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46 CR 13

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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@coloradosos.gov.

Notice of Proposed Rulemaking

Tracking number

2023-00342

Department

200 - Department of Revenue

Agency

206 - Colorado Lottery

CCR number

1 CCR 206-1

Rule title

LOTTERY RULES AND REGULATIONS

Rulemaking Hearing

Date

08/01/2023

Time

08:00 AM

Location

Zoom Meeting

Subjects and issues involved

The purpose of this Rulemaking Hearing is for the Colorado Lottery Commission to amend Rule 10.G Colorado Lotto+ with the Plus to reflect the changes made to the Colorado Lotto+ game, by the Colorado Lottery and to correct a grammatical error.

Statutory authority

The statutory basis for Rule 10.G are C.R.S. 44-40-109(1)(a) and (2), 44-40-113, and 44-40-114

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DEPARTMENT OF REVENUE

Colorado Lottery

LOTTERY RULES AND REGULATIONS

1 CCR 206-1

RULE 10.G IN-STATE JACKPOT GAME "COLORADO LOTTO+" – "PLUS"

BASIS AND PURPOSE OF RULE 10.G

The purpose of Rule 10.G is to provide details and requirements for the Colorado Lottery In-State Jackpot Game "Colorado Lotto+" - "Plus" option such as sale of Tickets, payment of Prizes, and method for selecting and validating winning Tickets. The statutory basis ~~bases~~ for Rule 10.G are C.R.S. 44-40-109(1)(a) and (2), 44-40-113, and 44-40-114.

10.G.1 General Provisions

The In-State Jackpot Game to be known as "Colorado Lotto+" shall have a game option known as "Plus" which allows players to pay an additional One Dollar ($1.00) for a chance to win in a second Drawing using the same six (6) Numbers as the "Colorado Lotto+" Play.

"Plus" shall be conducted pursuant to the following Rules and Regulations and under such further instructions and directives as the Colorado Lottery Director and Colorado Lottery Commission may issue. If a conflict arises between Rule 10 In-State Jackpot Lottery Games, Rule 10.A Colorado Lotto, and/or this Rule 10.G, Rule 10.G shall apply.

10.G.2 Definitions

Refer to the definitions provided in section 1.2 of Rule 1 General Rules, Regulations, and Definitions and section 10.A.2 Definitions of Rule 10.A Colorado Lotto.

10.G.3 Price of "Plus" Play

A. The price of each "Plus" Play shall be an additional One Dollar ($1.00).

10.G.4 Play for "Plus"

A. The six (6) Numbers out of forty (40) Numbers that were selected for the "Colorado Lotto+" Play will be eligible to win in a "Plus" Drawing. A winning "Plus" Play is achieved only when the following combinations of Numbers selected match, in any order, three (3), four (4), five (5), or six (6) of the winning Numbers drawn by the Lottery.

   1. The randomly selected multiplier value of 2X, 3X, 4X, or 5X that applies to the "Colorado Lotto+" Play non-jackpot Prizes will also apply to all "Plus" non-jackpot Prizes.

B. A player using a Play Slip can select the option of "Plus" to be eligible in the "Plus" Drawing. If a Play Slip is not available, the Licensee may select the "Plus" option via the keyboard at the time the "Colorado Lotto+" Ticket is generated.

C. A player may purchase up to ten (10) "Colorado Lotto+" Plays with ten (10) "Plus" Plays on a single Ticket.

10.G.5 Prizes For "Colorado Lotto+" with "Plus"

A. In addition to any prize won in the first "Colorado Lotto+" Draw (See Rule 10.A Colorado Lotto), the holder of a winning "Colorado Lotto+" with "Plus" Ticket may win only one (1) "Plus" Prize per Play in connection with the winning Numbers drawn in the second "Plus" Drawing and shall be entitled only to the highest Prize Category won by those Numbers.

B. All Prizes awarded, except as defined in 10.G.6.A, shall be paid as set Prizes with the foregoing odds of winning a Prize.

WINNING COMBINATIONS	BASE PRIZE CATEGORY	2X PRIZE CATEGORY	3X PRIZE CATEGORY	4X PRIZE CATEGORY	5X PRIZE CATEGORY	ODDS OF WINNING
All six (6) Numbers in a Play	$250,000	N/A	N/A	N/A	N/A	1 in 3,838,380
Any five (5) Numbers in a Play	$300	$600	$900	$1,200	$1,500	1 in 18,816
Any four (4) Numbers in a Play	$30	$60	$90	$120	$150	1 in 456
Any three (3) Numbers in a Play	$4	$8	$12	$16	$20	1 in 32
MULTIPLIER ODDS	N/A	1 in 2	3 in 10	1 in 10	1 in 10	N/A
					OVERALL ODDS	1 in 30

10.G.6 Payment of Prizes

A. The Jackpot Prize shall be a set Prize for one (1) to eight (8) Prize Winners in a single Drawing.

1. Nine (9) or more Jackpot Prize Winners in a single Drawing will equally divide Two Million Dollars ($2,000,000) by the number of Plays matching all six (6) of the winning Numbers.

B. All Prizes are paid in a single cash payment equal to the value of the Prize.

10.G.7 Drawings

A. The "Plus" Drawings shall be held ~~twice~~ each week on Monday, Wednesday and Saturday evenings, unless the Drawing schedule is changed by the Lottery. In the event of an act of Force Majeure the Drawing shall be rescheduled at the discretion of the Director or designee.

B. The Drawings will be conducted by Lottery officials and comply with all Colorado Lottery Statutes, Rules and Regulations, and Drawing Guidelines.

C. Each Drawing shall determine, at random, six (6) winning Numbers in accordance with Drawing Guidelines. Any Numbers drawn are not declared winning Numbers until the Drawing is certified by the Lottery in accordance with paragraph 10.G.7.D. The winning Numbers shall be used in determining all "Plus" Winners for that Drawing. If a Drawing is not certified, another Drawing

will be conducted to determine certified Prize Winners.

D. Each Drawing shall be witnessed by an independent auditor as required in C.R.S. 44-40-109(2)(d). All Drawing equipment used shall be examined prior to and immediately after, a Drawing. All Drawings, inspections, and tests shall be recorded.

E. A Drawing shall not be invalidated because the Numbers drawn create excessive Prize liability for the Lottery.

10.G.8 Sale of Tickets

A. A “Colorado Lotto+” Ticket with the “Plus” option may be purchased from a Licensee authorized to sell Jackpot Game Tickets.

B. A “Colorado Lotto+” Ticket with the “Plus” option shall show, at a minimum, the player’s selection of Numbers, the amount of Plays, the Drawing date, the multiplier number, and Validation numbers.

C. A purchaser of a “Colorado Lotto+” Ticket must choose, at the time of purchase, whether or not he/she wants the “Plus” option. If the purchaser chooses the “Plus” option for the Ticket, the additional cost for each “Colorado Lotto+” Play will be One Dollar ($1.00). The “Plus” option applies to all boards on a single Ticket and cannot be purchased on a board-by-board basis.

D. Plays may be entered manually using the Jackpot Gaming Terminal keypad or by means of a Play Slip provided by the Lottery. Facsimiles of Play Slips, copies of Play Slips, or other materials which are inserted into the Jackpot Gaming Terminal’s Play Slip reader and which are not printed or approved by the Lottery shall not be used to enter a Play. No device shall be connected to a Jackpot Gaming Terminal to enter Plays, except as may be approved by the Lottery. Unapproved Play Slips or other devices may be seized by the Lottery.

1. All Plays shall be marked on the Play Slip by hand. No machine-printed Play Slips shall be used to enter Plays. Machine-printed Play Slips may be seized by the Lottery.

E. A “Colorado Lotto+” Ticket with the “Plus” option may not be cancelled.

10.G.9 Advance Play

Advance Play provides the opportunity to purchase “Colorado Lotto+” Tickets with the “Plus” option for more than one (1) consecutive Drawing. Advance Play Tickets shall be available for purchase in variable increments. The Advance Play feature shall be available at the discretion of the Director.

Notice of Proposed Rulemaking

Tracking number

2023-00341

Department

200 - Department of Revenue

Agency

206 - Colorado Lottery

CCR number

1 CCR 206-1

Rule title

LOTTERY RULES AND REGULATIONS

Rulemaking Hearing

Date

08/01/2023

Time

08:00 AM

Location

Zoom Meeting

Subjects and issues involved

The purpose of this Rulemaking Hearing is for the Colorado Lottery Commission to amend Rule 10.A Colorado Lotto to reflect the changes made to the Colorado Lotto game, by the Colorado Lottery.

