban interface throughout Colorado. The Commission views reduction of the risks associated with wildfires and their potential for serious public health consequences as a result of the emissions from the fires as an important component in protecting public health and the environment. The Commission also views the use of methods to reduce risk that also reduce air pollution emissions compared to other methods as an additional important factor. In this rule adoption, the Commission acted to enlarge the options available to dispose of materials generated by projects conducted to reduce the risks of wildfire. It is the intention of the Commission that practical alternatives to burning be used when they exist.

The Commission reviewed the available emissions data and limited uses proposed for air curtain destructors. That information demonstrated to the satisfaction of the Commission that, with appropriate permit conditions, the destructors can safely be used to dispose of certain materials without endangering public health or causing or contributing to a violation of the National Ambient Air Quality Standards (NAAQS) and will reduce emissions compared to traditional pile burning.

The Division performed an air dispersion modeling analysis on December 30, 2003. The analysis is based on the assumption that the air curtain destructors operate no more than 13 hours per day and no more than 110 days per year at a single site. In addition, it is assumed that no more than 20 tons of fuel will be burned per hour. At this level of operation and fuel throughput, the device would be limited to 110 days per year to meet the restriction in the proposed regulation that no more than 100 tons of any criteria pollutant be emitted per year.

Screening level air quality analyses suggest that emissions from air curtain destructors are not expected to cause violations of the carbon monoxide, sulfur dioxide, and nitrogen dioxide ambient air quality standards except in situations where the air curtain destructor is operated next to a nearby source of air pollutants that is already causing high air pollution impacts in an area that, for one reason or another, has poor existing air quality. The analyses suggest it would be prudent to require setbacks in the regulation to prevent public exposure to potentially elevated PM10 levels near the units. The proposed setbacks of 150 feet and 300 feet for short-term versus long-term sites are reasonable except in situations where the air curtain destructor is located near another stationary source of fugitive PM10 emissions. Accordingly, the rule adopted prohibits co-location of an air curtain destructor with another air curtain destructor or any facility that is required to have an air quality permit or any commercial or industrial facility.

The rule adopted contains specific limitations to assure that the devices are operated consistently with the Commission's expectations. The rule adopted allows disposal of wood products generated by projects conducted to reduce the risks of wildfire. The information presented to the Commission did not demonstrate that air curtain destructors are appropriate for disposal of other materials including clean lumber.

G. Adopted December 15, 2005

This Statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, Section 24-4-103, C.R.S., and the Colorado Air Pollution Prevention and Control Act, Sections 25-7-110 and 25-7-110.5, C.R.S., and implements parts of Sections 25-7-106(7) and (8), 25-7-114.7 and 25-7-123, C.R.S.

Basis

This rule revision corrects clerical errors in published regulations related to the Smoke Management Program. The insertions and deletions to regulatory language in this rulemaking will bring published regulatory language into conformance with what the Commission adopted in actions at past rulemaking hearings.

Specific Statutory Authority

The Colorado Air Pollution Prevention and Control Act, Sections 25-7-109(2)(e) and 25-7-123, C.R.S., provides the authority for the Commission to adopt and modify a program including emissions control regulations to control burning activities.

The Commission's action is taken pursuant to procedures set forth in Sections 25-7-105, 25-7-110 and 25-7-110.5, C.R.S. The Commission took into consideration the appropriate items enumerated in Section 25-7-109(1)(b), C.R.S.

Purpose

In this proceeding, the Commission considered and adopted changes to Regulation Number 9 to bring the published versions of the regulation into conformance with what the Commission adopted during previous rulemaking hearings that occurred on February 19, 2004 and March 12, 2004. The corrections were needed due to clerical errors in the published versions of the rules that remained unnoticed until July 2005.

Accordingly, the Commission adopted corrections to Regulation Number 9.

H. Adopted December 14, 2006

This Statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, Section 24-4-103, C.R.S., and the Colorado Air Pollution Prevention and Control Act, Sections 25-7-110 and 25-7-110.5, C.R.S.

Basis

This rule revisions adopted change the percentages used to distribute the fees for users of planned and unplanned ignition prescribed fire permits utilizing the Division’s Smoke Management Program.

Specific Statutory Authority

The Colorado Air Pollution Prevention and Control Act, Sections 25-7-109(2)(e), C.R.S., provides the authority for the Commission to adopt and modify a program including emissions control regulations pertaining to open burning activities.

The Commission's action is taken pursuant to procedures set forth in Sections 25-7-105, 25-7-110 and 25-7-110.5, C.R.S. The Commission took into consideration the appropriate items enumerated in Section 25-7-109(1)(b), C.R.S.

Purpose

In January 2002, the Commission adopted regulations to implement the requirements of Senate Bill 01-214 relating to open burning activities by federal land managers and other users of fire for range and forest management. The regulation included a mechanism intended to distribute equitably the cost of the program among the users and to provide revenue certainty to the Division.

The fee distribution portion of the regulation was revised in 2003 at the request of federal land management agencies. Revisions adopted restructure the fee distribution system into the following components. The first is a flat fee of $1000 for all unplanned ignition fire permits. The second is a flat fee for small users of planned ignition prescribed fire, which are charged $100 for each permit. Rather than recalculating the program cost share each year for larger users, the Division determines the three-year average of proportion of permits and actual PM10 emissions for the user. That proportion is used to divide the program cost among the larger users. Although there are some variations in fees from year to year, they are much smaller than those occurring under the previous system. These proportions are to be recalculated every three years to accommodate program participation changes among users.

The revisions adopted update the recalculations of the proportions based on recent activity information collected by the Division of users of the smoke management program. The revisions are applicable for fee distribution calculations for users of the program during calendar years 2006, 2007, and 2008; with billing of users based on the adopted percents to occur in 2007, 2008 and 2009, respectively.

I. Adopted June 21, 2007

This Statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, Section 24-4-103, C.R.S., and the Colorado Air Pollution Prevention and Control Act, Sections 25-7-110 and 25-7-110.5, C.R.S.

Statutory Authority

The Air Quality Control Commission is authorized to adopt these revisions to Regulation Number 9 and Regulation Number 1 pursuant to C.R.S. Sections 25-7-106(7), (8) (2001) and 25-7-123(1) (2001).

Basis and Purpose

Prescribed Fire Regulation by Counties

Current regulations provide that the Division issues permits for a prescribed fire. This revision clarifies that the Division, as well as local agencies that have been designated agents of the Division, may issue wildland fire permits. The revision also exempts such permits issued by delegated local agencies from State fees. The Division retains oversight of the program should a local agency fail to administer the program as per Regulation Number 9.

The Division is authorized to delegate open burn regulation to local agencies under C.R.S. Section 25-7-111(2)(f). The Division may designate local agencies as agents of the state to administer powers and duties such as open burn regulation. Limited delegations are good policy because local governments are closest to the challenges of conducting such burning. They can work more closely and consistently with a larger number of local landowners to ensure timely inspection of proposed projects, more effective compliance assistance, and more effective smoke monitoring.

This revision is necessary to avoid any confusion among land managers regarding which agency issues burn permits. Over the past thirty years, the Division has designated agencies from twelve counties as agents of the Division for the purpose of administering general open burn permitting. However, the general open burn program is limited to de minimus wildland fuel piles (as defined in Regulation 9 Appendix A). The pine beetle epidemic has changed the needs of all stakeholders.

Certain Colorado counties are facing a critical need for tools to use in the management or disposal of dead timber after forests have been devastated by the pine beetle epidemic. The spread of the epidemic has been exponential, creating huge volumes of trees and woody debris to dispose of responsibly. The

United States Forest Service estimates that 50-60% of the mature lodge pole trees in Summit County are dead or dying. The numbers climb to 80-90% in Grand County. Eagle County is also heavily impacted. The risk of catastrophic wildfire has increased by these large stands of diseased or dead trees. While no one approach will solve all the problems associated with dealing with the huge volume of trees to be disposed of, responsible burning is one option.

Recently local county agencies and landowners in these areas have contacted the Division regarding the burning of piles of logged trees under local permitting. The Division has been collaborating with local counties affected by the mountain pine beetle epidemic to evaluate the prospect of delegating the prescribed fire program to willing and able county agencies.

It now makes sense to designate local agencies to permit larger pile burns than possible under a general open burning permit. The Division believes that in the face of the pine beetle kill challenge, if local agencies are properly staffed and prepared to assume the responsibilities of permitting, it is appropriate to consider developing a written delegation agreement. Thus, the Division is now working on a delegation for the prescribed fire program to local agencies.

Training and Instructional Fires

Wildland fuel burns that have a training or instructional component but are large enough to constitute prescribed fires will now be subject to Regulation 9 permitting requirements. Prescribed fires are burns large enough to be over the de minimus low smoke risk threshold in Regulation 9, Appendix A. This change will require the permittees to insure that the smoke is managed responsibly and that public health is considered. Open burns causing de minimus smoke emissions that are used for training purposes are still exempt from permitting requirements.

Prior to this revision, Regulations 1 and 9 exempted all training and instructional fires from permitting by the Division. However, this exemption does not reflect the realities of wildfire suppression training. Few, if any, burns are used exclusively for wildland fire suppression training. These burns accomplish several objectives in addition to training, such as habitat improvement, weed control, and wildfire fuel control. Most prescribed fires are used for training to some degree. Prior to this revision, these fires would arguably be entitled to an exemption.

Prescribed fires are, by definition, large with significant emissions that can impact residents in the vicinity of the fire. If the Division were to grant an exemption for every prescribed burn that involves training, few prescribed fires would be permitted. Without a permit, the Division cannot ensure that the land manager is implementing the controls that are necessary to protect public health and safety.

Wildland fire instructors usually consider applying for and obtaining a planned ignition fire permit from the Division as part of the training exercise. This revision reflects that burn permits are necessary for burns that exceed the de minimus smoke emissions threshold and the industry practice of requesting a permit.

The Division is aware of instances where structures were ignited under the training exemption yet did not receive a Demolition Notice from the Division prior to ignition to assure they were free from asbestos. This revision does not require permitting for structural fire fighting training, though it does include a cross reference to Regulation Number 8, Part B, Section III.E.1. concerning the possible need for a Demolition Notice to assure the structure is free of asbestos before the structure is burned.

J. Adopted June 19, 2008

This Statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, Section 24-4-103, C.R.S., and the Colorado Air Pollution Prevention and Control Act, Sections 25-7-110 and 25-7-110.5, C.R.S.

Basis and Purpose

The Commission hereby establishes a process to administer planning documents for prescribed fire in the event the ownership of the acreage in question changes. The Commission intends to ensure that new landowners or managers are aware of the planning document that applies to their land and intend to comply with the document.

Any new owner who qualifies as a significant user of prescribed fire and plans to use prescribed fire must do so pursuant to an approved planning document. Significant users of prescribed fire include any public or private entity that owns or manages 10,000 acres or more in Colorado and conducts enough wildland prescribed fire burns such that they generate at least 10 tons of PM10 per year.

Significant users must submit a planning document that explains how decisions are made about fuel treatment options and how the entity complies with applicable standards. The Commission reviews and approves the planning document following a public hearing. The Division may not issue prescribed fire permits to a significant user without an approved or valid planning document.

In the event of a change of ownership or management associated with acreage that is subject to a planning document, the Division will seek a written commitment from the new owner or land manager to comply with the document. The Division will no longer issue permits until a written commitment is received regarding the existing plan or the new owner or manager has submitted a new or amended planning document that is approved by the Commission at a public hearing.

Specific Statutory Authority

C.R.S. Section 25-7-106(7) and (8) authorizes and directs the Commission to develop a program to minimize impacts of actions by significant users of prescribed fire, including a requirement that significant users submit planning documents to the Commission.

K. Adopted December 19, 2008

This Statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, Section 24-4-103, C.R.S., and the Colorado Air Pollution Prevention and Control Act, Sections 25-7-110 and 25-7-110.5, C.R.S.

Basis

The rule revisions adopted change the percentages used to distribute the fees for users of planned and unplanned ignition prescribed fire permits utilizing the Division's Smoke Management Program. This rule revision also increases the cost of the smoke management program. Regulation Number 9 anticipates that the Commission will review and, as necessary, change the fee charged for the program. Finally, numerous format edits of Regulation Number 9 are adopted to achieve more consistency between Commission regulations.

Specific Statutory Authority

The Colorado Air Pollution Prevention and Control Act, Sections 25-7-109(2)(e) and 25-7-123, C.R.S., provides the authority for the Commission to adopt and modify a program including emissions control

regulations to control burning activities. Pursuant to Section 25-7-106(7)(a), C.R.S., the Commission program for significant users of prescribed fire includes fees necessary to administer the overall smoke management program. The Commission's action is taken pursuant to procedures set forth in Sections 25-7-105, 25-7-110 and 25-7-110.5, C.R.S. The Commission took into consideration the appropriate items enumerated in Section 25-7-109(1)(b), C.R.S.

Purpose

In January 2002, the Commission adopted regulations to implement the requirements of Senate Bill 01-214 relating to open burning activities by federal land managers and other users of fire for range and forest management. The regulation included a mechanism intended to distribute equitably the cost of the program among the users and to provide revenue certainty to the Division.

The fee distribution portion of the regulation was revised in 2003 at the request of federal land management agencies. Revisions adopted restructure the fee distribution system into the following components. The first is a flat fee of $1000 for all unplanned ignition fire permits. The second is a flat fee for small users of planned ignition prescribed fire, which are charged $100 for each permit. Rather than recalculating the program cost share each year for larger users, the Division determines the three-year average of proportion of permits and actual PM10 emissions for the user. That proportion is used to divide the program cost among the larger users. Although there are some variations in fees from year to year, they are much smaller than those occurring under the previous system. These proportions are to be recalculated every three years to accommodate program participation changes among users.

The revisions adopted update the recalculations of the proportions based on recent activity information collected by the Division of users of the smoke management program. The revisions are applicable for fee distribution calculations for users of the program during calendar years 2009, 2010, and 2011; with billing of users based on the adopted percents to occur in 2010, 2011 and 2012, respectively.

When it adopted Regulation Number 9 in order to implement Senate Bill 01-214, the Commission elected to treat the program costs, as the program "fee" required by the legislation. In the regulation, the Commission required the Division to recalculate the program cost annually and to provide a briefing to the Commission each August. Based on the Program Cost and Distribution Methodology contained in Appendix C, the Division calculated the initial cost for the program. The Commission included the total administrative cost of $129,646.45 for calendar year 2002 in Appendix C to the regulation. In a later proceeding, the Commission considered and adopted a change for the projected 2003 program to "$144,309.85 for calendar year 2003 and succeeding years." In 2005, the Commission again adopted a change for 2005 and succeeding years of $174,585.08.

The Division calculated the projected program cost for calendar year 2009 as $199,305.13, representing an increase of 14% over the 2005-2008 program cost. This increase largely results from small, accumulated increases in salaries and benefits for the Division positions supporting the SMP and a new charge for vehicle use. The calculation is based on the methodology contained in Appendix C. The Commission reviewed the calculation of the 2009 cost projection and concluded that the cost of the program amount proposed by the Division represents the program cost for calendar year 2009 and succeeding years. Accordingly, the Commission adopted $199,305.13 as the program cost and fee to begin in calendar year 2009.

Finally, in this proceeding the Commission considered and adopted format changes and edits to bring Regulation Number 9 into conformance with other Commission regulations. Accordingly, the Commission adopted the changes to Regulation Number 9.

L. Adopted December 15, 2011

This Statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, section 24-4-103, C.R.S., and the Colorado Air Pollution Prevention and Control Act, sections 25-7-110 and 25-7-110.5, C.R.S.

Basis

The rule revisions adopted change the percentages used to distribute the fees for users of planned and unplanned ignition prescribed fire permits utilizing the division's Smoke Management Program.

Specific Statutory Authority

The Colorado Air Pollution Prevention and Control Act, section 25-7-106(7)(a), C.R.S., provides authority to the Commission to develop a fee program for the Division's Smoke Management Program. Section 25-7-109(2)(e), C.R.S., provides the authority for the Commission to adopt and modify emissions control regulations pertaining to open burning activities.

The Commission's action is taken pursuant to procedures set forth in sections 25-7-105, 25-7-110 and 25-7-110.5, C.R.S. The Commission took into consideration the appropriate items enumerated in section 25-7-109(1)(b), C.R.S.

Purpose

In January 2002, the Commission adopted regulations to implement the requirements of Senate Bill 01-214 relating to open burning activities by federal land managers and other users of fire for range and forest management. The regulation included a mechanism intended to distribute equitably the cost of the program among the users and to provide revenue certainty to the Division.

The fee distribution portion of the regulation was revised in 2003 at the request of federal land management agencies. Revisions adopted restructure the fee distribution system into the following components. The first is a flat fee of $1000 for all unplanned ignition fire permits. The second is a flat fee for small users of planned ignition prescribed fire, which are charged $100 for each permit. Rather than recalculating the program cost share each year for larger users, the Division determines the three-year average of proportion of permits and actual PM_{10} emissions for the user. That proportion is used to divide the program cost among the larger users. Although there are some variations in fees from year to year, they are much smaller than those occurring under the previous system. These proportions are to be recalculated every three years to accommodate program participation changes among users.

The revisions adopted update the recalculations of the proportions based on recent activity information collected by the division of users of the smoke management program. The revisions are applicable for fee distribution calculations for users of the program during calendar years 2012, 2013 and 2014; with billing of users based on the adopted percents to occur in 2013, 2014 and 2015, respectively.

M. February 19, 2015

This Statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, section 24-4-103, C.R.S., and the Colorado Air Pollution Prevention and Control Act, sections 25-7-110 and 25-7-110.5, C.R.S.

Basis

The rule revisions adopted change the percentages used to distribute the fees for users of planned and unplanned ignition prescribed fire permits utilizing the division's Smoke Management Program.

Specific Statutory Authority

The Colorado Air Pollution Prevention and Control Act, section 25-7-106(7)(a), C.R.S., provides authority to the Commission to develop a fee program for the Division's Smoke Management Program. Section 25-7-109(2)(e), C.R.S., provides the authority for the Commission to adopt and modify emissions control regulations pertaining to open burning activities.

The Commission's action is taken pursuant to procedures set forth in sections 25-7-105, 25-7-110 and 25-7-110.5, C.R.S. The Commission took into consideration the appropriate items enumerated in section 25-7-109(1)(b), C.R.S.

Purpose

In January 2002, the Commission adopted regulations to implement the requirements of Senate Bill 01-214 relating to open burning activities by federal land managers and other users of fire for range and forest management. The regulation included a mechanism intended to distribute equitably the cost of the program among the users and to provide revenue certainty to the Division.

The fee distribution portion of the regulation was revised in 2003 at the request of federal land management agencies. Revisions adopted restructure the fee distribution system into the following components. The first is a flat fee of $1000 for all unplanned ignition fire permits. The second is a flat fee for small users of planned ignition prescribed fire, which are charged $100 for each permit. Rather than recalculating the program cost share each year for larger users, the Division determines the three-year average of proportion of permits and actual PM_{10} emissions for the user. That proportion is used to divide the program cost among the larger users. Although there are some variations in fees from year to year, they are much smaller than those occurring under the previous system. These proportions are to be recalculated every three years to accommodate program participation changes among users.

The revisions adopted update the recalculations of the proportions based on recent activity information collected by the division of users of the smoke management program. The revisions are applicable for fee distribution calculations for users of the program during calendar years 2015, 2016 and 2017; with billing of users based on the adopted percents to occur in 2016, 2017 and 2018, respectively.

N. Adopted May 21, 2020

This Statement of Basis, Specific Statutory Authority and Purpose complies with the requirements of the Colorado Administrative Procedures Act, § 24-4-103, C.R.S., the Colorado Air Pollution Prevention and Control Act ("Act"), §§ 25-7-110 and 25-7-110.5, C.R.S., and the Air Quality Control Commission's ("Commission") Procedural Rules.

Basis

The rule revisions added additional best smoke management techniques, clarified/added definitions, removed language that was no longer applicable or appropriate, removed the specific Smoke Management Program (SMP) scores that change every three years, and enlarged the timeframe regarding notice requirements prior to a prescribed burn.

Specific Statutory Authority

The Act, §§ 25-7-109(2)(e) and 25-7-123, C.R.S., provides authority for the Commission to adopt and modify a program, including emissions control regulations, to control burning activities. Section 25-7-106(7)(a), C.R.S. authorizes and directs the Commission to develop a program for significant users of

prescribed fire, which includes fees necessary to administer the overall smoke management program. The Commission's actions were taken pursuant to procedures set forth in Sections 25-7-105, 25-7-110 and 25-7-110.5, C.R.S. The Commission took into consideration the appropriate items enumerated in Section 25-7-109(1)(b), C.R.S.

Purpose

The Commission removed language that is no longer applicable or appropriate. Language regarding fire safety that is not related to air pollution or smoke was removed. Fire safety responsibility pertaining to prescribed fire is currently owned by several entities across the state, including the Colorado Division of Fire Prevention and Control (DFPC), federal land agencies, and local fire and law enforcement jurisdictions.

The Commission removed specific SMP scores, which change every three years, to avoid the need to open and alter Regulation Number 9 on a frequent basis. The revisions did not remove the SMP score calculation, which was retained within Regulation Number 9, Appendix C. The SMP scores will remain readily available by request from customers, reviewed and discussed at the annual SMP stakeholder meeting, and be viewable continuously on the SMP website.

The Commission removed language requiring the Simple Approach Smoke Estimation Modeling by the permittee since it has been determined to be inaccurate and the Division has not required it since approximately 2005-2006. The Division will continue to perform its own modeling before issuing any permits.

The Commission expanded the time public notice may be given. Previously, Regulation Number 9 limited the timing of public notification regarding prescribed fire to no more than five days before ignition. Allowing at the most five days' notice prior to ignition can, in some cases, be insufficient. Allowing the public to take action and/or provide feedback is critical in the prescribed fire process. Therefore, the Commission removed the restriction that permittees cannot provide notice more than five days before the burn.

The Commission added and clarified open burning definitions and requirements which are technologically feasible and economically reasonable and will reduce, prevent and control air pollution in Colorado, as required by § 25-7-102, C.R.S. Furthermore, the revisions also provided greater transparency regarding open burning best smoke management techniques.

The Commission also corrected typographical and grammatical errors.

Findings Pursuant to § 25-7-110.5(5), C.R.S.

In accordance with C.R.S. § 25-7-110.5(5)(b) and after considering all of the evidence in the record, the Commission determines:

(I) EPA does require states with Regional Haze State Implementation Plans, in developing its long-term strategy, to consider smoke management from wildland fires. This requirement does not limit states from developing more stringent requirements for open burning and prescribed fires.

(II) The federal rules discussed in (I) are primarily performance-based and there is flexibility in those requirements.

(III) Federal requirements regarding smoke management do not address the issues that are of concern to Colorado and did not take into account concerns unique to Colorado.

(IV) The proposed revisions will improve the ability of the regulated community to comply in a more cost-effective way by clarifying confusing or potentially conflicting requirements and increasing certainty.

(V) Any federal requirements regarding visibility have already been implemented and therefore there are no timing issues that might justify changing the time frame for implementation.

(VI) The proposed revisions will assist in establishing and maintaining a reasonable margin for accommodation of uncertainty and future growth.

(VII) The proposed revisions maintain reasonable equity in the requirements for various sources.

(VIII) Colorado citizens may face increased costs due to wildfires and health problems if the proposal is not adopted.

(IX) There are no federal requirements that specifically regulate prescribed fires and open burning. The proposed revisions include minimal monitoring, recordkeeping, and procedural requirements that are necessary to protect Colorado's citizens and environment.

(X) Demonstrated technology is available to comply with the proposed revisions since any additional requirements will only clarify best smoke management techniques, which permittees should already be implementing.

(XI) As set forth in the Economic Impact Analysis, the proposed revisions contribute to the prevention of air pollution and visibility impairment in a cost-effective manner.

(XII) Although alternative revisions may reduce smoke emissions and visibility impairment, the Commission determined that the division's proposal was reasonable and cost-effective.

Findings Pursuant to §25-7-110.8, C.R.S.

After considering all of the information in the record, the Commission makes the determination that:

(I) These revisions are based on reasonably available, validated and reviewed, and sound scientific methodologies demonstrating that exposure to smoke from open burning creates a public health hazard and may lead to a violation of the National Ambient Air Quality Standards. The Commission has considered all information submitted by interested parties.

(II) Evidence in the record supports the finding that the requirements of these revisions will result in a demonstrable reduction in air pollution and will bring about reductions in risks to human health and the environment, which justify the cost to government, the regulated community and to the public to implement and comply with the rule.

(III) Evidence in the record supports the finding that the revisions are the most cost-effective, which best balances cost-effectiveness, flexibility to the regulated community and maximization of air quality benefits.

COLORADO
Air Quality Control Commission
Department of Public Health & Environment

NOTICE OF RULEMAKING HEARING

Regarding proposed revisions to:

Regulation Number 9

SUBJECT:
The Air Quality Control Commission will hold a rulemaking hearing to consider revisions to Regulation Number 9 to clarify the requirements for Prescribed Fires and Open Burning. The revisions consist of five parts: 1) Remove language that is no longer applicable or appropriate; 2) Remove the specific dynamic Smoke Management Program (SMP) scores related to prescribed fire burning; 3) Remove the requirement for inaccurate modeling in the prescribed fire permitting process; 4) Expand the timing for public notification regarding prescribed burns; 5) Incorporate additional best smoke management techniques into the regulation and add/clarify definitions to ensure better air quality and transparency. Also includes changes to correct typographical errors.

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

HEARING SCHEDULE:

DATE: May 21, 2020
TIME: 9:00 a.m.
PLACE: Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South, Sabin Conference Room
Denver, CO 80246

PUBLIC COMMENT:
The Commission encourages input from non-parties, either orally during the public comment sessions or in writing prior to or at the hearing.

Written comments should be submitted no later than **May 1, 2020** 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

Oral public comment will generally not be permitted by persons who offer comment on behalf of an entity that is a party, or is a member of a party to the hearing. Those persons may however submit written public comment.

IMPORTANT DATES AND DEADLINES:

PROCESS DESCRIPTION	DUE DATE & TIME	NOTES
Request for Party Status	March 17, 2020 by 11:59 p.m.	Additional information below
Status Conference	March 19 at 9:30 a.m.	Colorado Dept. of Public Health & Environment 4300 Cherry Creek Drive South Sabin/Cleere Conference Rooms Denver, CO 80246
Alternate Proposal	April 10, 2020 by 11:59 p.m.	Additional information below
Prehearing Statement	April 10, 2020 by 11:59 p.m.	Additional information below
Prehearing Conference	April 16, 2020 at 4:00 p.m.	Colorado Dept. of Public Health & Environment 4300 Cherry Creek Drive South Sabin/Cleere Conference Rooms Denver, CO 80246
Rebuttal Statement	April 24, 2020 by 11:59 p.m.	Additional information below

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 applicants 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.

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: scott.landes@state.co.us
- Air Pollution Control Division attorney(s): 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. A conference call in line will be provided.

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:(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. Exhibits to alternate proposals must be submitted in a separate electronic transmission. Alternate proposals must be emailed to all persons listed on the party status list.

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 exhibits must be emailed to all persons listed on the party status list.

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 hearing officer will consider written requests for participation in the prehearing conference by phone for good cause shown.

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. Exhibits to a rebuttal statement must be submitted in a separate electronic transmission. Rebuttal statements and exhibits must be emailed to all persons listed on the party status list.

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 May 21, 2020.

STATUTORY AUTHORITY FOR THE COMMISSION'S ACTIONS:

The provisions of the Colorado Air Pollution Prevention and Control Act, Section 25-7-101, C.R.S., *et seq*, and specifically Sections 25-7-102, 25-7-105, 25-7-105.1, 25-7-106, 25-7-109, 25-7-114.1, 25-7-114.2, and 114.7, C.R.S., provide specific and general statutory authority for consideration of the regulatory amendments proposed by this notice. 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 21st day of February 2020 at Denver, Colorado

Colorado Air Quality Control Commission

Trisha Oeth, Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00092

Department

1000 - Department of Public Health and Environment

Agency

1001 - Air Quality Control Commission

CCR number

5 CCR 1001-26

Rule title

Colorado Greenhouse Gas Reporting and Emission Reduction Requirements

Rulemaking Hearing

Date

05/20/2020

Time

04:30 PM

Location

Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Sabin Conference Room

Subjects and issues involved

To consider establishing a new Regulation Number 22 as proposed by the Air Pollution Control Division to satisfy requirements the General Assembly set forth in the Colorado Air Pollution and Control Act (the Act), Section 25-7-140(2)(a)(I), C.R.S., directing adoption of reporting requirements for greenhouse gas (GHG) emitting entities; and an additional GHG reduction strategy toward addressing statewide reduction goals as set forth in Sections 25-7-102(g), 105(e)(1), and 140(2)(a)(III), C.R.S., through the phase-out of hydrofluorocarbons (HFCs) in manufacturing and end-uses involving aerosol propellants, chillers, foam, and stationary refrigeration.

Alternative proposals regarding the greenhouse gas reporting rule (Regulation Number 22, Part A, as proposed), including additional source categories and/or alternative reporting thresholds for source categories already covered in the proposed rule, additional voluntary reporting categories, alternative methods and protocols for reporting, and modified reporting deadlines may also be considered.

Alternative proposals regarding the HFC phase-out rule (Regulation Number 22, Part B., Section I., as proposed), including the regulation of additional categories of refrigerant use, may also be considered.

Statutory authority

Section 25-7-101, C.R.S., et seq, and specifically Sections 25-7-102, 25-7-105, 25-7-105.1, 25-7-106, 25-7-109, 25-7-114.1, 25-7-114.2, and 114.7; 25-7-140; 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 22

Colorado Greenhouse Gas Reporting and Emission Reduction Requirements

5 CCR 1001-26

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

Outline of Regulation

PART A Greenhouse Gas Reporting

PART B Greenhouse Gas Emission Reduction Requirements

PART C Statement 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 (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.gpo.gov/fdsys. Materials incorporated by reference are those editions in existence as of the date indicated and do not include any later amendments.

Unless otherwise indicated, any incorporation by reference of provisions of Title 40 of the Code of Federal Regulations (CFR) are to the edition effective as of July 1, 2019.

PART A Greenhouse Gas Reporting

I. General Provisions

I.A. This regulation establishes mandatory greenhouse gas (GHG) monitoring, recordkeeping and reporting requirements for owners and operators of certain facilities that directly emit GHGs, and retail or wholesale electric service providers. Additionally, certain suppliers will be required to report GHGs based upon the quantity that would be emitted from combustion or use of the products supplied.

I.B. Entities subject to this regulation that are also subject to the reporting requirements of the U.S. Environmental Protection Agency's (EPA) mandatory GHG reporting rule under 40 CFR Part 98 (Part 98) must also report directly to the State of Colorado under this regulation.

II. Definitions

II.A. "Anaerobic Process" means a procedure in which organic matter in wastewater, wastewater treatment sludge, or other material is degraded by microorganisms in the absence of oxygen, resulting in the generation of carbon dioxide (CO_2) and methane (CH_4). This source category consists of the following: anaerobic reactors, anaerobic lagoons, anaerobic sludge digesters, and biogas destruction devices (for example, burners, boilers, turbines, flares, or other devices).

II.B. “Carbon Dioxide Equivalent (CO2e)” means a metric measure used to compare the emissions from various GHG based upon their global warming potential (GWP). CO2e is determined by multiplying the mass amount of emissions (metric tons per year), for each GHG constituent by that gas’s GWP, and summing the resultant values to determine CO2e (metric tons per year). Note that this term differs from that defined in the Air Quality Control Commission Common Provisions Regulation and Regulation Number 3.

II.C. “CFR” means Code of Federal Regulations.

II.D. "Domestic Wastewater Treatment Plant" has the same meaning as defined by the Water Quality Control Commission in 5 Code of Colo. Regs. (CCR) 1002-22 (September 30, 2009).

II.E. “Electric Service Provider” or “electric utility” means any public utility as defined in Section 40-1-103, C.R.S., (July 1, 2019) providing electric services or providing electric energy for retail or wholesale sales, including imported and exported electric energy, in the State of Colorado.

II.F. “Emergency Generator” means a stationary combustion device, such as a reciprocating internal combustion engine or turbine that serves solely as a secondary source of mechanical or electrical power whenever the primary energy supply is disrupted or discontinued during power outages or natural disasters that are beyond the control of the owner or operator of a facility. An emergency generator operates only during emergency situations, for training of personnel under simulated emergency conditions, as part of emergency demand response procedures, or for standard performance testing procedures as required by law or by the generator manufacturer. A generator that serves as a back-up power source under conditions of load shedding, peak shaving, power interruptions pursuant to an interruptible power service agreement, or scheduled facility maintenance shall not be considered an emergency generator.

II.G. “Exported Electricity” means electricity generated inside the State of Colorado and delivered to serve load located outside the State of Colorado. Exported electricity does not include electricity that is generated outside the State of Colorado, is transmitted through the State of Colorado, and with the final point of delivery outside the State of Colorado.

II.H. “Facility” means any physical property, plant, building, structure, source, or stationary equipment located on one or more contiguous or adjacent properties in actual physical contact or separated solely by a public roadway or other public right of way and under common ownership or common control, that emits or may emit any greenhouse gas. Operators of military installations may classify such installations as more than a single facility based on distinct and independent functional groupings within contiguous military properties.

II.I. “Food Processing” means an operation used to manufacture or process meat, poultry, fruits, and/or vegetables as defined under NAICS 3116 (Meat Product Manufacturing) or NAICS 3114 (Fruit and Vegetable Preserving and Specialty Food Manufacturing). For information on NAICS codes, see http://www.census.gov/eos/www/naics/ (as published January 30, 2020).

II.J. "Global Warming Potential" or "GWP" means the ratio of the time-integrated radiative forcing from the instantaneous release of one kilogram of a trace substance relative to that of one kilogram of a reference gas, i.e., (CO_2). For the GHG emissions calculations requirements of this rule, the GWP values that must be used are as specified in Table A-1 to Subpart A of Title 40 CFR Part 98.

II.K. “Greenhouse Gas” or “GHG” means carbon dioxide (CO_2), methane (CH_4), nitrous oxide (N_2O), hydrofluorocarbons (HFCs), perfluorocarbons (PFCs), sulfur hexafluoride (SF_6) and Nitrogen Trifluoride (NF_3). Note that this term differs from that defined in the Air Quality Control Commission Regulation Number 3.

II.L. “Hydrofluorocarbons (HFCs)” means a class of GHGs consisting of hydrogen, fluorine, and carbon.

II.M. “Industrial Waste Landfill” means a landfill other than a municipal solid waste landfill, a Resource Conservation and Recovery Act (RCRA) Subtitle C hazardous waste landfill, or a Toxic Substance Control Act (TSCA) hazardous waste landfill, in which industrial solid waste, such as RCRA Subtitle D wastes (non-hazardous industrial solid waste, defined in 40 CFR § 257.2), commercial solid wastes, or conditionally exempt small quantity generator wastes, is placed. An industrial waste landfill includes all disposal areas at the facility.

II.N. “Industrial Wastewater Treatment” means use of anaerobic processes to treat industrial wastewater and industrial wastewater treatment sludge at pulp and paper manufacturing, food processing, ethanol production and petroleum refining facilities. Industrial wastewater treatment does not include municipal wastewater treatment plants or separate treatment of sanitary wastewater at industrial sites.

II.O. “Imported Electricity” means electricity generated outside the State of Colorado and delivered to serve load within the State of Colorado. Imported electricity does not include electricity that is generated outside the State of Colorado, is transmitted through the State of Colorado, and with the final point of delivery outside the State of Colorado.

II.P. “Local Distribution Company” or “LDC” means a company that owns or operates distribution pipelines, not interstate pipelines or intrastate pipelines, that physically deliver natural gas to end users and that are within a single state that are regulated as separate operating companies by State public utility commissions or that operate as independent municipally-owned distribution systems. LDCs do not include pipelines (both interstate and intrastate) delivering natural gas directly to major industrial users and farm taps upstream of the local distribution company inlet.

II.Q. “Metric Ton” means a common international measurement for mass equal to 1,000 kilograms, which is equivalent to 2204.6 pounds or 1.1 short tons.

II.R. “Municipal Solid Waste Landfill” or “MSW landfill” means an entire disposal facility in a contiguous geographical space where household waste is placed in or on land. An MSW landfill may also receive other types of RCRA Subtitle D wastes (40 CFR § 257.2) such as commercial solid waste, non-hazardous sludge, conditionally exempt small quantity generator waste, and industrial solid waste. Portions of an MSW landfill may be separated by access roads, public roadways, or other public right-of-ways. An MSW landfill may be publicly or privately owned.

II.S. “Natural Gas Transmission and Storage” has the same meaning as “natural gas transmission and storage segment” as defined in Air Quality Control Commission (AQCC) Regulation Number 7, Part D, Section IV.A. (effective February 14, 2020).

II.T. “North American Industry Classification System (NAICS) code(s)” means the six-digit code(s) that represents the product(s)/activity(s)/service(s) at a facility or supplier as listed in the Federal Register and defined in “North American Industrial Classification System Manual 2007,” available from the U.S. Department of Commerce, National Technical Information Service, Alexandria, VA 22312 and http://www.census.gov/eos/www/naics/ (as published January 30, 2020).

II.U. “Oil and Natural Gas Operations and Equipment” means the equipment and activities listed in AQCC Regulation Number 7, Part D, Section V.C. (effective February 14, 2020).

II.V. “Perfluorocarbons (PFCs)” means a class of greenhouse gases consisting on the molecular level of carbon and fluorine.

II.W. “Research and Development” means those activities conducted in process units or at laboratory bench-scale settings whose purpose is to conduct research and development for new processes, technologies, or products and whose purpose is not for the manufacture of products for commercial sale, except in a de minimis manner.

II.X. “Responsible Official” means the definition of that term found in the Air Quality Control Commission’s Common Provisions Regulation (effective January 14, 2016).

II.Y. "Supplier" means a producer, importer, or exporter in any supply category included in Table A-5 of Subpart A, 40 CFR Part 98, as defined by the appropriate subpart in 40 CFR Part 98.

II.Z. “Year” means calendar year.

III. Applicability and Emissions Quantification for Affected Sources

III.A. The GHG monitoring, recordkeeping, and reporting requirements of this rule apply to the owners and operators of any facility or entity that is located in the State of Colorado and that meets any of the following requirements:

III.A.1. Any electric service provider or electric utility. GHGs reported must include all emissions from electricity generation and transmission equipment, not including emergency generators.

III.A.2. Any local distribution company.

III.A.3 Any supplier. The GHGs reported must be based on the fuel delivered to retail providers or end users and are the quantity that is emitted from combustion or use of the fuel products delivered or supplied.

III.A.4. Any industrial waste landfill active at any point during the year. Inert material facilities as defined under 6 CCR 1007-2, Part 1 (November 30, 2019), are exempt from the requirements of this regulation. The GHGs reported must include emissions from the landfill, landfill gas collection systems, and destruction devices for landfill gases

III.A.5. Any industrial wastewater treatment.

III.A.6. Any underground coal mine active at any point during the year.

III.A.7. All oil and natural gas operations and equipment at or upstream of a natural gas processing plant and all natural gas transmission and storage.

III.A.8. Any facility or supplier not covered under Sections III.A.1. through III.A.7. that is required to report under 40 CFR Part 98 must report GHGs to the same extent as reported under 40 CFR Part 98.

III.A.9. Any municipal solid waste landfill not required to report under 40 CFR Part 98 may voluntarily report GHGs. The GHGs reported must include emissions from the landfill, landfill gas collection systems, and destruction devices for landfill gases.

III.A.10 Any domestic wastewater treatment plant may voluntarily report GHGs.

III.A.11. Any agricultural operation may voluntarily report GHGs or operational information sufficient to allow the Division to determine GHGs.

III.A.12. Research and development activities are excluded from GHG reporting requirements.

III.B. Owners and operators of facilities or entities covered under Paragraph III.A., whether as mandatory or voluntary reporters, must report all GHGs regardless of the amount emitted. Reported GHGs must include the mass of each GHG constituent and total CO2e. To quantify GHG emissions for the reporting purposes of this rule, the owner or operator of a facility or an entity identified in Paragraph III.A of this section must calculate GHG emissions by year as described below:

III.B.1. For an electric service provider or utility identified in Section III.A.1, GHG emissions must be calculated using the applicable calculation methodologies and appropriate equations specified in Subparts C, D, and DD of 40 CFR, Part 98.

III.B.2. For a local distribution company identified in Section III.A.2., GHG emissions must be calculated using the applicable calculation methodologies specified in Subparts W and NN of 40 CFR, Part 98.

III.B.3 For a supplier identified in Section III.A.3., GHG emissions must be calculated using the applicable calculation methodologies specified in Subparts LL, MM, or NN of 40 CFR, Part 98.

III.B.4. For an industrial waste landfill identified in Section III.A.4., GHG emissions must be calculated according to Subpart TT of 40 CFR, Part 98.

III.B.5. For industrial wastewater treatment identified in Section III.A.5., GHG emissions must be calculated according to Subpart II of 40 CFR, Part 98.

III.B.6. For an underground coal mine identified in Section III.A.6., GHG emissions must be calculated according to Subpart FF of 40 CFR, Part 98.

III.B.7. For oil and natural gas operations and equipment at or upstream of a natural gas processing plant identified in Section III.A.7., GHG emissions must be calculated according to the requirements of AQCC Regulation Number 7, Part D, Section V. (effective February 14, 2020). For natural gas transmission and storage identified in Section III.A.7., GHG emissions must be calculated according to the requirements of AQCC Regulation Number 7, Part D, Section IV. (effective February 14, 2020).

III.B.8. For a facility or supplier included pursuant to Section III.A.8., GHG emissions must be calculated using the calculation methodologies specified in each applicable Subpart of 40 CFR, Part 98.

III.B.9. For a municipal solid waste landfill identified in Section III.A.9., GHG emissions must be calculated according to Subpart HH of 40 CFR, Part 98.

III.B.10. For a domestic wastewater treatment plant identified in Section III.A.10., GHG emissions must be calculated according to the “U.S. Community Protocol for Accounting and Reporting of Greenhouse Gas Emissions ” (Version 1.2, July 2019), at Appendix F: Wastewater and Water Emission Activities and Sources, published by ICLEI: Local Governments for Sustainability and available in hardcopy at the offices of the CDPHE and for download at: [Division to create URL with document available for download].

III.B.11. For an agricultural operation identified in Section III.A.11., reported GHG emissions or operational information must utilize emission calculation protocols applicable to the specific activities in the agricultural sector.

IV. Reporting Requirements

IV.A. On or before March 31 of each year, unless otherwise specified, owners and operators of facilities or entities identified in Section III.A. must submit a report of GHG emissions in the previous calendar year. GHGs must be reported utilizing Division-approved format or forms.

IV.A.1. The first report for owners and operators of facilities or entities required to report for calendar year 2020 pursuant to 40 CFR, Part 98 is due on or before March 31, 2021.

IV.A.2. The first report for owners and operators of facilities or entities under Sections III.A.1. through III.A.6. and III.A.9. through III.A.11. that were not required to submit a federal report for calendar year 2020 pursuant to 40 CFR, Part 98 is due on or before March 31, 2022 for calendar year 2021.

IV.A.3. Owners and operators of oil and natural gas operations and equipment and natural gas transmission and storage identified in Section III.A.7. must report GHGs to the Division according to the inventory reporting requirements and deadlines of AQCC Regulation Number 7, Part D, Sections IV. and V. (effective February 14, 2020).

IV.B. GHG reports submitted must include the following:

IV.B.1. Individual GHG constituent emissions (metric tons per year) and associated CO2e emissions, and aggregated CO2e emissions.

IV.B.2. AIRS ID if assigned to a subject facility, along with the facility name, entity name or supplier name (as appropriate), and physical street address of the facility, entity or supplier, including the city, State, and zip code. If the facility does not have a physical street address, then the facility must provide the latitude and longitude representing the geographic centroid or center point of facility operations in decimal degree format. This must be provided in a comma-delimited “latitude, longitude” coordinate pair reported in decimal degrees to at least four digits to the right of the decimal point.

IV.B.3. NAICS code(s) that apply to the facility or supplier, including the primary NAICS code and any additional NAICS code(s).

IV.B.4. Year and months covered by the report.

IV.B.5. Date of submittal.

IV.B.6. Certification statement signed and dated by a responsible official that identifies the official’s title and contact information and attests that the report being submitted is true, accurate and complete to the best of the certifying individual’s knowledge.

IV.C. In addition to the information required under Section IV.B., electric service providers and electric utilities must also report the following information using a Division-approved form no later than June 30 of each year:

IV.C.1. The data elements verifying GHG emissions attributable to imported and exported electricity.

IV.C.2. The data elements confirming compliance with GHG reductions from plans approved by the Public Utilities Commission.

IV.D. Report Revisions Due to Substantive Errors

IV.D.1. A substantive error is an error that impacts the quantity of GHG emissions reported or otherwise prevents the reported data from being validated or verified.

IV.D.2. If one or more substantive errors as defined in Section IV.D.1. are discovered in a previously submitted GHG report by an entity responsible for preparing or submitting the report, or providing data for the report, the Division must be notified in writing of the errors within five (5) business days of discovery of the errors and a revised report that corrects the substantive errors must be submitted within forty-five (45) days of the discovery of the errors.

IV.D.3. If the Division identifies substantive errors in a submitted report, the Division may notify the entity responsible for the report of the errors and a revised report that corrects the substantive errors must be submitted within forty-five (45) days of the notification.

IV.D.4. The Division may provide reasonable extensions of the forty-five day (45) period for submission of a revised report on a case-by-case basis when requested in writing by the reporting entity. The extension request must include details on why the request is being made and the additional requested time needed to submit the revised report.

V. Recordkeeping Requirements

V.A. All data elements and reports listed below must be retained by the owners and operators of facilities or entities reporting under Section III.A. and be provided to the Division upon request:

V.A.1. All records of supporting documentation used to prepare and submit the GHG report, including but not limited to:

V.A.1.a. All units, operations, processes, and activities for which GHG emissions were calculated.

V.A.1.b. Operating data, fuel use records, or process information used for GHG emissions calculations.

V.A.1.c. GHG emissions calculations and methods used, including a written explanation if emission calculation methodologies used during the reporting period are changed.

V.A.1.d. Any records required to be retained pursuant to Subpart A of 40 CFR, Part 98 and the applicable Subparts of 40 CFR, Part 98 identified in Section III.B.

V.A.2. Reports submitted pursuant to the requirements of Section IV.

V.B. Records must be maintained for five (5) years from the date of submission of the annual GHG report.

PART B Greenhouse Gas Emission Reduction Requirements

I. Prohibitions on Use of Certain Hydrofluorocarbons in Aerosol Propellants, Chillers, Foam, and Stationary Refrigeration End-Uses

I.A. Purpose and Applicability

I.A.1. The purpose of this regulation is to reduce hydrofluorocarbon (HFC) emissions in the State of Colorado by adopting United States Environmental Protection Agency (EPA) Significant New Alternatives Policy (SNAP) Program prohibitions for certain HFCs in air conditioning and refrigeration equipment, aerosol propellants, and foam end-uses. This regulation is designed to support greenhouse gas emission reductions identified in Colorado Revised Statutes, Section 25-7-102(2)(g).

I.A.2. This regulation applies to any person who sells, offers for sale, leases, rents, installs, uses, or manufacturers in the State of Colorado any product or equipment that uses or will use an HFC in end-uses listed in Section I.E.1.

I.B. Definitions

I.B.1. “Aerosol Propellant” means a compressed gas that serves to dispense the contents of an aerosol container when the pressure is released.

I.B.2. “Air Conditioning Equipment” means chillers, both centrifugal chillers and positive displacement chillers, intended for comfort cooling of occupied spaces.

I.B.3. “Bunstock” or “Bun Stock” means a large solid box-like structure formed during the production of polyurethane, polyisocyanurate, phenolic, or polystyrene insulation.

I.B.4. “Capital Cost” means an expense incurred in the production of goods or in rendering services including but not limited to the cost of engineering, purchase, and installation of components and/or systems, and instrumentation, and contractor and construction fees.

I.B.5. “Centrifugal Chiller” means air conditioning equipment that utilizes a centrifugal compressor in a vapor-compression refrigeration cycle typically used for commercial comfort air conditioning. Centrifugal chiller in this definition is a chiller intended for comfort cooling and does not include cooling for industrial process cooling and refrigeration.

I.B.6. “Cold Storage Warehouse” means a cooled facility designed to store meat, produce, dairy products, and other products that are delivered to other locations for sale to the ultimate consumer.

I.B.7. “Component” means a part of a refrigeration system, including but not limited to condensing units, compressors, condensers, evaporators, and receivers; and all of its connections and subassemblies, without which the refrigeration system will not properly function or will be subject to failures.

I.B.8. “Cumulatively Replaced” means the addition of, or change in, multiple components within a three-year period.

I.B.9. “Date of Prohibition” means the applicable date after which the prohibition for use of HFCs in a specific end-use provided in Section I.E. goes into effect.

I.B.10. ‘‘End-use’’ means processes or classes of specific applications within industry sectors, including but not limited to those listed in Section I.E.

I.B.11. “Flexible Polyurethane” means a non-rigid synthetic foam containing polymers created by the reaction of isocyanate and polyol, including but not limited to that used in furniture, bedding, and chair cushions.

I.B.12. “Foam” means a product with a cellular structure formed via a foaming process in a variety of materials that undergo hardening via a chemical reaction or phase transition.

I.B.13. “Foam Blowing Agent” means a substance used to produce foam.

I.B.14. “Household Refrigerators and Freezers” means refrigerators, refrigerator-freezers, freezers, and miscellaneous household refrigeration appliances intended for residential use. For the purposes of this regulation, “household refrigerators and freezers” does not

include “household refrigerators and freezers - compact”, or “household refrigerators and freezers - built-in.”

I.B.15. “Household Refrigerators and Freezers - Compact” means any refrigerator, refrigerator-freezer or freezer intended for residential use with a total refrigerated volume of less than 7.75 cubic feet (220 liters).

I.B.16. “Household Refrigerators and Freezers - Built-in” means any refrigerator, refrigerator-freezer or freezer intended for residential use with 7.75 cubic feet or greater total volume and 24 inches or less depth not including doors, handles, and custom front panels; with sides which are not finished and not designed to be visible after installation; and that is designed, intended, and marketed exclusively to be: installed totally encased by cabinetry or panels that are attached during installation; securely fastened to adjacent cabinetry, walls or floor; and equipped with an integral factory-finished face or accept a custom front panel.

I.B.17. "Hydrofluorocarbons" or “HFC” means a class of greenhouse gases (GHGs) consisting of hydrogen, fluorine, and carbon.

I.B.18. “Integral Skin Polyurethane” means a synthetic self-skinning foam containing polyurethane polymers formed by the reaction of an isocyanate and a polyol, including but not limited to that used in car steering wheels and dashboards.

I.B.19. "Manufacturer" means any person, firm, association, partnership, corporation, governmental entity, organization, or joint venture that produces any product that contains or uses HFCs or is an importer or domestic distributor of such a product.

I.B.20. “Metered Dose Inhaler,” or “Medical Dose Inhaler,” or “MDI” means a device that delivers a measured amount of medication as a mist that a patient can inhale, typically used for bronchodilation to treat symptoms of asthma, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, and other respiratory illnesses. An MDI consists of a pressurized canister of medication in a case with a mouthpiece.

I.B.23. “Motor-Bearing” means refrigeration equipment containing motorized parts, including compressors, condensers, and evaporators.

I.B.24. “New” means products or equipment that are manufactured after the date of prohibition or equipment first installed for an intended purpose with new or used components after the date of prohibition, expanded by the addition of components to increase system capacity after the date of prohibition, or replaced or cumulatively replaced such that the cumulative capital cost of replacement after the date of prohibition exceeds 50% of the capital cost of replacing the whole system.

I.B.25. “Phenolic Insulation Board” means phenolic insulation including but not limited to that used for roofing and wall insulation.

I.B.26. “Polyolefin” means foam sheets and tubes made of polyolefin.

I.B.27. “Polystyrene Extruded Boardstock and Billet (XPS)” means a foam formed from predominantly styrene monomer and produced on extruding machines in the form of continuous foam slabs which can be cut and shaped into panels used for roofing, walls, and flooring.

I.B.28. “Polystyrene Extruded Sheet” means polystyrene foam including that used for packaging. It is also made into food-service items, including hinged polystyrene containers (for "take-

out" from restaurants); food trays (meat and poultry) plates, bowls, and retail egg containers.

I.B.29. “Positive Displacement Chiller” means vapor compression cycle chillers that use positive displacement compressors, typically used for commercial comfort air conditioning. Positive displacement chiller in this definition is a chiller intended for comfort cooling and does not include cooling for industrial process cooling and refrigeration.

I.B.30. “Refrigerant” or “Refrigerant Gas” means any substance, including blends and mixtures, which is used for heat transfer purposes.

I.B.31. “Refrigerated Food Processing and Dispensing Equipment” means retail food refrigeration equipment that is designed to process food and beverages dispensed via a nozzle that are intended for immediate or near-immediate consumption, including but not limited to chilled and frozen beverages, ice cream, and whipped cream. This end-use excludes water coolers, or units designed solely to cool and dispense water.

I.B.32. “Refrigeration Equipment” means any stationary device that is designed to contain and use refrigerant gas, including but not limited to retail or commercial refrigeration equipment, household refrigerators and freezers, and cold storage warehouses.

I.B.33. “Remote Condensing Units” means retail refrigeration equipment or units that have a central condensing portion and may consist of compressor(s), condenser(s), and receiver(s) assembled into a single unit, which may be located external to the sales area. The condensing portion (and often other parts of the system) is located outside the space or area cooled by the evaporator. Remote condensing units are commonly installed in convenience stores, specialty shops (e.g., bakeries, butcher shops), supermarkets, restaurants, and other locations where food is stored, served, or sold.

I.B.34. “Residential Use” means use by a private individual of a substance, or a product containing the substance, in or around a permanent or temporary household, during recreation, or for any personal use or enjoyment. Use within a household for commercial or medical applications is not included in this definition, nor is use in automobiles, watercraft, or aircraft.

I.B.35. “Retail Food Refrigeration” or “Commercial Refrigeration” means equipment designed to store and display chilled or frozen goods for commercial sale including but not limited to stand-alone units, refrigerated food processing and dispensing equipment, remote condensing units, supermarket systems, and vending machines.

I.B.36. “Retrofit” means to convert a system from one refrigerant to another refrigerant. Retrofitting includes the conversion of the system to achieve system compatibility with the new refrigerant and may include, but is not limited to, changes in lubricants, gaskets, filters, driers, valves, O-rings, or system components.

I.B.37. “Rigid Polyurethane and Polyisocyanurate Laminated Boardstock” means laminated board insulation made with polyurethane or polyisocyanurate foam, including that used for roofing and wall insulation.

I.B.38. “Rigid Polyurethane Appliance Foam” means polyurethane insulation foam in household appliances.

I.B.39. “Rigid Polyurethane Commercial Refrigeration and Sandwich Panels” means polyurethane insulation for use in walls and doors, including that used for commercial refrigeration equipment, and used in doors, including garage doors.

I.B.40. “Rigid Polyurethane High-pressure Two-component Spray Foam” means a foam product that is pressurized 800-1600 pounds per square inch (psi) during manufacture; sold in pressurized containers as two parts (i.e., A-side and B-side); and is blown and applied in situ using high-pressure pumps to propel the foam components, and may use liquid blowing agents without an additional propellant.

I.B.41. “Rigid Polyurethane Low-pressure Two-component Spray Foam” means a foam product that is pressurized to less than 250 psi during manufacture; sold in pressurized containers as two parts (i.e., A-side and B-side); and are typically applied in situ relying upon a gaseous foam blowing agent that also serves as a propellant so pumps typically are not needed.

I.B.42. “Rigid Polyurethane Marine Flotation Foam” means buoyancy or flotation foam used in boat and ship manufacturing for both structural and flotation purposes.

I.B.43. “Rigid Polyurethane Slabstock and Other” means a rigid closed-cell foam containing urethane polymers produced by the reaction of an isocyanate and a polyol and formed into slabstock insulation for panels and fabricated shapes for pipes and vessels.

I.B.44. “Stand-Alone Unit” means retail refrigerators, freezers, and reach-in coolers (either open or with doors) where all refrigeration components are integrated and the refrigeration circuit may be entirely brazed or welded. These systems are fully charged with refrigerant at the factory and typically require only an electricity supply to begin operation.

I.B.45. “Stand-Alone Low-Temperature Unit” means a stand-alone unit that maintains food or beverages at temperatures at or below 32°F (0 °C).

I.B.46. “Stand-Alone Medium-Temperature Unit” means a stand-alone unit that maintains food or beverages at temperatures above 32°F (0 °C).

I.B.47. “Substance” means any chemical intended for use in the end-uses listed in Section I.E of this regulation.

I.B.48. “Supermarket Systems” means multiplex or centralized retail food refrigeration equipment systems designed to cool or refrigerate, which typically operate with racks of compressors installed in a machinery room and which includes both direct and indirect systems.

I.B.49. “Use” means any utilization of any substance, including but not limited to utilization in a manufacturing process or product in the State of Colorado, consumption by the end-user in the State of Colorado, or in intermediate applications in the State of Colorado, such as formulation or packaging for other subsequent applications. For the purposes of this regulation, use excludes residential use, but it does not exclude manufacturing for the purpose of residential use.

I.B.50. “Vending Machine” means a self-contained unit that dispenses goods that must be kept cold or frozen.

I.C. Prohibitions and Exemptions

I.C.1. No person may sell, lease, rent, install, use, or manufacture in the State of Colorado, any product or equipment using a prohibited substance for any air-conditioning, refrigeration, foam, or aerosol propellant end-use listed in Section I.E.1.

I.C.2. Except where an existing system is retrofit after the date of prohibition, nothing in this regulation requires a person that acquired a product or equipment containing a prohibited substance prior to the applicable date of prohibition in Section I.E.1. to cease use of that product or equipment. Products or equipment manufactured prior to the applicable date of prohibition specified in Table 1 of Section I.E.1 (including spray foam systems not yet applied on site) may be sold, imported, exported, distributed, installed, and used after the specified date of prohibition.

I.C.3. End-uses that are exempted from Part B, Section I of this regulation are provided for in Section I.E.2.

I.D. Requirements

I.D.1. Disclosure Statement

I.D.1.a. Any person who manufactures or sells in the State of Colorado a product or equipment in the air-conditioning, refrigeration, foam, or aerosol propellant end-uses listed as prohibited in Section I.E.1., must provide a written disclosure to the buyer as part of the sales transaction and invoice or a label on the product or equipment as of the applicable date of prohibition for the end-use in Section 1.E.1.

I.D.1.a.(i) For motor-bearing refrigeration and air-conditioning equipment that is not factory-charged or pre-charged with refrigerant, the disclosure or label must state: “This equipment is prohibited from using any substance on the “List of Prohibited Substances” for that specific end-use, in accordance with State regulations for hydrofluorocarbons.”

I.D.1.a.(ii) Except for products and equipment with existing labeling required by state or local building codes and safety standards which contain the information required in this subsection I.D.2.a.ii., the disclosure or label for refrigeration and air-conditioning equipment that are factory-charged or pre-charged with a refrigerant must include the date of manufacture and the refrigerant and foam blowing agent the product or equipment contains.

I.D.1.a.(iii) For foam, the disclosure or label must include the date of manufacture and hydrofluorocarbon the product contains or the hydrofluorocarbon used to make the product. Alternatively, the disclosure or label may state: “Where sold, compliant with State HFC regulations.”

I.D.1.a.(iv) For aerosol propellant products, the disclosure or label must include the date of manufacture and the hydrofluorocarbon the product contains or the hydrofluorocarbon used to make the product. Alternatively, the disclosure requirement may be met if the hydrofluorocarbon the product contains or the hydrofluorocarbon used to make the product is listed in a Safety Data Sheet for the product that complies with the requirements of 29 CFR 1910.1200 (effective February 8, 2013).

I.D.2. Recordkeeping

I.D.2.a. Any person who manufactures any product or equipment in the end uses listed in Section I.E.1. for sale or entry into commerce in the State of Colorado must

maintain for five (5) years the following records, where applicable, as of the date of prohibition for that end-use:

I.D.1.a.(i) Date of manufacture of the equipment or product.

I.D.1.a.(ii) Date of sale of the equipment or product.

I.D.1.a.(iii) The refrigerant, aerosol propellant, or foam blowing agent(s) that the equipment or product is designed to use.

I.D.1.a.(iv) The refrigerants, aerosol propellants, or foam blowing agent used in the equipment or products and the full charge capacity, where available.

I.D.1.a.(v) A copy of the disclosure statement or label issued to the buyer or recipient of the equipment or product.

I.D.2.b. Records must be made available to the Division upon request.

I.E. List of Prohibited Substances and Exemptions

I.E.1. Table 1 lists prohibited substances in specific end-uses and the date of prohibition for each end-use, unless an exemption is provided for in Section I.E.2.

Table 1: End-Use, Prohibited Substances, and Date of Prohibition

End-Use Category: Aerosol Propellants		
End-Use	Prohibited Substances	Date of Prohibition
Aerosol Propellants	HFC-125, HFC-134a, HFC-227ea and blends of HFC-227ea and HFC-134a	January 1, 2021
End-Use Category: Air Conditioning		
End-Use	Prohibited Substances	Date of Prohibition
Centrifugal Chillers (New)	FOR12A, FOR12B, HFC-134a, HFC-227ea, HFC-236fa, HFC245fa, R-125/ 134a/ 600a (28.1/70/1.9), R-125/ 290/ 134a/ 600a (55.0/1.0/42.5/1.5), R-404A, R-407C, R-410A, R-410B, R-417A, R-421A, R-422B, R-422C, R-422D, R-423A, R-424A, R-434A, R438A, R-507A, RS-44 (2003 composition), THR-03	January 1, 2024
End-Use Category: Air Conditioning		
End-Use	Prohibited Substances	Date of Prohibition

Positive Displacement Chillers (New)	FOR12A, FOR12B, HFC-134a, HFC-227ea, KDD6, R125/ 134a/ 600a (28.1/70/1.9), R-125/ 290/ 134a/ 600a (55.0/1.0/42.5/1.5), R-404A, R-407C, R-410A, R-410B, R-417A, R-421A, R-422B, R-422C, R-422D, R-424A, R-434A, R-437A, R438A, R-507A, RS-44 (2003 composition), SP34E, THR-03	January 1, 2024
End-Use Category: Refrigeration		
End-Use	Prohibited Substances	Date of Prohibition
Cold Storage Warehouses (New)	HFC-227ea, R-125/290/134a/600a (55.0/1.0/42.5/1.5), R404A, R-407A, R-407B, R-410A, R-410B, R-417A, R-421A, R421B, R-422A, R-422B, R-422C, R-422D, R-423A, R-424A, R428A, R-434A, R-438A, R-507A, RS-44 (2003 composition)	January 1, 2023
Household Refrigerators and Freezers (New)	FOR12A, FOR12B, HFC-134a, KDD6, R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407C, R-407F, R-410A, R-410B, R-417A, R-421A, R-421B, R-422A, R-422B, R-422C, R-422D, R424A, R-426A, R-428A, R-434A, R-437A, R-438A, R-507A, RS24 (2002 formulation), RS-44 (2003 formulation), SP34E, THR-03	January 1, 2022
Household Refrigerators and Freezers—Compact (New)	FOR12A, FOR12B, HFC-134a, KDD6, R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407C, R-407F, R-410A, R-410B, R-417A, R-421A, R-421B, R-422A, R-422B, R-422C, R-422D, R424A, R-426A, R-428A, R-434A, R-437A, R-438A, R-507A, RS24 (2002 formulation), RS-44 (2003 formulation), SP34E, THR-03	January 1, 2021

End-Use Category: Refrigeration		
End-Use	Prohibited Substances	Date of Prohibition
Household Refrigerators and Freezers—Built-in (New)	FOR12A, FOR12B, HFC-134a, KDD6, R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407C, R-407F, R-410A, R-410B, R-417A, R-421A, R-421B, R-422A, R-422B, R-422C, R-422D, R424A, R-426A, R-428A, R-434A, R-437A, R-438A, R-507A, RS24 (2002 formulation), RS-44 (2003 formulation), SP34E, THR-03	January 1, 2023

Supermarket Systems (Retrofit)	R-404A, R-407B, R-421B, R-422A, R-422C, R-422D, R428A, R-434A, R-507A	January 1, 2021
Supermarket Systems (New)	HFC-227ea, R-404A, R-407B, R-421B, R-422A, R-422C, R-422D, R-428A, R-434A, R-507A	January 1, 2021
Remote Condensing Units (Retrofit)	R-404A, R-407B, R-421B, R-422A, R-422C, R-422D, R428A, R-434A, R-507A	January 1, 2021
Remote Condensing Units (New)	HFC-227ea, R-404A, R-407B, R-421B, R-422A, R-422C, R-422D, R-428A, R-434A, R-507A	January 1, 2021
Stand-alone Units (Retrofit)	R-404A, R-507A	January 1, 2021
End-Use Category: Refrigeration		
End-Use	Prohibited Substances	Date of Prohibition
Stand-alone Medium-Temperature Units (New)	FOR12A, FOR12B, HFC-134a, HFC-227ea, KDD6, R125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R407A, R-407B, R-407C, R-407F, R-410A, R-410B, R417A, R-421A, R-421B, R-422A, R-422B, R-422C, R422D, R-424A, R-426A, R-428A, R-434A, R-437A, R438A, R-507A, RS-24 (2002 formulation), RS-44 (2003 formulation), SP34E, THR-03	January 1, 2021
Stand-alone Low-Temperature Units (New)	HFC-227ea, KDD6, R-125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R-407A, R-407B, R-407C, R-407F, R-410A, R-410B, R-417A, R-421A, R-421B, R422A, R-422B, R-422C, R-422D, R-424A, R-428A, R434A, R-437A, R-438A, R-507A, RS-44 (2003 formulation)	January 1, 2021

Refrigerated Food Processing and Dispensing Equipment (New)	HFC-227ea, KDD6, R-125/ 290/ 134a/ 600a (55.0/1.0/42.5/1.5), R-404A, R-407A, R-407B, R-407C, R-407F, R-410A, R-410B, R417A, R-421A, R-421B, R-422A, R-422B, R-422C, R-422D, R424A, R-428A, R-434A, R-437A, R-438A, R-507A, RS-44 (2003 formulation)	January 1, 2021
End-Use Category: Refrigeration		
End-Use	Prohibited Substances	Date of Prohibition
Vending Machines (New)	FOR12A, FOR12B, HFC-134a, KDD6, R125/290/134a/600a (55.0/1.0/42.5/1.5), R-404A, R407C, R-410A, R-410B, R-417A, R-421A, R-422B, R422C, R-422D, R-426A, R-437A, R-438A, R-507A, RS-24 (2002 formulation), SP34E	January 1, 2022
Vending Machines (Retrofit)	R-404A, R-507A	January 1, 2022
End-Use Category: Foams		
End-Use	Prohibited Substances	Date of Prohibition
Rigid Polyurethane and Polyisocyanurate Laminated Boardstock	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof	January 1, 2021
Flexible Polyurethane	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof	January 1, 2021
Integral Skin Polyurethane	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof; Formacel TI, Formacel Z-6	January 1, 2021
Polystyrene Extruded Sheet	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof; Formacel TI, Formacel Z-6	January 1, 2021

End-Use Category: Foams		
End-Use	Prohibited Substances	Date of Prohibition
Phenolic Insulation Board and Bunstock	HFC-143a, HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof	January 1, 2021
Rigid Polyurethane Slabstock and Other	HFC-134a, HFC-245fa, HFC-365mfc and blends thereof; Formacel TI, Formacel Z-6	January 1, 2021
Rigid Polyurethane Appliance Foam	HFC-134a, HFC-245fa, HFC-365mfc and blends thereof; Formacel TI, Formacel Z-6	January 1, 2021
Rigid Polyurethane Commercial Refrigeration and Sandwich Panels	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof; Formacel TI, Formacel Z-6	January 1, 2021
Polyolefin	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof; Formacel TI, Formacel Z-6	January 1, 2021
Rigid Polyurethane Marine Flotation Foam	HFC-134a, HFC-245fa, HFC-365mfc and blends thereof; Formacel TI, Formacel Z-6	January 1, 2021
Polystyrene Extruded Boardstock and Billet (XPS)	HFC-134a, HFC-245fa, HFC-365mfc, and blends thereof; Formacel TI, Formacel B, Formacel Z-6	January 1, 2021
End-Use Category: Foams		
End-Use	Prohibited Substances	Date of Prohibition

Rigid Polyurethane High-pressure Two-component Spray Foam	HFC-134a, HFC-245fa, and blends thereof; blends of HFC365mfc with at least 4 percent HFC-245fa, and commercial blends of HFC-365mfc with 7 to 13 percent HFC-227ea and the remainder HFC-365mfc; Formacel TI	January 1, 2021
Rigid Polyurethane Low-pressure Two-component Spray Foam	HFC-134a, HFC-245fa, and blends thereof; blends of HFC365mfc with at least 4 percent HFC-245fa, and commercial blends of HFC-365mfc with 7 to 13 percent HFC-227ea and the remainder HFC-365mfc; Formacel TI	January 1, 2021
Rigid Polyurethane One-component foam sealants	HFC-134a, HFC-245fa, and blends thereof; blends of HFC365mfc with at least 4 percent HFC-245fa, and commercial blends of HFC-365mfc with 7 to 13 percent HFC-227ea and the remainder HFC-365mfc; Formacel TI	January 1, 2021

I.E.2. Table 2 lists exemptions to the prohibitions in Section I.E.1.

Table 2: Exemptions.

End-Use Category	Prohibited Substances	Acceptable Uses

Aerosol Propellants	HFC-134a	Cleaning products for removal of grease, flux and other soils from electrical equipment; refrigerant flushes; products for sensitivity testing of smoke detectors; lubricants and freeze sprays for electrical equipment or electronics; sprays for aircraft maintenance; sprays containing corrosion preventive compounds used in the maintenance of aircraft, electrical equipment or electronics, or military equipment; pesticides for use near electrical wires, in aircraft, in total release insecticide foggers, or in certified organic use pesticides for which EPA has specifically disallowed all other lower-GWP propellants; mold release agents and mold cleaners; lubricants and cleaners for spinnerettes for synthetic fabrics; duster sprays specifically for removal of dust from photographic negatives, semiconductor chips, specimens under electron microscopes, and energized electrical equipment; adhesives and sealants in large canisters; document preservation sprays; U.S. Food and Drug Administration (FDA)-approved MDIs for medical purposes; wound care sprays; topical coolant sprays for pain relief; products for removing bandage adhesives from skin; bear spray; and law enforcement pepper spray.
Aerosol Propellants	HFC-227ea and blends of HFC-227ea and HFC-134a	FDA-approved MDIs for medical purposes.
Air Conditioning	HFC–134a	Military marine vessels where reasonable efforts have been made to ascertain that other alternatives are not technically feasible due to performance or safety requirements.
Air Conditioning	HFC-134a and R-404A	Human-rated spacecraft and related support equipment where reasonable efforts have been made to ascertain that other alternatives are not technically feasible due to performance or safety requirements.
End-Use Category	Prohibited Substances	Acceptable Uses
Foams – Except Rigid polyurethane spray foam	All substances	Military applications where reasonable efforts have been made to ascertain that other alternatives are not technically feasible due to performance or safety requirements until January 1, 2022.
Foams – Except Rigid polyurethane spray foam	All substances	Space- and aeronautics-related applications where reasonable efforts have been made to ascertain that other alternatives are not technically feasible due to performance or safety requirements until January 1, 2025.

Rigid polyurethane two-component spray foam	All substances	Military or space- and aeronautics-related applications where reasonable efforts have been made to ascertain that other alternatives are not technically feasible due to performance or safety requirements until January 1, 2025.

PART C STATEMENTS OF BASIS, SPECIFIC STATUTORY AUTHORITY AND PURPOSE

I. Adopted: [date of the rulemaking hearing; if a multi-day hearing this would be the last day]

This Statement of Basis, Specific Statutory Authority, and Purpose complies with the requirements of the Colorado Administrative Procedure Act Section 24-4-103, the Colorado Air Pollution Prevention and Control Act Section 25-7-1. This Statement of Basis, Specific Statutory Authority, and Purpose complies with the requirements of the Colorado Administrative Procedure Act, Sections 24-4-101 - 108, C.R.S., at Section 103(4), the Colorado Air Pollution Prevention and Control Act (Act), Sections 25-7-101, C.R.S. et seq at Sections 105(1), 110, 110.5, and 110.8 C.R.S., and the Air Quality Commission's Procedural Rules, 5 CCR 1001-1.10 and 25-7-110.5, and the Air Quality Control Commission's Procedural Rules.

Basis

During the 2019 legislative session, Colorado's General Assembly adopted House Bill 2019-1261 (concerning the reduction of greenhouse gas pollution) (HB19-1261) amending the legislative declaration in Section 25-7-102 of the Act, and Senate Bill 2019-096 (concerning the collection of greenhouse gas emissions data) (SB19-096) creating Section 25-7-140 of the Act. HB19-1261 and SB19-096 both define greenhouse gas pollution as including carbon dioxide (CO_2), methane (CH_4), nitrous oxide (N_2O), hydrofluorocarbons (HFCs), perfluorocarbons (PFCs), sulfur hexafluoride (SF_6) and nitrogen trifluoride (NF_3).

In HB19-1261, now codified at Section 25-7-102(2), C.R.S., the General Assembly declared that "climate change adversely affects Colorado's economy, air quality and public health, ecosystems, natural resources, and quality of life[,]" acknowledged that "Colorado is already experiencing harmful climate impacts[,]" and that "many of these impacts disproportionately affect" certain disadvantaged communities. Consequently, the legislature updated Colorado's statewide greenhouse gas pollution reduction goals requiring the Commission to implement regulations to achieve a 26% reduction of statewide GHG by 2025; 50% reduction by 2030; and 90% reduction by 2050 as compared to 2005 levels. Section 25-7-102(g), C.R.S. To accomplish these important goals the legislature also passed SB19-096, now codified as Section 25-7-140, C.R.S., directing the Air Quality Control Commission to undertake two phases of rulemaking aimed first at requiring GHG emitters to monitor and report GHG emissions, Section 25-7-140(2)(a)(I), C.R.S., and second to implement measures allowing the state to cost-effectively meet its GHG reduction goals. Section 25-7-140(2)(a)(III), C.R.S.

With respect to GHG reporting and the statewide inventory, Section 25-7-140(2)(a)(I), C.R.S., requires the Commission to adopt rules by June 1, 2020, "requiring greenhouse gas-emitting entities to monitor and publicly report their emissions as the Commission deems appropriate to support Colorado's GHG inventory efforts and to facilitate implementation of rules that will timely achieve Colorado's greenhouse gas emission reduction goals." Further, Section 25-7-140(2)(a), C.R.S., requires the Commission to consider what information is already being reported for Colorado under EPA's current federal GHG reporting rule, otherwise known as the Mandatory Greenhouse Gas Reporting Rule codified in Title 40 CFR Part 98 (Part 98), and tailor new reporting requirements to fill any gaps in data as determined to be appropriate to allow for a comprehensive and robust state GHG inventory.

Sections 25-7-105(1)(e) and 140(2)(a)(III), C.R.S., further requires the Commission to implement GHG reduction strategies to achieve the reduction goals set forth in Section 25-7-102(2)(g), C.R.S. HFCs are

highly potent GHGs generally used in aerosols, refrigeration and air conditioning, and foam blowing. Phasing out HFCs from most manufacturing processes and end-uses is adopted as a strategy to accomplish the mandated GHG reductions.

Regulation Number 22, Part A and Part B, Section I. are intended to satisfy the requirements set forth by the General Assembly in Section 25-7-140(2)(a)(I), C.R.S., with respect to statewide GHG reporting and an initial GHG reduction strategy to address statewide reductions required by Section 25-7-140(2)(a)(III), C.R.S., and 25-7-105(1)(e), C.R.S., by implementing the phase-out of HFCs in manufacturing and end-use products in Colorado.

Specific Statutory Authority

The Act, specifically Section 25-7-105(1), C.R.S., directs the Commission to promulgate such rules and regulations as are consistent with the legislative declaration set forth in Section 25-7-102, C.R.S., and that are necessary for the proper implementation and administration of the Act.

Section 25-7-102(2), C.R.S., declares that "climate change adversely affects Colorado's economy, air quality and public health, ecosystems, natural resources, and quality of life" that reducing GHG is necessary "to limit the increase in the global average temperature" and that "reducing [GHG], Colorado will also reduce other harmful air pollutants, which will, in turn, improve public health, reduce health care costs, improve air quality, and help sustain the environment[.]" Further, Section 25-7-102(2), C.R.S., declares that reducing GHG will result in economic benefits to Colorado by creating new markets, spurring innovation, and driving investment in low-carbon technologies thus positioning Colorado's "economy, technology centers, financial institutions, and businesses to benefit from national and international efforts to reduce [GHG.]" Section 25-7-102(2)(f), C.R.S.

Section 25-7-106, C.R.S., 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(6), C.R.S., further authorizes the Commission to require owners and operators of any air pollution source to monitor, record, and report emission data and other information as the Commission may require.

Section 25-7-140(2)(a)(I), C.R.S., specifically directs the Commission to, by June 1, 2020, "adopt rules requiring [GHG]-emitting entities to monitor and publicly report their emissions as the commission deems appropriate to support Colorado's greenhouse gas emission inventory efforts and to facilitate implementation of rules that will timely achieve Colorado's greenhouse gas emission reduction goals. The commission shall consider what information is already being publicly reported by the federal environmental protection agency and tailor new reporting requirements to fill any gaps in data, as it determines is appropriate, to allow for maintaining and updating state inventories that are sufficiently comprehensive and robust. The rules must include requirements for providers of retail or wholesale electric service in the state of Colorado to track and report emissions from all generation sources within the state and elsewhere that electricity consumption by their customers in this state causes to be emitted. The commission may require emitting entities to report the amount of emissions of each of the seven individual components of greenhouse gases as well as the carbon dioxide equivalent of those emissions."

Section 25-7-140(2)(a)(III), C.R.S., requires the Commission to implement measures to cost-effectively allow the state to meet its GHG emission reduction goals, which includes reduction of HFCs as potent GHGs. Section 25-7-105(e), C.R.S., authorizes the Commission to promulgate implementing rules and regulations to achieve statewide GHG emission reduction goals, including emission reduction strategies that have been deployed by another sector to reduce multi-sector GHG emissions. Section 25-7-109(2), C.R.S., authorizes the Commission to adopt emission control regulations to reduce emissions of various pollutants, including chemical substances such as HFCs.

Purpose

The following section sets forth the Commission's purpose in adopting Regulation Number 22, and includes the technological and scientific rationale for the adoption of Regulation Number 22:

Part A: Greenhouse Gas Reporting

Part A has been developed to allow the reporters and the Division to leverage existing EPA reporting tools that are currently used by the majority of sources covered by this regulation, as well as for consistency with other U.S. Climate Alliance states that have implemented GHG reporting regulations. Use of existing EPA reporting tools will allow for the GHG data reporting program in Colorado to begin as expeditiously as possible and minimize the burden on the regulated sources. Additionally, consistency with EPA and other state data collection programs will be necessary if Colorado joins a regional program at some point in the future and will allow for a smooth transition if additional federal legislation or regulation is adopted for GHGs. To accomplish this, GHG data reporting by the affected sources under Part A, will be performed using the Intergovernmental Panel on Climate Change (IPCC) 4th Assessment Report, 100-year time horizon GWP values. Part A covers the collection of the GHG data pursuant to Section 25-7-140(2)(a)(I), C.R.S., and does not address how that data will be used in the Colorado GHG Inventory or other planning activities. Because the data will be collected for each individual GHG pollutant, the Division will be capable of converting and comparing reported data to CO2e using other IPCC Assessment Reports' GWP values and/or time horizons as appropriate.

Consistent with the Federal Mandatory Reporting Rule (Part 98), emissions of each GHG pollutant, as required and defined in Section 25-7-140, C.R.S., will be reported in metric tons of CO2e. Where emissions reporting of existing Colorado regulations is used to meet the obligations of this regulation, emissions will be reported by the source in the unit of measure required by the referenced regulation. The Division will convert the emissions to metric tons for use in the GHG inventory or other planning activities.

While Part A utilizes the reporting tools and protocols of the Federal Mandatory Reporting Rule (Part 98), the Division is removing the 25,000 metric ton reporting threshold in Colorado for certain source categories to obtain a more complete and granular data set to inform the inventory and planning processes. More detailed data will also inform local governments as they pursue their own climate change goals. The categories that are required to report all GHG emissions, below the current Federal Mandatory Reporting Rule thresholds, include electricity generation, suppliers including local distribution companies, industrial waste landfills, active coal mines, and industrial wastewater facilities.

GHG reporting for oil and gas operations and equipment and transmission and storage will be gathered in accordance with Regulation 7. These reporting requirements and protocols fill gaps in the federal reporting requirements by expanding the facilities required to report as well as the data reported under Regulation 7, Part D, Sections IV. and V.

Having considered all relevant factors, including but not limited to, current federal GHG reporting under Part 98, statutory requirements under Sections 24-4-103(2.7) and 29-1-304.5, C.R.S., and feedback from stakeholders, the Commission has decided to provide for optional GHG reporting from domestic wastewater plants and active municipal landfills not otherwise required to report under Part 98.

Any facilities or operations for which GHG reporting is optional should report in accordance with the protocols and deadlines set forth in Part A, Sections III and IV. In doing so, these facilities and operations will enable the Commission to establish a more robust statewide GHG inventory and better inform future reduction strategies.

The protocol selected for domestic wastewater treatment plants at Part A, Section III.B.10., has been developed by a nationally recognized organization focused on climate change solutions, ICLEI: Local Governments for Sustainability, and is already being used by some Colorado communities for estimating GHGs from domestic wastewater treatment plants for GHG inventories.

For an agricultural operation identified in Part A, Section III.A.11., the Division will collaborate with voluntary reporters and provide guidance on emission calculation protocols applicable to specific activities in the agricultural sector, such as those developed by the IPCC for the sector.

Part A will also quantify the GHG emissions associated with electricity imported into Colorado, as required by Section 25-7-140(2)(a)(I), C.R.S., and which is not covered by the federal mandatory reporting under Part 98 data submissions. This will be accomplished by requiring subject facilities to submit supplemental generation, distribution, sales, and emissions rate information to the Division. Direct reporting of this information, rather than relying on summaries provided through the Department of Energy, will give better granularity of the data for state and local GHG strategy development. Additionally, direct reporting to the Division will also allow for more timely incorporation into the Colorado GHG Inventory process and more detailed analysis and trending to assess the progress toward achieving the statewide carbon reduction goals.

Part B, Section I.: Prohibitions on Use of Certain Hydrofluorocarbons in Aerosol Propellants, Chillers, Foam, and Stationary Refrigeration End-Uses

The federal EPA adopted two rules under its Significant New Alternatives Policy (SNAP), Rule 20 in July 2015, and Rule 21 in December 2016, which require phasing out the use of high-GWP HFCs in retail and residential refrigeration and air conditioning (AC), aerosol products, and rigid and spray foam end-uses. Under SNAP Rule 20, the compliance dates for eliminating unacceptable HFCs ranged from July 2016 to January 2022, depending on the application. The compliance dates under SNAP Rule 21 ranged from January 2017 to January 2025. In August 2017, the D.C. Circuit of the United States Court of Appeals vacated SNAP Rule 20 to the extent it requires manufacturers to replace HFCs with a substitute substance finding the EPA had exceeded its authority under Section 612 of the Clean Air Act (42 U.S.C. § 7671k). However, the D.C. Circuit found that EPA's removal of HFCs from the list of safe substitutes under SNAP was lawful thus enabling the EPA to prohibit or limit prospective use of HFCs in manufacturing and end uses. Yet, in 2018, EPA guidance advised that it would not be enforcing SNAP Rule 20 until it developed new rules based on the D.C. Circuit's ruling, which has not occured. In April 2019, the D.C Circuit vacated SNAP Rule 21 to the same extent and on the same grounds as SNAP 20.

Absent federal enforcement regulating use of these highly potent GHGs, individual states have adopted, or are in the process of adopting, statutes and regulations phasing out the use of HFCs in manufacturing and end-use products. The U.S. Climate Alliance has drafted a model rule to promote uniformity of HFC regulation. Part B, Section I. is based upon the U.S. Climate Alliance's model rule as are proposed rules under consideration in other states.

Based on public comment and stakeholder feedback, Part B, Section I. differs from the U.S. Climate Alliance's model rule in the treatment of bear spray and law enforcement pepper spray. These two products in the aerosol-propellant category have been exempted in Part B, Section I.

Additional Considerations

The following are additional findings of the Commission made in accordance with the Act:

Section 25-7-110.5(5)(b), C.R.S.

As these revisions exceed and may differ from the federal rules under the federal act, in accordance with Section 25-7-110.5(5)(b), C.R.S., the Commission determines:

(I) Any federal requirements that are applicable to this situation with a commentary on those requirements;

Part A: In order to create a nationwide inventory of GHG emissions, 40 CFR Part 98 (Part 98) sets forth the federal GHG reporting requirements for qualifying source categories in accordance with the Federal

Clean Air Act. The Subparts to Part 98 establish the reporting protocols and methodologies for each source category. Part 98 effectively establishes three groups of source categories required to report annual GHG emissions: sources required to report regardless of emission volumes; sources only required to report if emissions meet or exceed specified thresholds (generally 25,000 metric tons of CO2e in combined emissions from stationary sources); and fuel suppliers that import or export product equivalent to 25,000 metric tons of CO2e or more. Through Part A the Commission builds upon established federal reporting requirements and closes reporting gaps by eliminating reporting thresholds for certain sources and expanding certain other source categories to report GHG emissions in order to establish a more robust and accurate GHG inventory for Colorado.

Part B, Section I.: To the extent Part B, Section I. requires manufacturers to replace HFCs, there are no applicable federal requirements as a result of the D.C. Circuit Court's vacature of SNAP Rules 20 and 21 and EPA's lack of progress in further regulating HFCs. To the extent that Part B, Section I. prohibits or restricts prospective uses of prohibited HFCs (phases out), it does not conflict with any applicable federal regulations.

(II) Whether the applicable federal requirements are performance-based or technology-based and whether there is any flexibility in those requirements, and if not, why not;

Part A: There are no control requirements associated with the Part A GHG reporting rule.

Part B, Section I.: To the extent SNAP Rules 20 and 21 remain in effect and are enforceable, the federal HFC rules are primarily technology-based in that the rules largely proscribe or severely limit the use of HFCs in certain manufacturing processes and end-uses thus requiring substitution or replacement with lower GWP substances.

(III) Whether the applicable federal requirements specifically address the issues that are of concern to Colorado and whether data or information that would reasonably reflect Colorado's concern and situation was considered in the federal process that established the federal requirements;

Part A: Colorado's General Assembly has determined that climate change adversely affects Colorado's economy, air quality and public health, ecosystems, natural resources, and quality of life and that reducing statewide GHG emissions can mitigate these impacts. § 25-7-102, C.R.S. While the EPA also indicated that its "mandatory GHG reporting program [set forth in Part 98] will provide EPA, other government agencies, and outside stakeholders with economy-wide data on facility-level (and in some cases corporate-level) GHG emissions," Section 25-7-140, C.R.S. explicitly requires the Commission to adopt GHG reporting requirements to fill any gaps in the federal reporting requirements. To the extent that reporting under 40 CFR Part 98 establishes adequate GHG reporting to satisfy this legislative directive, those requirements and reporting protocols have been adopted. To the extent that the Commission has determined certain source categories may be underreporting due to reporting thresholds or exemptions of certain source categories, those thresholds or exemptions have been eliminated. Additionally, Part A establishes new reporting requirements for certain source categories for which there are no federal reporting requirements.

Part B, Section I.: To the extent Part B, Section I. requires manufacturers to replace HFCs, there are no applicable federal requirements as contemplated in this regulation. As a result of the D.C. Circuit Court's vacature of SNAP Rules 20 and 21 and EPA's lack of progress in further regulating HFCs, there are no applicable federal requirements relating to the phase-out of HFCs as contemplated in this regulation. To the extent that Part B, Section I. prohibits or restricts prospective uses of prohibited HFCs (phases out), it does not conflict with any applicable federal regulations.

(IV) Whether the proposed requirement will improve the ability of the regulated community to comply in a more cost-effective way by clarifying confusing or potentially conflicting requirements (within or cross-media), increasing certainty, or preventing or reducing the need for costly retrofit to meet more stringent requirements later;

Part A: Part A will maintain reporting requirements for facilities already required to report under Part 98 and will require additional facilities to report under reporting protocols either set forth in Part 98 and related subparts or under state reporting requirements already in place (i.e. oil and gas operations). By adopting existing protocols and reporting procedures, Part A minimizes inefficiencies while still accomplishing the legislative mandate set forth in Section 25-7-140, C.R.S.

Part B, Section I.: To the extent Part B, Section I. requires manufacturers to replace HFCs, there are no applicable federal requirements as contemplated in this regulation. As a result of the D.C. Circuit Court's partial vacature of SNAP Rules 20 and 21 and EPA's lack of progress in further regulating HFCs, there are no applicable federal requirements relating to the phase-out of HFCs as contemplated in this regulation However, Part B, Section I. imposes restrictions on the same substances as those restricted under SNAP Rules 20 and 21 with which the regulated community had already started to comply before those rules were vacated. Absent federal regulation of HFCs, individual states have adopted legislation and regulations to phase-out HFCs. Absent federal progress in regulating use of these highly potent GHGs, individual states have adopted, or are in the process of adopting, statutes and regulations phasing out the use of HFCs in manufacturing and end-use products. The U.S. Climate Alliance has drafted a model rule to promote uniformity of HFC regulation. Part B, Section I. is based upon the U.S. Climate Alliance's model rule as are proposed rules under consideration in other states.

Based on public comment and stakeholder feedback, Part B, Section I. differs from the U.S. Climate Alliance's model rule in the treatment of bear spray and law enforcement pepper spray. These two products in the aerosol-propellant category have been exempted in Part B, Section I.

(V) Whether there is a timing issue which might justify changing the time frame for implementation of federal requirements;

Part A: The March 31 annual reporting deadline is the same under Regulation Number 22 and Part 98 for all reporters. Regulation Number 22 does not affect federal GHG reporting requirements for those sources subject to federal reporting requirements. With respect to any sources required to report under Regulation Number 22 but not under federal requirements, there is no timing issue related to implementation of any federal requirements.

Part B, Section I.: To the extent Regulation Number 22, Part B, Section I., requires manufacturers to replace HFCs, there are no applicable federal requirements as a result of the D.C. Circuit Court's vacature of SNAP Rules 20 and 21 and EPA's lack of progress in further regulating HFCs. To the extent that Regulation Number 22, Part B, Section I., prohibits or restricts prospective uses of prohibited HFCs (phases out), there are no timing issues that justify changing the time frame for implementation of any federal requirements.

(VI) Whether the proposed requirement will assist in establishing and maintaining a reasonable margin for accommodation of uncertainty and future growth;

Part A: Rule: Regulation Number 22, Part A's annual GHG reporting requirements are retrospective in that they are a report of past emissions and therefore are not subject to uncertainty and do not hinder or negatively affect future growth of facilities required to report past emissions.

Part B, Section I.: The HFC phase-out in Regulation Number 22, Part B, Section I. allows a reasonable time to comply and permits the substitution of lower-GWP substances or retrofit of components. As such, affected businesses or industrial sectors are afforded a reasonable margin for accommodation of uncertainty and future growth.

(VII) Whether the proposed requirement establishes or maintains reasonable equity in the requirements for various sources;

Part A:: With respect to any sources already required to report GHG emissions under the federal reporting requirements, Regulation Number 22, Part A, maintains reasonable equity as reporting requirements are the same for each source type. With respect to any sources newly required to report GHG emissions under Regulation Number 22, Part A, the rule establishes reasonable equity as reporting requirements are the same for each source type.

Part B, Section I.: Regulation Number 22, Part B, Section I., phases-out the use of HFCs across specific end-uses and manufacturing processes, with only limited exemptions. Reasonable equity is established among these end-uses and processes by use of phase-out dates that are the same as those determined to be achievable with industry input in the development of the SNAP rules. The rules are also based upon a uniform model rule to allow those subject to the rule to avoid varying requirements across states. Where phase-out dates differ from the federal or model dates, such as those for vending machines, have been adjusted based on direct feedback from stakeholders and are comparable to phase-out timelines in other states implementing comparable regulations.

(VIII) Whether others would face increased costs if a more stringent rule is not enacted;

Part A: No, it is not anticipated there would be increased direct costs to others if a more stringent rule is not enacted.

Part B, Section I.: The legislature has acknowledged that climate change impacts Colorado's economy and directed that GHG emissions should be reduced across the many sectors of our economy. Colorado has established specific GHG reduction goals. A more stringent HFC rule could achieve additional GHG reductions. Reductions not achieved in one sector will require measures in other sectors of the economy to achieve the state's GHG reduction goals. The HFC rule is drafted to strike a balance between the costs to the entities impacted under the rule and further measures that will need to be utilized in other sectors of the economy.

(IX) Whether the proposed requirement includes procedural, reporting, or monitoring requirements that are different from applicable federal requirements and, if so, why and what the "compelling reason" is for different procedural, reporting, or monitoring requirements;

Part A: Reporting requirements beyond those required under federal Part 98 are necessary to effectively quantify and measure Colorado's progress toward statewide GHG reductions and to achieve the public health, safety and welfare goals set forth in Section 25-7-102, C.R.S., Section 25-7-140(2)(a)(I), C.R.S., dictates that the Commission tailor new [GHG] reporting requirements to fill any gaps in the existing federal reporting requirements and "allow for maintaining and updating state inventories that are sufficiently comprehensive and robust."

Part 98 effectively establishes three groups of source categories required to report annual GHG emissions: sources required to report regardless of emission volumes; sources only required to report if emissions meet or exceed specified thresholds (generally 25,000 metric tons of CO2e in combined emissions from stationary sources); and fuel suppliers that import or export product equivalent to 25,000 metric tons of CO2e or more. Through Part A, the Division proposes building upon established federal reporting requirements and closes reporting gaps by lowering or eliminating reporting thresholds for certain sources, expanding certain other source categories, and requiring new source categories to report GHG emissions in order to establish a more robust and accurate GHG inventory for Colorado. Each of the bullets below identify the sources covered under the Part A rule.

Source categories required to report under EPA's Part 98 that will also submit these reports directly to Colorado under Regulation Number 22, Part A:

- Electricity Generating Units (EGUs)
- Electrical transmission and distribution equipment facilities (Sulfur Hexafluoride [SF_6] and Perfluorocarbons [PFCs] > 17,820 pounds)

- Cement Plants
- Steel Producers ($CO_2e \geq 25{,}000$ metric tons/year)
- Underground Coal Mines (CH_4 emissions ≥ 36,500,000 ACF/year)
- Petrochemical Refineries
- Importers/Exporters of refined petroleum and natural gas liquid (NGL) products [Suppliers] ($CO_2e > 25{,}000$ metric tons/year)
- Natural Gas Local Distribution Companies (LDC) (> 460,000 SCF of natural gas/year)
- Large Electronics Manufacturers ($CO_2e \geq 25{,}000$ metric tons/year)
- Municipal Solid Waste Landfills ($CO_2e \geq 25{,}000$ metric tons/year)
- Industrial Solid Waste Landfills ($CO_2e \geq 25{,}000$ metric tons/year)
- Industrial Wastewater Treatment ($CO_2e \geq 25{,}000$ metric tons/year)
- Other source categories for which Part 98 thresholds will not be affected by Regulation Number 22 (see 40 CFR § 98.2)

Source categories subject to EPA's Part 98, but below federal reporting thresholds that will be required to report under Regulation Number 22, Part A.:

- Industrial Solid Waste Landfills ($CO_2e < 25{,}000$ metric tons/year)
- Industrial Wastewater Treatment ($CO_2e < 25{,}000$ metric tons/year)
- Active Underground Coal Mines (CH4 emissions < 36,500,000 ACF/year)
- Local Distribution Companies (< 460,000 SCF of natural gas/year)
- Importers/Exporters of refined petroleum and NGL products [Suppliers] ($CO_2e < 25{,}000$ metric tons/year)

Source categories reporting to the Division under AQCC Regulation 7, Part D, Sections IV and V:

- Oil and Natural Gas Operations and Equipment upstream or at Natural Gas Processing Plants (Regulation 7, Part D, Section V)
- Natural Gas Transmission and Storage Equipment and Facilities (Regulation 7, Part D, Section IV)

Source categories with voluntary reporting under Regulation Number 22, Part A.:

- Municipal Solid Waste Landfills ($CO_2e < 25{,}000$ metric tons/year)
- Domestic Wastewater Treatment Plants
- Agricultural Sector

Part B, Section I.: To the extent Regulation Number 22, Part B, Section I., requires manufacturers to replace HFCs, there are no applicable federal requirements as a result of the D.C. Circuit Court's vacature of SNAP Rules 20 and 21 and EPA's lack of progress in further regulating HFCs. To the extent that Regulation Number 22, Part B, Section I., prohibits or restricts prospective uses of prohibited HFCs (phases out), there are no timing issues that justify changing the time frame for implementation of any federal requirements.

(X) Whether demonstrated technology is available to comply with the proposed requirement;

Part A: Part A maintains reporting requirements for facilities already required to report under Part 98 and will require additional facilities to report under reporting protocols either set forth in Part 98 and related subparts or under state reporting requirements already in place (i.e. oil and gas operations). Demonstrated technology exists to enable compliance with the reporting requirements of Regulation Number 22.

Part B, Section I.: Yes, non-HFC replacements with significantly lower GWP are generally available and widely used in manufacturing processes and end-uses phased out in Regulation Number 22, Part B, Section I.

(XI) Whether the proposed requirement will contribute to the prevention of pollution or address a potential problem and represent a more cost-effective environmental gain;

Part A: Under Regulation Number 22, Part A the Commission will develop a sufficiently comprehensive and robust GHG inventory to enable and inform future implementation strategies to cost-effectively reduce statewide GHG emissions to meet the legislative directive of Section 25-7-102(2)(g), C.R.S.

Part B, Section I.: The legislature has acknowledged that climate change impacts Colorado's economy and directed that GHG emissions should be reduced across the many sectors of our economy. Colorado has established specific GHG reduction goals. HFCs are a highly potent GHG such that small volumes of reduction can affect significant reductions of CO2e GHG emissions. A more stringent HFC rule could achieve additional GHG reductions. Reductions not achieved in one sector will require measures in other sectors of the economy to achieve the state's GHG reduction goals. Regulation Number 22, Part B, Section I. is drafted to strike a balance between the costs to the entities impacted under the rule and further measures that will need to be utilized in other sectors of the economy.

(XII) Whether an alternative rule, including a no-action alternative, would address the required standard.

Part A: Section 25-7-140, C.R.S., does not permit a no-action alternative and requires the Commission to adopt GHG reporting regulations "to allow for maintaining and updating state inventories that are sufficiently comprehensive and robust." Further, the statute requires the rules "include requirements for providers of retail and wholesale electric service in the state of Colorado to track and report emissions from all generation sources within the state and elsewhere that electricity consumption by their customers in this state causes to be emitted." While alternative requirements could address these mandates, the Commission has determined that the proposed reporting requirements are appropriate to establish statewide progress towards the GHG emission reduction goals mandated by the General Assembly in Section 25-7-102, C.R.S. To the extent alternative reporting thresholds and source categories were considered, they were determined to be inadequate to satisfy the directives set forth in Section 25-7-140, C.R.S. To the extent alternative reporting thresholds and source categories were considered for Part A they were determined to be inadequate to satisfy the directives set forth in Section 25-7-140, C.R.S.

Part B, Section I.: Section 25-7-105(1)(e), C.R.S., requires the Commission to implement GHG emission reduction strategies in order to accomplish the statewide GHG emission reduction goals set forth in Section 25-7-102(g), C.R.S. HFCs are a highly potent GHG such that small volumes of reduction can affect significant reductions of CO2e GHG emissions. A more stringent HFC rule could achieve additional GHG reductions. Reductions not achieved in one sector will require measures in other sectors of the economy to achieve the state's GHG reduction goals. The HFC rule is drafted to strike a balance between the costs to the entities impacted under the rule and further measures that will need to be utilized in other sectors of the economy. While the General Assembly has not explicitly required implementation of an HFC phase-out as a reduction strategy and therefore a no-action alternative is possible, given the statewide reduction goals and the potency of HFCs, no action on HFCs would require more stringent measures in other sectors in order to achieve the same GHG reductions.

Section 25-7-110.8, C.R.S.

To the extent that the Section 25-7-110.8, C.R.S., requirements apply to this rulemaking, and after considering all the information in the record, the Commission hereby makes the determination that:

(a) These rules are based on reasonably available, validated, reviewed, and sound scientific methodologies and all validated, reviewed, and sound scientific methodologies and information made available by interested parties has been considered.

(b) Evidence in the record supports the finding that the rule shall result in a demonstrable reduction in emission of HFCs and will enable the Commission to establish sufficiently comprehensive and robust inventories of GHGs as required by section 25-7-140, C.R.S.

(c) Evidence in the record supports the finding that the rule shall bring about reductions in risks to human health and the environment that will justify the costs to government, the regulated community, and to the public to implement and comply with the rule.

(d) The rules are the most cost-effective to achieve the necessary and desired results and reduction in air pollution.

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

Section 25-7-105(1)(e), C.R.S. - Statewide GHG Pollution Abatement

To the extent that the Section 25-7-105(1)(e), C.R.S., requirements apply to this rulemaking, and after considering all the information in the record, the Commission hereby makes the determination that:

Any impacts to disproportionately impacted communities and (IV) Coordination with other state agencies, stakeholders, and the public:

The Commission carefully considered the concerns of and potential impacts on communities disproportionately impacted by climate change in the following ways:

Stakeholder engagement: The Division provided multiple ways for the public, local governments, industry, environmental groups, and other stakeholders to provide comment during the development of the proposed rules. Opportunities for input included email, remote stakeholder meeting participation, and in-person meeting participation. Public stakeholder meetings were held from early afternoon until after 6pm in both Denver and Glenwood Springs, to maximize access for working and busy individuals. Language interpretation services for stakeholder meetings were made available (though none were requested during this process).

Potential economic impacts: The Division conducted outreach to determine potential impacts to disproportionately impacted communities for Part A and Part B, Section I. With respect to Part A, impacts on local governments and small rural operations were significant considerations in determining whether to require mandatory GHG reporting from domestic wastewater treatment facilities and municipal solid waste landfills with emissions below the reporting threshold in 40 CFR Part 98. Ultimately, in this rulemaking the Commission elected against mandatory reporting from these source categories, but to allow voluntary reporting. While more robust GHG data has the potential to enhance local climate efforts and ultimately reduce a variety of negative impacts on Colorado's communities, the Division recognizes that providing data can represent an administrative burden, particularly for small operations with fewer staff and serving smaller communities. For both domestic wastewater treatment and municipal solid waste landfill emissions (below the 40 CFR Part 98 threshold) reporting, the Division identified available reporting protocols to minimize the burden of the reporting process for any sources wishing to report voluntarily. In addition to public comments, the Division considered stakeholder comments from organizations representing local governments, local wastewater districts and the Wastewater Utility Council, and conducted outreach to the Solid Waste Association of North America's Colorado Chapter in the drafting of the proposed GHG reporting rule.

For Part B, Section I., Division outreach efforts sought to determine if any manufacturers (large or small) of equipment or small niche end-uses that might be impacted by the proposed HFC reduction rule exist in the state. Based on discussions with industry partners and trade groups, as well as online research and communication with the Colorado Department of Labor & Employment (CDLE), the Division concluded that there are currently no equipment manufacturers or small niche end-uses in Colorado that would be impacted by the HFC rule. Accordingly, the Commission has determined that the HFC-phase out in Part

B, Section I. will not result in an accumulation of negative or lack of positive environmental, health, economic, or social conditions within in a manner that disproportionately impacts certain communities within the state.

Coordination with other jurisdictions:

Absent federal enforcement regulating HFCs, individual states have adopted, or are in the process of adopting, statutes and regulations phasing out the use of HFCs in manufacturing and end-use products. The U.S. Climate Alliance has drafted a model rule to promote uniformity of HFC regulation. Part B, Section I. is based upon the U.S. Climate Alliance's model rule as are draft rules under consideration in other states.

Additional Considerations:

Having considered all relevant information in the record and those factors set forth in Section 25-7-105(1)(e)(VI), C.R.S., the Commission has determined that Part A and Part B, Section I. are appropriate measures necessary to implement statewide GHG pollution abatement. Through the Division's Economic Impact Analysis, the Commission concludes that GHG reporting in Part A and the HFC phase-out in Part B, Section I. will either directly result in health, environmental, and air quality benefits or otherwise enable the Commission and General Assembly to better regulate GHG emissions in the future through a more robust inventory. Furthermore, the costs of compliance with Part A and Part B, Section I. and any negative impacts to Colorado's jobs and economy are considerably outweighed by these benefits. Based on the Division's analysis, Part B, Section I. is anticipated to result in statewide GHG reductions in Colorado of about 560 thousand metric tons CO2e in 2025 and 1.15 million metric tons CO2e in 2030. Additionally, as these regulations will lower GHG emissions and the General Assembly has determined that reducing GHG emissions will result in economic and jobs growth by creating new markets, spurring innovation, and driving investments in low-carbon technologies. The time necessary for compliance under Part A and Part B, Section I. reflect consideration of existing state and federal requirements as well as feedback from stakeholders. As described in significant detail above, Part A will enable the Commission to better inventory analyze statewide GHG emission sources across diverse sectors and sources by utilizing existing federal reporting requirements in 40 CFR Part 98 and also expanding those requirements. Part A and Part B, Section I. are therefore determined to be appropriate and cost-effective.

COLORADO
Air Quality Control Commission
Department of Public Health & Environment

NOTICE OF RULEMAKING HEARING

Regarding proposed revisions to:

Regulation Number 22

SUBJECT:
The Air Quality Control Commission will hold a rulemaking hearing to consider establishing a new Regulation Number 22 as proposed by the Air Pollution Control Division to satisfy requirements the General Assembly set forth in the Colorado Air Pollution and Control Act (the Act), Section 25-7-140(2)(a)(I), C.R.S., directing adoption of reporting requirements for greenhouse gas (GHG) emitting entities; and an additional GHG reduction strategy toward addressing statewide reduction goals as set forth in Sections 25-7-102(g), 105(e)(1), and 140(2)(a)(III), C.R.S., through the phase-out of hydrofluorocarbons (HFCs) in manufacturing and end-uses involving aerosol propellants, chillers, foam, and stationary refrigeration.

Alternative proposals regarding the greenhouse gas reporting rule (Regulation Number 22, Part A, as proposed), including additional source categories and/or alternative reporting thresholds for source categories already covered in the proposed rule, additional voluntary reporting categories, alternative methods and protocols for reporting, and modified reporting deadlines may also be considered.

Alternative proposals regarding the HFC phase-out rule (Regulation Number 22, Part B., Section I., as proposed), including the regulation of additional categories of refrigerant use, may also be considered.

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

PUBLIC COMMENT SESSION
DATE: May 20, 2020
TIME: 4:30 – 7:30 p.m.
PLACE: Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South, Sabin Conference Room
Denver, CO 80246

PARTY TESTIMONY & DELIBERATIONS
DATE: May 21, 2020
TIME: To begin at 9:00 a.m. on May 21, 2020
PLACE: Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South, Sabin Conference Room
Denver, CO 80246
NOTE: No additional public comment will be taken during this time.

PUBLIC COMMENT:
The Commission encourages input from non-parties, either orally during the public comment sessions or in writing prior to or at the hearing.

Written comments should be submitted no later than **May 1, 2020** 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

Oral public comment will generally not be permitted by persons who offer comment on behalf of an entity that is a party, or is a member of a party to the hearing. Those persons may however submit written public comment.

IMPORTANT DATES AND DEADLINES:

PROCESS DESCRIPTION	DUE DATE & TIME	NOTES
Request for Party Status	March 17, 2020 by 11:59 p.m.	Additional information below
Status Conference	March 19 at 8:30 a.m.	Colorado Dept. of Public Health & Environment 4300 Cherry Creek Drive South Sabin/Cleere Conference Rooms Denver, CO 80246
Alternate Proposal	April 10, 2020 by 11:59 p.m.	Additional information below
Prehearing Statement	April 10, 2020 by 11:59 p.m.	Additional information below
Prehearing Conference	April 16, 2020 at 2:00 p.m.	Colorado Dept. of Public Health & Environment 4300 Cherry Creek Drive South Sabin/Cleere Conference Rooms Denver, CO 80246
Rebuttal Statement	April 24, 2020 by 11:59 p.m.	Additional information below

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 applicants 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.

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: clay.clarke@state.co.us
- Air Pollution Control Division attorney(s): david.beckstrom@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. A conference call in line will be provided.

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:(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. Exhibits to alternate proposals must be submitted in a separate electronic transmission. Alternate proposals must be emailed to all persons listed on the party status list.

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 exhibits must be emailed to all persons listed on the party status list.

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 hearing officer will consider written requests for participation in the prehearing conference by phone for good cause shown.

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. Exhibits to a rebuttal statement must be submitted in a separate electronic transmission. Rebuttal statements and exhibits must be emailed to all persons listed on the party status list.

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 provisions of the Colorado Air Pollution Prevention and Control Act, Section 25-7-101, C.R.S., *et seq*, and specifically Sections 25-7-102, 25-7-105, 25-7-105.1, 25-7-106, 25-7-109, 25-7-114.1, 25-7-114.2, and 114.7, C.R.S., provide specific and general statutory authority for consideration of the regulatory amendments proposed by this notice. 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 21st day of February 2020 at Denver, Colorado

Colorado Air Quality Control Commission

Trisha Oeth, Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00097

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 02

Rule title

CHAPTER 2 - GENERAL LICENSURE STANDARDS

Rulemaking Hearing

Date

04/15/2020

Time

10:00 AM

Location

Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246

Subjects and issues involved

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426% to provide an additional $28,438 in revenue.

Statutory authority

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

Contact information

Name

Grace Sandeno

Title

Policy Advisor

Telephone

303-692-2859

Email

grace.sandeno@state.co.us

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Kim Fear, Branch Chief, Fiscal & Administrative Services Branch, HFEMSD

Through: D. Randy Kuykendall, Director, DRK

Date: February 19, 2020

Subject: **Request for a Rulemaking Hearing** concerning increasing licensure fees in the following chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities in April 2020:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

In April 2019, the Division appeared before the Board with a request to increase the fees that licensees pay into the General Licensure Cash Fund (General Licensure Fund). At that time, the Division explained that over several years, expenditures from the General Licensure Fund had increased 24.6%, while the revenues paid into that fund had increased by only 0.6%. The requested fee increase was for 3.1769267%, which was expected to generate about $66,850. This amount was not expected to address the full difference between revenues and expenditures of the General Licensure Fund, but was the maximum the Board could increase fees due to Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. (As of June 4, 2012, the Board of Health may only increase the fees collected by the annual percentage change of the consumer price index for Denver-Aurora-Lakewood.)

Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund

monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

The Division is now requesting to increase fees paid into the General Licensure Fund by 1.2872426%, which again will not fully fund the expenditures of the General Licensure Fund, but is the maximum the Board may increase fees. This fee increase is expected to provide an additional $28,438 in revenue, but this amount will not be enough to offset the expected revenue shortfall in Fiscal Year 2021 and following years, so the Division anticipates requesting additional CPI-limited fee increases on a yearly basis going forward.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

Basis and Purpose.

HFEMSD's health facility licensing, oversight, and enforcement activities are funded through the collection of fees approved by the Board of Health. The fees paid by facilities licensed by the Division, with the exception of Assisted Living Residences (ALRs) and Home Care Agencies, are deposited to the Health Facilities General Licensure Cash Fund (General Licensure Fund), which is then the source of appropriations to the Division for its licensure and oversight activities. In accordance with Section 25-3-105(1)(a)(I)(A), C.R.S, fees are to be set at a level sufficient to meet the direct and indirect costs of these activities.

Although the Board approved a 3.1769267% fee increase for Fiscal Year 2020 (the maximum allowed by statute), the fees being paid into the General Licensure Fund remain insufficient to meet the Division's direct and indirect costs. Since the April 2019 fee increase request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable. For example, the ability to use fund balance will be eliminated, as the balance of the General Licensure Fund is estimated to be approximately $12,000 for Fiscal Year 2020, as opposed to over $200,000 in prior years. Additionally, purposely holding positions open means that a portion of the Division's work is not getting done.

Expenditures continue to increase for a number of predictable reasons, such as the general inflationary increases in personnel and travel costs over the past several years. The Division has been managing these expenditures through efforts like process efficiencies and the use of vacancy savings due to difficulties arising from health care staffing shortages in general. The Division, however, continues to experience high numbers of complaints, driving investigation workload. While generally increasing, complaints are variable and unpredictable, which makes it important to have revenues at a high enough level to investigate complaints coming

in, even in a higher-than typical year. The following table shows complaint variability, as well as overall growth:

General Licensure Cash Fund—Facility and Complaint Growth FY 2016 to FY 2019					
	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019	Percentage Increase/Decrease FY 16 to FY 19
Number of Facilities	892	905	912	902	1.1%
Number of Complaint Intakes	752	903	1,256	948	26.1%
Number of Complaint Allegations	2,384	2,910	4,007	2,912	22.1%
Top 3 Complaint Allegation Categories:					
Nursing Services	807	1,132	1,278	1,191	47.6%
Patient Rights	261	330	442	308	18.0%
Quality of Care	324	329	594	286	-11.7%

These needed expenditure increases cannot be offset by efforts previously used by the Division, and as a result the Division expects expenditures to exceed revenues by approximately $201,109 in Fiscal Year 2019-20, even after purposely holding $110,000 worth of positions vacant and using $237,592 of General Fund monies. If the Division were to fill positions to the full appropriated level and use only the General Licensure Fund money without supplementing with General Fund, the shortfall would be $542,132. The Division, therefore, is seeking a fee increase for all fees that pay into the fund to reduce the expected revenue shortfall.

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., limit fee increases for the fees paid into the General Licensure fund to no more than the annual increase in the Consumer Price Index (CPI) for Denver-Aurora-Lakewood. For the time period July 1, 2018 through June 30, 2019 (Fiscal Year 2018-19), that specific CPI increased by 1.2872426%. Therefore, consistent with statutory constraints, the Division is requesting that all fees paid into the General Licensure Fund be increased by that amount. This increase is expected to generate $28,437, based on the numbers and types of facilities currently licensed. Even with this full increase allowed by statute, the revenues for the General Licensure Fund are expected to be approximately $661,012 less than what is needed to fully fund the full, appropriate direct and indirect costs of licensing, oversight, and enforcement activities for the 902 facilities that pay into the fund for Fiscal Year 2021. The Division anticipates requesting the CPI-based fee increases annually going forward.

The Department requests that the fee increases be effective July 1, 2020.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), 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 incorporate materials by reference?

_____ Yes ___ URL

___x___ No

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

___x___ Yes

_____ 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.

REGULATORY ANALYSIS
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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/S/B
Facilities paying Chapter 2 fees	31	C
Facilities paying Chapter 4 fees	94	C
Facilities paying Chapter 5 fees	230	C
Facilities paying Chapter 8 fees	142	C
Facilities paying Chapter 9 fees	77	C
Facilities paying Chapter 10 fees	5	C
Facilities paying Chapter 15 fees	80	C
Facilities paying Chapter 18 fees	12	C
Facilities paying Chapter 19 fees	2	C
Facilities paying Chapter 20 fees	127	C
Facilities paying Chapter 21 fees	102	C
Industry/advocacy organizations for the facility types covered above	6	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.

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.

C: Fees are increased by 1.2872426% in the included chapters, causing an estimated total additional cost to licensed facilities of $28,438. The actual additional cost for a specific facility varies depending on the amount of its current fee (e.g., a facility with a current fee amount of $371.44 would see a fee increase of $4.78 per year, while a facility with a current fee of $6,190.62 would see a fee increase of $79.69). The following table provides details on the specific fees by chapter, the amounts of the requested increases, and the increased fee totals. It is important to note that facilities pay only the fee(s) that apply to them (e.g., a new facility pays for an initial license, an existing facility pays for a renewal license).

Entity Type Type of fee	Current Fee	Increase	New Fee
Chapter 2 – General Licensure Standards (31 Facilities)			
Initial License	$371.44	$4.78	$376.22
Renewal License	$371.44	$4.78	$376.22
Conditional License	$1,547.65	$19.92	$1,567.57
Provisional License	$1,031.77	$13.28	$1,045.05
Change of Ownership	$371.44	$4.78	$376.22
Change in Licensed Capacity	$371.44	$4.78	$376.22
Change of Name	$77.38	$1.00	$78.38
Chapter 4 – General Hospitals (94 Facilities)			
Initial License:			
1-25 beds	$8,254.15	$106.25	$8,360.40
26-50 beds	$10,317.69	$132.81	$10,450.50
51-100 beds	$12,897.12	$166.02	$13,063.14
101+ beds (base/per bed/fee cap)	$10,111.34/$51.59/ $20,635.39	$130.16/$0.66/ $265.63	$10,241.50/$52.25/ $20,901.02
Certified Long Term Hospital (base/per bed/fee cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License:			
Deemed 1-50 beds (base/per bed)	$835.73/$12.38	$10.76/$0.16	$846.49/$12.54
Non-deemed 1-50 beds (base/per bed)	$928.59/$12.38	$11.95/$0.16	$940.54/$12.54
Deemed 51-150 beds (base/per bed)	$1,300.03/$12.38	$16.73/$0.16	$1,316.76/$12.54
Non-deemed 51-150 beds (base/per bed)	$1,444.48/$12.38	$18.59/$0.16	$1,463.07/$12.54
Deemed 151+ beds (base/per bed/fee cap)	$1,857.18/$12.38/ $8,254.15	$23.91/$0.16/ $106.25	$1,881.09/$12.54/ $8,360.40

Non-Deemed 151+beds (base/per bed/fee cap)	$2,063.54/$12.38/ $8,254.15	$26.56/$0.16/ $106.25	$2,090.10/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Off-campus location addition—Critical Access Hospital	$515.88	$6.64	$522.52
Off-campus location addition	$1,031.77	$13.28	$1,045.05
Off-campus location renewal—deemed facility	$464.30	$5.98	$470.28
Off-campus location renewal	$515.88	$6.64	$522.52
Off-campus location removal	$371.44	$4.78	$376.22
Chapter 5 – Nursing Care Facilities (230 Facilities)			
Initial License	$6,190.62	$79.69	$6,270.31
Renewal License			
Certified Facilities—Medicare or Medicaid (base/per bed)	$1,650.83/$8.25	$21.25/$.11	$1,672.08/$8.36
Non-certified Facilities (base/per bed)	$3,590.56/$8.25	$46.22/$0.11	$3,636.78/$8.36
Change of Ownership	$6,190.62	$79.69	$6,270.31
Opening a Secure Unit	$1,650.83	$21.25	$1,672.08
Chapter 8 – Facilities for Persons with Intellectual or Developmental Disabilities (142 Facilities)			
Initial License			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Renewal License			
Community Residential Home	$773.83	$9.96	$783.79
Intermediate Care Facility	$1,650.83	$21.25	$1,672.08
Change of Ownership			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Chapter 9 – Community Clinics and Community Clinics and Emergency Centers (77 Facilities)			
Initial License			
Community Emergency Center	$2,837.37	$36.52	$2,873.89
Clinic Operating Inpatient Beds	$2,837.37	$36.52	$2,873.89
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,238.12	$15.94	$1,254.06
Other Clinic	$2,476.25	$31.88	$2,508.13
Renewal License			
Community Emergency	$1,392.89	$17.93	$1,410.82

Center			
Clinic Operating Inpatient Beds	$1,392.89	$17.93	$1,410.82
Clinic Operated Under Auspices of Department of Corrections	$1,341.30	$17.27	$1,358.57
Clinic Serving Un/Underinsured	$619.06	$7.97	$627.03
Other Clinic	$1,238.12	$15.94	$1,254.06
Change of Ownership			
Community Emergency Center	$3,198.48	$41.17	$3,239.65
Clinic Operating Inpatient Beds	$3,198.48	$41.17	$3,239.65
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,289.71	$16.60	$1,306.31
Other Clinic	$2,579.42	$33.20	$2,612.62
Chapter 10 - Rehabilitation Hospitals (5 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 15 - Dialysis Treatment Clinics (80 Facilities)			
Initial License	$5,303.29	$68.27	$5,371.56
Renewal License			
1-12 Stations	$1,650.83	$21.25	$1,672.08
13-23 Stations	$2,600.06	$33.47	$2,633.53
24+ Stations	$3,544.13	$45.62	$3,589.75
Change of Ownership	$5,303.29	$68.27	$5,371.56
Chapter 18 - Psychiatric Hospitals (12 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 19 - Hospital Units (2 Facilities)			
Initial License (base/per bed/ fee cap)	$5,468.38/$51.59/ $10,833.58	$70.39/$0.66/ $139.45	$5,538.77/$52.25/ $10,973.03
Renewal License (base/per bed/ fee cap)	$1,650.83/$12.38/ $3,095.31	$21.25/$0.16/ $39.84	$1,672.08/$12.54/ $3,135.15
Change of Ownership	$2,579.42	$33.20	$2,612.62

Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 20 - Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center (127 Facilities)			
Initial License			
Ambulatory Surgical Center (ASC)	$6,809.68	$87.66	$6,897.34
Ambulatory Surgical Center with Convalescent Center	$7,181.11	$92.44	$7,273.55
Add Convalescent Center to an existing license	$371.44	$4.78	$376.22
Renewal License			
Non-deemed ASC (base/per procedure room/fee cap)	$1,485.75/$206.35/ $3,095.31	$19.13/$2.66/ $39.84	$1,504.88/$209.01/ $3,135.15
Deemed ASC (base/per procedure room/ fee cap)	$1,337.18/$206.35/ $3,095.31	$17.21/$2.66/ $39.84	$1,354.39/$209.01/ $3,135.15
Additional fee for a Convalescent Center	$371.44	$4.78	$376.22
Renewal fee cap for ASC with Convalescent Center	$3,466.74	$44.63	$3,511.37
Change of Ownership			
ASC	$4,230.25	$54.45	$4,284.70
ASC with Convalescent Center	$4,601.69	$59.23	$4,660.92
Provisional			
ASC	$2,579.42	$33.20	$2,612.62
ASC with Convalescent Center	$2,950.86	$37.98	$2,988.84
Chapter 21 - Hospices (102 Facilities)			
Initial License	$6,572.37	$84.60	$6,656.97
Initial License if no other licensed hospice within 60 miles	$4,281.84	$55.12	$4,336.96
Renewal			
Base fee (if no other conditions are met)	$4,023.90	$51.80	$4,075.70
Not in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld counties and providing 75 percent of services outside those counties	$2,476.25	$31.88	$2,508.13
Fewer than 2,000 annual patient dates per most recent Medicare cost report	$1,547.65	$19.92	$1,567.57
Fewer than 1,000 annual	$773.83	$9.96	$783.79

patient dates per most recent Medicare cost report Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area licensed as one entity	$6,603.32	$85.00	$6,688.32
Workstation (per workstation, paid for Initial License and Renewal License)	$51.59	$0.66	$52.25
Change of Ownership	$6,572.37	$84.60	$6,656.97

During the stakeholder process for this fee increase, the stakeholders did not present concerns about economic or non-economic impacts of the change. The benefit of the fee increase is to reduce the shortfall of revenues that support the Division's licensing, oversight, and enforcement activities. Reducing or eliminating these costs would mean that the Division would not have the resources necessary to protect the health, safety, and welfare of Coloradans being served in licensed health facilities.

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

S: N/A

B: N/A

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.

This rule-making is limited to a fee increase of 1.2872426%, thus generating $28,438 to support the Division's ability to protect the health, safety, and welfare of Coloradans being served by facilities ranging from hospitals to group homes.

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:

Licensing fees will continue to be collected and processed using existing procedures. Increasing the amount of the fees collected will not increase the resources needed to collect and process the fees, and thus this proposed fee increase will not have a cost impact on CDPHE.

Anticipated Other State Agency Costs:

The cost of a Community Clinic license for the clinics operated under the auspices of the Department of Corrections will increase $17.27 per clinic. There are currently 23 of these clinics, so the total cost impact of this increase for those clinics will be $397.21.

Anticipated CDPHE Revenues:

This fee increase is expected to generate approximately $28,438, but this amount will not fully fund the revenue shortfall in the General Licensure Fund. Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by General Licensure Fund revenues. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

This rulemaking modifies fees:

Facility-specific fee increases are listed in the table in response to Question 2, above.

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
_X__ Improve public and environmental health practice.
_X__ Implement stakeholder feedback.
___ 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:

The cost of inaction is the Division not exhausting every avenue to secure revenue to meet its expenditures. This in turn limits the Division's ability to fulfill its responsibilities related to licensing, oversight, and enforcement for hospitals, nursing homes, facilities for persons with intellectual and developmental disabilities, community clinics and community clinics with emergency centers, rehabilitation hospitals, dialysis treatment clinics, psychiatric hospitals, ambulatory surgical centers and ambulatory surgical centers with convalescent centers, hospices, and birth centers. The Division's inability to fully perform these functions negatively impacts the health, safety, and welfare of all Coloradans receiving treatment by or residing in these facilities.

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

   No other less costly method or less intrusive method was available as the fees are set in rule per statute.

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

   The Division's options for considering alternatives to the requested fee increase are constrained by the statutory restriction limiting fee increases to annual CPI at Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. The Division cannot request a larger fee increase without modification to statute. While the Division could raise fees at an amount lower than the CPI increase, this option was not selected because even the maximum increase allowed by statute does not generate enough revenue to offset the expected revenue shortfall.

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 used the federal Bureau of Labor Statistics Data, CPI-All Urban Consumers, Series CUURS48BSA0 (Denver-Lakewood-Aurora) to calculate the amount of fee increase allowed by Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., and then applied that percentage increase to all fees that are paid into the General Licensure Fund. The increases were rounded to the nearest penny.

STAKEHOLDER ENGAGEMENT
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Centers
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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:

Since this fee increase involves multiple types of facilities and has been an ongoing issue, the Division has chosen to discuss the need for the annual CPI-based increases in a number of different settings, primarily ongoing stakeholder advisory groups and forums such as the 1294 Stakeholder Forum.

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).

__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.

No major factual or policy issues were encountered.

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:

> This is solely a fee increase to maintain existing activities regarding health facility licensing, oversight, and enforcement activities. There are no anticipated impacts on determinants of health or other health equity and environmental justice considerations, values, or outcomes.

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 Chap 02

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 2 Licensure Process

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2.13 License Fees

Unless explicitly set forth elsewhere in 6 CCR 1011-1 or statute, the following non-refundable fees shall apply and be submitted to the Department with the corresponding application or notification. More than one fee may apply depending upon the circumstances.

Initial license	~~$371.44~~ $376.22
Renewal license	~~$371.44~~ $376.22
Conditional license	~~$1,547.65~~ $1,567.57
First provisional license	~~$1,031.77~~ $1,045.05
Second provisional license	~~$1,031.77~~ $1,045.05
Change of ownership	~~$371.44~~ $376.22
Change in licensed capacity	~~$371.44~~ $376.22
Change of name	~~$77.38~~ $78.38
Renewal application late fee	Equal to the applicable renewal license fee including bed fees or operating/procedure room fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 04 - GENERAL HOSPITALS

6 CCR 1011-1 Chap 04

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES

3.101 SUBMITTAL OF FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows:

(a) See table below.

Number of Beds	Fee
1 - 25 beds	~~$8,254.15~~ $8,360.40
26 - 50 beds	~~$10,317.69~~ $10,450.50
51 - 100 beds	~~$12,897.12~~ $13,063.14
101 + beds	Base: ~~$10,111.34~~ $10,241.50
	Per bed: ~~$51.59~~ $52.25
	Cap: ~~$20,635.39~~ $20,901.02

(b) Notwithstanding the provisions of Section 3.101 (1)(a), the initial fee for facilities to be licensed as general hospitals but certified as long term hospitals pursuant to 42 CFR 482 et seq. shall submit: a base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee for long term hospitals shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the following table. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

Number of Beds	Fee	Fee with Deeming Discount
1 - 50 beds	Base: ~~$928.59~~ $940.54 Per bed: ~~$12.38~~ $12.54	Base: ~~$835.73~~ $846.49 Per bed: ~~$12.38~~ $12.54
51 - 150 beds	Base: ~~$1,444.48~~ $1,463.07 Per bed: ~~$12.38~~ $12.54	Base: ~~$1300.03~~ $1,316.76 Per bed: ~~$12.38~~ $12.54
151+ beds	Base: ~~$2,063.54~~ $2,090.10 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40	Base: ~~$1,857.18~~ $1,881.09 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

(5) Conditional License. A facility that is issued a conditional license by the Department shall submit a nonrefundable fee ranging from 10 to 25 percent of its applicable renewal fee. The Department shall assess the fee based on the anticipated costs of monitoring compliance with the conditional license. If the conditional license is issued concurrent with the initial or renewal license, the conditional license fee shall be in addition to the initial or renewal license fee.

(6) Other Regulatory Functions. If a facility requests an onsite inspection for a regulatory oversight function other than those listed in Sections 3.101 (1) through (3), the Department may conduct such onsite inspection upon notification to the facility of the fee in advance and payment thereof. The fee shall be calculated solely on the basis of the cost of conducting such survey. A detailed justification of the basis of the fee shall be provided to the facility upon request.

(7) Off-Campus Locations

(a) Addition, Annual Renewal and Termination of Off- Campus Locations. A licensee shall submit a nonrefundable fee, as set forth below, for the requested license action.

(i) ~~$1,031.77~~ $1,045.05 for the addition of each location to the list of off-campus locations under the license, except that critical access hospitals shall submit a nonrefundable fee of ~~$515.88~~ $522.52.

(ii) ~~$515.88~~ $522.52 for the annual renewal of each off-campus location listed under the license.

(iii) ~~$464.30~~ $470.28 for the annual renewal of licenses that expire on or after September 1, 2014, for each off-campus location that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(iv) ~~$371.44~~ $376.22 for the removal of each location from the list of off-campus locations under the license.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 5 - NURSING CARE FACILITIES

6 CCR 1011-1 Chap 05

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 32 LICENSING FEES

32.1 All license fees are non-refundable. The total fee shall be submitted with the appropriate license application.

32.2 Initial license - ~~$6,190.62~~ $6,270.31 per facility.

32.3 Renewal license - The annual renewal fee shall be as follows.

Medicare and/or Medicaid certified facility: ~~$1,650.83~~ $1,672.08 base fee plus ~~$8.25~~ $8.36 per bed.

Non-certified facility: ~~$3,590.56~~ $3,636.78 base fee plus ~~$8.25~~ $8.36 per bed.

32.4 Change of ownership - Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter 2, Part 2.7. The fee shall be ~~$6,190.62~~ $6,270.31 per facility.

32.5 Opening a secure unit - A facility that wishes to open a secure unit shall submit a fee of ~~$1,650.83~~ $1,672.08 in addition to any other applicable license fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 08 - FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

6 CCR 1011-1 Chap 08

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3 – Licensing Requirements

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3.4 License Fees

All license fees are non-refundable. More than one fee may apply depending upon the circumstances. The total fee shall be submitted with the appropriate license application.

(A) Initial License

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

(B) License Renewal

Effective July 1, ~~2019~~ 2020, the renewal fee shall be:

Community Residential Home: ~~$773.83~~ $783.79.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$1,650.83~~ $1,672.08.

(C) Change of ownership

Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter II, Part 2. The change of ownership fee shall be:

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 09 - COMMUNITY CLINICS AND COMMUNITY CLINICS AND EMERGENCY CENTERS

6 CCR 1011-1 Chap 09

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

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SUBCHAPTER IX.A - GENERAL REQUIREMENTS

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES.

(1) For new license applications received or renewal licenses that expire on or after July 1, ~~2019~~2020, a non-refundable fee shall be submitted with the license application as follows:

License Category	Initial license	Renewal license	Change of ownership
Community emergency center	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operating inpatient beds	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operated under the auspices of the Department of Corrections	~~$2,579.42~~ $2,612.62	~~$1,341.30~~ $1,358.57	~~$2,579.42~~ $2,612.62
Optional licensure pursuant to Section 2.101 (3)(a)(iv).			
Clinic serving the uninsured or underinsured:	~~$1,238.12~~ $1,254.06	~~$619.06~~ $627.03	~~$1,289.71~~ $1,306.31
Other clinic:	~~$2,476.25~~ $2,508.13	~~$1,238.12~~ $1,254.06	~~$2,579.42~~ $2,612.62

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 10 - REHABILITATION HOSPITALS

6 CCR 1011-1 Chap 10

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 15 - DIALYSIS TREATMENT CLINICS

6 CCR 1011-1 Chap 15

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3. FEES

3.1 License fees. All license fees are non-refundable and shall be submitted with the appropriate license application.

(A) Initial license fee - ~~$5,303.29~~ $5,371.56 per facility.

(B) Renewal license fee - For licenses that expire on or after July 1, ~~2019~~2020, the fee shall be based upon the maximum number of a facility's operational procedure stations as set forth below.

1 – 12 stations	~~$1,650.83~~ $1,672.08 per facility
13 – 23 stations	~~$2,600.06~~ $2,633.53 per facility
24 or more stations	~~$3,544.13~~ $3,589.75 per facility

(C) Change of ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, part 2. The fee shall be ~~$5,303.29~~ $5,371.56 per facility.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 18 - PSYCHIATRIC HOSPITALS

6 CCR 1011-1 Chap 18

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the department with an application for licensure as follows:

(1) Initial License: (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 19 - HOSPITAL UNITS

6 CCR 1011-1 Chap 19

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$5,468.38~~ $5,538.77 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License. A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(3) Change of Ownership. A license applicant shall submit a fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 20 - AMBULATORY SURGICAL CENTER AND AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

6 CCR 1011-1 Chap 20

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 24 - LICENSE FEES

24.1 As part of the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7, an applicant for an ambulatory surgical center license shall submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license: A license applicant shall submit with an application for licensure a nonrefundable fee of ~~$6,809.68~~ $6,897.34.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

BASE FEE	BASE FEE WITH DEEMING DISCOUNT	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,230.25~~ $4,284.70.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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SECTION 25 - AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

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25.7 License Fees: For new license applications received or renewal licenses that expire on or after March 1, 2015, an applicant for an ambulatory surgical center with a convalescent center license shall comply with the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7 and submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license:

(1) An applicant for an initial ambulatory surgical center with convalescent center license shall submit with an application for licensure a nonrefundable fee of ~~$7,181.11~~ $7,273.55.

(2) A current ambulatory surgical center licensee that applies to add a convalescent center to the license prior to the expiration of the surgical center license shall submit an application for initial licensure of the convalescent center along with a nonrefundable fee of ~~$371.44~~ $376.22. Upon expiration of the existing surgical center license term, the licensee shall follow the procedure set forth below for a renewal license.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,466.74~~ $3,511.37.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base ambulatory surgical center renewal fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

ASC BASE FEE	ASC BASE FEE WITH DEEMING DISCOUNT	CONVALESCENT CENTER FEE	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$371.44~~ $376.22	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,601.69~~ $4,660.92.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,950.86~~ $2,988.84. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 21 - HOSPICES

6 CCR 1011-1 Chap 21

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 14 LICENSE FEES

14.1 All license fees are non-refundable and the applicable fee total shall be submitted with the appropriate license application.

14.2 Initial License - ~~$6,572.37~~ $6,656.97 per hospice.

(A) If there are no licensed hospices within a 60-mile radius of the hospice applying for an initial license, the initial license fee shall be ~~$4,281.84~~ $4,336.96 per hospice.

14.3 Annual Renewal License

(A) For licenses expiring on or after July 1, ~~2019~~ 2020, the base renewal fee shall be ~~$4,023.90~~ $4,075.70 per hospice. The total renewal fee shall reflect all applicable adjustments as set forth below.

(1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be ~~$2,476.25~~ $2,508.13 per hospice.

(2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$1,547.65~~ $1,567.57 per hospice.

(3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$773.83~~ $783.79 per hospice.

(4) A discount of $300 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location.

(5) A discount of $425 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

(6) Upon request, the department may waive the fee for a hospice that demonstrates it is a not for profit organization that charges no fees and is staffed entirely by uncompensated volunteers.

(7) Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area shall be licensed as one entity. The fee shall be ~~$6,603.32~~ $6,688.32 and no other discounts shall apply except as set forth in (7)(a).

(a) A discount of $640 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

14.4 Workstation Fees

(A) A workstation is an offsite location maintained solely for the convenience of hospice staff to access policies and procedures, obtain forms or use various electronic communication tools. A workstation shall not contain patient records or be used for patient admissions and shall not display any public signage.

(B) In addition to any other licensure fees, a hospice that operates one or more satellite workstations shall pay an annual fee of ~~$51.59~~ $52.25 per workstation. The fee shall be submitted with the initial and/or renewal license application.

14.5 Change of Ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, Part 2. The fee shall be ~~$6,572.37~~ $6,656.97 per hospice.

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COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing Scheduled for April 15, 2020

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 April 15, 2020 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive, South, Denver, CO 80246, to consider the revision of the follow chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities:

- Chapter 2 - General Licensure Standards
- Chapter 4 - General Hospitals
- Chapter 5 - Nursing Care Facilities
- Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
- Chapter 9 - Community Clinics and Community Clinics and Emergency Services
- Chapter 10 - Rehabilitation Hospitals
- Chapter 15 - Dialysis Treatment Clinics
- Chapter 18 - Psychiatric Hospitals
- Chapter 19 - Hospital Units
- Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
- Chapter 21 - Hospices

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426%. The proposed rules have been developed by the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment pursuant to Section Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://www.colorado.gov/pacific/cdphe/boh 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 working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-2999.

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, April 9, 2020. 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 27th day of February, 2020.

Alexandra S. Haas

Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00098

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 04

Rule title

CHAPTER 4 - GENERAL HOSPITALS

Rulemaking Hearing

Date

04/15/2020

Time

10:00 AM

Location

Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246

Subjects and issues involved

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426% to provide an additional $28,438 in revenue.

Statutory authority

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

Contact information

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Grace Sandeno

Title

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303-692-2859

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Kim Fear, Branch Chief, Fiscal & Administrative Services Branch, HFEMSD

Through: D. Randy Kuykendall, Director, DRK

Date: February 19, 2020

Subject: **Request for a Rulemaking Hearing** concerning increasing licensure fees in the following chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities in April 2020:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

In April 2019, the Division appeared before the Board with a request to increase the fees that licensees pay into the General Licensure Cash Fund (General Licensure Fund). At that time, the Division explained that over several years, expenditures from the General Licensure Fund had increased 24.6%, while the revenues paid into that fund had increased by only 0.6%. The requested fee increase was for 3.1769267%, which was expected to generate about $66,850. This amount was not expected to address the full difference between revenues and expenditures of the General Licensure Fund, but was the maximum the Board could increase fees due to Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. (As of June 4, 2012, the Board of Health may only increase the fees collected by the annual percentage change of the consumer price index for Denver-Aurora-Lakewood.)

Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund

monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

The Division is now requesting to increase fees paid into the General Licensure Fund by 1.2872426%, which again will not fully fund the expenditures of the General Licensure Fund, but is the maximum the Board may increase fees. This fee increase is expected to provide an additional $28,438 in revenue, but this amount will not be enough to offset the expected revenue shortfall in Fiscal Year 2021 and following years, so the Division anticipates requesting additional CPI-limited fee increases on a yearly basis going forward.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

Basis and Purpose.

HFEMSD's health facility licensing, oversight, and enforcement activities are funded through the collection of fees approved by the Board of Health. The fees paid by facilities licensed by the Division, with the exception of Assisted Living Residences (ALRs) and Home Care Agencies, are deposited to the Health Facilities General Licensure Cash Fund (General Licensure Fund), which is then the source of appropriations to the Division for its licensure and oversight activities. In accordance with Section 25-3-105(1)(a)(I)(A), C.R.S, fees are to be set at a level sufficient to meet the direct and indirect costs of these activities.

Although the Board approved a 3.1769267% fee increase for Fiscal Year 2020 (the maximum allowed by statute), the fees being paid into the General Licensure Fund remain insufficient to meet the Division's direct and indirect costs. Since the April 2019 fee increase request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable. For example, the ability to use fund balance will be eliminated, as the balance of the General Licensure Fund is estimated to be approximately $12,000 for Fiscal Year 2020, as opposed to over $200,000 in prior years. Additionally, purposely holding positions open means that a portion of the Division's work is not getting done.

Expenditures continue to increase for a number of predictable reasons, such as the general inflationary increases in personnel and travel costs over the past several years. The Division has been managing these expenditures through efforts like process efficiencies and the use of vacancy savings due to difficulties arising from health care staffing shortages in general. The Division, however, continues to experience high numbers of complaints, driving investigation workload. While generally increasing, complaints are variable and unpredictable, which makes it important to have revenues at a high enough level to investigate complaints coming

in, even in a higher-than typical year. The following table shows complaint variability, as well as overall growth:

General Licensure Cash Fund—Facility and Complaint Growth FY 2016 to FY 2019					
	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019	Percentage Increase/Decrease FY 16 to FY 19
Number of Facilities	892	905	912	902	1.1%
Number of Complaint Intakes	752	903	1,256	948	26.1%
Number of Complaint Allegations	2,384	2,910	4,007	2,912	22.1%
Top 3 Complaint Allegation Categories:					
Nursing Services	807	1,132	1,278	1,191	47.6%
Patient Rights	261	330	442	308	18.0%
Quality of Care	324	329	594	286	-11.7%

These needed expenditure increases cannot be offset by efforts previously used by the Division, and as a result the Division expects expenditures to exceed revenues by approximately $201,109 in Fiscal Year 2019-20, even after purposely holding $110,000 worth of positions vacant and using $237,592 of General Fund monies. If the Division were to fill positions to the full appropriated level and use only the General Licensure Fund money without supplementing with General Fund, the shortfall would be $542,132. The Division, therefore, is seeking a fee increase for all fees that pay into the fund to reduce the expected revenue shortfall.

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., limit fee increases for the fees paid into the General Licensure fund to no more than the annual increase in the Consumer Price Index (CPI) for Denver-Aurora-Lakewood. For the time period July 1, 2018 through June 30, 2019 (Fiscal Year 2018-19), that specific CPI increased by 1.2872426%. Therefore, consistent with statutory constraints, the Division is requesting that all fees paid into the General Licensure Fund be increased by that amount. This increase is expected to generate $28,437, based on the numbers and types of facilities currently licensed. Even with this full increase allowed by statute, the revenues for the General Licensure Fund are expected to be approximately $661,012 less than what is needed to fully fund the full, appropriate direct and indirect costs of licensing, oversight, and enforcement activities for the 902 facilities that pay into the fund for Fiscal Year 2021. The Division anticipates requesting the CPI-based fee increases annually going forward.

The Department requests that the fee increases be effective July 1, 2020.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), 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 incorporate materials by reference?

_____ Yes ___ URL

___x___ No

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

___x___ Yes

_____ 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.

REGULATORY ANALYSIS
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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/S/B
Facilities paying Chapter 2 fees	31	C
Facilities paying Chapter 4 fees	94	C
Facilities paying Chapter 5 fees	230	C
Facilities paying Chapter 8 fees	142	C
Facilities paying Chapter 9 fees	77	C
Facilities paying Chapter 10 fees	5	C
Facilities paying Chapter 15 fees	80	C
Facilities paying Chapter 18 fees	12	C
Facilities paying Chapter 19 fees	2	C
Facilities paying Chapter 20 fees	127	C
Facilities paying Chapter 21 fees	102	C
Industry/advocacy organizations for the facility types covered above	6	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.

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.

C: Fees are increased by 1.2872426% in the included chapters, causing an estimated total additional cost to licensed facilities of $28,438. The actual additional cost for a specific facility varies depending on the amount of its current fee (e.g., a facility with a current fee amount of $371.44 would see a fee increase of $4.78 per year, while a facility with a current fee of $6,190.62 would see a fee increase of $79.69). The following table provides details on the specific fees by chapter, the amounts of the requested increases, and the increased fee totals. It is important to note that facilities pay only the fee(s) that apply to them (e.g., a new facility pays for an initial license, an existing facility pays for a renewal license).

Entity Type Type of fee	Current Fee	Increase	New Fee
Chapter 2 – General Licensure Standards (31 Facilities)			
Initial License	$371.44	$4.78	$376.22
Renewal License	$371.44	$4.78	$376.22
Conditional License	$1,547.65	$19.92	$1,567.57
Provisional License	$1,031.77	$13.28	$1,045.05
Change of Ownership	$371.44	$4.78	$376.22
Change in Licensed Capacity	$371.44	$4.78	$376.22
Change of Name	$77.38	$1.00	$78.38
Chapter 4 – General Hospitals (94 Facilities)			
Initial License:			
1-25 beds	$8,254.15	$106.25	$8,360.40
26-50 beds	$10,317.69	$132.81	$10,450.50
51-100 beds	$12,897.12	$166.02	$13,063.14
101+ beds (base/per bed/fee cap)	$10,111.34/$51.59/ $20,635.39	$130.16/$0.66/ $265.63	$10,241.50/$52.25/ $20,901.02
Certified Long Term Hospital (base/per bed/fee cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License:			
Deemed 1-50 beds (base/per bed)	$835.73/$12.38	$10.76/$0.16	$846.49/$12.54
Non-deemed 1-50 beds (base/per bed)	$928.59/$12.38	$11.95/$0.16	$940.54/$12.54
Deemed 51-150 beds (base/per bed)	$1,300.03/$12.38	$16.73/$0.16	$1,316.76/$12.54
Non-deemed 51-150 beds (base/per bed)	$1,444.48/$12.38	$18.59/$0.16	$1,463.07/$12.54
Deemed 151+ beds (base/per bed/fee cap)	$1,857.18/$12.38/ $8,254.15	$23.91/$0.16/ $106.25	$1,881.09/$12.54/ $8,360.40

Non-Deemed 151+beds (base/per bed/fee cap)	$2,063.54/$12.38/ $8,254.15	$26.56/$0.16/ $106.25	$2,090.10/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Off-campus location addition—Critical Access Hospital	$515.88	$6.64	$522.52
Off-campus location addition	$1,031.77	$13.28	$1,045.05
Off-campus location renewal—deemed facility	$464.30	$5.98	$470.28
Off-campus location renewal	$515.88	$6.64	$522.52
Off-campus location removal	$371.44	$4.78	$376.22
Chapter 5 – Nursing Care Facilities (230 Facilities)			
Initial License	$6,190.62	$79.69	$6,270.31
Renewal License			
Certified Facilities—Medicare or Medicaid (base/per bed)	$1,650.83/$8.25	$21.25/$.11	$1,672.08/$8.36
Non-certified Facilities (base/per bed)	$3,590.56/$8.25	$46.22/$0.11	$3,636.78/$8.36
Change of Ownership	$6,190.62	$79.69	$6,270.31
Opening a Secure Unit	$1,650.83	$21.25	$1,672.08
Chapter 8 – Facilities for Persons with Intellectual or Developmental Disabilities (142 Facilities)			
Initial License			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Renewal License			
Community Residential Home	$773.83	$9.96	$783.79
Intermediate Care Facility	$1,650.83	$21.25	$1,672.08
Change of Ownership			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Chapter 9 – Community Clinics and Community Clinics and Emergency Centers (77 Facilities)			
Initial License			
Community Emergency Center	$2,837.37	$36.52	$2,873.89
Clinic Operating Inpatient Beds	$2,837.37	$36.52	$2,873.89
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,238.12	$15.94	$1,254.06
Other Clinic	$2,476.25	$31.88	$2,508.13
Renewal License			
Community Emergency	$1,392.89	$17.93	$1,410.82

Center			
Clinic Operating Inpatient Beds	$1,392.89	$17.93	$1,410.82
Clinic Operated Under Auspices of Department of Corrections	$1,341.30	$17.27	$1,358.57
Clinic Serving Un/Underinsured	$619.06	$7.97	$627.03
Other Clinic	$1,238.12	$15.94	$1,254.06
Change of Ownership			
Community Emergency Center	$3,198.48	$41.17	$3,239.65
Clinic Operating Inpatient Beds	$3,198.48	$41.17	$3,239.65
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,289.71	$16.60	$1,306.31
Other Clinic	$2,579.42	$33.20	$2,612.62
Chapter 10 - Rehabilitation Hospitals (5 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 15 - Dialysis Treatment Clinics (80 Facilities)			
Initial License	$5,303.29	$68.27	$5,371.56
Renewal License			
1-12 Stations	$1,650.83	$21.25	$1,672.08
13-23 Stations	$2,600.06	$33.47	$2,633.53
24+ Stations	$3,544.13	$45.62	$3,589.75
Change of Ownership	$5,303.29	$68.27	$5,371.56
Chapter 18 - Psychiatric Hospitals (12 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 19 - Hospital Units (2 Facilities)			
Initial License (base/per bed/ fee cap)	$5,468.38/$51.59/ $10,833.58	$70.39/$0.66/ $139.45	$5,538.77/$52.25/ $10,973.03
Renewal License (base/per bed/ fee cap)	$1,650.83/$12.38/ $3,095.31	$21.25/$0.16/ $39.84	$1,672.08/$12.54/ $3,135.15
Change of Ownership	$2,579.42	$33.20	$2,612.62

Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 20 - Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center (127 Facilities)			
Initial License			
Ambulatory Surgical Center (ASC)	$6,809.68	$87.66	$6,897.34
Ambulatory Surgical Center with Convalescent Center	$7,181.11	$92.44	$7,273.55
Add Convalescent Center to an existing license	$371.44	$4.78	$376.22
Renewal License			
Non-deemed ASC (base/per procedure room/fee cap)	$1,485.75/$206.35/ $3,095.31	$19.13/$2.66/ $39.84	$1,504.88/$209.01/ $3,135.15
Deemed ASC (base/per procedure room/ fee cap)	$1,337.18/$206.35/ $3,095.31	$17.21/$2.66/ $39.84	$1,354.39/$209.01/ $3,135.15
Additional fee for a Convalescent Center	$371.44	$4.78	$376.22
Renewal fee cap for ASC with Convalescent Center	$3,466.74	$44.63	$3,511.37
Change of Ownership			
ASC	$4,230.25	$54.45	$4,284.70
ASC with Convalescent Center	$4,601.69	$59.23	$4,660.92
Provisional			
ASC	$2,579.42	$33.20	$2,612.62
ASC with Convalescent Center	$2,950.86	$37.98	$2,988.84
Chapter 21 - Hospices (102 Facilities)			
Initial License	$6,572.37	$84.60	$6,656.97
Initial License if no other licensed hospice within 60 miles	$4,281.84	$55.12	$4,336.96
Renewal			
Base fee (if no other conditions are met)	$4,023.90	$51.80	$4,075.70
Not in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld counties and providing 75 percent of services outside those counties	$2,476.25	$31.88	$2,508.13
Fewer than 2,000 annual patient dates per most recent Medicare cost report	$1,547.65	$19.92	$1,567.57
Fewer than 1,000 annual	$773.83	$9.96	$783.79

patient dates per most recent Medicare cost report Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area licensed as one entity	$6,603.32	$85.00	$6,688.32
Workstation (per workstation, paid for Initial License and Renewal License)	$51.59	$0.66	$52.25
Change of Ownership	$6,572.37	$84.60	$6,656.97

During the stakeholder process for this fee increase, the stakeholders did not present concerns about economic or non-economic impacts of the change. The benefit of the fee increase is to reduce the shortfall of revenues that support the Division's licensing, oversight, and enforcement activities. Reducing or eliminating these costs would mean that the Division would not have the resources necessary to protect the health, safety, and welfare of Coloradans being served in licensed health facilities.

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

S: N/A

B: N/A

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.

This rule-making is limited to a fee increase of 1.2872426%, thus generating $28,438 to support the Division's ability to protect the health, safety, and welfare of Coloradans being served by facilities ranging from hospitals to group homes.

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:

Licensing fees will continue to be collected and processed using existing procedures. Increasing the amount of the fees collected will not increase the resources needed to collect and process the fees, and thus this proposed fee increase will not have a cost impact on CDPHE.

Anticipated Other State Agency Costs:

The cost of a Community Clinic license for the clinics operated under the auspices of the Department of Corrections will increase $17.27 per clinic. There are currently 23 of these clinics, so the total cost impact of this increase for those clinics will be $397.21.

Anticipated CDPHE Revenues:

This fee increase is expected to generate approximately $28,438, but this amount will not fully fund the revenue shortfall in the General Licensure Fund. Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by General Licensure Fund revenues. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

This rulemaking modifies fees:

Facility-specific fee increases are listed in the table in response to Question 2, above.

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
_X__ Improve public and environmental health practice.
_X__ Implement stakeholder feedback.
___ 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:

The cost of inaction is the Division not exhausting every avenue to secure revenue to meet its expenditures. This in turn limits the Division's ability to fulfill its responsibilities related to licensing, oversight, and enforcement for hospitals, nursing homes, facilities for persons with intellectual and developmental disabilities, community clinics and community clinics with emergency centers, rehabilitation hospitals, dialysis treatment clinics, psychiatric hospitals, ambulatory surgical centers and ambulatory surgical centers with convalescent centers, hospices, and birth centers. The Division's inability to fully perform these functions negatively impacts the health, safety, and welfare of all Coloradans receiving treatment by or residing in these facilities.

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

   No other less costly method or less intrusive method was available as the fees are set in rule per statute.

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

   The Division's options for considering alternatives to the requested fee increase are constrained by the statutory restriction limiting fee increases to annual CPI at Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. The Division cannot request a larger fee increase without modification to statute. While the Division could raise fees at an amount lower than the CPI increase, this option was not selected because even the maximum increase allowed by statute does not generate enough revenue to offset the expected revenue shortfall.

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 used the federal Bureau of Labor Statistics Data, CPI-All Urban Consumers, Series CUURS48BSA0 (Denver-Lakewood-Aurora) to calculate the amount of fee increase allowed by Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., and then applied that percentage increase to all fees that are paid into the General Licensure Fund. The increases were rounded to the nearest penny.

STAKEHOLDER ENGAGEMENT
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Centers
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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:

Since this fee increase involves multiple types of facilities and has been an ongoing issue, the Division has chosen to discuss the need for the annual CPI-based increases in a number of different settings, primarily ongoing stakeholder advisory groups and forums such as the 1294 Stakeholder Forum.

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).

__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.

No major factual or policy issues were encountered.

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:

> This is solely a fee increase to maintain existing activities regarding health facility licensing, oversight, and enforcement activities. There are no anticipated impacts on determinants of health or other health equity and environmental justice considerations, values, or outcomes.

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 Chap 02

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 2 Licensure Process

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2.13 License Fees

Unless explicitly set forth elsewhere in 6 CCR 1011-1 or statute, the following non-refundable fees shall apply and be submitted to the Department with the corresponding application or notification. More than one fee may apply depending upon the circumstances.

Initial license	~~$371.44~~ $376.22
Renewal license	~~$371.44~~ $376.22
Conditional license	~~$1,547.65~~ $1,567.57
First provisional license	~~$1,031.77~~ $1,045.05
Second provisional license	~~$1,031.77~~ $1,045.05
Change of ownership	~~$371.44~~ $376.22
Change in licensed capacity	~~$371.44~~ $376.22
Change of name	~~$77.38~~ $78.38
Renewal application late fee	Equal to the applicable renewal license fee including bed fees or operating/procedure room fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 04 - GENERAL HOSPITALS

6 CCR 1011-1 Chap 04

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES

3.101 SUBMITTAL OF FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows:

(a) See table below.

Number of Beds	Fee
1 - 25 beds	~~$8,254.15~~ $8,360.40
26 - 50 beds	~~$10,317.69~~ $10,450.50
51 - 100 beds	~~$12,897.12~~ $13,063.14
101 + beds	Base: ~~$10,111.34~~ $10,241.50
	Per bed: ~~$51.59~~ $52.25
	Cap: ~~$20,635.39~~ $20,901.02

(b) Notwithstanding the provisions of Section 3.101 (1)(a), the initial fee for facilities to be licensed as general hospitals but certified as long term hospitals pursuant to 42 CFR 482 et seq. shall submit: a base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee for long term hospitals shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the following table. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

Number of Beds	Fee	Fee with Deeming Discount
1 - 50 beds	Base: ~~$928.59~~ $940.54 Per bed: ~~$12.38~~ $12.54	Base: ~~$835.73~~ $846.49 Per bed: ~~$12.38~~ $12.54
51 - 150 beds	Base: ~~$1,444.48~~ $1,463.07 Per bed: ~~$12.38~~ $12.54	Base: ~~$1300.03~~ $1,316.76 Per bed: ~~$12.38~~ $12.54
151+ beds	Base: ~~$2,063.54~~ $2,090.10 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40	Base: ~~$1,857.18~~ $1,881.09 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

(5) Conditional License. A facility that is issued a conditional license by the Department shall submit a nonrefundable fee ranging from 10 to 25 percent of its applicable renewal fee. The Department shall assess the fee based on the anticipated costs of monitoring compliance with the conditional license. If the conditional license is issued concurrent with the initial or renewal license, the conditional license fee shall be in addition to the initial or renewal license fee.

(6) Other Regulatory Functions. If a facility requests an onsite inspection for a regulatory oversight function other than those listed in Sections 3.101 (1) through (3), the Department may conduct such onsite inspection upon notification to the facility of the fee in advance and payment thereof. The fee shall be calculated solely on the basis of the cost of conducting such survey. A detailed justification of the basis of the fee shall be provided to the facility upon request.

(7) Off-Campus Locations

(a) Addition, Annual Renewal and Termination of Off- Campus Locations. A licensee shall submit a nonrefundable fee, as set forth below, for the requested license action.

(i) ~~$1,031.77~~ $1,045.05 for the addition of each location to the list of off-campus locations under the license, except that critical access hospitals shall submit a nonrefundable fee of ~~$515.88~~ $522.52.

(ii) ~~$515.88~~ $522.52 for the annual renewal of each off-campus location listed under the license.

(iii) ~~$464.30~~ $470.28 for the annual renewal of licenses that expire on or after September 1, 2014, for each off-campus location that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(iv) ~~$371.44~~ $376.22 for the removal of each location from the list of off-campus locations under the license.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 5 - NURSING CARE FACILITIES

6 CCR 1011-1 Chap 05

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 32 LICENSING FEES

32.1 All license fees are non-refundable. The total fee shall be submitted with the appropriate license application.

32.2 Initial license - ~~$6,190.62~~ $6,270.31 per facility.

32.3 Renewal license - The annual renewal fee shall be as follows.

Medicare and/or Medicaid certified facility: ~~$1,650.83~~ $1,672.08 base fee plus ~~$8.25~~ $8.36 per bed.

Non-certified facility: ~~$3,590.56~~ $3,636.78 base fee plus ~~$8.25~~ $8.36 per bed.

32.4 Change of ownership - Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter 2, Part 2.7. The fee shall be ~~$6,190.62~~ $6,270.31 per facility.

32.5 Opening a secure unit - A facility that wishes to open a secure unit shall submit a fee of ~~$1,650.83~~ $1,672.08 in addition to any other applicable license fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 08 - FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

6 CCR 1011-1 Chap 08

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3 – Licensing Requirements

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3.4 License Fees

All license fees are non-refundable. More than one fee may apply depending upon the circumstances. The total fee shall be submitted with the appropriate license application.

(A) Initial License

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

(B) License Renewal

Effective July 1, ~~2019~~ 2020, the renewal fee shall be:

Community Residential Home: ~~$773.83~~ $783.79.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$1,650.83~~ $1,672.08.

(C) Change of ownership

Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter II, Part 2. The change of ownership fee shall be:

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 09 - COMMUNITY CLINICS AND COMMUNITY CLINICS AND EMERGENCY CENTERS

6 CCR 1011-1 Chap 09

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

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SUBCHAPTER IX.A - GENERAL REQUIREMENTS

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES.

(1) For new license applications received or renewal licenses that expire on or after July 1, ~~2019~~2020, a non-refundable fee shall be submitted with the license application as follows:

License Category	Initial license	Renewal license	Change of ownership
Community emergency center	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operating inpatient beds	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operated under the auspices of the Department of Corrections	~~$2,579.42~~ $2,612.62	~~$1,341.30~~ $1,358.57	~~$2,579.42~~ $2,612.62
Optional licensure pursuant to Section 2.101 (3)(a)(iv).			
Clinic serving the uninsured or underinsured:	~~$1,238.12~~ $1,254.06	~~$619.06~~ $627.03	~~$1,289.71~~ $1,306.31
Other clinic:	~~$2,476.25~~ $2,508.13	~~$1,238.12~~ $1,254.06	~~$2,579.42~~ $2,612.62

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 10 - REHABILITATION HOSPITALS

6 CCR 1011-1 Chap 10

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 15 - DIALYSIS TREATMENT CLINICS

6 CCR 1011-1 Chap 15

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3. FEES

3.1 License fees. All license fees are non-refundable and shall be submitted with the appropriate license application.

(A) Initial license fee - ~~$5,303.29~~ $5,371.56 per facility.

(B) Renewal license fee - For licenses that expire on or after July 1, ~~2019~~2020, the fee shall be based upon the maximum number of a facility's operational procedure stations as set forth below.

1 – 12 stations	~~$1,650.83~~ $1,672.08 per facility
13 – 23 stations	~~$2,600.06~~ $2,633.53 per facility
24 or more stations	~~$3,544.13~~ $3,589.75 per facility

(C) Change of ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, part 2. The fee shall be ~~$5,303.29~~ $5,371.56 per facility.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 18 - PSYCHIATRIC HOSPITALS

6 CCR 1011-1 Chap 18

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the department with an application for licensure as follows:

(1) Initial License: (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 19 - HOSPITAL UNITS

6 CCR 1011-1 Chap 19

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$5,468.38~~ $5,538.77 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License. A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(3) Change of Ownership. A license applicant shall submit a fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 20 - AMBULATORY SURGICAL CENTER AND AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

6 CCR 1011-1 Chap 20

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 24 - LICENSE FEES

24.1 As part of the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7, an applicant for an ambulatory surgical center license shall submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license: A license applicant shall submit with an application for licensure a nonrefundable fee of ~~$6,809.68~~ $6,897.34.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

BASE FEE	BASE FEE WITH DEEMING DISCOUNT	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,230.25~~ $4,284.70.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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SECTION 25 - AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

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25.7 License Fees: For new license applications received or renewal licenses that expire on or after March 1, 2015, an applicant for an ambulatory surgical center with a convalescent center license shall comply with the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7 and submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license:

(1) An applicant for an initial ambulatory surgical center with convalescent center license shall submit with an application for licensure a nonrefundable fee of ~~$7,181.11~~ $7,273.55.

(2) A current ambulatory surgical center licensee that applies to add a convalescent center to the license prior to the expiration of the surgical center license shall submit an application for initial licensure of the convalescent center along with a nonrefundable fee of ~~$371.44~~ $376.22. Upon expiration of the existing surgical center license term, the licensee shall follow the procedure set forth below for a renewal license.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,466.74~~ $3,511.37.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base ambulatory surgical center renewal fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

ASC BASE FEE	ASC BASE FEE WITH DEEMING DISCOUNT	CONVALESCENT CENTER FEE	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$371.44~~ $376.22	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,601.69~~ $4,660.92.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,950.86~~ $2,988.84. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 21 - HOSPICES

6 CCR 1011-1 Chap 21

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 14 LICENSE FEES

14.1 All license fees are non-refundable and the applicable fee total shall be submitted with the appropriate license application.

14.2 Initial License - ~~$6,572.37~~ $6,656.97 per hospice.

(A) If there are no licensed hospices within a 60-mile radius of the hospice applying for an initial license, the initial license fee shall be ~~$4,281.84~~ $4,336.96 per hospice.

14.3 Annual Renewal License

(A) For licenses expiring on or after July 1, ~~2019~~ 2020, the base renewal fee shall be ~~$4,023.90~~ $4,075.70 per hospice. The total renewal fee shall reflect all applicable adjustments as set forth below.

(1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be ~~$2,476.25~~ $2,508.13 per hospice.

(2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$1,547.65~~ $1,567.57 per hospice.

(3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$773.83~~ $783.79 per hospice.

(4) A discount of $300 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location.

(5) A discount of $425 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

(6) Upon request, the department may waive the fee for a hospice that demonstrates it is a not for profit organization that charges no fees and is staffed entirely by uncompensated volunteers.

(7) Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area shall be licensed as one entity. The fee shall be ~~$6,603.32~~ $6,688.32 and no other discounts shall apply except as set forth in (7)(a).

(a) A discount of $640 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

14.4 Workstation Fees

(A) A workstation is an offsite location maintained solely for the convenience of hospice staff to access policies and procedures, obtain forms or use various electronic communication tools. A workstation shall not contain patient records or be used for patient admissions and shall not display any public signage.

(B) In addition to any other licensure fees, a hospice that operates one or more satellite workstations shall pay an annual fee of ~~$51.59~~ $52.25 per workstation. The fee shall be submitted with the initial and/or renewal license application.

14.5 Change of Ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, Part 2. The fee shall be ~~$6,572.37~~ $6,656.97 per hospice.

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COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing Scheduled for April 15, 2020

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 April 15, 2020 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive, South, Denver, CO 80246, to consider the revision of the follow chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities:

- Chapter 2 - General Licensure Standards
- Chapter 4 - General Hospitals
- Chapter 5 - Nursing Care Facilities
- Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
- Chapter 9 - Community Clinics and Community Clinics and Emergency Services
- Chapter 10 - Rehabilitation Hospitals
- Chapter 15 - Dialysis Treatment Clinics
- Chapter 18 - Psychiatric Hospitals
- Chapter 19 - Hospital Units
- Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
- Chapter 21 - Hospices

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426%. The proposed rules have been developed by the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment pursuant to Section Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://www.colorado.gov/pacific/cdphe/boh 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 working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-2999.

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, April 9, 2020. 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 27th day of February, 2020.

Alexandra S. Haas

Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00099

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 05

Rule title

CHAPTER 5 - NURSING CARE FACILITIES

Rulemaking Hearing

Date

04/15/2020

Time

10:00 AM

Location

Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246

Subjects and issues involved

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426% to provide an additional $28,438 in revenue.

Statutory authority

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

Contact information

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Title

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Kim Fear, Branch Chief, Fiscal & Administrative Services Branch, HFEMSD

Through: D. Randy Kuykendall, Director, DRK

Date: February 19, 2020

Subject: **Request for a Rulemaking Hearing** concerning increasing licensure fees in the following chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities in April 2020:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

In April 2019, the Division appeared before the Board with a request to increase the fees that licensees pay into the General Licensure Cash Fund (General Licensure Fund). At that time, the Division explained that over several years, expenditures from the General Licensure Fund had increased 24.6%, while the revenues paid into that fund had increased by only 0.6%. The requested fee increase was for 3.1769267%, which was expected to generate about $66,850. This amount was not expected to address the full difference between revenues and expenditures of the General Licensure Fund, but was the maximum the Board could increase fees due to Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. (As of June 4, 2012, the Board of Health may only increase the fees collected by the annual percentage change of the consumer price index for Denver-Aurora-Lakewood.)

Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund

monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

The Division is now requesting to increase fees paid into the General Licensure Fund by 1.2872426%, which again will not fully fund the expenditures of the General Licensure Fund, but is the maximum the Board may increase fees. This fee increase is expected to provide an additional $28,438 in revenue, but this amount will not be enough to offset the expected revenue shortfall in Fiscal Year 2021 and following years, so the Division anticipates requesting additional CPI-limited fee increases on a yearly basis going forward.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

Basis and Purpose.

HFEMSD's health facility licensing, oversight, and enforcement activities are funded through the collection of fees approved by the Board of Health. The fees paid by facilities licensed by the Division, with the exception of Assisted Living Residences (ALRs) and Home Care Agencies, are deposited to the Health Facilities General Licensure Cash Fund (General Licensure Fund), which is then the source of appropriations to the Division for its licensure and oversight activities. In accordance with Section 25-3-105(1)(a)(I)(A), C.R.S, fees are to be set at a level sufficient to meet the direct and indirect costs of these activities.

Although the Board approved a 3.1769267% fee increase for Fiscal Year 2020 (the maximum allowed by statute), the fees being paid into the General Licensure Fund remain insufficient to meet the Division's direct and indirect costs. Since the April 2019 fee increase request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable. For example, the ability to use fund balance will be eliminated, as the balance of the General Licensure Fund is estimated to be approximately $12,000 for Fiscal Year 2020, as opposed to over $200,000 in prior years. Additionally, purposely holding positions open means that a portion of the Division's work is not getting done.

Expenditures continue to increase for a number of predictable reasons, such as the general inflationary increases in personnel and travel costs over the past several years. The Division has been managing these expenditures through efforts like process efficiencies and the use of vacancy savings due to difficulties arising from health care staffing shortages in general. The Division, however, continues to experience high numbers of complaints, driving investigation workload. While generally increasing, complaints are variable and unpredictable, which makes it important to have revenues at a high enough level to investigate complaints coming

in, even in a higher-than typical year. The following table shows complaint variability, as well as overall growth:

General Licensure Cash Fund—Facility and Complaint Growth FY 2016 to FY 2019					
	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019	Percentage Increase/Decrease FY 16 to FY 19
Number of Facilities	892	905	912	902	1.1%
Number of Complaint Intakes	752	903	1,256	948	26.1%
Number of Complaint Allegations	2,384	2,910	4,007	2,912	22.1%
Top 3 Complaint Allegation Categories:					
Nursing Services	807	1,132	1,278	1,191	47.6%
Patient Rights	261	330	442	308	18.0%
Quality of Care	324	329	594	286	-11.7%

These needed expenditure increases cannot be offset by efforts previously used by the Division, and as a result the Division expects expenditures to exceed revenues by approximately $201,109 in Fiscal Year 2019-20, even after purposely holding $110,000 worth of positions vacant and using $237,592 of General Fund monies. If the Division were to fill positions to the full appropriated level and use only the General Licensure Fund money without supplementing with General Fund, the shortfall would be $542,132. The Division, therefore, is seeking a fee increase for all fees that pay into the fund to reduce the expected revenue shortfall.

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., limit fee increases for the fees paid into the General Licensure fund to no more than the annual increase in the Consumer Price Index (CPI) for Denver-Aurora-Lakewood. For the time period July 1, 2018 through June 30, 2019 (Fiscal Year 2018-19), that specific CPI increased by 1.2872426%. Therefore, consistent with statutory constraints, the Division is requesting that all fees paid into the General Licensure Fund be increased by that amount. This increase is expected to generate $28,437, based on the numbers and types of facilities currently licensed. Even with this full increase allowed by statute, the revenues for the General Licensure Fund are expected to be approximately $661,012 less than what is needed to fully fund the full, appropriate direct and indirect costs of licensing, oversight, and enforcement activities for the 902 facilities that pay into the fund for Fiscal Year 2021. The Division anticipates requesting the CPI-based fee increases annually going forward.

The Department requests that the fee increases be effective July 1, 2020.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), 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 incorporate materials by reference?

_____ Yes ___ URL

___x___ No

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

___x___ Yes

_____ 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.

REGULATORY ANALYSIS
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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/S/B
Facilities paying Chapter 2 fees	31	C
Facilities paying Chapter 4 fees	94	C
Facilities paying Chapter 5 fees	230	C
Facilities paying Chapter 8 fees	142	C
Facilities paying Chapter 9 fees	77	C
Facilities paying Chapter 10 fees	5	C
Facilities paying Chapter 15 fees	80	C
Facilities paying Chapter 18 fees	12	C
Facilities paying Chapter 19 fees	2	C
Facilities paying Chapter 20 fees	127	C
Facilities paying Chapter 21 fees	102	C
Industry/advocacy organizations for the facility types covered above	6	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.

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.

C: Fees are increased by 1.2872426% in the included chapters, causing an estimated total additional cost to licensed facilities of $28,438. The actual additional cost for a specific facility varies depending on the amount of its current fee (e.g., a facility with a current fee amount of $371.44 would see a fee increase of $4.78 per year, while a facility with a current fee of $6,190.62 would see a fee increase of $79.69). The following table provides details on the specific fees by chapter, the amounts of the requested increases, and the increased fee totals. It is important to note that facilities pay only the fee(s) that apply to them (e.g., a new facility pays for an initial license, an existing facility pays for a renewal license).

Entity Type Type of fee	Current Fee	Increase	New Fee
Chapter 2 – General Licensure Standards (31 Facilities)			
Initial License	$371.44	$4.78	$376.22
Renewal License	$371.44	$4.78	$376.22
Conditional License	$1,547.65	$19.92	$1,567.57
Provisional License	$1,031.77	$13.28	$1,045.05
Change of Ownership	$371.44	$4.78	$376.22
Change in Licensed Capacity	$371.44	$4.78	$376.22
Change of Name	$77.38	$1.00	$78.38
Chapter 4 – General Hospitals (94 Facilities)			
Initial License:			
1-25 beds	$8,254.15	$106.25	$8,360.40
26-50 beds	$10,317.69	$132.81	$10,450.50
51-100 beds	$12,897.12	$166.02	$13,063.14
101+ beds (base/per bed/fee cap)	$10,111.34/$51.59/ $20,635.39	$130.16/$0.66/ $265.63	$10,241.50/$52.25/ $20,901.02
Certified Long Term Hospital (base/per bed/fee cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License:			
Deemed 1-50 beds (base/per bed)	$835.73/$12.38	$10.76/$0.16	$846.49/$12.54
Non-deemed 1-50 beds (base/per bed)	$928.59/$12.38	$11.95/$0.16	$940.54/$12.54
Deemed 51-150 beds (base/per bed)	$1,300.03/$12.38	$16.73/$0.16	$1,316.76/$12.54
Non-deemed 51-150 beds (base/per bed)	$1,444.48/$12.38	$18.59/$0.16	$1,463.07/$12.54
Deemed 151+ beds (base/per bed/fee cap)	$1,857.18/$12.38/ $8,254.15	$23.91/$0.16/ $106.25	$1,881.09/$12.54/ $8,360.40

Non-Deemed 151+beds (base/per bed/fee cap)	$2,063.54/$12.38/ $8,254.15	$26.56/$0.16/ $106.25	$2,090.10/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Off-campus location addition—Critical Access Hospital	$515.88	$6.64	$522.52
Off-campus location addition	$1,031.77	$13.28	$1,045.05
Off-campus location renewal—deemed facility	$464.30	$5.98	$470.28
Off-campus location renewal	$515.88	$6.64	$522.52
Off-campus location removal	$371.44	$4.78	$376.22
Chapter 5 – Nursing Care Facilities (230 Facilities)			
Initial License	$6,190.62	$79.69	$6,270.31
Renewal License			
Certified Facilities—Medicare or Medicaid (base/per bed)	$1,650.83/$8.25	$21.25/$.11	$1,672.08/$8.36
Non-certified Facilities (base/per bed)	$3,590.56/$8.25	$46.22/$0.11	$3,636.78/$8.36
Change of Ownership	$6,190.62	$79.69	$6,270.31
Opening a Secure Unit	$1,650.83	$21.25	$1,672.08
Chapter 8 – Facilities for Persons with Intellectual or Developmental Disabilities (142 Facilities)			
Initial License			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Renewal License			
Community Residential Home	$773.83	$9.96	$783.79
Intermediate Care Facility	$1,650.83	$21.25	$1,672.08
Change of Ownership			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Chapter 9 – Community Clinics and Community Clinics and Emergency Centers (77 Facilities)			
Initial License			
Community Emergency Center	$2,837.37	$36.52	$2,873.89
Clinic Operating Inpatient Beds	$2,837.37	$36.52	$2,873.89
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,238.12	$15.94	$1,254.06
Other Clinic	$2,476.25	$31.88	$2,508.13
Renewal License			
Community Emergency	$1,392.89	$17.93	$1,410.82

Center			
Clinic Operating Inpatient Beds	$1,392.89	$17.93	$1,410.82
Clinic Operated Under Auspices of Department of Corrections	$1,341.30	$17.27	$1,358.57
Clinic Serving Un/Underinsured	$619.06	$7.97	$627.03
Other Clinic	$1,238.12	$15.94	$1,254.06
Change of Ownership			
Community Emergency Center	$3,198.48	$41.17	$3,239.65
Clinic Operating Inpatient Beds	$3,198.48	$41.17	$3,239.65
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,289.71	$16.60	$1,306.31
Other Clinic	$2,579.42	$33.20	$2,612.62
Chapter 10 - Rehabilitation Hospitals (5 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 15 - Dialysis Treatment Clinics (80 Facilities)			
Initial License	$5,303.29	$68.27	$5,371.56
Renewal License			
1-12 Stations	$1,650.83	$21.25	$1,672.08
13-23 Stations	$2,600.06	$33.47	$2,633.53
24+ Stations	$3,544.13	$45.62	$3,589.75
Change of Ownership	$5,303.29	$68.27	$5,371.56
Chapter 18 - Psychiatric Hospitals (12 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 19 - Hospital Units (2 Facilities)			
Initial License (base/per bed/ fee cap)	$5,468.38/$51.59/ $10,833.58	$70.39/$0.66/ $139.45	$5,538.77/$52.25/ $10,973.03
Renewal License (base/per bed/ fee cap)	$1,650.83/$12.38/ $3,095.31	$21.25/$0.16/ $39.84	$1,672.08/$12.54/ $3,135.15
Change of Ownership	$2,579.42	$33.20	$2,612.62

Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 20 - Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center (127 Facilities)			
Initial License			
Ambulatory Surgical Center (ASC)	$6,809.68	$87.66	$6,897.34
Ambulatory Surgical Center with Convalescent Center	$7,181.11	$92.44	$7,273.55
Add Convalescent Center to an existing license	$371.44	$4.78	$376.22
Renewal License			
Non-deemed ASC (base/per procedure room/fee cap)	$1,485.75/$206.35/ $3,095.31	$19.13/$2.66/ $39.84	$1,504.88/$209.01/ $3,135.15
Deemed ASC (base/per procedure room/ fee cap)	$1,337.18/$206.35/ $3,095.31	$17.21/$2.66/ $39.84	$1,354.39/$209.01/ $3,135.15
Additional fee for a Convalescent Center	$371.44	$4.78	$376.22
Renewal fee cap for ASC with Convalescent Center	$3,466.74	$44.63	$3,511.37
Change of Ownership			
ASC	$4,230.25	$54.45	$4,284.70
ASC with Convalescent Center	$4,601.69	$59.23	$4,660.92
Provisional			
ASC	$2,579.42	$33.20	$2,612.62
ASC with Convalescent Center	$2,950.86	$37.98	$2,988.84
Chapter 21 - Hospices (102 Facilities)			
Initial License	$6,572.37	$84.60	$6,656.97
Initial License if no other licensed hospice within 60 miles	$4,281.84	$55.12	$4,336.96
Renewal			
Base fee (if no other conditions are met)	$4,023.90	$51.80	$4,075.70
Not in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld counties and providing 75 percent of services outside those counties	$2,476.25	$31.88	$2,508.13
Fewer than 2,000 annual patient dates per most recent Medicare cost report	$1,547.65	$19.92	$1,567.57
Fewer than 1,000 annual	$773.83	$9.96	$783.79

patient dates per most recent Medicare cost report Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area licensed as one entity	$6,603.32	$85.00	$6,688.32
Workstation (per workstation, paid for Initial License and Renewal License)	$51.59	$0.66	$52.25
Change of Ownership	$6,572.37	$84.60	$6,656.97

During the stakeholder process for this fee increase, the stakeholders did not present concerns about economic or non-economic impacts of the change. The benefit of the fee increase is to reduce the shortfall of revenues that support the Division's licensing, oversight, and enforcement activities. Reducing or eliminating these costs would mean that the Division would not have the resources necessary to protect the health, safety, and welfare of Coloradans being served in licensed health facilities.

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

S: N/A

B: N/A

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.

This rule-making is limited to a fee increase of 1.2872426%, thus generating $28,438 to support the Division's ability to protect the health, safety, and welfare of Coloradans being served by facilities ranging from hospitals to group homes.

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:

Licensing fees will continue to be collected and processed using existing procedures. Increasing the amount of the fees collected will not increase the resources needed to collect and process the fees, and thus this proposed fee increase will not have a cost impact on CDPHE.

Anticipated Other State Agency Costs:

The cost of a Community Clinic license for the clinics operated under the auspices of the Department of Corrections will increase $17.27 per clinic. There are currently 23 of these clinics, so the total cost impact of this increase for those clinics will be $397.21.

Anticipated CDPHE Revenues:

This fee increase is expected to generate approximately $28,438, but this amount will not fully fund the revenue shortfall in the General Licensure Fund. Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by General Licensure Fund revenues. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

This rulemaking modifies fees:

Facility-specific fee increases are listed in the table in response to Question 2, above.

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
_X__ Improve public and environmental health practice.
_X__ Implement stakeholder feedback.
___ 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:

The cost of inaction is the Division not exhausting every avenue to secure revenue to meet its expenditures. This in turn limits the Division's ability to fulfill its responsibilities related to licensing, oversight, and enforcement for hospitals, nursing homes, facilities for persons with intellectual and developmental disabilities, community clinics and community clinics with emergency centers, rehabilitation hospitals, dialysis treatment clinics, psychiatric hospitals, ambulatory surgical centers and ambulatory surgical centers with convalescent centers, hospices, and birth centers. The Division's inability to fully perform these functions negatively impacts the health, safety, and welfare of all Coloradans receiving treatment by or residing in these facilities.

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

   No other less costly method or less intrusive method was available as the fees are set in rule per statute.

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

   The Division's options for considering alternatives to the requested fee increase are constrained by the statutory restriction limiting fee increases to annual CPI at Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. The Division cannot request a larger fee increase without modification to statute. While the Division could raise fees at an amount lower than the CPI increase, this option was not selected because even the maximum increase allowed by statute does not generate enough revenue to offset the expected revenue shortfall.

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 used the federal Bureau of Labor Statistics Data, CPI-All Urban Consumers, Series CUURS48BSA0 (Denver-Lakewood-Aurora) to calculate the amount of fee increase allowed by Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., and then applied that percentage increase to all fees that are paid into the General Licensure Fund. The increases were rounded to the nearest penny.

STAKEHOLDER ENGAGEMENT
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Centers
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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:

Since this fee increase involves multiple types of facilities and has been an ongoing issue, the Division has chosen to discuss the need for the annual CPI-based increases in a number of different settings, primarily ongoing stakeholder advisory groups and forums such as the 1294 Stakeholder Forum.

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).

__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.

No major factual or policy issues were encountered.

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:

> This is solely a fee increase to maintain existing activities regarding health facility licensing, oversight, and enforcement activities. There are no anticipated impacts on determinants of health or other health equity and environmental justice considerations, values, or outcomes.

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 Chap 02

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 2 Licensure Process

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2.13 License Fees

Unless explicitly set forth elsewhere in 6 CCR 1011-1 or statute, the following non-refundable fees shall apply and be submitted to the Department with the corresponding application or notification. More than one fee may apply depending upon the circumstances.

Initial license	~~$371.44~~ $376.22
Renewal license	~~$371.44~~ $376.22
Conditional license	~~$1,547.65~~ $1,567.57
First provisional license	~~$1,031.77~~ $1,045.05
Second provisional license	~~$1,031.77~~ $1,045.05
Change of ownership	~~$371.44~~ $376.22
Change in licensed capacity	~~$371.44~~ $376.22
Change of name	~~$77.38~~ $78.38
Renewal application late fee	Equal to the applicable renewal license fee including bed fees or operating/procedure room fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 04 - GENERAL HOSPITALS

6 CCR 1011-1 Chap 04

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES

3.101 SUBMITTAL OF FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows:

(a) See table below.

Number of Beds	Fee
1 - 25 beds	~~$8,254.15~~ $8,360.40
26 - 50 beds	~~$10,317.69~~ $10,450.50
51 - 100 beds	~~$12,897.12~~ $13,063.14
101 + beds	Base: ~~$10,111.34~~ $10,241.50
	Per bed: ~~$51.59~~ $52.25
	Cap: ~~$20,635.39~~ $20,901.02

(b) Notwithstanding the provisions of Section 3.101 (1)(a), the initial fee for facilities to be licensed as general hospitals but certified as long term hospitals pursuant to 42 CFR 482 et seq. shall submit: a base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee for long term hospitals shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the following table. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

Number of Beds	Fee	Fee with Deeming Discount
1 - 50 beds	Base: ~~$928.59~~ $940.54 Per bed: ~~$12.38~~ $12.54	Base: ~~$835.73~~ $846.49 Per bed: ~~$12.38~~ $12.54
51 - 150 beds	Base: ~~$1,444.48~~ $1,463.07 Per bed: ~~$12.38~~ $12.54	Base: ~~$1300.03~~ $1,316.76 Per bed: ~~$12.38~~ $12.54
151+ beds	Base: ~~$2,063.54~~ $2,090.10 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40	Base: ~~$1,857.18~~ $1,881.09 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

(5) Conditional License. A facility that is issued a conditional license by the Department shall submit a nonrefundable fee ranging from 10 to 25 percent of its applicable renewal fee. The Department shall assess the fee based on the anticipated costs of monitoring compliance with the conditional license. If the conditional license is issued concurrent with the initial or renewal license, the conditional license fee shall be in addition to the initial or renewal license fee.

(6) Other Regulatory Functions. If a facility requests an onsite inspection for a regulatory oversight function other than those listed in Sections 3.101 (1) through (3), the Department may conduct such onsite inspection upon notification to the facility of the fee in advance and payment thereof. The fee shall be calculated solely on the basis of the cost of conducting such survey. A detailed justification of the basis of the fee shall be provided to the facility upon request.

(7) Off-Campus Locations

(a) Addition, Annual Renewal and Termination of Off- Campus Locations. A licensee shall submit a nonrefundable fee, as set forth below, for the requested license action.

(i) ~~$1,031.77~~ $1,045.05 for the addition of each location to the list of off-campus locations under the license, except that critical access hospitals shall submit a nonrefundable fee of ~~$515.88~~ $522.52.

(ii) ~~$515.88~~ $522.52 for the annual renewal of each off-campus location listed under the license.

(iii) ~~$464.30~~ $470.28 for the annual renewal of licenses that expire on or after September 1, 2014, for each off-campus location that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(iv) ~~$371.44~~ $376.22 for the removal of each location from the list of off-campus locations under the license.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 5 - NURSING CARE FACILITIES

6 CCR 1011-1 Chap 05

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 32 LICENSING FEES

32.1 All license fees are non-refundable. The total fee shall be submitted with the appropriate license application.

32.2 Initial license - ~~$6,190.62~~ $6,270.31 per facility.

32.3 Renewal license - The annual renewal fee shall be as follows.

Medicare and/or Medicaid certified facility: ~~$1,650.83~~ $1,672.08 base fee plus ~~$8.25~~ $8.36 per bed.

Non-certified facility: ~~$3,590.56~~ $3,636.78 base fee plus ~~$8.25~~ $8.36 per bed.

32.4 Change of ownership - Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter 2, Part 2.7. The fee shall be ~~$6,190.62~~ $6,270.31 per facility.

32.5 Opening a secure unit - A facility that wishes to open a secure unit shall submit a fee of ~~$1,650.83~~ $1,672.08 in addition to any other applicable license fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 08 - FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

6 CCR 1011-1 Chap 08

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3 – Licensing Requirements

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3.4 License Fees

All license fees are non-refundable. More than one fee may apply depending upon the circumstances. The total fee shall be submitted with the appropriate license application.

(A) Initial License

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

(B) License Renewal

Effective July 1, ~~2019~~ 2020, the renewal fee shall be:

Community Residential Home: ~~$773.83~~ $783.79.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$1,650.83~~ $1,672.08.

(C) Change of ownership

Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter II, Part 2. The change of ownership fee shall be:

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 09 - COMMUNITY CLINICS AND COMMUNITY CLINICS AND EMERGENCY CENTERS

6 CCR 1011-1 Chap 09

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

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SUBCHAPTER IX.A - GENERAL REQUIREMENTS

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES.

(1) For new license applications received or renewal licenses that expire on or after July 1, ~~2019~~2020, a non-refundable fee shall be submitted with the license application as follows:

License Category	Initial license	Renewal license	Change of ownership
Community emergency center	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operating inpatient beds	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operated under the auspices of the Department of Corrections	~~$2,579.42~~ $2,612.62	~~$1,341.30~~ $1,358.57	~~$2,579.42~~ $2,612.62
Optional licensure pursuant to Section 2.101 (3)(a)(iv).			
Clinic serving the uninsured or underinsured:	~~$1,238.12~~ $1,254.06	~~$619.06~~ $627.03	~~$1,289.71~~ $1,306.31
Other clinic:	~~$2,476.25~~ $2,508.13	~~$1,238.12~~ $1,254.06	~~$2,579.42~~ $2,612.62

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 10 - REHABILITATION HOSPITALS

6 CCR 1011-1 Chap 10

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 15 - DIALYSIS TREATMENT CLINICS

6 CCR 1011-1 Chap 15

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3. FEES

3.1 License fees. All license fees are non-refundable and shall be submitted with the appropriate license application.

(A) Initial license fee - ~~$5,303.29~~ $5,371.56 per facility.

(B) Renewal license fee - For licenses that expire on or after July 1, ~~2019~~2020, the fee shall be based upon the maximum number of a facility's operational procedure stations as set forth below.

1 – 12 stations	~~$1,650.83~~ $1,672.08 per facility
13 – 23 stations	~~$2,600.06~~ $2,633.53 per facility
24 or more stations	~~$3,544.13~~ $3,589.75 per facility

(C) Change of ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, part 2. The fee shall be ~~$5,303.29~~ $5,371.56 per facility.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 18 - PSYCHIATRIC HOSPITALS

6 CCR 1011-1 Chap 18

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the department with an application for licensure as follows:

(1) Initial License: (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 19 - HOSPITAL UNITS

6 CCR 1011-1 Chap 19

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$5,468.38~~ $5,538.77 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License. A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(3) Change of Ownership. A license applicant shall submit a fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 20 - AMBULATORY SURGICAL CENTER AND AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

6 CCR 1011-1 Chap 20

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 24 - LICENSE FEES

24.1 As part of the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7, an applicant for an ambulatory surgical center license shall submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license: A license applicant shall submit with an application for licensure a nonrefundable fee of ~~$6,809.68~~ $6,897.34.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

BASE FEE	BASE FEE WITH DEEMING DISCOUNT	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,230.25~~ $4,284.70.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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SECTION 25 - AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

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25.7 License Fees: For new license applications received or renewal licenses that expire on or after March 1, 2015, an applicant for an ambulatory surgical center with a convalescent center license shall comply with the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7 and submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license:

(1) An applicant for an initial ambulatory surgical center with convalescent center license shall submit with an application for licensure a nonrefundable fee of ~~$7,181.11~~ $7,273.55.

(2) A current ambulatory surgical center licensee that applies to add a convalescent center to the license prior to the expiration of the surgical center license shall submit an application for initial licensure of the convalescent center along with a nonrefundable fee of ~~$371.44~~ $376.22. Upon expiration of the existing surgical center license term, the licensee shall follow the procedure set forth below for a renewal license.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,466.74~~ $3,511.37.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base ambulatory surgical center renewal fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

ASC BASE FEE	ASC BASE FEE WITH DEEMING DISCOUNT	CONVALESCENT CENTER FEE	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$371.44~~ $376.22	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,601.69~~ $4,660.92.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,950.86~~ $2,988.84. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 21 - HOSPICES

6 CCR 1011-1 Chap 21

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 14 LICENSE FEES

14.1 All license fees are non-refundable and the applicable fee total shall be submitted with the appropriate license application.

14.2 Initial License - ~~$6,572.37~~ $6,656.97 per hospice.

(A) If there are no licensed hospices within a 60-mile radius of the hospice applying for an initial license, the initial license fee shall be ~~$4,281.84~~ $4,336.96 per hospice.

14.3 Annual Renewal License

(A) For licenses expiring on or after July 1, ~~2019~~ 2020, the base renewal fee shall be ~~$4,023.90~~ $4,075.70 per hospice. The total renewal fee shall reflect all applicable adjustments as set forth below.

(1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be ~~$2,476.25~~ $2,508.13 per hospice.

(2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$1,547.65~~ $1,567.57 per hospice.

(3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$773.83~~ $783.79 per hospice.

(4) A discount of $300 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location.

(5) A discount of $425 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

(6) Upon request, the department may waive the fee for a hospice that demonstrates it is a not for profit organization that charges no fees and is staffed entirely by uncompensated volunteers.

(7) Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area shall be licensed as one entity. The fee shall be ~~$6,603.32~~ $6,688.32 and no other discounts shall apply except as set forth in (7)(a).

(a) A discount of $640 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

14.4 Workstation Fees

(A) A workstation is an offsite location maintained solely for the convenience of hospice staff to access policies and procedures, obtain forms or use various electronic communication tools. A workstation shall not contain patient records or be used for patient admissions and shall not display any public signage.

(B) In addition to any other licensure fees, a hospice that operates one or more satellite workstations shall pay an annual fee of ~~$51.59~~ $52.25 per workstation. The fee shall be submitted with the initial and/or renewal license application.

14.5 Change of Ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, Part 2. The fee shall be ~~$6,572.37~~ $6,656.97 per hospice.

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COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing Scheduled for April 15, 2020

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 April 15, 2020 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive, South, Denver, CO 80246, to consider the revision of the follow chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities:

- Chapter 2 - General Licensure Standards
- Chapter 4 - General Hospitals
- Chapter 5 - Nursing Care Facilities
- Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
- Chapter 9 - Community Clinics and Community Clinics and Emergency Services
- Chapter 10 - Rehabilitation Hospitals
- Chapter 15 - Dialysis Treatment Clinics
- Chapter 18 - Psychiatric Hospitals
- Chapter 19 - Hospital Units
- Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
- Chapter 21 - Hospices

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426%. The proposed rules have been developed by the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment pursuant to Section Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://www.colorado.gov/pacific/cdphe/boh 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 working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-2999.

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, April 9, 2020. 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 27th day of February, 2020.

Alexandra S. Haas

Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00100

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 08

Rule title

CHAPTER 8 - FACILITIES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Rulemaking Hearing

Date

04/15/2020

Time

10:00 AM

Location

Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246

Subjects and issues involved

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426% to provide an additional $28,438 in revenue.

Statutory authority

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

Contact information

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Title

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Kim Fear, Branch Chief, Fiscal & Administrative Services Branch, HFEMSD

Through: D. Randy Kuykendall, Director, DRK

Date: February 19, 2020

Subject: **Request for a Rulemaking Hearing** concerning increasing licensure fees in the following chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities in April 2020:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

In April 2019, the Division appeared before the Board with a request to increase the fees that licensees pay into the General Licensure Cash Fund (General Licensure Fund). At that time, the Division explained that over several years, expenditures from the General Licensure Fund had increased 24.6%, while the revenues paid into that fund had increased by only 0.6%. The requested fee increase was for 3.1769267%, which was expected to generate about $66,850. This amount was not expected to address the full difference between revenues and expenditures of the General Licensure Fund, but was the maximum the Board could increase fees due to Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. (As of June 4, 2012, the Board of Health may only increase the fees collected by the annual percentage change of the consumer price index for Denver-Aurora-Lakewood.)

Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund

monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

The Division is now requesting to increase fees paid into the General Licensure Fund by 1.2872426%, which again will not fully fund the expenditures of the General Licensure Fund, but is the maximum the Board may increase fees. This fee increase is expected to provide an additional $28,438 in revenue, but this amount will not be enough to offset the expected revenue shortfall in Fiscal Year 2021 and following years, so the Division anticipates requesting additional CPI-limited fee increases on a yearly basis going forward.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

Basis and Purpose.

HFEMSD's health facility licensing, oversight, and enforcement activities are funded through the collection of fees approved by the Board of Health. The fees paid by facilities licensed by the Division, with the exception of Assisted Living Residences (ALRs) and Home Care Agencies, are deposited to the Health Facilities General Licensure Cash Fund (General Licensure Fund), which is then the source of appropriations to the Division for its licensure and oversight activities. In accordance with Section 25-3-105(1)(a)(I)(A), C.R.S, fees are to be set at a level sufficient to meet the direct and indirect costs of these activities.

Although the Board approved a 3.1769267% fee increase for Fiscal Year 2020 (the maximum allowed by statute), the fees being paid into the General Licensure Fund remain insufficient to meet the Division's direct and indirect costs. Since the April 2019 fee increase request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable. For example, the ability to use fund balance will be eliminated, as the balance of the General Licensure Fund is estimated to be approximately $12,000 for Fiscal Year 2020, as opposed to over $200,000 in prior years. Additionally, purposely holding positions open means that a portion of the Division's work is not getting done.

Expenditures continue to increase for a number of predictable reasons, such as the general inflationary increases in personnel and travel costs over the past several years. The Division has been managing these expenditures through efforts like process efficiencies and the use of vacancy savings due to difficulties arising from health care staffing shortages in general. The Division, however, continues to experience high numbers of complaints, driving investigation workload. While generally increasing, complaints are variable and unpredictable, which makes it important to have revenues at a high enough level to investigate complaints coming

in, even in a higher-than typical year. The following table shows complaint variability, as well as overall growth:

General Licensure Cash Fund—Facility and Complaint Growth FY 2016 to FY 2019					
	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019	Percentage Increase/Decrease FY 16 to FY 19
Number of Facilities	892	905	912	902	1.1%
Number of Complaint Intakes	752	903	1,256	948	26.1%
Number of Complaint Allegations	2,384	2,910	4,007	2,912	22.1%
Top 3 Complaint Allegation Categories:					
Nursing Services	807	1,132	1,278	1,191	47.6%
Patient Rights	261	330	442	308	18.0%
Quality of Care	324	329	594	286	-11.7%

These needed expenditure increases cannot be offset by efforts previously used by the Division, and as a result the Division expects expenditures to exceed revenues by approximately $201,109 in Fiscal Year 2019-20, even after purposely holding $110,000 worth of positions vacant and using $237,592 of General Fund monies. If the Division were to fill positions to the full appropriated level and use only the General Licensure Fund money without supplementing with General Fund, the shortfall would be $542,132. The Division, therefore, is seeking a fee increase for all fees that pay into the fund to reduce the expected revenue shortfall.

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., limit fee increases for the fees paid into the General Licensure fund to no more than the annual increase in the Consumer Price Index (CPI) for Denver-Aurora-Lakewood. For the time period July 1, 2018 through June 30, 2019 (Fiscal Year 2018-19), that specific CPI increased by 1.2872426%. Therefore, consistent with statutory constraints, the Division is requesting that all fees paid into the General Licensure Fund be increased by that amount. This increase is expected to generate $28,437, based on the numbers and types of facilities currently licensed. Even with this full increase allowed by statute, the revenues for the General Licensure Fund are expected to be approximately $661,012 less than what is needed to fully fund the full, appropriate direct and indirect costs of licensing, oversight, and enforcement activities for the 902 facilities that pay into the fund for Fiscal Year 2021. The Division anticipates requesting the CPI-based fee increases annually going forward.

The Department requests that the fee increases be effective July 1, 2020.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), 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 incorporate materials by reference?

_____ Yes ___ URL

___x___ No

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

___x___ Yes

_____ 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.

REGULATORY ANALYSIS
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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/S/B
Facilities paying Chapter 2 fees	31	C
Facilities paying Chapter 4 fees	94	C
Facilities paying Chapter 5 fees	230	C
Facilities paying Chapter 8 fees	142	C
Facilities paying Chapter 9 fees	77	C
Facilities paying Chapter 10 fees	5	C
Facilities paying Chapter 15 fees	80	C
Facilities paying Chapter 18 fees	12	C
Facilities paying Chapter 19 fees	2	C
Facilities paying Chapter 20 fees	127	C
Facilities paying Chapter 21 fees	102	C
Industry/advocacy organizations for the facility types covered above	6	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.

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.

C: Fees are increased by 1.2872426% in the included chapters, causing an estimated total additional cost to licensed facilities of $28,438. The actual additional cost for a specific facility varies depending on the amount of its current fee (e.g., a facility with a current fee amount of $371.44 would see a fee increase of $4.78 per year, while a facility with a current fee of $6,190.62 would see a fee increase of $79.69). The following table provides details on the specific fees by chapter, the amounts of the requested increases, and the increased fee totals. It is important to note that facilities pay only the fee(s) that apply to them (e.g., a new facility pays for an initial license, an existing facility pays for a renewal license).

Entity Type Type of fee	Current Fee	Increase	New Fee
Chapter 2 – General Licensure Standards (31 Facilities)			
Initial License	$371.44	$4.78	$376.22
Renewal License	$371.44	$4.78	$376.22
Conditional License	$1,547.65	$19.92	$1,567.57
Provisional License	$1,031.77	$13.28	$1,045.05
Change of Ownership	$371.44	$4.78	$376.22
Change in Licensed Capacity	$371.44	$4.78	$376.22
Change of Name	$77.38	$1.00	$78.38
Chapter 4 – General Hospitals (94 Facilities)			
Initial License:			
1-25 beds	$8,254.15	$106.25	$8,360.40
26-50 beds	$10,317.69	$132.81	$10,450.50
51-100 beds	$12,897.12	$166.02	$13,063.14
101+ beds (base/per bed/fee cap)	$10,111.34/$51.59/ $20,635.39	$130.16/$0.66/ $265.63	$10,241.50/$52.25/ $20,901.02
Certified Long Term Hospital (base/per bed/fee cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License:			
Deemed 1-50 beds (base/per bed)	$835.73/$12.38	$10.76/$0.16	$846.49/$12.54
Non-deemed 1-50 beds (base/per bed)	$928.59/$12.38	$11.95/$0.16	$940.54/$12.54
Deemed 51-150 beds (base/per bed)	$1,300.03/$12.38	$16.73/$0.16	$1,316.76/$12.54
Non-deemed 51-150 beds (base/per bed)	$1,444.48/$12.38	$18.59/$0.16	$1,463.07/$12.54
Deemed 151+ beds (base/per bed/fee cap)	$1,857.18/$12.38/ $8,254.15	$23.91/$0.16/ $106.25	$1,881.09/$12.54/ $8,360.40

Non-Deemed 151+beds (base/per bed/fee cap)	$2,063.54/$12.38/ $8,254.15	$26.56/$0.16/ $106.25	$2,090.10/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Off-campus location addition—Critical Access Hospital	$515.88	$6.64	$522.52
Off-campus location addition	$1,031.77	$13.28	$1,045.05
Off-campus location renewal—deemed facility	$464.30	$5.98	$470.28
Off-campus location renewal	$515.88	$6.64	$522.52
Off-campus location removal	$371.44	$4.78	$376.22
Chapter 5 – Nursing Care Facilities (230 Facilities)			
Initial License	$6,190.62	$79.69	$6,270.31
Renewal License			
Certified Facilities—Medicare or Medicaid (base/per bed)	$1,650.83/$8.25	$21.25/$.11	$1,672.08/$8.36
Non-certified Facilities (base/per bed)	$3,590.56/$8.25	$46.22/$0.11	$3,636.78/$8.36
Change of Ownership	$6,190.62	$79.69	$6,270.31
Opening a Secure Unit	$1,650.83	$21.25	$1,672.08
Chapter 8 – Facilities for Persons with Intellectual or Developmental Disabilities (142 Facilities)			
Initial License			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Renewal License			
Community Residential Home	$773.83	$9.96	$783.79
Intermediate Care Facility	$1,650.83	$21.25	$1,672.08
Change of Ownership			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Chapter 9 – Community Clinics and Community Clinics and Emergency Centers (77 Facilities)			
Initial License			
Community Emergency Center	$2,837.37	$36.52	$2,873.89
Clinic Operating Inpatient Beds	$2,837.37	$36.52	$2,873.89
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,238.12	$15.94	$1,254.06
Other Clinic	$2,476.25	$31.88	$2,508.13
Renewal License			
Community Emergency	$1,392.89	$17.93	$1,410.82

Center			
Clinic Operating Inpatient Beds	$1,392.89	$17.93	$1,410.82
Clinic Operated Under Auspices of Department of Corrections	$1,341.30	$17.27	$1,358.57
Clinic Serving Un/Underinsured	$619.06	$7.97	$627.03
Other Clinic	$1,238.12	$15.94	$1,254.06
Change of Ownership			
Community Emergency Center	$3,198.48	$41.17	$3,239.65
Clinic Operating Inpatient Beds	$3,198.48	$41.17	$3,239.65
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,289.71	$16.60	$1,306.31
Other Clinic	$2,579.42	$33.20	$2,612.62
Chapter 10 - Rehabilitation Hospitals (5 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 15 - Dialysis Treatment Clinics (80 Facilities)			
Initial License	$5,303.29	$68.27	$5,371.56
Renewal License			
1-12 Stations	$1,650.83	$21.25	$1,672.08
13-23 Stations	$2,600.06	$33.47	$2,633.53
24+ Stations	$3,544.13	$45.62	$3,589.75
Change of Ownership	$5,303.29	$68.27	$5,371.56
Chapter 18 - Psychiatric Hospitals (12 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 19 - Hospital Units (2 Facilities)			
Initial License (base/per bed/ fee cap)	$5,468.38/$51.59/ $10,833.58	$70.39/$0.66/ $139.45	$5,538.77/$52.25/ $10,973.03
Renewal License (base/per bed/ fee cap)	$1,650.83/$12.38/ $3,095.31	$21.25/$0.16/ $39.84	$1,672.08/$12.54/ $3,135.15
Change of Ownership	$2,579.42	$33.20	$2,612.62

Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 20 - Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center (127 Facilities)			
Initial License			
Ambulatory Surgical Center (ASC)	$6,809.68	$87.66	$6,897.34
Ambulatory Surgical Center with Convalescent Center	$7,181.11	$92.44	$7,273.55
Add Convalescent Center to an existing license	$371.44	$4.78	$376.22
Renewal License			
Non-deemed ASC (base/per procedure room/fee cap)	$1,485.75/$206.35/ $3,095.31	$19.13/$2.66/ $39.84	$1,504.88/$209.01/ $3,135.15
Deemed ASC (base/per procedure room/ fee cap)	$1,337.18/$206.35/ $3,095.31	$17.21/$2.66/ $39.84	$1,354.39/$209.01/ $3,135.15
Additional fee for a Convalescent Center	$371.44	$4.78	$376.22
Renewal fee cap for ASC with Convalescent Center	$3,466.74	$44.63	$3,511.37
Change of Ownership			
ASC	$4,230.25	$54.45	$4,284.70
ASC with Convalescent Center	$4,601.69	$59.23	$4,660.92
Provisional			
ASC	$2,579.42	$33.20	$2,612.62
ASC with Convalescent Center	$2,950.86	$37.98	$2,988.84
Chapter 21 - Hospices (102 Facilities)			
Initial License	$6,572.37	$84.60	$6,656.97
Initial License if no other licensed hospice within 60 miles	$4,281.84	$55.12	$4,336.96
Renewal			
Base fee (if no other conditions are met)	$4,023.90	$51.80	$4,075.70
Not in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld counties and providing 75 percent of services outside those counties	$2,476.25	$31.88	$2,508.13
Fewer than 2,000 annual patient dates per most recent Medicare cost report	$1,547.65	$19.92	$1,567.57
Fewer than 1,000 annual	$773.83	$9.96	$783.79

patient dates per most recent Medicare cost report Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area licensed as one entity	$6,603.32	$85.00	$6,688.32
Workstation (per workstation, paid for Initial License and Renewal License)	$51.59	$0.66	$52.25
Change of Ownership	$6,572.37	$84.60	$6,656.97

During the stakeholder process for this fee increase, the stakeholders did not present concerns about economic or non-economic impacts of the change. The benefit of the fee increase is to reduce the shortfall of revenues that support the Division's licensing, oversight, and enforcement activities. Reducing or eliminating these costs would mean that the Division would not have the resources necessary to protect the health, safety, and welfare of Coloradans being served in licensed health facilities.

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

S: N/A

B: N/A

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.

This rule-making is limited to a fee increase of 1.2872426%, thus generating $28,438 to support the Division's ability to protect the health, safety, and welfare of Coloradans being served by facilities ranging from hospitals to group homes.

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:

Licensing fees will continue to be collected and processed using existing procedures. Increasing the amount of the fees collected will not increase the resources needed to collect and process the fees, and thus this proposed fee increase will not have a cost impact on CDPHE.

Anticipated Other State Agency Costs:

The cost of a Community Clinic license for the clinics operated under the auspices of the Department of Corrections will increase $17.27 per clinic. There are currently 23 of these clinics, so the total cost impact of this increase for those clinics will be $397.21.

Anticipated CDPHE Revenues:

This fee increase is expected to generate approximately $28,438, but this amount will not fully fund the revenue shortfall in the General Licensure Fund. Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by General Licensure Fund revenues. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

This rulemaking modifies fees:

Facility-specific fee increases are listed in the table in response to Question 2, above.

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
_X__ Improve public and environmental health practice.
_X__ Implement stakeholder feedback.
___ 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:

The cost of inaction is the Division not exhausting every avenue to secure revenue to meet its expenditures. This in turn limits the Division's ability to fulfill its responsibilities related to licensing, oversight, and enforcement for hospitals, nursing homes, facilities for persons with intellectual and developmental disabilities, community clinics and community clinics with emergency centers, rehabilitation hospitals, dialysis treatment clinics, psychiatric hospitals, ambulatory surgical centers and ambulatory surgical centers with convalescent centers, hospices, and birth centers. The Division's inability to fully perform these functions negatively impacts the health, safety, and welfare of all Coloradans receiving treatment by or residing in these facilities.

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

   No other less costly method or less intrusive method was available as the fees are set in rule per statute.

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

   The Division's options for considering alternatives to the requested fee increase are constrained by the statutory restriction limiting fee increases to annual CPI at Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. The Division cannot request a larger fee increase without modification to statute. While the Division could raise fees at an amount lower than the CPI increase, this option was not selected because even the maximum increase allowed by statute does not generate enough revenue to offset the expected revenue shortfall.

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 used the federal Bureau of Labor Statistics Data, CPI-All Urban Consumers, Series CUURS48BSA0 (Denver-Lakewood-Aurora) to calculate the amount of fee increase allowed by Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., and then applied that percentage increase to all fees that are paid into the General Licensure Fund. The increases were rounded to the nearest penny.

STAKEHOLDER ENGAGEMENT
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Centers
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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:

Since this fee increase involves multiple types of facilities and has been an ongoing issue, the Division has chosen to discuss the need for the annual CPI-based increases in a number of different settings, primarily ongoing stakeholder advisory groups and forums such as the 1294 Stakeholder Forum.

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).

__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.

No major factual or policy issues were encountered.

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:

> This is solely a fee increase to maintain existing activities regarding health facility licensing, oversight, and enforcement activities. There are no anticipated impacts on determinants of health or other health equity and environmental justice considerations, values, or outcomes.

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 Chap 02

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 2 Licensure Process

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2.13 License Fees

Unless explicitly set forth elsewhere in 6 CCR 1011-1 or statute, the following non-refundable fees shall apply and be submitted to the Department with the corresponding application or notification. More than one fee may apply depending upon the circumstances.

Initial license	~~$371.44~~ $376.22
Renewal license	~~$371.44~~ $376.22
Conditional license	~~$1,547.65~~ $1,567.57
First provisional license	~~$1,031.77~~ $1,045.05
Second provisional license	~~$1,031.77~~ $1,045.05
Change of ownership	~~$371.44~~ $376.22
Change in licensed capacity	~~$371.44~~ $376.22
Change of name	~~$77.38~~ $78.38
Renewal application late fee	Equal to the applicable renewal license fee including bed fees or operating/procedure room fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 04 - GENERAL HOSPITALS

6 CCR 1011-1 Chap 04

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES

3.101 SUBMITTAL OF FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows:

(a) See table below.

Number of Beds	Fee
1 - 25 beds	~~$8,254.15~~ $8,360.40
26 - 50 beds	~~$10,317.69~~ $10,450.50
51 - 100 beds	~~$12,897.12~~ $13,063.14
101 + beds	Base: ~~$10,111.34~~ $10,241.50
	Per bed: ~~$51.59~~ $52.25
	Cap: ~~$20,635.39~~ $20,901.02

(b) Notwithstanding the provisions of Section 3.101 (1)(a), the initial fee for facilities to be licensed as general hospitals but certified as long term hospitals pursuant to 42 CFR 482 et seq. shall submit: a base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee for long term hospitals shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the following table. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

Number of Beds	Fee	Fee with Deeming Discount
1 - 50 beds	Base: ~~$928.59~~ $940.54 Per bed: ~~$12.38~~ $12.54	Base: ~~$835.73~~ $846.49 Per bed: ~~$12.38~~ $12.54
51 - 150 beds	Base: ~~$1,444.48~~ $1,463.07 Per bed: ~~$12.38~~ $12.54	Base: ~~$1300.03~~ $1,316.76 Per bed: ~~$12.38~~ $12.54
151+ beds	Base: ~~$2,063.54~~ $2,090.10 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40	Base: ~~$1,857.18~~ $1,881.09 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

(5) Conditional License. A facility that is issued a conditional license by the Department shall submit a nonrefundable fee ranging from 10 to 25 percent of its applicable renewal fee. The Department shall assess the fee based on the anticipated costs of monitoring compliance with the conditional license. If the conditional license is issued concurrent with the initial or renewal license, the conditional license fee shall be in addition to the initial or renewal license fee.

(6) Other Regulatory Functions. If a facility requests an onsite inspection for a regulatory oversight function other than those listed in Sections 3.101 (1) through (3), the Department may conduct such onsite inspection upon notification to the facility of the fee in advance and payment thereof. The fee shall be calculated solely on the basis of the cost of conducting such survey. A detailed justification of the basis of the fee shall be provided to the facility upon request.

(7) Off-Campus Locations

(a) Addition, Annual Renewal and Termination of Off- Campus Locations. A licensee shall submit a nonrefundable fee, as set forth below, for the requested license action.

(i) ~~$1,031.77~~ $1,045.05 for the addition of each location to the list of off-campus locations under the license, except that critical access hospitals shall submit a nonrefundable fee of ~~$515.88~~ $522.52.

(ii) ~~$515.88~~ $522.52 for the annual renewal of each off-campus location listed under the license.

(iii) ~~$464.30~~ $470.28 for the annual renewal of licenses that expire on or after September 1, 2014, for each off-campus location that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(iv) ~~$371.44~~ $376.22 for the removal of each location from the list of off-campus locations under the license.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 5 - NURSING CARE FACILITIES

6 CCR 1011-1 Chap 05

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 32 LICENSING FEES

32.1 All license fees are non-refundable. The total fee shall be submitted with the appropriate license application.

32.2 Initial license - ~~$6,190.62~~ $6,270.31 per facility.

32.3 Renewal license - The annual renewal fee shall be as follows.

Medicare and/or Medicaid certified facility: ~~$1,650.83~~ $1,672.08 base fee plus ~~$8.25~~ $8.36 per bed.

Non-certified facility: ~~$3,590.56~~ $3,636.78 base fee plus ~~$8.25~~ $8.36 per bed.

32.4 Change of ownership - Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter 2, Part 2.7. The fee shall be ~~$6,190.62~~ $6,270.31 per facility.

32.5 Opening a secure unit - A facility that wishes to open a secure unit shall submit a fee of ~~$1,650.83~~ $1,672.08 in addition to any other applicable license fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 08 - FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

6 CCR 1011-1 Chap 08

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3 – Licensing Requirements

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3.4 License Fees

All license fees are non-refundable. More than one fee may apply depending upon the circumstances. The total fee shall be submitted with the appropriate license application.

(A) Initial License

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

(B) License Renewal

Effective July 1, ~~2019~~ 2020, the renewal fee shall be:

Community Residential Home: ~~$773.83~~ $783.79.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$1,650.83~~ $1,672.08.

(C) Change of ownership

Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter II, Part 2. The change of ownership fee shall be:

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 09 - COMMUNITY CLINICS AND COMMUNITY CLINICS AND EMERGENCY CENTERS

6 CCR 1011-1 Chap 09

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

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SUBCHAPTER IX.A - GENERAL REQUIREMENTS

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES.

(1) For new license applications received or renewal licenses that expire on or after July 1, ~~2019~~2020, a non-refundable fee shall be submitted with the license application as follows:

License Category	Initial license	Renewal license	Change of ownership
Community emergency center	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operating inpatient beds	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operated under the auspices of the Department of Corrections	~~$2,579.42~~ $2,612.62	~~$1,341.30~~ $1,358.57	~~$2,579.42~~ $2,612.62
Optional licensure pursuant to Section 2.101 (3)(a)(iv).			
Clinic serving the uninsured or underinsured:	~~$1,238.12~~ $1,254.06	~~$619.06~~ $627.03	~~$1,289.71~~ $1,306.31
Other clinic:	~~$2,476.25~~ $2,508.13	~~$1,238.12~~ $1,254.06	~~$2,579.42~~ $2,612.62

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 10 - REHABILITATION HOSPITALS

6 CCR 1011-1 Chap 10

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 15 - DIALYSIS TREATMENT CLINICS

6 CCR 1011-1 Chap 15

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3. FEES

3.1 License fees. All license fees are non-refundable and shall be submitted with the appropriate license application.

(A) Initial license fee - ~~$5,303.29~~ $5,371.56 per facility.

(B) Renewal license fee - For licenses that expire on or after July 1, ~~2019~~2020, the fee shall be based upon the maximum number of a facility's operational procedure stations as set forth below.

1 – 12 stations	~~$1,650.83~~ $1,672.08 per facility
13 – 23 stations	~~$2,600.06~~ $2,633.53 per facility
24 or more stations	~~$3,544.13~~ $3,589.75 per facility

(C) Change of ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, part 2. The fee shall be ~~$5,303.29~~ $5,371.56 per facility.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 18 - PSYCHIATRIC HOSPITALS

6 CCR 1011-1 Chap 18

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the department with an application for licensure as follows:

(1) Initial License: (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 19 - HOSPITAL UNITS

6 CCR 1011-1 Chap 19

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$5,468.38~~ $5,538.77 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License. A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(3) Change of Ownership. A license applicant shall submit a fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 20 - AMBULATORY SURGICAL CENTER AND AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

6 CCR 1011-1 Chap 20

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 24 - LICENSE FEES

24.1 As part of the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7, an applicant for an ambulatory surgical center license shall submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license: A license applicant shall submit with an application for licensure a nonrefundable fee of ~~$6,809.68~~ $6,897.34.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

BASE FEE	BASE FEE WITH DEEMING DISCOUNT	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,230.25~~ $4,284.70.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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SECTION 25 - AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

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25.7 License Fees: For new license applications received or renewal licenses that expire on or after March 1, 2015, an applicant for an ambulatory surgical center with a convalescent center license shall comply with the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7 and submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license:

(1) An applicant for an initial ambulatory surgical center with convalescent center license shall submit with an application for licensure a nonrefundable fee of ~~$7,181.11~~ $7,273.55.

(2) A current ambulatory surgical center licensee that applies to add a convalescent center to the license prior to the expiration of the surgical center license shall submit an application for initial licensure of the convalescent center along with a nonrefundable fee of ~~$371.44~~ $376.22. Upon expiration of the existing surgical center license term, the licensee shall follow the procedure set forth below for a renewal license.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,466.74~~ $3,511.37.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base ambulatory surgical center renewal fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

ASC BASE FEE	ASC BASE FEE WITH DEEMING DISCOUNT	CONVALESCENT CENTER FEE	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$371.44~~ $376.22	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,601.69~~ $4,660.92.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,950.86~~ $2,988.84. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 21 - HOSPICES

6 CCR 1011-1 Chap 21

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 14 LICENSE FEES

14.1 All license fees are non-refundable and the applicable fee total shall be submitted with the appropriate license application.

14.2 Initial License - ~~$6,572.37~~ $6,656.97 per hospice.

(A) If there are no licensed hospices within a 60-mile radius of the hospice applying for an initial license, the initial license fee shall be ~~$4,281.84~~ $4,336.96 per hospice.

14.3 Annual Renewal License

(A) For licenses expiring on or after July 1, ~~2019~~ 2020, the base renewal fee shall be ~~$4,023.90~~ $4,075.70 per hospice. The total renewal fee shall reflect all applicable adjustments as set forth below.

(1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be ~~$2,476.25~~ $2,508.13 per hospice.

(2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$1,547.65~~ $1,567.57 per hospice.

(3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$773.83~~ $783.79 per hospice.

(4) A discount of $300 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location.

(5) A discount of $425 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

(6) Upon request, the department may waive the fee for a hospice that demonstrates it is a not for profit organization that charges no fees and is staffed entirely by uncompensated volunteers.

(7) Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area shall be licensed as one entity. The fee shall be ~~$6,603.32~~ $6,688.32 and no other discounts shall apply except as set forth in (7)(a).

(a) A discount of $640 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

14.4 Workstation Fees

(A) A workstation is an offsite location maintained solely for the convenience of hospice staff to access policies and procedures, obtain forms or use various electronic communication tools. A workstation shall not contain patient records or be used for patient admissions and shall not display any public signage.

(B) In addition to any other licensure fees, a hospice that operates one or more satellite workstations shall pay an annual fee of ~~$51.59~~ $52.25 per workstation. The fee shall be submitted with the initial and/or renewal license application.

14.5 Change of Ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, Part 2. The fee shall be ~~$6,572.37~~ $6,656.97 per hospice.

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COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing Scheduled for April 15, 2020

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 April 15, 2020 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive, South, Denver, CO 80246, to consider the revision of the follow chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities:

- Chapter 2 - General Licensure Standards
- Chapter 4 - General Hospitals
- Chapter 5 - Nursing Care Facilities
- Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
- Chapter 9 - Community Clinics and Community Clinics and Emergency Services
- Chapter 10 - Rehabilitation Hospitals
- Chapter 15 - Dialysis Treatment Clinics
- Chapter 18 - Psychiatric Hospitals
- Chapter 19 - Hospital Units
- Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
- Chapter 21 - Hospices

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426%. The proposed rules have been developed by the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment pursuant to Section Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://www.colorado.gov/pacific/cdphe/boh 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 working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-2999.

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, April 9, 2020. 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 27th day of February, 2020.

Alexandra S. Haas

Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00101

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 09

Rule title

CHAPTER 9 - COMMUNITY CLINICS AND COMMUNITY CLINICS AND EMERGENCY CENTERS

Rulemaking Hearing

Date

04/15/2020

Time

10:00 AM

Location

Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246

Subjects and issues involved

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426% to provide an additional $28,438 in revenue.

Statutory authority

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

Contact information

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Title

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Kim Fear, Branch Chief, Fiscal & Administrative Services Branch, HFEMSD

Through: D. Randy Kuykendall, Director, DRK

Date: February 19, 2020

Subject: **Request for a Rulemaking Hearing** concerning increasing licensure fees in the following chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities in April 2020:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

In April 2019, the Division appeared before the Board with a request to increase the fees that licensees pay into the General Licensure Cash Fund (General Licensure Fund). At that time, the Division explained that over several years, expenditures from the General Licensure Fund had increased 24.6%, while the revenues paid into that fund had increased by only 0.6%. The requested fee increase was for 3.1769267%, which was expected to generate about $66,850. This amount was not expected to address the full difference between revenues and expenditures of the General Licensure Fund, but was the maximum the Board could increase fees due to Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. (As of June 4, 2012, the Board of Health may only increase the fees collected by the annual percentage change of the consumer price index for Denver-Aurora-Lakewood.)

Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund

monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

The Division is now requesting to increase fees paid into the General Licensure Fund by 1.2872426%, which again will not fully fund the expenditures of the General Licensure Fund, but is the maximum the Board may increase fees. This fee increase is expected to provide an additional $28,438 in revenue, but this amount will not be enough to offset the expected revenue shortfall in Fiscal Year 2021 and following years, so the Division anticipates requesting additional CPI-limited fee increases on a yearly basis going forward.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

Basis and Purpose.

HFEMSD's health facility licensing, oversight, and enforcement activities are funded through the collection of fees approved by the Board of Health. The fees paid by facilities licensed by the Division, with the exception of Assisted Living Residences (ALRs) and Home Care Agencies, are deposited to the Health Facilities General Licensure Cash Fund (General Licensure Fund), which is then the source of appropriations to the Division for its licensure and oversight activities. In accordance with Section 25-3-105(1)(a)(I)(A), C.R.S, fees are to be set at a level sufficient to meet the direct and indirect costs of these activities.

Although the Board approved a 3.1769267% fee increase for Fiscal Year 2020 (the maximum allowed by statute), the fees being paid into the General Licensure Fund remain insufficient to meet the Division's direct and indirect costs. Since the April 2019 fee increase request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable. For example, the ability to use fund balance will be eliminated, as the balance of the General Licensure Fund is estimated to be approximately $12,000 for Fiscal Year 2020, as opposed to over $200,000 in prior years. Additionally, purposely holding positions open means that a portion of the Division's work is not getting done.

Expenditures continue to increase for a number of predictable reasons, such as the general inflationary increases in personnel and travel costs over the past several years. The Division has been managing these expenditures through efforts like process efficiencies and the use of vacancy savings due to difficulties arising from health care staffing shortages in general. The Division, however, continues to experience high numbers of complaints, driving investigation workload. While generally increasing, complaints are variable and unpredictable, which makes it important to have revenues at a high enough level to investigate complaints coming

in, even in a higher-than typical year. The following table shows complaint variability, as well as overall growth:

General Licensure Cash Fund—Facility and Complaint Growth FY 2016 to FY 2019					
	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019	Percentage Increase/Decrease FY 16 to FY 19
Number of Facilities	892	905	912	902	1.1%
Number of Complaint Intakes	752	903	1,256	948	26.1%
Number of Complaint Allegations	2,384	2,910	4,007	2,912	22.1%
Top 3 Complaint Allegation Categories:					
Nursing Services	807	1,132	1,278	1,191	47.6%
Patient Rights	261	330	442	308	18.0%
Quality of Care	324	329	594	286	-11.7%

These needed expenditure increases cannot be offset by efforts previously used by the Division, and as a result the Division expects expenditures to exceed revenues by approximately $201,109 in Fiscal Year 2019-20, even after purposely holding $110,000 worth of positions vacant and using $237,592 of General Fund monies. If the Division were to fill positions to the full appropriated level and use only the General Licensure Fund money without supplementing with General Fund, the shortfall would be $542,132. The Division, therefore, is seeking a fee increase for all fees that pay into the fund to reduce the expected revenue shortfall.

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., limit fee increases for the fees paid into the General Licensure fund to no more than the annual increase in the Consumer Price Index (CPI) for Denver-Aurora-Lakewood. For the time period July 1, 2018 through June 30, 2019 (Fiscal Year 2018-19), that specific CPI increased by 1.2872426%. Therefore, consistent with statutory constraints, the Division is requesting that all fees paid into the General Licensure Fund be increased by that amount. This increase is expected to generate $28,437, based on the numbers and types of facilities currently licensed. Even with this full increase allowed by statute, the revenues for the General Licensure Fund are expected to be approximately $661,012 less than what is needed to fully fund the full, appropriate direct and indirect costs of licensing, oversight, and enforcement activities for the 902 facilities that pay into the fund for Fiscal Year 2021. The Division anticipates requesting the CPI-based fee increases annually going forward.

The Department requests that the fee increases be effective July 1, 2020.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), 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 incorporate materials by reference?

_____ Yes ___ URL

___x___ No

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

___x___ Yes

_____ 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.

REGULATORY ANALYSIS
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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/S/B
Facilities paying Chapter 2 fees	31	C
Facilities paying Chapter 4 fees	94	C
Facilities paying Chapter 5 fees	230	C
Facilities paying Chapter 8 fees	142	C
Facilities paying Chapter 9 fees	77	C
Facilities paying Chapter 10 fees	5	C
Facilities paying Chapter 15 fees	80	C
Facilities paying Chapter 18 fees	12	C
Facilities paying Chapter 19 fees	2	C
Facilities paying Chapter 20 fees	127	C
Facilities paying Chapter 21 fees	102	C
Industry/advocacy organizations for the facility types covered above	6	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.

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.

C: Fees are increased by 1.2872426% in the included chapters, causing an estimated total additional cost to licensed facilities of $28,438. The actual additional cost for a specific facility varies depending on the amount of its current fee (e.g., a facility with a current fee amount of $371.44 would see a fee increase of $4.78 per year, while a facility with a current fee of $6,190.62 would see a fee increase of $79.69). The following table provides details on the specific fees by chapter, the amounts of the requested increases, and the increased fee totals. It is important to note that facilities pay only the fee(s) that apply to them (e.g., a new facility pays for an initial license, an existing facility pays for a renewal license).

Entity Type Type of fee	Current Fee	Increase	New Fee
Chapter 2 – General Licensure Standards (31 Facilities)			
Initial License	$371.44	$4.78	$376.22
Renewal License	$371.44	$4.78	$376.22
Conditional License	$1,547.65	$19.92	$1,567.57
Provisional License	$1,031.77	$13.28	$1,045.05
Change of Ownership	$371.44	$4.78	$376.22
Change in Licensed Capacity	$371.44	$4.78	$376.22
Change of Name	$77.38	$1.00	$78.38
Chapter 4 – General Hospitals (94 Facilities)			
Initial License:			
1-25 beds	$8,254.15	$106.25	$8,360.40
26-50 beds	$10,317.69	$132.81	$10,450.50
51-100 beds	$12,897.12	$166.02	$13,063.14
101+ beds (base/per bed/fee cap)	$10,111.34/$51.59/ $20,635.39	$130.16/$0.66/ $265.63	$10,241.50/$52.25/ $20,901.02
Certified Long Term Hospital (base/per bed/fee cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License:			
Deemed 1-50 beds (base/per bed)	$835.73/$12.38	$10.76/$0.16	$846.49/$12.54
Non-deemed 1-50 beds (base/per bed)	$928.59/$12.38	$11.95/$0.16	$940.54/$12.54
Deemed 51-150 beds (base/per bed)	$1,300.03/$12.38	$16.73/$0.16	$1,316.76/$12.54
Non-deemed 51-150 beds (base/per bed)	$1,444.48/$12.38	$18.59/$0.16	$1,463.07/$12.54
Deemed 151+ beds (base/per bed/fee cap)	$1,857.18/$12.38/ $8,254.15	$23.91/$0.16/ $106.25	$1,881.09/$12.54/ $8,360.40

Non-Deemed 151+beds (base/per bed/fee cap)	$2,063.54/$12.38/ $8,254.15	$26.56/$0.16/ $106.25	$2,090.10/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Off-campus location addition—Critical Access Hospital	$515.88	$6.64	$522.52
Off-campus location addition	$1,031.77	$13.28	$1,045.05
Off-campus location renewal—deemed facility	$464.30	$5.98	$470.28
Off-campus location renewal	$515.88	$6.64	$522.52
Off-campus location removal	$371.44	$4.78	$376.22
Chapter 5 – Nursing Care Facilities (230 Facilities)			
Initial License	$6,190.62	$79.69	$6,270.31
Renewal License			
Certified Facilities—Medicare or Medicaid (base/per bed)	$1,650.83/$8.25	$21.25/$.11	$1,672.08/$8.36
Non-certified Facilities (base/per bed)	$3,590.56/$8.25	$46.22/$0.11	$3,636.78/$8.36
Change of Ownership	$6,190.62	$79.69	$6,270.31
Opening a Secure Unit	$1,650.83	$21.25	$1,672.08
Chapter 8 – Facilities for Persons with Intellectual or Developmental Disabilities (142 Facilities)			
Initial License			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Renewal License			
Community Residential Home	$773.83	$9.96	$783.79
Intermediate Care Facility	$1,650.83	$21.25	$1,672.08
Change of Ownership			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Chapter 9 – Community Clinics and Community Clinics and Emergency Centers (77 Facilities)			
Initial License			
Community Emergency Center	$2,837.37	$36.52	$2,873.89
Clinic Operating Inpatient Beds	$2,837.37	$36.52	$2,873.89
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,238.12	$15.94	$1,254.06
Other Clinic	$2,476.25	$31.88	$2,508.13
Renewal License			
Community Emergency	$1,392.89	$17.93	$1,410.82

Center			
Clinic Operating Inpatient Beds	$1,392.89	$17.93	$1,410.82
Clinic Operated Under Auspices of Department of Corrections	$1,341.30	$17.27	$1,358.57
Clinic Serving Un/Underinsured	$619.06	$7.97	$627.03
Other Clinic	$1,238.12	$15.94	$1,254.06
Change of Ownership			
Community Emergency Center	$3,198.48	$41.17	$3,239.65
Clinic Operating Inpatient Beds	$3,198.48	$41.17	$3,239.65
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,289.71	$16.60	$1,306.31
Other Clinic	$2,579.42	$33.20	$2,612.62
Chapter 10 - Rehabilitation Hospitals (5 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 15 - Dialysis Treatment Clinics (80 Facilities)			
Initial License	$5,303.29	$68.27	$5,371.56
Renewal License			
1-12 Stations	$1,650.83	$21.25	$1,672.08
13-23 Stations	$2,600.06	$33.47	$2,633.53
24+ Stations	$3,544.13	$45.62	$3,589.75
Change of Ownership	$5,303.29	$68.27	$5,371.56
Chapter 18 - Psychiatric Hospitals (12 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 19 - Hospital Units (2 Facilities)			
Initial License (base/per bed/ fee cap)	$5,468.38/$51.59/ $10,833.58	$70.39/$0.66/ $139.45	$5,538.77/$52.25/ $10,973.03
Renewal License (base/per bed/ fee cap)	$1,650.83/$12.38/ $3,095.31	$21.25/$0.16/ $39.84	$1,672.08/$12.54/ $3,135.15
Change of Ownership	$2,579.42	$33.20	$2,612.62

Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 20 - Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center (127 Facilities)			
Initial License			
Ambulatory Surgical Center (ASC)	$6,809.68	$87.66	$6,897.34
Ambulatory Surgical Center with Convalescent Center	$7,181.11	$92.44	$7,273.55
Add Convalescent Center to an existing license	$371.44	$4.78	$376.22
Renewal License			
Non-deemed ASC (base/per procedure room/fee cap)	$1,485.75/$206.35/ $3,095.31	$19.13/$2.66/ $39.84	$1,504.88/$209.01/ $3,135.15
Deemed ASC (base/per procedure room/ fee cap)	$1,337.18/$206.35/ $3,095.31	$17.21/$2.66/ $39.84	$1,354.39/$209.01/ $3,135.15
Additional fee for a Convalescent Center	$371.44	$4.78	$376.22
Renewal fee cap for ASC with Convalescent Center	$3,466.74	$44.63	$3,511.37
Change of Ownership			
ASC	$4,230.25	$54.45	$4,284.70
ASC with Convalescent Center	$4,601.69	$59.23	$4,660.92
Provisional			
ASC	$2,579.42	$33.20	$2,612.62
ASC with Convalescent Center	$2,950.86	$37.98	$2,988.84
Chapter 21 - Hospices (102 Facilities)			
Initial License	$6,572.37	$84.60	$6,656.97
Initial License if no other licensed hospice within 60 miles	$4,281.84	$55.12	$4,336.96
Renewal			
Base fee (if no other conditions are met)	$4,023.90	$51.80	$4,075.70
Not in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld counties and providing 75 percent of services outside those counties	$2,476.25	$31.88	$2,508.13
Fewer than 2,000 annual patient dates per most recent Medicare cost report	$1,547.65	$19.92	$1,567.57
Fewer than 1,000 annual	$773.83	$9.96	$783.79

patient dates per most recent Medicare cost report Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area licensed as one entity	$6,603.32	$85.00	$6,688.32
Workstation (per workstation, paid for Initial License and Renewal License)	$51.59	$0.66	$52.25
Change of Ownership	$6,572.37	$84.60	$6,656.97

During the stakeholder process for this fee increase, the stakeholders did not present concerns about economic or non-economic impacts of the change. The benefit of the fee increase is to reduce the shortfall of revenues that support the Division's licensing, oversight, and enforcement activities. Reducing or eliminating these costs would mean that the Division would not have the resources necessary to protect the health, safety, and welfare of Coloradans being served in licensed health facilities.

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

S: N/A

B: N/A

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.

This rule-making is limited to a fee increase of 1.2872426%, thus generating $28,438 to support the Division's ability to protect the health, safety, and welfare of Coloradans being served by facilities ranging from hospitals to group homes.

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:

Licensing fees will continue to be collected and processed using existing procedures. Increasing the amount of the fees collected will not increase the resources needed to collect and process the fees, and thus this proposed fee increase will not have a cost impact on CDPHE.

Anticipated Other State Agency Costs:

The cost of a Community Clinic license for the clinics operated under the auspices of the Department of Corrections will increase $17.27 per clinic. There are currently 23 of these clinics, so the total cost impact of this increase for those clinics will be $397.21.

Anticipated CDPHE Revenues:

This fee increase is expected to generate approximately $28,438, but this amount will not fully fund the revenue shortfall in the General Licensure Fund. Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by General Licensure Fund revenues. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

This rulemaking modifies fees:

Facility-specific fee increases are listed in the table in response to Question 2, above.

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
_X__ Improve public and environmental health practice.
_X__ Implement stakeholder feedback.
___ 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:

The cost of inaction is the Division not exhausting every avenue to secure revenue to meet its expenditures. This in turn limits the Division's ability to fulfill its responsibilities related to licensing, oversight, and enforcement for hospitals, nursing homes, facilities for persons with intellectual and developmental disabilities, community clinics and community clinics with emergency centers, rehabilitation hospitals, dialysis treatment clinics, psychiatric hospitals, ambulatory surgical centers and ambulatory surgical centers with convalescent centers, hospices, and birth centers. The Division's inability to fully perform these functions negatively impacts the health, safety, and welfare of all Coloradans receiving treatment by or residing in these facilities.

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

   No other less costly method or less intrusive method was available as the fees are set in rule per statute.

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

   The Division's options for considering alternatives to the requested fee increase are constrained by the statutory restriction limiting fee increases to annual CPI at Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. The Division cannot request a larger fee increase without modification to statute. While the Division could raise fees at an amount lower than the CPI increase, this option was not selected because even the maximum increase allowed by statute does not generate enough revenue to offset the expected revenue shortfall.

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 used the federal Bureau of Labor Statistics Data, CPI-All Urban Consumers, Series CUURS48BSA0 (Denver-Lakewood-Aurora) to calculate the amount of fee increase allowed by Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., and then applied that percentage increase to all fees that are paid into the General Licensure Fund. The increases were rounded to the nearest penny.

STAKEHOLDER ENGAGEMENT
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Centers
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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:

Since this fee increase involves multiple types of facilities and has been an ongoing issue, the Division has chosen to discuss the need for the annual CPI-based increases in a number of different settings, primarily ongoing stakeholder advisory groups and forums such as the 1294 Stakeholder Forum.

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).

__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.

No major factual or policy issues were encountered.

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:

> This is solely a fee increase to maintain existing activities regarding health facility licensing, oversight, and enforcement activities. There are no anticipated impacts on determinants of health or other health equity and environmental justice considerations, values, or outcomes.

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 Chap 02

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 2 Licensure Process

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2.13 License Fees

Unless explicitly set forth elsewhere in 6 CCR 1011-1 or statute, the following non-refundable fees shall apply and be submitted to the Department with the corresponding application or notification. More than one fee may apply depending upon the circumstances.

Initial license	~~$371.44~~ $376.22
Renewal license	~~$371.44~~ $376.22
Conditional license	~~$1,547.65~~ $1,567.57
First provisional license	~~$1,031.77~~ $1,045.05
Second provisional license	~~$1,031.77~~ $1,045.05
Change of ownership	~~$371.44~~ $376.22
Change in licensed capacity	~~$371.44~~ $376.22
Change of name	~~$77.38~~ $78.38
Renewal application late fee	Equal to the applicable renewal license fee including bed fees or operating/procedure room fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 04 - GENERAL HOSPITALS

6 CCR 1011-1 Chap 04

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES

3.101 SUBMITTAL OF FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows:

(a) See table below.

Number of Beds	Fee
1 - 25 beds	~~$8,254.15~~ $8,360.40
26 - 50 beds	~~$10,317.69~~ $10,450.50
51 - 100 beds	~~$12,897.12~~ $13,063.14
101 + beds	Base: ~~$10,111.34~~ $10,241.50
	Per bed: ~~$51.59~~ $52.25
	Cap: ~~$20,635.39~~ $20,901.02

(b) Notwithstanding the provisions of Section 3.101 (1)(a), the initial fee for facilities to be licensed as general hospitals but certified as long term hospitals pursuant to 42 CFR 482 et seq. shall submit: a base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee for long term hospitals shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the following table. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

Number of Beds	Fee	Fee with Deeming Discount
1 - 50 beds	Base: ~~$928.59~~ $940.54 Per bed: ~~$12.38~~ $12.54	Base: ~~$835.73~~ $846.49 Per bed: ~~$12.38~~ $12.54
51 - 150 beds	Base: ~~$1,444.48~~ $1,463.07 Per bed: ~~$12.38~~ $12.54	Base: ~~$1300.03~~ $1,316.76 Per bed: ~~$12.38~~ $12.54
151+ beds	Base: ~~$2,063.54~~ $2,090.10 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40	Base: ~~$1,857.18~~ $1,881.09 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

(5) Conditional License. A facility that is issued a conditional license by the Department shall submit a nonrefundable fee ranging from 10 to 25 percent of its applicable renewal fee. The Department shall assess the fee based on the anticipated costs of monitoring compliance with the conditional license. If the conditional license is issued concurrent with the initial or renewal license, the conditional license fee shall be in addition to the initial or renewal license fee.

(6) Other Regulatory Functions. If a facility requests an onsite inspection for a regulatory oversight function other than those listed in Sections 3.101 (1) through (3), the Department may conduct such onsite inspection upon notification to the facility of the fee in advance and payment thereof. The fee shall be calculated solely on the basis of the cost of conducting such survey. A detailed justification of the basis of the fee shall be provided to the facility upon request.

(7) Off-Campus Locations

(a) Addition, Annual Renewal and Termination of Off- Campus Locations. A licensee shall submit a nonrefundable fee, as set forth below, for the requested license action.

(i) ~~$1,031.77~~ $1,045.05 for the addition of each location to the list of off-campus locations under the license, except that critical access hospitals shall submit a nonrefundable fee of ~~$515.88~~ $522.52.

(ii) ~~$515.88~~ $522.52 for the annual renewal of each off-campus location listed under the license.

(iii) ~~$464.30~~ $470.28 for the annual renewal of licenses that expire on or after September 1, 2014, for each off-campus location that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(iv) ~~$371.44~~ $376.22 for the removal of each location from the list of off-campus locations under the license.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 5 - NURSING CARE FACILITIES

6 CCR 1011-1 Chap 05

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 32 LICENSING FEES

32.1 All license fees are non-refundable. The total fee shall be submitted with the appropriate license application.

32.2 Initial license - ~~$6,190.62~~ $6,270.31 per facility.

32.3 Renewal license - The annual renewal fee shall be as follows.

Medicare and/or Medicaid certified facility: ~~$1,650.83~~ $1,672.08 base fee plus ~~$8.25~~ $8.36 per bed.

Non-certified facility: ~~$3,590.56~~ $3,636.78 base fee plus ~~$8.25~~ $8.36 per bed.

32.4 Change of ownership - Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter 2, Part 2.7. The fee shall be ~~$6,190.62~~ $6,270.31 per facility.

32.5 Opening a secure unit - A facility that wishes to open a secure unit shall submit a fee of ~~$1,650.83~~ $1,672.08 in addition to any other applicable license fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 08 - FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

6 CCR 1011-1 Chap 08

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3 – Licensing Requirements

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3.4 License Fees

All license fees are non-refundable. More than one fee may apply depending upon the circumstances. The total fee shall be submitted with the appropriate license application.

(A) Initial License

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

(B) License Renewal

Effective July 1, ~~2019~~ 2020, the renewal fee shall be:

Community Residential Home: ~~$773.83~~ $783.79.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$1,650.83~~ $1,672.08.

(C) Change of ownership

Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter II, Part 2. The change of ownership fee shall be:

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 09 - COMMUNITY CLINICS AND COMMUNITY CLINICS AND EMERGENCY CENTERS

6 CCR 1011-1 Chap 09

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

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SUBCHAPTER IX.A - GENERAL REQUIREMENTS

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES.

(1) For new license applications received or renewal licenses that expire on or after July 1, ~~2019~~2020, a non-refundable fee shall be submitted with the license application as follows:

License Category	Initial license	Renewal license	Change of ownership
Community emergency center	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operating inpatient beds	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operated under the auspices of the Department of Corrections	~~$2,579.42~~ $2,612.62	~~$1,341.30~~ $1,358.57	~~$2,579.42~~ $2,612.62
Optional licensure pursuant to Section 2.101 (3)(a)(iv).			
Clinic serving the uninsured or underinsured:	~~$1,238.12~~ $1,254.06	~~$619.06~~ $627.03	~~$1,289.71~~ $1,306.31
Other clinic:	~~$2,476.25~~ $2,508.13	~~$1,238.12~~ $1,254.06	~~$2,579.42~~ $2,612.62

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 10 - REHABILITATION HOSPITALS

6 CCR 1011-1 Chap 10

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 15 - DIALYSIS TREATMENT CLINICS

6 CCR 1011-1 Chap 15

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3. FEES

3.1 License fees. All license fees are non-refundable and shall be submitted with the appropriate license application.

(A) Initial license fee - ~~$5,303.29~~ $5,371.56 per facility.

(B) Renewal license fee - For licenses that expire on or after July 1, ~~2019~~2020, the fee shall be based upon the maximum number of a facility's operational procedure stations as set forth below.

1 – 12 stations	~~$1,650.83~~ $1,672.08 per facility
13 – 23 stations	~~$2,600.06~~ $2,633.53 per facility
24 or more stations	~~$3,544.13~~ $3,589.75 per facility

(C) Change of ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, part 2. The fee shall be ~~$5,303.29~~ $5,371.56 per facility.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 18 - PSYCHIATRIC HOSPITALS

6 CCR 1011-1 Chap 18

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the department with an application for licensure as follows:

(1) Initial License: (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 19 - HOSPITAL UNITS

6 CCR 1011-1 Chap 19

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$5,468.38~~ $5,538.77 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License. A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(3) Change of Ownership. A license applicant shall submit a fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 20 - AMBULATORY SURGICAL CENTER AND AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

6 CCR 1011-1 Chap 20

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 24 - LICENSE FEES

24.1 As part of the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7, an applicant for an ambulatory surgical center license shall submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license: A license applicant shall submit with an application for licensure a nonrefundable fee of ~~$6,809.68~~ $6,897.34.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

BASE FEE	BASE FEE WITH DEEMING DISCOUNT	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,230.25~~ $4,284.70.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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SECTION 25 - AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

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25.7 License Fees: For new license applications received or renewal licenses that expire on or after March 1, 2015, an applicant for an ambulatory surgical center with a convalescent center license shall comply with the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7 and submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license:

(1) An applicant for an initial ambulatory surgical center with convalescent center license shall submit with an application for licensure a nonrefundable fee of ~~$7,181.11~~ $7,273.55.

(2) A current ambulatory surgical center licensee that applies to add a convalescent center to the license prior to the expiration of the surgical center license shall submit an application for initial licensure of the convalescent center along with a nonrefundable fee of ~~$371.44~~ $376.22. Upon expiration of the existing surgical center license term, the licensee shall follow the procedure set forth below for a renewal license.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,466.74~~ $3,511.37.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base ambulatory surgical center renewal fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

ASC BASE FEE	ASC BASE FEE WITH DEEMING DISCOUNT	CONVALESCENT CENTER FEE	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$371.44~~ $376.22	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,601.69~~ $4,660.92.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,950.86~~ $2,988.84. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 21 - HOSPICES

6 CCR 1011-1 Chap 21

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 14 LICENSE FEES

14.1 All license fees are non-refundable and the applicable fee total shall be submitted with the appropriate license application.

14.2 Initial License - ~~$6,572.37~~ $6,656.97 per hospice.

(A) If there are no licensed hospices within a 60-mile radius of the hospice applying for an initial license, the initial license fee shall be ~~$4,281.84~~ $4,336.96 per hospice.

14.3 Annual Renewal License

(A) For licenses expiring on or after July 1, ~~2019~~ 2020, the base renewal fee shall be ~~$4,023.90~~ $4,075.70 per hospice. The total renewal fee shall reflect all applicable adjustments as set forth below.

(1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be ~~$2,476.25~~ $2,508.13 per hospice.

(2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$1,547.65~~ $1,567.57 per hospice.

(3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$773.83~~ $783.79 per hospice.

(4) A discount of $300 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location.

(5) A discount of $425 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

(6) Upon request, the department may waive the fee for a hospice that demonstrates it is a not for profit organization that charges no fees and is staffed entirely by uncompensated volunteers.

(7) Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area shall be licensed as one entity. The fee shall be ~~$6,603.32~~ $6,688.32 and no other discounts shall apply except as set forth in (7)(a).

(a) A discount of $640 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

14.4 Workstation Fees

(A) A workstation is an offsite location maintained solely for the convenience of hospice staff to access policies and procedures, obtain forms or use various electronic communication tools. A workstation shall not contain patient records or be used for patient admissions and shall not display any public signage.

(B) In addition to any other licensure fees, a hospice that operates one or more satellite workstations shall pay an annual fee of ~~$51.59~~ $52.25 per workstation. The fee shall be submitted with the initial and/or renewal license application.

14.5 Change of Ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, Part 2. The fee shall be ~~$6,572.37~~ $6,656.97 per hospice.

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COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing Scheduled for April 15, 2020

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 April 15, 2020 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive, South, Denver, CO 80246, to consider the revision of the follow chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities:

- Chapter 2 - General Licensure Standards
- Chapter 4 - General Hospitals
- Chapter 5 - Nursing Care Facilities
- Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
- Chapter 9 - Community Clinics and Community Clinics and Emergency Services
- Chapter 10 - Rehabilitation Hospitals
- Chapter 15 - Dialysis Treatment Clinics
- Chapter 18 - Psychiatric Hospitals
- Chapter 19 - Hospital Units
- Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
- Chapter 21 - Hospices

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426%. The proposed rules have been developed by the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment pursuant to Section Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://www.colorado.gov/pacific/cdphe/boh 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 working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-2999.

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, April 9, 2020. 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 27th day of February, 2020.

Alexandra S. Haas

Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00102

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 10

Rule title

CHAPTER 10 - REHABILITATION CENTERS

Rulemaking Hearing

Date

04/15/2020

Time

10:00 AM

Location

Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246

Subjects and issues involved

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426% to provide an additional $28,438 in revenue.

Statutory authority

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

Contact information

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Title

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Kim Fear, Branch Chief, Fiscal & Administrative Services Branch, HFEMSD

Through: D. Randy Kuykendall, Director, DRK

Date: February 19, 2020

Subject: **Request for a Rulemaking Hearing** concerning increasing licensure fees in the following chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities in April 2020:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

In April 2019, the Division appeared before the Board with a request to increase the fees that licensees pay into the General Licensure Cash Fund (General Licensure Fund). At that time, the Division explained that over several years, expenditures from the General Licensure Fund had increased 24.6%, while the revenues paid into that fund had increased by only 0.6%. The requested fee increase was for 3.1769267%, which was expected to generate about $66,850. This amount was not expected to address the full difference between revenues and expenditures of the General Licensure Fund, but was the maximum the Board could increase fees due to Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. (As of June 4, 2012, the Board of Health may only increase the fees collected by the annual percentage change of the consumer price index for Denver-Aurora-Lakewood.)

Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund

monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

The Division is now requesting to increase fees paid into the General Licensure Fund by 1.2872426%, which again will not fully fund the expenditures of the General Licensure Fund, but is the maximum the Board may increase fees. This fee increase is expected to provide an additional $28,438 in revenue, but this amount will not be enough to offset the expected revenue shortfall in Fiscal Year 2021 and following years, so the Division anticipates requesting additional CPI-limited fee increases on a yearly basis going forward.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

Basis and Purpose.

HFEMSD's health facility licensing, oversight, and enforcement activities are funded through the collection of fees approved by the Board of Health. The fees paid by facilities licensed by the Division, with the exception of Assisted Living Residences (ALRs) and Home Care Agencies, are deposited to the Health Facilities General Licensure Cash Fund (General Licensure Fund), which is then the source of appropriations to the Division for its licensure and oversight activities. In accordance with Section 25-3-105(1)(a)(I)(A), C.R.S, fees are to be set at a level sufficient to meet the direct and indirect costs of these activities.

Although the Board approved a 3.1769267% fee increase for Fiscal Year 2020 (the maximum allowed by statute), the fees being paid into the General Licensure Fund remain insufficient to meet the Division's direct and indirect costs. Since the April 2019 fee increase request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable. For example, the ability to use fund balance will be eliminated, as the balance of the General Licensure Fund is estimated to be approximately $12,000 for Fiscal Year 2020, as opposed to over $200,000 in prior years. Additionally, purposely holding positions open means that a portion of the Division's work is not getting done.

Expenditures continue to increase for a number of predictable reasons, such as the general inflationary increases in personnel and travel costs over the past several years. The Division has been managing these expenditures through efforts like process efficiencies and the use of vacancy savings due to difficulties arising from health care staffing shortages in general. The Division, however, continues to experience high numbers of complaints, driving investigation workload. While generally increasing, complaints are variable and unpredictable, which makes it important to have revenues at a high enough level to investigate complaints coming

in, even in a higher-than typical year. The following table shows complaint variability, as well as overall growth:

General Licensure Cash Fund—Facility and Complaint Growth FY 2016 to FY 2019					
	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019	Percentage Increase/Decrease FY 16 to FY 19
Number of Facilities	892	905	912	902	1.1%
Number of Complaint Intakes	752	903	1,256	948	26.1%
Number of Complaint Allegations	2,384	2,910	4,007	2,912	22.1%
Top 3 Complaint Allegation Categories:					
Nursing Services	807	1,132	1,278	1,191	47.6%
Patient Rights	261	330	442	308	18.0%
Quality of Care	324	329	594	286	-11.7%

These needed expenditure increases cannot be offset by efforts previously used by the Division, and as a result the Division expects expenditures to exceed revenues by approximately $201,109 in Fiscal Year 2019-20, even after purposely holding $110,000 worth of positions vacant and using $237,592 of General Fund monies. If the Division were to fill positions to the full appropriated level and use only the General Licensure Fund money without supplementing with General Fund, the shortfall would be $542,132. The Division, therefore, is seeking a fee increase for all fees that pay into the fund to reduce the expected revenue shortfall.

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., limit fee increases for the fees paid into the General Licensure fund to no more than the annual increase in the Consumer Price Index (CPI) for Denver-Aurora-Lakewood. For the time period July 1, 2018 through June 30, 2019 (Fiscal Year 2018-19), that specific CPI increased by 1.2872426%. Therefore, consistent with statutory constraints, the Division is requesting that all fees paid into the General Licensure Fund be increased by that amount. This increase is expected to generate $28,437, based on the numbers and types of facilities currently licensed. Even with this full increase allowed by statute, the revenues for the General Licensure Fund are expected to be approximately $661,012 less than what is needed to fully fund the full, appropriate direct and indirect costs of licensing, oversight, and enforcement activities for the 902 facilities that pay into the fund for Fiscal Year 2021. The Division anticipates requesting the CPI-based fee increases annually going forward.

The Department requests that the fee increases be effective July 1, 2020.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), 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 incorporate materials by reference?

_____ Yes ___ URL

___x___ No

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

___x___ Yes

_____ 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.

REGULATORY ANALYSIS
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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/S/B
Facilities paying Chapter 2 fees	31	C
Facilities paying Chapter 4 fees	94	C
Facilities paying Chapter 5 fees	230	C
Facilities paying Chapter 8 fees	142	C
Facilities paying Chapter 9 fees	77	C
Facilities paying Chapter 10 fees	5	C
Facilities paying Chapter 15 fees	80	C
Facilities paying Chapter 18 fees	12	C
Facilities paying Chapter 19 fees	2	C
Facilities paying Chapter 20 fees	127	C
Facilities paying Chapter 21 fees	102	C
Industry/advocacy organizations for the facility types covered above	6	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.

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.

C: Fees are increased by 1.2872426% in the included chapters, causing an estimated total additional cost to licensed facilities of $28,438. The actual additional cost for a specific facility varies depending on the amount of its current fee (e.g., a facility with a current fee amount of $371.44 would see a fee increase of $4.78 per year, while a facility with a current fee of $6,190.62 would see a fee increase of $79.69). The following table provides details on the specific fees by chapter, the amounts of the requested increases, and the increased fee totals. It is important to note that facilities pay only the fee(s) that apply to them (e.g., a new facility pays for an initial license, an existing facility pays for a renewal license).

Entity Type Type of fee	Current Fee	Increase	New Fee
Chapter 2 – General Licensure Standards (31 Facilities)			
Initial License	$371.44	$4.78	$376.22
Renewal License	$371.44	$4.78	$376.22
Conditional License	$1,547.65	$19.92	$1,567.57
Provisional License	$1,031.77	$13.28	$1,045.05
Change of Ownership	$371.44	$4.78	$376.22
Change in Licensed Capacity	$371.44	$4.78	$376.22
Change of Name	$77.38	$1.00	$78.38
Chapter 4 – General Hospitals (94 Facilities)			
Initial License:			
1-25 beds	$8,254.15	$106.25	$8,360.40
26-50 beds	$10,317.69	$132.81	$10,450.50
51-100 beds	$12,897.12	$166.02	$13,063.14
101+ beds (base/per bed/fee cap)	$10,111.34/$51.59/ $20,635.39	$130.16/$0.66/ $265.63	$10,241.50/$52.25/ $20,901.02
Certified Long Term Hospital (base/per bed/fee cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License:			
Deemed 1-50 beds (base/per bed)	$835.73/$12.38	$10.76/$0.16	$846.49/$12.54
Non-deemed 1-50 beds (base/per bed)	$928.59/$12.38	$11.95/$0.16	$940.54/$12.54
Deemed 51-150 beds (base/per bed)	$1,300.03/$12.38	$16.73/$0.16	$1,316.76/$12.54
Non-deemed 51-150 beds (base/per bed)	$1,444.48/$12.38	$18.59/$0.16	$1,463.07/$12.54
Deemed 151+ beds (base/per bed/fee cap)	$1,857.18/$12.38/ $8,254.15	$23.91/$0.16/ $106.25	$1,881.09/$12.54/ $8,360.40

Non-Deemed 151+beds (base/per bed/fee cap)	$2,063.54/$12.38/ $8,254.15	$26.56/$0.16/ $106.25	$2,090.10/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Off-campus location addition—Critical Access Hospital	$515.88	$6.64	$522.52
Off-campus location addition	$1,031.77	$13.28	$1,045.05
Off-campus location renewal—deemed facility	$464.30	$5.98	$470.28
Off-campus location renewal	$515.88	$6.64	$522.52
Off-campus location removal	$371.44	$4.78	$376.22
Chapter 5 – Nursing Care Facilities (230 Facilities)			
Initial License	$6,190.62	$79.69	$6,270.31
Renewal License			
Certified Facilities—Medicare or Medicaid (base/per bed)	$1,650.83/$8.25	$21.25/$.11	$1,672.08/$8.36
Non-certified Facilities (base/per bed)	$3,590.56/$8.25	$46.22/$0.11	$3,636.78/$8.36
Change of Ownership	$6,190.62	$79.69	$6,270.31
Opening a Secure Unit	$1,650.83	$21.25	$1,672.08
Chapter 8 – Facilities for Persons with Intellectual or Developmental Disabilities (142 Facilities)			
Initial License			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Renewal License			
Community Residential Home	$773.83	$9.96	$783.79
Intermediate Care Facility	$1,650.83	$21.25	$1,672.08
Change of Ownership			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Chapter 9 – Community Clinics and Community Clinics and Emergency Centers (77 Facilities)			
Initial License			
Community Emergency Center	$2,837.37	$36.52	$2,873.89
Clinic Operating Inpatient Beds	$2,837.37	$36.52	$2,873.89
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,238.12	$15.94	$1,254.06
Other Clinic	$2,476.25	$31.88	$2,508.13
Renewal License			
Community Emergency	$1,392.89	$17.93	$1,410.82

Center			
Clinic Operating Inpatient Beds	$1,392.89	$17.93	$1,410.82
Clinic Operated Under Auspices of Department of Corrections	$1,341.30	$17.27	$1,358.57
Clinic Serving Un/Underinsured	$619.06	$7.97	$627.03
Other Clinic	$1,238.12	$15.94	$1,254.06
Change of Ownership			
Community Emergency Center	$3,198.48	$41.17	$3,239.65
Clinic Operating Inpatient Beds	$3,198.48	$41.17	$3,239.65
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,289.71	$16.60	$1,306.31
Other Clinic	$2,579.42	$33.20	$2,612.62
Chapter 10 - Rehabilitation Hospitals (5 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 15 - Dialysis Treatment Clinics (80 Facilities)			
Initial License	$5,303.29	$68.27	$5,371.56
Renewal License			
1-12 Stations	$1,650.83	$21.25	$1,672.08
13-23 Stations	$2,600.06	$33.47	$2,633.53
24+ Stations	$3,544.13	$45.62	$3,589.75
Change of Ownership	$5,303.29	$68.27	$5,371.56
Chapter 18 - Psychiatric Hospitals (12 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 19 - Hospital Units (2 Facilities)			
Initial License (base/per bed/ fee cap)	$5,468.38/$51.59/ $10,833.58	$70.39/$0.66/ $139.45	$5,538.77/$52.25/ $10,973.03
Renewal License (base/per bed/ fee cap)	$1,650.83/$12.38/ $3,095.31	$21.25/$0.16/ $39.84	$1,672.08/$12.54/ $3,135.15
Change of Ownership	$2,579.42	$33.20	$2,612.62

Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 20 - Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center (127 Facilities)			
Initial License			
Ambulatory Surgical Center (ASC)	$6,809.68	$87.66	$6,897.34
Ambulatory Surgical Center with Convalescent Center	$7,181.11	$92.44	$7,273.55
Add Convalescent Center to an existing license	$371.44	$4.78	$376.22
Renewal License			
Non-deemed ASC (base/per procedure room/fee cap)	$1,485.75/$206.35/ $3,095.31	$19.13/$2.66/ $39.84	$1,504.88/$209.01/ $3,135.15
Deemed ASC (base/per procedure room/ fee cap)	$1,337.18/$206.35/ $3,095.31	$17.21/$2.66/ $39.84	$1,354.39/$209.01/ $3,135.15
Additional fee for a Convalescent Center	$371.44	$4.78	$376.22
Renewal fee cap for ASC with Convalescent Center	$3,466.74	$44.63	$3,511.37
Change of Ownership			
ASC	$4,230.25	$54.45	$4,284.70
ASC with Convalescent Center	$4,601.69	$59.23	$4,660.92
Provisional			
ASC	$2,579.42	$33.20	$2,612.62
ASC with Convalescent Center	$2,950.86	$37.98	$2,988.84
Chapter 21 - Hospices (102 Facilities)			
Initial License	$6,572.37	$84.60	$6,656.97
Initial License if no other licensed hospice within 60 miles	$4,281.84	$55.12	$4,336.96
Renewal			
Base fee (if no other conditions are met)	$4,023.90	$51.80	$4,075.70
Not in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld counties and providing 75 percent of services outside those counties	$2,476.25	$31.88	$2,508.13
Fewer than 2,000 annual patient dates per most recent Medicare cost report	$1,547.65	$19.92	$1,567.57
Fewer than 1,000 annual	$773.83	$9.96	$783.79

patient dates per most recent Medicare cost report Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area licensed as one entity	$6,603.32	$85.00	$6,688.32
Workstation (per workstation, paid for Initial License and Renewal License)	$51.59	$0.66	$52.25
Change of Ownership	$6,572.37	$84.60	$6,656.97

During the stakeholder process for this fee increase, the stakeholders did not present concerns about economic or non-economic impacts of the change. The benefit of the fee increase is to reduce the shortfall of revenues that support the Division's licensing, oversight, and enforcement activities. Reducing or eliminating these costs would mean that the Division would not have the resources necessary to protect the health, safety, and welfare of Coloradans being served in licensed health facilities.

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

S: N/A

B: N/A

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.

This rule-making is limited to a fee increase of 1.2872426%, thus generating $28,438 to support the Division's ability to protect the health, safety, and welfare of Coloradans being served by facilities ranging from hospitals to group homes.

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:

Licensing fees will continue to be collected and processed using existing procedures. Increasing the amount of the fees collected will not increase the resources needed to collect and process the fees, and thus this proposed fee increase will not have a cost impact on CDPHE.

Anticipated Other State Agency Costs:

The cost of a Community Clinic license for the clinics operated under the auspices of the Department of Corrections will increase $17.27 per clinic. There are currently 23 of these clinics, so the total cost impact of this increase for those clinics will be $397.21.

Anticipated CDPHE Revenues:

This fee increase is expected to generate approximately $28,438, but this amount will not fully fund the revenue shortfall in the General Licensure Fund. Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by General Licensure Fund revenues. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

This rulemaking modifies fees:

Facility-specific fee increases are listed in the table in response to Question 2, above.

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
_X__ Improve public and environmental health practice.
_X__ Implement stakeholder feedback.
___ 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:

The cost of inaction is the Division not exhausting every avenue to secure revenue to meet its expenditures. This in turn limits the Division's ability to fulfill its responsibilities related to licensing, oversight, and enforcement for hospitals, nursing homes, facilities for persons with intellectual and developmental disabilities, community clinics and community clinics with emergency centers, rehabilitation hospitals, dialysis treatment clinics, psychiatric hospitals, ambulatory surgical centers and ambulatory surgical centers with convalescent centers, hospices, and birth centers. The Division's inability to fully perform these functions negatively impacts the health, safety, and welfare of all Coloradans receiving treatment by or residing in these facilities.

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

   No other less costly method or less intrusive method was available as the fees are set in rule per statute.

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

   The Division's options for considering alternatives to the requested fee increase are constrained by the statutory restriction limiting fee increases to annual CPI at Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. The Division cannot request a larger fee increase without modification to statute. While the Division could raise fees at an amount lower than the CPI increase, this option was not selected because even the maximum increase allowed by statute does not generate enough revenue to offset the expected revenue shortfall.

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 used the federal Bureau of Labor Statistics Data, CPI-All Urban Consumers, Series CUURS48BSA0 (Denver-Lakewood-Aurora) to calculate the amount of fee increase allowed by Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., and then applied that percentage increase to all fees that are paid into the General Licensure Fund. The increases were rounded to the nearest penny.

STAKEHOLDER ENGAGEMENT
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Centers
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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:

Since this fee increase involves multiple types of facilities and has been an ongoing issue, the Division has chosen to discuss the need for the annual CPI-based increases in a number of different settings, primarily ongoing stakeholder advisory groups and forums such as the 1294 Stakeholder Forum.

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).

__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.

No major factual or policy issues were encountered.

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:

> This is solely a fee increase to maintain existing activities regarding health facility licensing, oversight, and enforcement activities. There are no anticipated impacts on determinants of health or other health equity and environmental justice considerations, values, or outcomes.

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 Chap 02

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 2 Licensure Process

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2.13 License Fees

Unless explicitly set forth elsewhere in 6 CCR 1011-1 or statute, the following non-refundable fees shall apply and be submitted to the Department with the corresponding application or notification. More than one fee may apply depending upon the circumstances.

Initial license	~~$371.44~~ $376.22
Renewal license	~~$371.44~~ $376.22
Conditional license	~~$1,547.65~~ $1,567.57
First provisional license	~~$1,031.77~~ $1,045.05
Second provisional license	~~$1,031.77~~ $1,045.05
Change of ownership	~~$371.44~~ $376.22
Change in licensed capacity	~~$371.44~~ $376.22
Change of name	~~$77.38~~ $78.38
Renewal application late fee	Equal to the applicable renewal license fee including bed fees or operating/procedure room fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 04 - GENERAL HOSPITALS

6 CCR 1011-1 Chap 04

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES

3.101 SUBMITTAL OF FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows:

(a) See table below.

Number of Beds	Fee
1 - 25 beds	~~$8,254.15~~ $8,360.40
26 - 50 beds	~~$10,317.69~~ $10,450.50
51 - 100 beds	~~$12,897.12~~ $13,063.14
101 + beds	Base: ~~$10,111.34~~ $10,241.50
	Per bed: ~~$51.59~~ $52.25
	Cap: ~~$20,635.39~~ $20,901.02

(b) Notwithstanding the provisions of Section 3.101 (1)(a), the initial fee for facilities to be licensed as general hospitals but certified as long term hospitals pursuant to 42 CFR 482 et seq. shall submit: a base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee for long term hospitals shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the following table. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

Number of Beds	Fee	Fee with Deeming Discount
1 - 50 beds	Base: ~~$928.59~~ $940.54 Per bed: ~~$12.38~~ $12.54	Base: ~~$835.73~~ $846.49 Per bed: ~~$12.38~~ $12.54
51 - 150 beds	Base: ~~$1,444.48~~ $1,463.07 Per bed: ~~$12.38~~ $12.54	Base: ~~$1300.03~~ $1,316.76 Per bed: ~~$12.38~~ $12.54
151+ beds	Base: ~~$2,063.54~~ $2,090.10 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40	Base: ~~$1,857.18~~ $1,881.09 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

(5) Conditional License. A facility that is issued a conditional license by the Department shall submit a nonrefundable fee ranging from 10 to 25 percent of its applicable renewal fee. The Department shall assess the fee based on the anticipated costs of monitoring compliance with the conditional license. If the conditional license is issued concurrent with the initial or renewal license, the conditional license fee shall be in addition to the initial or renewal license fee.

(6) Other Regulatory Functions. If a facility requests an onsite inspection for a regulatory oversight function other than those listed in Sections 3.101 (1) through (3), the Department may conduct such onsite inspection upon notification to the facility of the fee in advance and payment thereof. The fee shall be calculated solely on the basis of the cost of conducting such survey. A detailed justification of the basis of the fee shall be provided to the facility upon request.

(7) Off-Campus Locations

(a) Addition, Annual Renewal and Termination of Off- Campus Locations. A licensee shall submit a nonrefundable fee, as set forth below, for the requested license action.

(i) ~~$1,031.77~~ $1,045.05 for the addition of each location to the list of off-campus locations under the license, except that critical access hospitals shall submit a nonrefundable fee of ~~$515.88~~ $522.52.

(ii) ~~$515.88~~ $522.52 for the annual renewal of each off-campus location listed under the license.

(iii) ~~$464.30~~ $470.28 for the annual renewal of licenses that expire on or after September 1, 2014, for each off-campus location that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(iv) ~~$371.44~~ $376.22 for the removal of each location from the list of off-campus locations under the license.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 5 - NURSING CARE FACILITIES

6 CCR 1011-1 Chap 05

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 32 LICENSING FEES

32.1 All license fees are non-refundable. The total fee shall be submitted with the appropriate license application.

32.2 Initial license - ~~$6,190.62~~ $6,270.31 per facility.

32.3 Renewal license - The annual renewal fee shall be as follows.

Medicare and/or Medicaid certified facility: ~~$1,650.83~~ $1,672.08 base fee plus ~~$8.25~~ $8.36 per bed.

Non-certified facility: ~~$3,590.56~~ $3,636.78 base fee plus ~~$8.25~~ $8.36 per bed.

32.4 Change of ownership - Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter 2, Part 2.7. The fee shall be ~~$6,190.62~~ $6,270.31 per facility.

32.5 Opening a secure unit - A facility that wishes to open a secure unit shall submit a fee of ~~$1,650.83~~ $1,672.08 in addition to any other applicable license fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 08 - FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

6 CCR 1011-1 Chap 08

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3 – Licensing Requirements

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3.4 License Fees

All license fees are non-refundable. More than one fee may apply depending upon the circumstances. The total fee shall be submitted with the appropriate license application.

(A) Initial License

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

(B) License Renewal

Effective July 1, ~~2019~~ 2020, the renewal fee shall be:

Community Residential Home: ~~$773.83~~ $783.79.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$1,650.83~~ $1,672.08.

(C) Change of ownership

Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter II, Part 2. The change of ownership fee shall be:

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 09 - COMMUNITY CLINICS AND COMMUNITY CLINICS AND EMERGENCY CENTERS

6 CCR 1011-1 Chap 09

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

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SUBCHAPTER IX.A - GENERAL REQUIREMENTS

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES.

(1) For new license applications received or renewal licenses that expire on or after July 1, ~~2019~~2020, a non-refundable fee shall be submitted with the license application as follows:

License Category	Initial license	Renewal license	Change of ownership
Community emergency center	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operating inpatient beds	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operated under the auspices of the Department of Corrections	~~$2,579.42~~ $2,612.62	~~$1,341.30~~ $1,358.57	~~$2,579.42~~ $2,612.62
Optional licensure pursuant to Section 2.101 (3)(a)(iv).			
Clinic serving the uninsured or underinsured:	~~$1,238.12~~ $1,254.06	~~$619.06~~ $627.03	~~$1,289.71~~ $1,306.31
Other clinic:	~~$2,476.25~~ $2,508.13	~~$1,238.12~~ $1,254.06	~~$2,579.42~~ $2,612.62

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 10 - REHABILITATION HOSPITALS

6 CCR 1011-1 Chap 10

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 15 - DIALYSIS TREATMENT CLINICS

6 CCR 1011-1 Chap 15

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3. FEES

3.1 License fees. All license fees are non-refundable and shall be submitted with the appropriate license application.

(A) Initial license fee - ~~$5,303.29~~ $5,371.56 per facility.

(B) Renewal license fee - For licenses that expire on or after July 1, ~~2019~~2020, the fee shall be based upon the maximum number of a facility's operational procedure stations as set forth below.

1 – 12 stations	~~$1,650.83~~ $1,672.08 per facility
13 – 23 stations	~~$2,600.06~~ $2,633.53 per facility
24 or more stations	~~$3,544.13~~ $3,589.75 per facility

(C) Change of ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, part 2. The fee shall be ~~$5,303.29~~ $5,371.56 per facility.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 18 - PSYCHIATRIC HOSPITALS

6 CCR 1011-1 Chap 18

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the department with an application for licensure as follows:

(1) Initial License: (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 19 - HOSPITAL UNITS

6 CCR 1011-1 Chap 19

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$5,468.38~~ $5,538.77 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License. A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(3) Change of Ownership. A license applicant shall submit a fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 20 - AMBULATORY SURGICAL CENTER AND AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

6 CCR 1011-1 Chap 20

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 24 - LICENSE FEES

24.1 As part of the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7, an applicant for an ambulatory surgical center license shall submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license: A license applicant shall submit with an application for licensure a nonrefundable fee of ~~$6,809.68~~ $6,897.34.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

BASE FEE	BASE FEE WITH DEEMING DISCOUNT	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,230.25~~ $4,284.70.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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SECTION 25 - AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

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25.7 License Fees: For new license applications received or renewal licenses that expire on or after March 1, 2015, an applicant for an ambulatory surgical center with a convalescent center license shall comply with the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7 and submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license:

(1) An applicant for an initial ambulatory surgical center with convalescent center license shall submit with an application for licensure a nonrefundable fee of ~~$7,181.11~~ $7,273.55.

(2) A current ambulatory surgical center licensee that applies to add a convalescent center to the license prior to the expiration of the surgical center license shall submit an application for initial licensure of the convalescent center along with a nonrefundable fee of ~~$371.44~~ $376.22. Upon expiration of the existing surgical center license term, the licensee shall follow the procedure set forth below for a renewal license.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,466.74~~ $3,511.37.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base ambulatory surgical center renewal fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

ASC BASE FEE	ASC BASE FEE WITH DEEMING DISCOUNT	CONVALESCENT CENTER FEE	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$371.44~~ $376.22	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,601.69~~ $4,660.92.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,950.86~~ $2,988.84. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 21 - HOSPICES

6 CCR 1011-1 Chap 21

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 14 LICENSE FEES

14.1 All license fees are non-refundable and the applicable fee total shall be submitted with the appropriate license application.

14.2 Initial License - ~~$6,572.37~~ $6,656.97 per hospice.

(A) If there are no licensed hospices within a 60-mile radius of the hospice applying for an initial license, the initial license fee shall be ~~$4,281.84~~ $4,336.96 per hospice.

14.3 Annual Renewal License

(A) For licenses expiring on or after July 1, ~~2019~~ 2020, the base renewal fee shall be ~~$4,023.90~~ $4,075.70 per hospice. The total renewal fee shall reflect all applicable adjustments as set forth below.

(1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be ~~$2,476.25~~ $2,508.13 per hospice.

(2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$1,547.65~~ $1,567.57 per hospice.

(3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$773.83~~ $783.79 per hospice.

(4) A discount of $300 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location.

(5) A discount of $425 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

(6) Upon request, the department may waive the fee for a hospice that demonstrates it is a not for profit organization that charges no fees and is staffed entirely by uncompensated volunteers.

(7) Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area shall be licensed as one entity. The fee shall be ~~$6,603.32~~ $6,688.32 and no other discounts shall apply except as set forth in (7)(a).

(a) A discount of $640 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

14.4 Workstation Fees

(A) A workstation is an offsite location maintained solely for the convenience of hospice staff to access policies and procedures, obtain forms or use various electronic communication tools. A workstation shall not contain patient records or be used for patient admissions and shall not display any public signage.

(B) In addition to any other licensure fees, a hospice that operates one or more satellite workstations shall pay an annual fee of ~~$51.59~~ $52.25 per workstation. The fee shall be submitted with the initial and/or renewal license application.

14.5 Change of Ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, Part 2. The fee shall be ~~$6,572.37~~ $6,656.97 per hospice.

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COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing Scheduled for April 15, 2020

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 April 15, 2020 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive, South, Denver, CO 80246, to consider the revision of the follow chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities:

- Chapter 2 - General Licensure Standards
- Chapter 4 - General Hospitals
- Chapter 5 - Nursing Care Facilities
- Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
- Chapter 9 - Community Clinics and Community Clinics and Emergency Services
- Chapter 10 - Rehabilitation Hospitals
- Chapter 15 - Dialysis Treatment Clinics
- Chapter 18 - Psychiatric Hospitals
- Chapter 19 - Hospital Units
- Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
- Chapter 21 - Hospices

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426%. The proposed rules have been developed by the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment pursuant to Section Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://www.colorado.gov/pacific/cdphe/boh 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 working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-2999.

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, April 9, 2020. 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 27th day of February, 2020.

Alexandra S. Haas

Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00103

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 15

Rule title

CHAPTER 15 - DIALYSIS TREATMENT CLINICS

Rulemaking Hearing

Date

04/15/2020

Time

10:00 AM

Location

Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246

Subjects and issues involved

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426% to provide an additional $28,438 in revenue.

Statutory authority

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

Contact information

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Title

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Kim Fear, Branch Chief, Fiscal & Administrative Services Branch, HFEMSD

Through: D. Randy Kuykendall, Director, DRK

Date: February 19, 2020

Subject: **Request for a Rulemaking Hearing** concerning increasing licensure fees in the following chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities in April 2020:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

In April 2019, the Division appeared before the Board with a request to increase the fees that licensees pay into the General Licensure Cash Fund (General Licensure Fund). At that time, the Division explained that over several years, expenditures from the General Licensure Fund had increased 24.6%, while the revenues paid into that fund had increased by only 0.6%. The requested fee increase was for 3.1769267%, which was expected to generate about $66,850. This amount was not expected to address the full difference between revenues and expenditures of the General Licensure Fund, but was the maximum the Board could increase fees due to Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. (As of June 4, 2012, the Board of Health may only increase the fees collected by the annual percentage change of the consumer price index for Denver-Aurora-Lakewood.)

Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund

monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

The Division is now requesting to increase fees paid into the General Licensure Fund by 1.2872426%, which again will not fully fund the expenditures of the General Licensure Fund, but is the maximum the Board may increase fees. This fee increase is expected to provide an additional $28,438 in revenue, but this amount will not be enough to offset the expected revenue shortfall in Fiscal Year 2021 and following years, so the Division anticipates requesting additional CPI-limited fee increases on a yearly basis going forward.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

Basis and Purpose.

HFEMSD's health facility licensing, oversight, and enforcement activities are funded through the collection of fees approved by the Board of Health. The fees paid by facilities licensed by the Division, with the exception of Assisted Living Residences (ALRs) and Home Care Agencies, are deposited to the Health Facilities General Licensure Cash Fund (General Licensure Fund), which is then the source of appropriations to the Division for its licensure and oversight activities. In accordance with Section 25-3-105(1)(a)(I)(A), C.R.S, fees are to be set at a level sufficient to meet the direct and indirect costs of these activities.

Although the Board approved a 3.1769267% fee increase for Fiscal Year 2020 (the maximum allowed by statute), the fees being paid into the General Licensure Fund remain insufficient to meet the Division's direct and indirect costs. Since the April 2019 fee increase request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable. For example, the ability to use fund balance will be eliminated, as the balance of the General Licensure Fund is estimated to be approximately $12,000 for Fiscal Year 2020, as opposed to over $200,000 in prior years. Additionally, purposely holding positions open means that a portion of the Division's work is not getting done.

Expenditures continue to increase for a number of predictable reasons, such as the general inflationary increases in personnel and travel costs over the past several years. The Division has been managing these expenditures through efforts like process efficiencies and the use of vacancy savings due to difficulties arising from health care staffing shortages in general. The Division, however, continues to experience high numbers of complaints, driving investigation workload. While generally increasing, complaints are variable and unpredictable, which makes it important to have revenues at a high enough level to investigate complaints coming

in, even in a higher-than typical year. The following table shows complaint variability, as well as overall growth:

General Licensure Cash Fund—Facility and Complaint Growth FY 2016 to FY 2019					
	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019	Percentage Increase/Decrease FY 16 to FY 19
Number of Facilities	892	905	912	902	1.1%
Number of Complaint Intakes	752	903	1,256	948	26.1%
Number of Complaint Allegations	2,384	2,910	4,007	2,912	22.1%
Top 3 Complaint Allegation Categories:					
Nursing Services	807	1,132	1,278	1,191	47.6%
Patient Rights	261	330	442	308	18.0%
Quality of Care	324	329	594	286	-11.7%

These needed expenditure increases cannot be offset by efforts previously used by the Division, and as a result the Division expects expenditures to exceed revenues by approximately $201,109 in Fiscal Year 2019-20, even after purposely holding $110,000 worth of positions vacant and using $237,592 of General Fund monies. If the Division were to fill positions to the full appropriated level and use only the General Licensure Fund money without supplementing with General Fund, the shortfall would be $542,132. The Division, therefore, is seeking a fee increase for all fees that pay into the fund to reduce the expected revenue shortfall.

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., limit fee increases for the fees paid into the General Licensure fund to no more than the annual increase in the Consumer Price Index (CPI) for Denver-Aurora-Lakewood. For the time period July 1, 2018 through June 30, 2019 (Fiscal Year 2018-19), that specific CPI increased by 1.2872426%. Therefore, consistent with statutory constraints, the Division is requesting that all fees paid into the General Licensure Fund be increased by that amount. This increase is expected to generate $28,437, based on the numbers and types of facilities currently licensed. Even with this full increase allowed by statute, the revenues for the General Licensure Fund are expected to be approximately $661,012 less than what is needed to fully fund the full, appropriate direct and indirect costs of licensing, oversight, and enforcement activities for the 902 facilities that pay into the fund for Fiscal Year 2021. The Division anticipates requesting the CPI-based fee increases annually going forward.

The Department requests that the fee increases be effective July 1, 2020.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), 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 incorporate materials by reference?

_____ Yes ___ URL

___x___ No

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

___x___ Yes

_____ 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.

REGULATORY ANALYSIS
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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/S/B
Facilities paying Chapter 2 fees	31	C
Facilities paying Chapter 4 fees	94	C
Facilities paying Chapter 5 fees	230	C
Facilities paying Chapter 8 fees	142	C
Facilities paying Chapter 9 fees	77	C
Facilities paying Chapter 10 fees	5	C
Facilities paying Chapter 15 fees	80	C
Facilities paying Chapter 18 fees	12	C
Facilities paying Chapter 19 fees	2	C
Facilities paying Chapter 20 fees	127	C
Facilities paying Chapter 21 fees	102	C
Industry/advocacy organizations for the facility types covered above	6	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.

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.

C: Fees are increased by 1.2872426% in the included chapters, causing an estimated total additional cost to licensed facilities of $28,438. The actual additional cost for a specific facility varies depending on the amount of its current fee (e.g., a facility with a current fee amount of $371.44 would see a fee increase of $4.78 per year, while a facility with a current fee of $6,190.62 would see a fee increase of $79.69). The following table provides details on the specific fees by chapter, the amounts of the requested increases, and the increased fee totals. It is important to note that facilities pay only the fee(s) that apply to them (e.g., a new facility pays for an initial license, an existing facility pays for a renewal license).

Entity Type Type of fee	Current Fee	Increase	New Fee
Chapter 2 – General Licensure Standards (31 Facilities)			
Initial License	$371.44	$4.78	$376.22
Renewal License	$371.44	$4.78	$376.22
Conditional License	$1,547.65	$19.92	$1,567.57
Provisional License	$1,031.77	$13.28	$1,045.05
Change of Ownership	$371.44	$4.78	$376.22
Change in Licensed Capacity	$371.44	$4.78	$376.22
Change of Name	$77.38	$1.00	$78.38
Chapter 4 – General Hospitals (94 Facilities)			
Initial License:			
1-25 beds	$8,254.15	$106.25	$8,360.40
26-50 beds	$10,317.69	$132.81	$10,450.50
51-100 beds	$12,897.12	$166.02	$13,063.14
101+ beds (base/per bed/fee cap)	$10,111.34/$51.59/ $20,635.39	$130.16/$0.66/ $265.63	$10,241.50/$52.25/ $20,901.02
Certified Long Term Hospital (base/per bed/fee cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License:			
Deemed 1-50 beds (base/per bed)	$835.73/$12.38	$10.76/$0.16	$846.49/$12.54
Non-deemed 1-50 beds (base/per bed)	$928.59/$12.38	$11.95/$0.16	$940.54/$12.54
Deemed 51-150 beds (base/per bed)	$1,300.03/$12.38	$16.73/$0.16	$1,316.76/$12.54
Non-deemed 51-150 beds (base/per bed)	$1,444.48/$12.38	$18.59/$0.16	$1,463.07/$12.54
Deemed 151+ beds (base/per bed/fee cap)	$1,857.18/$12.38/ $8,254.15	$23.91/$0.16/ $106.25	$1,881.09/$12.54/ $8,360.40

Non-Deemed 151+beds (base/per bed/fee cap)	$2,063.54/$12.38/ $8,254.15	$26.56/$0.16/ $106.25	$2,090.10/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Off-campus location addition—Critical Access Hospital	$515.88	$6.64	$522.52
Off-campus location addition	$1,031.77	$13.28	$1,045.05
Off-campus location renewal—deemed facility	$464.30	$5.98	$470.28
Off-campus location renewal	$515.88	$6.64	$522.52
Off-campus location removal	$371.44	$4.78	$376.22
Chapter 5 – Nursing Care Facilities (230 Facilities)			
Initial License	$6,190.62	$79.69	$6,270.31
Renewal License			
Certified Facilities—Medicare or Medicaid (base/per bed)	$1,650.83/$8.25	$21.25/$.11	$1,672.08/$8.36
Non-certified Facilities (base/per bed)	$3,590.56/$8.25	$46.22/$0.11	$3,636.78/$8.36
Change of Ownership	$6,190.62	$79.69	$6,270.31
Opening a Secure Unit	$1,650.83	$21.25	$1,672.08
Chapter 8 – Facilities for Persons with Intellectual or Developmental Disabilities (142 Facilities)			
Initial License			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Renewal License			
Community Residential Home	$773.83	$9.96	$783.79
Intermediate Care Facility	$1,650.83	$21.25	$1,672.08
Change of Ownership			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Chapter 9 – Community Clinics and Community Clinics and Emergency Centers (77 Facilities)			
Initial License			
Community Emergency Center	$2,837.37	$36.52	$2,873.89
Clinic Operating Inpatient Beds	$2,837.37	$36.52	$2,873.89
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,238.12	$15.94	$1,254.06
Other Clinic	$2,476.25	$31.88	$2,508.13
Renewal License			
Community Emergency	$1,392.89	$17.93	$1,410.82

Center			
Clinic Operating Inpatient Beds	$1,392.89	$17.93	$1,410.82
Clinic Operated Under Auspices of Department of Corrections	$1,341.30	$17.27	$1,358.57
Clinic Serving Un/Underinsured	$619.06	$7.97	$627.03
Other Clinic	$1,238.12	$15.94	$1,254.06
Change of Ownership			
Community Emergency Center	$3,198.48	$41.17	$3,239.65
Clinic Operating Inpatient Beds	$3,198.48	$41.17	$3,239.65
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,289.71	$16.60	$1,306.31
Other Clinic	$2,579.42	$33.20	$2,612.62
Chapter 10 - Rehabilitation Hospitals (5 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 15 - Dialysis Treatment Clinics (80 Facilities)			
Initial License	$5,303.29	$68.27	$5,371.56
Renewal License			
1-12 Stations	$1,650.83	$21.25	$1,672.08
13-23 Stations	$2,600.06	$33.47	$2,633.53
24+ Stations	$3,544.13	$45.62	$3,589.75
Change of Ownership	$5,303.29	$68.27	$5,371.56
Chapter 18 - Psychiatric Hospitals (12 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 19 - Hospital Units (2 Facilities)			
Initial License (base/per bed/ fee cap)	$5,468.38/$51.59/ $10,833.58	$70.39/$0.66/ $139.45	$5,538.77/$52.25/ $10,973.03
Renewal License (base/per bed/ fee cap)	$1,650.83/$12.38/ $3,095.31	$21.25/$0.16/ $39.84	$1,672.08/$12.54/ $3,135.15
Change of Ownership	$2,579.42	$33.20	$2,612.62

Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 20 - Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center (127 Facilities)			
Initial License			
Ambulatory Surgical Center (ASC)	$6,809.68	$87.66	$6,897.34
Ambulatory Surgical Center with Convalescent Center	$7,181.11	$92.44	$7,273.55
Add Convalescent Center to an existing license	$371.44	$4.78	$376.22
Renewal License			
Non-deemed ASC (base/per procedure room/fee cap)	$1,485.75/$206.35/ $3,095.31	$19.13/$2.66/ $39.84	$1,504.88/$209.01/ $3,135.15
Deemed ASC (base/per procedure room/ fee cap)	$1,337.18/$206.35/ $3,095.31	$17.21/$2.66/ $39.84	$1,354.39/$209.01/ $3,135.15
Additional fee for a Convalescent Center	$371.44	$4.78	$376.22
Renewal fee cap for ASC with Convalescent Center	$3,466.74	$44.63	$3,511.37
Change of Ownership			
ASC	$4,230.25	$54.45	$4,284.70
ASC with Convalescent Center	$4,601.69	$59.23	$4,660.92
Provisional			
ASC	$2,579.42	$33.20	$2,612.62
ASC with Convalescent Center	$2,950.86	$37.98	$2,988.84
Chapter 21 - Hospices (102 Facilities)			
Initial License	$6,572.37	$84.60	$6,656.97
Initial License if no other licensed hospice within 60 miles	$4,281.84	$55.12	$4,336.96
Renewal			
Base fee (if no other conditions are met)	$4,023.90	$51.80	$4,075.70
Not in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld counties and providing 75 percent of services outside those counties	$2,476.25	$31.88	$2,508.13
Fewer than 2,000 annual patient dates per most recent Medicare cost report	$1,547.65	$19.92	$1,567.57
Fewer than 1,000 annual	$773.83	$9.96	$783.79

patient dates per most recent Medicare cost report Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area licensed as one entity	$6,603.32	$85.00	$6,688.32
Workstation (per workstation, paid for Initial License and Renewal License)	$51.59	$0.66	$52.25
Change of Ownership	$6,572.37	$84.60	$6,656.97

During the stakeholder process for this fee increase, the stakeholders did not present concerns about economic or non-economic impacts of the change. The benefit of the fee increase is to reduce the shortfall of revenues that support the Division's licensing, oversight, and enforcement activities. Reducing or eliminating these costs would mean that the Division would not have the resources necessary to protect the health, safety, and welfare of Coloradans being served in licensed health facilities.

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

S: N/A

B: N/A

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.

This rule-making is limited to a fee increase of 1.2872426%, thus generating $28,438 to support the Division's ability to protect the health, safety, and welfare of Coloradans being served by facilities ranging from hospitals to group homes.

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:

Licensing fees will continue to be collected and processed using existing procedures. Increasing the amount of the fees collected will not increase the resources needed to collect and process the fees, and thus this proposed fee increase will not have a cost impact on CDPHE.

Anticipated Other State Agency Costs:

The cost of a Community Clinic license for the clinics operated under the auspices of the Department of Corrections will increase $17.27 per clinic. There are currently 23 of these clinics, so the total cost impact of this increase for those clinics will be $397.21.

Anticipated CDPHE Revenues:

This fee increase is expected to generate approximately $28,438, but this amount will not fully fund the revenue shortfall in the General Licensure Fund. Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by General Licensure Fund revenues. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

This rulemaking modifies fees:

Facility-specific fee increases are listed in the table in response to Question 2, above.

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
_X__ Improve public and environmental health practice.
_X__ Implement stakeholder feedback.
___ 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:

The cost of inaction is the Division not exhausting every avenue to secure revenue to meet its expenditures. This in turn limits the Division's ability to fulfill its responsibilities related to licensing, oversight, and enforcement for hospitals, nursing homes, facilities for persons with intellectual and developmental disabilities, community clinics and community clinics with emergency centers, rehabilitation hospitals, dialysis treatment clinics, psychiatric hospitals, ambulatory surgical centers and ambulatory surgical centers with convalescent centers, hospices, and birth centers. The Division's inability to fully perform these functions negatively impacts the health, safety, and welfare of all Coloradans receiving treatment by or residing in these facilities.

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

   No other less costly method or less intrusive method was available as the fees are set in rule per statute.

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

   The Division's options for considering alternatives to the requested fee increase are constrained by the statutory restriction limiting fee increases to annual CPI at Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. The Division cannot request a larger fee increase without modification to statute. While the Division could raise fees at an amount lower than the CPI increase, this option was not selected because even the maximum increase allowed by statute does not generate enough revenue to offset the expected revenue shortfall.

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 used the federal Bureau of Labor Statistics Data, CPI-All Urban Consumers, Series CUURS48BSA0 (Denver-Lakewood-Aurora) to calculate the amount of fee increase allowed by Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., and then applied that percentage increase to all fees that are paid into the General Licensure Fund. The increases were rounded to the nearest penny.

STAKEHOLDER ENGAGEMENT
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Centers
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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:

Since this fee increase involves multiple types of facilities and has been an ongoing issue, the Division has chosen to discuss the need for the annual CPI-based increases in a number of different settings, primarily ongoing stakeholder advisory groups and forums such as the 1294 Stakeholder Forum.

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).

__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.

No major factual or policy issues were encountered.

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:

> This is solely a fee increase to maintain existing activities regarding health facility licensing, oversight, and enforcement activities. There are no anticipated impacts on determinants of health or other health equity and environmental justice considerations, values, or outcomes.

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 Chap 02

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 2 Licensure Process

****

2.13 License Fees

Unless explicitly set forth elsewhere in 6 CCR 1011-1 or statute, the following non-refundable fees shall apply and be submitted to the Department with the corresponding application or notification. More than one fee may apply depending upon the circumstances.

Initial license	~~$371.44~~ $376.22
Renewal license	~~$371.44~~ $376.22
Conditional license	~~$1,547.65~~ $1,567.57
First provisional license	~~$1,031.77~~ $1,045.05
Second provisional license	~~$1,031.77~~ $1,045.05
Change of ownership	~~$371.44~~ $376.22
Change in licensed capacity	~~$371.44~~ $376.22
Change of name	~~$77.38~~ $78.38
Renewal application late fee	Equal to the applicable renewal license fee including bed fees or operating/procedure room fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 04 - GENERAL HOSPITALS

6 CCR 1011-1 Chap 04

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES

3.101 SUBMITTAL OF FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows:

(a) See table below.

Number of Beds	Fee
1 - 25 beds	~~$8,254.15~~ $8,360.40
26 - 50 beds	~~$10,317.69~~ $10,450.50
51 - 100 beds	~~$12,897.12~~ $13,063.14
101 + beds	Base: ~~$10,111.34~~ $10,241.50
	Per bed: ~~$51.59~~ $52.25
	Cap: ~~$20,635.39~~ $20,901.02

(b) Notwithstanding the provisions of Section 3.101 (1)(a), the initial fee for facilities to be licensed as general hospitals but certified as long term hospitals pursuant to 42 CFR 482 et seq. shall submit: a base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee for long term hospitals shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the following table. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

Number of Beds	Fee	Fee with Deeming Discount
1 - 50 beds	Base: ~~$928.59~~ $940.54 Per bed: ~~$12.38~~ $12.54	Base: ~~$835.73~~ $846.49 Per bed: ~~$12.38~~ $12.54
51 - 150 beds	Base: ~~$1,444.48~~ $1,463.07 Per bed: ~~$12.38~~ $12.54	Base: ~~$1300.03~~ $1,316.76 Per bed: ~~$12.38~~ $12.54
151+ beds	Base: ~~$2,063.54~~ $2,090.10 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40	Base: ~~$1,857.18~~ $1,881.09 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

(5) Conditional License. A facility that is issued a conditional license by the Department shall submit a nonrefundable fee ranging from 10 to 25 percent of its applicable renewal fee. The Department shall assess the fee based on the anticipated costs of monitoring compliance with the conditional license. If the conditional license is issued concurrent with the initial or renewal license, the conditional license fee shall be in addition to the initial or renewal license fee.

(6) Other Regulatory Functions. If a facility requests an onsite inspection for a regulatory oversight function other than those listed in Sections 3.101 (1) through (3), the Department may conduct such onsite inspection upon notification to the facility of the fee in advance and payment thereof. The fee shall be calculated solely on the basis of the cost of conducting such survey. A detailed justification of the basis of the fee shall be provided to the facility upon request.

(7) Off-Campus Locations

(a) Addition, Annual Renewal and Termination of Off- Campus Locations. A licensee shall submit a nonrefundable fee, as set forth below, for the requested license action.

(i) ~~$1,031.77~~ $1,045.05 for the addition of each location to the list of off-campus locations under the license, except that critical access hospitals shall submit a nonrefundable fee of ~~$515.88~~ $522.52.

(ii) ~~$515.88~~ $522.52 for the annual renewal of each off-campus location listed under the license.

(iii) ~~$464.30~~ $470.28 for the annual renewal of licenses that expire on or after September 1, 2014, for each off-campus location that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(iv) ~~$371.44~~ $376.22 for the removal of each location from the list of off-campus locations under the license.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 5 - NURSING CARE FACILITIES

6 CCR 1011-1 Chap 05

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 32 LICENSING FEES

32.1 All license fees are non-refundable. The total fee shall be submitted with the appropriate license application.

32.2 Initial license - ~~$6,190.62~~ $6,270.31 per facility.

32.3 Renewal license - The annual renewal fee shall be as follows.

Medicare and/or Medicaid certified facility: ~~$1,650.83~~ $1,672.08 base fee plus ~~$8.25~~ $8.36 per bed.

Non-certified facility: ~~$3,590.56~~ $3,636.78 base fee plus ~~$8.25~~ $8.36 per bed.

32.4 Change of ownership - Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter 2, Part 2.7. The fee shall be ~~$6,190.62~~ $6,270.31 per facility.

32.5 Opening a secure unit - A facility that wishes to open a secure unit shall submit a fee of ~~$1,650.83~~ $1,672.08 in addition to any other applicable license fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 08 - FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

6 CCR 1011-1 Chap 08

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3 – Licensing Requirements

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3.4 License Fees

All license fees are non-refundable. More than one fee may apply depending upon the circumstances. The total fee shall be submitted with the appropriate license application.

(A) Initial License

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

(B) License Renewal

Effective July 1, ~~2019~~ 2020, the renewal fee shall be:

Community Residential Home: ~~$773.83~~ $783.79.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$1,650.83~~ $1,672.08.

(C) Change of ownership

Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter II, Part 2. The change of ownership fee shall be:

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 09 - COMMUNITY CLINICS AND COMMUNITY CLINICS AND EMERGENCY CENTERS

6 CCR 1011-1 Chap 09

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

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SUBCHAPTER IX.A - GENERAL REQUIREMENTS

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES.

(1) For new license applications received or renewal licenses that expire on or after July 1, ~~2019~~2020, a non-refundable fee shall be submitted with the license application as follows:

License Category	Initial license	Renewal license	Change of ownership
Community emergency center	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operating inpatient beds	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operated under the auspices of the Department of Corrections	~~$2,579.42~~ $2,612.62	~~$1,341.30~~ $1,358.57	~~$2,579.42~~ $2,612.62
Optional licensure pursuant to Section 2.101 (3)(a)(iv).			
Clinic serving the uninsured or underinsured:	~~$1,238.12~~ $1,254.06	~~$619.06~~ $627.03	~~$1,289.71~~ $1,306.31
Other clinic:	~~$2,476.25~~ $2,508.13	~~$1,238.12~~ $1,254.06	~~$2,579.42~~ $2,612.62

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 10 - REHABILITATION HOSPITALS

6 CCR 1011-1 Chap 10

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 15 - DIALYSIS TREATMENT CLINICS

6 CCR 1011-1 Chap 15

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3. FEES

3.1 License fees. All license fees are non-refundable and shall be submitted with the appropriate license application.

(A) Initial license fee - ~~$5,303.29~~ $5,371.56 per facility.

(B) Renewal license fee - For licenses that expire on or after July 1, ~~2019~~2020, the fee shall be based upon the maximum number of a facility's operational procedure stations as set forth below.

1 – 12 stations	~~$1,650.83~~ $1,672.08 per facility
13 – 23 stations	~~$2,600.06~~ $2,633.53 per facility
24 or more stations	~~$3,544.13~~ $3,589.75 per facility

(C) Change of ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, part 2. The fee shall be ~~$5,303.29~~ $5,371.56 per facility.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 18 - PSYCHIATRIC HOSPITALS

6 CCR 1011-1 Chap 18

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the department with an application for licensure as follows:

(1) Initial License: (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 19 - HOSPITAL UNITS

6 CCR 1011-1 Chap 19

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$5,468.38~~ $5,538.77 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License. A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(3) Change of Ownership. A license applicant shall submit a fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 20 - AMBULATORY SURGICAL CENTER AND AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

6 CCR 1011-1 Chap 20

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 24 - LICENSE FEES

24.1 As part of the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7, an applicant for an ambulatory surgical center license shall submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license: A license applicant shall submit with an application for licensure a nonrefundable fee of ~~$6,809.68~~ $6,897.34.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

BASE FEE	BASE FEE WITH DEEMING DISCOUNT	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,230.25~~ $4,284.70.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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SECTION 25 - AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

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25.7 License Fees: For new license applications received or renewal licenses that expire on or after March 1, 2015, an applicant for an ambulatory surgical center with a convalescent center license shall comply with the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7 and submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license:

(1) An applicant for an initial ambulatory surgical center with convalescent center license shall submit with an application for licensure a nonrefundable fee of ~~$7,181.11~~ $7,273.55.

(2) A current ambulatory surgical center licensee that applies to add a convalescent center to the license prior to the expiration of the surgical center license shall submit an application for initial licensure of the convalescent center along with a nonrefundable fee of ~~$371.44~~ $376.22. Upon expiration of the existing surgical center license term, the licensee shall follow the procedure set forth below for a renewal license.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,466.74~~ $3,511.37.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base ambulatory surgical center renewal fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

ASC BASE FEE	ASC BASE FEE WITH DEEMING DISCOUNT	CONVALESCENT CENTER FEE	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$371.44~~ $376.22	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,601.69~~ $4,660.92.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,950.86~~ $2,988.84. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 21 - HOSPICES

6 CCR 1011-1 Chap 21

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 14 LICENSE FEES

14.1 All license fees are non-refundable and the applicable fee total shall be submitted with the appropriate license application.

14.2 Initial License - ~~$6,572.37~~ $6,656.97 per hospice.

(A) If there are no licensed hospices within a 60-mile radius of the hospice applying for an initial license, the initial license fee shall be ~~$4,281.84~~ $4,336.96 per hospice.

14.3 Annual Renewal License

(A) For licenses expiring on or after July 1, ~~2019~~ 2020, the base renewal fee shall be ~~$4,023.90~~ $4,075.70 per hospice. The total renewal fee shall reflect all applicable adjustments as set forth below.

(1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be ~~$2,476.25~~ $2,508.13 per hospice.

(2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$1,547.65~~ $1,567.57 per hospice.

(3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$773.83~~ $783.79 per hospice.

(4) A discount of $300 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location.

(5) A discount of $425 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

(6) Upon request, the department may waive the fee for a hospice that demonstrates it is a not for profit organization that charges no fees and is staffed entirely by uncompensated volunteers.

(7) Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area shall be licensed as one entity. The fee shall be ~~$6,603.32~~ $6,688.32 and no other discounts shall apply except as set forth in (7)(a).

(a) A discount of $640 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

14.4 Workstation Fees

(A) A workstation is an offsite location maintained solely for the convenience of hospice staff to access policies and procedures, obtain forms or use various electronic communication tools. A workstation shall not contain patient records or be used for patient admissions and shall not display any public signage.

(B) In addition to any other licensure fees, a hospice that operates one or more satellite workstations shall pay an annual fee of ~~$51.59~~ $52.25 per workstation. The fee shall be submitted with the initial and/or renewal license application.

14.5 Change of Ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, Part 2. The fee shall be ~~$6,572.37~~ $6,656.97 per hospice.

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COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing Scheduled for April 15, 2020

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 April 15, 2020 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive, South, Denver, CO 80246, to consider the revision of the follow chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities:

- Chapter 2 - General Licensure Standards
- Chapter 4 - General Hospitals
- Chapter 5 - Nursing Care Facilities
- Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
- Chapter 9 - Community Clinics and Community Clinics and Emergency Services
- Chapter 10 - Rehabilitation Hospitals
- Chapter 15 - Dialysis Treatment Clinics
- Chapter 18 - Psychiatric Hospitals
- Chapter 19 - Hospital Units
- Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
- Chapter 21 - Hospices

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426%. The proposed rules have been developed by the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment pursuant to Section Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://www.colorado.gov/pacific/cdphe/boh 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 working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-2999.

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, April 9, 2020. 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 27th day of February, 2020.

Alexandra S. Haas

Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00104

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 18

Rule title

CHAPTER 18 - PSYCHIATRIC HOSPITALS

Rulemaking Hearing

Date

04/15/2020

Time

10:00 AM

Location

Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246

Subjects and issues involved

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426% to provide an additional $28,438 in revenue.

Statutory authority

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

Contact information

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Grace Sandeno

Title

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303-692-2859

Email

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Kim Fear, Branch Chief, Fiscal & Administrative Services Branch, HFEMSD

Through: D. Randy Kuykendall, Director, DRK

Date: February 19, 2020

Subject: **Request for a Rulemaking Hearing** concerning increasing licensure fees in the following chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities in April 2020:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

In April 2019, the Division appeared before the Board with a request to increase the fees that licensees pay into the General Licensure Cash Fund (General Licensure Fund). At that time, the Division explained that over several years, expenditures from the General Licensure Fund had increased 24.6%, while the revenues paid into that fund had increased by only 0.6%. The requested fee increase was for 3.1769267%, which was expected to generate about $66,850. This amount was not expected to address the full difference between revenues and expenditures of the General Licensure Fund, but was the maximum the Board could increase fees due to Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. (As of June 4, 2012, the Board of Health may only increase the fees collected by the annual percentage change of the consumer price index for Denver-Aurora-Lakewood.)

Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund

monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

The Division is now requesting to increase fees paid into the General Licensure Fund by 1.2872426%, which again will not fully fund the expenditures of the General Licensure Fund, but is the maximum the Board may increase fees. This fee increase is expected to provide an additional $28,438 in revenue, but this amount will not be enough to offset the expected revenue shortfall in Fiscal Year 2021 and following years, so the Division anticipates requesting additional CPI-limited fee increases on a yearly basis going forward.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

Basis and Purpose.

HFEMSD's health facility licensing, oversight, and enforcement activities are funded through the collection of fees approved by the Board of Health. The fees paid by facilities licensed by the Division, with the exception of Assisted Living Residences (ALRs) and Home Care Agencies, are deposited to the Health Facilities General Licensure Cash Fund (General Licensure Fund), which is then the source of appropriations to the Division for its licensure and oversight activities. In accordance with Section 25-3-105(1)(a)(I)(A), C.R.S, fees are to be set at a level sufficient to meet the direct and indirect costs of these activities.

Although the Board approved a 3.1769267% fee increase for Fiscal Year 2020 (the maximum allowed by statute), the fees being paid into the General Licensure Fund remain insufficient to meet the Division's direct and indirect costs. Since the April 2019 fee increase request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable. For example, the ability to use fund balance will be eliminated, as the balance of the General Licensure Fund is estimated to be approximately $12,000 for Fiscal Year 2020, as opposed to over $200,000 in prior years. Additionally, purposely holding positions open means that a portion of the Division's work is not getting done.

Expenditures continue to increase for a number of predictable reasons, such as the general inflationary increases in personnel and travel costs over the past several years. The Division has been managing these expenditures through efforts like process efficiencies and the use of vacancy savings due to difficulties arising from health care staffing shortages in general. The Division, however, continues to experience high numbers of complaints, driving investigation workload. While generally increasing, complaints are variable and unpredictable, which makes it important to have revenues at a high enough level to investigate complaints coming

in, even in a higher-than typical year. The following table shows complaint variability, as well as overall growth:

General Licensure Cash Fund—Facility and Complaint Growth FY 2016 to FY 2019					
	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019	Percentage Increase/Decrease FY 16 to FY 19
Number of Facilities	892	905	912	902	1.1%
Number of Complaint Intakes	752	903	1,256	948	26.1%
Number of Complaint Allegations	2,384	2,910	4,007	2,912	22.1%
Top 3 Complaint Allegation Categories:					
Nursing Services	807	1,132	1,278	1,191	47.6%
Patient Rights	261	330	442	308	18.0%
Quality of Care	324	329	594	286	-11.7%

These needed expenditure increases cannot be offset by efforts previously used by the Division, and as a result the Division expects expenditures to exceed revenues by approximately $201,109 in Fiscal Year 2019-20, even after purposely holding $110,000 worth of positions vacant and using $237,592 of General Fund monies. If the Division were to fill positions to the full appropriated level and use only the General Licensure Fund money without supplementing with General Fund, the shortfall would be $542,132. The Division, therefore, is seeking a fee increase for all fees that pay into the fund to reduce the expected revenue shortfall.

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., limit fee increases for the fees paid into the General Licensure fund to no more than the annual increase in the Consumer Price Index (CPI) for Denver-Aurora-Lakewood. For the time period July 1, 2018 through June 30, 2019 (Fiscal Year 2018-19), that specific CPI increased by 1.2872426%. Therefore, consistent with statutory constraints, the Division is requesting that all fees paid into the General Licensure Fund be increased by that amount. This increase is expected to generate $28,437, based on the numbers and types of facilities currently licensed. Even with this full increase allowed by statute, the revenues for the General Licensure Fund are expected to be approximately $661,012 less than what is needed to fully fund the full, appropriate direct and indirect costs of licensing, oversight, and enforcement activities for the 902 facilities that pay into the fund for Fiscal Year 2021. The Division anticipates requesting the CPI-based fee increases annually going forward.

The Department requests that the fee increases be effective July 1, 2020.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), 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 incorporate materials by reference?

_____ Yes ___ URL

___x___ No

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

___x___ Yes

_____ 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.

REGULATORY ANALYSIS
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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/S/B
Facilities paying Chapter 2 fees	31	C
Facilities paying Chapter 4 fees	94	C
Facilities paying Chapter 5 fees	230	C
Facilities paying Chapter 8 fees	142	C
Facilities paying Chapter 9 fees	77	C
Facilities paying Chapter 10 fees	5	C
Facilities paying Chapter 15 fees	80	C
Facilities paying Chapter 18 fees	12	C
Facilities paying Chapter 19 fees	2	C
Facilities paying Chapter 20 fees	127	C
Facilities paying Chapter 21 fees	102	C
Industry/advocacy organizations for the facility types covered above	6	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.

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.

C: Fees are increased by 1.2872426% in the included chapters, causing an estimated total additional cost to licensed facilities of $28,438. The actual additional cost for a specific facility varies depending on the amount of its current fee (e.g., a facility with a current fee amount of $371.44 would see a fee increase of $4.78 per year, while a facility with a current fee of $6,190.62 would see a fee increase of $79.69). The following table provides details on the specific fees by chapter, the amounts of the requested increases, and the increased fee totals. It is important to note that facilities pay only the fee(s) that apply to them (e.g., a new facility pays for an initial license, an existing facility pays for a renewal license).

Entity Type Type of fee	Current Fee	Increase	New Fee
Chapter 2 – General Licensure Standards (31 Facilities)			
Initial License	$371.44	$4.78	$376.22
Renewal License	$371.44	$4.78	$376.22
Conditional License	$1,547.65	$19.92	$1,567.57
Provisional License	$1,031.77	$13.28	$1,045.05
Change of Ownership	$371.44	$4.78	$376.22
Change in Licensed Capacity	$371.44	$4.78	$376.22
Change of Name	$77.38	$1.00	$78.38
Chapter 4 – General Hospitals (94 Facilities)			
Initial License:			
1-25 beds	$8,254.15	$106.25	$8,360.40
26-50 beds	$10,317.69	$132.81	$10,450.50
51-100 beds	$12,897.12	$166.02	$13,063.14
101+ beds (base/per bed/fee cap)	$10,111.34/$51.59/ $20,635.39	$130.16/$0.66/ $265.63	$10,241.50/$52.25/ $20,901.02
Certified Long Term Hospital (base/per bed/fee cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License:			
Deemed 1-50 beds (base/per bed)	$835.73/$12.38	$10.76/$0.16	$846.49/$12.54
Non-deemed 1-50 beds (base/per bed)	$928.59/$12.38	$11.95/$0.16	$940.54/$12.54
Deemed 51-150 beds (base/per bed)	$1,300.03/$12.38	$16.73/$0.16	$1,316.76/$12.54
Non-deemed 51-150 beds (base/per bed)	$1,444.48/$12.38	$18.59/$0.16	$1,463.07/$12.54
Deemed 151+ beds (base/per bed/fee cap)	$1,857.18/$12.38/ $8,254.15	$23.91/$0.16/ $106.25	$1,881.09/$12.54/ $8,360.40

Non-Deemed 151+beds (base/per bed/fee cap)	$2,063.54/$12.38/ $8,254.15	$26.56/$0.16/ $106.25	$2,090.10/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Off-campus location addition—Critical Access Hospital	$515.88	$6.64	$522.52
Off-campus location addition	$1,031.77	$13.28	$1,045.05
Off-campus location renewal—deemed facility	$464.30	$5.98	$470.28
Off-campus location renewal	$515.88	$6.64	$522.52
Off-campus location removal	$371.44	$4.78	$376.22
Chapter 5 – Nursing Care Facilities (230 Facilities)			
Initial License	$6,190.62	$79.69	$6,270.31
Renewal License			
Certified Facilities—Medicare or Medicaid (base/per bed)	$1,650.83/$8.25	$21.25/$.11	$1,672.08/$8.36
Non-certified Facilities (base/per bed)	$3,590.56/$8.25	$46.22/$0.11	$3,636.78/$8.36
Change of Ownership	$6,190.62	$79.69	$6,270.31
Opening a Secure Unit	$1,650.83	$21.25	$1,672.08
Chapter 8 – Facilities for Persons with Intellectual or Developmental Disabilities (142 Facilities)			
Initial License			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Renewal License			
Community Residential Home	$773.83	$9.96	$783.79
Intermediate Care Facility	$1,650.83	$21.25	$1,672.08
Change of Ownership			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Chapter 9 – Community Clinics and Community Clinics and Emergency Centers (77 Facilities)			
Initial License			
Community Emergency Center	$2,837.37	$36.52	$2,873.89
Clinic Operating Inpatient Beds	$2,837.37	$36.52	$2,873.89
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,238.12	$15.94	$1,254.06
Other Clinic	$2,476.25	$31.88	$2,508.13
Renewal License			
Community Emergency	$1,392.89	$17.93	$1,410.82

Center			
Clinic Operating Inpatient Beds	$1,392.89	$17.93	$1,410.82
Clinic Operated Under Auspices of Department of Corrections	$1,341.30	$17.27	$1,358.57
Clinic Serving Un/Underinsured	$619.06	$7.97	$627.03
Other Clinic	$1,238.12	$15.94	$1,254.06
Change of Ownership			
Community Emergency Center	$3,198.48	$41.17	$3,239.65
Clinic Operating Inpatient Beds	$3,198.48	$41.17	$3,239.65
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,289.71	$16.60	$1,306.31
Other Clinic	$2,579.42	$33.20	$2,612.62
Chapter 10 - Rehabilitation Hospitals (5 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 15 - Dialysis Treatment Clinics (80 Facilities)			
Initial License	$5,303.29	$68.27	$5,371.56
Renewal License			
1-12 Stations	$1,650.83	$21.25	$1,672.08
13-23 Stations	$2,600.06	$33.47	$2,633.53
24+ Stations	$3,544.13	$45.62	$3,589.75
Change of Ownership	$5,303.29	$68.27	$5,371.56
Chapter 18 - Psychiatric Hospitals (12 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 19 - Hospital Units (2 Facilities)			
Initial License (base/per bed/ fee cap)	$5,468.38/$51.59/ $10,833.58	$70.39/$0.66/ $139.45	$5,538.77/$52.25/ $10,973.03
Renewal License (base/per bed/ fee cap)	$1,650.83/$12.38/ $3,095.31	$21.25/$0.16/ $39.84	$1,672.08/$12.54/ $3,135.15
Change of Ownership	$2,579.42	$33.20	$2,612.62

Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 20 - Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center (127 Facilities)			
Initial License			
Ambulatory Surgical Center (ASC)	$6,809.68	$87.66	$6,897.34
Ambulatory Surgical Center with Convalescent Center	$7,181.11	$92.44	$7,273.55
Add Convalescent Center to an existing license	$371.44	$4.78	$376.22
Renewal License			
Non-deemed ASC (base/per procedure room/fee cap)	$1,485.75/$206.35/ $3,095.31	$19.13/$2.66/ $39.84	$1,504.88/$209.01/ $3,135.15
Deemed ASC (base/per procedure room/ fee cap)	$1,337.18/$206.35/ $3,095.31	$17.21/$2.66/ $39.84	$1,354.39/$209.01/ $3,135.15
Additional fee for a Convalescent Center	$371.44	$4.78	$376.22
Renewal fee cap for ASC with Convalescent Center	$3,466.74	$44.63	$3,511.37
Change of Ownership			
ASC	$4,230.25	$54.45	$4,284.70
ASC with Convalescent Center	$4,601.69	$59.23	$4,660.92
Provisional			
ASC	$2,579.42	$33.20	$2,612.62
ASC with Convalescent Center	$2,950.86	$37.98	$2,988.84
Chapter 21 - Hospices (102 Facilities)			
Initial License	$6,572.37	$84.60	$6,656.97
Initial License if no other licensed hospice within 60 miles	$4,281.84	$55.12	$4,336.96
Renewal			
Base fee (if no other conditions are met)	$4,023.90	$51.80	$4,075.70
Not in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld counties and providing 75 percent of services outside those counties	$2,476.25	$31.88	$2,508.13
Fewer than 2,000 annual patient dates per most recent Medicare cost report	$1,547.65	$19.92	$1,567.57
Fewer than 1,000 annual	$773.83	$9.96	$783.79

patient dates per most recent Medicare cost report Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area licensed as one entity	$6,603.32	$85.00	$6,688.32
Workstation (per workstation, paid for Initial License and Renewal License)	$51.59	$0.66	$52.25
Change of Ownership	$6,572.37	$84.60	$6,656.97

During the stakeholder process for this fee increase, the stakeholders did not present concerns about economic or non-economic impacts of the change. The benefit of the fee increase is to reduce the shortfall of revenues that support the Division's licensing, oversight, and enforcement activities. Reducing or eliminating these costs would mean that the Division would not have the resources necessary to protect the health, safety, and welfare of Coloradans being served in licensed health facilities.

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

S: N/A

B: N/A

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.

This rule-making is limited to a fee increase of 1.2872426%, thus generating $28,438 to support the Division's ability to protect the health, safety, and welfare of Coloradans being served by facilities ranging from hospitals to group homes.

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:

Licensing fees will continue to be collected and processed using existing procedures. Increasing the amount of the fees collected will not increase the resources needed to collect and process the fees, and thus this proposed fee increase will not have a cost impact on CDPHE.

Anticipated Other State Agency Costs:

The cost of a Community Clinic license for the clinics operated under the auspices of the Department of Corrections will increase $17.27 per clinic. There are currently 23 of these clinics, so the total cost impact of this increase for those clinics will be $397.21.

Anticipated CDPHE Revenues:

This fee increase is expected to generate approximately $28,438, but this amount will not fully fund the revenue shortfall in the General Licensure Fund. Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by General Licensure Fund revenues. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

This rulemaking modifies fees:

Facility-specific fee increases are listed in the table in response to Question 2, above.

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
_X__ Improve public and environmental health practice.
_X__ Implement stakeholder feedback.
___ 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:

The cost of inaction is the Division not exhausting every avenue to secure revenue to meet its expenditures. This in turn limits the Division's ability to fulfill its responsibilities related to licensing, oversight, and enforcement for hospitals, nursing homes, facilities for persons with intellectual and developmental disabilities, community clinics and community clinics with emergency centers, rehabilitation hospitals, dialysis treatment clinics, psychiatric hospitals, ambulatory surgical centers and ambulatory surgical centers with convalescent centers, hospices, and birth centers. The Division's inability to fully perform these functions negatively impacts the health, safety, and welfare of all Coloradans receiving treatment by or residing in these facilities.

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

   No other less costly method or less intrusive method was available as the fees are set in rule per statute.

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

   The Division's options for considering alternatives to the requested fee increase are constrained by the statutory restriction limiting fee increases to annual CPI at Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. The Division cannot request a larger fee increase without modification to statute. While the Division could raise fees at an amount lower than the CPI increase, this option was not selected because even the maximum increase allowed by statute does not generate enough revenue to offset the expected revenue shortfall.

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 used the federal Bureau of Labor Statistics Data, CPI-All Urban Consumers, Series CUURS48BSA0 (Denver-Lakewood-Aurora) to calculate the amount of fee increase allowed by Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., and then applied that percentage increase to all fees that are paid into the General Licensure Fund. The increases were rounded to the nearest penny.

STAKEHOLDER ENGAGEMENT
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
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Chapter 21 - Hospices

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:

Since this fee increase involves multiple types of facilities and has been an ongoing issue, the Division has chosen to discuss the need for the annual CPI-based increases in a number of different settings, primarily ongoing stakeholder advisory groups and forums such as the 1294 Stakeholder Forum.

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).

__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.

No major factual or policy issues were encountered.

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:

> This is solely a fee increase to maintain existing activities regarding health facility licensing, oversight, and enforcement activities. There are no anticipated impacts on determinants of health or other health equity and environmental justice considerations, values, or outcomes.

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 Chap 02

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 2 Licensure Process

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2.13 License Fees

Unless explicitly set forth elsewhere in 6 CCR 1011-1 or statute, the following non-refundable fees shall apply and be submitted to the Department with the corresponding application or notification. More than one fee may apply depending upon the circumstances.

Initial license	~~$371.44~~ $376.22
Renewal license	~~$371.44~~ $376.22
Conditional license	~~$1,547.65~~ $1,567.57
First provisional license	~~$1,031.77~~ $1,045.05
Second provisional license	~~$1,031.77~~ $1,045.05
Change of ownership	~~$371.44~~ $376.22
Change in licensed capacity	~~$371.44~~ $376.22
Change of name	~~$77.38~~ $78.38
Renewal application late fee	Equal to the applicable renewal license fee including bed fees or operating/procedure room fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 04 - GENERAL HOSPITALS

6 CCR 1011-1 Chap 04

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES

3.101 SUBMITTAL OF FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows:

(a) See table below.

Number of Beds	Fee
1 - 25 beds	~~$8,254.15~~ $8,360.40
26 - 50 beds	~~$10,317.69~~ $10,450.50
51 - 100 beds	~~$12,897.12~~ $13,063.14
101 + beds	Base: ~~$10,111.34~~ $10,241.50
	Per bed: ~~$51.59~~ $52.25
	Cap: ~~$20,635.39~~ $20,901.02

(b) Notwithstanding the provisions of Section 3.101 (1)(a), the initial fee for facilities to be licensed as general hospitals but certified as long term hospitals pursuant to 42 CFR 482 et seq. shall submit: a base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee for long term hospitals shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the following table. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

Number of Beds	Fee	Fee with Deeming Discount
1 - 50 beds	Base: ~~$928.59~~ $940.54 Per bed: ~~$12.38~~ $12.54	Base: ~~$835.73~~ $846.49 Per bed: ~~$12.38~~ $12.54
51 - 150 beds	Base: ~~$1,444.48~~ $1,463.07 Per bed: ~~$12.38~~ $12.54	Base: ~~$1300.03~~ $1,316.76 Per bed: ~~$12.38~~ $12.54
151+ beds	Base: ~~$2,063.54~~ $2,090.10 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40	Base: ~~$1,857.18~~ $1,881.09 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

(5) Conditional License. A facility that is issued a conditional license by the Department shall submit a nonrefundable fee ranging from 10 to 25 percent of its applicable renewal fee. The Department shall assess the fee based on the anticipated costs of monitoring compliance with the conditional license. If the conditional license is issued concurrent with the initial or renewal license, the conditional license fee shall be in addition to the initial or renewal license fee.

(6) Other Regulatory Functions. If a facility requests an onsite inspection for a regulatory oversight function other than those listed in Sections 3.101 (1) through (3), the Department may conduct such onsite inspection upon notification to the facility of the fee in advance and payment thereof. The fee shall be calculated solely on the basis of the cost of conducting such survey. A detailed justification of the basis of the fee shall be provided to the facility upon request.

(7) Off-Campus Locations

(a) Addition, Annual Renewal and Termination of Off- Campus Locations. A licensee shall submit a nonrefundable fee, as set forth below, for the requested license action.

(i) ~~$1,031.77~~ $1,045.05 for the addition of each location to the list of off-campus locations under the license, except that critical access hospitals shall submit a nonrefundable fee of ~~$515.88~~ $522.52.

(ii) ~~$515.88~~ $522.52 for the annual renewal of each off-campus location listed under the license.

(iii) ~~$464.30~~ $470.28 for the annual renewal of licenses that expire on or after September 1, 2014, for each off-campus location that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(iv) ~~$371.44~~ $376.22 for the removal of each location from the list of off-campus locations under the license.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 5 - NURSING CARE FACILITIES

6 CCR 1011-1 Chap 05

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 32 LICENSING FEES

32.1 All license fees are non-refundable. The total fee shall be submitted with the appropriate license application.

32.2 Initial license - ~~$6,190.62~~ $6,270.31 per facility.

32.3 Renewal license - The annual renewal fee shall be as follows.

Medicare and/or Medicaid certified facility: ~~$1,650.83~~ $1,672.08 base fee plus ~~$8.25~~ $8.36 per bed.

Non-certified facility: ~~$3,590.56~~ $3,636.78 base fee plus ~~$8.25~~ $8.36 per bed.

32.4 Change of ownership - Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter 2, Part 2.7. The fee shall be ~~$6,190.62~~ $6,270.31 per facility.

32.5 Opening a secure unit - A facility that wishes to open a secure unit shall submit a fee of ~~$1,650.83~~ $1,672.08 in addition to any other applicable license fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 08 - FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

6 CCR 1011-1 Chap 08

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3 – Licensing Requirements

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3.4 License Fees

All license fees are non-refundable. More than one fee may apply depending upon the circumstances. The total fee shall be submitted with the appropriate license application.

(A) Initial License

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

(B) License Renewal

Effective July 1, ~~2019~~ 2020, the renewal fee shall be:

Community Residential Home: ~~$773.83~~ $783.79.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$1,650.83~~ $1,672.08.

(C) Change of ownership

Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter II, Part 2. The change of ownership fee shall be:

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 09 - COMMUNITY CLINICS AND COMMUNITY CLINICS AND EMERGENCY CENTERS

6 CCR 1011-1 Chap 09

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

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SUBCHAPTER IX.A - GENERAL REQUIREMENTS

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES.

(1) For new license applications received or renewal licenses that expire on or after July 1, ~~2019~~2020, a non-refundable fee shall be submitted with the license application as follows:

License Category	Initial license	Renewal license	Change of ownership
Community emergency center	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operating inpatient beds	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operated under the auspices of the Department of Corrections	~~$2,579.42~~ $2,612.62	~~$1,341.30~~ $1,358.57	~~$2,579.42~~ $2,612.62
Optional licensure pursuant to Section 2.101 (3)(a)(iv).			
Clinic serving the uninsured or underinsured:	~~$1,238.12~~ $1,254.06	~~$619.06~~ $627.03	~~$1,289.71~~ $1,306.31
Other clinic:	~~$2,476.25~~ $2,508.13	~~$1,238.12~~ $1,254.06	~~$2,579.42~~ $2,612.62

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 10 - REHABILITATION HOSPITALS

6 CCR 1011-1 Chap 10

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 15 - DIALYSIS TREATMENT CLINICS

6 CCR 1011-1 Chap 15

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3. FEES

3.1 License fees. All license fees are non-refundable and shall be submitted with the appropriate license application.

(A) Initial license fee - ~~$5,303.29~~ $5,371.56 per facility.

(B) Renewal license fee - For licenses that expire on or after July 1, ~~2019~~2020, the fee shall be based upon the maximum number of a facility's operational procedure stations as set forth below.

1 – 12 stations	~~$1,650.83~~ $1,672.08 per facility
13 – 23 stations	~~$2,600.06~~ $2,633.53 per facility
24 or more stations	~~$3,544.13~~ $3,589.75 per facility

(C) Change of ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, part 2. The fee shall be ~~$5,303.29~~ $5,371.56 per facility.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 18 - PSYCHIATRIC HOSPITALS

6 CCR 1011-1 Chap 18

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the department with an application for licensure as follows:

(1) Initial License: (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 19 - HOSPITAL UNITS

6 CCR 1011-1 Chap 19

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$5,468.38~~ $5,538.77 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License. A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(3) Change of Ownership. A license applicant shall submit a fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 20 - AMBULATORY SURGICAL CENTER AND AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

6 CCR 1011-1 Chap 20

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 24 - LICENSE FEES

24.1 As part of the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7, an applicant for an ambulatory surgical center license shall submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license: A license applicant shall submit with an application for licensure a nonrefundable fee of ~~$6,809.68~~ $6,897.34.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

BASE FEE	BASE FEE WITH DEEMING DISCOUNT	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,230.25~~ $4,284.70.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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SECTION 25 - AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

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25.7 License Fees: For new license applications received or renewal licenses that expire on or after March 1, 2015, an applicant for an ambulatory surgical center with a convalescent center license shall comply with the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7 and submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license:

(1) An applicant for an initial ambulatory surgical center with convalescent center license shall submit with an application for licensure a nonrefundable fee of ~~$7,181.11~~ $7,273.55.

(2) A current ambulatory surgical center licensee that applies to add a convalescent center to the license prior to the expiration of the surgical center license shall submit an application for initial licensure of the convalescent center along with a nonrefundable fee of ~~$371.44~~ $376.22. Upon expiration of the existing surgical center license term, the licensee shall follow the procedure set forth below for a renewal license.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,466.74~~ $3,511.37.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base ambulatory surgical center renewal fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

ASC BASE FEE	ASC BASE FEE WITH DEEMING DISCOUNT	CONVALESCENT CENTER FEE	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$371.44~~ $376.22	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,601.69~~ $4,660.92.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,950.86~~ $2,988.84. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 21 - HOSPICES

6 CCR 1011-1 Chap 21

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 14 LICENSE FEES

14.1 All license fees are non-refundable and the applicable fee total shall be submitted with the appropriate license application.

14.2 Initial License - ~~$6,572.37~~ $6,656.97 per hospice.

(A) If there are no licensed hospices within a 60-mile radius of the hospice applying for an initial license, the initial license fee shall be ~~$4,281.84~~ $4,336.96 per hospice.

14.3 Annual Renewal License

(A) For licenses expiring on or after July 1, ~~2019~~ 2020, the base renewal fee shall be ~~$4,023.90~~ $4,075.70 per hospice. The total renewal fee shall reflect all applicable adjustments as set forth below.

(1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be ~~$2,476.25~~ $2,508.13 per hospice.

(2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$1,547.65~~ $1,567.57 per hospice.

(3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$773.83~~ $783.79 per hospice.

(4) A discount of $300 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location.

(5) A discount of $425 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

(6) Upon request, the department may waive the fee for a hospice that demonstrates it is a not for profit organization that charges no fees and is staffed entirely by uncompensated volunteers.

(7) Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area shall be licensed as one entity. The fee shall be ~~$6,603.32~~ $6,688.32 and no other discounts shall apply except as set forth in (7)(a).

(a) A discount of $640 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

14.4 Workstation Fees

(A) A workstation is an offsite location maintained solely for the convenience of hospice staff to access policies and procedures, obtain forms or use various electronic communication tools. A workstation shall not contain patient records or be used for patient admissions and shall not display any public signage.

(B) In addition to any other licensure fees, a hospice that operates one or more satellite workstations shall pay an annual fee of ~~$51.59~~ $52.25 per workstation. The fee shall be submitted with the initial and/or renewal license application.

14.5 Change of Ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, Part 2. The fee shall be ~~$6,572.37~~ $6,656.97 per hospice.

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COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing Scheduled for April 15, 2020

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 April 15, 2020 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive, South, Denver, CO 80246, to consider the revision of the follow chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities:

- Chapter 2 - General Licensure Standards
- Chapter 4 - General Hospitals
- Chapter 5 - Nursing Care Facilities
- Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
- Chapter 9 - Community Clinics and Community Clinics and Emergency Services
- Chapter 10 - Rehabilitation Hospitals
- Chapter 15 - Dialysis Treatment Clinics
- Chapter 18 - Psychiatric Hospitals
- Chapter 19 - Hospital Units
- Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
- Chapter 21 - Hospices

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426%. The proposed rules have been developed by the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment pursuant to Section Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://www.colorado.gov/pacific/cdphe/boh 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 working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-2999.

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, April 9, 2020. 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 27th day of February, 2020.

Alexandra S. Haas

Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00105

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 19

Rule title

CHAPTER 19 - HOSPITAL UNITS

Rulemaking Hearing

Date

04/15/2020

Time

10:00 AM

Location

Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246

Subjects and issues involved

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426% to provide an additional $28,438 in revenue.

Statutory authority

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

Contact information

Name

Grace Sandeno

Title

Policy Advisor

Telephone

303-692-2859

Email

grace.sandeno@state.co.us

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Kim Fear, Branch Chief, Fiscal & Administrative Services Branch, HFEMSD

Through: D. Randy Kuykendall, Director, DRK

Date: February 19, 2020

Subject: **Request for a Rulemaking Hearing** concerning increasing licensure fees in the following chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities in April 2020:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

In April 2019, the Division appeared before the Board with a request to increase the fees that licensees pay into the General Licensure Cash Fund (General Licensure Fund). At that time, the Division explained that over several years, expenditures from the General Licensure Fund had increased 24.6%, while the revenues paid into that fund had increased by only 0.6%. The requested fee increase was for 3.1769267%, which was expected to generate about $66,850. This amount was not expected to address the full difference between revenues and expenditures of the General Licensure Fund, but was the maximum the Board could increase fees due to Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. (As of June 4, 2012, the Board of Health may only increase the fees collected by the annual percentage change of the consumer price index for Denver-Aurora-Lakewood.)

Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund

monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

The Division is now requesting to increase fees paid into the General Licensure Fund by 1.2872426%, which again will not fully fund the expenditures of the General Licensure Fund, but is the maximum the Board may increase fees. This fee increase is expected to provide an additional $28,438 in revenue, but this amount will not be enough to offset the expected revenue shortfall in Fiscal Year 2021 and following years, so the Division anticipates requesting additional CPI-limited fee increases on a yearly basis going forward.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
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Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

Basis and Purpose.

HFEMSD's health facility licensing, oversight, and enforcement activities are funded through the collection of fees approved by the Board of Health. The fees paid by facilities licensed by the Division, with the exception of Assisted Living Residences (ALRs) and Home Care Agencies, are deposited to the Health Facilities General Licensure Cash Fund (General Licensure Fund), which is then the source of appropriations to the Division for its licensure and oversight activities. In accordance with Section 25-3-105(1)(a)(I)(A), C.R.S, fees are to be set at a level sufficient to meet the direct and indirect costs of these activities.

Although the Board approved a 3.1769267% fee increase for Fiscal Year 2020 (the maximum allowed by statute), the fees being paid into the General Licensure Fund remain insufficient to meet the Division's direct and indirect costs. Since the April 2019 fee increase request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable. For example, the ability to use fund balance will be eliminated, as the balance of the General Licensure Fund is estimated to be approximately $12,000 for Fiscal Year 2020, as opposed to over $200,000 in prior years. Additionally, purposely holding positions open means that a portion of the Division's work is not getting done.

Expenditures continue to increase for a number of predictable reasons, such as the general inflationary increases in personnel and travel costs over the past several years. The Division has been managing these expenditures through efforts like process efficiencies and the use of vacancy savings due to difficulties arising from health care staffing shortages in general. The Division, however, continues to experience high numbers of complaints, driving investigation workload. While generally increasing, complaints are variable and unpredictable, which makes it important to have revenues at a high enough level to investigate complaints coming

in, even in a higher-than typical year. The following table shows complaint variability, as well as overall growth:

General Licensure Cash Fund—Facility and Complaint Growth FY 2016 to FY 2019					
	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019	Percentage Increase/Decrease FY 16 to FY 19
Number of Facilities	892	905	912	902	1.1%
Number of Complaint Intakes	752	903	1,256	948	26.1%
Number of Complaint Allegations	2,384	2,910	4,007	2,912	22.1%
Top 3 Complaint Allegation Categories:					
Nursing Services	807	1,132	1,278	1,191	47.6%
Patient Rights	261	330	442	308	18.0%
Quality of Care	324	329	594	286	-11.7%

These needed expenditure increases cannot be offset by efforts previously used by the Division, and as a result the Division expects expenditures to exceed revenues by approximately $201,109 in Fiscal Year 2019-20, even after purposely holding $110,000 worth of positions vacant and using $237,592 of General Fund monies. If the Division were to fill positions to the full appropriated level and use only the General Licensure Fund money without supplementing with General Fund, the shortfall would be $542,132. The Division, therefore, is seeking a fee increase for all fees that pay into the fund to reduce the expected revenue shortfall.

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., limit fee increases for the fees paid into the General Licensure fund to no more than the annual increase in the Consumer Price Index (CPI) for Denver-Aurora-Lakewood. For the time period July 1, 2018 through June 30, 2019 (Fiscal Year 2018-19), that specific CPI increased by 1.2872426%. Therefore, consistent with statutory constraints, the Division is requesting that all fees paid into the General Licensure Fund be increased by that amount. This increase is expected to generate $28,437, based on the numbers and types of facilities currently licensed. Even with this full increase allowed by statute, the revenues for the General Licensure Fund are expected to be approximately $661,012 less than what is needed to fully fund the full, appropriate direct and indirect costs of licensing, oversight, and enforcement activities for the 902 facilities that pay into the fund for Fiscal Year 2021. The Division anticipates requesting the CPI-based fee increases annually going forward.

The Department requests that the fee increases be effective July 1, 2020.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), 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 incorporate materials by reference?

_____ Yes ___ URL

___x___ No

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

___x___ Yes

_____ 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.

REGULATORY ANALYSIS
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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/S/B
Facilities paying Chapter 2 fees	31	C
Facilities paying Chapter 4 fees	94	C
Facilities paying Chapter 5 fees	230	C
Facilities paying Chapter 8 fees	142	C
Facilities paying Chapter 9 fees	77	C
Facilities paying Chapter 10 fees	5	C
Facilities paying Chapter 15 fees	80	C
Facilities paying Chapter 18 fees	12	C
Facilities paying Chapter 19 fees	2	C
Facilities paying Chapter 20 fees	127	C
Facilities paying Chapter 21 fees	102	C
Industry/advocacy organizations for the facility types covered above	6	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.

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.

C: Fees are increased by 1.2872426% in the included chapters, causing an estimated total additional cost to licensed facilities of $28,438. The actual additional cost for a specific facility varies depending on the amount of its current fee (e.g., a facility with a current fee amount of $371.44 would see a fee increase of $4.78 per year, while a facility with a current fee of $6,190.62 would see a fee increase of $79.69). The following table provides details on the specific fees by chapter, the amounts of the requested increases, and the increased fee totals. It is important to note that facilities pay only the fee(s) that apply to them (e.g., a new facility pays for an initial license, an existing facility pays for a renewal license).

Entity Type Type of fee	Current Fee	Increase	New Fee
Chapter 2 – General Licensure Standards (31 Facilities)			
Initial License	$371.44	$4.78	$376.22
Renewal License	$371.44	$4.78	$376.22
Conditional License	$1,547.65	$19.92	$1,567.57
Provisional License	$1,031.77	$13.28	$1,045.05
Change of Ownership	$371.44	$4.78	$376.22
Change in Licensed Capacity	$371.44	$4.78	$376.22
Change of Name	$77.38	$1.00	$78.38
Chapter 4 – General Hospitals (94 Facilities)			
Initial License:			
1-25 beds	$8,254.15	$106.25	$8,360.40
26-50 beds	$10,317.69	$132.81	$10,450.50
51-100 beds	$12,897.12	$166.02	$13,063.14
101+ beds (base/per bed/fee cap)	$10,111.34/$51.59/ $20,635.39	$130.16/$0.66/ $265.63	$10,241.50/$52.25/ $20,901.02
Certified Long Term Hospital (base/per bed/fee cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License:			
Deemed 1-50 beds (base/per bed)	$835.73/$12.38	$10.76/$0.16	$846.49/$12.54
Non-deemed 1-50 beds (base/per bed)	$928.59/$12.38	$11.95/$0.16	$940.54/$12.54
Deemed 51-150 beds (base/per bed)	$1,300.03/$12.38	$16.73/$0.16	$1,316.76/$12.54
Non-deemed 51-150 beds (base/per bed)	$1,444.48/$12.38	$18.59/$0.16	$1,463.07/$12.54
Deemed 151+ beds (base/per bed/fee cap)	$1,857.18/$12.38/ $8,254.15	$23.91/$0.16/ $106.25	$1,881.09/$12.54/ $8,360.40

Non-Deemed 151+beds (base/per bed/fee cap)	$2,063.54/$12.38/ $8,254.15	$26.56/$0.16/ $106.25	$2,090.10/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Off-campus location addition—Critical Access Hospital	$515.88	$6.64	$522.52
Off-campus location addition	$1,031.77	$13.28	$1,045.05
Off-campus location renewal—deemed facility	$464.30	$5.98	$470.28
Off-campus location renewal	$515.88	$6.64	$522.52
Off-campus location removal	$371.44	$4.78	$376.22
Chapter 5 – Nursing Care Facilities (230 Facilities)			
Initial License	$6,190.62	$79.69	$6,270.31
Renewal License			
Certified Facilities—Medicare or Medicaid (base/per bed)	$1,650.83/$8.25	$21.25/$.11	$1,672.08/$8.36
Non-certified Facilities (base/per bed)	$3,590.56/$8.25	$46.22/$0.11	$3,636.78/$8.36
Change of Ownership	$6,190.62	$79.69	$6,270.31
Opening a Secure Unit	$1,650.83	$21.25	$1,672.08
Chapter 8 – Facilities for Persons with Intellectual or Developmental Disabilities (142 Facilities)			
Initial License			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Renewal License			
Community Residential Home	$773.83	$9.96	$783.79
Intermediate Care Facility	$1,650.83	$21.25	$1,672.08
Change of Ownership			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Chapter 9 – Community Clinics and Community Clinics and Emergency Centers (77 Facilities)			
Initial License			
Community Emergency Center	$2,837.37	$36.52	$2,873.89
Clinic Operating Inpatient Beds	$2,837.37	$36.52	$2,873.89
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,238.12	$15.94	$1,254.06
Other Clinic	$2,476.25	$31.88	$2,508.13
Renewal License			
Community Emergency	$1,392.89	$17.93	$1,410.82

Center			
Clinic Operating Inpatient Beds	$1,392.89	$17.93	$1,410.82
Clinic Operated Under Auspices of Department of Corrections	$1,341.30	$17.27	$1,358.57
Clinic Serving Un/Underinsured	$619.06	$7.97	$627.03
Other Clinic	$1,238.12	$15.94	$1,254.06
Change of Ownership			
Community Emergency Center	$3,198.48	$41.17	$3,239.65
Clinic Operating Inpatient Beds	$3,198.48	$41.17	$3,239.65
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,289.71	$16.60	$1,306.31
Other Clinic	$2,579.42	$33.20	$2,612.62
Chapter 10 - Rehabilitation Hospitals (5 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 15 - Dialysis Treatment Clinics (80 Facilities)			
Initial License	$5,303.29	$68.27	$5,371.56
Renewal License			
1-12 Stations	$1,650.83	$21.25	$1,672.08
13-23 Stations	$2,600.06	$33.47	$2,633.53
24+ Stations	$3,544.13	$45.62	$3,589.75
Change of Ownership	$5,303.29	$68.27	$5,371.56
Chapter 18 - Psychiatric Hospitals (12 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 19 - Hospital Units (2 Facilities)			
Initial License (base/per bed/ fee cap)	$5,468.38/$51.59/ $10,833.58	$70.39/$0.66/ $139.45	$5,538.77/$52.25/ $10,973.03
Renewal License (base/per bed/ fee cap)	$1,650.83/$12.38/ $3,095.31	$21.25/$0.16/ $39.84	$1,672.08/$12.54/ $3,135.15
Change of Ownership	$2,579.42	$33.20	$2,612.62

Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 20 - Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center (127 Facilities)			
Initial License			
Ambulatory Surgical Center (ASC)	$6,809.68	$87.66	$6,897.34
Ambulatory Surgical Center with Convalescent Center	$7,181.11	$92.44	$7,273.55
Add Convalescent Center to an existing license	$371.44	$4.78	$376.22
Renewal License			
Non-deemed ASC (base/per procedure room/fee cap)	$1,485.75/$206.35/ $3,095.31	$19.13/$2.66/ $39.84	$1,504.88/$209.01/ $3,135.15
Deemed ASC (base/per procedure room/ fee cap)	$1,337.18/$206.35/ $3,095.31	$17.21/$2.66/ $39.84	$1,354.39/$209.01/ $3,135.15
Additional fee for a Convalescent Center	$371.44	$4.78	$376.22
Renewal fee cap for ASC with Convalescent Center	$3,466.74	$44.63	$3,511.37
Change of Ownership			
ASC	$4,230.25	$54.45	$4,284.70
ASC with Convalescent Center	$4,601.69	$59.23	$4,660.92
Provisional			
ASC	$2,579.42	$33.20	$2,612.62
ASC with Convalescent Center	$2,950.86	$37.98	$2,988.84
Chapter 21 - Hospices (102 Facilities)			
Initial License	$6,572.37	$84.60	$6,656.97
Initial License if no other licensed hospice within 60 miles	$4,281.84	$55.12	$4,336.96
Renewal			
Base fee (if no other conditions are met)	$4,023.90	$51.80	$4,075.70
Not in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld counties and providing 75 percent of services outside those counties	$2,476.25	$31.88	$2,508.13
Fewer than 2,000 annual patient dates per most recent Medicare cost report	$1,547.65	$19.92	$1,567.57
Fewer than 1,000 annual	$773.83	$9.96	$783.79

patient dates per most recent Medicare cost report Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area licensed as one entity	$6,603.32	$85.00	$6,688.32
Workstation (per workstation, paid for Initial License and Renewal License)	$51.59	$0.66	$52.25
Change of Ownership	$6,572.37	$84.60	$6,656.97

During the stakeholder process for this fee increase, the stakeholders did not present concerns about economic or non-economic impacts of the change. The benefit of the fee increase is to reduce the shortfall of revenues that support the Division's licensing, oversight, and enforcement activities. Reducing or eliminating these costs would mean that the Division would not have the resources necessary to protect the health, safety, and welfare of Coloradans being served in licensed health facilities.

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

S: N/A

B: N/A

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.

This rule-making is limited to a fee increase of 1.2872426%, thus generating $28,438 to support the Division's ability to protect the health, safety, and welfare of Coloradans being served by facilities ranging from hospitals to group homes.

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:

Licensing fees will continue to be collected and processed using existing procedures. Increasing the amount of the fees collected will not increase the resources needed to collect and process the fees, and thus this proposed fee increase will not have a cost impact on CDPHE.

Anticipated Other State Agency Costs:

The cost of a Community Clinic license for the clinics operated under the auspices of the Department of Corrections will increase $17.27 per clinic. There are currently 23 of these clinics, so the total cost impact of this increase for those clinics will be $397.21.

Anticipated CDPHE Revenues:

This fee increase is expected to generate approximately $28,438, but this amount will not fully fund the revenue shortfall in the General Licensure Fund. Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by General Licensure Fund revenues. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

This rulemaking modifies fees:

Facility-specific fee increases are listed in the table in response to Question 2, above.

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
_X__ Improve public and environmental health practice.
_X__ Implement stakeholder feedback.
___ 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:

The cost of inaction is the Division not exhausting every avenue to secure revenue to meet its expenditures. This in turn limits the Division's ability to fulfill its responsibilities related to licensing, oversight, and enforcement for hospitals, nursing homes, facilities for persons with intellectual and developmental disabilities, community clinics and community clinics with emergency centers, rehabilitation hospitals, dialysis treatment clinics, psychiatric hospitals, ambulatory surgical centers and ambulatory surgical centers with convalescent centers, hospices, and birth centers. The Division's inability to fully perform these functions negatively impacts the health, safety, and welfare of all Coloradans receiving treatment by or residing in these facilities.

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

   No other less costly method or less intrusive method was available as the fees are set in rule per statute.

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

   The Division's options for considering alternatives to the requested fee increase are constrained by the statutory restriction limiting fee increases to annual CPI at Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. The Division cannot request a larger fee increase without modification to statute. While the Division could raise fees at an amount lower than the CPI increase, this option was not selected because even the maximum increase allowed by statute does not generate enough revenue to offset the expected revenue shortfall.

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 used the federal Bureau of Labor Statistics Data, CPI-All Urban Consumers, Series CUURS48BSA0 (Denver-Lakewood-Aurora) to calculate the amount of fee increase allowed by Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., and then applied that percentage increase to all fees that are paid into the General Licensure Fund. The increases were rounded to the nearest penny.

STAKEHOLDER ENGAGEMENT
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
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Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
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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:

Since this fee increase involves multiple types of facilities and has been an ongoing issue, the Division has chosen to discuss the need for the annual CPI-based increases in a number of different settings, primarily ongoing stakeholder advisory groups and forums such as the 1294 Stakeholder Forum.

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).

__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.

No major factual or policy issues were encountered.

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:

> This is solely a fee increase to maintain existing activities regarding health facility licensing, oversight, and enforcement activities. There are no anticipated impacts on determinants of health or other health equity and environmental justice considerations, values, or outcomes.

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 Chap 02

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 2 Licensure Process

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2.13 License Fees

Unless explicitly set forth elsewhere in 6 CCR 1011-1 or statute, the following non-refundable fees shall apply and be submitted to the Department with the corresponding application or notification. More than one fee may apply depending upon the circumstances.

Initial license	~~$371.44~~ $376.22
Renewal license	~~$371.44~~ $376.22
Conditional license	~~$1,547.65~~ $1,567.57
First provisional license	~~$1,031.77~~ $1,045.05
Second provisional license	~~$1,031.77~~ $1,045.05
Change of ownership	~~$371.44~~ $376.22
Change in licensed capacity	~~$371.44~~ $376.22
Change of name	~~$77.38~~ $78.38
Renewal application late fee	Equal to the applicable renewal license fee including bed fees or operating/procedure room fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 04 - GENERAL HOSPITALS

6 CCR 1011-1 Chap 04

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES

3.101 SUBMITTAL OF FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows:

(a) See table below.

Number of Beds	Fee
1 - 25 beds	~~$8,254.15~~ $8,360.40
26 - 50 beds	~~$10,317.69~~ $10,450.50
51 - 100 beds	~~$12,897.12~~ $13,063.14
101 + beds	Base: ~~$10,111.34~~ $10,241.50
	Per bed: ~~$51.59~~ $52.25
	Cap: ~~$20,635.39~~ $20,901.02

(b) Notwithstanding the provisions of Section 3.101 (1)(a), the initial fee for facilities to be licensed as general hospitals but certified as long term hospitals pursuant to 42 CFR 482 et seq. shall submit: a base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee for long term hospitals shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the following table. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

Number of Beds	Fee	Fee with Deeming Discount
1 - 50 beds	Base: ~~$928.59~~ $940.54 Per bed: ~~$12.38~~ $12.54	Base: ~~$835.73~~ $846.49 Per bed: ~~$12.38~~ $12.54
51 - 150 beds	Base: ~~$1,444.48~~ $1,463.07 Per bed: ~~$12.38~~ $12.54	Base: ~~$1300.03~~ $1,316.76 Per bed: ~~$12.38~~ $12.54
151+ beds	Base: ~~$2,063.54~~ $2,090.10 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40	Base: ~~$1,857.18~~ $1,881.09 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

(5) Conditional License. A facility that is issued a conditional license by the Department shall submit a nonrefundable fee ranging from 10 to 25 percent of its applicable renewal fee. The Department shall assess the fee based on the anticipated costs of monitoring compliance with the conditional license. If the conditional license is issued concurrent with the initial or renewal license, the conditional license fee shall be in addition to the initial or renewal license fee.

(6) Other Regulatory Functions. If a facility requests an onsite inspection for a regulatory oversight function other than those listed in Sections 3.101 (1) through (3), the Department may conduct such onsite inspection upon notification to the facility of the fee in advance and payment thereof. The fee shall be calculated solely on the basis of the cost of conducting such survey. A detailed justification of the basis of the fee shall be provided to the facility upon request.

(7) Off-Campus Locations

(a) Addition, Annual Renewal and Termination of Off- Campus Locations. A licensee shall submit a nonrefundable fee, as set forth below, for the requested license action.

(i) ~~$1,031.77~~ $1,045.05 for the addition of each location to the list of off-campus locations under the license, except that critical access hospitals shall submit a nonrefundable fee of ~~$515.88~~ $522.52.

(ii) ~~$515.88~~ $522.52 for the annual renewal of each off-campus location listed under the license.

(iii) ~~$464.30~~ $470.28 for the annual renewal of licenses that expire on or after September 1, 2014, for each off-campus location that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(iv) ~~$371.44~~ $376.22 for the removal of each location from the list of off-campus locations under the license.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 5 - NURSING CARE FACILITIES

6 CCR 1011-1 Chap 05

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 32 LICENSING FEES

32.1 All license fees are non-refundable. The total fee shall be submitted with the appropriate license application.

32.2 Initial license - ~~$6,190.62~~ $6,270.31 per facility.

32.3 Renewal license - The annual renewal fee shall be as follows.

Medicare and/or Medicaid certified facility: ~~$1,650.83~~ $1,672.08 base fee plus ~~$8.25~~ $8.36 per bed.

Non-certified facility: ~~$3,590.56~~ $3,636.78 base fee plus ~~$8.25~~ $8.36 per bed.

32.4 Change of ownership - Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter 2, Part 2.7. The fee shall be ~~$6,190.62~~ $6,270.31 per facility.

32.5 Opening a secure unit - A facility that wishes to open a secure unit shall submit a fee of ~~$1,650.83~~ $1,672.08 in addition to any other applicable license fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 08 - FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

6 CCR 1011-1 Chap 08

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3 – Licensing Requirements

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3.4 License Fees

All license fees are non-refundable. More than one fee may apply depending upon the circumstances. The total fee shall be submitted with the appropriate license application.

(A) Initial License

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

(B) License Renewal

Effective July 1, ~~2019~~ 2020, the renewal fee shall be:

Community Residential Home: ~~$773.83~~ $783.79.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$1,650.83~~ $1,672.08.

(C) Change of ownership

Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter II, Part 2. The change of ownership fee shall be:

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

****

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 09 - COMMUNITY CLINICS AND COMMUNITY CLINICS AND EMERGENCY CENTERS

6 CCR 1011-1 Chap 09

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

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SUBCHAPTER IX.A - GENERAL REQUIREMENTS

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES.

(1) For new license applications received or renewal licenses that expire on or after July 1, ~~2019~~2020, a non-refundable fee shall be submitted with the license application as follows:

License Category	Initial license	Renewal license	Change of ownership
Community emergency center	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operating inpatient beds	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operated under the auspices of the Department of Corrections	~~$2,579.42~~ $2,612.62	~~$1,341.30~~ $1,358.57	~~$2,579.42~~ $2,612.62
Optional licensure pursuant to Section 2.101 (3)(a)(iv).			
Clinic serving the uninsured or underinsured:	~~$1,238.12~~ $1,254.06	~~$619.06~~ $627.03	~~$1,289.71~~ $1,306.31
Other clinic:	~~$2,476.25~~ $2,508.13	~~$1,238.12~~ $1,254.06	~~$2,579.42~~ $2,612.62

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 10 - REHABILITATION HOSPITALS

6 CCR 1011-1 Chap 10

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 15 - DIALYSIS TREATMENT CLINICS

6 CCR 1011-1 Chap 15

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3. FEES

3.1 License fees. All license fees are non-refundable and shall be submitted with the appropriate license application.

(A) Initial license fee - ~~$5,303.29~~ $5,371.56 per facility.

(B) Renewal license fee - For licenses that expire on or after July 1, ~~2019~~2020, the fee shall be based upon the maximum number of a facility's operational procedure stations as set forth below.

1 – 12 stations	~~$1,650.83~~ $1,672.08 per facility
13 – 23 stations	~~$2,600.06~~ $2,633.53 per facility
24 or more stations	~~$3,544.13~~ $3,589.75 per facility

(C) Change of ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, part 2. The fee shall be ~~$5,303.29~~ $5,371.56 per facility.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 18 - PSYCHIATRIC HOSPITALS

6 CCR 1011-1 Chap 18

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the department with an application for licensure as follows:

(1) Initial License: (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 19 - HOSPITAL UNITS

6 CCR 1011-1 Chap 19

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$5,468.38~~ $5,538.77 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License. A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(3) Change of Ownership. A license applicant shall submit a fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 20 - AMBULATORY SURGICAL CENTER AND AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

6 CCR 1011-1 Chap 20

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 24 - LICENSE FEES

24.1 As part of the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7, an applicant for an ambulatory surgical center license shall submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license: A license applicant shall submit with an application for licensure a nonrefundable fee of ~~$6,809.68~~ $6,897.34.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

BASE FEE	BASE FEE WITH DEEMING DISCOUNT	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,230.25~~ $4,284.70.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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SECTION 25 - AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

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25.7 License Fees: For new license applications received or renewal licenses that expire on or after March 1, 2015, an applicant for an ambulatory surgical center with a convalescent center license shall comply with the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7 and submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license:

(1) An applicant for an initial ambulatory surgical center with convalescent center license shall submit with an application for licensure a nonrefundable fee of ~~$7,181.11~~ $7,273.55.

(2) A current ambulatory surgical center licensee that applies to add a convalescent center to the license prior to the expiration of the surgical center license shall submit an application for initial licensure of the convalescent center along with a nonrefundable fee of ~~$371.44~~ $376.22. Upon expiration of the existing surgical center license term, the licensee shall follow the procedure set forth below for a renewal license.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,466.74~~ $3,511.37.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base ambulatory surgical center renewal fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

ASC BASE FEE	ASC BASE FEE WITH DEEMING DISCOUNT	CONVALESCENT CENTER FEE	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$371.44~~ $376.22	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,601.69~~ $4,660.92.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,950.86~~ $2,988.84. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 21 - HOSPICES

6 CCR 1011-1 Chap 21

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 14 LICENSE FEES

14.1 All license fees are non-refundable and the applicable fee total shall be submitted with the appropriate license application.

14.2 Initial License - ~~$6,572.37~~ $6,656.97 per hospice.

(A) If there are no licensed hospices within a 60-mile radius of the hospice applying for an initial license, the initial license fee shall be ~~$4,281.84~~ $4,336.96 per hospice.

14.3 Annual Renewal License

(A) For licenses expiring on or after July 1, ~~2019~~ 2020, the base renewal fee shall be ~~$4,023.90~~ $4,075.70 per hospice. The total renewal fee shall reflect all applicable adjustments as set forth below.

(1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be ~~$2,476.25~~ $2,508.13 per hospice.

(2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$1,547.65~~ $1,567.57 per hospice.

(3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$773.83~~ $783.79 per hospice.

(4) A discount of $300 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location.

(5) A discount of $425 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

(6) Upon request, the department may waive the fee for a hospice that demonstrates it is a not for profit organization that charges no fees and is staffed entirely by uncompensated volunteers.

(7) Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area shall be licensed as one entity. The fee shall be ~~$6,603.32~~ $6,688.32 and no other discounts shall apply except as set forth in (7)(a).

(a) A discount of $640 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

14.4 Workstation Fees

(A) A workstation is an offsite location maintained solely for the convenience of hospice staff to access policies and procedures, obtain forms or use various electronic communication tools. A workstation shall not contain patient records or be used for patient admissions and shall not display any public signage.

(B) In addition to any other licensure fees, a hospice that operates one or more satellite workstations shall pay an annual fee of ~~$51.59~~ $52.25 per workstation. The fee shall be submitted with the initial and/or renewal license application.

14.5 Change of Ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, Part 2. The fee shall be ~~$6,572.37~~ $6,656.97 per hospice.

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COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing Scheduled for April 15, 2020

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 April 15, 2020 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive, South, Denver, CO 80246, to consider the revision of the follow chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities:

- Chapter 2 - General Licensure Standards
- Chapter 4 - General Hospitals
- Chapter 5 - Nursing Care Facilities
- Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
- Chapter 9 - Community Clinics and Community Clinics and Emergency Services
- Chapter 10 - Rehabilitation Hospitals
- Chapter 15 - Dialysis Treatment Clinics
- Chapter 18 - Psychiatric Hospitals
- Chapter 19 - Hospital Units
- Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
- Chapter 21 - Hospices

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426%. The proposed rules have been developed by the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment pursuant to Section Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://www.colorado.gov/pacific/cdphe/boh 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 working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-2999.

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, April 9, 2020. 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 27th day of February, 2020.

Alexandra S. Haas

Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00106

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 20

Rule title

CHAPTER 20 - AMBULATORY SURGICAL CENTER AND AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

Rulemaking Hearing

Date

04/15/2020

Time

10:00 AM

Location

Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246

Subjects and issues involved

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426% to provide an additional $28,438 in revenue.

Statutory authority

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

Contact information

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Kim Fear, Branch Chief, Fiscal & Administrative Services Branch, HFEMSD

Through: D. Randy Kuykendall, Director, DRK

Date: February 19, 2020

Subject: **Request for a Rulemaking Hearing** concerning increasing licensure fees in the following chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities in April 2020:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

In April 2019, the Division appeared before the Board with a request to increase the fees that licensees pay into the General Licensure Cash Fund (General Licensure Fund). At that time, the Division explained that over several years, expenditures from the General Licensure Fund had increased 24.6%, while the revenues paid into that fund had increased by only 0.6%. The requested fee increase was for 3.1769267%, which was expected to generate about $66,850. This amount was not expected to address the full difference between revenues and expenditures of the General Licensure Fund, but was the maximum the Board could increase fees due to Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. (As of June 4, 2012, the Board of Health may only increase the fees collected by the annual percentage change of the consumer price index for Denver-Aurora-Lakewood.)

Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund

monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

The Division is now requesting to increase fees paid into the General Licensure Fund by 1.2872426%, which again will not fully fund the expenditures of the General Licensure Fund, but is the maximum the Board may increase fees. This fee increase is expected to provide an additional $28,438 in revenue, but this amount will not be enough to offset the expected revenue shortfall in Fiscal Year 2021 and following years, so the Division anticipates requesting additional CPI-limited fee increases on a yearly basis going forward.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

Basis and Purpose.

HFEMSD's health facility licensing, oversight, and enforcement activities are funded through the collection of fees approved by the Board of Health. The fees paid by facilities licensed by the Division, with the exception of Assisted Living Residences (ALRs) and Home Care Agencies, are deposited to the Health Facilities General Licensure Cash Fund (General Licensure Fund), which is then the source of appropriations to the Division for its licensure and oversight activities. In accordance with Section 25-3-105(1)(a)(I)(A), C.R.S, fees are to be set at a level sufficient to meet the direct and indirect costs of these activities.

Although the Board approved a 3.1769267% fee increase for Fiscal Year 2020 (the maximum allowed by statute), the fees being paid into the General Licensure Fund remain insufficient to meet the Division's direct and indirect costs. Since the April 2019 fee increase request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable. For example, the ability to use fund balance will be eliminated, as the balance of the General Licensure Fund is estimated to be approximately $12,000 for Fiscal Year 2020, as opposed to over $200,000 in prior years. Additionally, purposely holding positions open means that a portion of the Division's work is not getting done.

Expenditures continue to increase for a number of predictable reasons, such as the general inflationary increases in personnel and travel costs over the past several years. The Division has been managing these expenditures through efforts like process efficiencies and the use of vacancy savings due to difficulties arising from health care staffing shortages in general. The Division, however, continues to experience high numbers of complaints, driving investigation workload. While generally increasing, complaints are variable and unpredictable, which makes it important to have revenues at a high enough level to investigate complaints coming

in, even in a higher-than typical year. The following table shows complaint variability, as well as overall growth:

General Licensure Cash Fund—Facility and Complaint Growth FY 2016 to FY 2019					
	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019	Percentage Increase/Decrease FY 16 to FY 19
Number of Facilities	892	905	912	902	1.1%
Number of Complaint Intakes	752	903	1,256	948	26.1%
Number of Complaint Allegations	2,384	2,910	4,007	2,912	22.1%
Top 3 Complaint Allegation Categories:					
Nursing Services	807	1,132	1,278	1,191	47.6%
Patient Rights	261	330	442	308	18.0%
Quality of Care	324	329	594	286	-11.7%

These needed expenditure increases cannot be offset by efforts previously used by the Division, and as a result the Division expects expenditures to exceed revenues by approximately $201,109 in Fiscal Year 2019-20, even after purposely holding $110,000 worth of positions vacant and using $237,592 of General Fund monies. If the Division were to fill positions to the full appropriated level and use only the General Licensure Fund money without supplementing with General Fund, the shortfall would be $542,132. The Division, therefore, is seeking a fee increase for all fees that pay into the fund to reduce the expected revenue shortfall.

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., limit fee increases for the fees paid into the General Licensure fund to no more than the annual increase in the Consumer Price Index (CPI) for Denver-Aurora-Lakewood. For the time period July 1, 2018 through June 30, 2019 (Fiscal Year 2018-19), that specific CPI increased by 1.2872426%. Therefore, consistent with statutory constraints, the Division is requesting that all fees paid into the General Licensure Fund be increased by that amount. This increase is expected to generate $28,437, based on the numbers and types of facilities currently licensed. Even with this full increase allowed by statute, the revenues for the General Licensure Fund are expected to be approximately $661,012 less than what is needed to fully fund the full, appropriate direct and indirect costs of licensing, oversight, and enforcement activities for the 902 facilities that pay into the fund for Fiscal Year 2021. The Division anticipates requesting the CPI-based fee increases annually going forward.

The Department requests that the fee increases be effective July 1, 2020.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), 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 incorporate materials by reference?

_____ Yes ___ URL

___x___ No

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

___x___ Yes

_____ 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.

REGULATORY ANALYSIS
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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/S/B
Facilities paying Chapter 2 fees	31	C
Facilities paying Chapter 4 fees	94	C
Facilities paying Chapter 5 fees	230	C
Facilities paying Chapter 8 fees	142	C
Facilities paying Chapter 9 fees	77	C
Facilities paying Chapter 10 fees	5	C
Facilities paying Chapter 15 fees	80	C
Facilities paying Chapter 18 fees	12	C
Facilities paying Chapter 19 fees	2	C
Facilities paying Chapter 20 fees	127	C
Facilities paying Chapter 21 fees	102	C
Industry/advocacy organizations for the facility types covered above	6	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.

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.

C: Fees are increased by 1.2872426% in the included chapters, causing an estimated total additional cost to licensed facilities of $28,438. The actual additional cost for a specific facility varies depending on the amount of its current fee (e.g., a facility with a current fee amount of $371.44 would see a fee increase of $4.78 per year, while a facility with a current fee of $6,190.62 would see a fee increase of $79.69). The following table provides details on the specific fees by chapter, the amounts of the requested increases, and the increased fee totals. It is important to note that facilities pay only the fee(s) that apply to them (e.g., a new facility pays for an initial license, an existing facility pays for a renewal license).

Entity Type Type of fee	Current Fee	Increase	New Fee
Chapter 2 – General Licensure Standards (31 Facilities)			
Initial License	$371.44	$4.78	$376.22
Renewal License	$371.44	$4.78	$376.22
Conditional License	$1,547.65	$19.92	$1,567.57
Provisional License	$1,031.77	$13.28	$1,045.05
Change of Ownership	$371.44	$4.78	$376.22
Change in Licensed Capacity	$371.44	$4.78	$376.22
Change of Name	$77.38	$1.00	$78.38
Chapter 4 – General Hospitals (94 Facilities)			
Initial License:			
1-25 beds	$8,254.15	$106.25	$8,360.40
26-50 beds	$10,317.69	$132.81	$10,450.50
51-100 beds	$12,897.12	$166.02	$13,063.14
101+ beds (base/per bed/fee cap)	$10,111.34/$51.59/ $20,635.39	$130.16/$0.66/ $265.63	$10,241.50/$52.25/ $20,901.02
Certified Long Term Hospital (base/per bed/fee cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License:			
Deemed 1-50 beds (base/per bed)	$835.73/$12.38	$10.76/$0.16	$846.49/$12.54
Non-deemed 1-50 beds (base/per bed)	$928.59/$12.38	$11.95/$0.16	$940.54/$12.54
Deemed 51-150 beds (base/per bed)	$1,300.03/$12.38	$16.73/$0.16	$1,316.76/$12.54
Non-deemed 51-150 beds (base/per bed)	$1,444.48/$12.38	$18.59/$0.16	$1,463.07/$12.54
Deemed 151+ beds (base/per bed/fee cap)	$1,857.18/$12.38/ $8,254.15	$23.91/$0.16/ $106.25	$1,881.09/$12.54/ $8,360.40

Non-Deemed 151+beds (base/per bed/fee cap)	$2,063.54/$12.38/ $8,254.15	$26.56/$0.16/ $106.25	$2,090.10/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Off-campus location addition—Critical Access Hospital	$515.88	$6.64	$522.52
Off-campus location addition	$1,031.77	$13.28	$1,045.05
Off-campus location renewal—deemed facility	$464.30	$5.98	$470.28
Off-campus location renewal	$515.88	$6.64	$522.52
Off-campus location removal	$371.44	$4.78	$376.22
Chapter 5 – Nursing Care Facilities (230 Facilities)			
Initial License	$6,190.62	$79.69	$6,270.31
Renewal License			
Certified Facilities—Medicare or Medicaid (base/per bed)	$1,650.83/$8.25	$21.25/$.11	$1,672.08/$8.36
Non-certified Facilities (base/per bed)	$3,590.56/$8.25	$46.22/$0.11	$3,636.78/$8.36
Change of Ownership	$6,190.62	$79.69	$6,270.31
Opening a Secure Unit	$1,650.83	$21.25	$1,672.08
Chapter 8 – Facilities for Persons with Intellectual or Developmental Disabilities (142 Facilities)			
Initial License			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Renewal License			
Community Residential Home	$773.83	$9.96	$783.79
Intermediate Care Facility	$1,650.83	$21.25	$1,672.08
Change of Ownership			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Chapter 9 – Community Clinics and Community Clinics and Emergency Centers (77 Facilities)			
Initial License			
Community Emergency Center	$2,837.37	$36.52	$2,873.89
Clinic Operating Inpatient Beds	$2,837.37	$36.52	$2,873.89
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,238.12	$15.94	$1,254.06
Other Clinic	$2,476.25	$31.88	$2,508.13
Renewal License			
Community Emergency	$1,392.89	$17.93	$1,410.82

Center			
Clinic Operating Inpatient Beds	$1,392.89	$17.93	$1,410.82
Clinic Operated Under Auspices of Department of Corrections	$1,341.30	$17.27	$1,358.57
Clinic Serving Un/Underinsured	$619.06	$7.97	$627.03
Other Clinic	$1,238.12	$15.94	$1,254.06
Change of Ownership			
Community Emergency Center	$3,198.48	$41.17	$3,239.65
Clinic Operating Inpatient Beds	$3,198.48	$41.17	$3,239.65
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,289.71	$16.60	$1,306.31
Other Clinic	$2,579.42	$33.20	$2,612.62
Chapter 10 - Rehabilitation Hospitals (5 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 15 - Dialysis Treatment Clinics (80 Facilities)			
Initial License	$5,303.29	$68.27	$5,371.56
Renewal License			
1-12 Stations	$1,650.83	$21.25	$1,672.08
13-23 Stations	$2,600.06	$33.47	$2,633.53
24+ Stations	$3,544.13	$45.62	$3,589.75
Change of Ownership	$5,303.29	$68.27	$5,371.56
Chapter 18 - Psychiatric Hospitals (12 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 19 - Hospital Units (2 Facilities)			
Initial License (base/per bed/ fee cap)	$5,468.38/$51.59/ $10,833.58	$70.39/$0.66/ $139.45	$5,538.77/$52.25/ $10,973.03
Renewal License (base/per bed/ fee cap)	$1,650.83/$12.38/ $3,095.31	$21.25/$0.16/ $39.84	$1,672.08/$12.54/ $3,135.15
Change of Ownership	$2,579.42	$33.20	$2,612.62

Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 20 - Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center (127 Facilities)			
Initial License			
Ambulatory Surgical Center (ASC)	$6,809.68	$87.66	$6,897.34
Ambulatory Surgical Center with Convalescent Center	$7,181.11	$92.44	$7,273.55
Add Convalescent Center to an existing license	$371.44	$4.78	$376.22
Renewal License			
Non-deemed ASC (base/per procedure room/fee cap)	$1,485.75/$206.35/ $3,095.31	$19.13/$2.66/ $39.84	$1,504.88/$209.01/ $3,135.15
Deemed ASC (base/per procedure room/ fee cap)	$1,337.18/$206.35/ $3,095.31	$17.21/$2.66/ $39.84	$1,354.39/$209.01/ $3,135.15
Additional fee for a Convalescent Center	$371.44	$4.78	$376.22
Renewal fee cap for ASC with Convalescent Center	$3,466.74	$44.63	$3,511.37
Change of Ownership			
ASC	$4,230.25	$54.45	$4,284.70
ASC with Convalescent Center	$4,601.69	$59.23	$4,660.92
Provisional			
ASC	$2,579.42	$33.20	$2,612.62
ASC with Convalescent Center	$2,950.86	$37.98	$2,988.84
Chapter 21 - Hospices (102 Facilities)			
Initial License	$6,572.37	$84.60	$6,656.97
Initial License if no other licensed hospice within 60 miles	$4,281.84	$55.12	$4,336.96
Renewal			
Base fee (if no other conditions are met)	$4,023.90	$51.80	$4,075.70
Not in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld counties and providing 75 percent of services outside those counties	$2,476.25	$31.88	$2,508.13
Fewer than 2,000 annual patient dates per most recent Medicare cost report	$1,547.65	$19.92	$1,567.57
Fewer than 1,000 annual	$773.83	$9.96	$783.79

patient dates per most recent Medicare cost report Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area licensed as one entity	$6,603.32	$85.00	$6,688.32
Workstation (per workstation, paid for Initial License and Renewal License)	$51.59	$0.66	$52.25
Change of Ownership	$6,572.37	$84.60	$6,656.97

During the stakeholder process for this fee increase, the stakeholders did not present concerns about economic or non-economic impacts of the change. The benefit of the fee increase is to reduce the shortfall of revenues that support the Division's licensing, oversight, and enforcement activities. Reducing or eliminating these costs would mean that the Division would not have the resources necessary to protect the health, safety, and welfare of Coloradans being served in licensed health facilities.

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

S: N/A

B: N/A

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.

This rule-making is limited to a fee increase of 1.2872426%, thus generating $28,438 to support the Division's ability to protect the health, safety, and welfare of Coloradans being served by facilities ranging from hospitals to group homes.

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:

Licensing fees will continue to be collected and processed using existing procedures. Increasing the amount of the fees collected will not increase the resources needed to collect and process the fees, and thus this proposed fee increase will not have a cost impact on CDPHE.

Anticipated Other State Agency Costs:

The cost of a Community Clinic license for the clinics operated under the auspices of the Department of Corrections will increase $17.27 per clinic. There are currently 23 of these clinics, so the total cost impact of this increase for those clinics will be $397.21.

Anticipated CDPHE Revenues:

This fee increase is expected to generate approximately $28,438, but this amount will not fully fund the revenue shortfall in the General Licensure Fund. Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by General Licensure Fund revenues. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

This rulemaking modifies fees:

Facility-specific fee increases are listed in the table in response to Question 2, above.

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
_X__ Improve public and environmental health practice.
_X__ Implement stakeholder feedback.
___ 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:

The cost of inaction is the Division not exhausting every avenue to secure revenue to meet its expenditures. This in turn limits the Division's ability to fulfill its responsibilities related to licensing, oversight, and enforcement for hospitals, nursing homes, facilities for persons with intellectual and developmental disabilities, community clinics and community clinics with emergency centers, rehabilitation hospitals, dialysis treatment clinics, psychiatric hospitals, ambulatory surgical centers and ambulatory surgical centers with convalescent centers, hospices, and birth centers. The Division's inability to fully perform these functions negatively impacts the health, safety, and welfare of all Coloradans receiving treatment by or residing in these facilities.

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

   No other less costly method or less intrusive method was available as the fees are set in rule per statute.

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

   The Division's options for considering alternatives to the requested fee increase are constrained by the statutory restriction limiting fee increases to annual CPI at Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. The Division cannot request a larger fee increase without modification to statute. While the Division could raise fees at an amount lower than the CPI increase, this option was not selected because even the maximum increase allowed by statute does not generate enough revenue to offset the expected revenue shortfall.

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 used the federal Bureau of Labor Statistics Data, CPI-All Urban Consumers, Series CUURS48BSA0 (Denver-Lakewood-Aurora) to calculate the amount of fee increase allowed by Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., and then applied that percentage increase to all fees that are paid into the General Licensure Fund. The increases were rounded to the nearest penny.

STAKEHOLDER ENGAGEMENT
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
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Chapter 21 - Hospices

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:

Since this fee increase involves multiple types of facilities and has been an ongoing issue, the Division has chosen to discuss the need for the annual CPI-based increases in a number of different settings, primarily ongoing stakeholder advisory groups and forums such as the 1294 Stakeholder Forum.

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).

__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.

No major factual or policy issues were encountered.

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:

> This is solely a fee increase to maintain existing activities regarding health facility licensing, oversight, and enforcement activities. There are no anticipated impacts on determinants of health or other health equity and environmental justice considerations, values, or outcomes.

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 Chap 02

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 2 Licensure Process

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2.13 License Fees

Unless explicitly set forth elsewhere in 6 CCR 1011-1 or statute, the following non-refundable fees shall apply and be submitted to the Department with the corresponding application or notification. More than one fee may apply depending upon the circumstances.