Statutory authority

The statutory basis for Rule 10.A is found in C.R.S. 44-40-109 (1)(a) and (2), 44-40-113 and 44-40-114.

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DEPARTMENT OF REVENUE

Colorado Lottery

LOTTERY RULES AND REGULATIONS

1 CCR 206-1

RULE 10.A IN-STATE JACKPOT GAME "COLORADO LOTTO"

BASIS AND PURPOSE OF RULE 10.A

The purpose of Rule 10.A is to provide details and requirements for the Colorado Lottery In-State Jackpot Game "Colorado Lotto" such as sale of Tickets, payment of Prizes, and method for selecting and validating winning Tickets. The statutory basis for Rule 10.A is found in C.R.S. 44-40-109 (1)(a) and (2), 44-40-113 and 44-40-114.

10.A.1 General Provisions

The In-State Jackpot Game to be known as "Colorado Lotto" shall be conducted pursuant to the following Rules and Regulations and under such further instructions and directives as the Colorado Lottery Director and Colorado Lottery Commission may issue. If a conflict arises between Rule 10 In-State Jackpot Lottery Games and this Rule 10.A, Rule 10.A shall apply.

10.A.2 Definitions

In addition to the definitions provided in section 1.2 of Rule 1 General Rules Regulations, and Definitions and section 10.2 of Rule 10 In-State Jackpot Lottery Games:

A. "Game Board" means that area of the Play Slip where the grid contains forty (40) squares, numbers one (1) through forty (40).

B. "Jackpot Prize" means a pari-mutuel Prize that is advertised to be paid with per-winner annuities or as a lump sum cash payment, unless otherwise specified by the Lottery.

C. "Number" means any Play integer from one (1) through forty (40) inclusive.

D. "Play" means the six (6) numbers selected on each Game Board and printed on the Ticket.

E. "Roll-over" means the amount from the direct Prize Category contribution from previous Drawing(s) in the Jackpot Prize Category that is carried forward to the Jackpot Prize Category for the next Drawing.

10.A.3 Price of "Colorado Lotto" Ticket

The price of each "Colorado Lotto" Play shall be Two Dollars ($2.00).

10.A.4 Play for "Colorado Lotto"

A. A "Colorado Lotto" player must select six (6) numbers per Play; six (6) numbers out of forty (40). A winning Play is achieved only when the following combinations of numbers selected match, in any order, three (3), four (4), five (5), or six (6) of the winning Numbers drawn by the Lottery.

B. The player can use Play Slips, as described in Section 10.A.8.C to make number selections. The Jackpot Gaming Terminal reads the Play Slip and issues a Ticket with corresponding Play(s). If a Play Slip is not available, the Licensee may enter the selected numbers via the keyboard. If offered by the Lottery, a player may leave all or a portion of his/her Play selections

to a random number generator operated by the computer, commonly referred to as a Quick Pick or partial Quick Pick.

C. Each Ticket has a randomly selected multiplier value of 2X, 3X, 4X, or 5X that applies to all non-jackpot Prizes.

10.A.5 Prizes For "Colorado Lotto"

A. The Jackpot Prize shall be determined on a pari-mutuel basis. The Prize money allocated to the Jackpot Prize Category shall be divided equally by the number of Plays matching all six (6) of the winning Numbers. All other Prizes awarded shall be paid as set Prizes with the following odds of winning a Prize.

WINNING COMBINATIONS	BASE PRIZE CATEGORY	2X PRIZE CATEGORY	3X PRIZE CATEGORY	4X PRIZE CATEGORY	5X PRIZE CATEGORY	ODDS OF WINNING
All six (6) numbers in a Play	Jackpot	N/A	N/A	N/A	N/A	1 in 3,838,380
Any five (5) numbers in a Play	$250	$500	$750	$1,000	$1,250	1 in 18,816
Any four (4) numbers in a Play	$25	$50	$75	$100	$125	1 in 456
Any three (3) numbers in a Play	$3	$6	$9	$12	$15	1 in 32
MULTIPLIER ODDS	N/A	1 in 2	3 in 10	1 in 10	1 in 10	N/A
					OVERALL ODDS	1 in 30

B. The projected aggregate prizes as a percentage of sales for "Colorado Lotto" is fifty-five (55.5%). This projection does not include unclaimed prizes.

C. Prize Categories

1. Jackpot Prize – The Jackpot will start at an annuitized value of One Million Dollars ($1,000,000) for the first Drawing after it is won. The total Prize Category contribution for a Drawing may include the following:

   a. A direct Prize Category contribution of twenty-five percent (25%) of Net Sales for the Drawing, which may be adjusted as authorized by the Director.

   b. A base contribution of $500,000. The "Colorado Lotto" base contribution may be adjusted as authorized by the Director if increased sales warrant a higher starting jackpot.

c. A roll-over contribution as defined in Paragraph 10.A.2.E of this Rule 10.A.

d. An indirect Prize Category contribution authorized by the Director.

2. Second Prize – The second Prize Category may include the following:

a. The set base prize amount ($250) times the number of Shares for the Prize Category.

b. An indirect Prize Category contribution as authorized by the Director.

A Prize Amount shall be calculated by multiplying the base prize amount ($250) times the multiplier value displayed on the winning ticket.

3. Third Prize – The third Prize Category may include the following:

a. The set base prize amount ($25) times the number of Shares for the Prize Category.

b. An indirect Prize Category contribution as authorized by the Director.

A Prize Amount shall be calculated by multiplying the base prize amount ($25) times the multiplier value displayed on the winning ticket.

4. Fourth Prize – The fourth Prize Category may include the following:

a. The set base prize amount ($3) times the number of Shares for the Prize Category.

b. An indirect Prize Category contribution as authorized by the Director.

A Prize Amount shall be calculated by multiplying the base prize amount ($3) times the multiplier value displayed on the winning ticket

5. Additional Lottery Prizes may be awarded as authorized by the Director from the Indirect Prize Category contribution.

10.A.6 Payment of Prizes

A. The holder of a winning Ticket may win only one Prize per Play in connection with the winning Numbers drawn and shall be entitled only to the highest Prize Category won by those Numbers.

B. Players will be given the option of receiving their Share of the Jackpot Prize over a period of twenty-five (25) years through a fixed progressive twenty-five (25) year annuity with the initial payment made by the Lottery on the date of claim and twenty-four (24) additional payments made yearly on the anniversary of the first payment, or a one-time lump sum payment equal to fifty percent (50%) of their Share of the annuitized Jackpot Prize Amount.

C. The annuitized future value of the Jackpot Prize Category shall be twice the cash value of the total Jackpot Prize Category contribution as defined in section 10.A.5.C.1.

D. To determine the annuitized future value of each Prize Amount, the annuitized future value of the Prize Category is divided by the Shares. A Share is the matching combination, in one Play, of all six (6) numbers drawn (in any sequence).

E. If the annuitized future value of each Prize Amount results in an initial payment of Ten Thousand Dollars ($10,000) or more and the annuity option has been selected, the Prize Amount shall be a fixed progressive twenty-five (25) year annuity. The initial annuity payment shall be paid by the Lottery at the time of claim and be 2.5% of the future value of the annuity.

Each subsequent annual payment; two (2) through twenty-five (25) shall increase by 3.7% of the previous annual payment.

F. Players who select the annuitized payment shall have the ability to change their Prize payment selection from annuitized payment to lump sum payment for up to ninety days (90) from the original date of claim. This period may be extended at the discretion of the Director or designee. If a player chooses the lump sum payment after the initial annuitized payment is made to the player by the Lottery, the player will receive the remaining amount of the original cash value Prize, less taxes, in a single second payment.

G. If the annuitized future value of each Prize Amount results in an initial payment of less than Ten Thousand Dollars ($10,000) the annuity option will not be allowed and the Prize Amount will be paid in one (1) payment.

10.A.7 Drawings

A. The "Colorado Lotto" Drawings shall be held ~~twice~~ each week on Monday, Wednesday and Saturday evenings, unless the Drawing schedule is changed by the Lottery. In the event of an act of Force Majeure, the Drawing shall be rescheduled at the discretion of the Director or designee.

B. The Drawings will be conducted by Lottery officials and comply with all Colorado Lottery Statutes, Rules and Regulations, and Drawing Guidelines.

C. Each Drawing shall determine, at random, six (6) winning Numbers in accordance with Drawing guidelines. Any Numbers drawn are not declared winning Numbers until the Drawing is certified by the Lottery in accordance with section 10.A.7.E. The winning Numbers shall be used in determining all "Colorado Lotto" Prize Winners for that Drawing. If a Drawing is not certified, another Drawing will be conducted to determine certified Prize Winners.