Initial license	~~$371.44~~ $376.22
Renewal license	~~$371.44~~ $376.22
Conditional license	~~$1,547.65~~ $1,567.57
First provisional license	~~$1,031.77~~ $1,045.05
Second provisional license	~~$1,031.77~~ $1,045.05
Change of ownership	~~$371.44~~ $376.22
Change in licensed capacity	~~$371.44~~ $376.22
Change of name	~~$77.38~~ $78.38
Renewal application late fee	Equal to the applicable renewal license fee including bed fees or operating/procedure room fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 04 - GENERAL HOSPITALS

6 CCR 1011-1 Chap 04

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES

3.101 SUBMITTAL OF FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows:

(a) See table below.

Number of Beds	Fee
1 - 25 beds	~~$8,254.15~~ $8,360.40
26 - 50 beds	~~$10,317.69~~ $10,450.50
51 - 100 beds	~~$12,897.12~~ $13,063.14
101 + beds	Base: ~~$10,111.34~~ $10,241.50
	Per bed: ~~$51.59~~ $52.25
	Cap: ~~$20,635.39~~ $20,901.02

(b) Notwithstanding the provisions of Section 3.101 (1)(a), the initial fee for facilities to be licensed as general hospitals but certified as long term hospitals pursuant to 42 CFR 482 et seq. shall submit: a base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee for long term hospitals shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the following table. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

Number of Beds	Fee	Fee with Deeming Discount
1 - 50 beds	Base: ~~$928.59~~ $940.54 Per bed: ~~$12.38~~ $12.54	Base: ~~$835.73~~ $846.49 Per bed: ~~$12.38~~ $12.54
51 - 150 beds	Base: ~~$1,444.48~~ $1,463.07 Per bed: ~~$12.38~~ $12.54	Base: ~~$1300.03~~ $1,316.76 Per bed: ~~$12.38~~ $12.54
151+ beds	Base: ~~$2,063.54~~ $2,090.10 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40	Base: ~~$1,857.18~~ $1,881.09 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

(5) Conditional License. A facility that is issued a conditional license by the Department shall submit a nonrefundable fee ranging from 10 to 25 percent of its applicable renewal fee. The Department shall assess the fee based on the anticipated costs of monitoring compliance with the conditional license. If the conditional license is issued concurrent with the initial or renewal license, the conditional license fee shall be in addition to the initial or renewal license fee.

(6) Other Regulatory Functions. If a facility requests an onsite inspection for a regulatory oversight function other than those listed in Sections 3.101 (1) through (3), the Department may conduct such onsite inspection upon notification to the facility of the fee in advance and payment thereof. The fee shall be calculated solely on the basis of the cost of conducting such survey. A detailed justification of the basis of the fee shall be provided to the facility upon request.

(7) Off-Campus Locations

(a) Addition, Annual Renewal and Termination of Off- Campus Locations. A licensee shall submit a nonrefundable fee, as set forth below, for the requested license action.

(i) ~~$1,031.77~~ $1,045.05 for the addition of each location to the list of off-campus locations under the license, except that critical access hospitals shall submit a nonrefundable fee of ~~$515.88~~ $522.52.

(ii) ~~$515.88~~ $522.52 for the annual renewal of each off-campus location listed under the license.

(iii) ~~$464.30~~ $470.28 for the annual renewal of licenses that expire on or after September 1, 2014, for each off-campus location that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(iv) ~~$371.44~~ $376.22 for the removal of each location from the list of off-campus locations under the license.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 5 - NURSING CARE FACILITIES

6 CCR 1011-1 Chap 05

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 32 LICENSING FEES

32.1 All license fees are non-refundable. The total fee shall be submitted with the appropriate license application.

32.2 Initial license - ~~$6,190.62~~ $6,270.31 per facility.

32.3 Renewal license - The annual renewal fee shall be as follows.

Medicare and/or Medicaid certified facility: ~~$1,650.83~~ $1,672.08 base fee plus ~~$8.25~~ $8.36 per bed.

Non-certified facility: ~~$3,590.56~~ $3,636.78 base fee plus ~~$8.25~~ $8.36 per bed.

32.4 Change of ownership - Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter 2, Part 2.7. The fee shall be ~~$6,190.62~~ $6,270.31 per facility.

32.5 Opening a secure unit - A facility that wishes to open a secure unit shall submit a fee of ~~$1,650.83~~ $1,672.08 in addition to any other applicable license fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 08 - FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

6 CCR 1011-1 Chap 08

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3 – Licensing Requirements

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3.4 License Fees

All license fees are non-refundable. More than one fee may apply depending upon the circumstances. The total fee shall be submitted with the appropriate license application.

(A) Initial License

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

(B) License Renewal

Effective July 1, ~~2019~~ 2020, the renewal fee shall be:

Community Residential Home: ~~$773.83~~ $783.79.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$1,650.83~~ $1,672.08.

(C) Change of ownership

Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter II, Part 2. The change of ownership fee shall be:

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 09 - COMMUNITY CLINICS AND COMMUNITY CLINICS AND EMERGENCY CENTERS

6 CCR 1011-1 Chap 09

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

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SUBCHAPTER IX.A - GENERAL REQUIREMENTS

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES.

(1) For new license applications received or renewal licenses that expire on or after July 1, ~~2019~~2020, a non-refundable fee shall be submitted with the license application as follows:

License Category	Initial license	Renewal license	Change of ownership
Community emergency center	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operating inpatient beds	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operated under the auspices of the Department of Corrections	~~$2,579.42~~ $2,612.62	~~$1,341.30~~ $1,358.57	~~$2,579.42~~ $2,612.62
Optional licensure pursuant to Section 2.101 (3)(a)(iv).			
Clinic serving the uninsured or underinsured:	~~$1,238.12~~ $1,254.06	~~$619.06~~ $627.03	~~$1,289.71~~ $1,306.31
Other clinic:	~~$2,476.25~~ $2,508.13	~~$1,238.12~~ $1,254.06	~~$2,579.42~~ $2,612.62

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 10 - REHABILITATION HOSPITALS

6 CCR 1011-1 Chap 10

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 15 - DIALYSIS TREATMENT CLINICS

6 CCR 1011-1 Chap 15

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3. FEES

3.1 License fees. All license fees are non-refundable and shall be submitted with the appropriate license application.

(A) Initial license fee - ~~$5,303.29~~ $5,371.56 per facility.

(B) Renewal license fee - For licenses that expire on or after July 1, ~~2019~~2020, the fee shall be based upon the maximum number of a facility's operational procedure stations as set forth below.

1 – 12 stations	~~$1,650.83~~ $1,672.08 per facility
13 – 23 stations	~~$2,600.06~~ $2,633.53 per facility
24 or more stations	~~$3,544.13~~ $3,589.75 per facility

(C) Change of ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, part 2. The fee shall be ~~$5,303.29~~ $5,371.56 per facility.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 18 - PSYCHIATRIC HOSPITALS

6 CCR 1011-1 Chap 18

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the department with an application for licensure as follows:

(1) Initial License: (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 19 - HOSPITAL UNITS

6 CCR 1011-1 Chap 19

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$5,468.38~~ $5,538.77 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License. A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(3) Change of Ownership. A license applicant shall submit a fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 20 - AMBULATORY SURGICAL CENTER AND AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

6 CCR 1011-1 Chap 20

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 24 - LICENSE FEES

24.1 As part of the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7, an applicant for an ambulatory surgical center license shall submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license: A license applicant shall submit with an application for licensure a nonrefundable fee of ~~$6,809.68~~ $6,897.34.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

BASE FEE	BASE FEE WITH DEEMING DISCOUNT	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,230.25~~ $4,284.70.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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SECTION 25 - AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

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25.7 License Fees: For new license applications received or renewal licenses that expire on or after March 1, 2015, an applicant for an ambulatory surgical center with a convalescent center license shall comply with the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7 and submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license:

(1) An applicant for an initial ambulatory surgical center with convalescent center license shall submit with an application for licensure a nonrefundable fee of ~~$7,181.11~~ $7,273.55.

(2) A current ambulatory surgical center licensee that applies to add a convalescent center to the license prior to the expiration of the surgical center license shall submit an application for initial licensure of the convalescent center along with a nonrefundable fee of ~~$371.44~~ $376.22. Upon expiration of the existing surgical center license term, the licensee shall follow the procedure set forth below for a renewal license.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,466.74~~ $3,511.37.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base ambulatory surgical center renewal fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

ASC BASE FEE	ASC BASE FEE WITH DEEMING DISCOUNT	CONVALESCENT CENTER FEE	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$371.44~~ $376.22	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,601.69~~ $4,660.92.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,950.86~~ $2,988.84. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 21 - HOSPICES

6 CCR 1011-1 Chap 21

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 14 LICENSE FEES

14.1 All license fees are non-refundable and the applicable fee total shall be submitted with the appropriate license application.

14.2 Initial License - ~~$6,572.37~~ $6,656.97 per hospice.

(A) If there are no licensed hospices within a 60-mile radius of the hospice applying for an initial license, the initial license fee shall be ~~$4,281.84~~ $4,336.96 per hospice.

14.3 Annual Renewal License

(A) For licenses expiring on or after July 1, ~~2019~~ 2020, the base renewal fee shall be ~~$4,023.90~~ $4,075.70 per hospice. The total renewal fee shall reflect all applicable adjustments as set forth below.

(1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be ~~$2,476.25~~ $2,508.13 per hospice.

(2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$1,547.65~~ $1,567.57 per hospice.

(3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$773.83~~ $783.79 per hospice.

(4) A discount of $300 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location.

(5) A discount of $425 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

(6) Upon request, the department may waive the fee for a hospice that demonstrates it is a not for profit organization that charges no fees and is staffed entirely by uncompensated volunteers.

(7) Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area shall be licensed as one entity. The fee shall be ~~$6,603.32~~ $6,688.32 and no other discounts shall apply except as set forth in (7)(a).

(a) A discount of $640 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

14.4 Workstation Fees

(A) A workstation is an offsite location maintained solely for the convenience of hospice staff to access policies and procedures, obtain forms or use various electronic communication tools. A workstation shall not contain patient records or be used for patient admissions and shall not display any public signage.

(B) In addition to any other licensure fees, a hospice that operates one or more satellite workstations shall pay an annual fee of ~~$51.59~~ $52.25 per workstation. The fee shall be submitted with the initial and/or renewal license application.

14.5 Change of Ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, Part 2. The fee shall be ~~$6,572.37~~ $6,656.97 per hospice.

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COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing Scheduled for April 15, 2020

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 April 15, 2020 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive, South, Denver, CO 80246, to consider the revision of the follow chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities:

- Chapter 2 - General Licensure Standards
- Chapter 4 - General Hospitals
- Chapter 5 - Nursing Care Facilities
- Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
- Chapter 9 - Community Clinics and Community Clinics and Emergency Services
- Chapter 10 - Rehabilitation Hospitals
- Chapter 15 - Dialysis Treatment Clinics
- Chapter 18 - Psychiatric Hospitals
- Chapter 19 - Hospital Units
- Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
- Chapter 21 - Hospices

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426%. The proposed rules have been developed by the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment pursuant to Section Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://www.colorado.gov/pacific/cdphe/boh 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 working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-2999.

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, April 9, 2020. 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 27th day of February, 2020.

Alexandra S. Haas

Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00107

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 21

Rule title

CHAPTER 21 - HOSPICES

Rulemaking Hearing

Date

04/15/2020

Time

10:00 AM

Location

Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246

Subjects and issues involved

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426% to provide an additional $28,438 in revenue.

Statutory authority

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

Contact information

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Title

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Kim Fear, Branch Chief, Fiscal & Administrative Services Branch, HFEMSD

Through: D. Randy Kuykendall, Director, DRK

Date: February 19, 2020

Subject: **Request for a Rulemaking Hearing** concerning increasing licensure fees in the following chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities in April 2020:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

In April 2019, the Division appeared before the Board with a request to increase the fees that licensees pay into the General Licensure Cash Fund (General Licensure Fund). At that time, the Division explained that over several years, expenditures from the General Licensure Fund had increased 24.6%, while the revenues paid into that fund had increased by only 0.6%. The requested fee increase was for 3.1769267%, which was expected to generate about $66,850. This amount was not expected to address the full difference between revenues and expenditures of the General Licensure Fund, but was the maximum the Board could increase fees due to Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. (As of June 4, 2012, the Board of Health may only increase the fees collected by the annual percentage change of the consumer price index for Denver-Aurora-Lakewood.)

Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund

monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

The Division is now requesting to increase fees paid into the General Licensure Fund by 1.2872426%, which again will not fully fund the expenditures of the General Licensure Fund, but is the maximum the Board may increase fees. This fee increase is expected to provide an additional $28,438 in revenue, but this amount will not be enough to offset the expected revenue shortfall in Fiscal Year 2021 and following years, so the Division anticipates requesting additional CPI-limited fee increases on a yearly basis going forward.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

Basis and Purpose.

HFEMSD's health facility licensing, oversight, and enforcement activities are funded through the collection of fees approved by the Board of Health. The fees paid by facilities licensed by the Division, with the exception of Assisted Living Residences (ALRs) and Home Care Agencies, are deposited to the Health Facilities General Licensure Cash Fund (General Licensure Fund), which is then the source of appropriations to the Division for its licensure and oversight activities. In accordance with Section 25-3-105(1)(a)(I)(A), C.R.S, fees are to be set at a level sufficient to meet the direct and indirect costs of these activities.

Although the Board approved a 3.1769267% fee increase for Fiscal Year 2020 (the maximum allowed by statute), the fees being paid into the General Licensure Fund remain insufficient to meet the Division's direct and indirect costs. Since the April 2019 fee increase request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by the General Licensure Fund and the revenues of the Fund. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable. For example, the ability to use fund balance will be eliminated, as the balance of the General Licensure Fund is estimated to be approximately $12,000 for Fiscal Year 2020, as opposed to over $200,000 in prior years. Additionally, purposely holding positions open means that a portion of the Division's work is not getting done.

Expenditures continue to increase for a number of predictable reasons, such as the general inflationary increases in personnel and travel costs over the past several years. The Division has been managing these expenditures through efforts like process efficiencies and the use of vacancy savings due to difficulties arising from health care staffing shortages in general. The Division, however, continues to experience high numbers of complaints, driving investigation workload. While generally increasing, complaints are variable and unpredictable, which makes it important to have revenues at a high enough level to investigate complaints coming

in, even in a higher-than typical year. The following table shows complaint variability, as well as overall growth:

General Licensure Cash Fund—Facility and Complaint Growth FY 2016 to FY 2019					
	Fiscal Year 2016	Fiscal Year 2017	Fiscal Year 2018	Fiscal Year 2019	Percentage Increase/Decrease FY 16 to FY 19
Number of Facilities	892	905	912	902	1.1%
Number of Complaint Intakes	752	903	1,256	948	26.1%
Number of Complaint Allegations	2,384	2,910	4,007	2,912	22.1%
Top 3 Complaint Allegation Categories:					
Nursing Services	807	1,132	1,278	1,191	47.6%
Patient Rights	261	330	442	308	18.0%
Quality of Care	324	329	594	286	-11.7%

These needed expenditure increases cannot be offset by efforts previously used by the Division, and as a result the Division expects expenditures to exceed revenues by approximately $201,109 in Fiscal Year 2019-20, even after purposely holding $110,000 worth of positions vacant and using $237,592 of General Fund monies. If the Division were to fill positions to the full appropriated level and use only the General Licensure Fund money without supplementing with General Fund, the shortfall would be $542,132. The Division, therefore, is seeking a fee increase for all fees that pay into the fund to reduce the expected revenue shortfall.

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., limit fee increases for the fees paid into the General Licensure fund to no more than the annual increase in the Consumer Price Index (CPI) for Denver-Aurora-Lakewood. For the time period July 1, 2018 through June 30, 2019 (Fiscal Year 2018-19), that specific CPI increased by 1.2872426%. Therefore, consistent with statutory constraints, the Division is requesting that all fees paid into the General Licensure Fund be increased by that amount. This increase is expected to generate $28,437, based on the numbers and types of facilities currently licensed. Even with this full increase allowed by statute, the revenues for the General Licensure Fund are expected to be approximately $661,012 less than what is needed to fully fund the full, appropriate direct and indirect costs of licensing, oversight, and enforcement activities for the 902 facilities that pay into the fund for Fiscal Year 2021. The Division anticipates requesting the CPI-based fee increases annually going forward.

The Department requests that the fee increases be effective July 1, 2020.

Specific Statutory Authority.
Statutes that require or authorize rulemaking:

Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), 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 incorporate materials by reference?

_____ Yes ___ URL

___x___ No

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

___x___ Yes

_____ 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.

REGULATORY ANALYSIS
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Clinics
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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/S/B
Facilities paying Chapter 2 fees	31	C
Facilities paying Chapter 4 fees	94	C
Facilities paying Chapter 5 fees	230	C
Facilities paying Chapter 8 fees	142	C
Facilities paying Chapter 9 fees	77	C
Facilities paying Chapter 10 fees	5	C
Facilities paying Chapter 15 fees	80	C
Facilities paying Chapter 18 fees	12	C
Facilities paying Chapter 19 fees	2	C
Facilities paying Chapter 20 fees	127	C
Facilities paying Chapter 21 fees	102	C
Industry/advocacy organizations for the facility types covered above	6	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.

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.

C: Fees are increased by 1.2872426% in the included chapters, causing an estimated total additional cost to licensed facilities of $28,438. The actual additional cost for a specific facility varies depending on the amount of its current fee (e.g., a facility with a current fee amount of $371.44 would see a fee increase of $4.78 per year, while a facility with a current fee of $6,190.62 would see a fee increase of $79.69). The following table provides details on the specific fees by chapter, the amounts of the requested increases, and the increased fee totals. It is important to note that facilities pay only the fee(s) that apply to them (e.g., a new facility pays for an initial license, an existing facility pays for a renewal license).

Entity Type Type of fee	Current Fee	Increase	New Fee
Chapter 2 – General Licensure Standards (31 Facilities)			
Initial License	$371.44	$4.78	$376.22
Renewal License	$371.44	$4.78	$376.22
Conditional License	$1,547.65	$19.92	$1,567.57
Provisional License	$1,031.77	$13.28	$1,045.05
Change of Ownership	$371.44	$4.78	$376.22
Change in Licensed Capacity	$371.44	$4.78	$376.22
Change of Name	$77.38	$1.00	$78.38
Chapter 4 – General Hospitals (94 Facilities)			
Initial License:			
1-25 beds	$8,254.15	$106.25	$8,360.40
26-50 beds	$10,317.69	$132.81	$10,450.50
51-100 beds	$12,897.12	$166.02	$13,063.14
101+ beds (base/per bed/fee cap)	$10,111.34/$51.59/ $20,635.39	$130.16/$0.66/ $265.63	$10,241.50/$52.25/ $20,901.02
Certified Long Term Hospital (base/per bed/fee cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License:			
Deemed 1-50 beds (base/per bed)	$835.73/$12.38	$10.76/$0.16	$846.49/$12.54
Non-deemed 1-50 beds (base/per bed)	$928.59/$12.38	$11.95/$0.16	$940.54/$12.54
Deemed 51-150 beds (base/per bed)	$1,300.03/$12.38	$16.73/$0.16	$1,316.76/$12.54
Non-deemed 51-150 beds (base/per bed)	$1,444.48/$12.38	$18.59/$0.16	$1,463.07/$12.54
Deemed 151+ beds (base/per bed/fee cap)	$1,857.18/$12.38/ $8,254.15	$23.91/$0.16/ $106.25	$1,881.09/$12.54/ $8,360.40

Non-Deemed 151+beds (base/per bed/fee cap)	$2,063.54/$12.38/ $8,254.15	$26.56/$0.16/ $106.25	$2,090.10/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Off-campus location addition—Critical Access Hospital	$515.88	$6.64	$522.52
Off-campus location addition	$1,031.77	$13.28	$1,045.05
Off-campus location renewal—deemed facility	$464.30	$5.98	$470.28
Off-campus location renewal	$515.88	$6.64	$522.52
Off-campus location removal	$371.44	$4.78	$376.22
Chapter 5 – Nursing Care Facilities (230 Facilities)			
Initial License	$6,190.62	$79.69	$6,270.31
Renewal License			
Certified Facilities—Medicare or Medicaid (base/per bed)	$1,650.83/$8.25	$21.25/$.11	$1,672.08/$8.36
Non-certified Facilities (base/per bed)	$3,590.56/$8.25	$46.22/$0.11	$3,636.78/$8.36
Change of Ownership	$6,190.62	$79.69	$6,270.31
Opening a Secure Unit	$1,650.83	$21.25	$1,672.08
Chapter 8 – Facilities for Persons with Intellectual or Developmental Disabilities (142 Facilities)			
Initial License			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Renewal License			
Community Residential Home	$773.83	$9.96	$783.79
Intermediate Care Facility	$1,650.83	$21.25	$1,672.08
Change of Ownership			
Community Residential Home	$2,579.42	$33.20	$2,612.62
Intermediate Care Facility	$6,190.62	$79.69	$6,270.31
Chapter 9 – Community Clinics and Community Clinics and Emergency Centers (77 Facilities)			
Initial License			
Community Emergency Center	$2,837.37	$36.52	$2,873.89
Clinic Operating Inpatient Beds	$2,837.37	$36.52	$2,873.89
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,238.12	$15.94	$1,254.06
Other Clinic	$2,476.25	$31.88	$2,508.13
Renewal License			
Community Emergency	$1,392.89	$17.93	$1,410.82

Center			
Clinic Operating Inpatient Beds	$1,392.89	$17.93	$1,410.82
Clinic Operated Under Auspices of Department of Corrections	$1,341.30	$17.27	$1,358.57
Clinic Serving Un/Underinsured	$619.06	$7.97	$627.03
Other Clinic	$1,238.12	$15.94	$1,254.06
Change of Ownership			
Community Emergency Center	$3,198.48	$41.17	$3,239.65
Clinic Operating Inpatient Beds	$3,198.48	$41.17	$3,239.65
Clinic Operated Under Auspices of Department of Corrections	$2,579.42	$33.20	$2,612.62
Clinic Serving Un/Underinsured	$1,289.71	$16.60	$1,306.31
Other Clinic	$2,579.42	$33.20	$2,612.62
Chapter 10 - Rehabilitation Hospitals (5 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 15 - Dialysis Treatment Clinics (80 Facilities)			
Initial License	$5,303.29	$68.27	$5,371.56
Renewal License			
1-12 Stations	$1,650.83	$21.25	$1,672.08
13-23 Stations	$2,600.06	$33.47	$2,633.53
24+ Stations	$3,544.13	$45.62	$3,589.75
Change of Ownership	$5,303.29	$68.27	$5,371.56
Chapter 18 - Psychiatric Hospitals (12 Facilities)			
Initial License (base/bed/cap)	$5,881.08/$51.59/ $10,833.58	$75.70/$0.66/ $139.45	$5,956.78/$52.25/ $10,973.03
Renewal License (base/bed/cap)	$1,650.83/$12.38/ $8,254.15	$21.25/$0.16/ $106.25	$1,672.08/$12.54/ $8,360.40
Change of Ownership	$2,579.42	$33.20	$2,612.62
Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 19 - Hospital Units (2 Facilities)			
Initial License (base/per bed/ fee cap)	$5,468.38/$51.59/ $10,833.58	$70.39/$0.66/ $139.45	$5,538.77/$52.25/ $10,973.03
Renewal License (base/per bed/ fee cap)	$1,650.83/$12.38/ $3,095.31	$21.25/$0.16/ $39.84	$1,672.08/$12.54/ $3,135.15
Change of Ownership	$2,579.42	$33.20	$2,612.62

Provisional License	$2,579.42	$33.20	$2,612.62
Chapter 20 - Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center (127 Facilities)			
Initial License			
Ambulatory Surgical Center (ASC)	$6,809.68	$87.66	$6,897.34
Ambulatory Surgical Center with Convalescent Center	$7,181.11	$92.44	$7,273.55
Add Convalescent Center to an existing license	$371.44	$4.78	$376.22
Renewal License			
Non-deemed ASC (base/per procedure room/fee cap)	$1,485.75/$206.35/ $3,095.31	$19.13/$2.66/ $39.84	$1,504.88/$209.01/ $3,135.15
Deemed ASC (base/per procedure room/ fee cap)	$1,337.18/$206.35/ $3,095.31	$17.21/$2.66/ $39.84	$1,354.39/$209.01/ $3,135.15
Additional fee for a Convalescent Center	$371.44	$4.78	$376.22
Renewal fee cap for ASC with Convalescent Center	$3,466.74	$44.63	$3,511.37
Change of Ownership			
ASC	$4,230.25	$54.45	$4,284.70
ASC with Convalescent Center	$4,601.69	$59.23	$4,660.92
Provisional			
ASC	$2,579.42	$33.20	$2,612.62
ASC with Convalescent Center	$2,950.86	$37.98	$2,988.84
Chapter 21 - Hospices (102 Facilities)			
Initial License	$6,572.37	$84.60	$6,656.97
Initial License if no other licensed hospice within 60 miles	$4,281.84	$55.12	$4,336.96
Renewal			
Base fee (if no other conditions are met)	$4,023.90	$51.80	$4,075.70
Not in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld counties and providing 75 percent of services outside those counties	$2,476.25	$31.88	$2,508.13
Fewer than 2,000 annual patient dates per most recent Medicare cost report	$1,547.65	$19.92	$1,567.57
Fewer than 1,000 annual	$773.83	$9.96	$783.79

patient dates per most recent Medicare cost report Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area licensed as one entity	$6,603.32	$85.00	$6,688.32
Workstation (per workstation, paid for Initial License and Renewal License)	$51.59	$0.66	$52.25
Change of Ownership	$6,572.37	$84.60	$6,656.97

During the stakeholder process for this fee increase, the stakeholders did not present concerns about economic or non-economic impacts of the change. The benefit of the fee increase is to reduce the shortfall of revenues that support the Division's licensing, oversight, and enforcement activities. Reducing or eliminating these costs would mean that the Division would not have the resources necessary to protect the health, safety, and welfare of Coloradans being served in licensed health facilities.

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

S: N/A

B: N/A

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.

This rule-making is limited to a fee increase of 1.2872426%, thus generating $28,438 to support the Division's ability to protect the health, safety, and welfare of Coloradans being served by facilities ranging from hospitals to group homes.

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:

Licensing fees will continue to be collected and processed using existing procedures. Increasing the amount of the fees collected will not increase the resources needed to collect and process the fees, and thus this proposed fee increase will not have a cost impact on CDPHE.

Anticipated Other State Agency Costs:

The cost of a Community Clinic license for the clinics operated under the auspices of the Department of Corrections will increase $17.27 per clinic. There are currently 23 of these clinics, so the total cost impact of this increase for those clinics will be $397.21.

Anticipated CDPHE Revenues:

This fee increase is expected to generate approximately $28,438, but this amount will not fully fund the revenue shortfall in the General Licensure Fund. Since the April 2019 request, the difference between the revenues and expenditures for the General Licensure Fund has continued to grow. The Division is anticipating that, even with the 3.1769267% increase approved by the Board for Fiscal Year 2020, there will be a $542,132 difference between the expenditures that should be supported by General Licensure Fund revenues. The Division is managing that difference by using General Fund monies, fund balance, and purposely holding positions open rather than filling them when they become vacant. These methods, while appropriate for a short-term fix, are unsustainable.

This rulemaking modifies fees:

Facility-specific fee increases are listed in the table in response to Question 2, above.

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
_X__ Improve public and environmental health practice.
_X__ Implement stakeholder feedback.
___ 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:

The cost of inaction is the Division not exhausting every avenue to secure revenue to meet its expenditures. This in turn limits the Division's ability to fulfill its responsibilities related to licensing, oversight, and enforcement for hospitals, nursing homes, facilities for persons with intellectual and developmental disabilities, community clinics and community clinics with emergency centers, rehabilitation hospitals, dialysis treatment clinics, psychiatric hospitals, ambulatory surgical centers and ambulatory surgical centers with convalescent centers, hospices, and birth centers. The Division's inability to fully perform these functions negatively impacts the health, safety, and welfare of all Coloradans receiving treatment by or residing in these facilities.

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

   No other less costly method or less intrusive method was available as the fees are set in rule per statute.

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

   The Division's options for considering alternatives to the requested fee increase are constrained by the statutory restriction limiting fee increases to annual CPI at Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S. The Division cannot request a larger fee increase without modification to statute. While the Division could raise fees at an amount lower than the CPI increase, this option was not selected because even the maximum increase allowed by statute does not generate enough revenue to offset the expected revenue shortfall.

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 used the federal Bureau of Labor Statistics Data, CPI-All Urban Consumers, Series CUURS48BSA0 (Denver-Lakewood-Aurora) to calculate the amount of fee increase allowed by Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S., and then applied that percentage increase to all fees that are paid into the General Licensure Fund. The increases were rounded to the nearest penny.

STAKEHOLDER ENGAGEMENT
for Amendments to

6 CCR 1011-1, Standards for Hospitals and Health Facilities:

Chapter 2 - General Licensure Standards
Chapter 4 - General Hospitals
Chapter 5 - Nursing Care Facilities
Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
Chapter 9 - Community Clinics and Community Clinics and Emergency Centers
Chapter 10 - Rehabilitation Hospitals
Chapter 15 - Dialysis Treatment Centers
Chapter 18 - Psychiatric Hospitals
Chapter 19 - Hospital Units
Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
Chapter 21 - Hospices

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:

Since this fee increase involves multiple types of facilities and has been an ongoing issue, the Division has chosen to discuss the need for the annual CPI-based increases in a number of different settings, primarily ongoing stakeholder advisory groups and forums such as the 1294 Stakeholder Forum.

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).

__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.

No major factual or policy issues were encountered.

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:

> This is solely a fee increase to maintain existing activities regarding health facility licensing, oversight, and enforcement activities. There are no anticipated impacts on determinants of health or other health equity and environmental justice considerations, values, or outcomes.

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 Chap 02

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 2 Licensure Process

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2.13 License Fees

Unless explicitly set forth elsewhere in 6 CCR 1011-1 or statute, the following non-refundable fees shall apply and be submitted to the Department with the corresponding application or notification. More than one fee may apply depending upon the circumstances.

Initial license	~~$371.44~~ $376.22
Renewal license	~~$371.44~~ $376.22
Conditional license	~~$1,547.65~~ $1,567.57
First provisional license	~~$1,031.77~~ $1,045.05
Second provisional license	~~$1,031.77~~ $1,045.05
Change of ownership	~~$371.44~~ $376.22
Change in licensed capacity	~~$371.44~~ $376.22
Change of name	~~$77.38~~ $78.38
Renewal application late fee	Equal to the applicable renewal license fee including bed fees or operating/procedure room fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 04 - GENERAL HOSPITALS

6 CCR 1011-1 Chap 04

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES

3.101 SUBMITTAL OF FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows:

(a) See table below.

Number of Beds	Fee
1 - 25 beds	~~$8,254.15~~ $8,360.40
26 - 50 beds	~~$10,317.69~~ $10,450.50
51 - 100 beds	~~$12,897.12~~ $13,063.14
101 + beds	Base: ~~$10,111.34~~ $10,241.50
	Per bed: ~~$51.59~~ $52.25
	Cap: ~~$20,635.39~~ $20,901.02

(b) Notwithstanding the provisions of Section 3.101 (1)(a), the initial fee for facilities to be licensed as general hospitals but certified as long term hospitals pursuant to 42 CFR 482 et seq. shall submit: a base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee for long term hospitals shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the following table. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

Number of Beds	Fee	Fee with Deeming Discount
1 - 50 beds	Base: ~~$928.59~~ $940.54 Per bed: ~~$12.38~~ $12.54	Base: ~~$835.73~~ $846.49 Per bed: ~~$12.38~~ $12.54
51 - 150 beds	Base: ~~$1,444.48~~ $1,463.07 Per bed: ~~$12.38~~ $12.54	Base: ~~$1300.03~~ $1,316.76 Per bed: ~~$12.38~~ $12.54
151+ beds	Base: ~~$2,063.54~~ $2,090.10 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40	Base: ~~$1,857.18~~ $1,881.09 Per bed: ~~$12.38~~ $12.54 CAP: $8,360.40

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

(5) Conditional License. A facility that is issued a conditional license by the Department shall submit a nonrefundable fee ranging from 10 to 25 percent of its applicable renewal fee. The Department shall assess the fee based on the anticipated costs of monitoring compliance with the conditional license. If the conditional license is issued concurrent with the initial or renewal license, the conditional license fee shall be in addition to the initial or renewal license fee.

(6) Other Regulatory Functions. If a facility requests an onsite inspection for a regulatory oversight function other than those listed in Sections 3.101 (1) through (3), the Department may conduct such onsite inspection upon notification to the facility of the fee in advance and payment thereof. The fee shall be calculated solely on the basis of the cost of conducting such survey. A detailed justification of the basis of the fee shall be provided to the facility upon request.

(7) Off-Campus Locations

(a) Addition, Annual Renewal and Termination of Off- Campus Locations. A licensee shall submit a nonrefundable fee, as set forth below, for the requested license action.

(i) ~~$1,031.77~~ $1,045.05 for the addition of each location to the list of off-campus locations under the license, except that critical access hospitals shall submit a nonrefundable fee of ~~$515.88~~ $522.52.

(ii) ~~$515.88~~ $522.52 for the annual renewal of each off-campus location listed under the license.

(iii) ~~$464.30~~ $470.28 for the annual renewal of licenses that expire on or after September 1, 2014, for each off-campus location that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(iv) ~~$371.44~~ $376.22 for the removal of each location from the list of off-campus locations under the license.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 5 - NURSING CARE FACILITIES

6 CCR 1011-1 Chap 05

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 32 LICENSING FEES

32.1 All license fees are non-refundable. The total fee shall be submitted with the appropriate license application.

32.2 Initial license - ~~$6,190.62~~ $6,270.31 per facility.

32.3 Renewal license - The annual renewal fee shall be as follows.

Medicare and/or Medicaid certified facility: ~~$1,650.83~~ $1,672.08 base fee plus ~~$8.25~~ $8.36 per bed.

Non-certified facility: ~~$3,590.56~~ $3,636.78 base fee plus ~~$8.25~~ $8.36 per bed.

32.4 Change of ownership - Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter 2, Part 2.7. The fee shall be ~~$6,190.62~~ $6,270.31 per facility.

32.5 Opening a secure unit - A facility that wishes to open a secure unit shall submit a fee of ~~$1,650.83~~ $1,672.08 in addition to any other applicable license fees.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 08 - FACILITIES FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

6 CCR 1011-1 Chap 08

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3 – Licensing Requirements

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3.4 License Fees

All license fees are non-refundable. More than one fee may apply depending upon the circumstances. The total fee shall be submitted with the appropriate license application.

(A) Initial License

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

(B) License Renewal

Effective July 1, ~~2019~~ 2020, the renewal fee shall be:

Community Residential Home: ~~$773.83~~ $783.79.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$1,650.83~~ $1,672.08.

(C) Change of ownership

Change of ownership shall be determined in accordance with the criteria set forth in 6 CCR 1011-1, Chapter II, Part 2. The change of ownership fee shall be:

Community Residential Home: ~~$2,579.42~~ $2,612.62.

Intermediate Care Facility for Individuals with Intellectual Disabilities: ~~$6,190.62~~ $6,270.31.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 09 - COMMUNITY CLINICS AND COMMUNITY CLINICS AND EMERGENCY CENTERS

6 CCR 1011-1 Chap 09

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

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SUBCHAPTER IX.A - GENERAL REQUIREMENTS

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Part 3. DEPARTMENT OVERSIGHT

3.100 APPLICATION FEES.

(1) For new license applications received or renewal licenses that expire on or after July 1, ~~2019~~2020, a non-refundable fee shall be submitted with the license application as follows:

License Category	Initial license	Renewal license	Change of ownership
Community emergency center	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operating inpatient beds	~~$2,837.37~~ $2,873.89	~~$1,392.89~~ $1,410.82	~~$3,198.48~~ $3,239.65
Clinic operated under the auspices of the Department of Corrections	~~$2,579.42~~ $2,612.62	~~$1,341.30~~ $1,358.57	~~$2,579.42~~ $2,612.62
Optional licensure pursuant to Section 2.101 (3)(a)(iv).			
Clinic serving the uninsured or underinsured:	~~$1,238.12~~ $1,254.06	~~$619.06~~ $627.03	~~$1,289.71~~ $1,306.31
Other clinic:	~~$2,476.25~~ $2,508.13	~~$1,238.12~~ $1,254.06	~~$2,579.42~~ $2,612.62

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 10 - REHABILITATION HOSPITALS

6 CCR 1011-1 Chap 10

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES. Fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 15 - DIALYSIS TREATMENT CLINICS

6 CCR 1011-1 Chap 15

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Section 3. FEES

3.1 License fees. All license fees are non-refundable and shall be submitted with the appropriate license application.

(A) Initial license fee - ~~$5,303.29~~ $5,371.56 per facility.

(B) Renewal license fee - For licenses that expire on or after July 1, ~~2019~~2020, the fee shall be based upon the maximum number of a facility's operational procedure stations as set forth below.

1 – 12 stations	~~$1,650.83~~ $1,672.08 per facility
13 – 23 stations	~~$2,600.06~~ $2,633.53 per facility
24 or more stations	~~$3,544.13~~ $3,589.75 per facility

(C) Change of ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, part 2. The fee shall be ~~$5,303.29~~ $5,371.56 per facility.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 18 - PSYCHIATRIC HOSPITALS

6 CCR 1011-1 Chap 18

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the department with an application for licensure as follows:

(1) Initial License: (when such initial licensure is not a change of ownership). A license applicant shall submit a nonrefundable fee with an application for licensure as follows: base fee of ~~$5,881.08~~ $5,956.78 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License.

(a) A license applicant shall submit an application for licensure with a nonrefundable fee as follows: Base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The total renewal fee shall not exceed ~~$8,254.15~~ $8,360.40.

(b) For licenses that expire on or after September 1, 2014, a license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a $160 discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

(3) Change of Ownership. A license applicant shall submit a nonrefundable fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 19 - HOSPITAL UNITS

6 CCR 1011-1 Chap 19

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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Part 3. DEPARTMENT OVERSIGHT

3.101 APPLICATION FEES.

Nonrefundable fees shall be submitted to the Department as specified below.

(1) Initial License (when such initial licensure is not a change of ownership). A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$5,468.38~~ $5,538.77 and a per bed fee of ~~$51.59~~ $52.25. The initial licensure fee shall not exceed ~~$10,833.58~~ $10,973.03.

(2) Renewal License. A license applicant shall submit a fee with an application for licensure as follows: base fee of ~~$1,650.83~~ $1,672.08 and a per bed fee of ~~$12.38~~ $12.54. The renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(3) Change of Ownership. A license applicant shall submit a fee of ~~$2,579.42~~ $2,612.62 with an application for licensure.

(4) Provisional License. The license applicant may be issued a provisional license upon submittal of a fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

CHAPTER 20 - AMBULATORY SURGICAL CENTER AND AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

6 CCR 1011-1 Chap 20

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 24 - LICENSE FEES

24.1 As part of the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7, an applicant for an ambulatory surgical center license shall submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license: A license applicant shall submit with an application for licensure a nonrefundable fee of ~~$6,809.68~~ $6,897.34.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,095.31~~ $3,135.15.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base renewal license fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

BASE FEE	BASE FEE WITH DEEMING DISCOUNT	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,230.25~~ $4,284.70.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,579.42~~ $2,612.62. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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SECTION 25 - AMBULATORY SURGICAL CENTER WITH A CONVALESCENT CENTER

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25.7 License Fees: For new license applications received or renewal licenses that expire on or after March 1, 2015, an applicant for an ambulatory surgical center with a convalescent center license shall comply with the licensing process described at 6 CCR 1011-1, Chapter 2, sections 2.4 through 2.7 and submit, in the form and manner specified by the Department, a license application with the corresponding nonrefundable fee as set forth below:

(A) Initial license:

(1) An applicant for an initial ambulatory surgical center with convalescent center license shall submit with an application for licensure a nonrefundable fee of ~~$7,181.11~~ $7,273.55.

(2) A current ambulatory surgical center licensee that applies to add a convalescent center to the license prior to the expiration of the surgical center license shall submit an application for initial licensure of the convalescent center along with a nonrefundable fee of ~~$371.44~~ $376.22. Upon expiration of the existing surgical center license term, the licensee shall follow the procedure set forth below for a renewal license.

(B) Renewal license: A license applicant shall submit an application for licensure with a nonrefundable fee as shown in the table below. The total renewal fee shall not exceed ~~$3,466.74~~ $3,511.37.

(1) A license applicant that is accredited by an accrediting organization recognized by the Centers for Medicare and Medicaid Services as having deeming authority may be eligible for a 10 percent discount off the base ambulatory surgical center renewal fee. In order to be eligible for this discount, the license applicant shall authorize its accrediting organization to submit directly to the Department copies of all surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the license applicant has full accreditation status.

ASC BASE FEE	ASC BASE FEE WITH DEEMING DISCOUNT	CONVALESCENT CENTER FEE	PROCEDURE ROOM FEE
~~$1,485.75~~ $1,504.88	~~$1,337.18~~ $1,354.39	~~$371.44~~ $376.22	~~$206.35~~ $209.01 PER ROOM

(C) Change of Ownership: The new owner shall submit with an application for licensure a nonrefundable fee of ~~$4,601.69~~ $4,660.92.

(D) Provisional License: The license applicant may be issued a provisional license upon submittal of a nonrefundable fee of ~~$2,950.86~~ $2,988.84. If a provisional license is issued, the provisional license fee shall be in addition to the initial or renewal license fee.

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DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES: CHAPTER 21 - HOSPICES

6 CCR 1011-1 Chap 21

Adopted by the Board of Health on _____, 2020. Effective _____, 2020

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SECTION 14 LICENSE FEES

14.1 All license fees are non-refundable and the applicable fee total shall be submitted with the appropriate license application.

14.2 Initial License - ~~$6,572.37~~ $6,656.97 per hospice.

(A) If there are no licensed hospices within a 60-mile radius of the hospice applying for an initial license, the initial license fee shall be ~~$4,281.84~~ $4,336.96 per hospice.

14.3 Annual Renewal License

(A) For licenses expiring on or after July 1, ~~2019~~ 2020, the base renewal fee shall be ~~$4,023.90~~ $4,075.70 per hospice. The total renewal fee shall reflect all applicable adjustments as set forth below.

(1) For a hospice that is physically located in a county other than Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo or Weld; and that provides at least 75 percent of its services in counties other than those named in this paragraph, the fee shall be ~~$2,476.25~~ $2,508.13 per hospice.

(2) For hospices with less than 2000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$1,547.65~~ $1,567.57 per hospice.

(3) For hospices with less than 1000 annual patient days, as reported on the most recent Medicare cost report, the fee shall be ~~$773.83~~ $783.79 per hospice.

(4) A discount of $300 per hospice shall apply if the same business entity owns separately licensed hospices at more than one Colorado location.

(5) A discount of $425 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

(6) Upon request, the department may waive the fee for a hospice that demonstrates it is a not for profit organization that charges no fees and is staffed entirely by uncompensated volunteers.

(7) Hospices with the same ownership and governing body that provide both home and inpatient hospice care in the same geographic area shall be licensed as one entity. The fee shall be ~~$6,603.32~~ $6,688.32 and no other discounts shall apply except as set forth in (7)(a).

(a) A discount of $640 shall apply if the hospice is deemed by an accrediting organization recognized by the Centers for Medicare and Medicaid Services and remains in good standing with that organization. To be considered for this discount, the hospice shall authorize its accrediting organization to submit directly to the department copies of all the hospice's surveys and plan(s) of correction for the previous license year, along with the most recent letter of accreditation showing the hospice has full accreditation status.

14.4 Workstation Fees

(A) A workstation is an offsite location maintained solely for the convenience of hospice staff to access policies and procedures, obtain forms or use various electronic communication tools. A workstation shall not contain patient records or be used for patient admissions and shall not display any public signage.

(B) In addition to any other licensure fees, a hospice that operates one or more satellite workstations shall pay an annual fee of ~~$51.59~~ $52.25 per workstation. The fee shall be submitted with the initial and/or renewal license application.

14.5 Change of Ownership - change of ownership shall be determined in accordance with the criteria set forth in Chapter II, Part 2. The fee shall be ~~$6,572.37~~ $6,656.97 per hospice.

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COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing Scheduled for April 15, 2020

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 April 15, 2020 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive, South, Denver, CO 80246, to consider the revision of the follow chapters of 6 CCR 1011-1, Standards for Hospitals and Health Facilities:

- Chapter 2 - General Licensure Standards
- Chapter 4 - General Hospitals
- Chapter 5 - Nursing Care Facilities
- Chapter 8 - Facilities for Persons with Intellectual and Developmental Disabilities
- Chapter 9 - Community Clinics and Community Clinics and Emergency Services
- Chapter 10 - Rehabilitation Hospitals
- Chapter 15 - Dialysis Treatment Clinics
- Chapter 18 - Psychiatric Hospitals
- Chapter 19 - Hospital Units
- Chapter 20 – Ambulatory Surgical Center and Ambulatory Surgical Center with a Convalescent Center
- Chapter 21 - Hospices

The proposed rule changes increase fees paid into the General Licensure Fund by 1.2872426%. The proposed rules have been developed by the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment pursuant to Section Sections 25-3-103(1)(c) and 25-3-105(1)(a)(I)(B), C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://www.colorado.gov/pacific/cdphe/boh 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 working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-2999.

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, April 9, 2020. 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 27th day of February, 2020.

Alexandra S. Haas

Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00096

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1015-4

Rule title

STATEWIDE EMERGENCY MEDICAL AND TRAUMA CARE SYSTEM

Rulemaking Hearing

Date

04/15/2020

Time

10:00 AM

Location

Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246

Subjects and issues involved

The proposed rule changes modify the existing chapters to reflect trauma system development over the past 20 years, reorganize to provide a more logical flow of information, and streamline to reduce redundancy.

Statutory authority

Sections 25-3.5-101, 25-3.5-605(2.5), and 25-3.5-704(2), C.R.S.

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COLORADO
Department of Public Health & Environment

To: Members of the State Board of Health

From: Jeanne-Marie Bakehouse, Chief, EMTS Branch

Through: Randy Kuykendall, Director, Health Facilities and Emergency Medical Services Division, DRK

Date: February 19, 2020

Subject: Request for a Rulemaking Hearing concerning 6 CCR 1015-4, Chapters One-Four, Statewide Emergency Medical and Trauma Care System

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In 2017 the Health Facilities and Emergency Medical Services Division, in conjunction with affected stakeholders, began a comprehensive review of all four chapters of the trauma system regulations. The goal of the trauma system rules has always been to get the right trauma patient to the right trauma center in the right amount of time. This is not changing. However the rules have been significantly revised and streamlined with a goal of providing clarity for end users.

Three separate task forces comprised of subject matter experts were convened by the State Emergency Medical and Trauma Services Advisory Council (SEMTAC) and the Division to provide input and guidance on the revision of the trauma rules. Overall, the chapters were modified to reflect the realities of trauma system development over the past 20 years, reorganized to provide a more logical flow of information, and streamlined to reduce redundancy. Some of the chapters, specifically Chapter Two, State Emergency and Medical Trauma Care System Standards, and Chapter Four, Regional Emergency Medical and Trauma Advisory Councils, were reviewed in their entirety for necessary substantive changes. Chapter Three, Designation of Trauma Facilities, received a more targeted substantive review and focused on areas where the existing regulations did not reflect the current practice of trauma medicine and how trauma services are currently delivered. Chapter One, which includes the requirements for the trauma registry, was significantly revised in 2016. Thus the current review focused on non-substantive editorial updates.

The four sets of rules were presented to SEMTAC for review in January 2020. The Division will submit the final sets of rules to SEMTAC for a recommendation of approval in April 2020.

The Division requests that the Board of Health set a rulemaking hearing for April 15, 2020.

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
6 CCR 1015-4, Chapters One-Four, Statewide Emergency Medical and Trauma Care System

Basis and Purpose.

The proposed rules provide significant change to several chapters which have, prior to this, had only minor edits over the past 15 years. The new language more clearly espouses implementation of best practice-based standards and care focused on the unique needs of the patient.

Changes to Chapters One through Four
Completed non-substantive editorial changes including standardization of punctuation and verbiage between the various chapters.

- Updated references.
- Updated definitions and added definitions as necessary. The added definitions provide significantly more clarity to concepts previously mentioned but not defined.
- Removed extraneous definitions.
- Removed duplicative language.
- Added references where appropriate.

Changes to Chapter One – The Trauma Registry

- No substantive changes to this chapter. However, it is being moved, renumbered, and renamed "Chapter Two – The Trauma Registry." This change will provide a more logical flow to the entire 6 CCR 1015-4 rule set.

Changes to Chapter Two – State Emergency Medical and Trauma Care System Standards

- This chapter will be moved and renamed, "Chapter One - State Emergency Medical and Trauma Care System Standards." Moving this chapter places the standards that establish the construct of the trauma system first.
- The content of the new Chapter One is significantly reduced from the previous version, deleting antiquated language and concepts.
- New content better aligns with the components of a trauma system as outlined in Section 25-3.5-701, et seq., C.R.S. and is organized to provide an index of components, directing users to the chapter and section where specific rules can be found.
- New content better reflects the current realities of the Emergency Medical and Trauma Systems as they have evolved over the past 20 years by updating concepts such as air medical transport, scene times, divert, and bypass.
- References are inserted where similar content is discussed in other chapters to eliminate redundant language throughout 6 CCR 1015-4.
- The Prehospital Trauma Triage Algorithms, as contained in Exhibits A and B, are altered to create more consistent language and formatting. In addition, several clarifying statements are added or amended. Further, the potential issues associated with an aging population and trauma services are more significantly acknowledged in the proposed language.

Changes to Chapter Three – Designation of Trauma Facilities

- Combines the Level I and II rules into one unified rule set. The few differences between a Level I and Level II trauma center are highlighted. Redundant language is eliminated.
- Edits to create better uniformity in language across designation levels.
- Combines Level IV and V trauma center regulations, highlighting the few differences between a Level IV and Level V trauma center and eliminating redundant language.
- Clarifies requirements for nondesignated trauma facilities to provide necessary treatment to patients and to ensure the timely movement of trauma patients to designated centers. It also requires facilities to renew nondesignation agreements at least every three years.
- Consolidates rules regarding consultation and transfer into one chapter. Current rules are spread over 6 CCR 1015-4, Chapters Two and Three. Current rules also require many consultations between trauma centers for consideration of transfer. Proposed rules should significantly reduce the number of consultations required while encouraging consultation for unique circumstances or when lower level facilities simply need additional expertise.
- Completes revisions and additions to two sections regarding quality improvement and scope of care at Level III-V trauma centers.
- Removes duplicative language.
- Incorporates additional rules with regard to the management of pediatric nonaccidental trauma.
- Recognizes the value of board certification and Advanced Trauma Life Support (ATLS) certification for continued competency over traditional continuing medical education requirements.
- Adds continuing education requirements for physicians admitting patients at Level IV trauma centers that do not have continuous availability of a surgeon on the trauma call panel.
- Increases board eligibility to seven from five years consistent with current practice.
- Adds requirement for all general surgeons taking trauma call to maintain current ATLS.
- Adds the requirement for a tourniquet for all Level III-V facilities.
- Deletes antiquated requirement for diagnostic peritoneal lavage kit at Level III.
- Completes non-substantive editorial changes including standardization of punctuation and verbiage between the various levels of trauma centers.
- No changes to fees are proposed in this revision.

Changes to Chapter Four – Regional Emergency Medical and Trauma Advisory Councils

- Edits to conform rules to statutory language, to language in other chapters, and to changes in the RETAC program over the years.
- Adds language regarding the statutorily required annual financial report.
- Simplifies and clarifies biennial plan requirements.
- Integrates communication requirements from current Chapter Two into the biennial plan communications system.
- Adds requirement that RETACs develop prehospital destination protocols that are consistent with the Prehospital Trauma Triage Algorithms, as contained in New Chapter One, Exhibits A and B.
- Makes conforming changes to eliminate reference to repealed RETAC requirements contained in Regulation 4, 6 CCR 1009-5, Preparations For Bioterrorist Event, Pandemic Influenza, Or An Outbreak By A Novel And Highly Fatal Infectious Agent Or Biological Toxin.

Specific Statutory Authority.

Statutes that require or authorize rulemaking:
Section 25-3.5-101, et seq., C.R.S.
Section 25-3.5-605(2.5), C.R.S. regarding RETAC biennial plans
Section 25-3.5-704(2), C.R.S., authority for rules establishing a statewide emergency medical and trauma care system including, but not limited to, required services, transport protocols, RETAC duties, facility designation and participation, a statewide trauma registry, injury prevention, and trauma care for pediatric patients.

Other Relevant Statutes:

State Board of Health general authority to promulgate rules section 25-1-108(1)(c)(I), C.R.S.. Colorado Administrative Procedures Act, section 24-4-103, C.R.S., governing the rulemaking process

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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?

___X___ Yes ___ URL

_____ 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.

REGULATORY ANALYSIS
For amendments to
6 CCR 1015-4, Chapters One-Four, Statewide Emergency Medical and Trauma Care System

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
Regional Pediatric Trauma Center and Staff	1	C*/S
Level I Trauma Centers and Staff	5	C*/S
Level II Trauma Centers and Staff	12	C*/S
Level III Trauma Centers and Staff	27	C*/S
Level IV Trauma Centers and Staff	36	C*/S
Level V Trauma Centers and Staff	4	C*/S
Nondesignated Facilities and Staff	+/- 55	C*/S
EMS Providers and Agencies	19,000+ providers ~200 ground ambulance agencies, 34 air ambulance agencies	C/CLG/S
Regional Emergency Medical and Trauma Advisory Councils (RETAC)	11	C/CLG/S
Trauma Patients in Colorado	EMS (2018): 90,000 transports of injured patients (~80,000 were 911 responses, ~10,000 interfacility transports) In 2018, there were 34,098 inpatient records with a primary diagnosis of trauma at Level I-III facilities, plus several thousand patients admitted at Level IV/V trauma centers.	B

* Note: Impact on CLG is limited to any trauma center that is part of a special tax district or operates as a unit of a local government. However, trauma designation is voluntary in Colorado, and the requirements apply uniformly to all trauma centers providing certain services, not specifically to those operating as a part of a local government. Requirements for CLGs are the same as any other similar trauma center.

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.
CLG = local governments that must implement the rule in order to remain in compliance with the law.
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.

Please note that throughout the information below CLG (Local government) is included in Consumers. Nothing in this this rule applies uniquely to local government and nothing is required of local government that is not required of any other entity seeking trauma designation or nondesignation status.

In addition, some RETACs function within local governments while others are incorporated in other ways. All rules apply regardless of how the RETAC is incorporated.

Changes to Chapters One – Four
Economic Outcomes:
None

Non-economic Outcomes:
These changes should provide non-economic benefit particularly for customers, local governments that operate a trauma center, RETACs, stakeholders, and the general public in that they reduce redundancy and provide better clarity for users.

Changes to Chapter One – The Trauma Registry (Becoming Chapter Two)
Economic Outcomes: None
Non-economic Outcomes: None

Changes to Chapter Two – State Emergency Medical and Trauma Care System Standards (This is moving to become Chapter One)
The rules have been significantly revised and streamlined with a goal of providing clarity for end users.

Economic Outcomes:

C and CLG: Trauma patients may be routed past one trauma center in the prehospital setting to get the patient to the most appropriate trauma center (the center with the resources necessary for optimal patient care.) Please note this is NOT a new impact.

S: As above.

B: The economic impact of the Chapter Two rule is not new. Some facilities may be bypassed in the prehospital setting. The positive economic impact for patients is that they will be routed to the facility with the most appropriate resources, not necessarily the closest facility, avoiding a potentially costly interfacility transfer.

Non-Economic Outcomes:

C and CLG: New and revised definitions should create improved clarity for the regulated community. Language regarding mandatory transfer and consultation was moved from Chapter Two to Chapter Three, creating one place where trauma facilities need to look for all rules pertaining to designation. Inclusion of references to national best practice guidelines also provides for the provision of up-to-date care while improving the flexibility of the rules based on the constant changes in current medical practice.

S: The addition of a definition for "advisory" should benefit EMS by providing clarity about which patients should bypass a facility that is having a temporary issue limiting current availability of a specific resource. Again, the goal is to avoid unnecessary transfers.

B: Patients arriving via EMS should arrive at a facility that has the resources to meet their immediate needs during the first EMS transport, benefitting the patient by timeliness and appropriateness of care. This also benefits EMS by reducing interfacility transports.

Changes to Chapter Three – Designation of Trauma Facilities

The rule revision will potentially impact all trauma facilities, including nondesignated facilities, as well as all residents and visitors to Colorado who may need the resources of a trauma center. The benefit to affected classes will be more standardization in the trauma care offered across the state.

Economic Outcomes:

C and CLG: Proposed rules allow certain patients that were previously covered by mandatory transfer rules to be retained in Level III and IV facilities, after a consultation with a higher level of care, when the facility has appropriate resources to safely keep the patient. Further, the proposed revision limits patient costs associated with unnecessary transport. In addition, the revised rules contain fewer situations requiring consultation resulting in the need for fewer phone calls that do not result in actual patient transfer.

New rules require some additional consultations for pediatric patients being admitted for nonaccidental trauma. The consultations will create a new requirement for trauma centers admitting such patients, but this is balanced by not requiring transfer of all such patients. The fiscal impact of such required consults should be negligible as many consults happen already and are generally not billed.

The mandatory transfer criteria are not new, although the concept has evolved in this iteration of the rules. The task force concluded that requiring certain transfers ensures that potential pitfalls in care are not overlooked by lower level facilities or facilities with resource limitations when diagnosing and treating patients with complicated injuries. This revenue stream cannot be analyzed by Department

personnel since costs are not collected in trauma registry data; however, it would appear that the number of patients affected by the proposed changes is small, and the revenue will still be captured elsewhere in the trauma system.

There are new requirements for Level III-V facilities stating explicit mandatory transfer for certain pediatric patients. These rules generally codify current practice. Few of these children were kept at lower level trauma centers. The task force proposed these changes for mandatory transfers in order to ensure this vulnerable population receives the care it needs.

Discontinuing the requirement for most physicians to have a certain amount of continuing medical education should have a significant positive economic impact on trauma centers. Large facilities, some with hundreds of physicians to track, should see a reduction in FTE necessary to track such extensive requirements. Even the smallest facilities should see a reduction in the time spent tracking this requirement.

S: N/A

B: The department cannot quantify economic impact, as we do not have those data. However, the proposed rules should be at least cost-neutral to the trauma patient as they do not increase costs for trauma centers. Furthermore, if the rules have the intended impact of reducing interfacility transfers by getting patients to the right place the first time or by allowing the patient to remain closer to home, the rules should actually reduce costs for consumers.

Non-economic Outcomes:

C and CLG: Patients will benefit from the new regulations in that numerous rules have been rewritten to stress what resources are necessary to ensure the safe care of the patient. In addition the proposed rules encourage rapid and appropriate transfer of patients, after stabilization, if the facility does not have the resources to meet all patient needs.

All designated trauma centers and nondesignated facilities will benefit from having more clearly stated expectations for the transfer and care of patients. The proposed rules also work to ensure that potential pitfalls in care are not overlooked by lower level facilities when it comes to the diagnosis and treatment of complex trauma patients.

In addition, rule changes reflect the changing nature of trauma care and encourage use of current best practice models when available, encourage consultation and consideration of transfer when there is uncertainty, and require specialty consultation for at-risk pediatric patients.

Requirements for every level trauma center to have an explicit scope of practice should benefit facilities and patients alike by providing clearer parameters for which patients are able to be admitted. Again, the goal is to reduce unnecessary transfer.

S: EMS providers in the trauma system benefit by the implementation of revised prehospital trauma triage algorithms, providing better clarity on the destination for trauma patients.

B: The revised Chapter Three rules will mostly benefit individuals who live in medically underserved areas; one such change is the decrease in mandatory consultations for "consideration of transfer." These consultations have been problematic in that they are often seen as only a requirement to fulfill and not as a valuable source of information. The proposed revisions provide clarity that the focus is on the needs of patient. The revised rules also protect patients by requiring transfer when all concomitant services are not available. For example, current Rule 305.2.A requires Level III and IV trauma facilities to conduct a mandatory consultation after performing emergent surgery if they do not have the resources to care for the patient; transfer is discretionary. The proposed rule mandates transfer to a trauma center with the resources to meet the patient's needs.

The rules also assure that patients are kept at the closest hospital where all necessary services are available and are treated according to best practice standards.

Additional requirements for pediatric patients with nonaccidental trauma should help ensure the safe and comprehensive treatment of this vulnerable population without multiple additional transfers. Stakeholders were extensively involved in the development of these criteria and achieved agreement that the proposed rules are in the best interest of an extremely vulnerable trauma population.

Changes to Chapter Four – Regional Emergency Medical and Trauma Advisory Councils

Economic Outcomes:

In general, the revised Chapter Four reorganizes and updates the language of the existing RETAC rules and does not impose significant new requirements on the RETACs or local government.

C and CLG: The Department's Office of Emergency Preparedness and Response (OEPR) Regulation 4 (6 CCR 1009-5) required RETACs to perform a series of different emergency preparedness functions such as maintaining contact notification lists, conducting notification tests, and advising pre-hospital EMS agencies within the region on emergency plan development. The OEPR concluded that Regulation 4 was redundant due to the number of other entities within the state that are performing these same functions. In May 2019, the Board repealed Regulation 4 as unnecessary and unenforceable. Consequently, the proposed changes to Chapter Four delete the requirement that RETACs comply with the repealed bioterrorism rule.

The Prehospital Trauma Triage Algorithms in the current Chapter Two and the new Chapter One, 6 CCR 1015-4, require EMS providers to follow "Destination Instructions Per RETAC Protocol." Proposed Section 403.4 ensures uniform RETAC compliance by codifying the requirement that RETACs must develop prehospital destination protocols that conform to the algorithms. Minimal costs to implement this requirement are expected since RETACs have already been developing regional destination protocol guidelines. However, this change will help ensure that all trauma patients within the state get to "the right place" without unnecessary transfers or travel.

Proposed Section 405 requires the RETAC to submit an annual financial report to the State Emergency Medical and Trauma Services Advisory Council (SEMTAC) detailing how the

RETAC has spent moneys received. The annual financial report has been a statutory requirement since 2002 and is now being added to the rules. There should not be any new economic burdens on Cs and CLGs.

S: No economic outcome.

B: No economic outcome.

Non-economic Outcomes:

C and CLG: The requirement that the RETACs must develop prehospital destination protocols that conform to the new Chapter One Prehospital Trauma Triage Algorithms will result in a regional prehospital destination plan that ensures consistent, timely, and safe prehospital transport to the appropriate trauma facility.

S: Under proposed Section 403.4 RETACs will be required to develop prehospital destination protocols that conform to the Prehospital Trauma Triage Algorithms in the new Chapter One, 6 CCR 1015-4. EMS providers in the trauma system will benefit by receiving clear guidance concerning prehospital emergency transport. Additionally, the required guidelines will reduce the need for interfacility transports.

B: The regional destination protocol guidelines will also benefit patients by ensuring that all trauma patients within the RETAC are transported to "the right place at the right time."

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:

These rule changes should be cost neutral to CDPHE. For instance, compliance with rule changes with regard to trauma destination will be reviewed during trauma designation site reviews, staff visits, and reports on plans of correction, as they are currently handled.

Anticipated CDPHE Revenues:

N/A

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

C. 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:

__XX Comply with a statutory mandate to promulgate rules.
___ Comply with federal or state statutory mandates, federal or state regulations, and department funding obligations.
__XX_ Maintain alignment with other states or national standards.
__XX_ Implement a Regulatory Efficiency Review (rule review) result
__XX_ Improve public and environmental health practice.
__XX_ 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 20, 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_ Advance CDPHE Division-level strategic priorities.

The Division's goal is to provide the regulated community a set of standards that are simple, clear, and not redundant. This rule revision significantly clarifies the requirements while reducing redundancy. It provides additional freedom to facilities that have additional resources while protecting the minimum standards upon which all facilities are measured.

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 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.

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

The Chapter Two task force encountered two policy issues at the beginning of the stakeholder process that resulted in rulemaking suggestions the Department could not support as the requested actions exceeded the scope of the Department's rulemaking authority.

A. Existing 6 CCR 1015-4, Chapter Two, 202B sets forth prehospital ambulance response times. Consequently, the Chapter Two task force understandably perceived the subject matter of this existing rule and its underlying policy to lie within its rulemaking authority. However, the Department's internal review of this rule led it to conclude that it does not possess the statutory authority to impose rulemaking governing prehospital transport response times. While this process is an important component of the trauma system, the General Assembly has placed regulation of ground ambulance response times within the purview of counties. See Section 25-3.5-308(3), C.R.S.

Therefore, the Department advised the task force that the Department lacks the statutory authority to regulate prehospital ambulance response times. Some task force members countered that regulated response times that conform with best

practice standards would improve the state trauma system for which it was crafting rules. Ultimately, the task force recognized that its jurisdiction does not extend to ground ambulance prehospital response times and agreed to eliminate the rule.

B. Reacting to constraints such as the one discussed above, the Chapter Two task force proposed that it author and forward to SEMTAC a "vision statement" addressing statewide trauma care system best practices for global trauma issues, including those over which the Department lacks regulatory authority. The Department commended the stakeholders for their desire to improve the state trauma system but advised that we lack statutory authority to recommend regulation of entities and subject matters that lie outside our rulemaking boundaries.

C. Additional documentation regarding alternative rules that were considered can be found in the Stakeholder Engagement Section of this packet. See pp. SE 3-9.

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.

Chapters One – Four

The Department and task forces did not utilize numerical data. Rather, they relied heavily on the expertise and experience of task force members, as well as upon information and opinions provided by professional organizations, when developing the proposed rules. The national organization and federal regulation resources include:

The recommendations and standards published by the American College of Surgeons; Committee on Trauma (https://www.facs.org/quality-programs/trauma/tqp/center-programs/vrc);
Recommendations and practice guidelines published by the American College of Emergency Physicians (https://www.acep.org/, click on practice);
The American Academy of Pediatrics (https://www.aap.org/en-us/Pages/Default.aspx); and 42 C.F.R. § 482.15 (2019).

In order to ensure that the Department received the broadest amount of expertise and experience, staff reached out to potentially affected facilities to ensure that those facilities had the opportunity to attend meetings or provide written feedback.

STAKEHOLDER ENGAGEMENT
for Amendments to
6 CCR 1015-4, Chapters One-Four, Statewide Emergency Medical and Trauma Care System

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)
EMTS on the Go (newsletter mailing list)	This weekly newsletter is emailed to a list of 1800+ constituents from the EMS and trauma systems and provides details for all public meetings hosted by the EMTS Branch. The newsletter notified recipients of all meetings for each chapter over the course of the stakeholder process.
Chapter Two Revision Task Force	Kim Muramoto, Centura Health, chair. For list of members and interested parties see attachments.
Chapter Three Revision Task Force	Same as Chapter Two Task Force
Chapter Four Revision Task Force	John Hall, Summit County Ambulance, chair. For list of members and interested parties see attachments.
Expanded Scope Task Force	Charles Mains, Centura Health, chair
Trauma Coordinators and Trauma Program Managers	This list of 200 employees and managers represents the leadership of trauma programs at each of the 85 designated trauma centers and other interested parties.
RETAC Forum (RETAC Coordinators and RETAC Board Members)	This includes RETAC coordinators, other staff, and RETAC board members representing each of the 11 EMS and trauma regions. Over 60 individuals were updated about the trauma rulemaking processes on a quarterly basis.
State Emergency Medical and Trauma Services Advisory Council	32-member, governor appointed advisory council which MUST recommend any draft rule changes prior to presenting the proposed rules to the Board of Health. Periodic updates concerning the proposed rules were given throughout the rule revision process. The Department provided SEMTAC with the final proposed rules for all four chapters in January 2020.

	The Department will ask SEMTAC for a vote of support in April 2020.
Statewide Trauma Advisory Committee	11-member committee representing a variety of EMTS disciplines and comprised of a minimum of six SEMTAC members. Periodic updates concerning the proposed rules were given throughout the rule revision process.
Colorado Hospital Association	Gail Finley, Amber Burkhart
Pediatric Emergency Care Committee	Christine Darr, MD; Kathleen Adelgais, MD
Regional Medical Directors (representing most of the 11 RETACs)	Jeff Beckman, MD; Matt Angelidis, MD; Bill Clark; Michelle Flemmings, MD; Avery MacKenzie, MD; Addy Marantino; Joshua Poles, DO; Pat Thompson, MD; Sarah Weatherred; Kevin Weber, MD

Changes to Chapter One – The Trauma Registry

This chapter is not being changed, with the exception of the title, which will now be "Chapter Two – The Trauma Registry." With no substantive changes, this chapter did not require early stakeholder engagement. However, the State Emergency Medical and Trauma Services Advisory Council (SEMTAC), the Regional Emergency Medical and Trauma Advisory Councils, and the Statewide Trauma Advisory Committee have all been informed of the changes.

Chapter Two – State Emergency Medical and Trauma Care System Standards

The Chapter Two Task Force met monthly from November 2017 – November 2018. The meetings were public, and participation was available via telephone and web conference. Members represented SEMTAC, regional medical directors, the Colorado Hospital Association, RETACs, Emergency Medical Services Association of Colorado (EMSAC-the professional association for EMS providers), EMS Chiefs or Managers, Level I, II, III, and Level IV-V trauma centers, rural areas, EMS systems or emergency management, pediatric care representatives, and interested parties.

Chapter Three – Designation of Trauma Facilities

The Chapter Three Task Force met monthly from February 2019 – December 2019. The meetings were public, and participation was available via telephone and web conference. Membership was continuous from the Chapter Two Task Force and again represented SEMTAC, regional medical directors, the Colorado Hospital Association, RETACs, EMSAC, EMS Chiefs or Managers, Level I, II, and III, and Level IV-V trauma centers, rural areas, EMS systems or emergency management, pediatric care representatives, and interested parties.

Chapter Four – Regional Emergency Medical and Trauma Advisory Councils

The Chapter Four Task Force met monthly from December 2017 – October 2018 and inSeptember 2019 for some additional conforming language. The meetings were public, and participation was available via telephone and web conference. Membership represented each of the 11 RETACs, the Colorado Office of Emergency Preparedness and Response, a county commissioner from SEMTAC, and interested parties.

Each of the above committees met with a planned agenda and draft regulatory language to consider. Information about each meeting was sent to the public through the weekly "EMTS on the Go." A sample advert is listed here:

> "**Trauma Chapter Three Task Force** -- July 10, 8 to 9:45 a.m.; Adams State University, McDaniel Hall, Alamosa, Teleconferencing will be available at 1-669-900-6833, meeting ID: 589-098-195. The meeting will also be broadcast over Zoom. All meeting materials will be available here. If you have questions please email Martin Duffy."

Agendas, draft minutes, and all other documents were posted on a google drive with public access. Task Force members and interested parties were encouraged to engage other stakeholders in the discussions and to provide verbal or written comment for consideration at the next meeting.

Stakeholders were involved in every phase of this rule development process, including the initiation of three task forces that recommended the rule changes. Membership of the task forces encompassed care-givers (both physicians and nurses) from level I though V trauma centers, RETACs, and other interested parties. (See Attached Membership Rosters) All task force meetings were public. During the three years of task force meetings, there were many points of disagreement, but what the Board of Health is currently considering is a consensus document approved by task forces.

Additionally, the draft rule change was advertised as a discussion point at the October 2019 and January 2020 Statewide Trauma Advisory Committee and State Emergency Medical and Trauma Services Advisory Council meetings. The State Emergency Medical and Trauma Services Advisory Council will vote in April 2020 to recommend that the proposed rule change be brought to the Board of Health by the Department.

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_ N/A. This is a Request for Rulemaking Packet. Notification will occur if the Board of Health sets this matter for rulemaking.

____ Yes.

Summary of Major Factual and Policy Issues Encountered and the Stakeholder Feedback Received:

There were several points of disagreement along the way in this rule revision process. The Department presented all feedback to the task forces for additional discussion. When task force members or the public disagreed at task force meetings, the group explored options where consensus could be reached. In the few instances where consensus could not be reached, the task force membership voted, and majority-approved language was adopted. Each Task Force unanimously approved the modifications to the chapters it reviewed. The draft that the Board is considering is a compilation of those task forces' work.

Changes to Chapter One – The Trauma Registry – no changes, no disagreement.

Changes to Chapter Two – State Emergency Medical and Trauma Care System Standards

A. Communication Rules Moved from Chapter Two to Chapter Four:

Section 202.A of the existing Chapter Two rules addresses the minimum coordinated communications and dispatch system standards with which regions must comply. The Chapter Two task force concluded that these regional standards are more aptly considered by RETACs. Therefore, it requested the Chapter Four task force to consider whether regional communications standards should more appropriately be included in Chapter Four. The Chapter Four task force agreed that regional communications standards properly fall within RETAC jurisdiction and elected to incorporate the substance of Chapter Two's Section 202.A into Chapter Four as newly promulgated Section 406.B.7. Pursuant to that new rule, each RETAC must address and describe a myriad of communication system issues and methods employed within the region.

The Chapter Two task force addressed trauma communications in Chapter One, Section 109. The rule requires trauma facilities to meet all communications requirements appropriate to their designation levels.

B. Divert and Bypass Standards Moved from Chapter Two to Renumbered Chapter One, and conforming "Divert" definition revised in Chapter Three:

The current Chapter Two rules include a section that addresses the seven circumstances in which trauma facilities may go on "divert" status, as well as operating guidelines that govern facility diversion. (Section 202.E). Current Section 202.F provides that the prehospital trauma algorithms and other unique situations may require prehospital emergency transport providers to "bypass" the nearest trauma facility in favor of another. The Chapter Two task force determined that these standards should be updated to the extent necessary to reflect current best practices.

Discussion concerning the divert rule centered upon two notions: first, that facilities should be discouraged from going on divert status unless necessary; second, whether RETACs should be required to develop protocols informing and coordinating divert communications. The task force came to consensus upon a streamlined definition of "divert status" to reflect "[t]he facility cannot currently accept EMS traffic. EMS shall transport trauma patients to an alternate destination in accordance with the prehospital trauma triage algorithm." See proposed Chapter One, Section 100.7. The task force also elected to relocate the substance of current Section 202.E into proposed Chapter One, Section 101.2.A-D. And rather than imposing an extra-jurisdictional divert requirement upon RETACs, the task force promulgated new Section 101.2.D which requires trauma facilities to notify all impacted EMS agencies and local facilities of the divert status. The definition of "divert" was modified in Chapter Three to comport with the new Chapter One definition, and Chapter Three designation rules were modified to conform with and reflect that designated trauma facilities must provide complying divert notifications.

The task force engaged in robust debate concerning the new bypass definition and attendant rules. Bypass is now defined in Chapter One, Section 100.3 as "EMS transport of a trauma patient past a routinely used or closer receiving facility for the

purpose of accessing a higher level of trauma or specialty care." Disagreement primarily occurred over the new bypass rules (Section 101.3.A-B), based upon stated concerns that EMS providers may possibly allow personal bias, opinion, or value judgments about trauma facilities and/or facility staff to influence their invocation of "bypass" protocols. To address these concerns, the task force solicited stakeholder and public opinion concerning whether RETACs should be required to develop bypass protocols, or whether medical directors should be required to provide input before bypass protocols are invoked. The Department disagreed with these suggested policies on the grounds that they might result in additional complications. For example, the Department pointed out that mandatory medical director input might very well result in the appearance of bias should the medical director instruct EMS providers to bypass to other trauma facilities within the medical director's system. The Department advocated that EMS providers in the trauma system should be directed to follow the RETAC protocols and to solicit medical director guidance in circumstances where those protocols fail to address the bypass situation. The Department and Chapter Two task force reached consensus on the issue by agreeing to new language (Chapter One, Section 101.3.A-B) which provides that bypass protocols are driven by the best interests of the patient and the RETAC protocols contained in the algorithms.

The task force also amended Chapter Three Level I and II designation rules to incorporate conforming bypass provisions.

C. New Advisory Definition and Rule:

No dissension was encountered over the Chapter Two task force's decision to include a new definition and rule concerning a trauma facility's advisory status for trauma patients. The task force distinguished a divert situation, where all traffic must be routed away from the trauma facility, from circumstances where the trauma facility might experience a shortage of a specific resource only. Therefore, the task force promulgated this definition for "advisory"—"The trauma facility is experiencing a specific resource limitation." The accompanying Chapter One rule, Section 101.4 provides that, unlike divert status, "[t]he trauma facility may issue an advisory when it is experiencing specific resource limitations but is able to accept trauma patients who do not require the limited resource." Under these circumstances, "[a]mbulance agencies are advised to consider transport to other trauma facilities as time and conditions allow for patients impacted by the specific advisory."

D. Adult and Pediatric Prehospital Algorithms:

The Chapter Two task force addressed the use of prehospital algorithms by requiring EMS providers to transport adult and pediatric trauma patients in accordance with national best practice guidelines and the algorithms included in Chapter One as Exhibits A and B. The Chapter Two task force also updated the prehospital algorithms, most notably to include two new conditions on the adult algorithm (*e.g.*, low impact mechanism for older adults with suspicion of injury; and suspicion of nonaccidental trauma).

The task force discussed whether to develop a separate geriatric trauma algorithm. After consideration of the medical evidence, the task force was not able to come to consensus concerning the necessity of a separate algorithm, so it did not develop one.

Changes to Chapter Three – Designation of Trauma Facilities

A. Patient-Centric Rules:

Numerous references were changed in Chapter Three to create additional emphasis on the needs of the patient as opposed to the requirements of the facility. The phrase "…with the necessary resources to meet the patient's needs…" was added eight times to emphasize that the needs of the patient are paramount to other concerns such as convenience of the facility or staff, proximity, or organizational affiliation. There was no disagreement among the regulated community on this point, since the best interest of the patient is a stated value across the industry and is consistent with the legislative intent of the trauma system.

B. Continuing Medical Education (CME):

One issue that received substantial and sometimes disparate public feedback was the issue of continuing medical education and the value of required ATLS for physicians, particularly those who are also required to maintain board certification. Most of the task force and interested parties agreed that there is not an industry standard for how much continuing education is required to create a "safer" environment, and that education, on its own, does not necessarily change or improve practice.

The stakeholder community engaged in a robust discussion on this topic. Most stakeholders were in agreement that continuing education requirements for trauma were redundant with the physicians' requirements for continued board certification. In addition, the amount of time and energy required for tracking physician CME, particularly at larger institutions, is not commensurate with identifiable benefits. Finally, the national standards put forth by the American College of Surgeons have removed requirements for CME. As a result, most requirements for physician CME and some certification requirements were removed from these proposed rules. Stakeholders agreed with these recommendations.

One recommendation engendered significant debate. Chapter Three, 307.2.F.(5) reads, "Physicians admitting trauma patients at Level IV facilities without the continuous availability of a surgeon on the trauma call panel, as demonstrated by a published call schedule, shall have 10 trauma-specific CME hours annually, or 30 CME hours over the three year period preceding any site review." The discussion took place over several meetings between which the trauma program staff reached out to potentially affected facilities. After this outreach, outreach by the Colorado Hospital Association, and some clarification of the proposed language, the task force voted unanimously to endorse this new requirement. It was noted that these physicians are already required to have CME for their board renewal requirements, and this simply requires that some of those CME be devoted to topics of use in the care of trauma patients.

C. Neurosurgery and Orthopedic Surgery in Level I and II Facilities:

The task force discussed the idea that Level I and II trauma centers have very similar clinical platforms and that with a few exceptions (research, training, and some sub-specialties), the requirements for the levels should align, particularly in terms of response requirements.

The proposed language for both neurosurgery and orthopedic surgery indicate that the basic requirements for these specialties should be congruent between Level I and Level II facilities. The task force and stakeholders also agreed that the requirements should be congruent between the two specialties. The goal is to assure that whether trauma patients arrive at a Level I or Level II facility, they will have prompt access to a neurosurgeon or an orthopedic surgeon in the event of an emergency condition that requires those service lines.

D. Mandatory Transfers, Consults, and Scope of Care:

Current Chapter Two, which is being reorganized and renamed as Chapter One, contains mandatory transfer and mandatory consult criteria for pediatric and adult patients across all levels of trauma centers. Since compliance with these mandatory criteria has been assessed as part of the trauma designation process, it makes sense to reorganize these criteria into Chapter Three, the trauma designation rule set.

All trauma centers will now be required to write a detailed scope of care that describes what inpatient services are and are not available to pediatric and adult patients. In keeping with the patient-centric focus of the rules, facilities of all levels are directed to transfer patients requiring a specialty or service not available to a trauma center with the resources necessary to meet that specific need. While the Level I and II clinical platforms are very similar, there are resources that are limited even at this level of care, for example, burn care, pediatric specialties, microvascular surgery. Facilities are to determine if a trauma patient might benefit if transported to a lower level of care that offers more focused resources for the specific patient.

During this rule drafting process, stakeholders raised the issue of the significant burden that mandatory consults add to the trauma system. Consults must be documented on both ends of the conversation and are sometimes seen as not providing value to patient care. The task force viewed these concerns seriously and has proposed a rule set that contains fewer requirements for mandatory consult. Those that do exist focus on cases where the patient has unique injuries that require expertise not widely available (e.g., nonaccidental trauma or minor head trauma at Level III and IV facilities). The proposed rules should result in fewer consultations performed just to “check a box.”

Mandatory Transfer and Scope of Care, Level I and II: Even for Level I and II facilities, the scope of care policy will help inform decisions regarding mandatory transfers. The scope of care gives more freedom in determining which patients are appropriate for admission. For example, will pediatric head injuries be admitted or transferred? However, the policy will also be used to assess whether the facility is following its own scope of care or admitting patients that would be better served elsewhere.

Mandatory Transfers Level III –V Trauma Centers: Existing language was considered and some criteria were directly moved to Chapter Three, including mandatory transfer of aortic tears and liver injuries requiring packing. Other criteria were discussed and debated with decisions being made on the basis of what services are mandatory at every Level III or Level IV center. Decisions regarding the proposed transfer requirements focused on whether an injury was likely to be manageable at a Level III or IV facility not offering an expanded scope of care.

While all of these issues (scope of care, mandatory transfers, mandatory consults) generated discussion and significant rewording of some items, in the end, the lists of mandatory consults and transfers were adopted by the task force with agreement that the draft rules were in the best interest of patients.

E. Disaster Management:

Disaster management and emergency preparedness requirements were updated for Level I and II facilities. The current rule references outdated standards, whereas the proposed rules reference current federal standards issued by the Centers for Medicare and Medicaid Services that all hospitals must meet as a condition of program participation. Thus, the new rules will ensure that Level I and II trauma centers are prepared for emergencies while not creating any additional burden above federal requirements. No stakeholders disagreed with this change.

F. Nondesignated Facility Rules:

The Chapter Two task force decided to move all interfacility transfer and consultation provisions pertaining to nondesignated facilities into Chapter Three. Thus the current Chapter Two provisions that address nondesignated facility transfer and consultation (Sections 202.C.4, 202.D.6, 202.D.7, and 202.D.9), are now codified in Chapter Three, Section 301.3.A-B.

After extensive review of the existing rules, the Chapter Three task force agreed that trauma patient safety concerns require rule modifications to ensure the safe and timely delivery of Colorado trauma patients to the most appropriate trauma facility. Three rule revisions demonstrate the task force's patient-centric intent.

First, in Section 301.3.A.3, the task force developed a more refined triage, treatment, and interfacility transport rule based on different levels of patient need. In particular, the task force imposed a more prescriptive one-hour transfer timeline for trauma patients requiring emergent surgery, but kept the two-hour transfer timeline for other sets of trauma patients. These revised proposed rules ensure the safe and timely transfer of trauma patients to appropriate facilities with the resources necessary to meet the patient's needs. The proposed rule also clarifies triage and mandatory transfer responsibilities attendant to nondesignated facilities when dealing with different classes of trauma patients.

Second, the current rule requires transfer from a nondesignated facility "to the closest appropriate trauma facility as defined by RETAC protocols." The task force considered stakeholder input from rural and urban settings and weighed the value to trauma patients of retaining the geographic "closest appropriate" language. Ultimately the task force promulgated new Section 301.3.A.3, which substitutes language requiring "transfer to a trauma center with the resources necessary to meet the patient's [emergent] needs." The consensus of the task force was that the new rule requiring safe and timely transfer to a trauma facility with resources most appropriate for the patient advances the safety interests of the trauma patient in any setting.

Third, proposed Section 303.3.B requires nondesignated facilities to communicate and consult with its RETAC at least once every three years. The purpose of the rule is to ensure that nondesignated facilities are aware of the key resource facilities, communication systems, and various trauma resources within their regions that they

can access and utilize when treating and transporting trauma patients. Again, the task force advanced this new rule to bolster the safety and best interests of trauma patients who are treated, triaged, and transported by nondesignated facilities.

G. New Pediatric Nonaccidental Trauma Rules

Currently, Chapter Three Section 306.3.D.11 requires Level IV facilities to transfer trauma patients of all ages who have suspected or actual nonaccidental trauma injuries and require additional social or clinical resources. Task force consultation with pediatric trauma specialists led to the policy conclusion that pediatric nonaccidental trauma patients merit additional protections that are found in designated trauma facilities. To that end, it proposed two new rules to ensure pediatric nonaccidental trauma patient safety.

Section 303.9.C will require Level I and II facilities to transfer pediatric nonaccidental trauma patients requiring care beyond the facility's resources to a regional pediatric trauma center or facility with the necessary resources. Further, the task force unanimously agreed that these facilities shall consult with a child maltreatment specialist affiliated with a trauma center for diagnostic and care purposes.

Renumbered Section 305.3.C.5.k continues to require Level III and IV facilities to transfer nonaccidental trauma patients of all ages who require additional resources. However, in new Section 305.3.B.4, the task force unanimously agreed to impose the additional mandatory child maltreatment specialist consultation requirement upon Level III and IV facilities that admit pediatric patients with nonaccidental traumatic injury.

Changes to Chapter Four – Regional Emergency Medical and Trauma Advisory Councils

A. Role of RETAC

The Chapter Four task force initially addressed the role of RETACs in the state trauma system and concluded that RETACs are resources, not regulators. Accordingly, the proposed rule more clearly aligns the biennial plans with statutory requirements.

The Task Force also discussed whether the RETAC rules should incorporate the guiding principles of "EMS Agenda 2050: A PEOPLE-CENTERED VISION FOR THE FUTURE OF EMERGENCY MEDICAL SERVICES"[1] and the "people centered" focus of the Agenda. Again, the Task Force decided to focus on the relevant statutory provisions when revising the current rule.

[1] Guiding Principles: Inherently Safe & Effective; Integrated & Seamless; Reliable & Prepared; Socially Equitable; Sustainable & Efficient; and Adaptable & Innovative. EMS Agenda 2050 Technical Expert Panel. (2019, January). EMS Agenda 2050: A People-Centered Vision for the Future of Emergency Medical Services (Report No. DOT HS 812 664). Washington, DC: National Highway Traffic Safety Administration.

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

These rules are designed to benefit all people who receive emergency medical and trauma services in Colorado. They also enhance focus on patient safety in the trauma system.

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.	X	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.		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.	X	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.	X	Ensures a competent public and environmental health workforce or health care workforce.
	Other:_____ _____		Other:_____ _____

ATTACHMENT 1: Chapters Two and Three Task Forces Membership Roster

Role	Name	Affiliation	RETAC
SEMTAC and Task Force Chair	Kim Muramoto	RN, Centura Health	Mile-High
Regional medical directors	Stein Bronsky	MD, Penrose, Medical director P2P	P2P
Colorado Hospital Association	Gail Finley	CHA	
	Amber Burkhart	CHA	
RETACs	Addy Marantino	RETAC Coordinator, NWRETAC	NW
	Kim Schallenberger	P2P RETAC	P2P
EMSAC or Chiefs, Managers, etc.	Mitch Wagy	EMSAC	NE
	Tim Nowak	EMSAC	P2P
Level I trauma centers	Mitch Cohen	MD, Surgeon, Denver Health	Mile-High
	Melissa Sorensen	RN, Swedish Medical Center	Mile-High
Level II trauma centers	Vic Janoski	RN, Parkview	Southern
	Marilyn Sykes-Johnson	RN, Injury Prev, North Colo Medical Ctr	NE
Level III trauma centers	Keyan Riley	MD, TMD, Memorial North	P2P
	David Steinbruner	Memorial/Memo North	P2P
Level IV-V trauma centers	Jodi Kramer	RN, TPM, St. Joseph	Mile-High
	Patti Thompson	RN, San Luis Valley Reg. Medical Center	SLV
Rural Representative	Elizabeth Reis	Pagosa Mountain Hospital	SW
	Diana Koelliker,	Telluride Medical Center	Western
EMS systems or emergency mgmt	Kathy Mayer	Flight For Life	Foothills
Pediatric care rep	Kathleen Adelgais	MD, Children's, PECC	Mile-High
	Christine Darr	MD, Emergency physician, P/SL, PECC	Mile-High
Interested Parties	Linda Underbrink	Foothills RETAC	Foothills
	Jenna Steege	Longmont United	Foothills
	Wendy Erickson	St. Francis	P2P
	Cassie Greene	Colorado Plains	NE
	Pamela Howes	RN, MedEvac	NE
	Pam Bourg	RN, TPM, Centura Health	Foothills
	Krista Turner	MD, Surgeon, The Medical Ctr of Aurora	Mile-High
	Kathy Beauchamp	MD, neurosurgeon, Denver Health	Mile-High
	Robbie Dumond	RN, TPM, University of CO (Anschutz)	Mile-High
	Pam Bourg	RN, TPM, Centura Health	Foothills
	Heather Finch	RN, TPM, Memorial, with Marissa Mclean	P2P
	Marissa McLean	Backup to Heather Finch	
	Thomas Schroeppel	MD, TMD, Memorial	P2P
	Heather Sieracki	RN, Penrose (backup to Dr Hamilton)	P2P
	David Hamilton	MD, TMD, Penrose	P2P
	Abigail Blackmore	RN, TPM, St Anthony	Foothills
	George Theofanous	Comm Center Director, MedEvac	NE
	Carolle Anne Banville	Denver Health	Mile-High
	Barry Platnick	Denver Health	Mile-High
	Lara Rappaport	Denver Health	Mile-High
	Nate Hinze	Backup to Adelgais	
	Cecile D'Huyvetter	RN, MSN, South State Director, Centura	P2P
	Rick Lewis	EMS Chief, South Metro	Mile-High

	Bill Hall	MD, St. Mary's Grand Junction	NW

ATTACHMENT 2: Chapter Four Task Force Membership Roster

Role	Name	Affiliation	Position
SEMTAC Commissioner	Sean Wood		
SEMTAC Commissioner	David Weaver		Backup
SEMTAC and Task Force Chair	John Hall		Chair
RETACs	Jamie Woodworth	Central Mountains RETAC	Primary
	Anne Montera	Central Mountains RETAC	Secondary
	Tom Candlin	Foothills RETAC	Primary
	Linda Underbrink	Foothills RETAC	Secondary
	Charlie Mains	Mile-High RETAC	Primary
	Shirley Terry	Mile-High RETAC	Secondary
	Dave Bressler	Northeast Colorado RETAC	Primary
	Jeff Schanhals	Northeast Colorado RETAC	Secondary
	Mel Stewart	Northwest RETAC	Primary
	Addy Marantino	Northwest RETAC	Secondary
	Wendy Erickson	Plains to Peaks RETAC	Primary
	Kim Schallenberger/Tim Dienst	Plains to Peaks RETAC	Secondary
	Rodney King	San Luis Valley RETAC	Primary
	Jon Montano	San Luis Valley RETAC	Secondary
	Aaron Eveatt	Southeastern Colorado RETAC	Primary
	Josh Eveatt	Southeastern Colorado RETAC	Secondary
	Tom Anderson	Southern RETAC	Primary
	Brandon Chambers	Southern RETAC	Secondary
	Patrick Cain	Southwest RETAC	Primary
	Terri Foechterle	Southwest RETAC	Secondary
	Glenn Boyd	Western RETAC	Primary
	Kim Mitchell	Western RETAC	Secondary
	Danny Barela	Western RETAC	Secondary
Interested Parties	Gail Finley	Colorado Hospital Association	
	Amber Burkhardt	Colorado Hospital Association	
	Julie Bridges		
	Bill Clark		
	Kirby Clock		
	Richard Cornelius		
	Caroline Dullien		
	Ben Dunn		
	Chris Duran		
	Heather Finch		
	John Foechterle		
	Tim Grey		
	Josh Hadley		
	Stephanie Haley-Andrews		
	Tim Hurtado		
	Marissa McLean		

	Kathy Marden		
	Lori McDonald		
	Chris Montera		
	Toni Moses		
	Tim Nowak		
	Jordan Ourada		
	Bobby Putnam		
	John Recicar		
	Paul Reckard		
	Ron Seedorf		
	Mary Jo Seiter		
	Heather Sieracki		
	Elizabeth Spradlin		
	Andrew Srotnak		
	Pam Vanderberg		
	Reg Vickers		

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STATEWIDE EMERGENCY MEDICAL AND TRAUMA CARE SYSTEM

6 CCR 1015-4

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

CHAPTER ~~TWO~~ONE - STATE EMERGENCY MEDICAL AND TRAUMA CARE SYSTEM STANDARDS

INDEX TO SECTIONS

~~**201. In order to ensure effective system development, all regions must comply with the following minimum standards.**~~

~~**202. Minimum Standards for Regional Emergency Medical and Trauma Care Resources**~~

~~A. Communication~~

~~The region must provide communication and dispatch systems that insure coordinated coverage, specifically:~~

~~1. Utilization of the universal 9-1-1 or a local equivalent that is well publicized and accessible for citizens and visitors to the region.~~

~~2. Adequate dispatch services.~~

~~3. Paging and alerting system for notification of emergency medical/trauma personnel who routinely respond to emergency medical/trauma incidents.~~

~~4. Two-way communications between and among ambulances.~~

~~5. Two-way communications between ambulances and non-designated facilities and designated trauma facilities.~~

~~6. Two-way communications between ambulances and trauma facilities outside the Regional Emergency Medical and Trauma Advisory Council (RETAC) area.~~

7. A plan for utilization of an alternative communications system to serve as a back-up to the primary system.

8. A disaster communications plan.

9. A system for notification and alerting trauma teams, fixed and rotary wing emergency services, and trauma centers.

10. A system that is compatible with systems in adjacent regions.

B. Prehospital

First response units and ambulance services must meet the following criteria:

1. Minimum acceptable level of service:

a. Basic life support (BLS) service - Must have at least 1 person who is at first responder or higher level of training

b. Advanced life support (ALS) service - Must have at least 1 person who is at EMT-I or EMT-P level of training

2. Emergency response times for ground transport agencies:

	Time Limit
a. High density areas (metropolitan)	
(1) Provider service area encompasses 100,000 people or more	11 minutes, 90% of the time
b. Mid-density areas (urban or mixed)	
(1) Provider service area encompasses12,000 to 100,000 people	20 minutes, 90% of the time
c. Low density areas (rural, frontier)	
(1) Provider service area encompasses <12,000 people	45 minutes, 90% of the time

3. Optimal scene time limits — 15 minutes, 90% of the time

Scene time = time of arrival of transport agency at the scene to departure of the scene

4. Agencies shall conduct quality improvement monitoring for all response and scene times that exceed these parameters and make a plan of correction where necessary

5. Triage and transport of trauma patients must be in accordance with the prehospital transport destination algorithms (exhibits A and B to these regulations)

C. Interfacility Transfer and Consultation - Adult - Age 15 and older

1. Levels II and III trauma centers caring for the critically injured adult trauma patients listed below must comply with the actions required:

a. Bilateral pulmonary contusions requiring nontraditional ventilation

b. Patient with multisystem trauma with pre-existing coagulopathy (hemophilia)

c. Pelvic fractures with unrelenting hemorrhage

d. Aortic tears

e. Liver injuries requiring emergency surgery and requirement for liver packing or vena cava injury

Actions Required:

(1) Mandatory, timely (but within 6 hours after recognition of condition) consultation is required with a Level I trauma surgeon (who is a member of the attending staff) for consideration of transfer of the patient. The attending trauma surgeon of the referring facility should initiate the consultation.

(2) Consultation with the attending trauma surgeon is required in the determination of the necessity of transfer and the circumstances of transfer including, but not limited to, additional diagnostic/therapeutic issues, availability of resources, weather conditions.

2. Level III trauma centers caring for the high risk adult trauma patients with the following traumatic injuries must comply with the actions required:

a. Significant head injuries (intracranial bleeding or Glasgow Coma Scale (GCS) ≤ 10) or spinal cord injury with neurologic deficit where neurosurgical consultation and evaluation are not promptly available

b. Significant multisystem trauma as defined by:

(1) Head injury (intracranial bleeding or GCS ≤ 10) or spinal cord injury with neurologic deficit complicated by either significant chest and/or abdominal injuries as defined by:

(a) Chest Injury (as part of multisystem injuries):

i) Multiple rib fractures > 4 unilaterally or > 2 bilaterally

ii) Hemothorax

(b) Abdominal Injury (as part of multisystem trauma):

i) Significant intra or retroperitoneal bleeding

ii) Hollow organ or solid visceral injury

c. Bilateral femur fracture or posterior pelvic fracture complicated by significant chest and/or abdominal injuries as defined above

d. Trauma patient on mechanical ventilation for > 4 days

e. Life threatening complications, such as acute renal failure (creatinine > 2.5 mg/dl) or coagulopathy (twice the normal value for individual facility)

Actions Required:

(1) Mandatory timely (but within 12 hours after recognition of condition) consultation is required with a Level I or key resource facility trauma surgeon (who is a member of the attending staff) for consideration of transfer of the patient. The primary attending physician at the Level III facility should initiate the consultation.

(2) Consultation with the trauma surgeon is required in the determination of the necessity of transfer and the circumstances of transfer including, but not limited to, additional diagnostic/therapeutic issues, availability of resources, weather conditions.

(3) Consultation and/or transfer decisions in patients with traumatic injuries less severe than those listed above shall be determined by the RETAC based on resources, facilities, and personnel available in the region and shall be made in accordance with RETAC protocols.

3. Level IV trauma centers caring for patients with the following traumatic injuries must comply with the actions required:

a. Critical injuries listed in 6 CCR 1015-4, Chapter Two, Section 202, C.1

b. Significant head injuries (intracranial bleeding or GCS ≤ 10) or spinal cord injury with neurologic deficit

c. Significant multisystem trauma as defined by:

(1) Head injury (intracranial bleeding or GCS ≤ 10) or spinal cord injury with neurologic deficit complicated by either significant chest and/or abdominal injuries as defined by:

(a) Chest Injuries (as part of multisystem trauma):

i) Multiple rib fractures > 4 unilaterally or > 2 bilaterally

ii) Hemothorax

(b) Abdominal Injuries (as part of multisystem trauma):

i) Significant intra or retroperitoneal bleeding

ii) Hollow organ or solid visceral injury

d. Bilateral femur fracture or posterior pelvic fracture complicated by either significant chest or abdominal injuries as defined above

e. Trauma patient on mechanical ventilation

f. Life threatening complications, such as acute renal failure (creatinine > 2.5 mg/dl) or coagulopathy (twice the normal value for individual facility)

Actions required:

(1) Mandatory timely (but within 6 hours after recognition of condition) transfer is required for patients with the above defined injuries.

(2) The primary attending physician at the level IV trauma center shall consult with the attending trauma surgeon at the key resource facility prior to transfer to determine the most appropriate destination for such patients and to discuss the circumstances of transfer such as additional diagnostic/therapeutic issues, availability of resources, weather conditions, etc.

(3) Consultation and/or transfer decisions in patients with traumatic injuries less severe than those listed above shall be determined by the RETAC based on resources, facilities, and personnel available in the region and shall be in accordance with RETAC protocols.

4. Nondesignated Facilities

Within two hours of recognition that a patient has experienced a significant injury or mechanism as defined in 6 CCR 1015-4, Chapter Two, Sections 202C, 202D or the prehospital algorithms (exhibits A and B), the facility shall resuscitate, stabilize and/or initiate transfer of the patient, after consultation with a trauma surgeon or emergency physician at the closest designated trauma center. Transfer shall be to the closest appropriate trauma facility as defined by RETAC protocols and as determined in consultation with the trauma surgeon or emergency physician. Nondesignated facilities must transfer all trauma patients except those defined in 6 CCR 1015-4, Chapter Two, Section 202.C.5.

5. Noncomplicated Trauma Injuries

Interfacility transfer of single system injuries that are not threatening to life or limb and whose care is not complicated by co-morbid conditions shall be made in accordance with RETAC protocols. RETACs must monitor transport within their regions and report systematic exceptions to the protocols or regulations to the department.

6. RETACs must monitor treatment and transfer of patients with the above conditions.

Documentation and quality improvement monitoring must be completed on such patients. Systematic exceptions of the standards must be reported to the department. For example, if significantly injured patients with multisystem trauma injuries are consistently transported to undesignated or level IV facilities, such transport deviation from the standards would constitute a systematic exception that must be reported.

7. RETACs are responsible for ensuring that interfacility transfer agreements exist in all facilities transferring patients within and outside the area.

D. Interfacility Transfer and Consultation [1,2] - Pediatric - Age 0-14

1. For the purpose of 6 CCR 1015-4, Chapter Two, Section 202.D. “critical injuries” are defined as any of the following:

a. Bilateral pulmonary contusions requiring non-traditional ventilation

b. Multisystem trauma with preexisting or life threatening coagulopathy

c. Pelvic fractures with unrelenting hemorrhage

d. Aortic tears

e. Liver injuries with vena cava injury or requiring emergency surgery with liver packing

f. Coma for longer than 6 hours or with focal neurologic deficit

2. For the purpose of 6 CCR 1015-4, Chapter Two, Section 202.D,”high risk injuries” are defined as any of the following:

a. Penetrating injuries to head, neck, torso, or proximal extremities

b. Injuries resulting in the need for mechanical ventilation of > 16 hours

c. Persistent in-hospital evidence of physiologic compromise including: tachycardia relative to age plus signs of poor perfusion (capillary refill test > 2 seconds, cool extremities, decreased pulses, altered mental status, or respiratory distress), hypotension

d. Hemodynamically stable children with documented visceral injury admitted for "observational" management and requiring blood transfusion or fluids > 40cc/kg

e. Injury Severity Score ≥ 9 including, but not limited to:

(1) Multisystem blunt injuries (> 2 systems)

(2) Pelvic or long bone fractures in conjunction with multisystem injuries

(3) Altered mental status (GCS <10) with significant trauma

3. For the purpose of 6 CCR 1015-4, Chapter Two, Section 202.D. "high risk mechanisms" are defined as any of the following high energy transfer mechanisms:

a. Falls > 20 feet

b. Auto crashes with significant vehicle body damage

c. Significant motorcycle crashes

d. All terrain vehicle crashes

4. Level II trauma centers with pediatric commitment designation (LII/PC) that care for pediatric patients (age 0-14 years) with critical injuries must comply with the actions required:

Actions required:

a. Mandatory timely (but within 6 hours after recognition of condition) consultation [1,2] is required with an attending trauma surgeon from a Regional Pediatric Trauma Center (RPTC) or a Level I trauma center with Pediatric Commitment (LI/PC).

5. Level I and II trauma centers without pediatric commitment and Level III centers caring for pediatric trauma patients (age 0-14 years) with critical injuries or high risk injuries must comply with the actions required:

Actions required:

a. Children 0 - 5 years of age with critical injuries shall be transferred with prior consultation [1,2] to a RPTC. If such a center is not available, then transfer [1,2] shall be to a LI/PC. If such a center is not available, then transfer shall be to a LII/PC. If no center with pediatric commitment is available, transfer [1,2] shall be to the highest level trauma center available.

b. Children 6 - 14 years of age with critical injuries. Mandatory timely (but within 6 hours after recognition of condition) consultation [1,2] is required with an attending trauma surgeon at a RPTC or a LI/PC for consideration of transfer of the patient.

c. Children 0 - 14 years of age with high risk injuries. Mandatory timely (but within 6 hours of recognition of condition) consultation [1,2] is required with an attending trauma surgeon at a RPTC or LI/PC for consideration of transfer of the patient.

6. Level IV trauma centers and nondesignated facilities caring for pediatric patients (age 0-14 years) with critical injuries or high risk injuries must comply with the actions required:

Actions required:

a. Children 0 - 5 years of age with critical injuries shall be transferred [1,2] to a RPTC. If such a center is not available, then transfer [1,2] shall be to a LI/PC. If such a center is not available, then transfer shall be to a LII/PC. If no center with pediatric commitment is available, transfer [1,2] shall be to the highest level trauma center available.

b. Children 6 - 14 years of age with critical injuries shall be transferred [1,2] to a RPTC or a LI/PC. If such a center is not available, then to a LII/PC. If no center with pediatric commitment is available, transfer [1,2] to the highest level trauma center available.

c. Children 0 - 5 years of age with high risk injuries shall be transferred [1,2] to either a RPTC or a LI/PC. If such a center is not available, then to a LII/PC. If no center with pediatric commitment is available transfer [1,2] to the highest level trauma center available.

d. Children 6 - 14 years of age with high risk injuries shall be transferred with prior consultation [1,2] to either a RPTC, LI/PC or LII/PC. If no center with pediatric commitment is available then transfer to the highest level trauma center available.

7. Level IV trauma centers and nondesignated facilities caring for pediatric patients (age 0-14 years) who are injured by high risk mechanisms shall comply with the actions required:

Actions required:

a. Mandatory timely (but within 6 hours) consultation [1,2] is required with an attending trauma surgeon from a RPTC , LI/PC or LII/PC for consideration of transfer.

8. Consultation and/or transfer decisions in pediatric patients with traumatic injuries less severe than those listed above shall be determined by the RETAC based on resources, facilities, and personnel available in the region and shall be in accordance with the RETAC protocols.

9. Nondesignated Facilities

Nondesignated facilities that receive and are accountable for pediatric trauma patients (age 0-14 years) with any traumatic conditions other than non-complicated, non-life threatening, single system injuries must transfer those patients to the appropriate, designated trauma center. Transfer agreements are required.

10. RETACs must monitor transport of pediatric trauma patients within their regions and report systematic exceptions to the protocols or regulations to the department.

11. Where superscript [1] and/or [2] appear, the following shall apply:

[1] Consultation is required in the determination of the necessity of transfer and the circumstances of transfer including, but not limited to, additional diagnostic/therapeutic issues, availability of resources, weather conditions.

[2] Consultation must be initiated by the attending trauma surgeon of the referring Level I, II, or III trauma center or attending physician of the Level IV or nondesignated facility.

E. Divert

If coordinated within the RETAC and pursuant to protocol, facilities may go on divert status for the following reasons:

1. Lack of critical equipment

2. Operating room saturation

3. Emergency department saturation

4. Intensive care unit saturation

5. Facility structural compromise

6. Disaster

7. Lack of critical staff

Redirection of trauma patient transport shall be in accordance with the prehospital trauma triage algorithms (exhibits A and B) and these regulations when a trauma center is on divert status.

Trauma facilities must keep a record of times and reasons for going on divert status. This information must be made available for RETAC and/or department audit.

RETACs must audit facility diversion of trauma patients in their areas. Upon consideration of the reason for divert status, the authorizing personnel and other pertinent facts, RETACs may institute corrective action if the diversion was not reasonable or necessary.

F. Bypass

At times the prehospital trauma triage algorithms (exhibits A and B) may require that prehospital providers bypass the nearest facility to transport the patient to a higher level trauma center. The necessity for such bypass must be initially determined by the physiologic criteria in the algorithms. However, certain situations may require different transport such as excessive expected transport time to the nearest trauma center, or lengthy extrication time requiring air evacuation, or other emergency conditions (traumatic cardiac arrest or transfer to a subspecialty center).

RETACs must develop protocols for patient destination within their areas that address bypass for situations not addressed in the algorithms. Bypass situations must be monitored, and the RETAC must require justification for deviation.

203. Exemptions or Variances

~~The State Emergency Medical and Trauma Services Advisory Council (SEMTAC) may grant exemptions from one or more standards of these regulations if the applicant submits information that demonstrates that such exemption is justified.~~

~~SEMTAC must find, based upon the information submitted and other pertinent factors, that particular standards are inappropriate because of special circumstances, which would render such compliance unreasonable, burdensome or impractical. Exemptions or variances may be limited in time, or may be conditioned, as SEMTAC considers necessary to protect the public welfare.~~

100. DEFINITIONS

1. ADULT – ANY PATIENT AGE 15 AND OLDER IS CONSIDERED AN ADULT IN THE TRAUMA SYSTEM.

2. ADVISORY – THE TRAUMA FACILITY IS EXPERIENCING A SPECIFIC RESOURCE LIMITATION.

3. BYPASS – EMS TRANSPORT OF A TRAUMA PATIENT PAST A ROUTINELY USED OR CLOSER RECEIVING FACILITY FOR THE PURPOSE OF ACCESSING A HIGHER LEVEL OF TRAUMA OR SPECIALTY CARE.

4. DEPARTMENT - THE COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT.

5. DESIGNATED – A STATUS THAT THE DEPARTMENT ASSIGNS TO A HEALTH CARE FACILITY BASED ON THE LEVEL OF TRAUMA SERVICES THE FACILITY IS CAPABLE OF AND COMMITTED TO PROVIDING TO INJURED PERSONS. DESIGNATION LEVELS INCLUDE LEVELS I THROUGH V, AS DEFINED IN 25-3.5-703(4)(a)-(e), C.R.S., REGIONAL PEDIATRIC TRAUMA CENTERS AS DEFINED IN 25-3.5-703(4)(f), AND NON-DESIGNATED FACILITIES.

6. DISASTER MEDICAL CARE – MEDICAL CARE PROVIDED DURING THE OCCURRENCE OR IMMINENT THREAT OF WIDESPREAD OR SEVERE DAMAGE, INJURY, ILLNESS, OR LOSS OF LIFE RESULTING FROM AN EPIDEMIC OR A NATURAL, MAN-MADE, TECHNOLOGICAL, OR OTHER CAUSE.

7. DIVERT STATUS– THE FACILITY CANNOT CURRENTLY ACCEPT EMS TRAFFIC. EMS SHALL TRANSPORT TRAUMA PATIENTS TO AN ALTERNATE DESTINATION IN ACCORDANCE WITH THE PREHOSPITAL TRAUMA TRIAGE ALGORITHM.

8. FACILITY – FOR PURPOSES OF THESE RULES, ANY DESIGNATED HEALTH CARE FACILITY, REGIONAL PEDIATRIC TRAUMA CENTER, OR NON-DESIGNATED HEALTH CARE FACILITY.

9. INTERFACILITY TRANSFER - THE MOVEMENT OF A TRAUMA PATIENT FROM ONE LICENSED HEALTHCARE FACILITY PARTICIPATING IN THE TRAUMA SYSTEM TO ANOTHER LICENSED HEALTHCARE FACILITY PARTICIPATING IN THE TRAUMA SYSTEM.

10. NON-DESIGNATED – A FACILITY THAT HAS NOT MET THE CRITERIA OF LEVELS I-V OR REGIONAL PEDIATRIC TRAUMA CENTERS (RPTC) , BUT THAT RECEIVES AND IS ACCOUNTABLE FOR INJURED PERSONS, INCLUDING HAVING A TRANSFER AGREEMENT TO TRANSFER PERSONS TO LEVEL I TO V OR RPTC FACILITIES AS SET FORTH IN SECTION 25-3.5-703(4)(a.5)-(f), C.R.S. AND THESE RULES. “NON-DESIGNATED” IS CONSIDERED A DESIGNATION LEVEL PURSUANT TO SECTION 25-3.5-703(4)(a), C.R.S.

11. PEDIATRIC – ANY PATIENT FROM BIRTH THROUGH AGE 14 IS CONSIDERED A PEDIATRIC PATIENT IN THE TRAUMA SYSTEM.

12. PREHOSPITAL TRANSPORT - TRANSPORT BY AIR OR GROUND AMBULANCE SERVICE OF A TRAUMA PATIENT TO THE MOST APPROPRIATE RECEIVING FACILITY CONSISTENT WITH THE RETAC DESTINATION PROTOCOLS AND GUIDELINES AND THE BEST INTEREST OF THE PATIENT.

13. REGIONAL EMERGENCY MEDICAL AND TRAUMA SERVICES ADVISORY COUNCIL (RETAC) – THE REPRESENTATIVE BODY APPOINTED BY THE GOVERNING BODIES OF COUNTIES OR CITIES AND COUNTIES FOR THE PURPOSE OF PROVIDING

RECOMMENDATIONS CONCERNING REGIONAL AREA EMERGENCY MEDICAL AND TRAUMA SERVICE PLANS FOR SUCH COUNTIES OR CITIES AND COUNTIES.

14. TRAUMA TRANSPORT PROTOCOLS - WRITTEN STANDARDS ADOPTED BY THE STATE BOARD OF HEALTH THAT ADDRESS THE USE OF APPROPRIATE RESOURCES TO MOVE TRAUMA VICTIMS FROM ONE LEVEL OF CARE TO ANOTHER ON A CONTINUUM OF CARE.

15. TRAUMA CARE SYSTEM - MEANS AN ORGANIZED APPROACH TO PROVIDING QUALITY AND COORDINATED CARE TO TRAUMA VICTIMS THROUGHOUT THE STATE ON A TWENTY-FOUR-HOUR PER DAY BASIS BY TRANSPORTING A TRAUMA VICTIM TO THE APPROPRIATE DESIGNATED FACILITY.

101. PREHOSPITAL CARE

1. PREHOSPITAL ALGORITHMS

A. ADULT PATIENTS: SCENE TRANSPORT FOR ADULTS WITH TRAUMA OR SUSPECTED TRAUMA SHALL BE IN ACCORDANCE WITH NATIONAL BEST PRACTICE GUIDELINES, THE ALGORITHM FOUND IN EXHIBIT A OF THESE RULES, AND APPLICABLE RETAC PROTOCOLS.

B. PEDIATRIC PATIENTS: SCENE TRANSPORT FOR PEDIATRIC PATIENTS WITH TRAUMA OR SUSPECTED TRAUMA SHALL BE IN ACCORDANCE WITH NATIONAL BEST PRACTICE GUIDELINES, THE ALGORITHM FOUND IN EXHIBIT B, AND APPLICABLE RETAC PROTOCOLS.

2. FACILITY DIVERT STATUS

A. FACILITIES MAY GO ON DIVERT STATUS FOR THE FOLLOWING REASONS:

(1) LACK OF CRITICAL EQUIPMENT

(2) OPERATING ROOM SATURATION

(3) EMERGENCY DEPARTMENT SATURATION

(4) INTENSIVE CARE UNIT SATURATION

(5) FACILITY STRUCTURAL COMPROMISE

(6) INTERNAL/EXTERNAL DISASTER

(7) LACK OF EQUIPMENT/STAFF NECESSARY TO SAFELY AND ADEQUATELY CARE FOR THE TRAUMA PATIENT

B. WHEN A TRAUMA CENTER IS ON DIVERT STATUS, DESTINATION OF THE TRAUMA PATIENT SHALL BE IN ACCORDANCE WITH THE PREHOSPITAL TRAUMA TRIAGE ALGORITHMS (EXHIBITS A AND B).

C. TRAUMA FACILITIES MUST KEEP A RECORD OF TIMES AND REASONS FOR GOING ON DIVERT STATUS FOR AT LEAST 3 YEARS. THIS INFORMATION MUST BE MADE AVAILABLE FOR RETAC AND/OR DEPARTMENT AUDIT UPON REQUEST.

D. TRAUMA FACILITIES MUST NOTIFY IMPACTED EMS AGENCIES AND IMPACTED LOCAL FACILITIES OF DIVERT STATUS IN A MANNER CONSISTENT WITH RETAC PROTOCOLS.

Commented [BM1]: Moved and edited from current rules Chapter Two, 202.E (very similar to existing language)

3. BYPASS FOR TRAUMA PATIENTS

A. AT TIMES, THE BEST INTERESTS OF THE PATIENT AND THE PREHOSPITAL TRAUMA TRIAGE ALGORITHMS (EXHIBITS A AND B) MAY REQUIRE THAT PREHOSPITAL PROVIDERS BYPASS THE NEAREST FACILITY TO TRANSPORT THE PATIENT TO A HIGHER LEVEL TRAUMA CENTER OR FOR SPECIALTY CARE.

B. WHETHER BYPASS IS NECESSARY MUST INITIALLY BE DETERMINED BY THE CRITERIA IN THE ALGORITHMS. HOWEVER, DEVIATIONS FROM THE ALGORITHMS MAY OCCUR DUE TO THE PATIENT'S EMERGENCY CONDITIONS, EXCESSIVE TRANSPORT TIME TO THE NEAREST TRAUMA CENTER, SPECIFIC MEDICAL DIRECTION, OR IF IT IS DETERMINED THAT AIR TRANSPORT IS THE MOST APPROPRIATE OPTION FOR THE PATIENT.

Commented [BM2]: Moved and edited from current rules Chapter Two, 202.F (somewhat similar to existing language)

4. ADVISORY FOR TRAUMA PATIENTS

THE TRAUMA FACILITY MAY ISSUE AN ADVISORY WHEN IT IS EXPERIENCING SPECIFIC RESOURCE LIMITATIONS BUT IS ABLE TO ACCEPT TRAUMA PATIENTS WHO DO NOT REQUIRE THE LIMITED RESOURCE. AMBULANCE AGENCIES ARE ADVISED TO CONSIDER TRANSPORT TO OTHER TRAUMA FACILITIES AS TIME AND CONDITIONS ALLOW FOR PATIENTS IMPACTED BY THE SPECIFIC ADVISORY.

102. TRANSPORT PROTOCOLS

1. WHEN AN AIR OR GROUND AMBULANCE SERVICE TRANSPORTS A TRAUMA PATIENT TO A RECEIVING FACILITY, ITS DETERMINATION OF WHAT CONSTITUTES THE MOST APPROPRIATE RECEIVING FACILITY MUST CONFORM WITH:

A. THE APPLICABLE RETAC PLAN ASSESSMENT OF REGIONAL CONSIDERATIONS AS REQUIRED BY CHAPTER FOUR, 6 CCR 1015-4, SECTION 406.2.B.1; AND

B. THE RETAC TRAUMA DESTINATION PROTOCOL AS REQUIRED BY 6 CCR 1015-4, CHAPTER FOUR, SECTION 406 AND CHAPTER ONE, EXHIBITS A AND B.

2. EACH DESIGNATED AND NON-DESIGNATED FACILITY SHALL MEET THE TRANSFER REQUIREMENTS, INCLUDING TRANSFER AGREEMENTS AS REQUIRED BY STATUTE AND IN RULE, APPROPRIATE TO ITS DESIGNATION LEVEL, AS SET FORTH IN 6 CCR 1015-4, CHAPTER THREE.

3. EVERY LICENSED HEALTHCARE FACILITY THAT PARTICIPATES IN THE TRAUMA SYSTEM SHALL DEVELOP AND IMPLEMENT PROTOCOLS THAT, AT MINIMUM, ADDRESS THE FOLLOWING COMPONENTS OF THE TRAUMA SYSTEM AS SET FORTH IN 6 CCR 1015-4, CHAPTER THREE:

A. WHEN A PATIENT ARRIVES AT A FACILITY, THE FACILITY WILL PROVIDE THE PATIENT WITH THE APPROPRIATE AVAILABLE CARE BASED ON THE PATIENT'S INJURY, WHICH MAY INCLUDE STABILIZATION BEFORE TRANSFERRING TO A HIGHER LEVEL OF CARE OR SPECIALTY CARE;

B. IF THE PATIENT REQUIRES A HIGHER LEVEL OF CARE OR SPECIALTY CARE THAT IS NOT AVAILABLE, THE FACILITY SHALL TRANSFER THE PATIENT AS

SOON AS MEDICALLY FEASIBLE TO THE APPROPRIATE FACILITY, WHICH MAY BE IN OR OUT OF THE STATE; AND

C. WHEN DETERMINING WHAT RECEIVING FACILITY IS THE MOST APPROPRIATE TRAUMA FACILITY FOR THE INJURED PERSON, THE SENDING FACILITY SHALL CONSIDER, AT MINIMUM:

(1) ACCESSIBLITY TO THE RECEIVING FACILITY BY GROUND OR AIR TRANSPORT,

(2) TRANSPORT TIME TO THE RECEIVING FACILITY BY GROUND OR AIR TRANSPORT,

(3) TREATMENT OPTIONS AND TRANSPORT MODES THAT BEST MEET THE NEEDS OF THE PATIENT DURING GROUND OR AIR TRANSPORT, AND

(4) WHETHER THE BEST INTERESTS OF THE PATIENT REQUIRE THE ATTENDING PHYSICIAN AT THE SENDING FACILITY TO EXERCISE HIS OR HER DISCRETION TO BYPASS A CLOSER FACILITY.

103. HOSPITAL/FACILITY CARE

HOSPITAL/FACILITY CARE INCLUDES ALL CARE PROVIDED TO THE TRAUMA PATIENT IN LICENSED HEALTHCARE FACILITIES THAT ARE GOVERNED BY THE RULES AND REGULATIONS OF 6 CCR 1015-4, CHAPTER THREE AND 6 CCR 1015-4, CHAPTER FOUR, SECTION 406.

104. REHABILITATIVE CARE

EACH FACILITY SHALL MEET THE REHABILITATIVE CARE REQUIREMENTS APPROPRIATE TO ITS DESIGNATION LEVEL, AS SET FORTH IN 6 CCR 1015-4, CHAPTER THREE.

105. INJURY PREVENTION

EACH FACILITY SHALL MEET THE INJURY PREVENTION PROGRAM REQUIREMENTS APPROPRIATE TO ITS DESIGNATION LEVEL, AS REQUIRED BY 6 CCR 1015-4, CHAPTER THREE AND 6 CCR 1015-4, CHAPTER FOUR.

106. EDUCATION AND RESEARCH

EACH FACILITY SHALL MEET THE REQUIREMENTS PERTAINING TO PUBLIC INFORMATION, EDUCATION, AND RESEARCH (AS APPLICABLE) APPROPRIATE TO ITS DESIGNATION LEVEL, AS REQUIRED BY 6 CCR 1015-4, CHAPTER THREE.

107. STATE TRAUMA REGISTRY AND EPIDEMIOLOGY

EACH FACILITY SHALL MEET THE STATE REGISTRY REQUIREMENTS APPROPRIATE TO ITS DESIGNATION LEVEL, AS REQUIRED BY 6 CCR 1015-4, CHAPTER TWO.

108. DISASTER MEDICAL CARE

1. EACH FACILITY MUST PROVIDE TRAUMA PATIENTS WITH APPROPRIATE ACCESS TO DISASTER MEDICAL CARE TO THE EXTENT NECESSARY AND SUBJECT TO EACH FACILITY'S CAPABILITIES AND RESOURCES. FACILITIES SHALL COLLABORATE WITH AND COORDINATE THEIR PLANNING AND PROVISION OF DISASTER MEDICAL CARE

WITH LOCAL, REGIONAL, AND STATE EMERGENCY MEDICAL AND TRAUMA ORGANIZATIONS, AND ANY OTHER ENTITIES INVOLVED IN DISASTER RESPONSE.

2. FOR PURPOSES OF THESE RULES, “DISASTER MEDICAL CARE” IS DEFINED IN SECTION 100.6 OF THESE RULES.

109. TRAUMA COMMUNICATIONS

1. EACH FACILITY SHALL MEET THE TRAUMA COMMUNICATIONS REQUIREMENTS APPROPRIATE TO ITS DESIGNATION LEVEL, AS REQUIRED BY 6 CCR 1015-4, CHAPTER THREE.

2. EACH RETAC BIENNIAL PLAN SHALL ENSURE ACCESS TO EMERGENCY MEDICAL AND TRAUMA SERVICES THROUGH THE 911 TELEPHONE SYSTEM OR ITS LOCAL EQUIVALENT, AND INCLUDE ADEQUATE PROVISIONS FOR SERVICES, AS REQUIRED BY 6 CCR 1015-4, CHAPTER FOUR.

110. REGIONAL EMERGENCY MEDICAL AND TRAUMA ADVISORY COUNCILS

1. THE RULES GOVERNING RETACS IN THE TRAUMA SYSTEM ARE SET FORTH IN 6 CCR 1015-4, CHAPTER FOUR.

2. EACH FACILITY SHALL MEET THE RETAC REQUIREMENTS AS SET FORTH IN 6 CCR 1015-4, CHAPTERS THREE AND FOUR.

111. TRAUMA CARE FOR PEDIATRICS

1. EACH FACILITY SHALL MEET THE REQUIREMENTS PERTAINING TO THE CARE OF PEDIATRIC PATIENTS THAT IS APPROPRIATE TO ITS DESIGNATION LEVEL, AS REQUIRED BY 6 CCR 1015-4, CHAPTER THREE,

2. SCENE TRANSPORT, DIVERSION, BYPASS, AND RETAC DESTINATION PROTOCOLS PERTAINING TO PEDIATRIC PATIENTS SHALL BE IN ACCORDANCE WITH THIS CHAPTER AND AS OUTLINED IN EXHIBIT B.

EXHIBIT A

Prehospital Trauma Triage Algorithm
Adult Patients (Ages 15 and older)

UNABLE TO ADEQUATELY VENTILATE

Yes → **Destination DETERMINED per RETAC Protocol**

No

ANY PHYSIOLOGIC CRITERIA

1. Intubation or assisted ventilation
2. Respiratory rate < 10 or > 29
3. Systolic BP < 90 OR < 110 FOR AGE 65 PLUS
4. GCS motor score ≤ 5

Yes → **Destination DETERMINED per RETAC Protocol**

No

ANY ANATOMIC CRITERIA

~~Any one of the following (~~**Known or Suspected**~~)~~**:**

1. Penetrating injuries to the head, neck, torso, or extremities above the elbow or knee
2. Flail chest (CHEST WALL INSTABILITY OR DEFORMITY)
3. Two or more proximal long bone fractures ~~(humerus and/or femur)~~
4. Unstable pelvic fracture
5. Paralysis or NEUROLOGIC DEFICIT ~~other evidence of spinal cord injury~~
6. Amputation above the wrist or ankle
7. Crushed, degloved, mangled, or PULSELESS extremity
8. Open or depressed skull fracture

Yes → **Destination DETERMINED per RETAC Protocol**

No

ANY MECHANISM OF INJURY CRITERIA

~~Any one of the following:~~

1. Falls > 20 feet
2. High risk auto crash, with such components as:
   -Intrusion of vehicle of ≥ 12 inches in occupant compartment; > 18 inches any site
   -Ejection (partial or complete) from automobile
   -Death in same passenger compartment
3. Auto vs. pedestrian/bicyclist thrown, run over, or with significant impact ~~(auto going > or = 20 mph)~~
4. Motorcycle crash > 20 mph
5. Events involving high energy dissipation, such as:
   -Ejection from motorcycle, ATV, animal, etc.
   -Striking a fixed object with momentum
   -Blast or explosion
6. High energy electrical injury

Yes → **Destination DETERMINED per RETAC Protocol**

No

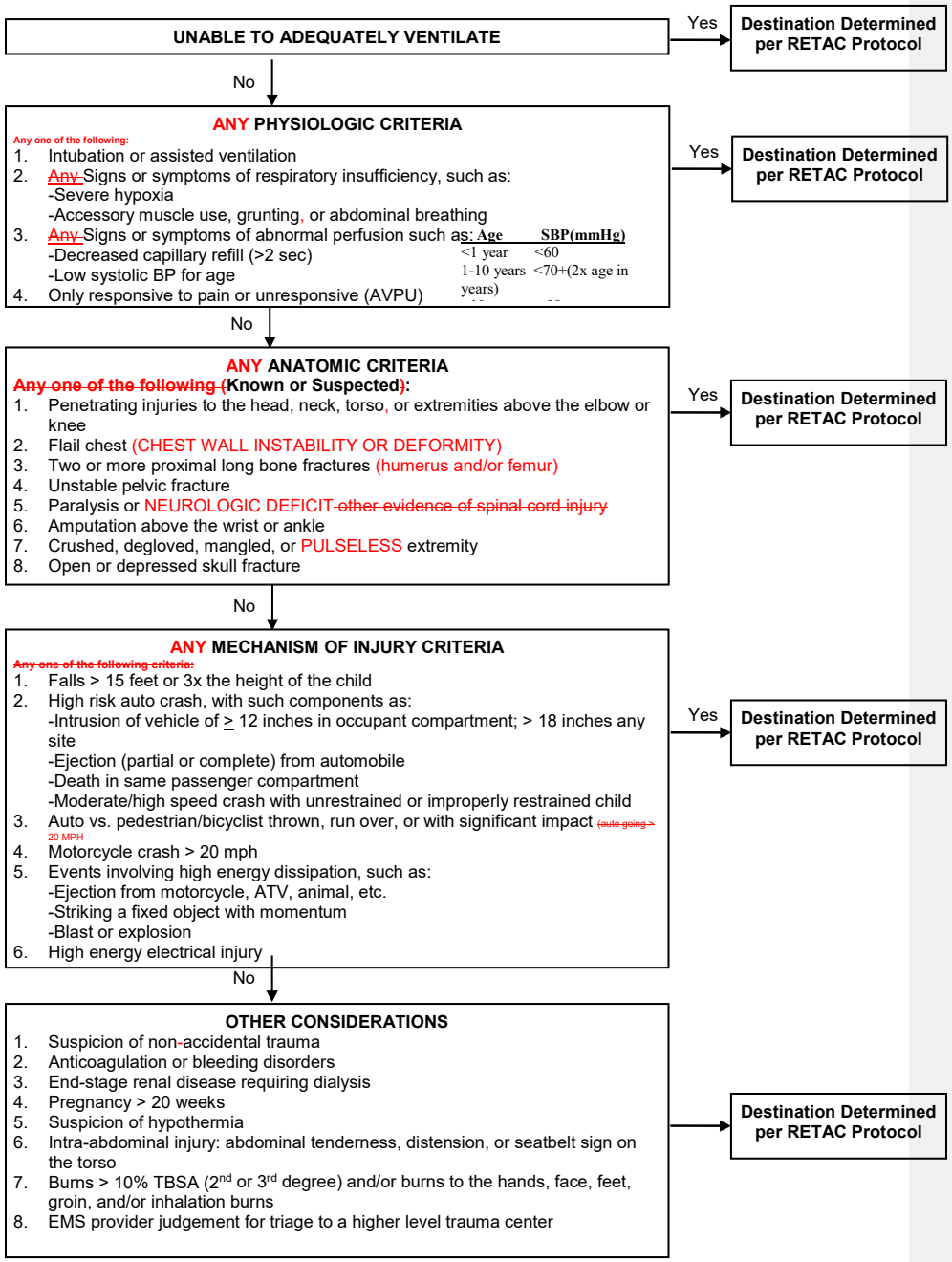
OTHER CONSIDERATIONS

1. Older adult: Risk of death increases after age 55 years
2. Anticoagulation or bleeding disorders
3. End-stage renal disease requiring dialysis
4. Pregnancy > 20 weeks
5. Suspicion of hypothermia
6. Suspicion of abdominal injury ~~/~~OR seatbelt sign
7. Burns > 10% TBSA (2^{nd} or 3^{rd} degree) and/or burns to the hands, face, feet, groin, and/or inhalation burns
8. EMS provider judgement for triage to a higher level trauma center
9. LOW IMPACT MECHANISM FOR OLDER ADULTS WITH SUSPICION OF INJURY
10. SUSPICION OF NONACCIDENTAL TRAUMA

→ **Destination DETERMINED per RETAC Protocol**

EXHIBIT B

Prehospital Trauma Triage Algorithm
Pediatric Patients (Less than 15 years old)



DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STATEWIDE EMERGENCY MEDICAL AND TRAUMA CARE SYSTEM

6 CCR 1015-4

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

CHAPTER ~~1~~TWO - THE TRAUMA REGISTRY

~~1~~200. Definitions

1. Admission - Inpatient or observation status for a principal diagnosis of trauma.

2. Blunt injury - Any injury other than penetrating or thermal.

3. Community Clinics and Emergency Centers (CCEC) - Facilities as licensed by the D~~d~~epartment under 6 CCR 1011-1, Chapter IX.

4. Department - The Colorado Department of Public Health and Environment.

5. Facility - A health facility licensed by the Department that receives ambulances such as a hospital, hospital unit, Critical Access Hospital (CAH) or Community Clinics and Emergency Centers (CCEC) caring for trauma patients.

6. Injury type - Can be blunt, penetrating or thermal and is based on the mechanism of injury.

7. Interfacility transfer - The movement of a trauma patient from one facility as defined by these rules to another facility. Transfers may occur between the emergency department of one facility and a second facility, or from inpatient status at one facility to a second facility.

8. Penetrating injury - Any wound or injury resulting in puncture or penetration of the skin and either entrance into a cavity, or for the extremities, into deeper structures such as tendons, nerves, vascular structures or deep muscle beds.

9. Readmission - A patient who is readmitted (for greater than 12 hours) to the same or to a different facility within 30 days of discharge from inpatient status for missed diagnoses or complications from the first admission. Readmission does not include subsequent hospitalizations that are part of routine care for a particular injury (such as removal of orthopedic hardware, skin grafts, colostomy takedowns, etc.)

10. Severity - An indication of the likelihood that the injury or all injuries combined will result in a significant decrease in functionality or loss of life.

11. State Emergency Medical and Trauma Services Advisory Committee (SEMTAC) - A council created in the Department pursuant to Section 25-3.5-104, C.R.S., which advises the Department on all matters relating to emergency medical and trauma services.

12. Statewide trauma registry - The statewide trauma registry means a statewide data base of information concerning injured persons and licensed facilities receiving injured persons, which information is used to: evaluate and improve the quality of patient management, facilitate trauma education, conduct research and promote injury prevention programs.

13. Thermal injury - Any trauma resulting from the application of heat or cold, such as thermal burns, scald, chemical burns, electrical burns, lightning or radiation.

14. Traumatic injury - A blunt, penetrating or thermal injury or wound to a living person caused by the application of an external force or by violence. Injuries that are not considered to be trauma include such conditions as: injuries due to repetitive motion, pathological fractures as determined by a physician and scheduled elective surgeries.

~~1~~201. Reporting of trauma data by facilities

1. Facilities designated as Level I, II, III or Regional Pediatric Trauma Centers, as defined in Section 25-3.5-703(4), C.R.S., shall submit data as defined by the Department based on recommendations by SEMTAC or a committee thereof. These data elements include but are not limited to:

A. The data for discharges, inpatients, transfers, readmits and deaths in a particular month shall be submitted as an electronic data file to the Department within 60 days of the end of that month. These data elements include but are not limited to:

(1)~~i.~~ Patient information: name; date of birth; gender; race/ethnicity; address; pre-existing medical diagnoses; medical record number;

(2)~~ii.~~ Injury information: date, time and location of injury; cause of injury; injury circumstances; whether or not protective devices were used by the patient; evidence of alcohol or other intoxication;

(3)~~iii.~~ Prehospital information: transport mode from the injury scene; name of agency providing transport to the facility; physiologic and anatomic conditions; times of notification, arrival at scene, departure from scene and arrival at destination;

(4)~~iv.~~ Emergency department information: clinical data upon arrival; procedures; providers; response times; disposition from the emergency department;

(5)~~v.~~ Interfacility transfer information: transfer mode from the referring facility; name of the referring facility; arrival and discharge times from the referring facility; whether the patient was seen in the emergency department only or was admitted as an inpatient at the referring hospital;

(6)~~vi.~~ Inpatient care information: name and address of the facility; admission date and time; admission service; surgical procedures performed; date and time of all surgical procedures; co morbid factors; total days in the Intensive Care Unit (ICU); date and time of discharge; discharge disposition; payer source; discharge diagnoses, including International Classification of Disease (ICD) codes, Abbreviated Injury Scale (AIS), body region, diagnosis description and Injury Severity Score (ISS);

(7)~~vii.~~ Readmission information: patient's name, date of birth, gender, address; medical record number, name of facility and the date of admission at the original facility; and medical record number, name of facility, date of readmission and the reason for admission at the readmitting facility;

(8)~~viii.~~ Death information: patient's name, date of birth, gender and address; patient's injury type, diagnostic codes, severity and cause; the time and date of arrival at the facility; the date of the death; autopsy status if performed (i.e. complete, pending, not done).

2. Level IV, V and non-designated facilities, as defined in Section 25-3.5-703(4), C.R.S., shall submit data as defined by the Department based on recommendations by SEMTAC or a committee thereof.

A. Data shall be submitted to the Department for all discharges, transfers and deaths on a quarterly basis within 60 days of the end of that quarter. These data elements include but are not limited to:

(1)i. Inpatient information: name, age, gender, zip code of residence, medical record number, admission date, discharge date, injury type, and cause;

(2)~~ii.~~ Interfacility transfer information, whether from the emergency department or after inpatient admission: the patient's name, age, gender and zip code of residence;

(3)~~iii.~~ Readmission information: patient's name, age, gender and zip code of residence; medical record number, name of facility and the date of admission at the original facility; medical record number, name of facility, date of readmission and the reason for admission at the readmitting facility;

(4)~~iv.~~ Death information: patient's name, age, gender and zip code of residence; patient's injury type and cause; the time and date of arrival at the facility; the date of the death.

B. Level IV, V and non-designated facilities shall fulfill the reporting requirement by participating in a reporting system approved by the Department with submission dates determined by the data system operator.

3. All facilities shall submit to the Department such additional information regarding the care, medical evaluation and clinical course of specified individual patients with trauma as requested by the Department for the purpose of evaluating the quality of trauma management and care. Such information shall be defined by the Department based on recommendations by SEMTAC or a committee thereof.

~~1~~202. Provision of technical assistance and training

1. The Department may contract with any public or private entity to perform its duties concerning the statewide trauma registry~~,~~ including, but not limited to, duties of providing technical assistance and training to facilities within the state or otherwise facilitating reporting to the registry.

~~1~~203. Confidentiality

1. Any data maintained in the trauma registry that identifies patients or physicians or is part of the patient's medical record shall be strictly confidential pursuant to Section 25-3.5-704(2)(f)(III), C.R.S., whether such data is recorded on paper or stored electronically. The data shall not be admissible in any civil or criminal proceeding.

2. The data in the trauma registry may not be released in any form to any agency, institution or individual if the data identifies patients or physicians.

3. The Department may establish procedures to allow access by outside agencies, institutions or individuals to information in the registry that does not identify patients or physicians. These procedures are outlined in the Colorado Trauma Registry Data Release Policy and other applicable Department data release policies.

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STATEWIDE EMERGENCY MEDICAL AND TRAUMA CARE SYSTEM

6 CCR 1015-4

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

CHAPTER THREE - DESIGNATION OF TRAUMA FACILITIES

Purpose and Authority for Rules

These rules address the designation process for trauma facilities, the enforcement and disciplinary procedures applicable to trauma facilities, and the designation criteria for Level I through V trauma facilities. The authority for the promulgation of these rules is set forth in Section 25-3.5-701 *et seq.*, C.R.S.

Index to Sections

300. Definitions

1. Advanced Trauma Life Support (ATLS) or equivalent - The training provided in accordance with the American College of Surgeons curriculum for Advanced Trauma Life Support. An equivalent program is one which has been approved by the ~~d~~Department. The burden shall be upon the applicant to prove that the program is equivalent to ATLS.

2. Consultation - Telephone or telemedicine, as specified in this chapter, to determine the necessity of transfer and the circumstances of transfer~~,~~ including, but not limited to, additional diagnostic/therapeutic issues, availability of resources, and weather conditions. Consultation occurs between the attending trauma surgeon, ~~(~~or physician in a Level IV OR V facility~~)~~, of a referring facility and an APPROPRIATE attending PHYSICIAN FROM THE TRAUMA SERVICE

~~trauma surgeon (who is a member of the attending staff)~~ at a receiving TRAUMA CENTER~~facility~~ WITH THE RESOURCES NECESSARY TO MEET THE PATIENT'S NEEDS. Trauma consultation shall include written documentation completed by STAFF AT BOTH FACILITIES ~~the trauma surgeon at the Levels II and III facilities, or the attending physicians at the Level IV facility~~. Disagreements as to patient disposition will be documented at both facilities FOR DEPARTMENT REVIEW.

Commented [SG3]: Discussed and recommended by task force.

3. Core group - the core group of surgeons is comprised of those surgeons identified by the trauma medical director who provide coverage for at least 60 percent of the trauma call schedule.

~~4. Critical Injuries (Adult) - Critical injuries for adult patients are defined as any of the following:~~

~~A. Bilateral pulmonary contusions requiring nontraditional ventilation,~~

~~B. Multi-system trauma with pre-existing coagulopathy (hemophilia),~~

~~C. Pelvic fractures with unrelenting hemorrhage,~~

~~D. Aortic tears,~~

~~E. Liver injuries with vena cava injury or requiring emergency surgery with liver packing.~~

~~5. Critical Injuries (Pediatric) - Critical injuries for pediatric patients (age 0-14 years) are defined as any of the following:~~

~~A. Bilateral pulmonary contusions requiring nontraditional ventilation,~~

~~B. Multi-system trauma with pre-existing or life threatening coagulopathy (hemophilia),~~

~~C. Pelvic fractures with unrelenting hemorrhage,~~

~~D. Aortic tears,~~

~~E. Liver injuries with vena cava injury or requiring emergency surgery with liver packing,~~

~~F. Coma for longer than 6 hours or with focal neurologic deficit.~~

Commented [SG4]: Concepts removed from chapter 2 and 3

4~~6~~. Department - The Colorado Department of Public Health and Environment, unless the context requires otherwise.

~~7. Divert - Redirection of the trauma patient to a different receiving facility. Redirection shall be in accordance with the prehospital trauma triage algorithms, as set forth in 6 CCR 1015-4, Chapter Two. Reasons for going on divert are limited to lack of critical equipment or staff; operating room, emergency department, or intensive care unit saturation; disaster or facility structural compromise.~~

Commented [SG5]: Suggest changing to new chapter one definition to be consistent. See language inserted below.

5. DIVERT – THE FACILITY CANNOT CURRENTLY ACCEPT EMS TRAFFIC. EMS SHALL TRANSPORT TRAUMA PATIENTS TO AN ALTERNATE DESTINATION IN ACCORDANCE WITH THE PREHOSPITAL TRAUMA TRIAGE ALGORITHM.

6. EMERGENT INTERVENTION – PROVISION OF MEDICAL SERVICES THAT CAN BE UNDERTAKEN TO ADDRESS:1) UNCONTROLLED BLEEDING; 2) PHYSIOLOGIC CRITERIA AS OUTLINED IN CHAPTER ONE, EXHIBIT A OR B OF THE PRE-HOSPITAL TRAUMA TRIAGE ALGORITHM; OR 3) A TRAUMATIC INJURY THAT REQUIRES EMERGENT SURGERY.

Commented [SG6]: Recommended by task force

7~~8~~. Emergent Surgery – A surgical procedure~~,~~ for which it has been determined that no alternative therapy is available and for which the delay could result in death or permanent impairment of health.

8~~9~~. Expanded Scope of Care - An expanded scope of care is any specialty or service line that provides treatment at a trauma center beyond the minimum requirements of the trauma center's designation level, either on a part-time or full-time basis.

9. FOCUSED REVIEW – A TYPE OF INTERIM TRAUMA DESIGNATION REVIEW FOCUSING ON THE AREAS OF CONCERN FROM A PREVIOUS REVIEW OR PLAN OF CORRECTION. BOTH THE APPLICATION AND THE REVIEW PROCESS MAY BE SHORTENED TO FOCUS ON PREVIOUS DEFICITS.

Commented [SG7]: New definition. Term is used in this chapter but was not previously defined.

10. Key Resource Facilities - Level I and II ~~designated~~ CERTIFIED trauma ~~centers~~ FACILITIES which have an expanded responsibility in providing on-going consultation, education, and technical support to referring facilities, individuals, or RETACS.

11. Met with R~~r~~eservations - Evidence of some degree of compliance with regulatory standards, but where further action is required for full compliance.

12. Morbidity and Mortality Review - A case presentation of all complications, deaths, and cases of interest for educational purposes to improve overall care to the trauma patient. Case presentations shall include all aspects and contributing factors of trauma care from pre-hospital care to discharge or death. The multi-disciplinary group of health professionals shall meet on a regular basis, but not less than every two months, OR EVERY QUARTER FOR LEVEL IV AND V FACILITIES. The documentation of the review shall include date, reason for review, problem identification, corrective action, resolution, and education. Documented minutes shall be maintained on site and readily available.

Commented [SG8]: Added from quality improvement rules, Section 304

13. Multidisciplinary Trauma Committee - This committee is responsible for the development, implementation, and monitoring of the trauma program at each designated trauma center. Functions include, but are not limited to: establishing policies and procedures; reviewing process issues, e.g., communications; promoting educational offerings; reviewing systems issues, e.g., response times and notification times; and reviewing and analyzing trauma registry data for program evaluation and utilization. Attendance ~~required~~REQUIREMENTS will be established by the committee. Membership will be established by the facility.

14. MULTISYSTEM TRAUMA - TWO OR MORE BODY REGIONS OR SYSTEMS THAT ARE INJURED WITH PHYSIOLOGIC CRITERIA OR THE POTENTIAL FOR PHYSIOLOGIC COMPROMISE, AS DEFINED IN CHAPTER ONE EXHIBITS A AND B OF THE PREHOSPITAL TRAUMA TRIAGE ALGORITHM.

Commented [SG9]: Recommended by task force

1~~5~~4. Outreach - The act of providing resources to other facilities in order to improve response to the injured patient. These resources shall include, but not be limited to, clinical consultation and public and professional education. Trauma centers shall be centers of excellence and shall share this expertise with other trauma centers and nondesignated facilities. Timely and appropriate communication, consultation, and feedback are imperative to patient outcome.

1~~6~~5. Plan of C~~c~~orrection - Identifies how the facility plans to correct deficiencies or standards identified as met with reservations cited in the ~~d~~Department's written notice to the facility, within an identified timeline. A plan of correction may also be required to meet a waiver request or fulfill a request from the ~~d~~Department to address a temporary issue identified by the ~~d~~Department or the facility.

1~~7~~6. Promptly Available - Unless otherwise specified, promptly available shall be a facility-defined timeframe based on current standards of clinically appropriate care.

1~~8~~7. Quality/Performance Improvement Program - A defined plan for the process to monitor and improve the performance of a trauma program is essential. This plan shall address the entire spectrum of services necessary to ensure optimal care to the trauma patient, from pre-hospital to rehabilitative care. This plan may be parallel to, and interactive with, the hospital-wide quality improvement program but shall not be replaced by the facility process. IN LEVEL IV- V FACILITIES, THIS PLAN MAY BE PART OF THE HOSPITAL-WIDE QUALITY IMPROVEMENT PROGRAM, BUT MUST HAVE FACILITY-DEFINED, TRAUMA-RELATED INDICATORS AND

COMPONENTS. IMPLEMENTATION OF THE PLAN IS OVERSEEN BY THE TRAUMA MEDICAL DIRECTOR. TRAUMA-RELATED ISSUES MUST BE DOCUMENTED SEPARATELY, AND THE TMD HAS AUTHORITY OVER ANY TRAUMA ISSUES.

Commented [SG10]: Additional language added from quality improvement section 304

19~~8~~. Regional Emergency Medical and Trauma Advisory Council (RETAC) - The representative body appointed by the governing bodies of counties or cities and counties for the purpose of providing recommendations concerning regional area emergency medical and trauma service plans for such counties or cities and counties.

20. RESOURCES OR NECESSARY RESOURCES – AS USED IN THIS 6 CCR 1015-4, CHAPTER THREE ARE THE INSTRUMENTS, EQUIPMENT, MEDICATIONS, TRAINING, AND QUALIFIED PERSONNEL REQUIRED TO PROVIDE APPROPRIATE CARE FOR THE PATIENT.

Commented [SG11]: Recommended by task force

21~~19~~. Scope of Care - A scope of care is a description of the facility's capabilities to manage the trauma patient. This description must include administrative support and specialty availability that ensures continuity of care for all admitted patients.

22~~0~~. State Emergency Medical and Trauma Services Advisory Council (SEMTAC) - ~~The council created in the Department p~~ Pursuant to Section 25-3.5-104(4), C.R.S., THE STATE EMERGENCY MEDICAL AND TRAUMA SERVICES ADVISORY COUNCIL IS A BOARD APPOINTED BY THE GOVERNOR THAT ADVISES AND MAKES RECOMMENDATIONS TO THE DEPARTMENT ON ALL MATTERS RELATING TO EMERGENCY MEDICAL AND TRAUMA SERVICES.

Commented [OK12]: THIS NEW LANGUAGE COMES FROM 25-3.5-104(4)(a) AND CONFORMS WITH NEW CHAP. 4 RETAC'S DEFINITION OF SEMTAC.

23~~1~~. Special Audit for Trauma Deaths - All trauma deaths shall be audited. A comprehensive review audit shall be initiated by the Trauma Medical Director in Levels I, II, III facilities and by the appropriate personnel designated by the Level IV and V facilities. The trauma nurse coordinator shall participate in these audits. A written critique shall be used to document the process to include the assessment, corrective action, and resolution.

24. TRANSFER AGREEMENT: A WRITTEN AGREEMENT WITH ONE OR MORE HOSPITALS OR HEALTHCARE INSTITUTIONS FOR THE TRANSFER OF PATIENTS FROM ONE TO ANOTHER.

Commented [SG13]: Recommended by task force Feb 19

25~~2~~. Trauma Nurse Coordinator - The terms "trauma nurse coordinator," "trauma coordinator" and "trauma program manager" are used interchangeably in these regulations (6 CCR 1015). The trauma nurse coordinator (TNC) works to promote optimal care for the trauma patient through participation in clinical programs, administrative functions, and professional and public education. The TNC shall be actively involved in the state trauma system. The essential responsibilities of the TNC include maintenance of the trauma registry, continuous quality improvement in trauma care, ~~and~~ educational activities, AND~~to include~~ injury prevention.

26~~3~~. Trauma Nurse Core Course (TNCC) or equivalent - the training provided in accordance with the Emergency Nurses Association curriculum. An equivalent program is one that has been approved by the ~~d~~Department. The burden shall be upon the applicant to prove that the program is equivalent to the TNCC.

27~~4~~. Trauma Service - The Trauma Service is an organized, identifiable program which includes: a Trauma Medical Director, a Trauma Nurse Coordinator, a Multi-disciplinary Trauma Committee, A Quality Improvement Program, Injury Prevention and Data Collection/Trauma Registry.

28~~5~~. Trauma Medical Director (TMD) - The Trauma Medical Director is a board certified general surgeon who is responsible for: service leadership, overseeing all aspects of trauma care, and administrative authority for the hospital trauma program including: trauma multidisciplinary committee, trauma quality improvement program, physician appointment to and removal from trauma service, policy and procedure enforcement, peer review, trauma research program, and key resource facility functions, if applicable; participates in the on-call schedule; practices at the facility for which he/she is medical director on a full time basis; and participates in all facility trauma-related committees. In Level I facilities, the Trauma Medical Director shall participate in an organized trauma research program with regular meetings with documented evidence of

productivity. In Level IV AND V, the Trauma Medical Director may be a physician so designated by the ~~hospital~~ FACILITY who takes responsibility for overseeing the program.

2926. Trauma Team - A facility-defined team of clinicians and ancillary staff, including those required by these rules.

3027. Trauma Team Activation - A facility-defined method (protocol) for notification of the trauma team of the impending arrival of a trauma patient based on the prehospital trauma triage algorithms as set forth in 6 CCR 1015-4, Chapter ~~Two~~ONE.

~~28. Verifiable, External Continuing Medical Education (CME) - A facility-defined, trauma-related continuing medical education program outside the facility, or a program given within the facility by visiting professors or invited speakers, or teaching an ATLS course.~~

Commented [SG14]: No longer necessary with the removal of CME requirements

3129. Waiver - A waiver is an exception to the trauma rules approved by the ~~d~~Department. The request for a waiver shall demonstrate that the alternative meets the intent of the rule. Waivers are generally granted for a limited term and shall be granted for a period no longer than the designation cycle. Waivers cannot be granted for any statutory requirement under state or federal law, requirements under state licensing, federal certification or local safety, fire, electrical, building, zoning, or similar codes.

301. NONDESIGNATION AND Designation ProcessES

1. General Provisions

A. Any Colorado facility receiving trauma patients by ambulance or other means shall follow the process for designation or nondesignation based upon its operational status as set forth in 301.2.A.

B. Healthcare facilities shall have state licensure before obtaining designation as a trauma center.

C. A separate designation OR NONDESIGNATION AGREEMENT is required for each distinct physical location where a facility provides trauma care services.

2. Process to be Applied

A. The current operational status of the facility will determine the designation process to be applied. The four types of operational statusES are:

(~~4~~1) Nondesignated facility - a hospital, CCEC, or other licensed facility that receives and is accountable for injured persons, but chooses not to seek trauma center designation.

(~~1~~2) New facility - a hospital, community clinic and emergency center (CCEC), or other licensed facility that is seeking trauma center designation for the first time or seeking to change to a different level of designation.

(~~2~~3) Replacement facility - an existing trauma center requesting designation at the current level for a new physical location and not retaining trauma center status at the old location.

(~~3~~4) Existing facility renewal - a currently designated trauma center seeking renewal at the same designation level.

B. The specific administrative and clinical criteria for each of the Level I-V AND RPTC designations are set forth in Section 303 through Section 307 AND SECTION 309 of this chapter.

C. Applications for designation are public documents. The facility is responsible for identifying any proprietary information. Proprietary documents are defined here as those that are protected by copyright, or are used, produced, or marketed under exclusive legal right of the facility.

D. At any time, the ~~d~~Department may move to revoke, suspend, or otherwise limit a facility's designation consistent with the enforcement and disciplinary process contained in Section 302 of this chapter.

3. ~~New Facility~~ NONDESIGNATED FACILITIES

A. A FACILITY REQUESTING NONDESIGNATION STATUS SHALL FILE A NONDESIGNATION AGREEMENT THAT, AT A MINIMUM, STATES THE FOLLOWING:

(1) THE FACILITY CHOOSES NOT TO SEEK SUCH DESIGNATION.

(2) THE FACILITY ACKNOWLEDGES AND AGREES THAT IT MAY ONLY ADMIT PATIENTS WITH SINGLE SYSTEM INJURIES THAT ARE NOT THREATENING TO LIFE OR LIMB AND WHOSE CARE IS NOT COMPLICATED BY COMORBID CONDITIONS.

(3) THE FACILITY ACKNOWLEDGES AND AGREES THAT IT SHALL TRIAGE AND TREAT PATIENTS ACCORDING TO THE FOLLOWING:

PATIENT CONDITION	TIME FRAME	REQUIRED ACTION
TRAUMATIC INJURY REQUIRING EMERGENT INTERVENTION	ONE HOUR	INITIATE RESUSCITATION AND TRANSFER TO A TRAUMA CENTER WITH THE RESOURCES NECESSARY TO MEET THE PATIENT'S EMERGENT NEEDS. TRANSFER MUST BE INITIATED BUT NEED NOT BE COMPLETED WITHIN ONE HOUR. TRANSFER SHALL NOT BE ENCUMBERED BY RESTRICTIONS TO KEEP PATIENTS WITHIN A PARTICULAR HEALTHCARE ORGANIZATION.
ANY NON-EMERGENT TRAUMATIC INJURY MEETING MANDATORY TRANSFER OR CONSULT CRITERIA AS DESCRIBED IN 6 CCR 1015-4, CHAPTER THREE, SECTION 305	TWO HOURS	INITIATE RESUSCITATION AND TRANSFER TO A TRAUMA CENTER WITH THE RESOURCES NECESSARY TO MEET THE PATIENT'S NEEDS. TRANSFER MUST BE INITIATED BUT NEED NOT BE COMPLETED WITHIN TWO HOURS.
ANY NON-EMERGENT TRAUMA PATIENT THAT HAS EXPERIENCED A SIGNIFICANT INJURY OR MECHANISM AS DEFINED IN 6 CCR 1015-4, CHAPTER ONE, PREHOSPITAL ALGORITHMS OR REQUIRING CARE BEYOND THE RESOURCES OF THE FACILITY	TWO HOURS	INITIATE RESUSCITATION AND TRANSFER TO A TRAUMA CENTER WITH THE RESOURCES NECESSARY TO MEET THE PATIENT'S NEEDS. TRANSFER MUST BE INITIATED BUT NEED NOT BE COMPLETED WITHIN TWO HOURS. DECISIONS REGARDING TRANSFER SHALL INCLUDE CONSIDERATION OF CO-MORBID CONDITIONS, POTENTIAL COMPLICATIONS, ETC.

(4) THE FACILITY HAS IDENTIFIED KEY RESOURCE FACILITIES FOR ADULT, PEDIATRIC, AND SPECIALTY CARE PATIENTS.

Commented [SG15]: This section is relocated from section 301.6 below. It has been stricken below with renumbering taking place in all sections in between. All changes recommended by task force.

Commented [SG16]: This is directly from current rule Chapter 2, 202.C.4 and 5 with addition for clarity.

Commented [SG17]: Proposed by staff, recommended by task force.

Commented [SG18]: This is directly from current rule Chapter 2, 202.C.4.

(5) THE FACILITY HAS ESTABLISHED TRANSFER AGREEMENTS AS REQUIRED BY SECTION 25-3.5-703(4)(a), C.R.S.

(6) NONDESIGNATION AGREEMENTS SHALL BE RENEWED ON A TRIENNIAL BASIS.

B. UPON INITIATION OR RENEWAL OF A NONDESIGNATION AGREEMENT, EACH NONDESIGNATED FACILITY SHALL CONTACT ITS RETAC. THE COMMUNICATION WILL BE DOCUMENTED AND A COPY OF THE DOCUMENTATION SHALL ACCOMPANY THE SIGNED NONDESIGNATION AGREEMENT DESCRIBED IN SECTION 301.6.A. THE DOCUMENTATION SHALL DEMONSTRATE THAT THE FOLLOWING WAS DISCUSSED:

(1) KEY RESOURCE FACILITIES IDENTIFIED BY THE RETAC PER 6 CCR 1015-4, CHAPTER FOUR, 402.10.

(2) TRAUMA SYSTEM RESOURCES AVAILABLE FOR ALL TYPES OF TRAUMA PATIENTS, INCLUDING SPECIALTY SERVICES SUCH AS BURNS, REIMPLANTATION, AND PEDIATRIC CARE. SUCH RESOURCES MAY BE LOCATED WITHIN OR OUTSIDE THE RETAC.

(3) COMMUNICATION SYSTEMS AVAILABLE WITHIN THE RETAC, SYSTEM CAPABILITIES, AND HOW TO INTEGRATE WITH THOSE SYSTEMS.

(4) RESOURCES AVAILABLE FOR PREHOSPITAL AND INTERFACILITY TRANSPORT.

Commented [SG19]: New language recommended by task force

~~3~~4. New Facility

A. Application Procedure

(1) A new facility shall submit a written notice to the ~~d~~Department at least 180 days in advance of either the anticipated date of opening or commencement of operation at a higher designation level. Facilities moving to a lower level of designation shall provide notice no later than 90 days in advance. The notice shall state the level of designation the facility is requesting.

(2) The facility shall complete a trauma designation application for new facilities on the ~~d~~Department's form and submit it along with the designation fee before the site visit according to the deadline specified by the ~~d~~Department.

(3) After an initial assessment of the application by the ~~d~~Department, the facility shall have ten (10) calendar days to respond to written notice of any application deficiency.

(4) If a facility does not correct application deficiencies in a timely manner, the ~~d~~Department may delay or cancel the review process. The ~~d~~Department may also consider the facility's failure to respond in a timely manner as grounds for denial of designation.

B. Fee Structure

(1) Facilities seeking simultaneous verification or consultation by the American College of Surgeons (ACS) shall pay any fees associated with the verification directly to the ACS, and the state fees identified below will be paid to the D~~d~~epartment. If the ACS is unable to supply all required team members for the state review, the facility shall pay the state an additional $3,000 per reviewer obtained by the state.

(2) The facility shall submit the non-refundable state designation fee with its application. The new facility designation fee is:

Level I/RPTC:	$17,500
Level II:	$17,500
Level III:	$11,300
Level IV/V:	$8,500

C. Site Review Procedure

(1) Any facility requesting a new Level I through V designation shall undergo an on-site review. The ~~d~~Department will set a review date no more than ninety (90) days before the new facility opens or commencement of operation at the new designation level.

(2) All equipment and policies for the requested designation level as currently required by Section 303 through Section 307 AND SECTION 309 of this chapter shall be in place for inspection or evidence of their placement shall be provided to the ~~d~~Department before the facility's opening or commencement of operation at the new designation level.

(3) All personnel for the requested designation level as currently required by Section 303 through Section 307 AND SECTION 309 of this chapter shall be identified and available for interview.

(4) The ~~d~~Department will select the new facility review team according to the following specifications:

a. Level I-II facilities:

i. A minimum of one trauma surgeon and one trauma nurse who live and work outside the State of Colorado,

ii. One state observer,

iii. Departmental discretion to designate additional reviewers up to a full team as set forth in 301.~~5~~6.C(1)a of this section.

b. Level III facilities:

i. A minimum of one trauma surgeon and one trauma nurse who live and work outside the facility's RETAC area,

ii. One state observer,

iii. Departmental discretion to designate additional reviewers up to a full team as set forth in 301.~~5~~6.C(1)b of this section.

c. Level IV-V facilities:

i. A minimum of one emergency physician or trauma surgeon and one trauma nurse who live and work outside the facility's RETAC area,

ii. One state observer,

iii. Departmental discretion to designate additional reviewers up to a full team as set forth in 301.~~5~~6.C(1)c of this section.

(5) All review team members shall also meet the following criteria:

a. Physician reviewers shall be certified by the American Board of Medical Specialties or the American Board of Osteopathic Medicine,

b. Physician reviewers shall be board certified in the specialty they are representing,

c. Be currently active in trauma care at the level being reviewed or above,

d. Have no conflict of interest with the facility under review, and

e. Live and work outside the facility's RETAC area.

(6) The ~~d~~Department will provide the applicant with the names of the on-site reviewers once they have been selected.

(7) If the applicant believes that a potential reviewer has a financial, professional or personal bias that may adversely affect the review, the facility shall notify the ~~d~~Department, in writing, no later than seven (7) calendar days after the ~~d~~Department's announcement of the proposed team members. Such notice shall contain all details of any alleged bias along with supporting documentation. The ~~d~~Department shall consider such notice and make a decision concerning replacement of the reviewer in question.

(8) The review may consist of, but is not limited to, consideration of the following:

a. Review of application,

b. Equipment check throughout the facility,

c. Review of all policies and procedures,

d. Review of quality improvement plans and other quality improvement documentation as may be appropriate,

e. Physical inspection of facility,

f. Interviews with staff,

g. Transfer protocols,

h. Call schedules,

i. Credentials of staff,

j. Review of the facility's planned interaction with prehospital transport, and

k. Other documents deemed appropriate by the ~~d~~Department.

(9) The review team shall provide a verbal report of its findings to the applicant before leaving the facility.

D. Designation Decision Procedure

(1) The ~~d~~Department shall present a summary of the Level I-II AND RPTC results to SEMTAC or a summary of the Level III-V results to the Designation Review Committee (DRC) for a recommendation on the new facility designation.

(2) The ~~d~~Department shall consider all evidence and notify the applicant in writing of its decision within thirty (30) calendar days of receiving the recommendation.

(3) The ~~d~~Department's final determination regarding each application shall be based upon consideration of all pertinent factors including, but not limited to, the application, the evaluation and recommendations of the on-site review team, the recommendation from SEMTAC or DRC, the best interests of trauma patients, and any unique attributes or circumstances that make the facility capable of meeting particular or special community needs.

(4) If the ~~d~~Department denies new facility designation, the provisions of Section 302.4 of this chapter shall apply.

E. Period of Designation

(1) A new facility designation is a one-time designation valid for 18 months.

(2) Once a new facility designation is issued, the facility will coordinate with the ~~d~~Department to schedule a full review within 12-14 months.

(3) Prior to the full review, the facility shall follow the application procedures described in 301.~~5~~6.A(2) through (4).

(4) The subsequent site review and designation decision procedures shall follow those described for renewal of existing facilities at 301.~~5~~6.B through D.

(5) Designation following the full review will mark the beginning of a full three-year designation cycle.

4~~5~~. Replacement Facility

A. Application Procedure

(1) A trauma designation review is required when the ~~d~~Department issues a new hospital or CCEC license based upon a change of location.

(2) A replacement facility shall submit a written notice to the ~~d~~Department at least 180 days in advance of the anticipated date of opening.

(3) The facility shall provide the ~~d~~Department with a copy of its last renewal application along with updated statistical data and information on any policy changes. The facility shall submit the application, designation fee, and additional information to the ~~d~~Department before the site visit according to the specified deadline.

(4) After an initial assessment of the application and updated information by the ~~d~~Department, the facility shall have ten (10) calendar days to respond to written notice of any application deficiency.

(5) If a facility does not correct application deficiencies in a timely manner, the ~~d~~Department may delay or cancel the review process. The ~~d~~Department may also consider the facility's failure to respond in a timely manner as grounds for denial of designation.

(6) The facility will coordinate with the ~~d~~Department to schedule a date for the replacement review to occur no sooner than the move to the replacement physical plant and no later than thirty (30) calendar days after the move.

(7) The facility's existing trauma designation continues until a replacement review occurs and the ~~d~~Department makes a decision on the replacement facility application.

B. Fee Structure

The facility shall submit the non-refundable designation fee with its application. The replacement facility designation fee is:

Level I/RPTC:	$6,500
Level II:	$6,500
Level III:	$1,800
Level IV/V:	$1,800

C. Site Review Procedure

(1) Any facility requesting replacement designation at the same level for a new physical plant shall undergo an on-site review at the new location.

(2) All equipment and policies required by the facility's current designation level shall be in place for inspection at the replacement facility.

(3) The ~~d~~Department will select the site review team for the replacement facility according to the following specifications:

a. Level I-II facilities:

i. A minimum of one trauma surgeon and one trauma nurse who live and work outside the State of Colorado,

ii. One state observer,

iii. Departmental discretion to designate additional reviewers up to a full team as set forth in 301.~~5~~6.C(1)a.

b. Level III-V facilities:

i. A minimum of one trauma nurse who lives and works outside the facility's RETAC area,

ii. One state observer,

iii. Departmental discretion to designate additional reviewers up to a full team as set forth in 301.~~5~~6.C(1)b and c.

(4) All review team members shall also meet the following criteria:

a. Physician reviewers shall be certified by the American Board of Medical Specialties or the American Board of Osteopathic Medicine,

b. Physician reviewers shall be board certified in the specialty they are representing,

c. Be currently active in trauma care at the level being reviewed or above,

d. Have no conflict of interest with the facility under review, and

e. Live and work outside the facility's RETAC area.

(5) The ~~d~~Department will provide the applicant with the names of the on-site reviewers once they have been selected.

(6) If the applicant believes that a potential reviewer has a financial, professional, or personal bias that may adversely affect the review, the facility shall notify the ~~d~~Department, in writing, no later than seven (7) calendar days after the ~~d~~Department's announcement of the proposed team members. Such notice shall contain all details of any alleged bias along with supporting documentation. The ~~d~~Department shall consider such notice and make a decision concerning replacement of the reviewer in question.

(7) The on-site review may consist of, but is not limited to, consideration of the following:

a. Equipment check throughout the facility,

b. Physical inspection of facility,

c. Review of all policies and procedures,

d. Interviews with staff,

e. Review of effects of the facility move on prehospital transport protocols, and

f. Other documents deemed appropriate by the ~~d~~Department.

(8) The team shall provide a verbal report of its findings to the applicant before leaving the facility.

D. Designation Decision Procedure

The designation decision procedure shall follow the one described for existing facility renewal at Section 301.~~5~~6.D of this chapter.

E. Designation Period

Designation following the replacement review will continue until the end of the facility's existing designation cycle.

~~5~~6. Renewal of Existing Facility

A. Application Procedure

(1) Existing facilities shall submit a letter of intent to maintain their current trauma level designation to the ~~d~~Department no later than 120 days before the current designation expiration date.

(2) The facility shall complete a trauma designation application for renewal of existing facilities on the ~~d~~Department's form and submit it to the ~~d~~Department before the site visit according to the deadline specified by the ~~d~~Department.

(3) After an initial assessment of the application by the ~~d~~Department, the facility shall have ten (10) calendar days to respond to written notice of any application deficiency.

(4) If a facility does not correct application deficiencies in a timely manner, the ~~d~~Department may delay or cancel the review process. The ~~d~~Department may

also consider the facility's failure to respond in a timely manner as grounds for denial of designation.

B. Fee Structure

(1) Facilities seeking state designation only:

a. The facility shall submit the required annual designation fee in the manner specified by the ~~d~~Department. The renewal of existing facility designation fee is:

Level I/RPTC:	$12,300
Level II:	$12,300
Level III:	$7,000
Level IV/V: Emergency Department Visits > 15,000 per year	$5,000
Level IV/V: Emergency Department Visits between 5,000 - 15,000 per year	$4,000
Level IV/V: Emergency Department Visits < 5,000 per year	$3,000

~~b. Fees submitted with the renewal application may be forfeited if the application is incomplete and the facility does not respond in a timely manner.~~

Commented [SG20]: Billing method has changed. No longer applicable

(2) Facilities seeking state designation and simultaneous ACS verification must pay each of the following fees separately:

a. Facilities seeking verification by the ACS shall pay any fees associated with the verification by the ACS directly to the ACS and the state fees identified below.

b. Facilities requesting simultaneous verification by the ACS at the time of the Colorado state trauma designation survey shall pay the following annual fee to the ~~d~~Department for the state designation process only:

LEVEL I/RPTC:	$8,100
LEVEL II:	$8,100
LEVEL III:	$5,000
LEVEL IV/V:	N/A

c. If the ACS is unable to supply all required team members for the designation review, the facility shall pay the ~~d~~Department an additional $3,000 per reviewer obtained by the state.

(3) The new fees shall be in effect on July 1, 2017, and the first annual payment shall be due on July 1 of the state fiscal year in which the current state designation expires.

C. Site Review Procedure

(1) The ~~d~~Department will select the site review members for renewal of an existing facility designation according to the following specifications:

a. Level I-II facilities - An out-of-state multidisciplinary team consisting of two trauma surgeons, one trauma nurse coordinator or RN involved in

trauma program management, one emergency physician, and one state observer.

b. Level III facilities - A team consisting of one trauma surgeon, one emergency physician, one trauma nurse coordinator or registered nurse involved in trauma program management, and one state observer.

c. Level IV-V facilities - A team consisting of one emergency physician or trauma surgeon, one trauma nurse coordinator or registered nurse involved in trauma program management, and one state observer.

(2) All review team members shall also meet the following criteria:

a. Physician reviewers shall be certified by the American Board of Medical Specialties or the American Board of Osteopathic Medicine,

b. Physician reviewers shall be board certified in the specialty they are representing,

c. Be currently active in trauma care at the level being reviewed or above,

d. Have no conflict of interest with the facility under review, and

e. Live and work outside the facility's RETAC area.

(3) The ~~d~~Department will provide the applicant with the names of the on-site reviewers once they have been selected.

(4) If the applicant believes that a potential reviewer has a financial, professional, or personal bias that may adversely affect the review, the facility shall notify the ~~d~~Department, in writing, no later than seven (7) calendar days after the ~~d~~Department's announcement of the proposed team members. Such notice shall contain all details of any alleged bias along with supporting documentation. The ~~d~~Department shall consider such notice and make a decision concerning replacement of the reviewer in question.

(5) The on-site review team shall evaluate the capability of the facility to meet the responsibilities, required equipment, and performance criteria appropriate to its designation level as identified in these rules through the following:

a. Review of application,

b. Physical inspection of the facility,

c. Review of trauma patient medical records,

d. Review of patient discharge summaries,

e. Review of patient care logs,

f. Review of quality improvement/management/assurance records and meeting minutes,

g. Review of rosters, schedules, and meeting minutes,

h. Interviews with appropriate facility personnel and other medical providers,

i. Review of research, prevention, and educational programs as applicable, and

j. Review of other documents as deemed appropriate by the team.

(6) The review team shall provide a verbal report of its findings to the applicant before leaving the facility.

D. Designation Decision Procedure

(1) The ~~d~~Department shall present a summary of the Level I-II OR RPTC results to SEMTAC or a summary of the Level III-V results to the Designation Review Committee (DRC) for a recommendation to the ~~d~~Department on the facility designation.

(2) If the ~~d~~Department determines that a plan of correction is appropriate, the facility shall follow the process set forth in Section 302.2 of this chapter.

(3) The ~~d~~Department shall notify the applicant in writing of its decision within thirty (30) calendar days of receiving the recommendation.

(4) The ~~d~~Department's final determination regarding each application shall be based upon consideration of all pertinent factors, including, but not limited to, the application, the evaluation and recommendations of the on-site review team, the recommendation from SEMTAC or DRC, compliance history, the best interests of trauma patients, and any unique attributes or circumstances that make the facility capable of meeting particular or special community needs.

(5) If the ~~d~~Department denies renewal of existing facility designation, the provisions of Section 302.4 of this chapter shall apply.

E. Period of Designation

(1) Renewal of existing facility designation will be valid for three years from the prior expiration date, unless voluntarily relinquished by the facility, revoked, suspended, or otherwise sanctioned pursuant to these rules.

~~6. Non-designated Facility~~

~~A. A facility requesting non-designation status shall file a non-designation agreement that, at a minimum, states the following:~~

~~(1) The facility chooses not to seek such designation.~~

~~(2) The facility acknowledges and agrees that it may only treat patients who have single system injuries that are not threatening to life or limb and whose care is not complicated by co-morbid conditions.~~

~~(3) The facility has established transfer agreements as required by Section 25-3.5-703(4)(a), C.R.S.~~

~~(4) Within two hours of recognition that a patient has experienced a significant injury or mechanism as defined in 6 CCR 1015-4, Chapter Two, Section 202.C, 202.D or the prehospital algorithms, the facility shall resuscitate, stabilize and/or initiate transfer of the patient, after consultation with a trauma surgeon or emergency physician at the closest designated trauma center, as required by 6 CCR 1015-4, Chapter Two, Section 202.C.4 and Section 202.D.9. Transfer shall be to the closest appropriate trauma facility as defined by RETAC protocols and as determined in consultation with the trauma surgeon or emergency physician.~~

Commented [SG21]: Replaced by new section 3 above.

7. Waivers

A. The ~~d~~Department may grant a waiver from one or more criteria that are established in this chapter for Level I-V trauma centers.

B. Facilities seeking a waiver shall submit a completed waiver application on the ~~d~~Department's form. The ~~d~~Department may require the applicant to provide additional information, and the application will not be considered complete until the required information is provided.

C. The facility seeking the waiver shall also post notice of the waiver application and a meaningful description of the substance of the request at all public entrances to the facility and in at least one area commonly used by the patients. The notice shall be posted no later than the application's submission date and shall remain posted for at least thirty (30) calendar days.

D. The notice shall describe where to send comments within that 30-day period. Comments should be directed to:

EMTS Branch
ATTN: Branch Chief
CDPHE, HFEMSD-~~A2~~
4300 Cherry Creek Drive South
Denver, CO 80246

E. At the same time the notice is posted in the facility, the facility shall also distribute a copy of the notice to prehospital emergency medical service providers active in the community served by the facility.

F. The completed waiver application shall be submitted to the ~~d~~Department at least thirty (30) calendar days before a SEMTAC meeting in order to be placed on the next agenda. Applications completed less than thirty (30) calendar days in advance will be placed on the subsequent agenda.

G. The ~~d~~Department shall distribute a copy of the public notice of the SEMTAC meeting regarding the waiver to all other designated trauma centers.

H. SEMTAC shall review the request and make recommendations to the ~~d~~Department. The ~~d~~Department shall make a decision and send notice of that decision to the facility administrator within thirty (30) calendar days of the recommendation.

(1) If the waiver is granted, the ~~d~~Department may:

a. Specify the terms and conditions of the waiver.

b. Specify the duration of the waiver. Under no circumstances shall a waiver be granted for a period longer than the designation cycle for that facility.

(2) The ~~d~~Department may require the submission of progress reports from any facility granted a waiver.

(3) If the waived rule is amended or repealed, obviating the need for the waiver, the waiver shall expire on the effective date of the rule change.

I. A facility shall notify the ~~d~~Department prior to any change of ownership of the facility as defined in 6 CCR 1011-1, Chapter ~~II~~2—GENERAL LICENSURE STANDARDS, Part 2.~~7~~6.

J. Facilities wishing to maintain a waiver beyond its expiration shall submit a new waiver application to the ~~d~~Department no less than ninety (90) days prior to the expiration of the waiver.

K. The ~~d~~Department may revoke or suspend a waiver if it determines:

(1) That its continuation jeopardizes the health, safety, and/or welfare of the patients,

(2) The applicant has provided false or misleading information in the waiver application,

(3) The applicant has failed to comply with conditions of the waiver, or

(4) The ~~d~~Department determines that a change in federal or state law prohibits continuation of the waiver.

L. If the ~~d~~Department denies, revokes, or suspends a waiver, the pertinent provisions of Sections 302.4, 302.5, or 302.6 of this chapter shall apply.

8. Designation Review Committee

A. The Designation Review Committee (DRC) shall make recommendations to the ~~d~~Department about the designation of Level III-V facilities and shall report such recommendations to SEMTAC.

B. The DRC shall be comprised of nine members. A minimum of five members shall be current SEMTAC members. The members shall represent the following constituencies and disciplines:

(1) One healthcare facility administrator,

(2) One board -certified general surgeon;

(3) One board -certified general surgeon with experience as a site reviewer or a trauma medical director at a Level III-V facility,

(4) One physician board -certified in emergency medicine,

(5) One physician board -certified in emergency medicine with experience as a site reviewer or a trauma medical director at a Level III-V facility,

(6) One trauma program manager or trauma nurse coordinator,

(7) One trauma program manager or trauma nurse coordinator with experience as a site reviewer or a Level III-V trauma nurse coordinator,

(8) One member representing the prehospital/EMS community/or public, and

(9) One member representing a RETAC.

C. SEMTAC shall make recommendations to the ~~d~~Department on the membership of the DRC along with the criteria to be used by the DRC.

D. The DRC meetings shall be public.

E. The DRC shall have access to a facility's application with any proprietary material extracted, a summary of the site review findings, and any plan of correction submitted by the facility.

302. Enforcement and Disciplinary Process

1. Unscheduled or Interim, Focused or Re-Reviews

A. At any time the ~~d~~Department may require and conduct an unscheduled or interim, focused or re-review of a currently designated facility based upon, but not limited to, the following criteria:

(1) Recent review results,

(2) A complaint, or

(3) Monitoring of the EMTS system.

2. Plans of Correction

A. Prior to making a designation decision, or after an unscheduled or interim, focused or re-review, the ~~d~~Department shall require a plan of correction from any facility with review deficiencies and/or met with reservations.

B. A plan of correction shall include, but not be limited to, the following:

(1) Identification of the problem(s) with the current activity and what the facility will do to correct each deficiency,

(2) A description of how the facility will accomplish the corrective action,

(3) A description of how the facility will monitor the corrective action to ensure the deficient practice is remedied and will not recur,

(4) A timeline with the expected implementation and completion date. Completion date is the date that the facility deems it can achieve compliance.

C. Completed plans of correction shall be:

(1) Submitted to the ~~d~~Department in the form and manner required by the ~~d~~Department,

(2) Submitted within thirty (30) calendar days after the date of the ~~d~~Department's written notice of deficiencies and/or criteria identified as met with reservations when areas of non-compliance with rules pertaining to the designation of trauma centers have been identified, and

(3) Signed by the facility administrator and facility trauma director.

D. The ~~d~~Department has the discretion to approve, modify, or reject plans of correction.

(1) If the plan of correction is accepted, the ~~d~~Department shall notify the facility by issuing a written notice of acceptance within thirty (30) calendar days of receipt of the plan.

(2) If the plan of correction is unacceptable, the ~~d~~Department shall notify the facility in writing, and the facility shall re-submit changes to the ~~d~~Department within fifteen (15) calendar days of the date of the written notice.

(3) If the facility fails to comply with the requirements or deadlines for submission of a plan or fails to submit requested changes to the plan, the ~~d~~Department may reject the plan of correction and impose disciplinary sanctions as set forth below.

(4) If the facility fails to timely implement the actions agreed to in the plan of correction, the ~~d~~Department may impose disciplinary sanctions as set forth below.

3. Re-Review Fee Structure

A. In the event the ~~d~~Department designates a facility with a required interim, focused, or re-review per Section 302.1.A.(1) above, the facility shall submit the required fee in the manner specified by the ~~d~~Department. The methodology used to determine the re-review fee for an existing facility is:

Levels I and II:	100% of costs of review team, excluding state observer time
Levels III through V:	75% of costs of review team, excluding state observer time

B. These fees shall apply to all on-site trauma re-reviews conducted subsequent to the effective date of these rules.

4. Denials

A. The ~~d~~Department may deny an application for Level I-V or RPTC designation to a new, replacement, or existing facility for reasons including, but not limited to, the following:

(1) The facility does not meet the criteria for designation as set forth in these regulations,

(2) The facility's application or accompanying documents contain a false statement of material fact,

(3) The facility refuses any part of an on-site review,

(4) The facility's failure to comply with or to successfully complete a plan of correction, or

(5) The facility is substantially out of compliance with any of the ~~d~~Department's regulations.

B. If the facility does not meet the level of designation criteria for which it has applied, the ~~d~~Department may recommend designation at a lesser level. Such action, unless agreed to by the applicant, shall represent a denial of the application.

C. If the ~~d~~Department denies an application for designation or waiver, the ~~d~~Department shall provide the facility with a notice explaining the basis for the denial. The notice shall also inform the facility of its right to appeal the denial and the procedure for appealing the denial.

D. Appeals of ~~d~~Departmental denials shall be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101, *et seq.*, C.R.S.

5. Revocation or Temporary Suspension

A. The ~~d~~Department may revoke the designation of a facility if any owner, officer, director, manager, or other employee:

(1) Fails or refuses to comply with the provisions of these regulations,

(2) Makes a false statement of material fact about facility capabilities or other pertinent circumstances in any record or in a matter under investigation for any purposes connected with this chapter,

(3) Prevents, interferes with, or attempts to impede in any way, the work of a representative of the ~~d~~Department in implementing or enforcing these regulations or the statute,

(4) Falsely advertises or in any way misrepresents the facility's ability to care for trauma patients based on its designation status,

(5) Is substantially out of compliance with these regulations and has not rectified such noncompliance,

(6) Fails to provide reports required by the registry or the state in a timely and complete fashion, or

(7) Fails to comply with or complete a plan of correction in the time or manner specified.

B. If the ~~d~~Department revokes or temporarily suspends a designation or waiver, it shall provide the facility with a notice explaining the basis for the action. The notice shall also inform the facility of its right to appeal and the procedure for appealing the action.

C. Appeals of ~~d~~Departmental revocations or suspensions shall be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101, *et seq.*, C.R.S.

6. Summary Suspension

A. The ~~d~~Department may summarily suspend a designation or waiver if it finds, after investigation, that a facility has engaged in a deliberate and willful violation of these regulations or that the public health, safety, or welfare requires immediate action.

B. If the ~~d~~Department summarily suspends a designation or waiver, it shall provide the facility with a notice explaining the basis for the summary suspension. The notice shall also inform the facility of its right to appeal and that it is entitled to a prompt hearing on the matter.

C. Appeals of summary suspensions shall be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101, *et. seq.*, C.R.S.

7. Redesignation at a ~~l~~Lesser ~~l~~Level

A. The ~~d~~Department may determine that a facility be redesignated at a lesser level due to the facility's inability to meet the designation criteria at its current level, notwithstanding any waiver previously granted.

B. If the ~~d~~Department seeks to redesignate the facility, it shall provide the facility with a notice explaining the basis for its action. The notice shall also inform the facility of its right to appeal and the procedure for appealing the action.

C. Appeals of involuntary redesignation shall be conducted in accordance with the State Administrative Procedure Act, Section 24-4-101, *et. seq.*, C.R.S.

8. Monetary Penalties

Any facility, provider, or employee of a facility that falsely misrepresents a facility's designation level or violates any rule adopted by the board shall be subject to a civil penalty of $500 per violation. The fee shall be assessed in accordance with Section 25-3.5-707(2), C.R.S.

303. Trauma Facility Designation Criteria - Level I AND II Facilities

1. Prehospital Trauma Care Integration

A. The facility shall participate in the development and improvement of prehospital care protocols and patient safety programs.

B. The trauma medical director shall be involved in the development of the trauma facility's divert protocol as it affects the trauma service.

C. A trauma surgeon shall be involved in any decision regarding divert as it affects the care of the trauma patient.

D. A liaison from the emergency department shall participate in prehospital peer review/performance improvement.

2. Interfacility Consultation, ~~and~~ Transfer Requirements, AND EMERGENT SURGERY

A. THE FACIILTY SHALL PROVIDE ON-GOING CONSULTATION, EDUCATION, AND TECHNICAL SUPPORT TO REFERRING FACILITIES, INDIVIDUALS, OR RETACS.

Commented [SG22]: This is directly from the definition of key resource facility.

B~~A~~. Provisions for direct physician-to-physician contact shall be included in the process of transferring a patient between facilities.

C~~B~~. ~~A decision to transfer a patient shall be based solely on the clinical needs of the patient and not on the requirements of the patient's specific provider network or the patient's ability to pay.~~ THE DECISION TO TRANSFER A PATIENT SHALL BE BASED ON THE CLINICAL NEEDS OF THE PATIENT. PHYSICIANS SHALL BE ALLOWED TO TRANSFER WHEN IN THE BEST INTEREST OF THE PATIENT AND SHALL NOT BE ENCUMBERED BY RESTRICTIONS TO KEEP PATIENTS WITHIN A PARTICULAR HEALTHCARE ORGANIZATION OR BASED ON THE PATIENT'S ABILITY TO PAY.

Commented [SG23]: Revised language recommended by task force and used across levels for consistency.

D~~C~~. If the facility does not have a burn service, a reimplantation service, a pediatric trauma service, or an acute rehabilitation service, the facility shall have written transfer guidelines for patients in these categories.

E. ALL LEVEL I AND II TRAUMA CENTERS MAY PERFORM EMERGENT SURGERY IF APPROPRIATE RESOURCES ARE AVAILABLE. IF AFTER THE EMERGENT SURGERY IS PERFORMED, THE FACILITY DOES NOT HAVE THE POST-OPERATIVE RESOURCES TO CARE FOR THE PATIENT AND FOR POTENTIAL COMPLICATIONS, THE FACILITY SHALL TRANSFER TO A TRAUMA CENTER WITH THE NECESSARY RESOURCES TO MEET THE PATIENT'S NEEDS.

Commented [SG24]: This is added to provide consistent language for level I-V as recommended by task force

F. MANDATORY TRANSFERS

(1) PATIENTS OF ANY AGE WITH A TRAUMATIC INJURY REQUIRING RESOURCES BEYOND THOSE AVAILABLE IN THE FACILITY'S SCOPE OF CARE, SEE 6 CCR 1015-4, CHAPTER THREE, 303.4.B.(1), SHALL BE TRANSFERRED.

(2) LEVEL I AND II TRAUMA CENTERS THAT ONLY ADMIT CHILDREN HAVING A SINGLE EXTREMITY ORTHOPEDIC FRACTURE OR MINOR HEAD TRAUMA, AS DETERMINED BY BEST PRACTICE GUIDELINES, SHALL TRANSFER ANY OTHER PEDIATRIC PATIENTS, AFTER EMERGENT SURGERY, IF NECESSARY.

(a) TRANSFER SHALL BE TO A REGIONAL PEDIATRIC TRAUMA CENTER OR TO A LEVEL I OR II TRAUMA CENTER THAT ADMITS PEDIATRIC TRAUMA PATIENTS.

(b) THE RECEIVING TRAUMA CENTER MUST MEET THE REQUIREMENTS SET FORTH IN 6 CCR 1015-4, CHAPTER THREE, SECTION 303.9.D AND HAVE A PEDIATRIC INTENSIVE CARE AREA STAFFED BY A BOARD CERTIFIED OR BOARD ELIGIBLE

PEDIATRIC INTENSIVIST AVAILABLE FOR CONSULTATION OR HAVE A TRANSFER PROTOCOL AND TRANSFER AGREEMENTS FOR PEDIATRIC PATIENTS REQUIRING INTENSIVE CARE.

(c) THE RECEIVING TRAUMA CENTER MUST HAVE A NEUROSURGEON ON CALL WITH QUALIFICATIONS NECESSARY TO MANAGE PEDIATRIC NEUROTRAUMA.

Commented [DM25]: New language recommended by task force

3. Performance Improvement Process

A. General Provisions

(1) The facility shall demonstrate a clearly defined trauma performance improvement program that shall be coordinated with the hospital-wide program.

(2) The facility shall be able to demonstrate that the trauma patient population can be identified for separate review regardless of the institutional performance improvement processes.

(3) Performance improvement shall be supported by a reliable method of data collection that consistently obtains valid and objective information necessary to identify opportunities for improvement. The process of analysis shall include multidisciplinary review and shall occur at regular intervals to meet the needs of the program. The results of analysis shall define corrective strategies and shall be documented.

(4) The facility shall demonstrate that the trauma registry is used to support the performance improvement program.

(5) The performance improvement program shall have defined audit filters based upon a regular review of registry and/or clinical data.

(6) There shall be appropriate, objectively defined standards to determine the quality of care.

(7) If more than 10 percent of injured patients with an Injury Severity Score greater than or equal to nine (excluding isolated hip fractures) are admitted to non-surgical services, the trauma facility shall demonstrate the appropriateness of that practice through the performance improvement program.

(8) Identified problem trends shall undergo peer review by the Peer Review/Performance Improvement Committee.

~~(9) A representative from the emergency department shall participate in prehospital peer review/performance improvement.~~

Commented [SG26]: Duplicate of 303.1.D

(9~~10~~) The facility shall review any diversion or double transfer (from another facility and then transferred for additional acute trauma care) of trauma patients.

~~(11) If a facility conducts an internal trauma educational process in lieu of external trauma CME, that process shall be, at least in part, based on information from the peer review/performance improvement process and the principles of practice-based learning.~~

Commented [SG27]: Unnecessary per CME changes

(10~~12~~) The facility shall demonstrate that its graded activation criteria are regularly evaluated by the performance improvement program.

~~(13) The Level I or II adult facility that admits only children with single extremity orthopedic fracture or minor head trauma with a negative computed tomography~~

~~exam shall demonstrate the oversight of pediatric care through a pediatric-specific peer review/performance improvement process.~~

Commented [SG28]: (Duplicate 303.9.B.(3))

~~(14) The Level I or II adult facility that admits children having other than single extremity orthopedic fracture or minor head trauma with a negative computed tomography exam shall have a pediatric-specific peer review/performance improvement process, which shall include pediatric-specific process filters and outcome measures.~~

Commented [SG29]: (Duplicate 303.9.C(5))

(11~~15~~) Physician availability to the trauma patient in the ICU shall be monitored by the peer review/performance improvement program.

B. Multidisciplinary Trauma Committee

(1) The facility shall have a multidisciplinary committee to address trauma program operational issues.

(2) A multidisciplinary trauma committee shall continuously evaluate the trauma program's processes and outcomes.

(3) The committee shall include, at a minimum, the trauma medical director or designee and all core surgeons as well as liaisons from orthopedic surgery, neurosurgery, emergency medicine, radiology, and anesthesia. Each of these liaisons shall attend at least 50 percent of the meetings.

(4) The exact format of the committee may be hospital specific, but shall be multidisciplinary and consist of hospital and medical staff members who work to identify and correct trauma program system issues.

(5) The committee minutes shall reflect the review of operational issues and, when appropriate, the analysis and proposed corrective actions. The process shall identify problems and shall demonstrate problem resolution.

(6) The committee shall monitor compliance with all required time frames for availability of trauma personnel~~,~~ including, but not limited to, response times for general surgery, orthopedics, neurosurgery, anesthesiology, radiology, and radiology, MRI, or CT techs.

(7) The availability of anesthesia services and the absence of delays in airway control or operations shall be monitored.

(8) Radiologists shall be involved in protocol development and trend analysis that relate to diagnostic imaging.

(9) The multidisciplinary committee shall review and address issues related to the availability of necessary personnel and equipment to monitor and resuscitate patients in the PACU.

C. Peer Review/Performance Improvement Committee

(1) The facility shall have a Peer Review/Performance Improvement Committee chaired by the trauma medical director or physician designee.

(2) The committee shall include, at a minimum, the core group of general surgeons and a physician liaison from orthopedic surgery, neurosurgery, emergency medicine, radiology, and anesthesia. Each liaison shall attend at least 50 percent of the meetings.

(3) Each liaison shall be available to the trauma medical director for committee issues that arise in his or her department.

(4) The Peer Review/Performance Improvement Committee shall document evidence of committee attendance and participation.

(5) The committee shall review the overall quality of care for the trauma service, selected deaths, complications, and sentinel events with the objective of identifying issues and appropriate responses.

(6) Trauma patient care may be evaluated initially by individual specialties within their usual ~~d~~Departmental review structures; however, identified problem trends shall undergo review within the Peer Review/Performance Improvement Committee.

(7) The facility shall also, in this committee or in another appropriate forum, provide for morbidity and mortality review of trauma cases. All trauma deaths shall be systematically reviewed and categorized as preventable, non-preventable, or potentially preventable OR EQUIVALENT TAXONOMY.

Commented [SG30]: Change approved by TF and added in other places with similar language for consistency.

(8) When a consistent problem or inappropriate variation is identified, corrective actions shall be taken and documented.

(9) The trauma medical director shall ensure dissemination of committee information to all non-core general surgeons with documentation.

(10) The Peer Review/Performance Improvement Committee shall review and monitor the organ donation rate.

(11) The committee shall demonstrate that the program complies with required surgical response times at least 80~~%~~ PERCENT of the time.

(12) The peer review/performance improvement program shall monitor changes in interpretation of diagnostic information.

4. Facility Organization and the Trauma Program

A. Facility Governing Body and Medical Staff Commitment

(1) The facility shall demonstrate the commitment of the facility's governing body and medical staff through a written document. The document shall be reaffirmed every three years and be current at the time of the site review.

(2) The administrative structure of the hospital/trauma facility shall include, at a minimum, an administrator, a trauma medical director, and a trauma program manager.

B. Trauma Program

~~(1) A multidisciplinary trauma committee shall continuously evaluate the trauma program's processes and outcomes.~~

Commented [SG31]: (Duplicate 303.3.B.(2))

(1) SCOPE OF CARE: ALL DESIGNATED LEVEL I AND II TRAUMA CENTERS SHALL DEFINE THEIR SCOPE OF CARE BASED ON THE RESOURCES THAT ARE AVAILABLE AT THE FACILITY FOR ADULT AND PEDIATRIC PATIENTS.

Commented [SG32]: Recommended by task force and consistent with other level facility rules

(2) The trauma program members or a representative of the program shall participate in state and regional trauma system planning, development, and operation.

(3) The trauma program shall have authority to address issues that involve multiple disciplines. The trauma medical director shall have the authority and administrative support to lead the program.

C. Trauma Medical Director

(1) The trauma medical director shall be a board -certified (not board -eligible) surgeon, as those boards are defined under the "Clinical Requirements for General Surgery" as described in Section 303.5.C or shall be a Fellow of the American College of Surgeons with special interest in trauma care, shall take trauma call, and shall ~~have successfully completed an~~ REMAIN CURRENT IN ATLS ~~course~~.

(2) The trauma medical director shall demonstrate membership and active participation in state and either regional or national trauma organizations.

(3) The trauma medical director shall have the authority to correct deficiencies in trauma care and exclude from taking trauma call all trauma team members who do not meet required criteria. Through the performance improvement program and hospital policy, the trauma medical director shall have the responsibility and authority to determine each general surgeon's ability to participate on the trauma panel based on an annual review.

(4) ~~The trauma medical director shall accrue an average of 16 hours verifiable, external, trauma-related CME annually or 48 hours in the three years prior to the designation site review, including no less than one national meeting per three years.~~

Commented [DM33]: Task force recommends deletion

D. Trauma Resuscitation Team

(1) The facility shall define criteria for trauma resuscitation team activation.

(2) The criteria for a graded activation shall be clearly defined and continuously evaluated by the performance improvement program.

E. Trauma Service

(1) A trauma service admission is a patient who is admitted to or evaluated by an identifiable surgical service staffed by credentialed trauma providers.

(2~~3~~) The facility shall demonstrate or provide documentation that the trauma service has sufficient infrastructure and support to ensure the adequate provision of care.

(3) THE TRAUMA SERVICE SHALL MAINTAIN OVERSIGHT OF THE ADMITTED PATIENT UNTIL TRAUMA CARE IS NO LONGER NECESSARY.

Commented [SG34]: Moved, previously in ICU where redundant.

(4~~1~~) LEVEL I ONLY: An adult trauma facility shall demonstrate an annual volume of at least 320 trauma patients with an Injury Severity Score (ISS) of 16 or greater.

F. Trauma Program Manager

The trauma program manager shall, at a minimum, be a registered nurse and demonstrate the following qualifications:

(1) Administrative ability,

(2) Evidence of educational preparation, AND

(3) Documented clinical experience. ~~, and~~

~~(4) Accrue an average of 16 hours of verifiable, external, trauma-related continuing education per year or 48 hours in the three years prior to the designation site review, including no less than one national trauma meeting per three years.~~

Commented [DM35]: Task force recommended for deletion

5. Clinical Requirements for General Surgery

A. Role/Availability

(1) The on-call attending trauma surgeon shall be in the emergency department on patient arrival, as set forth below, for the highest level of activation, with adequate notification from the field. The maximum response time is 15 minutes, tracked from patient arrival, 80 percent of the time. The Multidisciplinary Trauma Committee shall monitor compliance of the attending surgeon's arrival times.

(2) A resident in postgraduate year four or five may begin resuscitation while awaiting arrival of the attending surgeon based on facility-defined criteria.

B. Equipment/Resources

The facility shall provide all of the necessary resources, including instruments, equipment, and personnel, for current surgical trauma care.

C. Qualifications/Board Certification

(1) Except as provided below in subparagraph 2, all general surgeons on the trauma panel shall be fully credentialed in critical care and board certified in surgery by the American Board of Surgery (ABS), the Bureau of Osteopathic Specialists and Boards of Certification, or the Royal College of Physicians and Surgeons of Canada; or shall be board eligible, working toward certification, and less than five years out of residency.

(2) A foreign-trained, non-ABS boarded surgeon shall have the foreign equivalent of ABS certification in general surgery, clinical expertise in trauma care, an unrestricted Colorado license, and unrestricted credentials in surgery and critical care at the facility.

~~(3) The performance of all surgeons on the trauma panel shall be reviewed annually by the trauma medical director.~~

Commented [SG36]: Moved to D.(5) below

D. Clinical Commitment/Involvement

(1) All general surgeons on the trauma panel shall have general surgical privileges.

(2) The general surgeon on call shall be dedicated to one trauma facility when taking trauma call.

(3) A published general surgery back-up call schedule shall be available. The back-up surgeon shall be present within 30 minutes of being requested to respond.

(4) An attending surgeon shall be present at all trauma operations. The surgeon's presence shall be documented.

(5) THE PERFORMANCE OF ALL SURGEONS ON THE TRAUMA PANEL SHALL BE REVIEWED ANNUALLY BY THE TRAUMA MEDICAL DIRECTOR.

Commented [SG37]: This is moved verbatim from 303.5. C.(3)

E. Education/Continuing Education: ~~(1) All~~ general surgeons on the trauma panel shall REMAIN CURRENT IN ~~have successfully completed the American College of Surgeons~~ ATLS. ~~course at least once.~~

~~(2) All general surgeons who take trauma call shall accrue an average of 16 hours annually of verifiable, external, trauma-related CME or demonstrate participation in an internal educational process conducted by the trauma program based on the peer review/performance improvement program and the principles of practice-based learning.~~

~~(3) All general surgeons on the trauma panel shall be reviewed annually by the trauma medical director or designated representative to assure compliance with the facility's CME policy.~~

F. Participation in Statewide Trauma System

Each Level I AND II trauma facility shall provide a qualified surgeon as a state reviewer a minimum of one day per year, if requested by the ~~d~~Department.

6. Requirements for Emergency Medicine and the Emergency Department

A. Role/Availability

(1) The facility shall have a designated emergency department physician director supported by additional physicians to ensure immediate care for injured patients.

(2) A physician shall be present in the emergency department at all times.

(3) In facilities with emergency medicine residents, an in-house attending emergency physician shall provide supervision of the residents 24 hours per day.

(4) The facility shall designate an emergency physician to serve as the emergency medicine liaison to the trauma service.

B. Equipment/Resources

The trauma facility shall provide all of the necessary resources, including instruments, equipment, and personnel, for current emergency trauma care.

C. Qualifications/Board Certification

~~(1) Except as provided below in subparagraph 2, all emergency physicians on the trauma panel shall be board certified in emergency medicine by the American Board of Medical Specialties (ABS), the Bureau of Osteopathic Specialists and Boards of Certification, or the Royal College of Physicians and Surgeons of Canada; or shall be board eligible, working on certification, and less than five years out of residency.~~

~~(2) A foreign-trained, non-ABS-boarded emergency physician shall have the foreign equivalent of ABS certification in emergency medicine, clinical expertise in trauma care, an unrestricted Colorado license, and unrestricted credentials at the facility.~~

~~(3) The performance of all emergency physicians on the trauma panel shall be reviewed annually by the emergency medicine liaison or designated representative.~~

(1) ALL EMERGENCY PHYSICIANS ON THE TRAUMA PANEL SHALL HAVE SUCCESSFULLY COMPLETED ATLS AT LEAST ONCE.

Commented [SG38]: Revised per new CME/board certification discussion. Recommended by TF

Commented [SG39]: Delete per new CME requirements.

Commented [SG40]: Delete per newCME/eligibility requirements

Commented [SG41]: Moved to D.3 below

Commented [SG42]: Moved from 303.6.E.(1)

(2) PHYSICIANS PROVIDING INITIAL RESUSCITATION IN THE EMERGENCY DEPARTMENT SHALL BE:

(a) BOARD CERTIFIED IN EMERGENCY MEDICINE, OR

(b) HAVE CURRENT ATLS.

(3) BOARD CERTIFICATION SHALL BE ISSUED BY A CERTIFYING ENTITY THAT IS NATIONALLY RECOGNIZED IN THE UNITED STATES.

Commented [DM43]: New language recommended by task force

D. Clinical Commitment/Involvement

(1) The roles and responsibilities of the emergency physician shall be defined, agreed on, and approved by the trauma medical director.

(2) Emergency physicians on the call panel shall be regularly involved in the care of the injured patient.

(3) THE PERFORMANCE OF ALL EMERGENCY PHYSICIANS ON THE TRAUMA PANEL SHALL BE REVIEWED ANNUALLY BY THE EMERGENCY MEDICINE LIAISON OR DESIGNATED REPRESENTATIVE.

Commented [SG44]: Moved from 303.6.C.(3)

~~E. Education/Continuing Education~~

~~(1) All emergency physicians on the trauma panel shall have successfully completed the American College of Surgeons ATLS course at least once.(2)The trauma service emergency medicine liaison shall accrue an average of 16 hours annually of verifiable, external, trauma-related CME or 48 hours in the three years before the designation site review.~~

~~(3) All other emergency physicians on the trauma panel shall be reviewed annually by the emergency medicine liaison or designated representative to assure compliance with the facility's CME policy.~~

Commented [SG45]: Deleted per new CME/boarding requirements approved by TF

E~~F~~. Nursing Services

(1) A qualified nurse shall be available 24 hours per day to provide care for patients during the emergency department phase of care. Nursing personnel with special capability in trauma care shall provide continual monitoring of the trauma patient from hospital arrival to disposition in Intensive Care Unit (ICU), Operating Room (OR), or Patient Care Unit (PCU).

(2) The nurse/patient ratio shall be appropriate for the acuity of the trauma patients in the emergency department.

7. Clinical Requirements for Neurosurgery

A. Role/Availability

(1) The facility shall designate a neurosurgeon to serve as the neuroSURGICAL~~logical~~ liaison to the trauma service.

~~(2) The facility shall provide a neurotrauma on-call schedule, dedicated only to that facility, available 24 hours per day and either a posted second call or a contingency plan that includes transfer agreements with another designated Level I facility.~~ (moved below)

~~(3) Neurotrauma care shall be promptly available as defined by the facility. For less severe head injuries or injuries of the spine, neurotrauma care shall be available~~

~~when necessary. When requested, an attending neurosurgeon shall be promptly available as defined by the facility to the trauma service. Compliance with the facility-defined availability criteria shall be monitored by the Multidisciplinary Trauma Committee.~~ (replaced by below)

(2) THE FACILITY SHALL DEFINE CRITERIA FOR NEUROSURGICAL ATTENDING RESPONSE.

(3) NEUROSURGICAL CARE MUST BE CONTINUOUSLY AVAILABLE FOR ALL TRAUMATIC BRAIN IINJURY AND SPINAL CORD INJURY PATIENTS AND MUST BE PRESENT WITHIN 30 MINUTES, BASED ON THE FACILITY'S NEUROSURGICAL RESPONSE CRITERIA.

(4) COMPLIANCE WITH THE 30 MINUTE RESPONSE TIME TO NEUROSURGICAL PRESENCE SHALL BE MONITORED BY THE TRAUMA PROGRAM AND PRESENTED TO THE MULTIDISCIPLINARY TRAUMA COMMITTEE.

(5~~2~~) LEVEL I AVAILABILITY:

The facility shall provide a ~~neurotrauma~~ NEUROSURGICAL on-call schedule, dedicated only to that facility, available 24 hours per day, and either a posted ~~second call~~ BACKUP CALL SCHEDULE or a contingency plan that includes BYPASS AND transfer GUIDELINES ~~agreements~~ with another designated Level I, OR IN THE EVENT THAT NO OTHER LEVEL I IS AVAILABLE, THEN TO A LEVEL II FACILITY WITH THE NECESSARY RESOURCES TO MEET THE PATIENT'S NEEDS. ~~facility~~

(6) LEVEL II AVAILABILITY:

a. THE FACILITY SHALL PROVIDE A NEUROSURGICAL ON-CALL SCHEDULE, DEDICATED ONLY TO THAT FACILITY, AVAILABLE 24 HOURS PER DAY, AND EITHER A POSTED BACKUP CALL SCHEDULE OR A CONTINGENCY PLAN THAT INCLUDES BYPASS AND TRANSFER GUIDELINES WITH A DESIGNATED LEVEL I OR II FACILITY WITH THE NECESSARY RESOURCES TO MEET THE PATIENT'S NEEDS; OR

b. IF NEUROSURGEONS TAKE CALL AT MORE THAN ONE FACILITY (EITHER TRAUMA OR NON-TRAUMA) AT A TIME, WRITTEN PRIMARY AND BACKUP CALL SCHEDULES ARE REQUIRED AND A CONTINGENCY PLAN THAT INCLUDES BYPASS AND TRANSFER GUIDELINES WITH A DESIGNATED LEVEL I OR II FACILITY.

B. Equipment/Resources

The facility shall provide all of the necessary resources, including instruments, equipment, and personnel for current neurotrauma care.

C. Qualifications

(1) NEUROSURGEONS MUST BE:

a. BOARD CERTIFIED IN NEUROSURGERY, OR

b. BOARD ELIGIBLE AND LESS THAN SEVEN YEARS FROM RESIDENCY, OR

c. HAVE CURRENT ATLS, IF NO LONGER BOARDED OR BOARD ELIGIBLE.

Commented [SG46]: Deleted with revised requirements below,

Commented [DM47]: New language recommended by task force

Commented [SG48]: Moved from A.~~(3)~~ with edits

Commented [SG49]: New language recommended by TF

Commented [DM50]: New language recommended by task force

Commented [DM51]: New language recommended by TF

(2) ALL BOARD CERTIFICATIONS SHALL BE ISSUED BY A CERTIFYING ENTITY THAT IS NATIONALLY RECOGNIZED IN THE UNITED STATES.

Commented [SG52]: New language recommended by TF

~~(1) Except as provided below in subparagraph 2, all neurosurgeons who take trauma call shall be board certified in neurosurgery by the American Board of Surgery (ABS), the Bureau of Osteopathic Specialists and Boards of Certification, or the Royal College of Physicians and Surgeons of Canada; or shall be board eligible, working on certification, and less than five years out of residency.~~

~~(2) A foreign-trained, non-ABS-boarded neurosurgeon shall have the foreign equivalent of ABS certification in neurosurgery, clinical expertise in trauma care, an unrestricted Colorado license, and unrestricted credentials in neurosurgery at the facility.~~

Commented [SG53]: Deleted per new CME/boarding requirements approved by TF

~~(3) The performance of all neurosurgeons on the trauma panel shall be reviewed annually by the liaison or designated representative.~~

Commented [SG54]: Moved below to D.(3)

D. Clinical Commitment/Involvement

(1) Neurosurgeons shall be credentialed by the hospital with general neurosurgical privileges.

(2) Qualified neurosurgeons shall be regularly involved in the care of the head and spinal cord injured patients.

(3) THE PERFORMANCE OF ALL NEUROSURGEONS ON THE TRAUMA PANEL SHALL BE REVIEWED ANNUALLY BY THE LIAISON OR DESIGNATED REPRESENTATIVE.

Commented [SG55]: Moved from 303.7.C.3.

~~E. Education/Continuing Education~~

~~(1) The trauma service neurosurgery liaison shall accrue an average of 16 hours annually of verifiable, external, trauma-related CME or 48 hours in the three years before the designation site review.~~

~~(2) All other neurosurgeons on the trauma panel shall be reviewed annually by the liaison or designated representative to assure compliance with the facility's CME policy.~~

Commented [SG56]: Deleted per revised CME changes

8. Clinical Requirements for Orthopedic Surgery

A. Role/Availability/Specialists

(1) The facility shall designate an orthopedic surgeon to serve as the orthopedic liaison to the trauma program.

(2) THE FACILITY SHALL DEFINE CRITERIA FOR THE ORTHOPEDIC SURGEON ATTENDING RESPONSE.

(3) ORTHOPEDIC CARE MUST BE CONTINUOUSLY AVAILABLE FOR PATIENTS AND MUST BE PRESENT WITHIN 30 MINUTES BASED ON THE FACILITY'S ORTHOPEDIC RESPONSE CRITERIA.

Commented [SG57]: New language recommended by TF

(4) COMPLIANCE WITH THE 30 MINUTE RESPONSE TIME TO ORTHOPEDIC PRESENCE SHALL BE MONITORED BY THE TRAUMA PROGRAM AND PRESENTED TO THE MULTIDISCIPLINARY TRAUMA COMMITTEE.

Commented [SG58]: Moved from 303.8.A(2) below

(~~5~~2) LEVEL I AVAILABILITY:

~~a.~~The facility shall provide an orthopedic on-call schedule, dedicated only to that facility, available 24 hours per day and either a posted ~~second~~ BACKUP call

SCHEDULE or a contingency plan that includes BYPASS AND transfer ~~agreements~~GUIDELINES with another designated Level I, OR IN THE EVENT THAT NO OTHER LEVEL I IS AVAILABLE, THEN TO A LEVEL II FACILITY WITH THE NECESSARY RESOURCES TO MEET THE PATIENT'S NEEDS.. ~~Compliance with the facility-defined availability criteria shall be monitored by the Multidisciplinary Trauma Committee.(Moved above.)~~

(6) LEVEL II AVAILABILITY:

a. THE FACILITY SHALL PROVIDE AN ORTHOPEDIC ON-CALL SCHEDULE, DEDICATED ONLY TO THAT FACILITY, AVAILABLE 24 HOURS PER DAY AND EITHER A POSTED BACKUP CALL SCHEDULE OR A CONTINGENCY PLAN THAT INCLUDES BYPASS AND TRANSFER GUIDELINES WITH A DESIGNATED LEVEL I OR II FACILITY WITH THE NECESSARY RESOURCES TO MEET THE PATIENT'S NEEDS; OR

b. IF ORTHOPEDIC SURGEONS TAKE CALL AT MORE THAN ONE FACILITY (EITHER TRAUMA OR NON-TRAUMA) AT A TIME, WRITTEN PRIMARY AND BACKUP CALL SCHEDULES ARE REQUIRED AND A CONTINGENCY PLAN THAT INCLUDES BYPASS AND TRANSFER GUIDELINES WITH A DESIGNATED LEVEL I OR II FACILITY.

~~(4) Plastic surgery, hand surgery, and treatment of spinal injuries shall be available to the orthopedic patient.~~

(~~7~~5) A fully credentialed spine surgeon shall be promptly available, as defined by the facility, 24 hours per day.

(~~8~~2) LEVEL I ONLY: At least one orthopedic traumatologist with a minimum of six to twelve months of fellowship training (or equivalent) shall be a part of the trauma team.

B. Equipment/Resources

The facility shall provide all of the necessary resources including instruments, equipment, and personnel for current musculoskeletal trauma care.

C. Qualifications

(1) ORTHOPEDIC SURGEONS MUST BE:

a. BOARD CERTIFIED, OR

b. BOARD ELIGIBLE AND LESS THAN SEVEN YEARS FROM RESIDENCY, OR

c. HAVE CURRENT ATLS, IF NO LONGER BOARDED OR BOARD ELIGIBLE.

(2) ALL BOARD CERTIFICATIONS SHALL BE ISSUED BY A CERTIFYING ENTITY THAT IS NATIONALLY RECOGNIZED IN THE UNITED STATES.

~~(1) Except as provided below in subparagraph (2), all orthopedic surgeons who take trauma call shall be board certified in orthopedic surgery by the American Board of Surgery (ABS), the Bureau of Osteopathic Specialists and Boards of Certification, or the Royal College of Physicians and Surgeons of Canada; or shall be board eligible, working on certification, and less than five years out of residency.~~

Commented [OK59]: CONFORMING CHANGES WITH NEURO

Commented [SG60]: Moved from 304.8.D.(2).)

Commented [OK61]: CONFORMING CHANGES WITH NEURO

Commented [SG62]: Redundant, dealt with under surgical specialties.

Commented [DM63]: New language recommended by TF

~~(2) A foreign-trained, non-ABS orthopedic surgeon shall have the foreign equivalent of ABS certification in orthopedic surgery, clinical expertise in trauma care, an unrestricted Colorado license, and unrestricted credentials in orthopedic surgery at the facility.~~

Commented [SG64]: Deleted per revised CME/Boarding requirements.

~~(3) The performance of all orthopedic surgeons on the trauma panel shall be reviewed annually by the liaison or designated representative.~~

Commented [SG65]: Moved verbatim below

D. Clinical Commitment/Involvement

(1) Orthopedic surgeons shall be credentialed by the hospital with general orthopedic privileges.

~~(2) A published orthopedic surgery back-up call schedule shall be available with the back-up surgeon promptly available.~~

(2~~3~~) Orthopedic surgeons on the call panel shall be regularly involved in the care of the trauma patient.

(3) THE PERFORMANCE OF ALL ORTHOPEDIC SURGEONS ON THE TRAUMA PANEL SHALL BE REVIEWED ANNUALLY BY THE LIAISON OR DESIGNATED REPRESENTATIVE.

Commented [SG66]: Moved verbaim from above

~~E. Education/Continuing Education~~

~~(1) The trauma service orthopedic surgical liaison shall accrue an average of 16 hours annually of verifiable, external, trauma-related CME or 48 hours in the three years before the designation site review.~~

Commented [SG67]: Deleted per new CME/boarding requirements approved by TF

9. Pediatric Trauma Care

A. Pediatric trauma care shall refer to care delivered to children under age 15.

B. Level I AND II adult trauma facilities can and will receive pediatric trauma patients. All adult Level I AND II facilities shall:

(1) Provide evidence of safe pediatric trauma care to include age-specific medical devices and equipment as appropriate for the resuscitation and stabilization of the pediatric patient.

(2) Assure that the physician and nursing staff providing care to the pediatric patient demonstrates competency in the care of the injured child appropriate to the type of injured child.

(3) Demonstrate oversight of the pediatric care provided through a pediatric-specific peer review/performance improvement process.

C. NONACCIDENTAL TRAUMA

(1) PEDIATRIC PATIENTS WITH SUSPECTED OR EVIDENCE OF NONACCIDENTAL TRAUMA REQUIRING SOCIAL OR CLINICAL CARE BEYOND THE FACILITY'S RESOURCES SHALL BE TRANSFERRED TO A REGIONAL PEDIATRIC TRAUMA CENTER OR TO A LEVEL I OR II TRAUMA CENTER WITH THE NECESSARY RESOURCES THAT ADMITS PEDIATRIC TRAUMA PATIENTS. THE RECEIVING TRAUMA CENTER MUST MEET THE REQUIREMENTS SET FORTH IN 6 CCR 1015-4, CHAPTER THREE, SECTION 303.9.D.

(2) ALL LEVEL I-II FACILITIES ADMITTING PEDIATRIC PATIENTS WITH NONACCIDENTAL TRAUMATIC INJURY SHALL CONSULT WITH A SPECIALIST IN CHILD MALTREATMENT AFFILIATED WITH A TRAUMA CENTER FOR DIAGNOSTIC AND CARE CONSIDERATION PURPOSES.

Commented [SG68]: Recommended by task force

D~~C~~. A Level I OR II adult trauma facility that admits children having other than single extremity orthopedic fracture or minor head trauma AS DETERMINED BY BEST PRACTICE GUIDELINES ~~with a negative computed tomography~~ shall meet the following additional criteria:

(1) All physicians providing care to pediatric trauma patients shall be credentialed for pediatric trauma care by the hospital's credentialing body.

(2) The facility shall provide appropriate pediatric medical equipment in the emergency department.

(3) The facility shall provide a pediatric intensive care area STAFFED BY A BOARD CERTIFIED OR BOARD ELIGIBLE PEDIATRIC INTENSIVIST AVAILABLE FOR CONSULTATION or HAVE a transfer protocol and transfer agreements for pediatric patients requiring intensive care.

(4) A NEUROSURGEON ON CALL WITH QUALIFICATIONS NECESSARY TO MANAGE PEDIATRIC NEUROTRAUMA.

(4~~5~~) The facility shall provide appropriate pediatric resuscitation equipment in all pediatric care areas.

(~~5~~6) The facility shall have a pediatric-specific peer review/performance improvement process, which shall include pediatric-specific process filters and outcome measures.

(~~6~~7) The facility shall assure that the nursing staff providing care to the pediatric patient has specialized training in the care of the injured child.

10. Collaborative Clinical Services

A. Anesthesiology

(1) Role/Availability

a. The facility shall designate an anesthesiologist to serve as the anesthesia liaison to the trauma program.

b. Anesthesiology services shall be promptly available as defined by the facility ~~in-house~~ 24 hours per day for emergency operations and airway problems in the injured patient. Compliance with the facility-defined availability criteria shall be monitored by the Multidisciplinary Trauma Committee.

Commented [SG69]: Moved to below

c. When anesthesiology residents or certified registered nurse anesthetists are used to fulfill availability requirements, the staff anesthesiologist on call shall be notified and be present in the operating department. The process shall be monitored through the performance improvement process.

d. LEVEL I ONLY: ANESTHESIOLOGY COVERAGE SHALL BE IN HOUSE.

Commented [SG70]: (Moved from 303.10.A.(1)b.)

(2) Qualifications

~~a. All anesthesiologists who take trauma call shall be board certified or board eligible, working toward certification, and less than five years out of residency.~~

a. LEVEL I-II ANESTHESIOLOGISTS AND NURSE ANESTHETISTS MUST BE:

i. BOARD CERTIFIED, OR

ii. BOARD ELIGIBLE AND LESS THAN SEVEN YEARS FROM RESIDENCY, OR

iii. HAVE CURRENT ATLS, IF NO LONGER BOARDED OR BOARD ELIGIBLE.

b. ALL BOARD CERTIFICATIONS SHALL BE ISSUED BY A CERTIFYING ENTITY THAT IS NATIONALLY RECOGNIZED IN THE UNITED STATES.

Commented [DM71]: New language recommended by TF

c~~b~~. The performance of all anesthesiologists on the trauma panel shall be reviewed annually by the anesthesiology liaison or designated representative.

~~(3) Education/Continuing Education~~

~~a. The trauma service anesthesiologist liaison shall accrue an average of 16 hours annually of verifiable, external, trauma-related CME or 48 hours in the three years prior to the designation site review.~~

~~b. All other members of the anesthesiology team on the trauma panel shall be reviewed annually by the anesthesia liaison or designated representative to assure compliance with facility CME policy.~~

Commented [SG72]: Deleted per new CME/boarding requirements approved by TF

B. Operating Room

(1) General Requirements

a. A dedicated operating room team shall always be available.

b. If the primary operating room team is occupied, there shall be a mechanism in place to staff a second operating room.

c. There shall be a facility-defined access policy for urgent trauma cases of all specialties.

(2) Equipment Requirements

a. The facility shall have rapid infusers, thermal control equipment for patients and fluids, intraoperative radiological capabilities, equipment for fracture fixation, equipment for endoscopic evaluation (bronchoscopy and gastrointestinal endoscopy), and other equipment to provide operative care consistent with current practice.

b. The facility shall have the necessary equipment to perform a craniotomy.

c. LEVEL I ONLY: The facility shall have cardiopulmonary bypass equipment and an operating microscope available 24 hours per day.

C. Postanesthesia Care Unit (PACU)

(1) Qualified nurses shall be available 24 hours per day to provide care for the trauma patient, if needed, in the recovery phase.

(2) If the availability of PACU nurses is met with an on-call team from outside the hospital, the availability of the PACU nurses and absence of delays shall be monitored by the peer review/performance improvement program.

(3) The PACU shall provide all of the necessary resources including instruments, equipment, and personnel to monitor and resuscitate patients consistent with the facility-defined process of care.

(4) Recovery of the trauma patient in a critical care (intensive care) unit is also acceptable.

~~(5) The peer review/performance improvement program shall review and address issues related to the availability of necessary personnel and equipment to monitor and resuscitate patients in the PACU.~~

Commented [SG73]: (Duplicate 303.3.B.(9))

D. Radiology

(1) Role/Availability

a. Qualified radiologists shall be promptly available as defined by the facility for the interpretation of imaging studies and shall respond in person when requested.

b~~c~~. The facility shall designate a radiologist to serve as the radiology liaison to the trauma program.

c~~b~~. INTERVENTIONAL RADIOLOGY REQUIREMENTS:

i. LEVEL I: Personnel qualified in advanced neuro, endovascular, and interventional procedures shall be promptly available as defined by the facility 24 hours per day and available in less than 30 minutes when requested by a trauma surgeon.

ii. LEVEL II: PERSONNEL QUALIFIED IN INTERVENTIONAL PROCEDURES SHALL BE PROMPTLY AVAILABLE AS DEFINED BY THE FACILITY 24 HOURS PER DAY WHEN REQUESTED BY A TRAUMA SURGEON.

Commented [SG74]: Moved from 304.10.D.(1)b.)

(2) Clinical Commitment/Involvement

a. Diagnostic information shall be communicated in written form in a timely manner as defined by the facility.

b. Critical information that is deemed to immediately affect patient care shall be promptly communicated to the trauma team.

c. The final report shall accurately reflect the chronology and content of communications with the trauma team, including changes between the preliminary and final interpretation.

(3) Radiology Support Services

a. The facility shall have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transport to and while in the radiology department.

b. Conventional radiography and computed tomography (CT) shall be promptly available as defined by the facility 24 hours per day and available in less than 30 minutes when requested by a trauma surgeon.

c. An in-house radiographer and in-house CT technologist shall be promptly available as defined by the facility 24 hours per day and available in less than 30 minutes when requested by a trauma surgeon.

d. Conventional catheter angiography and sonography shall be promptly available as defined by the facility 24 hours per day and available in less than 30 minutes when requested by a trauma surgeon.

e. Magnetic resonance imaging capability shall be promptly available as defined by the facility 24 hours per day and available in less than 30 minutes when requested by a trauma surgeon.

f. The peer review/performance improvement program shall review and address any variance from facility-defined response times.

E. Critical Care

(1) Organization of the Intensive Care Unit (ICU)

a. ICU SERVICE LEADERSHIP:

i. LEVEL I: This service shall be led by a qualified surgeon who is board certified in critical care by the American Board of Surgery. The surgical director shall have obtained critical care training during residency or fellowship and shall have expertise in the perioperative and post injury care of injured patients.

ii. LEVEL II: THIS SERVICE SHALL BE DIRECTED OR CO-DIRECTED BY A QUALIFIED SURGEON WITH EXPERTISE IN THE CARE OF INJURED PATIENTS.

Commented [SG75]: Moved from 304.10.E.(1)a.)

b. This service may be staffed by critical care trained physicians from different specialties.

c. Physician coverage of critically ill trauma patients shall be promptly available as defined by the facility 24 hours per day. These physicians shall be capable of rapid response to deal with urgent problems as they arise. Availability shall be monitored by the peer review/performance improvement program.

d. All trauma surgeons shall be fully credentialed by the facility to provide all intensivist services in the ICU. There shall be full hospital privileges for critical care.

e. THE TRAUMA SURGEON SHALL RETAIN OVERSIGHT OF THE PATIENT WHILE IN THE ICU.

Commented [SG76]: Moved from below

f. ~~e.~~ LEVEL I ONLY: A facility-defined team shall provide daily multidisciplinary rounds to patients in the ICU.

~~(2) Responsibility for Trauma Patients: a. The trauma surgeon shall retain oversight of the patient while in the ICU.~~

Commented [SG77]: Moved above to e.

~~b. The trauma service shall maintain oversight of the patient throughout the course of hospitalization.~~

Commented [SG78]: Moved to 303.4.E.(4)

(~~3~~2) Nursing Services

a. A qualified nurse shall be available 24 hours per day to provide care for patients during the ICU phase of care.

b. The nurse/patient ratio shall be appropriate for the acuity of the trauma patients in the ICU.

c. The facility shall assure that the nursing staff providing care to the pediatric patient has specialized training in the care of the injured child.

(~~4~~3) Equipment

a. The ICU shall have the necessary resources including instruments and equipment to monitor and resuscitate patients consistent with the facility-defined process of care.

b~~c~~. Arterial pressure monitoring, pulmonary artery catheterization, patient rewarming, intracranial pressure monitoring, and other equipment to provide critical care consistent with current practice shall also be available.

c. VENTILATORY SUPPORT SHALL BE AVAILABLE FOR TRAUMA PATIENTS 24 HOURS PER DAY.

Commented [SG79]: Moved from 304.10.E.(4)b.)

d~~b~~. ~~LEVEL I ONLY: Non-conventional ventilatory support shall be available for trauma patients 24 hours per day.~~

Commented [SG80]: The concept of non-conventional ventilatory support is not mentioned elsewhere in the rules. TF recommends deleting since not defined.

F. Other Surgical Specialties - The facility shall have a full spectrum of surgical specialists on staff including, but not limited to, the following surgical specialties:

(1) T~~t~~horacic, peripheral vascular, obstetric, gynecological, otolaryngologic, urologic, ophthalmologic, facial trauma, and plastic

(2) IN ADDITION, LEVEL I ONLY: cardiac, microvascular, and hand.

G. Medical Consultants

(1) The facility shall have the following medical specialists AND THEIR RESPECTIVE SUPPORT TEAMS on staff: cardiology, infectious disease, internal medicine, pulmonary medicine, and nephrology. ~~and their respective support teams.~~

(2) A respiratory therapist shall be promptly available to care for trauma patients.

(3) Acute hemodialysis shall be promptly available for the trauma patient.

(4) Services shall be available 24 hours per day for the standard analyses of blood, urine, and other body fluids, coagulation studies, blood gases, and microbiology, including microsampling when appropriate.

(5) The blood bank shall be capable of blood typing and cross-matching and shall have an adequate supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, and appropriate coagulation factors to meet the needs of injured patients.

11. Rehabilitation Requirements

A. Rehabilitation services shall be available to the trauma patient:

(1) Within the hospital's physical facilities,~~;~~ or

(2) At a freestanding rehabilitation hospital. In this circumstance, the trauma facility shall have appropriate transfer agreements.

B. The following services shall be available during the trauma patient's ICU and other acute phases of care:

(1) Physical, occupational, and speech therapy, and

(2) Social services.

12. Trauma Registry

A. Trauma registry data shall be collected and analyzed by every trauma facility. It shall contain detailed, reliable, and readily accessible information that is necessary to operate a trauma facility.

B. Trauma data shall be submitted to the National Trauma Data Bank on an annual basis.

C. The facility shall demonstrate that the trauma registry is used to support the performance improvement program.

D. Trauma data shall be submitted to the Colorado Trauma Registry within 60 days of the end of the month during which the patient was discharged.

E. The trauma program shall have in place appropriate measures to assure that trauma data remain confidential.

F. The facility shall monitor data validity.

13. Outreach and Education

A. Public Outreach and Education: The facility shall engage in public education that includes prevention activities, referral, and access to trauma facility resources.

B. Professional Outreach and Education: The facility shall engage in professional outreach and education that include~~s~~, at a minimum:

(1) LEVEL I

a. Providing or participating in one ATLS course annually,

~~(2)~~ b. Providing a continuous rotation in trauma surgery for senior residents that is part of a program accredited by the Accreditation Council for Graduate Medical Education in either general surgery, orthopedic surgery, neurosurgery, or family medicine; or support of a critical care fellowship or an acute care surgery fellowship consistent with the educational requirements of the American Association for the Surgery of Trauma, and

~~(3)~~ c. Providing a mechanism to offer trauma-related education to nurses involved in trauma care.

(2) LEVEL II: INTERNAL AND EXTERNAL TRAUMA-RELATED EDUCATIONAL OPPORTUNITIES FOR PHYSICIANS, NURSES, AND ALLIED HEALTH PROFESSIONALS.

Commented [SG81]: Moved from 304.13.B.)

14. Prevention

A. The facility shall participate in injury prevention. The facility shall provide documentation of the presence of prevention activities that center on priorities based on local data.

B. The facility shall demonstrate evidence of a job description and salary support for an injury prevention coordinator who is a separate person from, but collaborates with, the trauma program manager.

C. The trauma service shall develop an injury prevention program that, at a minimum, incorporates the following:

(1) Selecting a target injury population,

(2) Gathering and analyzing data,

(3) Developing evidenced-based intervention strategies based on local data and best practices,

(4) Formulating a plan,

(5) Implementing the program, and

(6) Evaluating and revising the program as necessary.

D. The facility shall demonstrate collaboration with or participation in national, regional, or state injury prevention programs.

E. The facility shall have a mechanism to identify patients who may have an alcohol addiction. The facility shall also have the capability to provide an intervention for patients identified as potentially having an alcohol addiction.

F. The facility shall collaborate and mentor lower level trauma centers regarding injury prevention.

15. LEVEL I ONLY: Research and Scholarship

A. The facility shall meet one of the following options:

(1) Twenty peer-reviewed articles published in journals included in *Index Medicus* in a three-year period. These articles shall result from work related to the trauma facility.

a. Of the 20 articles, there shall be at least one authored or coauthored by members of the general surgery trauma team, and

b. There shall be at least one each from three of the following seven disciplines: neurosurgery, emergency medicine, orthopedics, radiology, anesthesia, nursing, or rehabilitation; or

(2) Ten peer-reviewed articles published in journals included in *Index Medicus* in a three-year period. These articles shall result from work related to the trauma facility.

a. Of the 10 articles, there shall be at least one authored or coauthored by members of the general surgery team, and

b. There shall be at least one each from three of the following seven disciplines: neurosurgery, emergency medicine, orthopedics, radiology, anesthesia, nursing, or rehabilitation; and

c. Four of the following scholarly activities shall be demonstrated:

i. Leadership in major trauma organizations.

ii. Peer-reviewed funding for trauma research.

iii. Evidence of dissemination of knowledge to include review articles, book chapters, technical documents, Web-based publications, editorial comments, training manuals, and trauma-related course materials.

iv. Display of scholarly application of knowledge as evidenced by case reports or reports of clinical series in journals included in MEDLINE.

v. Participation as a visiting professor or invited lecturer at national or regional trauma conferences.

vi. Support of resident participation in facility-focused scholarly activity, including laboratory experiences, clinical trials, or resident trauma paper competitions at the state, regional, or national level.

vii. Mentorship of residents and fellows, as evidenced by the development of a trauma fellowship program or successful matriculation of graduating residents into trauma fellowship programs.

B. The facility shall demonstrate support for the trauma research program by providing such items as basic laboratory space, sophisticated research equipment, advanced information systems, biostatistical support, salary support for basic and social scientists, or seed grants for less experienced faculty.

16. Organ Procurement Activities

A. The facility shall have an established relationship with a recognized organ procurement organization (OPO).

B. The facility shall have a written policy for triggering notification of the regional OPO.

C. The facility shall have written protocols defining clinical criteria and confirmatory tests for the diagnosis of brain death.

17. Disaster Planning and Management

A. The facility shall meet the Emergency Management-related requirements of the ~~Joint Commission~~ U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(1) These rules incorporate by reference the ~~*2011 Comprehensive Accreditation Manual for Hospitals: The Official Handbook*, effective December 2010~~ 42 CFR § 482.15, "CONDITION OF PARTICIPATION: EMERGENCY PREPAREDNESS FEDERAL REGULATIONS" (EFF. NOVEMBER 29, 2019).

(2) Such incorporation does not include later amendments to or editions of the referenced material. The Health Facilities and Emergency Medical Services Division of the ~~d~~Department maintains copies of the complete text of the incorporated materials for public inspection during regular business hours, and shall provide certified copies of any non-copyrighted material to the public at cost

upon request. Information regarding how the incorporated materials may be obtained or examined is available from the Division by contacting:

EMTS ~~Section~~ BRANCH Chief
Health Facilities and EMS Division
Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South
Denver, CO 80246-1530

~~These materials have been submitted to the state publications depository and distribution center and are available for interlibrary loan. The incorporated material may be examined at any state publications depository library.~~

These materials are available ~~for purchase from Joint Commission Resources at:~~ ~~WWW.JCRINC.COM~~ AND MAY BE ACCESSED AT: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=cd395e8123ef3c266ed31b354bb524f2&ty=HTML&h=L&mc=true&n=pt42.5.482&r=PART#se42.5.482_11

B. LEVEL I ONLY:

(1) A surgeon from the trauma panel shall participate on the hospital's disaster committee.

~~C.~~ (2) The facility shall have a disaster preparedness plan in its policy and procedure manual or equivalent.

~~D.~~ (3) Hospital drills that test the facility's preparedness plan shall be conducted no less than every six months.

~~E.~~ (4) The facility disaster preparedness plan shall be integrated into local, regional, and state disaster preparedness plans.

18. RETAC Integration

The facility shall demonstrate integration and cooperation with its Regional Emergency Medical and Trauma Advisory Council (RETAC). Evidence of such integration may include, but is not limited to: attendance at periodic RETAC meetings, participation in RETAC injury prevention activities, participation in RETAC data and/or quality improvement projects, etc.

~~304. Trauma Facility Designation Criteria – Level II Facilities~~

~~1. Prehospital Trauma Care Integration~~

~~A. The facility shall participate in the development and improvement of prehospital care protocols and patient safety programs.~~

~~B. The trauma medical director shall be involved in the development of the trauma facility's divert protocol as it affects the trauma service.~~

~~C. A trauma surgeon shall be involved in any decision regarding divert as it affects the care of the trauma patient.~~

~~D. A liaison from the emergency department shall participate in prehospital peer review/performance improvement.~~

~~2. Interfacility Consultation and Transfer Requirements~~

Commented [SG82]: This entire section has been integrated with the Level I rules.

A. Provisions for direct physician-to-physician contact shall be included in the process of transferring a patient between facilities.

B. A decision to transfer a patient shall be based solely on the clinical needs of the patient and not on the requirements of the patient's specific provider network or the patient's ability to pay.

C. If the facility does not have a burn service, a reimplantation service, a pediatric trauma service or an acute rehabilitation service, the facility shall have written transfer guidelines for patients in these categories.

3. Performance Improvement Process

A. General Provisions

(1) The facility shall demonstrate a clearly defined trauma performance improvement program that shall be coordinated with the hospital-wide program.

(2) The facility shall be able to demonstrate that the trauma patient population can be identified for separate review regardless of the institutional performance improvement processes.

(3) Performance improvement shall be supported by a reliable method of data collection that consistently obtains valid and objective information necessary to identify opportunities for improvement. The process of analysis shall include multidisciplinary review and shall occur at regular intervals to meet the needs of the program. The results of analysis shall define corrective strategies and shall be documented.

(4) The facility shall demonstrate that the trauma registry is used to support the performance improvement program.

(5) The performance improvement program shall have defined audit filters based upon a regular review of registry and/or clinical data.

(6) There shall be appropriate objectively defined standards to determine the quality of care.

(7) If more than 10 percent of injured patients with an Injury Severity Score greater than or equal to nine (excluding isolated hip fractures) are admitted to non-surgical services, the trauma facility shall demonstrate the appropriateness of that practice through the performance improvement program.

(8) Identified problem trends shall undergo peer review by the Peer Review/Performance Improvement Committee.

(9) A representative from the emergency department shall participate in prehospital peer review/performance improvement.

(10) The facility shall review any diversion or double transfer (from another facility and then transferred for additional acute trauma care) of trauma patients.

(11) If a facility conducts an internal trauma educational process in lieu of external trauma CME, that process shall be, at least in part, based on information from the peer review/performance improvement process and the principles of practice-based learning.

(12) The facility shall demonstrate that its graded activation criteria are regularly evaluated by the performance improvement program.

(13) The Level II adult facility that admits only children with single extremity orthopedic fracture or minor head trauma with a negative computed tomography exam shall demonstrate the oversight of pediatric care through a pediatric-specific peer review/performance improvement process.

(14) The Level II adult facility that admits children having other than single extremity orthopedic fracture or minor head trauma with a negative computed tomography exam shall have a pediatric-specific peer review/performance improvement process, which shall include pediatric-specific process filters and outcome measures.

(15) Physician availability to the trauma patient in the ICU shall be monitored by the peer review/performance improvement program.

B. Multidisciplinary Trauma Committee

(1) The facility shall have a multidisciplinary committee to address trauma program operational issues.

(2) A multidisciplinary trauma committee shall continuously evaluate the trauma program's processes and outcomes.

(3) The committee shall include, at a minimum, the trauma medical director or designee and all core surgeons as well as liaisons from orthopedic surgery, neurosurgery, emergency medicine, radiology and anesthesia. Each of these liaisons shall attend at least 50 percent of the meetings.

(4) The exact format of the committee may be hospital specific, but shall be multidisciplinary and consist of hospital and medical staff members who work to identify and correct trauma program system issues.

(5) The committee minutes shall reflect the review of operational issues and, when appropriate, the analysis and proposed corrective actions. The process shall identify problems and shall demonstrate problem resolution.

(6) The committee shall monitor compliance with all required time frames for availability of trauma personnel, including, but not limited to, response times for general surgery, orthopedics, neurosurgery, anesthesiology, radiology, and radiology, MRI or CT techs.

(7) The availability of anesthesia services and the absence of delays in airway control or operations shall be monitored.

(8) Radiologists shall be involved in protocol development and trend analysis that relate to diagnostic imaging.

(9) The multidisciplinary committee shall review and address issues related to the availability of necessary personnel and equipment to monitor and resuscitate patients in the PACU.

C. Peer Review/Performance Improvement Committee

(1) The facility shall have a Peer Review/Performance Improvement Committee chaired by the trauma medical director or physician designee.

(2) The committee shall include, at a minimum, the core group of general surgeons and a physician liaison from orthopedic surgery, neurosurgery, emergency medicine, radiology and anesthesia. Each liaison shall attend at least 50 percent of the meetings.

(3) Each liaison shall be available to the trauma medical director for committee issues that arise in his or her department.

(4) The Peer Review/Performance Improvement Committee shall document evidence of committee attendance and participation.

(5) The committee shall review the overall quality of care for the trauma service, selected deaths, complications and sentinel events with the objective of identifying issues and appropriate responses.

(6) Trauma patient care may be evaluated initially by individual specialties within their usual departmental review structures; however, identified problem trends shall undergo review within the Peer Review/Performance Improvement Committee.

(7) The facility shall also, in this committee or in another appropriate forum, provide for morbidity and mortality review of trauma cases. All trauma deaths shall be systematically reviewed and categorized as preventable, non-preventable or potentially preventable.

(8) When a consistent problem or inappropriate variation is identified, corrective actions shall be taken and documented.

(9) The trauma medical director shall ensure dissemination of committee information to all non-core general surgeons with documentation.

(10) The Peer Review/Performance Improvement Committee shall review and monitor the organ donation rate.

(11) The committee shall demonstrate that the program complies with required surgical response times at least 80% of the time.

(12) The peer review/performance improvement program shall monitor changes in interpretation of diagnostic information.

4. Facility Organization and the Trauma Program

A. Facility Governing Body and Medical Staff Commitment

(1) The facility shall demonstrate the commitment of the facility's governing body and medical staff through a written document. The document shall be reaffirmed every three years and be current at the time of the site review.

(2) The administrative structure of the hospital/trauma facility shall include, at a minimum, an administrator, a trauma medical director and a trauma program manager.

B. Trauma Program

(1) A multidisciplinary trauma committee shall continuously evaluate the trauma program's processes and outcomes.

(2) The trauma program members or a representative of the program shall participate in state and regional trauma system planning, development and operation.

(3) The trauma program shall have authority to address issues that involve multiple disciplines. The trauma medical director shall have the authority and administrative support to lead the program.

C. Trauma Medical Director

(1) The trauma medical director shall be a board-certified surgeon (not board-eligible), as those boards are defined under the "Clinical Requirements for General Surgery" as described in Section 304.5.C or shall be a Fellow of the American College of Surgeons with special interest in trauma care, shall take trauma call and shall have successfully completed an ATLS course.

(2) The trauma medical director shall demonstrate membership and active participation in state and either regional or national trauma organizations.

(3) The trauma medical director shall have the authority to correct deficiencies in trauma care and exclude from taking trauma call all trauma team members who do not meet required criteria. Through the performance improvement program and hospital policy, the trauma medical director shall have the responsibility and authority to determine each general surgeon's ability to participate on the trauma panel based on an annual review.

(4) The trauma medical director shall accrue an average of 16 hours verifiable, external trauma-related CME annually or 48 hours in the three years prior to the designation site review, including no less than one national meeting per three years.

D. Trauma Resuscitation Team

(1) The facility shall define criteria for trauma resuscitation team activation.

(2) The criteria for a graded activation shall be clearly defined and continuously evaluated by the performance improvement program.

E. Trauma Service

(1) A trauma service admission is a patient who is admitted to or evaluated by an identifiable surgical service staffed by credentialed trauma providers.

(2) The facility shall demonstrate or provide documentation that the trauma service has sufficient infrastructure and support to ensure the adequate provision of care.

F. Trauma Program Manager

The trauma program manager shall, at a minimum, be a registered nurse and demonstrate the following qualifications:

(1) Administrative ability,

(2) Evidence of educational preparation,

(3) Documented clinical experience, and

(4) Accrue an average of 16 hours of verifiable, external trauma-related continuing education per year or 48 hours in the three years prior to the designation site review including no less than one national trauma meeting per three years.

5. Clinical Requirements for General Surgery

A. Role/Availability

(1) The on-call attending trauma surgeon shall be in the emergency department on patient arrival, as set forth below, for the highest level of activation, with

adequate notification from the field. The maximum response time is 15 minutes, tracked from patient arrival, 80 percent of the time. The Multidisciplinary Trauma Committee shall monitor compliance of the attending surgeon's arrival times.

(2) A resident in postgraduate year four or five may begin resuscitation while awaiting arrival of the attending surgeon based on facility-defined criteria.

B. Equipment/Resources

The facility shall provide all of the necessary resources, including instruments, equipment and personnel, for current surgical trauma care.

C. Qualifications/Board Certification

(1) Except as provided below in subparagraph 2, all general surgeons on the trauma panel shall be fully credentialed in critical care and board certified in surgery by the American Board of Surgery (ABS), the Bureau of Osteopathic Specialists and Boards of Certification, or the Royal College of Physicians and Surgeons of Canada; or shall be board eligible, working toward certification and less than five years out of residency.

(2) A foreign-trained, non-ABS boarded surgeon shall have the foreign equivalent of ABS certification in general surgery, clinical expertise in trauma care, an unrestricted Colorado license and unrestricted credentials in surgery and critical care at the facility.

(3) The performance of all surgeons on the trauma panel shall be reviewed annually by the trauma medical director.

D. Clinical Commitment/Involvement

(1) All general surgeons on the trauma panel shall have general surgical privileges.

(2) The general surgeon on-call shall be dedicated to one trauma facility when taking trauma call.

(3) A published general surgery back-up call schedule shall be available. The back-up surgeon shall be present within 30 minutes of being requested to respond.

(4) An attending surgeon shall be present at all trauma operations. The surgeon's presence shall be documented.

E. Education/Continuing Education

(1) All general surgeons on the trauma panel shall have successfully completed the American College of Surgeons ATLS course at least once.

(2) All general surgeons who take trauma call shall accrue an average of 16 hours annually of verifiable, external trauma-related CME or demonstrate participation in an internal educational process conducted by the trauma program based on the peer review/performance improvement program and the principles of practice-based learning.

(3) All general surgeons on the trauma panel shall be reviewed annually by the trauma medical director or designated representative to assure compliance with the facility's CME policy.

F. Participation in Statewide Trauma System

~~Each Level II trauma facility shall provide a qualified surgeon as a state reviewer a minimum of one day per year if requested by the department.~~

~~6. Requirements for Emergency Medicine and the Emergency Department~~

~~A. Role/Availability~~

~~(1) The facility shall have a designated emergency department physician director supported by additional physicians to ensure immediate care for injured patients.~~

~~(2) A physician shall be present in the emergency department at all times.~~

~~(3) In facilities with emergency medicine residents, an in-house attending emergency physician shall provide supervision of the residents 24 hours per day.~~

~~(4) The facility shall designate an emergency physician to serve as the emergency medicine liaison to the trauma service.~~

~~B. Equipment/Resources~~

~~The trauma facility shall provide all of the necessary resources, including instruments, equipment and personnel, for current emergency trauma care.~~

~~C. Qualifications/Board Certification~~

~~(1) Except as provided below in subparagraph 2, all emergency physicians hired or contracted on or after the effective date of these rules to participate on the trauma panel shall be board certified in emergency medicine by the American Board of Medical Specialties (ABS), the Bureau of Osteopathic Specialists and Boards of Certification, or the Royal College of Physicians and Surgeons of Canada; or shall be board eligible, working on certification and less than five years out of residency.~~

~~(2) A foreign-trained, non-ABS boarded emergency physician shall have the foreign equivalent of ABS certification in emergency medicine, clinical expertise in trauma care, an unrestricted Colorado license, and unrestricted credentials at the facility.~~

~~(3) The performance of all emergency physicians on the trauma panel shall be reviewed annually by the emergency medicine liaison or designated representative.~~

~~D. Clinical Commitment/Involvement~~

~~(1) The roles and responsibilities of the emergency physician shall be defined, agreed on and approved by the trauma medical director.~~

~~(2) Emergency physicians on the call panel shall be regularly involved in the care of the injured patient.~~

~~E. Education/Continuing Education~~

~~(1) All emergency physicians on the trauma panel shall have successfully completed the American College of Surgeons ATLS course at least once.~~

~~(2) Physicians certified by boards other than emergency medicine who treat trauma patients in the emergency department shall remain current in ATLS.~~

(3) The trauma service emergency medicine liaison shall accrue an average of 16 hours annually of verifiable, external trauma-related CME or 48 hours in the three years before the designation site review.

(4) All other emergency physicians on the trauma panel shall be reviewed annually by the emergency medicine liaison or designated representative to assure compliance with the facility's CME policy.

F. Nursing Services

(1) A qualified nurse shall be available 24 hours per day to provide care for patients during the emergency department phase of care. Nursing personnel with special capability in trauma care shall provide continual monitoring of the trauma patient from hospital arrival to disposition in Intensive Care Unit (ICU), Operating Room (OR), or Patient Care Unit (PCU).

(2) The nurse/patient ratio shall be appropriate for the acuity of the trauma patients in the emergency department.

7. Clinical Requirements for Neurosurgery

A. Role/Availability

(1) The facility shall designate a neurosurgeon to serve as the neurological liaison to the trauma service.

(2) The facility shall define criteria for neurosurgical (attending and resident) activation.

(3) If neurosurgeons take call at more than one facility (either trauma or non-trauma) at a time, written primary and back-up call schedules are required, unless the combined volume of trauma-related emergency neurosurgical operative procedures in those facilities is less than an average of 25 per year over the last three calendar years for which data are available.

(4) When requested, an attending neurosurgeon shall be promptly available as defined by the facility to the trauma service. Compliance with the facility-defined availability criteria shall be monitored by the Multidisciplinary Trauma Committee.

B. Equipment/Resources

The facility shall provide all of the necessary resources, including instruments, equipment and personnel, for current neurotrauma care.

C. Qualifications

(1) Except as provided below in subparagraph 2, all neurosurgeons who take trauma call shall be board certified in neurosurgery by the American Board of Surgery (ABS), the Bureau of Osteopathic Specialists and Boards of Certification, or the Royal College of Physicians and Surgeons of Canada; or shall be board eligible, working on certification and less than five years out of residency.

(2) A foreign-trained, non-ABS boarded neurosurgeon shall have the foreign equivalent of ABS certification in neurosurgery, clinical expertise in trauma care, an unrestricted Colorado license and unrestricted credentials in neurosurgery at the facility.

(3) The performance of all neurosurgeons on the trauma panel shall be reviewed annually by the liaison or designated representative.

D. Clinical Commitment/Involvement

(1) Neurosurgeons shall be credentialed by the hospital with general neurosurgical privileges.

(2) Qualified neurosurgeons shall be regularly involved in the care of the head and spinal cord injured patients.

E. Education/Continuing Education

(1) The trauma service neurosurgery liaison shall accrue an average of 16 hours annually of verifiable, external trauma-related CME or 48 hours in the three years before the designation site review.

(2) All other neurosurgeons on the trauma panel shall be reviewed annually by the liaison or designated representative to assure compliance with the facility's CME policy.

8. Clinical Requirements for Orthopedic Surgery

A. Role/Availability/Specialists

(1) The facility shall designate an orthopedic surgeon to serve as the orthopedic liaison to the trauma program.

(2) The facility shall provide an orthopedic on-call schedule dedicated only to that facility, available 24 hours per day and either a posted second call or a contingency plan that includes transfer agreements with another designated Level I or II facility. Compliance with the facility-defined availability criteria shall be monitored by the Multidisciplinary Trauma Committee.

(3) Plastic surgery, hand surgery and treatment of spinal injuries shall be available to the orthopedic patient.

(4) A fully credentialed spine surgeon shall be promptly available, as defined by the facility, 24 hours per day.

B. Equipment/Resources

The facility shall provide all of the necessary resources including instruments, equipment and personnel, for current musculoskeletal trauma care.

C. Qualifications

(1) Except as provided below in subparagraph 2, all orthopedic surgeons who take trauma call shall be board certified in orthopedic surgery by the American Board of Surgery (ABS), the Bureau of Osteopathic Specialists and Boards of Certification, or the Royal College of Physicians and Surgeons of Canada; or shall be board eligible, working on certification and less than five years out of residency.

(2) A foreign-trained, non-ABS orthopedic surgeon shall have the foreign equivalent of ABS certification in orthopedic surgery, clinical expertise in trauma care, an unrestricted Colorado license and unrestricted credentials in orthopedic surgery at the facility.

(3) The performance of all orthopedic surgeons on the trauma panel shall be reviewed annually by the liaison or designated representative.

~~D. Clinical Commitment/Involvement~~

~~(1) Orthopedic surgeons shall be credentialed by the hospital with general orthopedic privileges.~~

~~(2) If orthopedic surgeons take call at more than one facility (either trauma or non-trauma) at a time, written primary and back-up call schedules are required.~~

~~(3) Orthopedic surgeons on the call panel shall be regularly involved in the care of the trauma patient.~~

~~E. Education/Continuing Education~~

~~(1) The trauma service orthopedic surgical liaison shall accrue an average of 16 hours annually of verifiable, external trauma-related CME or 48 hours in the three years before the designation site review.~~

~~(2) All other members of the orthopedic team on the trauma panel shall be reviewed annually by the liaison or designated representative to assure compliance with facility CME policy.~~

~~9. Pediatric Trauma Care~~

~~A. Pediatric trauma care shall refer to care delivered to children under age 15.~~

~~B. Level II adult trauma facilities can and will receive pediatric trauma patients. All adult Level II facilities shall:~~

~~(1) Provide evidence of safe pediatric trauma care to include age-specific medical devices and equipment as appropriate for the resuscitation and stabilization of the pediatric patient.~~

~~(2) Assure that the physician and nursing staff providing care to the pediatric patient demonstrates competency in the care of the injured child appropriate to the type of injured child.~~

~~(3) Demonstrate oversight of the pediatric care provided through a pediatric-specific peer review/performance improvement process.~~

~~C. A Level II adult trauma facility that admits children having other than single extremity orthopedic fracture or minor head trauma with a negative computed tomography shall meet the following additional criteria:~~

~~(1) All physicians providing care to pediatric trauma patients shall be credentialed for pediatric trauma care by the hospital's credentialing body.~~

~~(2) The facility shall provide appropriate pediatric medical equipment in the emergency department.~~

~~(3) The facility shall provide a pediatric intensive care area or a transfer protocol and transfer agreements for pediatric patients requiring intensive care.~~

~~(4) The facility shall provide appropriate pediatric resuscitation equipment in all pediatric care areas.~~

~~(5) The facility shall have a pediatric-specific peer review/performance improvement process, which shall include pediatric-specific process filters and outcome measures.~~

(6) The facility shall assure that the nursing staff providing care to the pediatric patient has specialized training in the care of the injured child.

10. Collaborative Clinical Services

A. Anesthesiology

(1) Role/Availability

a. The facility shall designate an anesthesiologist to serve as the anesthesia liaison to the trauma program.

b. Anesthesiology services shall be promptly available as defined by the facility 24 hours per day for emergency operations and airway problems in the injured patient. Compliance with the facility-defined availability criteria shall be monitored by the Multidisciplinary Trauma Committee.

c. When anesthesiology residents or certified registered nurse anesthetists are used to fulfill availability requirements, the staff anesthesiologist on call shall be notified and be present in the operating department. The process shall be monitored through the performance improvement process.

(2) Qualifications

a. All anesthesiologists who take trauma call shall be board certified or board eligible, working toward certification and less than five years out of residency.

b. The performance of all anesthesiologists on the trauma panel shall be reviewed annually by the anesthesiology liaison or designated representative.

(3) Education/Continuing Education

a. The trauma service anesthesiologist liaison shall accrue an average of 16 hours annually of verifiable, external trauma-related CME or 48 hours in the three years prior to the designation site review.

b. All other members of the anesthesiology team on the trauma panel shall be reviewed annually by the anesthesia liaison or designated representative to assure compliance with facility CME policy.

B. Operating Room

(1) General Requirements

a. A dedicated operating room team shall always be available.

b. If the primary operating room team is occupied, there shall be a mechanism in place to staff a second operating room.

c. There shall be a facility-defined access policy for urgent trauma cases of all specialties.

(2) Equipment Requirements

a. The facility shall have rapid infusers, thermal control equipment for patients and fluids, intraoperative radiological capabilities, equipment for

fracture fixation, equipment for endoscopic evaluation (bronchoscopy and gastrointestinal endoscopy) and other equipment to provide operative care consistent with current practice.

b. The facility shall have the necessary equipment to perform a craniotomy.

C. Postanesthesia Care Unit (PACU)

(1) Qualified nurses shall be available 24 hours per day to provide care for the trauma patient, if needed, in the recovery phase.

(2) If the availability of PACU nurses is met with an on-call team from outside the hospital, the availability of the PACU nurses and absence of delays shall be monitored by the peer review/performance improvement program.

(3) The PACU shall provide all of the necessary resources including instruments, equipment and personnel to monitor and resuscitate patients consistent with the facility-defined process of care.

(4) Recovery of the trauma patient in a critical care (intensive care) unit is also acceptable.

(5) The peer review/performance improvement program shall review and address issues related to the availability of necessary personnel and equipment to monitor and resuscitate patients in the PACU.

D. Radiology

(1) Role/Availability

a. Qualified radiologists shall be promptly available as defined by the facility for the interpretation of imaging studies and shall respond in person when requested.

b. Personnel qualified in interventional procedures shall be promptly available as defined by the facility 24 hours per day when requested by a trauma surgeon.

c. The facility shall designate a radiologist to serve as the radiology liaison to the trauma program.

(2) Clinical Commitment/Involvement

a. Diagnostic information shall be communicated in written form in a timely manner as defined by the facility.

b. Critical information that is deemed to immediately affect patient care shall be promptly communicated to the trauma team.

c. The final report shall accurately reflect the chronology and content of communications with the trauma team, including changes between the preliminary and final interpretation.

(3) Radiology Support Services

a. The facility shall have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transport to and while in the radiology department.

b. Conventional radiography and computed tomography (CT) shall be promptly available as defined by the facility 24 hours per day and available in less than 30 minutes when requested by a trauma surgeon.

c. An in-house radiographer and in-house CT technologist shall be promptly available as defined by the facility 24 hours per day and available in less than 30 minutes when requested by a trauma surgeon.

d. Conventional catheter angiography and sonography shall be promptly available as defined by the facility 24 hours per day and available in less than 30 minutes when requested by a trauma surgeon.

e. Magnetic resonance imaging capability shall be promptly available as defined by the facility 24 hours per day and available in less than 30 minutes when requested by a trauma surgeon.

f. The peer review/performance improvement program shall review and address any variance from facility-defined response times.

E. Critical Care

(1) Organization of the Intensive Care Unit (ICU)

a. This service shall be directed or co-directed by a qualified surgeon with expertise in the care of injured patients.

b. This service may be staffed by critical care trained physicians from different specialties.

c. Physician coverage of critically ill trauma patients shall be promptly available as defined by the facility 24 hours per day. These physicians shall be capable of rapid response to deal with urgent problems as they arise. Availability shall be monitored by the peer review/performance improvement program.

d. All trauma surgeons shall be fully credentialed by the facility to provide all intensivist services in the ICU. There shall be full hospital privileges for critical care.

(2) Responsibility for Trauma Patients

a. The trauma surgeon shall retain oversight of the patient while in the ICU.

b. The trauma service shall maintain oversight of the patient throughout the course of hospitalization.

(3) Nursing Services

a. A qualified nurse shall be available 24 hours per day to provide care for patients during the ICU phase of care.

b. The nurse/patient ratio shall be appropriate for the acuity of the trauma patients in the ICU.

c. The facility shall assure that the nursing staff providing care to the pediatric patient has specialized training in the care of the injured child.

(4) Equipment

a. The ICU shall have the necessary resources including instruments and equipment to monitor and resuscitate patients consistent with the facility-defined process of care.

b. Ventilatory support shall be available for trauma patients 24 hours per day.

c. Arterial pressure monitoring, pulmonary artery catheterization, patient rewarming, intracranial pressure monitoring and other equipment to provide critical care consistent with current practice shall also be available.

F. Other Surgical Specialties

The facility shall have a full spectrum of surgical specialists on staff including but not limited to the following surgical specialties: thoracic, peripheral vascular, obstetric, gynecological, otolaryngologic, urologic, ophthalmologic, facial trauma, spine and plastic.

G. Medical Consultants

(1) The facility shall have the following medical specialists on staff: cardiology, infectious disease, internal medicine, pulmonary medicine and nephrology and their respective support teams.

(2) A respiratory therapist shall be promptly available to care for trauma patients.

(3) Acute hemodialysis shall be promptly available for the trauma patient.

(4) Services shall be available 24 hours per day for the standard analyses of blood, urine, and other body fluids, coagulation studies, blood gases, and microbiology, including microsampling when appropriate.

(5) The blood bank shall be capable of blood typing and cross-matching and shall have an adequate supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate and appropriate coagulation factors to meet the needs of injured patients.

11. Rehabilitation Requirements

A. Rehabilitation services shall be available to the trauma patient:

(1) Within the hospital's physical facilities; or

(2) At a freestanding rehabilitation hospital. In this circumstance, the trauma facility shall have appropriate transfer agreements.

B. The following services shall be available during the trauma patient's ICU and other acute phases of care:

(1) Physical, occupational and speech therapy, and

(2) Social services.

12. Trauma Registry

A. Trauma registry data shall be collected and analyzed by every trauma facility. It shall contain detailed, reliable and readily accessible information that is necessary to operate a trauma facility.

B. Trauma data shall be submitted to the National Trauma Data Bank on an annual basis.

C. The facility shall demonstrate that the trauma registry is used to support the performance improvement program.

D. Trauma data shall be submitted to the Colorado Trauma Registry within 60 days of the end of the month during which the patient was discharged.

E. The trauma program shall have in place appropriate measures to assure that trauma data remain confidential.

F. The facility shall monitor data validity.

13. Outreach and Education

A. Public Outreach and Education

The facility shall engage in public education that includes prevention activities, referral and access to trauma facility resources.

B. Professional Outreach and Education

The trauma facility shall engage in professional outreach and education activities that include, at minimum, internal and external trauma-related educational opportunities for physicians, nurses and allied health professionals.

14. Prevention

A. The facility shall participate in injury prevention. The facility shall provide documentation of the presence of prevention activities that center on priorities based on local data.

B. The facility shall demonstrate evidence of a job description and salary support for an injury prevention coordinator who is a separate person from but collaborates with the trauma program manager.

C. The trauma service shall develop an injury prevention program that, at a minimum, incorporates the following:

(1) Selecting a target injury population,

(2) Gathering and analyzing data,

(3) Developing evidenced based intervention strategies based on local data and best practices,

(4) Formulating a plan,

(5) Implementing the program, and

(6) Evaluating and revising the program as necessary.

D. The facility shall demonstrate collaboration with or participation in national, regional or state injury prevention programs.

E. The facility shall have a mechanism to identify patients who may have an alcohol addiction. The facility shall also have the capability to provide an intervention for patients identified as potentially having an alcohol addiction.

~~F. The facility shall collaborate and mentor lower level trauma centers regarding injury prevention.~~

~~15. Organ Procurement Activities~~

~~A. The facility shall have an established relationship with a recognized organ procurement organization (OPO).~~

~~B. The facility shall have a written policy for triggering notification of the regional OPO.~~

~~C. The facility shall have written protocols defining clinical criteria and confirmatory tests for the diagnosis of brain death.~~

~~16. Disaster Planning and Management~~

~~A. The facility shall meet the Emergency Management-related requirements of the Joint Commission. These rules incorporate by reference the *2011 Comprehensive Accreditation Manual for Hospitals: The Official Handbook*, effective December 2010.~~

~~B. Such incorporation does not include later amendments to or editions of the referenced material. The Health Facilities and Emergency Medical Services Division of the department maintains copies of the complete text of the incorporated materials for public inspection during regular business hours, and shall provide certified copies of any non-copyrighted material to the public at cost upon request. Information regarding how the incorporated materials may be obtained or examined is available from the Division by contacting:~~

~~EMTS Section Chief~~
~~Health Facilities and EMS Division~~
~~Colorado Department of Public Health and Environment~~
~~4300 Cherry Creek Drive South~~
~~Denver, CO 80246-1530~~

~~These materials have been submitted to the state publications depository and distribution center and are available for interlibrary loan. The incorporated material may be examined at any state publications depository library.~~

~~These materials are available for purchase from Joint Commission Resources at WWW.JCRINC.COM .~~

~~17. RETAC Integration~~

~~The facility shall demonstrate integration and cooperation with its Regional Emergency Medical and Trauma Advisory Council (RETAC). Evidence of such integration may include but is not limited to: attendance at periodic RETAC meetings, participation in RETAC injury prevention activities, participation in RETAC data and or quality improvement projects, etc.~~

30~~4~~5. Trauma Quality Improvement Programs for Designated Trauma Centers Level III-V

1. All designated Level III-V trauma centers shall have an organized trauma quality improvement program that demonstrates a plan, process, and accountability for continuous quality improvement in the delivery of trauma care.

A. Each facility shall define its Scope of Care (SOC) based on the resources that are available to the facility.

B. Each facility shall have a formal transfer policy when specialty resources are not available.

C. Administration must support the trauma program and the Trauma Medical Director (TMD) in providing staff education commensurate with the level of care and based on patient population served.

2. The trauma quality improvement plan shall address the entire spectrum of services necessary to ensure optimal care to the trauma patient, from pre-hospital to rehabilitative care. The plan shall ensure the continuity of care for all admitted patients. ~~If the facility does not have the resources available to manage medical co-morbidities, then the patient shall be transferred.~~

Commented [SG83]: Deleted section is duplicate 306.3.A.(4).

A. In Level III facilities, this plan may be parallel to, and interactive with, the hospital-wide quality improvement program as defined in ~~C.R.S. §~~ SECTION 25-3-109, C.R.S. but may not be replaced by the facility process.

B. In Level IV-V facilities, this plan may be part of the hospital-wide quality improvement program~~,~~ but must have ~~specific~~FACILITY-defined, trauma-related indicators AND components ~~is overseen by the TMD.~~ Trauma-related issues must be documented separately, and the TMD has ~~purview~~ AUTHORITY over any trauma issues.

Commented [SG84]: Duplicate language

C. This plan shall include identification of:

(1) The trauma center's organizational structure responsible for the administration of the plan, to include a description of who has the authority to change policies, procedures, or protocols related to trauma care.

(2) The responsibility of the TMD, in coordination with the trauma nurse coordinator (TNC), for:

a. The ~~identification~~ IMPLEMENTATION of and responsibility for the oversight of the plan.

b. The facility-defined standards of medical care for the trauma patient.

c. The data sources to support an effective monitoring system, to include but not be limited to, retrospective and concurrent medical record review, including:

i. Primary level of review at least weekly.

ii. Secondary level of review, TMD in collaboration with TNC, at least twice a month.

iii. Tertiary level of review at least every other month at level IIIs and at least quarterly at level IV and Vs.

d. Identification of system issues to be addressed in multidisciplinary committee.

e. Identification of peer issues to be addressed in trauma peer review.

f. Review of all inpatients, transfers in or out, and trauma deaths.

g. Provide appropriate physician, mid-level, ancillary, and nursing staff education commensurate with the scope of care AS DESCRIBED IN 304.1.A.

h. Provide a mechanism for external review of specialty specific trauma cases that are not just limited to deaths.

3. The trauma quality program shall include a multidisciplinary committee responsible for trauma program performance.

~~A. Membership will be established by the facility and shall include representation from specialties that care for trauma patients.~~

A. AT A MINIMUM, ATTENDANCE AT MULTIDISCIPLINARY COMMITTEE SHALL INCLUDE REPRESENTATION FROM SPECIALTIES AND SERVICE LINES INVOLVED IN THE CARE OF TRAUMA PATIENTS.

B. AT A MINIMUM, ATTENDANCE REQUIREMENTS SHALL BE 50 PERCENT ATTENDANCE BY EMERGENCY MEDICINE, ORTHOPEDICS, GENERAL SURGERY, NEUROSURGERY, ANESTHESIA, AND MEDICINE IN FACILITIES WHERE THOSE SPECIALTIES ARE INVOLVED IN THE CARE OF TRAUMA PATIENTS.

C. FACILITY-DEFINED SPECIALTY CARE FILTERS SHALL BE BASED ON THE WRITTEN SCOPE OF CARE AND NATIONALLY RECOGNIZED BEST PRACTICE GUIDELINES.

~~B. The committee will establish attendance requirements.~~

~~C~~ D. The committee must meet on a regular basis, but not less than every two months for Level III facilities and quarterly for Level IV-V facilities, to assure timely review and corrective action.

~~D.~~E. The committee must review all services essential to the care and management of the trauma patient.

~~E.~~F. Performance management functions include, but are not limited to:

(1) A process for issue identification, case summarization, discussion, action plan, resolution, or outcome for loop closure.

(2) Initiation of corrective action as needed.

(3) A process for pre-hospital trauma care review.

(4) A process for the identification and review of facility-defined audit filters, patient sentinel events, complications, and trends.

(5) Facility-specific nursing audits for nursing documentation.

(6) Establishing and enforcing policies and procedures.

(7) Reviewing system issues, e.g., communications, notification times, and response times.

(8) Promoting educational offerings.

(9) Reviewing and analyzing trauma registry data for program evaluation and utilization.

(10) Provision for case presentations of interest for educational purposes to improve overall care of the trauma patient including all aspects and contributing factors of trauma care, from pre-hospital to discharge or death.

4. The trauma quality program shall include a method and process for conducting multidisciplinary trauma peer review comparable to the peer review defined in ~~C.R.S. §~~ SECTION 12-36.5-104 et. seq., C.R.S.

Commented [SG85]: CONFLICTS with requirement below.

Commented [SG86]: Moved from section 305.5.

Commented [SG87]: Moved from section 305.5. and slightly revised

Commented [SG88]: Moved from section 305.5.

Commented [SG89]: Conflicts with above mandatory attendance requirements

A. The facility shall define standards of care for the trauma patient.

B. The performance improvement process shall monitor compliance with, or adherence to, facility-defined standards.

C. Documentation of findings and recommendations must be maintained with an identified reporting process for loop closure.

D. Review any event that deviates from an anticipated outcome.

E. Compliance with all facility trauma care policies, protocols, and practice guidelines.

F. Conducting a review of all trauma deaths with:

(1) A report summary of the trauma peer review findings to the trauma multidisciplinary committee.

(2) All trauma centers shall have a policy that includes the process and criteria for utilization of a resource outside the facility for specialty specific peer review. Qualifications of outside peer reviewer must be identified by the facility as defined in ~~C.R.S. §~~SECTION 12-36.5-104, C.R.S.

(3) The deaths shall be identified as unanticipated mortality with opportunity for improvement (preventable), anticipated mortality with opportunity for improvement (potentially preventable), or mortality without opportunity for improvement (non-preventable), OR EQUIVALENT TAXONOMY.

Commented [SG90]: Inserted to allow for multiple methods. Language consistent across all levels.

5. The trauma quality program shall demonstrate accountability by:

A. The development and implementation of on-going reporting and trending of facility-specific audit filters.

B. Documenting and maintaining minutes available for trauma multidisciplinary committee, trauma peer review committee, or any other committees used in this process. Written documentation of the process to include date, issue identification, case summarization, assessment, any corrective action, recommendations, policy revision, education, and resolution.

C. Maintaining a system (such as a log) for tracking patient disposition and deaths.

D. Evidence of provider response times when the trauma team is activated.

E. Evidence of provider response times when consultations are required.

F. Evidence that nursing care issues are reviewed as part of the trauma program.

30~~5~~6. ~~Expanded~~ Scope of Care for Designated Trauma Centers Level III – ~~I~~V

Commented [SG91]: Please note that while this section 305 looks completely new, it is only rearranged for a more logical flow of ideas. New language is marked as such.

1. GENERAL REQUIREMENTS

A.~~1.~~ All designated Level III~~ and I~~V trauma centers shall define their Scope of Care (SOC) based on the resources that are available at the facility. ~~Physicians shall be allowed to transfer patients when in the best interest of the patient and shall not be encumbered by organizational restrictions to keep patients within a system. Facilities that provide an expanded scope of care shall have:~~

Commented [SG92]: Moved to 305.1.B.

~~A. A written policy for the management of each expanded scope service line being offered, for example, orthopedic surgery, plastic surgery or neurosurgery.~~

~~B. A written policy and plan for patient management when each service is not available, to include:~~

~~(1) A defined service that manages inpatient care for continuity.~~

~~(2) A written plan to ensure continuity of care for all admitted patients when the service is not available.~~

~~(3) Regular communication with transport providers and referring hospitals on availability of the expanded scope service(s).~~

~~(4) Hospital defined continuity of care plan that includes time of availability and proof of communication between services.~~

~~C. Formal transfer guidelines for times when a facility does not have specialty coverage and for unusual conditions such as weather, disaster, etc.~~

Commented [SG93]: Moved with edits to 305.3.A.(1)

~~D. Management guidelines based on the defined scope of care and nationally recognized best practice standards.~~

Commented [SG94]: Moved to section 305.4.A, C-E.

~~E. For Level IV facilities, if there is an emergency physician serving as the trauma medical director, there shall be a physician with surgical expertise to assist with performance improvement.~~

Commented [SG95]: Moved to 305.4.B

B. A DECISION TO TRANSFER A PATIENT SHALL BE BASED ON THE CLINICAL NEEDS OF THE PATIENT. PHYSICIANS SHALL BE ALLOWED TO TRANSFER WHEN IN THE BEST INTEREST OF THE PATIENT AND SHALL NOT BE ENCUMBERED BY RESTRICTIONS TO KEEP PATIENTS WITHIN A PARTICULAR HEALTHCARE ORGANIZATION OR BASED ON THE PATIENT'S ABILITY TO PAY.

Commented [SG96]: Moved from **305. 1. A.** with edits

2. Emergent Surgery at Level III and IV Trauma Centers

A. All Level III and IV trauma centers may ~~attempt~~ PERFORM emergent surgery if appropriate resources are available. ~~Once the patient is stabilized to the extent of the facility's capabilities, i~~If AFTER THE EMERGENT SURGERY IS PERFORMED, the facility does not have the POST-OPERATIVE ~~clinical platform~~ RESOURCES to care for the patient and for potential complications, the facility shall ~~consult with a higher level trauma center or T~~transfer TO A TRAUMA CENTER WITH THE NECESSARY RESOURCES TO MEET THE PATIENT'S NEEDS.~~at the discretion of the surgeon.~~

B~~C~~. If the surgeon on call AT A LEVEL III OR IV is encumbered in the operating room, the attending emergency department physician shall consult the surgeon to determine the plan of care, including the potential to ~~transfer to or~~consult with OR TRANSFER TO a higher level trauma center.

Commented [SG97]: Switched B and C for more logical flow of ideas

C~~B~~. For patients at Level IV trauma centers that require emergent surgery, the emergency physician shall consult the trauma surgeon on call. IF THE TIME TO SURGEON AND OPERATING ROOM AVAILABILITY EXCEEDS THE TRANSFER TIME TO A TRAUMA CENTER WITH THE NECESSARY RESOURCES, ~~to determine if the time to transfer would exceed the time to surgeon and operating room availability. If the surgeon's arrival and operating room capability time exceeds the transfer time,~~ the patient shall be transferred ~~to a higher level trauma center~~.

3. Mandatory Transfers and CONSULTATION,~~Consideration for Transfer~~ LEVEL III-V TRAUMA CENTERS

~~A. Nothing in these rules shall preclude any facility with the appropriate resources from providing emergent surgery as described above.~~

Commented [SG98]: Moved to 305.3.A.(2)

~~B. All Level III and IV trauma centers shall transfer patients with any injuries requiring resources beyond those available under the facility's scope of care and patients with the~~

Commented [SG99]: Moved to 305.3.A.(3)

following injuries, in addition to patients with injuries described in 6 CCR 1015-4, Chapter Two:

(1) Hemodynamically unstable pelvic fracture.

(2) Pelvic fracture requiring operative fixation.

(3) Fracture or dislocation with vascular injury requiring operative vascular repair.

Commented [SG100]: Moved to 3035.3.C.(1)

C. All Level III and IV trauma centers shall consult a trauma surgeon at a Level I or II key resource facility regarding any multiply injured patient requiring massive transfusion protocol (MTP). The consult for consideration of transfer shall occur within two hours of the initiation of the massive transfusion protocol.

Commented [SG101]: Moved and revised. See 305.3.B.(1)

D. All Level IV trauma centers shall transfer trauma patients under the following conditions, in addition to patients with injuries described in 6 CCR 1015-4, Chapter Two:

(1) Bilateral femur fractures.

(2) Femoral shaft fracture with any of the following:

a. Head injury with any evidence of intracranial hemorrhage, depressed skull fracture or skull fracture with sinus involvement.

b. Chest injury - multiple rib fractures (> 4 unilaterally or > 2 bilaterally) or hemothorax.

c. Abdomen - hollow organ or solid visceral injury, intra or retroperitoneal bleeding.

(3) Age greater than 65 years with multiple rib fractures greater than 4 unilaterally or greater than 2 bilaterally.

(4) Flail chest; 3 or more ribs, any age.

(5) Persistent pneumothorax that is unresponsive after adequately placed chest tube having a massive or prolonged air leak.

(6) Hemothorax treated with an initial chest tube that does not achieve complete evacuation within twenty-four (24) hours.

(7) Mechanical ventilation anticipated to be greater than twenty-four (24) hours if the facility does not have the clinical platform to provide ongoing ventilator management.

(8) Solid visceral or hollow organ injury if the facility does not have the clinical platform to care for the patient.

(9) Vascular injury requiring operative vascular repair.

(10) Crushed, de-gloved or mangled extremity.

(11) Suspected or actual evidence of non-accidental trauma requiring social or clinical care beyond the facility's resources.

Commented [SG102]: Moved almost verbatim to 305.3.C.(5)

E. Level III trauma centers with no neurosurgical/orthopedic spine coverage and all level IV and V trauma centers receiving trauma patients of any age under the following conditions, in addition to patients with injuries described in 6 CCR 1015-4, Chapter Two:

~~(1) Shall transfer the following:~~

~~a. Glasgow Coma Motor Score ≤ 4 due to trauma with a normal CT scan.~~

~~b. Any intracranial hemorrhage on anti-coagulation or anti-platelet therapy.~~

~~c. Lateralizing or focal neurologic deficit.~~

~~d. Any open, depressed, or basilar skull fracture.~~

~~e. Any unstable spinal column fracture.~~

~~f. Spinal column fracture with any motor or sensory deficit.~~

~~g. No spinal column fracture but nerve root injury with focal motor deficit or bilateral sensory deficit.~~

Commented [SG103]: Moved to 305.3.C.(3)

~~(2) Shall consider transferring the following:~~

~~a. Any patient with intracranial hemorrhage or evidence of cerebral edema due to trauma. Consult a neurosurgeon at a higher level of care for consideration of transfer. If the patient is admitted at the level III or IV, after consultation, the trauma surgeon shall admit and manage the patient through the course of high acuity care.~~

Commented [SG104]: Moved to 305.3.B.(2)

~~b. Any patient with a spinal column fracture other than a lumbar or thoracic transverse process fracture. Consult a spinal specialist at a higher level of care for consideration of transfer.~~

Commented [SG105]: Moved to 305.3.B.(3)

~~F. All level III trauma centers with part-time neurosurgical/orthopedic spine coverage shall:~~

~~(1) Have a published call schedule.~~

~~(2) Communicate with pre-hospital regarding availability of neurosurgical coverage.~~

~~(3) Meet the standards in 6 CCR 1015-4, Chapter Three 306.3.E. when there is no neurosurgical/orthopedic spine coverage.~~

Commented [SG106]: Moved to 305.4.J.(1)(a-c)

~~G. All level III trauma centers with full or part-time neurosurgical/orthopedic spine coverage shall transfer any patient with a Glasgow Coma Score < 9 due to trauma or any spinal cord injury except those with a transient or unilateral sensory deficit.~~

Commented [SG107]: Moved to 305.3.C.(4)

~~H. All Level III and IV trauma centers shall transfer patients if the facility does not have the resources and clinical expertise to manage their medical co-morbidities such as:~~

~~(1) Severe chronic obstructive pulmonary disease with home O2 requirement > 4L.~~

~~(2) Pulmonary hypertension.~~

~~(3) Critical aortic stenosis.~~

~~(4) Coronary artery disease and/or recent myocardial infarction within 6 months.~~

~~(5) Renal disease requiring dialysis.~~

~~(6) End stage liver disease with a MELD score >19.~~

~~(7) Unmanageable coagulopathy.~~

~~(8) Body mass index > 40.~~

~~(9) Pregnancy > 20 weeks.~~

Commented [SG108]: Moved to 305.3.C.(2)

~~I. All Level IV trauma centers with part-time specialty coverage:~~

~~(1) Level IV facilities with part-time orthopedic coverage shall not operate on femoral fractures unless there is general surgery availability.~~

~~(2) Cases shall be reviewed for projected length of stay. If the length of stay is greater than the specialty coverage and general surgery availability, then the patient shall be transferred.~~

Commented [SG109]: Moved to 305.4.J.

A. GENERAL REQUIREMENTS FOR TRANSFER

(1) EVERY TRAUMA CENTER SHALL ESTABLISH A POLICY AND PROCEDURE FOR ADDRESSING WHEN A PATIENT OR PATIENT'S REPRESENTATIVE REFUSES TRANSFER AND FOR WHEN WEATHER, DISASTER, OR OTHER EXTREME CONDITIONS PROHIBIT THE SAFE TRANSFER OF THE PATIENT.

Commented [SG110]: Weather, disaster, moved from section **306.**1.C.

(2) NOTHING IN THESE RULES SHALL PRECLUDE ANY FACILITY WITH THE APPROPRIATE RESOURCES FROM PROVIDING EMERGENT SURGERY AS PROVIDED IN SECTION 305.2.

Commented [SG111]: Moved from **306.**.3.A. with slight rewording in the reference language only

(3) PATIENTS OF ANY AGE WITH A TRAUMATIC INJURY REQUIRING RESOURCES BEYOND THOSE AVAILABLE IN THE FACILITY'S SCOPE OF CARE SHALL BE TRANSFERRED.

Commented [SG112]: Moved from **306.**3.B. with slight rewording

(4) PEDIATRIC PATIENTS REQUIRING TRANSFER BUT NOT REQUIRING EMERGENT INTERVENTION SHALL BE TRANSFERRED TO A REGIONAL PEDIATRIC TRAUMA CENTER OR TO A LEVEL I OR II TRAUMA CENTER THAT ADMITS PEDIATRIC TRAUMA PATIENTS. THE RECEIVING TRAUMA CENTER MUST MEET THE REQUIREMENTS SET FORTH IN 6 CCR 1015-4, CHAPTER THREE, SECTION 303.9.D.

Commented [DM113]: New language recommended by the TF

B. MANDATORY CONSULTATION

(1) ALL LEVEL III AND IV TRAUMA CENTERS TREATING PATIENTS WITH A TRAUMATIC INJURY REQUIRING A MASSIVE TRANSFUSION SHALL CONSULT A TRAUMA SURGEON AT A LEVEL I OR II KEY RESOURCE FACILITY FOR DIAGNOSTIC AND CARE CONSIDERATION PURPOSES, INCLUDING CONSIDERATION OF TRANSFER.

Commented [SG114]: Moved and edited from **306.**3.C. and 4.F(2).

(2) LEVEL III TRAUMA CENTERS WITH NO NEUROSURGICAL/ORTHOPEDIC SPINE COVERAGE AND ALL LEVEL IV TRAUMA CENTERS TREATING ANY PATIENT WITH INTRACRANIAL HEMORRHAGE OR EVIDENCE OF CEREBRAL EDEMA DUE TO TRAUMA SHALL CONSULT A NEUROSURGEON AT A HIGHER LEVEL OF CARE FOR CONSIDERATION OF TRANSFER. IF THE PATIENT IS ADMITTED AT THE LEVEL III OR IV, AFTER CONSULTATION, A GENERAL SURGEON ON THE TRAUMA PANEL SHALL ADMIT AND MANAGE THE PATIENT THROUGH THE COURSE OF HIGH ACUITY CARE.

Commented [SG115]: Moved from current section **306.3.**E(2) a. with some edits.

(3) ALL LEVEL III AND IV TRAUMA CENTERS SHALL CONSULT A SPINAL SPECIALIST AT A HIGHER LEVEL OF CARE TO DETERMINE THE NEED FOR TRANSFER FOR ANY SPINAL COLUMN FRACTURE OTHER THAN A LUMBAR OR THORACIC TRANSVERSE PROCESS FRACTURE.

Commented [SG116]: Moved from current section**3056.3.E.(2) b.** with edits.

(4) ALL LEVEL III-V FACILITIES ADMITTING PEDIATRIC PATIENTS WITH NONACCIDENTAL TRAUMATIC INJURY SHALL CONSULT WITH A

SPECIALIST IN CHILD MALTREATMENT AFFILIATED WITH A TRAUMA CENTER FOR DIAGNOSTIC AND CARE CONSIDERATION PURPOSES.

C. MANDATORY TRANSFERS FOR PATIENTS OF ALL AGES

(1) LEVEL III - V TRAUMA CENTERS SHALL TRANSFER WITH THE FOLLOWING TRAUMATIC INJURIES:

a. HEMODYNAMICALLY UNSTABLE PELVIC FRACTURE.

b. PELVIC FRACTURE REQUIRING OPERATIVE FIXATION.

c. FRACTURE OR DISLOCATION WITH VASCULAR INJURY REQUIRING OPERATIVE VASCULAR REPAIR.

d. AORTIC TEARS.

e. ABDOMINAL OR PELVIC INJURY REQUIRING EMERGENT SURGERY AND PACKING WITH NON-DEFINITIVE CLOSURE.

f. BURNS IN ACCORDANCE WITH 6 CCR 1015-4, CHAPTER THREE, Section 308.

(2) ALL LEVEL III - V TRAUMA CENTERS SHALL TRANSFER PATIENTS IF THE FACILITY DOES NOT HAVE THE RESOURCES AND CLINICAL EXPERTISE TO MANAGE THEIR MEDICAL CO-MORBIDITIES, INCLUDING, BUT NOT LIMITED TO:

a. SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH HOME O_2 REQUIREMENT > 4L.

b. PULMONARY HYPERTENSION.

c. CRITICAL AORTIC STENOSIS.

d. CORONARY ARTERY DISEASE AND/OR RECENT MYOCARDIAL INFARCTION WITHIN 6 MONTHS.

e. RENAL DISEASE REQUIRING DIALYSIS.

f. END STAGE LIVER DISEASE.

g. UNMANAGEABLE COAGULOPATHY.

h. BODY MASS INDEX > 40.

i. PREGNANCY > 20 WEEKS.

(3) LEVEL III TRAUMA CENTERS WITH NO NEUROSURGICAL/ORTHOPEDIC SPINE COVERAGE AND ALL LEVEL IV AND V TRAUMA CENTERS RECEIVING TRAUMA PATIENTS SHALL TRANSFER UNDER THE FOLLOWING CONDITIONS:

a. GLASGOW MOTOR SCORE ≤ 4 DUE TO TRAUMA WITH A NORMAL CT SCAN.

b. ANY INTRACRANIAL HEMORRHAGE ON ANTI-COAGULATION OR ANTI-PLATELET THERAPY.

c. LATERALIZING OR FOCAL NEUROLOGIC DEFICIT.

Commented [SG117]: Recommended by task force, language edited to be consistent with Level I/II

Commented [SG118]: Moved verbatim from **306.**3.B, 1-3

Commented [DM119]: New language recommended by TF

Commented [SG120]: Moved almost verbatim from section **306.** 3.H.

d. ANY OPEN, DEPRESSED, OR BASILAR SKULL FRACTURE.

e. ANY UNSTABLE SPINAL COLUMN FRACTURE.

f. SPINAL COLUMN FRACTURE WITH ANY MOTOR OR SENSORY DEFICIT.

g. NO SPINAL COLUMN FRACTURE BUT NERVE ROOT INJURY WITH FOCAL MOTOR DEFICIT OR BILATERAL SENSORY DEFICIT.

Commented [SG121]: Moved verbatim from **306.** 3.E(1)(a-g).

(4) ALL LEVEL III TRAUMA CENTERS WITH FULL OR PART-TIME NEUROSURGICAL/ORTHOPEDIC SPINE COVERAGE SHALL TRANSFER ANY PATIENT WITH A GLASGOW COMA SCORE < 9 DUE TO TRAUMA OR ANY SPINAL CORD INJURY EXCEPT THOSE WITH A TRANSIENT OR UNILATERAL SENSORY DEFICIT.

Commented [SG122]: Moved verbatim from **306.** 3.G.

(5) IN ADDITION, LEVEL IV-V TRAUMA CENTERS SHALL TRANSFER TRAUMA PATIENTS OF ANY AGE WITH THE FOLLOWING TRAUMATIC INJURIES:

a. BILATERAL FEMUR FRACTURES.

b. FEMORAL SHAFT FRACTURE WITH ANY OF THE FOLLOWING:

i. HEAD INJURY WITH ANY EVIDENCE OF INTRACRANIAL HEMORRHAGE, DEPRESSED SKULL FRACTURE, OR SKULL FRACTURE WITH SINUS INVOLVEMENT.

ii. CHEST INJURY - MULTIPLE RIB FRACTURES (> 4 UNILATERALLY OR > 2 BILATERALLY) OR HEMOTHORAX.

iii. ABDOMEN - HOLLOW ORGAN OR SOLID VISCERAL INJURY, INTRA- OR RETROPERITONEAL BLEEDING.

c. FLAIL CHEST.

d. AGE GREATER THAN 65 YEARS WITH MULTIPLE RIB FRACTURES (>4 UNILATERALLY OR >2 BILATERALLY.)

e. PERSISTENT PNEUMOTHORAX THAT IS UNRESPONSIVE AFTER ADEQUATELY PLACED CHEST TUBE HAVING A MASSIVE OR PROLONGED AIR LEAK.

f. HEMOTHORAX TREATED WITH AN INITIAL CHEST TUBE THAT DOES NOT ACHIEVE COMPLETE EVACUATION WITHIN TWENTY-FOUR (24) HOURS.

g. MECHANICAL VENTILATION ANTICIPATED TO BE GREATER THAN TWENTY-FOUR (24) HOURS, IF THE FACILITY DOES NOT HAVE THE NECESSARY RESOURCES TO PROVIDE ONGOING VENTILATOR MANAGEMENT.

h. SOLID VISCERAL OR HOLLOW ORGAN INJURY, IF THE FACILITY DOES NOT HAVE THE NECESSARY RESOURCES TO CARE FOR THE PATIENT.

i. VASCULAR INJURY REQUIRING OPERATIVE VASCULAR REPAIR.

j. CRUSHED, DE-GLOVED, OR MANGLED EXTREMITY.

k. SUSPECTED OR EVIDENCE OF NONACCIDENTAL TRAUMA REQUIRING SOCIAL OR CLINICAL CARE BEYOND THE FACILITY'S RESOURCES.

Commented [SG123]: Moved almost verbatim from **306.** 3.D.

D. MANDATORY TRANSFERS FOR PEDIATRIC PATIENTS: IN ADDITION TO THE INJURIES LISTED ABOVE, ALL LEVEL III-V TRAUMA CENTERS SHALL TRANSFER PATIENTS AGES 0-14 WITH:

(1) INTRACRANIAL HEMORRHAGE, EVIDENCE OF CEREBRAL EDEMA, DUE TO TRAUMA, GLASGOW MOTOR SCORE ≤ 4 WITH A NORMAL CT SCAN, OR LATERALIZING OR FOCAL NEUROLOGIC DEFICIT.

(2) INTRACRANIAL, INTRATHORACIC, OR INTRA-ABDOMINAL PENETRATING INJURIES OR PENETRATING INJURIES WITH ORTHOPEDIC OR NEUROVASCULAR COMPROMISE.

(3) INJURIES RESULTING IN THE NEED FOR MECHANICAL VENTILATION.

(4) INJURIES RESULTING IN THE NEED FOR A TRANSFUSION OF PACKED RED BLOOD CELLS.

(5) HEMOTHORAX.

(6) PULMONARY CONTUSIONS RESULTING IN ASSOCIATED HYPOXIA.

(7) MULTIPLE RIB FRACTURES OR FLAIL CHEST.

(8) ABDOMINAL HOLLOW ORGAN OR SOLID VISCERAL INJURY, INTRA- OR RETROPERITONEAL BLEEDING.

(9) VASCULAR INJURY REQUIRING OPERATIVE VASCULAR REPAIR

Commented [DM124]: New pediatric language recommended by the TF

4. ~~Expanded Scope Required Resources~~LEVEL III AND IV TRAUMA CENTERS PROVIDING AN EXPANDED SCOPE OF CARE SHALL HAVE:

A. A WRITTEN POLICY FOR THE MANAGEMENT OF EACH EXPANDED SCOPE SERVICE LINE BEING OFFERED, FOR EXAMPLE, ORTHOPEDIC SURGERY, PLASTIC SURGERY, GENERAL SURGERY, OR NEUROSURGERY.

Commented [SG125]: Moved verbatim with addition of general surgery from 306.1.A.

B. FOR LEVEL IV FACILITIES, IF THERE IS AN EMERGENCY PHYSICIAN SERVING AS THE TRAUMA MEDICAL DIRECTOR, THERE SHALL BE A PHYSICIAN WITH SURGICAL EXPERTISE TO ASSIST WITH PERFORMANCE IMPROVEMENT.

Commented [SG126]: Moved verbatim from 306.1.E

C. A WRITTEN POLICY AND PLAN FOR PATIENT MANAGEMENT WHEN EACH SERVICE IS NOT AVAILABLE, TO INCLUDE:

(1) A DEFINED SERVICE THAT MANAGES INPATIENT CARE FOR CONTINUITY.

(2) A WRITTEN PLAN TO ENSURE CONTINUITY OF CARE FOR ALL ADMITTED PATIENTS.

(3) REGULAR COMMUNICATION WITH TRANSPORT PROVIDERS AND REFERRING HOSPITALS ON AVAILABILITY OF THE EXPANDED SCOPE SERVICE(S).

(4) A HOSPITAL DEFINED CONTINUITY OF CARE PLAN THAT INCLUDES TIME OF AVAILABILITY AND PROOF OF COMMUNICATION BETWEEN SERVICES.

D. FORMAL TRANSFER GUIDELINES FOR TIMES WHEN A FACILITY DOES NOT HAVE SPECIALTY COVERAGE.

E. MANAGEMENT GUIDELINES BASED ON THE DEFINED EXPANDED SCOPE OF CARE AND NATIONALLY RECOGNIZED BEST PRACTICE STANDARDS.

FA. An ~~E~~emergency ~~D~~department with:

(1) A defined call response time for each specialty consultation.

(2) A massive transfusion protocol~~. If the facility initiates the MTP, consultation with a higher level trauma facility will be required to expedite transfer or discuss further stabilization.~~

GB An Operating Room with:

(1) Defined operating room availability, within 30 minutes, if the facility is providing emergent surgery as part of an expanded scope of care.

(2) Anesthesia service and appropriate operating room staff shall match fully functional operating room availability.

(3) Facilities shall match specialty provider availability with operating room availability.

(4) Intra-operative equipment and radiology capability commensurate with the EXPANDED scope of care provided.

HC Inpatient services with:~~(1) Mm~~edical consultation with a physician appropriately credentialed by the facility to treat medical co-morbidities.

ID Education, including:

(1) Administrative support for the trauma program and the trauma medical director in providing appropriate staff education commensurate with the EXPANDED scope of care and based on patient population served.

(2) The facility shall ensure that the physician specialists direct and/or provide education to the team looking after their patients, including:

a. Post-operative care.

b. RECOGNITION AND CARE OF POTENTIAL ~~C~~complication~~S recognition and care~~.

c. Recognition and care of hemodynamic instability.

J. WITH RESPECT TO LEVEL III-IV TRAUMA CENTERS THAT PROVIDE AN EXPANDED SCOPE OF CARE WITH PART-TIME SPECIALTY COVERAGE:

(1) ALL LEVEL III TRAUMA CENTERS WITH PART-TIME NEUROSURGICAL/ORTHOPEDIC SPINE COVERAGE SHALL:

a. HAVE A PUBLISHED CALL SCHEDULE.

b. COMMUNICATE WITH PRE-HOSPITAL REGARDING AVAILABILITY OF NEUROSURGICAL/ORTHOPEDIC SPINE COVERAGE.

c. MEET THE STANDARDS IN 6 CCR 1015-4, CHAPTER THREE 305.3.C.(3). WHEN THERE IS NO NEUROSURGICAL/ORTHOPEDIC SPINE COVERAGE.

Commented [SG127]: Moved verbatim from 306. 1 B-D

Commented [SG128]: This section and following are re-lettered because they are current language just moved within the same section

Commented [SG129]: Moved to 305.3.B.1

Commented [SG130]: Moved verbatim from **306.** 3.F.

(2) LEVEL IV FACILITIES WITH PART-TIME ORTHOPEDIC COVERAGE SHALL NOT OPERATE ON FEMORAL FRACTURES UNLESS THERE IS GENERAL SURGERY AVAILABILITY.

(3) CASES SHALL BE REVIEWED FOR PROJECTED LENGTH OF STAY AND MONITORED THROUGH THE PERFORMANCE IMPROVEMENT PROCESS. IF THE LENGTH OF STAY FOR ANY PATIENT REQUIRING AN EXPANDED SCOPE SERVICE IS GREATER THAN THE SPECIALTY COVERAGE AND GENERAL SURGERY AVAILABILITY, THEN THE PATIENT SHALL BE TRANSFERRED.

~~J.5. Performance Improvement and Patient Safety~~

~~.A. Attendance at multidisciplinary committee shall include representation from all specialties and service lines involved in the care of trauma patients to include 50% attendance by emergency medicine, orthopedics, general surgery, anesthesia and medicine.~~

~~B. Level III - IV facilities shall have a mechanism for outside review of specialty-specific trauma cases.~~

~~C. Facility-defined specialty care filters based on the written scope of care and nationally recognized best practice guidelines~~

Commented [SG131]: Moved almost verbatim from section **306.**3.I. above.

Commented [SG132]: Moved from 306.3.J, with addtions. Recommended by TF

Commented [SG133]: Deleted, duplicative

Commented [SG134]: Moved to section 304.3. (quality improvement for level III-V)

306~~7~~. Trauma Facility Designation Criteria - Level III

Standards for facilities designated as Level III Trauma Centers - The facility must be licensed as a general OR CRITICAL ACCESS hospital.

1. ~~Administration and Organization Criteria.~~ A Level III Trauma Center shall have~~:A. A~~ a trauma program with:

A. ~~(1)~~ An administrative organizational structure that identifies the institutional support and commitment. The program's location within that structure must be placed so that it may interact with at least equal authority with other departments providing patient care within the facility.

B. ~~(2)~~ Medical staff commitment to support the program demonstrated by a written commitment to provide the specialty care needed to support optimal care of the injured patient and specific delineation of surgical privileges.

C. ~~(3)~~ Policies that identify and establish the scope of ~~trauma~~ care for both adult and pediatric patients~~,~~ including, but not limited to:

(1)~~a.~~ Initial resuscitation and stabilization;

(2)~~b.~~ Admission and inter-facility consultation and transfer criteria;

(3)~~c.~~ Surgical capabilities;

(4)~~d.~~ Critical care capabilities;

(5)~~e.~~ Rehabilitation capabilities, if available;

(6)~~f.~~ Neurosurgical capabilities, if available;

(7)~~g.~~ Spinal ~~C~~cord surgical capabilities, if available;

(8)~~h.~~ Other ~~specialist~~ capabilities, if available;~~ and~~

(9)~~i.~~ Written procedure for receipt and transfer of patients by fixed and rotary wing aircraft; AND

(10) ANY EXPANDED SCOPE OF CARE CAPABILITIES NOT ALREADY DESCRIBED.

D.~~(4)~~ A Trauma Medical Director who is a board certified general surgeon, or is board qualified working toward board certification. A facility may have another physician as a co-trauma medical director. The Trauma Medical Director:

(1)~~a.~~ Is responsible for service leadership, overseeing all aspects of trauma care, with administrative authority for the hospital trauma program including:

a.~~i.~~ Trauma multidisciplinary program,

b.~~ii.~~ Trauma quality improvement program,

c.~~iii.~~ Provision of recommendations for physician appointment to and removal from the trauma service,

d.~~iv.~~ Policy and procedure development and enforcement, and

e.~~v.~~ Peer review.

(2)~~b.~~ Participates on a local or statewide basis in trauma educational activities for healthcare providers or the public.

(3)~~c.~~ Functions as trauma medical director at only one facility.

(4)~~d.~~ Participates in the on-call schedule.

(5)~~e.~~ Participates in regional trauma system development.

E.~~(5)~~ A facility-defined trauma team, with an identifiable team leader.

F.~~(6)~~ A facility-defined trauma team activation protocol that includes who is notified and the response requirements. The protocol shall base activation of the team on the anatomical, physiological, mechanism of injury criteria, and ~~co-morbid factors~~OTHER CONSIDERATIONS as outlined in the pre-hospital trauma triage algorithms as set forth in 6 CCR 1015-4, Chapter ONE~~Two~~.

Commented [SG135]: Conforming change with chapter one algorithm

G.~~(7)~~ A facility-defined trauma service with the personnel and resources identified as needed to provide care for the injured patient.

H.~~(8)~~ A registered nurse identified as the Trauma Nurse Coordinator with educational preparation and clinical experience in care of the injured patient as defined by the facility. This position is responsible for the organization of services and systems necessary for a multidisciplinary approach to care of the injured patient.

I.~~(9)~~ A m~~M~~ulti-disciplinary trauma committee with specialty representation. This ~~committee is involved in the development of a plan of care for the injured patient and i~~s responsible for trauma program performance. Membership will be established by the facility and attendance requirements established by the committee. MINIMUM ACCEPTABLE STANDARDS ARE SET FORTH IN SECTION 304.

J.~~(10)~~ A quality improvement program as defined in Section 304~~8~~ of this chapter.

K. POLICIES, PROCEDURES, AND PRACTICE CONSISTENT WITH THE SCOPE OF CARE AND EXPANDED SCOPE OF CARE, AS APPLICABLE, FOR DESIGNATED LEVEL III TRAUMA CENTERS AS FOUND IN SECTION 305 OF THIS CHAPTER.

L~~(11)~~ Divert protocols, to include:

(1)~~a.~~ Coordination with the RETAC,

(2)~~b.~~ Notification of pre-hospital providers AND OTHER IMPACTED FACILITIES, CONSISTENT WITH RETAC PROTOCOLS, IF ANY.

(3)~~c.~~ Reason for divert, AND

(4)~~d.~~ A method for monitoring times and reasons for going on divert.

M.~~(12)~~ A trauma registry as required in Chapter TWO~~1~~ of these rules, and trauma data entry support~~,~~.

N.~~(13)~~ Participation in the RETAC and statewide quality improvement programs as required in rule.

~~B. Hospital departments/divisions/sections~~

~~(1) Surgery~~

~~(2) Emergency Medicine~~

~~(3) Anesthesia~~

Commented [SG136]: Duplicative

2. A Level III trauma center shall meet all of the following clinical capabilities criteria:

A. Emergency Medicine in house 24 hours a day.

B. ~~The following service~~ GENERAL SURGERY available in person 24 hours a day within 20 minutes of trauma team activation~~:~~,

(1) ~~General surgery:~~ ~~C~~coverage shall be provided by.:

(1)~~a.~~ The attending board certified surgeon or board qualified surgeon working toward certification,

(2) W~~w~~ho may only take call at one facility at any one time, AND

(3)~~b.~~ The surgeon will meet those patients meeting facility-defined Trauma Team Activation criteria upon arrival, by ambulance, in the emergency department. For those patients meeting Trauma Team Activation criteria where adequate prior notification is not possible, the surgical response shall be 20 minutes from notification.

C. The following services on - call and available within 30 minutes of request by the trauma team leader:

(1) ANESTHESIA COVERAGE SHALL BE BY AN ANESTHESIOLOGIST OR A CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA).

Commented [SG137]: Language from below streamlined.

~~a. A board certified anesthesiologist, or board qualified anesthesiologist working toward certification,; or~~

~~b. A Certified Registered Nurse Anesthetist (CRNA).~~

Commented [SG138]: Conforming changes regarding board certification

(2) Orthopedic surgery. ~~Coverage shall be by: a. A board certified or board qualified orthopedic surgeon working toward certification.~~

D. The following non-surgical specialists on call, credentialed, and available in person or by tele-radiology for patient service upon request of the trauma team leader:

(1) A radiologist, and

(2) Internal medicine.

3. A Level III trauma center shall have all of the following facilities, resources, and capabilities:

A. An ~~E~~emergency ~~D~~department with:

(1) Personnel, to include:

a. A designated physician director who is board certified in emergency medicine, family practice, internal medicine, or surgery, and whose primary practice is in emergency medicine.

~~b. Physician(s) designated as member(s) of the trauma team:~~

~~i. Physically present in the Emergency Department 24 hours/day.~~

~~ii. And who are board certified in emergency medicine, family practice, internal medicine, or surgery. and~~

~~ii. Who are Advanced Trauma Life Support verified unless board certified in emergency medicine.~~

~~iii. Whose primary practice is in emergency medicine.~~

~~iv. All physicians hired or contracted for services after 2005 must be board certified in emergency medicine or board qualified working toward certification.1~~

~~c~~b. Registered ~~N~~nurses in-house 24 hours a day who:

i. Provide continuous monitoring of the trauma patient until release from the ~~E~~emergency ~~D~~department, and

ii. At least one ~~R~~registered ~~N~~nurse in the ~~E~~emergency ~~D~~department 24 hours/day who maintains current ~~verification~~ CERTIFICATION in Trauma Nurse Core Course or equivalent.

(2) Equipment for the resuscitation of patients of all ages shall include but not be limited to:

a. Airway control and ventilation equipment including: laryngoscopes and endotracheal tubes of all sizes, bag mask resuscitators, and oxygen;

b. Pulse oximetry;

c. End - tidal CO_2 determination;

d. Suction devices;

e. Electrocardiograph ~~oscilloscope~~ AND defibrillator;

Commented [DM139]: Conforming amendments regarding board eligibility

Commented [SG140]: Conforming changes regarding board certification

Commented [SG141]: Removed because conflicts with 2.A above

Commented [SG142]: Removed per new CME/ATLS/boarding requirements

Commented [SG143]: Antequated language

f. Internal paddles - adult and pediatric;

g. Apparatus to establish central venous pressure monitoring;

h. Standard intravenous fluids and administration devices, including large bore intravenous catheters;

i. Sterile surgical sets for:

i. Airway control/cricothyrotomy,

ii. Thorocostomy - needle and tube,

iii. Thoracotomy, AND

iv. Vascular access to include central line insertion and interosseous access.

~~v. Peritoneal lavage~~

Commented [SG144]: Task force approved deletion; antequated language

j. Gastric decompression;

k. Drugs necessary for emergency care;

l. X-ray availability, 24 hours a day;

m. Two-way communication with emergency transport vehicles;

n. Spinal immobilization equipment/cervical traction devices;

o. Arterial catheters;

p. Thermal control equipment for:

i. Patients, AND

ii. Blood and fluids.

q. Rapid infuser system;

r. Medication chart, tape, or other system to assure ready access to information on proper dose-per-kilogram for resuscitation drugs and equipment sizes for pediatric patients; AND

S. TOURNIQUET.

Commented [SG145]: Added per best practice. Also added elsewhere for consistency.

B. An operating room available 24/hours a day with:

(1) Facility-defined operating room team on-call and available within 30 minutes of request by trauma team leader~~.~~;

(2) Equipment for all ages shall include, but not be limited to:

a. Thermal control equipment for:

i. Patients, AND

ii. Blood and fluids;

b. X-ray capability, including c-arm image intensifier;

c. Endoscope, broncoscope;

d. Equipment for fixation of long bone and pelvic fractures;

e. Rapid infuser system; AND

f. Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange.

C. Postanesthesia Care Unit (surgical intensive care unit is acceptable) with:

(1) Registered nurses available within 30 minutes of request, 24 hours a day;

(2) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange; AND

(3) Thermal control equipment for:

a. Patients, AND

b. Blood and fluids.

D. Intensive Care Unit for injured patients with:

(1) Personnel, to include:

a. A director, or co-director, who is a surgeon with facility privileges to admit patients to the critical care area~~,~~ and is responsible for setting policies and oversight of the care related to trauma ICU patients;

b. A physician, approved by the trauma director who is available within 30 minutes of notification to respond to the needs of the trauma ICU patient; and

c. Registered nurses.

(2) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange.

E. Radiological Services, available 24 hours a day, with:

(1) A radiology technician available within 30 minutes of notification of Trauma Team Activation;

(2) A Computed Tomography technician available within 30 minutes of request;

(3) Computed tomography (CT); and

(4) Ultrasound.

F. Clinical Laboratory Services, to include:

(1) Standard analysis of blood, urine, and other body fluids;

(2) Blood typing and cross matching;

(3) Coagulation studies;

(4) Blood and blood components available from in-house, or through community services, to meet patient needs and blood storage capability;

(5) Blood gases and pH determination;

(6) Microbiology;

(7) Serum alcohol and toxicology determination; and

(8) A clinical laboratory technician in-house.

G. Respiratory therapy services, in-house.

H. Neuro-trauma Management AS REQUIRED IN SECTION 305.3 AND 305.4.

~~(1) Acute Spinal Cord Management with:~~

~~a. Neurosurgeons or orthopedic surgeons with special qualifications in acute spinal cord management, on-call and available within a facility defined time of request of the trauma team leader, or~~

~~b. Written transfer guidelines for patients with spinal cord injuries.~~

~~(2) Acute Brain Injury Management with a:~~

~~a. Neurosurgeon on-call and available within 30 minutes of the request of the trauma team leader, or~~

~~b. Written transfer guidelines for patients with acute brain injuries.~~

Commented [SG146]: New and more detailed language now included section 305

I. Organized burn care for those patients identified in Section 308~~9~~ of this chapter, and transfer and consultation guidelines with a burn center as defined in Section 308~~9~~ of this chapter.

J. Rehabilitation services with:

(1) A physician who is credentialed by the facility to provide leadership for physical medicine and rehabilitation, and

(2) Policies and procedures for the early assessment of the rehabilitation needs of the injured patient, and

(3) Physical therapy, and

(4) Occupational therapy, and

(5) Speech therapy, and

(6) Social Services; or

(7) Transfer guidelines for access to rehabilitation services.

K. Injury Prevention/Public Education, with:

(1) Outreach activities and program development;

(2) Information resources for the public; and

(3) Facility developed or collaboration with existing national, regional, and/OR state programs.

L In-house trauma-related continuing education, for:

(1) Non-physician trauma team members, and

(2) Nurses in the Eemergency Ddepartment and Iintensive Ccare Uunit with facility-defined competency testing and orientation programs.

M. CONTINUING MEDICAL EDUCATION REQUIREMENTS~~CME requirements for surgeons, orthopedic surgeons, emergency physicians, anesthesiologists/CRNA's and neurosurgeons if providing trauma care, to include:~~

~~(1) 10 hours of trauma-related, facility-defined CME annually or 30 hours over the three-year period preceding any site review,~~

(1~~2~~) LEVEL III PHYSICIANS PROVIDING INITIAL RESUSCITATION IN THE EMERGENCY DEPARTMENT ~~All emergency physicians on the trauma panel~~ shall have successfully completed ATLS at least once.

(2) LEVEL III PHYSICIANS PROVIDING INITIAL RESUSCITATION IN THE EMERGENCY DEPARTMENT SHALL BE BOARD CERTIFIED IN EMERGENCY MEDICINE OR HAVE CURRENT ATLS.

(3) LEVEL III GENERAL SURGEONS ON THE TRAUMA CALL PANEL SHALL BE CURRENT IN ATLS.

(4) LEVEL III ORTHOPEDIC SURGEONS, NEUROSURGEONS, ANESTHESIOLOGISTS, AND NURSE ANESTHETISTS MUST BE:

a. BOARD CERTIFIED, OR

b. BOARD ELIGIBLE AND LESS THAN SEVEN YEARS FROM RESIDENCY, OR

c. HAVE CURRENT ATLS, IF NO LONGER BOARDED OR BOARD ELIGIBLE.

(5) ALL BOARD CERTIFICATIONS SHALL BE ISSUED BY A CERTIFYING ENTITY THAT IS NATIONALLY RECOGNIZED IN THE UNITED STATES.

~~Current Advanced Trauma Life Support verification for all physicians providing emergency department coverage who are not board certified in emergency medicine,~~

~~(3) Documentation of successful completion of an Advanced Trauma Life Support course for surgeons and all emergency physicians who are board certified in emergency medicine.~~

30~~7~~8. Trauma Facility Designation Criteria - Level IV AND V

~~Standards for facilities designated as Level IV Trauma Centers~~

~~The facility~~ LEVEL IV TRAUMA CENTERS must be licensed as ~~one of the following~~: a general hospital, a ~~c~~Community ~~c~~Clinic and ~~e~~Emergency ~~c~~Center (CCEC), AS DEFINED IN 6 CCR 1011-1 CHAPTER 9, PART 2.101.(3) and (4), ~~and be open 24 hours a day, 365 days a year~~ or a Ccritical Aaccess Hhospital ~~(~~CAH~~)~~ and be open 24 hours a day, 365 days a year with physician coverage for trauma patients arriving by ambulance ~~as described in the clinical capabilities criteria~~.

Commented [SG147]: Conforming with new requirements throughout

Commented [SG148]: New language recommended by task force

Level V Trauma Centers ~~- The facility~~ must be licensed as: a general hospital, a Ccommunity Cclinic and Eemergency Cceenter (CCEC), or a Ccritical Aaccess Hhospital ~~(CAH)~~ AND HAVE A POLICY ABOUT HOURS OF OPERATION AS DESCRIBED BELOW.

1. ~~Administration and Organization Criteria.~~ A Level IV OR V Trauma Center shall have:

A. Commitment by administration and medical staff to support the trauma program demonstrated by written commitment from the facility's board of directors, owner/operator, or administrator to provide the required services.

B. A written commitment to regional planning~~/g~~ and system development activities.

C. A trauma program with policies that identify and establish the scope of ~~trauma~~ care for both adult and pediatric patients~~,~~ including, but not limited to:

(1) Initial resuscitation and stabilization;

(2) Rehabilitation capabilities if available; ~~and~~

(3) Written procedure for transfer of patients by fixed and rotary wing aircraft;

(4) HOSPITALS ONLY (NOT APPLICABLE TO CCECS) Admission criteria;

(5) LEVEL IV ONLY:

a. Surgical capabilities, if available;

b. Critical care capabilities, if available;

c. ANY EXPANDED SCOPE OF CARE CAPABILITIES AS REQUIRED IN SECTION 305.

(6) LEVEL V ONLY: HOURS OF OPERATION. THE SERVICES AS DEFINED IN THE SCOPE OF TRAUMA SERVICE POLICY SHALL INCLUDE AN AFTER-HOURS PLAN FOR AVAILABILITY OF SERVICES.

Commented [SG149]: Moved from Level V rules

D. A physician designated by the facility as the Trauma Medical Director who takes responsibility for the trauma program. Responsibilities include:

(1) Participation in trauma educational activities for healthcare providers or the public;

(2) Leadership for the trauma program and oversight of the trauma quality improvement process; and

(3) Administrative authority for the trauma program, including~~,~~: recommendations for trauma privileges, policy and procedure enforcement, and peer review.

E. A facility-defined trauma team activation protocol that includes who is notified and the response expectations. The protocol shall base activation of personnel on anatomical, physiological, mechanism of injury criteria, and OTHER CONSIDERATIONS ~~co-morbid factors~~ as outlined in the prehospital trauma triage algorithms as set forth in 6 CCR 1015-4, Chapter ONE ~~Two~~.

Commented [SG150]: Conforming language change from chapter one algorithm

F. A defined method of activating trauma response personnel consistent with the scope of trauma care provided by the facility.

G. A staff person identified as the Trauma NURSE Coordinator with clinical experience in care of the injured patient, who is responsible for coordination of the trauma program functions.

~~H. An identified multidisciplinary committee involved in the development of a plan of care for the injured patient and is responsible for trauma program performance. Membership will be established by the facility and the committee will establish attendance.~~

~~I~~H. A quality improvement program as defined in Section 3048 of this chapter.

I. POLICIES, PROCEDURES, AND PRACTICE CONSISTENT WITH THE SCOPE OF CARE AND EXPANDED SCOPE OF CARE, AS APPLICABLE, FOR DESIGNATED TRAUMA CENTERS LEVEL IV – V AS FOUND IN SECTION 305 OF THIS CHAPTER.

J. Divert protocols, to include:

(1) Coordination with the Regional Emergency Medical and Trauma Advisory Council (RETAC);

(2) Notification of pre-hospital providers AND OTHER IMPACTED FACILITIES, CONSISTENT WITH RETAC PROTOCOLS, IF ANY;

(3) Reason for divert; AND

(4) A method for monitoring times and reasons for going divert.

K. Interfacility transfer criteria/guidelines as a transferring facility. ~~(if applicable)~~

L. Interfacility transfer policies and protocols.

M. Participation in the state trauma registry as required in Chapter ~~1~~TWO.

N. Participation in the RETAC and statewide quality improvement programs as required in rule.

O. If licensed as a Community Clinic with Emergency Care (CCEC):

(1) A central log on each trauma patient/individual presenting with an emergency condition who comes seeking assistance and whether he or she refused treatment, was refused treatment, or whether the individual was transferred, admitted and treated, died, stabilized and transferred, or discharged.

(2) A policy requiring the provision of a medical screening of all individuals with trauma-related emergencies that come to the clinic and request an examination or treatment. The policy shall not delay the provision of a medical screening in order to inquire about an individual's' method of payment or insurance status.

(3) Provide further medical examination and such treatment as may be required to stabilize the traumatic injury within the staff and facility's capabilities available at the clinic, or to transfer the individual. The transferring clinic must provide the medical treatment, within its capacity, which minimizes the risk to the individual, send all pertinent medical records available at the time of transfer, effect the transfer through qualified persons and transportation equipment, and obtain the consent of the receiving trauma center.

~~2. A Level IV OR V trauma center shall meet all of the following clinical capabilities criteria:~~

~~A. The physician must be present in the emergency department at the time of arrival of the trauma patient meeting facility-defined Trauma Team Activation criteria, arriving by~~

Commented [SG151]: REDUNDANT WITH SECTION 304 regarding performance improvement for level III-V trauma centers

Commented [SG152]: Redundant since paragraph below is moved

Commented [SG153]: MOVED BELOW

~~ambulance. For those patients where adequate prior notification is not possible, the emergency physician shall be available within 20 minutes of notification.~~

~~2~~3. A Level IV OR V trauma center shall have all of the following facilities, resources, and capabilities:

A. An ~~E~~emergency ~~D~~department with:

(1) A. ~~The~~ A PHYSICIAN WHO MUST BE PRESENT IN THE EMERGENCY DEPARTMENT AT THE TIME OF ARRIVAL OF THE TRAUMA PATIENT MEETING FACILITY-DEFINED TRAUMA TEAM ACTIVATION CRITERIA, ARRIVING BY AMBULANCE. FOR THOSE PATIENTS WHERE ADEQUATE PRIOR NOTIFICATION IS NOT POSSIBLE, THE EMERGENCY PHYSICIAN SHALL BE AVAILABLE WITHIN 20 MINUTES OF NOTIFICATION.

Commented [SG154]: Moved from above.

~~(1) Physicians who are credentialed by the facility to provide emergency medical care and maintain current Advanced Trauma Life Support (ATLS) verification.~~

Commented [SG155]: CHANGED SEE F.1. below

(2) Registered nurses who provide continuous monitoring of the trauma patient until release from the ED.

a. LEVEL IV: At least one registered nurse in house 24 hours a day who maintains current Trauma Nurse Core Course ~~verification~~ CERTIFICATION or equivalent;

b. LEVEL V: AT LEAST ONE REGISTERED NURSE IN-HOUSE DURING HOURS OF OPERATION THAT MAINTAINS CURRENT TRAUMA NURSE CORE COURSE CERTIFICATION OR EQUIVALENT.

Commented [SG156]: Moved from Level V rules

(3) Equipment for the resuscitation of patients of all ages ~~shall~~ include~~d~~ING, but not limited to:

a. Airway control and ventilation equipment including laryngoscopes and endotracheal tubes of all sizes, bag mask resuscitators, and oxygen;

b. Pulse oximetry;

c. End-tidal CO_2 determination;

d. Suction devices;

e. Electrocardiograph ~~oscilloscope~~ AND defibrillator;

Commented [SG157]: Antequated language

f. Standard intravenous fluids and administration devices, including large bore intravenous catheters;

g. Sterile surgical sets for:

i. Airway control/cricothyrotomy;

ii. Vascular access to include central line insertion and interosseous access;

iii. Thorocostomy - needle and tube;

h. Gastric decompression;

i. Drugs necessary for emergency care;

j. X-ray availability:

i. LEVEL IV: 24 hours a day;

ii. LEVEL V: DURING HOURS OF OPERATION;

k. Two-way communication with emergency transport vehicles;

l. Spinal immobilization equipment;

m. Thermal control equipment for patients and fluids;

n. Medication chart, tape or other system to assure ready access to information on proper dose-per-kilogram for resuscitation drugs and equipment sizes for pediatric patients.; AND

o. TOURNIQUET.

B. LEVEL IV ONLY: If an operating room and/or intensive care unit are utilized for the trauma patient, there must be policies that identify and define the scope of care OR EXPANDED SCOPE OF CARE, IF APPLICABLE, that include the supervision, staffing and equipment requirements that the facility will utilize.

C. Radiological capabilities available with a radiology technician or person with limited certification in x-ray available within 30 minutes of notification of trauma team activation.

a. LEVEL IV: ~~available~~ 24 hours a day.

b. LEVEL V: DURING HOURS OF OPERATION.

D. Clinical laboratory services available, INCLUDING: ~~24 hours a day.~~ A~~a~~ spun hematocrit, dip urinalysis, and the ability to collect blood samples to be sent with transferred patients must be available.

a. LEVEL IV: 24 HOURS A DAY.

b. LEVEL V: DURING HOURS OF OPERATION.

E. Participates in local/regional/statewide ~~I~~injury ~~P~~prevention/~~P~~public ~~E~~education.

F. Continuing education for all physicians providing trauma care, with:

(1) LEVEL IV AND V PHYSICIANS PROVIDING INITIAL RESUSCITATION IN THE EMERGENCY DEPARTMENT SHALL BE BOARD CERTIFIED IN EMERGENCY MEDICINE OR HAVE CURRENT ATLS.

(2) LEVEL IV GENERAL SURGEONS ON THE TRAUMA CALL PANEL SHALL BE CURRENT IN ATLS.

(3) LEVEL IV ORTHOPEDIC SURGEONS, ANESTHESIOLOGISTS, AND NURSE ANESTHETISTS ON THE TRAUMA CALL PANEL MUST BE:

A. BOARD CERTIFIED, OR

B. BOARD ELIGIBLE AND LESS THAN SEVEN YEARS FROM RESIDENCY, OR

C. HAVE CURRENT ATLS, IF NO LONGER BOARDED OR BOARD ELIGIBLE.

Commented [SG158]: Moved from level V rules

Commented [SG159]: Inserted per best practice

Commented [SG160]: Moved from Level V

Commented [SG161]: Moved from level V

(4) ALL BOARD CERTIFICATIONS SHALL BE ISSUED BY A CERTIFYING ENTITY THAT IS NATIONALLY RECOGNIZED IN THE UNITED STATES.

~~10 hours of trauma-related, facility-defined CME annually or 30 hours over the 3 year period preceding any site review.~~

(5) PHYSICIANS ADMITTING TRAUMA PATIENTS AT LEVEL IV FACILITIES WITHOUT THE CONTINUOUS AVAILABILITY OF A SURGEON ON THE TRAUMA CALL PANEL, AS DEMONSTRATED BY A PUBLISHED CALL SCHEDULE, SHALL HAVE 10 TRAUMA-SPECIFIC CME HOURS ANNUALLY OR 30 CME HOURS OVER THE THREE YEAR PERIOD PRECEDING ANY SITE REVIEW.

G. Facility-defined, trauma-related continuing medical education requirements for nurses.

~~309. Trauma Facility Designation Criteria - Level V~~

~~Standards for facilities designated as Level V Trauma Centers - The facility must be licensed as a general hospital, a community clinic and emergency center (CCEC) or a critical access hospital (CAH).~~

~~1. Administration and Organization Criteria. A Level V Trauma Center shall have:~~

~~A. Commitment by administration and medical staff to support the trauma program as demonstrated by written commitment from the facility's Board of Directors, owner/operators, or administrator to provide the required services.~~

~~B. A written commitment to regional planning and system development activities.~~

~~C. A trauma program with policies that identify and establish the scope of trauma care for both adult and pediatric patients, including but not limited to:~~

~~(1) Initial resuscitation and stabilization;~~

~~(2) Admission criteria;~~

~~(3) Hours of operation. If the facility is not open 24 hours a day, the services as defined in the scope of trauma service policy shall include after-hours plan for availability of services; and~~

~~(4) Critical care capabilities if available;~~

~~(5) Rehabilitation capabilities if available; and~~

~~(6) Written procedure for transfer of patients by fixed and rotary aircraft.~~

~~D. A physician designated by the facility as the Trauma Medical Director who takes responsibility for the trauma program. Responsibilities include:~~

~~(1) Participation in trauma educational activities for healthcare providers or the public;~~

~~(2) Leadership for the trauma program and oversight of the trauma quality improvement process; and~~

~~(3) Administrative authority for the trauma program, including recommendations for trauma privileges, policy and procedure enforcement, and peer review.~~

Commented [SG162]: New language recommended by task force

Commented [DM163]: New language; Task force recommended

Commented [SG164]: Level V combined with level IV and now redundant

E. A facility defined trauma team activation protocol that includes who is notified and the response expectations. The protocol shall base activation of personnel on anatomical, physical, mechanism of injury criteria and co-morbid factors as outlined in the prehospital trauma triage algorithms as set forth in 6 CCR 1015-4, Chapter Two.

F. A defined method of activating trauma response personnel consistent with the scope of trauma care provided by the facility.

G. A staff person identified as the Trauma Coordinator with clinical experience in care of the injured person, who is responsible for coordination of the trauma program functions.

H. An identified multidisciplinary committee involved in the development of a plan of care for the injured patient and is responsible for trauma program performance. Membership will be established by the facility and the committee will establish attendance.

I. A quality improvement program as defined in Section 308 of this chapter.

J. Divert protocols, to include:

(1) Coordination with the Regional Emergency Medical and Trauma Advisory Councils (RETACs)

(2) Notification of prehospital providers

(3) Reason for divert

(4) A method for monitoring times and reasons for going on divert.

K. Interfacility transfer criteria/guidelines as a transferring facility (if applicable).

L. Interfacility transfer policies and protocols.

M. Participation in the state trauma registry as required in Chapter 1.

N. Participation in the RETAC and statewide quality improvement programs as required in rule.

O. If licensed as a Community Clinics with Emergency Care (CCEC):

(1) A central log on each trauma patient/individual presenting with an emergency condition who comes seeking assistance and whether he or she refused treatment, was refused treatment, or whether the individual was transferred, admitted and treated, died, stabilized and transferred, or discharged.

(2) A policy requiring the provision of a medical screening of all individuals with trauma related emergencies that come to the clinic and request an examination or treatment. The policy shall not delay the provision of a medical screening in order to inquire about an individuals' method of payment or insurance status.

(3) Provide further medical examination and such treatment as may be required to stabilize the traumatic injury within the staff and facility's capabilities available at the clinic, or to transfer the individual. The transferring clinic must provide the medical treatment, within its' capacity, which minimizes the risk to the individual, send all pertinent medical records available at the time of transfer, effect the transfer through qualified persons and transportation equipment, and obtain the consent of the receiving trauma center.

2. A Level V trauma center shall meet all of the following clinical capabilities criteria:

A. The physician must be present in the emergency department at the time of arrival of the trauma patient meeting facility defined Trauma Team Activation criteria, arriving by ambulance. For those patients where adequate prior notification is not possible, the emergency physician shall be available with 20 minutes of notification.

3. A Level V trauma center shall have all of the following facilities, resources, and capabilities:

A. Emergency Department with:

(1) Physicians who are credentialed by the facility to provide emergency medical care and maintain current Advanced Trauma Life Support (ATLS) verification.

(2) Registered nurses who provide continuous monitoring of the trauma patient until release from the emergency department. At least one RN in house during hours of operation that maintains current Trauma Nurse Core Course verification or equivalent.

(3) Equipment for resuscitation of patients of all ages, including but not limited to:

a. Airway control and ventilation equipment including laryngoscopes and endotracheal tubes of all sizes, bag mask resuscitators, and oxygen;

b. Pulse oximetry;

c. End-tidal CO_2 determination;

d. Suction devices;

e. Electrocardiograph-oscilloscope-defibrillator;

f. Standard intravenous fluids and administration devices; including large bore intravenous catheters;

g. Sterile surgical sets for:

i. Airway control/cricothyrotomy

ii. Vascular access to include central line insertion and I/O access

iii. Thorocostomy- needle and tube

h. Gastric decompression;

i. Drugs necessary for emergency care;

j. X-ray availability

k. Two way communication with emergency transport vehicles

l. Spinal immobilization equipment

m. Thermal control equipment for patients/fluids

n. Medication chart, tape or other system to assure ready access to information on proper dose-per-kilogram for resuscitation drugs and equipment sizes for pediatric patients

~~B. If an operating room and/or intensive care unit are utilized for the trauma patient, there must be policies that identify and define the scope of care that include the supervision, staffing and equipment requirements that the facility will utilize.~~

~~C. Radiological capabilities available during hours of operation with a radiology technician or person with limited certification in x-ray available within 30 minutes of notification of trauma team activation.~~

~~D. Clinical laboratory services available during hours of operation. A spun hematocrit, dip urinalysis and the ability to collect blood samples to be sent with transferred patients must be available.~~

~~E. Participates in local/regional/statewide Injury Prevention/Public Education.~~

~~F. Continuing education for physicians providing trauma care, with:~~

~~(1) Current ATLS, and~~

~~(2) 10 hours of trauma related facility defined CME annually or 30 hours over the 3 year period preceding any site review.~~

~~G. Facility defined, trauma related continuing medical education requirements for nurses.~~

30810. Burn Unit Referral Criteria

A burn unit may treat adults or children or both. The attending surgeon at a burn unit shall be consulted for any of the following burn injuries:

1. Partial thickness burn greater than 10% total body surface area (TBSA).

2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints.

3. Third-degree burns in any age group.

4. Electrical burns, including lightning injury.

5. Chemical burns.

6. Inhalation injury.

7. Burn injury in patients with pre-existing medical disorders that could complicate management, prolong recovery, or affect mortality.

8. Any patients with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient may be initially stabilized in a trauma center before being transferred to a burn unit. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.

9. Burned children in hospitals without qualified personnel or equipment for the care of children.

10. Burn injury in patients who will require special social, emotional, or long-term rehabilitative intervention.

30911. Facility Designation Criteria - Regional Pediatric Trauma Centers

1. Administration and organization criteria. A Regional Pediatric Trauma Center as defined in Section 25-3.5-703(4)(f) C.R.S. shall have a trauma program with:

A. An administrative organizational structure which identifies the institutional support and commitment. The program's location within that structure must be placed so that it may

interact with at least equal authority with other departments providing patient care within the facility.

B. Medical staff commitment to support the program demonstrated by a written commitment to provide the specialty care needed to support optimal care of the injured patient and specific delineation of surgical privileges.

C. A Trauma Medical Director who is a board certified pediatric surgeon, credentialed by the facility for pediatric trauma care.

D. A facility-defined Trauma Team, with an identifiable team leader.

E. A facility-defined Trauma Team activation protocol. The protocol shall base activation of the team on the anatomical, physiological, mechanism of injury, and co-morbid factors as outlined in the ~~p~~Pediatric ~~p~~Prehospital ~~t~~Trauma ~~t~~Triage ~~a~~Algorithms as set forth in 6 CCR 1015-4, Chapter ~~Two~~ONE.

F. A facility-defined trauma service comprised of the personnel and resources identified as needed to provide care for the injured patient. All multi-system trauma patients shall be admitted to this service. The Trauma Medical Director shall direct the service and the cadre of residents or other allied health personnel assigned to that service at any given time.

G. A full time registered nurse identified as the Trauma Program Manager, with educational preparation, ~~verification~~CERTIFICATION, and clinical experience in care of the injured as defined by the facility. This position is responsible for the organization of services and systems necessary for a multidisciplinary approach to care of the injured patient.

H. A multi-disciplinary Trauma Committee with specialty representation. This committee is involved in the development of a plan of care for the injured patient and is responsible for trauma program performance.

I. A multidisciplinary Peer Review Committee as defined by the facility. This committee is responsible for monitoring compliance to the facility-defined clinical and system standards of care for trauma patients.

J. Hospital departments/divisions/sections:

(1) General Pediatric Surgery;

(2) Neurological Surgery;

(3) Orthopedic Surgery;

(4) Emergency Medicine; and

(5) Anesthesia.

K. Support services/ancillary services, with policies and procedures for access to:

(1) Chemical dependency services;

(2) Child and adult protection services;

(3) Clergy or pastoral care;

(4) Nutritionist services;

(5) Occupational therapy services;

(6) Pediatric therapeutic recreation;

(7) Pharmacy, with aN in-house pharmacist;

(8) Physical therapy services;

(9) Psychological services;

(10) Rehabilitation services;

(11) Social services; and

(12) Speech therapy services.

2. Clinical capabilities criteria

A. The following services in house and available 24 hours a day with:

(1) Pediatric surgery within five minutes of Trauma Team activation. Coverage shall be provided by:

a. ~~a~~An attending board certified pediatric surgeon credentialed by the facility for pediatric trauma care who may only take call at one facility at any one time or have a published backup call schedule; or

b. ~~a~~A post graduate year four (PGY4) or above surgical resident may initiate evaluation and treatment upon the patient's arrival until the arrival of the attending surgeon. In this case, the attending surgeon shall be available within 20 minutes of request by the resident,

(2) Pediatric neurosurgery. Coverage shall be provided by:

a. the attending board certified neurosurgeon, who may only take call at one facility at any one time or have a published backup call schedule; or

b. a surgeon who has been judged competent by the chief of neurosurgery to initiate measures to stabilize the patient and initiate diagnostic procedures. In this case, the attending neurosurgeon shall be available within 30 minutes of notification or request by the Trauma Team leader,

(3) Pediatric anesthesiology. Coverage shall be provided by:

a. a board certified anesthesiologist in the O.R. at time of arrival of the patient; and

b. a chief resident or fellow within 5 minutes of request by the Trauma Team leader,

(4) Pediatric emergency medicine. Coverage shall be provided by:

a. a physician board certified in pediatric emergency medicine; or

b. a physician in a pediatric emergency medicine fellowship at PGY5 level or higher; or

c. a physician having completed pediatric emergency medicine training within the past five years.

B. The following surgical services on-call and present within 30 minutes of request by the Trauma Team leader:

(1) Cardio/thoracic surgery;

(2) Ophthalmic surgery;

(3) Oral/maxillofacial/ENT surgery;

(4) Orthopedic surgery with a board certified orthopedic surgeon, who may only take call at one facility at any one time or have a published backup call schedule; and

(5) Urologic surgery.

C. The following non-surgical and surgical specialties including:

(1) A pediatric radiologist on call and available for patient service within 30 minutes of request by the Trauma Team leader~~,~~.

(2) The following services on call and available for patient consultation or management:

a. ~~c~~Cardiology;

b. ~~i~~Infectious disease;

c. ~~h~~Hand surgery~~,~~;

d. ~~m~~Microvascular surgery;

e. ~~p~~Plastic surgery;

f. ~~p~~Pulmonary medicine;

g. ~~n~~Nephrology; and

h. ~~h~~Hematology.

3. Facilities/resources/capabilities criteria:

A. An emergency department with:

(1) Personnel, to include:

a. ~~a~~A designated physician director who is board certified in pediatric emergency medicine;

b. ~~p~~Physician(s) designated as a member of the Trauma Team, physically present in the ~~E~~emergency ~~D~~department 24 hours a day, who:

i. ~~a~~Are board certified in pediatric emergency medicine; or

ii. ~~a~~Are in a pediatric emergency medicine fellowship at PGY5 level~~:~~; OR

iii. ~~or h~~Have completed pediatric emergency medicine training within the past five years.

c. ~~r~~Registered nursing personnel who provide continuous monitoring of the trauma patient until release from the ~~E~~emergency ~~D~~department, who have successfully completed a Trauma Nurse Core Course (TNCC) or equivalent course, and a Pediatric Advanced Life Support (PALS) course~~,~~.

(2) Equipment for the resuscitation of patients of all ages shall include but not be limited to:

a. airway control and ventilation equipment including laryngoscopes and endotracheal tubes of all sizes, bag mask resuscitators, and oxygen;

b. pulse oximetry;

c. end-tidal CO_2 determination;

d. suction devices;

e. electrocardiograph-~~oscilloscope~~ AND defibrillator with internal paddles - adult and pediatric;

Commented [SG165]: Antequated language. Removal conforms with other levels.

f. apparatus to establish central venous pressure monitoring;

g. standard intravenous fluids and administration devices, including large bore intravenous catheters;

h. sterile surgical sets for:

i. airway control/cricothyrotomy;

ii. thorocostomy needle and tube;

iii. thoracotomy;

iv. vascular/intraosseous access;

~~v. peritoneal lavage;~~

Commented [SG166]: Antequated language. Removal conforms with other levels.

v~~i~~. central line insertion; and

vi~~i~~. ICP monitoring equipment.

i. gastric decompression;

j. drugs necessary for emergency care;

k. X-ray availability, 24 hours a day;

l. two-way communication with emergency transport vehicles;

m. spinal immobilization equipment;

n. arterial catheters;

o. thermal control equipment for:

i. patients; and

ii. blood and fluids.

p. rapid infuser system; and

q. length-based emergency tape (LBET).

(3) Protocols/procedures for management of the injured child in the emergency department.

B. An operating room available within 30 minutes of request 24 hours a day with:

(1) Facility-defined operating room team in-house and available within 10 minutes of request of Trauma Team leader~~,~~.

(2) Equipment for all ages shall include, but not be limited to:

a. ~~c~~Cardiopulmonary bypass capability;

b. ~~o~~Operating microscope and microinstruments;

c. ~~t~~Thermal control equipment for:

i. ~~p~~Patients; and

ii. ~~b~~Blood and fluids.

d. ~~x~~X-ray capability, including C-arm image intensifier;

e. ~~e~~Endoscopes;

f. ~~c~~Craniotomy instruments;

g. ~~e~~Equipment for fixation of long bone and pelvic fracture; and

h. ~~e~~Equipment for spinal immobilization and instrumentation.

C. Postanesthesia Care Unit (surgical intensive care unit is acceptable) with:

(1) Registered nurses available within 30 minutes of request 24 hours a day;

(2) Equipment for the continuous monitoring of temperature, hemodynamics, gas exchange, and intracranial pressure;

(3) Thermal control equipment for:

a. ~~p~~Patients; and

b. ~~b~~Blood and fluids~~,~~;

(4) Compartmental pressure monitoring equipment.

D. Intensive care unit for injured patients with:

(1) Personnel, to include:

a. ~~a~~A surgical director, who:

i. ~~i~~Is responsible for setting policies and administration related to pediatric trauma ICU patients; and

ii. ~~h~~Has obtained critical care training during residency or fellowship and has expertise in the perioperative and post injury care of the injured child.

b. ~~a~~A physician, credentialed in pediatric critical care, or a pediatric intensivist, approved by the Trauma Medical Director, who is in the hospital and available within 30 minutes of notification.

c. ~~r~~Registered nurses with facility-defined trauma education program.

(2) Equipment for monitoring and resuscitation, to include: intracranial pressure monitoring, compartment pressure monitoring, and continuous monitoring of temperature, hemodynamics, and gas exchange.

E. Acute hemodialysis available in house.

F. Radiological services, available 24 hours a day to the trauma patient, with:

(1) The following technicians:

a. ~~i~~In-house radiology technician available within 10 minutes of notification; and

b. ~~i~~In-house CT technician available within 10 minutes of notification.

(2) The following services:

a. MRI, on site without vehicular transfer of the patient;

b. ~~a~~Angiography;

c. ~~s~~Sonography;

d. ~~c~~Computed tomography (CT); and

e. ~~i~~Interventional radiology.

(3) Physician and technical support staff for the services identified above shall be in-house or available within 30 minutes.

G. Clinical laboratory services, to include:

(1) Standard analysis of blood, urine, and other body fluids;

(2) Blood typing and cross matching;

(3) Coagulation studies;

(4) Blood and blood components available from in-house, or through community services, to meet patient needs and blood storage capability;

(5) Blood gases and pH determination;

(6) Microbiology;

(7) Serum alcohol and toxicology determination; and

(8) Clinical laboratory technician available in house.

H. Respiratory therapy services, in house.

I. Acute spinal cord management, with surgeons capable of addressing acute spinal cord injury, and with protocols/procedures to address early assessment of the spinal cord injured patient for management or transfer.

J. Organized burn care for those patients identified in Section 3089 of this chapter with:

(1) Specialty designation as a burn center; or

(2) Transfer agreements with a facility with a specialty designation as a burn center.

K. Rehabilitation services, with:

(1) Leadership of the service by a physician who is a physiatrist or who specializes in orthopedic or neurologic rehabilitation, and

a. ~~p~~Protocols/procedures for the early assessment of the rehabilitation needs of the injured child;

b. ~~p~~Physical therapy;

c. ~~o~~Occupational therapy;

d. ~~s~~Speech therapy; and

e. ~~s~~Social services.

L. Outreach program, with telephone and on-site consultations with physicians of the community and outlying areas regarding pediatric trauma care.

M. Injury prevention/public education, with:

(1) Injury prevention with:

a. ~~a~~A designated prevention coordinator;

b. ~~o~~Outreach activities and program development;

c. ~~i~~Information resources for the public; and

d. ~~c~~Collaboration with existing national, regional, and state programs.

(2) Injury control research, which may include:

a. ~~c~~Collaboration with other facilities in prevention research;

b. ~~m~~Monitoring progress/effect of prevention programs; and

c. ~~s~~Special surveillance project/data collection projects.

N. Trauma research program, with:

(1) A designated director;

(2) Regular meetings of the research group;

(3) Evidence of productivity, to include:

a. ~~p~~Proposals reviewed by an Internal Review Board (IRB);

b. ~~p~~Presentations at local/regional/national meetings;

c. ~~p~~Publications in peer-reviewed journals; and

d. ~~p~~Peer-reviewed extramural funding for research activities.

O. Continuing medical education (CME), with

(1) In-house CME for:

a. ~~s~~Staff physicians;

b. ~~n~~Nurses;

c. ~~a~~Allied health personnel; and

d. ~~c~~Community physicians.

(2) Physician CME requirements for emergency medicine, trauma surgery, orthopedics, and neurosurgery -16 ~~hours~~ CME HOURS annually or 48 CME hours over THE 3 YEAR PERIOD PRECEEDING ANY SITE REVIEW ~~3 years~~, with half outside own facility.

(3) Nursing CME requirements for emergency department and ICU - 8 hours annually or 24 hours over 3 years.

P. Organ/tissue procurement protocols/procedures.

Q. Trauma divert protocols, to include:

(1) A method to report trauma diverts to the Regional Emergency Medical and Trauma Advisory Council (RETAC) for monitoring;

(2) A method for notification of prehospital providers when on divert;

(3) Facility-defined criteria for going on divert, not to exceed those identified in 6 CCR 1015-4, CHAPTER ONE~~the definition section of this chapter~~; and

(4) A method for monitoring times and reasons for going on divert.

R. Trauma transfer agreements as a transferring and receiving facility, renewed every 3 years.

S. Interfacility consultation protocols/procedures for attending surgeon availability for responding to mandatory consultations and arranging transfers from Level I, II, III, IV, V, and nondesignated trauma centers.

T. A trauma registry as required in 6 CCR 1015-4, Chapter ~~1~~TWO and trauma data entry support.

U. A performance improvement process in accordance with Section 303.3.A of this chapter.

V. Participation in RETAC quality improvement programs established in accordance with 6 CCR 1015-4, Chapter ~~Two~~FOUR.

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STATEWIDE EMERGENCY MEDICAL AND TRAUMA CARE SYSTEM

6 CCR 1015-4

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

CHAPTER FOUR - REGIONAL EMERGENCY MEDICAL AND TRAUMA SERVICES ADVISORY COUNCILS

~~400. In order to ensure effective system development and regional emergency medical and trauma planning, all regions must comply with the following minimum standards and planning regulations. RESERVED.~~

400~~4~~. Definitions. As used in this article, unless the context otherwise requires:

1. "Biennial Plan" - AN ~~regional~~ emergency medical and trauma services system plan DEVELOPED BY THE RETAC THAT DETAILS AND UPDATES THE RETAC'S ORIGINAL EMTS PLAN, INCLUDING ANY REVISIONS PURSUANT TO SECTION 25-3.5-704(2)(c), C.R.S. BY DESCRIBING METHODS FOR PROVIDING THE APPROPRIATE SERVICES AND CARE TO PERSONS WHO ARE ILL OR INJURED. THE BIENNIAL PLAN shall be in a format specified by ~~the Council~~ SEMTAC and the Department, and submitted to ~~the Council~~ SEMTAC ~~for approval~~ FOR A DETERMINATION OF ADEQUACY every other year on July 1~~, beginning July 1, 2003~~.

2. "City and County" - A city that shares the same boundaries as the county IN WHICH it resides ~~in~~.

3. "Continuing Quality Improvement" - The ongoing issue of improving the quality of the regional emergency medical and trauma services system.

~~4. "Council" – The State Emergency Medical and Trauma Services Advisory Council created in section 25-3.5-104.~~

~~5.~~4. "Department" – The Colorado Department of Public Health and Environment.

~~6.~~5. "EMTS System" - ~~Emergency Medical and Trauma Services System~~. PURSUANT TO SECTION 25-3.5-101, C.R.S., ET SEQ., THE EMERGENCY MEDICAL AND TRAUMA SERVICES SYSTEM CONSISTS OF THE TOTALITY OF THE VARIOUS SUBSYSTEMS THAT, IN COLORADO, ARE DESIGNED TO PREVENT PREMATURE MORTALITY AND TO REDUCE THE MORBIDITY THAT ARISES FROM TRAUMA AND MEDICAL EMERGENCIES.

6. EMTS PLAN - THE ORIGINAL EMERGENCY MEDICAL AND TRAUMA SERVICES PLAN THAT A RETAC DEVELOPED, UPON FORMATION, FOR ITS REGION.

7. "Financial Report" - A regional financial accounting in a format specified by ~~the Council~~ SEMTAC and the Department that details the expenditure of money received.

8. "Key Resource Facility" - AS DEFINED IN SECTION 25-3.5-703(6.5) C.R.S., MEANS a Level I or II certified trauma facility that provides consultation and technical assistance to a RETAC, regarding education, quality, training, communication, and other trauma issues described in ~~C.R.S. 25-3.5~~ TITLE 25, ARTICLE 3.5, Part 7 OF THE COLORADO REVISED STATUTES that relate to the development of the Statewide Trauma Care System.

9. REGION - A DISTINCT PART OF THE STATEWIDE EMERGENCY MEDICAL AND TRAUMA CARE SYSTEM THAT IS THE AREA TO BE SERVED BY THE RETAC.

~~9.~~10. ~~"RETAC" -~~ Regional Emergency Medical and Trauma SERVICES Advisory Council (RETAC) – the representative body appointed by the governing bodies of counties or ~~cites~~ CITIES and counties for the purpose of providing recommendations concerning regional area emergency medical and trauma service plans for such counties or cities and counties.

~~10.~~11. ~~"SEMTAC" -~~ ~~The~~ State Emergency Medical and Trauma Services Advisory Council (SEMTAC) - PURSUANT TO SECTION 25-3.5-104(4), C.R.S., A BOARD APPOINTED BY THE GOVERNOR THAT ADVISES AND MAKES RECOMMENDATIONS TO THE DEPARTMENT ON ALL MATTERS RELATING TO EMERGENCY MEDICAL AND TRAUMA SERVICES.

40~~2~~1. Organizational Requirements

~~A.~~1. ~~On or before July 1, 2002,~~ ~~The~~ THE governing body of each county or city and county throughout the state shall establish a RETAC, with the governing body of four or more OTHER counties, or with the governing body of a city and county, to form a multicounty RETAC.

~~B.~~2. ~~County government from counties comprising each RETAC shall determine how members are selected.~~ RETACS MUST BE COMPRISED OF COUNTIES THAT ARE CONTIGUOUS.

~~C.~~3. ~~Membership shall reflect, as equally as possible, representation between hospital and prehospital providers, and from each participating county, and city and county.~~ THE GOVERNING BODY FROM THE COUNTIES AND/OR CITIES AND COUNTIES COMPRISING EACH RETAC SHALL DETERMINE HOW MEMBERS ARE APPOINTED.

~~D.~~4. ~~There shall be at least one member from each participating county and city and county in the RETAC~~. THE PARTICIPATING COUNTIES SHALL DEFINE THE NUMBER OF MEMBERS ON THE RETAC.

~~E.~~5. ~~The participating counties shall define the number of members on the RETAC.~~ MEMBERSHIP SHALL REFLECT, AS EQUALLY AS POSSIBLE, REPRESENTATION BETWEEN HOSPITAL AND PREHOSPITAL PROVIDERS, AND FROM EACH PARTICIPATING COUNTY AND/OR CITY AND COUNTY.

~~F.~~6. ~~Each RETAC shall meet a minimum if four times per year~~. THERE SHALL BE AT LEAST ONE MEMBER FROM EACH PARTICIPATING COUNTY AND/OR CITY AND COUNTY IN THE RETAC.

~~G.~~7. ~~After the appointment of members to the RETAC, the RETAC shall establish By-laws, which includes responsibilities and other pertinent matters concerning the structure and operations of the organization. A chairperson shall be elected and that person or his/her designee shall serve as the liaison for the region's communications with the Department~~. EACH RETAC SHALL MEET A MINIMUM OF FOUR TIMES PER YEAR.

~~H.~~8. ~~RETACs must be comprised of counties that are contiguous~~. AFTER THE APPOINTMENT OF MEMBERS TO THE RETAC, THE RETAC SHALL ESTABLISH AND MAINTAIN BY-LAWS, WHICH INCLUDE RESPONSIBILITIES AND OTHER PERTINENT MATTERS CONCERNING THE STRUCTURE AND OPERATIONS OF THE ORGANIZATION. A CHAIRPERSON SHALL BE ELECTED, AND THAT PERSON OR THEIR DESIGNEE SHALL SERVE AS THE LIAISON FOR THE REGION'S COMMUNICATIONS WITH THE DEPARTMENT.

~~I.~~9. At least seventy-five percent of the ~~council~~ RETAC membership must reside in or provide health care services within the region.

~~J.~~10. Each RETAC must identify one or more key resource facilities for the region. The key resource facility shall provide consultation and technical assistance to the RETAC in resolving trauma~~, medical, and age specific~~ care issues that arise in the region~~,~~ and in coordinating patient destination and inter-facility transfer policies to assure that patients are transferred to the appropriate facility for treatment in or outside of the region.

~~K.~~11. Each ~~region~~ RETAC shall utilize designated staff to manage the day-to-day business of the RETAC~~,~~ and provide administrative support and technical assistance to SEMTAC ~~the council~~ as it carries OUT its statutory obligations.

403~~2~~. MINIMUM Operational Requirements

~~A.~~1. EACH RETAC~~s~~ must establish A continuing quality improvement plan FOR ITS REGION with goals AND system-monitoring protocols. ~~and periodically assess the quality of their emergency medical and trauma system. The regional continuous quality improvement system plan shall be utilized in evaluating the effectiveness of the regional EMTS systems as defined elsewhere in the rules pertaining to Statewide Emergency Medical and Trauma Care System.~~

2. WHEN FORMULATING ITS BIENNIAL PLAN, EACH RETAC SHALL PERIODICALLY ASSESS THE QUALITY OF ITS REGIONAL EMERGENCY MEDICAL AND TRAUMA SYSTEM. AS PART OF THIS ASSESSMENT, EACH RETAC SHALL UTILIZE ITS REGIONAL CONTINUOUS QUALITY IMPROVEMENT SYSTEM PLAN TO EVALUATE THE EFFECTIVENESS OF ITS REGIONAL EMTS SYSTEM IN RELATION TO 6 CCR 1015-4, CHAPTER ONE, THE STATEWIDE EMERGENCY MEDICAL AND TRAUMA CARE SYSTEM.

~~B.~~3. RETACs shall coordinate with the Department and ~~local health departments~~ THE COUNTY OR DISTRICT PUBLIC HEALTH AGENCY in developing and implementing regional injury prevention, public information, and educational programs promoting the development of the ~~EMTS~~ REGIONAL EMERGENCY MEDICAL AND TRAUMA system. These programs should include, but not be limited to, ~~a~~ pediatric injury prevention and public awareness component~~S~~.

~~C.~~4. RETACs must provide technical assistance and serve as a resource, and to the extent possible, integrate the provision of emergency medical and trauma services with other local, state, and federal agency disaster plans.

~~D.~~5. ~~Regional Patient Destination Protocols~~

~~(Reserved)~~

RETACS SHALL DEVELOP PREHOSPITAL DESTINATION PROTOCOLS FOR ADULT AND PEDIATRIC PATIENTS WITH TRAUMA OR SUSPECTED TRAUMA IN ACCORDANCE WITH THE ALGORITHMS CONTAINED IN EXHIBITS A AND B IN 6 CCR 1015-4, CHAPTER ONE.

~~E. RETACS must comply with Board of Health Regulation 4 of the rules and regulations pertaining to preparation for a bioterrorism event, pandemic influenza, or an outbreak by of novel and highly and infectious agent or biological toxin.~~

404~~3~~. Waivers

~~A.~~The Department may grant waivers from one or more standards of these rules, to the extent not contrary to statute, based on a waiver review process reviewed and approved by SEMTAC and adopted by the Department.

405~~4~~. Annual Financial Report

~~(Reserved)~~

ON OR BEFORE OCTOBER 1 OF EACH YEAR, THE RETAC SHALL SUBMIT AN ANNUAL FINANCIAL REPORT TO SEMTAC THAT DETAILS THE EXPENDITURE OF MONEYS RECEIVED IN A FORMAT SPECIFIED BY SEMTAC AND THE DEPARTMENT.

IF SEMTAC FINDS THE ANNUAL FINANCIAL REPORT IS INADEQUATE, THE RETAC SHALL RESUBMIT THE REPORT TO SEMTAC BY DECEMBER 1 OF THE SAME YEAR.

406. RETAC EMTS System Biennial Plan Requirements

~~On July 1, 2003 and every odd numbered year thereafter on July 1, each Regional Emergency Medical and Trauma Advisory Council, with the approval from the governing bodies for the RETAC, must prepare~~

~~a regional emergency medical and trauma services system plan to create and maintain coordinated, integrated emergency medical and trauma system services throughout the region. The Department shall provide technical assistance to any RETAC for preparation, implementation, and modification of the plan. This plan shall be submitted to SEMTAC for evaluation and recommendations for approval to the Department. The plan will be in a format specified by the Department with advice from SEMTAC. If the RETAC fails to submit a plan, does not include a county or city and county within their region in the plan, or the plan is not approved through the evaluation process established by SEMTAC, the Department shall design a plan for the RETAC. This plan, referred to hereafter as the Biennial Plan, shall be comprised of fifteen components. The components are listed below. Each component, at a minimum, shall address the current level of activity within that component. The RETAC should develop their plan based on data collected from sources such as, but not limited to, county plans, EMS Council plans, agency profiles, financial reports and strategic planning documents. Every RETAC plan shall provide the following:~~

~~A. The plan shall identify the needs of the region to provide minimum services to sick and injured patients at the most appropriate facility. Needs shall be based on but not limited to the following factors:~~

~~1. Transfer agreements and protocols used by facilities to move patients to higher levels of care.~~

~~2. Facility defined triage and transport plans to be developed by all facilities within the RETAC.~~

~~3. Geographical barriers to the transportation of patients.~~

~~4. Population density challenges to providing care.~~

~~5. Out of hospital resources within the region for the treatment and transportation of sick and injured persons.~~

~~6. Accessibility to Department designated facilities within and outside the region~~

~~B. The plan shall describe the commitment of each of the member counties or city and counties. Commitment includes but may not be limited to:~~

~~1. Cooperation among county and local organizations in the development and implementation of the statewide EMTS system.~~

~~2. Participation and representation within the RETAC.~~

~~3. Dedicated financial and in-kind resources for regional systems development.~~

~~4. Cooperation among county and local organizations in the development and implementation of a coordinated statewide communications system.~~

~~C. The plan shall include the description of processes used to ensure facilities, agencies, counties, and city and counties adherence to the RETAC EMTS plan. Processes shall include but not be limited to:~~

~~1. A compliance reporting process as defined by SEMTAC and the Department.~~

~~2. A continuing quality improvement system as defined by SEMTAC and the Department.~~

~~D. The plan shall include a description of public information, education, and prevention programs used within the region to reduce illness and injury.~~

~~E. The plan shall describe any functions of the RETAC accomplished through contracted services.~~

F. The plan shall identify any needs of the REGIONAL EMTS system through the use of a needs assessment instrument. The needs assessment instrument used by the RETAC must be approved by the RETAC member counties and city and counties. Needs assessment instruments must be approved by or supplied by the Department.

G. The plan shall include a description of the following communication issues:

1. Communication method in place to ensure citizen access to emergency medical and trauma services through the 911 telephone system or its local equivalent.

2. Primary communication method for dispatch of personnel who respond to provide prehospital care.

3. Communication methods used between ambulances and other responders and between ambulances and designated and undesignated facilities.

4. Communication methods used among trauma facilities and between facilities and other medical care facilities.

5. Communication methods used among service agencies to coordinate prehospital and day-to-day requests for service.

6. Communication methods used within and between the RETAC to coordinate service during multicasualty events (interoperability).

H. The plan components shall include:

1. Integration of Health Services - Activities to improve patient care through collaborative efforts among health related agencies, facilities and organizations within the region. The desired outcome of this component is to improve the system by encouraging groups involved in EMTS to work with other entities (e.g. health related, state, local and private agencies and institutions) to share expertise, to evaluate and make recommendations, and mutually address and solve problems within the region.

2. EMTS Research - Determines the effectiveness and efficiency of the EMTS system through scientific investigation. A continuous and comprehensive effort to validate current EMTS system practices in an effort to improve patient care, determine the appropriate allocation of resources and prevent injury and illness and ultimately death and disability.

3. Legislation and Regulation - Issues related to legislation, regulation and policy that affects all components of the EMTS system. This component defines the level of authority and responsibility for system planning, implementation and evaluation.

4. System Finance - Defines the financial resources necessary to develop and maintain a quality EMTS system.

5. Human Resource - The acquisition of knowledge and skills, recruitment and retention of providers are priorities for a quality EMTS system.

6. Education Systems - Includes the education and training of all providers within the EMTS system and includes efforts to coordinate and evaluate programs to ensure they meet the needs of the EMTS system.

7. Public Access - Includes all means by which users can access the system (9-1-1). This component also includes the provision of pre-arrival instructions provided by emergency medical dispatchers.

~~8. Evaluation - A process of assessing the attributes (system integration and components) of the EMTS system to ensure that continual improvement can be designed and implemented.~~

~~9. Communications System - The efficient transfer of information by voice and data occurring between dispatch centers, EMTS providers, physicians, facilities, public safety agencies and patients seeking care through emergency medical dispatch. Includes EMTS system communications interoperability within and outside the region for multicasualty incidents.~~

~~10. Medical Direction - Supervision and direction of patient care within the EMTS system by qualified and authorized physicians, including the medical communities involvement in maintaining quality of care through accepted standards of medical practice and through innovation.~~

~~11. Clinical Care - Clinical methods, technologies and delivery systems utilized in providing EMTS in and out of the hospital. Includes emerging community health services, rescue services and mass casualty management.~~

~~12. Mass Casualty - Defines the responsibility and authority for planning, coordination and infrastructure for all medical care during incidents where the normal capacity to respond is exceeded.~~

~~13. Public Education - Includes the public's involvement in learning experiences to promote and encourage good health and reduce morbidity and mortality.~~

~~14. Prevention - Solutions designed through data collection and analysis, education and intervention strategies to reduce morbidity and mortality related to intentional and unintentional injury and illness~~

~~15. Information Systems - The collection of data and analysis as a tool to monitor and evaluate the EMTS system. Information systems are key to providing a means of improving the effectiveness and integration of healthcare delivery.~~

~~406.1 RETACs must submit their Biennial Plan to SEMTAC on or before July 1, 2003 and every odd numbered year by July 1. If the plan is found to be inadequate, it will be returned to the RETAC with recommendations for revisions. The revised plan shall be submitted to the Council by September 14th. If the revised plan is not approved, the Department will design a plan for the RETAC. Plan submissions must occur by the dates stated or the opportunity for further submissions is forfeited.~~

406~~5~~. RETAC EMERGENCY MEDICAL AND TRAUMA SYSTEM BIENNIAL PLAN REQUIREMENTS

1. ~~A.~~ON JULY 1 OF EVERY ODD NUMBERED YEAR, EACH RETAC, WITH THE APPROVAL FROM THE GOVERNING BODIES FOR THE RETAC, MUST PREPARE A REGIONAL EMERGENCY MEDICAL AND TRAUMA SERVICES SYSTEM PLAN TO CREATE AND MAINTAIN COORDINATED, INTEGRATED EMERGENCY MEDICAL AND TRAUMA SYSTEM SERVICES THROUGHOUT THE REGION. THE DEPARTMENT SHALL PROVIDE TECHNICAL ASSISTANCE TO ANY RETAC FOR PREPARATION, IMPLEMENTATION, AND MODIFICATION OF THE PLAN. THIS PLAN SHALL BE SUBMITTED TO SEMTAC FOR EVALUATION. ONCE SEMTAC HAS DETERMINED THE PLAN IS ADEQUATE, IT WILL MAKE A RECOMMENDATION TO THE DEPARTMENT FOR APPROVAL. THE PLAN SHALL BE SUBMITTED IN THE FORM AND MANNER REQUIRED BY THE DEPARTMENT, BASED ON THE ADVICE FROM SEMTAC. IF THE RETAC FAILS TO SUBMIT A PLAN, DOES NOT INCLUDE A COUNTY AND/OR CITY AND COUNTY WITHIN THEIR REGION IN THE PLAN, OR THE PLAN IS NOT APPROVED THROUGH THE EVALUATION PROCESS ESTABLISHED BY SEMTAC, THE DEPARTMENT SHALL DESIGN A PLAN FOR THE RETAC.

~~B.~~2. IN DEVELOPING THE BIENNIAL PLAN, THE RETAC SHALL REVIEW DATA COLLECTED FROM SOURCES SUCH AS, BUT NOT LIMITED TO, COUNTY PLANS, SEMTAC PLANS,

ORGANIZATIONAL PROFILES, FINANCIAL REPORTS, AND STRATEGIC PLANNING DOCUMENTS.

~~2.~~3. THE BIENNIAL PLAN SHALL BE COMPRISED OF TWO SECTIONS: SYSTEM COMPONENTS AND STATUTORY REQUIREMENTS.

A. ONE SECTION OF EVERY BIENNIAL PLAN SHALL INCLUDE THE SYSTEM COMPONENTS LISTED BELOW. EACH PLAN COMPONENT, AT A MINIMUM, SHALL ADDRESS THE CURRENT LEVEL OF ACTIVITY WITHIN THAT COMPONENT:

(1) INTEGRATION OF HEALTH SERVICES - ACTIVITIES TO IMPROVE PATIENT CARE THROUGH COLLABORATIVE EFFORTS AMONG HEALTH RELATED AGENCIES, FACILITIES, AND ORGANIZATIONS WITHIN THE REGION. THE DESIRED OUTCOME OF THIS COMPONENT IS TO IMPROVE THE SYSTEM BY ENCOURAGING GROUPS INVOLVED IN EMTS TO WORK WITH OTHER ENTITIES (E.G., HEALTH RELATED, STATE, LOCAL, AND PRIVATE AGENCIES AND INSTITUTIONS); SHARE EXPERTISE; EVALUATE AND MAKE RECOMMENDATIONS; AND MUTUALLY ADDRESS AND SOLVE PROBLEMS WITHIN THE REGION.

(2) EMTS RESEARCH - DETERMINES THE EFFECTIVENESS AND EFFICIENCY OF THE EMTS SYSTEM THROUGH SCIENTIFIC INVESTIGATION. A CONTINUOUS AND COMPREHENSIVE EFFORT TO VALIDATE CURRENT EMTS SYSTEM PRACTICES IN AN EFFORT TO IMPROVE PATIENT CARE, DETERMINE THE APPROPRIATE ALLOCATION OF RESOURCES, AND PREVENT INJURY AND ILLNESS AND ULTIMATELY DEATH AND DISABILITY.

(3) LEGISLATION AND REGULATION - ISSUES RELATED TO LEGISLATION, REGULATION, AND POLICY THAT AFFECT ALL COMPONENTS OF THE EMTS SYSTEM. THIS COMPONENT DEFINES THE LEVEL OF AUTHORITY AND RESPONSIBILITY FOR SYSTEM PLANNING, IMPLEMENTATION, AND EVALUATION.

(4) SYSTEM FINANCE - DEFINES THE FINANCIAL RESOURCES NECESSARY TO DEVELOP AND MAINTAIN A QUALITY EMTS SYSTEM.

(5) HUMAN RESOURCE - THE ACQUISITION OF KNOWLEDGE AND SKILLS, RECRUITMENT, AND RETENTION OF PROVIDERS ARE PRIORITIES FOR A QUALITY EMTS SYSTEM.

(6) EDUCATION SYSTEMS - INCLUDES THE EDUCATION AND TRAINING OF ALL PROVIDERS WITHIN THE EMTS SYSTEM AND INCLUDES EFFORTS TO COORDINATE AND EVALUATE PROGRAMS TO ENSURE THEY MEET THE NEEDS OF THE EMTS SYSTEM.

(7) PUBLIC ACCESS - INCLUDES ALL MEANS BY WHICH USERS CAN ACCESS THE 911 SYSTEM. THIS COMPONENT ALSO INCLUDES THE PROVISION OF PRE-ARRIVAL INSTRUCTIONS PROVIDED BY EMERGENCY MEDICAL DISPATCHERS.

(8) EVALUATION - A PROCESS OF ASSESSING THE ATTRIBUTES (SYSTEM INTEGRATION AND COMPONENTS) OF THE EMTS SYSTEM TO ENSURE THAT CONTINUAL IMPROVEMENT CAN BE DESIGNED AND IMPLEMENTED.

(9) COMMUNICATIONS SYSTEM - THE EFFICIENT TRANSFER OF INFORMATION BY VOICE AND DATA OCCURRING BETWEEN DISPATCH CENTERS, EMTS PROVIDERS, PHYSICIANS, FACILITIES, PUBLIC SAFETY AGENCIES, AND PATIENTS SEEKING CARE THROUGH EMERGENCY

MEDICAL DISPATCH. INCLUDES EMTS SYSTEM COMMUNICATIONS INTEROPERABILITY WITHIN AND OUTSIDE THE REGION FOR MULTICASUALTY INCIDENTS.

(10) MEDICAL DIRECTION - SUPERVISION AND DIRECTION OF PATIENT CARE WITHIN THE EMTS SYSTEM BY QUALIFIED AND AUTHORIZED PHYSICIANS, INCLUDING THE MEDICAL COMMUNITIES INVOLVEMENT IN MAINTAINING QUALITY OF CARE THROUGH ACCEPTED STANDARDS OF MEDICAL PRACTICE AND THROUGH INNOVATION.

(11) CLINICAL CARE - CLINICAL METHODS, TECHNOLOGIES, AND DELIVERY SYSTEMS UTILIZED IN PROVIDING EMERGENCY MEDICAL AND TRAUMA SERVICES IN AND OUT OF THE HOSPITAL THAT INCLUDES: EMERGING COMMUNITY HEALTH SERVICES, RESCUE SERVICES, AND MASS CASUALTY MANAGEMENT.

(12) MASS CASUALTY - DEFINES THE RESPONSIBILITY AND AUTHORITY FOR PLANNING, COORDINATION, AND INFRASTRUCTURE FOR ALL MEDICAL CARE DURING INCIDENTS WHERE THE NORMAL CAPACITY TO RESPOND IS EXCEEDED.

(13) PUBLIC EDUCATION - INCLUDES THE PUBLIC'S INVOLVEMENT IN LEARNING EXPERIENCES TO PROMOTE AND ENCOURAGE GOOD HEALTH AND REDUCE MORBIDITY AND MORTALITY.

(14) PREVENTION - SOLUTIONS DESIGNED THROUGH DATA COLLECTION AND ANALYSIS, EDUCATION, AND INTERVENTION STRATEGIES TO REDUCE MORBIDITY AND MORTALITY RELATED TO INTENTIONAL AND UNINTENTIONAL INJURY AND ILLNESS.

(15) INFORMATION SYSTEMS - THE COLLECTION OF DATA AND ANALYSIS AS A TOOL TO MONITOR AND EVALUATE THE EMTS SYSTEM. INFORMATION SYSTEMS ARE KEY TO PROVIDING A MEANS OF IMPROVING THE EFFECTIVENESS AND INTEGRATION OF HEALTHCARE DELIVERY.

B. THE OTHER SECTION OF EVERY BIENNIAL PLAN SHALL ADDRESS THE FOLLOWING ISSUES, AS REQUIRED BY STATUTE.

(1) THOSE REGIONAL FACTORS THAT IMPACT THE PROVISION OF MINIMUM SERVICES AND CARE TO SICK AND INJURED PATIENTS AT THE MOST APPROPRIATE FACILITY. SUCH FACTORS INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING:

a. INTERFACILITY TRANSFER AGREEMENTS AND PROTOCOLS USED BY FACILITIES TO MOVE PATIENTS TO HIGHER LEVELS OF CARE.

b. FACILITY-DEFINED TRIAGE AND TRANSPORT PLANS TO BE DEVELOPED BY ALL FACILITIES WITHIN THE RETAC.

c. GEOGRAPHICAL BARRIERS TO THE TRANSPORTATION OF PATIENTS.

d. POPULATION DENSITY CHALLENGES TO PROVIDING CARE.

e. OUT- OF- HOSPITAL RESOURCES WITHIN THE REGION FOR THE TREATMENT AND TRANSPORTATION OF SICK AND INJURED PERSONS.

f. ACCESSIBILITY TO DESIGNATED TRAUMA FACILITIES WITHIN AND OUTSIDE THE REGION.

(2) THE LEVEL OF COMMITMENT OF EACH OF THE MEMBER COUNTIES AND/OR CITY AND COUNTIES. COMMITMENT INCLUDES, BUT MAY NOT BE LIMITED TO:

a. COOPERATION AMONG COUNTY AND LOCAL ORGANIZATIONS IN THE DEVELOPMENT AND IMPLEMENTATION OF THE STATEWIDE EMERGENCY MEDICAL AND TRAUMA CARE SYSTEM.

b. PARTICIPATION AND REPRESENTATION WITHIN THE RETAC(S).

c. DEDICATED FINANCIAL AND IN-KIND RESOURCES FOR REGIONAL SYSTEMS DEVELOPMENT.

d. COOPERATION AMONG COUNTY AND LOCAL ORGANIZATIONS IN THE DEVELOPMENT AND IMPLEMENTATION OF A COORDINATED STATEWIDE COMMUNICATIONS SYSTEM.

(3) METHODS FOR ENSURING FACILITY, AGENCY, AND COUNTY, AND/OR CITY AND COUNTY ADHERENCE TO THE RETAC EMERGENCY MEDICAL AND TRAUMA SERVICES SYSTEM PLAN. METHODS SHALL INCLUDE, BUT NOT BE LIMITED TO:

a. A COMPLIANCE REPORTING PROCESS AS DEFINED BY SEMTAC AND THE DEPARTMENT.

b. A CONTINUING QUALITY IMPROVEMENT SYSTEM AS DEFINED BY SEMTAC AND THE DEPARTMENT.

(4) DESCRIPTION OF PUBLIC INFORMATION, EDUCATION, AND PREVENTION PROGRAMS USED WITHIN THE REGION TO REDUCE ILLNESS AND INJURY.

(5) ANY FUNCTIONS OF THE RETAC ACCOMPLISHED THROUGH CONTRACTED SERVICES.

(6) IDENTIFICATION OF REGIONAL EMERGENCY MEDICAL AND TRAUMA SYSTEM NEEDS THROUGH THE USE OF A NEEDS ASSESSMENT INSTRUMENT DEVELOPED BY THE DEPARTMENT; EXCEPT THAT THE USE OF SUCH INSTRUMENT SHALL BE SUBJECT TO APPROVAL BY THE COUNTIES AND/OR CITY AND COUNTIES INCLUDED IN A RETAC. APPROVAL BY THE COUNTIES AND/OR CITY AND COUNTIES SHALL NOT BE UNREASONABLY WITHHELD.

(7) A DESCRIPTION OF THE FOLLOWING COMMUNICATIONS SYSTEM ISSUES:

a. COMMUNICATION METHOD IN PLACE TO ENSURE CITIZEN ACCESS TO EMERGENCY MEDICAL AND TRAUMA SERVICES THROUGH THE 911 TELEPHONE SYSTEM OR ITS LOCAL EQUIVALENT.

b. PRIMARY COMMUNICATION METHOD FOR DISPATCH OF PERSONNEL WHO RESPOND TO PROVIDE PREHOSPITAL CARE.

c. COMMUNICATION METHODS USED BETWEEN AMBULANCES AND OTHER RESPONDERS AND BETWEEN AMBULANCES AND DESIGNATED AND NONDESIGNATED FACILITIES.

d. COMMUNICATION METHODS USED AMONG TRAUMA FACILITIES AND BETWEEN FACILITIES AND OTHER MEDICAL CARE FACILITIES.

e. COMMUNICATION METHODS USED AMONG SERVICE AGENCIES TO COORDINATE PREHOSPITAL AND DAY-TO-DAY REQUESTS FOR SERVICE AND DURING MULTICASUALTY (DISASTER) ACTIVITIES.

f. COMMUNICATION METHODS USED AMONG COUNTIES AND RETACS TO COORDINATE PREHOSPITAL AND DAY-TO-DAY REQUESTS FOR SERVICE AND DURING MULTICASUALTY (DISASTER) ACTIVITIES.

(8) EACH BIENNIAL PLAN SHALL IDENTIFY THE KEY RESOURCE FACILITIES FOR THE REGION.

COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing Scheduled for April 15, 2020

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 April 15, 2020 at 10 a.m. in the Sabin-Cleere Conference Room of the Colorado Department of Public Health and Environment, Bldg. A, First Floor, 4300 Cherry Creek Drive, South, Denver, CO 80246, to consider the revision of 6 CCR 1015-4, Statewide Emergency Medical and Trauma Care System, Chapter 1, The Trauma Registry; 2, State Emergency Medical and Trauma Care System Standards; 3, Designation of Trauma Facilities and; 4, Regional Emergency Medical and Trauma Advisory Councils. The proposed rules have been developed by the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment pursuant to Sections 25-3.5-101, 25-3.5-605(2.5), and 25-3.5-704(2), C.R.S.

The agenda for the meeting and the proposed amendments will also be available on the Board's website, https://www.colorado.gov/pacific/cdphe/boh 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 working days prior to the hearing. Copies of the proposed rules may be obtained by contacting the Colorado Department of Public Health and Environment, Health Facilities and Emergency Medical Services Division, 4300 Cherry Creek Drive S., Denver, CO 80246, 303-692-6495.

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, April 9, 2020. 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 27th day of February, 2020.

Alexandra S. Haas
Alexandra Haas
Board of Health Administrator

Notice of Proposed Rulemaking

Tracking number

2020-00094

Department

1300 - Department of Local Affairs

Agency

1302 - Division of Housing

CCR number

8 CCR 1302-16

Rule title

Housing investment trust fund income limits and definition of a single person as an eligible entity for assistance

Rulemaking Hearing

Date

04/14/2020

Time

01:00 PM

Location

1313 Sherman Street, Room 318, Denver, CO 80203

Subjects and issues involved

Rule #1 sets the income limits for a low- or moderate-income family with regard to eligibility for housing produced with funds from the Housing Investment Trust Fund. Rule #2 defines a single person as an eligible entity for housing created with funds from the Housing Investment Trust Fund.

Statutory authority

CRS 24-32-717

Contact information

Name

Wendy Hawthorne

Title

Deputy Director

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Email

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DEPARTMENT OF LOCAL AFFAIRS

Division of Housing

Housing investment trust fund income limits and definition of a single person as an eligible entity for assistance

8 CCR 1302-16

Rule 1. Income limits for Housing Investment Trust Fund

Low-income families are those with incomes of less than 80% of median household income for specific geographical areas and household size as published in the HUD Multifamily Tax Subsidy Income Limits.

Moderate income families are those with incomes of less than 120% of the median household income for specific geographical areas and household size as published in the HUD Multifamily Tax Subsidy Income Limits.

Rule 2. Definition of a single person as an eligible entity for housing created with assistance from the housing investment trust fund.

A single person is eligible for housing created with assistance under the housing investment trust fund when such person's income, added to the income(s) of any persons residing at the same address, do not, in total, exceed the income limits established for the housing investment trust fund.

Notice of Proposed Rulemaking

Tracking number

2020-00114

Department

500,1008,2500 - Department of Human Services

Agency

2503 - Income Maintenance (Volume 3)

CCR number

9 CCR 2503-5

Rule title

ADULT FINANCIAL PROGRAMS

Rulemaking Hearing

Date

04/03/2020

Time

08:30 AM

Location

405 W. 9th Street, Pueblo, CO 81003

Subjects and issues involved

The purpose of this rule addition is to add language pursuant to HB19-1223 which creates a program to help clients applying for or receiving Aid to the Needy Disabled State Only (AND_SO) apply for federal disability benefits. AND-SO provides interim assistance to adults with disabilities while they pursue federal disability benefits. The program created with HB19-1223 creates a program that offers navigation services to assist this vulnerable population with the federal disability application and appeal process. The rules will outline county requirements for operating the program, information about evaluation, and language around the allocation.

Statutory authority

26-1-107, C.R.S. (2019); 26-1-111, C.R.S. (2019); 26-2-119.7, C.R.S.

Contact information

Name

Sam Hughes

Title

Disability Navigator Program Administrator

Telephone

303.866.5365

Email

samantha.hughes@state.co.us

Title of Proposed Rule:	Disability Navigator for the Aid to the Needy Disabled - State Only (AND-SO) Program
CDHS Tracking #:	**20-01-09-02**
CCR #:	9 C.C.R. 2503-5
Office, Division, & Program:	OES, EBD
Phone:	303.866.5365
Rule Author:	Sam Hughes (Disability Navigator Program Administrator)
E-Mail:	samantha.hughes@state.co.us

RULEMAKING PACKET

Type of Rule: *(complete a and b, below)*

a. [X] Board [ ] Executive Director

b. [X] Regular [ ] 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	
	Amended Rules
X	New Rules
	Repealed Rules
	Reviewed Rules

What month is being requested for this rule to first go before the State Board?	April

What date is being requested for this rule to be effective?	July 1, 2020
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 April 3, 2020 2nd Board May 8, 2020 Effective Date July 1, 2020

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***

Title of Proposed Rule:	Disability Navigator for the Aid to the Needy Disabled - State Only (AND-SO) Program		
CDHS Tracking #:	**20-01-09-02**		
CCR #:	9 C.C.R. 2503-5		
Office, Division, & Program:	OES, EBD	Phone:	303.866.5365
Rule Author:	Sam Hughes (Disability Navigator Program Administrator)	E-Mail:	samantha.hughes@state.co.us

The purpose of this rule addition is to add language pursuant to HB19-1223 which creates a program to help clients applying for or receiving Aid to the Needy Disabled – State Only (AND_SO) apply for federal disability benefits. AND-SO provides interim assistance to adults with disabilities while they pursue federal disability benefits. The program created with HB19-1223 creates a program that offers navigation services to assist this vulnerable population with the federal disability application and appeal process. The rules will outline county requirements for operating the program, information about evaluation, and language around the allocation.

An emergency rule-making (which waives the initial Administrative Procedure Act noticing requirements) is necessary:

☐ to comply with state/federal law and/or

☐ to preserve public health, safety and welfare

Justification for emergency:

State Board Authority for Rule:

Code	Description
26-1-107, C.R.S. (2019)	State Board to promulgate rules
26-1-111, C.R.S. (2019)	State department to promulgate rules for public assistance and welfare activities.