D. Each Drawing shall be witnessed by an independent auditor as required in C.R.S. 44-40-109(2)(d). All Drawing equipment used shall be examined prior to and immediately after a Drawing. All Drawings, inspections, and tests shall be recorded.

E. A Drawing shall not be invalidated because the numbers drawn create excessive Prize liability for the Lottery.

10.A.8 Sale of Tickets

A. "Colorado Lotto" Tickets may be purchased from a Licensee authorized to sell In-State Jackpot Tickets.

B. "Colorado Lotto" Tickets shall show, at a minimum, the player's selection of numbers, the number of Plays, the Drawing date, and Validation numbers.

C. Plays may be entered manually using the Jackpot Gaming Terminal keypad or by means of a Play Slip provided by the Lottery. Facsimiles of Play Slips, copies of Play Slips, or other materials which are inserted into the Jackpot Gaming Terminal's Play Slip reader and which are not printed or approved by the Lottery shall not be used to enter a Play. No device shall be connected to a Jackpot Gaming Terminal to enter Plays, except as may be approved by the Lottery. Unapproved Play Slips or other devices may be seized by the Lottery.

1. All Plays shall be marked on the Play Slip by hand. No machine-printed Play Slips shall be used to enter Plays. Machine-printed Play Slips may be seized by the Lottery.

D. "Colorado Lotto" Tickets may not be cancelled.

10.A.9 Advance Play

Advance Play provides the opportunity to purchase "Colorado Lotto" Tickets for more than one (1)

consecutive Drawing. Advance Play Tickets shall be available for purchase in variable increments. The Advance Play feature shall be available at the discretion of the Director.

Notice of Proposed Rulemaking

Tracking number

2023-00340

Department

200 - Department of Revenue

Agency

212 - Marijuana Enforcement Division

CCR number

1 CCR 212-3

Rule title

COLORADO MARIJUANA RULES

Rulemaking Hearing

Date

10/30/2023

Time

09:00 AM

Location

1707 Cole Blvd., Ste. 300, Red Rocks Conference Room Lakewood, CO 80401

Subjects and issues involved

The State Licensing Authority will consider proposed rule recommendations to establish and amend fees required for applications, renewals, licenses, permits, and other fees required to accompany applications and submissions to the Division.

Statutory authority

CO Const., Art. XVIII, Sec. 16, 44-10-101 et seq., C.R.S., and CO APA, section 24-4-103, C.R.S. 44-10-103, 44-10-202(1)(b), 44-10-202(1)(c), 44-10-202(1)(e), 44-10-203(1)(i) 44-10-203(1)(k), 44-10-203(2)(b), 44-10-203(2)(h), 44-10-203(2)(n), 44-10-203(2)(o),44-10-203(2)(q), 44-10-203(2)(r), 44-10-203(2)(s), 44-10-203(2)(w), 44-10-203(2)(dd)(XII), 44-10-203(2)(ff), 44-10-203(2)(gg), 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

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DEPARTMENT OF REVENUE

Marijuana Enforcement Division

COLORADO MARIJUANA RULES

1 CCR 212-3

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

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)(k), 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. Levels. The following levels apply to Regulated Marijuana Businesses with direct Controlling Beneficial Owners, which includes but is not limited to natural persons, Owner Entities, Publicly Traded Companies, Trusts, Qualified Institutional Investors and Qualified Private Funds. This does not include indirect Controlling Beneficial Owners of the licensed Regulated Marijuana Business, in accordance with Rules 2-235(A)(2)(a) and 2-235(B)(1)(b). The levels are:

   a. Level 1: One (1) to four (4) Controlling Beneficial Owners.

   b. Level 2: Five (5) to nine (9) Controlling Beneficial Owners.

   c. Level 3: Ten (10) or more Controlling Beneficial Owners.

2. Medical Marijuana Businesses.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**

Medical Marijuana Store	Level 1: $5,0006,440.00 Level 2: $9,680.00 Level 3: $12,880.00	Level 1: $2,4401,6160.00 Level 2: $2,420.00 Level 3: $3,220.00	Level 1: $7,4408,050.00 Level 2: $12,100.00 Level 3: $16,100.00
Medical Marijuana Products Manufacturer	Level 1: $1,0002,440.00 Level 2: $3,680.00 Level 3: $4,880.00	Level 1: $1,830610.00 Level 2: $920.00 Level 3: $1,220.00	Level 1: $2,8303,050.00 Level 2: $4,600.00 Level 3: $6,100.00
Medical Marijuana Cultivation Facility Class 1 (1-500 plants)	Level 1: $1,0002,440.00 Level 2: $3,680.00 Level 3: $4,880.00	Level 1: $1,830610.00 Level 2: $920.00 Level 3: $1,220.00	Level 1: $2,8303,050.00 Level 2: $4,600.00 Level 3: $6,100.00
Medical Marijuana Testing Facility	Level 1: $1,0002,440.00 Level 2: $3,680.00 Level 3: $4,880.00	Level 1: $1,830610.00 Level 2: $920.00 Level 3: $1,220.00	Level 1: $2,833,0500.00 Level 2: $4,600.00 Level 3: $6,100.00
Medical Marijuana Transporter	$1,005,5200.00	$5,3681,380.00	$6,368900.00
Medical Marijuana Business Operator	Level 1: $1,0003,200.00 Level 2: $4,800.00 Level 3: $6,400.00	Level 1: $2,684800.00 Level 2: $1,200.00 Level 3: $1,600.00	Level 1: $3,6844,000.00 Level 2: $6,000.00 Level 3: $8,000.00
Marijuana Research and Development Facility	Level 1: $1,002,4240.00 Level 2: $3,680.00 Level 3: $4,880.00	Level 1: $1,830610.00 Level 2: $920.00 Level 3: $1,220.00	Level 1: $2,833,0500.00 Level 2: $4,600.00 Level 3: $6,100.00

2. Retail Marijuana Businesses.

License Type	Application Fee	License Fee	Total Due at Application
Retail Marijuana Store	$5,000.00	Level 1: $2,8544~~0~~.00 Level 2: $5,550.00 Level 3: $8,200.00	~~Separate~~ State Check~~s~~ Level 1: $4~~,945~~,350.00 ~~State~~ Level 2: $8,050.00 Level 3: $10,700.00 Local Check $2,500.00 ~~Local~~
Retail Marijuana Products Manufacturer	$5,000.00	Level 1: $~~1,830~~2,200.00 Level 2: $4,550.00 Level 3: $6,900.00	~~Separate~~ State Check~~s~~ Level 1: $4,~~330~~700.00 ~~State~~ Level 2: $7,050.00 Level 3: $9,400.00 Local Check $2,500.00 ~~Local~~
Retail Marijuana Cultivation Facility Tier 1 (1-1,800 plants)	$5,000.00	Level 1: $~~1,830~~2,200.00 Level 2: $4,550.00 Level 3: $6,900.00	~~Separate~~ State Check~~s~~ Level 1: $4,~~330~~700.00 ~~State~~ Level 2: $7.050.00 Level 3: $9,400.00 Local Check $2,500.00 ~~Local~~

Retail Marijuana Testing Facility	$1,000.00	Level 1: $21,8305000.00 Level 2: $32,2750.00 Level 3: $4,5000.00	**Separate State Checks** Level 1: $2,330500.00 State Level 2: $3,750.00 Level 3: $5,000.00 **Local Check** $500.00 Local
Retail Marijuana Transporter	$1,000.00	$5,368850.00	**Separate State Checks** $5,8686,350.00 State **Local Check** $500.00 Local
Retail Marijuana Business Operator	$1,000.00	Level 1: $2,684950.00 Level 2: $4,700.00 Level 3: $6,400.00	**Separate State Checks** Level 1: $3,184450.00 State Level 2: $5,200.00 Level 3: $6,900.00 **Local Check** $500.00 Local
Marijuana Hospitality Business (Eff. Jan. 1, 2020)	$1,000.00	$1,220350.00	**Separate State Checks** $1,720850.00 State **Local Check** $500.00 Local
Retail Marijuana Hospitality and Sales Business (Eff. Jan. 1, 2020)	$5,000.00	$2,440850.00	**Separate State Checks** $4,945,350.00 State **Local Check** $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~~1,840.00	$~~1,833~~460.00	$2,~~130~~300.00
Medical Marijuana Products Manufacturer	$1,84~~30~~0.00	$~~1,833~~460.00	$2,~~130~~300.00
Medical Marijuana Cultivation Facility Class 1 (1-500 plants)	$~~300~~1,840.00	$~~1,833~~460.00	$2,~~130~~300.00
Class 2 (501-1,500 plants)	$2,680.00	$~~2,806~~670.00	$3,~~106~~350.00
Class 3 (1,501-3,000 plants)	$3,960.00	$~~4,279~~990.00	$4,~~570~~950.00
Expanded Production Management (The amount shown is charged in addition to the Class 3 fee for each class of 3,000 plants over Class 3)	$840.00	$210.00	$1,050.00
Medical Marijuana Testing Facility	$~~300~~1,840.00	$~~1,833~~460.00	$2,~~130~~300.00
Medical Marijuana Transporter (every 2 years)	$~~300~~4,880.00	$~~5,368~~1,200.00	$~~5,668~~6,100.00
Medical Marijuana Business Operator	$~~300~~2,560.00	$~~2,684~~640.00	$~~2,984~~3,200.00
Marijuana Research and Development Facility	$~~300~~1,840.00	$~~1,833~~460.00	$2,~~130~~300.00

2. Retail Marijuana Businesses.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Retail Marijuana Store	$~~300~~1,840.00	$~~1,830~~460.00	$~~2,130~~2,300.00
Retail Marijuana Products Manufacturer	$~~300~~1,840.00	$~~1,830~~460.00	$~~2,130~~2,300.00
Retail Marijuana Cultivation Facility Tier 1 (1-1,800 plants)	$~~300~~1,840.00	$~~1,830~~460.00	$2,30~~13~~0.00
Tier 2 (1,801-3,600 plants)	$2,680.00	$~~2,806~~670.00	$3,~~106~~350.00
Tier 3 (3,601-6,000 plants)	$3,440.00	$~~3,68~~860.00	$~~3,964~~4,300.00

Tier 4 (6,001-10,200 plants)	$5,000.00	$5,4901,250.00	$5,7966,250.00
Tier 5 (10,201-13,800 plants)	$7,120.00	$7,9311,780.00	$8,230900.00
Expanded Production Management (The amount shown is charged in addition to the Tier 5 fee for each additional tier of 3,600 plants over Tier 5)	$840.00	$7,930.00 [Plus $976.00 for each additional tier of 3,600 plants over Tier 5]$210.00	$8,230.00 [Plus $976.00 for each additional tier of 3,600 plants over Tier 5]$1,050.00
Retail Marijuana Testing Facility	$3001,840.00	$1,83460.00	$2,130300.00
Retail Marijuana Transporter	$3004,880.00	$5,3681,220.00	$5,6686,100.00
Retail Marijuana Business Operator	$3002,560.00	$2,684640.00	$2,9843,200.00
Marijuana Hospitality Business (Eff. Jan. 1, 2020)	$3001,040.00	$915260.00	$1,215300.00
Retail Marijuana Hospitality and Sales Business (Eff. Jan. 1, 2020)	$1,840300.00	$1,83460.00	$2,130300.00

C. Owner Requests 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. Levels. The fee for Owner Entities corresponds to the number of Controlling Beneficial Owners of the licensed Regulated Marijuana Business created through the Owner Entity, in accordance with Rule 2-235(A)(2)(a).$800.00 per Natural Person

b2. Requests for Finding of Suitability Fees.$400.00 per Natural Person in possession of a valid Owner's License who is an Accelerator-Endorsed Licensee and seeking to have the existing Owner's License designated as a Social Equity Licensee.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Controlling Beneficial Owner - Natural Person	$680.00	$170.00	$850.00
Controlling Beneficial Owner – Natural Person – Social Equity (applies to Applicant seeking to be found suitable as a Social Equity Licensee)	$680.00	$170.00	$850.00
Passive Beneficial Owner	$680.00	$170.00	$850.00
Owner Entity:			

Level 1: One (1) to four (4) Controlling Beneficial Owners and/or Owner Entities	$680.00	$170.00	$850.00
Level 2: Five (5) to nine (9) Controlling Beneficial Owners and/or Owner Entities	$1,040.00	$260.00	$1,300.00
Level 3: Ten (10) or more Controlling Beneficial Owners and/or Owner Entities	$1,360.00	$340.00	$1,700.00
Controlling Beneficial Owner - Publicly Traded Corporation (PTC)	$16,720.00	$4,180.00	$20,900.00
Controlling Beneficial Owner - Qualified Private Fund – Qualified Institutional Investor	$3,400.00	$850.00	$4,250.00
Controlling Beneficial Owner - Trust	$3,400.00	$850.00	$4,250.00

3. License Renewal Fees.c. ~~$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~~

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Owner Individual Licensees, Passive Beneficial Owners who elect to be found suitable for licensure as an Owner	$440.00	$110.00	$550.00
Owner Entities			
Level 1: One (1) to four (4) Controlling Beneficial Owners and/or Owner Entities	$440.00	$110.00	$550.00
Level 2: Five (5) to nine (9) Controlling Beneficial Owners and/or Owner Entities	$660.00	$165.00	$825.00
Level 3: Ten (10) or more Controlling Beneficial Owners and/or Owner Entities	$880.00	$220.00	$1,100.00
Controlling Beneficial Owner – Publicly Traded Corporation (PTC)	$4,000.00	$1,000.00	$5,000.00
Controlling Beneficial Owner – Qualified Private Fund – Qualified Institutional Investor – Trust	$1,600.00	$400.00	$2,000.00

~~d. $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.

License Type	Application Fee	License Fee	Total Due at Application
Employee License	$120.00	$30.00	$150.00
Conditional Employee License	$160.00	$40.00	$200.00
Employee License Renewal	$80.00	$20.00	$100.00

1. Employee License Initial Application and License Fee – $105.00

a. Of the total Employee License application and license fee, $75.00 is the application fee and $30.00 is the license fee. An individual submitting an application for an Employee License may submit the total fee of $105.00 in one form of payment.

2. Employee License Renewal Fee – $80.00

a. Of the total Employee License Renewal fee, $50.00 is the application fee and $30.00 is the license fee. An individual submitting an application for an Employee License renewal may submit the total fee of $80.00 in one form of payment.

b. 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.

3. Conditional Employee License Fee - $200.00

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

License Type	Application Fee	License Fee	Total Due at Application
Temporary Appointee Registration (Natural Person)	$240.00	$60.00	$300.00
Temporary Appointee Registration (Entity)	$840.00	$210.00	$1,050.00
Temporary Appointee Registration (Natural Person) Renewal	$240.00	$60.00	$300.00
Temporary Appointee Registration (Entity) Renewal	$680.00	$170.00	$850.00

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1. Natural Person – $274.00

~~2. Entity – $976.00~~

F. Other Application Fees. The following other fees apply:

1. Permits.

License Type	Total Due at Application
Transition Permit:	$350.00
Delivery Permit:	$5,250.00
Delivery Permit Renewal:	$2,650.00
Centralized Distribution Permit	$50.00
Off-Premises Storage Facility Permit	$2,000.00
R&D Co-Location Permit	$100.00

~~a. Off Premises Storage Permit – $1,830.00~~

~~b. Transporter Off Premises Storage Permit – $2,684.00~~

~~c. Centralized Distribution Permit – $24.00~~

~~d. R&D Co-Location Permit – $61.00~~

~~e. Delivery Permit:~~

~~i. Initial Fee if the Store or Transporter Business License will expire in 6 months or less - $2,440.00.~~

~~ii. Initial Fee if the Store or Transporter Business License will expire in more than 6 months - $4,880.00.~~

~~iii. All Renewals - $2,440.00~~

~~f. Transition Permit – $305.00~~

2. ~~Regulated Marijuana Business Changes. The following fees apply per license~~Changes of Ownership - Fees:

~~a. Change of Controlling Beneficial Owner – $1,952.00~~

License Type	Total Due at Application
Change of Controlling Beneficial Owner:	
Involving up to four (4) Controlling Beneficial Owners and/or Owner Entities, (i.e. buyers and sellers)	$2,800.00
Involving five (5) to nine (9) Controlling Beneficial Owners	$4,900.00

and/or Owner Entities, (i.e. buyers and sellers)	
Involving ten (10) or more Controlling Beneficial Owners and/or Owner Entities, (i.e. buyers and sellers)	$6,350.00
Changes Exempt from a Change of Ownership not involving a reallocation	$1,150.00
Changes Exempt from a Change of Ownership involving a reallocation	$2,000.00

~~b~~2. Applications to Modify - Fees.