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
26-2-119.7	State department to promulgate rules establishing an allocation formula for money appropriated for the Disability Navigator Program.

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.					

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 County Departments who choose to opt-in to the Disability Navigator Program. Aid to the Needy Disabled – State Only (AND-SO) clients who reside in counties which

Title of Proposed Rule:	Disability Navigator for the Aid to the Needy Disabled - State Only (AND-SO) Program		
CDHS Tracking #:	**20-01-09-02**		
CCR #:	9 C.C.R. 2503-5		
Office, Division, & Program:	OES, EBD	Phone:	303.866.5365
Rule Author:	Sam Hughes (Disability Navigator Program Administrator)	E-Mail:	samantha.hughes@state.co.us

choose to operate the Disability Navigator Program will benefit from the additional services related to securing federal benefits offered through the Social Security Administration.

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 current AND-SO caseload is 5,100 cases. This rule change has the ability to impact that number of clients if all counties opt-in to the Disability Navigator Program. The program will assist those clients throughout the application process for SSA benefits with the goal of attaching those clients to a higher amount of income more quickly.

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 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)*

HB19-1223 allocated funds for this program. All expenditures will be within the allocation outlined in the long bill.

County Fiscal Impact

There will be no fiscal impact to counties as there are funds allocated to the counties who choose to operate this program. Counties may experience a reduced AND-SO caseload over time as clients attach more quickly to federal benefits. These savings cannot be predicted.

Federal Fiscal Impact

There may be federal fiscal impacts due to clients attaching to federal disability benefits more quickly and/or more often than they would have without assistance. There is no way to predict this impact.

Other Fiscal Impact *(such as providers, local governments, etc.)*

There are no additional fiscal impacts.

4. Data Description

List and explain any data, such as studies, federal announcements, or questionnaires, which were relied upon when developing this rule?

Title of Proposed Rule:	Disability Navigator for the Aid to the Needy Disabled - State Only (AND-SO) Program		
CDHS Tracking #:	**20-01-09-02**		
CCR #:	9 C.C.R. 2503-5		
Office, Division, & Program:	OES, EBD	Phone:	303.866.5365
Rule Author:	Sam Hughes (Disability Navigator Program Administrator)	E-Mail:	samantha.hughes@state.co.us

A workgroup was utilized to develop this rule. Data from a similar pilot program authorized under SB 14-012, the AND-SO Pilot Project, was utilized as well as best practices identified through agencies doing similar work in other programs.

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 means we will be out of compliance with 26-2-119.7, C.R.S. (2019) requiring rules for this program. Some of these requirements have been written into contractual agreements as a short term solution.

Title of Proposed Rule: Disability Navigator for the Aid to the Needy Disabled - State Only (AND-SO) Program

CDHS Tracking #: **20-01-09-02**

CCR #: 9 C.C.R. 2503-5

Office, Division, & Program: OES, EBD Phone: 303.866.5365

Rule Author: Sam Hughes (Disability Navigator Program Administrator) E-Mail: samantha.hughes@state.co.us

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
7.000	*Incorrect Statutory Reference*	*Section 26.5.103 C.R.S.*	*Section 26.5-101(3) C.R.S.*		
3.540.2	New rule incorporating HB19-1223	New rule language	A. AND-SO DISABILITY NAVIGATION SERVICES ARE AVAILABLE IN COUNTIES THAT CHOOSE TO PARTICIPATE IN THE PROGRAM. COUNTIES CHOOSING TO PARTICIPATE IN THE PROGRAM MUST ENTER INTO AN AGREEMENT WITH THE STATE DEPARTMENT. THE AGREEMENT WILL OUTLINE: 1. DATA TRACKING AND EVALUATION REQUIREMENTS. 2. ONGOING TRAINING REQUIREMENTS FOR STAFF OFFERING NAVIGATION. 3. THE AMOUNT OF FUNDS ALLOCATED TO THE COUNTY. B. ANNUALLY, FUNDS TO OPERATE AND-SO DISABILITY NAVIGATION SERVICES ARE MADE AVAILABLE VIA THE FOLLOWING ALLOCATION. 1. THE DEPARTMENT WILL ALLOCATE APPROPRIATED FUNDS BASED ON THE MOST RECENT ANNUAL AVERAGE AND-SO CASELOAD. 2. COUNTIES WILL INDICATE IF THEY WILL OPERATE THE PROGRAM OR REGIONALIZE AND WHICH COUNTY WILL SERVE AS THE FISCAL AGENT. 3. ANY ALLOCATED AND UNSPENT FUNDS WILL BE POOLED AND REDISTRIBUTED TO COUNTIES THROUGH THE CLOSE OUT PROCESS. 4. THE STATE, WITH INPUT FROM COUNTIES AND STAKEHOLDERS, WILL REVIEW THE ALLOCATION FORMULA FOLLOWING EACH EVALUATION, BUT NO GREATER THAN EVERY FIVE (5) YEARS. C. IN COUNTIES WHICH OPERATE AND-SO DISABILITY NAVIGATION SERVICES, THE FOLLOWING SERVICES ARE MADE AVAILABLE TO ANY AND-SO CLIENT RESIDING IN THE COUNTY OR SERVICE AREA WITH A PENDING AND-SO APPLICATION OR APPROVED AND-SO PROGRAM. SERVICES MAY BE PROVIDED INDIVIDUALLY OR IN A GROUP SETTING, WHEN APPROPRIATE. 1. FOR AND-SO CLIENTS WHO DO NOT HAVE A CURRENT PENDING SSI APPLICATION, SERVICES PROVIDED SHALL INCLUDE: A. ASSISTANCE SECURING A PROTECTED FILING DATE FOR THE SSI APPLICATION DATE AS SOON AS POSSIBLE, BUT NO LATER THAN FIFTEEN (15) CALENDAR DAYS FROM THE DATE OF REFERRAL TO NAVIGATION SERVICES. B. ASSISTANCE DEVELOPING A THOROUGH, QUALITY APPLICATION FOR SSI BENEFITS. C. ASSISTANCE SUBMITTING THE APPLICATION FOR SSI BENEFITS WHEN REQUESTED BY THE CLIENT AND/OR SERVING AS THE CLIENT'S APPOINTED REPRESENTATIVE WITH THE SOCIAL SECURITY ADMINISTRATION (SSA).	Incorporating new program into rule as required by HB19-1223	No

			2. FOR AND-SO CLIENTS WHO HAVE A PENDING SSI APPLICATION, ARE DENIED SSI, OR WHO ARE APPEALING A DENIAL THROUGH SSA, SERVICES PROVIDED SHALL INCLUDE: A. PROVIDE PROMPT RESPONSE TO THE SSA AND DISABILITY DETERMINATION SERVICES (DDS) INQUIRIES, WITHIN TEN (10) CALENDAR DAYS OF THE INQUIRY. B. OUTREACH TO THE CLIENT AS NEEDED TO STAY CONNECTED THROUGHOUT THE DETERMINATION PROCESS. C. ASSISTANCE FILING RECONSIDERATIONS AND/OR APPEALS OF FEDERAL DISABILITY BENEFITS WHEN REQUESTED BY THE CLIENT. 3. ADDITIONALLY, SERVICES TO ALL AND-SO CLIENTS MAY INCLUDE: A. SERVING AS THE CLIENT'S APPOINTED REPRESENTATIVE FOR INTERACTIONS WITH THE SSA. B. COMMUNICATE AS NEEDED WITH THE SSA AND DDS REGARDING THE STATUS OF CLIENTS' CLAIMS. C. WRITING A COMPREHENSIVE FUNCTION REPORT AND GATHER SUPPORTING MEDICAL OPINIONS WHEN AVAILABLE. D. PARTICIPATING IN THE SSA INTERVIEW PROCESS. E. MAKING REFERRALS TO APPROPRIATE MEDICAL PROVIDERS AND OTHER PROFESSIONALS WHOSE ASSESSMENTS ARE REQUIRED AS PART OF AN APPLICATION FOR FEDERAL DISABILITY BENEFITS. F. COLLECTING MEDICAL RECORDS, ASSESSMENTS, CASE MANAGEMENT NOTES AND COLLATERAL CONTACT INFORMATION. G. APPOINTMENT COORDINATION WITH DOCTORS, THERAPISTS, SSA, ETC. D. COUNTIES SHALL ENSURE THAT AND-SO DISABILITY NAVIGATION SERVICES ARE OFFERED BY PEOPLE WITH AN APPROPRIATE LEVEL OF EXPERTISE AND WHO ARE NOT DISQUALIFIED OR SUSPENDED FROM ACTING AS A REPRESENTATIVE WITH THE SSA AND ARE NOT PROHIBITED BY ANY LAW FROM ACTING AS A REPRESENTATIVE. EXPERTISE CAN BE DEMONSTRATED BY AT LEAST ONE OF THE FOLLOWING: 1. BEING AN ATTORNEY LICENSED IN COLORADO OR LICENSED TO APPEAR IN ANY U.S. FEDERAL COURT, IN GOOD STANDING; 2. OBTAINING OR HAVING SSI/SSDI OUTREACH, ACCESS, AND RECOVERY (SOAR) CERTIFICATION; 3. RECEIVING ADEQUATE TRAINING BY A LICENSED ATTORNEY OR SOAR CERTIFIED PERSON AND HAVING SUBMITTED AT LEAST TEN APPLICATIONS TO THE SSA IN THE PAST YEAR; OR 4. OTHER CERTIFICATIONS OR EXPERIENCE APPROVED BY THE STATE DEPARTMENT IN WRITING OR ELECTRONICALLY.		

Title of Proposed Rule:	Disability Navigator for the Aid to the Needy Disabled - State Only (AND-SO) Program		
CDHS Tracking #:	**20-01-09-02**		
CCR #:	9 C.C.R. 2503-5		
Office, Division, & Program:	OES, EBD	Phone:	303.866.5365
Rule Author:	Sam Hughes (Disability Navigator Program Administrator)	E-Mail:	samantha.hughes@state.co.us

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):

Colorado Center on Law and Policy, Disability Determination Services, county departments as approved by Sub-PAC, Easter Seals, Bayaud Industries, Project Worthmore, DRCOG

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; PAC; Economic Security Sub-PAC; Colorado Center on Law and Policy; Colorado Commission on Aging; Colorado Senior Lobby; Colorado Cross Disability Coalition; Colorado Legal Services; Colorado Gerontological Society; 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	February 6, 2020		
What issues were raised?	Funding of the project/scope of work requires that counties/contractor work with all applicants and there are concerns about volume and the amount of allocation not being adequate.		
Vote Count	*For*	*Against*	*Abstain*
	11	1	3
If not presented, explain why.			

PAC

Have these rules been approved by PAC?

[ ] Yes [X] No

Date presented	March 5, 2020

Title of Proposed Rule:	Disability Navigator for the Aid to the Needy Disabled - State Only (AND-SO) Program		
CDHS Tracking #:	**20-01-09-02**		
CCR #:	9 C.C.R. 2503-5		
Office, Division, & Program:	OES, EBD	Phone:	303.866.5365
Rule Author:	Sam Hughes (Disability Navigator Program Administrator)	E-Mail:	samantha.hughes@state.co.us

What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.			

Other Comments

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 C.C.R. 2503-5)

****

3.540.2 AID TO THE NEEDY DISABLED-STATE ONLY (AND-SO) DISABILITY NAVIGATION SERVICES

A. AND-SO DISABILITY NAVIGATION SERVICES ARE AVAILABLE IN COUNTIES THAT CHOOSE TO PARTICIPATE IN THE PROGRAM. COUNTIES CHOOSING TO PARTICIPATE IN THE PROGRAM MUST ENTER INTO AN AGREEMENT WITH THE STATE DEPARTMENT. THE AGREEMENT WILL OUTLINE:

1. DATA TRACKING AND EVALUATION REQUIREMENTS.

2. ONGOING TRAINING REQUIREMENTS FOR STAFF OFFERING NAVIGATION.

3. THE AMOUNT OF FUNDS ALLOCATED TO THE COUNTY.

B. ANNUALLY, FUNDS TO OPERATE AND-SO DISABILITY NAVIGATION SERVICES ARE MADE AVAILABLE VIA THE FOLLOWING ALLOCATION.

1. THE DEPARTMENT WILL ALLOCATE APPROPRIATED FUNDS BASED ON THE MOST RECENT ANNUAL AVERAGE AND-SO CASELOAD.

2. COUNTIES WILL INDICATE IF THEY WILL OPERATE THE PROGRAM OR REGIONALIZE AND WHICH COUNTY WILL SERVE AS THE FISCAL AGENT.

3. ANY ALLOCATED AND UNSPENT FUNDS WILL BE POOLED AND REDISTRIBUTED TO COUNTIES THROUGH THE CLOSE OUT PROCESS.

4. THE STATE, WITH INPUT FROM COUNTIES AND STAKEHOLDERS, WILL REVIEW THE ALLOCATION FORMULA FOLLOWING EACH EVALUATION, BUT NO GREATER THAN EVERY FIVE (5) YEARS.

C. IN COUNTIES WHICH OPERATE AND-SO DISABILITY NAVIGATION SERVICES, THE FOLLOWING SERVICES ARE MADE AVAILABLE TO ANY AND-SO CLIENT RESIDING IN THE COUNTY OR SERVICE AREA WITH A PENDING AND-SO APPLICATION OR APPROVED AND-SO PROGRAM. SERVICES MAY BE PROVIDED INDIVIDUALLY OR IN A GROUP SETTING, WHEN APPROPRIATE.

1. FOR AND-SO CLIENTS WHO DO NOT HAVE A CURRENT PENDING SSI APPLICATION, SERVICES PROVIDED SHALL INCLUDE:

A. ASSISTANCE SECURING A PROTECTED FILING DATE FOR THE SSI APPLICATION DATE AS SOON AS POSSIBLE, BUT NO LATER THAN FIFTEEN (15) CALENDAR DAYS FROM THE DATE OF REFERRAL TO NAVIGATION SERVICES.

B. ASSISTANCE DEVELOPING A THOROUGH, QUALITY APPLICATION FOR SSI BENEFITS.

C. ASSISTANCE SUBMITTING THE APPLICATION FOR SSI BENEFITS WHEN REQUESTED BY THE CLIENT AND/OR SERVING AS THE CLIENT'S APPOINTED REPRESENTATIVE WITH THE SOCIAL SECURITY ADMINISTRATION (SSA).

2. FOR AND-SO CLIENTS WHO HAVE A PENDING SSI APPLICATION, ARE DENIED SSI, OR WHO ARE APPEALING A DENIAL THROUGH SSA, SERVICES PROVIDED SHALL INCLUDE:

A. PROVIDE PROMPT RESPONSE TO THE SSA AND DISABILITY DETERMINATION SERVICES (DDS) INQUIRIES, WITHIN TEN (10) CALENDAR DAYS OF THE INQUIRY.

B. OUTREACH TO THE CLIENT AS NEEDED TO STAY CONNECTED THROUGHOUT THE DETERMINATION PROCESS.

C. ASSISTANCE FILING RECONSIDERATIONS AND/OR APPEALS OF FEDERAL DISABILITY BENEFITS WHEN REQUESTED BY THE CLIENT.

3. ADDITIONALLY, SERVICES TO ALL AND-SO CLIENTS MAY INCLUDE:

A. SERVING AS THE CLIENT'S APPOINTED REPRESENTATIVE FOR INTERACTIONS WITH THE SSA.

B. COMMUNICATE AS NEEDED WITH THE SSA AND DDS REGARDING THE STATUS OF CLIENTS' CLAIMS.

C. WRITING A COMPREHENSIVE FUNCTION REPORT AND GATHER SUPPORTING MEDICAL OPINIONS WHEN AVAILABLE.

D. PARTICIPATING IN THE SSA INTERVIEW PROCESS.

E. MAKING REFERRALS TO APPROPRIATE MEDICAL PROVIDERS AND OTHER PROFESSIONALS WHOSE ASSESSMENTS ARE REQUIRED AS PART OF AN APPLICATION FOR FEDERAL DISABILITY BENEFITS.

F. COLLECTING MEDICAL RECORDS, ASSESSMENTS, CASE MANAGEMENT NOTES AND COLLATERAL CONTACT INFORMATION.

G. APPOINTMENT COORDINATION WITH DOCTORS, THERAPISTS, SSA, ETC.

D. COUNTIES SHALL ENSURE THAT AND-SO DISABILITY NAVIGATION SERVICES ARE OFFERED BY PEOPLE WITH AN APPROPRIATE LEVEL OF EXPERTISE AND WHO ARE NOT DISQUALIFIED OR SUSPENDED FROM ACTING AS A REPRESENTATIVE WITH THE SSA AND ARE NOT PROHIBITED BY ANY LAW FROM ACTING AS A REPRESENTATIVE. EXPERTISE CAN BE DEMONSTRATED BY AT LEAST ONE OF THE FOLLOWING:

1. BEING AN ATTORNEY LICENSED IN COLORADO OR LICENSED TO APPEAR IN ANY U.S. FEDERAL COURT, IN GOOD STANDING;

2. OBTAINING OR HAVING SSI/SSDI OUTREACH, ACCESS, AND RECOVERY (SOAR) CERTIFICATION;

3. RECEIVING ADEQUATE TRAINING BY A LICENSED ATTORNEY OR SOAR CERTIFIED PERSON AND HAVING SUBMITTED AT LEAST TEN APPLICATIONS TO THE SSA IN THE PAST YEAR; OR

4. OTHER CERTIFICATIONS OR EXPERIENCE APPROVED BY THE STATE DEPARTMENT IN WRITING OR ELECTRONICALLY.

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Notice of Proposed Rulemaking

Tracking number

2020-00113

Department

500,1008,2500 - Department of Human Services

Agency

2503 - Income Maintenance (Volume 3)

CCR number

9 CCR 2503-6

Rule title

COLORADO WORKS PROGRAM

Rulemaking Hearing

Date

04/03/2020

Time

08:30 AM

Location

405 W. 9th Street, Pueblo, CO 81003

Subjects and issues involved

The current rule has descriptions of work activities that are inconsistent with Colorados new Work Verification Plan. In addition, the current assessment rule is outdated and requires more than what is federally required. The proposed rule eliminates references to work activities as previously federally defined in the Work Verification Plan. The new rule will refer back to the Work Verification Plan for consistency. The section addressing assessments will be updated to match the federal language. The current rule does not list the statutorily required disqualification period for Intentional Program Violations.

Statutory authority

26-1-107, C.R.S. (2019); 26-1-111, C.R.S. (2019); 26-1-109, C.R.S. (2019); 26-2-128(1) C.R.S. (2019); 45 CFR 261-11(a); 45 CFR 261-62; 45 CFR 261-63

Contact information

Name

Rebecca Balu

Title

Employment and Training Manager

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Email

rebecca.balu@state.co.us

Title of Proposed Rule:	Technical Clean-up of Colorado Works		
CDHS Tracking #:	**20-01-09-01**		
CCR #:	9 CCR 2503-6		
Office, Division, & Program:	OES, EBD	Phone:	303.866.3795
Rule Author:	Rebecca Balu (Employment and Training Manager)	E-Mail:	rebecca.balu@state.co.us

RULEMAKING PACKET

Type of Rule: *(complete a and b, below)*

a. [X] Board [ ] Executive Director

b. [X] Regular [ ] 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
X	New Rules
	Repealed Rules
	Reviewed Rules

What month is being requested for this rule to first go before the State Board?	May

What date is being requested for this rule to be effective?	July 1, 2020
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 April 3, 2020 2nd Board May 8, 2020 Effective Date July 1, 2020

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***

Title of Proposed Rule:	Technical Clean-up of Colorado Works		
CDHS Tracking #:	**20-01-09-01**		
CCR #:	9 CCR 2503-6		
Office, Division, & Program:	OES, EBD	Phone:	303.866.3795
Rule Author:	Rebecca Balu (**Employment and Training Manager**)	E-Mail:	rebecca.balu@state.co.us

The current rule has descriptions of work activities that are inconsistent with Colorado's new Work Verification Plan. In addition, the current assessment rule is outdated and requires more than what is federally required.

The proposed rule eliminates references to work activities as previously federally defined in the Work Verification Plan. The new rule will refer back to the Work Verification Plan for consistency.

The section addressing assessments will be updated to match the federal language.

The current rule does not list the statutorily required disqualification period for Intentional Program Violations.

An emergency rule-making (which waives the initial Administrative Procedure Act noticing requirements) is necessary:

☐ to comply with state/federal law and/or

☐ to preserve public health, safety and welfare

Justification for emergency:

State Board Authority for Rule:

Code	Description
26-1-107, C.R.S. (2019)	State Board to promulgate rules
26-1-111, C.R.S. (2019)	State department to promulgate rules for public assistance and welfare activities.

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
26-1-109, C.R.S. (2019)	State department rules to coordinate with federal programs
26-2-128(1) C.R.S. (2019)	Recovery from Recipient- Estate – Generally describes the disqualification process for individuals who have committed an intentional program violation
45 CFR 261-11(a)	The State must make an initial assessment of the skills, prior work experience, and employability of each recipient who is at least age 18 or who has not completed high school (or equivalent) and is not attending secondary school.
45 CFR 261-62	Submit to the secretary for approval of the State's Work Verification Plan in accordance with paragraph B of this section.
45 CFR 261-63	A state must submit its Work Verification Plan to the U.S. Department of Health and Human Services for approval when the State modifies its verification procedures for TANF or SSP-MOE work activities or its internal controls for ensuring a consistent measurement of the work participation rate.

Does the rule incorporate material by reference?		Yes		X	No
Does this rule repeat language found in statute?		Yes		X	No

Title of Proposed Rule:	Technical Clean-up of Colorado Works		
CDHS Tracking #:	**20-01-09-01**		
CCR #:	9 CCR 2503-6		
Office, Division, & Program:	OES, EBD	Phone:	303.866.3795
Rule Author:	Rebecca Balu (Employment and Training Manager)	E-Mail:	rebecca.balu@state.co.us

If yes, please explain.						

Title of Proposed Rule:	Technical Clean-up of Colorado Works		
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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 County Departments who process Colorado Works cases by eliminating the contradictory language found in rule and the Work Verification Plan. The change to align the assessment requirements with the federal TANF assessment requirements will impact all County Departments who process Colorado Works by requiring fewer assessment criteria to be met in order to continue a Colorado Works case. All Colorado Works customers who commit an Intentional Program Violation will be impacted by the incorporation of the statute requiring a disqualification period for Intentional Program Violations in other public assistance programs.

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 current Colorado Works caseload is approximately 15,000. This rule impacts all clients in the program and all County Departments. While the rule changes are technical in nature, there is an impact in how clients are assessed, where county staff and clients access current rules, and the penalties for Intentional Program Violations.

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 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)*

There are no state fiscal impacts because the rule is an incorporation of federal requirements and are absorbed within the current allocation. All changes made to the CBMS are within existing allocations.

County Fiscal Impact

Counties may experience a time savings in the work that relates to the required assessments for the Colorado Works program. These will be minimal savings and cannot be predicted.

Federal Fiscal Impact

Title of Proposed Rule:	Technical Clean-up of Colorado Works		
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There are no federal fiscal impacts because the changes are a clean-up of language to incorporate federal and statutory language. These changes fall within existing federal appropriations.

Other Fiscal Impact *(such as providers, local governments, etc.)*

There are no additional fiscal impacts.

4. Data Description

List and explain any data, such as studies, federal announcements, or questionnaires, which were relied upon when developing this rule?

Not applicable. This is a technical clean-up to ensure alignment with our federal agreement and State statute.

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 means we will be out of compliance with the federal agreement we have with the Administration of Children and Families (ACF). This leaves the State open to unfavorable audit findings and potential fiscal sanctions. Taking no action means we will also be out of compliance with State statute.

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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
7.000	*Incorrect Statutory Reference*	*Section 26.5.103 C.R.S.*	*Section 26.5-101(3) C.R.S.*		
3.604.2.R	Currently out of compliance with Statute	New Rule Addition	7. IF THE CLIENT IS FOUND TO HAVE COMMITTED AN IPV IN ANY OTHER PUBLIC ASSISTANCE PROGRAM, THE CLIENT IS DISQUALIFIED FROM PARTICIPATION IN COLORADO WORKS FOR THE PENALTY PERIODS ASCRIBED TO THOSE VIOLATIONS AND FOR THE SAME TIME PERIOD.	Incorporation of disqualification required by statute: Statute 26-2-128: "To the extent not otherwise prohibited by state or federal law, if the recipient is found to have committed an intentional program violation, the recipient is disqualified from participation in any public assistance program under this article for twelve months for the first incident, twenty-four months for a second incident, and permanently for a third or subsequent incident."	No
3.607.1, B	Mis-alignment with federal rule	3.607 ASSESSMENT AND OTHER PROGRAM REQUIREMENTS 3.607.1 Assessment [Rev. eff. 9/15/12] A. Requirement of Assessment As a condition of continued eligibility, all work eligible individuals must complete an initial assessment within thirty (30) calendar days from the date the application was submitted. Failure to complete the assessment within thirty (30) calendar days will result in the termination or denial of payment. B. Complete Assessment	3.607 ASSESSMENT AND OTHER PROGRAM REQUIREMENTS 3.607.1 Assessment [Rev. eff. 9/15/12] A. Requirement of Assessment As a condition of continued eligibility, all work eligible individuals must complete an initial assessment within thirty (30) calendar days from the date the application was submitted. Failure to complete the assessment within thirty (30) calendar days will result in the termination or denial of payment. B. Complete Assessment A county department shall perform ~~an~~ skills assessment which shall consist of an evaluation of basic skills, past employment, AND employability~~, educational level, needs of the assistance unit, and other relevant factors~~ for an applicant or participant who is eighteen	Match Assessment requirements to federal requirements	No

		A county department shall perform ~~an~~ skills assessment which shall consist of an evaluation of basic skills, past employment, employability, educational level, needs of the assistance unit, ~~and~~ other relevant factors for an applicant or participant who is eighteen (18) years of age or older, or who is sixteen (16) years of age or older, but is not yet eighteen (18) years old and has not completed high school or obtained a certificate of high school equivalency, and is not attending high school or a high school equivalency program. Supportive services, other assistance, and/or family needs cash payments shall be based on the results of the assessment. The assessment shall also provide information needed to determine whether an eligible applicant should receive basic cash assistance or a diversion payment. The applicant(s) or participant(s) shall complete the assessment with the county worker responsible for the case maintenance. In addition, updated assessments may be conducted at county department discretion.	(18) years of age or older, or who is sixteen (16) years of age or older, but is not yet eighteen (18) years old and has not completed high school or obtained a certificate of high school equivalency, and is not attending high school or a high school equivalency program. Supportive services, other assistance, and/or family needs cash payments shall be based on the results of the assessment. The assessment shall also provide information needed to determine whether an eligible applicant should receive basic cash assistance or a diversion payment. ~~The applicant(s) or participant(s) shall complete the assessment with the county worker responsible for the case maintenance.~~ In addition, updated assessments may be conducted at county department discretion.		
3.608.1, B	3.608.2 is referenced.	B. Requirements for Receipt of Cash Assistance/ Basic Cash Assistance	B. Requirements for Receipt of Cash Assistance/ Basic Cash Assistance As a condition of continued	Remove reference to section 3.608.2 in current Colorado Works (Volume 3.600) rule.	No

		As a condition of continued eligibility, all assistance units that include an adult member who is receiving basic cash assistance, shall have such adult member in a work activity, either federal or county defined in Section 3.608.2 "Work Activities." Work Eligible Individuals shall have the work activity(s) outlined in his or her Individualized Plan (IP) in order to receive Colorado Works cash assistance. A single parent with a child(ren) under age six (6) shall be notified in writing of the terms and conditions under which a county determines that child care is unavailable. This notification shall be in written format and shall include the county's definition of the unavailability of child care. This definition must include the criteria listed at Section 3.608.4 "Noncompliance." This notice shall inform an individual of the procedures for applying for and being considered for an exemption from the work requirements and the procedures for applying for the exemption. The notice shall also include the statement that this exemption does not exempt the single parent from program time limits.	eligibility, all assistance units that include an adult member who is receiving basic cash assistance, shall have such adult member in a work activity, either federal or county defined. ~~in Section 3.608.2 "Work Activities."~~ Work Eligible Individuals shall have the work activity(s) outlined in his or her Individualized Plan (IP) in order to receive Colorado Works cash assistance. A single parent with a child(ren) under age six (6) shall be notified in writing of the terms and conditions under which a county determines that child care is unavailable. This notification shall be in written format and shall include the county's definition of the unavailability of child care. This definition must include the criteria listed at Section 3.608.4 "Noncompliance." This notice shall inform an individual of the procedures for applying for and being considered for an exemption from the work requirements and the procedures for applying for the exemption. The notice shall also include the statement that this exemption does not exempt the single parent from program time limits.		

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3.608.2.A-B		3.608.2 Work Activities [Rev. eff. 7/1/15] A. Engaged in Work Activities As a condition of continued eligibility, a parent or specified caretaker receiving assistance as an adult is required to engage in one or more of the following work activities or any county-defined work activities. This requirement includes dependent children between the ages of sixteen (16) and eighteen (18) years old who are not attending school. All activities in the Individualized Plan shall relate to the outcome of both initial and ongoing assessments. A parent is required to engage in a work activity and is a mandatory member of the assistance unit. A specified caretaker has the opportunity to be a mandatory member of the assistance unit and, as such, receive a cash payment. As a mandatory member, the specified caretaker must engage in a work activity per the definition of a specified caretaker at Section 3.601 "Program Definitions." B. Allowable Work Activities Work activities are defined as: 1. Unsubsidized employment - Part-time or full-time	3.608.2 Work Activities [Rev. eff. 7/1/15] A. Engaged in Work Activities As a condition of continued eligibility, a parent or specified caretaker receiving assistance as an adult is required to engage in one or more ~~of the following~~ work activities ~~or any county-defined work activities.~~ This requirement includes dependent children between the ages of sixteen (16) and eighteen (18) years old who are not attending school. All activities in the Individualized Plan shall relate to the outcome of both initial and ongoing assessments. A parent is required to engage in a work activity and is a mandatory member of the assistance unit. A specified caretaker has the opportunity to be a mandatory member of the assistance unit and, as such, receive a cash payment. As a mandatory member, the specified caretaker must engage in a work activity per the definition of a specified caretaker at Section 3.601 "Program Definitions." B. Allowable Work Activities FEDERAL ~~W~~Work activities are defined IN COLORADO'S FEDERALLY APPROVED WORK VERIFICATION PLAN WHICH CAN BE FOUND AT WWW.COLORADO.GOV/PACIFIC/CDHS/POLICIES-3.~~as:~~ COUNTY DEFINED WORK ACTIVITIES ARE LISTED IN COUNTY POLICY WHICH CAN BE REVIEWED AT THE COUNTY DEPARTMENT. THESE REGULATIONS ARE ALSO AVAILABLE FOR PUBLIC INSPECTION AND COPYING AT THE COLORADO DEPARTMENT OF HUMAN SERVICES, DIRECTOR OF THE EMPLOYMENT AND BENEFITS DIVISION, 1575 SHERMAN STREET, DENVER, COLORADO, 80203, OR AT ANY STATE PUBLICATIONS LIBRARY DURING REGULAR BUSINESS HOURS. ~~1. Unsubsidized employment - Part-time or full-time employment in the public or private sector that is not~~	Remove definitions that are included in the Work Verification Plan.	No

		employment in the public or private sector that is not subsidized by TANF or other public program. 2. Subsidized private or public sector employment - Part-time or full-time work with any private or public sector employer for which wages are paid by the employer and for which the employer receives a subsidy; from TANF or other public funds to offset some or all of the wages and costs of employing a recipient. 3. Work experience - a work activity performed in return for Colorado Works cash assistance payments, that provides an individual with an opportunity to acquire the general skills, training, knowledge and work habits necessary to obtain employment. Work experience assignments must improve the employability of those who cannot find unsubsidized employment. 4. On-The-Job-Training - training in the public or private sector that is given to a paid employee while he or she is engaged in productive work and that provides knowledge and skills essential to the full and adequate performance of the job. 5. Job search and job readiness	~~subsidized by TANF or other public program.~~ ~~2. Subsidized private or public sector employment - Part-time or full-time work with any private or public~~ ~~sector employer for which wages are paid by the employer and for which the employer receives a subsidy; from TANF or other public funds to offset some or all of the wages and costs of employing a~~ ~~recipient.~~ ~~3. Work experience - a work activity performed in return for Colorado Works cash assistance payments,~~ ~~that provides an individual with an opportunity to acquire the general skills, training, knowledge and work habits necessary to obtain employment. Work experience assignments must improve the employability of those who cannot find unsubsidized employment.~~ ~~4. On-The-Job-Training - training in the public or private sector that is given to a paid employee while he or she is engaged in productive work and that provides knowledge and skills essential to the full and adequate performance of the job.~~ ~~5. Job search and job readiness assistance - Job search may be conducted in either a group or individual setting and may include employer contacts either in person, by telephone, or by electronic methods; job readiness assistance includes activities supporting preparation of an individual to seek or obtain employment. This includes activities such as preparing a resume or job application, training in~~ ~~interviewing skills, instruction in work place expectations, as well as life skills training. Substance abuse treatment, mental health treatment, or rehabilitation activities are allowed for those who are otherwise employable. Such treatment or therapy must be determined necessary and certified by a qualified medical or mental health professional.~~ ~~6. Community service programs - Structured work programs~~		

		assistance - Job search may be conducted in either a group or individual setting and may include employer contacts either in person, by telephone, or by electronic methods; job readiness assistance includes activities supporting preparation of an individual to seek or obtain employment. This includes activities such as preparing a resume or job application, training in interviewing skills, instruction in work place expectations, as well as life skills training. Substance abuse treatment, mental health treatment, or rehabilitation activities are allowed for those who are otherwise employable. Such treatment or therapy must be determined necessary and certified by a qualified medical or mental health professional. 6. Community service programs - Structured work programs performed for the direct benefit of the community under the auspices of public or non-profit organizations. Community services programs must be limited to projects that serve a useful community purpose in fields such as health, social service, environmental	~~performed for the direct benefit of the~~ ~~community under the auspices of public or non-profit organizations. Community services programs must~~ ~~be limited to projects that serve a useful community purpose in fields such as health, social service,~~ ~~environmental protection, education, urban and rural redevelopment, welfare, recreation, public facilities, public safety, and child care.~~ ~~7. Vocational educational training - Organized educational programs that are directly related to the~~ ~~preparation of individuals for employment in current or emerging occupations requiring training.~~ ~~8. Child care for community service participants - Providing child care services to an individual who is~~ ~~participating in a community service program. It does not include providing child care to enable a TANF~~ ~~recipient to participate in any of the other ten allowable work activities. Child care provided to individuals~~ ~~in community service must adhere to established child care licensing rules and statutes.~~ ~~9. Job skills training directly related to employment - Training and education for job skills required by an~~ ~~employer or to advance or adapt to the changing demands of the workplace, including basic remediation, English as a Second Language, and/or short-term training directly related to local labor market demands.~~ ~~10. Education directly related to employment shall be an option only in the case of a participant who has~~ ~~not received a high school diploma or a certificate of high school equivalency. This work activity is used~~ ~~for education courses designed to provide knowledge and skills for specific occupations or work settings~~ ~~and may include adult basic~~		

		protection, education, urban and rural redevelopment, welfare, recreation, public facilities, public safety, and child care. 7. Vocational educational training - Organized educational programs that are directly related to the preparation of individuals for employment in current or emerging occupations requiring training. 8. Child care for community service participants - Providing child care services to an individual who is participating in a community service program. It does not include providing child care to enable a TANF recipient to participate in any of the other ten allowable work activities. Child care provided to individuals in community service must adhere to established child care licensing rules and statutes. 9. Job skills training directly related to employment - Training and education for job skills required by an employer or to advance or adapt to the changing demands of the workplace, including basic remediation, English as a Second Language, and/or short-term training directly related to local labor market	~~education, English as a Second Language (ESL) and education leading to a General Education Development (GED) or high school equivalency diploma.~~ ~~11. Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence shall be an option only in the case of a participant who has not completed secondary school or received such a certificate. Regular attendance, in accordance with the requirements of the secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate. This activity may not include other related educational activities, such as adult basic education or language instruction.~~ ~~a. Full-time attendance in secondary school, vocational or technical school, or cooperative training programs means twenty-five (25) clock hours per week or as defined by the school system.~~ ~~b. Part-time attendance means a minimum of twelve hours of school attendance per week, or as defined by the school system.~~ C. Work Activity Outlined in the Individualized Plan For purposes of meeting the work participation requirements of this section, a Colorado Works participant shall be considered to be engaged in work program requirements if they are participating in the work activities listed in THE WORK VERIFICATION PLAN~~Section 3.608.2, B,~~ or in any other work activities designed to lead to self sufficiency as determined by the county department and as outlined in their Individualized Plan.		

		demands. 10. Education directly related to employment shall be an option only in the case of a participant who has not received a high school diploma or a certificate of high school equivalency. This work activity is used for education courses designed to provide knowledge and skills for specific occupations or work settings and may include adult basic education, English as a Second Language (ESL) and education leading to a General Education Development (GED) or high school equivalency diploma. 11. Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence shall be an option only in the case of a participant who has not completed secondary school or received such a certificate. Regular attendance, in accordance with the requirements of the secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate. This activity may not include other related			

		educational activities, such as adult basic education or language instruction. a. Full-time attendance in secondary school, vocational or technical school, or cooperative training programs means twenty-five (25) clock hours per week or as defined by the school system. b. Part-time attendance means a minimum of twelve hours of school attendance per week, or as defined by the school system. C. Work Activity Outlined in the Individualized Plan For purposes of meeting the work participation requirements of this section, a Colorado Works participant shall be considered to be engaged in work program requirements if they are participating in the work activities listed in Section 3.608.2, B, or in any other work activities designed to lead to self sufficiency as determined by the county department and as outlined in their Individualized Plan.			
3.608.3, A		3.608.3 Work Participation Rate [Rev. eff. 7/1/15] A. A separate work participation rate will be established by the State Department based on federal	3.608.3 Work Participation Rate [Rev. eff. 7/1/15] A. A separate work participation rate will be established by the State Department based on federal requirements for all families and for two parent families. The rate to be achieved by each county department shall	Remove definitions that are included in the Work Verification Plan.	No

		requirements for all families and for two parent families. The rate to be achieved by each county department shall be negotiated and will be included in the annual performance contract. A. Federal Participation Rate Calculations A Colorado Works participant is considered to be engaged in work for a month if he or she is participating in the work activities defined in the Work Verification Plan for at least the minimum number of hours per week as required by Federal law. The federal work participation rate guidelines are outlined below: 1. The federal all families work participation rate requirement is an average of thirty (30) hours per week per calendar month. 2. The federal two-parent participation rate requirement is an average of thirty-five (35) hours per week if no federally funded child care is provided. If federal child care is provided, the average weekly hours must meet or exceed fifty-five (55) hours per calendar month. 3. A parent(s) under twenty (20) years of age is considered to be engaged in a work activity if he or	be negotiated and will be included in the annual performance contract. ~~A. Federal Participation Rate Calculations~~ ~~A Colorado Works participant is considered to be engaged in work for a month if he or she is participating in the work activities defined in the Work Verification Plan for at least the minimum number of hours per week as required by Federal law. The federal work participation rate guidelines are outlined below:~~ ~~1. The federal all families work participation rate requirement is an average of thirty (30) hours per week per calendar month.~~ ~~2. The federal two-parent participation rate requirement is an average of thirty-five (35) hours per week if no federally funded child care is provided. If federal child care is provided, the average weekly hours must meet or exceed fifty-five (55) hours per calendar month.~~ ~~3. A parent(s) under twenty (20) years of age is considered to be engaged in a work activity if he or she is maintaining satisfactory attendance in high school or GED, or participating in education directly related to employment for an average of at least twenty (20) hours per week during a calendar month.~~ ~~4. A single parent with a child(ren) under age six (6) is deemed to be meeting work participation requirements if he or she is engaged in work for an average of twenty (20) hours per week during a calendar month.~~ ~~5. Excused absences and holidays will be counted as hours toward the federal work participation rate for only scheduled work activities as outlined in Section 3.608.2, B, and contained in the participant's Individualized Plan. Absences~~		

		she is maintaining satisfactory attendance in high school or GED, or participating in education directly related to employment for an average of at least twenty (20) hours per week during a calendar month. 4. A single parent with a child(ren) under age six (6) is deemed to be meeting work participation requirements if he or she is engaged in work for an average of twenty (20) hours per week during a calendar month. 5. Excused absences and holidays will be counted as hours toward the federal work participation rate for only scheduled work activities as outlined in Section 3.608.2, B, and contained in the participant's Individualized Plan. Absences and holiday hours are allowed only as approved in the most current Colorado Works work verification plan submitted and approved by the U.S. Department of Health and Human Services, Office of Family Assistance. 6. All cases subject to time limitations shall be included in the denominator for calculating the work participation rate. B. Job Placement	~~and holiday hours are allowed only as approved in the most current Colorado Works work verification plan submitted and approved by the U.S. Department of Health and Human Services, Office of Family Assistance.~~ ~~6. All cases subject to time limitations shall be included in the denominator for calculating the work participation rate.~~ B. Job Placement Agencies In addition to other categories of expenditures, counties may use Colorado Works funds to provide vouchers for approved job placement agencies. C. Employment Incentives In addition to other categories of expenditures, county departments may provide employment incentives to participants or employers as provided in a county policy.		

		Agencies In addition to other categories of expenditures, counties may use Colorado Works funds to provide vouchers for approved job placement agencies. C. Employment Incentives In addition to other categories of expenditures, county departments may provide employment incentives to participants or employers as provided in a county policy.			

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):

N/A, this is a technical clean-up.

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; PAC; Economic Security Sub-PAC; Colorado Department of Human Services Food & Energy Assistance Division; Colorado Center on Law and Policy; Colorado Legal Services; All Families Deserve a Chance Coalition; 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	February 6, 2020		
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
	12		3
If not presented, explain why.			

PAC

Have these rules been approved by PAC?

[ ] Yes [X] No

Date presented	March 5, 2020		
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.			

Other Comments

Comments were received from stakeholders on the proposed rules:

[ ] Yes [X] 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.

3.604.2
****

R. Penalties for Disqualified and Excluded Persons

7. IF THE CLIENT IS FOUND TO HAVE COMMITTED AN IPV IN ANY OTHER PUBLIC ASSISTANCE PROGRAM, THE CLIENT IS DISQUALIFIED FROM PARTICIPATION IN COLORADO WORKS FOR THE PENALTY PERIODS ASCRIBED TO THOSE VIOLATIONS AND FOR THE SAME TIME PERIOD.

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3.607 ASSESSMENT AND OTHER PROGRAM REQUIREMENTS

3.607.1 Assessment [Rev. eff. 9/15/12]

A. Requirement of Assessment

As a condition of continued eligibility, all work eligible individuals must complete an initial assessment within thirty (30) calendar days from the date the application was submitted. Failure to complete the assessment within thirty (30) calendar days will result in the termination or denial of payment.

B. Complete Assessment

A county department shall perform ~~a~~an skills assessment which shall consist of an evaluation of basic skills, past employment, AND employability~~, educational level, needs of the assistance unit, and other relevant factors~~ for an applicant or participant who is eighteen (18) years of age or older, or who is sixteen (16) years of age or older, but is not yet eighteen (18) years old and has not completed high school or obtained a certificate of high school equivalency, and is not attending high school or a high school equivalency program. Supportive services, other assistance, and/or family needs cash payments shall be based on the results of the assessment. The assessment shall also provide information needed to determine whether an eligible applicant should receive basic cash assistance or a diversion payment. ~~The applicant(s) or participant(s) shall complete the assessment with the county worker responsible for the case maintenance.~~ In addition, updated assessments may be conducted at county department discretion.

****

3.608.1 Workforce Development [Rev. eff. 7/1/15]

B. Requirements for Receipt of Cash Assistance/ Basic Cash Assistance

As a condition of continued eligibility, all assistance units that include an adult member who is receiving basic cash assistance, shall have such adult member in a work activity, either federal or county defined. ~~in Section 3.608.2 "Work Activities."~~ Work Eligible Individuals shall have the work activity(s) outlined in his or her Individualized Plan (IP) in order to receive Colorado Works cash assistance. A single parent with a child(ren) under age six (6) shall be notified in writing of the terms and conditions under which a county determines that child care is unavailable. This notification shall be in written format and shall include the county's definition of the unavailability of child care. This definition must include the criteria listed at Section 3.608.4 "Noncompliance." This notice shall inform an individual of the procedures for applying for and being considered for

an exemption from the work requirements and the procedures for applying for the exemption. The notice shall also include the statement that this exemption does not exempt the single parent from program time limits.

****

3.608.2 Work Activities [Rev. eff. 7/1/15]

A. Engaged in Work Activities
As a condition of continued eligibility, a parent or specified caretaker receiving assistance as an adult is required to engage in one or more ~~of the following~~ work activities ~~or any county-defined work activities.~~ This requirement includes dependent children between the ages of sixteen (16) and eighteen (18) years old who are not attending school. All activities in the Individualized Plan shall relate to the outcome of both initial and ongoing assessments. A parent is required to engage in a work activity and is a mandatory member of the assistance unit. A specified caretaker has the opportunity to be a mandatory member of the assistance unit and, as such, receive a cash payment. As a mandatory member, the specified caretaker must engage in a work activity per the definition of a specified caretaker at Section 3.601 “Program Definitions.”

B. Allowable Work Activities
FEDERAL ~~W~~Work activities are defined IN COLORADO'S FEDERALLY APPROVED WORK VERIFICATION PLAN WHICH CAN BE FOUND AT WWW.COLORADO.GOV/PACIFIC/CDHS/POLICIES-3. ~~as:~~ COUNTY DEFINED WORK ACTIVITIES ARE LISTED IN COUNTY POLICY WHICH CAN BE REVIEWED AT THE COUNTY DEPARTMENT. THESE REGULATIONS ARE ALSO AVAILABLE FOR PUBLIC INSPECTION AND COPYING AT THE COLORADO DEPARTMENT OF HUMAN SERVICES, DIRECTOR OF THE EMPLOYMENT AND BENEFITS DIVISION, 1575 SHERMAN STREET, DENVER, COLORADO, 80203, OR AT ANY STATE PUBLICATIONS LIBRARY DURING REGULAR BUSINESS HOURS.
~~1. Unsubsidized employment - Part-time or full-time employment in the public or private sector that is not subsidized by TANF or other public program.~~
~~2. Subsidized private or public sector employment - Part-time or full-time work with any private or public sector employer for which wages are paid by the employer and for which the employer receives a subsidy; from TANF or other public funds to offset some or all of the wages and costs of employing a recipient.~~
~~3. Work experience - a work activity performed in return for Colorado Works cash assistance payments, that provides an individual with an opportunity to acquire the general skills, training, knowledge and work habits necessary to obtain employment. Work experience assignments must improve the employability of those who cannot find unsubsidized employment.~~
~~4. On-The-Job-Training - training in the public or private sector that is given to a paid employee while he or she is engaged in productive work and that provides knowledge and skills essential to the full and adequate performance of the job.~~
~~5. Job search and job readiness assistance - Job search may be conducted in either a group or individual setting and may include employer contacts either in person, by telephone, or by electronic methods; job readiness assistance includes activities supporting preparation of an individual to seek or obtain employment. This includes activities such as preparing a resume or job application, training in interviewing skills, instruction in work place expectations, as well as life skills training. Substance abuse treatment, mental health treatment, or rehabilitation activities are allowed for those who are otherwise employable. Such treatment or therapy must be determined necessary and certified by a qualified medical or mental health professional.~~
~~6. Community service programs - Structured work programs performed for the direct benefit of the community under the auspices of public or non-profit organizations. Community services~~

~~programs must be limited to projects that serve a useful community purpose in fields such as health, social service, environmental protection, education, urban and rural redevelopment, welfare, recreation, public facilities, public safety, and child care.~~
~~7. Vocational educational training - Organized educational programs that are directly related to the preparation of individuals for employment in current or emerging occupations requiring training.~~
~~8. Child care for community service participants - Providing child care services to an individual who is participating in a community service program. It does not include providing child care to enable a TANF recipient to participate in any of the other ten allowable work activities. Child care provided to individuals in community service must adhere to established child care licensing rules and statutes.~~
~~9. Job skills training directly related to employment - Training and education for job skills required by an employer or to advance or adapt to the changing demands of the workplace, including basic remediation, English as a Second Language, and/or short-term training directly related to local labor market demands.~~
~~10. Education directly related to employment shall be an option only in the case of a participant who has not received a high school diploma or a certificate of high school equivalency. This work activity is used for education courses designed to provide knowledge and skills for specific occupations or work settings and may include adult basic education, English as a Second Language (ESL) and education leading to a General Education Development (GED) or high school equivalency diploma.~~
~~11. Satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence shall be an option only in the case of a participant who has not completed secondary school or received such a certificate. Regular attendance, in accordance with the requirements of the secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate. This activity may not include other related educational activities, such as adult basic education or language instruction.~~
~~a. Full-time attendance in secondary school, vocational or technical school, or cooperative training programs means twenty-five (25) clock hours per week or as defined by the school system.~~
~~b. Part-time attendance means a minimum of twelve hours of school attendance per week, or as defined by the school system.~~

C. Work Activity Outlined in the Individualized Plan

For purposes of meeting the work participation requirements of this section, a Colorado Works participant shall be considered to be engaged in work program requirements if they are participating in the work activities listed in THE WORK VERIFICATION PLAN ~~Section 3.608.2, B,~~ or in any other work activities designed to lead to self sufficiency as determined by the county department and as outlined in their Individualized Plan.

****

3.608.3 Work Participation Rate [Rev. eff. 7/1/15]

A. A separate work participation rate will be established by the State Department based on federal requirements for all families and for two parent families. The rate to be achieved by each county department shall be negotiated and will be included in the annual performance contract.

~~A. Federal Participation Rate Calculations~~

~~A Colorado Works participant is considered to be engaged in work for a month if he or she is participating in the work activities defined in the Work Verification Plan for at least the minimum number of hours per week as required by Federal law. The federal work participation rate guidelines are outlined below:~~

~~1. The federal all families work participation rate requirement is an average of thirty (30) hours per week per calendar month.~~

~~2. The federal two-parent participation rate requirement is an average of thirty-five (35) hours per week if no federally funded child care is provided. If federal child care is provided, the average weekly hours must meet or exceed fifty-five (55) hours per calendar month.~~

~~3. A parent(s) under twenty (20) years of age is considered to be engaged in a work activity if he or she is maintaining satisfactory attendance in high school or GED, or participating in education directly related to employment for an average of at least twenty (20) hours per week during a calendar month.~~

~~4. A single parent with a child(ren) under age six (6) is deemed to be meeting work participation requirements if he or she is engaged in work for an average of twenty (20) hours per week during a calendar month.~~

~~5. Excused absences and holidays will be counted as hours toward the federal work participation rate for only scheduled work activities as outlined in Section 3.608.2, B, and contained in the participant's Individualized Plan. Absences and holiday hours are allowed only as approved in the most current Colorado Works work verification plan submitted and approved by the U.S. Department of Health and Human Services, Office of Family Assistance.~~

~~6. All cases subject to time limitations shall be included in the denominator for calculating the work participation rate.~~

B. Job Placement Agencies In addition to other categories of expenditures, counties may use Colorado Works funds to provide vouchers for approved job placement agencies.

C. Employment Incentives In addition to other categories of expenditures, county departments may provide employment incentives to participants or employers as provided in a county policy.

==========

Notice of Proposed Rulemaking

Tracking number

2020-00095

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

04/10/2020

Time

09:00 AM

Location

303 East 17th Avenue, 11th Floor, Denver, CO 80203

Subjects and issues involved

See attached

Statutory authority

25.5-1-301 through 25.5-1-303, C.R.S. (2019)

Contact information

Name

Chris Sykes

Title

Medical Services Board Coordinator

Telephone

3038664416

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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, April 10, 2020, 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 19-03-12-A, Revision to the Medical Assistance Act Rule concerning Family Planning Services, Section 8.730

Medical Assistance. The rule is being revised to remove the exclusion of spermicide and female condoms from covered family planning services to reflect current Department practice. Spermicide and female condoms are covered per Department of Health and Human Services guidance regarding coverage of contraceptives. The revision also removes the Family Planning Clinic provider type (PT 29), as it is no longer available. The revision also makes miscellaneous revisions to promote rule clarity, including terminology updates and addressing a numbering error.

The authority for this rule is contained in 42 CFR § 440.210 and 25.5-1-301 through 25.5-1-303, C.R.S. (2019).

MSB 19-11-05-A, Revisions to Healthcare Affordability and Sustainability Fee Collection and Disbursement and Creation of Hospital Transformation Program, Section 8.3000

Medical Assistance. The rule change makes necessary revisions for the federal fiscal year (FFY) 2019-20 Hospital Affordability and Sustainability (HAS) provider 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 provider fee to fund Colorado Medicaid and CHP+ expansions and HAS supplemental payments.

The authority for this rule is contained in 42 CFR 433.68 and 42 U.S.C. § 1396b(w); 25.5-4-402.4(4)(g) and sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019).

MSB 19-11-21-A, Revision to the Medical Assistance Act Rule concerning the Children's Habilitation Residential Program (CHRP) waiver, Section 8.500

Medical Assistance. The basis of this rule change is to align the CHRP rules with the waiver amendment approved by the Centers for Medicare and Medicaid Services (CMS) effective January 1, 2020. The purpose is to amend the rule to allow for family members who are not parents or legally

responsible parties to be reimbursed for certain services as specified in the waiver. Additionally, the revision is to make technical changes including updated regulatory citations and spelling errors.

The authority for this rule is contained in Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. § 1396a (2011); 25.5-5-306, C.R.S. and 25.5-6-903 (2018) and 25.5-1-301 through 25.5-1-303, C.R.S. (2019).

MSB 19-12-16-A, Revision to Medical Assistance Rule Concerning Service Plan Authorization Limit (SPAL) Section 8.500.102.B

Medical Assistance. The Department is revising the section of the rule to allow for the addition of Waiver Transition Services to the existing list of services which are exempt from the service plan authorization limit (SPAL) for Supported Living Services. The Department sought and ultimately received legislative approval through House Bill 18-1326 to include four transition services in six Home and Community Based Service (HCBS) waiver programs, with the necessary funds appropriated, starting January 1, 2019. These services are excluded from the SPAL therefore the rules implementing the program 10 CCR 2505-10 8.500.102 must be revised.

The authority for this rule is contained in 25.5-6-1501, C.R.S. (2019) and sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019).

MSB 20-01-14-A, Revision to the Medical Assistance Payments for Outpatient Hospital Services Rule Concerning Drug Payment Reweighting, Section 8.300.6

Medical Assistance. The Department has received feedback from its Critical Access and Medicare Dependent Hospital stakeholder community that Medicaid payments for drugs do not adequately align with the drug costs. After analysis, the Department has determined that costs for drugs for such hospitals are higher than their urban counterparts which the current payment methodology which is not properly account for. Therefore, a rule is being added to 10 C.C.R. 2505-10 Section 8.300.6 which will allow increased Medicaid reimbursement for drugs for Critical Access and Medicare Dependent Hospitals. Since this is a budget neutral change, Medicaid reimbursement for outpatient hospital drugs at urban non-independent hospitals will be decreased.

The authority for this rule is contained in 24-4-103(6) (2019); 25.5-4-402.4(5)(b)(I) (2019) and 25.5-1-301 through 25.5-1-303, C.R.S. (2019).

Permanent Rules Adopted

Department

Department of Revenue

Agency

Colorado Racing Commission

CCR number

1 CCR 208-1

Rule title

1 CCR 208-1 RACING 1 - eff 05/15/2020

Effective date

05/15/2020

Statement of Authority, Basis and Purpose
of Amendment of Regulation

1 CCR 208-1

Chapter 1 -- Definitions

Basis and Purpose:

To define the meaning of "Digital Tattoo" and to clearly explain that an RFID microchip alone is not sufficient to be accepted as a digital tattoo; the chip must be inspected and certified by an appropriate agent and the agent must have uploaded sufficient documentation as required by the appropriate breed registry.

This rule is recommended by the Director under her statutory responsibility to do so for the improvement and conduct of racing in Colorado. This rule is within the authority of the Commission to promulgate reasonable rules for control of licensees and the successful operation of race meets.

CHAPTER 1 DEFINITIONS

The following definitions are interpretations of racing, pari-mutuel and simulcast wagering terms and are to be considered as part of these rules and regulations.

DIGITAL TATTOO – A radio-frequency identification (RFID) microchip implant inserted under the skin of an animal that has been inspected and certified by the Thoroughbred Racing Protective Bureau and digitally documented with information about the animal that may be used to positively identify the animal.

Statement of Authority, Basis and Purpose
of Amendment of Regulation

1 CCR 208-1

Rule #3.419

Basis and Purpose:

To ensure that all vehicles and their owners entering the restricted stable area at a race track are known to the Division and so that the Division may take action against an owner who has parked their vehicle in a manner that is considered an obstacle to the flow of both horse and other vehicle traffic or has parked in a location that is otherwise prohibited by the racing association.

This rule is recommended by the Director under her statutory responsibility to do so for the improvement and conduct of racing in Colorado. This rule is within the authority of the Commission to promulgate reasonable rules for control of licensees and the successful operation of race meets.

3.419 - All motor vehicles entering the restricted area at a racetrack must be registered with the Division and must display the Division-issued proof of registration in the upper left corner of the vehicle's windshield. The owner-licensee of any motor vehicle not displaying the Division-issued proof of registration may be subject to administrative action.

Statement of Authority, Basis and Purpose
of Amendment of Regulation

1 CCR 208-1

Rule #3.656

Basis and Purpose:

To prevent jockey agents, whether intentionally or unintentionally, from controlling the entering process in any manner that may favor the agent or a jockey the agent represents.

This rule is within the authority of the Commission to promulgate reasonable rules for control of licensees and the successful operation of race meets.

3.656 - A jockey agent shall not be named by another as a person authorized to enter a horse into a race. If a jockey agent is permitted to enter a horse, the jockey agent, the entry clerk, the trainer and/or owner may all be subject to administrative action.

Statement of Authority, Basis and Purpose
of Amendment of Regulation

1 CCR 208-1

Rule #4.622

Basis and Purpose:

To align with recent trends in the racing industry to move to a digital identification system for race horses that will replace the old method of checking lip tattoos against paper records.

This rule is recommended by the Director under her statutory responsibility to do so for the improvement and conduct of racing in Colorado. This rule is within the authority of the Commission to promulgate reasonable rules for control of licensees and the successful operation of race meets.

4.622 - A horse will not be allowed to start unless the horse is identified from its original or duplicate foal certificate and either lip tattooed or digitally tattooed by an official tattooer for the appropriate breed registry.

Statement of Authority, Basis and Purpose
of Amendment of Regulation

1 CCR 208-1

Rule #5.246

Basis and Purpose:

To update the current rule to conform to track and breed registry practice.

This rule is recommended by the Director under her statutory responsibility to do so for the improvement and conduct of racing in Colorado. This rule is within the authority of the Commission to promulgate reasonable rules for control of licensees and the successful operation of race meets.

5.246 - A horse competing in time trials that has posted one of the fifteen (15) fastest times may not be removed from the stable area without written permission from the Board and the Racing Secretary, obtained at least thirty (30) minutes prior to the horse's recorded departure time. If the horse is removed without permission or is removed with permission but without the Board granting continued eligibility, it shall become ineligible, barred from further participation in that race series and any fee paid for entry and/or participation in the time trials and/or race series shall be forfeited. The Board and the Racing Secretary may decline to grant permission for any reason and may set a date whereby permission shall not be granted, so long as at least fifteen (15) days of notice have been given to the horsemen.

Statement of Authority, Basis and Purpose
of Amendment of Regulation

1 CCR 208-1

Rule #9.202

Basis and Purpose:

To officially recognize the Colorado Arabian Breeders Alliance as the official registry for Colorado-bred Arabian racehorses.

This rule is within the authority of the Commission to promulgate reasonable rules for the control, supervision and direction of licensees. This rule removes a defunct organization as the official breed registry and officially recognizes a new, operational organization as the breed registry.

9.202 - The Colorado Thoroughbred Breeders Association will act as the official registry for Colorado bred thoroughbred horses. The Rocky Mountain Quarter Horse Association will act as the official registry for Colorado bred Quarter horses. The Colorado Appaloosa Racing Association will act as the official registry for Colorado bred appaloosa horses. The Rocky Mountain Paint Racing Club will act as the official registry for Colorado bred paint horses. The Colorado Arabian Breeders Alliance will act as the official registry for Colorado bred Arabian horses.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

STATE OF COLORADO
DEPARTMENT OF LAW

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Office of the Attorney General

Tracking number: 2019-00769

Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado Racing Commission

on 02/11/2020

1 CCR 208-1

RACING

The above-referenced rules were submitted to this office on 02/26/2020 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.

February 28, 2020 10:01:27

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Education

Agency

Colorado State Board of Education

CCR number

1 CCR 301-111

Rule title

1 CCR 301-111 Rules for the Administration of the School Leadership Pilot Program 1 - eff 04/01/2020

Effective date

04/01/2020

DEPARTMENT OF EDUCATION

Colorado State Board of Education

RULES FOR THE ADMINISTRATION OF THE SCHOOL LEADERSHIP PILOT PROGRAM

1 CCR 301-111

1.00 STATEMENT OF BASIS AND PURPOSE

Section 22-13-201, et seq. C.R.S., creates the School Leadership Pilot Program. The program provides embedded, experiential professional development to a cohort of school principals to improve the quality of school principals and empower them to exercise distributive and collaborative leadership that supports collaboration among the professional educators in the building. Pursuant to statute, the Colorado Department of Education designs and implements the program.

The statutory authority for these rules is found in section 22-13-203(3), C.R.S., which requires the State Board to adopt rules regarding time frames, procedures, and content for program applications.

2.0 DEFINITIONS

2.1 "Department" means the Department of Education created and existing pursuant to section 24-1-115, C.R.S.

2.2 "Program" means the School Leadership Pilot Program created in section 22-13-203, C.R.S.

2.3 "Public school" means a school that derives its support, in whole or in part, from money raised by a general state or school district tax and includes a school of a school district, a public school operated by a board of cooperative services, and an institute charter school authorized by the State Charter School Institute pursuant to part 5 of Article 30.5 of Title 22.

2.4 "School principal" means an individual who is employed as the chief administrative officer of a public elementary, middle, or high school in Colorado.

2.5 "State Board" means the state board of education created in Section 1 of Article IX of the State Constitution.

3.0 APPLICATIONS

School principals who seek to receive training through the program must submit an application to the Department.

3.1 Application timeline

3.01(1) The Department will make the application form available to applicants by February 2020.

3.01(2) Applications must be submitted to the Department by April 30, 2020.

3.01(3) The Department will notify all applicants as to whether they have been selected to receive professional development through the program for the 2020-21 and 2021-22 budget years no later than May 31, 2020.

3.01(4) The Department will begin implementation of the program no later than July 2020.

3.2 Application contents

3.02(1) The Department will develop a program application form. Each application must specify:

3.02(1)(a) Applicant name

3.02(1)(b) Race

3.02(1)(c) Gender

3.02(1)(d) School at which the applicant serves as a school principal

3.02(1)(e) School level and type (e.g. elementary, K-8, middle, high, Alternative Education Campus)

3.02(1)(f) District in which applicant is employed

3.02(1)(g) Years of school leadership experience

3.02(1)(h) District setting (urban, suburban, rural) as determined by the Department and outlined in the application materials.

3.02(1)(i) School Performance Framework rating for school at which the applicant serves as a school principal

3.02(2) In addition to the information in Rule 3.02(1), each application must include open-ended questions developed by the Department, which address school leadership topics, including but not limited to:

3.02(2)(a) Cohort learning

3.02(2)(b) Positive climate and culture

3.02(2)(c) Distributive leadership

3.02(2)(d) Daily workload and priorities

3.02(2)(e) Increased student academic outcomes

3.02(2)(e)(i) For elementary or K-8 school principals, increased student academic outcomes in reading proficiency

3.02(2)(f) Teacher retention 3.02(2)

(g) Self-reflection and feedback

3.02(3) Documented evidence that the applicant's employer and building staff support the applicant's participation in the School Leadership Pilot Program.

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: 2019-00731

Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado State Board of Education

on 02/12/2020

1 CCR 301-111

RULES FOR THE ADMINISTRATION OF THE SCHOOL LEADERSHIP PILOT PROGRAM

The above-referenced rules were submitted to this office on 02/14/2020 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.

February 19, 2020 09:00:32

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Securities

CCR number

3 CCR 704-1

Rule title

3 CCR 704-1 RULES UNDER THE COLORADO SECURITIES ACT 1 - eff 03/30/2020

Effective date

03/30/2020

DEPARTMENT OF REGULATORY AGENCIES

Division of Securities

RULES UNDER THE COLORADO SECURITIES ACT

3 CCR 704-1

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

CHAPTER 1 (Reserved for future use)

CHAPTER 2 DEFINITIONS AND FEDERAL COORDINATION

51-2.1 The following terms as used in these Rules, unless the context otherwise requires, are defined:

A. "Commissioner" or "Securities Commissioner" means the Colorado Securities Commissioner.

B. "Confidential Personal Information" shall mean a first name or first initial and last name in combination with any one or more of the following data elements:

(1) Social Security number;

(2) Driver's license number or identification card number;

(3) Account number or credit or debit card number, in combination with any required security code, access code, or password that would permit access to a resident's financial account;

(4) Individual's digitized or other electronic signature; or

(5) User name, unique identifier or electronic mail address in combination with a password, access code, security questions or other authentication information that would permit access to an online account.

"Confidential Personal Information" does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records or widely distributed media.

C. "CRD" means the Central Registration Depository of the Financial Industry Regulatory Authority, Inc. and the North American Securities Administrators Association, Inc. The CRD address is P.O. Box 9401, Gaithersburg, MD 20898-9401.

D. "Division" means the Colorado Division of Securities, 1560 Broadway, Suite 900, Denver, CO 80202.

E. "NASAA" means the North American Securities Administrators Association, Inc.

F. "FINRA" means the Financial Industry Regulatory Authority.

G. "SEC" means the federal Securities and Exchange Commission.

H. "33 Act" means the federal Securities Act of 1933 and the Rules and regulations promulgated thereunder.

I. "34 Act" means the federal Securities Exchange Act of 1934 and the Rules and regulations promulgated thereunder.

J. "Mortgage broker-dealer" means a "broker-dealer" other than a broker-dealer registered under the 34 Act whose business is limited exclusively to effecting transactions in notes, bonds or evidences of indebtedness secured by mortgages or deeds of trust upon real estate.

K. "Mortgage sales representative" means a "sales representative" who represents a mortgage broker-dealer.

L. "40 Act" means the federal Investment Advisers Act of 1940 and the Rules and regulations promulgated thereunder.

M. "IARD" means the Investment Adviser Registration Depository of the federal Securities and Exchange Commission and the North American Securities Administrators Association, Inc., as maintained by the Financial Industry Regulatory Authority, Inc. The IARD address is 9509 Key West Avenue, Rockville, Maryland 20850.

51-2.1.1 Pursuant to the authority of the Securities Commissioner provided at section 11-51-201(2)(d), C.R.S., "broker-dealer" as defined at section 11-51-201(2), C.R.S., does not include:

A. A person who is resident in Canada, has no office or other physical presence in this state, and complies with the following conditions:

1. Only effects or attempts to effect transactions in securities

a. With or through the issuers of securities involved in the transactions, broker-dealers, banks, savings institutions, trust companies, insurance companies, investment companies (as defined in the federal Investment Company Act of 1940), pension or profit-sharing trusts, or other financial institutions or institutional buyers, whether acting for themselves or as trustees;

b. With or for a person from Canada who is present temporarily in this state, with whom the Canadian person had a bona fide business relationship before the person entered this state, or

c. With or for a person from Canada who is present in this state, whose transactions are in a self-directed tax advantaged retirement plan in Canada of which the person is the holder or contributor; and

2. Files a notice in the form of his current application required by the jurisdiction in which the head office of such person is located and a consent to service of process;

3. Is a member of a self-regulatory organization or stock exchange in Canada;

4. Maintains the provincial or territorial registration and membership in a self-regulatory organization or stock exchange of such person in good standing;

5. Discloses to the clients of such person in this state that such person is not subject to the full regulatory requirements of the Colorado Securities Act; and

6. Is not in violation of section 11-51-501(1), C.R.S.

B. A person who acts as a business broker with respect to a transaction involving the offer or sale of all of the stock or other equity interests in any closely held corporation or limited liability company provided that such stock or other equity interest is sold to no more than one person, as that term is defined in the Act.

51-2.2 SEC Amendments Coordinated

A. If any SEC Rule or regulation incorporated in these Rules is amended by the SEC subsequent to the date the Colorado Rule was adopted, pursuant to section 11-51-202, C.R.S., such subsequent amendment may apply to the Rule provided that the Securities Commissioner does not commence Rule making proceedings within ninety (90) days of the effective date of any such amendment.

B. Information concerning any SEC Rule or regulation incorporated in these Rules may be obtained from:

Deputy Securities Commissioner 1560 Broadway, Suite 900 Denver CO 80202

CHAPTER 3 REGISTRATION OF SECURITIES AND EXEMPTIONS

51-3.1 Registration by Coordination.

Preliminary Note: Securities for which a registration statement has been filed under the federal "Securities Act of 1933" or any securities for which filings have been made pursuant to the SEC's regulation A may be registered by coordination in Colorado. Various sections of the Colorado Securities Act, these Rules, and certain NASAA forms require a person seeking registration by coordination to file with the Securities Commissioner certain documents that are submitted to the SEC. The Division finds that the duplicative filing of such documents increases offering costs and harms the environment, and, therefore, not requiring these paper filings is in the public interest.

A. Filing Information

1. When securities are registered by coordination under Section 11-51-303, C.R.S., any document filed with the SEC in connection with such offering shall be considered filed with the Securities Commissioner when such document is received by the SEC.

2. Application for registration by coordination in the State of Colorado is made by filing the NASAA Form U-1 and the documents required by it, along with the information required for registration by coordination under section 11-51-303(1)(a) and (b)(I)-(III), C.R.S.

3. The application for registration by coordination shall also include a specimen, copy, or detailed description of the security to be offered and sold. The description shall include details of all terms and conditions to which the security, or its holder, are subject.

4. A person seeking registration by coordination shall also file a Consent to Service of Process on the NASAA Form U-2 (see Rule 51-7.1) with the Securities Commissioner, along with a filing fee as specified by the Securities Commissioner.

B. Effective Date

1. A registration statement required to be filed with the Securities Commissioner in connection with a registration by coordination is considered effective simultaneously with or subsequent to the registration statement filed with the SEC when the following conditions are satisfied:

   a. A stop order issued under sections 11-51-303(4) or 11-51-306, C.R.S., or a stop order issued by the SEC, is not in effect, and a proceeding is not pending against the person seeking registration by coordination under section 11-51-410, C.R.S.; and

   b. The complete registration statement has been on file with the Securities Commissioner for a period of at least ten (10) days.

2. The person seeking registration by coordination shall promptly notify the Securities Commissioner of the date when the registration statement filed with the SEC becomes effective, and the content of any price amendment. The notification containing the price amendment shall be promptly filed with the Securities Commissioner, and if not timely filed, the Securities Commissioner may, without prior notice or hearing, issue a stop order under section 11-51-306, C.R.S., which stop order shall retroactively deny the effectiveness of the registration statement, or suspend the effectiveness of the registrations statement until the person seeking registration complies with the conditions in this Rule 51-3.1.

3. The Securities Commissioner shall promptly notify the person seeking registration of a stop order by telegram, telephone, facsimile, or other electronic means, and shall maintain evidence that such notification was given in the form of a certificate or affidavit of service or other appropriate document.

4. In the event the person seeking registration complies with the notice requirements of this Rule 51-3.1.B. subsequent to entry of a stop order, the stop order shall become void as of the date of its issuance.

5. In the event the Securities Commissioner intends to institute a proceeding for a stop order under section 11-51-306, C.R.S., in connection with the registration statement, the Securities Commissioner shall notify the person seeking such registration. Evidence of such notice by the Securities Commissioner may include a certificate or affidavit of service, or other appropriate documentary evidence.

C. Amendments

Any amendments to the federal prospectus filed with the Securities Commissioner pursuant to section 11-51-303(2) shall be made by filing an amended Form U-1 and an amended registration statement. The amendment becomes effective when the amended registration becomes effective with the SEC and any requirements of this Rule 51-3.1 have been satisfied. Such amendment shall also contain any post-effective amendments to such SEC registration that would result in net proceeds from the sale of registered securities that are subject to the escrow requirements of section 11-51-302(6), C.R.S. and Rule 51-3.4.

D. Closing Report

Within 30 days of the close of the offering or the termination of the registration statement, whichever occurs first, the registrant shall file with the Securities Commissioner a closing report. The closing report shall be filed on the Division’s Form RC-C.

E. Designees

At such time as the Securities Commissioner authorizes the electronic filing of registration statements, the Securities Commissioner may designate other persons or entities to receive filings on behalf of the Division under this Rule 51-3.1, including but not limited to, applications, registration statements, and fees. Any such designation shall be for the sole purpose of receiving such filings and transmitting those documents to the Division.

F. Prompt filing; Notification

1. For purposes of this Rule 51-3.1, when an act is required to be done “promptly,” or any person is required to “promptly file” or “promptly notify,” such terms shall mean within five (5) business days of the date the action was taken or order entered.

2. Methods of “notification,” as required by this Rule 51-3.1, may include certified or registered mail, telegram, telephone, facsimile, e-mail, or other electronic means. The person sending any required notification shall assure receipt of such notification by retaining all necessary documents reflecting that the notice was sent and received, including preparing and maintaining a certificate or affidavit of service, with appropriate documentation attached.

51-3.2 Registration by Qualification

A. An application for registration of an offering of securities by qualification pursuant to section 11-51-304(2), C.R.S., is made by filing with the Securities Commissioner Form RQ, and a registration statement as required by said section. Pursuant to section 11-51-302(4), C.R.S., the Securities Commissioner will permit public offerings made under Rule 504 of the SEC to apply for registration on Form U-7 (Registration Form for Small Corporate Offerings), provided that the form is completed and there is full compliance with all of the form's requirements, conditions and limitations.

B. A person seeking registration by qualification must also file a Consent to Service of Process form (see Rule 51-7.1) with the Securities Commissioner.

51-3.3 Limited Offering Registration

A. An application for registration of a limited offering of securities under section 11-51-304(6), C.R.S., is made by filing with the Securities Commissioner a registration statement on Form RL.

B. A person seeking registration by qualification under section 11-51-304(6), C.R.S., must also file a Consent to Service of Process form (see Rule 51-7.1) with the Securities Commissioner.

51-3.4 Escrow and Release of Funds under Section 11-51-302(6), C.R.S.

A. For the purposes of section 11-51-302(6), C.R.S.:

1. “Committed for use” means an identification of general or specific purposes for which specific portions of the net proceeds from the offering are intended in good faith to be used in the manner and within the time specified in the registration statement. Nothing contained herein shall preclude the issuer from making a good faith reallocation of anticipated expenditures of the net proceeds within the categories specified in the registration statement, or an allocation to new categories not reasonably anticipated at the date the registration statement was declared effective.

2. “Completion of a transaction or series of transactions” means the closing or other completion of substantially all of the material obligations, but for the actual conveyance of escrow funds, of all parties to one or more agreements between an issuer subject to the escrow requirements of section 11-51-302(6), C.R.S., and one or more other persons by which the issuer obtains interests in one or more specific lines of business.

3. “Improper release” means any release by a depository of escrowed funds without certification to the depository by the issuer that the requirements for such release under subsections 11-51-302(6)(a)(I) and (II), C.R.S., are satisfied, and where, in fact, such requirements are not satisfied at the time of the release, unless the depository is in receipt of a notification from the Securities Commissioner that the release prior to the expiration of the time period specified in section 11-51-302(6)(a)(II), C.R.S., is permissible.

4. “Net proceeds” means the gross proceeds less selling and organizational costs.

5. “Selling and organizational costs” means all expenses incurred by the issuer within twelve (12) months prior to the date of effectiveness of the registration in Colorado and those reasonably anticipated to be incurred within six (6) months after the date in connection with:

    a. the issuance and distribution of the securities to be registered in the offering, including, but not limited to, registration and filing fees, printing and engraving expenses, accounting and legal fees and expenses, “blue sky” fees and expenses, transfer and warrant agent fees, expenses of other experts, and underwriting discounts and commissions; and

    b. the organization of the issuer and the preparation of the organizational documents, including, but not limited to, filing fees, and legal, accounting, and tax planning fees and expenses, provided that said expenses are to be paid out of the proceeds of the offering.

6. “Specific line of business” means any commercial, industrial or investment activity that is generally recognized as a distinct economic undertaking or enterprise intended to generate a profit for the issuer. Although certain characteristics may commonly be used to assist in determining whether a specific line of business has been so identified, no single characteristic is determinative in all cases. The determination whether a specific line of business has been identified depends on the Securities Commissioner's review of the facts and circumstances of each case and the Commissioner's determination as to whether the management of the issuer has acted in good faith.

B. To comply with the escrow requirements of section 11-51-302(6), C.R.S., an issuer, or one or more broker-dealers or sales representatives acting on behalf of such issuer, shall deliver at least eighty percent (80%) of the net proceeds received from the offering of securities to an unaffiliated depository to be held in accordance with section 11-51-302(6), C.R.S., until completion of a transaction or series of transactions in which at least fifty percent (50%) of the gross proceeds is committed to a specific line of business. If such transactions have not been completed within two (2) years from the date of effectiveness of the offering in Colorado, the funds shall be distributed to the then security holders of record of the securities sold pursuant to the registered offering (except warrants or other rights to subscribe to or purchase other securities) unless said security holders have approved by majority vote the renewal of the escrow not to exceed one year. The escrow agreement may be renewed in subsequent years by means of the same procedure. The Commissioner shall not be a party to an escrow agreement, but an executed or conformed copy of the escrow agreement shall be provided to the Commissioner.

1. In any instance where the escrow of the proceeds of sale of securities is required pursuant to section 11-51-302(6), C.R.S., the escrow shall be evidenced by a written agreement between the issuer (as depositor) and an unaffiliated depository, and other interested parties.

2. Each agreement for the establishment of an escrow shall include:

    a. The date of the agreement;

    b. The names and addresses of the issuer, the depository, and any other parties to the agreement;

    c. The terms of the escrow, including a specific reference to section 11-51-302(6), C.R.S.;

    d. The conditions under which the escrowed funds are to be released to the issuer or are to be distributed, and by whom and in what manner such distribution is to be effected;

    e. Whether the escrowed funds will earn interest, and if so, a description of the manner in which interest accrued on the escrowed funds will be used or otherwise distributed; and

    f. A statement that the proceeds of the escrow may not be released to the issuer until the lapse of more than nine (9) days after the receipt by the Commissioner of notice of the proposed release of funds from such escrow or upon authorization of the Commissioner of any earlier release.

3. The Commissioner may, in his sole discretion, authorize release of funds escrowed pursuant to section 11-51-302(6), C.R.S., prior to the lapse of nine (9) days after receipt by the Commissioner of the notice provided in paragraph C. below. In such cases, the

Commissioner shall provide the issuer with such authorization in writing in a form that may be presented to the depository.

C. A notice of proposed release of funds from escrow under section 11-51-302(6), C.R.S., shall be filed with the Commissioner on Form ES. Proof of filing of the Form ES with the Commissioner may be established by a receipt or other writing upon which the Commissioner, by stamp or other writing, evidences that the Form ES was received.

D. The notice shall contain, at a minimum, the following information:

1. The gross amount of aggregate proceeds received from the sale of any and all of the securities registered in this offering;

2. Whether the offering has closed;

3. Whether any additional funds may be received by the issuer in exchange for securities issued in the offering;

4. Whether a transaction or series of transactions has been completed which commit(s) at least fifty percent (50%) of the gross amount of aggregate proceeds for use in one or more specific lines of business;

5. A description of each transaction, including the dates of each transaction, the parties to each transaction, the amount committed in each transaction, a description of how the proceeds are to be spent under the terms of each transaction, and the specific lines of business; and,

6. Any additional information the Securities Commissioner may require as material to the Commissioner's determination.

51-3.5 (Repealed)

51-3.6 Required Filings for Exemption for Certain Non-Issuer Distributions under Section 11-51-308(1)(b)(V), C.R.S.

The information that must be filed with the Securities Commissioner in order for the transactional securities registration exemption provided by section 11-51-308(1)(b)(V), C.R.S., for a non-issuer distribution of the outstanding securities of an issuer to apply shall be filed by the issuer on Form ST.

51-3.7 Notification of Exemption under Section 11-51-308(1)(p), C.R.S., for Certain Securities or Transactions Exempt from Registration under the 33 Act

A. The notification of exemption required under section 11-51-308(1)(p), C.R.S., is made by filing with the Securities Commissioner, or his or her designee, the forms which must be filed with the SEC pursuant to Rules and regulations promulgated under the 33 Act in connection with reliance on a securities or transactional exemption from registration created by said Rules or regulations under the 33 Act relevant to the Colorado exemption, and by paying a filing fee.

B. The required filings must be made with the Securities Commissioner no later than the time when such filings in connection with the federal exemption would have to be made with the SEC. Any filing required under (A), and any amendment required under (C) or (D), must be submitted to the Securities Commissioner through the Electronic Filing Depository (EFD) operated by NASAA, and must comply with the following;

1. All filing fees shall likewise be submitted through EFD;

2. A person duly authorized by the issuer shall affix his or her electronic signature to the Form D filing by typing his or her name in the appropriate fields and submitting the filing through the EFD, which shall constitute irrefutable evidence of legal signature by the individual whose name is typed on the filing; and

3. The electronic filing of documents and the collection of related filing fees shall not be required until such time as the EFD system provides for receipt of such filings and fees. Any documents or fees required to be filed with the Securities Commissioner that are not permitted to be filed with, or cannot be accepted by, the EFD system shall be filed directly with the Securities Commissioner.

C. An issuer may file an amendment to a previously filed notice of sales on Form D at any time.

D. An issuer must file an amendment to a previously filed notice of sales on Form D for an offering:

1. To correct a material mistake of fact or error in the previously filed notice of sales on Form D, as soon as practicable after discovery of the mistake or error;

2. To reflect a change in the information provided in the previously filed notice of sales on Form D, as soon as practicable after the change, except that no amendment is required to reflect a change that occurs after the offering terminates or a change that occurs solely in the following information:

   a. The address or relationship of the issuer of a related person identified in response to Item 3 of the notice of sales on Form D;

   b. An issuer's revenues or aggregate net asset value;

   c. The minimum investment amount, if the change is an increase, or if the change, together with all other changes in that amount since the previously filed notice of sales on Form D, does not result in a decrease of more than ten percent;

   d. Any address or state(s) of solicitation shown in response to Item 12 of the notice of sales on Form D;

   e. The total offering amount, if the change is a decrease, or if the change, together with all other changes in that amount since the previously filed notice of sales on Form D, does not result in an increase of more than ten percent;

   f. The amount of securities sold in the offering or the amount remaining to be sold;

   g. The number of non-accredited investors who have invested in the offering, as long as the change does not increase the number to more than thirty-five;

   h. The total number of investors who have invested in the offering;

   i. The amount of sales commissions, or use of proceeds for payment to executive officers, directors or promoters, if the change is a decrease, or if the change, together with all the other changes in that amount since the previously filed notice of sales on Form D, does not result in an increase of more than ten percent; and

3. Annually, on or before the first anniversary of the filing of the notice of sales on Form D or the filing of the most recent amendment to the notice of sales on Form D, if the offering is continuing at that time.

E. An issuer that files an amendment to a previously filed notice of sales on Form D must provide current information in response to all requirements of the notice of sales on Form D regardless of why the amendment is filed.

51-3.8 Multijurisdictional Disclosure Statement ("MJDS")

A. Canadian registration statements filed with the Securities and Exchange Commission on forms designated as Form F-7, F-8, F-9 or F-10 by the SEC may be filed with the Securities Commissioner as registration statements under section 11-51-303, C.R.S. For those offerings for which a registration statement has been filed with the Securities Commissioner on the Form F-7, F-8, F-9 or F-10, the registration statement will take effect upon effectiveness with the SEC pursuant to section 11-51-303, C.R.S.

B. Financial statements and financial information which have been prepared in accordance with Canadian generally accepted accounting principles, consistently applied, and contained in a registration statement which has been filed with the Securities Commissioner on Form F-7, F-8, F-9, or F-10, will be accepted without reconciliation with U.S. generally accepted accounting principles.

C. The Commissioner will accept Form F-7 in lieu of any form that may be required to be filed by the Colorado Securities Act to claim an exemption for any transaction pursuant to an offer to existing security holders of the issuer making the Rights Offering under a Multijurisdictional Disclosure Statement.

D. The Commissioner exempts from registration any non-issuer transaction, whether or not effected through a broker-dealer, involving any class of an issuer's security where the issuer has filed with the Commissioner a registration statement on Form F-8, F-9, or F-10 that is effective.

51-3.9 Transactional Securities Exemption for Non-Issuer Distribution of Outstanding Security

For the purposes of section 11-51-308(1)(b)(I), C.R.S., the following manuals are recognized:

A. Mergent Industrial Manual;

B. Mergent Municipal and Government Manual;

C. Mergent Transportation Manual;

D. Mergent Public Utility Manual;

E. Mergent Bank and Finance Manual;

F. Mergent OTC Industrial Manual;

G. Mergent International Manual;

H. OTC Markets Group Inc. (with respect to securities included in the OTCQX and OTCQB markets).

I. Periodic supplements to each recognized securities manual.

51-3.10 Exemption for Oil and Gas Auctions

The offer and sale by auction of interests in or under oil, gas or mining leases, fees, or titles, including real property from which the minerals have not been severed, or contracts relating thereto, are transactions in securities exempted from the securities registration requirements of the Colorado Securities Act, provided as follows:

A. This transactional exemption applies only to:

1. transactions in those securities within the meaning of the clause “interests in or under oil, gas or mining leases, fees, or titles, including real property from which the minerals have not been severed, or contracts relating thereto,” as contained in the definition of “security” provided at section 11-51-201(17), C.R.S., (hereinafter described as “interests”), and

2. offers and sales of such interests that are not part of an offering or other distribution by an issuer of said interests and are not being made for the benefit of an issuer or any affiliate of an issuer of the interests.

B. All offers and sales by auction of the interests are conducted by a Colorado licensed broker-dealer registered with the SEC as a broker and dealer and a member of FINRA.

C. The purchaser at auction of such interests either must be engaged in the business of oil and gas exploration or production, or must be an “accredited investor” as defined in Regulation D, promulgated by the SEC under section 3(b) of the 33 Act.

D. The transactional securities registration exemption shall apply only to those interests that the seller acquired for investment purposes and not those acquired with the intention of reselling, unless the seller was forced to acquire the interests in a package in order to obtain other properties in the package.

E. The interests being auctioned are not “fractionalized” or converted into undivided interests in the interest for the purpose of resale at auction. The seller is required to offer its entire ownership of the interest being offered for sale; however, the seller shall not be considered to be fractionalizing its interest in sales where the seller horizontally severs the property by retaining all of its existing rights in certain formations or depths under the whole property. There must be only one purchaser for each interest offered and sold.

F. With respect to each interest offered or sold at auction, the seller must make available to the prospective and actual purchaser(s) of said interest all material information regarding said interests.

G. The seller or the broker-dealer/auction company must record, or in the alternative, must deliver to the purchaser the documents or notices necessary for the purchasers themselves to record, evidence of lawful conveyance of said interests to the purchaser. All payments for properties shall be made by the purchasers to an independent bank that shall act as escrow agent for the proceeds of the sales.

H. The only compensation received by the broker-dealer is a commission based on the sales of the interests.

51-3.11 Unavailability of Exemptions for Certain Issuers

The exemptions specified at section 11-51-308(1)(i), (1)(j), or (1)(p), C.R.S., are unavailable if the issuer, any of its predecessors, or any of the issuer's directors, officers, general partners, beneficial owners of ten percent or more of any class of its equity securities, or any of its promoters then presently connected with the

issuer in any capacity has been convicted within the past ten years of any felony in connection with the purchase or sale of any security.

51-3.12 Transactional Securities Registration Exemption for Securities Issued Pursuant to Court or Governmental Order

The offer and sale of securities in exchange for bona fide claims or property interests within or from this State made pursuant to a final judgment or order, in either event no longer subject to appeal, of a federal or state court of competent jurisdiction or other governmental authority expressly authorized by law are transactions in securities exempted from the securities registration requirements of the Colorado Securities Act, provided as follows:

A. The terms and conditions of such offers and sales are approved by said court or governmental authority; and

B. The final judgment or order was issued after reasonable notice and opportunity to be heard is given to all interested parties.

51-3.13 Transactional Securities Registration Exemptions under section 11-51-308(1)(p)

A. The exclusion of Regulation A from the registration exemption in 11-51-308(1)(p) shall only apply to Tier 1 offerings. The following provisions apply to offerings made under Tier 2 of federal Regulation A and Section 18(b)(3)of the Securities Act of 1933:

    1. Initial filing. An issuer planning to offer and sell securities in this state in an offering exempt under Tier 2 of federal Regulation A shall submit the following at least 21 calendar days prior to the initial sale in this state:

        a. A completed Regulation A – Tier 2 notice filing form or copies of all documents filed with the Securities and Exchange Commission;

        b. A consent to service of process on Form U-2 if not filing on the Regulation A – Tier 2 notice filing form; and

        c. The filing fee prescribed by the securities commissioner.

    2. The initial notice filing is effective for twelve months from the date of the filing with this state.

B. For each additional twelve-month period in which the same offering is continued, an issuer conducting a Tier 2 offering under federal Regulation A may renew its notice filing by filing the following on or before the expiration of the notice filing:

    1. The Regulation A – Tier 2 notice filing form marked “renewal” and/or a cover letter or other document requesting renewal; and

    2. The renewal fee prescribed by the securities commissioner to renew the unsold portion of securities for which a filing fee has previously been paid.

C. An issuer may increase the amount of securities offered in this state by submitting a Regulation A – Tier 2 notice filing form marked “amendment” or other document describing the transaction and a fee prescribed by the securities commissioner.

51-3.14 Securities Registration Exemption for Securities Issued by Persons Organized for Religious. Educational, Benevolent or Charitable Purposes

Any security issued by a person organized and operated not for private profit but exclusively for religious, educational, benevolent or charitable purposes shall be exempt from the securities registration requirement of the Colorado Securities Act (“Act”) provided as follows:

A. The issuer has not defaulted during the current fiscal year and within the three preceding fiscal years in the payment of principal, interest or dividends on any security or debt of the issuer (or any predecessor of the issuer) with a fixed maturity or a fixed interest or dividend provision:

B. The issuer‘s total debt service, after completion of the offering, does not exceed 35 percent of the issuer‘s gross revenues for the previous full fiscal year or the previous twelve months. The total debt service of the first two years may be lower than later years of debt service payments provided the

lowest payment is equal to at least interest on the debt and the greatest payment does not exceed a payment amount that is 10 percent higher than the straight line method of payment, using the same total number of years; and

C. The issuer‘s debt is secured by real estate and such other properties necessary to secure the debt, pursuant to a trust indenture and related deed of trust, trust deed, or mortgage, and the aggregate amount of the indebtedness created by the issuance of the securities does not exceed 75 percent of the value of the properties pledged to secure the debt.

For purposes of this subsection C., the term “value” shall mean book value, as found in audited financial statements, or market value of existing real estate securing the debt, as contained in a written report prepared by a qualified appraiser in accordance with the Uniform Standards of Professional Appraisal Practices adopted by the Appraisal Standards Board of the Appraisal Foundation. Both book value and market value may be increased by anticipated construction costs and property to be acquired with proceeds of the offering, if applicable.

51-3.15 Securities Registration Exemption for Securities Issued by Certain Religious Organizations

Any security issued by a person organized and operated not for private profit but exclusively for religious, educational, benevolent or charitable purposes shall be exempt from the securities registration requirement of the Colorado Securities Act (“Act”) provided as follows:

A. The issuer is: (1) a religious organization affiliated with, associated with, or authorized by a religious denomination or denominations, or (2) a religious organization that consists of or acts on behalf of individual or local churches or local or regional church organizations;

B. The issuer is an organization that qualifies and operates under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended;

C. The issuer, alone or through its predecessor organization:

1. Has been in existence for over ten years;

2. Has received audited financial statements with an unqualified opinion from a certified public accountant for its most recent three fiscal years; and

3. Has experienced no defaults on any outstanding obligations to investors for the period that it has issued securities;

D. The issuer's:

1. Cash, cash equivalents and readily marketable assets have had a market value of at least five percent of the principal balance of its total outstanding debt securities for the last three fiscal years or 36 months prior to the issue; or

2. Net worth, as that term is used in Generally Accepted Accounting Principles, has been at least equal to three percent of its total assets for the last three fiscal years or 36 months prior to the issue;

E. Prior to any sale of the securities, the issuer provides an investor with a disclosure document reflecting financial and other information concerning the issuer and relevant risks involved in the investment;

F. The issuer makes loans to or otherwise utilizes the net proceeds of the offering in support of:

1. Local churches, or other religious organizations affiliated or associated with such churches; or

2. Related religious organizations; and

G. The issuer:

1. Has a net worth, as that term is used in Generally Accepted Accounting Principles, of $5,000,000.00 or more which includes all church owned property; or

2. Makes loans, secured by either real property or by a pledge of readily marketable securities, at all times, having equal or greater value than the loan amount, to finance the purchase, construction or improvement of church related property, buildings, related capital expenditures, or to refinance existing debt to be secured by such property, or for other

operating expenses of the entities described in F. above provided the obligation is secured by such property.

51-3.16 Securities Registration Exemption for Securities Issued by Student Loan Organizations

Any security issued by a person organized and operated not for private profit but exclusively for religious, educational, benevolent or charitable purposes shall be exempt from the securities registration requirement of the Colorado Securities Act ("Act") provided as follows:

A. The issuer is established for the purpose of acquiring or originating student and parent education loans ("Student Loans") under state or federal law regarding such organizations;

B. There is nothing in such laws that would prohibit the issuance of securities by such entities; and

C. The net proceeds of the offering of such securities are used to either finance the acquisition or the origination of Student Loans, or to refund or otherwise redeem or retire previous issues of securities made in connection with Student Loans.

51-3.17 Securities Registration Exemption for Securities Offered, Sold or Purchased by Canadian Broker-Dealers Excluded from Broker-Dealer Definition Pursuant to Rule 51-2.1.1.

Any offer, sale or purchase of a security effected by a person excluded from the definition of "broker-dealer" pursuant to Rule 51-2.1.1 shall be exempt from the securities registration requirement of the Colorado Securities Act.

51-3.18 World Class Issuer Exemption

Any security that meets all of the following conditions shall be exempt from the securities registration requirements of the Colorado Securities Act:

A. The securities are:

1. Equity securities except options, warrants, preferred stock, subscription rights, securities convertible into equity securities or any right to subscribe to or purchase such options, warrants, convertible securities or preferred stock;

2. Units consisting of equity securities permitted under subparagraph (1) and warrants to purchase the same equity security being offered in the unit;

3. Non-convertible debt securities rated in one of the four highest rating categories of Standard and Poor's, Moody's, Dominion Bond Rating Services of Canadian Bond Rating Services or such other rating organization the Commissioner by Rule or order may designate. For purposes of this subparagraph (2), the term "non-convertible debt securities" means securities that cannot be converted for at least one year from the date of issuance and then, only into equity shares of the issuer or its parent; or

4. American Depositary Receipts representing securities described in subparagraphs (1) and (2) above;

B. The issuer is not organized under the laws of the United States, or of any state, territory or possession of the United States, or of the District of Columbia or Puerto Rico;

C. The issuer, at the time an offer or sale is made in reliance on the securities exemption embodied in this Rule, has been a going concern engaged in continuous business operations for the immediate past five years and during that period has not been the subject of a proceeding relating to insolvency, bankruptcy, involuntary administration, receivership or similar proceeding. For purposes of this paragraph, the operating history of any predecessor that represented more than 50% of the value of the assets of the issuer that otherwise would have met the conditions of this Rule may be used toward the five year requirement;

D. The issuer, at the time an offer or sale is made in reliance on the securities exemption embodied in this Rule, has a public float of US $1 billion or more. For purposes of this paragraph:

1. The term "public float" means the market value of all outstanding equity shares owned by non-affiliates;

2. The term “equity shares” means common shares, non-voting equity shares and subordinate or restricted voting equity shares, but does not include preferred shares; and

3. An “affiliate” is anyone who owns beneficially, directly or indirectly, or exercises control or direction over, more than 10% of the outstanding equity shares of such person;

E. The market value of the issuer's equity shares, at the time an offer or sale is made in reliance on the securities exemption embodied in this Rule, is US $3 billion or more. For purposes of this paragraph, the term “equity shares” means common shares, non-voting equity shares and subordinate or restricted voting equity shares, but does not include preferred shares; and

F. The issuer, at the time an offer or sale is made in reliance on the securities exemption embodied in this Rule, has a class of equity securities listed for trading on or through the facilities of a foreign securities exchange or recognized foreign securities market included in SEC Rule 902(a)(1) or designated by the SEC under SEC Rule 902(a)(2).

51-3.19 Model Accredited Investor Exemption

Any offer or sale of a security by an issuer in a transaction that meets the requirements of this Rule is exempted from the securities registration requirements of the Colorado Securities Act (“the Act”).

A. Sales of securities shall be made only to persons who are or the issuer reasonably believes are “accredited investors” as that term is defined in SEC Rule 501(a) of Regulation D.

B. The exemption is not available to an issuer that is in the development stage that either has no specific business plan or purpose or has indicated that its business plan is to engage in a merger or acquisition with an unidentified company or companies, or other entity or person.

C. The issuer reasonably believes that all purchasers are purchasing for investment and not with the view to or for sale in connection with a distribution of the security. Any resale of a security sold in reliance on this exemption within 12 months of sale shall be presumed to be with a view to distribution and not for investment, except a resale pursuant to a registration statement effective under the securities registration requirements of the Act or to an accredited investor pursuant to another applicable exemption under the Act.

D. Disqualification

1. This exemption is not available to an issuer if the issuer, any of the issuer's predecessors, any affiliated issuer, any of the issuer's directors, officers, general partners, beneficial owners of 10% or more of any class of its equity securities, any of the issuer's promoters presently connected with the issuer in any capacity, any underwriter of the securities to be offered, or any partner, director or officer of such underwriter:

a. within the last five years, has filed a registration statement that is the subject of a currently effective registration stop order entered by any state securities administrator or the SEC;

b. within the last five years, has been convicted of any criminal offense in connection with the offer, purchase or sale of any security, or involving fraud or deceit;

c. is currently subject to any state or federal administrative enforcement order or judgment, entered within the last five years, finding fraud or deceit in connection with the purchase or sale of any security; or

d. is currently subject to any order, judgment or decree of any court of competent jurisdiction, entered within the last five years, temporarily, preliminarily or permanently restraining or enjoining such party from engaging in or continuing to engage in any conduct or practice involving fraud or deceit in connection with the purchase or sale of any security.

2. Subparagraph D.1. shall not apply if:

a. the party subject to the disqualification is licensed or registered to conduct securities-related business in the state in which the order, judgment or decree creating the disqualification was entered against such party;

b. before the first offer under this exemption, the state securities administrator, or the court or regulatory authority that entered the order, judgment, or decree, waives the disqualification; or

c. the issuer establishes that it did not know and in the exercise of reasonable care, based on a factual inquiry, could not have known that a disqualification existed under this paragraph.

E. General Announcement

1. A general announcement of the proposed offering may be made by any means.

2. The general announcement shall include only the following information, unless additional information is specifically permitted by the Commissioner:

a. The name, address and telephone number of the issuer of the securities;

b. The name, a brief description and price (if known) of any security to be issued;

c. A brief description of the business of the issuer in 25 words or less;

d. The type, number and aggregate amount of securities being offered;

e. The name, address and telephone number of the person to contact for additional information; and

f. A statement that:

i sales will only be made to accredited investors;

ii. no money or other consideration is being solicited or will be accepted by way of this general announcement; and

iii. the securities have not been registered with or approved by any state securities agency or the SEC and are being offered and sold pursuant to an exemption from registration.

F. The issuer, in connection with an offer, may provide information in addition to the general announcement under paragraph E., if such information:

1. is delivered through an electronic database that is restricted to persons who have been prequalified as accredited investors; or

2. is delivered after the issuer reasonably believes that the prospective purchaser is an accredited investor.

G. No telephone solicitation shall be permitted unless prior to placing the call, the issuer reasonably believes that the prospective purchaser to be solicited is an accredited investor.

H. Dissemination of the general announcement of the proposed offering to persons who are not accredited investors shall not disqualify the issuer from claiming the exemption under this Rule.

I. The issuer must file or cause to be filed with the Commissioner a notice of exemption in the form prescribed by the Commissioner, a copy of any general announcement, and the prescribed fee, as provided in Rule 51-3.7, all within 15 days after the first sale in this state.

51-3.20. Crowdfunding – Fees and Notice Filing Forms

A. Not less than ten days before the commencement of an offering pursuant to the exemption from registration provided in section 11-51-308.5 (the Colorado Crowdfunding Act), the issuer shall pay a fee, which shall be determined and collected pursuant to section 11-51-707.

B. Before acting as an on-line intermediary for an offering pursuant to the exemption from registration provided in section 11-51-308.5 (the Colorado Crowdfunding Act), the on-line intermediary shall pay a fee, which shall be determined and collected pursuant to section 11-51-707.

C. The issuer notice filing required by section 11-51-308.5(3)(a)(IV)(A) of the Colorado Crowdfunding Act shall be made by filing Form CF-1 with the Securities Commissioner.

D. The notice of intention to act as an on-line intermediary for an offering to be conducted pursuant to the Colorado Crowdfunding Act required by section 11-51-308.5(3)(c)(I)(E) shall be made by filing Form CF-3 with the Securities Commissioner.

E. Notice Filing Review.

1. If an issuer, submits a crowdfunding notice filing pursuant to section 11-51-308.5(3)(a)(IV)(A), that fails to comply with, and/or violates section 11-51-308.5, C.R.S., Rules under the Colorado Crowdfunding Act, the Colorado Securities Act, Rules under the Colorado Securities Act, and/or any order or orders issued by the securities commissioner; the securities commissioner may reject the notice filing, require that the issuer correct the incompliance and/or violation(s), and re-submit the notice filing.

2. Revised crowdfunding notice filings shall be re-submitted pursuant to section 11-51-308.5(3)(a)(IV)(A) and shall occur not less than ten days before the commencement of the offering, pursuant to the exemption from registration provided in the Colorado Crowdfunding Act.

3. If any notice filing that was corrected and is resubmitted pursuant to section 11-51-308.5(3)(a)(IV)(A), fails to comply with, and/or violates section 11-51-308.5, C.R.S., Rules under the Colorado Crowdfunding Act, the Colorado Securities Act, Rules under the Colorado Securities Act, and/or any order or orders issued by the securities commissioner, the securities commissioner may reject the re-submitted notice filing, require that the issuer correct the incompliance and/or violation(s), and re-submit the notice filing.

51-3.21. Crowdfunding – Consent to Service of Process Form

A. The issuer consent to service of process required by section 11-51-308.5(3)(a)(IV)(A) of the Colorado Crowdfunding Act shall be made by filing NASAA Form U-2 with the Securities Commissioner at the same time that the issuer files Form CF-2 with the Securities Commissioner.

51-3.22. Crowdfunding – Disclosure Document

A. Not fewer than ten days before commencing an offering pursuant to the exemption from registration provided in the Colorado Crowdfunding Act, and to comply with section 11-51-308.5(3)(a)(IV)(C), the issuer of securities shall timely file with the Securities Commissioner a completed Form CF-2 together with the escrow agreement required to be filed with the Securities Commissioner pursuant to section 11-51-308.5(3)(a)(IV)(D). Before commencement of any offering pursuant to the Colorado Crowdfunding Act, the issuer shall also provide a completed Form CF-2 to the broker-dealer, sales representative, or on-line intermediary through which the offering pursuant to the Colorado Crowdfunding Act is being conducted, and provide a copy of the filed Form CF-2 to each offeree at the time the offer of securities is made. The issuer can comply with section 11-51-308.5(3)(a)(X) by ensuring that the broker-dealer, sales representative, or on-line intermediary provides a copy of the filed Form CF-2 to each offeree.

B. Utilizing Form CF-2 to conduct an offering pursuant to the Colorado Crowdfunding Act through a broker-dealer, sales representative, or on-line intermediary shall not relieve the issuer of its obligation to provide full and fair disclosure to investors of all material facts relating to the issuer and the securities being offered as required by section 11-51-501(1).

C. If the offering is for more than $1 million, the Form CF-2 must include the issuer's financial statements for its most recently-completed fiscal year which have been reviewed by a certified public accountant licensed to practice accountancy within the state of Colorado. If the end of the most recently completed fiscal year of an issuer subject to this subsection is of a date that is more than four months before the commencement of the offering pursuant to the Colorado Crowdfunding Act, interim financial statements, which must be reviewed by the same certified public accountant that performed the audit, as of a date within four months of the commencement of the offering must be included. No issuer subject to this subsection may complete the sale of any securities pursuant to the Colorado Crowdfunding Act if the most recently audited or reviewed financial statements are for a period ending more than twelve months before the completion of the sale.

D. Within five (5) business days of any material change, addition, or update, an issuer shall file with the Commissioner, and provide to the broker-dealer, sales representative, or on-line intermediary and to all other holders of the issuer's securities an amendment to the disclosure document to disclose any

material changes, additions, or updates to information that it provided to investors if the offering has not yet been completed or terminated.

E. An issuer must disclose to the Commissioner and (through the broker-dealer, sales representative, or on-line intermediary) to offerees and (directly by the issuer) to all other holders of its securities its progress in meeting the target offering amount no later than five (5) business days after the issuer reaches the minimum and maximum target offering amount, and after the date the offering proceeds are released from any escrow, or upon termination of the offering being conducted pursuant to the Colorado Crowdfunding Act when the offering is not completed and the offering proceeds are returned to the offerees who subscribed to purchase the securities in accordance with the escrow agreement.

51-3.23. Crowdfunding – Issuer Records

A Issuers shall make and preserve all records with respect to any offering conducted pursuant to the exemption provided by the Colorado Crowdfunding Act for five years after the completion or termination of the offering. These records shall include, at a minimum:

1. All organizational documents, including but not limited to, partnership agreements, operating agreements, articles of incorporation or organization, bylaws, minute books, and stock certificate books (or other similar type documents) and any agreements among the issuer's owners relating to voting or transferability of the owner's interests;

2. The issuer's Form CF-1, Form CF-2, including all exhibits, together with all amendments thereto, and Form ES-CF;

3. All records related to any person who purchases or attempts to purchase securities through the on-line intermediary or issuer, including evidence of residency from each such person in the offering as well as documentation obtained by the issuer showing that such person met any suitability standards set forth in the Form CF-2, including all records and information used to establish that an investor is an accredited investor as defined by the Securities and Exchange Commission's Rule 501 of Regulation D (17 CFR 230.501);

4. Records of all communications with all other holders of the issuer's securities, including all quarterly reports;

5. The escrow agreement executed in connection with the offering;

6. Any agreement between the issuer and any broker-dealer, sales representative, or on-line intermediary, and records reflecting the payment of compensation by the issuer or any person on behalf of the issuer to any broker-dealer, sales representative, or on-line intermediary; and

7. All records required to demonstrate compliance with section 11-51-308.5(3)(a)(VII).

B. The issuer may contract with the on-line intermediary or other service provider to collect such information and preserve such records, but the issuer retains the responsibility for the accuracy, completeness, and availability of such records.

51-3.24. Crowdfunding – Additional Issuer Requirements

A. *Investor Qualifications*.

1. Before accepting any investment, an issuer must verify that the aggregate amount sold by the issuer to any person during the twelve-month period preceding the date of sale does not exceed $5,000, or take reasonable steps to verify that any person who has purchased an aggregate amount greater than $5,000 from the issuer during any twelve-month period satisfies the accredited investor definition under the SEC's Rule 501 of Regulation D (17 CFR 230.501).

2. Before accepting any offer to purchase securities from any person pursuant to the Colorado Crowdfunding Act, an issuer must comply with the certification requirements of section 11-51-308.5(3)(a)(VII).

B. *Communications Between the Offerees and the Issuer*. After reviewing any Form CF-2 posted by an issuer through an on-line intermediary, any offeree may communicate directly with the issuer

pursuant to the method described in the Form CF-2 to obtain further information or to provide the issuer with a notice that the offeree intends to make an investment in the offering as described in the Form CF-2.

C. *Notice of Investment Commitment*. After a person directs funds to the escrow account in an offering being conducted through an on-line intermediary, the issuer must promptly send to such person a notification disclosing:

1. The dollar amount of the investment commitment;
2. The price of the securities;
3. The name of the issuer;
4. The amount of the minimum offering and the maximum offering;
5. The amount of proceeds received in the escrow account as of the date of such notification; and
6. Whether such person has the right to cancel their investment prior to the deadline in the escrow agreement to reach the minimum offering amount and what such person must do to invoke that right.

D. *Notice of Completion of Transaction*. The issuer must, at or before the release of funds from escrow pursuant to Rule 51-3.24(F), send to each investor a notification disclosing:

1. The date of the transaction;
2. The type of security that such person is purchasing;
3. The identity, price, and number of securities being purchased by such person, as well as the number of securities sold by the issuer in the transaction through the date of the notification, and the price at which the securities were sold;
4. If a debt security, the interest rate and yield to maturity calculated from the price paid and the maturity date;
5. If a callable security, the first date that the security can be called by the issuer;
6. Whether the offering is being continued or is completed; and
7. Other information that the issuer determines is appropriate or necessary to provide to the person purchasing securities from the issuer in the offering being conducted pursuant to the Colorado Crowdfunding Act.

E. *Transmission of Funds*. The on-line intermediary and issuer shall direct investors to transmit all payments for the purchase of securities directly to the escrow account specified in the Form CF-2 until the offering is completed or terminated.

F. *Escrow Agreement*. For transactions occurring pursuant to section 11-51-308.5, C.R.S., issuers must place all funds received from investors in an escrow account which shall be established pursuant to a written agreement between the issuer (as depositor) and an unaffiliated depository institution or other escrow agent approved by the commissioner, and other interested parties (if any). The written agreement shall meet the requirements of the Colorado Crowdfunding Act and these Rules.

1. Each agreement for the establishment of an escrow account shall include:
    a. The date of the agreement;
    b. The names and addresses of the issuer, the escrow agent, and any other parties to the agreement;
    c. The terms of the escrow, including a specific reference to section 11-51-308.5, C.R.S.;
    d. A provision for the delivery of the purchased securities by the issuer to the investor at the time of, or prior to, the release of funds to the issuer;
    e. Whether the escrowed funds will earn interest and, if so, a description of the manner in which interest accrued on the escrowed funds will be used or otherwise distributed;

f. Unless the minimum/maximum requirement is waived or modified by the commissioner, the agreement shall contain a provision that prohibits the issuer from accessing the escrowed funds until the aggregate funds raised from all investors equals or exceeds the minimum offering amount in a timely fashion (as the minimum offering amount and the period of the offering are defined in the issuer's Form CF-2 as filed with the Commissioner), a provision detailing the conditions under which the escrowed funds are to be released to the issuer or are to be returned to the prospective investors, and whether, after any initial closing and distribution of funds to the issuer, the offering may continue with further funds being deposited into the escrow account; and

g. A statement that the escrowed funds may not be released to the issuer until the lapse of at least seven (7) days after the receipt by the Commissioner of notice of the proposed release of funds from such escrow, provided in paragraph 3 below, or upon written authorization of the Commissioner of any earlier release.

2. The Commissioner may, in his sole discretion, authorize release of escrowed funds pursuant to section 11-51-308.5, C.R.S. prior to the lapse of seven (7) days after receipt by the Commissioner of the notice provided in paragraph 3 below. In such cases, the Commissioner shall provide the issuer with such authorization in writing in a form that may be presented to the escrow agent.

3. A notice of proposed release of funds from escrow under section 11-51-308.5, C.R.S. shall be filed with the Commissioner on Form ES-CF. Proof of filing the Form ES-CF with the Commissioner may be established by a receipt or other writing upon which the Commissioner, by stamp or other writing, evidences that the Form ES-CF was received.

4. The notice shall contain, at a minimum, the following information:

a. The gross amount of aggregate proceeds received from the sale of any and all of the securities sold in the offering;

b. Whether the offering is completed;

c. Whether any additional funds may be received by the issuer in exchange for securities issued in the offering;

d. A description of each transaction, including the dates of each transaction, the parties to each transaction, the amount committed in each transaction, a description of how the proceeds are to be spent under the terms of each transaction, including the specific lines of business, and a description of how the securities will be delivered to the purchaser; and

e. Any additional information the Commissioner may require as material to the Commissioner's determination.

G. *Single Intermediary*. An issuer shall not conduct an offering or concurrent offerings in reliance on the Colorado Crowdfunding Act using more than one on-line intermediary.

H. *Sales Representative*. An issuer shall not conduct an offering in reliance on the Colorado Crowdfunding Act through a sales representative who is not associated with nor acting on behalf of a broker-dealer that is a member of FINRA.

I. *Quarterly Report Timing*. Each quarterly report shall be provided to all holders of the issuer's securities and the Commissioner within forty-five days after the end of each fiscal quarter.

J. *Issuer Distribution of Notice of Offering*. The issuer may, in accordance with section 11-51-308.5(3)(a)(XIV), distribute a statement that the issuer is conducting an offering. When used in section 11-51-308.5(3)(a)(XIV), the term "within Colorado" includes a statement distributed by, at the direction of, or on behalf of the issuer on the issuer's website or through electronic mail or social media if the statement includes (at a minimum) disclaimers and restrictive legends making it clear that the offering is limited to residents of Colorado and there is in fact a confirmation of residency before the recipient or viewer of such statement can access the Form CF-2 or other information related to the offering.

K. Single Plan of Financing. In accordance with section 11-51- 308.5(3)(a)(XI), the exemption provided by the Colorado Crowdfunding Act shall not be used in conjunction with any other exemption pursuant to section 11-51- 307, 11-51- 308, or 11-51- 309 during the immediately preceding twelve-month period which is part of the same issue. The determination whether offers, offers to sell, offers

for sale, and sales of securities are part of the same issue (i.e., are deemed to be integrated) is a question of fact and will depend on the particular circumstances. In determining whether offers and sales should be regarded as part of the same issue and thus should be integrated, any one or more of the following factors may be determinative:

1. Are the offerings part of a single plan of financing;
2. Do the offerings involve issuance of the same class of securities;
3. Are the offerings made at or about the same time;
4. Is the same type of consideration to be received; and
5. Are the offerings made for the same general purpose.

L. Federal Rules Applicable. Offerings made pursuant to the Colorado Crowdfunding Act must be conducted in a manner consistent with SEC Rule 147 (17 CFR 230.144) or Rule 147A (17 CFR 230.147A).

M. Failure of an issuer to comply with any of the provisions of section 11-51-308.5, these Rules, or any order, will constitute a violation of those provisions, Rules, or orders, and subject the issuer to the enforcement authority of the Commissioner under section 11-51-602.

51-3.25. Crowdfunding – On-line Intermediary Records

A. An on-line intermediary shall make and preserve all records required to demonstrate compliance with the requirements of section 11-51-308.5(3)(c) and any applicable Rules under the Colorado Securities Act, including the following records, for five (5) years after the completion or termination of an offering:

1. All records of compensation received for acting as an on-line intermediary, including the amount of compensation and method used to determine such amount, the name of the payor, the date of payment, and name of the issuer;
2. All records related to issuers who offer or attempt to offer securities through the on-line intermediary and the control persons of such issuers, including all information used to establish Colorado residency;
3. Records of all communications that occur on or through the on-line intermediary's website;
4. All records related to persons that use communication channels provided by an on-line intermediary to promote an issuer's securities or communicate with potential investors;
5. To the extent received by the on-line intermediary, all records and information used to establish that an investor is an accredited investor as defined by the Securities and Exchange Commission's Rule 501 of Regulation D (17 CFR 230.501);
6. All notices provided by such on-line intermediary to issuers and investors generally through the on-line intermediary's website or otherwise, including, but not limited to, notices addressing hours of on-line intermediary operations (if any), on-line intermediary malfunctions, changes to on-line intermediary procedures, maintenance of hardware and software, instructions pertaining to access to the on-line intermediary and denials of, or limitations on, access to the on-line intermediary;
7. All agreements and contracts between the on-line intermediary and an issuer or investor;
8. All information that the on-line intermediary is required to collect from persons pursuant to Rule 51-3.28;
9. Any other records of all offers of securities effected through the on-line intermediary's website; and
10. Any written supervisory procedures or policies as required by section 11-51-308.5(3)(c)(II)(C).

B. An on-line intermediary shall make and preserve during the operation of the on-line intermediary and of any successor on-line intermediary all organizational documents relating to the on-line intermediary, including, but not limited to, partnership agreements, articles of incorporation or charter, minute books, and stock certificate books (or other similar type documents).

C. The records required to be made and preserved pursuant to paragraph A. of this Rule must be produced, reproduced, and maintained in the original, non-alterable format in which they were created.

51-3.26. Crowdfunding – On-line Intermediary Financial and Other Information

A. An on-line intermediary shall make an annual filing with the Commissioner listing each offering completed pursuant to section 11-51-308.5 accompanied by how much compensation the on-line intermediary received for each offering completed and listing all other offerings pursuant to section 11-51-308.5 accompanied by how much compensation the on-line intermediary received for all other offerings for the reporting period. This filing shall be made on Form CF-4.

51-3.27. Crowdfunding – Small Offering Exemption

Upon approval of the Commissioner, an issuer who files a Form CF-1, a consent to service of process, and a Form CF-2 as required by Rules 51-3.20, 51-3.21 and 51-3.22, pays the required fees, maintains issuer records required by Rule 51-3.23, meets the additional issuer requirements set forth in Rule 51-3.24 and is not disqualified as contemplated in Rule 51-3.30, and the issuer is not seeking to raise not more than $500,000 in any twelve-month period, the issuer may proceed with the offering under these Rules without imposing a minimum offering and without using an online intermediary. If the offering is proceeding without imposing a minimum offering, the offering may proceed without requiring that the proceeds be placed in escrow provided that the funds are maintained in a segregated account until spent on a proposed use of proceeds.

51-3.28. Crowdfunding – Additional On-line Intermediary Requirements

A. Before permitting any person to view offerings being conducted through the on-line intermediary, the on-line intermediary shall gather the following information from such person:

1. Such person's name;

2. Such person's address;

3. Such person's telephone number;

4. Such person's email address;

5. Such person's date of birth; and

6. Information to establish Colorado residency.

B. Before permitting any person to view the offerings being conducted through the on-line intermediary, the on-line intermediary shall have each such person acknowledge that:

THESE SECURITIES HAVE NOT BEEN REGISTERED WITH, APPROVED BY, OR RECOMMENDED BY ANY FEDERAL OR STATE AGENCY. IN MAKING AN INVESTMENT DECISION, PURCHASHERS MUST RELY ON THEIR OWN EXAMINATION OF THE ISSUER AND THE TERMS OF THE OFFERING, INCLUDING THE MERITS AND RISKS INVOLVED. THESE SECURITIES HAVE NOT BEEN RECOMMENDED BY ANY FEDERAL OR STATE SECURITIES COMMISSION OR DIVISION OR OTHER REGULATORY AUTHORITY. FURTHERMORE, THE FOREGOING AUTHORITIES HAVE NOT CONFIRMED THE ACCURACY OR DETERMINED THE ADEQUACY OF THIS DOCUMENT. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE. THESE SECURITIES ARE SUBJECT TO RESTRICTIONS ON TRANSFERABILITY AND RESALE AND MAY NOT BE TRANSFERRED OR RESOLD EXCEPT AS PERMITTED BY SUBSECTION (e) OF SECURITIES AND EXCHANGE COMMISSION RULE 147, 17 CFR 230.147(e), AS PROMULGATED PURSUANT TO THE FEDERAL "SECURITIES ACT OF 1933," AS AMENDED, AND THE APPLICABLE STATE SECURITIES LAWS, PURSUANT TO REGISTRATION OR EXEMPTION THEREFROM. INVESTORS SHOULD BE AWARE THAT THEY WILL BE REQUIRED TO BEAR THE FINANCIAL RISKS OF THIS INVESTMENT FOR AN INDEFINITE PERIOD OF TIME.

C. An on-line intermediary in a transaction involving the offer or sale of securities in reliance on the Colorado Crowdfunding Act must deny access to its platform if the on-line intermediary:

1. Has a reasonable basis for believing that an issuer is not in compliance with section 11-51-308.5;

2. Has a reasonable basis for believing that the issuer has not established means to keep accurate records as required by the Colorado Crowdfunding Act and these Rules; or

3. Has a reasonable basis for believing that the issuer or offering presents the potential for fraud or otherwise raises concerns regarding investor protection.

D. An on-line intermediary that has denied an issuer access to its platform based upon any of the grounds specified in Rule 51-3.28(C) shall promptly report such denial to the Commissioner.

E. Failure of the on-line intermediary to comply with any of the provisions of section 11-51-308.5, these Rules, or any order, will constitute a violation of those provisions, Rules, or orders, and subject the on-line intermediary to the enforcement authority of the Commissioner under section 11-51-602.

51-3.29. Crowdfunding – On-line Intermediary Prohibited Activities

A. An on-line intermediary shall not:

1. Offer investment advice or recommendations absent licensure and residency as stated in section 11-31-308.5(3)(b)(I) or (II);

2. Receive a financial interest in an issuer as compensation for services provided to or on behalf of an issuer unless disclosed on Form CF-2; or

3. Hold, manage, possess, or otherwise handle purchaser funds or securities.

B. An on-line intermediary that does nothing more than collect information regarding the purchase of securities pursuant to the Colorado Crowdfunding Act and provides a link to transmit funds to the escrow agent is not conducting any activity prohibited by Rule 51-3.29(A).

C. The fee charged by an online intermediary may be a variable amount based upon the number of investors in an offering.

51-3.30. Crowdfunding – Disqualification from Relying on Crowdfunding Exemption

A. No exemption under section 11-51-308.5 shall be available for a sale of securities if the issuer; any predecessor of the issuer; any affiliated issuer; any director, executive officer, other officer participating in the offering, general partner or managing member or manager of the issuer; any beneficial owner of 20% or more of the issuer's outstanding voting equity securities, calculated on the basis of voting power; any promoter connected with the issuer in any capacity at the time of such sale; any person that has been or will be paid (directly or indirectly) remuneration for solicitation of purchasers in connection with such sale of securities; any general partner or managing member of any such solicitor; or any director, executive officer or other officer participating in the offering of any such solicitor or general partner or managing member of such solicitor:

1. Has a conviction that became final within ten years before such sale, of any felony or misdemeanor:

a. In connection with the purchase or sale of any security;

b. Involving the making of any false filing with the Securities and Exchange Commission or a state securities regulatory agency;

c. Arising out of the conduct of the business of an underwriter, broker, dealer, municipal securities dealer, investment adviser or paid solicitor of purchasers of securities; or

d. Involving fraud or deceit in which the loss to the victim or victims exceeds $10,000;

2. Is subject to any final order, judgment or decree of any court of competent jurisdiction, entered within five years before such sale, that, at the time of such sale, restrains or enjoins such person from engaging or continuing to engage in any conduct or practice:

a. In connection with the purchase or sale of any security;

b. Involving the making of any false filing with the Securities and Exchange Commission or a state securities regulatory agency; or

c. Arising out of the conduct of the business of an underwriter, broker, dealer, municipal securities dealer, investment adviser or paid solicitor of purchasers of securities;

3. Is subject to a final order of a state securities commission (or an agency or officer of a state performing like functions); a state authority that supervises or examines banks, savings associations, or credit unions; a state insurance commission (or an agency or officer of a

state performing like functions); a federal banking agency; the Securities and Exchange Commission, the U.S. Commodity Futures Trading Commission; the Federal Trade Commission, the Consumer Financial Protection Bureau, or the National Credit Union Administration that:

a. At the time of such sale, bars the person from:

i. Association with an entity regulated by such commission, authority, agency, bureau or officer;

ii. Engaging in the business of securities, insurance or banking; or

iii. Engaging in savings association or credit union activities; or

b. Constitutes a final order based on a violation of any law or regulation that prohibits fraudulent, manipulative, or deceptive conduct, including making untrue statements of material facts or omitting to state material facts, entered within five years before such sale;

4. Is subject to a final order of the Securities and Exchange Commission entered pursuant to section 15(b) or 15B(c) of the Securities Exchange Act of 1934 (15 U.S.C. 78o(b) or 78o–4(c)) or section 203(e) or (f) of the Investment Advisers Act of 1940 (15 U.S.C. 80b–3(e) or (f)) that, at the time of such sale:

a. Suspends or revokes such person's registration as a broker, dealer, municipal securities dealer or investment adviser;

b. Places limitations on the activities, functions or operations of such person; or

c. Bars such person from being associated with any entity or from participating in the offering of any penny stock;

5. Is subject to any final order of the Securities and Exchange Commission entered within five years before such sale that orders the person to cease and desist from committing or causing a violation or future violation of:

a. Any scienter based anti-fraud provision of the federal securities laws, including without limitation section 17(a)(1) of the Securities Act of 1933 (15 U.S.C. 77q(a)(1)), section 10(b) of the Securities Exchange Act of 1934 (15 U.S.C. 78j(b)) and 17 CFR 240.10b–5, section 15(c)(1) of the Securities Exchange Act of 1934 (15 U.S.C. 78o(c)(1)) and section 206(1) of the Investment Advisers Act of 1940 (15 U.S.C. 80b–6(1)), or any other Rule or regulation thereunder; or

b. Section 5 of the Securities Act of 1933 (15 U.S.C. 77e);

6. Is suspended or expelled from membership in, or suspended or barred from association with a member of, a registered national securities exchange or a registered national or affiliated securities association for any act or omission constituting conduct inconsistent with just and equitable principles of trade;

7. Has filed (as a registrant or issuer), or was or was named as an underwriter in, any registration statement or Regulation A offering statement filed with the Securities and Exchange Commission that, within five years before such sale, was the subject of a final refusal order, stop order, or order suspending the Regulation A exemption, or is, at the time of such sale, the subject of an investigation or proceeding to determine whether a stop order or suspension order should be issued;

8. Is subject to a final United States Postal Service false representation order entered within five years before such sale, or is, at the time of such sale, subject to a temporary restraining order or preliminary injunction with respect to conduct alleged by the United States Postal Service to constitute a scheme or device for obtaining money or property through the mail by means of false representations;

9. Has filed a registration statement which is subject to a final stop order entered under section 11-51-306, or any other state's securities law, within five years before such sale; or

10. Is currently subject to any final state administrative enforcement order or judgment, including Colorado, entered by the Commissioner, or any other state's securities administrator, within five years prior to such sale.

B. For purposes of paragraph A. of this Rule, “final order” shall mean a written directive or declaratory statement issued by a federal or state agency described in subparagraph A.3. under applicable statutory authority that provides for notice and an opportunity for hearing, which constitutes a final disposition or action by that federal or state agency.

C. The Commissioner may, following a written request, and in the exercise of discretion, waive, either before or after an offering has commenced, subparagraphs 5. through 10. of paragraph A. of this Rule and subsections (d)(1)(v) through (viii) of Rule 506 (17 CFR 230.506(d)(1)(v)-(viii)) if upon a showing of good cause and without prejudice to any other action by the Commissioner, the Commissioner determines that, in balancing all relevant factors, granting the waiver is consistent with the objective of the Colorado Securities Act to protect investors and maintain public confidence in securities markets while avoiding unreasonable burdens on participants in capital markets.

51-3.31. Notice Filing Requirement for Federal Crowdfunding Offerings

The following provisions apply to offerings made under federal Regulation Crowdfunding (17 CFR §227) and Sections 4(a)(6) and 18(b)(4)(C) of the Securities Act of 1933:

A. Initial filing.

1. An issuer that offers and sells securities in this state in an offering exempt under federal Regulation Crowdfunding, and that either (1) has its principal place of business in this state or (2) sells 50% or greater of the aggregate amount of the offering to residents of this state, shall file the following with the securities commissioner:

   a. A completed Uniform Notice of Federal Crowdfunding Offering form or copies of all documents filed with the Securities and Exchange Commission

   b. A consent to service of process on Form U-2 if not filing on the Uniform Notice of Federal Crowdfunding Offering form; and

   c. The filing fee prescribed by the securities commissioner.

2. If the issuer has its principal place of business in this state, the filing required under paragraph (A) shall be filed with the securities commissioner when the issuer makes its initial Form C filing concerning the offering with the Securities and Exchange Commission. If the issuer does not have its principal place of business in this state but residents of this state have purchased 50% or greater of the aggregate amount of the offering, the filing required under paragraph (A) shall be filed when the issuer becomes aware that such purchases have met this threshold and in no event later than thirty (30) days from the date of completion of the offering.

3. The initial notice filing is effective for twelve (12) months from the date of the filing with the securities commissioner.

B. Renewal. For each additional twelve-month period in which the same offering is continued, an issuer conducting an offering under federal Regulation Crowdfunding may renew its notice filing by filing the following on or before the expiration of the notice filing:

1. A completed Uniform Notice of Federal Crowdfunding Offering form marked “renewal” and/or a cover letter or other document requesting renewal; and

2. The renewal fee prescribed by 11-51-308.5(3)(a)(IV)(B).

3. If the amount of securities subject to the notice filing is being increased, the fee prescribed by the securities commissioner.

51-3.32 Use of Electronic Offering Documents and Electronic Signatures

A. The following terms are defined for purposes of this section, 51-3.32

1. “Offering documents” include, but are not limited to, the registration statement, prospectus, applicable agreements, charter, by-laws, opinion of counsel and other opinions, specimen, indenture, consent to service of process and associated resolution, sales materials, subscription agreement, and applicable exhibits.

2. “Sales materials” include only those materials to be used in connection with the solicitation of purchasers of the securities approved as sales literature or other related materials by the SEC, FINRA, and the States, as applicable.

B. Use of Electronic Offering Documents and Subscription Agreements

1. An issuer of securities or agent acting on behalf of the issuer may deliver offering documents over the Internet or by other electronic means, or in machine readable format, provided:

a. Each offering document:

i. is prepared, updated and delivered in a manner consistent and in compliance with state and federal securities laws;

ii. satisfies the formatting requirements applicable to printed documents, such as font size and typeface, and which is identical in content to the printer version (other than electronic instructions and/or procedures as may be displayed and non-substantive updates to daily net asset value which can be updated more efficiently in the electronic version);

iii. is delivered as a single, integrated document or file; when delivering multiple offering documents, the documents must be delivered together as a single package or list;

iv. where a hyperlink to documents or content that is external to the offering documents is included, provides notice to investors or prospective investors that the document or content being accessed is provided by an external source; and

v. is delivered in an electronic format that intrinsically enables the recipient to store, retrieve and print the documents;

AND

b. the issuer or agent acting on behalf of the issuer:

i. obtains informed consent from the investor or prospective investor to receive offering documents electronically;

ii. ensures that the investor or prospective investor receives timely, adequate, and direct notice when an electronic offering document has been delivered;

iii. employs safeguards to ensure that delivery of offering documents occurred at or before the time required by law in relation to the time of sale; and

iv. maintains evidence of delivery by keeping records of its electronic delivery of Offering Documents and makes those records available on demand by the Commissioner.

2. Subscription agreements may be provided by an issuer or agent acting on behalf of the issuer electronically for review and completion, provided the subscription process is administered in a manner that is similar to the administration of subscription agreement in paper form, as follows:

a. before completion of any subscription agreement, the issuer or agent acting on behalf of the issuer must review with the prospective investor all appropriate documentation related to the prospective investment including on how to complete the subscription agreement;

b. mechanisms are established to ensure a prospective investor reviews all required disclosure and scrolls through the document in its entirety prior to initialing and/or signing; and

c. unless otherwise allowed by the securities commissioner, a single subscription agreement is used to subscribe a prospective investor in no more than one offering

3. Delivery requires that the offering documents be conveyed to and received by the investor or prospective investor, or that the storage media in which the offering documents are stored be

physically delivered to the investor or prospective investor in accordance with subsection (A)(1).

4. Each electronic document shall be preceded by or presented concurrently with the following notice: "**Clarity of text in this document may be affected by the size of the screen on which it is displayed."**

5. Informed consent to receive offering documents electronically pursuant to (A)(2)(a) in this section may be obtained in connection with each new offering or globally, either by an issuer or an agent acting on behalf of the issuer. The investor may revoke this consent at any time by informing the party to whom the consent was give, or, if such party is no longer available, the issuer.

6. Investment opportunities shall not be conditioned on participation in the electronic offering documents and subscription agreements initiative.

7. Investors or prospective investors who decline to participate in an electronic offering documents and subscription agreements initiative shall not be subjected to higher costs- other than the actual direct cost of printing, mailing, processing, and storing offering documents and subscription agreements- as a result of their lack of participation in the initiative, and no discount shall be given for participating in an electronic offering documents and subscription agreements initiative.

8. Entities participating in an electronic initiative shall maintain, and shall require participating underwriters, dealer-managers, placement agents, broker-dealers, and/or other selling agents to maintain written policies and procedures covering the use of electronic offering documents and subscription services.

9. Entities and their contractors and agents having custody and possession of electronic offering documents, including electronic subscription agreements, shall store them in a non-rewriteable and non-erasable format.

10. This section does not change or waive any other requirement of law concerning registration or presale disclosure of securities offerings.

C. Use of Electronic Signatures

1. An issuer of securities or agent acting on behalf of the issuer may provide for the use of electronic signatures provided:

   a. The process by which electronic signatures are obtained:

      i. will be implemented in compliance with the Electronic Signatures in Global and National Commerce Act ("Federal E-Sign"), and the Uniform Electronic Transactions Act, including an appropriate level for security and assurances of accuracy, and where applicable, required federal disclosures

      ii. will employ an authentication process to establish signer credentials;

      iii. will employ security features that protect signed records from alteration, and;

      iv. will provide for retention of electronically signed documents in compliance with applicable laws and regulations, by either the issuer or agent acting on behalf of the issuer;

   b. An investor or prospective investor shall expressly opt-in to the electronic signature initiative, and participation may be terminated at any time; and

   c. Investment opportunities shall not be conditioned on participation in the electronic signature initiative.

2. Entities that participate in an electronic signature initiatives shall maintain, and shall require underwriters, dealer-managers, placement agents, broker-dealers, and other selling agents to maintain, written policies and procedures covering the use of electronic signatures

3. An election to participate in an electronic signature initiative pursuant to (1)(b) in this section may be obtained in connection with each new offering, or by an agent acting on behalf of the issuer, The investor may revoke this consent at any time informing the party to whom the consent was given, or , if such party is no longer available, the issuer.

D. Incorporation by Reference

1. Electronic Signatures in Global and National Commerce Act ("Federal E-Sign"), as effective on June 30, 2000 is hereby incorporated by reference. No later amendment or edition of Federal E-Sign is incorporated into this Section 51-3.32. All referenced laws and regulations shall be available for copying or public inspection during regular business hours from the Division of Securities, Department of Regulatory Agencies, 1560 Broadway, Suite 900, Denver, CO 80202. The Division of Securities will provide certified copy of the material incorporated at cost or will provide the requester with information on how to obtain a certified copy.

2. Uniform Electronic Transactions Act, C.R.S. section §24-71.3-102 et seq., as effective on May 30, 2002 is hereby incorporated by reference. No later amendment or edition 24-71.3-101 et seq., is incorporated into this Section 51-3.32. All referenced laws and regulations shall be available for copying or public inspection during regular business hours from the Division of Securities, Department of Regulatory Agencies, 1560 Broadway, Suite 900, Denver, CO 80202. The Division of Securities will provide certified copy of the material incorporated at cost or will provide the requester with information on how to obtain a certified copy.

Rule 3.33. Licensing Exemption for Merger and Acquisition Brokers

A. IN GENERAL Except as provided in paragraphs (B) and (C), a Merger and Acquisition Broker shall be exempt from licensing pursuant to C.R.S. § 11-51-402 under this section.

B. EXCLUDED ACTIVITIES – A Merger and Acquisition Broker is not exempt from licensing under this paragraph if such broker does any of the following:

1. Directly or indirectly, in connection with the transfer of ownership of an eligible privately held company, receives, holds, transmits, or has custody of the funds or securities to be exchanged by the parties to the transaction.

2. Engages on behalf of an issuer in a public offering of any class of securities that is registered, or is required to be registered, with the United States Securities and Exchange Commission under Section 12 of the Securities Exchange Act of 1934, 15 U.S.C. 78l or with respect to which the issuer files, or is required to file, periodic information, documents, and reports under the Securities Exchange Act of 1934 Section 15 subsection (d), 15 U.S.C. 78o(d).

3. Engages on behalf of any party in a transaction involving a public shell company.

C. DISQUALIFICATIONS – A Merger and Acquisition Broker is not exempt from licensing under this paragraph if such broker is subject to –

1. Suspension or revocation of registration under Section 15(b)(4) of the Securities Exchange Act of 1934, 15 U.S.C. 78o(b)(4);

2. A statutory disqualification described in section 3(a)(39) of the Securities Exchange Act of 1934, 15 U.S.C. 78c(a)(39);

3. A disqualification under the Rules adopted by the United States Securities and Exchange Commission under Section 926 of the Dodd-Frank Wall Street Reform and Consumer Protection Act (15 U.S.C. 77d note); or

4. A final order described in paragraph (4)(H) of Section 15(b) of the Securities Exchange Act of 1934, 15 U.S.C. 78o(b)(4)(H).

D. RULE OF CONSTRUCTION – Nothing in this paragraph shall be construed to limit any other authority of this Commission, to exempt any person, or any class of persons, from any provision of this title, or from any provision of any Rule or regulation thereunder.

E. DEFINITIONS – In this paragraph:

1. CONTROL – The term "control" means the power, directly or indirectly, to direct the management or policies of a company, whether through ownership of securities, by contract, or otherwise. There is a presumption of control for any person who –

a. is a director, general partner, member, or manager of a limited liability company, or officer exercising executive responsibility (or has similar status or functions);

b. has the right to vote 20 percent or more of a class of voting securities or the power to sell or direct the sale of 20 percent or more of a class of voting securities; or

c. in the case of a partnership or limited liability company, has the right to receive upon dissolution, or has contributed, 20 percent or more of the capital.

2. ELIGIBLE PRIVATELY HELD COMPANY –IN GENERAL – The term “eligible privately held company” means a company meeting both of the following conditions:

a. The company does not have any class of securities registered, or required to be registered, with the United States Securities and Exchange Commission under Section 12 of the Securities Exchange Act of 1934, 15 U.S.C. 78l, or with respect to which the company files, or is required to file, periodic information, documents, and reports under subsection (d), 15 U.S.C. 78o(d).

b. In the fiscal year ending immediately before the fiscal year in which the services of the Merger and Acquisition Broker are initially engaged with respect to the securities transaction, the company meets either or both of the following conditions (determined in accordance with the historical financial accounting records of the company):

i. The earnings of the company before interest, taxes, depreciation, and amortization are less than $25,000,000.

ii. The gross revenues of the company are less than $250,000,000.

3. Merger and Acquisition Broker – The term “Merger and Acquisition Broker” means any broker and any person associated with a broker engaged in the business of effecting securities transactions solely in connection with the transfer of ownership of an eligible privately held company, regardless of whether that broker acts on behalf of a seller or buyer, through the purchase, sale, exchange, issuance, repurchase, or redemption of, or a business combination involving, securities or assets of the eligible privately held company –

a. if the broker reasonably believes that upon consummation of the transaction, any person acquiring securities or assets of the eligible privately held company, acting alone or in concert, will control and, directly or indirectly, will be active in the management of the eligible privately held company or the business conducted with the assets of the eligible privately held company; and

b. if any person is offered securities in exchange for securities or assets of the eligible privately held company, such person will, prior to becoming legally bound to consummate the transaction, receive or have reasonable access to the most recent fiscal year-end financial statements of the issuer of the securities as customarily prepared by its management in the normal course of operations and, if the financial statements of the issuer are audited, reviewed, or compiled, any related statement by the independent accountant; a balance sheet dated not more than 120 days before the date of the exchange offer; and information pertaining to the management, business, results of operations for the period covered by the foregoing financial statements, and any material loss contingencies of the issuer.

4. PUBLIC SHELL COMPANY – The term “public shell company” is a company that at the time of a transaction with an eligible privately held company –

a. has any class of securities registered, or required to be registered, with the United States Securities and Exchange Commission under Section 12, 15 U.S.C. 78l, or with respect to which the company files, or is required to file, periodic information, documents, and reports under subsection (d), 15 U.S.C. 78o(d); and

b. has no or nominal operations; and

c. has –

i. no or nominal assets;

ii. assets consisting solely of cash and cash equivalents; or

iii. assets consisting of any amount of cash and cash equivalents and nominal other assets.

F. INFLATION ADJUSTMENT

1. IN GENERAL – On the date that is five years after the date of the enactment of the Rule, and every five years thereafter, each dollar amount in subparagraph (E)(ii)(II) shall be adjusted by –

    a. dividing the annual value of the Employment Cost Index For Wages and Salaries, Private Industry Workers (or any successor index), as published by the Bureau of Labor Statistics, for the calendar year preceding the calendar year in which the adjustment is being made by the annual value of such index (or successor) for the calendar year ending December 31, 2012; and

    b. multiplying such dollar amount by the quotient obtained under sub clause (I).

2. ROUNDING – Each dollar amount determined under clause (i) shall be rounded to the nearest multiple of $100,000.

51-3.34. Digital Token Act Registration Exemption – Fees, Notice Filing Forms and Review

A. For all digital tokens issued on or after August 2, 2019, the issuer shall provide notice of exemption to the securities commissioner before the issuance of a digital token that is exempt from registration as provided in section 11-51-308.7 of the Colorado Digital Token Act.

B. For digital tokens issued before August 2, 2019, the issuer shall provide notice of exemption to the securities commissioner of a digital token that is exempt from registration as provided in section 11-51-308.7 of the Colorado Digital Token Act.

C. The registration exemption notice filing required by section 11-51-308.7(3)(a) of the Colorado Digital Token Act shall be made by filing Form DT-1 with the securities commissioner.

D. A Colorado Digital Token Act registration exemption notice filed pursuant to section 11-51-308.7(3)(a), that fails to comply with, and/or violates section 11-51-308.7(a), the Colorado Digital Token Act, Rules under the Colorado Digital Token Act, the Colorado Securities Act, Rules under the Colorado Securities Act, the Colorado Commodity Code and/or any order or orders issued by the securities commissioner; the securities commissioner may reject the notice filing or require that the issuer correct any deficiencies and re-submit the notice filing.

E. An issuer of an exempt digital token must file an amendment to a previously filed notice to correct a material mistake in the previously filed notice or to reflect a material change in the previously filed notice within 30 days after discovery of the mistake or change.

51-3.35 Digital Token Act Licensing Exemption – Fees, Notice Filing Forms and Review

A. A person who engages in the business of effecting or attempting to effect the purchase, sale, or transfer of a digital token who is exempt from the licensing requirements of section 11-51-401, as provided in section 11-51-308.7 of the Colorado Digital Token Act, shall provide notice of exemption to the securities commissioner.

B. The exemption from licensing is only available to a person who is engaged in the business of effecting or attempting to effect the purchase, sale, or transfer of digital tokens that have a primarily consumptive purpose.

C. The licensing exemption notice filing required by section 11-51-308.7(3)(c) of the Colorado Digital Token Act shall be made by filing Form DT-2 with the securities commissioner.

D. A Colorado Digital Token Act licensing exemption notice filed pursuant to section 11-51-308.7(3)(c), that fails to comply with, and/or violates section 11-51-308.7(b), the Colorado Digital Token Act, Rules under the Colorado Digital Token Act, the Colorado Securities Act, Rules under the Colorado Securities Act, the Colorado Commodity Code and/or any order or orders issued by the securities commissioner; the securities commissioner may reject the notice filing or require that the issuer correct any deficiencies and re-submit the notice filing.

E. A person who is exempt from licensing pursuant to section 11-51-308.7 of the Colorado Digital Token Act must file an amendment to a previously filed notice to correct a material mistake in the previously filed notice or to reflect a material change in the previously filed notice within 30 days after discovery of the mistake or change.

51-3.36. Digital Token Act – Books and Records Requirements

A. An Issuer or person filing notice of an exemption from registration or licensing shall make and preserve all records with respect to any issuance, purchase, sale, offer or transfer of a digital token conducted pursuant to the exemptions provided by the Colorado Digital Token Act for a period of five years.

B. The securities commissioner, in a manner reasonable under the circumstances, may examine, without notice, the records, within or without this state, of a person claiming an issuer or licensing exemption under 11-51-308.7 of the Colorado Digital Token Act.

CHAPTER 4 LICENSING OF BROKER-DEALERS AND SALES REPRESENTATIVES

51-4.1 Application for a Broker-Dealer License

A. A person applying for a license as a broker-dealer in Colorado shall make application for such license and amendments to such application on Form BD (Uniform Application for Broker-Dealer Registration).

B. A person applying for a license as a broker-dealer in Colorado who is registered under the 34 Act shall send such application and amendments to such application, and any applicable fee, made payable to FINRA (or such other payee as FINRA or CRD may designate), to the CRD with Colorado designated as a recipient state. An application or amendment shall be deemed filed with the Securities Commissioner on the date CRD enters it if CRD verification is not required, or the date CRD verifies it if CRD verification is required.

C. A person applying for a license as a broker-dealer in Colorado who is not registered or registering as such under the 34 Act shall send such application and amendments to such application to the Securities Commissioner.

D. Any applicant for a broker-dealer license must also file a Consent to Service of Process form (see Rule 51-7.1) with the Securities Commissioner.

E. A mortgage broker-dealer whose business is limited exclusively to effecting transactions with financial institutions [as defined in section 11-51-201(6), C.R.S.] is exempt from the licensing requirements of section 11-51-401(1), C.R.S.

51-4.2 Withdrawal of a Broker-Dealer License

A. An application to withdraw as a licensed broker-dealer in Colorado and any amendments to such application shall be made on Form BDW (Uniform Request for Withdrawal from Registration as a Broker-Dealer).

B. A broker-dealer licensed in Colorado who is or was registered under the 34 Act shall send any application for withdrawal and any amendments to such application to the CRD with Colorado designated as a recipient state. An application for withdrawal and any amendments shall be deemed filed with the Securities Commissioner on the date CRD enters it if CRD verification is not required, or the date CRD verifies it if CRD verification is required.

C. A Colorado broker-dealer who is not and was not registered under the 34 Act shall send any such application and any amendments to such application to the Securities Commissioner.

51-4.3 Application for a Sales Representative License

A. A person applying for a license as a sales representative in Colorado shall make application for such license and amendments to such application on Form U-4 (Uniform Application for Securities Industry Registration or Transfer).

B. A person affiliated with a FINRA broker-dealer applying for a license as a sales representative in Colorado shall send the application, any amendments to such application and any applicable fee,

with check made payable to FINRA (or such other payee as FINRA or CRD may designate), through such FINRA broker-dealer, to the CRD with Colorado designated as a recipient state. An application and amendments to such application shall be deemed filed with the Securities Commissioner on the date CRD enters it if CRD verification is not required, or the date CRD verifies it if CRD verification is required.

C. A person who is not affiliated with a FINRA broker-dealer who is applying for a license as a sales representative in Colorado shall send the application and amendments to such application, through the broker-dealer or issuer with which the person is affiliated, to the Securities Commissioner.

D. Any applicant for a sales representative license must also file a Consent to Service of Process form (see Rule 51-7.1) with the Commissioner.

E. An applicant for a license under section 11-51-403, C.R.S., as a sales representative for a broker-dealer who is not registered as a broker-dealer under the 34 Act, including a mortgage sales representative, or for an issuer shall successfully complete the Uniform Securities Agent State Law Examination (Series 63) administered through FINRA.

F. In addition to the examination required by paragraph E above, an applicant for a license under section 11-51-403, C.R.S., as a sales representative for either a broker-dealer who is not registered as a broker-dealer under the 34 Act and whose securities business is limited solely to the offer and sale of direct participation investments involving real estate related securities or an issuer whose business is equally limited, in addition to the examination required in paragraph E above, shall successfully complete the Direct Participation Program Representative Examination (Series 22) or the Direct Participation Principal Examination (Series 39) administered through FINRA.

G. Unless currently licensed as a sales representative with a broker-dealer registered under the 34 Act, the examination requirement described in paragraph E above may be satisfied upon proof that the respective examination was successfully completed within the two (2) year period immediately preceding the date of the application for licensing.

H. A sales representative of an issuer that qualifies for an exemption from registration pursuant to Rule 51-3.15 is exempt from the licensing requirements of section 11-51-401(1), C.R.S. if:

1. That sales representative is an officer, director, partner, trustee, employee or other representative of the issuer; and

2. That individual acts as a sales representative only with respect to the offer and sale of securities for and on behalf of the issuer; and

3. That sales representative receives no commissions, fees or other special remuneration for or arising out of the offer and sale of securities.

I. No FINRA broker-dealer or SEC registered entity shall permit any applicant for a sales representative license in Colorado to apply for such a license, or any affiliated sales representative license in Colorado to continue to perform duties as a sales representative, unless such person has complied with the requirements of subparagraph (1) hereof.

1. Any applicant or affiliated sales representative must be lawfully present in the United States. An applicant or affiliated sales representative may verify their lawful presence in the United States by producing to FINRA broker dealer or SEC registered entity any of the following:

   a. Federal Form I-9 Employment Eligibility Verification Form;

   b. An executed affidavit stating that he or she is a United States citizen or legal permanent resident in a form substantially similar to Form AE;

2. Every FINRA broker-dealer or SEC registered entity shall record, maintain, and preserve in an easily accessible place the documentation, or copies thereof, which the applicant and affiliated sales representative produced which verifies their lawful presence in the United States.

J. A person who is not affiliated with either a FINRA broker-dealer or SEC registered entity, who is applying for a license as a sales representative in Colorado, or continuing to perform duties as a sales representative in Colorado, shall send with their application or renewal to the Securities Commissioner the following documentation:

1. Documentation verifying their lawful presence in the United States. A person may verify their lawful presence in the United States by providing to the Securities Commissioner the following:

   a. An executed affidavit stating that he or she is a United States citizen or legal permanent resident in a form substantially similar to Form AE;

2. Documentation verifying the applicant's identity by providing to the Securities Commissioner any of the following documents:

   a. Any Colorado Driver License, Colorado Driver permit, or Colorado Identification Card, expired less than one year (Temporary paper license with invalid Colorado Driver License, Colorado Driver Permit, or Colorado Identification Card, expired less than one year is considered acceptable);

   b. Out-of-state issued photo Driver's License or photo identification card, photo driver's permit expired less than one year;

   c. Valid foreign passport with I-94 or validly processed for 1551 stamps;

   d. Valid I-94 issued by Canadian government with L1 or R1 status and a valid Canadian driver's license or valid Canadian identification card;

   e. Valid 1551 Resident Alien/Permanent Resident card. No border crosser or USA B1/B2 Visa/BCC cards;

   f. Valid 1688 Temporary Resident Card, 1688B and 1766 Employment Authorization Card;

   g. Valid U.S. Military Identification (active duty, dependent, retired, reserve and National Guard);

   h. Tribal Identification Card with intact photo (U.S. or Canadian);

   i. Certificate of Naturalization with intact photo;

   j. Certificate of U.S. Citizenship with intact photo.

K. Sales Representative Business Email.

1. Each person licensed as a sales representative in this state shall file such person's current business email address with the Securities Commissioner. The business email address shall be filed electronically on an annual basis through a link provided by the Division on its website.

2. Each person's employing broker-dealer may file the person's required email address with the Securities Commissioner on behalf of the person using a form designated by the Securities Commissioner.

51-4.4 Withdrawal of a Sales Representative License

A. An application to withdraw as a sales representative in Colorado and any amendments to such application shall be made on Form U-5 (Uniform Termination Notice for Securities Industry Registration).

B. For a person affiliated with a FINRA broker-dealer, an application to withdraw as a sales representative in Colorado and any amendments to such application shall be sent, through such FINRA broker-dealer, to the CRD with Colorado designated as a recipient state. An application for withdrawal and any amendments to such application shall be deemed filed with the Securities Commissioner on the date CRD enters it if CRD verification is not required, or the date CRD verifies it if CRD verification is required.

C. For a person not affiliated with a FINRA broker-dealer, an application for withdrawal from licensing in Colorado as a sales representative and any amendments to such application shall be sent through the broker-dealer or issuer with which the person is affiliated to the Securities Commissioner.

D. The Securities Commissioner may deem an application for licensing as a broker-dealer or securities sales representative to be abandoned when an applicant fails to adequately respond to any request for additional information required under § 11-51-403, C.R.S. or the regulations thereunder. The Commissioner shall provide written notice of warning 30 calendar days before the applications is

deemed abandoned. The applicant may, with the consent of the Commissioner, withdraw the application.

51-4.5 Books and Records Requirements for Licensed Broker-Dealers

Unless otherwise provided by Rule or order of the Securities Commissioner, every broker-dealer must make, maintain and preserve the books and records required under SEC Rules 15g, 15c2-11, 17a-3 and 17a-4, found at 17 CFR 240.15g-1 through g-100, 17 CFR 240.15c2-11, 17 CFR 240.17a-3 and 17 CFR 240.17a-4.

51-4.6 Financial Responsibility and Books and Records Requirements for Mortgage Broker-Dealers

A. A mortgage broker-dealer who does not maintain possession or control of investor funds or securities is not required to satisfy minimum financial responsibility requirements. A mortgage broker-dealer will not be deemed to be in possession of investor funds or securities if:

1. All funds received from an investor in connection with the purchase of securities are deposited no later than within forty-eight (48) hours of receipt in an escrow account maintained for the funds of customers of the mortgage broker-dealer at a financial institution. Investor checks or other forms of payment by which such a purchase is made are made payable to this escrow account. Funds held in the escrow account may only be disbursed to a specific loan escrow account for the purpose of purchasing a particular security;

2. The escrow agreement provides that the escrowed funds will not be subject to any claims of creditors of the mortgage broker-dealer. The escrow agreement further provides a date on which each deposit of an investor placed in the general escrow account will be returned to said investor if not transferred to a specific loan escrow account within sixty (60) days after the date the funds were received by the mortgage broker-dealer from the investor; and

3. Promptly following the disbursement of funds from the escrow account to a specific loan escrow account in connection with the purchase of a security, the mortgage broker-dealer records or causes to be recorded the applicable instruments in the appropriate place.

B. A mortgage broker-dealer who maintains possession or control of investor funds or securities must meet at least one of the following requirements:

1. Maintain minimum net liquid assets of at least twenty-five thousand dollars ($25,000) calculated by totaling all liquid assets then subtracting from that all current liabilities;

2. Maintain minimum net worth of at least one million dollars ($1,000,000) as determined by generally accepted accounting principles; or

3. File a surety bond in the face amount of at least fifty thousand dollars ($50,000) in a form satisfactory to the Securities Commissioner.

C. A mortgage broker-dealer must file an affidavit in connection with the payment of the annual license fee verifying to the Securities Commissioner that at least one of the requirements of paragraph B. above are satisfied. A mortgage broker-dealer failing to meet at least one of these requirements must notify the Securities Commissioner in writing as to such failure within no more than seventy-two (72) hours of the occurrence of such failure, and must immediately cease all sales of securities.

D. Mortgage broker-dealers are exempt from the books and records requirements set out in Rule 51-4.5. However, mortgage broker-dealers must maintain and keep current the following books and records:

1. All checkbooks, bank statements, deposit slips and canceled checks;

2. General and auxiliary ledgers, or other comparable records, reflecting the assets, liabilities, capital, income and expense accounts;

3. Documentation to support the source of and purpose for each receipt of funds in order that the receipts may be reconciled to bank deposits and to the books of the mortgage broker-dealer;

4. Documentation to support all disbursements of funds;

5. Separate loan files for each loan which has been funded or for which the mortgage broker-dealer is soliciting funds, which file shall, at a minimum, contain:

a. the loan application of the borrower and all supporting documents such as the credit report on the borrower;

b. a copy of each appraisal relied upon

c. copies of all documents of title representing current interest in the real property securing the loan;

d. copies of title insurance policies and any other insurance policies on the real property securing the loan; and

e. all contracts, letters, notes and memoranda for each customer;

6. Separate investor files for each loan which has been funded or for which the mortgage broker-dealer is soliciting funds, which file shall, at a minimum, contain:

a. copies of acknowledgment of receipt by each investor of the disclosure information required by Rule 51-4.7.G.1 below;

b. any subscription agreement; and

c. all correspondence with the investor relating to the loan;

7. Separate files for all written complaints by investors and action taken by the mortgage broker-dealer, if any, or a separate record of each such complaint and a clear reference to the file containing the correspondence connected with it;

8. Full, correct and complete copies of any and all Forms U-4 and U-5 for their mortgage sales representatives; and

9. For mortgage broker-dealers subject to the requirements of paragraph B. above, such records as are necessary to establish compliance with said paragraph, and:

a. Separate records of account for each investor;

b. Copies of all service agreements; and

c. Ledgers or accounts (or other records) itemizing separately each cash account of every investor, including but not limited to:

i. funds in the escrow and trust account of the mortgage broker-dealer:

ii. proceeds of sales;

iii. refinancing or foreclosure of or similar transaction regarding the property securing all loans; and

iv. all monies collected from borrowers on behalf of investors.

E. Preservation of Records

1. All mortgage broker-dealers shall preserve for a period of not less than three (3) years [the first two (2) years, in an easily accessible place] such books and records as are required by paragraph D. above. All mortgage broker-dealers shall preserve employment or similar information for a period of not less than three (3) years after a mortgage sales representative has terminated employment or any other association with the mortgage broker-dealer. All books and records as are required by paragraph D. 9. above shall be preserved for the life of the loan and for two (2) years thereafter.

2. If a mortgage broker-dealer subject to the requirements of paragraph D. above withdraws from licensing or otherwise ceases to engage in business as a mortgage broker-dealer, such mortgage broker-dealer shall nonetheless preserve the records required by said paragraph for the period of time specified.

51-4.6.1 Mortgage Broker-Dealer Cybersecurity

A. A mortgage broker-dealer must establish and maintain written procedures reasonably designed to ensure cybersecurity. In determining whether the cybersecurity procedures are reasonably designed, the commissioner may consider:

1. The firm's size;

2. The firm’s relationships with third parties;

3. The firm's policies, procedures, and training of employees with regard to cybersecurity practices;

4. Authentication practice

5. The firm's use of electronic communications;

6. The automatic locking of devices that have access to Confidential Personal Information; and

7. The firm's process for reporting of lost or stolen devices;

B. A mortgage broker-dealer must include cybersecurity as part of its risk assessment.

C. To the extent reasonably possible, the cybersecurity procedures must provide for:

1. An annual assessment by the firm or an agent of the firm of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of Confidential Personal information;

2. The use of secure email for email containing Confidential Personal Information, including use of encryption and digital signatures;

3. Authentication practices for employee access to electronic communications, databases and media;

4. Procedures for authenticating client instructions received via electronic communication; and

5. Disclosure to clients of the risks of using electronic communications.

51-4.7 Unfair and Dishonest Dealings

The following practices shall be deemed to be “unfair and dishonest dealings” for purposes of section 11-51-410(1)(g), C.R.S.:

A. Executing a transaction for a customer without legal authority or actual authorization of the customer to do so;

B. Recommending to a customer the purchase, sale or exchange of any security without reasonable grounds for believing that the recommendation is suitable for such customer upon the basis of the information furnished by the customer after reasonable inquiry concerning the customer's investment objectives, financial situation and needs, and any other information known by the broker-dealer or sales representative;

C. Acting in violation of the following SEC Rules

[for purposes of this Rule, the terms “broker” and “dealer” as used in the SEC Rules shall have the same meaning as “broker-dealer” as defined in Section 11-51-201(2), C.R.S., and the term “penny stock” shall have the meaning as set forth in SEC Rule 3a51-1, found at 17 CFR 240.3a51-1]:

1.

a. SEC Rule 15c2-6, found at 17 CFR 240.15c2-6;

b. SEC Rule 15c2-11, found at 17 CFR 240.15c2-11;

2. Unless the subject transactions are exempt under SEC Rule 15g-1, found at 17 CFR 240.15g-1, or otherwise:

a. SEC Rule 15g-2, found at 17 CFR 240.15g-2;

b. SEC Rule 15g-3, found at 17 CFR 240.15g-3;

c. SEC Rule 15g-4, found at 17 CFR 240.15g-4;

d. SEC Rule 15g-5, found at 17 CFR 240.15g-5; or

e. SEC Rule 15g-6, found at 17 CFR 240.15g-6;

D. Failing or refusing, after a solicited purchase of securities by a customer in connection with a principal transaction, to execute promptly sell orders in said securities placed by said customer;

E. In connection with a principal transaction, imposing as a condition of the purchase or sale of one security, the purchase or sale of another security;

F. Failure by a sales representative, in connection with a customer's purchase or sale of a security which is not recorded on the books and records of the broker-dealer by which the sales representative is employed or otherwise engaged, to obtain the broker-dealer's prior written approval of the sales representative's participation in the purchase or sale of the security.

G. Failing to comply with any of the following applicable fair practice or ethical standards contained in the following sections of the FINRA Rules:

1. Section 2000, Duties and Conflicts;

2. Section 3000, Supervision and Responsibilities Relating to Associated Persons;

3. Section 4000, Financial and Operational Rules; and

4. Section 5000, Securities Offering and Trading Standards and Practices.

H. In connection with the offer or sale of securities by mortgage broker-dealers and mortgage sales representatives:

1. Failing to provide to each investor prior to the time of the sale a written disclosure document which shall contain at least the following:

a. A description of the priority of the lien created by the security and the total face amount of any senior lien(s). (A title insurance policy running to the benefit of the purchaser may be provided in lieu of the description of the priority liens);

b. A statement as to whether any future advances may have a priority senior to that of the lien created by the security;

c. A copy of the most recent property tax statement covering the real property underlying the security;

d. The value of the real property underlying the security provided by either the tax assessed value if it is one hundred percent (100%) of the true cash value and is on the same property underlying the security, or an appraisal by an independent appraiser [subsequent to July 1, 1991, this appraisal must be performed by a licensed real estate appraiser under section 12-61-701, *et seq.,* C.R.S.];

e. The debtor's payment record on the instrument being sold for the two (2) years immediately preceding the sale or if not available, the payment record to date or a statement that payment records are not available, and a current credit report on the debtor prepared by a credit reporting agency or a current financial statement of the debtor;

f. The terms of any senior lien or a copy of the instrument creating the lien and any assignments;

g. A statement of any commissions, collection fees, and other costs chargeable to the purchaser of the security;

h. A prominent statement of any balloon payments;

i. In the case of a sale of a note, bond or evidence of indebtedness secured by a mortgage or deed of trust on real estate which is junior to one or more senior liens, a statement of the risk of loss on foreclosure of such senior lien(s); and

j. A statement as to whether or not the purchaser of the security will be insured against casualty loss;

2. Failing to deliver to the purchaser or licensed escrow agent or title company the original written evidence of the obligation properly endorsed or a lost instrument bond in twice the amount of the face value of the instrument, together with the original or a certified copy of the instrument creating the lien;

3. Failing in a timely manner to record or cause to be recorded the instrument creating the lien or assignment of lien involved in the county or counties where the property is located;

4. Causing an investor to sign a reconveyance of title, quit claim deed, or any like instrument before such instrument is required in connection with a transaction such as a payoff or a foreclosure;

5. Failing to deliver proceeds due to an investor within a reasonable time after receipt by the mortgage broker-dealer; or

6. In the case of a mortgage broker-dealer who undertakes to provide to an investor management and collection services in connection with the note, bond or evidence of indebtedness involved, failing to provide in writing to the investor that:

a. Payments received will be deposited in a specific loan escrow account immediately upon receipt by the mortgage broker-dealer;

b. Investor funds will not be commingled with those of the mortgage broker-dealer or used in any manner not specifically authorized in advance by the investor;

c. If the mortgage broker-dealer uses funds of the mortgage broker-dealer to make a payment due from the borrower to the investor, the mortgage broker-dealer may recover the amount of such advance from the specific loan escrow account when the past due payment is received by the mortgage broker-dealer from the borrower; and

d. That the mortgage broker-dealer will file a request for notice of default upon any prior encumbrance on the real property securing the obligation that is the subject of the servicing

agreement and will promptly notify the investor of any default on such prior encumbrance, or on the obligation.

I.

1. The use of a senior specific certification or designation by any person in connection with the offer, sale, or purchase of securities, or the provision of advice as to the value of or the advisability of investing in, purchasing, or selling securities, either directly or indirectly or through publications or writings, or by issuing or promulgating analyses or reports relating to securities, that indicates or implies that the user has special certification or training in advising or servicing senior citizens or retirees, in such a way as to mislead any person shall be a dishonest and unethical practice in the securities, commodities, and investment business within the meaning of the Colorado Securities Act. The prohibited use of such certifications or professional designation includes, but is not limited to, the following:

    a. use of a certification or professional designation by a person who has not actually earned or is otherwise ineligible to use such certification or designation;

    b. use of a nonexistent or self-conferred certification or professional designation;

    c. use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training, or experience that the person using the certification or professional designation does not have; and

    d. use of a certification or professional designation that was obtained from a designating or certifying organization that:

        i. is primarily engaged in the business of instruction in sales and/or marketing;

        ii. does not have reasonable standards or procedures for assuring the competency of its designees or certificants;

        iii. does not have reasonable standards or procedures for monitoring and disciplining its designees or certificants for improper or unethical conduct; or

        iv. does not have reasonable continuing education requirements for its designees or certificants in order to maintain the designation or certificate.

2.

    a. There is a rebuttable presumption that a designating or certifying organization is not disqualified solely for purposes of paragraph 1(d) above when the organization has been accredited by:

        1. The American National Standards Institute; or

        2. The National Commission for Certifying Agencies.

    b. Certifications or professional designations offered by an organization that is on the United States Department of Education's list entitled "Accrediting Agencies Recognized for Title IV Purposes" may qualify when the certification or professional designation program also specifically meets the paragraph 1(d) requirements listed above.

3. In determining whether a combination of words (or an acronym standing for a combination of words) constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing senior citizens or retirees, factors to be considered shall include:

    a. use of one or more words such as "senior," "retirement," "elder," or like words, combined with one or more words such as "certified," "registered," "chartered," "adviser," "specialist," "consultant," "planner," or like words, in the name of the certification or professional designation; and

    b. the manner in which those words are combined.

4. For purposes of this Rule, a certification or professional designation does not include a job title within an organization that is licensed or registered by a state or federal financial services regulatory agency, when that job title:

   a. indicates seniority or standing within the organization; or

   b. specifies an individual's area of specialization within the organization

   For purposes of this subsection, financial services regulatory agency includes, but is not limited to, an agency that regulates broker-dealers, investment advisers, or investment companies as defined under the Investment Company Act of 1940.

5. Nothing in this Rule shall limit the Securities Commissioner's authority to enforce existing provisions of law.

J. Failing to comply with a child support order as described in section 26-13-126, C.R.S. This rule incorporates the requirements of section 26-13-126, C.R.S. An individual may inspect a copy of section 24-13-126, C.R.S. by making such request to the Colorado Department of Human Services at 1575 Sherman Street, 8th Floor, Denver, Colorado 80203 or the Colorado Division of Securities at 1560 Broadway, Suite 900, in Denver, Colorado 80203.

51-4.8 Broker-Dealer Cybersecurity

A. A broker-dealer must establish and maintain written procedures reasonably designed to ensure cybersecurity. In determining whether the cybersecurity procedures are reasonably designed, the commissioner may consider:

   1. The firm's size;

   2. The firm's relationships with third parties;

   3. The firm's policies, procedures, and training of employees with regard to cybersecurity practices;

   4. Authentication practices;

   5. The firm's use of electronic communications;

   6. The automatic locking of devices that have access to Confidential Personal Information; and

   7. The firm's process for reporting of lost or stolen devices;

B. A broker-dealer must include cybersecurity as part of its risk assessment.

C. To the extent reasonably possible, the cybersecurity procedures must provide for:

   1. An annual assessment by the firm or an agent of the firm of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of Confidential Personal information;

   2. The use of secure email for email containing Confidential Personal Information, including use of encryption and digital signatures;

   3. Authentication practices for employee access to electronic communications, databases and media;

   4. Procedures for authenticating client instructions received via electronic communication; and

   5. Disclosure to clients of the risks of using electronic communications.

CHAPTER 4 (IA) NOTICE FILING FROM FEDERAL COVERED ADVISERS. LICENSING OF INVESTMENT ADVISERS AND INVESTMENT ADVISER REPRESENTATIVES

51-4.1(IA) General Provisions

A. Pursuant to section 11-51-403(4), C.R.S., the Securities Commissioner designates the IARD to receive and store filings and collect related fees from investment advisers and investment adviser representatives on behalf of the Securities Commissioner.

B. Unless otherwise provided, all investment adviser and investment adviser representative applications, amendments, reports, notices, related filings and fees required to be filed with the Securities Commissioner

on or after July 31, 2001, shall be filed electronically with and transmitted to IARD. The following conditions relate to such electronic filings:

1. When a signature or signatures are required by the particular instructions of any filing to be made through IARD, a duly authorized officer of the applicant or the applicant him or herself, as may be, shall affix his or her electronic signature to the filing by typing his or her name in the appropriate fields and submitting the filing to IARD. Submission of a filing in this manner shall constitute irrefutable evidence of legal signature by any individuals whose names are typed on the filing.

2. Solely for the purposes of a filing made through IARD, a document is considered filed with the Securities Commissioner when all fees are received and the filing is accepted by IARD on behalf of the Securities Commissioner.

C. Notwithstanding subsection B. of this Rule, the electronic filing of any particular document and the collection of related processing fees, if any, shall not be required until such time as IARD provides for receipt of such filings and fees and 30 days notice is provided by the Securities Commissioner. The notice provided by the Securities Commissioner may set the effective date for any such electronic filing. Any documents or fees required to be filed with the Securities Commissioner that are not permitted to be filed with or cannot be accepted by IARD shall be filed directly with the Securities Commissioner.

D. Investment advisers or investment adviser representatives licensed or required to be licensed in Colorado who experience unanticipated technical difficulties that prevent submission of an electronic filing to IARD may request a temporary hardship exemption from the requirements to file electronically, upon compliance with the following conditions:

1. File Form ADV-H in paper format with the Securities Commissioner no later than one business day after the filing subject to the Form ADV-H was due; and

2. Submit the filing that is the subject of the Form ADV-H in electronic format to IARD no later than seven (7) business days after the filing was due.

The hardship exemption will be deemed effective upon receipt by the Securities Commissioner of the complete Form ADV-H, and only for the period provided in this paragraph F. Multiple temporary hardship exemption requests within the same calendar year may be disallowed by the Securities Commissioner.

51-4.2(IA) Notice Filing from a Federal Covered Adviser

A. The notice filing for a federal covered adviser pursuant to section 11-51-403(3), C.R.S., shall be filed with IARD on an executed Form ADV (Uniform Application for Investment Adviser Registration). A notice filing of a federal covered adviser shall be deemed filed when the fee required by section 11-51-403(4), C.R.S., and the Form ADV are filed with and accepted by IARD on behalf of the Securities Commissioner.

B. Until IARD provides for the filing of Part 2 of Form ADV, the Securities Commissioner will deem filed Part 2 of Form ADV if a federal covered adviser provides, within 5 days of a request from the Securities Commissioner, Part 2 of Form ADV. Because the Securities Commissioner deems Part 2 of the Form ADV to be filed, a federal covered adviser is not required to submit Part 2 of Form ADV to the Securities Commissioner unless requested.

C. The annual renewal of the notice filing for a federal covered adviser pursuant to section 11-51-403, C.R.S., shall be filed with IARD. The renewal of the notice filing for a federal covered adviser shall be deemed filed when the fee required by section 11-51-403(4), C.R.S., is submitted to and accepted by IARD on behalf of the Securities Commissioner.

D. A federal covered adviser must file with IARD, in accordance with the instructions in the Form ADV, any amendments to the federal covered adviser's Form ADV.

E. A federal covered adviser must also file a Consent to Service of Process form (see Rule 51-7.1) with the Securities Commissioner.

51-4.3(IA) Application for an Investment Adviser License

A. A person applying for an initial license as an investment adviser in Colorado shall make application for such license by completing Form ADV (Uniform Application for Investment Adviser Registration) in accordance with the form instructions and by filing the form with IARD.

B. Any applicant for an investment adviser license must also file a Consent to Service of Process form (see Rule 51-7.1) with the Securities Commissioner.

C. An application and any amendments to such application shall be deemed filed with the Securities Commissioner on the date any required fee and all required submissions have been received by the Securities Commissioner.

D. Unless a proceeding under section 11-51-410, C.R.S., is instituted, the license of an investment adviser becomes effective upon the last to occur of the following:

1. The passage of thirty days after the filing of the application or, in the event any amendment is filed before the license becomes effective, the passage of thirty days after the filing of the latest amendment, if the application, including all amendments, if any, was complete at the commencement of the thirty-day period;

2. The requirements of section 11-51-407, C.R.S., are satisfied;

3. The fee required under section 11-51-403, C.R.S., have been paid; and

4. Any other information the Securities Commissioner may reasonably require.

E. The annual license fee required by section 11-51-404, C.R.S., for an investment adviser shall be filed with IARD.

F. Updates and amendments to an investment adviser's Form ADV shall be filed with IARD in accordance with the instructions in Form ADV. An amendment will be considered promptly filed if the amendment is filed within thirty (30) days of the event that requires the filing of the amendment.

G. Within ninety (90) days after the end of the investment adviser’s fiscal year, an investment adviser shall file with IARD an Annual Updating Amendment of Form ADV.

H. The Securities Commissioner may authorize an earlier effective date of licensing.

I. The license of an investment adviser is effective until terminated by revocation or withdrawal.

J. Acts or practices which require licensing as an investment adviser and compliance with statutes and Rules pertaining thereto

1. Lawyers, accountants, engineers or teachers

a. A lawyer, accountant, engineer or teacher (professional) must be licensed as an investment adviser or investment adviser representative if the professional provides investment advice or investment advisory services to the professional's clients for a fee, if the advice is not "solely incidental" to the professional's regular professional practice with respect to clients.

b. For purposes of this subparagraph (1), providing investment advice under ANY of the following circumstances would NOT be considered to be "solely incidental":

i The investment advice the professional or the investment advisory service the professional renders clients is the primary professional advice for which the professional charges or is paid a fee;

ii. The professional advertises or otherwise holds himself out to the public as a provider of investment advice; or

iii. The professional holds funds for clients pursuant to discretionary authority to invest such funds.

c. The following are examples to assist in understanding the meaning of "solely incidental":

i. If the primary professional advice for which the professional receives a fee involves business or tax planning and the professional neither advertises or otherwise holds himself out as a provider of investment advice, nor holds funds which the professional invests for clients. The professional may also provide investment

advice to clients in connection with the planning or other professional services, without being required to become licensed as an investment adviser.

ii. If the professional advertises or otherwise holds himself out as a provider of investment advice, the professional must be licensed as an investment adviser whether or not the professional actually provides investment advice.

iii. If the professional holds client funds which the professional invests for the client, the professional must be licensed as an investment adviser whether or not the professional actually provides investment advice.2. Broker-dealers and broker-dealer agents

a. A broker-dealer or broker-dealer agent must be licensed as an investment adviser or investment adviser representative if for a fee, the securities broker-dealer or sales agent of the securities broker-dealer provides investment advice to clients if the investment advice is not "solely incidental" to the conduct of business as a broker-dealer or broker-dealer agent.

b. For purposes of this subparagraph, providing investment advice under ANY of the following circumstances would NOT be considered "solely incidental":

i. Providing investment advice to a client for a fee in addition to any commission received in connection with transactions in which the client either purchases or sells securities;

ii. Providing investment advice, for a fee, to clients who are not clients of the broker-dealer with which the agent is licensed; or

iii. Receiving compensation from an investment adviser to whom the broker-dealer or agent refers clients.

3. Insurance agents

a. An insurance agent who, for a fee, provides investment advice to a client must be licensed as an investment adviser or investment adviser representative.

b. An insurance agent who, performs an analysis of a client's estate, for a fee, which recommends that the client purchases or sells either specific securities or specific types of securities must be licensed as an investment adviser or investment adviser representative.

c. An insurance agent who, receives a commission from the sale of insurance to a client who makes such purchase with the proceeds of securities the insurance agent recommended be sold, must be licensed as an investment adviser or investment adviser representative.

4. Others

a. One must be licensed as an investment adviser or investment adviser representative, as appropriate, whether or not described in subparagraphs (1), (2), or (3) of paragraph (J) if:

i. Advertising, or otherwise holding oneself out as a provider of investment advice;

ii. Publishing a newspaper, news column, newsletter, news magazine, or business or financial publication, which, for a fee, gives investment advice based upon the specific investment situations of the clients; or

iii. Receiving a fee from an investment adviser for client referrals.

51-4.4(IA) Application for an Investment Adviser Representative License

A. A person applying for a license as an investment adviser representative in Colorado pursuant to section 11-51-403, C.R.S., shall make application for such license and any amendments to such application by completing Form U-4 (Uniform Application for Securities. Industry Registration or Transfer) in accordance with the form instructions and by filing the Form U-4 with IARD. The application for such initial licensing shall also include the following:

1. The fee required by section 11-51-403, C.R.S.;

2. Verification of the applicant's lawful presence in the United States by providing to the affiliated Investment Adviser any of the following documents:

   a. Federal Form I-9 Employment Eligibility Verification Form;

   b. An executed affidavit stating that he or she is a United States citizen or legal permanent resident in a form substantially similar to Form AE;

3. Documentation verifying the applicant's identity by providing to the affiliated Investment Adviser any of the following documents:

   a. Any Colorado Driver License, Colorado Driver permit, or Colorado Identification Card, expired less than one year (Temporary paper license with invalid Colorado Driver License, Colorado Driver Permit, or Colorado Identification Card, expired less than one year is considered acceptable);

   b. Out-of-state issued photo Driver's License or photo identification card, photo driver's permit expired less than one year;

   c. Valid foreign passport with I-94 or validly processed for 1551 stamps;

   d. Valid I-94 issued by Canadian government with L1 or R1 status and a valid Canadian driver's license or valid Canadian identification card;

   e. Valid 1551 Resident Alien/Permanent Resident card. No border crosser or USA B1/B2 Visa/BCC cards;

   f. Valid 1688 Temporary Resident Card, 1688B and 1766 Employment Authorization Card;

   g. Valid U.S. Military Identification (active duty, dependent, retired, reserve and National Guard);

   h. Tribal Identification Card with intact photo (U.S. or Canadian);

   i. Certificate of Naturalization with intact photo;

   j. Certificate of U.S. Citizenship with intact photo.

4. The Investment Adviser shall record, maintain, and preserve in an easily accessible place the documentation, or copies thereof, produced by the applicant or affiliated investment adviser representative in compliance with the subparagraphs (2) and (3) hereof.

5. Any other information the Securities Commissioner may reasonably require.

B. Any applicant for an investment adviser license must also file a Consent to Service of Process form (see Rule 51-7.1) with the Securities Commissioner.

C. An application and any amendments to such application shall be deemed filed with the Securities Commissioner on the date any required fee and all required submissions have been received by the Securities Commissioner.

D. An investment adviser representative is under a continuing obligation to update information required by Form U-4 as changes occur. In this regard, an investment adviser representative and the investment adviser must file promptly with IARD any amendments to the representative's Form U-4 to reflect such changes. Such amendment will be considered to be filed promptly if the amendment is filed within thirty (30) days of the event that requires the filing of the amendment.

E. Except as otherwise provided in sections F and G below, an applicant for a license under section 11-51-403, C.R.S., as an investment adviser representative shall obtain a passing score on one of the following examinations:

1. The Uniform Investment Advisor Law Examination (Series 65 examination) within the two (2) year period immediately preceding the date of the application for licensing; or

2. The Uniform Combined Law Examination (Series 66 examination) within the two (2) year period immediately preceding the date of the application for licensing and

   a. The General Securities Representative Examination (Series 7 examination) within a two (2) year

period immediately preceding the date of the application for licensing (Series 7 examination prior to October 1, 2018), or

b. An active agent registration or license (Series 7 examination qualified prior to October 1, 2018) within a two (2) year period immediately preceding the date of the application for licensing, or

c. As of October 1, 2018, The Securities Industry Essentials Examination (SIE examination) within four (4) or more years immediately preceding the date of the application for licensing and the revised Series 7 examination within a two (2) year period immediately preceding the date of the application for licensing, or

d. After October 1, 2018, an active agent registration or license (SIE examination four (4) or more years immediately preceding the date of the application for licensing and the Series 7 examination within a two (2) year period immediately preceding the date of the application for licensing).

F. At the discretion of the commissioner, an investment adviser representative who has been licensed or registered as an investment adviser representative, or its equivalent, under the securities act of any state or jurisdiction and whose most recent license or registration in such capacity has been terminated for not more than two years immediately before the date of the application for licensing shall not be required to satisfy the examination requirement in section (E) above.

G. The examination requirements described in section (E) above may be satisfied upon proof of alternative qualifications or credentials in good standing including:

1. Designation of Chartered Financial Analyst (CFA) granted by the Association for Investment Management and Research;

2. Designation of Chartered Investment Counselor (CIC) granted by the Investment Adviser Association;

3. Certification as a Chartered Financial Consultant (ChFC) granted by The American College;

4. Designation of Certified Financial Planner (CFP) by the Certified Financial Planner Board of Standards;

5. Designation of Personal Financial Specialist (PFS) granted by the American Institute of Certified Public Accountants.

H. The annual license fee required by section 11-51-404, C.R.S. for an investment adviser representative shall be filed with IARD.

I. Investment Adviser Representative Business Email.

1. Each person licensed as an investment adviser representative in this state shall file such person's current business email address annually with the Securities Commissioner. The business email address shall be filed electronically through a link provided by the Division on its website.

2. Each person's employing investment adviser may file the person's required email address with the Securities Commissioner on behalf of the person using a form designated by the Securities Commissioner.

J. Regardless of subsection (A) of this provision, an investment adviser representative applicant, who also has an unpaid FINRA arbitration award against them, pursuant to section 11-51-403, C.R.S. must submit a written explanation stating the reason(s) for not paying the award. In addition, the applicant must provide the following:

1. Where the complaint was filed, who filed the complaint, and the facts and circumstances surrounding the complaint;

2. Type of controversy and type of security involved;

3. The final order from arbitration;

4. Any other information reasonably related to the proceeding.

51-4.5(IA) Withdrawal of an Investment Adviser or Investment Adviser Representative License

A. An application for withdrawal from licensing as an investment adviser in Colorado and any amendment to such application shall be completed by following the instructions on Form ADV-W (Notice of Withdrawal from Registration as Investment Adviser) and filed upon Form ADV-W with IARD.

B. An application for withdrawal from licensing as an investment adviser representative for an investment adviser or federal covered adviser in Colorado and any amendment to such application shall be completed by following the instructions on Form U-5 (Uniform Termination Notice for Securities Industry Registration) and filed upon Form U-5 with IARD.

C. The Securities Commissioner may deem an application for licensing as an investment adviser or investment adviser representative to be abandoned when an applicant fails to adequately respond to any request for additional information required under § 11-51-403, C.R.S. or the regulations thereunder. The Commissioner shall provide written notice of warning 30 calendar days before such the application is deemed abandoned. The applicant may, with the consent of the Commissioner, withdraw the application.

51-4.6(IA) Books and Records Requirements for Licensed Investment Advisers

A. Except as otherwise provided in section I for out-of-state investment advisers, every investment adviser licensed or required to be licensed under the Act shall make and keep true, accurate and current the following books, ledgers and records:

1. A journal or journals, including cash receipts and disbursements records, and any other records of original entry forming the basis of entries in any ledger;

2. General and auxiliary ledgers (or other comparable records) reflecting asset, liability, reserve, capital, income and expense accounts;

3. A memorandum of each order given by the investment adviser for the purchase or sale of any security, of any instruction received by the investment adviser from the client concerning the purchase, sale, receipt or delivery of a particular security, and of any modification or cancellation of any such order or instruction. In any such memorandum, the investment adviser shall:

   a. show the terms and conditions of the order, instruction, modification or cancellation;

   b. identify the person connected with the investment adviser who recommended the transaction to the client and the person who placed the order; and

   c. show the account for which entered, the date of entry, and the bank, broker-dealer by or through whom executed where appropriate.

   d. Orders entered pursuant to the exercise of discretionary power shall be so designated;

4. All check books, bank statements, canceled checks and cash reconciliations of the investment adviser;

5. All bills or statements (or copies of), paid or unpaid, relating to the investment adviser's business as an investment adviser;

6. All trial balances, financial statements (prepared in accordance with generally accepted accounting principles i.e. accrual basis) and internal audit working papers relating to the investment adviser's business as an investment adviser. [For purposes of this subsection, the term “financial statements” means a balance sheet prepared in accordance with generally accepted accounting principles, an income statement and a cash flow statement];

7. Originals of all written communications received and copies of all written communications sent by the investment adviser relating to:

a. any recommendation made or proposed to be made and any advice given or proposed to be given;

b. any receipt, disbursement or delivery of funds or securities; or

c. the placing or execution of any order to purchase or sell any security, provided, however, that the investment adviser shall not be required to keep any unsolicited market letters and other similar communications of general public distribution not prepared by or for the investment adviser; and if the investment adviser sends any notice, circular or other advertisement offering any report, analysis, publication or other investment advisory service to more than 10 persons, the investment adviser shall not be required to keep a record of the names and addresses of the persons to whom it was sent; except that if the notice, circular or advertisement is distributed to persons named on any list, the investment adviser shall retain with the copy of the notice, circular or advertisement, a memorandum describing the list and its source;

8. A list or other record of all clients and accounts, including a list of services provided to each client/account;

9. A copy of all powers of attorney and other evidences of the granting of any discretionary authority by any client to the investment adviser;

10. A copy in writing of each agreement or investment advisory contract entered into by the investment adviser with any client, and all other written agreements otherwise relating to the investment adviser's business as an investment adviser;

11. A file containing a copy of each notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication (including by electronic media) the investment adviser circulates or distributes, directly or indirectly, to two or more persons (other than persons connected with the investment adviser), and, if in such notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication (including by electronic media), the investment adviser recommends the purchase or sale of a specific security but does not state the reasons for the recommendation, a memorandum of the investment adviser indicating the reasons for the recommendation;

12. A record of transactions in a security in which the investment adviser or any advisory representative (as hereinafter defined) of the investment adviser has, or by reason of any transaction acquires, any direct or indirect beneficial ownership (except transactions effected in any account over which neither the investment adviser nor any advisory representative of the investment adviser has any direct or indirect influence or control, and transactions in securities that are direct obligations of the United States),

a. such record shall state:

i. the title and amount of the security involved;

ii. the date and nature of the transaction (i.e., purchase, sale or other acquisition or disposition);

iii. the price at which it was effected; and

iv. the name of the broker-dealer or bank with or through whom the transaction was effected.

b. The record may also contain a statement in which the investment adviser declares that the reporting or recording of any transaction shall not be construed as an admission the investment adviser or advisory representative has any direct or indirect beneficial ownership in the security.

c. A transaction shall be recorded not later than 10 days after the end of the calendar quarter in which the transaction was effected.

d. For purposes of this Rule subsection (A)(12):

i. the term “advisory representative” means:

A. any partner, officer or director of the investment adviser;

B. any employee who participates in any way in the determination of which recommendations shall be made;

C. any employee who, in connection with his/her duties, obtains any information concerning which securities are being recommended prior to the effective dissemination of the recommendations; and

D. any of the following persons who obtain information concerning securities recommendations being made by the investment adviser prior to the effective dissemination of the recommendations:

I. any person in a control relationship to the investment adviser;

II. any affiliated person of a controlling person; and

III. any affiliated person of an affiliated person;

ii. the term "control" means the power to exercise a controlling influence over the management or policies of a company, unless such power is solely the result of an official position with such company. Any person who owns beneficially, either directly or through one or more controlled companies, more than 25% of the voting securities of a company is presumed to control such company.

e. An investment adviser shall not be deemed to have violated the provisions of this Rule subsection (A)(12) because of the failure to record securities transactions of any advisory representative if the investment adviser establishes it instituted adequate procedures and used reasonable diligence to obtain promptly reports of all transactions required to be recorded.

13. Notwithstanding the provisions of Rule subsection (A)(12) above, where the investment adviser is primarily engaged in a business or businesses other than advising investment advisory clients, a record must be maintained of every transaction in a security in which the investment adviser or any advisory representative of the investment adviser has, or by reason of any transaction acquires, any direct or indirect beneficial ownership (except transactions effected in any account over which neither the investment adviser nor any advisory representative of the investment adviser has any direct or indirect influence or control; and transactions in securities that are direct obligations of the United States),

a. such record shall state:

i. the title and amount of the security involved;

ii. the date and nature of the transaction (*i.e.*, purchase, sale, or other acquisition or disposition);

iii. the price at which it was effected; and

iv. the name of the broker-dealer or bank with or through whom the transaction was effected.

b. The record may also contain a statement in which the investment adviser declares that the reporting or recording of any transaction shall not be construed as an admission that the investment adviser or advisory representative has any direct or indirect beneficial ownership in the security.

c. A transaction shall be recorded not later than 10 days after the end of the calendar quarter in which the transaction was effected.

d. For purposes of this Rule subsection (A)(13):

i. An investment adviser is "primarily engaged in a business or businesses other than advising investment advisory clients" when, for each of its most recent three fiscal years or for the period of time since organization, whichever is lesser, the investment adviser derived, on an unconsolidated basis, more than 50% of:

A. its total sales and revenues; and

B. its income (or loss) before income taxes and extraordinary items, from such other business or businesses.

ii. the term “advisory representative”, when used in connection with a company primarily engaged in a business or businesses other than advising investment advisory clients, means any partner, officer, director or employee of the investment adviser who participates in any way in the determination of which recommendation shall be made, or whose functions or duties relate to the determination of which securities are being recommended prior to the effective dissemination of the recommendations; and any of the following persons, who obtain information concerning securities recommendations being made by the investment adviser prior to the effective dissemination of the recommendations or of the information concerning the recommendations:

A. any person in a control relationship to the investment adviser;

B. any affiliated person of a controlling person; and

C. any affiliated person of an affiliated person; and

iii. the term “control” means the power to exercise a controlling influence over the management or policies of a company, unless such power is solely the result of an official position with such company. Any person who owns beneficially, either directly or through one or more controlled companies, more than 25% of the voting securities of a company shall be presumed to control such company.

e. An investment adviser shall not be deemed to have violated the provisions of this Rule subsection (A)(13) because of the failure to record securities transactions of any advisory representative if the investment adviser establishes that it instituted adequate procedures and used reasonable diligence to obtain promptly reports of all transactions required to be recorded.

14. A copy of each written statement and each amendment or revision, given or sent to any client or prospective client of the investment adviser in accordance with the provisions of section 11-51-409.5, C.R.S. and a record of the dates that each written statement, and each amendment or revision, was given, or offered to be given, to any client or prospective client who subsequently becomes a client.

15. All accounts, books, internal working papers, and any other records or documents necessary to form the basis for or demonstrate the calculation of the performance or rate of return of all managed accounts or securities recommendations in any notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication including but not limited to electronic media that the investment adviser circulates or distributes, directly or indirectly, to two or more persons (other than persons connected with the investment adviser); provided, however, that, with respect to the performance of managed accounts, the retention of all account statements, if they reflect all debits, credits, and other transactions in a client's account for the period of the statement, and all worksheets necessary to demonstrate the calculation of the performance or rate of return of all managed accounts satisfies the requirements of this Rule subsection (A)(16).

16. A file containing a copy of all written communications received or sent regarding any litigation involving the investment adviser or any investment adviser representative or employee, and regarding any written customer or client complaint.

17. Written information about each investment advisory client that is the basis for making any recommendation or providing any investment advice to such client.

18. Written procedures to supervise the activities of employees and investment adviser representatives.

An investment adviser must establish and maintain written supervisory procedures to supervise the activities of employees and investment adviser representatives that are reasonably designed to achieve compliance with applicable securities laws and regulations.

19. A file containing a copy of each document (other than any notices of general dissemination) filed with or received from any state or federal agency or self-regulatory organization and that pertains to the licensee or its advisory representatives as that term is defined in Rule subsection (A)(12)(d) above, which file should contain, but is not limited to, all applications, amendments, renewal filings and correspondence.

20. Copies, with original signatures of the investment adviser's appropriate signatory and the investment adviser representative, of each initial Form U-4 and each amendment to Disclosure Reporting Pages (DRPs U-4) must be retained by the investment adviser and on behalf of the investment adviser representative for whom it is filing, and must be made available for inspection upon request by the Securities Commissioner.

21. A file memorializing the due diligence conducted for alternative and non-exchange traded investment products recommended to or purchased on behalf of clients.

B. If an investment adviser has custody or possession of securities or funds of any client, the following records are required to be made and kept in addition to those required in section (A) above:

1. A journal or other record showing all purchases, sales, receipts and deliveries of securities (including certificate numbers) for all accounts and all other debits and credits to the accounts;

2. A separate ledger account for each client showing all purchases, sales, receipts and deliveries of securities, the date and price of each purchase and sale, and all debits and credits;

3. Copies of confirmations of all transactions effected by or for the account of any client; and

4. A record for each security in which any client has a position, in which record shall be shown the name of each client having any interest in each security, the amount or interest of each client, and the location of each security;

C. Every investment adviser licensed or required to be licensed as such under the Act who renders any investment supervisory or management service to any client shall, with respect to the portfolio being supervised or managed and to the extent that the information is reasonably available to or obtainable by the investment adviser, make and keep true, accurate and current:

1. Records in which are shown separately for each client the securities purchased and sold, and the date, amount and price of each purchase and sale; and

2. For each security in which any client has a current position, information from which the investment adviser can promptly furnish the name of each client, and the current amount or interest of the client;

D. Any required books or records may be maintained by the investment adviser in such manner that the identity of any client to whom the investment adviser renders investment supervisory services are indicated by numerical or alphabetical code or some similar designation;

E. Every investment adviser licensed or required to be licensed as such under the Act shall preserve the following records in the manner prescribed:

1. All books and records required to be made under the provisions of Rule sections (A) and (B) and subsection (C)(1) above, inclusive, [except for books and records required to be made under the provisions of Rule subsections (A)(11) and (16) above], shall be maintained and preserved in an easily accessible place for a period of not less than five years from the end of the fiscal year during which the last entry was made on record, the first two years in the principal office of the investment adviser;

2. Partnership articles and any amendments, articles of incorporation, charters, minute books, and stock certificate books of the investment adviser and of any predecessor, shall be maintained in the principal office of the investment adviser and preserved until at least three years after termination of the enterprise;

3. Books and records required to be made under the provisions of Rule subsections (A)(11) and (16) above shall be maintained and preserved in an easily accessible place for a period of not less than five years, the first two years in an the principal office of the investment adviser, from the end of the fiscal year during which the investment adviser last published or otherwise disseminated, directly or

indirectly, the notice, circular, advertisement, newspaper article, investment letter, bulletin, or other communication including by electronic media;

4. Books and records required to be made under the provisions of subsections (A)(17)-(A)(20), inclusive, of this Rule shall be maintained and preserved in an easily accessible place for a period of not less than five years from the end of the fiscal year during which the last entry was made on such record, the first two years in the principal office of the investment adviser, or for the time period during which the investment adviser was licensed or required to be licensed in the state, if less;

5. Notwithstanding other record preservation requirements of this Rule, the following records or copies shall be required to be maintained at the business location of the investment adviser from which the customer or client is being provided or has been provided with investment advisory services:

   a. records required to be preserved under Rule subsections (A)(3), (7)–(10), (14)–(15), (17)–(19), and sections (B) and (C) above, inclusive; and

   b. records or copies required under the provision of Rule subsections (A)(11) and (16) above in which records or related records identify the name of the investment adviser representative providing investment advice from that business location, or which identify the business locations' physical address, mailing address, electronic mailing address, or telephone number.

   c. The records will be maintained for the period described in this Rule section (E)

F. An investment adviser licensed or required to be licensed as such under the Act, before ceasing to conduct or discontinuing business as an investment adviser, shall arrange and be responsible for the preservation of the books and records required to be maintained and preserved under this Rule for the remainder of the period specified in this Rule, and shall notify the Securities Commissioner in writing of the exact address where the books and records will be maintained during the period.

1. The records required to be maintained and preserved pursuant to this Rule may be immediately produced or reproduced by photograph on film or, as provided in Rule subsection (F)(2) below, on magnetic disk, tape or other computer storage medium, and be maintained and preserved for the required time in that form. If records are produced or reproduced by photographic film or computer storage medium, the investment adviser shall:

   a. arrange the records and index the films or computer storage medium so as to permit the immediate location of any particular record;

   b. be ready at all times to provide promptly any facsimile enlargement of film or computer printout or copy of the computer storage medium that the examiners or other representatives of the Securities Commissioner request;

   c. store separately from the original one other copy of the film or computer storage medium for the time required;

   d. with respect to records stored on computer storage medium, maintain procedures for maintenance and preservation of, and access to, records so as to reasonably safeguard records from loss, alteration, or destruction; and

   e. with respect to records stored on photographic film, at all times have available for the Securities Commissioner's examination of its records pursuant to section 11-51-409 of the Act, facilities for immediate, easily readable projection of the film and for producing easily readable facsimile enlargements.

2. Pursuant to Rule subsection (F)(1) above, an investment adviser may maintain and preserve on computer tape or disk or other computer storage medium records that, in the ordinary course of the investment adviser's business, are created by the investment adviser on electronic media or are received by the investment adviser solely on electronic media or by electronic data transmission.

G. For purposes of Rule 51-4.6(IA):

1. the term “investment supervisory services” means the giving of continuous advice as to the investment of funds on the basis of the individual needs of each client; and

2. the term “discretionary power” does not include discretion as to the price at which or the time when a transaction is or is to be effected, if, before the order is given by the investment adviser, the client has directed or approved the purchase or sale of a definite amount of the particular security.

H. Any book or other record made, kept, maintained and preserved in compliance with Rules 17a-3 [17 C.F.R. 240.17a-3] and 17a-4 [17 C.F.R. 240.17a-4] under the 34 Act that is substantially the same as the book or other record required to be made, kept, maintained and preserved under this Rule 51-4.6(IA) shall be deemed to be made, kept, maintained and preserved in compliance with this Rule.

I. Every investment adviser licensed or required to be licensed in this state and that has its principal place of business in a state other than this state shall be exempt from the requirements of this Rule, provided the investment adviser is licensed or registered in such state and is in compliance with such state's recordkeeping requirements.

51-4.7(IA) Mandatory Disclosure

A. An investment adviser and its investment adviser representative shall furnish each advisory client and prospective advisory client a copy of Part 2 of the investment adviser's Form ADV.

B. INITIAL DELIVERY. An investment adviser and its investment adviser representative, except as provided in section (F), shall deliver the disclosure statement required by this section to an advisory client or prospective advisory client:

1. not less than 48 hours prior to entering into any written investment advisory contract with such client or prospective client, or

2. at the time of entering into any such contract, if the advisory client has a right to terminate the contract without penalty within five business days after entering into the contract.2.

C. ANNUAL DELIVERY: An investment adviser and its investment adviser representative, except as provided in section (F) must:

1. Deliver within one hundred twenty days of the end of your fiscal year a free, updated disclosure statement required by this section which include or are accompanied by a summary of the material changes; or

2. Deliver a summary of material changes that includes an offer to provide a copy of the updated disclosure statement and information on how the client may obtain a copy of the disclosure statement.

D. An investment adviser and its investment adviser representative shall furnish each advisory client or prospective client participating in a wrap fee program a copy of Part 2 of the investment advisors Form ADV in addition to a copy of Part 2A Appendix 1 of Form ADV (the wrap fee brochure).

E. An investment adviser and its investment adviser representative shall furnish each advisory client or prospective client participating in a pooled investment vehicle, including hedge funds, a copy of Part 2 of the investment adviser’s Form ADV.

F. Delivery of the statement required by section (A) need not be made to clients who receive only impersonal advise and who pay less than $500 in fees per year.

G. Nothing in this rule shall relieve any investment adviser or investment adviser representative from any obligation pursuant to any provision of the Act or the Rules and regulations thereunder or other federal or state law to disclose any information to its advisory clients or prospective advisory clients not specifically required by this Rule.

51-4.8(IA) Dishonest and Unethical Conduct

Introduction

A person who is an investment adviser, an investment adviser representative or a federal covered adviser is a fiduciary and has a duty to act primarily for the benefit of its clients. The provisions of this subsection apply to federal covered advisers to the extent that the conduct alleged is fraudulent, deceptive, or as otherwise permitted by the National Securities Markets Improvement Act of 1996 (Pub. L. No. 104-290). While the extent and nature of this duty varies according to the nature of the relationship between an investment adviser or an investment adviser

representative and its clients and the circumstances of each case, an investment adviser, an investment adviser representative or a federal covered adviser shall not engage in unethical business practices, including the following:

A. Recommending to a client, to whom investment supervisory, management or consulting services are provided, the purchase, sale, or exchange of any security without reasonable grounds to believe that the recommendation is suitable for the client on the basis of information furnished by the client after reasonable inquiry concerning the client's investment objectives, financial situation and needs, and any other information known by the investment adviser.

B. Exercising any discretionary power in placing an order for the purchase or sale of securities for a client without obtaining written discretionary authority from the client within ten (10) business days after the date of the first transaction placed pursuant to oral discretionary authority, unless the discretionary power relates solely to the price at which, or the time when, an order involving a definite amount of a specific security that shall be executed, or both.

C. Inducing trading in a client's account that is excessive in size or frequency in view of the client's financial resources, investment objectives and the character of the account in light of the fact that an adviser in such situations can directly benefit from the number of securities transactions effected in a client's account.

D. Placing an order to purchase or sell a security for the account of a client without authority to do so.

E. Placing an order to purchase or sell a security for the account of a client upon instruction of a third party without first having obtained a written third-party trading authorization from the client.

F. Borrowing money or securities from a client, unless the client is a broker-dealer, an affiliate of the investment adviser, a family member, or a financial institution engaged in the business of loaning funds.

G. Loaning money to a client unless the investment adviser is a financial institution engaged in the business of loaning funds or the client is an affiliate of the investment adviser or a family member.

H. To misrepresent to any advisory client, or prospective advisory client, the qualifications of the investment adviser or any employee of the investment adviser, or to misrepresent the nature of the advisory services being offered or fees to be charged for such service, or to omit to state a material fact necessary to make the statements made regarding qualifications, services, or fees, in light of the circumstances under which they are made, not misleading.

I. Providing a report or recommendation to any advisory client prepared by someone other than the adviser without disclosing that fact. This prohibition does not apply to a situation where the adviser uses published research reports or statistical analyses to render advice or where an adviser orders such a report in the normal course of providing service.

J. Charging a client an advisory fee that is unreasonable in light of the type of services to be provided, the experience of the adviser, the sophistication and bargaining power of the client, and whether the adviser has disclosed that lower fees for comparable services may be available from other sources.

K. Failing to disclose to clients, in writing, before any advice is rendered, any material conflict of interest relating to the adviser or any of its employees which could reasonably be expected to impair the rendering of unbiased and objective advice, including:

    1. Compensation arrangements connected with advisory services to clients which are in addition to compensation from such clients for such services; and

    2. Charging a client an advisory fee for rendering advice when a commission for executing securities transactions pursuant to such advice will be received by the adviser or its employees,

L. Guaranteeing a client that a specific result will be achieved (gain or no loss) with advice to be rendered.

M. Publishing, circulating, or distributing any advertisement which does not comply with Rule 206 (4)-1 under the 40 Act.

N. Disclosing the identity, affairs, or investments of any client, unless required by law to do so, or unless consented to by the client.

O. Taking any action, directly or indirectly, with respect to those securities or funds in which any client has any beneficial interest, where the investment adviser has custody or possession of such securities or funds when

the adviser's action is subject to and does not comply with the requirements of11-51-407(5)(a)-(f), C.R.S. or Reg. 206 (4) -2 under the 40 Act (for federally covered advisers).

P. Entering into, extending, or renewing any investment advisory contract, unless such contract is in writing and discloses, in substance, the information required by Part 2of Form ADV. The information required by Part 2 of Form ADV may be disclosed in a document other than the investment advisory contract, so long as it is disclosed at the time the contract is entered into, extended or renewed.

Q. Failing to establish, maintain, and enforce written policies and procedures reasonably designed to prevent the misuse of material nonpublic information in violation of Section 204A of the 40 Act.

R. Entering into, extending, or renewing any investment advisory contract contrary to the provisions of Section 205 of the 40 Act. This provision shall apply to all advisers and investment adviser representatives licensed or required to be licensed under this Act notwithstanding whether such adviser would be exempt from federal registration pursuant to section 203(b) of the 40 Act.

S. To indicate, in an advisory contract any condition, stipulation, or provision binding any person to waive compliance with any applicable provision of this Act, any Rule promulgated thereunder or the 40 Act, or any Rule promulgated thereunder, or to engage in or any other practice that would violate Section 215 of the 40 Act.

T. Engaging in any act, practice, or course of business which is fraudulent, deceptive, or manipulative in contrary to the provisions of Section 206(4) of the 40 Act notwithstanding the fact that such investment adviser is not registered or required to be registered under Section 203 of the 40 Act.

U. Engaging in any conduct or any act, indirectly or through or by any other person, which would be unlawful for such person to do directly under the provisions of this act or any Rule thereunder. Such conduct or act includes, but is not limited to, that conduct set forth in this Rule. Engaging in other conduct such as forgery, embezzlement, theft, exploitation, non-disclosure, incomplete disclosure or misstatement of material facts, manipulative or deceptive practices, or aiding or abetting any unethical practice, shall be deemed an unethical business practice and shall be grounds for denial, suspension or revocation of a license. The federal statutory and regulatory provisions referenced herein shall apply to all investment advisers and investment adviser representatives only to the extent permitted by the National Securities Markets Improvement Act of 1996.

V. The use of a senior specific certification or designation by any person in connection with the offer, sale, or purchase of securities, or the provision of advice as to the value of or the advisability of investing in, purchasing, or selling securities, either directly or indirectly or through publications or writings, or by issuing or promulgating analyses or reports relating to securities, that indicates or implies that the user has special certification or training in advising or servicing senior citizens or retirees, in such a way as to mislead any person shall be a dishonest and unethical practice in the securities, commodities, and investment business within the meaning of the Colorado Securities Act. The prohibited use of such certifications or professional designation includes, but is not limited to, the following:

1. use of a certification or professional designation by a person who has not actually earned or is otherwise ineligible to use such certification or designation;

2. use of a nonexistent or self-conferred certification or professional designation;

3. use of a certification or professional designation that indicates or implies a level of occupational qualifications obtained through education, training, or experience that the person using the certification or professional designation does not have; and

4. use of a certification or professional designation that was obtained from a designating or certifying organization that:

   a. is primarily engaged in the business of instruction in sales and/or marketing;

   b. does not have reasonable standards or procedures for assuring the competency of its designees or certificants;

   c. does not have reasonable standards or procedures for monitoring and disciplining its designees or certificants for improper or unethical conduct; or

d. does not have reasonable continuing education requirements for its designees or certificants in order to maintain the designation or certificate.

5.

a. There is a rebuttable presumption that a designating or certifying organization is not disqualified solely for purposes of paragraph 1(d) above when the organization has been accredited by:

i. The American National Standards Institute; or

ii. The National Commission for Certifying Agencies.

b. Certifications or professional designations offered by an organization that is on the United States Department of Education's list entitled "Accrediting Agencies Recognized for Title IV Purposes" may qualify when the certification or professional designation program also specifically meets the paragraph 1(d) requirements listed above.

6. In determining whether a combination of words (or an acronym standing for a combination of words) constitutes a certification or professional designation indicating or implying that a person has special certification or training in advising or servicing senior citizens or retirees, factors to be considered shall include:

a. use of one or more words such as "senior," "retirement," "elder," or like words, combined with one or more words such as "certified," "registered," "chartered," "adviser," "specialist," "consultant," "planner," or like words, in the name of the certification or professional designation; and

b. the manner in which those words are combined.

7. For purposes of this Rule, a certification or professional designation does not include a job title within an organization that is licensed or registered by a state or federal financial services regulatory agency, when that job title:

a. indicates seniority or standing within the organization; or

b. specifies an individual's area of specialization within the organization

For purposes of this subsection, financial services regulatory agency includes, but is not limited to, an agency that regulates broker-dealers, investment advisers, or investment companies as defined under the Investment Company Act of 1940.

8. Nothing in this Rule shall limit the Securities Commissioner's authority to enforce existing provisions of law.

W. Failing to provide advisory fee billing information to each client in compliance with the requirements of Rule 51-4.10(IA)(B)(2).

X. Accessing a client's account by using the client's own unique identifying information (such as username and password).

Y. Failing to comply with a child support order as described in section 26-13-126, C.R.S. This rule incorporates the requirements of section 26-13-126, C.R.S. An individual may inspect a copy of section 24-13-126, C.R.S. by making such request to the Colorado Department of Human Services at 1575 Sherman Street, 8th Floor, Denver, Colorado 80203 or the Colorado Division of Securities at 1560 Broadway, Suite 900, in Denver, Colorado 80203.

51-4.9(IA) Financial Reporting Requirements for Investment AdvisersEvery licensed investment adviser who has custody of client funds or securities other than that provided for in Rule 51-4.10(IA)B.2 or requires payment of advisory fees six months or more in advance in excess of $500 for any one client shall file an audited balance sheet with the commissioner at the end of the adviser's fisical year. The balance sheet filed pursuant to this Rule must be:

A. Audited by an independent certified public accountant;

B. Examined in accordance with generally accepted accounting auditing standards and prepared in conformity with GAAP;

C. Accompanied by an opinion of the accountant as to the report of financial position and by note stating the principles used to prepare it.

51-4.10(IA) Custody and Safekeeping Requirements

A. Definitions. For purposes of this section:

1. "Custody" means holding directly or indirectly, client funds or securities, or having any authority to obtain possession of them or has the ability to appropriate them.

a. Custody includes:

i. Any arrangement (including a general power of attorney) under which you are authorized or permitted to withdraw client funds or securities maintained with a custodian upon your instruction to the custodian; and

ii. Any capacity (such as general partner of a limited partnership, managing member of a limited liability company or a comparable position for another type of pooled investment vehicle) that gives you or your supervised person legal ownership of or access to client funds or securities.

2. "Independent representative" means a certified public accountant or attorney who:

a. Acts as agent for an advisory client, including in the case of a pooled investment vehicle, for limited partners of a limited partnership, members of a limited liability company, or other beneficial owners of another type of pooled investment vehicle and by law or contract is obliged to act in the best interest of the advisory client or the limited partners, members, or other beneficial owners;

b. Is engaged by you to act as a gatekeeper for the payment of fees, expenses and capital withdrawals from the pooled investment;

c. Does not control, is not controlled by, and is not under common control with the investment adviser, investment adviser representative, or any related entity; and

d. Does not have, and has not had within the past two years, a material business relationship with the investment adviser, investment adviser representative, or any related entity.

3. "Qualified custodian" means the following independent institutions or entities that are not affiliated with the adviser by any direct or indirect common control and have not had a material business relationship with the adviser in the previous two years:

a. A bank or savings association that has deposits insured by the Federal Deposit Insurance Corporation under the Federal Deposit Insurance Act;

b. A licensed broker-dealer holding the client assets in customer accounts;

c. A registered futures commission merchant registered under Section 4f(a) of the Commodity Exchange Act, holding the client assets in customer accounts, but only with respect to clients' funds and security futures, or other securities incidental to transactions in contracts for the purchase or sale of a commodity for future delivery and options thereon; and

d. A foreign financial institution that customarily holds financial assets for its customers, provided that the foreign financial institution keeps the advisory clients' assets in customer accounts segregated from its proprietary assets.

B. No investment adviser or investment adviser representative, licensed or required to be licensed in this state shall take or maintain custody or possession of any funds or securities in which any client of such person has any beneficial interest unless:

1. The investment adviser or investment adviser representative complies with § 11-51-407 (5)(a)-(f), or

2. If the investment adviser or investment adviser representative has custody as defined in Rule 51-4.10(IA).A.1 due solely by having fees directly deducted from the client accounts and complies and provides the following safeguard requirements:

a. Written Authorization. Investment advisers directly deducting fees must have written authorization from the client to deduct fees from the account held with the qualified custodian;

b. Notice of fee deduction. Each time a fee is charged directly to a client or directly deducted from a client account, the investment adviser must concurrently:

i. Send the qualified custodian an invoice specifying the amount of the fee to be deducted from the client's account; and

ii. Send the client an invoice specifying and itemizing the fee. Itemization includes the formula used to calculate the fee, the amount of assets under management or investment advisory services the fee is based on, the amount of time charged and the services provided for hourly billing and the time period covered by the fee;

c. The qualified custodian sends statements to the clients showing all disbursements for the custodian account, including the amount of the advisory fee. Statements should coincide with the investment adviser or investment adviser representative billing period.

d. The investment adviser notifies the Commissioner in writing that the investment adviser intends to use the safeguards provided above. Such notification is required to be given on Form ADV, or

3. If the investment adviser or investment adviser representative has custody as defined in Rule 51-4.10(IA).A.1 by having an association or an affiliation with a Pooled Investment Vehicle and complies and provides the following safeguard requirements:

a. Engage an Independent Representative. Hire an independent representative to review all fees, expenses and capital withdrawals from the pooled accounts;

b. Review of Fees. Send all invoices or receipts to the independent representative, detailing the amount of the fee, expenses or capital withdrawal and the method of calculation such that the independent representative can:

i. Determine that the payment is in accordance with the pooled investment vehicle standards (generally the partnership agreement or membership agreement); and

ii. Forward, to the qualified custodian, approval for payment of the invoice with a copy to the investment adviser.

c. Notice of Safeguards. The investment adviser notifies the Commissioner in writing that the investment adviser intends to use the safeguards provided above. Such notification is required to be given on Form ADV.

51-4.11(IA). Licensing Exemption for Investment Advisers to Private Funds.

A. Definitions. For purposes of this regulation, the following definitions shall apply:

1. "Value of primary residence" means the fair market value of a person's primary residence, subtracted by the amount of debt secured by the property up to its fair market value.

2. "Private fund adviser" means an investment adviser who provides advice solely to one or more qualifying private funds.

3. "Qualifying private fund" means a private fund that meets the definition of a qualifying private fund in SEC Rule 203(m)-1, 17 C.F.R. 275.203(m)-1.

4. "3(c)(1) fund" means a qualifying private fund that is eligible for the exclusion from the definition of an investment company under section 3(c)(1) of the Investment Company Act of 1940, 15 U.S.C. 80a-3(c)(1).

5. "Venture capital fund" means a private fund that meets the definition of a venture capital fund in SEC Rule 203(l)-1, 17 C.F.R. § 275.203(l)-1.

B. Exemption for private fund advisers. Subject to the additional requirements of paragraph (c) below, a private fund adviser shall be exempt from the licensing requirements of Section 11-51-401(1.5) if the private fund adviser satisfies each of the following conditions:

1. neither the private fund adviser nor any of its advisory affiliates are subject to an event that would disqualify an issuer under Rule 506(d)(1) of SEC Regulation D, 17 C.F.R. § 230.506(d)(1);

2. the private fund adviser files with the state each report and amendment thereto that an exempt reporting adviser is required to file with the Securities and Exchange Commission pursuant to SEC Rule 204-4, 17 C.F.R. § 275.204-4; and

3. the private fund adviser pays the fees prescribed by the securities commissioner.

C. Additional requirements for private fund advisers to certain 3(c)(1) funds. In order to qualify for the exemption described in paragraph (b) of this regulation, a private fund adviser who advises at least one (3)(c)(1) fund that is not a venture capital fund shall, in addition to satisfying each of the conditions specified in paragraphs (b)(1) through (b)(3), comply with the following requirements:

1. The private fund adviser shall advise only those 3(c)(1) funds (other than venture capital funds) whose outstanding securities (other than short-term paper) are beneficially owned entirely by persons who, after deducting the value of the primary residence from the person's net worth, would each meet the definition of a qualified client in SEC Rule 205-3, 17 C.F.R. § 275.205-3, at the time the securities are purchased from the issuer;

2. At the time of purchase, the private fund adviser shall disclose the following in writing to each beneficial owner of a 3(c)(1) fund that is not a venture capital fund:

   a. all services, if any, to be provided to individual beneficial owners;

   b. all duties, if any, the investment adviser owes to the beneficial owners; and

   c. any other material information affecting the rights or responsibilities of the beneficial owners.

3. The private fund adviser shall obtain on an annual basis audited financial statements of each 3(c)(1) fund that is not a venture capital fund, and shall deliver a copy of such audited financial statements to each beneficial owner of the fund.

D. Federal covered investment advisers. If a private fund adviser is licensed with the Securities and Exchange Commission, the adviser shall not be eligible for this exemption and shall comply with the state notice filing requirements applicable to federal covered investment advisers in Section 11-51-401(1.6)

E. Investment adviser representatives. A person is exempt from the licensing requirements of Section 11-51-403 if he or she is employed by or associated with an investment adviser that is exempt from licensing in this state pursuant to this regulation and does not otherwise act as an investment adviser representative.

F. Electronic filing. The report filings described in paragraph (B)(2) above shall be made electronically through the IARD. A report shall be deemed filed when the report and the fee prescribed by the securities commissioner are filed and accepted by the IARD on the state's behalf.

G. Transition. An investment adviser who becomes ineligible for the exemption provided by this Rule must comply with all applicable laws and Rules requiring licensing or notice filing within ninety (90) days from the date the investment adviser's eligibility for this exemption ceases.

H. Waiver Authority with Respect to Statutory Disqualification. Paragraph (B)(1) shall not apply upon a showing of good cause and without prejudice to any other action of the Colorado Securities Commissioner, if the securities commissioner determines that it is not necessary under the circumstances that an exemption be denied.

51-4.12(IA) Business Continuity and Succession Planning

A. Every investment adviser shall establish, implement, and maintain written procedures relating to a Business Continuity and Succession Plan.

B. The plan shall be based upon the facts and circumstances of the investment adviser's business model including the size of the firm, type(s) of services provided, and the number of locations of the investment adviser.

C. The plan shall provide for at least the following:

1. The protection, backup, and recovery of books and records.

2. Alternate means of communications with customers, key personnel, employees, vendors, service providers (including third-party custodians),and regulators, including, but not limited to, providing notice of a significant business interruption or the death or unavailability of key personnel or other disruptions or cessation of business activities.

3. Office relocation in the event of temporary or permanent loss of a principal place of business.

4. Assignment of duties to qualified responsible persons in the event of the death or unavailability of key personnel.

5. Otherwise minimizing service disruptions and client harm that could result from a sudden significant business interruption.

51-4.13(IA) Net Worth Requirements

A. Liquid Net Worth Requirements:

1. Positive Liquid Net Worth Requirement for Investment Advisers. An investment adviser must maintain a positive net worth at all times calculated under the requirements of Rule 51-4.6(IA)(A)(6).

2. Minimum Liquid Net Worth for Investment Advisers with Discretionary Authority. An investment adviser with discretionary authority over client funds or securities must maintain a minimum liquid net worth of ten thousand dollars ($10,000) at all times, unless the investment adviser is subject to the greater requirements of subdivision (3) below.

3. Minimum Liquid Net Worth for Investment Advisers with Custody. An investment adviser with custody of client funds or securities must maintain a minimum liquid net worth of thirty-five thousand dollars ($35,000) at all times, except investment advisors with custody solely because the investment adviser has fees directly deducted from client accounts and the investment adviser complies with the safekeeping requirements in 51-4.10(IA) above and the recordkeeping requirements of 51-4.6(IA);

4 Notification. An investment adviser must notify the commissioner by the close of business on the next business day if the investment adviser's liquid net worth is less than the minimum required. After filing the notice, the investment adviser must file a report with the commissioner of its financial condition by the close of business on the business day following notice including:

a. A trial balance of all ledger accounts;

b. A statement of all client funds or securities that are not segregated;

c. A computation of the aggregate amount of client ledger debit balances; and

d. A statement indicating the number of client accounts.

5. Appraisals. The commissioner may require an investment adviser to submit a current appraisal to establish the worth of any asset.

6. Exception for Out-of-State Advisers. An investment adviser with its principal place of business in a state other than Colorado, properly licensed in that state must maintain the minimum capital required by that state.

B. Surety Bond.

1. Additional Bond Requirement. An investment adviser with discretionary authority or custody who does not meet the minimum liquid net worth requirement of subdivisions (A)(2) and (3) above must also be bonded for the amount of the net worth deficiency rounded up to the nearest five thousand dollars ($5,000) and file a Form U-SB with the commissioner.

2. Exemptions. An investment adviser is exempt from the requirements of subdivision (1) above if the investment adviser:

a. Does not have discretionary authority; or

b. Has its principal place of business in a state other than Colorado, is properly licensed in that state, and satisfies the bonding requirements of that state.

51-4.14(IA) Investment Adviser Cybersecurity

A. An investment adviser must establish and maintain written procedures reasonably designed to ensure cybersecurity. In determining whether the cybersecurity procedures are reasonably designed, the commissioner may consider:

1. The firm's size;
2. The firm's relationships with third parties;
3. The firm's policies, procedures, and training of employees with regard to cybersecurity practices;
4. Authentication practices;
5. The firm's use of electronic communications;
6. The automatic locking of devices that have access to Confidential Personal Information; and
7. The firm's process for reporting of lost or stolen devices;

B. An investment adviser must include cybersecurity as part of its risk assessment.

C. To the extent reasonably possible, the cybersecurity procedures must provide for:

1. An annual assessment by the firm or an agent of the firm of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of Confidential Personal Information;
2. The use of secure email containing Confidential Personal Information, including use of encryption and digital signatures;
3. Authentication practices for employee access to electronic communications, databases and media;
4. Procedures for authenticating client instructions received via electronic communication; and
5. Disclosure to clients of the risks of using electronic communications

51-4.15(IA) Performance-Based Compensation Exemption for Investment Advisers

Any licensed investment adviser who wishes to charge a fee based on a share of the capital gains or the capital appreciation of the funds or any portion of the funds of a client must comply with SEC Rule 205-3 (17 Code of Federal Regulations §275.205-3), which permits the use of such fee if the client is a "qualified client" as defined therein.

CHAPTER 5 (Reserved for future use)

CHAPTER 6 PROCEDURES FOR HEARINGS CONDUCTED BY THE COLORADO SECURITIES BOARD AND THE OFFICE OF ADMINISTRATIVE COURTS

51-6.0 Definitions.

In addition to those terms defined in Rule 51-2.1, unless the context otherwise requires, the following are defined:

1. "Administrative Law Judge." An administrative law judge with the Office of Administrative Courts appointed pursuant to section 24-30-1001, et seq., C.R.S.
2. "Authorized Representative". An attorney, or other person authorized by a Party to represent him/her/it in a cease and desist proceeding.
3. "Board". The Colorado Securities Board as created pursuant to section 11-51-702.5, C.R.S.
4. "Business Day". Any calendar day except Saturday or Sunday, New Year's day, Dr. Martin Luther King Jr. day, Washington-Lincoln day, Memorial day, Independence day, Labor day, Columbus day, Veteran's day, Thanksgiving, Christmas, or any other day upon which the Division is not open for business.
5. "Party". The Division and/or the specifically named Person(s) whose legal rights, duties or privileges are being determined in a cease and desist proceeding; any other Person(s) who, as a matter of constitutional right or by any provision of the law, is entitled to participate fully in the proceeding.
6. "Presiding Member". The member of the Board designated by the chairperson to preside over a cease and desist proceeding before the Board.

7. “Person”. Those individuals, entities or organizations set forth in section 11-51-201(12), C.R.S.

8. “Respondent”. Party(ies) who are named in the petition filed by the Division initiating the cease and desist proceeding.

51-6.10 Representation

A**.** At all hearings, an individual may appear on his or her own behalf, or be represented by an attorney authorized to engage in the practice of law in Colorado. Any other person or entity who is a Party must be represented by an attorney who is licensed or otherwise authorized to engage in the practice of law in Colorado, except as described by § 13-1-127, C.R.S.

B. An attorney representing a Respondent shall enter his or her appearance with the Division, and as the case may be, with either the Office of Administrative Courts or the Board prior to the time a written answer is due. The entry of appearance shall contain the attorney’s name, address, telephone number, bar number, facsimile number, the firm name, if the attorney is a member of a law firm, and the name, address and telephone number of the Party represented.

51-6.1 Hearings to Review Either Summary Stop Orders or Summary Orders Suspending an Exemption

A. Any person against whom the Commissioner has entered either a summary stop order or a summary order suspending an exemption pursuant to section 11-51-606(3) (a) or (b), C.R.S. may make a written request for a hearing before the Colorado Securities Board (the “Board”). A written request in the form provided for by this Rule must be received by the Division within twenty-one (21) calendar days from the date of the order that is the subject of the appeal, or the Commissioner's order shall become final twenty-one days after entry if no such request is received.

B. The written request for hearing shall respond to each provision of the Commissioner's order and shall state with reasonable particularity the reasons why the order should not be continued. The written request shall further specify any dates within the next twenty-one (21) calendar days on which the requesting party shall be unable to attend a hearing.

C. Upon receipt of a satisfactory written request for a hearing, the Commissioner immediately shall notify the chairperson of the Board who, after consulting with other Board members, the Commissioner and the Attorney General's Office, shall set a date and time for the requested hearing within twenty-one (21) calendar days from the date the written request was received by the Division. Written notice of the date and time of the haring shall be provided immediately by mail to the parties. No continuance of the hearing shall be granted by the Board except as necessary to enable Board members to attend or as agreed to by mutual consent of all parties to the hearing.

D. The Board chairperson shall designate three (3) member of the Board to serve as a hearing panel to conduct the hearing and issue an initial decision on behalf of the Board. If a member of the hearing panel shall recuse himself or herself from participation, the remaining panel members shall conduct the hearing and issue the initial decision.

E. The sole issues for review at the hearing shall be whether the Commissioner's summary order was based upon sufficient evidence of violations of the securities laws and whether immediate issuance of the summary order was imperatively necessary for the protection of investors.

F. The hearing shall be conducted pursuant to section 24-4-105, C.R.S., the hearings provisions of the state Administrative Procedures Act. The hearing panel may order such procedures as may be necessary to conduct a fair hearing within the expedited time period, including, but not limited to: expedited discovery procedures, restrictions on the number of witnesses and length of testimony presented and limits on the length of argument and the extent of any motion practice.

G. A person requesting a hearing shall be represented by legal counsel, who shall enter an appearance when the request for hearing is filed, unless that person is an individual appearing on his or her own behalf. Notices concerning the hearing shall be mailed first class to the attorney of record or to the person if appearing on his or her own behalf.

H. No later than fourteen (14) calendar days following the completion of the hearing, unless extended by the hearing panel for good cause, the hearing panel shall issue its initial decision, accompanied by findings of fact and conclusions of law. A copy of the initial decision shall be mailed to the attorneys for the parties, and

to any individual appearing on his or her own behalf. The Commissioner shall enter his final decision, based upon the initial decision of the Board, that shall be a final order for purposes of judicial review.

51-6.2 Hearings on Orders to Show Cause Why a Securities License Should Not be Suspended Summarily

A. At the time of entry of an order to show cause pursuant to section 11-51-606(4), C.R.S. the Commissioner shall contact the chairperson of the Colorado Securities Board (the "Board") and obtain a date and time for a hearing before the board to consider the order to show cause. The hearing shall commence no sooner than seven (7), nor later than twenty (20), calendar days following the date the order to show cause is mailed to the persons against whom the order has been entered. The notice sent to such persons shall contain a copy of the order to show cause and specify the date and time for the hearing, which date shall not be continued. The notice shall be mailed as required by section 11-51-606(4) (b) and contain a certificate by an employee of the Division that the statutory requirements for providing notice have been met. Once commenced, the hearing may be recessed only if necessary to permit Board members to participate or upon mutual consent of the parties and approval by the Board.

B. No later than five (5) business days prior to the hearing date, the respondent shall file a written answer to the order to show cause responding specifically to the provisions of the order to show cause and raising any defenses that the respondent believes are applicable. A copy of the answer shall be filed with the Division, which shall provide copies immediately of the chairperson of the Board and the office of the attorney general.

C. The Board chairperson shall designate three (3) members of the Board to serve as a hearing panel to conduct the hearing and issue an initial decision on behalf of the Board. If a member of the hearing panel shall recuse himself or herself from participation, the remaining panel members shall conduct the hearing and issue the initial decision.

D. If the respondent does not appear at the date and time of the hearing, the Division shall present evidence that notification was promptly sent to the respondent as required by section 11-51-606(4) (b), C.R.S. and evidence to establish there is a reasonable basis to believe the respondent either received actual notice, or, after reasonable search by the Division, cannot be located. The Division shall have the burden to present evidence to establish that the securities license of the respondent should be suspended summarily or that the securities activities of the respondent should be limited or conditions imposed summarily pending final determination of a proceeding under the State Administrative Procedures Act.

E. The sole issues for review at the hearing shall be whether there is sufficient evidence that any of the grounds specified in section 11-51-410(1) exist so as to warrant summary suspension of respondent's securities license or the imposition of limitations on respondent's securities activities pending full administrative review.

F. The hearing shall be conducted pursuant to section 24-4-105, C.R.S., the hearings provision of the state Administrative Procedures Act. The hearing panel may order such procedures as may be necessary to conduct a fair hearing within the expedited time period, including, but not limited to: expedited discovery procedures, restrictions on the number of witnesses and length of testimony presented and limits on the length of argument and the extent of any motion practice.

G. Any respondent who is not an individual shall be represented at the hearing by legal counsel, who shall enter an appearance at the time the written answer is due. An individual respondent may appear on his or her own behalf.

H. Promptly after the conclusion of the hearing, the hearing panel shall enter findings of fact, conclusions of law, and its initial decision recommending to the Commissioner what action should be taken. A copy of the initial decision shall be mailed immediately to legal counsel for the parties at the hearing, or directly to respondent, if not represented by legal counsel, at the last known mailing address or if respondent as shown on the records of the Division. Within ten (10) calendar days of the date of entry of the initial decision, either respondent or the Division may file written exceptions to the initial decision with the Commissioner; provided, however, that if the initial decision is mailed on a date later than the date the initial decision was entered, the ten (10) day period shall begin on the date the initial decision was mailed. On the basis of the initial decision and any written exceptions, the Commissioner shall then issue his order, that shall be a final order for purposes of judicial review.

51-6.3 Hearings on Orders to Show Cause Why a Cease and Desist Order Should Not Enter.

A. Scope of this Rule

1. Pursuant to section 11-51-606(1.5)(d)(III), C.R.S., this Rule 51-6.3 shall govern cease and desist proceedings under section 11-51-606(1.5), C.R.S., and shall be supplemented by the Administrative Procedures Act as adopted in Colorado, and specifically section 24-4-105, C.R.S., the hearings provision of the State Administrative Procedures Act.

2. To the extent a specific provision of this Rule is in conflict with the State Administrative Procedures Act, the provision of this Rule shall govern.

3. To the extent a specific provision of this Rule is in conflict with the Rules of Procedure for the Office of Administrative Courts, the provisions of this Rule shall govern.

B. Commencement of Cease and Desist Proceedings

1. The Division may commence a cease and desist proceeding by filing with the Commissioner a Petition, signed by an officer or employee of the Division, requesting the Commissioner issue an order to the named Respondent(s) to show cause why the Commissioner should not enter a final order directing such person(s) to cease and desist from the unlawful act or practice specified, or impose such other sanctions as provided in section 11-51-606(1.5)(d)(IV), C.R.S.

2. The Petition shall state clearly and concisely the facts which are the grounds for the unlawful act or practice in question as set forth in section 11-51-606(1.5)(b), C.R.S., the relief sought, and any other additional information or documents in support of the grounds in the Petition.

3. The Commissioner, upon issuance of the order to show cause, may refer, in his or her sole discretion, the matter for conduct of the hearing either to an Administrative Law Judge or the Board, based upon the complexity of the matter, number of parties to the matter, and legal issues presented in the matter.

4. Within two calendar days of issuance of an order to show cause pursuant to section 11-51-606(1.5)(a), C.R.S., the Commissioner shall notify the Board or the Office of Administrative Courts, and obtain a date, time, and place for a hearing on the Order to Show Cause. The hearing shall commence no sooner than ten (10), nor later than twenty-one (21) calendar days following service or transmission of the Notice, the Order to Show Cause, and other information as required by section 11-51-606(1.5)(c), C.R.S. The hearing may be continued by agreement of all of the Parties based upon the complexity of the matter, number of parties to the matter, and legal issues presented in the matter, but in no event shall the hearing commence later than thirty-five (35) calendar days following the service or transmission of the Notice as required by section 11-51-606(1.5)(c), C.R.S.

5. The Notice shall be delivered, transmitted or served as required by section 11-51-606(1.5)(c), C.R.S., and contain a certificate by an employee or officer of the Division that the statutory requirements for providing notice have been met. Such certificate shall be deemed competent evidence of service of the Notice.

6. In cases referred to the Board by the commissioner, the chairperson of the Board shall designate no less than three (3) members of the Board to serve as the Hearing Panel to conduct the hearing on the Order to Show Cause. The Board chairperson shall also designate the Presiding Member for purposes of the hearing. The Hearing Panel, through the Presiding Member, shall have the authority to do all things necessary and appropriate to discharge their duties, including, but not limited to, the following:

    a. Administering oaths and affirmations;

    b. Signing and issuing subpoenas as authorized by law, subject to the provisions of subparagraph E.9., below;

    c. Regulating the course of the proceeding and the conduct of the Parties and their counsel;

    d. Allowing the appearance or participation of Hearing Panel members, witnesses, or Parties by telephone, as the Panel, in its sole discretion, deems appropriate;

e. Conducting such prehearing conferences or proceedings as the Hearing Panel deems appropriate, and issuing appropriate orders that shall control the subsequent course of the proceedings;

f. Allowing recusal of any Hearing Panel member from participating in the proceedings or hearing, in which case the remaining panel members shall conduct the hearing and issue findings of fact, conclusions of law, and the Hearing Panel's initial decision;

g. Requiring the filing of briefs and proposed findings of fact and conclusions of law by the Parties in preparation for the initial decision;

h. Disposing of motions made during the course of the hearing;

i. Ruling on admissibility or exclusion of evidence; and

j. Preparing and transmitting the initial decision to the Commissioner as required in section 11-51-606(1.5)(d)(III), C.R.S.

7. No later than three (3) business days prior to the hearing date, the Respondent(s) shall file a written answer to the Order to Show Cause admitting, denying, or otherwise specifically responding to the allegations and assertions in the Order and Petition, and raising any defenses that the Respondent(s) believes are applicable. A copy of the answer shall be filed in accordance with Rule 51-6.3.D.3., and served on the other Parties to the proceeding.

8. No later than three (3) business days prior to the hearing date, the Parties shall file a written statement in accordance with Rule 51-6.3.D.3., with service on the other Parties, setting forth the name, address, telephone number, and a brief statement of the substance of the testimony for each witness the Party intends to call at the hearing, including any expert witness. The Hearing Panel or the Administrative Law Judge, in their discretion, may permit modification of, or divergence from the written statement prior to or during the hearing, for good cause shown.

9. All discovery, either by deposition or in writing, including requests for production of documents, shall not be allowed in cease and desist proceedings.

10. In cases referred to the Office of Administrative Courts by the Commissioner, Rule 18 of Office of Administrative Courts' Rules of Procedure shall apply as to subpoenas.

11. In a matter referred to the Board by the Commissioner, the Hearing Panel, through the Presiding Member, as identified below in this Rule, may issue subpoenas requiring the attendance and testimony of witnesses in accordance with the following provisions:

a. A Party may make a written application to the Hearing Panel no later than three (3) business days prior to the hearing date. The Hearing Panel may issue the subpoena requested in the name of the Commissioner, and the Presiding Member for the Hearing Panel may sign the subpoena. Where it appears to the Hearing Panel that the subpoena sought may be unreasonable, oppressive, excessive in scope, unduly burdensome, or may result in undue delay in the proceedings, the Presiding Member may, in his or her discretion, require the Party requesting the subpoena to show the general relevance and reasonable scope of the testimony or evidence sought. In the event the Hearing Panel and Presiding Member, after consideration of all the circumstances, determine that the subpoena or any of its terms are unreasonable, oppressive, excessive in scope, unduly burdensome, or will result in undue delay, they may refuse to issue the subpoena, or issue the subpoena only upon such terms and conditions as fairness requires.

b. Every subpoena shall show on its face the name and address of the requesting Party. Notice to the other Parties shall not be required for issuance of a subpoena. The form of the subpoena shall adhere to the form used in administrative hearings before the Division Administrative Hearings in the Department of General Support Services.

c. Any Person to whom a subpoena is directed may, no later than three (3) calendar days prior to the date set for the hearing, file in writing a motion that the subpoena be vacated or modified. The Presiding Member shall give prompt notice to the Party who requested issuance of the subpoena of the motion. The Hearing Panel, through the Presiding Member, may grant the petition in whole, or in part, upon a finding that the testimony or evidence

requested does not relate with reasonable directness to any matter in question, or upon a finding that the subpoena is unreasonable, oppressive, excessive in scope, unduly burdensome, or will cause undue delay in the proceedings, or has not been served with forty-eight (48) hours of the commencement of hearing, as required by Rule 45 of the Colorado Rules of Civil Procedure.

d. A subpoena issued under this Rule shall be delivered to the Party requesting the subpoena and served by such Party in the same manner as a subpoena issued by a district court in Colorado.

e. Except for witnesses subpoenaed by the Division, witnesses subpoenaed pursuant to this Rule shall be paid by the requesting Party the same fees for attendance and mileage at the time of service, as are paid witnesses in the district courts of the state of Colorado.

f. Upon the failure or refusal of any witness to comply with a subpoena issued and served upon them under this Rule, the Board, through the Division, may petition the District Court for the City and County of Denver for an order citing such witness in contempt for such failure or refusal. The procedure for such contempt proceedings shall be governed pursuant to section 24-4-105(5), C.R.S..

C. Pleadings; Signatures; Copies; Computation of Time; Service

1. Pleadings and other papers filed in a cease and desist proceeding shall contain the caption "BEFORE THE SECURITIES COMMISSIONER, STATE OF COLORADO," the title of the proceeding, designated as "IN THE MATTER OF (name of Respondent(s))," the docket number and the name of the pleading. Such pleadings and papers shall be submitted on 8 ½ -inch by 11-inch paper, with left-hand margins not less than 1 ½ inches wide and the other margins not less than 1 inch. The impression contained on such pleadings or papers shall be only on one side of the page.

2. Pleadings and papers filed in cease and desist proceedings shall be signed and dated by the Party on whose behalf the filing is made or by the Party's Authorized Representative, and also contain the address, telephone number and facsimile number of such Party or Authorized Representative. Signature constitutes a certification by the signer that he has read the document, knows the contents thereof, that such statements are true, that it is not interposed for delay, and that if the document has been signed by an Authorized Representative, that such Representative has full power and authority to do so.

3. Each Party filing pleadings or papers in cases referred to the Board by the Commissioner will file the original and two copies, with the original and one copy filed with the Board, and one copy filed with the Division, unless otherwise directed by the Commissioner or the Board. Such pleadings and papers shall be filed by sending or delivering them to the Board, in care of the Division at its current address, and to the Division at its current address. In cases referred to an Administrative Law Judge by the Commissioner, each Party will file the original pleading or papers with the Office of Administrative Courts and one copy filed with the Division.

4. Except when otherwise provided by this Rule, service of all pleadings and other papers by a Party shall be made by personal delivery, U.S. Mail (including express or overnight mail or delivery), or facsimile transmission as follows:

a. Service of such pleadings or papers shall be deemed complete as of the date of delivery by hand, the date of deposit in the United States mails, postage prepaid, or the date a facsimile is transmitted and received. A Party who has served a pleading or paper shall attach proof of service to the original filed in accordance with this Rule, which proof of service shall be in affidavit form and specify the method of service, the identity of the server, the person served (if by personal service), the date and place of service, and the address to which the materials were mailed. If the service is made by certified or registered mail, the mailing receipt shall be attached to the affidavit of service. If service is made by facsimile transmission, a copy of the cover page indicating the documents transmitted, the date of transmission, the person transmitting the materials, the Party receiving the transmission, and successful transmission of the materials shall be attached to the affidavit of service.

b. In computing any period of time prescribed or allowed by this Rule, the provisions of Rule 6(e) of the Colorado Rules of Civil Procedure shall apply.

5. Unless otherwise specifically provided by law, computation of any time period referred to in this Rule 51-6.3 shall begin with the first day following the act that initiates the running of the time period. The last day of the time period so computed is to be included unless it is a Saturday, Sunday, legal holiday, or any other day on which the Division is closed, in which event the period shall run until the end of the next following business day. When the time period is less than seven (7) days, intervening days when the Division is closed shall be excluded in the computation.

6. In cases referred to the Board by the Commissioner, the Division will maintain all records of, and filings received by the Board in accordance with statutory requirements.

7. An attorney representing a Party in a cease and desist proceeding may withdraw his or her appearance of the Party only upon notice of such withdrawal being filed no later than two (2) business days before the scheduled hearing, with such notice served upon the Party as provided in this Rule. Any such withdrawal shall not be effective unless approved by the Board or the Administrative Law Judge. The approved withdrawal shall not constitute grounds for continuance of the commencement of the hearing in the cease and desist proceeding.

D. Conduct of the Hearing

1. The sole issues for determination at the hearing shall be whether Respondents have engaged, or are about to engage in any of the acts or practices specified in section 11-51-606(1.5)(b), C.R.S. so as to warrant the imposition of sanctions as provided in section 11-51-606(1.5)(d)(IV), C.R.S.

2. The burden of proof at the hearing shall be on the Division to establish that the Respondent(s) have or are about to commit any of the acts or practices set forth in section 11-51-606(1.5)(b), C.R.S. by a preponderance of the evidence. Any Party asserting an affirmative defense, including any exemption, exception or exclusion, shall have the burden of proof to establish such defense, exemption, exception or exclusion by a preponderance of the evidence.

3. In the event the Respondent(s) does not appear at the date and time of the hearing, the Division shall present evidence as follows:

   a. That notification was properly sent or served upon such Respondent(s) as required by section 11-51-606(1.5)(c), C.R.S.; and

   b. To establish there is a reasonable basis to believe the Respondent(s) either received the notification, or, after reasonable search by the Division, cannot be located.

4. In the event the Respondent(s) fails to file an answer as provided in this Rule, in addition to the Division presenting the evidence as set forth in clauses (a) and (b) of this subparagraph D.3., the Division shall present evidence, or request the Hearing Panel or the Administrative Law Judge to take Administrative Notice, that the Respondent(s) failed to file an answer as provided in this Rule.

5. Unless otherwise provided by law, the Hearing Panel and the Administrative Law Judge shall observe a relaxed standard in applying the Colorado Rules of Evidence. The Hearing Panel and the Administrative Law Judge shall, however, observe the Rules of privilege as provided by law. Evidence admissible at the hearing includes, but shall not be limited to, such evidence as may be admissible in a civil non-jury case in Colorado under the Colorado Rules of Evidence; hearsay evidence, unless the Hearing Panel or Administrative Law Judge determines that the potential prejudice of such evidence clearly outweighs its probative value; certified or self-authenticated documents, orders, or other papers; and any record, investigative report, document and stipulation which is offered and is not determined to be irrelevant or immaterial by the Hearing Panel or Administrative Law Judge. The Hearing Panel or Administrative Law Judge may take notice of any fact that may be judicially noticed by the courts of Colorado, or of general, technical or scientific facts within the Panel's specialized knowledge, and which is specified in the record. The Hearing Panel or Administrative Law Judge will notify the Parties of the material so noticed and provide the Parties an opportunity to contest the facts so noticed.

6. Evidence objected to may be received by the Hearing Panel or Administrative Law Judge, and rulings on the admissibility or exclusion of such evidence, if not made at the hearing, shall be made as part of the findings of fact, conclusions of law, and initial decision. The Hearing Panel or Administrative Law Judge shall be authorized to impose limits on the number of witnesses and documentary or other evidence on any issue to prevent undue delay, waste of time, or the needless

presentation of cumulative evidence. This authority shall include the power to limit or preclude the testimony of any expert witness called by any Party.

7. The weight to be attached to any evidence on the record will rest within the sound discretion of the Hearing Panel or Administrative Law Judge. The Hearing Panel or Administrative Law Judge may require any Party, with appropriate notice to the other Parties, to submit additional evidence on any matter relevant to the issues in the hearing.

8. The proceedings conducted in connection with the hearing shall be electronically or stenographically recorded. Transcripts of the proceedings shall be supplied to any Party, upon reasonable request, at the expense of the requesting Party. In such event, a copy of the transcript and the record, as defined herein, shall be provided to the Board, through the Division, at no expense to the Board, and upon such other terms as the Commissioner shall order. The record of the hearing shall include, in addition to the transcript, all pleadings, motions, papers and filings; all evidence received or considered, including a statement of matters officially noted; questions or offers of proof, objections, and rulings on such objections; findings of fact, conclusions of law, and initial decision; and the final order entered by the Commissioner.

9. In the case of any hearing not continued by agreement of the parties, the hearing shall conclude no later than twenty-six (26) calendar days following the service or transmission of the Notice as required by section 11-51-606(1.5)(c), C.R.S. In the case of any hearing continued by agreement of the parties, the hearing shall conclude no later than forty (40) calendar days following the service or transmission of the Notice as required by section 11-51-606(1.5)(c), C.R.S. The Hearing Panel or Administrative Law Judge shall not evade the time limits contained herein by commencing the hearing within the time requirements and then recessing or continuing the hearing, or conducting any portion of the hearing, past the time limits for concluding the hearing set forth herein.

E. Initial Decision; Final Order

1. After the conclusion of the hearing, the Hearing Panel or Administrative Law Judge shall enter written findings of fact, conclusions of law, and its initial decision based on the record of the hearing, recommending to the Commissioner that a final order be issued affirming, denying, vacating, or otherwise modifying the Order to Show Cause. These findings of fact, conclusions of law and initial decision shall be issued within ten calendar days after the conclusion of the hearing and shall be promptly submitted to the Commissioner, with courtesy copies served on the Parties by the Division.

2. If, after reviewing the findings of fact, conclusions of law, and initial decision, and the record of the hearing, the Commissioner reasonably finds that the Respondent(s) has engaged, or is about to engage, in any of the acts or practices set forth in section 11-51-606(1.5)(b), C.R.S., and upon making the findings required by section 11-51-704(2), C.R.S., the Commissioner may issue a final cease and desist order imposing one or more of the sanctions set forth in section 11-51-606(1.5)(d)(IV), C.R.S. The Commissioner shall provide notice of the final order within ten calendar days after receiving the initial decision.

3. The Division shall promptly provide notice of the final order to all the Parties and each Party against whom such order has been entered pursuant to section 11-51-606(1.5)(c), C.R.S.

51-6.4 Hearings on the denial, suspension or revocation of a registration statement and the denial or revocation of exemption from registration.

A. Following the filing of request for any hearing filed pursuant to 11-51-310, C.R.S., the Commissioner shall notify the Office of Administrative Courts, and obtain a date, time, and place for a hearing. The hearing shall commence no later than 120 calendar days following filing at the Office of Administrative Courts of the Notice to Set, Notice of Duty to Answer or Notice of Charges. The hearing may be continued by agreement of all of the Parties based upon the complexity of the matter, number of parties to the matter, and legal issues presented in the matter. The hearing shall be conducted pursuant to section 24-4-105, C.R.S., the hearings provision of the state Administrative Procedures Act.

B. An attorney representing a Party in a hearing on a denial, suspension or revocation of a registration statement and the denial or revocation of exemption from registration may withdraw his or her appearance of the Party only upon notice of such withdrawal being filed no later than two (2) business days before the scheduled hearing, with such notice served upon the Party as provided in this Rule. Any such withdrawal shall not be effective unless approved by the Board or the Administrative Law Judge. The approved

withdrawal shall not constitute grounds for continuance of the commencement of the hearing in the denial, suspension or revocation proceeding.

51-6.5 Hearings on the denial of an applicant or suspension, revocation, censure, limit or other conditions on the securities activities of a broker-dealer, sales representative, investment adviser or investment adviser representative.

A. Following the filing of request for any hearing filed pursuant to 11-51-410, C.R.S., the Commissioner shall notify the Office of Administrative Courts, and obtain a date, time, and place for a hearing. The hearing shall commence no later than 120 calendar days following filing at the Office of Administrative Courts of the Notice of Duty to Answer or Notice of Charges. The hearing may be continued by agreement of all of the Parties based upon the complexity of the matter, number of parties to the matter, and legal issues presented in the matter. The hearing shall be conducted pursuant to section 24-4-105, C.R.S., the hearings provision of the state Administrative Procedures Act.

B. An attorney representing a Party in hearing on the suspension or revocation or the denial of an application of a license as broker-dealer, sales representative, investment advisor or investment advisor representative may withdraw his or her appearance of the Party only upon notice of such withdrawal being filed no later than two (2) business days before the scheduled hearing, with such notice served upon the Party as provided in this Rule. Any such withdrawal shall not be effective unless approved by the Board or the Administrative Law Judge. The approved withdrawal shall not constitute grounds for continuance of the commencement of the hearing in the denial of an applicant or suspension, revocation, censure, limit or other condition on the securities activities proceeding.

CHAPTER 7 ADMINISTRATION AND FEES

51-7.1 Consent to Service of Process

A. An applicant who files Form BD, ADV, or U-4, pursuant to Chapter 4 or Chapter 4 (IA) of these Rules, shall file the required Consent to Service of Process by completing the relevant portion of Form BD, ADV or U-4.

B. An applicant who is registered or registering with FINRA or who is affiliated with a FINRA broker-dealer shall file the Consent to Service of Process, through such FINRA broker-dealer, with the CRD. The Consent to Service of Process shall be deemed to be filed with the Securities Commissioner on the date CRD enters it if CRD verification is not required, or the date CRD verifies it if CRD verification is required.

C. An applicant who is registered or registering with the SEC, or is licensed or licensing with the Securities Commissioner as an investment adviser, or who is affiliated with an investment adviser or federal covered adviser shall file the Consent to Service of Process, through such investment adviser, with the IARD. The Consent to Service of Process shall be deemed to be filed with the Securities Commissioner on the date all fees are received and the filing is accepted by IARD on behalf of the Securities Commissioner.

D. The Consent to Service of Process of a sales representative who is not registered or registering with FINRA or who is not affiliated with a FINRA broker-dealer shall be filed through the broker-dealer, or issuer with which the person is affiliated with the Securities Commissioner.

E. Any other person who must file a Consent to Service of Process form shall file Forms U-2 (Uniform Consent to Service of Process) and U-2A (Uniform Corporate Resolution), if applicable, with the Securities Commissioner.

51-7.2 Requests for Notification of Rule Making

A. Pursuant to section 24-4-103(3) (b), C.R.S. (1989), the Division shall keep a list of persons who request to be notified of proposed rule making.

B. Any person who requests to be placed on this list must send a written request to the Securities Commissioner.

C. It is the responsibility of the person requesting such notification to keep the Division informed in writing of any changes in the address to which the notice is to be sent.

D. A person may request such notification only on his or her own behalf.

51-7.3 Filing of Forms and Payment of Fees

Unless otherwise specified by the Colorado Securities Act or by Rule or order promulgated thereunder:

A. All forms or notices required to be filed under the Colorado Securities Act and the Rules and orders promulgated thereunder must be filed with the Securities Commissioner at the following address:

Colorado Division of Securities 1560 Broadway, Suite 900 Denver, Colorado 80202

B. All fees shall be made by check or warrant payable to the “Colorado State Treasurer.”

51-7.4 Form and Content of Financial Statements

A. The annual financial statements, or any other financial statements required to be filed with the Commissioner, except as noted in B. below, shall be audited by a Certified Public Accountant (“CPA”) and contain:

An Unqualified Auditor's Report,

Balance Sheet,

Statement of Operations,

Statement of Changes in Shareholders' Equity,

Statement of Cash Flows, and

All notes and disclosures as required by generally accepted accounting principles (“GAAP”)

Comparative financial statements shall be prepared for all entities that have been in operation for more than 12 months.

B. The interim financial statements required to be filed with the Commissioner shall be reviewed by a CPA and contain:

A CPA's Unqualified Accountant's Review Report,

Balance Sheet,

Statement of Operations,

Statement of Changes in Shareholders' Equity,

Statement of Cash Flows, and

All notes and disclosures as required by GAAP unless waived by order of the Commissioner.

Comparative financial statements shall be prepared for all entities that have been in operation for more than 12 months.

C. Any and all other presentations of financial data including, but not limited to, projections and supplementary data shall be reviewed by a CPA and be covered by an Unqualified Accountant's Review Report issued by a CPA.

CHAPTER 8 EFFECTIVE DATE

51-8.1 Savings Provisions

For the purposes of section 11-51-802(3), C.R.S. (1990), the phrase “... an offering begun in good faith before July 1, 1990 ...” means an offering of securities in which at least one offer was made in good faith in Colorado prior to July 1, 1990.

CHAPTER 9 LOCAL GOVERNMENT INVESTMENT POOL TRUST FUNDS

51-9.1 Authority

The regulations provided in this Chapter 9 have been adopted pursuant to the authority granted to the securities commissioner in sections 11-51-901, et seq. C.R.S. and 24-75-701, et seq., C.R.S.

51-9.2 Definitions

For purposes of this Rule, the terms identified below shall have the following meanings:

A. “Board of trustees” shall have the same meaning as that term is defined in section 24-75-701(2), C.R.S.;

B. “Investment adviser” shall have the same meaning as that term is defined in section 24-75-701(5), C.R.S.;

C. “Local government investment pool trust fund” shall have the same meaning as that term is defined in section 24-75-701(9), C.R.S., and as established pursuant to sections 11-51-901, et seq., and 24-75-701, et seq., C.R.S. (“LGIP”);

D. “Participating local government” shall have the same meaning as that term is defined in 24-75-701(10), C.R.S.; and

E. “Securities commissioner” shall have the same meaning as that term is defined in section 24-75-701(11), C.R.S.

51-9.3 Registration, Reports and Bookkeeping of the Local Government Investment Pool Trust Funds

A. Prior to an LGIP’s investment of any trust fund assets, the LGIP board of trustees must register the LGIP with the Securities Commissioner pursuant to section 11-51-905, C.R.S.

B. Quarterly reports to the Securities Commissioner pursuant to section 11-51-906(2), C.R.S., shall be filed by all LGIPs with the Securities Commissioner within thirty (30) days after the end of the quarter and shall contain the following information:

1. Financial statements that contain a balance sheet, an income statement, and a statement of changes in net assets for the previous quarter; and

2. The quarterly report to participating local governments.

C. The quarterly report to participating local governments shall include, at a minimum, the following information:

1. A statement of net assets;

2. A statement of operations;

3. A statement of changes in net assets;

4. A listing of portfolio assets that, at a minimum, describes each investment instrument by issuer, face value, yield at purchase, final maturity date, cost, and market value;

5. The average daily yield for the month and the average annualized yield;

6. The expense ratio;

7. A diversification report that, at a minimum, identifies the percentage of the total net assets of the fund by each issuer and the percentage of the total issue the fund invested in any individual issue; and

8. The weighted average maturity to final and the weighted average maturity to reset.

9. Any other material information.

51-9.4 Written Policies and Procedures

All LGIPs shall establish, maintain, and enforce written policies and procedures that are reasonably designed to achieve compliance with the following requirements:

A. Written policies and procedures intended to ensure that each entity that seeks to become a participating local government, and entities actively participating in an LGIP are “local governments” as that term is defined in section 24-75-701(8), C.R.S., for the duration of the local governments’ participation in an LGIP.

B. Written policies and procedures to ensure that the LGIP complies with GASB Statement No. 79, Certain External Investment Pools and Pool Participants, if the LGIP elects to report on an amortized cost basis. An LGIP that does not comply with GASB Statement No. 79 may continue to operate as a stable Net Asset Value pool but must use fair value for financial reporting purposes in accordance with GASB Statement No. 31, Accounting and Financial Reporting for Certain Investments and for External Investment Pools, or FASB Accounting Standards Codification 820, Fair Value Measurement.

C. Written investment policies and procedures that define the credit, liquidity, maturity, and diversification objectives of the LGIP and the means to achieve these objectives. These policies and procedures shall, at a minimum, address:

1. Safety of capital as a priority so as to ensure preservation of principal;

2. Sufficient liquidity be maintained to enable funding of all reasonably expected cash needs given the participant composition and history as well as economic and market conditions;

3. Investment return, taking into consideration a pool's cash flow expectations;

4. Diversification of investment, including deposits adequate to reduce portfolio risks from an over concentration in any specific maturity, issuer, counterparty, depository, security, or class of securities;

5. Defining, monitoring and controlling interest rate risk; and,

6. Compliance with section 24-75-601.1,C.R.S.

D. Written policies and procedures that require the LGIP to monitor redemptions and reduce risk of unusually high redemptions in order to meet participants' daily cash flow needs. The written policies and procedures shall require the LGIP to position its portfolio so as to be able to fund unexpected withdrawals. The level of liquidity may be adjusted to take into consideration the distinctive characteristics and composition of the participating local governments and historical redemption patterns for the pool. A minimum of 90 percent of an LGIP's portfolio should be comprised of highly liquid investments and deposits. Liquid investments and deposits are investments and deposits that can be redeemed or sold within five business days.

E. Written policies and procedures for managing credit that require a thorough, constant and independent credit analysis process that adequately assess and manage the credit risk of an LGIP's investments. These policies shall at a minimum require:

1. Utilization of an experienced credit analyst that has the ability to manage and analyze credit risk;

2. For securities other than U.S. Treasuries and Agencies, an approved issuer list that is updated regularly; and

3. Policies that address assessing and liquidating positions in distressed credit situations as well as assessing and monitoring the credit quality and value of pledged collateral.

F. Written policies and procedures requiring LGIP's to perform and maintain the results of, and assumptions used in connection with, monthly, or more frequent, stress testing. Such written policies and procedures shall further require the board of trustees and investment adviser of the LGIP to review the results of each stress test performed.

G. Written policies and procedures that require each LGIP that utilizes amortized cost accounting to calculate a "shadow" NAV daily.

H. Written policies and procedures that require compliance reviews to be performed at least weekly to assure compliance with investment policies, guidelines and procedures.

I. Written policies and procedures intended to ensure that private information of an LGIP's participants remains confidential at all times;

J. Written policies and procedures intended to ensure that LGIP's and its investment adviser(s)' computers, servers, cloud storage and backup system(s), and web-based portals and applications are reasonably protected against cyber-attacks and hardware failure;

K. Written business continuity plan intended to ensure continuous, efficient and timely critical business operations in the event of an emergency and/or unforeseen disruption to normal business operations of the LGIP and/or its investment adviser(s).

51-9.5 Recordkeeping

A. For a period of not less than five years following an LGIP's replacement of any written policies or procedures with new written policies or procedures, the LGIP must maintain and preserve copies of the replaced policies and/or procedures.

B. For a period of not less than five years following a board of trustees' considerations and actions in connection with the discharge of the board of trustees' responsibilities, a written record of such considerations and actions must be maintained and preserved by the LGIP.

51-9.6 Notice to the Commissioner

Each LGIP shall promptly notify the Securities Commissioner, or the Securities Commissioner's designee, by electronic mail of any:

A. Default or insolvency of any issuer of a security that is held by the LGIP; and

B. Instance wherein a board of trustees believes that the applicable LGIP may be unable to comply with an actual or potential request by a participating local government to liquidate the participating local government's funds.

51-9.7 Incorporation by Reference

A. GASB Statement No. 79, *Certain External Investment Pools and Pool Participants*, as effective on December 2015, is hereby incorporated by reference. No later amendment or edition of GASB Statement No. 79 is incorporated into this Section 51-9.3. All referenced laws and regulations shall be available for copying or public inspection during regular business hours from the Division of Securities, Department of Regulatory Agencies, 1560 Broadway, Suite 900, Denver, CO 80202. The Division of Securities will provide certified copy of the material incorporated at cost or will provide the requester with information on how to obtain a certified copy.

B. GASB Statement No. 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools*, as effective on December 2015, is hereby incorporated by reference. No later amendment or edition of GASB Statement No. 31 is incorporated into this Section 51-9.3. All referenced laws and regulations shall be available for copying or public inspection during regular business hours from the Division of Securities, Department of Regulatory Agencies, 1560 Broadway, Suite 900, Denver, CO 80202. The Division of Securities will provide certified copy of the material incorporated at cost or will provide the requester with information on how to obtain a certified copy.

C. FASB Accounting Standards Codification 820, *Fair Value Measurement*, as effective on May 2011 is hereby incorporated by reference. No later amendment or edition of FASB Accounting Standards Codification 820 is incorporated into this Section 51-9.3. All referenced laws and regulations shall be available for copying or public inspection during regular business hours from the Division of Securities, Department of Regulatory Agencies, 1560 Broadway, Suite 900, Denver, CO 80202. The Division of Securities will provide certified copy of the material incorporated at cost or will provide the requester with information on how to obtain a certified copy.

Editor's Notes

History

Sections 51-3.5, 51-3.7, 51-4.7, 51-4.8(1A) eff. 12/01/2008.

Sections 51-2.1; 51-3.9(a-g), 51-3.10b; 51-4.1B, 51-4.3, 51-4.4; 51-4.1(1A)(C-D), 51-4.3(1A)(G-I), 51-4.4(1A) A, E-H, 51-4.5(1A)C, 51-4.6(1A)A15(c), 51-4.8(1A)R, 51-4.10(1A), 51-7.1 eff. 11/30/2010.

Section 51-2.1.1.B eff. 10/15/2013.

Sections 51-4.7.G-51-4.7.I eff. 01/30/2015.

Sections 51-4.3.K, 51-4.4(IA).I eff. 06/01/2015.

Sections 51-3.20-51-3.30 emer. rules eff. 08/05/2015.

Sections 51-3.20-51.3.30 eff. 10/15/2015.

Sections 51-3.1, 51-3.7 eff. 01/30/2016.

Form DT-1 (08/2019)

Colorado Division of Securities
1560 Broadway St., Ste. 900
Denver, CO 80202
(303) 894-2320

Initial Filing _____
Amended Filing _____

NOTICE OF CLAIM OF EXEMPTION FROM REGISTRATION FOR CERTAIN DIGITAL TOKENS

The person submitting notice of this exemption from the licensing requirements from section 11-51-401, certifies that the following is true. Pursuant to the requirements of section 11-51-308.7, C.R.S. notice of claim of exemption from the registration requirements of the Colorado Securities Act is submitted to the Securities Commissioner as follows:

1. ISSUE DESCRIPTION:

Name of Token and date of initial issuance:

_____

_____

_____

_____

Describe how the token has a primarily consumptive use

_____

_____

_____

2. NAME, TITLE, FIRM, ADDRESS & PHONE NUMBER OF RELATED PERSONS (Related persons include each executive officer and director of the issuer and persons performing similar functions):

_____

_____

_____

EXEMPTIONS FROM REGISTRATION UNDER
THE COLORADO DIGITAL TOKEN ACT

(All references are to either section 11-51-308.7, C.R.S. or Rules 51-3.34, 51-3.35 & 51-3.36 promulgated under section 11-51-308.7(3)(a)(I)(A).

The person submitting notice of this exemption for the digital token(s) listed in section 1 (Issue Description) of this Form DT-1, certifies that the following is true:

(CHECK ALL THAT APPLY)

1. The primary purpose of the digital token(s) is a consumptive purpose: ____

2. The issuer of the digital token has marketed the digital token to be used for a consumptive purpose: _____

3. The issuer of the digital token has not marketed and will not market the digital token to be used for a speculative or investment purpose: ____

4. Availability of the digital token:

A. The consumptive purpose of the digital token is available at the time of sale. ____

OR

B.

1. The consumptive purpose of the digital token will be available within one hundred eight days after the time of sale or transfer of the digital token: ___

2. The initial buyers are prohibited from reselling or transferring the digital token until the consumptive purpose of the digital token is available: ____

3. The initial buyers will provide a knowing and clear acknowledgement that initial buyers purchased the digital token with the primary intent to use the digital token for a consumptive purpose and not for a speculative or investment purpose: ____

In the event that the information contained in this Notice of Intent becomes inaccurate in any material respect, for any reason, the noticing party, the issuer of the digital token or other person shall file an amendment to this Notice of Intent with the securities commissioner within thirty days.

By: _____ _____
Name of person filing notice of exemption Title

_____ _____

Signature

Form DT-2 (08/2019)

Colorado Division of Securities
1560 Broadway St., Ste. 900
Denver, CO 80202
(303) 894-2320

NOTICE OF CLAIM OF EXEMPTION FROM LICENSING FOR PURCHASE, SALE OR TRANSFER OF CERTAIN DIGITAL TOKENS

Pursuant to the requirements of sections 11-51-308.7(3)(b) & (c), C.R.S. this notice of intent is submitted to the Securities Commissioner as follows:

NAME, TITLE, FIRM, ADDRESS & PHONE NUMBER OF RELATED PERSONS (Related persons include each executive officer and director of the issuer and persons performing similar functions):

_____

_____

_____

The person submitting notice of this exemption from the licensing requirements from section 11-51-401, certifies that the following is true:

1. The person/entity seeking the exemption from licensing engages in the business of effecting or attempting to effect the purchase, sale or transfer of a digital token; and
2. The digital token that is purchased, sold or transferred can be used for a consumptive purpose at the time the person/entity effects or attempts to effect, the purchase, sale, or transfer of the digital token; and
3. The person/entity will take reasonably prompt action to cease effecting, or attempting to effect, the purchase, sale or transfer of any digital asset that does not conform to the requirements for exemption found at 11-51-308.7(3)(b) and rules promulgated pursuant to the Colorado Digital Token Act.

In the event that the information contained in this Notice of Intent becomes inaccurate in any material respect, for any reason, the noticing party, the issuer of the digital token or other person shall file an amendment to this Notice of Intent with the securities commissioner within thirty days.

By: _____ _____
Name of person filing notice of exemption Title

_____
Signature

_____
Date

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
1300 Broadway, 10th Floor
Denver, Colorado 80203
Phone (720) 508-6000

Office of the Attorney General

Tracking number: 2019-00746

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Securities

on 01/30/2020

3 CCR 704-1

RULES UNDER THE COLORADO SECURITIES ACT

The above-referenced rules were submitted to this office on 01/30/2020 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.

February 18, 2020 08:10:19

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 Medical Board

CCR number

3 CCR 713-44

Rule title

3 CCR 713-44 RULE 135 - RULES AND REGULATIONS REGARDING SUBSTANCE USE PREVENTION TRAINING FOR LICENSE RENEWAL, REACTIVATION, OR REINSTATEMENT 1 - eff 03/30/2020

Effective date

03/30/2020

DEPARTMENT OF REGULATORY AGENCIES

Colorado Medical Board

RULE 135 – RULES AND REGULATIONS REGARDING SUBSTANCE USE PREVENTION TRAINING FOR LICENSE RENEWAL, REACTIVATION, OR REINSTATEMENT

3 CCR 713-44

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

44.1 INTRODUCTION

A. Basis: The general authority for promulgation of these rules and regulations by the Colorado Medical Board ("Board") is set forth in sections 12-20-204(1), 12-240-106(1)(a), and 12-30-114(1), C.R.S.

B. These Rules are adopted by the Board pursuant to section 12-30-114, C.R.S., in order to require physicians and physician assistants to complete training to demonstrate competency in preventing substance abuse and/or to demonstrate competency in treating patients with substance use disorders.

44.2 RULES AND REGULATIONS

A. Every physician and physician assistant is required to complete at least two cumulative hours of training per renewal period in order to demonstrate competency regarding the topics/areas specified in section 12-30-114(1)(a), C.R.S.

B. Training, for the purposes of this section includes, but is not limited to, relevant continuing education courses; self-study of relevant scholarly articles or relevant policies/guidelines; peer review proceedings that involve opioid prescribing; relevant volunteer service; attendance at a relevant conference (or portion of a conference); teaching a relevant class/course; or participation in a relevant presentation, such as with your practice. All such training must cover or be related to the topics specified in section 12-30-114(1)(a), C.R.S.

C. The Board shall exempt a physician or physician assistant from the requirements of this section who qualifies for either exemption set forth in section 12-30-114(1)(b), C.R.S.

D. This section shall apply to any application for reinstatement of an expired license pursuant to Rule 130 or reactivation of an inactive license.

E. Applicants for license renewal, reactivation, or reinstatement shall attest during the application process to either their compliance with this substance abuse training requirement or their exemption from the requirement for training, as specified in section (C) of this Rule.

F. The Board may audit compliance with this section. Physicians and physician assistants must submit documentation of their compliance with this substance abuse training requirement or basis for their exemption, upon request by the Board.

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Tracking number: 2019-00758

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Colorado Medical Board

on 02/20/2020

3 CCR 713-44

RULE 135 - RULES AND REGULATIONS REGARDING SUBSTANCE USE PREVENTION TRAINING FOR LICENSE RENEWAL, REACTIVATION, OR REINSTATEMENT

The above-referenced rules were submitted to this office on 02/20/2020 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.

February 28, 2020 09:52:10

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Personnel and Administration

Agency

State Personnel Board and State Personnel Director

CCR number

4 CCR 801-1

Rule title

4 CCR 801-1 STATE PERSONNEL BOARD RULES AND PERSONNEL DIRECTOR'S ADMINISTRATIVE PROCEDURES 1 - eff 04/01/2020

Effective date

04/01/2020

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 them from 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.

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 rulemaking by the State Personnel Director as follows: This version reflects rulemaking by the State Personnel Director as follows: to modify Procedures 1-10, 1-11, 1-15, 1-22, 1-38.1, 1-48, 1-72, 1-79, 1-79.A, 1-79.B, 3-29, 3-35, 3-36, 5-5, 5-10, 5-13, 5-15.B.3, 10-4.C, and add Procedures 1-38.2, 1-38.3, 1-45.1, 1-55.1, 1-55.2, 1-80, 11-28, 11-29, 11-30, and repeal Procedures 1-9.C, 1-79.E, and 1-79.D, effective April 1, 2020.

Chapter 1 Organization, Responsibilities, Ethics, Payroll Deduction, and Definitions

Authority for rules promulgated in this chapter is found in State of Colorado Constitution Article XII, Sections 13, 14 and 15, State of Colorado Revised Statutes (C.R.S.) §§24-50-103, 104(8), 112.5, 116, 117, 124, 128, 129, 130, 132, 145, 24-2-103, 24-6-402, 24-31-301-104, 24-30-2103, 24-30-2105, 24-50.3-105, 24-50.3-105, 24-50.5-103, 24-72-201, -204.5, 25-75-112, and 24-18-101 through 205, Title 24 Article 18, Part 1, Code of Ethics, Title 24, Article 50: 101, 102, 103, 104, 109.5, 112.5, 114, 116, 123, 124, 125, 125.3, 125.4, 126, 128, 129, 130, 134, 135, 137, 141, 203, 503, and 507. Board rules are identified by cites beginning with "Board Rule." (04/01/2020)

General Principle

Board Rule 1-1. The purpose of the rules promulgated herein by the Colorado State Personnel Board (hereafter "Board") and the Colorado State Personnel Director's (hereafter "Director") administrative procedures is to provide a sound, comprehensive system of human resources management for the employees within the state personnel system. This system recognizes employee rights, values the differing roles and relevant contributions of various stakeholders, allows reasonable discretion for departments to establish their own operating practices, and ensures the Board rules and Director's administrative procedures (hereinafter "rules") complement each other. It is the intent of the Board and the Director to adopt the minimum rules necessary to ensure the least cumbersome process possible for administering the state personnel system while meeting legal requirements.

State Personnel Board

Board Rule 1-2. Certified employees shall be eligible to elect members of the Board in accordance with §24-50-103, C.R.S

A. The Board's director shall conduct an election to fill the vacant position of an elected Board member within three (3) months of the date of vacancy.

B. A certified employee may contest the election of an elected Board member in the manner described at §24-50-103(3)(c)(II), C.R.S., only after:

1. Giving notice to the Board of the grounds for contest within seven (7) business days after the election has been certified; and

2. Giving the Board, through its director, at least twenty-one (21) days to cure the allegedly invalid election. (1/01/15)

Board Rule 1-3. The Board's director, or other person with written delegation, is the agent for service of process for any action involving the Board.

Board Rule 1-4. The Board shall meet as often as necessary to conduct its business, or at such other times as may be determined by the Board chairperson or a majority of the Board. Reasonable notice of any regular or special meeting shall be given to the Board members, interested parties, and the public as provided in §24-6-402, C.R.S., or successor statute.

Board Rule 1-5. Unless otherwise ordered, all materials to be considered by the Board at its monthly meeting must be received in the Board's office at least twelve (12) calendar days before the meeting. The party must provide the original and nine (9) copies of all materials to be considered by the Board, except as otherwise provided in these rules. (1/1/07).

State Personnel Director

1-6. The Director, under a current written delegation, may delegate certain Director's powers to heads of principal departments and presidents of institutions of higher education (hereafter "department"). Such delegated power is discretionary and subject to the Director's review. Law and the Director specify powers that shall not be delegated outside the Department of Personnel.

1-7. The Director may delegate any and all powers, duties, and functions to the Division of Human Resources in the Department of Personnel.

Appointing Authority

1-8. Executive directors of principal departments and presidents of institutions of higher education (hereafter "department" and "department head") are appointing authorities for their own offices and division directors. Division directors as defined by law are appointing authorities for their respective divisions. An appointing authority may delegate in writing any and all human resource functions, including the approval of further delegation beyond the initial designee. In the area of corrective, disciplinary, or other actions that have an adverse effect on base pay, status, or tenure, each department shall establish a written document specifying the appointing authority for each individual employee and this information shall be made available to the employee.

1-9. Appointing authority powers include, but are not limited to: hiring and evaluating performance; determining the amount and type of any non-base incentive within policies issued by the Director and the department's written plan; defining a job; administering corrective/disciplinary action; determining work hours including meal periods and breaks, and safe conditions and tools of employment; identifying positions to be created or abolished; assigning employees to positions; determining work location; and accountability for any other responsibilities in rule. (7/1/07)

1-10. Appointing authorities have a duty to ensure employees are oriented to the workplace, including communicating requirements and rights. (04/01/2020)

1-11. All appointing authorities, managers, and supervisors are accountable for compliance with these rules and all applicable laws, including implementation of policy directives and executive orders. (04/01/2020)

Employee Activities

Board Rule 1-12. Employees are required to know and adhere to personnel rules, laws, and executive orders governing their employment. Departments are required to make those rules, laws, and executive orders available to employees.

Board Rule 1-13. No employee is allowed to engage in any outside employment or other activity that is directly incompatible with the duties and responsibilities of the employee's state position, including any business transaction, private business relationship, or ownership. The employee is not allowed to accept outside compensation for performance of state duties. This includes acceptance of any fee, compensation, gift, reward, gratuity, expenses, or other thing of monetary value that could result in preferential treatment, impediment of governmental efficiency or economy, loss of complete independence and impartiality, decision making outside official channels, and disclosure or use of confidential information acquired through state employment. Incompatibility includes reasonable inference that the above has occurred, may occur, or has any other adverse effect on the public's confidence in the integrity of state government.

A. If the employee receives any such form of compensation that cannot be returned, it is to be immediately turned over to the appropriate state official as state property except for

the following. The employee may accept awards from non-profit organizations for meritorious public contributions. Honoraria or expenses for papers, demonstrations, and appearances made with approval of the appointing authority may also be kept if the activity occurs during a holiday, leave, a scheduled day off, or outside normal work hours.

B. An employee shall give advance notice to the appointing authority and take necessary steps to avoid any direct conflict between the employee's state position and outside employment or other activity.

Board Rule 1-14. Employees may engage in outside employment with advance written approval from the appointing authority. The appointing authority shall base approval on whether the outside employment interferes with the performance of the state job or is inconsistent with the interests of the state, including raising criticism or appearance of a conflict.

A. An employee may be retained by a different department through a personal services contract to perform a different function consistent with the requirements of Chapter 10.

B. A personal services contract involving an employee shall not be used to evade overtime.

1-15. Employment with more than one (1) department is commonly referred to as dual employment. An employee may be employed by and receive compensation from more than one (1) department with advance written approval of both appointing authorities. There shall be a written agreement between the appointing authorities that specifies the terms and conditions of the arrangement including any overtime considerations. For further information, refer to the "Compensation" chapter. (04/01/2020)

Board Rule 1-16. It is the duty of state employees to protect and conserve state property. No employee shall use state time, property, equipment, or supplies for private use or any other purpose not in the interests of the State of Colorado.

Board Rule 1-17. Employees may participate in political activities subject to state and federal laws. No state time or property may be used for this purpose.

Board Rule 1-18. Employees have the right to associate, self-organize, and designate representatives of their choice. Membership in any employee organization or union is not a condition of state employment. No employee may be coerced into joining or not joining and solicitation of members shall not occur during work hours without the approval of the appointing authority. The employee's representative may confer, with prior consent from the supervisor, on employment matters during work hours. Such conferences should be scheduled to minimize disruption to productivity and the general work environment. A supervisor's consent shall not be unreasonably withheld.

Board Rule 1-19. An employee may voluntarily and knowingly waive, in writing, all rights under the state personnel system, except where prohibited by state or federal law.

Records

Board Rule 1-20. The Board and the Director shall maintain records of personnel activities that have legal, administrative, or historical value in accordance with statute. Legal value is defined as a Board appeal record less than twenty (20) years old or the statement of basis and purpose for a rule that is in effect or was in effect during the past five (5) years. Administrative value is defined as a record that is less than five (5) years old and summarizes department cost efficiencies, including staffing and workload statistics. Historical value is defined as a record documenting a major change in the function of the Board or the Department of Personnel.

1-21. Departments shall maintain official records in written or electronic form. Access to records is governed by §24-72-201, C.R.S, et seq. Each department shall have an authorized records custodian who is accountable for the maintenance, access and confidentiality, and disposition of all records required by state and federal law. The Division of Human Resources shall have access to records required for the monitoring of delegated authorities and other official duties.

1-22. When an employee transfers or reinstates to a different department, all official employee records shall be forwarded to the new department within ten (10) business days. Failure to forward these records may result in liability for violation of these rules and any applicable laws. (04/01/2020)

1-23. Official Personnel File. Each employee's official personnel file shall include the following and be retained ten (10) years after separation: a separate record of all employment actions; most current application information; corrective/disciplinary action information unless rescinded by the Board or further appeal or removed by the appointing authority; final annual performance evaluations for at least the past three (3) years; grievance and other dispute information; letters of recommendation, reference, or commendation as requested; and, any other information desired by the appointing authority. An employee shall be given a copy of any information placed in the personnel file, except for reference checks. (7/1/07)

1-24. Medical Records. Any medical information on the employee or a family member shall be maintained in a separate, confidential medical file with limited access in accordance with law.

1-25. Selection Records. Selection records shall be kept for two (2) years after expiration of the eligible list, except when notified of a charge of discrimination. In such a case, the record is maintained until the charge is resolved. The content of selection records shall include all related information up to the establishment of the eligible list. (3/30/13)

Human Resource Innovation Programs

Board Rule 1-26. A written statement of each Human Resource Innovation Program (HRIP) implemented by the agency shall be submitted by the head of the agency to the State Personnel Board or State Personnel Director, as appropriate, at 1525 Sherman Street, Denver, CO, 80203, commensurate with the implementation of each HRIP. The description shall indicate the following:

A. In developing the HRIP, input was obtained from both management and non-management employees in the department; and,

B. The HRIP complies with the Colorado Constitution, statutes, and rules.

The Board shall forward HRIPs within the Director's jurisdiction to the Director. After review, the Director will issue a written consultation. The Board will review each HRIP within the Board's jurisdiction at the next regularly scheduled public Board meeting and issue a written consultation.

Each department head is responsible for updating the statement and submitting any modifications or revisions of the HRIP to the Board or Director commensurate with such changes. (1/01/15)

Definitions

1-27. Advisor. Individual who assists a party during a grievance or the performance management dispute resolution process by explaining the process, helping identify the issues, preparing documents, and attending meetings. (7/1/07)

1-28. Allocation. Assignment of an individual position to the proper class.

1-29. Announcement. The published notice for a position or class that will be filled on the basis of merit and fitness.

1-30. Applicant. An individual who applies for employment in the state personnel system.

1-31. Applicant Pool. A group of individuals who have applied for employment in the state personnel system.

1-32. Base Pay. An employee's salary without premium pay. Synonymous with base salary.

Board Rule 1-32.1. Certified. The status of an employee who has successfully completed a probationary period or a trial service period. (3/15/11)

1-33. Class. A group of positions whose essential character (general nature of the work and responsibilities) warrants the same pay grade, title, and similar qualifications for entry into the class.

1-34. Class Conversion. Automatic movement of a current title and grade to a new title and grade.

1-35. Class Description. The official written description of a class series and its levels as issued by the Department of Personnel.

1-36. Class Placement. Portion of a system maintenance study in which all affected positions are individually placed in the proper new class.

1-37. Class Series. A group of classes engaged in the same kind of occupational work but representing different levels.

1-37.1. Comparative analysis. A process that utilizes professionally accepted standards that compares specific job-related knowledge, skills, abilities, behaviors and other competencies. Such a process may be numeric or non-numeric. (3/30/13)

1-38. Competencies. Observable, measurable patterns of knowledge, skills and abilities, behaviors, and other characteristics that employees need to successfully perform work-related tasks.

1-38.1. Conditional Appointments. A temporary appointment to a permanent position approved by the Appointing Authority. The appointment applies to a current certified employee who is qualified and temporarily promotes into a permanent vacancy for which no eligible list exists. (04/01/2020)

1-38.2. Conditions of Employment. Conditions of employment refer to requirements of a position such as passing a criminal background check, meeting travel demands, regularly lifting a specified amount of weight, driving requirements and driver's license requirements. Conditions of employment may be based on job analysis and may be documented in the position description. Note: Conditions of employment apply to a position, whereas minimum qualifications apply to a job class. (04/01/2020)

1-38.3. Critical Positions. Positions departments determine as critical to their operations. Employees in critical positions can be FLSA exempt or nonexempt and can be expected to work and/or remain at their worksite in delayed start, early release, or closure situations. (04/01/2020)

Board Rule 1-39. Day. Calendar day unless otherwise specified.

Board Rule 1-40. Department. One of the principal departments defined in law and institutions of higher education.

Board Rule 1-40.1. Departmental Reemployment List. A list which is established on a departmental basis, as listed in the "Separation" chapter, containing the names of certified employees who meet one (1) of the following conditions: (a) separated from employment due to layoff; (b) voluntarily demoted in lieu of layoff or as a result of a position's reallocation; and/or (c) former position no longer exists upon return from an exempt position accepted at the request of the governor or other elected or appointed official and the employee is laid off. (3/15/11)

Board Rule 1-41. Disciplinary Suspension. A type of disciplinary action in which an employee is not allowed to work and is not paid for a specified period of time.

Board Rule 1-42. Dismissal. Disciplinary termination of employment.

1-43. Eligible List. A list of persons who have successfully passed through a comparative analysis and may be considered for appointment. Referrals are drawn from this list. (1/1/14)

Board Rule 1-44. Employee. An individual who occupies a full-time or part-time position in the state personnel system.

Board Rule 1-45. Employment Lists. Statutory term that includes promotional and open-competitive eligible lists and reemployment lists.

1-45.1. Essential Positions. Positions that perform essential law enforcement, highway maintenance, and other support services directly necessary for the health, safety, and welfare of patients, residents, and inmates of state institutions or state facilities. Employees in essential positions can be only FLSA nonexempt and can be required to work unexpected or unusual work hours to perform the essential and/or emergency services of the department without delay and/or without interruption. (04/01/2020)

1-46. Examination. A numerical assessment of job-related competencies, knowledge, skills, abilities and job fit to screen applicants for the eligible list. (3/30/13)

Board Rule 1-47. Exempt Employee. One who is not eligible for overtime.

1-47.1. Fair Labor Standards Act (FLSA). The Fair Labor Standards Act (FLSA) includes but is not limited to, the establishment of minimum wage, overtime pay, recordkeeping, and child labor standards affecting full-time and part-time workers in the private sector and in Federal, State, and local governments. Special rules apply to State and local government employment including but not limited to: (a) compensatory time off instead of cash overtime pay, (b) fire protection and law enforcement activities and (c) volunteer services. (04/01/2020)

1-48. Full-Time. A position scheduled and budgeted for 2080 hours per fiscal year. (04/01/2020)

Board Rule 1-49. Good Cause. Any cause not attributable to a party's or counsel's act or omission, including but not limited to: death or incapacitation of a party or the attorney for the party; a court order staying or otherwise necessitating a continuance; a change in the parties or pleadings sufficiently significant to require a postponement; a showing that more time is clearly necessary to complete authorized discovery or other mandatory preparation for hearing; or agreement of the parties to a settlement which has been or will likely be approved by the final decision maker.

A. Good cause will normally not include: unavailability of counsel due to an engagement in another judicial or administrative proceeding, unless such other proceeding was involuntarily set subsequent to the present case; unavailability of a necessary witness if the witness' testimony can be taken by telephone or deposition; or failure of an attorney to timely prepare for the hearing.

1-50. Health Care Provider. For purposes of family/medical leave only, a doctor of medicine or osteopathy, dentist, podiatrist, clinical psychologist, optometrist, chiropractor limited to manual manipulation of the spine to correct a subluxation as demonstrated by x-ray, nurse practitioner, physician's assistant, nurse mid-wife, Christian Science practitioner listed with First Church of Christ, Scientist in Boston, and clinical social worker. Health care providers shall be authorized to practice and be performing within the scope of their practice.

1-51. Independent Contractor. A firm or individual who is responsible to the state for the results of certain work, but is not subject to the state's control as to the means and methods of accomplishing those results. For purposes of determining independent contractor status, the Director will apply the criteria set forth in the fiscal rules of the state controller, and state and federal law. Independent contractor is synonymous with contractor for purposes of these rules. (5/1/10)

1-52. Job Description. The official document summarizing the primary duties and responsibilities assigned to a position by the appointing authority.

1-53. Job Evaluation System. System of classes and assigned pay grades developed by the Director. All positions are placed in the system during a system maintenance study or are allocated when an assignment changes or a position is created.

1-53.1. Job Qualifications. Includes the minimum qualifications for a vacancy's class; any special qualifications, including but not limited to any required education or experience and any licensure or certification requirements; and/or any pre- or post-employment screening requirements. (3/15/11)

1-54. Laid Off. Involuntary non-disciplinary separation from a position in the state personnel system and, if applicable, the offer of retention rights and/or placement on a reemployment list. (3/30/13)

1-55. Layoff. Process of involuntarily separating an employee from a position in the state personnel system due to abolishment of the position for lack of work, lack of funds, reorganization, or displacement by another employee exercising retention rights. (3/30/13)

1-55.01. Minimum Qualification. The type and level of education, experience, licensure, certification, and/or any applicable substitutions required for entry into a defined state personnel system job class. Minimum Qualifications are established by the Director. (04/01/2020)

1-55.02. Nonexempt Employee. Employee in a position that is eligible for overtime under the FLSA. (04/01/2020)

Board Rule 1-55.1. Non-disciplinary Demotion. An appointment which is a voluntary change to a class with a lower pay range maximum. (3/15/11)

Board Rule 1-56. Non-Permanent Position. A position established for a nine-month period or less. It may be a full-time or part-time work schedule. Synonymous with temporary. (3/30/13)

1-56.1. Open Competitive List. A list containing the names of individuals who have successfully completed any applicable comparative analysis process resulting from a job announcement that was not restricted to current state employees. (3/30/13)

1-56.2. Part-Time. A position scheduled for less than 2080 hours per fiscal year. (04/01/2020)

1-57. Party or Parties. A person appealing and any person or department against whom an appeal is filed.

1-58. Pay Grade. Reflects the minimum and maximum base salary rates for work in a specific class. Individual salaries vary within the ranges depending on individual movements in accordance with these provisions. Synonymous with pay level, range, or band.

1-59. Pay Plans. Listing of all pay grades and their corresponding ranges for occupational groups.

1-59.1. Pay Plan - Medical. The pay plan that applies to classified positions in specific class series within the Health Care Services Occupational Group. The statutory lid for the class series pay ranges is greater than the general statutory lid. Employees occupying these positions are compensated based solely on performance as established in the required annual contract. (04/01/2020)

1-60. Pay Rate. Actual base pay or salary amount.

Board Rule 1-61. Permanent Position. A position that is carried on the staffing pattern in excess of nine (9) months or on an annual, seasonal basis. It may be a full- or part-time work schedule. (3/30/13)

Board Rule 1-62. Position. An individual job, as defined by an appointing authority, within the state personnel system.

Board Rule 1-62.1. Probationary. A person who is not a current certified employee and who has been selected from a referral list for a permanent position but has not yet been certified to the class for that position. (3/15/11)

1-62.2. Promotional List. A list containing the names of individuals who have successfully completed any applicable comparative analysis process resulting from a job announcement restricted to current state employees or former state employees separated from employment due to layoff. (3/30/13)

1-62.2.1. Provisional Appointment. An immediate temporary appointment to a position with a person from outside of the state personnel system for which no eligible list exists. Employees with a provisional appointment do not have the rights and benefits provided to classified employees within the state personnel system except for those mandated by law and pay range minimums. Appointees shall possess the minimum qualifications for the position. Appointees shall not retain the position as provisional longer than nine (9) months from the date of entrance of duty or one (1) month after the establishment of a referral list intended to permanently fill the position, whichever date is earlier. (04/01/2020)

1-62.3. Qualified Applicant. An individual who submits a timely and sufficient application in response to an announcement and meets the job qualifications for the vacancy. (3/30/13)

1-62.4. Qualified Applicant Pool. All individuals who are eligible to be included in any applicable comparative analysis process because each of them satisfies the definition of qualified applicant for the respective position or class. (3/30/13)

1-62.5. Rank. Relative to position or degree of value. (1/1/14)

1-63. Reemployment. The right of an employee to be returned or rehired to the class from which separated by layoff.

Board Rule 1-64. Reemployment List. List of certified employees who were involuntarily terminated or demoted due to layoff.

1-64.1. Referral List. A list of the top six (6) individuals drawn from the eligible list who are to be considered by the appointing authority. In cases in which a non-numerical comparative analysis has been used, the appointing authority shall also consider all applicants who are eligible for veteran's preference. (1/1/14)

Board Rule 1-64.2. Reinstatement. An appointment of a former or current employee either to a class in which the person was certified and resigned or voluntarily demoted in good standing or to a related class at the same or lower pay range maximum. (3/15/11)

Board Rule 1-65. Resignation. Voluntary separation from the state personnel system.

Board Rule 1-66. Retention Credit. Credit of time and, if necessary, the calculation of an employee's ranking under the department's matrix in a layoff situation, in order to calculate the employee's retention rights. (10/1/07)

Board Rule 1-67. Retirement. Separation of an employee from the state personnel system who is eligible to retire under the provisions of the state retirement plan in which the employee is enrolled (e.g., Public Employees' Retirement Association's defined benefit plan). (1/1/07)

1-68. Saved Pay Rate. Temporary means of maintaining current base pay during certain situations that accommodate base pay amounts between the maximum of a pay grade and a statutory lid.

1-69. Serious Health Condition. For purposes of family/medical leave, an illness, injury, impairment, physical or mental condition that requires inpatient care in a hospital, hospice, or residential medical care facility or continuing treatment by a health care provider. Continuing treatment is a period of incapacity of more than three (3) calendar days, pregnancy, a chronic serious health condition, or permanent long-term condition for which there is no treatment but the patient is under supervision, or multiple treatments without which a period of incapacity would result.

1-70. Service Date. The date continuous state service begins, including state employment outside the state personnel system, but excluding temporary and student employment. Service dates do not change except for separation from service of more than ninety (90) days, or any break in a probationary period. (5/1/10)

Board Rule 1-71. Sexual Harassment. Quid pro quo sexual harassment is unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when submission to or rejection of such conduct is used as the basis for an employment decision. Hostile work environment sexual harassment is any harassment or unequal treatment based on sex, even if not sexual in nature, which results in unreasonable interference with an individual's work performance or creates an intimidating, hostile, or offensive working environment.

1-72. Special Qualifications. Position specific requirements that add to but do not substitute for existing minimum qualifications. Special Qualifications shall not supersede nor diminish an existing minimum qualification. (04/01/2020)

Board Rule 1-73. Status. Categories that determine the rights of an employee under the state personnel system, i.e., probationary, trial service, certified, conditional, provisional, and temporary.

1-73.1. Substitute Appointment. A temporary appointment that is made to perform the duties of a filled position during a leave or for training purposes. (3/15/11)

1-74. System Maintenance Study. The process used to determine classes and/or pay grades and to properly place all affected positions into new classes. It includes class placement.

1-74.1. Temporary Appointee. This refers to a qualified person who is appointed to a position or positions for a period not to exceed nine (9) months in any twelve (12) month period inclusive of all temporary appointments with any state employer. Temporary appointees include temporary, conditional, provisional, and substitute appointments. (04/01/2020)

1-74.2. Temporary Employee. A person who holds a temporary appointment in a temporary position and is employed at-will, not having the rights and benefits provided to permanent employees, except those mandated by law and pay range minimums. (04/01/2020)

Board Rule 1-75. Tenure. Combination of rights which vest in a certified employee by virtue of certified status, seniority, and years of service.

Board Rule 1-76. Termination. Separation of an employee from the state personnel system by resignation, retirement, layoff, dismissal, or death.

Board Rule 1-76.1. Transfer. An appointment of a qualified and current employee to a different position in the same class or to a class with the same pay grade. (3/15/11)

1-77. Treatment. For purposes of family/medical leave, examination to determine if a serious health condition exists, subsequent exams to evaluate the condition, and a course of prescriptive medication or therapy requiring special equipment. Routine exams or treatments that do not require the intervention or continuing supervision of a health care provider are excluded.

Board Rule 1-77.1. Trial Service. Status of a current certified employee or reemployment applicant who promotes or, unless appointing authority requires a probationary period, a reinstated applicant. May also apply, at the discretion of the appointing authority, to a current employee who transfers within the same class or to a current certified employee or a reemployed applicant who transfers to a different class with the same pay range maximum. (3/15/11)

Board Rule 1-78. Unclassified Position. A position in state government that is not covered by the state personnel system.

Payroll Deduction

1-79. State departments and institutions of higher education shall process payroll deductions including but not limited to, those required by federal law, state statute, executive order, through partnership agreements or state sponsorship, and including: (04/01/2020)

A. Pre-tax benefit contributions governed by the State's Salary Deduction Plan; and/or (04/01/2020)

B. The reimbursement of monies owed to the state from an employee (e.g., higher education tuition, uniforms, salary overpayment). (04/01/2020)

C. – E. Repealed. (04/01/2020)

1-80. All employee requests to start or terminate a payroll deduction shall be made within specific time frames and on forms approved by the Director, department head or their designee, except as otherwise required by law. (04/01/2020)

Chapter 3 – Compensation

Authority for rules promulgated in this chapter is found in State of Colorado Constitution Article XII, Section 13, State of Colorado Revised Statutes (C.R.S.) §§24-50-104 (1)(a), (b), (c), (e), (f), (4), (5), (6), (9), and 24-50-104.5(1), 109.5, 136, 137, and 208, C.R.S. Board rules are identified by cites beginning with "Board Rule." (04/01/2019)

General Principles

3-1. The Department of Personnel shall establish rules governing compensation for the state personnel system. Compensation practices shall provide for equitable treatment of similarly situated employees.

3-2. Pay grades shall reflect prevailing labor market compensation and any other pertinent considerations. No individual employee's base pay shall be less than the minimum of the grade or exceed a statutory lid. In the case of disciplinary action, base pay may be less than the minimum of the grade for a period not to exceed twelve (12) months, subject to the FLSA requirements.

Annual Compensation Survey

3-3. The Department of Personnel shall conduct the annual compensation survey. The Director shall establish and publish the distribution of annual compensation changes among salaries, including establishment of statewide priority groups and group benefit contributions, which shall be effective as provided by law. (9/1/12)

3-4. When upward pay grade changes are implemented, the grade minimum and maximum shall be adjusted and no employee shall be paid outside of the new grade, except in disciplinary actions resulting in salary temporarily below the new minimum and continuation of saved pay above the new maximum. (7/1/07)

3-5. If pay grade changes are downward, employees' base pay shall remain unchanged, subject to the statutory three (3) year limitation on saved pay.

Pay Rates

3-6. The Department of Personnel shall publish the annual pay plan. Departments shall use an hourly rate based on an annual salary to compensate employees who do not work a predetermined or full schedule. (1/1/18)

3-7. Saved pay applies to downward movements due to individual allocation, system maintenance studies, and the annual compensation survey to maintain an employee's current base pay when it falls above the new grade maximum. It may also apply when retention rights are exercised pursuant to the "Separation" chapter. In no case shall the employee's base pay remain above the grade maximum after three (3) years from the action, even if it results in a loss in pay. (1/1/18)

3-8. Unless authorized by the Director, the rate resulting from multiple actions effective on the same date shall be computed in the following order. The Director may withhold salary adjustments for any employee with a final overall rating of needs improvement, except as provided in Rule 3-4. (7/1/07)

A. System maintenance studies.

B. Upward, downward, or lateral movements.

C. Repealed. (8/1/08)

D. Changes in pay grade minimums and maximums to implement approved annual compensation changes to the pay structure.

E. Across-the-board increases authorized by the General Assembly. (1/1/18)

F. Adjustments to the base pay of employees due to merit pay in approved annual compensation changes, subject to the new grade maximum and Rule 3-19(C)(1)(a). (1/1/18)

G. Bring salaries to the new grade minimum as a result of compensation survey pay grade changes, except in disciplinary actions. (1/1/18)

H. Non-base merit payments (based on new annual salary). (1/1/18)

3-9. The appointing authority shall determine the hiring salary within the pay grade for a new employee, including one returning after resignation, which is typically the grade minimum unless recruitment difficulty or other unusual conditions exist. (7/1/06)

A. Recruitment difficulty means difficulty in obtaining qualified applicants or an inadequate number of candidates to promote competition despite recruitment efforts.

B. Unusual conditions exist when the position requires experience and competencies beyond the entry level or the best candidate cannot be obtained by hiring at the minimum of the pay grade. (1/1/18)

C. The appointing authority's determination shall consider such factors as, but not limited to, labor market supply, recruitment efforts, nature of the assignment and required competencies, qualifications and salary expectations of the best candidate, salaries of current and recently hired employees in similar positions in the department, available funds and the long-term impact on personal services budgets of hiring above the minimum of the pay grade.

3-10. In the case of fiscal emergency or other budget reasons, an employee may agree to voluntarily reduce current base pay, which shall be approved in writing by the appointing authority and employee. If funds become available at a later date, the department may restore base pay to any rate up to, and including, the former base pay. This policy shall not be used to substitute for other provisions in this chapter.

3-11. When an unclassified position is brought into the state personnel system, the base pay for an employee appointed to the position shall be computed in accordance with the Department of Personnel's directives that shall ensure that total compensation is preserved to the greatest extent possible, except that base pay shall not exceed the grade maximum. (1/1/18)

Downward Adjustments

3-12. Downward movement is a change to a different class with a lower range maximum (e.g., non-disciplinary or disciplinary demotions, individual allocations, system maintenance studies including class placement, or the annual compensation survey).

3-13. In the case of system maintenance studies and individual allocations of positions, the employee's base pay shall remain the same, including saved pay.

A. A department head has sole discretion to grant saved pay when employees exercise

retention rights and the decision shall be applied consistently throughout the retention area. If saved pay is granted, the employee's name shall not be placed on a reemployment list. (7/1/07)

3-14. In the case of other downward movements, the base pay shall not be above the maximum in the new grade.

A. Upon reversion of a trial service employee to the previously certified class, base pay shall be the amount the employee would be making had the promotion or reinstatement not occurred. (1/1/14)

Upward Adjustments

3-15. Upward movement is a change to a different class with a higher range maximum (e.g., promotions, individual allocations, system maintenance studies including class placement, or the annual compensation survey).

3-16. In the case of system maintenance studies, employees' base pay shall remain the same. If the Director finds that severe and immediate recruitment and retention problems make it imperative to increase pay to maintain critical services, the Director may order that base pay be increased up to the percentage increase for the new class.

3-17. In the case of other upward movements, the employee's base pay may increase or remain the same, in which case the employee would receive the economic opportunity by moving to the new grade. In no case shall the new base rate be lower than the minimum, except in disciplinary actions, or higher than the maximum of the new grade. Continuation of a salary increase is subject to satisfactory completion of the trial service period.

A. When conditional employees move upward, the base pay shall be computed based on the certified class.

Lateral Adjustments

3-18. Lateral movement is a change to a different class or position with the same range maximum (e.g., transfers, individual allocations, system maintenance studies including class placement), or an in-range salary movement in the same class and position. Base pay can be offered at a rate that falls within the pay range of the class and does not exceed the grade maximum. In addition, in-range salary movements are subject to the provisions below. (1/1/14)

<u>In-Range Salary Movements.</u> A department may use these discretionary movements to increase base salaries of permanent employees who remain in their current classes and positions when there is a critical need not addressed by any other pay mechanism. The use of in-range salary movements is not guaranteed and shall be funded within existing budgets. These movements shall not be retroactive and unless specifically noted in these rules, frequency is limited to one (1) in- range salary movement in a twelve (12) month period. No aspect of granting these movements is subject to grievance or appeal, except for alleged discrimination; however, an alleged violation of the department's plan can be disputed. A department's decision in the dispute is final and no further recourse is available. Once granted, a reduction in base salary is subject to appeal. Departments shall develop a written plan addressing appropriate criteria for the use of any movement based on sound business practice and needs, e.g., eligibility, funding sources, approval requirements, and measures to ensure consistent use. The plan shall be communicated within the department and a copy provided to the Director prior to implementation. If granted, there shall be an individual written agreement between the employee and the appointing authority that stipulates the terms and conditions of the movement. Records of any aspect of these movements shall be provided to the Director when requested. (02/2017)

A. Salary Range Compression. Used as a salary leveling increase where longer-term or more experienced employees are paid lower in the range for the class than new hires or less experienced employees over a period of time resulting in documented retention difficulties. Thus, there is a valid need to increase one (1) or more employee's base salary in the class to recognize contributions equal to or greater than the newly hired or less experienced employees. Justification shall be required based on facts. To be eligible, an employee shall be performing satisfactorily as evidenced by the most recent final overall performance rating. The increase may be up to ten percent (10%) or the maximum permitted by the department's policy on hiring salaries, whichever is greater, and subject to the pay grade maximum. (9/1/12)

B. Counteroffer. Used when an employee with critical, strategic skills receives a higher salary offer from another department or outside employer and the appointing authority needs to increase the employee's base salary for retention purposes. To be eligible, an employee shall be performing satisfactorily as evidenced by the most recent final overall performance rating. Written confirmation of the other entity's salary offer is required. The increase may be up to ten percent (10%) or the maximum permitted by the department's policy on promotional pay, whichever is greater, and subject to the pay grade maximum.

C. Delayed Transfer or Promotional Pay Increase. Used when a transfer or promotion is made with no salary increase or partial salary increase because performance expectations are unproven and/or funds may be unavailable at the time of transfer or promotion. This is a one (1) time base salary increase within twelve (12) months of the date of transfer or promotion when funds become available and the employee's contributions are fulfilled. The intent to provide a later salary increase shall be documented at the time of the transfer or promotion. To be eligible, an employee shall be performing satisfactorily as evidenced by the most recent final overall performance rating. The increase may be up to ten percent (10%) or the maximum amount permitted in the department's policy on transfer or promotional pay increases, whichever is greater, and subject to the pay grade maximum. Transfer, promotion, demotion, or separation of the employee will negate the delayed increase. (1/1/18)

D. New Hires. Used at the time an employee is hired when performance expectations are unproven and/or funds may be unavailable. This is a one (1) time base salary increase within twelve (12) months of hire. The intent to provide a later salary increase shall be documented at the time of hire. To be eligible, early satisfactory completion of specified training objectives shall be documented. This is limited to a one (1) time increase up to ten percent (10%) or the maximum permitted by the department's policy on promotional pay increases, whichever is greater, and subject to the pay grade maximum. Transfer, promotion, demotion, or separation of the employee will negate the delayed increase. (02/2017)

E. Competency-Based Increase. Used when an employee applies the complete set, or a subset, of competencies required to successfully perform the work of a specific position. Required competencies shall be specifically defined with deadlines and evaluation criteria for achievement, and shall be communicated in writing to the employee prior to granting an increase. Competencies that are the basis for this increase shall be required to perform permanent, essential functions assigned to the position. The intent of this increase is to promote career development by aligning pay increases with achieving all required competencies to fully perform the job. Increases are limited to no more than two (2) per twelve (12) month period. This type of increase shall not be applied as a substitute for Merit Pay. To be eligible, an employee shall demonstrate required competencies as evidenced by a written evaluation by the appointing authority. The increase may be up to ten percent (10%) or the maximum permitted by the department's

policy, whichever is greater, and subject to the pay grade maximum.

Merit Pay (9/1/12)

3-19. Merit pay consists of both base and non-base building adjustments. Any permanent employee is eligible for merit pay, except as provided below and as otherwise provided in this chapter. Prior to the payment of merit pay, the Director shall specify and publish the percentage for any merit pay increase for applicable priority groups. Adjustments are effective on July 1. The employee shall be employed on July 1 to receive payment. The employee's current department as of July 1 is responsible for payment, unless arrangements are made whereas the transferring department will provide full payment of a portion of any non-base building merit pay increase. (1/1/18)

A. If the final overall rating is needs improvement, the employee is ineligible for any merit pay. Merit pay shall not be denied because of a corrective or disciplinary action issued for an incident after the close of the previous performance cycle. (9/1/12)

B. Employees hired into the state personnel system during the performance evaluation cycle shall receive a prorated portion of any base or non-base building merit pay. The proration shall be based on the number of calendar months worked. (1/1/18)

C. Base building merit pay shall be based on final performance evaluation and salary position within the pay range on June 1. (1/1/18)

1. Payment of base building merit pay shall not cause an employee's base pay to exceed the grade maximum, and is paid as regular salary. (9/1/12)

a. The payment of any remaining portion of base building merit pay that would cause base pay to exceed grade maximum shall be paid as a onetime, non-base building lump sum in the July payroll. The statutory salary lid does not apply to such a payment. (1/1/14)

2. Payment of base building market pay shall be a comparison of state personnel system salaries to market salaries for the purpose of measuring competitiveness. Market shall result in base building increases to pay, only when an employee's salary is below a newly adjusted pay range minimum. (9/1/12)

D. Non-base building merit pay shall be a non-base building or one (1) time lump sum payment and shall be calculated after any annual compensation adjustments, including base building merit pay. (1/1/18)

1. Non-base building merit pay shall be earned each year and shall be paid as a one-time lump sum in the July payroll. The grade maximum and statutory lid do not apply to non-base building merit pay. (9/1/12)

a. An employee shall be employed on the date of the payment in order to be eligible to receive a non-base building merit payment. (9/1/12)

E. Base building or non-base building merit pay may be provided to employees, at a department's discretion if approved by the Governor's Office of State Planning and Budgeting, when funded from a department's state employee reserve fund using department reversions. These discretionary merit payments shall only be paid to certified employees, in order of priority grouping established by the Director. (1/1/18)

1. Base building merit pay increases funded from a department's state employee reserve fund shall be provided only if the department can justify sustainability as

determined by the Governor's Office of State Planning and Budgeting. (9/1/12)

2. Merit pay increases funded from a department's state employee reserve fund shall not be provided more than one (1) time in a twelve (12) month period per employee. 9/1/12)

3. Repealed. (1/1/18)

F. Repealed. (1/1/18)

Incentives

3-20. Departments are strongly encouraged to use incentives. (7/1/06)

3-21. An appointing authority may grant an immediate non-base cash or non-cash incentive award to an employee in recognition of special accomplishments or contributions throughout the year or to augment merit pay, e.g., on-the-spot cash awards, work-life options, or administrative leave, in accordance with a department's established incentive plan. Other than augmenting merit pay, incentives shall not be used to supplement or substitute for annual compensation adjustments or other base pay movements. The statutory salary lid does not apply to these incentives. (9/1/12)

A. Departments shall have an incentive plan prior to the use of incentives. Such plans shall include eligibility criteria, the types of incentives allowed, cash amounts or limits and payment methods, and a communication plan. Such plans shall be developed with the input of employees and managers.

1. If a department uses a type of incentive that shares cost savings from innovations, the following applies.

a. Employees are ineligible if they are wholly responsible for control and operation of a division (or equivalent), the primary assignment includes responsibility for identifying efficiencies and cost reductions, or the position has statewide program or budget authority.

b. Savings are the result of innovative ideas that increase productivity and service levels while decreasing costs. Savings are not the result of normal progressive business evolution, obvious solutions to mandated budget cuts, cost avoidance or revenue enhancement, nor do they have adverse cost impact on other departments.

c. Savings are the difference between anticipated expenditures prior to implementation and actual expenditures following implementation for a full twelve (12) month period. The complete award amount shall be no more than ten percent (10%) of the first year's savings, not to exceed a total of one thousand dollars ($1,000) per employee.

3-22. Repealed. (8/1/08)

3-23. Repealed. (8/1/08)

Medical Plan

3-24. Employees in the medical pay plan shall be compensated based solely on performance as established in the required annual contract to be negotiated by July 1 of the contract year, or within thirty (30) days of hire or movement within the medical pay plan for the remainder of the contract year. Employees are not eligible for any pay adjustments, such as merit pay. Current performance contracts may be modified during the contract year but not compensation. Change in compensation shall only occur at the end of a contract period, unless an employee moves to another position, and may increase, decrease, or remain unchanged from the previous year. In the case of upward or downward movement in the medical pay plan, compensation shall be no lower than the minimum or higher than the maximum rates of the new grade and a new contract shall be negotiated for the remainder of the contract year. (9/1/12)

A. If no contract is negotiated, the existing contract continues and base pay stays the same until a new contract is negotiated. Employees in the medical pay plan may grieve the rate unless it is lower, which is then subject to appeal. If the employee moves into or out of the medical pay plan into another open-range class, the base pay shall be negotiated subject to the grade maximum of the new class.

FLSA and Overtime

3-25. All employees are covered by the FLSA. Under the FLSA, the state is considered to be a single employer. Employees cannot waive their rights under the FLSA. (04/01/2020)

3-26. The state's standard FLSA workweek is Saturday at 12:00am through Friday at 11:59pm. This standard FLSA workweek applies to agencies that use the official payroll system designated by the State Controller. (11/1/2019)

A. For law enforcement, healthcare, and fire protection employees, appointing authorities may adopt a "work period" under the FLSA between seven (7) consecutive days to twenty-eight (28) consecutive days in length. Overtime compensation is not required until the employee satisfies the maximum hour standard under the federal regulations. (11/1/2019)

3-27. Overtime is the actual hours worked by a nonexempt employee in excess of the forty (40) hours during a standard FLSA workweek or in excess of established work hours in adopted work periods for law enforcement, healthcare, and fire protection employees. Such excess hours are paid at one and one-half (1 ½) times the employee's regular hourly base pay rate, including applicable premium pay. Nonexempt employees paid on a biweekly or monthly pay cycle shall be paid overtime on the employee's next regularly scheduled payroll following the period the overtime was earned. Biweekly employees shall be paid on the biweekly payroll and monthly employees shall be paid on the monthly payroll. (11/1/2019)

A. Overtime for nonexempt employees shall be approved in accordance with a department's procedure. A department head shall establish a policy to address unauthorized overtime work; however, prohibition of unauthorized overtime does not avoid the requirement to pay if it is actually worked.

B. Compensatory time in lieu of monetary payment is allowed if there is a written agreement between the department and any employee hired after April 15, 1986. Written agreements for those hired prior to April 15, 1986, are unnecessary provided that the department had a regular practice in place for granting compensatory time. Acceptance of compensatory time may be a condition of employment for new employees. Appointing authorities shall ensure that compensatory time is scheduled as soon as practical.

Compensatory time shall not exceed two hundred and forty (240) hours (or four hundred and eighty (480) hours – see the FLSA) and any additional overtime shall be paid as indicated in Rule 3-27. If a department wants to place limits on the accrual or payment of compensatory time up to two hundred and forty (240) hours (or four hundred and eighty (480) hours – see the FLSA), a policy shall be developed and communicated prior to use and on an ongoing basis. Unused compensatory time at termination or transfer to another department shall be paid at that time. (11/1/2019)

Eligibility

3-28. Department heads are responsible for determining if each position is exempt or nonexempt based on the actual duties performed regardless of class. Determinations shall be entered into the payroll system and a record kept on file.

3-29. An exempt employee's pay is not subject to reduction except as follows: (04/01/2020)

A. Deductions in increments of one (1) day are allowed for a major workplace rule violation.

B. Deductions are allowed for any amount of time if:

1. a leave of absence was not requested or was denied and accrued leave is not used;

2. the time is covered by the Family and Medical Leave Act (FMLA); or the state family medical leave; (04/01/2020)

3. accrued leave is exhausted;

4. the time is a voluntary furlough; or

5. the time is a mandatory furlough for budgetary reasons. (04/01/2020)

3-30. Exempt employees shall not be granted extra pay for hours worked in excess of forty (40) hours in a workweek. An appointing authority may grant discretionary administrative leave or other incentives but such awards shall not be tied to hours worked. (7/1/06)

3-31. An employee may request a review of a decision regarding eligibility, calculation of overtime hours, and payment to the Director in accordance with the "Dispute Resolution" chapter.

Dual Employment

3-32. In a properly authorized dual employment arrangement, the written agreement shall include the exemption status designation based on the combined duties, the department responsible for paying any overtime, and the overtime hourly rate. The overtime rate, if applicable, is either the regular rate from one (1) of the jobs or a weighted rate from both jobs. Work time from both jobs is combined to calculate overtime. (1/1/18)

Work Hours

3-33. In order to minimize overtime liability, appointing authorities may deny, delay, or cancel leave before it is taken. Appointing authorities may require the use of accrued compensatory time but cannot schedule compensatory time if that will make an employee forfeit annual leave at the end of the fiscal year. (1/1/18)

3-34. Compensatory time is not leave, but a form of compensation. Therefore, it is not included in the

calculation of work hours for overtime purposes.

3-35. Overtime does not accrue until a nonexempt employee works more than the maximum hours allowed in a standard FLSA workweek or designated work period as permitted in Rule 3-26 (A). All time worked shall be recorded on a daily basis. Overtime is calculated based on the total time worked in the standard FLSA workweek or designated work period as permitted in Rule 3-26 (A), rounded to the nearest quarter (¼) hour. Overtime pay for nonexempt employees for time worked over forty (40) hours in a standard FLSA workweek or in excess of established work hours in adopted work periods as permitted in Rule 3-26 (A), excludes paid leave or holiday leave with the exception of Essential Positions, see Rule 3-36. If operational needs require an employee to regularly report to work early or leave late, that time is counted as work hours for the calculation of weekly overtime. (04/01/2020)

3-36. Essential nonexempt positions, as designated by a department head, shall have paid leave counted as work time. Essential positions perform law enforcement, highway maintenance, and support services directly responsible for the health, safety, and welfare of patients, residents, students, and inmates. (04/01/2020)

3-37. Scheduled meal periods are discretionary. Scheduled meal periods are not work time and shall be at least twenty (20) minutes. However, if the employee is materially interrupted or not completely free from duties, the meal period is counted as work time.

3-38. Work breaks are discretionary. If granted, breaks of up to twenty (20) minutes are work time. Breaks shall not offset other work time or substitute for paid leave, not be taken at the beginning or end of the workday, nor be used to extend meal periods.

3-39. Ordinary travel to and from work is not work time. Travel from work site to work site is work time. When an employee is required to travel a substantial distance to perform a job away from the regular work site, the travel is work time.

3-40. Mandatory training or meetings are work time. Voluntary training during work hours, as approved by the appointing authority, which is directly related to an employee's job and is designed to enhance performance, is work time. Voluntary training after hours to gain additional skill or knowledge is not work time, even if it is job related.

Recordkeeping

3-41. The FLSA requires that certain basic records be maintained for both exempt and nonexempt employees. Each department is accountable for maintaining those records. (7/1/07)

3-42. Time records shall be approved by both the employee and the supervisor. The time records are the basis for overtime calculation and compensation. (11/1/2019)

Other Premium Pay

3-43. Shift Differential is additional pay beyond base pay for employees working shifts. Eligible classes are published in the annual pay plan. Department heads may designate eligibility for individual positions in classes not published and shall maintain records for such cases. Shift differential does not apply to any periods of paid leave. Second shift rate applies when half or more of the scheduled work hours fall between 4:00 p.m. and 11:00 p.m. Third shift rate applies when half or more of the scheduled work hours fall between 11:00 p.m. and 6:00 a.m. If hours are evenly split between shifts, the higher shift differential rate applies to all hours worked during the shift. (1/1/18)

3-44. Call Back applies when an eligible employee is required to report to work before the start or after the end of a scheduled shift. If there is no release from work between the call back hours and regular shift, it is considered a continuation of the shift and call back does not apply. When call back applies, a minimum of two (2) hours of the employee's regular base pay is guaranteed. Eligible employees are those who are eligible for overtime, and any call back time is counted as work time. Employees exempt from overtime are also eligible when approved by a department head. (1/1/18)

3-45. On Call is additional pay beyond base pay for employees specifically assigned, in advance, to be accessible outside of normal work hours and where freedom of movement and use of personal time is significantly restricted. Eligible classes and the rate are published in the annual pay plan. A department head may designate eligibility for individual positions in classes not published and maintain records of such on-call designations. Only time while actually on call shall be paid at the special rate. In call back situations, employees eligible for both on call and call back pay shall receive call back pay only. (1/1/18)

3-46. Second Domicile is additional discretionary pay up to ten percent (10%) of base pay for employees who are required to maintain a second domicile for more than ten (10) consecutive calendar days while working out-of-state on official state business. The department head shall authorize such payments.

3-47. Repealed. (1/1/18)

3-48. Housing Premium is a stipend granted by a department head to designated employees living and working in high housing cost areas with demonstrated recruitment and retention problems. It is not part of the base rate and may begin or end at any time. Records on any aspect of this premium shall be provided to the Director when requested.

3-49. Discretionary Pay Differentials. A department may use non-base building discretionary pay differentials on a temporary basis, which shall be funded within existing budgets. Use of these pay differentials is at the discretion of the appointing authority and shall not be used as a substitute for annual compensation adjustments, other pay policies, or promotions. No differential is guaranteed and, if granted, may be discontinued at any time. No aspect of any discretionary pay differential is subject to grievance or appeal, except for discrimination; however, an alleged violation of the department's plan can be disputed. A department's decision in the dispute is final and no further recourse is available. Departments shall develop and communicate a written plan addressing appropriate criteria for the use of any differential based on sound business practice and needs. If granted, there shall be an individual written agreement between the employee and appointing authority that stipulates the terms and conditions of the differential, including the dates the differential will begin and end. Records of any aspect of these differentials shall be provided to the Director when requested. (8/1/08)

A. Counteroffer to a verifiable job offer may be used when an employee with critical strategic skills receives a higher salary offer from another department or outside employer and the appointing authority needs to retain the employee. The sum of a non-base building differential and current base pay cannot exceed a statutory lid in any given month and may be paid in one (1) or more payments. (8/1/08)

B. Signing bonus is a non-base building lump sum that may be used to attract new permanent employees into the state personnel system. It may be paid in one (1) or several payments; however, the sum of the bonus and current base pay cannot exceed a

statutory lid in any given month. Signing bonuses may be used for the following reasons:

1. to fill positions in critical occupations where there is a documented shortage in the labor market and recruitment or retention difficulty in the department that jeopardizes its mission; or,

2. when the applicant possesses a unique, critical skill in relation to the job market.

C. Referral award is a non-base building lump sum that may be granted to a current employee for the referral and subsequent hire of a new employee into the state personnel system where the position requires a unique, specialized skill and there is a documented shortage in the labor market and recruitment or retention difficulty in the department. This award is to be used for permanent employees unless the Director grants an exception. Employees who influence or are responsible for hiring and those performing recruitment as part of their regular assignments are ineligible. The sum of the award and current base pay cannot exceed a statutory lid in any given month.

D. Temporary pay differential is a non-base building award that may be granted to a current permanent employee in the same position. The sum of the temporary award and current base pay shall not exceed a statutory lid in any given month and is paid through regular payroll. This differential shall not be used as a substitute for the promotional or allocation process. Temporary pay differentials may be used for the following reasons:

1. acting assignment where the employee assumes the full set of duties (not “in absence of”) of a higher-level position that is vacant or the incumbent is on extended leave for a period longer than thirty (30) days but less than nine (9) months. The differential shall not exceed nine (9) months for any given acting assignment;

2. long-term project assignment that is not an expected or customary part of the regular assignment and is critical to the mission and operations of the department as defined by the purpose of the project, its time frame, and the critical nature and expected results; or,

3. retain a unique, specialized set of skills or knowledge that is critical to the mission and productivity of the department. The loss would result in documented severe adverse effect on the department’s mission and productivity.

3-50. Hazardous Duty is a non-base building premium that may be granted to positions working in occupations where exposure to physical hazards is not a customary part or expectation of the occupation and its preparation for entry. Such positions work for a majority of their time in settings that involve clear, direct, and unavoidable exposure to risk of major injury or loss of life even after making allowances for safety. This premium is not guaranteed and, if granted, may be discontinued at any time. No aspect of this premium pay can be grieved or appealed, except for alleged discrimination. Departments shall develop appropriate criteria for the use of hazard pay based on sound business practice and need, and communicate these criteria prior to use of this premium. The premium rate will be published in the annual pay plan and, in combination with current base pay and other premium pay, cannot exceed a statutory lid in any given month. (1/1/18)

Postemployment Compensation (9/1/12)

3-51. Postemployment compensation, which includes voluntary separation incentives or severance pay, are discretionary financial payments that may be offered to certified employees when a layoff has happened or may happen based upon documented lack of funds, lack of work, or reorganization. Postemployment compensation may include, but is not limited to, a hiring preference, payment towards the continuation of health benefits, tuition or educational training vouchers, portion of salary, placement on a reemployment list. Postemployment compensation may be contingent upon an employee's waiver of retention and reemployment rights, but waiving those rights does not affect the employee's eligibility for reinstatement. A department head shall establish a postemployment compensation plan before a department makes any postemployment compensation offers. (1/1/14)

3-52. Any total postemployment compensation payment and other benefits shall not exceed an amount equal to one (1) week of an employee's salary for every year of his or her service, up to eighteen (18) weeks. Any additional limitations shall be established and published by the director, taking into consideration prevailing market practice and other factors. (1/1/18)

3-53. Repealed. (1/1/18)

3-54. The employee and department shall execute a written contract before payment of any post employment compensation. The contract shall include the following provisions. (1/1/14)

A. A statement that the employee is required to pay all applicable taxes on the payment;

B. The employee's acknowledgement that the state will withhold taxes according to law before payment;

C. The employee's agreement to waive retention and reemployment rights, if applicable, along with a statement that the contract is voluntary and not coerced or obtained through means other than the terms of the contract; (9/1/12)

D. The date of the employee's last day of work;

E. An acknowledgement that no payment will be made until after the last day of work and compliance with other provisions of the contract; and,

F. Upon signature, a copy of each contract shall be provided to the state personnel director. (9/1/12)

G. The employee's agreement to waive any and all claims they may have or assert against the employer, relative to their employment prior to the execution of this agreement. (9/1/12)

Chapter 5 - Time Off

Authority for rules promulgated in this chapter 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), 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. (04/01/2020).

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. Unauthorized use of any leave may result in the denial of paid leave and/or corrective or disciplinary action.

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)

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)

5-5. Sick leave is for health reasons only, including 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 including domestic partners, in-laws and step relatives. Special consideration will also be given to any other person whose association with the employee is similar to a family member. (04/01/2020)

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. Sick leave shall be charged but annual leave shall be charged if sick leave is exhausted; unpaid leave if both annual and sick leave are exhausted. (02/2017)

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)

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 (02/2017)

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					
Years 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).

*** 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.

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.

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 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 sick leave has been exhausted. Any remaining sick

leave beyond the thirty (30) day waiting period shall be exhausted prior to eligibility for short-term disability benefit payments.

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. 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 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)

5-16. Administrative leave that exceeds twenty (20) consecutive working days shall be reported to the department head and the Director. (02/2017)

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 or at least thirty (30) days prior to the exhaustion of all accrued sick leave. The employee shall also notify the department at the same time that a benefit application is submitted.

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.

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 also is 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 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. (11/1/2019)

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 Definition. (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 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.

F.

Chapter 10 Personal Services Agreements

Authority for rules promulgated in this chapter is found in §§24-50-501 through 514 (Part 5), C.R.S.

10-1. The Colorado Constitution does not specify the services that shall be performed by state employees and offers no guidance concerning criteria or mechanisms for delineating, enlarging, or reducing the state personnel system. The Director promulgates these rules to effectuate the labor policy established by the General Assembly in statute, balancing personal services contracting and the state personnel system. Contracts for personal services that create an independent contractor relationship are permissible if they satisfy the provisions of this chapter regarding the business case, the impact on the state personnel system, and contract process and requirements.

10-2. Determination of the Business Case. The threshold decision for entering into any personal services contract requires the department head to determine the business case based on accountability, cost, and quality.

A. Consideration of accountability includes:

1. whether there are adequate safeguards to ensure that government authority is not improperly delegated;

2. the extent to which the function requires direct daily control over individual workers in order to effectively establish and implement state policy regarding public health, welfare, peace, and safety;

3. the extent to which the service can be provided through alternative means should the contractor fail to perform; and,

4. the extent to which the department has sufficient resources and expertise to monitor, measure, and enforce performance of the contract.

B. Consideration of cost includes an analysis in accordance with appropriate fiscal and procurement requirements, including the following, if applicable:

1. the extent to which the state will not realize the full value of, or recover the investment in, capital improvements or equipment;

2. a comparison of state costs to the contract price, including any fixed and variable costs solely attributable to the particular function, as well as inspection, supervision, and monitoring;

3. any price increases over the term of the contract; and,

4. the difference between the state’s and the contractor’s contributions to employee health insurance, to ensure that projected state savings are not attributable to lower contractor costs of health insurance.

C. Consideration of quality includes timeliness, functionality, durability, efficiency, contractor qualifications, flexibility, and any additional investment that yields greater effectiveness over the term of the contract.

10-3. Evaluation of Potential Impact on Certified Employees. In addition to the business case, the department head shall also evaluate the potential impact on the state personnel system. The following provisions apply depending on the nature of the contract and the statutory basis for approval.

A. For purposes of determining whether a “service agreement” exists, in which the services are incidental to the purchase or lease of real or personal property, the department head shall consider whether the predominant purpose of the contract is the acquisition of labor, skills, creativity, or judgment, as opposed to acquisition of property.

B. If a contract involves equipment, materials, facilities, or maintenance and operational support services, the department head will consider the following:

1. whether the demand for services in a particular geographic area is insufficient to justify investment in hiring permanent employees and purchasing capital equipment; and,

2. whether it is impractical or cost effective for departments in a particular geographic area to share the costs and use permanent state employees to meet the total demand upon the state in that geographic area.

C. Services for persons in the physical or legal custody of the state are not “purchased services”.

D. A contract for personal services does not implicate the state personnel system if the department head determines that it is necessary to retain outside contractors to meet a labor demand that is for: (7/1/07)

1. a temporary need for a specific task or result for a finite period of time. Such a contract shall state an ending date;

2. an occasional need that is seasonal, irregular, or fluctuating in nature; or,

3. an urgent need for immediate action to protect the health, welfare, or safety of people or property, or to meet an externally imposed deadline beyond the department’s control.

E. A department shall not use a succession of alternating temporary employment and personal services contracts in order to avoid either the timely creation or filling of permanent positions. A person may work as a state temporary employee nine (9) months and subsequently be retained as a contract worker by a different department. (3/30/13)

F. The department head shall approve each purchase order or contract for services acquired against an authorized price agreement unless the Director has approved the agreement in advance. A proposed acquisition shall comply with any conditions established by the Director regarding the use of a price agreement.

10-4. Contract Process and Requirements. All personal services contracts will conform to the following requirements regarding forms, reporting, and content.

A. As used in this chapter, contracts include any amendments but do not include acquisitions where a commitment voucher (e.g., state contract, purchase order) is not required by state fiscal rule, as such minor acquisitions of services do not implicate the state personnel system as a whole. Commitments to acquire services shall not be artificially divided to avoid review. Departments shall establish methods for retrieval of payment vouchers for personal services obtained within the scope of this exemption.

B. All personal services contracts shall be accompanied by supporting documents in the form prescribed by the Director.

C. Repealed (04/01/2020)

D. Consideration shall be given to contractors providing a preference for hiring veterans of military service in the following manner.

1. In all solicitations for personal services, whether by competitive sealed bidding or competitive sealed proposals, as defined by law, any tie between offerors shall first be broken by awarding the contract to the offeror utilizing the greatest quantitative or numerical preference for veterans in hiring offeror's employees.

2. Solicitations for personal services done by competitive sealed proposal may include as a scored criterion the extent and quality of any preference for veterans of military service given by offeror in the hiring of offeror's employees. The relative weight assigned such criterion for veteran's preferences in personal services contract solicitations, consistent with the preference given by the state personnel system to veterans in the hiring of state employees, shall not exceed five percent (5%).

E. In addition to contract provisions required by statute, personal services contracts shall contain:

1. provisions addressing the consequences and potential mitigation of improper or failed performance by the contractor;

2. clearly defined measurements of performance outcomes;

3. sanctions for untimely or poor performance;

4. the independent contractor clause as required within contract special provisions of state fiscal rules; and

5. provisions concerning the orderly transition of functions between the department and the contractor during implementation or following termination of the contract, if applicable.

F. A personal services contract shall not create an employment relationship.

Chapter 11 – State Benefit Plans

Authority for rules promulgated in this chapter is found in State of Colorado Revised Statutes (C.R.S.) §§24-50-104, 24-50-109.5, and Part 6, the State of Colorado Constitution Article XII, Section 13, The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA), and 26 U.S.C. 63, The Family Medical Leave Act (FMLA), Americans with Disabilities Act (ADA), Family Care Act (FCA), Uniformed Services Employment and Reemployment Rights Act (USERRA), 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. (02/2017)

General Principles

11-1. The state reserves the sole right to add, modify, or discontinue any state group benefits as deemed necessary. (7/1/10)

11-2. The Director complies with applicable federal and state law and regulations that govern state group benefit plans, as well as the terms and conditions of the state group benefit plans contracts and plan documents. Governing laws and regulations, and these rules shall prevail in the event of a conflict with contracts or plan documents. (7/1/10)

11-3. The rules in Chapter 11, State Benefit Plans, apply to all departments administering and all employees eligible for state benefit plans. (02/2017)

Director Responsibilities

11-4. The Director will provide all group benefits information, written directives and training to departments necessary for department benefit administrators to fulfill their responsibilities as delegated agents to the plans. (7/1/10)

11-5. The Director has sole authority to determine eligibility, negotiate contracts, determine plan designs, set rates and coverage tiers, define the plan year, and establish open enrollment periods, in accordance with law, regulations, and approved funding. (7/1/10)

11-6. The Director's online benefits administration system is the official system of record for all eligibility and enrollment transactions. (7/1/10)

Department Responsibilities

11-7. All departments shall exercise due diligence when administering group benefits in the best interests of the plans and all members. As delegated agents of the Director in their respective departments, each department benefits administrator's responsibilities include, but are not limited to, the following. (7/1/10)

A. Know and comply with plan documents and basic plan features, law and regulations, rules, benefits administration system, deadlines, the Director's website, and written directives.

B. Communicate, disseminate, explain, and answer questions on all benefits-related information including, but not limited to, options and changes, process, requirements and eligibility.

C. Provide prompt notice of enrollment opportunities and information so employees can elect benefits during open enrollment or enroll within 31 days of hire or an employee's

notice of a qualified event. The first day (day 1 of the 31 days) is the day after hire or a qualified event. (1/1/14)

D. Monitor deadlines and assist employees with meeting those deadlines.

E. Provide access to and training in the use of the benefits administration system, and assist employees with transactions.

F. Refrain from advising an employee of which individual elections to make and assisting an employee in the commission of fraud or attempted fraud of a state benefit plan.

G. Process timely and accurate transactions and payments. This includes regular review of pending actions, supporting documentation, and system reports in order to promptly approve elections, terminate coverage, investigate suspicious or questionable actions or data, correct errors, and verify continuing dependent eligibility.

H. Repealed (02/2017)

11-8 These responsibilities apply to all departments, including those that offer their own separate group benefit plans to other employees not covered by the “State Employees Group Benefits Act”. (7/1/10)

Employee Responsibilities

11-9. Employees are responsible for knowing, understanding, and adhering to these rules, plan documents for the terms and conditions of coverage, and eligibility and enrollment requirements in order to make timely and informed choices, including, but not limited to, the following. (1/1/14)

A. Employees shall enter all required information in the benefits administration system in a timely and accurate manner in order to comply with eligibility and enrollment requirements for themselves and eligible dependents.

B. Enrollment of employees and eligible dependents is restricted to initial hire, annual open enrollment, and limited qualified events defined by law and plan documents. Elections are irrevocable for the plan year, except in limited circumstances specified by law or regulations. Failure to enroll or change elections within deadlines is not a qualifying event.

1. Any permitted enrollment, modification, or termination of enrollment shall be entered into the official benefit administration system within 31 days of a qualifying event. Any supporting documentation required for the enrollment, modification, or termination of enrollment shall be submitted within 45 days of the qualifying event. The first day of the 31-day period is the day after the qualifying event. For open enrollment, transactions shall be entered into the official benefits administration system with accompanying documentation within the allotted time period established. (02/2017)

2. Failure to enroll or modify enrollment on or before the 31st day of the qualifying event requires the employee to wait until the next open enrollment or at the time of another qualifying event. (02/2017)

3. Enroll and verify elections annually.

4. Employees who transfer from one (1) department to another shall notify both department benefit administrators to avoid a potential lapse in coverage.

C. Employees shall remove any dependent by the end of the month in which the dependent ceases to meet eligibility requirements. Failure to do so results in the employee's continuing financial liability for total premium (employee and employer contributions) and cost of paid claims for the ineligible dependent, as specified in law and regulations, plan documents, and these rules.

D. Any enrollment or qualified change to enrollment constitutes authorization to begin or end payroll deductions.

1. Employees shall verify the accuracy of their payroll deductions and notify their department benefits administrator of any error. The notice shall be in writing and within 15 days from the pay date in which the first payroll deduction occurred.

2. If an employee fails to notify the department of the payroll error within the 15-day period, the employee will continue to be liable for the election for the remainder of the plan year unless the election is not consistent with plan documents, rules, laws, regulations, and written directives.

11-10. It is unlawful for any employee, or dependent to intentionally provide false, incomplete, or misleading facts, information, or document in written or electronic form, including the benefits administration system for the purpose of defrauding or attempting to defraud the State of Colorado. The Director shall investigate when there is reason to believe an employee or dependent is committing or attempting to commit fraud against any state group benefit plan. If the Director finds evidence of fraud or attempted fraud, the employee, dependent, or both may be subject to any or all of the following sanctions. (7/1/10)

A. Immediate termination of coverage.

B. Denial of future enrollment.

C. Requirement to reimburse the state contributions and claims costs during the time of ineligible coverage.

D. Filing of criminal charges.

E. Notice to the employee's department, which may take employment action, such as corrective or disciplinary action.

Eligibility

11-11. Employees and their dependents shall meet the eligibility requirements as defined in state law, plan documents, and rules to qualify for enrollment in the state group benefit plans. (7/1/10)

A. Dependents may not enroll in the State Benefit Plans unless the employee is enrolled. If the employee and spouse/partner are both employees of the state, each may be enrolled as an employee or covered as a dependent of the other person but not both. If both the employee and spouse/partner make a separate election under the State Benefit Plans, only one (1) parent may enroll children as dependents. (02/2017)

11-12. Additional criteria and documentation requirements are contained in the State of Colorado Salary Reduction Plan, law and regulations, rule, and other written directives, which are available in the Employee Benefits Unit. Dependents may be federal tax dependents (qualified) or non-tax dependents (non-qualified). Non-qualified dependents' coverage is subject to taxable income regulations. Eligible dependents are specified in statutes, primarily § 24-50-603(5) and (6.5),

C.R.S., as modified or further defined by other state statutes (e.g., Title 10) or federal regulations (e.g., Affordable Care Act [ACA], IRC on taxable income). (02/2017)

11-13. Legal documentation is required to add any dependent to State benefits. (1/1/14)

Coverage of Benefits

11-14. Initial coverage in group benefit plans is effective on the first day of the month following the date of hire or initial eligibility unless otherwise specified by the contracts, law, or regulations. (1/1/14)

11-15. All coverage for a qualifying event is prospective from the beginning of the next month or the date of entry into the official benefit administration system, whichever is later, except for initial coverage for new employees and newborn children. (1/1/14)

11-16. Elections made during open enrollment are effective the first day of the new plan year, with the exception of optional benefits. (02/2017)

11-17. Termination of coverage is subject to law and regulation, plan documents, and contracts, as well as the following rules. (7/1/10)

A. If at any time during the plan year any dependent ceases to meet the eligibility criteria, coverage ends on the last day of the month in which that dependent becomes ineligible.

B. Coverage in state group benefit plans is terminated on the last day of the month that employment ends.

Payment of Contributions

11-18. Departments shall make prompt monthly payments based on enrollment in the official benefit administration system. (7/1/10)

A. The employee's current department as of the last day of the month is responsible for payment.

B. A department is liable for both state and employee contributions when failing to promptly enter an employee termination.

11-19. Employees shall make an irrevocable election for the plan year to have contributions deducted on a pre-tax or after-tax basis as defined by the State of Colorado Salary Reduction Plan, law and regulations, rule, and written directives. The employee's contribution is deducted from the employee's pay or, under certain circumstances, paid by personal payment for the selected state group benefit plans, in arrears as of the end of the month in which an employee is covered. (02/2017)

11-20. An enrolled employee who works or is on paid leave one (1) or more regularly scheduled, full workdays in a month is eligible for the full state benefit contribution. (7/1/10)

11-21. When an employee is on leave, departments shall continue to pay the state contribution for non-contributory, fully paid benefits (e.g., basic life and short-term disability) as long as the employee remains on the payroll, regardless of status. (1/1/14)

A. During paid leave or mandatory furlough, the employee contribution continues to be paid through payroll deduction and the department continues to pay the state contribution.

B. During unpaid leave, the employee shall pay the total premium (employee and employer

contributions) to the department within the month of coverage, except as follows.

1. During unpaid leave pursuant to the Family Medical Leave Act of 1993, the department shall continue to pay the state contribution as long as the employee continues to pay the employee contribution by the due date specified in the family/medical leave notice. If the employee fails to pay the employee contribution when due, coverage will be terminated but shall be reinstated upon return to work. In the event any contributions are owed upon the employee's return to work, such contributions shall be collected from the employee. If the employee fails to return after the leave, any contributions due will be recovered as specified by federal regulations. (02/2017)

2. While an employee is on voluntary furlough or short-term disability leave, the department shall continue to pay the state contribution as long as the employee continues to pay the employee contribution in a timely manner. If the employee fails to pay the employee contribution by the due date, coverage shall be terminated and the employee shall wait for the next annual open enrollment.

11-22. Refunds for employee and state contributions are subject to plan limitations and as defined in law and regulations, rule, and written directives. (7/1/10)

11-23. When there is a difference between the contribution paid by the employee and the actual contribution due, the difference is paid by the employee (e.g., change in coverage tier). (7/1/10)

Appeal Procedures

11-24. Appeals regarding denial of eligibility for state group benefit plans shall be submitted in writing to the Director, at the address below, within 31 days of receipt of the ineligibility decision. Use of the standard ***"Colorado State Employees Group Benefits Eligibility Determination Appeal Form"*** found on the Director's website is required. (1/1/14)

Appeals should be submitted to the Department of Personnel and Administration, Division of Human Resources via mail, email, or by fax.

Department of Personnel and Administration
Division of Human Resources
1525 Sherman Street
Denver, CO 80203 benefits@state.co.us
Fax: 303-866-3879

The Director will issue a final written decision within 45 days of receipt of the appeal. The ineligibility decision is overturned only if found to be arbitrary, capricious or contrary to rule or law.

11-25. Appeals of denied claims under any of the state group benefit plans shall follow the specific appeal process defined in the specific contract, plan document, summary plan description, or regulated entity. The provider will issue a final written decision in accordance with its process. (7/1/10)

A. Appeals of denied claims under fully insured plans are regulated by the State of Colorado Division of Insurance, and follow the plan's appeal process as defined in the contract and plan document.

B. Appeals of denied claims under self-funded plans are not regulated by the State of Colorado Division of Insurance, and follow the third-party administrator's appeal process as defined in the contract and plan document.

Colorado State Employee Assistance Program

11-26. Services provided include but are not limited to counseling services, crisis intervention, consultations with supervisors and managers, facilitated groups, trainings, and workshops. (7/1/10)

11-27. Any state employee and any department may participate in the program. (7/1/10)

A. The program may request the participation of other persons if necessary to provide effective assistance to the employee.

B. The limit per employee is one (1), six (6) session course of counseling in a twelve (12) month period. At the discretion of the counselor, additional sessions may be authorized.

Supplement State Contribution Program

11-28. Eligible state employee means state employees who are eligible to enroll in medical and dental benefits, and have at least one (1) dependent child who will be covered under state benefits. A child cannot be covered under Child Health Plan Plus (CHP+). (04/01/2020)

11-29. Approval of application is subject to the established Supplement State Contribution Program's policy. (04/01/2020)

11-30. Determination of the Supplement State Contribution Program is final and cannot be appealed, as it does not relate to eligibility. (04/01/2020)

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Office of the Attorney General

Tracking number: 2019-00764

Opinion of the Attorney General rendered in connection with the rules adopted by the

State Personnel Board and State Personnel Director

on 02/09/2020

4 CCR 801-1

STATE PERSONNEL BOARD RULES AND PERSONNEL DIRECTOR'S ADMINISTRATIVE PROCEDURES

The above-referenced rules were submitted to this office on 02/10/2020 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.

February 28, 2020 10:02:47

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Agriculture

Agency

Plant Industry Division

CCR number

8 CCR 1203-6

Rule title

8 CCR 1203-6 ADMINISTRATION AND ENFORCEMENT OF THE COLORADO SEED ACT 1 - eff 03/30/2020

Effective date

03/30/2020

DEPARTMENT OF AGRICULTURE

Plant Industry Division

ADMINISTRATION AND ENFORCEMENT OF THE COLORADO SEED ACT

8 CCR 1203-6

Part 10. THE SAMPLING OF SEED LOTS.

10.1. General Procedure:

(a) In order to secure a representative sample, equal portions shall be taken from evenly distributed parts of the quantity of seed to be sampled. Access shall be had to all parts of that quantity.

(b) For free-flowing seed in bags or bulk, a probe or trier, shall be used. For small free-flowing seed in bags a probe or trier long enough to sample all portions of the bag shall be used.

(c) Nonfree-flowing seeds, such as certain grass seed, uncleaned seed, or screenings, difficult to sample with a probe or trier, shall be sampled by thrusting the hand into the bulk and withdrawing representative portions.

(d) Composite samples shall be obtained to determine the quality of a lot of seed, such as the percentages of pure seed, other crop seed, weed seed, inert matter, noxious weed seed, germination, varietal purity, freedom from disease, and effectiveness of seed treatment. Individual bag samples may be obtained to determine whether the seed is of uniform quality.

10.2. Sampling Equipment:

For sampling seeds in bags a trier long enough to reach all areas in the bag shall be used. The trier shall be so designed that it will remove an equal volume of seed from each part of the bag through which the trier travels. Unless the trier has partitions in the seed chamber it must be inserted into the bags horizontally. Nonfree-flowing seeds difficult to sample with a trier shall be sampled by thrusting the hand into the seed and removing representative portions. When a sample is taken with the hand, insert the hand flat and with the fingers together. Keep the fingers together as the hand is closed and withdrawn. Because of possible segregation, hand samples should be taken from various points in bags or in bulk.

10.3. Obtaining a “Submitted Sample”:

(a) Seed in Bags:

(1) When more than one core is drawn from a bag, follow different paths. When more than one handful is taken from a bag, take them from well separated points.

(2) For lots of one to six bags, sample each bag and take a total of at least five cores or handfuls.

(3) For lots of more than six bags, sample five bags plus at least 10% of the number of bags in the lot. Round numbers with decimals to the nearest whole number. Regardless of the lot size, it is not necessary to sample more than thirty bags.

Examples:								
No. bags in lot	7	10	23	50	100	200	300	400
No. bags to sample	6	6	7	10	15	25	30	30

(b) Bulk Seed: To obtain a composite sample, take at least as many cores or handfuls as if the same quantity of seed were in bags of an ordinary size. Take the cores or handfuls from well distributed points throughout the bulk.

(c) Seed in small containers: Seed in small containers shall be sampled by taking entire unopened containers in sufficient number to supply a minimum size sample as required in Part 10.4. The contents of a single container or the combined contents of multiple containers of the same lot shall be considered representative of the entire lot of seed sampled.

10.4. Size of Submitted Sample:

(a) For the composite sample to test for quality. The following are minimum weights for samples of seed to be submitted for analysis, test or examination.

(1) Two ounces (approximately 55 grams) of grass seed not otherwise mentioned, white or alsike clover, or seeds not larger than these.

(2) Five ounces (approximately 150 grams) of red or crimson clover, alfalfa, lespedezas, ryegrasses, bromegrasses, millet, flax, rape, or seeds of similar size.

(3) One pound of sudangrass, proso, or seeds of similar size.

(4) Two pounds (approximately 1,000 grams) of cereals, vetches, sorghums, or seeds of similar or larger size.

(5) Vegetable and ornamental seed samples shall consist of at least 800 seeds per sample. If a purity analysis or a noxious weed seed examination is required, the submitted sample shall provide at least the minimum weights of working samples set forth in Association of Official Seed Analysts Rules for Testing Seeds (October 2019). (As to incorporation of materials see Part 14.)

(6) Tree and shrub seed samples shall consist of at least 600 seeds per sample for germination purposes (1,000 seeds for paired tests). If a purity analysis or a noxious weed seed examination is required, the submitted sample shall provide at least the minimum weights of working samples set forth in Association of Official Seed Analysts Rules for Testing Seeds (October 2019). (As to incorporation of materials see Part 14.)

(b) For individual bag samples to test for uniformity:

(1) The size of any individual bag sample to determine uniformity in a lot of seed shall be not less than the quantities set out in the column “Minimum Weight for Noxious Weed Seed Examination” for the respective kinds of seed listed in Table 1, found in Association of Official Seed Analysts Rules for Testing Seeds, (October 2019). (As to incorporation of materials see Part 14.)

(2) If the sample drawn is larger than required it shall be thoroughly mixed before it is divided to the desired size.

10.5. Forwarding and Receipt of Official Samples: Before being forwarded to analysis, test, or examination the containers of official samples shall be properly sealed, identified, initialed and dated.

Part 11. ANALYSIS AND TESTING OF SEEDS.

11.1. The methods of analyzing and testing seed samples shall be the same as prescribed in the Association of Official Seed Analysts Rules for Testing Seeds (October 2019) (as to incorporation of materials see Part 14), except that:

a) Kinds of seeds that do not have germination testing protocols in the Association of Official Seed Analysts Rules for Testing Seeds (October 2019) may be tested with a tetrazolium test in place of a germination test; and

b) Notwithstanding the fact that such protocols exist for Indian ricegrass (Achnatherum hymenoides), fourwing saltbrush (Atriplex canescens), and chokecherry (Prunus virginiana), these kinds of seeds may also be tested with a tetrazolium test in place of a germination test.

11.2. Except as provided in Rule 11.3 below, a standard germination test is valid for thirteen (13) months, unless the seed is stored in a hermetically sealed container, in which case it shall be valid for twenty-four (24) months.

11.3 Germination tests for seeds of the following kinds of cool season lawn and turf grasses shall be valid for sixteen (16) months, unless hermitically sealed: colonial bentgrass, creeping bentgrass, Kentucky bluegrass, chewings fescue, hard fescue, red fescue, tall fescue, annual ryegrass, intermediate ryegrass, and perennial ryegrass. If the seed is stored in a hermitically sealed container the test shall be valid for twenty-four (24) months.

11.4 The time for which a tetrazolium test is valid in place of a germination test shall be thirteen (13) months, unless the seed is stored in a hermetically sealed container, in which case it shall be valid for twenty-four (24) months.

Part 12. TOLERANCES.

12.1. Tolerances allow for the variation which may reasonably be expected in results obtained from different analyses or tests of the same lot of seed. They are for the protection of the labeler and shall not be used to show higher quality on the label than is indicated by the test.

12.2. Tolerances and methods of determination used in the enforcement of these rules shall be the same as prescribed in the Association of Official Seed Analysts Rules for Testing Seeds (October 2019). (As to incorporation of materials see Part 14.)

Part 14. INCORPORATION BY REFERENCE.

14.1. The 2010 edition of the Tetrazolium Testing Handbook (“Handbook”), published by the Society of Commercial Seed Technologists and the Association of Official Seed Analysts, is hereby incorporated by reference and made a part of these Rules. The incorporated Handbook does not include later revisions. The Handbook is available for public inspection during regular business hours at the Colorado Department of Agriculture, 305 Interlocken Parkway, Broomfield, Colorado 80021 and available for purchase from the Society of Commercial Seed Technologists/Association of Official Seed Analysts at https://www.analyzeseeds.com/product/tetrazolium-testing-handbook-2018/.

14.2. The October 1, 2019 edition of the Rules for Testing Seed ("Testing Rules"), published by the Association of Official Seed Analysts, is hereby incorporated by reference and made a part of these Rules. The incorporated Testing Rules do not include later revisions. The Testing Rules are available for public inspection during regular business hours at the Colorado Department of Agriculture, 305 Interlocken Parkway, Broomfield, Colorado 80021 and available for purchase from the Association of Official Seed Analysts at https://www.analyzeseeds.com/product/aosa-rules-volume-1-principles-rocedures-2019/.

Part 20. STATEMENTS OF BASIS AND PURPOSE.

20.8 Adopted February 12, 2020 – Effective March 30, 2020

Statutory Authority

The amendments to these rules are proposed for adoption by the Commissioner of the Colorado Department of Agriculture ("CDA") pursuant to the authority under the Colorado Seed Act (the "Act"), § 35-27-114(1)(b), C.R.S.

Purpose

The purpose of the proposed rule amendments is to:

1. Update incorporation by reference language for the Tetrazolium Testing Handbook ("Handbook") and the Rules for Testing Seed ("Testing Rules"), published by the Society of Commercial Seed Technologists and/or the Association of Official Seed Analysts, to meet the requirements of § 24-4-103(12.5)(a)(iv), C.R.S, of the State Administrative Procedure Act.

Factual and Policy Basis Issues

The factual and policy issues encountered when developing these rules include:

1. The State Administrative Procedure Act sets forth the requirements for incorporating by reference all or any part of a code, standard, guideline, or rule that has been adopted by an agency of the United States, this state, or another state, or adopted or published by a nationally recognized organization or association.

2. Specifically, the State Administrative Procedure Act requires that the rule states where copies of the code, standard, guideline, or rule are available for a reasonable charge from the agency adopting the rule and where copies are available from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline, or rule.

3. Although the rules identified the publishers of the Handbook and the Testing Rules by name, they did not provide an address or website where the Handbook or Testing Rules could be obtained from the publishers. The amendments to the rules now include a specific URL where the Handbook and Testing Rules can be obtained for purchase from the publishers.

4. A newer version of the Testing Rules became effective October 1, 2019, and the rule amendments update the relevant edition to 2019.

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Attorney General

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Chief Deputy Attorney General

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STATE OF COLORADO
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Office of the Attorney General

Tracking number: 2019-00648

Opinion of the Attorney General rendered in connection with the rules adopted by the

Commissioner of Agriculture

on 02/12/2020

8 CCR 1203-6

ADMINISTRATION AND ENFORCEMENT OF THE COLORADO SEED ACT

The above-referenced rules were submitted to this office on 02/13/2020 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.

February 28, 2020 09:57:49

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Public Safety

Agency

Colorado State Patrol

CCR number

8 CCR 1507-1

Rule title

8 CCR 1507-1 RULES AND REGULATIONS CONCERNING MINIMUM STANDARDS FOR THE OPERATION OF COMMERCIAL VEHICLES 1 - eff 04/01/2020

Effective date

04/01/2020

DEPARTMENT OF PUBLIC SAFETY
DIVISION OF STATE PATROL

RULES AND REGULATIONS CONCERNING MINIMUM STANDARDS FOR THE OPERATION OF COMMERCIAL VEHICLES

STATEMENT OF BASIS, STATUTORY AUTHORITY, AND PURPOSE

Pursuant to §42-4-235(4) (a) (I), CRS, the Chief of the Colorado State Patrol (CSP) has the authority to promulgate rules and regulations for the minimum standards for the operation of commercial vehicles within the State of Colorado.

Amendments are being proposed to 8 Colorado Code of Regulations 1507-1 to ensure compliance and consistency with state law and federal regulations. Specifically, these amendments incorporate the most recently promulgated Out of Service Criteria set forth by the Commercial Vehicle Safety Alliance (CVSA); pertinent sections of the October 2019 Federal Motor Carrier Safety Regulations required as a result of federal law, state law and grant requirements; to clarify the applicability of these rules to vehicles supporting snowplowing operations and the inapplicability of the financial responsibility (insurance) requirements of rules to vehicles operated by river outfitters regulated by the Colorado Department of Natural Resources, Division of Wildlife; and to address minor grammar and formatting issues.

It has been declared by the General Assembly that the safe operation of commercial vehicles is a matter of statewide concern. The absence of implementing rules to carry out the purpose of the statutes would be contrary to the public health, peace, safety and welfare of the state. For these reasons, it is necessary that these proposed amendments be adopted.

_____ _____

Colonel Matthew C. Packard — Date of Adoption
Chief, Colorado State Patrol

DEPARTMENT OF PUBLIC SAFETY
DIVISION OF STATE PATROL

RULES AND REGULATIONS CONCERNING MINIMUM STANDARDS FOR THE OPERATION OF COMMERCIAL VEHICLES

AUTHORITY TO ADOPT STANDARDS AND SPECIFICATIONS

The Chief of the Colorado State Patrol (CSP) is authorized by the provisions of §42-4-235(4) (a) (I), CRS, to adopt rules and regulations for safety standards and specifications for the operation of all commercial vehicles in Colorado, both in interstate and intrastate transportation.

I. APPLICABILITY

A. These rules and regulations shall apply to individuals, corporations, Colorado government or governmental subdivisions or agencies, or other legal entities who operate commercial vehicles as defined in §42-4-235(1) (a), CRS.

1. In addition to this rule, anyone who transports hazardous materials as defined in 49 CFR 171.8 §42-20-103 (3), CRS and/or nuclear materials as defined in §42-20-402 (3) (a)-(c), CRS, shall comply with the CSP Rules and Regulations Concerning the Permitting, Routing, and Safe Transportation of Hazardous and Nuclear Materials and the Intrastate Transportation of Agricultural Products in the state of Colorado found in 8 CCR 1507-25.

2. The CSP Motor Carrier Safety Section (MCSS) may consider and grant requests for temporary variance from the rules in 8 CCR 1507-1, for intrastate commercial motor carriers only, provided the variance is not in violation of §42-4-235, CRS.

II. GENERAL DEFINITIONS

A. Definitions relevant to these rules are found in Title 49 of the Code of Federal Regulations (CFR). These definitions are amended, where necessary, to conform to the Colorado Revised Statutes (CRS). Those definitions controlled by the CRS that are applicable to these rules are referenced below:

1. **Commercial Vehicle**: The definition of commercial vehicle will be as it is set forth in §42-4-235 (1) (a), CRS.

2. **Enforcement Official**: The definition of enforcement official will be as it is set forth in §§ 16-2.5-101, 16-2.5-114, 16-2.5-115, and 16-2.5-143 and also as set

forth in 42-20-103 (2), CRS.

3. **Motor Carrier**: The definition of motor carrier will be as it is set forth in §42-4-235 (1) (c), CRS.

III. AUTHORITY TO INSPECT VEHICLES, DRIVERS, CARGO, BOOKS AND RECORDS

A. Enforcement officials, who are authorized to perform motor vehicle safety inspections on commercial motor vehicles and drivers, shall be required to meet the inspector qualifications set forth in §42-4-235(4) (a)(I), CRS, while performing a Level I North American Standard Safety Inspection. All enforcement officials performing Level I-VI North American Standard Safety Inspections must maintain certification requirements prescribed in the Commercial Vehicle Safety Alliance (CVSA) Operations Manual.

B. Authorized enforcement officials shall at all times have the authority to inspect commercial vehicles, commercial vehicle drivers, cargo, and any required documents, set forth in 49 CFR, Subchapter B, Parts 387, 390, 391, 392, 393, 395, 396, 397 and 399 CFR, as revised October 1, 2019.

C. CSP Enforcement officials who are certified by the Federal Motor Carrier Safety Administration (FMCSA) pursuant to 49 CFR 385, Subpart C to perform compliance reviews and safety audits shall have the authority to enter the facilities of and inspect any motor carrier, as defined in §42-4-235 (1) (c), CRS, and any required records and supporting documents, set forth in 49 CFR, Subchapter B, Parts 40, 380, 382, 385, 387, 390, 391, 392, 393, 395, 396, 397 and 399, and Appendix G, CFR, as revised October 1, 2019.

IV. INSPECTIONS STANDARDS AND REPORTS

A. Through a Memorandum of Understanding (MOU) with the CVSA, dated October 1, 2019, the CSP adopts the standards and procedures established for the inspection of commercial vehicles, collectively known as the North American Uniform Driver/Vehicle Inspection.

B. Authorized enforcement officials performing safety inspections on commercial vehicles, drivers, and cargo shall use as general guidelines the levels, methods of inspections and Out-of-Service criteria, found in the CVSA bylaws, as revised April 1, 2020.

C. Authorized enforcement officials shall, on completion of each inspection, prepare a report which at minimum fully identifies the inspector, the inspector's agency, the carrier's name and address, the date and time of the inspection, the location of the inspection, the vehicle, the driver, the defects found, if any, and the disposition of the

vehicle. A copy of the inspection report shall be given to the driver or motor carrier.

V. REGULATIONS

A. All intrastate and interstate motor carriers, commercial vehicles and drivers thereof operating within the state of Colorado shall operate in compliance with the safety regulations contained in:

49 CFR 40	Procedures for Transportation Workplace Drug and Alcohol Testing Programs
49 CFR 380	Special Training Requirements
49 CFR 382	Controlled Substances and Alcohol Use and Testing
49 CFR 385 Subparts C & D	Safety Fitness Procedures
49 CFR 387	Minimum Levels of Financial Responsibility for Motor Carriers
49 CFR 390	Federal Motor Carrier Safety Regulations: General
49 CFR 391	Qualifications of Drivers and Longer Combination Vehicle (LCV) Driver Instructors
49 CFR 392	Driving of Commercial Motor Vehicles
49 CFR 393	Parts & Accessories Necessary for Safe Operation
49 CFR 395	Hours of Service of Drivers
49 CFR 396	Inspections, Repair, and Maintenance
49 CFR 397	Transportation of Hazardous Materials; Driving and Parking Rules
49 CFR 399	Employee Safeties and Health Standards
49 CFR Appendix G:	Minimum Periodic Inspection Standards

of the United States Department of Transportation's Motor Carrier Safety Regulations as the same were in effect on October 1, 2019 and published in Title 49 of the Code of Federal Regulations (CFR), subtitle B chapter III, Parts 200 through 399, with references therein, with the following modifications:

1. Unless otherwise specified, all references to interstate commerce shall include intrastate commerce.

2. 49 CFR 380.509 (a) shall be amended to read: "Each employer must ensure each entry level driver, who first begins operating a commercial motor vehicle requiring a commercial driver's license under §42-2-404, CRS, receives the training required by 49 CFR 380.503."

3. 49 CFR 385.301 (b) and (c), through 385.305 through 385.308 and 385.319 (b) Through 385.337 shall not apply. 49 CFR 385.309 through 385.319 (a), hereafter referred to as the Colorado Intrastate New Entrant Safety Assurance Program, shall apply to intrastate motor carriers who are beginning in intrastate operations and are required to obtain an intrastate USDOT identification number from the FMCSA. Intrastate motor carriers can confirm if they need a USDOT number and

complete an application online by going to HTTPS://WWW.FMCSA.DOT.GOV/REGISTRATION/DO-I-NEED-USDOT-NUMBER. A prior interstate safety audit or compliance review shall meet the requirement for an intrastate safety audit.

a. All interstate motor carriers beginning operations in Colorado must submit to a Safety Audit as defined in 49 CFR 385.3.

i. Safety audits on interstate carriers beginning operations in the state of Colorado will be conducted by the CSP MCSS.

b. All intrastate motor carriers beginning operations in Colorado are eligible for the Colorado Intrastate New Entrant Safety Assurance Program. New intrastate carriers may schedule training by contacting the CSP MCSS.

4. Pursuant to §42-4-235(4) (a) (I), CRS, the financial responsibility and insurance provisions of these rules do not apply to commercial vehicles regulated by the Colorado Public Utilities Commission (PUC). These provisions also do not apply to those commercial vehicles operated by river outfitters regulated by the Colorado Department of Natural Resources, Division of Wildlife under 2 CCR 405-3. These noted exceptions aside, 49 CFR 387.1 through 387.17, 387.303, 387.305 and 387.309 shall apply to the operation of commercial vehicles with the following exceptions:

a. 49 CFR 387.7 (e) and (g) shall not apply.

b. 49 CFR 387.9 (4) applies only to interstate and foreign commerce.

c. Transportation carriers may obtain a certificate of self insurance issued pursuant to §42-7-501, CRS, or 49 CFR 387.

d. Motor carriers subject to these rules shall carry a minimum level of cargo liability coverage of $10,000 for loss or damage to property carried on any one motor vehicle or an amount adequate to cover the value of the property being transported, whichever is less, unless the shipper and the property carrier otherwise agree by written contract to a lesser amount.

5. 49 CFR 390.3 (f), (1-2) and (6) shall not apply.

6. 49 CFR 390.5 Definitions:

a. The definition of “Commercial Motor Vehicle” and “Motor Carrier” shall not apply.

b. The definition of an “Emergency” is amended by adding the following: “A governmental agency has determined that a local emergency requires relief from the maximum driving time in 49 CFR 395.3 or 395.5.”

7. 49 CFR 390.19T (a) is amended to read: "Each motor carrier that conducts operations in intrastate commerce must apply for and receive an intrastate USDOT identification number prior to beginning operations within the state. The motor carrier is required to update this information every 24 months."

a. Identification numbers for intrastate motor carriers are processed by the Federal Motor Carrier Safety Administration (FMCSA).

8. 49 CFR 390.21 (b) is amended by adding the following: "Intrastate carriers must mark their vehicles with the assigned intrastate USDOT identification number, preceded by the letters "USDOT" and followed by the suffix "CO" (e.g.: USDOT 1234567 CO).

a. Motor carriers operating in intrastate commerce, not transporting 16 or more passengers (including the driver) or transporting placarded hazardous materials and having a GVWR or GCWR equal to or in excess of 16,001 lbs. but not in excess of 26,000 lbs., may meet the marking requirements of 49 CFR 390.21 by marking the trailer or secondary unit, if the GVWR of the self-propelled unit is less than 16,001 lbs.

b. In the interests of public safety, repossessors as defined within §42-6-146 (4), CRS, operating intrastate are not subject to the marking requirements of 49 CFR 390.21.

9. 49 CFR 391.11(b)(1) shall be amended to read: "Is at least 21 years old if engaged in interstate commerce or transporting hazardous materials of a type or quantity that would require the vehicle to be marked or placarded under 49 CFR 177.823. All other drivers must be at least 18 years of age."

10. Public transit agency carriers and their drivers operating in intrastate commerce may meet the requirement in 49 CFR 395.1 (e) (1) (ii) by either meeting the existing regulation or by replacing 49 CFR 395.1 (e) (1) (ii) with "the driver is released from work within 12 consecutive hours."

11. 49 CFR 395.3 or 395.5 shall not apply to drivers of either Colorado governmental vehicles or tow trucks working an emergency, as defined in 49 CFR 390.

12. 49 CFR 395.3 shall not apply to tow drivers who are towing a vehicle from a public roadway at the request of a police officer or other law enforcement purpose.

13. Drivers transporting livestock, poultry, slaughtered animals or the grain, corn, feed, hay etc. used to feed animals are eligible to use the agricultural operations exception in 49 CFR 395.1 (k).

14. 49 CFR 395.1 (k) is amended to read: "Is conducted during the planting and harvesting seasons within Colorado as determined by the Department of Agriculture to be from January 1 to December 31."

15. All references to federal agencies and authorized personnel shall be construed to include the CSP, PUC, and law enforcement agencies with a signed MOU with the CSP and their authorized personnel.

16. All reporting requirements referred to in 49 CFR 40, 368, 380, 382, 385, 387, 390, 391, 392, 393, 395, 396, 397 and 399, upon request shall be filed with or provided to the CSP MCSS, 15075 S. Golden Rd., Golden, CO 80401, or by mutually agreed upon methods of electronic document delivery.

B. These Rules and Regulations apply to all vehicles which meet the definition of a commercial vehicle set forth in §42-4-235 (1) (a), CRS, and drivers which meet the definition of "Driver" as described in 49 CFR 390.5, with the following exceptions:

1. Drivers of intrastate vehicles and combination of vehicles with a gross vehicle weight rating (GVWR) or gross combined weight rating (GCWR) of not more than 26,000 pounds, and which do not require a commercial driver's license to operate, are not subject to 49 CFR 391, Subpart E, Physical Qualifications and Examinations;

2. Vehicles owned and operated by the Federal Government or state government or political subdivision thereof not domiciled in Colorado, which are not transporting hazardous materials of a type and quantity that requires the vehicle to be marked or placarded under 49 CFR 172.504;

3. The operation of authorized emergency vehicles, as defined in §42-1-102 (6), CRS, while in emergency and related operations;

4. The operations of snowplows, as defined in §42-1-102 (91), CRS, and all other vehicles engaged in supporting the use thereof when snowplows are removing snow/ice from the roadway or related snow/ice removal operations.

C. Traction Devices Required

Drivers operating a commercial vehicle as defined in Colorado Department of Transportation (CDOT) rule 2 CCR 601-14, with the exception of mobile cranes, that are operated on Interstate 70 between milepost 133 and milepost 259 from September 1st to May 31st inclusive, must carry tire chains as defined in §42-4-106 (5) (a) (I) CRS. Alternative traction devices or tire cables may be used in lieu of tire chains as identified in 2 CCR 601-14.

VI. INTRASTATE MEDICAL WAIVERS

A. Approval of Medical Waivers

a. The CSP MCSS may grant variances/waivers to drivers unable to satisfy the requirements of 49 CFR 391, Subpart E. Individual applications requesting a variance/waiver of specific requirements may be approved when the approval of the variance/waiver is supported by the decision of a certified medical examiner and the documented determination of an appropriate medical professional, combined with satisfaction of any applicable performance standards, to support a decision that a medical condition has no adverse impact on safety.

b. Medical waiver requirements, submission information and documents are available online at WWW.COLORADO.GOV/PACIFIC/CSP/MEDICAL-WAIVERS.

B. Medical Waiver Application Denial

a. An application for a medical waiver may be denied if:

i. The applicant does not currently possess or is not in the process of attaining a state of Colorado Commercial Driver's License;

ii. If the applicant has a medical condition for which a waiver or variance is not available; or

iii. If either the certified medical examiner or the medical professional fail to complete or certify the required waiver form(s).

iv. If, upon review of relevant motor vehicle operation data available to the CSP at the time of receipt of paperwork to re-issue a medical waiver to an individual having an expired or expiring waiver, the CSP determines that to re-issue a medical waiver to an individual will not promote safety, protect human life, or preserve the highways of this state.

A. The denial of an application for the re-issue of a medical waiver to an individual based upon relevant motor vehicle operation data available to the CSP at the time of the receipt of paperwork will be afforded the same appeal rights as a waiver revocation.

b. Denial of a medical waiver application will be by written notice by the CSP MCSS.

C. Medical Waiver Revocation

1. A medical waiver may be revoked by the CSP when a waiver holder fails to comply with applicable terms and conditions of the CSP Medical Waiver Program.

2. A medical waiver may be revoked by the CSP when it is determined by the CSP that the continued use of a waiver by a holder fails to promote safety, protect human life, or preserve the highways of this state.

i. Medical waiver cardholders are provided written notice of relevant program terms and conditions at the time of card approval and subsequent renewal.

ii. Revocation of any medical waiver will be by written notice from the CSP MCSS.

D. Right to Appeal Medical Waiver Revocation

1. Within 30 days of receiving written notice from the CSP MCSS revoking a medical waiver, the holder of the waiver may request a hearing.

i. Hearing requests by waiver holders must be made in writing.

ii. Hearing requests must be addressed to the Chief of the CSP or his or her designee at the CSP MCSS, 15075 S. Golden Rd., Golden Co, 80401.

E. Hearing and Review

1. The Chief of the CSP or his or her designee will hold the hearing.

i. The scope of the hearing will be limited to whether the applicant or permit holder complied with the terms and conditions applicable to the medical waiver program.

ii. The Chief of the CSP or his or her designee will issue a written decision within 20 business days of the completed hearing.

A. If the Chief of the CSP or his or her designee finds that evidence of non-compliance and/or ineligibility is sufficient, the medical waiver revocation will be sustained.

B. If the Chief of the CSP or his or her designee finds that evidence of non-compliance and/or ineligibility is not sufficient, the medical waiver revocation will be immediately overturned and the medical waiver will be reinstated.

iii. The decision by the Chief of the CSP or his or her designee shall constitute a final agency action and is subject to judicial review as described by §24-4-106, CRS.

VII. INTRASTATE SAFETY FITNESS RATINGS AND CIVIL PENALTIES

A. The Colorado Department of Public Safety (CDPS) is authorized by the provisions of

§42-4-235 (2) (a), CRS, to collect civil penalties levied against intrastate carriers found in violation of the rules adopted by the CDPS pursuant to §42-4-235 (4) (a), CRS. The following procedure shall apply to the determination and issuance of those penalties.

B. The CSP must establish a Safety Fitness Rating for each motor carrier upon which it conducts a Compliance Review. The CSP shall use as general guidelines the procedures and definitions contained in 49 CFR 385.

1. Scope, Authority and Application

a. §42-4-235 (2) (a), CRS, Minimum Standards for Commercial Vehicles. No person shall operate a commercial vehicle on a public highway of this state unless such vehicle is in compliance with the rules adopted by CSP. Any person who violates such rules shall be subject to the civil penalties authorized pursuant to 49 CFR 386, Subpart G.

i. Intrastate motor carriers shall not be subject to any provisions in 49 CFR 386, Subpart G that relate the amount of a penalty to a violator's ability to pay. Such penalties shall be based upon the nature and gravity of the violation, the degree of culpability and such other matters as justice and public safety may require.

b. The CSP shall have exclusive enforcement authority to conduct Compliance Reviews, as defined in 49 CFR 385.3 and to impose civil penalties pursuant to such rules.

c. The Civil Penalty will be applied at the completion of a Compliance Review by a Motor Carrier Safety Investigator certified by the FMCSA as a Compliance Review investigator.

2. Definitions

a. Civil Penalty Process: The process and proceedings to collect civil penalties by the CSP for violations of §42-4-235 (4) (a), CRS.

b. Notice of Claim Letter (NOC): The written order informing the motor carrier of their penalty, the rights associated with the penalty, and the process for responding to the penalty.

c. Commercial Vehicle: Shall have the same meaning as described in §42-4- 235 (1) (a), CRS.

d. Compliance Review: An examination of motor carrier operations, such as driver's hours of service, maintenance and inspection, driver qualification, commercial driver's license requirements, financial responsibility, accidents, hazardous materials, and other safety and transportation records to determine

whether a motor carrier meets the safety fitness standard.

e. Conditional Safety Rating: Indicates that a motor carrier does not have adequate safety management controls in place to ensure compliance with the safety fitness standard that could result in occurrences listed in 49 CFR 385.5.

f. Motor Carrier: Shall have the same meaning as described in §42-4-235 (1) (c), CRS.

g. Served/Service: Indicates NOC or other service document was sent by first class mail to the last address furnished to the CSP MCSS by the motor carrier or was personally served by a uniformed member of the CSP.

i. Service of a NOC or document by first class mail is considered complete when it is mailed, not when it is received.

h. Satisfactory Safety Rating: Indicates a motor carrier has in place and functioning adequate Safety Fitness controls to meet the safety fitness standard prescribed in 49 CFR 385.5. Safety Fitness controls are adequate if they are appropriate for the size and type of operation of the particular motor carrier.

i. Unrated Safety Rating: Indicates a safety rating has not been assigned to the motor carrier by the CSP.

j. Unsatisfactory Safety Rating: Indicates a motor carrier does not have adequate safety management controls in place to ensure compliance with the safety fitness standard which has resulted in occurrences listed in 49 CFR 385.5.

3. Safety Fitness Rating

a. Upon completion of a Compliance Review the CSP shall assign a proposed Safety Fitness Rating that shall be based on the degree of compliance with the federal motor carrier safety fitness standard for motor carriers found in 49 CFR 385.5. The Safety Fitness Rating will be determined using the factors prescribed in 49 CFR 385.7. A motor carrier may determine their degree of compliance with the safety fitness standard by reviewing 49 CFR 385.5.

b. On the 61st day after the assignment of a proposed Safety Fitness Rating the motor carrier's Safety Fitness Rating will become a final Safety Fitness Rating.

c. The final Safety Fitness Rating of an intrastate motor carrier will be available to the public upon request by contacting the CSP Central Records Unit (CRU) office at:

Colorado State Patrol
Central Records Unit
700 Kipling St.
Lakewood, CO 80215
303-239-4500

d. If a motor carrier believes the CSP committed an error in assigning its Safety Fitness Rating they may request an administrative review. The request must conform to the following provisions.

i. The request must be in writing addressed to the Chief of the CSP or his or her designee within 30 days of the assignment of the proposed Safety Fitness Rating.

ii. The request must explain the error the motor carrier believes the CSP committed in issuing the Safety Fitness Rating. The motor carrier must include a list of all factual and procedural issues in dispute, and any information or documentation that supports its argument.

iii. The Chief of the CSP or his or her designee may request more information and/or require the motor carrier to attend a conference to discuss the rating. If the motor carrier does not provide the information requested or attend the conference then the chief/designee may dismiss the request.

iv. The Chief of the CSP or his or her designee will serve the decision within 30 days of receiving the request.

v. The proposed Safety Fitness Rating will remain as a proposed Safety Fitness Rating until the decision of the Chief of the CSP or his or her designee.

vi. The decision will include the assignment of a final Safety Fitness Rating. The decision constitutes final action by the CSP.

e. In the event a Safety Fitness Rating is assigned to an intrastate motor carrier, the motor carrier may request a change to their Safety Fitness Rating based on corrective actions taken by the motor carrier. This request cannot be made and will not be acted upon sooner than 90 days after the assignment of a proposed Safety Fitness Rating. The request must be in writing and addressed to the Chief of the CSP or his or her designee. The request must conform to the following provisions:

i. The motor carrier must submit a description of corrective action taken,

hereinafter referred to as the Cooperative Safety Plan.

ii. The Cooperative Safety Plan shall address each violation on the most recent Compliance Review that was an acute and/or critical violation. It shall also address factor six (crashes) of the Compliance Review when the rating for factor six is "unsatisfactory."

iii. The Cooperative Safety Plan must identify why the violation(s) cited as acute and critical were permitted to occur.

iv. The Cooperative Safety Plan must discuss the actions to be taken to correct the deficiency or deficiencies that allowed the acute and or critical violations to occur.

v. Actions taken to insure these critical and/or acute violations do not reoccur in the future.

vi. If factor six (crashes) is rated as unsatisfactory an accident countermeasure program must be included as part of the Cooperative Safety Plan. The program must include, but not limited to, defensive driving training.

vii. If the Cooperative Safety Plan includes actions taken in the near future, such as training, reorganization of departments, purchasing of computer programs etc., a schedule of when that activity is to occur must be included.

viii. Any additional documentation or information that relates to motor carrier safety and the prevention of crashes and hazardous materials incidents must be included.

ix. The Cooperative Safety Plan must include a written statement certifying that the motor carrier will operate in compliance with the motor carrier safety and hazardous materials regulations adopted by the CSP pursuant to §§42-4-235 and 42-20-108, CRS, and all applicable state and local laws.

x. The Cooperative Safety Plan must be signed by a corporate officer in the case of a corporation, a member or manager in the case of a limited liability company, by the general partner of a limited partnership or by all partners or proprietors in the case of a general partnership or proprietorship.

f. The motor carrier may request a change in their Safety Fitness Rating by requesting a follow up Compliance Review, as follows:

i. The request must be made to the Chief of the CSP or his or her

designee. The request cannot be made and will not be acted upon sooner than three months after the assignment of a proposed Safety Fitness Rating.

ii. The Compliance Review investigator will review the corrective actions taken by the motor carrier since the last Compliance Review.

4. Civil Penalty

a. The Compliance Review may result in the assessment of a Civil Penalty as prescribed by §42-4-235(2), CRS, for violations discovered during the Compliance Review.

b. The amount of the Civil Penalty will be determined by taking into account the following factors:

i. Nature and gravity of the violation;

ii. Degree of culpability;

iii. History of offenses within three years preceding the date of the Compliance Review;

iv. Such other matters as justice and public safety not to include any consideration of a violator's ability to pay the Civil Penalty.

c. The intrastate operation of implements of husbandry shall not be subject to the civil penalties provided in 49 CFR 386, Subpart G.

d. The Compliance Review investigator will use the Uniform Fine Assessment (UFA), as codified by §42-4-235 (2) (a), CRS, to determine the Civil Penalty levied upon the motor carrier.

5. Civil Penalty Process

a. Notification. Upon determination of the Civil Penalty, the Compliance Review investigator will serve notification in the form of a NOC.

b. Payment or Administrative Review. The motor carrier shall serve the CSP MCSS with their response to the NOC within 30 days of service of the NOC in one of the following ways:

i. Pay the full amount of the Civil Penalty as instructed in the NOC; or

ii. Submit a written request for a payment plan to the Commander of the CSP MCSS; or

iii. If a motor carrier believes the CSP committed an error in determining its Civil Penalty, they may request an administrative review of that penalty. The following provisions will govern the administrative review:

A. The request must be in writing addressed to the Chief of the CSP or his or her designee within 30 days of the service of the NOC letter.

B. The request must explain the error the motor carrier believes the CSP committed in issuing the Civil Penalty. The motor carrier must include a list of issues in dispute, and any supporting information or documentation.

C. The Chief of the CSP or his or her designee may request additional information and/or require the motor carrier to attend a conference to discuss the penalty. If the motor carrier does not provide the information requested or attend the conference then the Chief of the CSP or his or her designee may dismiss the request.

D. The Chief of the CSP or his or her designee shall serve the motor carrier with a written decision within 30 days after the Chief of the CSP or his or her designee has determined that the administrative record is complete. This decision shall constitute final agency action.