License Type	**Total Due at Application**
Modification of Premises Fee (MOP)	$150.00
Request Fee (for Tier Increase / Class Increase)	$300.00
Change of Trade Name (COTN)	$100.00
Change of Location (COL)	$650.00
Security Waiver	$600.00
Contingency Plan	$1,300.00

3. Other Fees.~~Changes Exempt from Change of Owner Application Requirement – $976.00~~

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Reduced Testing Allowance Certification (effective January 1, 2024)	$4,000.00	$0	$4,000.00
Duplicate Business License	$50.00	$0	$50.00
Duplicate Owner/Employee License	$50.00	$0	$50.00
Reinstatement Fee	$350.00	$0	$350.00
Responsible Vendor Program Provider:			
Responsible Vendor Program Provider Initial Application	$1,100.00	$0	$1,100.00
Duplicate Responsible Vendor Program Provider Certificate	$100.00	$0	$100.00
Responsible Vendor Program Provider	$360.00	$90.00	$450.00

Renewal			
R&D Project Proposal Fee	$650.00	$0	$650.00
Security Waiver Renewal Fee	$300.00	$0	$300.00

~~c. Change of Trade Name – $61.00~~

~~d. Change of Location – $610.00~~

~~e. Modification of Licensed Premises – $122.00~~

~~3. Marijuana Research and Development Facility Research Project Proposal – $610.00~~

~~4. Responsible Vendor Provider Applications.~~

~~a. Responsible Vendor Program Provider Initial Application – $1,037.00~~

~~b. Responsible Vendor Program Provider Renewal Application – $427.00~~

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

~~a. Duplicate Business License – $24.00~~

~~b. Duplicate Owner or Employee Identification Badge – $24.00~~

~~c. Responsible Vendor Program Provider Duplicate Certificate – $61.00~~

~~d. Reinstatement of Regulated Marijuana Business License - $305.00~~

~~6. Outdoor Contingency Plan Review - $1,200.00~~

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

Basis and Purpose – 2-206

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)(k), 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), 44-10-308(5); 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 by Social Equity Licensees.

2-206 – Social Equity Fees

A. When Reduced Fees Apply. Reduced fees apply to Licensees who have been found suitable as a Social Equity Licensee pursuant to Rule 2-220(C) under the following circumstances:

1. The first Owner Entity initial finding of suitability application submitted by the Social Equity Licensee;

2. The first and second initial Regulated Marijuana Business License applications submitted by the Licensee;

3. The first and second initial delivery permit applications submitted by the Licensee (if applicable);

4. The first renewal after July 1, 2023 of any two Regulated Marijuana Business Licenses issued;

5. The first renewal after July 1, 2023 of any two delivery permits issued;

6. The first renewal after July 1, 2023 of one Owner Entity License issued; and

7. The first renewal after July 1, 2023 of one Owner License issued.

B. Finding of Suitability Requests and Owner License Renewals.

1. Finding of Suitability Requests Fees.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Controlling Beneficial Owner – Natural Person – Social Equity (applies to Applicant seeking to be found suitable as a Social Equity Licensee)	$680.00	$170.00	$850.00
Controlling Beneficial Owner – Owner Entity	$160.00	$40.00	$200.00

2. Controlling Beneficial Owner License Renewal Fees.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Controlling Beneficial Owner Licensees, including Passive Beneficial Owners electing to be subject to licensure	$120.00	$30.00	$150.00
Controlling Beneficial Owner – Owner Entity	$120.00	$30.00	$150.00

C. Retail Marijuana Business – Initial and Renewal Application and License Fees.

1. Initial Application and License Fees.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Retail Marijuana Store	$0	$1,350.00	$1,350.00
Retail Marijuana Products Manufacturer	$0	$1,200.00	$1,200.00
Retail Marijuana Cultivation Facility – Tier 1	$0	$1,200.00	$1,200.00
Retail Marijuana Testing Facility	$0	$650.00	$650.00

Retail Marijuana Transporter	$0	$1,600.00	$1,600.00
Retail Marijuana Business Operator	$0	$850.00	$850.00
Marijuana Hospitality Business	$0	$450.00	$450.00
Retail Marijuana Hospitality and Sales Business	$0	$1,350.00	$1,350.00

2. Renewal Application and License Fees.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Retail Marijuana Store	$480.00	$120.00	$600.00
Retail Marijuana Products Manufacturer	$480.00	$120.00	$600.00
Retail Marijuana Cultivation Facility Tier 1 (1 - 1,800 Plants)	$480.00	$120.00	$600.00
Tier 2 (1,801 – 3,600 Plants)	$680.00	$170.00	$850.00
Tier 3 (3,601 – 6,000 Plants)	$880.00	$220.00	$1,100.00
Tier 4 (6,001 – 10,200 Plants)	$1,240.00	$310.00	$1,550.00
Tier 5 (10,201 – 13,800 Plants)	$1,800.00	$450.00	$2,250.00
Expanded Production Management (The amount shown is charged in addition to the Tier 5 fee for each additional 3,600 plans after Tier 5)	$200.00	$50.00	$250.00
Retail Marijuana Testing Facility	$480.00	$120.00	$600.00
Retail Marijuana Transporter (every 2 years)	$1,240.00	$310.00	$1,550.00
Retail Marijuana Business Operator	$640.00	$160.00	$800.00
Marijuana Hospitality Business	$280.00	$70.00	$350.00
Retail Marijuana Hospitality and Sales Business	$480.00	$120.00	$600.00

D. Medical Marijuana Business – Initial and Renewal Application and License Fees.

1. Initial Application and License Fees.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Medical Marijuana Store	$1,600.00	$400.00	$2,000.00

Medical Marijuana Products Manufacturer	$600.00	$150.00	$750.00
Medical Marijuana Cultivation Facility – Class 1	$600.00	$150.00	$750.00
Medical Marijuana Testing Facility	$600.00	$150.00	$750.00
Medical Marijuana Transporter	$1,400.00	$350.00	$1,750.00
Medical Marijuana Business Operator	$800.00	$200.00	$1,000.00
Marijuana Research and Development Facility	$600.00	$150.00	$750.00

2. Renewal Application and License Fees.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Medical Marijuana Store	$480.00	$120.00	$600.00
Medical Marijuana Products Manufacturer	$480.00	$120.00	$600.00
Medical Marijuana Cultivation Facility – Class 1	$480.00	$120.00	$600.00
Class 2	$680.00	$170.00	$850.00
Class 3	$1,000.00	$250.00	$1,250.00
Expanded Production Management (The amount shown is charged in addition to the Class 3 fee for each class of 3,000 plants over Class 3)	$200.00	$50.00	$250.00
Medical Marijuana Testing Facility	$480.00	$120.00	$600.00
Medical Marijuana Transporter (every 2 years)	$1,240.00	$310.00	$1,550.00
Medical Marijuana Business Operator	$640.00	$160.00	$800.00
Marijuana Research and Development Facility	$480.00	$120.00	$600.00

E. Delivery Permit Fees.

License Type	**Application Fee**	**License Fee**	**Total Due at Application**
Delivery Permit	$1,300.00	$0	$1,300.00
Delivery Permit Renewal	$65520.00	$0130.00	$650.00

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

COLORADO
Department of Revenue

NOTICE OF PERMANENT RULEMAKING HEARING

The State Licensing Authority ("State Licensing Authority") of the Colorado Department of Revenue, Marijuana Enforcement Division ("Division"), will consider the promulgation of additions and amendments to the State Licensing Authority's Colorado Marijuana Rules ("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 regarding the proposed rule changes, please refer to the contents of this Notice. Initial proposed rules will be made available on the 2023 Fee Rulemaking webpage on the Division's website and will be presented to stakeholders and other interested parties. Additional details regarding the initial proposed rules, public meetings, and opportunities for public comment are provided below.

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 Division held an initial public meeting of a representative group of participants with an interest in the subject of the rulemaking ("stakeholder meeting") on **Monday, June 5, 2023**. The stakeholder meeting included a presentation that provided a brief history of fees and proposed rules and solicited questions from stakeholders. All information shared at the initial stakeholder meeting is available on the 2023 Fee Rulemaking webpage, including the recording of the stakeholder meeting, and the proposed rule revisions. Additionally, the Division will hold a second stakeholder meeting to receive public comments regarding the proposed rules and fees. The Division will send notification of the fee and any additional stakeholder meetings to licensees and other stakeholders subscribed to receive updates from the Division. The Division will retain a record of the initial proposed rules as part of the rulemaking record. The initial proposed rules, which are available on the Division's 2023 Fee Rulemaking webpage, are intended to provide interested persons with the initial drafts of the permanent rules. Initial proposed rules may be amended during the stakeholder engagement process and based on information received through written and oral comments.

The Division intends to recommend to the State Licensing Authority for his consideration the promulgation of new and amended rules on the subjects outlined below.

Please take note that in addition to the subject matters addressed in the initial proposed rules, the State Licensing Authority may 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.

RULES TO BE CONSIDERED FOR ADOPTION PURSUANT TO THE MARIJUANA CODE

The Colorado Marijuana Rules, at 1 CCR 212-3, will amend Rule 2-205 and add new Rule 2-206.

Part 2 – Applications and Licenses

Rule 2-205 – Fees

Rule 2-206 – Social Equity Fees

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

RULEMAKING RECORD AND PUBLIC PARTICIPATION

1. Official Rulemaking Record. The official rulemaking record 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 by **Friday, October 20, 2023** in order to provide the Division and the State Licensing Authority with sufficient time to review comments prior to the rulemaking hearing.

The deadline to submit written comments is 5:00 pm Monday, October 30, 2023.

The State Licensing Authority will accept all written comments, but strongly encourages written comments to be submitted on the Marijuana Enforcement Division Suggested Revision to Rules Form ("Rule Form").

Interested parties may also submit written comments in hard copy to the Division's Lakewood office at 1697 Cole Blvd., Ste. 200, Lakewood, CO 80401 (Attn.: MED Rulemaking Comment).

3. Oral Comments. The State Licensing Authority may also afford interested parties an opportunity to make brief oral presentations at the rulemaking hearing.

HEARING SCHEDULE

Date: **Monday, October 30, 2023**
Time: **9:00 a.m.**
Place: 1707 Cole Blvd., Ste. 300, Red Rocks Conference Room
Lakewood, CO 80401

Virtual Meeting Option
Join Zoom Meeting: https://us02web.zoom.us/j/86115519267
Call in option: (719) 359- 4580
Meeting ID: 861 1551 9267

The full set of proposed rules and other relevant information the Division will present at the rule hearing will be posted on the Division's website no later than **Monday, October 23, 2023**.

If you are an individual with a disability who needs reasonable accommodation in order to participate in this rulemaking hearing, please contact Christopher Poirier at christopher.poirier@state.co.us by Monday, October 23, 2023.

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 his judgment are justified by the rulemaking record and applicable law.

Dated this 29th day of June, 2023.

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

Mark Ferrandino

Digitally signed by Mark Ferrandino
Date: 2023.06.29 09:12:21 -06'00'

Mark Ferrandino, CEO/ Executive Director
State Licensing Authority
Colorado Department of Revenue

Notice of Proposed Rulemaking

Tracking number

2023-00352

Department

400 - Department of Natural Resources

Agency

405 - Colorado Parks and Wildlife (405 Series, Parks)

CCR number

2 CCR 405-1

Rule title

CHAPTER P-1 - PARKS AND OUTDOOR RECREATION LANDS

Rulemaking Hearing

Date

08/24/2023

Time

08:00 AM

Location

Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487

Subjects and issues involved

Chapter P-1 - Parks and Outdoor Recreation Lands 2 CCR 405-1 - see attached

Statutory authority

See attached

Contact information

Name

Hilary Hernandez

Title

Regulations Manager

Telephone

3032917226

Email

hilary.hernandez@state.co.us

June 30, 2023

RULE-MAKING NOTICE
PARKS AND WILDLIFE COMMISSION MEETING
August 24-25, 2023

In accordance with the State Administrative Procedure Act, section 24-4-103, C.R.S., the Parks and Wildlife Commission gives notice that regulations will be considered for adoption at their next meeting on **August 24-25, 2023 with a virtual participation option. The Parks and Wildlife Commission meeting will be held at Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, 80487. For up-to-date information on the meeting, please refer to the Parks and Wildlife Commission website: https://cpw.state.co.us/aboutus/Pages/CommissionMeetings.aspx. The public is encouraged to comment before the meeting by submitting written comments to the Commission's email address at: dnr_cpwcommission@state.co.us.**

Comment deadlines: Written comments will be accepted at any time. However, to ensure sufficient time for consideration prior to the meeting, **comments should be provided to the Division of Parks and Wildlife by noon on the following date:**

August 10, 2023, for mailing by the Division of Parks and Wildlife to the Parks and Wildlife Commission on **August 11, 2023.**

Comments received by the Division between noon on **August 10, 2023** and noon on **August 18, 2023,** will be provided to the Commission two business days before the meeting. Comments received after noon on **August 18, 2023** will be held and shared with the Commission as part of the subsequent meeting mailing.

More information on submitting public comments is available at: https://cpw.state.co.us/aboutus/Pages/Submit-Public-Comments.aspx.

The following regulatory subjects and issues shall be considered pursuant to the Commission's authority in sections 33-9-101 to 111, C.R.S. ("Administration of Parks and Wildlife"), in sections 33-1-101 to 33-6-209, C.R.S. (the "Wildlife Act"), and especially sections 33-1-104, 33-1-105, 33-1-106, 33-1-107, 33-1-108, 33-1-121, 33-2-104, 33-2-105, 33-2-106, 33-3-104, 33-4-101, 33-4-102 and 33-5.5-102, 33-6-107, 33-6-109, 33-6-112, 33-6-113, 33-6-114, 33-6-114.5, 33-6-117, 33-6-119, 33-6-121, 33-6-124, 33-6-125, 33-6-127, 33-6-128, 33-6-130, 33-6-205, 33-6-206, 33-6-207, 33-6-208, 33-6-209, C.R.S., and in sections 33-10-101 to 33-33-113, C.R.S. (the "Parks Act"), and especially sections 33-10-106, 33-10-107, 33-10.5-107, 33-11-109, 33-12-101, 33-12-103, 33-12-103.5, 33-12-106, 33-12.5-103, 33-13-103, 33-13-104, 33-13-106, 33-13-109, 33-13-110, 33-13-111, 33-14-107, 33-14.5-107, 33-32-103 and 33-33-105. C.R.S.

FINAL REGULATORY ADOPTION – **August 24-25, 2023,** beginning **at 8:00 a.m.***

EFFECTIVE DATE OF REGULATIONS approved during the August 2023 Parks and Wildlife Commission meeting: October 1, 2023, unless otherwise noted.

FINAL REGULATIONS

PARK REGULATIONS

Chapter P-1 - "Parks and Outdoor Recreation Lands" 2 CCR 405-1

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Open for final consideration of regulations including, but not limited to, the following:

- Extending the pilot testing of the timed entry reservation system at Eldorado Canyon State Park.
- Updating the property specific regulations for Fishers Peak as the park is developed.

WILDLIFE REGULATIONS

Chapter W-2 - "Big Game" 2 CCR 406-2

Open for consideration of any necessary corrections or administrative clean-ups to regulations previously adopted by the Parks and Wildlife Commission for the 2023 big game seasons, including, but not limited to, the season dates for over-the-counter hunt code BE087U6R from 09/01/2023 - 11/26/2023 to 09/02/2023 - 11/26/2023.

Chapter W-9 - "Wildlife Properties" 2 CCR 406-9

Open for consideration of any necessary corrections or administrative clean-ups to regulations previously adopted by the Parks and Wildlife Commission, including, but not limited to:

- Removing the public access prohibition from March 1-Aug. 14 at San Luis Hills SWA.
- Moving Williams Hill SWA back to #900 from #902.

DRAFT REGULATIONS

WILDLIFE REGULATIONS

Chapter W-0 - "General Provisions" 2 CCR 406-0, and those related provisions of Chapter W-2 ("Big Game" 2 CCR 406-2), Chapter W-3 ("Furbearers and Small Game, Except Migratory Birds" 2 CCR 406-3), Chapter W-11 ("Wildlife Parks and Unregulated Wildlife" 2 CCR 406-11), Chapter W-15 ("Division Agents" 2 CCR 406-15), and Chapter P-7 ("Passes, Permits and Registrations" – 2 CCR 405-7) necessary to accommodate changes to or ensure consistency with Chapter W-0

Open for consideration of regulations including, but not limited to, adjusting license fees and license agent commission rates according to adjustments to the Denver-Aurora-Lakewood Consumer Price Index.

ISSUES IDENTIFICATION

PARK REGULATIONS

Chapter P-3 – "River Outfitters" – 2 CCR 405-3

Open for annual review of the entire chapter including, but not limited to, consideration of regulations regarding river outfitter requirements.