E. The motor carrier has 30 days from the date of the service of the decision to pay the penalty, to arrange for a payment plan as described in 5 (b) (ii) or 35 days from the date of final agency action to file an action in the appropriate district court as provided by §24-4-106 (4), CRS.

i. If, after the 30 days, the carrier does not pay the penalty, request a payment plan or file an action in the appropriate district court the carrier will be deemed to have failed to pay. The CSP MCSS will forward notice to the Colorado Department of Revenue for any carrier deemed to have failed to pay, consistent with §42-4-235 (2) (d) (I), CRS.

ii. If a carrier has failed to pay the assessed or adjudicated penalty, the registrations of the carrier's vehicles shall be cancelled pursuant to §42-3-120, CRS.

VIII. MISCELLANEOUS

A. All contact with the CSP regarding these rules or their applicability should be addressed to:

Colorado State Patrol
Motor Carrier Safety Section
15075 South Golden Road
Golden, CO 80401
303-273-1875
303-273-1939 (Fax)
MCSAP@STATE.CO.US

B. All publications, standards, guidelines, and rules adopted and incorporated by reference in these rules are on file and available upon request for public inspection by contacting the CSP MCSS at 15075 S. Golden Road, Golden, CO., 80401-3990. These rules are available online through the CSP Motor Carrier Safety Webpage accessible through the CDPS Website at WWW.COLORADO.GOV/PUBLIC SAFETY.

1. All publications, standards, guidelines, and rules adopted and incorporated by reference in these rules will be provided to and made available for examination at any state publications depository library as required by §24-4-103 (12.5), CRS. The following publications, standards, guidelines and rules are adopted as amended within these rules in accordance with §24-4-103 (12.5), CRS:

a. Commercial Vehicle Safety Alliance (2020). North American Standard Out-of-Service Criteria (OOSC). April 1, 2020. Greenbelt, MD: Author.

b. Federal Motor Carrier Safety Regulations, 49 CFR §§ 40, 380, 382, 385, 387, 390-397, 399, and Appendix G (2019). This information is also available online through the Government Publishing Office website at: HTTPS://WWW.ECFR.GOV/CGI-BIN/ECFR?PAGE=BROWSE.

2. The CSP MCSS shall maintain copies of the complete texts of each of the aforementioned publications, standards, guidelines and rules and will make them available for public inspection during regular business hours. Interested parties may access these documents free of charge online. Interested parties may also inspect the referenced incorporated materials and/or obtain copies of the adopted standards for a reasonable fee by contacting the CSP MCSS at 15075 S. Golden Rd., Golden, CO., 80401. Copies of the adopted publications, standards, guidelines and rules may also be available from the organizations of original issue:

a. 2020 CVSA Out-Of-Service Inspection Criteria: Commercial Vehicle Safety Alliance (CVSA), 6303 Ivy Lane, Suite 310, Greenbelt, Maryland 20770-6319. Phone: 301-830-6143. Email: CVSAHQ@CVSA.ORG.

b. Federal Motor Carrier Safety Administration (FMCSA), 1200 New Jersey Ave., SE, Room W-65-206, Washington, DC, 20590. Phone: 1-800-832-5660.

Website: WWW.FMCSA.DOT.GOV.

C. These rules do not include later amendments to or editions of any publications, standards, guidelines or rules incorporated by reference herein.

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: 2019-00765

Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado State Patrol

on 02/05/2020

8 CCR 1507-1

RULES AND REGULATIONS CONCERNING MINIMUM STANDARDS FOR THE OPERATION OF COMMERCIAL VEHICLES

The above-referenced rules were submitted to this office on 02/07/2020 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.

February 25, 2020 11:48:45

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Public Safety

Agency

Colorado State Patrol

CCR number

8 CCR 1507-22

Rule title

8 CCR 1507-22 CLAIMS FOR REIMBURSEMENT FOR THE COSTS OF RESPONSE AND MITIGATION OF HAZARDOUS SUBSTANCE INCIDENTS 1 - eff 04/01/2020

Effective date

04/01/2020

DEPARTMENT OF PUBLIC SAFETY
COLORADO STATE PATROL

RULES AND REGULATIONS CONCERNING CLAIMS FOR REIMBURSEMENT FOR THE COSTS OF RESPONSE and MITIGATION OF HAZARDOUS SUBSTANCE INCIDENTS

STATEMENT OF BASIS, STATUTORY AUTHORITY, AND PURPOSE

Pursuant to §29-22-104 (6) (A), CRS, the Executive Director of the Colorado Department of Public Safety shall promulgate rules creating a process by which a public entity, political subdivision of the state, or unit of local government claiming reimbursement pursuant to this section must establish that costs attributed to a hazardous substance incident are reasonable, necessary and documented.

Pursuant to §29-22-104 (6) (b), CRS, the Executive Director of the Colorado Department of Public Safety shall also promulgate rules and regulations creating a process by which the parties involved in a dispute may access and receive assistance from qualified, knowledgeable persons able to perform the role of a voluntary ombudsman, mediator, or arbitrator to resolve disputed claims for reimbursement of costs resulting from response to a hazardous substance incident.

These rules are being amended as a consequence of routine department rule review to assess continued viability, applicability and effectiveness of these rules. As a consequence of this review, the address for the section email for designated emergency response authorities has been updated and references to the Federal Emergency Management Agency (FEMA) schedule of equipment rates as set forth in 44 CFR 206.228 have been added to satisfy the requirements of §24-4-103 (12.5), CRS. These rules now also include a reference to the reimbursement rates schedule calculated internally by the CSP for expenses incurred by the CSP when responding to or mitigating hazardous substance incidents. Minor grammar and formatting items are addressed throughout without changes to either the substantive content or present interpretation of these rules.

It has been declared by the General Assembly that the creating and establishing of these processes for hazardous incident claims for reimbursement is a matter of statewide concern. The absence of implementing rules to carry out the purpose of the statutes would be contrary to the peace, health, safety and welfare of the citizens of this state. For these reasons, it is necessary that these amended rules be adopted.

Stan Hilkey, Executive Director
Colorado Department of Public Safety

Date of Adoption

DEPARTMENT OF PUBLIC SAFETY
COLORADO STATE PATROL

RULES AND REGULATIONS CONCERNING CLAIMS FOR REIMBURSEMENT FOR THE COSTS OF RESPONSE and MITIGATION OF HAZARDOUS SUBSTANCE INCIDENTS

AUTHORITY TO ADOPT RULES AND REGULATIONS

Pursuant to §29-22-104 (6) (A), CRS, the Executive Director of the Colorado Department of Public Safety (CDPS) is authorized to adopt rules and regulations establishing a process through which a public entity, political subdivision of the state, or unit of local government may claim reimbursement of reasonable, necessary and documented response and/or mitigation costs attributable to a hazardous substance incident. The Executive Director is further authorized by §29-22-104 (6) (B), CRS, to establish access to qualified persons to assist in the mediation or arbitration of disputed hazardous incident response claims.

APPLICABILITY

These rules and regulations are applicable to all public entities, political subdivisions of this state, and/or units of local government. These rules apply to the submission of reimbursement claims arising out of response and mitigation of hazardous substance incidents where the Colorado State Patrol (CSP) is the Designated Emergency Response Authority (DERA) as defined within §29-22-102, CRS, pursuant to the provisions of §29-22-104, CRS.

DEFINITIONS

Unless otherwise specified, the definitions provided in §29-22-101(2), CRS, shall apply to these rules. The following definitions are also applicable:

A. COSTS: Means the amount of money and/or damages related to hazardous substance incident response and mitigation activities. Costs may be direct or indirect.

1. **DIRECT COSTS:** Include those costs specifically incurred as a result of responding to and/or mitigation of a hazardous substance incident. Direct costs may include costs related to personnel salaries (inclusive of benefits); equipment use/damage; vehicle use and/or damage; expenditure of response/mitigation supplies; use of contract services; laboratory testing; and disposal and/or storage of hazardous materials/substances.

2. **INDIRECT COSTS:** Include costs resulting from responding to a hazardous substance incident that are not considered a direct cost. Indirect costs may include

clerical, accounting and legal services; report preparation costs; hazardous substance incident planning; and those costs arising out of subsequent processing or resolution of a claim for reimbursement.

B. DEPARTMENT: Means the Colorado Department of Public Safety (CDPS).

C. DESIGNATED EMERGENCY RESPONSE AUTHORITY (DERA): Shall have the same meaning as set forth within §29-22-102, CRS.

D. DIRECTOR: Means the CDPS Director.

E. RESPONSIBLE PARTY: Means the person or persons having care, custody and/or control of a hazardous substance at the time it is involved in a hazardous substance incident.

HSCR 1: HAZARDOUS SUBSTANCE INCIDENT RESPONSE DOCUMENTATION

A. Responding agencies must provide to the Hazardous Materials Training and Response Section of the CSP, hereinafter the CSP Hazardous Materials Section, written documentation of any hazardous substance incident response and/or mitigation activity. this written documentation must detail~~s~~, at minimum:

1. The date, time and location of the hazardous substance incident;

2. Identification of the hazardous substance;

3. Identification of the DERA and all other agencies present at the scene of the incident;

4. A summary describing the incident and all mitigation activity performed by the responding agency;

5. The type and number of response personnel;

6. The type and number of response vehicles; and

7. The type of equipment used.

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HSCR 2: ESTABLISHING REIMBURSABLE COSTS

A. Eligible reimbursement costs may include direct and/or indirect costs.

B. All claims for direct and/or indirect costs must be in writing.

1. When calculating reimbursement claims for direct costs, agencies should include in their written claim the following information, as applicable:

i. The actual hourly rate for personnel salaries (regular and/or overtime);

ii. The actual cost of expended supplies;

iii. The actual cost to replace or repair equipment (not vehicles) used during a response to a hazardous substance incident;

iv. An amortization/depreciation schedule for vehicles or the Federal Emergency Management Agency (FEMA) schedule of equipment rates set forth in 44 CFR 206.228.

v. A reimbursement rates schedule for expenses incurred by the CSP when responding to or mitigating hazardous substance incidents referencing applicable FEMA schedule rates together with applicable, averaged CSP costs shall be available upon request to the public. The CSP hazardous materials section will update this schedule biannually.

2. When calculating claims for indirect costs, responding agencies may either calculate indirect costs:

i. Using a formula currently in use by the responding agency to calculate indirect costs; or

ii. By electing a standard calculation for indirect costs that equal up to 10% of the total direct costs being claimed by the agency.

HSCR 3: CLAIMS PROCESSING

A. Claims for reimbursement shall be submitted to the responsible party as soon as possible after a hazardous substance incident site is declared safe by the DERA.

1. All communications from an agency claiming reimbursement for response to a hazardous substance incident to a responsible party must be in writing.

i. The initial delivery of a reimbursement claim from an agency to a responsible party must be by certified mail.

HSCR 4: DISPUTE RESOLUTION

A. The Director will maintain a list of qualified persons available to perform as volunteer

ombudsmen, mediators or arbitrators to resolve disputes related to these claims. This list will be made available upon receipt of a written request addressed to the Director or his or her designee.

1. Persons volunteering to act as an ombudsmen, mediators or arbitrators for disputes related to hazardous substance incident reimbursement claims must meet the qualifications listed in §29-22-104 (6) (b), CRS.

B. The parties involved in the dispute resolution may enter into such agreements or understandings as may be necessary to resolve the claim.

HSCR 5: DERA REPORTING RESPONSIBILITIES

A. Pursuant to §29-22-102 (3) (a) and (b), CRS, the designation of a DERA to respond to substance incidents occurring within the corporate limits of a town, city, city and county or within unincorporated areas of a county will be reported annually to the CSP Hazardous Materials Section.

B. Annually reported DERA designation information shall be submitted to the CSP Hazardous Materials Section electronically at dera@STATE.CO.US.

PUBLICATIONS AND RULES INCORPORATED BY REFERENCE

A. All publications and rules referred to in these regulations are on file and available for public inspection by contacting the CSP Hazardous Materials Section, 15065 South Golden Road, Golden, CO 80401.

1. All publications, standards, guidelines, and rules adopted and incorporated by reference in these rules will be provided to and made available for examination at any state publications depository library as required by §24-4-103 (12.5), CRS. the following publications, standards, guidelines and rules are adopted as amended within these rules in accordance with §24-4-103 (12.5), CRS:

a. Federal Emergency Management Agency, Department of Homeland Security, 44 CFR § 206.228 (2009). The amortization/depreciation schedule of equipment rates is available online through the FEMA website at: HTTPS://WWW.FEMA.GOV/MEDIA-LIBRARY-DATA/1444398992310-B880A945B45F4EE2503909C4550ECD20/2015EQUIPMENTRATES508.PDF.

2. The CSP Hazardous Materials Section shall maintain copies of the complete texts of each of the aforementioned publications, standards, guidelines and rules and will make them available for public inspection during regular business hours. Interested parties may access these documents free of charge online. Interested parties may also inspect the referenced incorporated materials and/or obtain copies for the adopted standards

for a reasonable fee by contacting the CSP Hazardous Materials Section at 15065 S. Golden Rd., Golden, CO., 80401. Copies of the adopted publications, standards, guidelines and rules may also be available from the organizations of original issue.

a. Federal Emergency Management Agency (FEMA), Department of Homeland Security (DHS), 500 C. ST. SW., Washington, DC, 20472. Phone: 1-800-621-3362. Website: WWW.FEMA.GOV.

B. These rules do not include later amendments to or editions of any publications, standards, guidelines or rules incorporated by reference herein.

C. These rules are available online through the CSP Hazardous Materials Section webpage at HTTPS://WWW.COLORADO.GOV/PACIFIC/CSP/HAZARDOUS-MATERIALS. All contact with the CSP regarding these rules or their applicability should be addressed to:

Colorado State Patrol
Hazardous Materials Section
15065 S. Golden Rd.
Golden, CO. 80401
303-273-1900

PHILIP J. WEISER
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NATALIE HANLON LEH
Chief Deputy Attorney General

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Office of the Attorney General

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on 02/06/2020

8 CCR 1507-22

CLAIMS FOR REIMBURSEMENT FOR THE COSTS OF RESPONSE AND MITIGATION OF HAZARDOUS SUBSTANCE INCIDENTS

The above-referenced rules were submitted to this office on 02/07/2020 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.

February 25, 2020 11:50:04

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Public Safety

Agency

Colorado State Patrol

CCR number

8 CCR 1507-25

Rule title

8 CCR 1507-25 THE PERMITTING, ROUTING AND TRANSPORTATION OF HAZARDOUS AND NUCLEAR MATERIALS AND THE INTRASTATE TRANSPORTATION OF AGRICULTURAL PRODUCTS IN THE STATE OF COLORADO 1 - eff 04/01/2020

Effective date

04/01/2020

DEPARTMENT OF PUBLIC SAFETY
DIVISION OF STATE PATROL

RULES AND REGULATIONS CONCERNING THE PERMITTING, ROUTING & TRANSPORTATION OF HAZARDOUS AND NUCLEAR MATERIALS AND THE INTRASTATE TRANSPORTATION OF AGRICULTURAL PRODUCTS IN THE STATE OF COLORADO

STATEMENT OF BASIS, STATUTORY AUTHORITY, AND PURPOSE

Pursuant to §42-20-108 (1) and (2), CRS, the Chief of the Colorado State Patrol (CSP) has the authority to promulgate rules and regulations for the permitting, routing, and safe transportation of hazardous materials by motor vehicles within the state of Colorado. Pursuant to §§42-20-403, 504 and 508, CRS, the Chief of the CSP has the authority to promulgate rules and regulations for the permitting, routing, and safe transportation of nuclear materials by motor vehicles within the state of Colorado. Pursuant to §42-20-108.5, CRS, the Chief of the CSP is authorized to also adopt rules and regulations which exempt agricultural products from the hazardous materials rules.

The rules are being amended to update and confirm references to both federal regulations and state statutes; to update references to out of service and hazardous response criteria; to elaborate upon criteria required for hazardous materials routing applications previously adopted but not expounded upon; to clarify the requirements of law enforcement officers performing inspections pursuant to the CVSA North American Operations Manual; to incorporate the most current version of the Emergency Response Guidebook; and to correct minor grammar, formatting and website address errors.

It has been declared by the General Assembly that the permitting, routing, and transportation of vehicles transporting hazardous and nuclear materials is a matter of statewide concern. The absence of implementing rules to carry out the purpose of the statutes would be contrary to the public health, peace, safety and welfare of the state. For these reasons, it is necessary that these rule amendments be adopted.

_____ _____

Colonel Matthew C. Packard
Chief, Colorado State Patrol

Date of Adoption

DEPARTMENT OF PUBLIC SAFETY
DIVISION OF STATE PATROL

RULES AND REGULATIONS CONCERNING THE PERMITTING, ROUTING & TRANSPORTATION OF HAZARDOUS AND NUCLEAR MATERIALS AND THE INTRASTATE TRANSPORTATION OF AGRICULTURAL PRODUCTS IN THE STATE OF COLORADO

AUTHORITY

The Chief of the Colorado State Patrol (CSP) is authorized by §42-20-108 (1) and (2) and §§42-20-403, 504, and 508, CRS, to promulgate rules and regulations for the permitting, routing and safe transportation of hazardous and nuclear materials by motor vehicle within the state of Colorado, both in interstate and intrastate transportation. Pursuant to §42-20-108.5, CRS, the Chief of the CSP is also authorized to adopt rules and regulations which exempt agricultural products from the hazardous materials rules.

APPLICABILITY

These rules and regulations shall apply to all persons who transport, ship, or cause to be transported or shipped, a hazardous material by motor vehicle over the public roads of this state.

COMPLIANCE WITH 8 CCR 1507-1

All commercial vehicles that transport hazardous and/or nuclear materials shall comply with the Rules and Regulations Concerning the Minimum Standards for the Operation of Commercial Vehicles, 8 CCR 1507-1.

GENERAL DEFINITIONS

Unless otherwise specified, definitions of general applicability throughout these rules are:

Enforcement Official: As identified within §42-20-103 (2), CRS, is limited to a peace officer who is an officer of the CSP as described in §§16-2.5-101 and 114, CRS; a certified peace officer who is a certified Port of Entry (POE) officer as described in §§16-2.5-101 and 115, CRS; a peace officer who is an investigating official of the Public Utilities Commission (PUC) transportation section as described in §§16-2.5-101 and 143, CRS; or any peace officer as described in §16-2.5-101, CRS.

Hazardous Materials: As defined within §42-20-103 (3), CRS, are those materials listed in Tables 1 and 2 of Title 49, Code of Federal Regulations (CFR), 172.504 (49 CFR 172.504), excluding highway route controlled quantities of radioactive materials as defined in 49 CFR 173.403 (1), excluding ores, and the wastes and tailing there from, and excluding special fireworks where the aggregate amount of flash powder does not exceed 50 pounds.

Motor Vehicle: As defined within §42-20-103(4), CRS, is any device capable of moving from place to place upon public roads. The term includes, but is not limited to, any motorized vehicle or any such vehicle with a trailer or semi-trailer attached thereto.

Person: As defined within §42-20-103 (6), CRS, is an individual, a corporation, a government or governmental subdivision or agency, a partnership, an association, or any other legal entity; except that separate divisions of the same corporation may, at their request, be treated as separate persons.

PART I

HAZARDOUS MATERIALS TRANSPORTATION

HMT 1

APPLICATION OF TITLE 49, CODE OF FEDERAL REGULATIONS

The transportation of hazardous materials by motor vehicle must comply with the regulations contained in:

49 CFR 107	Hazardous Materials Program Procedures
49 CFR 171	General information, Regulations, and Definitions
49 CFR 172	Hazardous Materials Table, Special Provisions, Hazardous Materials Communications, Emergency Response Information, Training Requirements, and Security Plans
49 CFR 173	Shippers- General Requirements for Shipments and Packagings
49 CFR 177	Carriage by Public Highway
49 CFR 178	Specifications for Packagings
49 CFR 180	Continuing Qualification and Maintenance of Packagings
49 CFR 387	Minimum Levels of Financial Responsibility for Motor Carriers
49 CFR 397	Transportation of Hazardous Materials; Driving and Parking Rules

of the United States Department of Transportation Hazardous Materials Regulations as the same were in effect on October 1, 2019. As authorized by §42-20-108 (3), CRS, these federal regulations are used as general guidelines by the Chief of the CSP in promulgating these rules and are adopted for enforcement by law enforcement officials with the following modifications:

1. The definition of person provided within 49 CFR 107.1 does not apply.

2. 49 CFR 171.1 (d) (5) does not apply.

HMT 2

INSPECTION STANDARDS

A. Through a Memorandum of Understanding (MOU), dated October 1, 2019, between the Commercial Vehicle Safety Alliance (CVSA), the CSP, as a division of the Colorado Department of Public Safety (CDPS), adopts the CVSA inspection procedures, decal application policies, and Out-of-Service (OOS) criteria established for the inspection of commercial motor vehicles.

B. Enforcement officials performing safety inspections on motor vehicles transporting hazardous materials shall use the inspection procedures, decal application policies, and OOS criteria, found in the CVSA Operations Manual, effective April 1, 2020.

HMT 3

NOTIFICATION OF INCIDENTS

A. The driver of a motor vehicle transporting hazardous materials as cargo involved in a hazardous material spill, whether intentional or unintentional, shall give immediate notice of the location of such spill and such other information as necessary to the nearest law enforcement agency as required by §42-20-113 (3), CRS.

B. A driver of a motor vehicle involved in an incident that may result in a potential spill of hazardous material cargo shall give immediate notice of the incident location and such other information as necessary to the nearest law enforcement agency.

C. The driver of a motor vehicle involved in a spill of hazardous material from a fuel tank that provides fuel for the motor vehicle and/or equipment thereon, shall give immediate notice of the location of such spill and such other information as necessary to the nearest law enforcement agency.

D. As it applies to the above paragraphs in this HMT 3, "…such other information as necessary…" includes, but is not limited to the:

1. Name of the person reporting the incident;

2. Phone number where person reporting incident can be contacted;

3. Type of incident;

4. Type of motor vehicle involved;

5. Name of motor carrier involved, if applicable;

6. Extent of injuries, if any;

7. Classification, name, and quantity of hazardous materials involved; and

8. If a continuing danger to public safety or the environment exists at the scene.

E. As soon as possible after initial notification of a hazardous material spill/incident to the nearest law enforcement agency, the driver or a company representative shall provide the same required information to the:

1. CSP at (303) 239-4501; and

2. Colorado Department of Public Health and Environment (CDPHE) Environmental Spill Reporting Line at (877) 518-5608.

HMT 4

AUTHORITY TO INSPECT MOTOR VEHICLES, BOOKS AND RECORDS

A. Enforcement officials who are authorized to perform motor vehicle safety inspections on commercial motor vehicles as defined by §42-4-235 (1) (a), CRS, and the drivers thereof, shall be required to meet the inspector qualifications set forth in §42-4-235 (4) (a) (I), CRS, while performing a Level I North American Standard Safety Inspection. All enforcement officials performing Level I-VI North American Standard Safety Inspections must also maintain the certification requirements prescribed in the CVSA Operations Manual.

B. Enforcement officials shall at all times have the authority to inspect motor vehicles, motor vehicle drivers, cargo, and any required documents set forth in 49 CFR 368, 387, 390, 391, 392, 393, 395, 396, 397, and 399, as revised October 1, 2019, whenever motor vehicles are transporting hazardous materials on streets and public roads in the state of Colorado.

C. CSP Enforcement officials who are certified by the Federal Motor Carrier Safety Administration (FMCSA) (49 CFR 385, Subpart C) to perform Compliance Reviews and

Safety Audits shall have the authority to enter the facilities of and inspect any motor carrier as defined by§42-4-235 (1) (c), CRS, and any required records and supporting documents, as set forth in 49 CFR 40, 368, 380, 382, 385, 387, 390, 391, 392, 393, 395, 396, 397, and 399, and Appendix G, as revised October 1, 2019.

HMT 5

MOTOR VEHICLE OUT-OF-SERVICE (OOS) CRITERIA

A. The CSP adopts and incorporates by reference the CVSA North American Uniform OOS Criteria, as revised April 1, 2020.

B. Enforcement officials shall use the CVSA North American Uniform OOS Criteria when determining whether a motor vehicle should be placed OOS pursuant to §42-20-110, CRS.

HMT 6

VIOLATION PENALTY

Any person shipping or transporting hazardous materials in violation of any of the rules of this part is guilty of a misdemeanor and upon conviction thereof shall be punished by such fine and/or imprisonment as provided in §42-20-109, CRS.

PART II

HAZARDOUS MATERIALS PERMITS

DEFINITIONS

For purposes of this Part II, the following definitions shall apply:

Liability Insurance or Surety: As used in these rules means insurance or surety for public liability.

Longer Vehicle Combination: Abbreviated as "LVC," is any of a number of vehicle configurations including a truck tractor as a power unit and multiple trailer combinations identified within §42-4-505(2) (a)-(d), CRS.

Peace Officer: Shall be as defined in §16-2.5-101, CRS.

Public Liability: Liability for bodily injury or property damage, including liability for environmental restoration, as defined within 49 CFR 387.5.

Transmix: Also known as Petroleum Distillates, N.O.S., and only as used within this section, is a mixture of refined products specifically and individually exempted under HMP 5. Transmix, as defined by these rules, is a combination of gasoline, diesel, jet fuel and/or other refined petroleum products transported to processing plants for purposes of distillation and product separation. Transmix falls under UN1268 and is placarded as class 3 hazardous materials.

HMP 1

ANNUAL PERMIT APPLICATION AND FEES

A. All applications and renewals for Hazardous Materials Transportation Permits are to be submitted to the Colorado Public Utilities Commission (PUC) at 1560 Broadway, Ste. 250, Denver, Colorado. The permit application or renewal process may be started online at HTTPS://DORAAPPS.STATE.CO.US/PUC/TRANSPORTATIONAPPLICATIONS/.

B. Checks should be made payable to the "Colorado Public Utilities Commission."

C. The annual hazardous material transport permit fee schedule is based on the number of motor vehicles an applicant operates within Colorado and may be found at §42-20-202 (1) (b), CRS.

HMP 2

PERMIT CONDITIONS

A. Hazardous materials transporters operating within the state of Colorado are required to obtain a motor carrier identification number pursuant to the provisions of 49 CFR 390.19T prior to submission of their annual permit application.

B. The PUC shall, upon review and approval of a permit application, issue an annual permit pursuant to the provisions of §42-20-201, CRS.

C. The fee assessed by the PUC for an annual permit shall be determined by the number of vehicles being permitted and will be as described within §42-20-202 (1) (b), CRS.

D. When the number of vehicles indicated on a motor carrier's annual permit application is 301 or more, the permit shall contain written authorization for a motor carrier to make as many copies of the permit as necessary to facilitate placing one copy in each of their vehicles that operate within or through the state of Colorado.

E. The required permits must be readily available for inspection as required by §42-20-203, CRS. This requirement will be met if a peace officer or enforcement official is able to determine that the permit can be electronically verified as valid at the time of contact.

F. Any increase in the total number of declared vehicles operating within or through the state of Colorado must be communicated immediately to the PUC in writing.

G. No annual permit is to be altered, amended or copied unless authorized in writing by the PUC, or, in the case of a single trip permit (HMP 3), by any enforcement official.

HMP 3

SINGLE TRIP PERMITS

A. Pursuant to §42-20-202 (1) (c), CRS, single trip permits may be obtained from the CSP at all Port of Entry (POE) weigh stations. Each person transporting hazardous materials in, to, from, or through this state who has not obtained an annual permit from the PUC shall apply for a single trip permit at the closest possible CSP POE weigh station or to a CSP POE officer or office.

1. Each single trip permit shall be valid for a single continuous business venture, but in no event shall the permit be valid for more than 72 hours, unless extended by any enforcement official for any reason the official deems advisable, including mechanical difficulties and road and weather conditions.

2. The single trip permit shall be issued upon the approval of the permit application and payment of a 25 dollar permit fee.

B. Persons making application for a hazardous materials transportation single trip permit are required by §42-20-202 (3) (a), CRS, to supply proof of liability insurance or surety or sign a verification at time of permit application.

C. Applicants who sign a verification in lieu of supplying acceptable proof of financial responsibility (liability insurance or surety) shall, within 30 days following the date of issuance of the permit:

1. Return their copy of the single trip permit to the PUC hazardous materials permitting section; and,

2. Include a copy of the acceptable proof of financial responsibility required by §42-20-202, CRS, and as defined in paragraph HMP 4 (B) below.

HMP 4

LIABILITY INSURANCE (§42-20-202 (2) (a) and (3) (a), CRS)

A. Persons making application for an annual hazardous materials transportation permit must obtain and keep in force public liability insurance or surety at all times that shall not be less than the minimum limits set forth in 49 CFR 387 with schedules and endorsements covering all vehicles that may be operated by, for, or under the control of the carrier.

B. The carrier shall cause to be filed with the PUC one of the following:

1. A National Association of Regulatory Utility Commission (NARUC) "Form E," Uniform Major Carrier Bodily Injury and Property Damage Liability Certificate of Insurance, executed by a duly authorized agent of the insurer. Also required with this filing is the MCS-90, "Endorsement for Motor Carrier Policies of Insurance for Public Liability under Sections 29 and 30 of the Motor Carrier Act of 1980," issued by an insurer(s), and signed by an authorized representative of the insurance company.

2. A form MCS-82, "Motor Carrier Surety Bond for Public Liability under Section 30 of the Motor Carrier Safety Act of 1980," issued by a surety, and signed by an "Attorney-In-Fact" with a copy of the Power of Attorney attached; or

3. A copy of a written decision, order, or authorization of the FMCSA authorizing the motor carrier to self-insure pursuant to 49 CFR 387.309.

C. All insurance and surety forms coverage must be filed with the exact same name, initial, corporate and trade name (if any), and address as shown in the hazardous materials permit application records of the PUC.

D. Subsequent name or policy number changes shall be reflected by the insurer filing an endorsement with the PUC.

E. Every insurance certificate or surety bond required by and filed with the PUC shall be kept in full force and effect, unless and until canceled by a 30-day written notice or not renewed by a 90-day written notice on a NARUC "Form K," Uniform Notice of Cancellation of Motor Carrier Insurance Policies; "Form BMC 35," Notice of Cancellation of Motor Carrier Insurance; or "Form BMC 36," Notice of Cancellation of Motor Carrier Surety Bond, as applicable, from the insurer or surety to the PUC. The 30-day and 90-day notice shall commence from the date the notice is received by the PUC and the insurance certificate or surety bond shall contain a statement to this effect.

HMP 5

LONGER VEHICLE COMBINATIONS

A. Motor vehicles defined as "Longer Vehicle Combinations" or "LVCs" operating under the provisions of the Colorado Department of Transportation (CDOT) Rules and Regulations promulgated pursuant to the provisions of §43-4-505, CRS, are prohibited from transporting the following specified hazardous material types and quantities:

1. Any quantity of hazardous material within the hazard classes specified in 49 CFR 172.504, Table 1.

2. Any material, unless otherwise specified herein, within the hazardous classes specified in 49 CFR 172.504, Table 2, that:

a. Exceeds 55 gallons per package.

b. Is transported in bulk quantities (containment system in excess of 3500 water gallons), except as provided in HMP 5 paragraph (B), 1 through 6.

c. Is classified as a "Material Poisonous by Inhalation"- as defined in 49 CFR, Part 171.8.

d. Requires evacuation of populated areas as specified in the most current version of the North American Emergency Response Guidebook in publication as of April 1, 2020.

B. The prohibition in subparagraph A (2) (b) above, does not apply to the following petroleum based products when transported in bulk quantities in an LVC of the type described in §42-4-505 (c) and (d), CRS:

1. Gasoline, UN1203

2. Diesel Fuel, NA1993

3. Crude Oil, UN1267

4. Liquefied Petroleum Gas, UN1075

5. Aviation Fuel, UN1863

6. Transmix, UN1268

C. Persons operating LVCs must comply with all other provisions of state law, rules and regulations as applicable.

HMP 6

VIOLATION PENALTY

Any person shipping or transporting hazardous materials in violation of any rule in this Part II shall be punished as provided in §42-20-204, CRS.

PART III

HAZARDOUS MATERIALS ROUTE DESIGNATION

DEFINITIONS

The definitions provided in §§42-20-103 and 29-22-101, CRS, shall apply to these rules and regulations. The following definitions shall also apply:

Petition: As used within these rules, means the CSP Hazardous Material Route Designation Petitioning Packet, including the route analysis process, worksheets, and petition resolution.

Petitioning Entity: Or Petitioning Entities, as used within these rules, means local governmental entities, CDOT, a public highway authority and any governmental entity that is a partner in a public-private partnership with respect to any highway, road or street it maintains, when making an application to the CSP for a new hazardous materials route designation or for a change to an existing route designation as is allowed under §42-20-302 (1) (a)-(e), CRS.

Routing Factors: Factors that must be considered and specifically addressed as part of any application made to the CSP for a new hazardous materials route designation or for a change to an existing route designation. For purposes of applications to the CSP, Petitioning Entities must address factors for consideration as identified by 49 CFR 397.71 (b) (9) as are applicable to the route represented by the application.

Sensitive Areas: Sensitive Areas are areas that may experience a disparate impact in the event of exposure to the release of hazardous materials. The reason for this disparate impact may be environmental, social, etc., and could result in a greater demand on emergency and public resources in the event of an emergency related to the release of hazardous materials. Sensitive Areas include but are not limited to private homes; commercial buildings; special populations in hospitals, schools, prisons, stadium, senior or group homes; ESL speaking individuals, the physically or mentally disabled; water sources, and natural areas such as parks, wetlands and wildlife reserves.

Special Populations: Groups, individuals, or institutions included in a population that could be potentially exposed in the event of a hazardous materials incident that are also members of groups that may not be able or are unable to mobilize effectively without the assistance of emergency or other public services personnel in response to a threat to public health or safety.

HMR 1

APPLICATION FOR ROUTE DESIGNATION

A. Petitioning Entities making application to the CSP for a new hazardous materials route designation or for a change in an existing route designation pursuant to §42-20-302, CRS, may submit a petition for either to the CSP, no more than once a year.

B. Petitioning Entities seeking to petition for a hazardous materials route designation should consult with and request guidance from the CDOT Mobility and Freight Unit regarding the applicable process, format and substance of the route petition. Introductory information on the process, FAQS and unit contact information are available online at HTTPS://WWW.CODOT.GOV/BUSINESS/HAZMAT-ROUTING. Correspondence may be delivered to the CDOT Mobility and Freight Unit at 2829 W. Howard Pl., Denver CO, 80204.

C. 49 CFR 397 is adopted without amendment by these rules; the factors identified for consideration by 49 CFR 397.71 (b) (9) are applicable to all new and existing hazardous materials route petitions.

1. 49 CFR 397.71 (b) (9) discusses 13 categories of factors that must be considered when any hazardous material route, new or existing, is the subject of a hazardous materials routing petition. Broadly, these 13 categories are:

i. Population Density: The population that will be potentially exposed in the event hazardous materials are released, inclusive of residents, employees, motorists, and other persons in the area with specific discussion of any of those persons or groups that may be considered to be special populations. The relationship of population density levels and the potential release of hazardous materials must also be addressed.

ii. Type of Highway: The type and characteristics of the highway to be travelled must be identified.

iii. Types and Quantities OF Hazardous Materials: The type and amount of hazardous material that will normally be transported along the petitioned route.

iv. Emergency Response Capabilities: An analysis of the emergency response capabilities resulting from consultation with the proper fire, law enforcement and highway safety agencies and based upon proximity of facilities and resources to the potential impact zone in the event hazardous materials are released shall be completed and included with the petition.

v. Petitioning Entity must include the results of any consultation conducted in accordance with persons and/or entities who will be affected by the petitioned routing.

vi. Petitioning entity must include discussion defining the exposure and risk factors associated with any of the hazardous materials likely to be transported along the petitioned route. exposure risks for sensitive areas must be addressed.

vii. Terrain Considerations: Topography along and adjacent to the petitioned routing that may affect severity of an accident, control of hazardous materials in the event of a release, and impact the control and clean up of the release of any hazardous materials must be discussed.

viii. Continuity of Routes: Information on any efforts of outreach to adjacent jurisdictions to consult and ensure routing continuity should be referenced.

ix. Alternate Routes: Information should be provided as to any alternate routes considered and petitioning entity should provide information as to why the route being petitioned for is the most appropriate option and is safer than the alternative options or, in the event of existing route, the current route.

x. Effects on Commerce: The routing proposed shall not impose an unreasonable burden upon interstate or intrastate commerce.

xi. Delays in Transportation: The routing proposed shall not create unnecessary delays in the transport of hazardous materials.

xii. Climatic Conditions: Weather conditions that are unique to a proposed route must be addressed, including the impact of the weather conditions upon the potential release of any hazardous materials, control of a hazardous materials release, and clean up thereof.

xiii. Congestion and Accident History: Petitioning Entity should also consider the congestion and accident history of the specific route they are petitioning to become a hazardous materials route and the impact of these factors upon the public, emergency response, and general transportation in the event of a potential hazardous materials release.

2. Any petition applications delivered to the CSP failing to include discussion of the consideration factors set forth by 49 CFR 397 (b) (9) as may be applicable to the route application submitted will be determined "Insufficient for Consideration" (IFC) and returned to the applicant without prejudice.

3. A Petitioning Entity resubmitting a corrected or previously determined IFC petition application to the CSP shall not be considered to be in violation of the one application per year limitation set forth in HMR 1 part A and §42-20-302, CRS.

4. Prepared petitions should be delivered to:

Colorado State Patrol
Hazardous Materials Section
15065 S. Golden Rd.
Golden, CO 80401-3990
Phone: 303-273-1900

E. All petitions received by the CSP will be considered to be "submitted" as required by §42-20-302 (1), CRS.

F. The filing date for a "complete petition" as referenced by §42-20-302 (4), CRS, shall be the date of its acceptance by the CSP. Petitioning Entities will be notified in writing of the date of acceptance.

HMR 2

ROUTE DESIGNATION SIGNS

A. Local governmental authorities electing to use signs to give notice of approved route designations within their jurisdiction pursuant §42-20-303, CRS, shall use the hazardous materials route designation and/or restriction sign standards adopted by CDOT.

B. Local governmental authorities must specify the location of each sign erected to mark an approved route in writing to the CSP Hazardous Materials Section within 60 days of the route designation approval.

HMR 3

PROFESSIONAL QUALITY MAPS

A. Local governmental authorities electing to use professional quality maps to identify approved route designations within their jurisdiction pursuant to §42-20-302 (8), CRS, shall meet the following minimum requirements:

1. Scale: The map scale should be of sufficient proportions to clearly show the passage of a designated route within or through the jurisdiction.

2. Colors: Designated routes or other approved route restrictions must be printed in red on a white background. All other printing should be in black.

3. Legend: The map legend should clearly describe the graphic representations used within the map.

4. Map
Graphics: The map should use graphic symbols that clearly represent the difference between designated routes, other highways, and jurisdiction boundaries.

5. Route Information: The map should include a telephone number where the operator of a motor vehicle transporting hazardous materials can obtain additional information on routes, guidance regarding other restrictions within the jurisdiction or emergency assistance on a 24 hour basis.

B. Local governmental authorities must submit copies of their professional quality maps within 60 days of an approved route designation to the CSP Hazardous Materials Section for approval.

HMR 4

DESIGNATED ROUTE REVIEWS/SURVEYS

A. Petitioning authorities must communicate changes in the original data and/or information used to evaluate the risk level associated with an approved route to the CSP Hazardous Materials Section immediately, or as soon as is practicable, following the change. A change would be considered to be, but not limited to, the following:

1. A change in the accident rate;

2. A change in the mandatory or subjective factors affecting the route or required to be considered by 49 CFR 397.71 (b) (9).

B. The CSP will periodically review the status of designated routes to determine if the approval terms of §42-20-302 (8) (a) (I-IV), CRS, continue to be met. Upon review, routes demonstrating a change in the risk level of the route toward a higher risk factor or that are

impacted significantly by a change in a mandatory or subjective factor may be subject to reevaluation by the CSP.

C. The CSP will notify petitioning authorities in writing if, after reevaluation, any designated route within their jurisdiction no longer meets the acceptance terms specified in §42-20-302 (8) (a) (I-IV), CRS.

D. If a designated route no longer meets the above referenced acceptance terms, the CSP will consult with the petitioning authority to coordinate the submission of a revised petition. Petitions submitted for a change in an existing route designation are subject to the conditions and procedures of §42-20-302, CRS.

E. The CSP will conduct route surveys on designated routes on an as-needed basis. These surveys will be conducted to determine the type and quantity of materials being transported and the frequency of such transportation. Surveys conducted in incorporated areas will only be done after consultation with the appropriate local governmental agency.

F. There will be no exceptions and/or exemptions to designated hazardous materials routes other than those already specified within Title 42, Article 20, CRS.

HMR 5

EMERGENCY ROAD CLOSURE

A. The closing of a public road that is designated as a hazardous materials route, or restrictions on the movement of traffic over the same due to highway construction, severe weather, or other factors, must be communicated by CDOT or the affected county road and bridge office as soon as possible to the CSP Hazardous Materials Section during normal business hours at (303) 273-1900. The CSP Denver Regional Communications Center must be contacted where these events occur outside of normal business hours at (303) 239-4501.

B. When a hazardous materials route is restricted and/or closed, the CSP will determine if a temporary alternate route should be identified.

C. In the event of a declaration of emergency, the CSP Chief may determine a temporary hazardous material transportation route or routes. If determined appropriate, the CSP will declare a temporary hazardous material route or routes that may remain in effect for period not to exceed the duration of the declared emergency.

1. The definition of "Emergency" shall be consistent with and as adopted within 8 CCR 1507-1, The Rules and Regulations Concerning Minimum Standards for the Operation of Commercial Vehicles.

D. The CSP will notify the appropriate local law enforcement agencies regarding any temporary closure and whether or not an alternate route has been temporarily designated.

HMR 6

EMERGENCY RESPONSE CAPABILITIES

A. Local governmental authorities petitioning for a route designation must provide the CSP Hazardous Materials Section with the following information on hazardous materials emergency response services within their jurisdiction:

1. The agencies who provide emergency services along the proposed route(s) and available alternatives identified in the analysis;

2. Of these, which agencies respond to hazardous materials incidents and during what periods of time service is available;

3. Which agencies have emergency response teams and the total number of teams they have;

4. The total number of emergency response personnel for each agency and their level of hazardous materials training; and

5. An inventory, list, or other information identifying the hazardous materials response equipment available from each agency.

B. Provide the following information for each agency identified above:

1. Response agency name;

2. Agency address;

3. Name of contact person and an alternate;

4. 24-hour emergency phone number;

5. Non-emergency phone number; and

6. Radio frequencies and call signs.

C. Any changes to the above information should be communicated in writing, as soon as possible but no later than 45 days following the change, to the CSP Hazardous Materials Section at 15065 S Golden Rd., Golden, Colorado, 80401-3990.

HMR 7

COLORADO DEPARTMENT OF TRANSPORTATION (CDOT)

CDOT is not required to meet the reporting requirements of Rule HMR 6. However, where CDOT, by agreement, submits a petition for a local governmental authority pursuant to §42-20-302 (9), CRS, provision must be made within the agreement for compliance with the above reporting requirements.

HMR 8

ROUTES TO BE USED FOR THE TRANSPORTATION OF HAZARDOUS MATERIALS PURSUANT TO §42-20-305, CRS

A. North – South Routes:

1. Colorado 9 from US 40 in Kremmling to Interstate 70 in Silverthorne.

2. Colorado 13 from Wyoming to Moffat County Road 183 North of Craig.

3. Colorado 13 from US 40 West of Craig South to US 6 West of Rifle.

4. Colorado 17 from US 285 near Mineral Hot Springs to US 160 near Alamosa.

5. Interstate 25 from Wyoming to New Mexico.

6. Colorado 47 from Interstate 25 to the junction of US 50.

7. Colorado 71 from Colorado 14 to US 24 in Limon (East junction).

8. Colorado 71 from US 24 in Limon (West junction) to US 50 near Rocky Ford.

9. Colorado 79 from Colorado 52 to Interstate 70 at Bennett.

10. Colorado 83 from US 24 to Colorado 115.

11. Colorado 91 from Interstate 70 to US 24 near Leadville.

12. Colorado 113 from Nebraska to US 138.

13. Colorado 115 from Colorado 83 to US 50.

14. Colorado 119 from Colorado 157 to Colorado 52.

15. Colorado 125 from Wyoming to US 40 West of Granby.

16. Colorado 127 from Wyoming to Colorado 125.

17. US 138 from Colorado 113 to US 6 (Chestnut St.) in Sterling.

18. Colorado 139 from Colorado 64 in Rangely to Interstate 70 near Loma.

19. Colorado 141 from Interstate 70 business loop near Grand Junction to US 50.

20. Colorado 141 from US 50 to US 491.

21. Colorado 157 from US 36 to Colorado 119.

22. Interstate 225 from Interstate 70 to Interstate 25.

23. US 287 from US 40 in Kit Carson to Oklahoma.

24. US 285 from US 160 in Alamosa to New Mexico.

25. US 285 from Colorado 470 to Colorado 112.

26. US 491 from Utah to New Mexico.

27. US 285 from Colorado 112 to US 160.

28. US 85 from Wyoming to Interstate 76.

29. Colorado 71 from Nebraska to Colorado 14.

30. US 385 from Interstate 76 in Julesburg to US 40 in Cheyenne Wells.

31. The City of Lamar's Second Street from US 50/385 to Maple Street.

32. The City of Lamar's Maple Street from Second Street to US 50/287.

33. The City of Craig's Great Divide Road from US 40 North to the city limits.

34. Moffat County Road 7 (Great Divide Road) from the Craig city limits North to Moffat County Road 183.

35. Moffat County Road 183 from Moffat County Road 7 (Great Divide Road) East to Colorado 13.

B. East – West Routes:

1. US 6 (Loveland Pass) from Interstate 70 just East of the Eisenhower/Johnson Tunnels to Interstate 70 at Silverthorne.

2. US 6 from Colorado 13 West of Rifle West to exit/entrance number 87 on Interstate 70.

3. US 6 from State Highway 14 (Main St.) in Sterling to Nebraska.

4. Colorado 10 from Interstate 25 in Walsenburg to US 50 in La Junta.

5. Colorado 14 from US 40 to Colorado 125.

6. Colorado 14 from interstate 25 to US 6 in Sterling.

7. US 24 from Colorado 91 at Leadville to Interstate 25 in Colorado Springs.

8. US 24 from Colorado 83 to Interstate 70 at West Limon (Exit 359).

9. US 24 business route from US 24 on the West side of Limon to the West junction of Colorado 71.

10. US 24 business route from the East junction of Colorado 71 (in Limon) to I-70 (Exit 363).

11. US 34 from Interstate 25 to Interstate 76.

12. US 34 from the West junction of Colorado 71 to Nebraska.

13. US 36 from Interstate 25 to Colorado 157.

14. US 36 from Interstate 70 in Byers to Kansas.

15. US 40 from Utah to the intersection of Colorado 13 West of Craig.

16. US 40 from Moffat County Road CG 2 (First Street) just East of Craig to Interstate 70.

17. US 40 from I-70 (Exit 363) in Limon to Kansas.

18. US 50 from the North junction of Colorado 141 near Grand Junction to Kansas.

19. Colorado 52 from Colorado 119 to Colorado 79.

20. Colorado 64 from US 40 in Dinosaur to Colorado 13.

21. Interstate 70 from Utah to US 6 at Silverthorne (Loveland Pass).

22. Interstate 70 from US 6 just East of Loveland Pass to Interstate 25.

23. Interstate 70 from Interstate 270 to Kansas.

24. Interstate 70 business route from Interstate 70 East of Grand Junction to Colorado 141.

25. Interstate 76 from Interstate 25 to Nebraska.

26. Colorado 112 from US 285 to US 160.

27. US 160 from New Mexico to Interstate 25 business route in Walsenburg, South to Exit 49 on Interstate 25.

28. Interstate 270 from Interstate 70 to Interstate 76.

29. Colorado 470 from US 285 to Interstate 70.

30. US 550 from US 160 to New Mexico.

31. The City of Craig's 1st Street from Colorado 13 East to the city limits at Colorado 394.

32. Moffat County Road CG 2 (First Street) from the Craig city limits at Colorado 394 East to US 40.

C. While generally required to employ designated state, federal and interstate roadways, transporters of Gasoline, Diesel Fuel and Liquefied Petroleum Gas may routinely travel on the following state and federal highways:

1. US 160 from Interstate-25 to the Kansas border.

2. US 350 from US 160 to US 50.

3. US 385 from US 50 to US 40.

4. SH 96 from SH 71 to the Kansas Border, and

5. SH 109 from US 160 to East 3rd Street in La Junta.

HMR 9

PARKING REGULATIONS AND ORDINANCES

A. Local governmental jurisdictions requiring approval of parking regulations or ordinances pursuant to the provisions of §42-20-302, CRS, must submit a copy of the proposed regulations or ordinances to:

Colorado State Patrol

Hazardous Materials Section

15065 S. Golden Rd.

Golden, CO 80401-3990

B. The criteria for approval of regulations or ordinances concerning the parking of motor vehicles transporting hazardous materials contained herein apply only to those parking regulations and ordinances submitted by local governmental jurisdictions which affect such vehicles operating in conjunction with the use of a designated hazardous material route or routes.

C. The CSP will use the criteria of this HMR 9 when reviewing regulations or ordinances for approval.

D. Parking regulations or ordinances adopted by local governmental jurisdictions pursuant to the authority provided in §42-20-302 (2), CRS, as amended, must not unreasonably limit parking:

1. On or near a designated hazardous material route;

2. For the purpose of pick up or delivery of hazardous materials;

3. In an emergency, i.e., breakdown or accident; or

4. For the purpose of a rest stop, i.e., meals, restroom breaks, or to comply with the driver's hours-of-service requirements as defined in 49 CFR 395 as revised October 1, 2019.

E. For the purposes of this Rule HMR 9, parking regulations or ordinances may be deemed to "unreasonably limit" when they are at variance with and more stringent than the regulations of the United States Department of Transportation as published in 49 CFR 397, as revised October 1, 2019.

F. No parking regulation or ordinance shall require a permit or payment of a fee for parking which is necessary and incident to the transportation of hazardous materials on or near a hazardous materials route. This provision does not apply where fees are collected from all motor vehicles, regardless of the type of commodity being transported, i.e. metered parking.

HMR 10

VIOLATION PENALTY

Any person shipping or transporting hazardous materials in violation of any of the rules of this part shall be punished as provided in §42-20-305, CRS.

PART IV

TRANSPORTATION OF NUCLEAR MATERIALS

DEFINITIONS

The definitions provided in §§42-20-103 and §42-20-402, CRS, shall apply to these rules and regulations. The following definition will also apply:

Complaint: A written document stating the essential facts and supporting documentation regarding any offense(s) charged.

NMT 1

APPLICATION OF 10 AND 49 CFR

A. The transportation of nuclear materials as defined within §42-20-402 (3) (a)-(c), CRS, by motor vehicle must comply with the regulations contained in:

49 CFR 107 Hazardous Materials Program Procedures

49 CFR 171	General Information, Regulations, and Definitions
49 CFR 172	Hazardous Materials Table, Special Provisions, Hazardous Materials Communications, Emergency Response Information, Training Requirements, and Security Plans
49 CFR 173	Shippers- General Requirements for Shipments and Packagings
49 CFR 177	Carriage by Public Highway
49 CFR 178	Specifications for Packagings
49 CFR 180	Continuing Qualification and Maintenance of Packagings
49 CFR 387	Minimum Levels of Financial Responsibility for Motor Carriers
49 CFR 397	Transportation of Hazardous Materials Driving; and Parking Rules

of the United States Department of Transportation Hazardous Materials Regulations as the same were in effect on October 1, 2019. As authorized by §42-20-403, CRS, these rules are promulgated by the Chief of the CSP for the safe transportation of nuclear materials with the following modifications:

1. The definition of person provided within 49 CFR 107.1 does not apply.

B. Licensees shipping a Highway Route Controlled Quantity of nuclear material, as defined in 49 CFR 173.403, within or through the state, and not otherwise required to comply with the provisions of 10 CFR 71.97 or 73.27, must provide advanced notification of shipment to the Governor or his designee in accordance with the requirements of 10 CFR 71.97 (c).

NMT 2

INSPECTION REQUIREMENTS

A. Shipments entering the state: All motor vehicles carrying nuclear materials and entering the state on public roads shall be inspected by officers of the CSP nearest to the point at which the shipment enters the state or at a location specified by the CSP.

B. Shipments originating within the state: All motor vehicles carrying nuclear materials shipments which originate within the state shall be inspected by the CSP at the point-of-origin.

C. Inspection procedures by the CSP shall be in accordance with the CVSA inspection procedures, decal application policies and OOS criteria, as are in effect on April 1, 2020.

D. Before being authorized to continue its journey after being involved in a crash, the motor vehicle and shipping container shall be inspected by a qualified inspector in accordance with the procedures identified in paragraph C above.

NMT 3

ANNUAL PERMIT APPLICATION AND FEES

A. All annual nuclear materials transportation permit applications and fees shall be submitted to the Colorado PUC at 1560 Broadway, Ste. 250, Denver, Colorado 80203. This application may be downloaded from DORA online at HTTPS://WWW.COLORADO.GOV/PACIFIC/DORA/HAZ-MAT.

B. The annual permit fee shall be $500 and each permit will be valid for one year from the date of issuance.

C. In addition to the annual permit fee, each carrier shall pay a $200 fee for each shipment that is transported.

1. Shipment fees shall be paid by mail and postmarked seven (7) days prior to the date the shipment is made or at the time the shipment enters the state (at the POE weigh station nearest the point at which the shipment enters the state). If a regularly scheduled shipment is to be made, the carrier may make arrangements with the PUC to pay shipment fees on a monthly basis.

2. If the shipment originates within the state, payment shall be made at the POE weigh station nearest the point of shipment origination, or mailed as provided in NMT 3 (C) (1) above.

3. Make checks payable to the "Colorado Public Utilities Commission."

D. No person shall transport nuclear materials into, within, through, or out of the state of Colorado until a permit authorizing such transportation has been issued in accordance with provisions of NMT 3.

E. Each person transporting nuclear materials within this state shall carry a copy of the shipping papers required in 49 CFR 172, Subpart C, as revised October 1, 2019 and a copy of the nuclear materials transportation permit in the motor vehicle.

F. Permit Conditions

1. Nuclear materials transporters operating within the state of Colorado are required to obtain a motor carrier identification number pursuant to the provisions of 49 CFR 390.19T prior to submission of their nuclear materials transportation permit application.

2. The PUC shall, upon review and approval of a nuclear materials transportation permit application, issue a nuclear materials transportation permit pursuant to §42-20-501, CRS.

3. A copy of the nuclear materials transportation permit shall be placed in each motor vehicle operated within or through the state of Colorado except that, if a peace officer or any other enforcement official may determine that the nuclear materials transportation permit can be electronically verified at the time of the contact, a copy of the permit need not be carried by the person transporting nuclear materials.

4. No nuclear materials transportation permit is to be altered, amended or copied unless authorized in writing by the PUC, or, in the case of a single permit, by any law enforcement official.

NMT 4

AUTHORITY TO INSPECT MOTOR VEHICLES, BOOKS AND RECORDS

A. Personnel of the CSP may at any time inspect any vehicle driver, cargo, shipping papers, nuclear materials transportation permit, and any other papers as required by law or rule to be carried when transporting nuclear materials on public roads in the state of Colorado.

B. Personnel of the CSP and the PUC may inspect any and all books and records connected with the shipment of nuclear materials by any carrier, shipper, or person who transports, ships or who causes to be transported or shipped any nuclear materials within the state of Colorado.

NMT 5

VIOLATIONS- CIVIL PENALTIES

A. Any person who violates any provision of Article 20, Title 42, Parts 4 and 5, CRS, or these rules and regulations, except for the violations enumerated in subsection (3) of §42-20-406, CRS, and of §42-20-505, CRS, shall be subject to a civil penalty of not more than 10,000 per day for each day during which the violation occurs. The penalty shall be assessed by the Chief of the CSP upon receipt of a complaint by any investigative personnel of the PUC, POE, or CSP, and after written notice and opportunity for a hearing pursuant to §24-4-105, CRS.

B. Any person who commits any of the acts enumerated in §42-20-406 (3), CRS, shall be subject to the civil penalties listed in §42-20-406 (3) (a) through (w), CRS.

C. Any person who violates any of the provisions of NMT 3 or 4 of these rules~~,~~ shall be subject to the civil penalties listed in §42-20-505, CRS.

D. Any person who violates a compliance order of the Chief of the CSP which is not subject to a stay pending judicial review and which has been issued pursuant to §42-20-208, CRS, shall be subject to a civil penalty of not more than $10,000 per day for each day during which the violation occurs.

NMT 6

CIVIL PENALTY ASSESSMENT PROCEDURES

A. All violations of statutes cited in NMT 5(A), (C), and (D) shall be investigated and summarized in a complaint filed by an authorized investigator of the PUC or the CSP. The investigation shall include, as applicable, the nature and gravity of any violations, the degree of culpability, any history of violations, and other public safety concerns.

B. Civil penalties for violations of §§42-20-406 (3), and §42-20-505 (2), CRS, shall be assessed pursuant to statute and shall appear on the complaint prior to service.

C. The complaint shall be served in person or by certified mail at the motor carrier's last known address on file at the CSP.

D. Complaints containing violations of NMT 5 (A) and §42-20-505 (1), CRS, shall provide notice of an opportunity to appear before the Chief of the CSP, or his or her designee, for the purpose of contesting the violation or for providing mitigating factors to be considered in determining the amount of civil penalty to be assessed.

1. Within 30 days of service of the complaint, the carrier shall file a written response containing:

a. A request for a formal hearing before the Chief of the CSP or his or her designee pursuant to §24-4-105, CRS;

b. A request for an informal hearing before the Chief of the CSP or his or her designee; or

c. A waiver of the right to a hearing before the Chief of the CSP or his or her designee.

2. A request for an informal hearing before the Chief of the CSP or designee shall constitute a waiver of the right to a hearing pursuant to §24-4-105, CRS.

3. Failure to timely file a written response shall constitute a default. Upon entry of a default, the Chief of the CSP or his or her designee shall assess a civil penalty against the carrier. For good cause shown, the entry of default may be set aside by the Chief of the CSP or any designee within 10 days of the default.

4. Within 30 days of receiving all relevant information, the Chief of the CSP or his or her designee shall issue a final written agency decision to include the specific violations and civil penalties assessed. The final agency decision shall be served upon the carrier in person or by first class mail at the motor carrier's last known address on file at the CSP.

NMT 7

MISCELLANEOUS REQUIREMENTS

A. Motor vehicles transporting nuclear materials shall schedule trips through all Colorado municipalities of over 50,000 in population so as to avoid rush-hour traffic.

1. For purposes of these rules, rush-hour is defined to be between 6:00 am to 9:00 am and 3:00 pm to 6:00 pm, Monday through Friday.

2. As a practical matter, this applies to the cities of Fort Collins, Denver (greater metropolitan area), Colorado Springs, and Pueblo.

3. Motor vehicles transporting nuclear materials may access the POE weigh station on Interstate 25 in Fort Collins during rush-hour periods for the purpose of being inspected as required by §42-20-404, CRS.

NMT 8

ESCORT REQUIREMENT

A. The CSP, based on security and/or emergency response concerns, may require motor vehicles transporting nuclear materials to be escorted by a CSP Hazardous Materials Team when traveling within or through the state. When it is required, the Hazardous Materials Team escort will supplement, but not replace, the escort(s) required for a shipment of irradiated reactor fuel under the provisions of 10 CFR 73.37 (b) and (c).

B. A licensee (10 CFR 2.4) will be notified that a CSP Hazardous Materials Team escort is required following receipt of the shipment notification by the Governor or Governor's designee, in accordance with the provisions of 10 CFR 73.37 (b) and (c).

NMT 9

NOTIFICATION OF INCIDENTS

A. A driver of a motor vehicle involved in a spill or potential spill of nuclear materials shall comply with the incident notification provision contained in HMT 3.

B. The driver of a motor vehicle transporting nuclear materials as cargo involved in a motor vehicle crash, regardless of whether there is damage to the transporting motor vehicle, shall immediately notify the CSP at (303) 239-4501.

PART V

NUCLEAR MATERIAL ROUTE DESIGNATION

NMR 1

ROUTES TO BE USED FOR THE TRANSPORTATION OF NUCLEAR MATERIALS

A. In order to ensure safe and environmentally acceptable transportation of nuclear materials within the state of Colorado, motor vehicles transporting nuclear materials shall travel only on those state highway segments as follows:

1. For vehicles traveling North on Interstate Highway 25 and then going East on Interstate Highway 70, the following route will be used. Vehicles following the opposite direction will use the same routing in the opposite direction:

a. On Interstate Highway 25 between the Colorado-New Mexico state line and the junction with Interstate Highway 225; then,

b. On Interstate Highway 225 between the junction with Interstate Highway 25 and the junction with Interstate Highway 70; then,

c. On Interstate Highway 70 between the junction with Interstate Highway 225 and the Colorado-Kansas state line.

2. For vehicles traveling West on Interstate Highway 70 and then going North on Interstate Highway 25, the following route will be used. Vehicles following the opposite direction will use the same routing in the opposite direction:

a. On Interstate Highway 70 between the Colorado-Kansas state line and the junction with Interstate Highway 270; then,

b. On Interstate Highway 270 between the junction with Interstate Highway 70 and the junction with Interstate Highway 25; then,

c. On Interstate Highway 25 between the junction with Interstate Highway 270 and the Colorado-Wyoming state line.

3. For vehicles traveling North on Interstate Highway 25 between the Colorado-New Mexico state line and the Colorado-Wyoming state line the following route will be used. Vehicles following the opposite direction will use the same routing in the opposite direction:

a. On Highway 25 between the Colorado-New Mexico state line and the Colorado-Wyoming state line.

4. For vehicles traveling North on Interstate Highway 25 and then going North on Interstate Highway 76, the following route will be used. Vehicles following the opposite direction will use the same routing in the opposite direction:

a. On Interstate Highway 25 between the Colorado-New Mexico state line and the junction with Interstate Highway 76; then,

b. On Interstate Highway 76 between the junction with Interstate Highway 25 and The Colorado-Nebraska state line.

B. Motor vehicles transporting nuclear materials shall under no circumstances travel on those state highway segments designated as follows:

1. On Interstate Highway 70 between the Colorado-Utah state line and the junction with U.S. 40, at milepost 361.630.

2. On Interstate Highway 70 between the junction with Interstate Highway 25 at milepost 274.039 and the junction with State Highway 2 at milepost 276.572.

C. No carrier shall deviate from the routes designated in this rule except:

1. In cases of emergency conditions making continued use of the designated route unsafe;

2. When the designated route is closed due to road conditions, road construction, or maintenance operations.

3. To make local pickups and deliveries; or

4. To refuel. When making local pickups and deliveries or when refueling, the carrier shall minimize the distance traveled on non-designated routes.

NMR 2

EMERGENCY ROAD CLOSURE

A. The closing of a public road that is designated as a nuclear materials route, or restrictions on the movement of traffic over the same due to highway construction, severe weather, or other factors must be communicated by CDOT or the effected county road and bridge office as soon as possible to the CSP Hazardous Materials Section during normal business hours at (303) 273-1900. The CSP Denver Regional Communication Center must be contacted where these events occur outside of normal business hours at (303) 239- 4501.

B. When a nuclear materials route is restricted and/or closed, the CSP will determine if a temporary alternative route should be identified.

C. The CSP will notify the appropriate local law enforcement agencies regarding any temporary closure and if an alternate route has been temporarily designated.

D. Vehicles transporting nuclear materials are required to be escorted while traveling off a designated nuclear materials route due to an emergency road closure or other condition that restricts the movement of traffic over the same. The escort will be provided by the CSP, or when previously arranged by the CSP, by the local law enforcement agency in whose jurisdiction the closure or restriction occurs.

PART VI

INTRASTATE TRANSPORTATION OF AGRICULTURAL PRODUCTS

AUTHORITY

The CSP is mandated by the provisions of §42-20-108.5, CRS, to adopt rules and regulations concerning the intrastate transportation of agricultural products in the state of Colorado.

APPLICABILITY

These rules and regulations shall apply to any person transporting an agricultural product in accordance with 49 CFR 173.5, as revised October 1, 2019.

DEFINITIONS

For purposes of this Part VI, the following definitions apply:

Agricultural Product: As defined by §42-20-108.5 (2) (a), CRS, a hazardous material, other than hazardous waste, whose end use directly supports the production of an agricultural commodity including, but not limited to, a fertilizer, pesticide, soil amendment, or fuel. An agricultural product is limited to a material in Class 3, 8, or 9, division 2.1, 2.2, 5.1, 6.1 or an ORM-D material as set forth in 49 CFR 172 and 173.

Farmer: As defined by §42-20-108.5 (2) (b), CRS, a person or such person's agent or contractor engaged in the production or raising of crops, poultry, or livestock.

EXEMPTIONS FROM THE FEDERAL RULES IN 49 CFR 173.5

The Chief of the CSP hereby adopts by rule and regulation the exemption provisions authorized in the federal regulations, 49 CFR 173.5, and authorized by §42-20-108.5, CRS.

PUBLICATIONS AND RULES INCORPORATED BY REFERENCE

A. All publications, standards, guidelines, and rules adopted and incorporated by reference in these rules are on file and available upon request for public inspection by contacting the CSP, Hazardous Materials Section, 15065 S. Golden Rd., Golden, CO 80401-3990.

1. All publications, standards, guidelines, and rules adopted and incorporated by reference in these rules will be provided to and made available for examination at any state publications depository library as required by §24-4-103 (12.5), CRS. The following publications, standards, guidelines and rules are adopted as amended within these rules in accordance with §24-4-103 (12.5), CRS:

a. Commercial Vehicle Safety Alliance (2020). North American Standard Out-of-Service Criteria (OOSC). April 1, 2020. Greenbelt, MD: Author.

b. Federal Motor Carrier Safety Regulations, 49 CFR §§ 40, 380, 382, 385, 387, 390-397, 399, and Appendix G (2019). This information is also available online through the government publishing office website at: HTTPS://WWW.ECFR.GOV/CGI-BIN/ECFR?PAGE=BROWSE

c. Pipeline and Hazardous Materials Safety Regulations, 49 CFR §§107, 171-173, 177-178, AND 180 (2019). This information is also available online through the Government Publishing Office website at: HTTPS://WWW.ECFR.GOV/CGI-BIN/ECFR?PAGE=BROWSE

d. Nuclear Regulatory Commission Regulations, 10 CFR §§71.97, 73.27, AND 73.37 (2019). This information is also available online through the Government Publishing Office website at: HTTPS://WWW.ECFR.GOV/CGI-BIN/ECFR?PAGE=BROWSE

e. US Department of Transportation Pipeline and Hazardous Materials Safety Administration. 2020 Emergency Response Guidebook. Washington, DC: Author.

2. The CSP Hazardous Materials Section shall maintain copies of the complete texts of each of the aforementioned publications, standards, guidelines and rules and will make them available for public inspection during regular business hours. Interested parties may access these documents free of charge online. Interested parties may also inspect the referenced incorporated materials and/or obtain copies for the adopted standards for a reasonable fee by contacting the CSP Hazardous Materials Section at 15065 S. Golden Rd, Golden, CO., 80401. Copies of the adopted publications, standards, guidelines and rules may also be available from the organizations of original issue:

a. 2020 CVSA Out-Of-Service Inspection Criteria: Commercial Vehicle Safety Alliance (CVSA), 6303 Ivy Lane, Suite 310, Greenbelt, Maryland 20770-6319. Phone: 301-830-6143. Email: CVSAHQ@CVSA.ORG.

b. Federal Motor Carrier Safety Administration (FMCSA), US Department of Transportation, 1200 New Jersey Ave., SE Room W-65-206, Washington, DC, 20590. Phone: 1-800-832-5660. Website: WWW.FMCSA.DOT.GOV.

c. Pipeline and Hazardous Materials Safety Administration, US Department of Transportation, 1200 New Jersey Ave., SE, Washington, DC, 20590. Phone: 202-366-4433. Website: WWW.PHMSA.DOT.GOV.

d. U.S. Nuclear Regulatory Commission, Washington, DC, 20555-001. Phone: 1-800368-5642 OR 301-415-7000. Website: WWW.NRC.GOV.

e. 2020 Emergency Response Guidebook: Hazardous Materials Training Program, U.S. Department of Transportation, Pipeline and Hazardous Materials Safety Administration, 1200 New Jersey Ave., SE, Washington, DC, 20590. Phone: 202-366-4900. Website: WWW.PHMSA.DOT.GOV.

B. These rules do not include later amendments to or editions of any publications, standards, guidelines or rules incorporated by reference herein.

C. These rules are available online through the CSP hazardous material section webpage accessible through the CDPS website at HTTPS://WWW.COLORADO.GOV/PACIFIC/CSP/HAZARDOUS-MATERIALS. All contact with the CSP regarding these rules or their applicability should be addressed to:

Colorado State Patrol

Hazardous Materials Section

15065 S. Golden RD.

Golden, CO. 80401

303-273-1900

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Office of the Attorney General

Tracking number: 2019-00767

Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado State Patrol

on 02/05/2020

8 CCR 1507-25

THE PERMITTING, ROUTING AND TRANSPORTATION OF HAZARDOUS AND NUCLEAR MATERIALS AND THE INTRASTATE TRANSPORTATION OF AGRICULTURAL PRODUCTS IN THE STATE OF COLORADO

The above-referenced rules were submitted to this office on 02/07/2020 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.

February 25, 2020 11:51:35

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Public Safety

Agency

Colorado State Patrol

CCR number

8 CCR 1507-28

Rule title

8 CCR 1507-28 PORT OF ENTRY RULES FOR COMMERCIAL MOTOR CARRIER SIZE, WEIGHT AND CLEARANCE 1 - eff 04/01/2020

Effective date

04/01/2020

DEPARTMENT OF PUBLIC SAFETY
DIVISION OF STATE PATROL

PORT OF ENTRY RULES FOR COMMERCIAL MOTOR CARRIER SIZE, WEIGHT AND CLEARANCE

STATEMENT OF BASIS, STATUTORY AUTHORITY, AND PURPOSE

Pursuant to §42-8-104(1), CRS, the Chief of the Colorado State Patrol has authority to promulgate rules necessary to implement the enforcement of applicable statutes and regulations concerning commercial motor carriers, owners and operators through the operation of Port of Entry weigh stations on public highways within the state of Colorado.

Amendments are being proposed to 8 Colorado Code of Regulations 1507-28 to ensure compliance and consistency with state law and federal regulations. The amendments here proposed to these rules by the Colorado State Patrol Port of Entry Branch clarify wheel and axle weight information as it relates to specified single drive axle vehicles; update references to maximum height allowances for all vehicles; update provisions relevant to the Special Revocable Permit Program regarding the processing of applications; and edit existing email and physical address information. Also addressed is any minor grammar or formatting items existing in the present rule.

It has been declared by the General Assembly that the safe operation of commercial vehicles is a matter of statewide concern. It has also been declared, by the General Assembly, that ensuring compliance with state law and ensuring the equal distribution of fee payments, licenses, and taxes on motor carriers and the owners and operators of motor vehicles is an important state interest. The non-implementation of rules to carry out the purpose of the statutes would be contrary to the public health, peace, safety and welfare of the state. For these reasons, it is necessary that these proposed amendments be adopted.

_____ _____

Colonel Matthew C. Packard, Chief Date of Adoption
Colorado State Patrol

DEPARTMENT OF PUBLIC SAFETY
COLORADO STATE PATROL- PORT OF ENTRY

PORT OF ENTRY RULES FOR COMMERCIAL MOTOR CARRIER SIZE, WEIGHT AND CLEARANCE

I. AUTHORITY TO ADOPT STANDARDS AND SPECIFICATIONS

A. The Chief of the Colorado State Patrol (CSP) is authorized by the provisions of §42-8-104 (1), CRS, to adopt rules and regulations deemed necessary to enforce applicable statutes and regulations regarding commercial motor carriers, owners and operators through the operation of Port of Entry (POE) weigh stations on public highways within the state of Colorado.

II. GENERAL DEFINITIONS

A. With respect to these rules, the following definitions are applicable unless otherwise specified:

1. **AFFECTED POE:** A permanent weigh station that is identified within a Special Revocable Permit (SRP). An SRP may affect more than one POE weigh station.

2. **ALTERNATIVE FUEL**: Includes Compressed Natural Gas (CNG), propane, ethanol, or any mixture of ethanol containing 85% or more ethanol by volume with gasoline, electricity or other fuels, including clean diesel and reformulated gasoline so long as these other fuels make comparable reductions in carbon monoxide emissions and brown cloud pollutants as determined by the air quality control commission.

3. **APPURTENANCE:** A non-cargo bearing piece of equipment that is affixed or attached to a motor vehicle or trailer and is used for a specific purpose or task. Includes awnings, support hardware and extractable equipment. Does not include any item or equipment that is temporarily affixed or attached to the exterior of a motor vehicle for the purpose of transporting such vehicle.

4. **CARGO:** The goods carried as freight by a commercial vehicle.

5. **COOPR:** The CDOT Colorado Oversize/Overweight Permitting and Routing System.

6. **HIGH-RISK MOTOR CARRIER:** A non-passenger carrier that:

   a. Has a ranking at or above the 90th percentile in the unsafe driving, hours of service (HOS) compliance, vehicle maintenance, or crash indicator, behavior analysis safety improvement categories (collectively referred to as "BASICs") for two or more consecutive months as reported by information received by the Federal Motor Carrier Safety Administration (FMCSA); and

   b. Has not received an onsite investigation in the previous 18 months for property-carrying motor carriers or in the previous 12 months for passenger-carrying motor carriers.

7. **OVER-THE-ROAD BUS:** A bus characterized by an elevated passenger deck located over a baggage compartment and typically operated on the interstate highway system or on roads previously designated as making up the federal-aid primary system.

8. **PERMIT HOLDER:** A carrier, owner or operator to whom a permit is issued is a permit holder. Permit holders are responsible for any violations received by vehicle operators who operate vehicles affected by a permit on behalf of the permit holder.

9. **PORT OF ENTRY (POE) OFFICER:** A law enforcement officer and a uniformed member of the CSP who is not a trooper nor a civilian member. The scope of authority and the duties of a POE officer are described within §42-8-104 (2), CRS.

10. **PROBATIONARY SPECIAL REVOCABLE PERMIT:** An SRP that may be issued for a period of 12 months or less to a carrier, owner or operator who is:

    a. Determined eligible, but unsatisfactory following review of their application, and violation, safety and/or port clearance records; or

    b. An SRP permit holder applying for a new SRP following the revocation of a prior SRP.

11. **REGULARLY SCHEDULED ROUTE:** A route provided to the CSP POE by an applicant for an SRP. Factors considered in whether the route traveled by an SRP applicant is regular include times or places of repeated normal departure, arrival,

delivery, and/or loading activity. To be eligible for an SRP, a regularly scheduled route provided by an applicant to the CSP POE must come within five (5) road miles of a permanent weigh station.

12. **SINGLE AXLE:** All wheels, whose centers may be included within two (2)-parallel transverse vertical planes not more than 40 inches apart, extending across the full width of the vehicle.

13. **SINGLE AXLE WEIGHT:** The total weight transmitted to the road by all wheels whose centers may be included between two (2) parallel transverse vertical planes not more than 40 inches apart, extending across the full width of the vehicle.

14. **SPECIAL REVOCABLE PERMIT (SRP):** A permit that a carrier, owner or operator may apply for pursuant to §42-8-105 (4), CRS. An SRP waives the requirement of §42-8-105 (1), CRS, for a period of 36 months or less to seek and obtain clearance at a POE station that is not directly located on a carrier or operator's regularly scheduled route. Eligibility for an SRP is based, in part, on the applicant's or permit holder's safety record and "BASICs" scores reported by the Federal Motor Carrier Safety Administration (FMCSA).

15. **SPECIALIZED AUTOMOBILE TRANSPORTER:** A vehicle combination designed and used specifically for the transport of assembled highway vehicles, including truck camper units. The Specialized Automobile Transporter will be designed to carry vehicles on the power unit behind the cab or on an over-cab rack.

16. **TANDEM AXLE:** Two or more consecutive axles, the centers of which may be included between parallel vertical planes, spaced more than 40 inches and not more than 96 inches apart, extending across the full width of the vehicle, all of which are in contact with the ground.

    a. If only one of a set of multiple axles is in contact with the ground, the configuration is not a tandem axle until it is actually used as such.

17. **TANDEM AXLE WEIGHT:** The total weight transmitted to the road by two (2) or more consecutive axles whose centers may be included between parallel transverse vertical planes spaced more than 40 inches and not more than 96 inches apart, extending across the full width of the vehicle.

III. PORT OF ENTRY OPERATIONS AND AUTHORITY

A. DELEGATION OF AUTHORITY

Delegation of any authority held by the Director of the CSP POE Branch relevant to POE Operations will occur in conformity with CSP policies.

B. PERMANENT AND MOBILE POE OPERATIONS

1. The Chief of the CSP shall authorize the establishment and operation of permanent POE weigh stations.

a. Permanent POE weigh stations shall be established and operated at such points along public highways of this state as are determined necessary.

b. The location or relocation of permanent weigh stations shall be determined by the Chief of the CSP.

c. All permanent POE weigh stations shall be operated at times determined by the Chief of the CSP so as to reasonably allow owners and operators of motor vehicles subject to fees, licenses, taxes, or to rules imposed by the state of Colorado, to comply with all such laws and rules by clearance at a POE weigh station.

2. The Chief of the CSP shall authorize the establishment and operation of mobile POE weigh stations.

a. Mobile POE weigh stations shall be established and operated at such points along public highways of this state as are determined necessary.

i. Mobile POE weigh stations will post signs giving notice of their operations. This notice shall inform owners and operators of vehicles required to stop and obtain clearance of their need to clear the mobile weigh station.

b. Mobile POE weigh stations have the same duties and authority as permanent POE weigh stations.

C. AUTHORITY OF POE OFFICERS

1. PEACE OFFICERS

A POE officer, during the time that he or she is actually engaged in performing his or her duties and while acting under proper orders or rules issued by the Chief of the CSP, shall have and exercise all powers invested in peace officers in connection with the enforcement of §42-8-101, et al., CRS; Articles 2, 3, and 20 of Title 42, CRS; §42-4-501, et al., CRS; §42-4-209, CRS; §42-4-225 (1.5), CRS; §42-4-235, CRS; §42-4-1407, CRS; §42-4-1409, CRS; and §42-4-1414, CRS.

2. DETENTION OF OPERATORS, VEHICLES AND VEHICLE IMPOUND

Within the scope of their authority, POE officers may restrain or detain persons and/or vehicles, impound vehicles or collect outstanding taxes on behalf of the state of Colorado.

a. POE officers may also restrain or detain persons and/or vehicles, impound vehicles or collect outstanding taxes pursuant to a lawful request from any other law enforcement agency recognized by this state.

i. An agency requesting detention must provide sufficient verifiable information that can be reliably used to identify the person or vehicle to be restrained, detained or impounded, in addition to providing a reasonable basis by rule of law for the detention, restraint or impoundment.

ii. Information supplied by a requesting agency for the detention or impoundment of any person or vehicle may be communicated verbally or in writing and must include:

1. The name of the agency requesting the detention or impoundment;

2. The name of the agency official requesting the detention or impoundment;

3. The rule of law that is being violated or suspected of being violated; and

4. The maximum time that a vehicle or operator is to be detained.

b. Motor vehicles detained or impounded by POE officers at the request of the Department of Revenue (DOR) may be released promptly upon:

i. Payment of taxes and fees due;

ii. Making a deposit sufficient to pay the same in full, after proper computations and adjustments have been made; or

iii. Request of DOR.

c. The cargo of any impounded vehicle may be transferred to any properly licensed and qualified motor vehicle and permitted to proceed.

IV. REGULATIONS

A. POE CLEARANCE

1. DUTY TO STOP AND WEIGH

a. Owners or operators of motor vehicles required to obtain clearance from the CSP POE pursuant to §42-8-105 (1), CRS, include:

i. Owners or operators of motor vehicles that are subject to payment of registration fees pursuant to §42-3-306 (5) (b), CRS;

ii. Owners or operators of motor vehicles displaying apportioned or GVW license plates; or

iii. Owners or operators of motor vehicles or motor vehicle combinations having a Gross Vehicle Weight Rating (GVWR) or Gross Combined Weight Rating (GCWR) in excess of 26,000 pounds.

b. Owners or operators of motor vehicles may obtain required clearance by:

i. Securing a valid clearance from a CSP officer or POE weigh station before operating or causing the operation of the vehicle or combination of vehicles on the public highways of this state; or

ii. Obtaining clearance from the first POE weigh station located within five (5) road miles of the route that the owner or operator would normally follow from their point of departure to the point of destination if a previous clearance or SRP has not been secured. To be valid, clearance must occur prior to arriving at the point of destination and before removing the load from the motor vehicle.

1. The route which a reasonable commercial vehicle owner or operator would take from the same points of departure and destination is considered to be the "route that an owner or operator would normally follow."

2. Any owner or operator is in violation of §42-8-105, CRS, if they fail to seek out a permanent POE weigh station that is located within five (5) road miles of the route that the owner or operator would normally follow.

c. Every owner or operator of a motor vehicle required to obtain clearance must stop at every POE weigh station located within five (5) road miles of their route of travel.

i. Vehicles with a seating capacity of 14 or more passengers registered under the requirements of §§42-3-304 (13) or 42-3-306 (2) (c) (I), CRS, are not required to secure a valid clearance.

B. VEHICLE WEIGHT REQUIREMENTS

1. WHEEL AND AXLE LOADS

a. Vehicles having a single drive-axle configuration and equipped with pneumatic tires are not subject to the axle weight limitations set forth within §42-4-507 (2) (b), CRS, and may operate in excess of 20,000 pounds axle weight when:

i. The single drive-axle vehicle is equipped with a self-compactor; and

ii. Is used solely for the transporting of trash.

iii. Vehicles equipped with, but not using a tandem drive-axle configuration, will not be permitted to operate in excess of an axle weight of 20,000 pounds and must comply with the axle weight limitations set forth within §42-4-507 (2) (B), CRS.

2. AUXILIARY POWER UNITS (APU) AND IDLE REDUCTION TECHNOLOGY UNITS

a. Any vehicle that uses an APU or idle reduction technology unit in order to reduce fuel use and emissions resulting from engine idling shall have the actual weight of the APU or idle reduction technology unit exempted from the calculation of the actual axle and Gross Vehicle Weight (GVW), up to 550 pounds. To be eligible for this weight exemption, the operator of the vehicle must provide:

i. Written certification of the actual weight of the APU or idle reduction technology unit; and

ii. Written certification or demonstration that confirms the idle reduction technology unit is fully functional at all times.

3. BUSES

a. Any over-the-road bus, or any vehicle which is regularly and exclusively used as an intrastate public agency transit passenger bus, is exempted from compliance with the axle limits set forth within §42-4-507 (2) (b), CRS.

C. GROSS VEHICLE WEIGHT (GVW)

1. DETERMINATION OF GVW

a. The legal GVW or Gross Combined Weight (GCW) limit for any vehicle or combination of vehicles specified within §42-4-508 (1), CRS, shall be determined by the actual number of axles in contact with the road surface and the applicable Bridge Weight Formula.

i. Except where otherwise provided by §§42-4-508 or 42-4-510, CRS, vehicles or vehicle combinations operating on any highway or bridge that is part of the national system of interstate and defense highways (otherwise known as the interstate highway system) must:

1. Have their total weight distributed so that no axle exceeds the legal axle weight limit for the highway traveled;

2. Comply with the federal bridge formula set forth within §42-4-508 (1) (c), CRS; and

3. Not exceed a maximum of 80,000 pounds in the calculation of the federal bridge formula.

a. Natural gas alternative fuel system vehicles may operate up to a Gross Vehicle Weight of 82,000 lbs.

i. The allowable weight for a natural gas alternative fuel system vehicle is increased by an amount equal to the difference between the weight attributable to the vehicle's natural gas tank and fueling system and the weight of a comparable diesel tank and fueling system, up to a maximum Gross Vehicle Weight of 82,000 lbs.

b. Alternative fuel vehicles not operating natural gas systems may operate up to a maximum Gross Vehicle Weight of 80,000 lbs.

ii. Except where otherwise provided by §§42-4-508 or 42-4-510, CRS, vehicles or vehicle combinations operating on any highway other than a highway identified as part of the interstate highway system must:

1. Have their total weight distributed so that no axle exceeds the legal axle weight limit for the highway traveled;

2. Comply with the state bridge formula set forth within §42-4-508 (1) (b), CRS; and

3. Not exceed a maximum of 85,000 pounds in the calculation of the state bridge formula.

D. VEHICLE WIDTH

1. MEASUREMENT OF COMMERCIAL MOTOR VEHICLE WIDTH

a. Vehicle width will be measured from the point farthest from the center of the motor vehicle or combination of motor vehicles on each side.

b. Vehicle components not excluded by law or regulation shall be included in the measurement of commercial motor vehicle width. Components that are excluded from the measured width of a commercial motor vehicle include but shall not be limited to:

i. Rear view mirrors, turn signal lamps, handholds for cab entry/egress, splash and spray suppressant devices, load induced tire bulge; and

ii. All non-property carrying devices, or components thereof, that do not extend more than three (3) inches beyond each side of the vehicle.

E. VEHICLE LENGTH

1. MEASUREMENT OF COMMERCIAL MOTOR VEHICLE LENGTH

a. Vehicle length is generally measured from the front-most fixed point (generally the front bumper) to the rear-most fixed point (generally where the brake lights are located).

i. Any permanently mounted appurtenance that extends beyond the front or rear of the vehicle to which it is mounted becomes part of the vehicle. A permanently mounted appurtenance is included in the overall measurement of vehicle length.

b. Vehicle components not excluded by law or regulation shall be included in the measurement of the length of commercial motor vehicles. Components that are excluded from the measured length of a commercial motor vehicle include but shall not be limited to:

i. Rear view mirrors, turn signal lamps, handholds for entry/egress, splash and spray suppressant devices;

ii. All non-property-carrying devices, or components thereof that do not exceed 24 inches beyond the rear of the vehicle as stated within 23 CFR 658.16;

iii. Resilient bumpers that do not extend more than six (6) inches beyond the front or rear of the vehicle;

iv. Lamps or flags on projecting loads pursuant to §42-4-209, CRS, or devices exempted from length are not considered a projection or overhang.

2. LENGTH MEASUREMENT OF SPECIALIZED AUTOMOBILE TRANSPORTERS

a. The overall length measurement of a specialized automobile transporter is calculated exclusive of:

i. Front and rear cargo overhang;

ii. Safety devices not designed or used for carrying cargo; or

iii. Any extension device (ramp or “flippers”) that may be used for loading beyond the extreme front or rear end of a vehicle or combination of vehicles.

1. Extendable ramps "or flippers" on specialized automobile transporters that have not been retracted and are not supporting vehicles will be included in the measurement of vehicle length.

3. MEASUREMENT OF TRAILERS

a. TRAILER DRAWBAR OR TONGUE LENGTH

i. Where the drawbar or tongue is of rigid construction, the measurement will be taken from the rear-most point of the power unit's cargo box to the front-most point of the trailer's mainframe.

ii. Where the drawbar is hinged, the measurement will be taken from the rear-most of the power unit's cargo box to the front-most point of the hinge.

iii. A tool or accessory box that is welded or attached to the drawbar or tongue is not included in the calculation of the drawbar or tongue length of a trailer.

iv. A drawbar may not exceed 15 feet between two (2) vehicle units except when:

1. The connection is between any two (2) vehicles transporting poles, pipe, machinery or other objects of a structural nature which cannot be readily dismembered; or

2. Connections between vehicles where the connection is of rigid construction, is included as part of the structural design of the towed vehicle, and the overall combined length of the vehicles and the connection does not exceed 55 feet.

a. Adjustable pole trailers that are primarily designed for the transportation of cargo must have the connection between vehicles reduced to 15 feet or less when operating without cargo if the overall vehicle combination exceeds 55 feet.

F. VEHICLE HEIGHT

1. Maximum height limits shall be designated by the Colorado Department of Transportation.

2. Vehicles, laden or unladen, shall not exceed a height of 14 feet six inches and must be operated in compliance with §42-4-504 (1), CRS.

V. PERMITS

A. SPECIAL REVOCABLE PERMITS (SRP)

1. AUTHORITY TO ISSUE AND LEGAL EFFECT OF AN SRP

An SRP may be issued to an owner or operator of any vehicle being operated over a regularly scheduled route within five (5) road miles of a permanent POE weigh station pursuant to §42-8-105 (1), CRS.

a. An SRP waives the requirement that an owner or operator seek out and secure a valid clearance at a permanent POE that is located within five (5) road miles of an identified regularly scheduled route.

b. The use or issuance of any SRP is contingent upon an applicant's or permit holder's compliance with any applicable rules, laws (federal, state, county and local) and the requirements set forth within Part V (A) of these rules.

2. APPLICATION FOR SRP

Application for an SRP is made by completing and submitting an application to the CSP POE.

a. SRP applications are provided by the CSP POE upon request, online and may also be submitted to the CSP POE online through the COOPR website.

b. The CSP POE shall collect any information identified as necessary to determine an applicant's eligibility for an SRP. Information necessary to determine an applicant's eligibility includes:

i. The legal name of the applicant and the name under which the applicant conducts business, if applicable;

ii. The physical and mailing addresses of the applicant;

iii. The USDOT# assigned and used by the applicant;

iv. The number of vehicles proposed to be subject to the SRP if it is issued and the VINs for each vehicle;

v. The POE weigh station~~s~~ location(s) the applicant would like the SRP to affect;

vi. The name~~s~~ and signature of the person submitting the SRP application on behalf of the applicant; and

vii. A detailed description of the applicant's regularly scheduled route. This description should, at minimum, identify the points of origin and destination(s) for the route.

viii. If the information initially provided by the applicant is insufficient, additional information will be requested.

3. SRP APPROVAL

When an application for an SRP is approved, the SRP shall be issued by the CSP POE upon the recommendation and with the approval of the POE Director or designee.

a. Within its discretion, the CSP POE reserves the right to attach special conditions to the issuance of any SRP where the CSP POE determines that it is necessary or advisable to include specific conditions beyond those required of a permit holder to maintain the SRP.

b. Any SRP issued to an applicant/permit holder must be:

i. Carried at all times in any authorized vehicle when being operated over the approved regularly scheduled route; and

ii. Available upon demand for inspection by the CSP POE or any other state or law enforcement officer.

iii. Electronic copies of the permit are acceptable.

c. An SRP issued to an eligible SRP applicant by the CSP POE may be valid up to 36 months, except where an otherwise eligible applicant is determined unsatisfactory following a review of their violation, safety and/or port clearance records.

i. Eligibility for an SRP is based in part on the applicant's safety record and "BASICs" reported by the FMCSA.

ii. The number and type of violation convictions received by drivers operating vehicles for the applicant within the state of Colorado is considered when determining applicant eligibility.

iii. The number of port clearances during the 12-month period prior to the SRP application date is relevant in determining eligibility.

iv. The permit holder's compliance with the conditions of any previously issued SRP will factor in the decision to issue any subsequent SRP to the applicant.

d. An SRP applicant determined to be an unsatisfactory applicant may be eligible for a Probationary SRP where:

i. The applicant does not meet the definition of a "High-Risk Motor Carrier"; or

ii. The applicant meets the definition of "High-Risk Motor Carrier" but the applicant's carrier snapshot confirms a conditional or satisfactory rating for the applicant.

e. An SRP applicant who is issued a Probationary SRP:

i. Must demonstrate that corrective actions are being made to continue to be eligible for an SRP.

ii. May apply for an SRP at the conclusion of the Probationary SRP period.

1. The permit holder's compliance with the conditions of the Probationary SRP will factor in the decision to issue any subsequent SRP to the applicant.

2. An SRP applicant applying for an SRP following the revocation of their prior SRP will first be eligible to apply for a Probationary SRP.

f. An SRP:

i. Is not transferrable from company to company or between vehicles without prior approval of CSP POE;

ii. Does not affect the right of any lawful authority to stop a vehicle to check for:

1. Operating credentials;

2. Applicable oversize or overweight violations; or

3. Violations of other motor vehicle laws.

iii. Is valid only when used by an authorized vehicle operating within the scope of the approved regularly scheduled route.

g. The CSP POE will respond to all complete SRP applications with a decision to either issue or deny an SRP within 7 calendar days of receipt.

4. DENIAL OF SRP

An application for an SRP may be denied if:

a. The applicant has failed to pay taxes or registration fees when due;

b. The applicant is subject to the payment of recurrent distraint penalties as set forth within §39-21-114 (7), CRS;

c. In the 12 month period prior to the SRP application date, any vehicle operator of the applicant demonstrates a pattern of non-compliance with the duty to stop and weigh or the duty to obtain clearance imposed by §§42-4-509 (3) and 42-8-105, CRS, respectively;

d. In the 12 month period prior to the SRP application date, any vehicle operator of the applicant has been convicted of three (3) or more violations of size and weight requirements set forth within §42-4-501, et seq., CRS;

e. The applicant meets the definition of a "High-Risk Motor Carrier" and the company snapshot does not have a carrier rating or has a rating of "unsatisfactory";

f. In the 12-month period prior to the SRP application date, violation convictions received by any vehicle operator of an applicant demonstrates a pattern of non-compliance with applicable laws;

g. Following suspension or revocation of an SRP, vehicle operators of an applicant continue to violate the laws that resulted in the suspension or revocation of the SRP;

h. The applicant has misused, or used in a fraudulent manner, or has otherwise failed to comply with the conditions of any previously issued valid permit or license;

i. The application for the SRP misrepresents or provides inaccurate information regarding the regularly scheduled route; or

j. A request for additional information deemed necessary to consider the eligibility of an SRP applicant by the CSP POE is not responded to within 30 calendar days.

i. An applicant whose SRP application is denied due to the applicant's failure to respond to a request from CSP POE to provide additional information may resubmit their application without prejudice.

ii. The CSP POE will have 7 calendar days to respond to the resubmitted SRP application.

5. PERMIT SUSPENSION AND REVOCATION

a. A permit holder's SRP(s) may be suspended when:

i. A permit holder fails to pay taxes or registration fees when due;

ii. A permit holder is subject to the payment of recurrent distraint penalties as described within §39-21-114 (7), CRS;

iii. A permit holder used the permit for the purposes of evading any law;

iv. In a 12 month period during which an SRP has been issued, any vehicle operator of a permit holder has been convicted of three (3) or more violations in a vehicle assigned an SRP of the size and weight requirements of §42-4-501, et seq., CRS;

v. In a 12 month period during which an SRP has been issued, any vehicle operator of a permit holder demonstrates a pattern of non-compliance with either the duties to stop and weigh or obtain clearance as set forth within §§ 42-4-509 (3) and 42-8-105, CRS, respectively;

vi. In a 12-month period during which an SRP has been issued, violation convictions received by any vehicle operator for a permit holder demonstrates a pattern of non-compliance with applicable laws;

vii. Any authorized vehicle utilizing an SRP does not obtain port clearance from the affected POE weight station(s) at least once per quarter during the period the SRP is valid;

1. The quarterly clearance requirement cannot be satisfied using Prepass, Drivewyze, or any other electronic clearance program.

viii. The approved regularly scheduled route for which an SRP is issued to a permit holder is altered or discontinued;

ix. A permit holder is identified as a "High-Risk Motor Carrier" and their company snapshot does not have a carrier rating or reports an "unsatisfactory" carrier rating;

x. A permit holder violates any conditions applicable to an SRP; or

xi. The permit holder misuses any permit or license.

b. A Permit holder's SRP(s) may be revoked when:

i. A permit holder who has been subject to SRP suspension continues to demonstrate a pattern of non-compliance with applicable laws and rules;

ii. A permit holder fails to comply with the terms of any Probationary SRP; and/or

iii. A permit holder fails to take any steps as may be directed by the CSP POE to improve or achieve compliance within a prescribed time period.

6. APPEAL OF SRP APPLICATION DENIAL, SRP SUSPENSION OR SRP REVOCATION

a. WRITTEN NOTICE

Denial, suspension or revocation of any SRP will be by written notice from the CSP POE.

b. RIGHT TO APPEAL AND REQUEST A HEARING

Within 30 days of receiving written notice from the CSP POE denying, suspending or revoking an SRP, an applicant or permit holder may request a hearing.

i. Hearing requests by applicants or permit holders must be:

1. Made in writing; and

2. Addressed to the Chief of the CSP or his or her designee at the CSP POE Branch at 15075 S. Golden Rd., Golden CO, 80401.

c. HEARING AND REVIEW

The Chief of the CSP or his or her delegate will hold the hearing.

i. The scope of the hearing will be limited to whether the applicant or permit holder has complied with these rules.

ii. The Chief of the CSP or his or her delegate will issue a written decision within 20 business days of the completed hearing.

1. If the Chief of the CSP or his or her delegate finds that evidence of non-compliance and ineligibility is sufficient, the SRP application denial, suspension or revocation will be sustained.

2. If the Chief of the CSP or his or her delegate finds that evidence of non-compliance and ineligibility is not sufficient, the SRP application denial, suspension or revocation will be immediately overturned and the SRP or previous SRP(s) will be issued or reinstated.

3. If the Chief of the CSP or his or her delegate finds that evidence of non-compliance and ineligibility is not sufficient to support application denial,

permit suspension or revocation but is sufficient to find an SRP applicant or permit holder to be unsatisfactory, it is within the discretion of the Chief of the CSP or his or her delegate to issue or reinstate any SRP as a Probationary SRP for a period not to exceed one (1) year.

iii. The decision by the Chief of the CSP or his or her delegate shall constitute a final agency action and is subject to judicial review as described by §24-4-106, CRS.

VI. MISCELLANEOUS

A. All contact with the CSP POE with regard to these rules or their applicability should be addressed to:

Colorado State Patrol

Port of Entry Branch

15075 S Golden Rd

Golden, CO 80401

303-273-1870 (Main Phone)

303-278**-**2434 (Fax)

B. All publications, standards or guidelines adopted and incorporated by reference in these rules are on file and available upon request for public inspection by contacting the CSP POE Branch at 15075 S. Golden Rd., Golden, CO., 80401-3990. These rules are available online through the "Size, Weight and Permit Information" tab on the CSP Motor Carrier Safety Webpage accessible through the CDPS website at HTTPS://WWW.COLORADO.GOV/

PACIFIC/CSP/MCSAP.

1. All publications, standards, guidelines, and rules adopted and incorporated by reference in these rules will be provided and made available for examination at any state publication depository library as required by §24-4-103 (12.5), CRS. The following publications, standards, and guidelines have been referenced within these rules in accordance with §24-4-103 (12.5), CRS:

a. United States Department of Transportation, Federal Motor Carrier Safety Administration (2018). High Risk Carriers Investigations Report. Status of High-Risk Carrier Investigations. Retrieved January 9, 2019 from HTTPS://WWW.FMCSA.DOT.GOV/MISSION/POLICY/HIGH-RISK-CARRIERS-INVESTIGATION-REPORT.

2. The CSP POE Branch shall maintain copies of the complete texts of the aforementioned publications, standards, guidelines, and rules and will make them available for public inspection during regular business hours. Interested parties may access these documents free of charge online. Interested parties may also inspect the referenced materials and/or obtain copies of the adopted standards for a reasonable fee by contacting the CSP POE Branch at 15075 S. Golden Rd., Golden, CO., 80401. Copies of the adopted publications, standards, guidelines and rules may also be available from the organization of original issue:

a. United States Department of Transportation, Federal Motor Carrier Safety Administration, (FMCSA), 1200 New Jersey Ave., SE Room W-65-206, Washington, DC, 20590. Phone: 1-800-832-5660. Website: WWW.FMCSA.DOT.GOV.

C. These rules do not include later amendments to or editions of any publications, standards, guidelines or rules incorporated by reference herein.

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
1300 Broadway, 10th Floor
Denver, Colorado 80203
Phone (720) 508-6000

Office of the Attorney General

Tracking number: 2019-00768

Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado State Patrol

on 02/05/2020

8 CCR 1507-28

PORT OF ENTRY RULES FOR COMMERCIAL MOTOR CARRIER SIZE, WEIGHT AND CLEARANCE

The above-referenced rules were submitted to this office on 02/07/2020 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.

February 25, 2020 11:53:21

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Revenue

Agency

Marijuana Enforcement Division

CCR number

1 CCR 212-3

Rule title

1 CCR 212-3 COLORADO MARIJUANA RULES 1 - eff 02/07/2020

Effective date

02/07/2020

DEPARTMENT OF REVENUE
MARIJUANA ENFORCEMENT DIVISION
COLORADO MARIJUANA RULES
1 CCR 212-3

Part 2 – Applications and Licenses

2-200 Series – Applications and Licenses Rules

Basis and Purpose – 2-205

The statutory basis for this rule includes but is not limited to sections 44-10-103, 44-10-202(1)(b), 44-10-202(1)(c), 44-10-202(1)(e), 44-10-203(1)(j), 44-10-203(1)(i), 44-10-203(2)(b), 44-10-203(2)(h), 44-10-203(2)(q), 44-10-203(2)(w), 44-10-203(2)(dd)(XII), 44-10-303(2)(b), 44-10-310(7), 44-10-313, 44-10-401, 44-10-801, 44-10-802, 44-10-803, 44-10-1201, 44-10-1202, C.R.S. Authority also exists in the Colorado Constitution at Article XVIII, Subsection 16(5)(a)(II). The purpose of this rule is to establish fees required for applications, renewals, licenses fees, permits, and other fees required to accompany applications and submissions to the Division. The Division anticipates evaluating all fees in connection with a fee analysis. Any recommendations from the fee analysis will be considered during subsequent rulemaking proceedings. This Rule 2-205 was previously Rules M 207, 208, 209, 210, 235, and 236, 1 CCR 212-1, and Rules R 207, 208, 209, 210, 234, and 235, 1 CCR 212-2.

2-205 – Fees

A. Regulated Marijuana Business Initial Application and License Fees.

1. Medical Marijuana Businesses.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Medical Marijuana Store	$5,000.00	$2,000.00	$7,000.00
Medical Marijuana Products Manufacturer	$1,000.00	$1,500.00	$2,500.00
Medical Marijuana Cultivation Facility Class 1 (1-500 plants)	$1,000.00	$1,500.00	$2,500.00
Medical Marijuana Testing Facility	$1,000.00	$1,500.00	$2,500.00
Medical Marijuana Transporter	$1,000.00	$4,400.00	$5,400.00
Medical Marijuana Business Operator	$1,000.00	$2,200.00	$3,200.00
Marijuana Research and Development Facility	$1,000.00	$1,500.00	$2,500.00

2. Retail Marijuana Businesses.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Retail Marijuana Store	$5,000.00	$2,000.00	**Separate Checks** $4,500.00 State $2,500.00 Local
Retail Marijuana Products Manufacturer	$5,000.00	$1,500.00	**Separate Checks** $4,000.00 State $2,500.00 Local
Retail Marijuana Cultivation Facility Tier 1 (1-1,800 plants)	$5,000.00	$1,500.00	**Separate Checks** $4,000.00 State $2,500.00 Local
Retail Marijuana Testing Facility	$1,000.00	$1,500.00	**Separate Checks** $2,000.00 State $500.00 Local
Retail Marijuana Transporter	$1,000.00	$4,400.00	**Separate Checks** $4,900.00 State $500.00 Local
Retail Marijuana Business Operator	$1,000.00	$2,200.00	**Separate Checks** $2,700.00 State $500.00 Local
Marijuana Hospitality Business (Eff. Jan. 1, 2020)	$1,000.00	$1,000.00	**Separate Checks** $1,500.00 State $500.00 Local
Retail Marijuana Hospitality and Sales Business (Eff. Jan. 1, 2020)	$5,000.00	$2,000.00	**Separate Checks** $4,500.00 State $2,500.00 Local

B. Regulated Marijuana Business Renewal Application and License Renewal Fees.

1. Medical Marijuana Businesses.

License Type	Application Fee	License Fee	Total Due at Application
Medical Marijuana Store	$300.00	$1,500.00	$1,800.00
Medical Marijuana Products Manufacturer	$300.00	$1,500.00	$1,800.00
Medical Marijuana Cultivation Facility Class 1 (1-500 plants)	$300.00	$1,500.00	$1,800.00
Class 2 (501-1,500 plants)		$2,300.00	$2,600.00
Class 3 (1,501-3,000 plants)		$3,500.00	$3,800.00
Expanded Production Management (for each class of 3,000 plants over Class 3)		$3,500.00 [Plus $800 for each additional class of 3,000 plants over Class 3]	$3,800.00 [Plus $800 for each additional class of 3,000 plants over Class 3]
Medical Marijuana Testing Facility	$300.00	$1,500.00	$1,800.00
Medical Marijuana Transporter	$300.00	$4,400.00	$4,700.00
Medical Marijuana Business Operator	$300.00	$2,200.00	$2,500.00
Marijuana Research and Development Facility	$300.00	$1,500.00	$1,800.00

2. Retail Marijuana Businesses.

License Type	Application Fee	License Fee	Total Due at Application
Retail Marijuana Store	$300.00	$1,500.00	$1,800.00
Retail Marijuana Products Manufacturer	$300.00	$1,500.00	$1,800.00
Retail Marijuana Cultivation Facility Tier 1 (1-1,800 plants)	$300.00	$1,500.00	$1,800.00
Tier 2 (1,801-3,600 plants)		$2,300.00	$2,600.00
Tier 3 (3,601-6,000 plants)		$3,000.00	$3,300.00

Tier 4 (6,001-10,200 plants)		$4,500.00	$4,800.00
Tier 5 (10,201-13,800 plants)		$6,500.00	$6,800.00
Expanded Production Management (for each additional tier of 3,600 plants over Tier 5)		$6,500.00 [Plus $800.00 for each additional tier of 3,600 plants over Tier 5]	$6,800.00 [Plus $800.00 for each additional tier of 3,600 plants over Tier 5]
Retail Marijuana Testing Facility	$300.00	$1,500.00	$1,800.00
Retail Marijuana Transporter	$300.00	$4,400.00	$4,700.00
Retail Marijuana Business Operator	$300.00	$2,200.00	$2,500.00
Marijuana Hospitality Business (Eff. Jan. 1, 2020)	$300.00	$750.00	$1,050.00
Retail Marijuana Hospitality and Sales Business (Eff. Jan. 1, 2020)	$300.00	$1,500.00	$1,800.00

C. Owner Request for a Finding of Suitability, Owner License, and Owner Identification Badge – Initial Application and Renewal Fees.

1. Controlling Beneficial Owner Request for a Finding of Suitability Fee.

   a. $800.00 per Natural Person

   b. $800.00 for an Entity that is not a Publicly Traded Corporation, plus the fee in paragraph (C)(1)(a) and (C)(1)(b), for each associated natural person subject to suitability

   c. $5,000.00 for a Publicly Traded Corporation, plus the fee in paragraph (C)(1)(a) and (C)(1)(b), for each associated natural person or Entity subject to suitability.

2. Passive Beneficial Owner Request for Finding of Suitability Fee. A Passive Beneficial Owner may, but is not required to, apply for an Owner License and Identification Badge, and if the Passive Beneficial Owner chooses to do so, must submit the fees required by subparagraph (C)(1).

3. Renewal Fee for an Owner License. All Controlling Beneficial Owners and licensed Passive Beneficial Owners - $500.00.

D. Employee License – Initial Fees and Renewal Fees.

1. Employee License Initial Application and License Fee – $100.00

   a. Of the total Employee License application and license fee, $75.00 is the application fee and $25.00 is the license fee. An individual submitting an

application for an Employee License may submit the total fee of $100.00 in one form of payment.

2. Employee License Renewal Fee – $75.00

a. Of the total Employee License Renewal fee, $50.00 is the application fee and $25.00 is the license fee. An individual submitting an application for an Employee License renewal may submit the total fee of $75.00 in one form of payment.

3. All Key Licenses and Support Licenses issued before January 1, 2020 will be converted to an Employee License upon the first license renewal following January 1, 2020.

E. Temporary Appointee Registration – Request for Finding of Suitability Fees.

1. Natural Person – $225.00

2. Entity – $800.00

F. Other Fees. The following other fees apply:

1. Permits.

a. Off Premises Storage Permit – $1,500.00

b. Transporter Off Premises Storage Permit – $2,200.00

c. Centralized Distribution Permit Initial and Renewal Fee – $20.00

d. R&D Co-Location Permit Initial and Renewal Fee – $50.00

e. Delivery Permit:

i. Initial Fee Business License that will expire in 6 months or less - $2,000.00.

ii. Initial Fee Business License that will expire in more than 6 months - $4,000.00.

iii. All Renewals - $2,000.00

f. Transition Permit – $250.00

2. Regulated Marijuana Business Changes. The following fees apply per license:

a. Change of Controlling Beneficial Owner – $1,600.00

b. Changes Exempt from Change of Owner Application Requirement – $800.00

c. Change of Trade Name – $50.00

d. Change of Location – $500.00

e. Modification of Licensed Premises – $100.00

3. Marijuana Research and Development Facility Research Project Proposal – $500.00

4. Responsible Vendor Provider Applications.

   a. Responsible Vendor Program Provider Initial Application – $850.00

   b. Responsible Vendor Program Provider Renewal Application – $350.00

5. Duplicate License, Identification Badge, Certificate, Regulated Marijuana Business License Reinstatement.

   a. Duplicate Business License – $20.00

   b. Duplicate Owner or Employee Identification Badge – $20.00

   c. Responsible Vendor Program Provider Duplicate Certificate – $50.00

   d. Reinstatement of Regulated Marijuana Business License - $250.00

G. When Fees are Due. All fees in this Rule are due at the time the application or request is submitted.

Basis and Purpose – 2-225

The statutory basis for this rule includes but is not limited to sections 44-10-202(1)(c), 44-10-202(1)(e), 44-10-203(1)(c), 44-10-203(2)(a), 44-10-203(2)(c), 44-10-203(2)(w), 44-10-203(2)(ee), 44-10-203(7), 44-10-307, 44-10-308, 44-10-309, 44-10-313, 44-10-314, and 44-10-316 C.R.S. The purpose of this rule is to establish the requirements and procedures for the license renewal process, including the circumstances under which an expired license may be reinstated.

2-225 – Renewal Application Requirements for All Licensees

A. License Periods.

1. Regulated Marijuana Business and Owner Licenses are valid for one year from the date of issuance.

2. Medical Marijuana Transporters, Retail Marijuana Transporters, and Employee Licenses are valid for two years from the date of issuance.

B. Division Notification Prior to Expiration.

1. The Division will send a notice of license renewal 90 days prior to the expiration of an existing license by first class mail to the Licensee's physical address of record.

2. Failure to receive the Division notification does not relieve the Licensee of the obligation to timely renew the license.

C. Renewal Deadline.

1. A Licensee must apply for the renewal of an existing license prior to the License's expiration date.

2. A renewal application submitted to the Division prior to the license's expiration date shall be deemed timely pursuant to subsection 24-4-104(7), C.R.S., and the Licensee may continue to operate until Final Agency Order on the renewal application.

D. If License Not Renewed Before Expiration. A license is immediately invalid upon expiration if the Licensee has not filed a renewal application and remitted all of the required application and license fees prior to the license expiration date. A Regulated Marijuana Business that fails to file a renewal application and remit all required application and license fees prior to the license expiration date must not operate unless it first obtains a new state license and any required local license.

1. Reinstatement of Expired Regulated Marijuana Business License. A Regulated Marijuana Business that fails to file a renewal application and remit all required application and license fees prior to the license expiration date may request that the Division reinstate an expired license only in accordance to the following:

a. The Regulated Marijuana Business License expired within the previous 30 days;

b. The Regulated Marijuana Business has submitted an initial application pursuant to Rule 2-220. The initial application must be submitted prior to, or currently with, the request for reinstatement;

c. The Regulated Marijuana Business has paid the reinstatement fee in Rule 2-205; and

d. Any license or approval from the Local Licensing Authority or Local Jurisdiction is still valid or has been obtained.

2. Reinstatement Not Available for Surrendered or Revoked Licenses. A request for reinstatement cannot be submitted and will not be approved for a Regulated Marijuana Business license that was surrendered or revoked.

3. Reinstatement Not Available for Owner Licenses or Employee Licenses. A request for reinstatement cannot be submitted and will not be approved for expired, surrendered, or revoked Owner Licenses or Employee Licenses.

4. Denial of Request for Reinstatement or Administrative Action. If the Licensee requesting reinstatement of a Regulated Marijuana Business License operated during a period that the license was expired, the request may be subject to denial or subject to any administrative action authorized by the Marijuana Code or these Rules.

5. Approval of Request for Reinstatement. Upon approval of any request for reinstatement of an expired Regulated Marijuana Business License, the Licensee may resume operations until final agency action on the Licensee's initial application for a Regulated Marijuana Business license.

a. Approval of a request for reinstatement of an expired Regulated Marijuana Business License does not guarantee approval of the Regulated Marijuana Business license initial application.

b. Approval of a request for reinstatement of an expired license does not waive the State Licensing Authority's authority to pursue administrative action on the expired license or initial application for Regulated Marijuana Business license.

6. Final Agency Order on Initial Application for Regulated Marijuana Business.

a. If the initial application for Regulated Marijuana Business license submitted pursuant to this rule is approved, the Regulated Marijuana Business Licensee will replace the reinstated License.

b. If the initial application for Regulated Marijuana Business submitted pursuant to this rule is denied, the Licensee must immediately cease all operations including, but not limited to, Transfer of Regulated Marijuana. See Rule 2-270 – Application Denial and Voluntary Withdrawal; 8-115 – Disposition of Unauthorized Regulated Marijuana; 8-130 – Administrative Warrants.

E. Voluntarily Surrendered or Revoked Licenses Not Eligible for Renewal. Any license that was voluntarily surrendered or that was revoked by a Final Agency Order is not eligible for renewal. Any Licensee who voluntarily surrendered its license or has had its license revoked by a Final Agency Order may only submit an initial application. The State Licensing Authority will consider the voluntary surrender or the Final Agency Order and all related facts and circumstances in determining approval of any subsequent initial application.

F. Licenses Subject to Ongoing Administrative Action. Licenses subject to an administrative action are subject to the requirements of this Rule. Licenses that are not timely renewed expire and cannot be renewed.

G. Documents Required at Renewal. A Regulated Marijuana Business must provide the following documents with every renewal application:

1. Any document required by Rule 2-220(A)(1) through (10) that has changed since the document was last submitted to the Division. It is a license violation affecting public safety to fail to submit any document that changed since the last submission for the purpose of circumventing the requirements of the Marijuana Code, or these Rules;

2. A copy of the Local Licensing Authority or Local Jurisdiction approval, licensure, and/or documentation demonstrating timely submission of pending local license renewal application;

3. A list of any sanctions, penalties, assessments, or cease and desist orders imposed by any securities regulatory agency, including but not limited to the United States Securities and Exchange Commission or the Canadian Securities Administrators;

4. A Regulated Marijuana Business operating under a single Entity name with more than one license may submit the following documents only once each calendar year on the first license renewal in lieu of submission with every license renewal in the same calendar year:

a. Tax documents and financial statements required by Rule 2-220(A)(11) and (12);

b. If the Regulated Marijuana Business is a Publicly Traded Corporation, the most recent list of Non-Objecting Beneficial Owners possessed by the Regulated Marijuana Business;

c. A copy of all management agreement(s) the Regulated Marijuana Business has entered into regardless of whether the Person is licensed or unlicensed.; and

d. Contracts, agreements, royalty agreements, equipment leases, financing agreement, or security contract for any Indirect Financial Interest Holder that is required to be disclosed by Rule 2-230(A)(3).

H. Controlling Beneficial Owner Signature. At least one Controlling Beneficial Owner shall sign the renewal application. However, other Controlling Beneficial Owners may be required to sign authorizations and/or requests to release information.

COLORADO
Department of Revenue

Emergency Rule Adoption
Colorado Marijuana Rules
1 CCR 212-3

- Rule 2-205 - Fees
- Rule 2-225 – Renewal Application Requirements for All Licensees

February 7, 2020

Questions:

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COLORADO
Department of Revenue

COLORADO DEPARTMENT OF REVENUE
MARIJUANA ENFORCEMENT DIVISION

Emergency Rule Adoption

Amended Rules, 1 CCR 212-3

Rule 2-205 – Fees
Rule 2-225 – Renewal Application Requirements for All Licensees

Statement of Emergency Justification and Adoption

Pursuant to sections 24-4-103 and 44-10-203, C.R.S., I, Heidi Humphreys, Deputy Executive Director of the Department of Revenue and State Licensing Authority, hereby adopt the aforementioned revised Colorado Marijuana Rules, which are attached hereto.

Section 24-4-103(6), C.R.S., authorizes the State Licensing Authority to issue an emergency rule if the State Licensing Authority finds that the immediate adoption of the rule is imperatively necessary to comply with state law, or for the preservation of public health, safety, or welfare, and compliance with the requirements of section 24-4-103, C.R.S., would be contrary to the public interest.

I find: (1) the immediate adoption of these revised rules is necessary to comply with the constitutional and statutory mandates of the Colorado Marijuana Code, sections 44-10-101 *et seq.*, C.R.S.; (2) the immediate adoption of these revised rules is necessary to preserve the public health, safety, and welfare; and (3) compliance with the notice and public hearing requirements of section 24-4-103, C.R.S., would be contrary to the public interest.

Statutory Authority

The statutory authority for the attached revised rules 2-205 and 2-225 is identified in the statement of basis and purpose preceding each rule. Statutory authority for these rules includes but is not limited to section 44-10-203(2)(w), C.R.S.

Purpose

The purpose of the revisions to these rules on an emergency basis is as follows:

The State Licensing Authority adopted Emergency Rules 2-205 and 2-225, 1 CCR 212-3 on **February 7, 2020**. The purpose of the Emergency Rules is to implement Senate Bill 19-224 Concerning the Continuation of the Regulated Marijuana Programs, and, In Connection Therewith, Implementing the Recommendations Contained in the 2018 Sunset Report by the Department of Regulatory, which amended section 44-10-314, C.R.S., regarding renewal of all licenses issued pursuant to the Colorado Marijuana Code.

Under previous law, the statute[1] provided licensees a 90-day period following the expiration of a license, within which to submit a renewal application; however, SB 19-224 amended this provision to eliminate the 90-day period following expiration during which a licensee could submit a renewal application. Therefore, the statute now provides any license which is not renewed ***prior*** to the expiration date, is immediately invalid and can no longer operate.

During and following the 2019 permanent rulemaking to implement SB 19-224, the Marijuana Enforcement Division took steps to alert licensees of this upcoming change and restriction on licensees' ability to operate following the expiration of a license. However, neither the Marijuana Enforcement Division nor the regulated marijuana industry identified how the change in law would impact retail marijuana business licenses in a disparate manner compared to medical marijuana business licenses, and how such change in law could lead to public health, safety, and welfare concerns.

Retail Marijuana Business License Application Restriction

Pursuant to Colorado Constitution art. XVIII, sec. 16(5)(g)(III) and section 44-10-104(2)(b), C.R.S., "the state licensing authority shall act upon a retail marijuana business license application…no sooner than forty-five days and no later than ninety days after the date of the retail marijuana business license application." The timeframe within which the state licensing authority may either approve or deny an application for a retail marijuana business license derives from the constitutional amendment authorizing retail marijuana sales. The same timeframe restriction does not apply to medical marijuana businesses.

This distinction in timing is important in light of the change in law regarding renewal applications because this means that a retail marijuana business license that expires must apply for a new license and wait at least forty-five days before final action, whereas a medical marijuana business license that expires can apply for a new license and begin operation upon approval (assuming local jurisdiction approval and/or licensure is maintained during the period of expiration). The Emergency Rules address this disparity by providing a path for an expired retail marijuana business to request reinstatement of an expired license which, if granted, would permit the business to operate pending final agency action on the new business license application. This provides more equal treatment to expired medical and retail marijuana businesses.

Further, despite regulator and industry efforts to ensure that licenses would not expire due to failure to renew prior to expiration, neither identified the public health, safety, and welfare issues that could arise in the event a license does expire. All marijuana in the regulated system is tracked by licensees through 24/7 access to the state-mandated inventory tracking system while the license is valid. However, when the license expires, the licensee can no longer use the inventory tracking system, thus resulting in loss of seed-to-sale tracking of the marijuana on that licensed premises. Seed-to-sale tracking is a regulatory tool used by the Marijuana Enforcement Division and State Licensing Authority to ensure knowledge of both the location and quantity of regulated marijuana. Without such seed-to-sale tracking capabilities, a licensee and the state are at an increased risk of diversion of marijuana, ultimately threatening the public health, safety, and welfare.

[1] SB 19-224 repealed the previous Medical Marijuana Code, sections 44-11-101 *et seq.*, C.R.S., and Retail Marijuana Code, sections 44-12-101 *et seq.*, C.R.S., and replaced those statutes with the Colorado Marijuana Code. The license renewal statutory provisions in both the Medical Marijuana Code and the Retail Marijuana Code was substantively the same, each allowing for the 90-day grace period within which to submit a renewal application.

Effective Date of Emergency Rules and Permanent Rulemaking

The attached emergency rules are effective immediately upon adoption.

The prior versions of Rules 2-205 and 2-225, 1 CCR 212-3, are hereby amended.

The attached emergency rules remain in effect until their expiration date, 120 days from the date of adoption or until replaced rules promulgated pursuant to the emergency or permanent rulemaking process.

The State Licensing Authority intends to initiate a permanent rulemaking to implement other provisions of SB 19-224, with an effective date of July 1, 2020. To ensure there is no lapse in these Emergency Rules, the State Licensing Authority may either readopt the Emergency Rules and/or initiate a separate permanent rulemaking proceeding.

Heidi Humphreys

Digitally signed by Heidi Humphreys
DN: cn=Heidi Humphreys, o=Colorado Department of Revenue, ou=EDO, email=heidi.humphreys@state.co.us, c=US
Date: 2020.02.07 14:09:34 -07'00'

Heidi Humphreys
Deputy Executive Director/Chief Operating Officer
Colorado Department of Revenue
State Licensing Authority

2-7-2020
Date

DEPARTMENT OF REVENUE
MARIJUANA ENFORCEMENT DIVISION
COLORADO MARIJUANA RULES
1 CCR 212-3

Part 2 – Applications and Licenses

2-200 Series – Applications and Licenses Rules

Basis and Purpose – 2-205

The statutory basis for this rule includes but is not limited to sections 44-10-103, 44-10-202(1)(b), 44-10-202(1)(c), 44-10-202(1)(e), 44-10-203(1)(j), 44-10-203(1)(i), 44-10-203(2)(b), 44-10-203(2)(h), 44-10-203(2)(q), 44-10-203(2)(w), 44-10-203(2)(dd)(XII), 44-10-303(2)(b), 44-10-310(7), 44-10-313, 44-10-401, 44-10-801, 44-10-802, 44-10-803, 44-10-1201, 44-10-1202, C.R.S. Authority also exists in the Colorado Constitution at Article XVIII, Subsection 16(5)(a)(II). The purpose of this rule is to establish fees required for applications, renewals, licenses fees, permits, and other fees required to accompany applications and submissions to the Division. The Division anticipates evaluating all fees in connection with a fee analysis. Any recommendations from the fee analysis will be considered during subsequent rulemaking proceedings. This Rule 2-205 was previously Rules M 207, 208, 209, 210, 235, and 236, 1 CCR 212-1, and Rules R 207, 208, 209, 210, 234, and 235, 1 CCR 212-2.

2-205 – Fees

A. Regulated Marijuana Business Initial Application and License Fees.

1. Medical Marijuana Businesses.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Medical Marijuana Store	$5,000.00	$2,000.00	$7,000.00
Medical Marijuana Products Manufacturer	$1,000.00	$1,500.00	$2,500.00
Medical Marijuana Cultivation Facility Class 1 (1-500 plants)	$1,000.00	$1,500.00	$2,500.00
Medical Marijuana Testing Facility	$1,000.00	$1,500.00	$2,500.00
Medical Marijuana Transporter	$1,000.00	$4,400.00	$5,400.00
Medical Marijuana Business Operator	$1,000.00	$2,200.00	$3,200.00
Marijuana Research and Development Facility	$1,000.00	$1,500.00	$2,500.00

2. Retail Marijuana Businesses.

License Type	Application Fee	License Fee	Total Due at Application
Retail Marijuana Store	$5,000.00	$2,000.00	**Separate Checks** $4,500.00 State $2,500.00 Local
Retail Marijuana Products Manufacturer	$5,000.00	$1,500.00	**Separate Checks** $4,000.00 State $2,500.00 Local
Retail Marijuana Cultivation Facility Tier 1 (1-1,800 plants)	$5,000.00	$1,500.00	**Separate Checks** $4,000.00 State $2,500.00 Local
Retail Marijuana Testing Facility	$1,000.00	$1,500.00	**Separate Checks** $2,000.00 State $500.00 Local
Retail Marijuana Transporter	$1,000.00	$4,400.00	**Separate Checks** $4,900.00 State $500.00 Local
Retail Marijuana Business Operator	$1,000.00	$2,200.00	**Separate Checks** $2,700.00 State $500.00 Local
Marijuana Hospitality Business (Eff. Jan. 1, 2020)	$1,000.00	$1,000.00	**Separate Checks** $1,500.00 State $500.00 Local
Retail Marijuana Hospitality and Sales Business (Eff. Jan. 1, 2020)	$5,000.00	$2,000.00	**Separate Checks** $4,500.00 State $2,500.00 Local

B. Regulated Marijuana Business Renewal Application and License Renewal Fees.

1. Medical Marijuana Businesses.

License Type	Application Fee	License Fee	Total Due at Application
Medical Marijuana Store	$300.00	$1,500.00	$1,800.00
Medical Marijuana Products Manufacturer	$300.00	$1,500.00	$1,800.00
Medical Marijuana Cultivation Facility Class 1 (1-500 plants)	$300.00	$1,500.00	$1,800.00
Class 2 (501-1,500 plants)		$2,300.00	$2,600.00
Class 3 (1,501-3,000 plants)		$3,500.00	$3,800.00
Expanded Production Management (for each class of 3,000 plants over Class 3)		$3,500.00 [Plus $800 for each additional class of 3,000 plants over Class 3]	$3,800.00 [Plus $800 for each additional class of 3,000 plants over Class 3]
Medical Marijuana Testing Facility	$300.00	$1,500.00	$1,800.00
Medical Marijuana Transporter	$300.00	$4,400.00	$4,700.00
Medical Marijuana Business Operator	$300.00	$2,200.00	$2,500.00
Marijuana Research and Development Facility	$300.00	$1,500.00	$1,800.00

2. Retail Marijuana Businesses.

License Type	Application Fee	License Fee	Total Due at Application
Retail Marijuana Store	$300.00	$1,500.00	$1,800.00
Retail Marijuana Products Manufacturer	$300.00	$1,500.00	$1,800.00
Retail Marijuana Cultivation Facility	$300.00	$1,500.00	$1,800.00

Tier 1 (1-1,800 plants) Tier 2 (1,801-3,600 plants) Tier 3 (3,601-6,000 plants) Tier 4 (6,001-10,200 plants) Tier 5 (10,201-13,800 plants) Expanded Production Management (for each additional tier of 3,600 plants over Tier 5)		$2,300.00 $3,000.00 $4,500.00 $6,500.00 $6,500.00 [Plus $800.00 for each additional tier of 3,600 plants over Tier 5]	$2,600.00 $3,300.00 $4,800.00 $6,800.00 $6,800.00 [Plus $800.00 for each additional tier of 3,600 plants over Tier 5]
Retail Marijuana Testing Facility	$300.00	$1,500.00	$1,800.00
Retail Marijuana Transporter	$300.00	$4,400.00	$4,700.00
Retail Marijuana Business Operator	$300.00	$2,200.00	$2,500.00
Marijuana Hospitality Business (Eff. Jan. 1, 2020)	$300.00	$750.00	$1,050.00
Retail Marijuana Hospitality and Sales Business (Eff. Jan. 1, 2020)	$300.00	$1,500.00	$1,800.00

C. Owner Request for a Finding of Suitability, Owner License, and Owner Identification Badge – Initial Application and Renewal Fees.

1. Controlling Beneficial Owner Request for a Finding of Suitability Fee.

   a. $800.00 per Natural Person

   b. $800.00 for an Entity that is not a Publicly Traded Corporation, plus the fee in paragraph (C)(1)(a) and (C)(1)(b), for each associated natural person subject to suitability

   c. $5,000.00 for a Publicly Traded Corporation, plus the fee in paragraph (C)(1)(a) and (C)(1)(b), for each associated natural person or Entity subject to suitability.

2. Passive Beneficial Owner Request for Finding of Suitability Fee. A Passive Beneficial Owner may, but is not required to, apply for an Owner License and Identification Badge, and if the Passive Beneficial Owner chooses to do so, must submit the fees required by subparagraph (C)(1).

3. Renewal Fee for an Owner License. All Controlling Beneficial Owners and licensed Passive Beneficial Owners - $500.00.

D. Employee License – Initial Fees and Renewal Fees.

1. Employee License Initial Application and License Fee – $100.00

    a. Of the total Employee License application and license fee, $75.00 is the application fee and $25.00 is the license fee. An individual submitting an application for an Employee License may submit the total fee of $100.00 in one form of payment.

2. Employee License Renewal Fee – $75.00

    a. Of the total Employee License Renewal fee, $50.00 is the application fee and $25.00 is the license fee. An individual submitting an application for an Employee License renewal may submit the total fee of $75.00 in one form of payment.

3. All Key Licenses and Support Licenses issued before January 1, 2020 will be converted to an Employee License upon the first license renewal following January 1, 2020.

E. Temporary Appointee Registration – Request for Finding of Suitability Fees.

1. Natural Person – $225.00

2. Entity – $800.00

F. Other Fees. The following other fees apply:

1. Permits.

    a. Off Premises Storage Permit – $1,500.00

    b. Transporter Off Premises Storage Permit – $2,200.00

    c. Centralized Distribution Permit Initial and Renewal Fee – $20.00

    d. R&D Co-Location Permit Initial and Renewal Fee – $50.00

    e. Delivery Permit:

        i. Initial Fee Business License that will expire in 6 months or less - $2,000.00.

        ii. Initial Fee Business License that will expire in more than 6 months - $4,000.00.

        iii. All Renewals - $2,000.00

    f. Transition Permit – $250.00

2. Regulated Marijuana Business Changes. The following fees apply per license:

    a. Change of Controlling Beneficial Owner – $1,600.00

    b. Changes Exempt from Change of Owner Application Requirement – $800.00

    c. Change of Trade Name – $50.00

d. Change of Location – $500.00

e. Modification of Licensed Premises – $100.00

3. Marijuana Research and Development Facility Research Project Proposal – $500.00

4. Responsible Vendor Provider Applications.

a. Responsible Vendor Program Provider Initial Application – $850.00

b. Responsible Vendor Program Provider Renewal Application – $350.00

5. Duplicate License, Identification Badge, ~~or~~ Certificate, Regulated Marijuana Business License Reinstatement.

a. Duplicate Business License – $20.00

b. Duplicate Owner or Employee Identification Badge – $20.00

c. Responsible Vendor Program Provider Duplicate Certificate – $50.00

d. Reinstatement of Regulated Marijuana Business License - $250.00

G. When Fees are Due. All fees in this Rule are due at the time the application or request is submitted.

Basis and Purpose – 2-225

The statutory basis for this rule includes but is not limited to sections 44-10-202(1)(c), 44-10-202(1)(e), 44-10-203(1)(c), 44-10-203(2)(a), 44-10-203(2)(c), 44-10-203(2)(w), 44-10-203(2)(ee), 44-10-203(7), 44-10-307, 44-10-308, 44-10-309, 44-10-313, 44-10-314, and 44-10-316 C.R.S. The purpose of this rule is to establish the requirements and procedures for the license renewal process, including the circumstances under which an expired license may be reinstated.

2-225 – Renewal Application Requirements for All Licensees

A. License Periods.

1. Regulated Marijuana Business and Owner Licenses are valid for one year from the date of issuance.

2. Medical Marijuana Transporters, Retail Marijuana Transporters, and Employee Licenses are valid for two years from the date of issuance.

B. Division Notification Prior to Expiration.

1. The Division will send a notice of license renewal 90 days prior to the expiration of an existing license by first class mail to the Licensee's physical address of record.

2. Failure to receive the Division notification does not relieve the Licensee of the obligation to timely renew the license.

C. Renewal Deadline.

1. A Licensee must apply for the renewal of an existing license prior to the License's expiration date.

2. A renewal application submitted to the Division prior to the license's expiration date shall be deemed timely pursuant to subsection 24-4-104(7), C.R.S., and the Licensee may continue to operate until Final Agency Order on the renewal application.

D. If License Not Renewed Before Expiration. A license is immediately invalid upon expiration if the Licensee has not filed a renewal application and remitted all of the required application and license fees prior to the license expiration date. A Regulated Marijuana Business that fails to file a renewal application and remit all required application and license fees prior to the license expiration date must not operate unless it first obtains a new state license and any required local license.

1. Reinstatement of Expired Regulated Marijuana Business License. A Regulated Marijuana Business that fails to file a renewal application and remit all required application and license fees prior to the license expiration date may request that the Division reinstate an expired license only in accordance to the following:

   a. The Regulated Marijuana Business License expired within the previous 30 days;

   b. The Regulated Marijuana Business has submitted an initial application pursuant to Rule 2-220. The initial application must be submitted prior to, or currently with, the request for reinstatement;

   c. The Regulated Marijuana Business has paid the reinstatement fee in Rule 2-205; and

   d. Any license or approval from the Local Licensing Authority or Local Jurisdiction is still valid or has been obtained.

2. Reinstatement Not Available for Surrendered or Revoked Licenses. A request for reinstatement cannot be submitted and will not be approved for a Regulated Marijuana Business license that was surrendered or revoked.

3. Reinstatement Not Available for Owner Licenses or Employee Licenses. A request for reinstatement cannot be submitted and will not be approved for expired, surrendered, or revoked Owner Licenses or Employee Licenses.

4. Denial of Request for Reinstatement or Administrative Action. If the Licensee requesting reinstatement of a Regulated Marijuana Business License operated during a period that the license was expired, the request may be subject to denial or subject to any administrative action authorized by the Marijuana Code or these Rules.

5. Approval of Request for Reinstatement. Upon approval of any request for reinstatement of an expired Regulated Marijuana Business License, the Licensee may resume operations until final agency action on the Licensee's initial application for a Regulated Marijuana Business license.

   a. Approval of a request for reinstatement of an expired Regulated Marijuana Business License does not guarantee approval of the Regulated Marijuana Business license initial application.

b. Approval of a request for reinstatement of an expired license does not waive the State Licensing Authority's authority to pursue administrative action on the expired license or initial application for Regulated Marijuana Business license.

6. Final Agency Order on Initial Application for Regulated Marijuana Business.

a. If the initial application for Regulated Marijuana Business license submitted pursuant to this rule is approved, the Regulated Marijuana Business Licensee will replace the reinstated License.

b. If the initial application for Regulated Marijuana Business submitted pursuant to this rule is denied, the Licensee must immediately cease all operations including, but not limited to, Transfer of Regulated Marijuana. See Rule 2-270 – Application Denial and Voluntary Withdrawal; 8-115 – Disposition of Unauthorized Regulated Marijuana; 8-130 – Administrative Warrants.

E. Voluntarily Surrendered or Revoked Licenses Not Eligible for Renewal. Any license that was voluntarily surrendered or that was revoked by a Final Agency Order is not eligible for renewal. Any Licensee who voluntarily surrendered its license or has had its license revoked by a Final Agency Order may only submit an initial application. The State Licensing Authority will consider the voluntary surrender or the Final Agency Order and all related facts and circumstances in determining approval of any subsequent initial application.

F. Licenses Subject to Ongoing Administrative Action. Licenses subject to an administrative action are subject to the requirements of this Rule. Licenses that are not timely renewed expire and cannot be renewed.

G. Documents Required at Renewal. A Regulated Marijuana Business must provide the following documents with every renewal application:

1. Any document required by Rule 2-220(A)(1) through (10) that has changed since the document was last submitted to the Division. It is a license violation affecting public safety to fail to submit any document that changed since the last submission for the purpose of circumventing the requirements of the Marijuana Code, or these Rules;

2. A copy of the Local Licensing Authority or Local Jurisdiction approval, licensure, and/or documentation demonstrating timely submission of pending local license renewal application;

3. A list of any sanctions, penalties, assessments, or cease and desist orders imposed by any securities regulatory agency, including but not limited to the United States Securities and Exchange Commission or the Canadian Securities Administrators;

4. A Regulated Marijuana Business operating under a single Entity name with more than one license may submit the following documents only once each calendar year on the first license renewal in lieu of submission with every license renewal in the same calendar year:

a. Tax documents and financial statements required by Rule 2-220(A)(11) and (12);

b. If the Regulated Marijuana Business is a Publicly Traded Corporation, the most recent list of Non-Objecting Beneficial Owners possessed by the Regulated Marijuana Business;

c. A copy of all management agreement(s) the Regulated Marijuana Business has entered into regardless of whether the Person is licensed or unlicensed.; and

d. Contracts, agreements, royalty agreements, equipment leases, financing agreement, or security contract for any Indirect Financial Interest Holder that is required to be disclosed by Rule 2-230(A)(3).

H. Controlling Beneficial Owner Signature. At least one Controlling Beneficial Owner shall sign the renewal application. However, other Controlling Beneficial Owners may be required to sign authorizations and/or requests to release information.

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: 2020-00062

Opinion of the Attorney General rendered in connection with the rules adopted by the

Marijuana Enforcement Division

on 02/07/2020

1 CCR 212-3

COLORADO MARIJUANA RULES

The above-referenced rules were submitted to this office on 02/07/2020 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.

February 13, 2020 11:59:42

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 1505-1

Rule title

8 CCR 1505-1 ELECTIONS 1 - eff 02/03/2020

Effective date

02/03/2020

COLORADO SECRETARY OF STATE

[8 CCR 1505-1]

ELECTION RULES

Rules as Adopted - Clean

February 3, 2020

(*Publication instructions/notes* may be included):

Amendments to 8 CCR 1505-1 follow:

Amendments to current Rule 7.2.3(b) and new Rule 7.2.3(c), concerning ballots and ballot packets:

7.2.3 In accordance with section 1-7.5-107(3), C.R.S., the county clerk must mail ballots no later than 18 days before election day.

(a) The county clerk must process all new registration applications and updates received by the 22-day deadline to mail applicants a ballot in accordance with section 1-7.5-107(3), C.R.S.

(b) Beginning the 15th day before election day, the county clerk must process all registration applications and updates within one business day of receipt.

(c) Beginning the 14th day before election day, the county clerk must deliver any original or replacement ballot to the United States Postal Service within one business day after processing a registration application or update.

New Rule 7.2.17:

7.2.17 The county clerk must send all mail ballots by first-class mail beginning the 11th day before election day.

New Rule 7.9.11, concerning voter service and polling centers:

7.9.11 The county clerk of any county that has a tribal nation headquarters located within the county borders must notify the tribal council by letter that the tribal nation has the right to request that a voter service and polling center be located within the boundaries of the tribal nation in the upcoming general election. The county clerk must send this notification by mail no later than 225 days before the date of any general election.

New Rule 7.17:

7.17 Closure of VSPCs due to emergency condition

7.17.1 If as a result of an extreme weather event, natural disaster, act of God, human made incident, or disruption to, or threat of disruption to critical infrastructure, a county government or other entity closes all day, closes early, or delays the opening of a building where a voter service and polling center is located, then the county clerk may close for the day, close early, or delay the opening of any voter service and polling center located in those buildings affected.

7.17.2 The county clerk must immediately notify the Secretary of State and the public of any closure or delayed opening of a voter service and polling center under this rule.

7.17.3 A county clerk must request approval from the Secretary of State before closing or delaying the opening of a voter service and polling center under this rule beginning four days before election day through election day.

7.17.4 The Secretary of State may petition a court under section 1-7-101 (1)(b), C.R.S. to extend the polling hours in a county or statewide if voter service and polling centers are closed or delayed opening under this rule.

7.17.5 If a county clerk closes or delays the opening of a voter service and polling center under this rule, then the Secretary of State and county clerk must issue an emergency ballot available under section 1-7.5-115, C.R.S. to any voter who requests it due to the delay or closure.

Amendments to Rule 11.3.2(e), including new Rule 11.3.2(e)(2), concerning logic and accuracy test:

(e) Completing the test

(1) The county must keep all test materials, when not in use, in a durable, secure box. Each member of the Testing Board must verify the seals and initial the chain-of-custody log maintained by the county clerk. If the records are opened for inspection, at least two election officials must verify the seals and initial the chain-of-custody log.

(2) The county must backup and preserve the election database or project containing test results, and export and preserve the test results and CVR files. The county must prepare and preserve a ballot manifest corresponding to the test CVR file.

(3) The county must upload the test results file during the ENR test required under Rule 11.9.3. The county must hash and upload the CVR and ballot manifest to the RLA software during the RLA practice period, as required under Rule 25.2.2(b).

(4) After testing, the Testing Board must watch the county reset and seal each voting device, if applicable.

(5) The Testing Board and the county clerk must sign a written statement attesting to the qualification of each device successfully tested, the number of the seal attached to the voting device at the end of the test, if applicable, any problems discovered, and any other documentation necessary to provide a full and accurate account of the condition of a given device.

(6) The county may not change the programming of any voting device after completing the logic and accuracy test for an election, except as required to conduct a recount or as authorized by the Secretary of State.

Amendments to Rule 25.2.2, including new Rules 25.2.2(b) and 25.2.2(c)(2), concerning risk limiting audit:

25.2.2 Preparing for the audit

(a) Risk limit. No later than 32 days before election day, the Secretary of State will establish and publish on the Audit Center the risk limits that will apply in RLAs for that election. The Secretary of State may establish different risk limits for comparison audits and ballot polling audits, and for audits of statewide and countywide contests. In comparison audits the risk limit will not exceed five percent for statewide contests, and ten percent for countywide contests.

(b) Practice Period. Beginning 20 days before the election counties may practice conducting the audit. The county must, at a minimum, hash and upload the ballot manifest and CVR file from the logic and accuracy test to the RLA software.

(c) Audit board. No later than 15 days before election day, the designated election official must appoint an audit board to conduct the risk-limiting audit. The audit board must consist of electors nominated by the major political party county chairpersons. The designated election official must give written notice to the county chairpersons of their obligation to nominate audit board members and may designate appropriately affiliated electors as audit board members if one or both county chairpersons fail to do so in a timely manner.

(1) At least two canvass board members must observe at least the first round of the RLA, and members of the canvass board may serve as members of the audit board. The designated election official, members of his or her staff, and other duly appointed election judges may assist the audit board in conducting the audit. To the extent practicable, the audit board should not consist of individuals who participated in ballot resolution or

adjudication during the election being audited. Each member of the audit board must take the election judge oath.

(2) If the Secretary of State randomly selects five or fewer ballots for any audit round after the first, the designated election official may appoint as the audit board members of staff of different party affiliations to conduct and sign off on the audit round in question. The designated election official must get approval from the Secretary of State before appointing staff as the audit board. The designated election official may not appoint themselves to conduct any audit round.

[Not shown: Rules 25.2.2(c)-(k) are renumbered accordingly to 25.2.2(d)-(l)]

STATE OF COLORADO
Department of State
1700 Broadway
Suite 200
Denver, CO 80290

Jena Griswold
Secretary of State

Jenny Flanagan
Deputy Secretary of State

Statement of Justification and Reasons for Adoption of Temporary Rules

Office of the Secretary of State
Election Rules
8 CCR 1505-1

February 3, 2020

Amended Rules: 7.2.3(b), 11.3.2(e), 25.2.2 (includes renumbering 25.2.2(c)-(k)).

New Rules: 7.2.3(c), 7.2.17, 7.9.11, 7.17, 11.3.2(e)(2), 25.2.2(b) and (c)(2).

In accordance with Colorado election law,[1] the Secretary of State finds that certain amendments to the existing election rules must be adopted and effective immediately to ensure the uniform and proper administration and enforcement of Colorado election laws.

Adoption of these rules on a temporary basis is necessary given the approaching March 3, 2020, Presidential Primary Election. These rules address specific issues identified during the 2019 coordinated election that must be addressed prior to this election. Rule 7.9.11 is also needed on a temporary basis to ensure that the rights of tribal nations under Colorado law are protected for the upcoming general election. The rules are immediately effective as is necessary to provide clear guidance to interested parties, including, but not limited to: county clerks and the general public.

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 election rules is imperatively necessary to comply with state and federal law and to promote public interests.[2]

[1] Sections 1-1-107 (1) (c), 1-1-107(2) (a), 1-7.5-104, C.R.S. (2019).
[2] Section 24-4-103(3) (6), C.R.S. (2019).

PHILIP J. WEISER
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Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

STATE OF COLORADO
DEPARTMENT OF LAW

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Office of the Attorney General

Tracking number: 2020-00057

Opinion of the Attorney General rendered in connection with the rules adopted by the

Secretary of State

on 02/03/2020

8 CCR 1505-1

ELECTIONS

The above-referenced rules were submitted to this office on 02/03/2020 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.

February 21, 2020 09:54:56

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Human Services

Agency

Food Assistance Program (Volume 4B)

CCR number

10 CCR 2506-1

Rule title

10 CCR 2506-1 RULE MANUAL VOLUME 4B, FOOD ASSISTANCE 1 - eff 02/07/2020

Effective date

02/07/2020

4.801.2 Establishing Claims Against Households

A. Establishing a Claim

1. The local office shall establish claims in accordance with the thresholds outlined below.

   a. For participating households, the county department shall not establish a claim for overpayment due to Administrative Error (AE) or Inadvertent Household Error (IHE), except in the following circumstances:

      1. When the amount of the claim is greater than $200; or,

      2. When the overpayment is identified through a federal or state level quality control review; or,

      3. When the IHE claim is being pursued as an intentional program violation (IPV), except that if the IHE claim does not result in an IPV, collection shall not be pursued.

   b. For households not participating in the Food Assistance program, the county department shall not establish a claim for overpayment except in the following circumstances:

      1. When the amount of the AE claim is greater than $400; or,

      2. When the amount of the claim is due to an IHE and is greater than $200; or,

      3. When the overpayment is identified through a federal or state level quality control review.

      4. When an IHE claim is being pursued as an IPV, except that if the IHE claim does not result in an IPV, collection shall not be pursued.

2. An AE or IHE claim shall not be established for a period of more than twelve (12) months from the date the local office was notified, in writing or orally, or discovered through the normal course of business that an error occurred which led to the household receiving more benefits than it was entitled to receive.

   A claim associated with an IPV must be calculated back to the month the act of IPV first occurred and cannot be established for a period more than six (6) years from the date the local office was notified, in writing or orally, or discovered through the normal course of business that an error occurred which led to the household receiving more benefits than it was entitled to receive.

***

4.801.3 Calculating the Amount of a Claim

A. Compromising Claims

If the full amount or remaining amount of an AE or IHE claim cannot be liquidated in three (3) years, the local office may compromise the claim by reducing it to an amount that will allow the household to pay the claim in three (3) years. Intentional program violation claims shall not be compromised, unless specified in a court decision. The local office may use the full amount of the claim, including any amount compromised, to offset lost benefits. Decisions regarding compromises shall be documented in the case record.

A payment plan on a claim that has been compromised may be renegotiated if necessary. Claims that are already reduced by either an administrative or district court order are considered compromised claims, and thus are not eligible for additional compromise.

Local offices shall review the household's circumstances and determine if a compromise would be appropriate. Local offices do not have the option of refusing to consider compromising claims. Local offices cannot institute a policy of never compromising claims.

Claims should be compromised if the household demonstrates need, such as the inability to repay the claim within three (3) years, or if the household proves that financial, physical, or mental hardship would exist if forced to pay the full amount of the original claim. Some circumstances include, but are not limited to medical hardships, high shelter costs, loan payments, and other extraordinary expenses. A compromise based on hardship may be applied to a Food Assistance case whether or not the household is still receiving Food Assistance benefits.

Consideration should be given to the future earning potential of the household over the next three (3) years to pay back the claim based on age, disability, and other household factors.

B. Claims Resulting from Trafficking

The value of claims resulting from trafficking related offenses is the value of the trafficked benefits as determined by the individual's admission, through adjudication, or the documentation that forms the basis for the trafficking determination. Documentation could include such items as notarized statements or printouts from the Electronic Benefit Transfer (EBT) systems.

C. Agency Error and Inadvertent Household Error Claims

1. If the household received a larger allotment than it was entitled to receive, the local office shall establish a claim against the household that is equal to the difference between the allotment that the household received and the actual allotment it should have received. Benefits authorized under Colorado Electronic Benefits Transfer System (CO/EBTS) shall be used to calculate the claim.

   After calculating the amount of a claim and establishing claims, the local office must offset the amount of the claim against any amounts which have not yet been restored to the household. Expungements and any return of benefits that occur must be used to offset the amount of the claim.

2. The claim must also be offset against restored benefits owed to:

   a. Any household that contains a member who was an adult member of the original household;

   b. Any household that contains an authorized representative that caused the overpayment or trafficking.

   c. In no circumstance may the local office collect more than the amount of the claim.

3. For households eligible under basic categorical eligibility, a claim shall only be determined when it can be computed on the basis of changed household net income and/or household size. A claim shall not be established if there was not a change in net income and/or household size.

   If a household receives both Temporary Assistance for Needy Families (TANF) and Food Assistance and mis-reports information to TANF in accordance with the TANF reporting requirements, and the mis-report of information to TANF resulted in the household being over paid TANF or ineligible for TANF, any resulting Food Assistance claim should be based on the actual TANF issued.

4. The correct allotment shall be calculated using the same methods applied to an actual certification. The twenty percent (20%) earned income deduction shall not be applied to that part of any earned income that the household failed to report in a timely manner when this act is the basis for the claim; therefore, any portion of the claim that is due to earned

income being reported in an untimely manner will be calculated without allowing the twenty percent (20%) earned income deduction. The actual circumstances of the household shall be used to calculate the claim. In instances when a claim is caused by the household's failure to report information as required, the amount of the claim is based on the allotment difference from what the household actually received compared to what the household would have received if the household would have reported the information as required. For example, if a simplified reporting household did not report income at initial application as required, the income used to calculate the overpayment would be the income that the household actually received in the month of application, as this would have been used to determine the household's ongoing monthly amount. Actual income received each subsequent month is not required to calculate each month of the claim, as any fluctuation in monthly income that was received by the household after the initial month of application was not required to be reported by the household. If the household failed to report a change in household circumstances that would have resulted in an increase in benefits during the time period of the claim, the local office shall act on the change in information as of the date the change was reported to the local office.

5. When a household certified below 130% FPL fails to report an increase in household income over 130% FPL. The local office shall establish the claim for each month in which an over-issuance of Food Assistance has occurred.

    a. In cases involving household failure to report an increase in income within the required timeframes, the first (1st) month affected by the household's failure to report shall be the first (1st) month in which the change would have been effective had it been timely reported. However, in no event shall the determination of the first (1st) month in which the change would have been effective be any later than two (2) months from the month in which the change occurred. For purposes of calculating the claim, the local office shall assume that the change would have been reported properly and timely acted upon by the local office.

    b. If the household timely reported an increase in income but the local office failed to act on the change within the required timeframes, the first (1st) month affected by the local office's failure to act shall be the first (1st) month the office would have made the change effective had it acted timely. If a Notice of Adverse Action was required, the local office shall assume, for the purpose of calculating the claim, that the Notice of Adverse Action period would have expired without the household requesting a fair hearing.

D. IPV Claims

1. Prior to a waiver or consent agreement being signed or the determination of intentional program violation/fraud, the claim being pursued as an IPV claim shall be pursued as an IHE claim.

2. For each month that a household received an over-issuance due to an act of intentional program violation/fraud, the local office shall determine the correct amount of Food Assistance benefits, if any, the household was entitled to receive. If the household member is determined to have intentionally failed to report a change in its household's circumstances, the claim shall be established for each month in which the failure to report would have affected the household's Food Assistance allotment.

3. Once the amount of the IPV claim is established, the local office shall offset the claim against any amount of lost benefits that have not yet been restored to the household.

***

4.801.4 Collecting Payments on Claims

***

D. Negotiating Payment Plans

Households participating in the program are subject to allotment reduction in accordance with Section 4.801.41.B, unless the claim is being collected at a higher amount, per agreement with the household. Allotment reduction must begin with the first allotment issued ten (10) calendar days after the demand letter is mailed.

When a household is subject to allotment reduction, then a repayment agreement is not necessary unless the household wants to make voluntary payments in addition to the allotment reduction or elects to make monthly payments in amount greater than what would be repaid through allotment reduction.

If a household is not participating in the program, then the local office shall negotiate a payment schedule with the household for repayment of any amounts of the claim not repaid through a lump sum payment.

1. Establishing a Payment Plan

The local office shall negotiate a payment schedule with the household for repayment of any amounts of the claim not repaid through a lump sum payment or through allotment reduction. Payments shall be accepted in regular installments. The household may use Food Assistance benefits as full or partial payment of any installment. The local office shall ensure that the negotiated amount of any payment schedule to be repaid each month through installment payments is not less than the amount that could be recovered through an allotment reduction. Once negotiated, the amount to be repaid each month through installment payments shall remain unchanged regardless of subsequent changes in the household's monthly allotment. However, both the local office and the household shall have the option to initiate renegotiation of the payment schedule if they believe that the household's economic circumstances have changes enough to warrant such action.

2. Household’s Failure to Respond to the Repayment Agreement

If the household is not participating in the program when collection action for claim is initiated or if collection action has been initiated for repayment of a claim and no response is made to the first (1st) demand letter, additional demand letters shall be sent at reasonable Intervals, such as thirty (30) calendar days apart. The demand letters shall be sent until the household responds by paying or agreeing to pay the claim, until the criteria for suspending collection has been met or until the local office initiates ether collection actions.

3. Household’s Failure to Pay in Accordance with Payment Plan

a. If the household fails to make a payment in accordance with the established repayment schedule either by making a payment of a lesser amount or by making no payment, the local office shall send the household a notice that:

1) Explains that no payment or an insufficient payment was received;

2) Informs the household that it may contact the local office to discuss renegotiation of the payment schedule;

3) Informs the household that unless the overdue payments are made or the local office is contacted to discuss renegotiation of the payment schedule, the allotment of a currently participating household against which a claim has been established shall be reduced.

b. If the household responds to the notice, the local office shall take one of the following actions as appropriate:

1) If the household makes the overdue payments and wishes to continue payments based on the previous schedule, the local office shall permit the household to do so, but shall also require the household to sign a new repayment agreement;

2) If the household requests renegotiation and the local office concurs with the request, the local office shall negotiate a new payment schedule.

***

4.801.41 Methods of Collecting Payment on Claims ~~[Rev. eff. 1/1/16]~~

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B. Food Assistance Allotment Reduction

1. The local office shall collect payments for claims from households currently participating in the Program by reducing the household's Food Assistance allotment. For claims where there is a court-ordered judgment for repayment, allotment reduction shall not occur.

   Prior to reduction, the local office shall inform the household of:

   a. The appropriate formula for determining the amount of Food Assistance to be recovered each month; and,

   b. The amount of Food Assistance the local office expects will be recovered each month; and,

   c. The availability of other methods of repayment.

2. The household's allotment will be reduced based on the recoupment amounts for each type of claim, unless a payment schedule has been negotiated with the household.

   The local office may collect on a claim by invoking benefit allotment reduction on two (2) separate households for the same claim. However, the local office is not required to perform this simultaneous reduction.

3. The amount of Food Assistance to be recovered each month through allotment reduction shall be determined as follows:

   a. For AE claims and IHE claims, the amount of Food Assistance to be recovered each month from a household shall either be ten percent (10%) of the household's monthly allotment or ten dollars ($10) each month, whichever is greater.

   b. For IPV claims, the amount of Food Assistance benefit reduction shall either be twenty percent (20%) of the household's monthly allotment or twenty dollars ($20) per month, whichever is greater.

4. Benefits authorized for an initial month will not be reduced to offset a claim. Ongoing benefits will be recouped based on the above criteria.

***

4.801.5 Claims Discharged Through Bankruptcy

A. IPV claims tied to an actual determination of fraud through either an ADH or a court hearing cannot be discharged through bankruptcy. If an individual signs an ADH waiver and admits to committing fraud or guilt when accepting the disqualification, the IPV claims cannot be discharged through bankruptcy. If the individual signs the ADH waiver without admitting to fraud or guilt, there is no actual determination of fraud and the IPV claim may potentially be dischargeable through bankruptcy.

B. Local offices shall act on behalf of, and as an agent of, FNS in any bankruptcy proceedings against bankrupt households owing Food Assistance claims. Local offices shall possess any rights, priorities, liens, and privileges and shall participate in any distribution of assets, to the same extent as FNS. Acting as FNS, local offices shall have the power and authority to file objections to discharge proof of claims, exceptions to discharge, petition for revocation of discharge, and any other documents, motions, or objections which FNS might have filed.

Title of Proposed Rule: Food Assistance Recipient Claims Updates 2020
CDHS Tracking #: **20-01-17-01**
CCR #: 10 CCR 2506-1
Office, Division, & Program: OES, FEAD, Food Assistance Phone: 303-866-5813
Rule Author: Teri Chasten E-Mail: Teri.chasten@state.co.us

RULEMAKING PACKET

This package is submitted to State Board Administration as: *(check all that apply)*

[X] AG Initial Review [X] Initial Board Reading [ ] AG 2nd Review [ ] 2nd Board Reading / Adoption

This package contains the following types of revisions to the rule: *(number of sections with the following edits)*

_____ Amended
_____ New
_____ Repealed
_____ Reviewed

What month is being requested for this rule to first go before the State Board? February 2020

What date is being requested for this rule to be effective? February 7, 2020

Is this date legislatively required? No

Is this rule change based on legislation? No If so, bill number:

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	February 2020 (emergency adoption)	2nd Board	March 2020 (permanent adoption)	Effective Date	February 2020	7

Title of Proposed Rule: Food Assistance Recipient Claims Updates 2020
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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. ***Firm 1500 character maximum, please count before submitting.***

These sections of rule were reviewed by the United States Department of Agriculture, Food and Nutrition Service (FNS), during a Recipient Claims and Treasury Offset Program Management Evaluation Review in August 2019. The Food and Energy Assistance Division (FEAD) received the final report from FNS in late October 2019 with a formal corrective action response required by January 17, 2020. Updates to these regulations were noted as resolution to the audit findings in the FEAD formal corrective action response.

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:

Colorado Food Assistance regulations must be updated to come into compliance with Federal SNAP regulations. Keeping these regulations as they are currently written would open the state to risk of a federal sanction.

State Board Authority for Rule:

Code	Description
26-1-107, C.R.S. (2019)	State Board to promulgate rules
26-1-109, C.R.S. (2019)	State department rules to coordinate with federal programs
26-1-111, C.R.S. (2019)	State department to promulgate rules for public assistance and welfare activities.
24-4-103, C.R.S. (2019)	Provides for emergency adoption of rules

Program Authority for Rule: *Give federal and/or state citations and a summary of the language authorizing the rule-making function AND authority.* ***This is mandatory, do not leave blank.***

Code	Description
26-2-301, C.R.S. (2019)	Designates the Colorado Department of Human Services as the responsible agency to administer the Food Assistance Program in the State of Colorado.
26-2-302, C.R.S. (2019)	Prohibits any interference that would prevent the Colorado Department of Human Services from complying with federal mandates prescribed under the federal "Food Stamp Act" as amended.
7 CFR Subtitle B, Chapter II, Subchapter C, §271.4	Federal Supplemental Nutrition Assistance Program regulations delegates authority for the State administration of SNAP
7 CFR Subtitle B, Chapter II, Subchapter C, §273	Federal Supplemental Nutrition Assistance Program regulations regarding certification of SNAP households
7 USC § 51	Supplemental Nutrition Assistance Program Act

Does the rule incorporate material by reference? [ ] Yes [X] No

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Does this rule repeat language found in statute? [ ] Yes [X] No

If yes, please explain.

Type of Rule: *(complete a and b, below)*

a. [X] Board or [ ] Executive Director

b. [ ] Regular or [X] Emergency

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?

State of Colorado Food Assistance program staff, County Food Assistance staff, Food Assistance recipients.

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?

Food Assistance recipients will be positively impacted by the reduction in the amount of time a claim can be created and collected on. Other aspects of these regulation changes provide clarification to rules in order for Colorado to be in compliance with federal regulation.

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 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)*

There would be a fiscal impact to the amount of funds Colorado and counties are able to retain if a claim is collected through the Treasury Offset Program. Per federal regulation, states are able to receive a 20% retention rate for collections on IHE claims. These funds are retained by the counties and the overall state's administrative funds are reduced by the amount that is retained, as USDA expects states/counties to use the retained funds to pay for SNAP expenses. Thus, even with a reduction in retained funds, the overall administrative funds for SNAP will not be significantly impacted.

County Fiscal Impact

There would be a fiscal impact to the amount of funds Colorado and counties are able to retain if a claim is collected through the Treasury Offset Program.. Per federal regulation, states are able to receive a 20% retention rate for collections on IHE claims. These funds are retained by the counties and the overall state's administrative funds are reduced by the amount that is retained, as USDA expects states/counties to use the retained funds to pay for SNAP expenses. Thus, even with a reduction in retained funds, the overall administrative funds for SNAP will not be significantly impacted.

Federal Fiscal Impact

Title of Proposed Rule:	Food Assistance Recipient Claims Updates 2020
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There are no federal fiscal impacts associated with this rule change because these are regulatory changes that do not impact the overall funding received from the USDA.

Other Fiscal Impact *(such as providers, local governments, etc.)*

4. Data Description

List and explain any data, such as studies, federal announcements, or questionnaires, which were relied upon when developing this rule?

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…"**

There are no other alternatives to incorporate these regulations because Colorado Food Assistance regulations must be updated to ensure compliance with Federal SNAP regulation.

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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
4.801.2(A)	Updated abbreviations and added clarifying language.	A. Establishing a Claim 1. The local office shall establish claims in accordance with the thresholds outlined below. a. For participating households, the county department shall not establish a claim for overpayment due to Administrative Error (AE) or Inadvertent Household Error (IHE), except in the following circumstances: 1. When the amount of the claim is greater than $200; or, 2. When the overpayment is identified through a federal or state level quality control review; or, 3. When the inadvertent household error claim is being pursued as an intentional program violation (IPV), except that if the inadvertent household error claim does not result in an IPV, collection shall not be pursued. b. For households not participating in the food assistance program, the county department shall not establish a claim for overpayment except in the following circumstances: 1. When the amount of the claim is greater than $400; or,	A. Establishing a Claim 1. The local office shall establish claims in accordance with the thresholds outlined below. a. For participating households, the county department shall not establish a claim for overpayment due to Administrative Error (AE) or Inadvertent Household Error (IHE), except in the following circumstances: 1. When the amount of the claim is greater than $200; or, 2. When the overpayment is identified through a federal or state level quality control review; or, 3. When the IHE claim is being pursued as an IPV, except that if the IHE claim does not result in an IPV, collection shall not be pursued. b. For households not participating in the Food Assistance program, the county department shall not establish a claim for overpayment except in the following circumstances: 1. When the amount of the AE claim is greater than $400; or, 2. When the amount of the claim is due to an IHE and is greater than $200; or, 3. When the overpayment is identified through a	IHE and IPV abbreviations were added as the full language was included in this section and in definitions. Aligned the IHE collection for those currently receiving Food Assistance and those not currently receiving Food Assistance. Updated timeframe for how far back an Inadvertent Household Error claim can be created to the federally allowable minimum timeframe (12 months) from the maximum timeframe (6 years).	

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Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
		2. When the amount of the claim is due to an inadvertent household error and is greater than $200; or, 3. When the overpayment is identified through a federal or state level quality control review. 2. An administrative error claim shall not be established for a period more than twelve (12) months from the date the local office was notified, in writing or orally, or discovered through the normal course of business that an error occurred which led to the household receiving more benefits than it was entitled to receive. , excluding over-issuances identified through a federal or state quality control review. An over-issuance of benefits identified through a federal or state quality control review shall be established, regardless of the amount and length of the overpayment.	federal or state level quality control review. 4. When the IHE claim is being pursued as an IPV, except that if the IHE claim does not result in an IPV, collection shall not be pursued. 2. An AE or IHE claim shall not be established for a period of more than twelve (12) months from the date the local office was notified, in writing or orally, or discovered through the normal course of business that an error occurred which led to the household receiving more benefits than it was entitled to receive. A claim associated with an IPV must be calculated back to the month the act of IPV first occurred and cannot be established for a period more than six (6) years from the date the local office was notified, in writing or orally, or discovered through the normal course of business that an error occurred which led to the household receiving more benefits than it was entitled to receive.		
4.801.3(A)	Spelling correction, language clarification	A. Compromising Claims If the full amount or remaining amount of an administrative error or inadvertent household error claim cannot be liquidated in three (3) years, the local office may compromise the clam by reducing it to an amount that will allow the household to pay the claim in three (3) years. Intentional program violation claims shall not be compromised, unless specified in a court decision. The local office may use the full amount of the claim, including any amount compromised, to offset lost benefits. Decisions	A. Compromising Claims If the full amount or remaining amount of an AE or IHE claim cannot be liquidated in three (3) years, the local office may compromise the claim by reducing it to an amount that will allow the household to pay the claim in three (3) years. Intentional program violation claims shall not be compromised, unless specified in a court decision. The local office may use the full amount of the claim, including any amount compromised, to offset lost benefits. Decisions regarding compromises shall be documented in the case record.	Changed the work clam to claim. Added abbreviations to be consistent with regulation. Clarified that a household does not need to make a request for compromise in order of the county to consider the	

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Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
		regarding compromises shall be documented in the case record. A payment plan on a claim that has been compromised may be renegotiated if necessary. Claims that are already reduced by either an administrative or district court order are considered compromised claims, and thus are not eligible for additional compromise. Local offices shall review the circumstances of a household that requests a compromise and determine if a compromise would be appropriate. Local offices do not have the option of refusing to consider compromising claims. Local offices cannot institute a policy of never compromising claims. Claims should be compromised if the household demonstrates need, such as the inability to repay the claim within three (3) years, or if the household proves that financial, physical, or mental hardship would exist if forced to pay the full amount of the original claim. Some circumstances include, but are not limited to medical hardships, high shelter costs, loan payments, and other extraordinary expenses. A compromise based on hardship may be applied to a Food Assistance case whether or not the household is still receiving Food Assistance benefits. Consideration should be given to the future earning potential of the household over the next three (3) years to pay back the claim based on age, disability, and other household factors.	A payment plan on a claim that has been compromised may be renegotiated if necessary. Claims that are already reduced by either an administrative or district court order are considered compromised claims, and thus are not eligible for additional compromise. Local offices shall review the household's circumstances and determine if a compromise would be appropriate. Local offices do not have the option of refusing to consider compromising claims. Local offices cannot institute a policy of never compromising claims. Claims should be compromised if the household demonstrates need, such as the inability to repay the claim within three (3) years, or if the household proves that financial, physical, or mental hardship would exist if forced to pay the full amount of the original claim. Some circumstances include, but are not limited to medical hardships, high shelter costs, loan payments, and other extraordinary expenses. A compromise based on hardship may be applied to a Food Assistance case whether or not the household is still receiving Food Assistance benefits. Consideration should be given to the future earning potential of the household over the next three (3) years to pay back the claim based on age, disability, and other household factors.	option of compromising the claim.	

Title of Proposed Rule: Food Assistance Recipient Claims Updates 2020
CDHS Tracking #: **20-01-17-01**
CCR #: 10 CCR 2506-1
Office, Division, & Program: OES, FEAD, Food Assistance Phone: 303-866-5813
Rule Author: Teri Chasten E-Mail: Teri.chasten@state.co.us

Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
4.801.3(C)	Updated language and removed redundant information.	C. Agency Error and Inadvertent Household Error Claims 1. If the household received a larger allotment than it was entitled to receive, the local office shall establish a claim against the household that is equal to the difference between the allotment that the household received and the actual allotment it should have received. Benefits authorized under Colorado Electronic Benefits Transfer System (CO/EBTS) shall be used to calculate the claim. After calculating the amount of a claim and establishing claims, the local office may offset the amount of the claim against any amounts which have not yet been restored to the household. Expungements and any return of benefits that occur shall be used to offset the amount of the claim. 2. The claim may also be offset against restored benefits owed to: a. Any household that contains a member who was an adult member of the original household; b. Any household that contains an authorized representative that caused the overpayment or trafficking. c. In no circumstance, may the local office collect more than the amount of the claim.	C. Agency Error and Inadvertent Household Error Claims 1. If the household received a larger allotment than it was entitled to receive, the local office shall establish a claim against the household that is equal to the difference between the allotment that the household received and the actual allotment it should have received. Benefits authorized under Colorado Electronic Benefits Transfer System (CO/EBTS) shall be used to calculate the claim. After calculating the amount of a claim and establishing claims, the local office must offset the amount of the claim against any amounts which have not yet been restored to the household. Expungements and any return of benefits that occur must be used to offset the amount of the claim. 2. The claim must also be offset against restored benefits owed to: a. Any household that contains a member who was an adult member of the original household; b. Any household that contains an authorized representative that caused the overpayment or trafficking. c. In no circumstance, may the local office collect more than the amount of the claim. 3. For households eligible under basic categorical	Updated a few 'may' statements to 'must' statements to be clear there that the stated actions are a requirement. Removed a paragraph explaining the timeframe by which to estimate a claim as this is covered in 4.801.2.	

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		3. The Food Assistance office shall calculate the amount of an agency error or inadvertent household error claim back to the month the over-issuance occurred. However, in no event shall the amount of the administrative error claim be calculated for any period prior to one (1) year from the date the local office was notified, in writing or orally, or discovered through the normal course of business, that an error occurred which led to the household receiving more benefits than it was entitled to receive. All other claims shall be established for a period no greater than six years from the date the agency discovered the overpayment. 4. For households eligible under basic categorical eligibility, a claim shall only be determined when it can be computed on the basis of changed household net income and/or household size. A claim shall not be established if there was not a change in net income and/or household size. If a household receives both Temporary Assistance for Needy Families (TANF) and Food Assistance and mis-reports information to TANF in accordance with the TANF reporting requirements, and the mis-report of information to TANF resulted in the household being over paid TANF or ineligible for TANF, any resulting Food Assistance claim should be based on the actual TANF issued. 5. The correct allotment shall be calculated using the same methods applied to an actual certification. The twenty percent (20%) earned income deduction shall not be applied to that	eligibility, a claim shall only be determined when it can be computed on the basis of changed household net income and/or household size. A claim shall not be established if there was not a change in net income and/or household size. If a household receives both Temporary Assistance for Needy Families (TANF) and Food Assistance and mis-reports information to TANF in accordance with the TANF reporting requirements, and the mis-report of information to TANF resulted in the household being over paid TANF or ineligible for TANF, any resulting Food Assistance claim should be based on the actual TANF issued. 4. The correct allotment shall be calculated using the same methods applied to an actual certification. The twenty percent (20%) earned income deduction shall not be applied to that part of any earned income that the household failed to report in a timely manner when this act is the basis for the claim; therefore, any portion of the claim that is due to earned income being reported in an untimely manner will be calculated without allowing the twenty percent (20%) earned income deduction. The actual circumstances of the household shall be used to calculate the claim. In instances when a claim is caused by the household's failure to report information as required, the amount of the claim is based on the allotment difference from what the household actually received compared to what the household would have received if the household would have reported the information as required. For example, if a simplified reporting household did not report income at initial application as required, the income used to calculate the overpayment would be the income that the household actually		

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		part of any earned income that the household failed to report in a timely manner when this act is the basis for the claim; therefore, any portion of the claim that is due to earned income being reported in an untimely manner will be calculated without allowing the twenty percent (20%) earned income deduction. The actual circumstances of the household shall be used to calculate the claim. In instances when a claim is caused by the household's failure to report information as required, the amount of the claim is based on the allotment difference from what the household actually received compared to what the household would have received if the household would have reported the information as required. For example, if a simplified reporting household did not report income at initial application as required, the income used to calculate the overpayment would be the income that the household actually received in the month of application, as this would have been used to determine the household's ongoing monthly amount. Actual income received each subsequent month is not required to calculate each month of the claim, as any fluctuation in monthly income that was received by the household after the initial month of application was not required to be reported by the household. If the household failed to report a change in household circumstances that would have resulted in an increase in benefits during the time period of the claim, the local office shall act on the change in information as of the date the change was reported to the local office. 6. When a household certified below 130% FPL	received in the month of application, as this would have been used to determine the household's ongoing monthly amount. Actual income received each subsequent month is not required to calculate each month of the claim, as any fluctuation in monthly income that was received by the household after the initial month of application was not required to be reported by the household. If the household failed to report a change in household circumstances that would have resulted in an increase in benefits during the time period of the claim, the local office shall act on the change in information as of the date the change was reported to the local office. 5. When a household certified below 130% FPL fails to report an increase in household income over 130% FPL. The local office shall establish the claim for each month in which an over-issuance of Food Assistance has occurred. a. In cases involving household failure to report an increase in income within the required timeframes, the first (1st) month affected by the household's failure to report shall be the first (1st) month in which the change would have been effective had it been timely reported. However, in no event shall the determination of the first (1st) month in which the change would have been effective be any later than two (2) months from the month in which the change occurred. For purposes of calculating the claim, the local office shall assume that the change would have been reported properly and timely acted upon by the local office.		

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		fails to report an increase in household income over 130% FPL. The local office shall establish the claim for each month in which an over-issuance of Food Assistance has occurred. a. In cases involving household failure to report an increase in income within the required timeframes, the first (1st) month affected by the household's failure to report shall be the first (1st) month in which the change would have been effective had it been timely reported. However, in no event shall the determination of the first (1st) month in which the change would have been effective be any later than two (2) months from the month in which the change occurred. For purposes of calculating the claim, the local office shall assume that the change would have been reported properly and timely acted upon by the local office. b. If the household timely reported an increase in income but the local office failed to act on the change within the required timeframes, the first (1st) month affected by the local office's failure to act shall be the first (1st) month the office would have made the change effective had it acted timely. If a Notice of Adverse Action was required, the local office shall assume, for the purpose of calculating the claim, that the Notice of Adverse Action period would have expired without the household requesting a fair hearing.	b. If the household timely reported an increase in income but the local office failed to act on the change within the required timeframes, the first (1st) month affected by the local office's failure to act shall be the first (1st) month the office would have made the change effective had it acted timely. If a Notice of Adverse Action was required, the local office shall assume, for the purpose of calculating the claim, that the Notice of Adverse Action period would have expired without the household requesting a fair hearing.		
4.801.3(D)	Removed redundant language	D. Intentional Program Violation Claims	D. IPV Claims	Removed the language that states an IPV	

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		1. Prior to a waiver or consent agreement being signed or the determination of intentional program violation/fraud, the claim being pursued as an intentional program violation claim shall be pursued as an inadvertent household error claim. 2. For each month that a household received an over-issuance due to an act of intentional program violation/fraud, the local office shall determine the correct amount of Food Assistance benefits, if any, the household was entitled to receive. The amount of the intentional program violation/fraud claim shall be calculated back to the month the intentional program violation occurred. However, in no event shall the amount of the claim be calculated for any period prior to six (6) years from the date the intentional program violation was discovered. If the household member is determined to have intentionally failed to report a change in its household's circumstances, the claim shall be established for each month in which the failure to report would have affected the household's Food Assistance allotment. 3. Once the amount of the intentional program violation/fraud claim is established, the local office shall offset the claim against any amount of lost benefits that have not yet been restored to the household.	1. Prior to a waiver or consent agreement being signed or the determination of IPV, the claim being pursued as an IPV claim shall be pursued as an IHE claim. 2. For each month that a household received an over-issuance due to an act of intentional program violation/fraud, the local office shall determine the correct amount of Food Assistance benefits, if any, the household was entitled to receive. If the household member is determined to have intentionally failed to report a change in its household's circumstances, the claim shall be established for each month in which the failure to report would have affected the household's Food Assistance allotment. 3. Once the amount of the IPV claim is established, the local office shall offset the claim against any amount of lost benefits that have not yet been restored to the household.	cannot be calculated back further than six years. This information is included in 4.801.2(A).	
4.801.4(D)	Updated language	D. Negotiating Payment Plans Households participating in the program are subject to allotment reduction in accordance with Section 4.801.41, B, unless the claim is being collected at a higher amount.	D. Negotiating Payment Plans Households participating in the program are subject to allotment reduction in accordance with Section 4.801.41, B, unless the claim is being collected at a higher amount, per agreement with the household. Allotment reduction must begin with the first allotment	Language was updated to clearly note the federal requirement that an allotment reduction must begin within 10	

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		If a household is not participating in the program, then the local office shall negotiate a payment schedule with the household for repayment of any amounts of the claim not repaid through a lump sum payment. If a household is subject to allotment reduction, then a repayment agreement is not necessary unless the household wants to make voluntary payments in addition to the allotment reduction or elects to make monthly payments in amount greater than what would be repaid through allotment reduction. 1. Establishing a Payment Plan The local office shall negotiate a payment schedule with the household for repayment of any amounts of the claim not repaid through a lump sum payment or through allotment reduction. Payments shall be accepted in regular installments. The household may use Food Assistance benefits as full or partial payment of any installment. The local office shall ensure that the negotiated amount of any payment schedule to be repaid each month through installment payments is not less than the amount that could be recovered through an allotment reduction. Once negotiated, the amount to be repaid each month through installment payments shall remain unchanged regardless of subsequent changes in the household's monthly allotment. However, both the local office and the household shall have the option to initiate renegotiation of the payment schedule if they believe that the	issued ten (10) calendar days after the demand letter is mailed. When a household is subject to allotment reduction, then a repayment agreement is not necessary unless the household wants to make voluntary payments in addition to the allotment reduction or elects to make monthly payments in amount greater than what would be repaid through allotment reduction. If a household is not participating in the program, then the local office shall negotiate a payment schedule with the household for repayment of any amounts of the claim not repaid through a lump sum payment. 1. Establishing a Payment Plan The local office shall negotiate a payment schedule with the household for repayment of any amounts of the claim not repaid through a lump sum payment or through allotment reduction. Payments shall be accepted in regular installments. The household may use Food Assistance benefits as full or partial payment of any installment. The local office shall ensure that the negotiated amount of any payment schedule to be repaid each month through installment payments is not less than the amount that could be recovered through an allotment reduction. Once negotiated, the amount to be repaid each month through installment payments shall remain unchanged regardless of subsequent changes in the household's monthly allotment. However, both the local office and the household shall have the option to initiate renegotiation of the payment schedule if they believe that the household's economic circumstances have changes	days of the demand letter, not after waiting for the household to respond to repayment agreement.	

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		household's economic circumstances have changes enough to warrant such action. 2. Household's Failure to Respond to the Repayment Agreement a. If the household against which collection action has been initiated for repayment of a inadvertent household or agency error or intentional program violation claim is currently participating in the program and does not respond to the written demand letter within ten (10) calendar days of the date the notice is mailed, benefit allotment reduction shall begin with the first (1st) allotment issued ten (10) calendar days from the date given to respond without further notice. A household that does not pay the claim amount in full by the deadline will have allotment reduction begin with the next allotment issued. b. If the household is not participating in the program when collection action for claim is initiated or if collection action has been initiated for repayment of a claim and no response is made to the first (1st) demand letter, additional demand letters shall be sent at reasonable Intervals, such as thirty (30) calendar days apart. The demand letters shall be sent until the household responds by paying or agreeing to pay the claim, until the criteria for suspending collection has been met or until the local office initiates ether collection actions. c. If the household responds by requesting renegotiation of the amount of its	enough to warrant such action. 2. Household's Failure to Respond to the Repayment Agreement If the household is not participating in the program when collection action for claim is initiated or if collection action has been initiated for repayment of a claim and no response is made to the first (1st) demand letter, additional demand letters shall be sent at reasonable Intervals, such as thirty (30) calendar days apart. The demand letters shall be sent until the household responds by paying or agreeing to pay the claim, until the criteria for suspending collection has been met or until the local office initiates ether collection actions. 3. Household's Failure to Pay in Accordance with Payment Plan a. If the household fails to make a payment in accordance with the established repayment schedule either by making a payment of a lesser amount or by making no payment, the local office shall send the household a notice that: 1) Explains that no payment or an insufficient payment was received; 2) Informs the household that it may contact the local office to discuss renegotiation of the payment schedule; 3) Informs the household that unless the overdue payments are made or the local office is contacted to discuss renegotiation of the		

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		repayment schedule within ten (10) calendar days from the date the notice is mailed but the local office believes that the household's economic circumstances have not changed enough to warrant the requested settlement, allotment reductions may be invoked. 3. Household's Failure to Pay in Accordance with Payment Plan a. If the household fails to make a payment in accordance with the established repayment schedule either by making a payment of a lesser amount or by making no payment, the local office shall send the household a notice that: 1) Explains that no payment or an insufficient payment was received; 2) Informs the household that it may contact the local office to discuss renegotiation of the payment schedule; 3) Informs the household that unless the overdue payments are made or the local office is contacted to discuss renegotiation of the payment schedule, the allotment of a currently participating household against which a claim has been established shall be reduced. b. If the household responds to the notice, the local office shall take one of the following actions as appropriate:	payment schedule, the allotment of a currently participating household against which a claim has been established shall be reduced. b. If the household responds to the notice, the local office shall take one of the following actions as appropriate: 1) If the household makes the overdue payments and wishes to continue payments based on the previous schedule, the local office shall permit the household to do so, but shall also require the household to sign a new repayment agreement; 2) If the household requests renegotiation and the local office concurs with the request, the local office shall negotiate a new payment schedule.		

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		1) If the household makes the overdue payments and wishes to continue payments based on the previous schedule, the local office shall permit the household to do so, but shall also require the household to sign a new repayment agreement; 2) If the household requests renegotiation and the local office concurs with the request, the local office shall negotiate a new payment schedule.			
4.801.41(B)	Updated language	B. Food Assistance Allotment Reduction 1. The local office shall collect payments for claims from households currently participating in the Program by reducing the household's Food Assistance allotment. For claims where there is a court-ordered judgment for repayment, allotment reduction shall not occur. Prior to reduction, the local office shall inform the household of: a. The appropriate formula for determining the amount of Food Assistance to be recovered each month; and, b. The amount of Food Assistance the local office expects will be recovered each month; and, c. The availability of other methods of	B. Food Assistance Allotment Reduction 1. The local office shall collect payments for claims from households currently participating in the Program by reducing the household's Food Assistance allotment. For claims where there is a court-ordered judgment for repayment, allotment reduction shall not occur. Prior to reduction, the local office shall inform the household of: a. The appropriate formula for determining the amount of Food Assistance to be recovered each month; and, b. The amount of Food Assistance the local office expects will be recovered each month; and, c. The availability of other methods of repayment.	Removed language in order to match the federal requirement that all allotment amounts are reduced by the same percentages. 10% for IHE and AE and 20% for IPV	

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		repayment. 2. The household's allotment will be reduced based on the recoupment amounts for each type of claim, unless a payment schedule has been negotiated with the household. One- and two-person households receiving a minimum allotment, which is eight percent (8%) of the maximum allotment for a one-person household, shall be reduced to a lower benefit level in accordance with Section 4.801.41, C, 2. The local office may collect on a claim by invoking benefit allotment reduction on two (2) separate households for the same claim. However, the local office is not required to perform this simultaneous reduction. 3. The amount of Food Assistance to be recovered each month through allotment reduction shall be determined as follows: a. For agency error claims and inadvertent household error claims, the amount of Food Assistance to be recovered each month from a household shall either be ten percent (10%) of the household's monthly allotment or ten dollars ($10) each month, whichever is greater. b. For intentional program violation/fraud claims, the amount of Food Assistance benefit reduction shall either be twenty percent (20%) of the household's monthly allotment or twenty dollars ($20)	2. The household's allotment will be reduced based on the recoupment amounts for each type of claim, unless a payment schedule has been negotiated with the household. The local office may collect on a claim by invoking benefit allotment reduction on two (2) separate households for the same claim. However, the local office is not required to perform this simultaneous reduction. 3. The amount of Food Assistance to be recovered each month through allotment reduction shall be determined as follows: a. For AE claims and IHE claims, the amount of Food Assistance to be recovered each month from a household shall either be ten percent (10%) of the household's monthly allotment or ten dollars ($10) each month, whichever is greater. b. For IPV claims, the amount of Food Assistance benefit reduction shall either be twenty percent (20%) of the household's monthly allotment or twenty dollars ($20) per month, whichever is greater. 4. Benefits authorized for an initial month will not be reduced to offset a claim. Ongoing benefits will be recouped based on the above criteria.		

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		per month, whichever is greater. If the household is receiving the minimum allotment, the allotment reduction will be ten percent (10%) or ten dollars ($10), whichever is greater. 4. Benefits authorized for an initial month will not be reduced to offset a claim. Ongoing benefits will be recouped based on the above criteria.			
4.801.5	Added federal clarification	Claims Discharged Through Bankruptcy Local offices shall act on behalf of, and as an agent of, FNS in any bankruptcy proceedings against bankrupt households owing Food Assistance claims. Local offices shall possess any rights, priorities, liens, and privileges and shall participate in any distribution of assets, to the same extent as FNS. Acting as FNS, local offices shall have the power and authority to file objections to discharge proof of claims, exceptions to discharge, petition for revocation of discharge, and any other documents, motions, or objections which FNS might have filed. Any amounts collected under this authority shall be transmitted to the Food Assistance Programs Division as provided in Section 4.801.8.	Claims Discharged Through Bankruptcy A. IPV claims tied to an actual determination of fraud through either an ADH or a court hearing cannot be discharged through bankruptcy. if an individual signs an ADH waiver and admits to committing fraud or guilt when accepting the disqualification, the IPV claims cannot be discharged through bankruptcy. if the individual signs the ADH waiver without admitting to fraud or guilt, there is no actual determination of fraud and the IPV claim may potentially be dischargeable through bankruptcy. B. Local offices shall act on behalf of, and as an agent of, FNS in any bankruptcy proceedings against bankrupt households owing Food Assistance claims. Local offices shall possess any rights, priorities, liens, and privileges and shall participate in any distribution of assets, to the same extent as FNS. Acting as FNS, local offices shall have the power and authority to file objections to discharge proof of claims,	Federal guidance requires clarification on when IPV claims can or cannot be discharged through bankruptcy.	

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			exceptions to discharge, petition for revocation of discharge, and any other documents, motions, or objections which FNS might have filed.		

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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):

Sub-PAC, PAC, CDHS Food Assistance Program staff and leadership

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:

Hunger Free Colorado, Colorado Center on Law and Policy

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?

[ ] Yes [X] No

Name of Sub-PAC	Scheduled for an electronic vote.		
Date presented			
What issues were raised?	None		
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.	This packet is an emergency rule.		

PAC

Have these rules been approved by PAC? ***Packets will not be presented to AG until after packet has been approved by PAC. Please plan your process accordingly.***

[ ] Yes [X] No

Date presented	Scheduled for 2/6/20		
What issues were raised?	None		
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.	This packet is an emergency rule.		

Other Comments

Comments were received from stakeholders on the proposed rules:

[ ] Yes [x] 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.

4.801.2 Establishing Claims Against Households ~~[Rev. eff. 1/1/16]~~

A. Establishing a Claim

1. The local office shall establish claims in accordance with the thresholds outlined below.

   a. For participating households, the county department shall not establish a claim for overpayment due to Administrative Error (AE) or Inadvertent Household Error (IHE), except in the following circumstances:

      1. When the amount of the claim is greater than $200; or,

      2. When the overpayment is identified through a federal or state level quality control review; or,

      3. When the ~~inadvertent household error~~ IHE claim is being pursued as an IPV ~~intentional program violation (IPV)~~, except that if the ~~inadvertent household error~~ IHE claim does not result in an IPV, collection shall not be pursued.

   b. For households not participating in the ~~food assistance~~ FOOD ASSISTANCE program, the county department shall not establish a claim for overpayment except in the following circumstances:

      1. When the amount of the AE claim is greater than $400; or,

      2. When the amount of the claim is due to an IHE ~~inadvertent household error~~ and is greater than $200; or,

      3. When the overpayment is identified through a federal or state level quality control review.

      4. WHEN AN IHE CLAIM IS BEING PURSUED AS AN IPV, EXCEPT THAT IF THE IHE CLAIM DOES NOT RESULT IN AN IPV, COLLECTION SHALL NOT BE PURSUED.

2. An AE OR IHE ~~administrative error~~ claim shall not be established for a period OF more than twelve (12) months from the date the local office was notified, in writing or orally, or discovered through the normal course of business that an error occurred which led to the household receiving more benefits than it was entitled to receive. ~~, excluding over-issuances identified through a federal or state quality control review.~~

   ~~An over-issuance of benefits identified through a federal or state quality control review shall be established, regardless of the amount and length of the overpayment.~~

   A CLAIM ASSOCIATED WITH AN IPV MUST BE CALCULATED BACK TO THE MONTH THE ACT OF IPV FIRST OCCURRED AND CANNOT BE ESTABLISHED FOR A PERIOD MORE THAN SIX (6) YEARS FROM THE DATE THE LOCAL OFFICE WAS NOTIFIED, IN WRITING OR ORALLY, OR DISCOVERED THROUGH THE NORMAL COURSE OF BUSINESS THAT AN ERROR OCCURRED WHICH LED TO THE HOUSEHOLD RECEIVING MORE BENEFITS THAN IT WAS ENTITLED TO RECEIVE.

***

4.801.3 Calculating the Amount of a Claim ~~[Rev. eff. 1/1/16]~~

A. Compromising Claims

If the full amount or remaining amount of an AE ~~administrative error~~ or IHE ~~inadvertent household error~~ claim cannot be liquidated in three (3) years, the local office may compromise the CLAIM ~~clam~~ by reducing it to an amount that will allow the household to pay the claim in three (3) years. Intentional program violation claims shall not be compromised, unless specified in a court decision. The local office may use the full amount of the claim, including any amount compromised, to offset lost benefits. Decisions regarding compromises shall be documented in the case record.