WILDLIFE REGULATIONS

Chapter W-0 – "General Provisions" – 2 CCR 406-0

Open for consideration of regulations including, but not limited to, importation, transportation, and possession of crayfish.

Chapter W-1- "Fishing" 2 CCR 406-1 and those related provisions of Chapter W-0 ("General Provisions" 2 CCR 406-0) and Chapter W-9 ("Wildlife Properties" 2 CCR 406-9) necessary to accommodate changes to or ensure consistency with Chapter W-1

Open for annual review of the entire chapter including, but not limited to, consideration of regulations regarding season dates, bag and possession limits, licensing requirements, manner of take provisions and special conditions or restrictions applicable to waters of the state.

Chapter W-3 - "Furbearers and Small Game, except Migratory Birds" 2 CCR 406-3

Open for annual review of regulations regarding turkey hunting, including but not limited to, license areas, season dates, and manner of take provisions for the 2024 turkey hunting seasons.

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Notice of Proposed Rulemaking

Tracking number

2023-00353

Department

400 - Department of Natural Resources

Agency

405 - Colorado Parks and Wildlife (405 Series, Parks)

CCR number

2 CCR 405-3

Rule title

CHAPTER P-3 - RIVER OUTFITTERS

Rulemaking Hearing

Date

08/24/2023

Time

08:00 AM

Location

Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487

Subjects and issues involved

Chapter P-3 River Outfitters 2 CCR 405-3 - see attached

Statutory authority

See attached

Contact information

Name

Hilary Hernandez

Title

Regulations Manager

Telephone

3032917226

Email

hilary.hernandez@state.co.us

June 30, 2023

RULE-MAKING NOTICE
PARKS AND WILDLIFE COMMISSION MEETING
August 24-25, 2023

In accordance with the State Administrative Procedure Act, section 24-4-103, C.R.S., the Parks and Wildlife Commission gives notice that regulations will be considered for adoption at their next meeting on **August 24-25, 2023 with a virtual participation option. The Parks and Wildlife Commission meeting will be held at Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, 80487. For up-to-date information on the meeting, please refer to the Parks and Wildlife Commission website: https://cpw.state.co.us/aboutus/Pages/CommissionMeetings.aspx. The public is encouraged to comment before the meeting by submitting written comments to the Commission's email address at: dnr_cpwcommission@state.co.us.**

Comment deadlines: Written comments will be accepted at any time. However, to ensure sufficient time for consideration prior to the meeting, **comments should be provided to the Division of Parks and Wildlife by noon on the following date:**

August 10, 2023, for mailing by the Division of Parks and Wildlife to the Parks and Wildlife Commission on **August 11, 2023.**

Comments received by the Division between noon on **August 10, 2023** and noon on **August 18, 2023,** will be provided to the Commission two business days before the meeting. Comments received after noon on **August 18, 2023** will be held and shared with the Commission as part of the subsequent meeting mailing.

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The following regulatory subjects and issues shall be considered pursuant to the Commission's authority in sections 33-9-101 to 111, C.R.S. ("Administration of Parks and Wildlife"), in sections 33-1-101 to 33-6-209, C.R.S. (the "Wildlife Act"), and especially sections 33-1-104, 33-1-105, 33-1-106, 33-1-107, 33-1-108, 33-1-121, 33-2-104, 33-2-105, 33-2-106, 33-3-104, 33-4-101, 33-4-102 and 33-5.5-102, 33-6-107, 33-6-109, 33-6-112, 33-6-113, 33-6-114, 33-6-114.5, 33-6-117, 33-6-119, 33-6-121, 33-6-124, 33-6-125, 33-6-127, 33-6-128, 33-6-130, 33-6-205, 33-6-206, 33-6-207, 33-6-208, 33-6-209, C.R.S., and in sections 33-10-101 to 33-33-113, C.R.S. (the "Parks Act"), and especially sections 33-10-106, 33-10-107, 33-10.5-107, 33-11-109, 33-12-101, 33-12-103, 33-12-103.5, 33-12-106, 33-12.5-103, 33-13-103, 33-13-104, 33-13-106, 33-13-109, 33-13-110, 33-13-111, 33-14-107, 33-14.5-107, 33-32-103 and 33-33-105. C.R.S.

FINAL REGULATORY ADOPTION – **August 24-25, 2023,** beginning **at 8:00 a.m.***

EFFECTIVE DATE OF REGULATIONS approved during the August 2023 Parks and Wildlife Commission meeting: October 1, 2023, unless otherwise noted.

FINAL REGULATIONS

PARK REGULATIONS

Chapter P-1 - "Parks and Outdoor Recreation Lands" 2 CCR 405-1

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Open for final consideration of regulations including, but not limited to, the following:

- Extending the pilot testing of the timed entry reservation system at Eldorado Canyon State Park.
- Updating the property specific regulations for Fishers Peak as the park is developed.

WILDLIFE REGULATIONS

Chapter W-2 - "Big Game" 2 CCR 406-2

Open for consideration of any necessary corrections or administrative clean-ups to regulations previously adopted by the Parks and Wildlife Commission for the 2023 big game seasons, including, but not limited to, the season dates for over-the-counter hunt code BE087U6R from 09/01/2023 - 11/26/2023 to 09/02/2023 - 11/26/2023.

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DRAFT REGULATIONS

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Chapter W-0 - "General Provisions" 2 CCR 406-0, and those related provisions of Chapter W-2 ("Big Game" 2 CCR 406-2), Chapter W-3 ("Furbearers and Small Game, Except Migratory Birds" 2 CCR 406-3), Chapter W-11 ("Wildlife Parks and Unregulated Wildlife" 2 CCR 406-11), Chapter W-15 ("Division Agents" 2 CCR 406-15), and Chapter P-7 ("Passes, Permits and Registrations" – 2 CCR 405-7) necessary to accommodate changes to or ensure consistency with Chapter W-0

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ISSUES IDENTIFICATION

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Notice of Proposed Rulemaking

Tracking number

2023-00354

Department

400 - Department of Natural Resources

Agency

405 - Colorado Parks and Wildlife (405 Series, Parks)

CCR number

2 CCR 405-7

Rule title

CHAPTER P-7 - PASSES, PERMITS AND REGISTRATIONS

Rulemaking Hearing

Date

08/24/2023

Time

08:00 AM

Location

Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487

Subjects and issues involved

Chapter P-7 - Passes, Permits and Registrations 2 CCR 405-7 - see attached

Statutory authority

See attached

Contact information

Name

Hilary Hernandez

Title

Regulations Manager

Telephone

3032917226

Email

hilary.hernandez@state.co.us

June 30, 2023

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August 24-25, 2023

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Notice of Proposed Rulemaking

Tracking number

2023-00345

Department

400 - Department of Natural Resources

Agency

406 - Colorado Parks and Wildlife (406 Series, Wildlife)

CCR number

2 CCR 406-0

Rule title

CHAPTER W-0 - GENERAL PROVISIONS

Rulemaking Hearing

Date

08/24/2023

Time

08:00 AM

Location

Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487

Subjects and issues involved

Chapter W-0 - General Provisions 2 CCR 406-0 - see attached

Statutory authority

See attached

Contact information

Name

Hilary Hernandez

Title

Regulations Manager

Telephone

3032917226

Email

hilary.hernandez@state.co.us

June 30, 2023

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- Removing the public access prohibition from March 1-Aug. 14 at San Luis Hills SWA.
- Moving Williams Hill SWA back to #900 from #902.

DRAFT REGULATIONS

WILDLIFE REGULATIONS

Chapter W-0 - "General Provisions" 2 CCR 406-0, and those related provisions of Chapter W-2 ("Big Game" 2 CCR 406-2), Chapter W-3 ("Furbearers and Small Game, Except Migratory Birds" 2 CCR 406-3), Chapter W-11 ("Wildlife Parks and Unregulated Wildlife" 2 CCR 406-11), Chapter W-15 ("Division Agents" 2 CCR 406-15), and Chapter P-7 ("Passes, Permits and Registrations" – 2 CCR 405-7) necessary to accommodate changes to or ensure consistency with Chapter W-0

Open for consideration of regulations including, but not limited to, adjusting license fees and license agent commission rates according to adjustments to the Denver-Aurora-Lakewood Consumer Price Index.

ISSUES IDENTIFICATION

PARK REGULATIONS

Chapter P-3 – "River Outfitters" – 2 CCR 405-3

Open for annual review of the entire chapter including, but not limited to, consideration of regulations regarding river outfitter requirements.