A payment plan on a claim that has been compromised may be renegotiated if necessary. Claims that are already reduced by either an administrative or district court order are considered compromised claims, and thus are not eligible for additional compromise.

Local offices shall review the HOUSEHOLD'S circumstances ~~of a household that requests a compromise~~ and determine if a compromise would be appropriate. Local offices do not have the option of refusing to consider compromising claims. Local offices cannot institute a policy of never compromising claims.

Claims should be compromised if the household demonstrates need, such as the inability to repay the claim within three (3) years, or if the household proves that financial, physical, or mental hardship would exist if forced to pay the full amount of the original claim. Some circumstances include, but are not limited to medical hardships, high shelter costs, loan payments, and other extraordinary expenses. A compromise based on hardship may be applied to a Food Assistance case whether or not the household is still receiving Food Assistance benefits.

Consideration should be given to the future earning potential of the household over the next three (3) years to pay back the claim based on age, disability, and other household factors.

B. Claims Resulting from Trafficking

The value of claims resulting from trafficking related offenses is the value of the trafficked benefits as determined by the individual's admission, through adjudication, or the documentation that forms the basis for the trafficking determination. Documentation could include such items as notarized statements or printouts from the Electronic Benefit Transfer (EBT) systems.

C. Agency Error and Inadvertent Household Error Claims

1. If the household received a larger allotment than it was entitled to receive, the local office shall establish a claim against the household that is equal to the difference between the allotment that the household received and the actual allotment it should have received. Benefits authorized under Colorado Electronic Benefits Transfer System (CO/EBTS) shall be used to calculate the claim.

   After calculating the amount of a claim and establishing claims, the local office MUST ~~may~~ offset the amount of the claim against any amounts which have not yet been restored to the household. Expungements and any return of benefits that occur MUST ~~shall~~ be used to offset the amount of the claim.

2. The claim ~~may~~ MUST also be offset against restored benefits owed to:

   a. Any household that contains a member who was an adult member of the original household;

   b. Any household that contains an authorized representative that caused the overpayment or trafficking.

   c. In no circumstance may the local office collect more than the amount of the claim.

~~3. The Food Assistance office shall calculate the amount of an agency error or inadvertent household error claim back to the month the over-issuance occurred. However, in no event shall the amount of the administrative error claim be calculated for any period prior to one (1) year from the date the local office was notified, in writing or orally, or discovered through the normal course of business, that an error occurred which led to the household receiving more benefits than it was entitled to receive. All other claims shall be established for a period no greater than six years from the date the agency discovered the overpayment.~~

~~4~~. 3. For households eligible under basic categorical eligibility, a claim shall only be determined when it can be computed on the basis of changed household net income and/or household size. A claim shall not be established if there was not a change in net income and/or household size.

If a household receives both Temporary Assistance for Needy Families (TANF) and Food Assistance and mis-reports information to TANF in accordance with the TANF reporting requirements, and the mis-report of information to TANF resulted in the household being over paid TANF or ineligible for TANF, any resulting Food Assistance claim should be based on the actual TANF issued.

~~5~~.4. The correct allotment shall be calculated using the same methods applied to an actual certification. The twenty percent (20%) earned income deduction shall not be applied to that part of any earned income that the household failed to report in a timely manner when this act is the basis for the claim; therefore, any portion of the claim that is due to earned income being reported in an untimely manner will be calculated without allowing the twenty percent (20%) earned income deduction. The actual circumstances of the household shall be used to calculate the claim. In instances when a claim is caused by the household's failure to report information as required, the amount of the claim is based on the allotment difference from what the household actually received compared to what the household would have received if the household would have reported the information as required. For example, if a simplified reporting household did not report income at initial application as required, the income used to calculate the overpayment would be the income that the household actually received in the month of application, as this would have been used to determine the household's ongoing monthly amount. Actual income received each subsequent month is not required to calculate each month of the claim, as any fluctuation in monthly income that was received by the household after the initial month of application was not required to be reported by the household. If the household failed to report a change in household circumstances that would have resulted in an increase in benefits during the time period of the claim, the local office shall act on the change in information as of the date the change was reported to the local office.

~~6~~. 5. When a household certified below 130% FPL fails to report an increase in household income over 130% FPL. The local office shall establish the claim for each month in which an over-issuance of Food Assistance has occurred.

a. In cases involving household failure to report an increase in income within the required timeframes, the first (1st) month affected by the household's failure to report shall be the first (1st) month in which the change would have been effective had it been timely reported. However, in no event shall the determination of the first (1st) month in which the change would have been effective be any later than two (2) months from the month in which the change occurred. For purposes of calculating the claim, the local office shall assume that the change would have been reported properly and timely acted upon by the local office.

b. If the household timely reported an increase in income but the local office failed to act on the change within the required timeframes, the first (1st) month affected by the local office's failure to act shall be the first (1st) month the office would have made the change effective had it acted timely. If a Notice of Adverse Action was required, the local office shall assume, for the purpose of

calculating the claim, that the Notice of Adverse Action period would have expired without the household requesting a fair hearing.

D. IPV ~~Intentional Program Violation~~ Claims

1. Prior to a waiver or consent agreement being signed or the determination of IPV ~~intentional program violation/fraud~~, the claim being pursued as an IPV ~~intentional program violation~~ claim shall be pursued as an IHE ~~inadvertent household error~~ claim.

2. For each month that a household received an over-issuance due to an act of intentional program violation/fraud, the local office shall determine the correct amount of Food Assistance benefits, if any, the household was entitled to receive. ~~The amount of the intentional program violation/fraud claim shall be calculated back to the month the intentional program violation occurred. However, in no event shall the amount of the claim be calculated for any period prior to six (6) years from the date the intentional program violation was discovered.~~ If the household member is determined to have intentionally failed to report a change in its household's circumstances, the claim shall be established for each month in which the failure to report would have affected the household's Food Assistance allotment.

3. Once the amount of the IPV ~~intentional program violation/fraud~~ claim is established, the local office shall offset the claim against any amount of lost benefits that have not yet been restored to the household.

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4.801.4 Collecting Payments on Claims ~~[Rev. eff. 1/1/16]~~

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D. Negotiating Payment Plans

Households participating in the program are subject to allotment reduction in accordance with Section 4.801.41, B, unless the claim is being collected at a higher amount, PER AGREEMENT WITH THE HOUSEHOLD. ALLOTMENT REDUCTION MUST BEGIN WITH THE FIRST ALLOTMENT ISSUED TEN (10) CALENDAR DAYS AFTER THE DEMAND LETTER IS MAILED.

WHEN A HOUSEHOLD IS SUBJECT TO ALLOTMENT REDUCTION, THEN A REPAYMENT AGREEMENT IS NOT NECESSARY UNLESS THE HOUSEHOLD WANTS TO MAKE VOLUNTARY PAYMENTS IN ADDITION TO THE ALLOTMENT REDUCTION OR ELECTS TO MAKE MONTHLY PAYMENTS IN AMOUNT GREATER THAN WHAT WOULD BE REPAID THROUGH ALLOTMENT REDUCTION.

If a household is not participating in the program, then the local office shall negotiate a payment schedule with the household for repayment of any amounts of the claim not repaid through a lump sum payment.

~~If a household is subject to allotment reduction, then a repayment agreement is not necessary unless the household wants to make voluntary payments in addition to the allotment reduction or elects to make monthly payments in amount greater than what would be repaid through allotment reduction.~~

1. Establishing a Payment Plan

The local office shall negotiate a payment schedule with the household for repayment of any amounts of the claim not repaid through a lump sum payment or through allotment reduction. Payments shall be accepted in regular installments. The household may use Food Assistance benefits as full or partial payment of any installment. The local office shall

ensure that the negotiated amount of any payment schedule to be repaid each month through installment payments is not less than the amount that could be recovered through an allotment reduction. Once negotiated, the amount to be repaid each month through installment payments shall remain unchanged regardless of subsequent changes in the household's monthly allotment. However, both the local office and the household shall have the option to initiate renegotiation of the payment schedule if they believe that the household's economic circumstances have changes enough to warrant such action.

2. Household's Failure to Respond to the Repayment Agreement

~~a. If the household against which collection action has been initiated for repayment of a inadvertent household or agency error or intentional program violation claim is currently participating in the program and does not respond to the written demand letter within ten (10) calendar days of the date the notice is mailed, benefit allotment reduction shall begin with the first (1st) allotment issued ten (10) calendar days from the date given to respond without further notice. A household that does not pay the claim amount in full by the deadline will have allotment reduction begin with the next allotment issued.~~

~~b~~. If the household is not participating in the program when collection action for claim is initiated or if collection action has been initiated for repayment of a claim and no response is made to the first (1st) demand letter, additional demand letters shall be sent at reasonable Intervals, such as thirty (30) calendar days apart. The demand letters shall be sent until the household responds by paying or agreeing to pay the claim, until the criteria for suspending collection has been met or until the local office initiates ether collection actions.

~~c. If the household responds by requesting renegotiation of the amount of its repayment schedule within ten (10) calendar days from the date the notice is mailed but the local office believes that the household's economic circumstances have not changed enough to warrant the requested settlement, allotment reductions may be invoked.~~

3. Household's Failure to Pay in Accordance with Payment Plan

a. If the household fails to make a payment in accordance with the established repayment schedule either by making a payment of a lesser amount or by making no payment, the local office shall send the household a notice that:

1) Explains that no payment or an insufficient payment was received;

2) Informs the household that it may contact the local office to discuss renegotiation of the payment schedule;

3) Informs the household that unless the overdue payments are made or the local office is contacted to discuss renegotiation of the payment schedule, the allotment of a currently participating household against which a claim has been established shall be reduced.

b. If the household responds to the notice, the local office shall take one of the following actions as appropriate:

1) If the household makes the overdue payments and wishes to continue payments based on the previous schedule, the local office shall permit the household to do so, but shall also require the household to sign a new repayment agreement;

2) If the household requests renegotiation and the local office concurs with the request, the local office shall negotiate a new payment schedule.

***

4.801.41 Methods of Collecting Payment on Claims ~~[Rev. eff. 1/1/16]~~

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B. Food Assistance Allotment Reduction

1. The local office shall collect payments for claims from households currently participating in the Program by reducing the household's Food Assistance allotment. For claims where there is a court-ordered judgment for repayment, allotment reduction shall not occur.

   Prior to reduction, the local office shall inform the household of:

   a. The appropriate formula for determining the amount of Food Assistance to be recovered each month; and,

   b. The amount of Food Assistance the local office expects will be recovered each month; and,

   c. The availability of other methods of repayment.

2. The household's allotment will be reduced based on the recoupment amounts for each type of claim, unless a payment schedule has been negotiated with the household. ~~One- and two-person households receiving a minimum allotment, which is eight percent (8%) of the maximum allotment for a one-person household, shall be reduced to a lower benefit level in accordance with Section 4.801.41, C, 2.~~

   The local office may collect on a claim by invoking benefit allotment reduction on two (2) separate households for the same claim. However, the local office is not required to perform this simultaneous reduction.

3. The amount of Food Assistance to be recovered each month through allotment reduction shall be determined as follows:

   a. For AE ~~agency error~~ claims and IHE ~~inadvertent household error~~ claims, the amount of Food Assistance to be recovered each month from a household shall either be ten percent (10%) of the household's monthly allotment or ten dollars ($10) each month, whichever is greater.

   b. For IPV ~~intentional program violation/fraud~~ claims, the amount of Food Assistance benefit reduction shall either be twenty percent (20%) of the household's monthly allotment or twenty dollars ($20) per month, whichever is greater. ~~If the household is receiving the minimum allotment, the allotment reduction will be ten percent (10%) or ten dollars ($10), whichever is greater.~~

4. Benefits authorized for an initial month will not be reduced to offset a claim. Ongoing benefits will be recouped based on the above criteria.

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4.801.5 Claims Discharged Through Bankruptcy

A. IPV CLAIMS TIED TO AN ACTUAL DETERMINATION OF FRAUD THROUGH EITHER AN ADH OR A COURT HEARING CANNOT BE DISCHARGED THROUGH BANKRUPTCY. IF AN INDIVIDUAL SIGNS AN ADH WAIVER AND ADMITS TO COMMITTING FRAUD OR GUILT WHEN ACCEPTING THE DISQUALIFICATION, THE IPV CLAIMS CANNOT BE DISCHARGED

THROUGH BANKRUPTCY. IF THE INDIVIDUAL SIGNS THE ADH WAIVER WITHOUT ADMITTING TO FRAUD OR GUILT, THERE IS NO ACTUAL DETERMINATION OF FRAUD AND THE IPV CLAIM MAY POTENTIALLY BE DISCHARGEABLE THROUGH BANKRUPTCY.

B. Local offices shall act on behalf of, and as an agent of, FNS in any bankruptcy proceedings against bankrupt households owing Food Assistance claims. Local offices shall possess any rights, priorities, liens, and privileges and shall participate in any distribution of assets, to the same extent as FNS. Acting as FNS, local offices shall have the power and authority to file objections to discharge proof of claims, exceptions to discharge, petition for revocation of discharge, and any other documents, motions, or objections which FNS might have filed. ~~Any amounts collected under this authority shall be transmitted to the Food Assistance Programs Division as provided in Section 4.801.8.~~

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Tracking number: 2020-00066

Opinion of the Attorney General rendered in connection with the rules adopted by the

Food Assistance Program (Volume 4B)

on 02/07/2020

10 CCR 2506-1

RULE MANUAL VOLUME 4B, FOOD ASSISTANCE

The above-referenced rules were submitted to this office on 02/11/2020 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.

February 27, 2020 18:24:28

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Human Services

Agency

Food Assistance Program (Volume 4B)

CCR number

10 CCR 2506-1

Rule title

10 CCR 2506-1 RULE MANUAL VOLUME 4B, FOOD ASSISTANCE 1 - eff 02/07/2020

Effective date

02/07/2020

4.100 Definitions

“Able-Bodied Adult Without Dependent (ABAWD)” means an individual between the ages of eighteen (18) and fifty (50) without a physical or mental disability, who is not pregnant, and who lives in a Food Assistance household with no one under the age of eighteen (18).

****
“Countable month” means a month in which an ABAWD received full Food Assistance allotment but did not meet work requirements or have an exemption from those requirements.

***
“Disqualified individuals” means any individual who is ineligible to receive Food Assistance due to having been disqualified for an Intentional Program Violation/fraud, failure to provide or obtain a SSN, ineligible non-citizens, individuals disqualified for failure to cooperate with work requirements, individuals disqualified for failure to cooperate with the State quality assurance division, and ABAWDs who already received three countable months of Food Assistance within thirty-six (36) months without meeting an exemption or ABAWD work requirements.

***
“Level sanction” means a specified period of ineligibility imposed against an individual who failed to take a required action as part of his or her eligibility for Food Assistance.

***
”Questionable" means inconsistent or contradictory information, statements, documents or case documentation that requires verification from the household to determine eligibility.

***
“Voluntary quit” means when a Food Assistance recipient voluntarily quit a job of 30 or more hours a week or reduced work effort to less than 30 hours a week without good cause.

****

4.310 GENERAL WORK REQUIREMENTS

As a condition of eligibility for Food Assistance benefits, each household member not determined exempt must comply with the following work requirements:

A. Register for work at the time of initial application and ate every recertification by signing the application for assistance or redetermination. The application must be signed by the member required to register, an authorized representative, or by another adult household member;

B. Provide eligibility staff with sufficient information regarding employment status or availability for work;

C. Cannot commit an act of voluntary quit;

D. Accept an offer of suitable employment;

E. Report to an employer if referred by the county if the potential employment is suitable employment;

4.310.1 Work Requirements and Verification

Client statements are considered acceptable verification unless questionable.

If verification is requested from the client because client statement is considered questionable, case documentation must thoroughly explain why the original client statement was considered questionable.

A. Examples of verification that can be obtained to resolve questionable information can include but is not limited to:

    1. Receipt of temporary or permanent disability benefits issued by government or private sources; or

    2. Persons may provide a statement from a physician, physician's assistance, nurse, nurse practitioner, designated representative of the physician's office, or a licensed or certified psychologist. A county agency may determine other licensed medical personnel appropriate to provide verification that a work registrant is physically or mentally unfit for employment; or

    3. A statement from a licensed social worker or a social worker employed by or acting on behalf of a 501(C)(3) non-profit organization or government entity.

4.310.2 Informing the Household of General Work Requirements

At the point of initial application and redetermination, when an interview is required, Food Assistance households must receive from the eligibility staff written notice and a verbal explanation of:

A. The Food Assistance general work requirements;

B. The rights and responsibilities of household members subject to work requirements;

C. The consequences of failure to comply with these work requirements; and

D. The availability of additional employment and training programs and services, outside of Employment First, within their community.

When an interview is not required at recertification, the written statement of these requirements to the work registrants of these requirements to the work registrants in the household is sufficient.

4.310.3 General Work Requirement Exemptions

At all determinations of eligibility including initial, ongoing, and redetermination, eligibility staff must explore if the household member meets an exemption rather than placing the burden solely on the household member to self-report.

General work requirement exemptions include:

A. A person 15 years of age or younger or a person 60 years of age or older;

    1. A person age 16 or 17 who is not the head of a household, or who is attending school, or is enrolled in an employment training program, on at least a half-time basis, is also exempt.

B. A parent or other household member responsible for the care of a dependent child under 6 or an incapacitated person;

C. A person physically or mentally unfit for employment;

Examples of being physically or mentally unfit for employment can include but are not limited to:

1. Persons experiencing homelessness defined in 4.100

2. Recently released from an institution

3. Person with disabilities as defined in 4.100 and includes but is not limited to:
    a. Persons with self-declared temporary conditions that would prevent successful participation in work activities
    b. Persons receiving temporary or permanent disability benefits issued by government or private sources
    c. Persons participating in vocational rehabilitation
    d. Persons applying for and/or appealing SSI benefits

4. Persons unable to maintain employment

5. Persons impacted by domestic violence

D. A student enrolled at least half-time, as defined by the educational facility, in any recognized school, training program, or institution of higher education;

1. A student who is enrolled in an institute of higher education must meet student eligibility requirements to receive Food Assistance.

2. Students who are eligible for Food Assistance remain exempt from work requirements during normal periods of class attendance and school breaks.

3. Persons who are not enrolled at least half-time or who experience a break in their enrollment status due to graduation, expulsion, suspension, or who drop out or otherwise do not intend to register for the next normal school term (other than summer), shall not be eligible for this exemption.

E. Employed or self-employed individuals who are working a minimum of thirty (30) hours per week or receiving weekly earnings at least equal to the federal minimum wage multiplied by thirty (30) hours;

1. This shall include migrant and seasonal farm workers who are under contract or similar agreement with an employer or crew chief to begin employment within thirty (30) days.

2. Persons working in action programs, including VISTA, are exempt from work requirements if they work at least thirty (30) hours per week even if the compensation is not consistent with prevailing community wage, since an employer-employee relationship can be documented.

F. A person applying for or receiving Unemployment Insurance Benefits (UIB). The local office shall verify application for or receipt of UIB, if questionable. A person who has been denied UIB and who is appealing the decision is exempt;

G. A regular participant in drug or alcohol treatment or rehabilitation program;

H. A person subject to and complying with CW or the Colorado Refugee Services Program (CRSP) work programs.

4.310.4 Changes in Exemption Status

Individuals exempt from work requirements are not required to report changes in their exemption status during their certification period. At redetermination, all individuals subject to work requirements will be reassessed for work requirement exemptions.

If an individual loses their exemption status during their certification period, they shall retain their original work requirement exemption through their certification period unless they are considered an ABAWD.

4.310.5 Voluntary Quit

A. When a household files an initial application or redetermination, the local office must determine if any household member who is not exempt from work requirements voluntarily quit his or her job of 30 or more hours a week or reduced his or her work effort to be less than 30 hours a week without good cause. Benefits must not be delayed beyond the normal processing times pending the determination of voluntary quit.

B. A level sanction will be imposed if voluntary quit occurred within sixty (60) calendar days prior to the date of application or after the date of application but prior to eligibility determination and the voluntary quit was without good cause.

    1. Individuals who voluntary quit are ineligible to participate in the Food Assistance Program and shall be treated as a disqualified member. If the disqualified member joins another household, the ABAWD disqualification period for that individual shall continue until the ABAWD disqualification period is completed.

C. An employee of the federal, state, or local government who participates in a strike against such a government and is dismissed from his or her job because of participation in the strike, will be considered to have voluntarily quit his or her job without good cause.

    If an individual quits a job, secures new employment at comparable wages or hours, and, through no fault of his or her own loses the new job, the prior voluntary quit will not be a basis for disqualification.

4.310.6 Suitable Employment

Employment will be considered suitable, unless any of the following apply:

A. The wages offered are less than the higher of:

    1. The applicable federal or state minimum wage.

    2. Eighty percent (80%) of the federal minimum wage if neither the federal or state minimum wage is applicable.

B. The employment offered is on a piece-rate and the average hourly yield the employee can reasonably be expected to earn is less than the applicable hourly wage specified above.

C. The household member, as a condition of employment, is required to join, resign from, or refrain from joining any legitimate labor organization.

D. The work offered is at a site subject to a strike or lockout at the time of the offer unless the strike has been enjoined under the Labor Management Relations or the Railway Labor Act.

E. The household member that can demonstrate or the local office becomes aware that:

1. The degree of risk to the health and safety is unreasonable.

2. He/she is physically or mentally unfit to perform the employment as established by documentary medical evidence or reliable information obtained from other sources.

3. The employment offered is not in his/her major field experience unless, after a period of thirty (30) calendar days from registration, job opportunities in his/her major field have not been offered.

4. The distance from the member's home to the place of employment is unreasonable considering the expected wage and the time and cost of commuting.

5. The daily commuting time exceeds two (2) hours per day, not including the transporting of a child or children to and from a child care facility.

6. The distance to the place of employment prohibits walking and neither public nor private transportation is available to transport the member to the job site.

7. The working hours or nature of the employment interferes with the member's religious observances, convictions, or beliefs.

4.310.7 Good Cause for Voluntary Quit and Suitable Employment

The local office is responsible for determining good cause when a non-exempt individual appears to have voluntarily quit or failed to accept an offer of suitable employment. Good cause and/or lack of good cause must be clearly documented in the case file.

Good cause for voluntary quit includes circumstances beyond the household member's control, such as, but not limited to:

A. Discrimination by an employer based on age, race, sex, color, handicap, religious beliefs, national origin or political beliefs;

B. Work demands or conditions that render continued employment unreasonable, such as working without being paid on schedule;

C. Acceptance by the individual of employment; or enrollment of at least half-time in any recognized school, training program, or institution of higher education, that requires the individual to leave employment;

D. Acceptance by any other household member of employment or enrollment at least half-time in any recognized school, training program, or institution of higher education in another county or political subdivision which requires the household to move and thereby requires the individual to leave employment;

E. Resignations by persons under the age of sixty (60) that are recognized by the employer as retirement;

F. Resignation from employment that does not meet suitable employment;

G. Because of circumstances beyond the control of the individual, accepted full time employment subsequently either does not materialize or results in employment of less than thirty (30) hours a week or weekly earning of less than the federal minimum wage multiplied by thirty (30) hours;

H. Leaving a job in connection with patterns of employment in which workers frequently move from one employer to another, such as migrant farm labor or construction work, even though employment at the new site has not actually begun;

I. Illness of the individual;

J. Illness of another household member requiring the presence of the individual;

K. A household emergency;

L. Unavailability of transportation;

M. Employer demands a reduction in participant's work effort or salary through no fault of the employee; and

N. Lack of adequate child care for children who have reached age 6 but are under age 12.

4.310.8 Level Sanction Periods

A. If the local office determines that an individual has voluntarily quit or failed to accept suitable employment without good cause, that individual shall be ineligible to participate in the Food Assistance Program and shall be treated as a disqualified member. If the disqualified member joins another household, the disqualification period for that individual shall continue until the disqualification period is completed.

1. The first (1st) time, the individual shall be disqualified for a period of one (1) month after the date the individual became ineligible.

2. The second (2nd) time an individual fails without good cause to comply with work requirements, the individual shall be disqualified for a period of three (3) months after the date the individual became ineligible.

3. The third (3rd) or subsequent time an individual fails without good cause to comply with work requirements, the individual shall be disqualified for a period of six (6) months after the date the individual became ineligible.

B. The disqualification period shall begin the month following the expiration of the Notice of Adverse Action, unless a fair hearing is requested.

C. If the level sanction disqualified individual is the sole member of the Food Assistance household and then becomes exempt, the newly exempt individual can reapply for benefits. The newly exempt individual will be eligible based on the date of the application or, if in the case of reinstatement, the date exemption information was provided to the county office.

If the level sanction disqualified individual is in a Food Assistance household with other eligible members and then becomes exempt, the newly exempt individual will be eligible based on the date exemption information was provided to the county office. .

4.311 ABAWD WORK REQUIREMENTS

ABAWDs must fulfill an ABAWD work requirement in addition to the general work requirements.

For the remainder of this section, client statement is considered acceptable verification unless questionable. If verification is requested from the client, case documentation must thoroughly explain why the original client statement was considered questionable.

A. To fulfill the ABAWD work requirement, the ABAWD must be:

1. Working 20 hours per week or averaged monthly for a total of 80 hours a month; or

    a. Working includes:

        i. Work completed in exchange for money (compensated work); or

        ii. Work completed in exchange for goods or services (in-kind work); or

        iii. Any combination of compensated work or in-kind work.

2. Participating in and complying with the requirements of a work program 20 hours per week or averaged monthly for a total of 80 hours a month; or

    a. A work program includes:

        i. A program of employment and training operated or supervised by the CDHS program other than a job search program or a job search training program;

        ii. A program under the Workforce Innovation and Opportunity Act (WIOA);

        iii. A program under Section 236 of the Trade Act of 1974 (19 USC 2296, “Trade Adjustment Assistance”).

3. In any combination of working and participating in a work program for a total of 20 hours per week or averaged monthly for a total of 80 hours a month; or

4. Participating in and complying with the Colorado Workfare program.

B. Non-exempt ABAWDs must submit monthly hours to EF for work activity tracking so countable months can be determined.

Failure to work with the EF program or provide the EF program information needed to determine compliance with the ABAWD work requirement will result in the ABAWD losing eligibility as a result of the accruing three countable months within a thirty-six (36) calendar month period.

4.311.1 ABAWD Exemptions

While ABAWDs can be exempt under general work requirement exemptions, these individuals could also meet one of the following ABAWD exemptions:

A. Younger than eighteen (18) years of age or older than forty-nine (49) years of age. The month of the household member's birthday is not a countable month;

B. Exempt from the general work requirements;

C. Is residing in a Food Assistance household where a household member is under age 18;

D. Pregnancy;

E. Exempt under a waiver approved by the USDA, FNS;

F. Exempt using Colorado defined state exemptions as identified in the current Food Assistance Employment and Training State Plan.

4.311.2 Changes in ABAWD Exemption Status

ABAWDs are not required to report changes in their exemption status during a certification period. However, if the ABAWD loses their exemption status during a certification period, the months the ABAWD was not exempt will count toward their three countable months in a thirty-six (36) calendar month period. Any remaining months of benefits received during that certification period are not considered overpayments and claims will not be established.

4.311.3 ABAWD Time Limits

ABAWDs are not eligible to participate in Food Assistance if they have received Food Assistance benefits for more than three countable months during a thirty-six (36) month period.

However, ABAWDs may be eligible for up to three additional consecutive months after regaining eligibility In accordance with paragraph (C) of this section.

A. Countable months

Countable months are accrued when an ABAWD received Food Assistance benefits for the full benefit month but did not:

1. Meet an exemption; or

2. Fulfill their work requirements.

B. Good cause for countable months

If an ABAWD would have worked an average of 20 hours per week but missed some work for good cause, the ABAWD shall be considered to have me the work requirement if the absence from work is temporary and the individual retains his or her job.

Good cause for countable months shall include circumstances beyond the individual's control, such as, but not limited to, illness, illness of another household member requiring the presence of the member, a household emergency, or the unavailability of transportation.

C. ABAWD time limit clock

The ABAWD time limit clock:

1. Counts accrued countable months for all ABAWDs who are not in compliance with work requirements and do not have an exemption; and

2. Resets accrued countable months and ABAWD disqualifications, regardless of start date, for all ABAWDs every 36 calendar months starting October 1st, 2019.

D. Regaining eligibility

1. An individual who is denied eligibility under this provision can regain eligibility if in a thirty (30) calendar day period, the individual:

   a. Is employed eighty (80) or more hours;
   b. Participates in and complies with the requirements of a work program for eighty (80) or more hours as determined by EF;
   c. Participates and complies with Workfare; or
   d. Becomes exempt

2. The individual will be reinstated if otherwise eligible and will continue to be eligible as long as the individual continues to meet the work requirement or is exempt.

3. Three additional consecutive months.

   If an individual regains eligibility but then fails to continue meeting these requirements, the individual shall remain eligible for a consecutive three-month period after the individual notifies the county department. The individual can only have this provision applied for a single three-month period in the thirty-six (36) calendar month period.

4.312 EMPLOYMENT FIRST (EF)

In Colorado, the Employment and Training program is called EF. The purpose of the program is to assist members of households participating in the Food Assistance Program in gaining skills, training, work, or experience that will increase their ability to obtain employment.

CDHS must submit an annual Employment and Training State Plan for approval by the USDA, Food and Nutrition Service. A copy of the CDHS Employment and Training plan is available for inspection during normal working hours by contacting the SNAP Director, Food and Energy Assistance Division, Colorado Department of Human Services, 1575 Sherman Street, Denver, Colorado 80203.

The EF program is a voluntary work program for Food Assistance applicants and recipients. Failure to participate with the EF program will not result in a work requirement disqualification.

4.312.1 County Administration Requirements for EF

A county department choosing to or required to administer an EF program shall submit a county plan as prescribed by CDHS and shall operate their EF program in alignment with the CDHS Employment and Training plan. Failure to adhere to the requirements as described in the CDHS Employment and Training plan will result in a Corrective Action Plan (CAP).

A county department may enter into a contractual agreement for all or any part of the EF program service delivery. These contractual agreements shall be reviewed by CDHS for adherence to the program requirements before implementation.

A. Every EF program must monitor ABAWDs to ensure they are meeting ABAWD work requirements. This monitoring may include obtaining employment or volunteer working hours information and/or ensuring the ABAWD is participating in an allowable Employment First component as set forth in the annual CDHS Employment and Training plan and the specific county EF plan.

B. The EF provider shall:

1. Schedule the first appointment with EF within fourteen (14) calendar days from the date referred from the local office;

2. Enter the required information from the work registration form into the EF automated system for each person referred;

3. Deliver case management services as prescribed in the CDHS EF State Plan;

4. Compile data and submit required reports within prescribed timeframes;

5. Coordinate program operations with the state EF staff, in accordance with the annual CDHS Employment and Training plan as well as the specific county EF plan;

6. Ensure that participants receive the appropriate reimbursement for participation, such as actual costs of transportation or other costs as outlined in the CDHS Employment and Training plan;

7. Utilize required forms as prescribed or approved by the state;

8. Attend scheduled EF program meetings and training as required;

9. Ensure that all funds expended are allowable program costs per the annual CDHS Employment and Training plan;

10. Ensure program services are not suspended for longer than fourteen (14) consecutive days for any reason;

11. Ensure that any exemptions discovered through working with participants are communicated to county eligibility.

4.313 COLORADO WORKFARE PROGRAM

In Colorado, the Section 20 Workfare Program of the Food and Nutrition Act of 20018 (codified at 7 USC Sec. 2011 et seq) is called the Colorado Workfare Program.

CDHS must submit an annual Section 20 Workfare State Plan for approval by the USDA, Food and Nutrition Service. A copy of the CDHS Section 20 Workfare plan is available for inspection during normal working hours by contacting the SNAP Director, Food and Energy Assistance Division, Colorado Department of Human Services, 1575 Sherman Street, Denver, Colorado 80203.

4.313.1 County Administration Requirements for Workfare

A county department choosing to administer a Colorado Workfare program shall submit a county plan as prescribed by CDHS and shall operate their Workfare program in alignment with the CDHS Section 20 Workfare plan. Failure to adhere to the requirements as described in the CDHS Section 20 Workfare plan will result in a Correct Action Plan (CAP).

4.504.6 Information Considered Verified Upon Receipt

A. Verified upon receipt is a term given to a state-prescribed list of specific information that comes directly from the primary source of the information and is free from question.

B. Information that is considered verified upon receipt shall be acted upon for both simplified reporting households and non-simplified reporting households. Information considered verified upon receipt shall be acted on at the time of application, recertification, periodic report, and during a household's certification period if the information causes a change in the Food Assistance benefit amount. A household shall not be convicted of fraud for not reporting a change in the information it is not required to report.

C. Information considered verified upon receipt shall be considered verified unless the office has reason to believe that the information may be inaccurate. Advance notice of adverse action shall be given when acting on information that is considered verified upon receipt, except as noted in Section 4.608.1.

D. The local office shall consider only the following information as verified upon receipt:

1. Social Security and SSI benefit amounts obtained from SSA.

   SSI and benefit amounts obtained from the SSA are considered reported and verified on the day the information is first known to the agency, either through the IEVS, SDX, BENDEX or another automated interface of information, whichever is sooner.

2. Death information received from the Burial Assistance program.

   Death information received from the Burial Assistance program is considered reported and verified on the day the information is first known to the agency.

3. Unemployment insurance benefits (UIB) that are reported through the IEVS and obtained through the Department of Labor and Employment (DOLE).

   The UIB information shall be considered reported and verified on the date of the IEVS notification. Advance notice of adverse action shall be given when acting on the change in information.

4. PA benefit amounts (Colorado Works, Aid to the Needy Disabled (AND) program consisting of AND-State Only (AND-SO) and AND-Colorado Supplement (AND-CS), Home Care Allowance (HCA), and Old Age Pension (OAP), obtained from the State Department.

   Such information shall be considered reported and verified on the day the public assistance benefit amount is authorized.

5. Information that is reported and verified to a public assistance program which results in a change to the PA benefit amount and that meets the Food Assistance regulations for verification.

   Such information shall be considered reported and verified on the day the public assistance program processes the change and authorizes the new PA benefit amount.

6. Child support income and expense amounts obtained through the ACSES.

   Such information is considered reported and verified on the day the information is reported through an automated interface with ACSES.

7. Non-compliance information obtained from EF agencies of the failure of an ABAWD to meet work requirements.

8. Colorado IPVs.

9. Information obtained from the SAVE system regarding non-citizen status.

10. Changes in household composition that are reported and verified and result in one or more members being removed from one Food Assistance household and added to a new or existing Food Assistance household.

    Duplicate benefits shall not be issued for a particular individual when removing that individual from one Food Assistance household and adding him/her to a new Food Assistance household.

11. Changes in household composition that are reported and verified by child welfare agencies and result in a child being removed from one Food Assistance household and added to a new or existing Food Assistance household.

12. The disqualification of a household member who is determined to be a fleeing felon or a probation or parole violator.

Title of Proposed Rule: SNAP Employment First Updates 2020
CDHS Tracking #: 20-01-21-01
CCR #: 10 CCR 2506-1
Office, Division, & Program: OES, FEAD, Food Assistance Phone: 303-866-4748
Rule Author: Andrea Poole E-Mail: Andrea.Poole@state.co.us

RULEMAKING PACKET

This package is submitted to State Board Administration as: *(check all that apply)*

[ ] AG Initial Review [X] Initial Board Reading [ ] AG 2nd Review [ ] 2nd Board Reading / Adoption

This package contains the following types of revisions to the rule: *(number of sections with the following edits)*

15 Amended
6 New
7 Repealed
_____ Reviewed

What month is being requested for this rule to first go before the State Board? February 2020

What date is being requested for this rule to be effective? February 2020

Is this date legislatively required? No

Is this rule change based on legislation? No If so, bill number:

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 February 2020 2nd Board 3/6/2020 Effective Date February 2020

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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. ***Firm 1500 character maximum, please count before submitting.***

These changes are being proposed to simplify the Food Assistance rules by removing duplicative sections, redundancies and to meet one of the Governor's Wildly Important Goals.

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:

In October 2019, Employment First (EF) moved to a voluntary model. As a result of this change in conjunction with recent federal audit findings related to SNAP E&T, these regulations update 10 CCR 2506-1 to reflect the changes required by the audit and shift to voluntary EF. These sections of the Food Assistance rule could not be updated to reflect the EF voluntary model and policy concepts until all clarifications and implementation guidance had been finalized from our federal partners. Running this as an emergency rule after these final clarifications were received is intended to reduce the likelihood of multiple rule packages to incorporate all of the changes.

State Board Authority for Rule:

Code	Description
26-1-107, C.R.S. (2019)	State Board to promulgate rules

Program Authority for Rule: *Give federal and/or state citations and a summary of the language authorizing the rule-making function AND authority.* ***This is mandatory, do not leave blank.***

Code	Description
26-1-109, C.R.S. (2019)	State department rules to coordinate with federal programs
26-2-301 (2019), C.R.S.	Designates the Colorado Department of Human Services as the responsible agency to administer the Food Assistance Program in the State of Colorado.
26-2-302 (2019), C.R.S.	Nothing in Article should be construed to prevent the Colorado Department of Human Services from complying with federal mandates prescribed under the federal "Food Stamp Act" as amended.
7 CFR Subtitle B, Chapter II, Subchapter C, §271.4	Federal Supplemental Nutrition Assistance Program regulations delegates authority for the State administration of SNAP
7 CFR Subtitle B, Chapter II, Subchapter C, §273	Federal Supplemental Nutrition Assistance Program regulations regarding certification of SNAP households
7 USC § 51	Supplemental Nutrition Assistance Program Act authorizing State agency shall have responsibility for certifying households and issuing EBT cards.

Does the rule incorporate material by reference? [ ] Yes [X] No
Does this rule repeat language found in statute? [ ] Yes [X] No

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If yes, please explain.

Type of Rule: *(complete a and b, below)*

a. [X] Board or [ ] Executive Director

b. [X] Regular or [ ] Emergency

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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?

Food Assistance applicants, recipients, State of Colorado Food Assistance program staff, and County Food Assistance staff.

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?

Food Assistance applicants, recipients, and administrators of the program will experience a more user friendly version of these rules to assist with implementation and understanding of these requirements as they relate to Food Assistance benefits.

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 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)*

There will be a fiscal impact associated with the updates to the Colorado Benefits Management System as a result of these regulatory changes. This system project is already included in the budget hours for system enhancements and is also in the process and development phase.

County Fiscal Impact

There is no anticipated county fiscal impact as these regulations at this time.

Federal Fiscal Impact

These rule changes will allow the State to avoid federal fiscal sanctions related to the federal audit and reduce SNAP payment errors related to EF participation.

Other Fiscal Impact *(such as providers, local governments, etc.)*

4. Data Description

List and explain any data, such as studies, federal announcements, or questionnaires, which were relied upon when developing this rule?

Data was not a primary factor in the revisions to these regulations as this is a state option and the decision to change this model was informed by a federal audit of the EF program and based on the recommendations from our federal partners.

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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…"**

In discussions regarding the findings from the FNS audit of the EF program, it was determined that changing program model from mandatory to voluntary (including these updates to the correlating regulations) would have the most long-term benefit to SNAP applicants and participants. There were no alternatives to make this change as regulations were previously based on the mandatory model of the EF program.

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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
4.100	Updates to definitions	4.100 Definitions “ABAWD County” means a county with an Employment First Program that requires ABAWDs to meet a mandatory monthly ABAWD work requirement of working or participating in an acceptable work activity eighty (80) hours per month or completing all assigned workfare hours monthly. “Able-Bodied Adult Without Dependent (ABAWD)” means an individual between the ages of eighteen (18) and fifty (50) without a physical or mental disability, who is not pregnant, and who lives in a food assistance household with no one under the age of eighteen (18). “Disqualified individuals” means any individual who is ineligible to receive Food Assistance due to having been disqualified for an intentional Program violation/fraud, failure to provide or obtain a SSN, ineligible non-citizens, individuals disqualified for failure to cooperate with work requirements, individuals disqualified for failure to cooperate with the State quality assurance division, and Able-Bodied Adults Without Dependents who already received three countable months of Food Assistance within thirty-six (36) months without meeting an exemption or ABAWD work requirements. “Sanction” means a specified period of ineligibility imposed against an individual who failed to take a required action as part of his or her eligibility for either Food Assistance or Colorado Works.	4.100 Definitions “Able-Bodied Adult Without Dependent (ABAWD)” means an individual between the ages of eighteen (18) and fifty (50) without a physical or mental disability, who is not pregnant, and who lives in a Food Assistance household with no one under the age of eighteen (18). “Countable month” means a month in which an ABAWD received full food assistance allotment but did not meet work requirements or have an exemption from those requirements. “Disqualified individuals” means any individual who is ineligible to receive Food Assistance due to having been disqualified for an Intentional Program Violation/fraud, failure to provide or obtain a SSN, ineligible non-citizens, individuals disqualified for failure to cooperate with work requirements, individuals disqualified for failure to cooperate with the State quality assurance division, and ABAWDs who already received three countable months of Food Assistance within thirty-six (36) months without meeting an exemption or ABAWD work requirements. “Level Sanction” means a specified period of ineligibility imposed against an individual who failed to take a required action as part of his or her eligibility for Food Assistance. ”Questionable" means inconsistent or contradictory information, statements, documents, or case documentation that requires verification from the household to determine eligibility. “Voluntary Quit” means when a Food Assistance recipient voluntarily quit a job of 30 or more hours a week or reduced work effort to less than 30 hours a week without good cause.	Removed the following definitions: ABAWD County, Non-ABAWD County, and Non-Employment First County Updated those listed in new language with only technical corrections. Added definitions for Countable Month and Questionable.	

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Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
		"Non-ABAWD County" means a county that is not requiring ABAWDs to meet the mandatory monthly ABAWD work requirement; although, the individual may be required to participate in non-ABAWD work program activities. "Non-Employment First County" means a county in which there is no Employment First Program; although, work registrants must still sign an affidavit attesting that he/she will seek work opportunities through available resources. "Voluntary Quit" means when a Food Assistance recipient voluntarily quit a job of 30 or more hours a week or reduce work effort to less than 30 hours a week without good cause.			
4.310	Updated language	4.310 WORK REGISTRATION The Food and Nutrition Act of 2008, as amended, requires that all members of eligible households, who have attained the age of sixteen (16) and have not yet reached their sixtieth (60th) birthday, shall register for work, participate in an employment and training program as required, accept suitable employment, and provide sufficient information to allow the agency to determine the employment status or the job availability of the individual, unless exempt as noted below. This requirement shall include a person not working because of a strike or lockout at his/her usual place of employment. Compliance with the work registration requirement is a prerequisite to certification. The requirement cannot be waived, and benefits may not be granted conditionally prior to registration of all household members who are required to do so. Work registration shall be accomplished through the	4.310 GENERAL WORK REQUIREMENTS As a condition of eligibility for Food Assistance benefits, each household member not determined exempt must comply with the following work requirements: A. Register for work at the time of initial application and at every recertification, by signing the application for assistance or redetermination. the application must be signed by the member required to register, an authorized representative, or by another adult household member; B. Provide eligibility staff with sufficient information regarding employment status or availability for work; C. Cannot commit an act of voluntarily quit; D. Accept an offer of suitable employment; E. Report to an employer if referred by the county if the potential employment is suitable employment;		

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Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
		completion of the Food Assistance application in Employment First counties all household members between the ages of sixteen (16) and sixty (60), except the persons described in the following sections, at the time of application and once every twelve (12) months. The work registration form shall be signed by the member required to register or by another adult household member.			
4.310.1	Updated language	4.310.1 Work Registration and Referral to Employment First in Employment First Counties "Work registration" means notification and referral of a work registrant after completion of the Food Assistance application. The local office shall complete an appointment form for all household members not exempt from work registration under Section 4.310.3. In Employment First counties, the Food Assistance eligibility technician shall provide the written notice of referral to each work-registered household member, send a copy to the Employment First Unit, and retain a copy of the referral in the case record. Upon determination that the person should be referred to an Employment First Unit, the local office shall explain to the applicant the pertinent work requirements, the rights and responsibilities of work-registered household members, and the consequences of failing to comply. The local office shall provide a written statement of these requirements to each work registrant in the household and to each previously exempt or new household member when that person becomes subject to work registration and at recertification.	4.310.1 Work Requirements and Verification Client statements are considered acceptable verification unless questionable. If verification is requested from the client because client statement is considered questionable, case documentation must thoroughly explain why the original client statement was considered questionable. A. Examples of verification that can be obtained to resolve questionable information can include but is not limited to: 1. Receipt of temporary or permanent disability benefits issued by government or private sources; or 2. Persons may provide a statement from a physician, physician's assistant, nurse, nurse practitioner, designated representative of the physician's office or a licensed or certified psychologist. A county agency may determine other licensed medical personnel appropriate to provide verification that a work registrant is physically or mentally unfit for employment; or 3. A statement from a licensed social worker or a social worker employed by or acting on behalf of a 501(c)(3) non-profit organization or government entity.		

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Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
		Individuals who are not determined exempt from work registration shall be referred to Employment First at the application interview. Food Assistance applicants may volunteer for Employment First services prior to the application interview. Exempt recipients may volunteer at any time. Employment First may exempt individuals for whom they determine participation in an Employment First component is impractical. Reasons for such exemption include lack of job readiness, remoteness from work opportunities (remoteness shall mean a one-way commute of more than one hour), or lack of transportation, medical or family problems, such as a lack of child care, migrant or seasonal farm work status, or other reasons as Employment First determines limit practicability. Job-attached persons (e.g., those on temporary layoff or those expecting to return to work within sixty (60) days shall be exempt from referral to Employment First for sixty (60) calendar days at which time the local office shall review the job-attached status. Reasons for exemption should be reviewed at recertification or more frequently if a change affecting the exempt status occurs, and shall be documented in the case record. Any resident or non-resident participant in a drug or alcohol center's treatment and rehabilitation program is exempt from the work registration requirement. This exemption is not meant to discourage participants in such a program from seeking and accepting employment on their			

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Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
		own.			
4.310.11	Removed citation	4.310.11 Work Registration in Non-Employment First Counties Fulfillment of the work registration requirement in non-employment first counties shall occur when an applicant household completes and signs a Food Assistance application.			
4.310.2	Updated language	4.310.2 Work Requirements for Ages Eighteen (18) through Forty-Nine (49) Years A. No individual shall be eligible to participate in the Food Assistance Program as a member of any household if, during the preceding thirty-six (36) month period, the individual received Food Assistance benefits for not less than three (3) months (consecutively or not) during which time the individual: 1. Was not employed twenty (20) hours or more each week, averaged monthly; or, 2. Did not participate in and comply with the requirements of a work program for twenty (20) hours or more each week; or, 3. Did not participate in and comply with Section 20 Workfare program of the Food and Nutrition Act of 2008 (codified at 7 USC sec. 2011 et seq.). B. A work program is defined as: 1. A program of employment and training operated or supervised by the Employment First program other than a job search program or a job search training program;	4.310.2 Informing the Household of General Work Requirements At the point of initial application and redetermination, when an interview is required, Food Assistance households must receive from the eligibility staff written notice and a verbal explanation of : A. The Food Assistance general work requirements; B. The rights and responsibilities of household members subject to work requirements; C. The consequences of failure to comply with these work requirements; and D. The availability of additional employment and training programs and services, outside of employment first, within their community When an interview is not required at recertification, the written statement of these requirements to the work registrants in the household is sufficient.		

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		2. A program under the Workforce Innovation and Opportunity Act (WIOA); 3. A program under Section 236 of the Trade Act of 1974 (19 USC 2296, "Trade Adjustment Assistance"); 4. Workfare under Section 20 of the Food Stamp Act, as amended. C. The limit of three (3) months in a thirty-six (36) month period shall not apply to individuals who are: 1. Under eighteen (18) or fifty (50) years of age or older; 2. Physically or mentally unfit for employment as described in section 4.310.3 (C); 3. Is residing in a household where a household member is under age 18, even if the household member who is under 18 is not him or herself eligible for food stamps; 4. Pregnant; 5. Exempt from work registration under the exemptions listed in Section 4.310.3; 6. Exempt under a waiver approved by the USDA, FNS. Counties may request such a waiver through the Food Assistance Programs Division (FAPD). FAPD will also consult with Employment First and submit requests for counties or areas that the State Department considers as meeting this requirement. All affected counties will be notified by written correspondence. The waiver from these			

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		requirements can be requested when the area has an unemployment rate of ten percent (10%) or the area does not have a sufficient number of jobs to provide employment for the individuals. D. Regaining Eligibility 1. An individual who is denied eligibility under this provision can regain eligibility if in a thirty (30) calendar day period, the individual is employed eighty (80) or more hours, participates in and complies with the requirements of a work program for eighty (80) or more hours as determined by Employment First, or participates and complies with Section 20 Workfare. 2. The individual will be reinstated the month following the month of compliance if otherwise eligible and will continue to be eligible as long as compliance with these requirements continues or the individual becomes exempt. 3. If an individual regains eligibility but then fails to continue meeting these requirements, the individual shall remain eligible for a consecutive three-month period after the individual notifies the county department. The individual can only have this provision apply for a single three-month period in any thirty-six (36) month period.			
4.310.3	Updated language	4.310.3 Exemptions from Work Registration A. Persons Under Age Eighteen (18) A person age sixteen (16) or seventeen (17) who is not the head of a household is exempt. A sixteen (16) or seventeen (17) year-old head of household who is attending school, or enrolled in an employment training program on at least a half-	4.310.3 General Work Requirement Exemptions At all determinations of eligibility including initial, ongoing, and redetermination, eligibility staff must explore if the household member meets an exemption rather than placing the burden solely on the household member to self-report. General work requirement exemptions include:		

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		time basis is exempt from work registration. B. Persons Caring for Children and Incapacitated Household Members The able-bodied parent or other household member who is responsible for the care of a dependent child under the age of six (6) or an incapacitated person is exempt from work registration. If the child reaches his or her sixth (6th) birthday within a certification period, the individual responsible for care of the child shall register for work at the next scheduled certification, unless the individual qualifies for another exemption. C. Physically or Mentally Unfit for Employment 1. Persons physically or mentally unfit for employment are exempt from work registration. If the determination of unfit for work is not obvious, verification may be required. Appropriate verification may consist of: a. Receipt of temporary or permanent disability benefits issued by government or private sources; or b. Persons may provide a statement from a physician, physician's assistant, nurse, nurse practitioner, designated representative of the physician's office or a licensed or certified psychologist. A county agency may determine other licensed medical personnel appropriate to provide verification that a work registrant is physically or mentally unfit for employment; or c. A statement from a licensed social worker or a social worker employed by or acting on behalf of a 501(C)(3) Non-profit organization or government entity. 2. Those that are chronically homeless may be	A. A person 15 years of age or younger or a person 60 years of age or older; 1. A person age 16 or 17 who is not the head of a household, or who is attending school, or is enrolled in an employment training program, on at least a half-time basis, is also exempt. B. A parent or other household member responsible for the care of a dependent child under 6 or an incapacitated person; C. A person physically or mentally unfit for employment; Examples of being physically or mentally unfit for employment can include but are not limited to: 1. Persons experiencing homelessness defined in 4.100 2. Recently released from an institution 3. Persons with disabilities as defined in 4.100 and includes but is not limited to: a. Persons with self-declared temporary conditions that would prevent successful participation in work activities b. Persons receiving temporary or permanent disability benefits issued by government or private sources c. Persons participating in vocational rehabilitation		

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		deemed physically or mentally unfit for employment and may be exempt from work registration. Chronic homelessness is defined as lacking nighttime residence. D. Eligible Students Eligible students are those enrolled at least half-time, as defined by the educational facility, in any recognized school or training program, and those in an institution of higher education who have met the eligibility conditions in Section 4.306 are exempt from work registration. Eligible students shall remain exempt from work registration during normal periods of class attendance, vacation, and recess. Persons who are not enrolled at least half-time or who experience a break in their enrollment status due to graduation, expulsion, suspension, or who drop out or otherwise do not intend to register for the next normal school term (other than summer), shall not be considered students for the purpose of qualifying for this exemption. E. Employed and Self-Employed Employed or self-employed individuals who are working a minimum of thirty (30) hours per week or receiving weekly earnings at least equal to the federal minimum wage multiplied by thirty (30) hours are exempt from work registration. This shall include migrant and seasonal farm workers who are under contract or similar agreement with an employer or crew chief to begin employment within thirty (30) days. Persons working in Action programs (including VISTA) are exempt from work registration if they work at least thirty (30) hours per week even if compensation is not consistent with prevailing community wage, since an	d. Persons applying for and/or appealing SSI benefits 4. Persons unable to maintain employment 5. Persons impacted by domestic violence D. A student enrolled at least half-time, as defined by the educational facility, in any recognized school, training program, or institution of higher education. 1. A student who is enrolled in an institute of higher education must meet student eligibility requirements to receive food assistance. 2. Students who are eligible for food assistance remain exempt from work requirements during normal periods of class attendance and school breaks. 3. Persons who are not enrolled at least half-time or who experience a break in their enrollment status due to graduation, expulsion, suspension, or who drop out or otherwise do not intend to register for the next normal school term (other than summer), shall not be eligible for this exemption. E. Employed or self-employed individuals who are working a minimum of thirty (30) hours per week or receiving weekly earnings at least equal to the federal minimum wage multiplied by thirty (30) hours. 1. This shall include migrant and seasonal farm workers who are under contract or similar agreement with an employer or crew chief to begin employment within thirty (30) days.		

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		employer-employee relationship can be documented. Those engaged in volunteer work or hobby activity cannot be considered gainfully employed unless the income is consistent with thirty (30) hours employment as herein defined, regardless of the time spent in such endeavor. F. Unemployment Compensation Benefits A person applying for or receiving Unemployment Insurance Benefits (UIB) shall be exempt from work registration requirements. The local office shall verify application for or receipt of UIB, if questionable. A person who has been denied UIB and who is appealing the decision is exempt. G. Drug/Alcohol Rehabilitation Regular participants in drug or alcohol treatment or rehabilitation programs are exempt from work registration. H. Title IV-A/IV-F Requirements Persons subject to and complying with any work requirement under Title IV of the Social Security Act (codified at 42 USC 607-687) are exempt from work registration requirements. The Act does not include any later amendments to or editions of the incorporated material. Copies of the federal laws are available for inspection during normal working hours by contacting: Director, Food Assistance Programs Division, Colorado Department of Human Services, 1575 Sherman Street, Denver, Colorado 80203; or a state publications depository. I. Colorado Refugee Services Program (CRSP)	2. Persons working in action programs, including vista, are exempt from work requirements if they work at least thirty (30) hours per week even if compensation is not consistent with prevailing community wage, since an employer-employee relationship can be documented. F. A person applying for or receiving unemployment insurance benefits (UIB). The local office shall verify application for or receipt of UIB, if questionable. A person who has been denied UIB and who is appealing the decision is exempt. G. A regular participant in drug or alcohol treatment or rehabilitation program. H. A person subject to and complying with CW or the Colorado Refugee Services Program (CRSP) work programs.		

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		Registrants Any registrant for the Colorado Refugee Services Program is exempt from work registration requirements as CRSP work registration requirements satisfy the requirements of the Food Assistance Program. J. SSI and Food Assistance Jointly Processed Applicants Members of households who are applying for SSI and Food Assistance shall have the requirement for work registration waived until: 1. They are determined eligible for SSI and thereby become exempt from work registration; or, 2. They are determined ineligible for SSI and where applicable, a determination of their work registration status is then made by the local office through recertification procedures.			
4.310.31	Removed citation	4.310.31 Verification and Documentation of Work Registration Exemption In all cases, the specific reason for each person exempted from work registration and necessary supporting verification shall be clearly documented in the case record. Whenever any question of the propriety of the exemption from the work registration requirement arises, the head of the household and the household member shall cooperate in furnishing evidence to support the contention of exemption. Failure to cooperate in furnishing such evidence will result in the member being required to register.			
4.310.4	Updated language	4.310.4 Changes in Exemption Status	4.310.4 Changes in Exemption Status		

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		A. Persons losing exemption status due to any change in circumstances that is subject to the reporting requirements in Section 4.603 (such as a loss of employment that also results in a loss in income or departure from the household of the sole dependent child for whom an otherwise nonexempt household member was caring) shall register for employment when the change is reported through completion of a work registration form or an affidavit. B. Persons losing exemption status due to changes that are not subject to such reporting requirements shall register for employment at recertification. C. Persons who are no longer work registered for Title IV-A/IV-F or UIB shall register for employment, unless otherwise exempt. The local office shall provide the household with a work registration form when the change is reported.	Individuals exempt from work requirements are not required to report changes in their exemption status during their certification period. At redetermination, all individuals subject to work requirements will be reassessed for work requirement exemptions. If an individual loses their exemption status during their certification period, they shall retain their original work requirement exemption through their certification period unless they are considered an ABAWD.		
4.310.5	Updated language	4.310.5 Requirements of Work Registrants Persons work-registered by the local office shall: A. Participate in Employment First if designated as a mandatory work registrant, including reporting for all appointments and classes and meeting all other program requirements as detailed in the participation contract. B. Provide Employment First with sufficient information to allow Employment First to determine the employment status or job availability of the individual. C. Report to an employer in an appropriate manner and be prepared to accept an offer of suitable	4.310.5 Voluntary Quit A. When a household files an initial application or redetermination, the local office must determine if any household member who is not exempt from work requirements voluntarily quit his or her job of 30 or more hours a week or reduced his or her work effort to less than 30 hours a week without good cause. Benefits must not be delayed beyond the normal processing times pending the determination of voluntary quit. B. A level sanction will be imposed if voluntary quit occurred within sixty (60) calendar days prior to the date of application or after the date of application but prior to eligibility determination and the voluntary quit was without good cause.		

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		employment.	1. Individuals who voluntary quit are ineligible to participate in the food assistance program and shall be treated as a disqualified member. If the disqualified member joins another household, the ABAWD disqualification period for that individual shall continue until the ABAWD disqualification period is completed. C. An employee of the federal, state, or local government, who participates in a strike against such a government and is dismissed from his or her job because of participation in the strike, will be considered to have voluntarily quit his or her job without good cause. If an individual quits a job, secures new employment at comparable wages or hours, and, through no fault of his or her own loses the new job, the prior voluntary quit will not be a basis for disqualification.		
4.310.51	Removed citation	4.310.51 Suitability of Work No employment offered will be considered suitable for any registrant if: A. The wages offered are less than the higher of: 1. The applicable federal or State minimum wage. 2. Eighty percent (80%) of the federal minimum wage if neither the federal or State minimum wage is applicable. B. The employment offered is on a piece-rate and the average hourly yield the employee can reasonably be expected to earn is less than the applicable hourly wage specified above. C. The registrant, as a condition of employment, is			

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		required to join, resign from, or refrain from joining any legitimate labor organization. D. The work offered is at a site subject to a strike or a lockout at the time of the offer unless the strike has been enjoined under the Labor Management Relations or the Railway Labor Act.			
4.310.52	Removed citation	4.310.52 Registrant Proof of Unsuitability Any employment offered a particular registrant shall be considered suitable unless the registrant can demonstrate that, or the local office becomes aware that: A. The degree of risk to health and safety is unreasonable. B. He/she is physically or mentally unfit to perform the employment as established by documentary medical evidence or reliable information obtained from other sources. C. The employment offered is not in his/her major field experience unless, after a period of thirty (30) calendar days from registration, job opportunities in his/her major field have not been offered. D. The distance from the member's home to the place of employment is unreasonable considering the expected wage and the time and cost of commuting. Employment shall not be considered suitable if daily commuting time exceeds two (2) hours per day, not including the transporting of a child to and from a child care facility. Nor shall employment be considered suitable if the distance to the place of employment prohibits walking and neither public nor private transportation is available to transport the member to the job site.			

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		E. The working hours or nature of the employment interferes with the member's religious observances, convictions, or beliefs.			
4.310.6	Updated language	4.310.6 Disqualification Period for Mandatory Work Registrants A. If the local office determines that an individual has refused to register for work or failed without good cause to comply with Employment First requirements, that individual shall be ineligible to participate in the Food Assistance Program and shall be treated as a disqualified member. If the disqualified member joins another household, the disqualification period for that individual shall continue until the disqualification period is completed. 1. The first (1st) time an individual refuses to comply with work registration or fails without good cause to comply with Employment First, the individual shall remain ineligible until the later of the date the individual becomes eligible by complying with requirement or the date that is one (1) month after the date the individual became ineligible. 2. The second (2nd) time an individual becomes ineligible, the individual shall remain ineligible until the later of the date the individual becomes eligible by complying with requirements or the date that is three (3) months after the date the individual became ineligible. 3. The third (3rd) or subsequent time that an individual becomes ineligible, the individual shall remain ineligible until the later of the date the individual becomes eligible by complying with requirements or the date that is six (6) months after the date the individual became ineligible.	4.310.6 Suitable Employment Employment will be considered suitable, unless any of the following apply: A. The wages offered are less than the higher of: 1. The applicable federal or state minimum wage. 2. Eighty percent (80%) of the federal minimum wage if neither the federal or state minimum wage is applicable. B. The employment offered is on a piece-rate and the average hourly yield the employee can reasonably be expected to earn is less than the applicable hourly wage specified above. C. The household member, as a condition of employment, is required to join, resign from, or refrain from joining any legitimate labor organization. D. The work offered is at a site subject to a strike or lockout at the time of the offer unless the strike has been enjoined under the labor management relations or the railway labor act. E. The household member can demonstrate or the local office becomes aware that: 1. The degree of risk to health and safety is unreasonable. 2. He/she is physically or mentally unfit to perform		

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		B. Ineligibility shall continue either until the member complies with the requirement or becomes exempt (other than by Title IV-A/IV-F, Colorado Refugee Services Program (CRSP) registration or UIB application). If an individual has served the disqualification, but the case has the certification expire during the disqualification period, the nonexempt individual will be eligible at the later of the date of the application or the date of compliance with Employment First. C. The disqualification period shall begin the month following the expiration of the Notice of Adverse Action, unless a fair hearing is requested. The member may stop the disqualification if the member becomes exempt from these requirements during the disqualification period. The disqualified member shall continue to be disqualified for noncompliance but may resume participation after the disqualification period (if otherwise eligible) by becoming exempt from work registration or complying with the appropriate work requirement. A disqualified member will be added back into the household after the disqualification period is over if the individual has complied with Employment First or has become exempt. D. The action to add the ineligible member shall be handled as a reported change. E. The Employment First Program shall determine when an individual has refused or failed to comply with an Employment and Training requirement. F. The local office and Employment First shall consider the facts and circumstances, including information submitted by the household member involved to determine whether good cause for the noncompliance exists. Good cause shall include circumstances beyond the member's control, such	the employment as established by documentary medical evidence or reliable information obtained from other sources. 3. The employment offered is not in his/her major field experience unless, after a period of thirty (30) calendar days from registration, job opportunities in his/her major field have not been offered. 4. The distance from the member's home to the place of employment is unreasonable considering the expected wage and the time and cost of commuting. 5. The daily commuting time exceeds two (2) hours per day, not including the transporting of a child or children to and from a child care facility. 6. The distance to the place of employment prohibits walking and neither public nor private transportation is available to transport the member to the job site. 7. The working hours or nature of the employment interferes with the member's religious observances, convictions, or beliefs.		

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		as, but not limited to, illness, illness of another household member requiring the presence of the member, a household emergency, the unavailability of transportation. 1. If good cause does not exist, Employment First can initiate the Notice of Adverse Action, advising the household member of the pertinent Employment First requirements and the consequences of failing to comply. The household member shall be informed of the actions necessary for compliance and the date by which compliance shall be achieved to avoid disqualification. To avoid disqualification, the member shall perform a verifiable act of compliance as established by Employment First. Verbal commitment by the household member is not sufficient, unless the household member is prevented from complying by circumstances beyond the household member's control. 2. If Employment First advises the local office of noncompliance with work requirements and requests that the local office issue the Notice of Adverse Action (NOAA) (See Section 4.608), the local office shall issue the NOAA. Both the NOAA and the disqualification may be cancelled if Employment First verifies that compliance was achieved before the NOAA was issued or before the period of adverse action expires. 3. The NOAA shall be issued within fifteen (15) calendar days from the date of noncompliance.			
4.310.61	Removed citation	4.310.61 Failure to Comply with Title IV-A/IV-F Components, Colorado Refugee Services Program (CRSP) Job Search, or Unemployment Insurance Benefits Work Requirements			

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		A household containing a member who was exempt from Food Assistance work registration and Employment First requirements because he or she was registered for work under Title IV-A/IVF, CRSP, or was a registrant for unemployment insurance, and who fails to comply with a comparable Title IVA/IVF, a comparable CRSP, or a comparable unemployment insurance job search requirement, shall be treated as though the member had failed to comply with Food Assistance employment and training requirements.			
4.310.7	Updated language	4.310.7 Right to a Fair Hearing Each individual has a right to appeal a denial, reduction, or termination of benefits due to a determination of non-exempt status or failure to comply with Employment First. The individual may also appeal action by Employment First or the local office determining exemption status, the type of requirements imposed, or refusal to make a finding of good cause. If a fair hearing is requested, the individuals shall be allowed to examine their Employment First case file at a reasonable time before the fair hearing. Confidential information (which may include test results) should be protected from release. However, information withheld from the individual may not be used by either party at the hearing. A representative of Employment First shall receive sufficient advance notice to be available for questioning either in person or by phone. The results of the fair hearing shall be binding on the local office.	4.310.7 Good Cause for Voluntary Quit and Suitable Employment A. The local office is responsible for determining good cause when a non-exempt individual appears to have voluntarily quit or failed to accept an offer of suitable employment. Good cause and/or lack of good cause must be clearly documented in the case file. B. Good cause for voluntary quit includes circumstances beyond the household member's control, such as, but not limited to: 1. Discrimination by an employer based on age, race, sex, color, handicap, religious beliefs, national origin, or political beliefs; 2. Work demands or conditions that render continued employment unreasonable, such as working without being paid on schedule; 3. Acceptance by the individual of employment; or enrollment of at least half-time in any recognized school, training program, or institution of higher education, that requires the individual to leave employment; 4. Acceptance by any other household member of		

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			employment or enrollment at least half-time in any recognized school, training program, or institution of higher education in another county or political subdivision which requires the household to move and thereby requires the individual to leave employment; 5. Resignations by persons under the age of sixty (60) that are recognized by the employer as retirement; 6. Resignation from employment that does not meet suitable employment 7. Because of circumstances beyond the control of the individual, accepted full time employment subsequently either does not materialize or results in employment of less than thirty (30) hours a week or weekly earnings of less than the federal minimum wage multiplied by thirty (30) hours; 8. Leaving a job in connection with patterns of employment in which workers frequently move from one employer to another, such as migrant farm labor or construction work, even though employment at the new site has not actually begun; 9. Illness of the individual; 10. Illness of another household member requiring the presence of the individual; 11. A household emergency; 12. Unavailability of transportation;		

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			13. Employer demands a reduction in participant's work effort or salary through no fault of the employee; and 14. Lack of adequate child care for children who have reached age 6 but are under age 12.		
4.310.8	Updated language	4.310.8 Food Assistance Employment First Components County Employment First components shall correspond to components contained in the state Food Assistance Employment and Training Program plan. County components may consist of direct or support activities which expand the abilities of Food Assistance applicants and recipients to obtain meaningful employment and educational programs or activities to improve basic skills or improve employability. Educational components shall not make a participant subject to student provisions when Employment First requires the attendance to improve employability.	4.310.8 Level Sanction Periods A. If the local office determines that an individual has voluntarily quit or failed to accept suitable employment without good cause, that individual shall be ineligible to participate in the Food Assistance Program and shall be treated as a disqualified member. If the disqualified member joins another household, the disqualification period for that individual shall continue until the disqualification period is completed. 1. The first (1st) time, the individual shall be disqualified for a period of one (1) month after the date the individual became ineligible. 2. The second (2nd) time, the individual shall be disqualified for a period of three (3) months after the date the individual became ineligible. 3. The third (3rd) or subsequent time, the individual shall be disqualified for a period of six (6) months after the date the individual became ineligible. B. The disqualification period shall begin the month following the expiration of the Notice of Adverse Action,		

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			unless a fair hearing is requested. C. If the level sanction disqualified individual is the sole member of the Food Assistance household and then becomes exempt, the newly exempt individual can reapply for benefits. The newly exempt individual will be eligible based on the date of the application or, if in the case of reinstatement, the date exemption information was provided to the county office. If the level sanction disqualified individual is in a Food Assistance household with other eligible members and then becomes exempt, the newly exempt individual will be eligible based on the date exemption information was provided to the county office.		
4.310.81	Removed citation	4.310.81 Period of Participation An applicant for Food Assistance may be required to participate in any component from the time of application. The certification office shall not delay determination of eligibility nor issuing benefits during this period. The length of participation in an Employment First component and the number of components to which a Food Assistance Employment First participant may be referred shall be determined by the State Department or the local Employment First program. In no event may the time spent collectively in an Employment First work component, as described in the state Employment First plan, exceed the number of hours equal to that household's allotment, for that month, divided by the federal minimum wage. The total hours of participation in an Employment First non-work component together with any hours worked in a workfare program or hours worked for			

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		compensation (cash or in kind) may not exceed one hundred twenty (120) hours each month for any household member.			
4.310.82	Removed citation	4.310.82 Participant Reimbursement Employment First shall reimburse participants in a component for the actual costs of transportation or other costs (excluding dependent care) necessary and directly related to participation in that Employment First component. This reimbursement shall be based either on actual costs incurred and verified to Employment First or an allowance based on estimated costs associated with participation. Participants who report to Employment First that they are unable to incur a cost necessary for participation, and are, therefore, unable to participate, may be determined by Employment First to have good cause for nonparticipation or the participant may be assigned to a different component. A participant is not entitled to the dependent care reimbursement if a member of the participant's Food Assistance household provides the dependent care services. Employment First must verify the participant's need for dependent care and the cost of the dependent care prior to the issuance of the reimbursement. The verification must include the name and address of the dependent care provider, the costs and the hours of service, for example, five (5) hours each day, five (5) days each week for two (2) weeks. A participant may not be reimbursed for dependent care services beyond that which is required for participation in the Employment First program. In lieu of providing reimbursements for dependent care expense, Employment First may arrange for dependent care through providers by the use of purchase of service contracts, by providing vouchers to the household or by other means.			

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		Dependent care provided or arranged by Employment First shall meet all applicable standards of state and local law, including requirements designed to ensure basic health and safety protection, such as fire safety and licensure. A participant may refuse available appropriate dependent care as provided or arranged by Employment First if the participant can arrange other dependent care or can show that such refusal will not prevent or interfere with participation in the Employment First program. Allowable dependent care expenses that exceed the reimbursement shall be considered in determining a dependent care deduction when calculating net income for eligibility. Employment First shall inform all mandatory Employment First participants that they may be exempted from participation if their monthly expenses that are reasonably necessary and directly related to participation in the Employment First program exceed the allowable reimbursement amount. Persons for whom allowable monthly expenses in a component exceed the total of the reimbursement for dependent care and other costs shall not be required to participate in that component. These individuals shall be placed, if possible, in another suitable component in which the individual's monthly expenses would not exceed the allowable reimbursable amount paid by Employment First. If a suitable component is not available, these individuals shall be exempted from participation until a suitable component is available or the individual's circumstances change and his/her monthly expenses do not exceed the total of the allowable reimbursable amounts. Individuals exempted because their monthly			

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		expenses exceed the reimbursable amount may volunteer to participate in the Employment First program. Volunteers must be informed that their allowable expenses in excess of the reimbursable amount will not be reimbursed.			
4.310.9	Removed old language in this citation and moved section to 4.312 with updated language	4.310.9 Requirements for County Participation in the Food Assistance Employment and Training Program In Colorado, the employment and training program under the Food and Nutrition Act of 2008, as amended, is called Employment First. The purpose of the program is to assist members of households participating in the Food Assistance Program in gaining skills, training, work, or experience that will increase their ability to obtain employment. All counties shall operate an Employment First program unless they can demonstrate their county has a ten percent (10%) unemployment rate or there are an insufficient number of jobs available. A county department CHOOSING to or required to administer an Employment First program shall submit a COUNTY- plan in a format prescribed by the State Department to the Colorado Department of Human Services, Employment and Benefits Division, for approval. Each county shall include a description of their program operations. Counties operating an Employment First Program are required to serve ABAWDs. Upon approval of the plan, the state department shall notify the county department of such approval, plus any conditions or limitations required for the approval. The State Department shall keep on file official copies of Food Assistance Employment First plans for public inspection. An annual Employment First Plan of Operation is required for a county to maintain Employment and Training status. The annual plan will be submitted in a format prescribed by the state. Operation of an	4.312 Employment First (EF) In Colorado, the employment and training program is called EF. The purpose of the program is to assist members of households participating in the Food Assistance Program in gaining skills, training, work, or experience that will increase their ability to obtain employment. CDHS must submit an annual employment and training state plan for approval by the USDA, Food and Nutrition Service. A copy of the CDHS Employment and Training plan is available for inspection during normal working hours by contacting the SNAP Director, Food and Energy Assistance Division, Colorado Department of Human Services, 1575 Sherman Street, Denver, Colorado 80203. The EF program is a voluntary work program for Food Assistance applicants and recipients. Failure to participate with the EF program will not result in a work requirement disqualification.		

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		Employment First program is contingent on approval of the county plan of operation. A county department may enter into a contractual agreement for all or any part of the Employment First program service delivery. These contractual agreements shall be reviewed by the State Department for adherence to program requirements before implementation. The only exception is that the Section 20 workfare, Colorado Workfare, may only be operated by a public or private non-profit agency. Employment First funds shall not be used to supplant funds used for existing services and activities that promote the purpose of any component. Every Employment First program shall monitor participants who work at least twenty (20) hours a week, averaged monthly, but who do not yet work thirty (30) hours a week or earn wages equal to at least thirty (30) hours a week multiplied by the prevailing federal minimum wage. A. A county shall also provide each non-exempt eighteen (18) to fifty (50) year old work registrant who is not working at least twenty (20) hours a week, a Section 20 workfare program, or other component or combination of components that equal a minimum of twenty (20) hours of participation weekly. Allowable components include the following: 1. Educational programs or activities to improve basic skills and literacy or otherwise improve employability, including, but not limited to, General Equivalency Degree (GED), adult basic education, English as a Second Language, vocational training, and employability training. 2. Community service program participation. 3. A program designed to increase the self-sufficiency of recipients through selfemployment, including programs that provide instruction for self-employment. 4. A program under the Workforce Innovation and Opportunity Act (WIOA). 5. A program under Section 236 of the Trade Act of 1974. 6. A county may also provide those individuals who			

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		are exempt from the eighteen (18) to fifty (50) year old work requirements in Section 4.310.2 with a job seeking skills component approved by the state office. B. The local Employment First provider shall: 1. Schedule the first appointment with Employment First within fourteen (14) calendar days from the date referred from the local office; 2. Enter required information from the work registration form into the Employment First automated system for each person referred from the local office to the Employment First; 3. Create a case file for each individual referred by the local office to Employment First; 4. Complete an assessment as prescribed by the state office and provide appropriate service for each referred, non-exempt participant who reports to Employment First; 5. Complete a participant contract for each individual enrolled in an Employment First activity; 6. Notify the local office of the determination of non-compliance without good cause; 7. Compile data and submit required reports within prescribed timeframes; 8. Coordinate program operations with the state Employment First staff; 9. Ensure that participants receive the appropriate reimbursement for participation; 10. Utilize required forms as prescribed or approved by the state; 11. Attend scheduled Employment First program meetings and training as required; 12. Ensure that all funds expended are allowable program costs; 13. Ensure program services are not suspended for longer than fourteen (14) consecutive days for any reason; 14. At a minimum, maintain monthly contact with each Employment First participant; and, 15. Verify all reported employment.			
4.310.2	Duplicate citation was renumbered to 4.313 and language updated	4.310.2 Colorado Workfare Program All counties with an Employment First program can operate a Section 20 Workfare program. In	4.313 Colorado Workfare Program In Colorado, the Section 20 Workfare program of the Food and Nutrition Act of 2008 (codified at 7 USC sec. 2011 et seq) is		

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		Colorado, Section 20 Workfare is called the Colorado Workfare program. Only a public or private non-profit agency can be designated as the operating agency for Workfare. The operating agency is responsible for administering Workfare in accordance with state regulations and policy. An annual plan of operation shall be submitted to the Employment First Workfare office by the operating agency. The operating agency is defined as the organization that has been identified in the plan as being responsible for establishing and monitoring job sites, interviewing and assessing eligible recipients, assigning eligible recipients to appropriate job sites, monitoring participant compliance and making the initial determination of good cause for household noncompliance. Workfare job slots may only be located in public or private, nonprofit agencies. There shall be a written agreement between the Workfare Program and any separate job site sponsors. One copy of the agreement shall be forwarded to the state Employment First office. Files shall be maintained that record all activity by workfare participants. At a minimum, these records shall contain household identification information, job sites and hours assigned, hours completed, copies of all communication with the participant and all communications with the job site sponsor. These files may become part of the participant's file, but shall be maintained as a separate section. All files shall be kept accessible for a minimum of three (3) years from the date of referral. Under the workfare program, nonexempt Food	called the Colorado workfare program. CDHS must submit an annual Section 20 workfare state plan for approval by the USDA, Food and Nutrition Service. A copy of the CDHS Section 20 workfare plan is available for inspection during normal working hours by contacting the SNAP Director, Food And Energy Assistance Division, Colorado Department of Human Services, 1575 Sherman Street, Denver, Colorado 80203.		

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		Assistance recipients may be required to perform work in a public service capacity as a condition of eligibility to receive the Food Assistance benefit allotment to which their household is normally entitled. Household members subject to the work registration requirements shall also be subject to the workfare requirements in those counties that operate a workfare program. In addition, those Food Assistance recipients exempt from work registration requirements due to being subject to the work requirements under Title IV-A/IV-F of the Social Security Act shall be subject to workfare if they are currently participating less than twenty (20) hours a week in Title IV-A/IV-F and do not have a child under six (6) years of age. Such participation shall be outlined in the Title IV-A/IV-F employability plan. Those recipients exempt from work registration requirements due to the application for or receipt of unemployment compensation shall be subject to Section 20 workfare requirements. Those recipients exempt from work registration requirements due to being a parent or other household member responsible for the care of a dependent child under the age of six (6) shall be subject to workfare requirements once the child reaches the age of six. If the child has his/her sixth (6th) birthday within a certification period, the individual responsible for the care shall be subject to the workfare requirements as part of the next scheduled recertification process, unless otherwise exempt.			
4.311	Added new citation		4.311 ABAWD Work Requirements ABAWDs must fulfill an ABAWD work requirement in addition to		

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			the general work requirements. For the remainder of this section, client statement is considered acceptable verification unless questionable. If verification is requested from the client, case documentation must thoroughly explain why the original client statement was considered questionable. A. To fulfill the ABAWD work requirement, the ABAWD must be: 1. Working 20 hours per week or averaged monthly for a total of 80 hours a month; or a. Working includes: i. Work completed in exchange for money (compensated work); or ii. Work completed in exchange for goods or services (in-kind work); or iii. Any combination of compensated work or in-kind work. 2. Participating in and complying with the requirements of a work program 20 hours per week or averaged monthly for a total of 80 hours a month; or b. A work program includes: i. A program of employment and		

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			training operated or supervised by the CDHS program other than a job search program or a job search training program; ii. A program under the Workforce Innovation and Opportunity Act (WIOA); iii. A program under Section 236 of the Trade Act of 1974 (19 USC 2296, "Trade Adjustment Assistance"). 3. In any combination of working and participating in a work program for a total of 20 hours per week or averaged monthly for a total of 80 hours a month; or 4. Participating in and complying with the Colorado Workfare program. B. Non- exempt ABAWDs must submit monthly hours to EF for work activity tracking so countable months can be determined. Failure to work with the EF program or provide the EF program information needed to determine compliance with the ABAWD work requirement will result in the ABAWD losing eligibility as a result of accruing three countable months within a thirty-six (36) calendar month period.		
4.311.1	Added new citation		4.311.1 ABAWD Exemptions While ABAWDs can be exempt under general work requirement exemptions, these individuals could also meet one of the		

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			following ABAWD exemptions: A. Younger than eighteen (18) years of age or older than forty-nine (49) years of age. The month of the household member's birthday is not a countable month; B. Exempt from the general work requirements; C. Is residing in a Food Assistance household where a household member is under age 18; D. Pregnancy; E. Exempt under a waiver approved by the USDA, FNS; F. Exempt using Colorado defined state exemptions as identified in the current Food Assistance Employment and Training state plan.		
4.311.2	Added new citation		4.311.2 Changes in ABAWD Exemption Status ABAWDs are not required to report changes in their exemption status during a certification period. However, if the ABAWD loses their exemption status during a certification period, the months the ABAWD was not exempt will count toward their three countable months in a thirty-six (36) calendar month period. Any remaining months of benefits received during that certification period are not considered overpayments and claims will not be established.		
4.311.3	Added new citation		4.311.3 ABAWD Time Limits ABAWDs are not eligible to participate in food assistance if they		

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			have received food assistance benefits for more than three countable months during a thirty-six (36) month period. However, ABAWDs may be eligible for up to three additional consecutive months after regaining eligibility in accordance with paragraph (c) of this section. A. Countable Months Countable months are accrued when an ABAWD receives food assistance benefits for the full benefit month but did not: 1. Meet an exemption; or 2. Fulfill their work requirements. B. Good Cause for Countable Months If an ABAWD would have worked an average of 20 hours per week but missed some work for good cause, the ABAWD shall be considered to have met the work requirement if the absence from work is temporary and the individual retains his or her job. Good cause for countable months shall include circumstances beyond the individual's control, such as, but not limited to, illness, illness of another household member requiring the presence of the member, a household emergency, or the unavailability of transportation. C. ABAWD Time Limit Clock The ABAWD time limit clock:		

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			1. Counts accrued countable months for all ABAWDs who are not in compliance with work requirements and do not have an exemption; and 2. Resets accrued countable months and ABAWD disqualifications, regardless of start date, for all ABAWDs every 36 calendar months starting October 1st, 2019. D. Regaining Eligibility 1. An individual who is denied eligibility under this provision can regain eligibility if in a thirty (30) calendar day period, the individual; a. Is employed eighty (80) or more hours, b. Participates in and complies with the requirements of a work program for eighty (80) or more hours as determined by EF; c. Participates and complies with workfare; or d. Becomes exempt. 2. The individual will be reinstated if otherwise eligible and will continue to be eligible as long as the individual continues to meet the work requirement or is exempt. 3. Three Additional Consecutive Months If an individual regains eligibility but then fails to		

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			continue meeting these requirements, the individual shall remain eligible for a consecutive three-month period after the individual notifies the county department. The individual can only have this provision applied for a single three-month period in the thirty-six (36) calendar month period.		
4.312	Moved updated language from 4.310.9 here		4.312 Employment First (EF) In Colorado, the employment and training program is called EF. The purpose of the program is to assist members of households participating in the Food Assistance Program in gaining skills, training, work, or experience that will increase their ability to obtain employment. CDHS must submit an annual employment and training state plan for approval by the USDA, Food and Nutrition Service. A copy of the CDHS Employment and Training plan is available for inspection during normal working hours by contacting the SNAP Director, Food and Energy Assistance Division, Colorado Department of Human Services, 1575 Sherman Street, Denver, Colorado 80203. The EF program is a voluntary work program for Food Assistance applicants and recipients. Failure to participate with the EF program will not result in a work requirement disqualification.		
4.312.1	Added new citation		4.312.1 County Administration Requirements for EF A county department choosing to or required to administer an EF program shall submit a county plan as prescribed by CDHS and shall operate their EF program in alignment with the CDHS employment and training plan. Failure to adhere to the requirements as described in the CDHS employment and training plan will result in a corrective action plan (cap).		

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			A county department may enter into a contractual agreement for all or any part of the EF program service delivery. These contractual agreements shall be reviewed by CDHS for adherence to program requirements before implementation. A. Every EF program must monitor ABAWDs to ensure they are meeting ABAWD work requirements. This monitoring may include obtaining employment or volunteer working hours information and/or ensuring the ABAWD is participating in an allowable employment first component as set forth in the annual CDHS employment and training plan and the specific county EF plan. B. The EF provider shall: 1. Schedule the first appointment with EF within fourteen (14) calendar days from the date referred from the local office; 2. Enter the required information from the work registration form into the EF automated system for each person referred; 3. Deliver case management services as prescribed in the CDHS EF state plan; 4. Compile data and submit required reports within prescribed timeframes; 5. Coordinate program operations with the state EF staff, in accordance with the annual CDHS employment and training plan as well as the specific county EF plan;		

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			6. Ensure that participants receive the appropriate reimbursement for participation, such as actual costs of transportation or other costs as outlined in the CDHS employment and training plan; 7. Utilize required forms as prescribed or approved by the state; 8. Attend scheduled EF program meetings and training as required; 9. Ensure that all funds expended are allowable program costs per the annual CDHS employment and training plan; 10. Ensure program services are not suspended for longer than fourteen (14) consecutive days for any reason; 11. Ensure that any exemptions discovered through working with participants are communicated to county eligibility.		
4.313	Moved updated language from duplicate citation 4.310.2 here	4.310.2 Colorado Workfare Program All counties with an Employment First program can operate a Section 20 Workfare program. In Colorado, Section 20 Workfare is called the Colorado Workfare program. Only a public or private non-profit agency can be designated as the operating agency for Workfare. The operating agency is responsible for administering Workfare in accordance with state regulations and policy. An annual plan of operation	4.313 Colorado Workfare Program In Colorado, the Section 20 Workfare program of the Food and Nutrition Act of 2008 (codified at 7 USC sec. 2011 et seq) is called the Colorado workfare program. CDHS must submit an annual Section 20 workfare state plan for approval by the USDA, Food and Nutrition Service. A copy of the CDHS Section 20 workfare plan is available for inspection during normal working hours by contacting the SNAP Director, Food and Energy Assistance Division, Colorado Department of Human Services, 1575 Sherman Street, Denver, Colorado 80203.		

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		shall be submitted to the Employment First Workfare office by the operating agency. The operating agency is defined as the organization that has been identified in the plan as being responsible for establishing and monitoring job sites, interviewing and assessing eligible recipients, assigning eligible recipients to appropriate job sites, monitoring participant compliance and making the initial determination of good cause for household noncompliance. Workfare job slots may only be located in public or private, nonprofit agencies. There shall be a written agreement between the Workfare Program and any separate job site sponsors. One copy of the agreement shall be forwarded to the state Employment First office. Files shall be maintained that record all activity by workfare participants. At a minimum, these records shall contain household identification information, job sites and hours assigned, hours completed, copies of all communication with the participant and all communications with the job site sponsor. These files may become part of the participant's file, but shall be maintained as a separate section. All files shall be kept accessible for a minimum of three (3) years from the date of referral. Under the workfare program, nonexempt Food Assistance recipients may be required to perform work in a public service capacity as a condition of eligibility to receive the Food Assistance benefit allotment to which their household is normally entitled. Household members subject to the work registration requirements shall also be subject to the workfare requirements in those counties that operate a workfare program.			

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		In addition, those Food Assistance recipients exempt from work registration requirements due to being subject to the work requirements under Title IV-A/IV-F of the Social Security Act shall be subject to workfare if they are currently participating less than twenty (20) hours a week in Title IV-A/IV-F and do not have a child under six (6) years of age. Such participation shall be outlined in the Title IV-A/IV-F employability plan. Those recipients exempt from work registration requirements due to the application for or receipt of unemployment compensation shall be subject to Section 20 workfare requirements. Those recipients exempt from work registration requirements due to being a parent or other household member responsible for the care of a dependent child under the age of six (6) shall be subject to workfare requirements once the child reaches the age of six. If the child has his/her sixth (6th) birthday within a certification period, the individual responsible for the care shall be subject to the workfare requirements as part of the next scheduled recertification process, unless otherwise exempt.			
4.313.1	Added new citation		4.313.1 County Administration Requirements For Workfare A county department choosing to administer a Colorado Workfare program shall submit a county plan as prescribed by CDHS and shall operate their workfare program in alignment with the CDHS Section 20 Workfare plan. Failure to adhere to the requirements as described in the CDHS Section 20 Workfare plan will result in a corrective action plan (CAP).		
4.504.6	Updated existing language to	4.504.6 Information Considered Verified Upon Receipt	4.504.6 Information Considered Verified Upon Receipt		

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	incorporate EF changes and Adult Financial program updates	A. Verified upon receipt is a term given to a state-prescribed list of specific information that comes directly from the primary source of the information and is free from question. B. Information that is considered verified upon receipt shall be acted upon for both simplified reporting households and non-simplified reporting households. Information considered verified upon receipt shall be acted on at the time of application, recertification, periodic report, and during a household's certification period if the information causes a change in the Food Assistance benefit amount. A household shall not be convicted of fraud for not reporting a change in information it is not required to report. C. Information considered verified upon receipt shall be considered verified unless the office has reason to believe that the information may be inaccurate. Advance notice of adverse action shall be given when acting on information that is considered verified upon receipt, except as noted in Section 4.608.1. D. The local office shall consider only the following information as verified upon receipt: 1. Social Security and SSI benefit amounts obtained from SSA. SSI and benefit amounts obtained from the SSA are considered reported and verified on the day the information is first known to the agency, either through the IEVS, SDX, BENDEX or another automated interface of information, whichever is sooner.	A. Verified upon receipt is a term given to a state-prescribed list of specific information that comes directly from the primary source of the information and is free from question. B. Information that is considered verified upon receipt shall be acted upon for both simplified reporting households and non-simplified reporting households. Information considered verified upon receipt shall be acted on at the time of application, recertification, periodic report, and during a household's certification period if the information causes a change in the Food Assistance benefit amount. A household shall not be convicted of fraud for not reporting a change in the information it is not required to report. C. Information considered verified upon receipt shall be considered verified unless the office has reason to believe that the information may be inaccurate. Advance notice of adverse action shall be given when acting on information that is considered verified upon receipt, except as noted in Section 4.608.1. D. The local office shall consider only the following information as verified upon receipt: 1. Social Security and SSI benefit amounts obtained from SSA. SSI and benefit amounts obtained from the SSA are considered reported and verified on the day the information is first known to the agency, either through the IEVS, SDX, BENDEX or another automated interface of information, whichever is sooner.		

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		2. Death information received from the Burial Assistance program. Death information received from the Burial Assistance program is considered reported and verified on the day the information is first known to the agency. 3. Unemployment insurance benefits that are reported through the IEVS and obtained through the Department of Labor and Employment (DOLE). The unemployment insurance benefit (UIB) information shall be considered reported and verified on the date of the IEVS notification. Advance notice of adverse action shall be given when acting on the change in information. 4. Public Assistance (PA) benefit amounts (Colorado Works, Aid to the Needy Disabled (AND), Old Age Pension (OAP), Aid to the Blind (AB), and Colorado Supplement to SSI) obtained from the State Department. Such information shall be considered reported and verified on the day the public assistance benefit amount is authorized. 5. Information that is reported and verified to a public assistance program which results in a change to the PA benefit amount and that meets the Food Assistance regulations for verification. Such information shall be considered reported and verified on the day the public assistance program processes the change and authorizes the new PA benefit amount. 6. Child support income and expense	2. Death information received from the Burial Assistance program. Death information received from the Burial Assistance program is considered reported and verified on the day the information is first known to the agency. 3. Unemployment insurance benefits (UIB) that are reported through the IEVS and obtained through the Department of Labor and Employment (DOLE). The UIB information shall be considered reported and verified on the date of the IEVS notification. Advance notice of adverse action shall be given when acting on the change in information. 4. PA benefit amounts (Colorado Works, Aid to the Needy Disabled (AND) program consisting of AND- State Only (AND-SO) and AND-Colorado Supplement (AND-CS), Home Care Allowance (HCA), and Old Age Pension (OAP), obtained from the State Department. Such information shall be considered reported and verified on the day the public assistance benefit amount is authorized. 5. Information that is reported and verified to a public assistance program which results in a change to the PA benefit amount and that meets the Food Assistance regulations for verification.		

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		amounts obtained through the Automated Child Support Enforcement System (ACSES). Such information is considered reported and verified on the day the information is reported through an automated interface with ACSES. 7. Non-compliance information obtained from Employment First (EF) agencies for failure to participate in a mandated work program. 8. Colorado intentional Program violations (IPV). 9. Information obtained from the Systematic Alien Verification for Entitlements (SAVE) system regarding non-citizen status. 10. Changes in household composition that are reported and verified and result in one or more members being removed from one Food Assistance household and added to a new or existing Food Assistance household. Duplicate benefits shall not be issued for a particular individual when removing that individual from one Food Assistance household and adding him/her to a new Food Assistance household. 11. Changes in household composition that are reported and verified by child welfare agencies and result in a child being removed from one Food Assistance household and added to a new or existing Food Assistance household. 12. The disqualification of a household	Such information shall be considered reported and verified on the day the public assistance program processes the change and authorizes the new PA benefit amount. 6. Child support income and expense amounts obtained through the ACSES. Such information is considered reported and verified on the day the information is reported through an automated interface with ACSES. 7. Non-compliance information obtained from EF agencies of the failure of an ABAWD to meet work requirements. 8. Colorado IPVs. 9. Information obtained from the SAVE system regarding non-citizen status. 10. Changes in household composition that are reported and verified and result in one or more members being removed from one Food Assistance household and added to a new or existing Food Assistance household. Duplicate benefits shall not be issued for a particular individual when removing that individual from one Food Assistance household and adding him/her to a new Food Assistance household. 11. Changes in household composition that are reported and verified by child welfare agencies and result in a child being removed from one		

Title of Proposed Rule: SNAP Employment First Updates 2020
CDHS Tracking #: 20-01-21-01
CCR #: 10 CCR 2506-1
Office, Division, & Program: OES, FEAD, Food Assistance Phone: 303-866-4748
Rule Author: Andrea Poole E-Mail: Andrea.Poole@state.co.us

Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
		member determined to be a fleeing felon or probation or parole violator.	Food Assistance household and added to a new or existing Food Assistance household. 12. The disqualification of a household member who is determined to be a fleeing felon or a probation or parole violator.		

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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):

Employment and Benefits Division, Sub-PAC, Legislative Liaison, Office of Appeals, and Office of Administrative Courts, County partners

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:

Hunger Free Colorado, Colorado Center on Law and Policy, Colorado Blueprint to End Hunger

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?

[ ] Yes [X] No

Name of Sub-PAC			
Date presented	Scheduled for 2/6/20 vote		
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.			

PAC

Have these rules been approved by PAC? ***Packets will not be presented to AG until after packet has been approved by PAC. Please plan your process accordingly.***

[ ] Yes [X] No

Date presented	Scheduled for 2/6/20 vote		
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.			

Other Comments

Comments were received from stakeholders on the proposed rules:

[ ] Yes [x] No

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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.

4.100 Definitions

~~"ABAWD County" means a county with an Employment First Program that requires ABAWDs to meet a mandatory monthly ABAWD work requirement of working or participating in an acceptable work activity eighty (80) hours per month or completing all assigned workfare hours monthly.~~

"Able-Bodied Adult Without Dependent (ABAWD)" means an individual between the ages of eighteen (18) and fifty (50) without a physical or mental disability, who is not pregnant, and who lives in a F~~f~~ood A~~a~~ssistance household with no one under the age of eighteen (18).

****

"COUNTABLE MONTH" MEANS A MONTH IN WHICH AN ABAWD RECEIVED FULL FOOD ASSISTANCE ALLOTMENT BUT DID NOT MEET WORK REQUIREMENTS OR HAVE AN EXEMPTION FROM THOSE REQUIREMENTS.

***

"Disqualified individuals" means any individual who is ineligible to receive Food Assistance due to having been disqualified for an I~~i~~ntentional Program V~~v~~iolation/fraud, failure to provide or obtain a SSN, ineligible non-citizens, individuals disqualified for failure to cooperate with work requirements, individuals disqualified for failure to cooperate with the State quality assurance division, and ~~Able-Bodied Adults Without Dependent~~ABAWDs who already received three countable months of Food Assistance within thirty-six (36) months without meeting an exemption or ABAWD work requirements.

***

"LEVEL Sanction" means a specified period of ineligibility imposed against an individual who failed to take a required action as part of his or her eligibility for ~~either~~ Food Assistance ~~or Colorado Works~~.

***

~~"Non-ABAWD County" means a county that is not requiring ABAWDs to meet the mandatory monthly ABAWD work requirement; although, the individual may be required to participate in non-ABAWD work program activities.~~

~~"Non-Employment First County" means a county in which there is no Employment First Program; although, work registrants must still sign an affidavit attesting that he/she will seek work opportunities through available resources.~~

***

"QUESTIONABLE" MEANS INCONSISTENT OR CONTRADICTORY INFORMATION, STATEMENTS, DOCUMENTS, OR CASE DOCUMENTATION THAT REQUIRES VERIFICATION FROM THE HOUSEHOLD TO DETERMINE ELIGIBILITY.

***

"Voluntary Quit" means when a Food Assistance recipient voluntarily quit a job of 30 or more hours a week or reduceD work effort to less than 30 hours a week without good cause.

~~**~~**

4.310 ~~WORK REGISTRATION~~ GENERAL WORK REQUIREMENTS

~~The Food and Nutrition Act of 2008, as amended, requires that all members of eligible households, who have attained the age of sixteen (16) and have not yet reached their sixtieth (60th) birthday, shall register for work, participate in an employment and training program as required, accept suitable employment, and provide sufficient information to allow the agency to determine the employment status or the job availability of the individual, unless exempt as noted below. This requirement shall include a person not working because of a strike or lockout at his/her usual place of employment.~~

~~Compliance with the work registration requirement is a prerequisite to certification. The requirement cannot be waived, and benefits may not be granted conditionally prior to registration of all household members who are required to do so.~~

~~Work registration shall be accomplished through the completion of the Food Assistance application in Employment First counties all household members between the ages of sixteen (16) and sixty (60), except the persons described in the following sections, at the time of application and once every twelve (12) months. The work registration form shall be signed by the member required to register or by another adult household member.~~

AS A CONDITION OF ELIGIBILITY FOR FOOD ASSISTANCE BENEFITS, EACH HOUSEHOLD MEMBER NOT DETERMINED EXEMPT MUST COMPLY WITH THE FOLLOWING WORK REQUIREMENTS:

A. REGISTER FOR WORK AT THE TIME OF INITIAL APPLICATION AND AT EVERY RECERTIFICATION, BY SIGNING THE APPLICATION FOR ASSISTANCE OR REDETERMINATION. THE APPLICATION MUST BE SIGNED BY THE MEMBER REQUIRED TO REGISTER, AN AUTHORIZED REPRESENTATIVE, OR BY ANOTHER ADULT HOUSEHOLD MEMBER;

B. PROVIDE ELIGIBILITY STAFF WITH SUFFICIENT INFORMATION REGARDING EMPLOYMENT STATUS OR AVAILABILITY FOR WORK;

C. CANNOT COMMIT AN ACT OF VOLUNTARILY QUIT;

D. ACCEPT AN OFFER OF SUITABLE EMPLOYMENT;

E. REPORT TO AN EMPLOYER IF REFERRED BY THE COUNTY IF THE POTENTIAL EMPLOYMENT IS SUITABLE EMPLOYMENT;

4.310.1 WORK REQUIREMENTS AND VERIFICATION

CLIENT STATEMENTS ARE CONSIDERED ACCEPTABLE VERIFICATION UNLESS QUESTIONABLE.

IF VERIFICATION IS REQUESTED FROM THE CLIENT BECAUSE CLIENT STATEMENT IS CONSIDERED QUESTIONABLE, CASE DOCUMENTATION MUST THOROUGHLY EXPLAIN WHY THE ORIGINAL CLIENT STATEMENT WAS CONSIDERED QUESTIONABLE.

B. EXAMPLES OF VERIFICATION THAT CAN BE OBTAINED TO RESOLVE QUESTIONABLE INFORMATION CAN INCLUDE BUT IS NOT LIMITED TO:
   1. RECEIPT OF TEMPORARY OR PERMANENT DISABILITY BENEFITS ISSUED BY GOVERNMENT OR PRIVATE SOURCES; OR
   2. PERSONS MAY PROVIDE A STATEMENT FROM A PHYSICIAN, PHYSICIAN'S ASSISTANT, NURSE, NURSE PRACTITIONER, DESIGNATED REPRESENTATIVE OF THE PHYSICIAN'S OFFICE OR A LICENSED OR CERTIFIED PSYCHOLOGIST. A COUNTY AGENCY MAY DETERMINE OTHER LICENSED MEDICAL PERSONNEL APPROPRIATE TO PROVIDE VERIFICATION THAT A WORK REGISTRANT IS PHYSICALLY OR MENTALLY UNFIT FOR EMPLOYMENT; OR
   3. A STATEMENT FROM A LICENSED SOCIAL WORKER OR A SOCIAL WORKER EMPLOYED BY OR ACTING ON BEHALF OF A 501(C)(3) NON-PROFIT ORGANIZATION OR GOVERNMENT ENTITY.

~~4.310.1~~ 4.310.2 ~~Work Registration and Referral to Employment First in Employment First Counties~~ INFORMING THE HOUSEHOLD OF GENERAL WORK REQUIREMENTS

~~"Work registration" means notification and referral of a work registrant after completion of the Food Assistance application. The local office shall complete an appointment form for all household members not exempt from work registration under Section 4.310.3.~~

~~In Employment First counties, the Food Assistance eligibility technician shall provide the written notice of referral to each work-registered household member, send a copy to the Employment First Unit, and retain a copy of the referral in the case record.~~

~~Upon determination that the person should be referred to an Employment First Unit, the local office shall explain to the applicant the pertinent work requirements, the rights and responsibilities of work-registered household members, and the consequences of failing to comply. The local office shall provide a written statement of these requirements to each work registrant in the household and to each previously exempt or new household member when that person becomes subject to work registration and at recertification.~~

~~Individuals who are not determined exempt from work registration shall be referred to Employment First at the application interview. Food Assistance applicants may volunteer for Employment First services prior to the application interview. Exempt recipients may volunteer at any time.~~

~~Employment First may exempt individuals for whom they determine participation in an Employment First component is impractical. Reasons for such exemption include lack of job readiness, remoteness from work opportunities (remoteness shall mean a one-way commute of more than one hour), or lack of transportation, medical or family problems, such as a lack of child care, migrant or seasonal farm work status, or other reasons as Employment First determines limit practicability.~~

~~Job-attached persons (e.g., those on temporary layoff or those expecting to return to work within sixty (60) days shall be exempt from referral to Employment First for sixty (60) calendar days at which time the local office shall review the job-attached status.~~

~~Reasons for exemption should be reviewed at recertification or more frequently if a change affecting the exempt status occurs, and shall be documented in the case record.~~

~~Any resident or non-resident participant in a drug or alcohol center's treatment and rehabilitation program is exempt from the work registration requirement. This exemption is not meant to discourage participants in such a program from seeking and accepting employment on their own~~

AT THE POINT OF INITIAL APPLICATION AND REDETERMINATION, WHEN AN INTERVIEW IS REQUIRED, FOOD ASSISTANCE HOUSEHOLDS MUST RECEIVE FROM THE ELIGIBILITY STAFF WRITTEN NOTICE AND A VERBAL EXPLANATION OF:

A. THE FOOD ASSISTANCE GENERAL WORK REQUIREMENTS;

B. THE RIGHTS AND RESPONSIBILITIES OF HOUSEHOLD MEMBERS SUBJECT TO WORK REQUIREMENTS;

C. THE CONSEQUENCES OF FAILURE TO COMPLY WITH THESE WORK REQUIREMENTS; AND

D. THE AVAILABILITY OF ADDITIONAL EMPLOYMENT AND TRAINING PROGRAMS AND SERVICES, OUTSIDE OF EMPLOYMENT FIRST, WITHIN THEIR COMMUNITY.

WHEN AN INTERVIEW IS NOT REQUIRED AT RECERTIFICATION, THE WRITTEN STATEMENT OF THESE REQUIREMENTS TO THE WORK REGISTRANTS IN THE HOUSEHOLD IS SUFFICIENT.

~~4.310.11 Work Registration in Non-Employment First Counties~~

~~Fulfillment of the work registration requirement in non-employment first counties shall occur when an applicant household completes and signs a Food Assistance application~~

~~4.310.2~~ 4.310.3 ~~Work Requirements for Ages Eighteen (18) through Forty-Nine (49) Years~~ GENERAL WORK REQUIREMENT EXEMPTIONS

A. No individual shall be eligible to participate in the Food Assistance Program as a member of any household if, during the preceding thirty-six (36) month period, the individual received Food Assistance benefits for not less than three (3) months (consecutively or not) during which time the individual:

1. Was not employed twenty (20) hours or more each week, averaged monthly; or,

2. Did not participate in and comply with the requirements of a work program for twenty (20) hours or more each week; or,

3. Did not participate in and comply with Section 20 Workfare program of the Food and Nutrition Act of 2008 (codified at 7 USC sec. 2011 et seq.).

B. A work program is defined as:

1. A program of employment and training operated or supervised by the Employment First program other than a job search program or a job search training program;

2. A program under the Workforce Innovation and Opportunity Act (WIOA);

3. A program under Section 236 of the Trade Act of 1974 (19 USC 2296, "Trade Adjustment Assistance");

4. Workfare under Section 20 of the Food Stamp Act, as amended.

C. The limit of three (3) months in a thirty-six (36) month period shall not apply to individuals who are:

1. Under eighteen (18) or fifty (50) years of age or older;

2. Physically or mentally unfit for employment as described in section 4.310.3 (C);

3. Is residing in a household where a household member is under age 18, even if the household member who is under 18 is not him or herself eligible for food stamps;

4. Pregnant;

5. Exempt from work registration under the exemptions listed in Section 4.310.3;

6. Exempt under a waiver approved by the USDA, FNS. Counties may request such a waiver through the Food Assistance Programs Division (FAPD). FAPD will also consult with Employment First and submit requests for counties or areas that the State Department considers as meeting this requirement. All affected counties will be notified by written correspondence. The waiver from these requirements can be requested when the area has an unemployment rate of ten percent (10%) or the area does not have a sufficient number of jobs to provide employment for the individuals.

D. Regaining Eligibility

1. An individual who is denied eligibility under this provision can regain eligibility if in a thirty (30) calendar day period, the individual is employed eighty (80) or more hours, participates in and complies with the requirements of a work program for eighty (80) or more hours as determined by Employment First, or participates and complies with Section 20 Workfare.

2. The individual will be reinstated the month following the month of compliance if otherwise eligible and will continue to be eligible as long as compliance with these requirements continues or the individual becomes exempt.

3. If an individual regains eligibility but then fails to continue meeting these requirements, the individual shall remain eligible for a consecutive three-month period after the individual notifies

~~the county department. The individual can only have this provision apply for a single three-month period in any thirty-six (36) month period.~~

AT ALL DETERMINATIONS OF ELIGIBILITY INCLUDING INITIAL, ONGOING, AND REDETERMINATION, ELIGIBILITY STAFF MUST EXPLORE IF THE HOUSEHOLD MEMBER MEETS AN EXEMPTION RATHER THAN PLACING THE BURDEN SOLELY ON THE HOUSEHOLD MEMBER TO SELF-REPORT.

GENERAL WORK REQUIREMENT EXEMPTIONS INCLUDE:

A. A PERSON 15 YEARS OF AGE OR YOUNGER OR A PERSON 60 YEARS OF AGE OR OLDER;

    1. A PERSON AGE 16 OR 17 WHO IS NOT THE HEAD OF A HOUSEHOLD, OR WHO IS ATTENDING SCHOOL, OR IS ENROLLED IN AN EMPLOYMENT TRAINING PROGRAM, ON AT LEAST A HALF-TIME BASIS, IS ALSO EXEMPT.

B. A PARENT OR OTHER HOUSEHOLD MEMBER RESPONSIBLE FOR THE CARE OF A DEPENDENT CHILD UNDER 6 OR AN INCAPACITATED PERSON;

C. A PERSON PHYSICALLY OR MENTALLY UNFIT FOR EMPLOYMENT;

    EXAMPLES OF BEING PHYSICALLY OR MENTALLY UNFIT FOR EMPLOYMENT CAN INCLUDE BUT ARE NOT LIMITED TO:

    1. PERSONS EXPERIENCING HOMELESSNESS DEFINED IN 4.100

    2. RECENTLY RELEASED FROM AN INSTITUTION

    3. PERSON WITH DISABILITIES AS DEFINED IN 4.100 AND INCLUDES BUT IS NOT LIMITED TO:
        a. PERSONS WITH SELF-DECLARED TEMPORARY CONDITIONS THAT WOULD PREVENT SUCCESSFUL PARTICIPATION IN WORK ACTIVITIES
        b. PERSONS RECEIVING TEMPORARY OR PERMANENT DISABILITY BENEFITS ISSUED BY GOVERNMENT OR PRIVATE SOURCES
        c. PERSONS PARTICIPATING IN VOCATIONAL REHABILITATION
        d. PERSONS APPLYING FOR AND/OR APPEALING SSI BENEFITS
    4. PERSONS UNABLE TO MAINTAIN EMPLOYMENT
    5. PERSONS IMPACTED BY DOMESTIC VIOLENCE

D. A STUDENT ENROLLED AT LEAST HALF-TIME, AS DEFINED BY THE EDUCATIONAL FACILITY, IN ANY RECOGNIZED SCHOOL, TRAINING PROGRAM, OR INSTITUTION OF HIGHER EDUCATION;

    1. A STUDENT WHO IS ENROLLED IN AN INSTITUTE OF HIGHER EDUCATION MUST MEET STUDENT ELIGIBILITY REQUIREMENTS TO RECEIVE FOOD ASSISTANCE.

    2. STUDENTS WHO ARE ELIGIBLE FOR FOOD ASSISTANCE REMAIN EXEMPT FROM WORK REQUIREMENTS DURING NORMAL PERIODS OF CLASS ATTENDANCE AND SCHOOL BREAKS.

    3. PERSONS WHO ARE NOT ENROLLED AT LEAST HALF-TIME OR WHO EXPERIENCE A BREAK IN THEIR ENROLLMENT STATUS DUE TO GRADUATION, EXPULSION, SUSPENSION, OR WHO DROP OUT OR OTHERWISE DO NOT INTEND TO REGISTER FOR THE NEXT NORMAL SCHOOL TERM (OTHER THAN SUMMER),

SHALL NOT BE ELIGIBLE FOR THIS EXEMPTION.

E. EMPLOYED OR SELF-EMPLOYED INDIVIDUALS WHO ARE WORKING A MINIMUM OF THIRTY (30) HOURS PER WEEK OR RECEIVING WEEKLY EARNINGS AT LEAST EQUAL TO THE FEDERAL MINIMUM WAGE MULTIPLIED BY THIRTY (30) HOURS;

1. THIS SHALL INCLUDE MIGRANT AND SEASONAL FARM WORKERS WHO ARE UNDER CONTRACT OR SIMILAR AGREEMENT WITH AN EMPLOYER OR CREW CHIEF TO BEGIN EMPLOYMENT WITHIN THIRTY (30) DAYS.

2. PERSONS WORKING IN ACTION PROGRAMS, INCLUDING VISTA, ARE EXEMPT FROM WORK REQUIREMENTS IF THEY WORK AT LEAST THIRTY (30) HOURS PER WEEK EVEN IF COMPENSATION IS NOT CONSISTENT WITH PREVAILING COMMUNITY WAGE, SINCE AN EMPLOYER-EMPLOYEE RELATIONSHIP CAN BE DOCUMENTED.

F. A PERSON APPLYING FOR OR RECEIVING UNEMPLOYMENT INSURANCE BENEFITS (UIB). THE LOCAL OFFICE SHALL VERIFY APPLICATION FOR OR RECEIPT OF UIB, IF QUESTIONABLE. A PERSON WHO HAS BEEN DENIED UIB AND WHO IS APPEALING THE DECISION IS EXEMPT;

G. A REGULAR PARTICIPANT IN DRUG OR ALCOHOL TREATMENT OR REHABILITATION PROGRAM;

H. A PERSON SUBJECT TO AND COMPLYING WITH CW OR THE COLORADO REFUGEE SERVICES PROGRAM (CRSP) WORK PROGRAMS.

~~4.310.3~~ 4.310.4 CHANGES IN EXEMPTION STATUS ~~Exemptions from Work Registration~~

~~A. Persons Under Age Eighteen (18) A person age sixteen (16) or seventeen (17) who is not the head of a household is exempt. A sixteen (16) or seventeen (17) year-old head of household who is attending school, or enrolled in an employment training program on at least a half-time basis is exempt from work registration.~~

~~B. Persons Caring for Children and Incapacitated Household Members The able-bodied parent or other household member who is responsible for the care of a dependent child under the age of six (6) or an incapacitated person is exempt from work registration. If the child reaches his or her sixth (6th) birthday within a certification period, the individual responsible for care of the child shall register for work at the next scheduled certification, unless the individual qualifies for another exemption.~~

~~C. Physically or Mentally Unfit for Employment~~

~~1. Persons physically or mentally unfit for employment are exempt from work registration. If the determination of unfit for work is not obvious, verification may be required. Appropriate verification may consist of:~~

~~a. Receipt of temporary or permanent disability benefits issued by government or private sources; or~~

~~b. Persons may provide a statement from a physician, physician's assistant, nurse, nurse practitioner, designated representative of the physician's office or a licensed or certified psychologist. A county agency may determine other licensed medical personnel appropriate to provide verification that a work registrant is physically or mentally unfit for employment; or~~

~~c. A statement from a licensed social worker or a social worker employed by or acting on behalf of a 501(C)(3) Non-profit organization or government entity.~~

2. Those that are chronically homeless may be deemed physically or mentally unfit for employment and may be exempt from work registration. Chronic homelessness is defined as lacking nighttime residence.

D. Eligible Students

Eligible students are those enrolled at least half-time, as defined by the educational facility, in any recognized school or training program, and those in an institution of higher education who have met the eligibility conditions in Section 4.306 are exempt from work registration. Eligible students shall remain exempt from work registration during normal periods of class attendance, vacation, and recess.

Persons who are not enrolled at least half-time or who experience a break in their enrollment status due to graduation, expulsion, suspension, or who drop out or otherwise do not intend to register for the next normal school term (other than summer), shall not be considered students for the purpose of qualifying for this exemption.

E. Employed and Self-Employed

Employed or self-employed individuals who are working a minimum of thirty (30) hours per week or receiving weekly earnings at least equal to the federal minimum wage multiplied by thirty (30) hours are exempt from work registration. This shall include migrant and seasonal farm workers who are under contract or similar agreement with an employer or crew chief to begin employment within thirty (30) days.

Persons working in Action programs (including VISTA) are exempt from work registration if they work at least thirty (30) hours per week even if compensation is not consistent with prevailing community wage, since an employer-employee relationship can be documented. Those engaged in volunteer work or hobby activity cannot be considered gainfully employed unless the income is consistent with thirty (30) hours employment as herein defined, regardless of the time spent in such endeavor.

F. Unemployment Compensation Benefits

A person applying for or receiving Unemployment Insurance Benefits (UIB) shall be exempt from work registration requirements. The local office shall verify application for or receipt of UIB, if questionable. A person who has been denied UIB and who is appealing the decision is exempt.

G. Drug/Alcohol Rehabilitation

Regular participants in drug or alcohol treatment or rehabilitation programs are exempt from work registration.

H. Title IV-A/IV-F Requirements

Persons subject to and complying with any work requirement under Title IV of the Social Security Act (codified at 42 USC 607-687) are exempt from work registration requirements. The Act does not include any later amendments to or editions of the incorporated material. Copies of the federal laws are available for inspection during normal working hours by contacting: Director, Food Assistance Programs Division, Colorado Department of Human Services, 1575 Sherman Street, Denver, Colorado 80203; or a state publications depository.

I. Colorado Refugee Services Program (CRSP)

Registrants Any registrant for the Colorado Refugee Services Program is exempt from work registration requirements as CRSP work registration requirements satisfy the requirements of the Food Assistance Program.

J. SSI and Food Assistance Jointly Processed Applicants

Members of households who are applying for SSI and Food Assistance shall have the requirement for work registration waived until:

~~1. They are determined eligible for SSI and thereby become exempt from work registration; or,~~

~~2. They are determined ineligible for SSI and where applicable, a determination of their work registration status is then made by the local office through recertification procedures.~~

Individuals exempt from work requirements are not required to report changes in their exemption status during their certification period. At redetermination, all individuals subject to work requirements will be reassessed for work requirement exemptions.

If an individual loses their exemption status during their certification period, they shall retain their original work requirement exemption through their certification period unless they are considered an ABAWD.

~~4.310.31 Verification and Documentation of Work Registration Exemption~~

~~In all cases, the specific reason for each person exempted from work registration and necessary supporting verification shall be clearly documented in the case record. Whenever any question of the propriety of the exemption from the work registration requirement arises, the head of the household and the household member shall cooperate in furnishing evidence to support the contention of exemption. Failure to cooperate in furnishing such evidence will result in the member being required to register.~~

~~4.310.4~~ 4.310.5 ~~Changes in Exemption Status~~ VOLUNTARY QUIT

~~A. Persons losing exemption status due to any change in circumstances that is subject to the reporting requirements in Section 4.603 (such as a loss of employment that also results in a loss in income or departure from the household of the sole dependent child for whom an otherwise nonexempt household member was caring) shall register for employment when the change is reported through completion of a work registration form or an affidavit.~~

~~B. Persons losing exemption status due to changes that are not subject to such reporting requirements shall register for employment at recertification.~~

~~C. Persons who are no longer work registered for Title IV-A/IV-F or UIB shall register for employment, unless otherwise exempt. The local office shall provide the household with a work registration form when the change is reported.~~

A. WHEN A HOUSEHOLD FILES AN INITIAL APPLICATION OR REDETERMINATION, THE LOCAL OFFICE MUST DETERMINE IF ANY HOUSEHOLD MEMBER WHO IS NOT EXEMPT FROM WORK REQUIREMENTS VOLUNTARILY QUIT HIS OR HER JOB OF 30 OR MORE HOURS A WEEK OR REDUCED HIS OR HER WORK EFFORT TO LESS THAN 30 HOURS A WEEK WITHOUT GOOD CAUSE. BENEFITS MUST NOT BE DELAYED BEYOND THE NORMAL PROCESSING TIMES PENDING THE DETERMINATION OF VOLUNTARY QUIT.

B. A LEVEL SANCTION WILL BE IMPOSED IF VOLUNTARY QUIT OCCURRED WITHIN SIXTY (60) CALENDAR DAYS PRIOR TO THE DATE OF APPLICATION OR AFTER THE DATE OF APPLICATION BUT PRIOR TO ELIGIBILITY DETERMINATION AND THE VOLUNTARY QUIT WAS WITHOUT GOOD CAUSE.

   INDIVIDUALS WHO VOLUNTARY QUIT ARE INELIGIBLE TO PARTICIPATE IN THE FOOD ASSISTANCE PROGRAM AND SHALL BE TREATED AS A DISQUALIFIED MEMBER. IF THE DISQUALIFIED MEMBER JOINS ANOTHER HOUSEHOLD, THE ABAWD DISQUALIFICATION PERIOD FOR THAT INDIVIDUAL SHALL CONTINUE UNTIL THE ABAWD DISQUALIFICATION PERIOD IS COMPLETED.

C. AN EMPLOYEE OF THE FEDERAL, STATE, OR LOCAL GOVERNMENT WHO PARTICIPATES IN A STRIKE AGAINST SUCH A GOVERNMENT AND IS DISMISSED FROM HIS OR HER JOB BECAUSE OF PARTICIPATION IN THE STRIKE, WILL BE CONSIDERED TO HAVE VOLUNTARILY QUIT HIS OR HER JOB WITHOUT GOOD CAUSE.

D. IF AN INDIVIDUAL QUITS A JOB, SECURES NEW EMPLOYMENT AT COMPARABLE WAGES OR HOURS, AND, THROUGH NO FAULT OF HIS OR HER OWN LOSES THE NEW JOB, THE PRIOR VOLUNTARY QUIT WILL NOT BE A BASIS FOR DISQUALIFICATION.

~~4.310.5~~ 4.310.6 ~~Requirements of Work Registrants~~ SUITABLE EMPLOYMENT

~~Persons work-registered by the local office shall:~~

~~A. Participate in Employment First if designated as a mandatory work registrant, including reporting for all appointments and classes and meeting all other program requirements as detailed in the participation contract.~~

~~B. Provide Employment First with sufficient information to allow Employment First to determine the employment status or job availability of the individual.~~

~~C. Report to an employer in an appropriate manner and be prepared to accept an offer of suitable employment.~~

EMPLOYMENT WILL BE CONSIDERED SUITABLE, UNLESS ANY OF THE FOLLOWING APPLY:

A. THE WAGES OFFERED ARE LESS THAN THE HIGHER OF:

   1. THE APPLICABLE FEDERAL OR STATE MINIMUM WAGE.

   2. EIGHTY PERCENT (80%) OF THE FEDERAL MINIMUM WAGE IF NEITHER THE FEDERAL OR STATE MINIMUM WAGE IS APPLICABLE.

B. THE EMPLOYMENT OFFERED IS ON A PIECE-RATE AND THE AVERAGE HOURLY YIELD THE EMPLOYEE CAN REASONABLY BE EXPECTED TO EARN IS LESS THAN THE APPLICABLE HOURLY WAGE SPECIFIED ABOVE.

C. THE HOUSEHOLD MEMBER, AS A CONDITION OF EMPLOYMENT, IS REQUIRED TO JOIN, RESIGN FROM, OR REFRAIN FROM JOINING ANY LEGITIMATE LABOR ORGANIZATION.

D. THE WORK OFFERED IS AT A SITE SUBJECT TO A STRIKE OR LOCKOUT AT THE TIME OF THE OFFER UNLESS THE STRIKE HAS BEEN ENJOINED UNDER THE LABOR MANAGEMENT RELATIONS OR THE RAILWAY LABOR ACT.

E. THE HOUSEHOLD MEMBER CAN DEMONSTRATE OR THE LOCAL OFFICE BECOMES AWARE THAT:

   1. THE DEGREE OF RISK TO HEALTH AND SAFETY IS UNREASONABLE.

   2. HE/SHE IS PHYSICALLY OR MENTALLY UNFIT TO PERFORM THE EMPLOYMENT AS ESTABLISHED BY DOCUMENTARY MEDICAL EVIDENCE OR RELIABLE INFORMATION OBTAINED FROM OTHER SOURCES.

   3. THE EMPLOYMENT OFFERED IS NOT IN HIS/HER MAJOR FIELD EXPERIENCE UNLESS, AFTER A PERIOD OF THIRTY (30) CALENDAR DAYS FROM REGISTRATION, JOB OPPORTUNITIES IN HIS/HER MAJOR FIELD HAVE NOT BEEN OFFERED.

   4. THE DISTANCE FROM THE MEMBER'S HOME TO THE PLACE OF EMPLOYMENT IS UNREASONABLE CONSIDERING THE EXPECTED WAGE AND THE TIME AND COST OF COMMUTING.

   5. THE DAILY COMMUTING TIME EXCEEDS TWO (2) HOURS PER DAY, NOT INCLUDING THE TRANSPORTING OF A CHILD OR CHILDREN TO AND FROM A CHILD CARE FACILITY.

6. THE DISTANCE TO THE PLACE OF EMPLOYMENT PROHIBITS WALKING AND NEITHER PUBLIC NOR PRIVATE TRANSPORTATION IS AVAILABLE TO TRANSPORT THE MEMBER TO THE JOB SITE.

7. THE WORKING HOURS OR NATURE OF THE EMPLOYMENT INTERFERES WITH THE MEMBER'S RELIGIOUS OBSERVANCES, CONVICTIONS, OR BELIEFS.

~~4.310.51 Suitability of Work~~ 4.310.7 GOOD CAUSE FOR VOLUNTARY QUIT AND SUITABLE EMPLOYMENT

~~No employment offered will be considered suitable for any registrant if:~~

~~A. The wages offered are less than the higher of:~~

~~1. The applicable federal or State minimum wage.~~

~~2. Eighty percent (80%) of the federal minimum wage if neither the federal or State minimum wage is applicable.~~

~~B. The employment offered is on a piece-rate and the average hourly yield the employee can reasonably be expected to earn is less than the applicable hourly wage specified above.~~

~~C. The registrant, as a condition of employment, is required to join, resign from, or refrain from joining any legitimate labor organization.~~

~~D. The work offered is at a site subject to a strike or a lockout at the time of the offer unless the strike has been enjoined under the Labor Management Relations or the Railway Labor Act.~~

THE LOCAL OFFICE IS RESPONSIBLE FOR DETERMINING GOOD CAUSE WHEN A NON-EXEMPT INDIVIDUAL APPEARS TO HAVE VOLUNTARILY QUIT OR FAILED TO ACCEPT AN OFFER OF SUITABLE EMPLOYMENT. GOOD CAUSE AND/OR LACK OF GOOD CAUSE MUST BE CLEARLY DOCUMENTED IN THE CASE FILE.

GOOD CAUSE FOR VOLUNTARY QUIT INCLUDES CIRCUMSTANCES BEYOND THE HOUSEHOLD MEMBER'S CONTROL, SUCH AS, BUT NOT LIMITED TO:

A. DISCRIMINATION BY AN EMPLOYER BASED ON AGE, RACE, SEX, COLOR, HANDICAP, RELIGIOUS BELIEFS, NATIONAL ORIGIN, OR POLITICAL BELIEFS;

B. WORK DEMANDS OR CONDITIONS THAT RENDER CONTINUED EMPLOYMENT UNREASONABLE, SUCH AS WORKING WITHOUT BEING PAID ON SCHEDULE;

C. ACCEPTANCE BY THE INDIVIDUAL OF EMPLOYMENT; OR ENROLLMENT OF AT LEAST HALF-TIME IN ANY RECOGNIZED SCHOOL, TRAINING PROGRAM, OR INSTITUTION OF HIGHER EDUCATION, THAT REQUIRES THE INDIVIDUAL TO LEAVE EMPLOYMENT;

D. ACCEPTANCE BY ANY OTHER HOUSEHOLD MEMBER OF EMPLOYMENT OR ENROLLMENT AT LEAST HALF-TIME IN ANY RECOGNIZED SCHOOL, TRAINING PROGRAM, OR INSTITUTION OF HIGHER EDUCATION IN ANOTHER COUNTY OR POLITICAL SUBDIVISION WHICH REQUIRES THE HOUSEHOLD TO MOVE AND THEREBY REQUIRES THE INDIVIDUAL TO LEAVE EMPLOYMENT;

E. RESIGNATIONS BY PERSONS UNDER THE AGE OF SIXTY (60) THAT ARE RECOGNIZED BY THE EMPLOYER AS RETIREMENT;

F. RESIGNATION FROM EMPLOYMENT THAT DOES NOT MEET SUITABLE EMPLOYMENT;

G. BECAUSE OF CIRCUMSTANCES BEYOND THE CONTROL OF THE INDIVIDUAL, ACCEPTED FULL TIME EMPLOYMENT SUBSEQUENTLY EITHER DOES NOT MATERIALIZE OR RESULTS IN EMPLOYMENT OF LESS THAN THIRTY (30) HOURS A WEEK OR WEEKLY EARNINGS OF LESS THAN THE FEDERAL MINIMUM WAGE MULTIPLIED BY THIRTY (30) HOURS;

H. LEAVING A JOB IN CONNECTION WITH PATTERNS OF EMPLOYMENT IN WHICH WORKERS FREQUENTLY MOVE FROM ONE EMPLOYER TO ANOTHER, SUCH AS MIGRANT FARM LABOR OR CONSTRUCTION WORK, EVEN THOUGH EMPLOYMENT AT THE NEW SITE HAS NOT ACTUALLY BEGUN;

I. ILLNESS OF THE INDIVIDUAL;

J. ILLNESS OF ANOTHER HOUSEHOLD MEMBER REQUIRING THE PRESENCE OF THE INDIVIDUAL;

K. A HOUSEHOLD EMERGENCY;

L. UNAVAILABILITY OF TRANSPORTATION;

M. EMPLOYER DEMANDS A REDUCTION IN PARTICIPANT'S WORK EFFORT OR SALARY THROUGH NO FAULT OF THE EMPLOYEE; AND

N. LACK OF ADEQUATE CHILD CARE FOR CHILDREN WHO HAVE REACHED AGE 6 BUT ARE UNDER AGE 12.

~~4.310.52 Registrant Proof of Unsuitability~~

~~Any employment offered a particular registrant shall be considered suitable unless the registrant can demonstrate that, or the local office becomes aware that:~~

~~A. The degree of risk to health and safety is unreasonable.~~

~~B. He/she is physically or mentally unfit to perform the employment as established by documentary medical evidence or reliable information obtained from other sources.~~

~~C. The employment offered is not in his/her major field experience unless, after a period of thirty (30) calendar days from registration, job opportunities in his/her major field have not been offered.~~

~~D. The distance from the member's home to the place of employment is unreasonable considering the expected wage and the time and cost of commuting. Employment shall not be considered suitable if daily commuting time exceeds two (2) hours per day, not including the transporting of a child to and from a child care facility. Nor shall employment be considered suitable if the distance to the place of employment prohibits walking and neither public nor private transportation is available to transport the member to the job site.~~

~~E. The working hours or nature of the employment interferes with the member's religious observances, convictions, or beliefs.~~

~~4.310.6~~ 4.310.8 LEVEL SANCTION ~~Disqualification~~ PeriodS ~~for Mandatory Work~~ Registrants

A. If the local office determines that an individual has VOLUNTARILY QUIT OR FAILED TO ACCEPT SUITABLE EMPLOYMENT ~~refused to register for work or failed~~ without good cause ~~comply with Employment First requirements~~, that individual shall be ineligible to participate in the Food Assistance Program and shall be treated as a disqualified member. If the disqualified member joins another household, the disqualification period for that individual shall continue until the disqualification period is completed.

1. The first (1st) time ~~an individual fails without good cause to comply with work registration or fails without good cause to comply with Employment First requirements~~, the individual shall ~~remain ineligible until the later of the date the individual becomes eligible by complying with requirement or the date that is~~ BE DISQUALIFIED FOR A PERIOD OF one (1) month after the date the individual became ineligible.

2. The second (2nd) time an individual ~~becomes ineligible~~ fails without good cause to comply with work requirements, the individual shall ~~remain ineligible until the later of the date the individual becomes eligible by complying with requirements or the date that is~~ BE DISQUALIFIED FOR A PERIOD OF three (3) months after the date the individual became ineligible.

3. The third (3rd) or subsequent time an individual ~~becomes ineligible~~ fails without good cause to comply with work requirements, the individual shall ~~remain ineligible until the later of the date the individual becomes eligible by complying with requirements or the date that is~~ BE DISQUALIFIED FOR A PERIOD OF six (6) months after the date the individual became ineligible.

~~B. Ineligibility shall continue either until the member complies with the requirement or becomes exempt (other than by Title IV-A/IV-F, Colorado Refugee Services Program (CRSP) registration or UIB application). If an individual has served the disqualification, but the case has the certification expire during the disqualification period, the nonexempt individual will be eligible at the later of the date of the application or the date of compliance with Employment First.~~

~~C~~.B. The disqualification period shall begin the month following the expiration of the Notice of Adverse Action, unless a fair hearing is requested. ~~The member may stop the disqualification if the member becomes exempt from these requirements during the disqualification period. The disqualified member shall continue to be disqualified for noncompliance but may resume participation after the disqualification period (if otherwise eligible) by becoming exempt from work registration or complying with the appropriate work requirement. A disqualified member will be added back into the household after the disqualification period is over if the individual has complied with Employment First or has become exempt.~~

C. IF THE LEVEL SANCTION DISQUALIFIED INDIVIDUAL IS THE SOLE MEMBER OF THE FOOD ASSISTANCE HOUSEHOLD AND THEN BECOMES EXEMPT, THE NEWLY EXEMPT INDIVIDUAL CAN REAPPLY FOR BENEFITS. THE NEWLY EXEMPT INDIVIDUAL WILL BE ELIGIBLE BASED ON THE DATE OF THE APPLICATION OR, IF IN THE CASE OF REINSTATEMENT, THE DATE EXEMPTION INFORMATION WAS PROVIDED TO THE COUNTY OFFICE.

IF THE LEVEL SANCTION DISQUALIFIED INDIVIDUAL IS IN A FOOD ASSISTANCE HOUSEHOLD WITH OTHER ELIGIBLE MEMBERS AND THEN BECOMES EXEMPT, THE NEWLY EXEMPT INDIVIDUAL WILL BE ELIGIBLE BASED ON THE DATE EXEMPTION INFORMATION WAS PROVIDED TO THE COUNTY OFFICE.

~~D. The action to add the ineligible member shall be handled as a reported change.~~

~~E. The Employment First Program shall determine when an individual has refused or failed to comply with an Employment and Training requirement.~~

~~F. The local office and Employment First shall consider the facts and circumstances, including information submitted by the household member involved to determine whether good cause for the noncompliance exists. Good cause shall include circumstances beyond the member's control, such as, but not limited to, illness, illness of another household member requiring the presence of the member, a household emergency, the unavailability of transportation.~~

~~1. If good cause does not exist, Employment First can initiate the Notice of Adverse Action, advising the household member of the pertinent Employment First requirements and the consequences of failing to comply. The household member shall be informed of the actions~~

necessary for compliance and the date by which compliance shall be achieved to avoid disqualification. To avoid disqualification, the member shall perform a verifiable act of compliance as established by Employment First. Verbal commitment by the household member is not sufficient, unless the household member is prevented from complying by circumstances beyond the household member's control.

2. If Employment First advises the local office of noncompliance with work requirements and requests that the local office issue the Notice of Adverse Action (NOAA) (See Section 4.608), the local office shall issue the NOAA. Both the NOAA and the disqualification may be cancelled if Employment First verifies that compliance was achieved before the NOAA was issued or before the period of adverse action expires.

3. The NOAA shall be issued within fifteen (15) calendar days from the date of noncompliance.

4.310.61 Failure to Comply with Title IV-A/IV-F Components, Colorado Refugee Services Program (CRSP) Job Search, or Unemployment Insurance Benefits Work Requirements

A household containing a member who was exempt from Food Assistance work registration and Employment First requirements because he or she was registered for work under Title IV-A/IVF, CRSP, or was a registrant for unemployment insurance, and who fails to comply with a comparable Title IVA/IVF, a comparable CRSP, or a comparable unemployment insurance job search requirement, shall be treated as though the member had failed to comply with Food Assistance employment and training requirements.

4.310.7 Right to a Fair Hearing

Each individual has a right to appeal a denial, reduction, or termination of benefits due to a determination of non-exempt status or failure to comply with Employment First. The individual may also appeal action by Employment First or the local office determining exemption status, the type of requirements imposed, or refusal to make a finding of good cause.

If a fair hearing is requested, the individuals shall be allowed to examine their Employment First case file at a reasonable time before the fair hearing. Confidential information (which may include test results) should be protected from release. However, information withheld from the individual may not be used by either party at the hearing. A representative of Employment First shall receive sufficient advance notice to be available for questioning either in person or by phone. The results of the fair hearing shall be binding on the local office.

4.310.8 Food Assistance Employment First Components

County Employment First components shall correspond to components contained in the state Food Assistance Employment and Training Program plan. County components may consist of direct or support activities which expand the abilities of Food Assistance applicants and recipients to obtain meaningful employment and educational programs or activities to improve basic skills or improve employability. Educational components shall not make a participant subject to student provisions when Employment First requires the attendance to improve employability.

4.310.81 Period of Participation

An applicant for Food Assistance may be required to participate in any component from the time of application. The certification office shall not delay determination of eligibility nor issuing benefits during this period.

The length of participation in an Employment First component and the number of components to which a Food Assistance Employment First participant may be referred shall be determined by the State Department or the local Employment First program. In no event may the time spent collectively in an Employment First work component, as described in the state Employment First plan, exceed the number of hours equal to that household's allotment, for that month, divided by the federal minimum wage. The total hours of participation in an Employment First non-work component together with any hours worked in

~~a workfare program or hours worked for compensation (cash or in kind) may not exceed one hundred twenty (120) hours each month for any household member.~~

~~4.310.82 Participant Reimbursement~~

~~Employment First shall reimburse participants in a component for the actual costs of transportation or other costs (excluding dependent care) necessary and directly related to participation in that Employment First component. This reimbursement shall be based either on actual costs incurred and verified to Employment First or an allowance based on estimated costs associated with participation. Participants who report to Employment First that they are unable to incur a cost necessary for participation, and are, therefore, unable to participate, may be determined by Employment First to have good cause for nonparticipation or the participant may be assigned to a different component.~~

~~A participant is not entitled to the dependent care reimbursement if a member of the participant's Food Assistance household provides the dependent care services. Employment First must verify the participant's need for dependent care and the cost of the dependent care prior to the issuance of the reimbursement. The verification must include the name and address of the dependent care provider, the costs and the hours of service, for example, five (5) hours each day, five (5) days each week for two (2) weeks. A participant may not be reimbursed for dependent care services beyond that which is required for participation in the Employment First program. In lieu of providing reimbursements for dependent care expense, Employment First may arrange for dependent care through providers by the use of purchase of service contracts, by providing vouchers to the household or by other means. Dependent care provided or arranged by Employment First shall meet all applicable standards of state and local law, including requirements designed to ensure basic health and safety protection, such as fire safety and licensure.~~

~~A participant may refuse available appropriate dependent care as provided or arranged by Employment First if the participant can arrange other dependent care or can show that such refusal will not prevent or interfere with participation in the Employment First program. Allowable dependent care expenses that exceed the reimbursement shall be considered in determining a dependent care deduction when calculating net income for eligibility.~~

~~Employment First shall inform all mandatory Employment First participants that they may be exempted from participation if their monthly expenses that are reasonably necessary and directly related to participation in the Employment First program exceed the allowable reimbursement amount. Persons for whom allowable monthly expenses in a component exceed the total of the reimbursement for dependent care and other costs shall not be required to participate in that component. These individuals shall be placed, if possible, in another suitable component in which the individual's monthly expenses would not exceed the allowable reimbursable amount paid by Employment First. If a suitable component is not available, these individuals shall be exempted from participation until a suitable component is available or the individual's circumstances change and his/her monthly expenses do not exceed the total of the allowable reimbursable amounts. Individuals exempted because their monthly expenses exceed the reimbursable amount may volunteer to participate in the Employment First program. Volunteers must be informed that their allowable expenses in excess of the reimbursable amount will not be reimbursed.~~

4.311 ABAWD WORK REQUIREMENTS

ABAWDS MUST FULFILL AN ABAWD WORK REQUIREMENT IN ADDITION TO THE GENERAL WORK REQUIREMENTS.

FOR THE REMAINDER OF THIS SECTION, CLIENT STATEMENT IS CONSIDERED ACCEPTABLE VERIFICATION UNLESS QUESTIONABLE. IF VERIFICATION IS REQUESTED FROM THE CLIENT, CASE DOCUMENTATION MUST THOROUGHLY EXPLAIN WHY THE ORIGINAL CLIENT STATEMENT WAS CONSIDERED QUESTIONABLE.

A. TO FULFILL THE ABAWD WORK REQUIREMENT, THE ABAWD MUST BE:

1. WORKING 20 HOURS PER WEEK OR AVERAGED MONTHLY FOR A TOTAL OF 80 HOURS A MONTH; OR

a. WORKING INCLUDES:

i. WORK COMPLETED IN EXCHANGE FOR MONEY (COMPENSATED WORK); OR

ii. WORK COMPLETED IN EXCHANGE FOR GOODS OR SERVICES (IN-KIND WORK); OR

iii. ANY COMBINATION OF COMPENSATED WORK OR IN-KIND WORK.

2. PARTICIPATING IN AND COMPLYING WITH THE REQUIREMENTS OF A WORK PROGRAM 20 HOURS PER WEEK OR AVERAGED MONTHLY FOR A TOTAL OF 80 HOURS A MONTH; OR

a. A WORK PROGRAM INCLUDES:

iv. A PROGRAM OF EMPLOYMENT AND TRAINING OPERATED OR SUPERVISED BY THE CDHS PROGRAM OTHER THAN A JOB SEARCH PROGRAM OR A JOB SEARCH TRAINING PROGRAM;

v. A PROGRAM UNDER THE WORKFORCE INNOVATION AND OPPORTUNITY ACT (WIOA);

vi. A PROGRAM UNDER SECTION 236 OF THE TRADE ACT OF 1974 (19 USC 2296, “TRADE ADJUSTMENT ASSISTANCE”).

3. IN ANY COMBINATION OF WORKING AND PARTICIPATING IN A WORK PROGRAM FOR A TOTAL OF 20 HOURS PER WEEK OR AVERAGED MONTHLY FOR A TOTAL OF 80 HOURS A MONTH; OR

4. PARTICIPATING IN AND COMPLYING WITH THE COLORADO WORKFARE PROGRAM.

B. NON-EXEMPT ABAWDS MUST SUBMIT MONTHLY HOURS TO EF FOR WORK ACTIVITY TRACKING SO COUNTABLE MONTHS CAN BE DETERMINED.

FAILURE TO WORK WITH THE EF PROGRAM OR PROVIDE THE EF PROGRAM INFORMATION NEEDED TO DETERMINE COMPLIANCE WITH THE ABAWD WORK REQUIREMENT WILL RESULT IN THE ABAWD LOSING ELIGIBILITY AS A RESULT OF ACCRUING THREE COUNTABLE MONTHS WITHIN A THIRTY-SIX (36) CALENDAR MONTH PERIOD.

4.311.1 ABAWD EXEMPTIONS

WHILE ABAWDS CAN BE EXEMPT UNDER GENERAL WORK REQUIREMENT EXEMPTIONS, THESE INDIVIDUALS COULD ALSO MEET ONE OF THE FOLLOWING ABAWD EXEMPTIONS:

A. YOUNGER THAN EIGHTEEN (18) YEARS OF AGE OR OLDER THAN FORTY-NINE (49) YEARS OF AGE. THE MONTH OF THE HOUSEHOLD MEMBER’S BIRTHDAY IS NOT A COUNTABLE MONTH;

B. EXEMPT FROM THE GENERAL WORK REQUIREMENTS;

C. IS RESIDING IN A FOOD ASSISTANCE HOUSEHOLD WHERE A HOUSEHOLD MEMBER IS UNDER AGE 18;

D. PREGNANCY;

E. EXEMPT UNDER A WAIVER APPROVED BY THE USDA, FNS;

F. EXEMPT USING COLORADO DEFINED STATE EXEMPTIONS AS IDENTIFIED IN THE CURRENT FOOD ASSISTANCE EMPLOYMENT AND TRAINING STATE PLAN.

4.311.2 CHANGES IN ABAWD EXEMPTION STATUS

ABAWDS ARE NOT REQUIRED TO REPORT CHANGES IN THEIR EXEMPTION STATUS DURING A CERTIFICATION PERIOD. HOWEVER, IF THE ABAWD LOSES THEIR EXEMPTION STATUS DURING A CERTIFICATION PERIOD, THE MONTHS THE ABAWD WAS NOT EXEMPT WILL COUNT TOWARD THEIR THREE COUNTABLE MONTHS IN A THIRTY-SIX (36) CALENDAR MONTH PERIOD. ANY REMAINING MONTHS OF BENEFITS RECEIVED DURING THAT CERTIFICATION PERIOD ARE NOT CONSIDERED OVERPAYMENTS AND CLAIMS WILL NOT BE ESTABLISHED.

4.311.3 ABAWD TIME LIMITS

ABAWDS ARE NOT ELIGIBLE TO PARTICIPATE IN FOOD ASSISTANCE IF THEY HAVE RECEIVED FOOD ASSISTANCE BENEFITS FOR MORE THAN THREE COUNTABLE MONTHS DURING A THIRTY-SIX (36) MONTH PERIOD.

HOWEVER, ABAWDS MAY BE ELIGIBLE FOR UP TO THREE ADDITIONAL CONSECUTIVE MONTHS AFTER REGAINING ELIGIBILITY IN ACCORDANCE WITH PARAGRAPH (C) OF THIS SECTION.

A. COUNTABLE MONTHS

COUNTABLE MONTHS ARE ACCRUED WHEN AN ABAWD RECEIVES FOOD ASSISTANCE BENEFITS FOR THE FULL BENEFIT MONTH BUT DID NOT:

1. MEET AN EXEMPTION; OR

2. FULFILL THEIR WORK REQUIREMENTS.

B. GOOD CAUSE FOR COUNTABLE MONTHS

IF AN ABAWD WOULD HAVE WORKED AN AVERAGE OF 20 HOURS PER WEEK BUT MISSED SOME WORK FOR GOOD CAUSE, THE ABAWD SHALL BE CONSIDERED TO HAVE MET THE WORK REQUIREMENT IF THE ABSENCE FROM WORK IS TEMPORARY AND THE INDIVIDUAL RETAINS HIS OR HER JOB.

GOOD CAUSE FOR COUNTABLE MONTHS SHALL INCLUDE CIRCUMSTANCES BEYOND THE INDIVIDUAL'S CONTROL, SUCH AS, BUT NOT LIMITED TO, ILLNESS, ILLNESS OF ANOTHER HOUSEHOLD MEMBER REQUIRING THE PRESENCE OF THE MEMBER, A HOUSEHOLD EMERGENCY, OR THE UNAVAILABILITY OF TRANSPORTATION.

C. ABAWD TIME LIMIT CLOCK

THE ABAWD TIME LIMIT CLOCK:

1. COUNTS ACCRUED COUNTABLE MONTHS FOR ALL ABAWDS WHO ARE NOT IN COMPLIANCE WITH WORK REQUIREMENTS AND DO NOT HAVE AN EXEMPTION; AND

2. RESETS ACCRUED COUNTABLE MONTHS AND ABAWD DISQUALIFICATIONS, REGARDLESS OF START DATE, FOR ALL ABAWDS EVERY 36 CALENDAR MONTHS STARTING OCTOBER 1ST, 2019.

D. REGAINING ELIGIBILITY

1. AN INDIVIDUAL WHO IS DENIED ELIGIBILITY UNDER THIS PROVISION CAN REGAIN ELIGIBILITY IF IN A THIRTY (30) CALENDAR DAY PERIOD, THE INDIVIDUAL:

    a. IS EMPLOYED EIGHTY (80) OR MORE HOURS;
    b. PARTICIPATES IN AND COMPLIES WITH THE REQUIREMENTS OF A WORK PROGRAM FOR EIGHTY (80) OR MORE HOURS AS DETERMINED BY EF;
    c. PARTICIPATES AND COMPLIES WITH WORKFARE; OR
    d. BECOMES EXEMPT

2. THE INDIVIDUAL WILL BE REINSTATED IF OTHERWISE ELIGIBLE AND WILL CONTINUE TO BE ELIGIBLE AS LONG AS THE INDIVIDUAL CONTINUES TO MEET THE WORK REQUIREMENT OR IS EXEMPT.

3. THREE ADDITIONAL CONSECUTIVE MONTHS.

    IF AN INDIVIDUAL REGAINS ELIGIBILITY BUT THEN FAILS TO CONTINUE MEETING THESE REQUIREMENTS, THE INDIVIDUAL SHALL REMAIN ELIGIBLE FOR A CONSECUTIVE THREE-MONTH PERIOD AFTER THE INDIVIDUAL NOTIFIES THE COUNTY DEPARTMENT. THE INDIVIDUAL CAN ONLY HAVE THIS PROVISION APPLIED FOR A SINGLE THREE-MONTH PERIOD IN THE THIRTY-SIX (36) CALENDAR MONTH PERIOD.

~~4.310.9~~ 4.312 ~~Requirements for County Participation in the Food Assistance Employment and Training Program~~ EMPLOYMENT FIRST (EF)

In Colorado, the employment and training program ~~under the Food and Nutrition Act of 2008, as amended,~~ is called ~~Employment First~~ EF. The purpose of the program is to assist members of households participating in the Food Assistance Program in gaining skills, training, work, or experience that will increase their ability to obtain employment. ~~All counties shall operate an Employment First program unless they can demonstrate their county has a ten percent (10%) unemployment rate or there are an insufficient number of jobs available.~~

~~A county department CHOOSING to or required to administer an Employment First program shall submit a COUNTY- plan in a format prescribed by the State Department to the Colorado Department of Human Services, Employment and Benefits Division, for approval. Each county shall include a description of their program operations. Counties operating an Employment First Program are required to serve ABAWDs. Upon approval of the plan, the state department shall notify the county department of such approval, plus any conditions or limitations required for the approval. The State Department shall keep on file official copies of Food Assistance Employment First plans for public inspection.~~

~~An annual Employment First Plan of Operation is required for a county to maintain Employment and Training status. The annual plan will be submitted in a format prescribed by the state. Operation of an Employment First program is contingent on approval of the county plan of operation.~~

~~A county department may enter into a contractual agreement for all or any part of the Employment First program service delivery. These contractual agreements shall be reviewed by the State Department for adherence to program requirements before implementation. The only exception is that the Section 20 workfare, Colorado Workfare, may only be operated by a public or private non-profit agency. Employment First funds shall not be used to supplant funds used for existing services and activities that promote the purpose of any component.~~

~~Every Employment First program shall monitor participants who work at least twenty (20) hours a week, averaged monthly, but who do not yet work thirty (30) hours a week or earn wages equal to at least thirty (30) hours a week multiplied by the prevailing federal minimum wage.~~

~~A. A county shall also provide each non-exempt eighteen (18) to fifty (50) year old work registrant who is not working at least twenty (20) hours a week, a Section 20 workfare program, or other component or~~

~~combination of components that equal a minimum of twenty (20) hours of participation weekly. Allowable components include the following:~~

~~1. Educational programs or activities to improve basic skills and literacy or otherwise improve employability, including, but not limited to, General Equivalency Degree (GED), adult basic education, English as a Second Language, vocational training, and employability training.~~

~~2. Community service program participation.~~

~~3. A program designed to increase the self-sufficiency of recipients through self employment, including programs that provide instruction for self-employment.~~

~~4. A program under the Workforce Innovation and Opportunity Act (WIOA).~~

~~5. A program under Section 236 of the Trade Act of 1974. 6. A county may also provide those individuals who are exempt from the eighteen (18) to fifty (50) year old work requirements in Section 4.310.2 with a job seeking skills component approved by the state office.~~

~~B. The local Employment First provider shall:~~

~~1. Schedule the first appointment with Employment First within fourteen (14) calendar days from the date referred from the local office;~~

~~2. Enter required information from the work registration form into the Employment First automated system for each person referred from the local office to the Employment First;~~

~~3. Create a case file for each individual referred by the local office to Employment First;~~

~~4. Complete an assessment as prescribed by the state office and provide appropriate service for each referred, non-exempt participant who reports to Employment First;~~

~~5. Complete a participant contract for each individual enrolled in an Employment First activity;~~

~~6. Notify the local office of the determination of non-compliance without good cause;~~

~~7. Compile data and submit required reports within prescribed timeframes;~~

~~8. Coordinate program operations with the state Employment First staff;~~

~~9. Ensure that participants receive the appropriate reimbursement for participation;~~

~~10. Utilize required forms as prescribed or approved by the state;~~

~~11. Attend scheduled Employment First program meetings and training as required;~~

~~12. Ensure that all funds expended are allowable program costs;~~

~~13. Ensure program services are not suspended for longer than fourteen (14) consecutive days for any reason;~~

~~14. At a minimum, maintain monthly contact with each Employment First participant; and,~~

~~15. Verify all reported employment.~~

CDHS MUST SUBMIT AN ANNUAL EMPLOYMENT AND TRAINING STATE PLAN FOR APPROVAL BY THE USDA, FOOD AND NUTRITION SERVICE. A COPY OF THE CDHS EMPLOYMENT AND TRAINING PLAN IS AVAILABLE FOR INSPECTION DURING NORMAL WORKING HOURS BY

CONTACTING THE SNAP DIRECTOR, FOOD AND ENERGY ASSISTANCE DIVISION, COLORADO DEPARTMENT OF HUMAN SERVICES, 1575 SHERMAN STREET, DENVER, COLORADO 80203.

THE EF PROGRAM IS A VOLUNTARY WORK PROGRAM FOR FOOD ASSISTANCE APPLICANTS AND RECIPIENTS. FAILURE TO PARTICIPATE WITH THE EF PROGRAM WILL NOT RESULT IN A WORK REQUIREMENT DISQUALIFICATION.

4.310.2 Colorado Workfare Program

All counties with an Employment First program can operate a Section 20 Workfare program. In Colorado, Section 20 Workfare is called the Colorado Workfare program. Only a public or private non-profit agency can be designated as the operating agency for Workfare.

The operating agency is responsible for administering Workfare in accordance with state regulations and policy. An annual plan of operation shall be submitted to the Employment First Workfare office by the operating agency. The operating agency is defined as the organization that has been identified in the plan as being responsible for establishing and monitoring job sites, interviewing and assessing eligible recipients, assigning eligible recipients to appropriate job sites, monitoring participant compliance and making the initial determination of good cause for household noncompliance.

Workfare job slots may only be located in public or private, nonprofit agencies. There shall be a written agreement between the Workfare Program and any separate job site sponsors. One copy of the agreement shall be forwarded to the state Employment First office.

Files shall be maintained that record all activity by workfare participants. At a minimum, these records shall contain household identification information, job sites and hours assigned, hours completed, copies of all communication with the participant and all communications with the job site sponsor. These files may become part of the participant's file, but shall be maintained as a separate section. All files shall be kept accessible for a minimum of three (3) years from the date of referral.

Under the workfare program, nonexempt Food Assistance recipients may be required to perform work in a public service capacity as a condition of eligibility to receive the Food Assistance benefit allotment to which their household is normally entitled. Household members subject to the work registration requirements shall also be subject to the workfare requirements in those counties that operate a workfare program.

In addition, those Food Assistance recipients exempt from work registration requirements due to being subject to the work requirements under Title IV-A/IV-F of the Social Security Act shall be subject to workfare if they are currently participating less than twenty (20) hours a week in Title IV-A/IV-F and do not have a child under six (6) years of age. Such participation shall be outlined in the Title IV-A/IV-F employability plan.

Those recipients exempt from work registration requirements due to the application for or receipt of unemployment compensation shall be subject to Section 20 workfare requirements.

Those recipients exempt from work registration requirements due to being a parent or other household member responsible for the care of a dependent child under the age of six (6) shall be subject to workfare requirements once the child reaches the age of six. If the child has his/her sixth (6th) birthday within a certification period, the individual responsible for the care shall be subject to the workfare requirements as part of the next scheduled recertification process, unless otherwise exempt.

4.310.21 Referral to Employment First/Workfare

The Food Assistance Workfare Counselor shall notify any workfare participant of where and when the participant is to report, to whom the participant is to report, a brief description of duties for the particular placement, and the number of hours to be worked.

No participant shall be required to accept an offer of workfare employment if such employment fails to meet the criteria established in Sections 4.310.51and 4.310.52.

The Food Assistance Workfare Counselor shall ensure that all persons employed in workfare jobs receive job-related benefits to the same extent as similar non-workfare employees. These benefits are related to the actual work being performed, such as worker's compensation, and not to employment by a particular agency, such as health benefits.

All persons employed in workfare jobs shall have working conditions provided other employees similarly employed. The provision of Section 2(a) (3) of the Service Contract Act of 1965 (Public Law No. 89-286 and codified at 41 USC 351, et seq.,) relating to health and safety conditions shall apply to the workfare program. The Act does not include any later amendments to or editions of the incorporated material. Copies of the federal laws are available for inspection during normal working hours by contacting: Director, Food Assistance Programs Division, Colorado Department of Human Services, 1575 Sherman Street, Denver, Colorado 80203; or a state publications depository.

Workfare participants shall not replace or prevent employment of an individual not participating in the workfare program. Vacancies, due to hiring freezes, terminations or layoffs, shall not be filled by a workfare participant unless it can be demonstrated that such vacancies are a result of insufficient funds to sustain former staff levels.

Workfare jobs shall not infringe on the promotional opportunities available to regular employees. Workfare jobs shall not be related in any way to political activities.

4.310.22 Period of Participation

An individual initially certified for Food Assistance may be required to look for work for a period of thirty (30) calendar days before the individual is assigned to a workfare job site.

The maximum total number of hours of work required of a household each month in the workfare program shall be determined by dividing the household's Food Assistance allotment by the federal minimum wage. Fractions of hours of obligation shall be rounded down. The household's hours of obligation for any given month may not be carried over into another month except when the household wishes to end a disqualification due to noncompliance.

No workfare participant shall be required to work more than eight (8) hours a day. A participant may volunteer to work additional hours beyond those required by his/her workfare obligation. Food Assistance recipients not placed by the Title IV-A/IV-F (TANF/Colorado Works) program may be required to work up to, but not to exceed, thirty (30) hours a week. Participants placed in Workfare by the Title IV-A/IV-F program shall meet the hours required by that program.

4.310.23 Participant Reimbursement

The workfare program shall reimburse or provide allowances to participants for actual costs of transportation or other costs as determined necessary by the workfare counselor and directly related to participation. This reimbursement shall be based on actual costs incurred and verified to the Workfare Counselor.

Reimbursable costs may include the cost of personal items or equipment required for the performance of work if these items are also purchased by regular employees. The costs of meals away from home shall not be reimbursed. Dependent care costs that are reimbursed may not be claimed as expenses in calculating the household benefits.

4.310.24 Disqualification for Failure to Comply with a Workfare Assignment

For mandatory work registrants, the Workfare Counselor shall notify the local office of noncompliance with workfare by providing a description of the particular act of noncompliance committed. The determination of failure to comply with the workfare program is handled in the same manner as with the Employment

First determination. The sanction process for Title IV-A/IV-F employment program participants shall be governed by Title IV-A/IV-F rules and IS the responsibility of the Title IV-A/IV-F case manager.

The local office and the Workfare Counselor shall consider the facts and circumstances, including information submitted by the household member involved and the employer, to determine whether good cause for the noncompliance exists. Good cause shall include circumstances beyond the member's control, such as, but not limited to, illness, illness of another household member requiring the presence of that member, a household emergency, the unavailability of transportation, conflict due to compliance with Unemployment Insurance or Title IV-A/IV-F requirements.

Good cause includes a household that moves out of the area of the workfare project. In addition, instances where cost of transportation and other costs have exceeded twenty five dollars ($25) per month and are not being reimbursed will also be considered good cause.

Within ten (10) calendar days of the determination of noncompliance with a workfare assignment without good cause, the local office shall provide the participant with a Notice of Adverse Action. Such notice shall contain the particular act of noncompliance committed, the proposed period of disqualification, and shall specify that the individual may reapply at the end of the disqualification period and that participation may resume if the disqualified household member is determined eligible. The notice shall also specify the terms and conditions on which disqualification can be ended.

The disqualification period for noncompliance with Workfare shall be handled in the same manner as the disqualification for failure to work register or noncompliance with Employment First (see Section 4.310.6).

The disqualification period shall begin with the first (1st) month following the expiration of the adverse notice period, or following a fair hearing if requested, in which the household would normally have received benefits. A household member shall not be required to perform work at a job site when the household is no longer receiving benefits unless the household has chosen to meet the conditions for ending disqualification. Until the disqualification is actually invoked, the household, if otherwise eligible, will continue to have a workfare obligation.

Voluntary participants in workfare shall not be disqualified for failure to comply.

Following the end of the disqualification period for noncompliance with the workfare provisions, an individual may resume participation in the Food Assistance Program if the individual complies and is determined eligible or becomes exempt from these requirements.

If an over-issuance is discovered for a month or months in which a participant has already performed a workfare or work component requirement, the local office shall follow claim recovery procedures specified below.

A. If a person who performed the work is still subject to a work obligation, the local office shall determine how many extra hours were worked because of the improper benefit. The participant should be credited that number of hours toward future work obligations.

B. If a workfare or work component requirement does not continue, the local office shall determine whether the over-issuance was the result of an Intentional Program Violation (IPV), an Inadvertent Household Error (IHE) or an agency error. For an IPV, a claim should be established for the entire amount of the over-issuance. If the over-issuance was caused by an IHE or agency error, the local office shall determine whether the number of hours worked in workfare are more than the number which could have been assigned had the proper benefit level been used in calculating the number of hours to work. A claim shall be established for the amount of the overissuance not “worked off,” if any. If the hours worked equal the amount of hours calculated by dividing the over-issuance by the federal minimum wage, no claim shall be established. No credit for future work requirements shall be given.

4.310.25 Right to a Fair Hearing

~~Each individual has a right to appeal a denial, reduction, or termination of benefits due to a determination of non-exempt status or failure to comply with workfare. The individual may also appeal action by the Workfare Program or local office determining exemption status, the type of requirements imposed, or refusal to make a finding of good cause.~~

~~If a fair hearing is requested, the individual shall be allowed to examine its workfare case file at a reasonable time before the fair hearing. Confidential information (which may include test results) should be protected from release. However, information withheld from the member may not be used by either party at the hearing. A representative of the workfare program shall receive sufficient advance notice to be available for questioning either in person or by phone. The results of the fair hearing shall be binding on the local office.~~

4.312.1 COUNTY ADMINISTRATION REQUIREMENTS FOR EF

A COUNTY DEPARTMENT CHOOSING TO OR REQUIRED TO ADMINISTER AN EF PROGRAM SHALL SUBMIT A COUNTY PLAN AS PRESCRIBED BY CDHS AND SHALL OPERATE THEIR EF PROGRAM IN ALIGNMENT WITH THE CDHS EMPLOYMENT AND TRAINING PLAN. FAILURE TO ADHERE TO THE REQUIREMENTS AS DESCRIBED IN THE CDHS EMPLOYMENT AND TRAINING PLAN WILL RESULT IN A CORRECTIVE ACTION PLAN (CAP).

A COUNTY DEPARTMENT MAY ENTER INTO A CONTRACTUAL AGREEMENT FOR ALL OR ANY PART OF THE EF PROGRAM SERVICE DELIVERY. THESE CONTRACTUAL AGREEMENTS SHALL BE REVIEWED BY CDHS FOR ADHERENCE TO PROGRAM REQUIREMENTS BEFORE IMPLEMENTATION.

A. EVERY EF PROGRAM MUST MONITOR ABAWDS TO ENSURE THEY ARE MEETING ABAWD WORK REQUIREMENTS. THIS MONITORING MAY INCLUDE OBTAINING EMPLOYMENT OR VOLUNTEER WORKING HOURS INFORMATION AND/OR ENSURING THE ABAWD IS PARTICIPATING IN AN ALLOWABLE EMPLOYMENT FIRST COMPONENT AS SET FORTH IN THE ANNUAL CDHS EMPLOYMENT AND TRAINING PLAN AND THE SPECIFIC COUNTY EF PLAN.

B. THE EF PROVIDER SHALL:

1. SCHEDULE THE FIRST APPOINTMENT WITH EF WITHIN FOURTEEN (14) CALENDAR DAYS FROM THE DATE REFERRED FROM THE LOCAL OFFICE;

2. ENTER THE REQUIRED INFORMATION FROM THE WORK REGISTRATION FORM INTO THE EF AUTOMATED SYSTEM FOR EACH PERSON REFERRED;

3. DELIVER CASE MANAGEMENT SERVICES AS PRESCRIBED IN THE CDHS EF STATE PLAN;

4. COMPILE DATA AND SUBMIT REQUIRED REPORTS WITHIN PRESCRIBED TIMEFRAMES;

5. COORDINATE PROGRAM OPERATIONS WITH THE STATE EF STAFF, IN ACCORDANCE WITH THE ANNUAL CDHS EMPLOYMENT AND TRAINING PLAN AS WELL AS THE SPECIFIC COUNTY EF PLAN;

6. ENSURE THAT PARTICIPANTS RECEIVE THE APPROPRIATE REIMBURSEMENT FOR PARTICIPATION, SUCH AS ACTUAL COSTS OF TRANSPORTATION OR OTHER COSTS AS OUTLINED IN THE CDHS EMPLOYMENT AND TRAINING PLAN;

7. UTILIZE REQUIRED FORMS AS PRESCRIBED OR APPROVED BY THE STATE;

8. ATTEND SCHEDULED EF PROGRAM MEETINGS AND TRAINING AS REQUIRED;

9. ENSURE THAT ALL FUNDS EXPENDED ARE ALLOWABLE PROGRAM COSTS PER THE ANNUAL CDHS EMPLOYMENT AND TRAINING PLAN;

10. ENSURE PROGRAM SERVICES ARE NOT SUSPENDED FOR LONGER THAN FOURTEEN (14) CONSECUTIVE DAYS FOR ANY REASON;

11. ENSURE THAT ANY EXEMPTIONS DISCOVERED THROUGH WORKING WITH PARTICIPANTS ARE COMMUNICATED TO COUNTY ELIGIBILITY.

4.313 COLORADO WORKFARE PROGRAM

IN COLORADO, THE SECTION 20 WORKFARE PROGRAM OF THE FOOD AND NUTRITION ACT OF 2008 (CODIFIED AT 7 USC SEC. 2011 ET SEQ) IS CALLED THE COLORADO WORKFARE PROGRAM.

CDHS MUST SUBMIT AN ANNUAL SECTION 20 WORKFARE STATE PLAN FOR APPROVAL BY THE USDA, FOOD AND NUTRITION SERVICE. A COPY OF THE CDHS SECTION 20 WORKFARE PLAN IS AVAILABLE FOR INSPECTION DURING NORMAL WORKING HOURS BY CONTACTING THE SNAP DIRECTOR, FOOD AND ENERGY ASSISTANCE DIVISION, COLORADO DEPARTMENT OF HUMAN SERVICES, 1575 SHERMAN STREET, DENVER, COLORADO 80203.

4.313.1 COUNTY ADMINISTRATION REQUIREMENTS FOR WORKFARE

A COUNTY DEPARTMENT CHOOSING TO ADMINISTER A COLORADO WORKFARE PROGRAM SHALL SUBMIT A COUNTY PLAN AS PRESCRIBED BY CDHS AND SHALL OPERATE THEIR WORKFARE PROGRAM IN ALIGNMENT WITH THE CDHS SECTION 20 WORKFARE PLAN. FAILURE TO ADHERE TO THE REQUIREMENTS AS DESCRIBED IN THE CDHS SECTION 20 WORKFARE PLAN WILL RESULT IN A CORRECTIVE ACTION PLAN (CAP).

4.504.6 Information Considered Verified Upon Receipt

A. Verified upon receipt is a term given to a state-prescribed list of specific information that comes directly from the primary source of the information and is free from question.

B. Information that is considered verified upon receipt shall be acted upon for both simplified reporting households and non-simplified reporting households. Information considered verified upon receipt shall be acted on at the time of application, recertification, periodic report, and during a household's certification period if the information causes a change in the Food Assistance benefit amount. A household shall not be convicted of fraud for not reporting a change in the information it is not required to report.

C. Information considered verified upon receipt shall be considered verified unless the office has reason to believe that the information may be inaccurate. Advance notice of adverse action shall be given when acting on information that is considered verified upon receipt, except as noted in Section 4.608.1.

D. The local office shall consider only the following information as verified upon receipt:

1. Social Security and SSI benefit amounts obtained from SSA.

   SSI and benefit amounts obtained from the SSA are considered reported and verified on the day the information is first known to the agency, either through the IEVS, SDX, BENDEX or another automated interface of information, whichever is sooner.

2. Death information received from the Burial Assistance program.

Death information received from the Burial Assistance program is considered reported and verified on the day the information is first known to the agency.

3. Unemployment insurance benefits (UIB) that are reported through the IEVS and obtained through the Department of Labor and Employment (DOLE).

   The UIB information shall be considered reported and verified on the date of the IEVS notification. Advance notice of adverse action shall be given when acting on the change in information.

4. PA benefit amounts (Colorado Works, Aid to the Needy Disabled (AND) PROGRAM CONSISTING OF AND- STATE ONLY (AND-SO) AND AND-COLORADO SUPPLEMENT (AND-CS), HOME CARE ALLOWANCE (HCA), AND Old Age Pension (OAP), ~~Aid to the Blind (AB), and Colorado Supplement to SSI)~~ obtained from the State Department.

   Such information shall be considered reported and verified on the day the public assistance benefit amount is authorized.

5. Information that is reported and verified to a public assistance program which results in a change to the PA benefit amount and that meets the Food Assistance regulations for verification.

   Such information shall be considered reported and verified on the day the public assistance program processes the change and authorizes the new PA benefit amount.

6. Child support income and expense amounts obtained through the ACSES.

   Such information is considered reported and verified on the day the information is reported through an automated interface with ACSES.

7. Non-compliance information obtained from ~~Employment First (~~EF~~)~~ agencies ~~for~~ OF THE failure ~~to participate in a mandated work program~~ OF AN ABAWD TO MEET WORK REQUIREMENTS.

8. Colorado IPVs.

9. Information obtained from the SAVE system regarding non-citizen status.

10. Changes in household composition that are reported and verified and result in one or more members being removed from one Food Assistance household and added to a new or existing Food Assistance household.

    Duplicate benefits shall not be issued for a particular individual when removing that individual from one Food Assistance household and adding him/her to a new Food Assistance household.

11. Changes in household composition that are reported and verified by child welfare agencies and result in a child being removed from one Food Assistance household and added to a new or existing Food Assistance household.

12. The disqualification of a household member who is determined to be a fleeing felon or a probation or parole violator.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

STATE OF COLORADO
DEPARTMENT OF LAW

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Denver, Colorado 80203
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Office of the Attorney General

Tracking number: 2020-00065

Opinion of the Attorney General rendered in connection with the rules adopted by the

Food Assistance Program (Volume 4B)

on 02/07/2020

10 CCR 2506-1

RULE MANUAL VOLUME 4B, FOOD ASSISTANCE

The above-referenced rules were submitted to this office on 02/11/2020 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.

February 27, 2020 18:22:34

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Human Services

Agency

Commission for the Deaf, Hard of Hearing, and DeafBlind (Volume 27)

CCR number

12 CCR 2516-1

Rule title

12 CCR 2516-1 RULE MANUAL 27, COMMISSION FOR THE DEAF, HARD OF HEARING, AND DEAFBLIND 1 - eff 02/07/2020

Effective date

02/07/2020

12 CCR 2516-1 § 130

F. The applicant's household income must be less than 400% of the Federal Poverty Guidelines (FPG) based on family size as indicated by the United States Department of Health and Human Services (HHS). FPG refers to figures set by the HHS annually. These figures, based on gross yearly income levels for corresponding household size, are included in the below table. Effective January 15, 2020, yearly gross income levels, for one hundred percent (100%) and four hundred percent (400%) of the FPG for the corresponding household size are as follows:

Family Size	**100% Federal Poverty Guidelines**	**400% Federal Poverty Guidelines**
1	$12,760	$51,040
2	$17,240	$68,960
3	$21,720	$86,880
4	$26,200	$104,800
5	$30,680	$122,720
6	$35,160	$140,640
7	$39,640	$158,560
8	$44,120	$176,480
Each Additional person	$4,480	$17,920

Title of Proposed Rule:	**Technical Update for the Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind's Communications Technology Program**	
CDHS Tracking #:	**20-01-22-01**	
Office, Division, & Program:	Rule Author: JoAnne Hirsch	Phone: 303-866-2097 E-Mail: joanne.hirsch@state.co.us

RULEMAKING PACKET

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?	February 2020

What date is being requested for this rule to be effective?	February 2020
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 2/7/2020 2nd Board 3/5/2020 Effective Date 2/7/2020

Title of Proposed Rule:	**Technical Update for the Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind's Communications Technology Program**	
CDHS Tracking #:	**20-01-22-01**	
Office, Division, & Program:	Rule Author: JoAnne Hirsch	Phone: 303-866-2097 E-Mail: joanne.hirsch@state.co.us

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***

The Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind's Communications Technology Program (CTP) was established in 2002. Under the Federal "Americans with Disabilities Act," Colorado has a duty to provide the deaf, hard of hearing and deafblind equivalent access to governmental services. This is accomplished by the dissemination of communications technology in the form of amplified and captioned phones, cellular devices, such as smartphones, flip phones and tablets, ring signalers and amplified tools, as well as specialized communications technology for deafblind though a federal grant.
The proposed rule changes are necessary to update 27.130 ELIGIBILITY FOR THE COMMUNICATIONS TECHNOLOGY PROGRAM, Section F, in order for the numbers to reflect the current 2020's Federal Poverty Guidelines.

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:

Federal Poverty Guidelines for 2020 were announced January 15, 2020, effective immediately. CDHS regulations contain reference to the 2019 figures and need to be adjusted to comply with federal law.

State Board Authority for Rule:

Code	Description
26-1-107(5), (6), C.R.S. (2019)	State Board to promulgate rules

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
Section 26-21-106(1)(d), (3), C.R.S. (2019)	Assessing how technology has affected the needs of the deaf and hard of hearing community. The commission shall assess the type and amount of equipment needed by low-income deaf, hard-of-hearing, and deafblind persons. The commission shall establish a telecommunications equipment distribution program that is consistent with the findings of subsection (1) of this section to obtain and distribute interactive telecommunications equipment needed by deaf, hard-of-hearing, and deafblind persons.
Section 26-21-107.5(3) C.R.S. (2019)	The state department shall adopt rules addressing timelines and guidelines for the grant program and establishing criteria for approving or disapproving grant applications.

Title of Proposed Rule:	**Technical Update for the Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind's Communications Technology Program**	
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Does the rule incorporate material by reference?	[ ]	Yes	[X]	No
Does this rule repeat language found in statute?	[X]	Yes	[ ]	No

If yes, please explain.

The 2020 federal poverty guidelines are found at 85 Fed. Reg. 3060 and are repeated in this rule.

Title of Proposed Rule:	**Technical Update for the Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind's Communications Technology Program**	
CDHS Tracking #:	**20-01-22-01**	
Office, Division, & Program:	Rule Author: JoAnne Hirsch	Phone: 303-866-2097 E-Mail: joanne.hirsch@state.co.us

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?

Deaf, hard-of-hearing and deafblind individuals/consumers
Colorado Division of Vocational Rehabilitation
Colorado Public Utilities Commission (Telephone Users with Disabilities Fund)
Government Services
Communications technology businesses, such as ADCO Hearing Products, Inc., Teltex Inc., Weitbrecht Communications, Inc., RAZ Mobility, etc.

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?

None

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 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)*

There is a potential fiscal impact as the Federal Poverty Guidelines has increased and therefore more people may qualify for assistance.

County Fiscal Impact

None

Federal Fiscal Impact

None

Other Fiscal Impact *(such as providers, local governments, etc.)*

None

4. Data Description

List and explain any data, such as studies, federal announcements, or questionnaires, which were relied upon when developing this rule?

None

5. Alternatives to this Rule-making

Title of Proposed Rule:	**Technical Update for the Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind's Communications Technology Program**	
CDHS Tracking #:	**20-01-22-01**	
Office, Division, & Program:	Rule Author: JoAnne Hirsch	Phone: 303-866-2097
		E-Mail: joanne.hirsch@state.co.us

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…"**

No alternative because this technical update is required to align with the current Federal Poverty Guidelines.

Title of Proposed Rule:	**Technical Update for the Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind's Communications Technology Program**	
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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
27.130	Federal Poverty Guidelines need to be updated as revised guidelines have already taken effect as of Jan. 15, 2020.	Table consisting of 2019 Federal Poverty Guidelines for 100% and 400%	Table consisting of 2020 Federal Poverty Guidelines for 100% and 400%	Federal Poverty Guidelines took effect Jan. 15, 2020.	no

Title of Proposed Rule:	**Technical Update for the Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind's Communications Technology Program**	
CDHS Tracking #:	**20-01-22-01**	
Office, Division, & Program:	Rule Author: JoAnne Hirsch	Phone: 303-866-2097 E-Mail: joanne.hirsch@state.co.us

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):

none

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:

none

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 ☒ No

If yes, who was contacted and what was their input?

Sub-PAC

Have these rules been reviewed by the appropriate Sub-PAC Committee?

☐ Yes ☒ No

Name of Sub-PAC	Rules Related to the Commission for the Deaf, Hard of Hearing, and DeafBlind do not go before a Sub-PAC.		
Date presented			
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.			

PAC

Have these rules been approved by PAC?

☐ Yes ☒ No

Date presented	Rules Related to the Commission for the Deaf, Hard of Hearing, and DeafBlind do not go before PAC.		
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.			

Other Comments

Comments were received from stakeholders on the proposed rules:

☐ Yes ☒ No

Title of Proposed Rule:	**Technical Update for the Colorado Commission for the Deaf, Hard of Hearing, and DeafBlind's Communications Technology Program**	
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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.

12 CCR 2516-1 § 130

F. The applicant's household income must be less than 400% of the Federal Poverty Guidelines (FPG) based on family size as indicated by the United States Department of Health and Human Services (HHS). FPG refers to figures set by the HHS annually. These figures, based on gross yearly income levels for corresponding household size, are included in the below table. Effective January 15, 2020, yearly gross income levels, for one hundred percent (100%) and four hundred percent (400%) of the FPG for the corresponding household size are as follows:

Family Size	**100% Federal Poverty Guidelines** -	**400% Federal Poverty Guidelines**
1	~~$12,490~~ 12,760	~~$49,960~~ 51,040
2	~~$16,910~~ 17,240	~~$67,640~~ 68,960
3	~~$21,330~~ 21,720	~~$85,320~~ 86,880
4	~~$25,750~~ 26,200	~~$103,000~~ 104,800
5	~~$30,170~~ 30,680	~~$120,680~~ 122,720
6	~~$34,590~~ 35,160	~~$138,360~~ 140,640
7	~~$39,010~~ 39,640	~~$156,040~~ 158,560
8	~~$43,430~~ 44,120	~~$173,520~~ 176,480
Each Additional person	~~$4,420~~ 4,480	~~$17,680~~ 17,920

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: 2020-00064

Opinion of the Attorney General rendered in connection with the rules adopted by the

Commission for the Deaf, Hard of Hearing, and DeafBlind (Volume 27)

on 02/07/2020

12 CCR 2516-1

RULE MANUAL 27, COMMISSION FOR THE DEAF, HARD OF HEARING, AND DEAFBLIND

The above-referenced rules were submitted to this office on 02/11/2020 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.

February 27, 2020 18:21:43

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Nonrulemaking Public Notices and other Miscellaneous Rulemaking Notices

Filed on 02/11/2020

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

COLORADO
Department of Health Care Policy & Financing

1570 Grant Street
Denver, CO 80203

Public Notice Home and Community-Based Services (HCBS) Waiver Amendment Public Comment

February 13, 2020 through March 13, 2020

The Department intends to submit a waiver amendment for the Developmental Disabilities (DD) Home and Community-Based Services (HCBS) waiver.

The proposed waiver amendment includes the following changes:

- Align Preventative Basic Dental Service Span Dates to Fiscal Year
- Updates to Quality Improvement Strategies
- Update Performance Measure Language
- Update Post Payment Review (PPR)
- Update Unduplicated Count and Point in Time Cap
- Remove References to the Division of Intellectual and Developmental Disabilities
- Update Cost Neutrality Projections
- Geographical Minimum Wage Language Addition

The Department will post the amendment for public notice from February 13, 2020 through March 13, 2020. The Department will ask for an effective date of June 30, 2020 for this amendment.

For a more detailed summary of all changes, please go to the Department's website at https://www.colorado.gov/pacific/hcpf/hcbs-waiver-transition to view the full draft waivers and the amendment fact sheet. You may also obtain a paper or electronic copy by calling 303-866-3684 or by writing the Department at 1570 Grant St, Denver, CO 80203.

To provide public comment or request a paper or electronic copy of any materials, please contact Hcpf_LTSS.PublicComment@state.co.us ; submit by phone at 303-866-3684; by fax at 303-866-2786 ATTN: DD HCBS Waiver Amendment; or in-person at 1570 Grant Street, Denver, CO 80203.

Public Comments will be accepted February 13, 2020 – March 13, 2020.

General Information

A link to this notice is posted on the Department's website. Written comments may be addressed to: Department of Health Care Policy & Financing, ATTN: DD HCBS Waiver Amendment, 1570 Grant Street, Denver, CO 80203.

Nonrulemaking Public Notices and other Miscellaneous Rulemaking Notices

Filed on 02/26/2020

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

COLORADO
Department of Health Care Policy & Financing

PUBLIC NOTICE

March 10, 2020

Changes to Federally Qualified Health Center Payment Methodology (Correction to June 25, 2019 Public Notice)

The Department of Health Care Policy and Financing (Department) intends to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to change the Department's payment methodology for Federally Qualified Health Centers (FQHCs) by adding a methodology to reimburse FQHCs a per member per month (PMPM) rate instead of an encounter rate for medical services for attributed members, effective July 1, 2020. The addition of a PMPM payment methodology will allow for greater flexibility in services provided at FQHCs. This payment methodology change will impact FQHC services by incentivizing alternative forms of care such as telemedicine and nurse visits and also providing a more stable income stream to FQHCs. This State Plan Amendment also removes the quality modifier application to the specialty behavioral health rates. The quality modifier has not been used to impact rates and will not until July 1, 2020. The quality modifier program has been built for physical health rates and not specialty behavioral health rates.

The annual aggregate increase in FQHC expenditures (including state funds and federal funds) is $0.00 in FFY 2019-20 and $0.00 in FFY 2020-21.

General Information

A link to this notice will be posted on the Department's website starting on March 10, 2020. Written comments may be addressed to:

Director, Health Programs Office
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

County Contact Information

Copies of the proposed changes are available for public review at the following county locations:

County Name	Official Name	Physical Address	Mailing Address
Adams	Adams County Human Services Department	11860 Pecos Street Westminster, CO 80234	Same as physical
Alamosa	Alamosa County Department of Human Services	8900 C Independence Way, Alamosa, CO 81101	PO Box 1310, Alamosa, CO 81101
Arapahoe	Arapahoe County Human Services	14980 E. Alameda Dr., Aurora, CO 80012	14980 E. Alameda Dr., Aurora, CO 80012
Arapahoe	Satellite Office	1690 W. Littleton Blvd., Littleton, CO 80120	
Archuleta	Archuleta County Human Services	551 Hot Springs Blvd., Pagosa Springs, CO 81147	PO Box 240, Pagosa Springs, CO 81147
Baca	Baca County Department of Social Services	772 Colorado St. Ste #1, Springfield, CO 81073	Same as physical
Bent	Bent County Social Services	138 6th Street, Las Animas, CO 81054	Same as physical
Boulder	Boulder County Department of Housing & Human Services	3400 Broadway, Boulder, CO 80304	PO Box 471, Boulder, CO 80306
Broomfield	Broomfield Health and Human Services	100 Spader Way, Broomfield, CO 80020	Same as physical
Chaffee	Chaffee County Department of Human Services	448 E. 1st St, Ste 166, Salida, CO 81201	PO Box 1007, Salida, CO 81201
Cheyenne	Cheyenne County Department of Human Services	560 W. 6 N, Cheyenne Wells, CO 80810	PO Box 146, Cheyenne Wells, CO 80810
Conejos	Conejos County Department of Social Services	12989 Cty. Rd. G.6, Conejos, CO 81129	PO Box 68, Conejos, CO 81129
Costilla	Costilla County Department of Social Services	233 Main St, San Luis, CO 81152	Same as physical
Crowley	Crowley County Department of Human Services	631 Main Street Ste 100, Ordway, CO 81063	Same as physical
Custer	Custer County Department of Human Services	205 S. 6th St., Westcliffe, CO 81252	PO Box 929 Westcliffe, CO 81252
Delta	Delta County Department of Human Services	560 Dodge St, Delta, CO 81416	Same as physical
Denver	Denver Department of Human Services	1200 Federal Blvd, Denver, CO 80204	Same as physical
Dolores	Dolores County Department of Social Services	409 Main Street, Dove Creek, CO 81324	PO Box 485 Dove Creek, CO 81324

Douglas	Douglas County Department of Human Services	4400 Castleton Court, Castle Rock, CO 80109	Same as physical
Eagle	Eagle County Department of Human Services	551 Broadway, Eagle, CO 81631	PO Box 660, Eagle, CO 81631
El Paso	El Paso County Department of Human Services	1675 W. Garden of the Gods Road, Colorado Springs, CO 80907	Same as physical
Elbert	Elbert County Health and Human Services	75 Ute. Ave, Kiowa, CO 80117	PO Box 924, Kiowa, CO 80117
Fremont	Fremont County Department of Human Services	172 Justice Center Road, Canon City, CO 81212	Same as physical
Garfield	Garfield County Department of Human Services	195 W. 14th St., Rifle, CO 81650	Same as physical
Gilpin	Gilpin County Department of Human Services	2960 Dory Hill Rd. Ste 100, Black Hawk, CO 80422	Same as physical
Grand	Grand County Department of Social Services	620 Hemlock St., Hot Sulphur Springs, CO 80451	PO Box 204, Hot Sulphur Springs, CO 80451
Huerfano	Huerfano County Department of Social Services	121 W. 6th St., Walsenburg, CO 81089	Same as physical
Jackson	Grand County Department of Social Services	620 Hemlock St., Hot Sulphur Springs, CO 80451	PO Box 204, Hot Sulphur Springs, CO 80451
Jefferson	Jefferson County Human Services	900 Jefferson County Parkway, Golden, CO 80401	Same as physical
Kiowa	Kiowa County Department of Social Services	1307 Maine St., Eads, CO 81036	PO Box 187, Eads, CO 81036-0187
Kit Carson	Kit Carson County Department of Human Services	252 S. 14th St., Burlington, CO 80807	PO Box 70, Burlington, CO 80807
La Plata	La Plata County Department of Human Services	10 Burnett Court 1st Floor, Durango, CO 81301	Same as physical
Lake	Lake County Department of Human Services	112 W. 5th St. Leadville, CO 80461	PO Box 884 Leadville, CO 80461
Larimer	Larimer County	1501 Blue Spruce Drive	Same as physical
Las Animas	Las Animas County Department of Human Services	204 S. Chestnut St., Trinidad, CO 81082	Same as physical

Lincoln	Lincoln County Department of Human Services	103 3rd Ave, Hugo, CO 80821	PO Box 37, Hugo, CO 80821
Logan	Logan County Department of Human Services	508 S. 10th Ave, STE B, Sterling, CO 80751	Same as physical
Mesa	Mesa County Department of Human Services	510 29 1/2 Rd, Grand Junction, CO 81504	PO Box 20000, Grand Junction, CO 81502
Mineral	Rio Grande/Mineral County Department of Social Services	1015 6th St, Del Norte, CO 81132	Same as physical
Moffat	Moffat County Department of Social Services	595 Breeze St., Craig, CO 81625	Same as physical
Montezuma	Montezuma County Department of Social Services	109 W. Main St. Room 2013, Cortez, CO 81321	Same as physical
Montrose	Montrose County Health & Human Services	1845 S. Townsend Ave., Montrose, CO 81401	PO Box 216, Montrose, CO 81402-216
Morgan	Morgan County Department of Human Services	800 E. Beaver Ave., Fort Morgan, CO 80701	PO Box 220, Fort Morgan, CO 80701
Otero	Otero County Department of Human Services	215 Raton Ave, La Junta, CO 81050	PO Box 494, La Junta, CO 81050
Ouray	Ouray DSS	177 Sherman St., Unit 104, Ridgway, CO 81432	PO Box 530 Ridgway, CO 81432
Phillips	Phillips County Department of Social Services	127 E Denver St., Holyoke, CO, 80734	Same as physical
Pitkin	Pitkin County Department of Health and Human Services	0405 Castle Creek Rd., Suite 104, Aspen, CO 81611	Same as physical
Pueblo	Pueblo County Department of Social Services	201 W. 8th St, Pueblo, CO 81003	320 W. 10th St, Pueblo, CO 81003
Rio Blanco	Rio Blanco County Department of Health and Human Services	345 Market St., Meeker, CO 81641	Same as physical
Routt	Routt County Department of Human Services	135 6th St., Steamboat Springs, CO 80477	PO Box 772790, Steamboat Springs, CO 80477
Saguache	Saguache County Department of Social Services	605 Christy Ave, Saguache, CO 81149	PO Box 215, Saguache, CO 81149
San Miguel	San Miguel DSS	333 W. Colorado Ave, Telluride, CO 81435 (San Miguel);	PO Box 96 Telluride, CO 81435

Sedgwick	Sedgwick County Human Services	118 W. 3rd St., Julesburg, CO 80737	PO Box 27, Julesburg, CO 80737
Washington	Washington County DHS	126 W. 5th St., Akron, CO 80720	PO Box 395, Akron, CO 80720
Yuma	Yuma County Department of Human Services	340 S. Birch, Wray, CO 80758	Same as physical

Calendar of Hearings

Hearing Date/Time	Agency	Location
04/06/2020 10:00 AM	Division of Motor Vehicles	1881 Pierce Street, Lakewood, CO 80214 Room 110
03/30/2020 01:00 PM	Marijuana Enforcement Division	1707 Cole Blvd., Ste. 300, Lakewood, CO 80401
04/03/2020 08:30 AM	Behavioral Health	405 W 9th St, Pueblo, CO 81003
05/21/2020 09:00 AM	Air Quality Control Commission	Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Sabin Conference Room
05/21/2020 09:00 AM	Air Quality Control Commission	Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Sabin Conference Room
05/21/2020 09:00 AM	Air Quality Control Commission	Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Sabin Conference Room
05/20/2020 04:30 PM	Air Quality Control Commission	Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Sabin Conference Room
04/15/2020 10:00 AM	Health Facilities and Emergency Medical Services Division (1011, 1015 Series)	Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246
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04/15/2020 10:00 AM	Health Facilities and Emergency Medical Services Division (1011, 1015 Series)	Sabin-Cleere Conference Room, 4300 Cherry Creek S. Drive, Denver, CO 80246
04/14/2020 01:00 PM	Division of Housing	1313 Sherman Street, Room 318, Denver, CO 80203
04/03/2020 08:30 AM	Income Maintenance (Volume 3)	405 W. 9th Street, Pueblo, CO 81003
04/03/2020 08:30 AM	Income Maintenance (Volume 3)	405 W. 9th Street, Pueblo, CO 81003
04/10/2020 09:00 AM	Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)	303 East 17th Avenue, 11th Floor, Denver, CO 80203