WILDLIFE REGULATIONS

Chapter W-0 – "General Provisions" – 2 CCR 406-0

Open for consideration of regulations including, but not limited to, importation, transportation, and possession of crayfish.

Chapter W-1- "Fishing" 2 CCR 406-1 and those related provisions of Chapter W-0 ("General Provisions" 2 CCR 406-0) and Chapter W-9 ("Wildlife Properties" 2 CCR 406-9) necessary to accommodate changes to or ensure consistency with Chapter W-1

Open for annual review of the entire chapter including, but not limited to, consideration of regulations regarding season dates, bag and possession limits, licensing requirements, manner of take provisions and special conditions or restrictions applicable to waters of the state.

Chapter W-3 - "Furbearers and Small Game, except Migratory Birds" 2 CCR 406-3

Open for annual review of regulations regarding turkey hunting, including but not limited to, license areas, season dates, and manner of take provisions for the 2024 turkey hunting seasons.

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OTHER AGENDA ITEMS: The Parks and Wildlife Commission may consider and make policy, program implementation, and other non-regulatory decisions, which may be of public interest at this meeting. A copy of the complete meeting agenda can be viewed on the Division of Parks and Wildlife's internet home page at **https://cpw.state.co.us**, on or after **August 14, 2023**.

Notice of Proposed Rulemaking

Tracking number

2023-00346

Department

400 - Department of Natural Resources

Agency

406 - Colorado Parks and Wildlife (406 Series, Wildlife)

CCR number

2 CCR 406-1

Rule title

CHAPTER W-1 - FISHING

Rulemaking Hearing

Date

08/24/2023

Time

08:00 AM

Location

Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487

Subjects and issues involved

Chapter W-1- Fishing 2 CCR 406-1 - see attached

Statutory authority

See attached

Contact information

Name

Hilary Hernandez

Title

Regulations Manager

Telephone

3032917226

Email

hilary.hernandez@state.co.us

June 30, 2023

RULE-MAKING NOTICE
PARKS AND WILDLIFE COMMISSION MEETING
August 24-25, 2023

In accordance with the State Administrative Procedure Act, section 24-4-103, C.R.S., the Parks and Wildlife Commission gives notice that regulations will be considered for adoption at their next meeting on **August 24-25, 2023 with a virtual participation option. The Parks and Wildlife Commission meeting will be held at Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, 80487. For up-to-date information on the meeting, please refer to the Parks and Wildlife Commission website: https://cpw.state.co.us/aboutus/Pages/CommissionMeetings.aspx. The public is encouraged to comment before the meeting by submitting written comments to the Commission's email address at: dnr_cpwcommission@state.co.us.**

Comment deadlines: Written comments will be accepted at any time. However, to ensure sufficient time for consideration prior to the meeting, **comments should be provided to the Division of Parks and Wildlife by noon on the following date:**

August 10, 2023, for mailing by the Division of Parks and Wildlife to the Parks and Wildlife Commission on **August 11, 2023.**

Comments received by the Division between noon on **August 10, 2023** and noon on **August 18, 2023,** will be provided to the Commission two business days before the meeting. Comments received after noon on **August 18, 2023** will be held and shared with the Commission as part of the subsequent meeting mailing.

More information on submitting public comments is available at: https://cpw.state.co.us/aboutus/Pages/Submit-Public-Comments.aspx.

The following regulatory subjects and issues shall be considered pursuant to the Commission's authority in sections 33-9-101 to 111, C.R.S. ("Administration of Parks and Wildlife"), in sections 33-1-101 to 33-6-209, C.R.S. (the "Wildlife Act"), and especially sections 33-1-104, 33-1-105, 33-1-106, 33-1-107, 33-1-108, 33-1-121, 33-2-104, 33-2-105, 33-2-106, 33-3-104, 33-4-101, 33-4-102 and 33-5.5-102, 33-6-107, 33-6-109, 33-6-112, 33-6-113, 33-6-114, 33-6-114.5, 33-6-117, 33-6-119, 33-6-121, 33-6-124, 33-6-125, 33-6-127, 33-6-128, 33-6-130, 33-6-205, 33-6-206, 33-6-207, 33-6-208, 33-6-209, C.R.S., and in sections 33-10-101 to 33-33-113, C.R.S. (the "Parks Act"), and especially sections 33-10-106, 33-10-107, 33-10.5-107, 33-11-109, 33-12-101, 33-12-103, 33-12-103.5, 33-12-106, 33-12.5-103, 33-13-103, 33-13-104, 33-13-106, 33-13-109, 33-13-110, 33-13-111, 33-14-107, 33-14.5-107, 33-32-103 and 33-33-105. C.R.S.

FINAL REGULATORY ADOPTION – **August 24-25, 2023,** beginning **at 8:00 a.m.***

EFFECTIVE DATE OF REGULATIONS approved during the August 2023 Parks and Wildlife Commission meeting: October 1, 2023, unless otherwise noted.

FINAL REGULATIONS

PARK REGULATIONS

Chapter P-1 - "Parks and Outdoor Recreation Lands" 2 CCR 405-1

**Please reference the Commission agenda, to be posted on or after August 14, 2023, to ensure when each regulatory item will be addressed by the Commission. The agenda will be posted at https://cpw.state.co.us/aboutus/Pages/CommissionMeetings.aspx.*

Open for final consideration of regulations including, but not limited to, the following:

- Extending the pilot testing of the timed entry reservation system at Eldorado Canyon State Park.
- Updating the property specific regulations for Fishers Peak as the park is developed.

WILDLIFE REGULATIONS

Chapter W-2 - "Big Game" 2 CCR 406-2

Open for consideration of any necessary corrections or administrative clean-ups to regulations previously adopted by the Parks and Wildlife Commission for the 2023 big game seasons, including, but not limited to, the season dates for over-the-counter hunt code BE087U6R from 09/01/2023 - 11/26/2023 to 09/02/2023 - 11/26/2023.

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DRAFT REGULATIONS

WILDLIFE REGULATIONS

Chapter W-0 - "General Provisions" 2 CCR 406-0, and those related provisions of Chapter W-2 ("Big Game" 2 CCR 406-2), Chapter W-3 ("Furbearers and Small Game, Except Migratory Birds" 2 CCR 406-3), Chapter W-11 ("Wildlife Parks and Unregulated Wildlife" 2 CCR 406-11), Chapter W-15 ("Division Agents" 2 CCR 406-15), and Chapter P-7 ("Passes, Permits and Registrations" – 2 CCR 405-7) necessary to accommodate changes to or ensure consistency with Chapter W-0

Open for consideration of regulations including, but not limited to, adjusting license fees and license agent commission rates according to adjustments to the Denver-Aurora-Lakewood Consumer Price Index.

ISSUES IDENTIFICATION

PARK REGULATIONS

Chapter P-3 – "River Outfitters" – 2 CCR 405-3

Open for annual review of the entire chapter including, but not limited to, consideration of regulations regarding river outfitter requirements.

WILDLIFE REGULATIONS

Chapter W-0 – "General Provisions" – 2 CCR 406-0

Open for consideration of regulations including, but not limited to, importation, transportation, and possession of crayfish.

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Notice of Proposed Rulemaking

Tracking number

2023-00347

Department

400 - Department of Natural Resources

Agency

406 - Colorado Parks and Wildlife (406 Series, Wildlife)

CCR number

2 CCR 406-2

Rule title

CHAPTER W-2 - BIG GAME

Rulemaking Hearing

Date

08/24/2023

Time

08:00 AM

Location

Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487

Subjects and issues involved

Chapter W-2 - Big Game 2 CCR 406-2 - see attached

Statutory authority

See attached

Contact information

Name

Hilary Hernandez

Title

Regulations Manager

Telephone

3032917226

Email

hilary.hernandez@state.co.us

June 30, 2023

RULE-MAKING NOTICE
PARKS AND WILDLIFE COMMISSION MEETING
August 24-25, 2023

In accordance with the State Administrative Procedure Act, section 24-4-103, C.R.S., the Parks and Wildlife Commission gives notice that regulations will be considered for adoption at their next meeting on **August 24-25, 2023 with a virtual participation option. The Parks and Wildlife Commission meeting will be held at Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, 80487. For up-to-date information on the meeting, please refer to the Parks and Wildlife Commission website: https://cpw.state.co.us/aboutus/Pages/CommissionMeetings.aspx. The public is encouraged to comment before the meeting by submitting written comments to the Commission's email address at: dnr_cpwcommission@state.co.us.**

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FINAL REGULATORY ADOPTION – **August 24-25, 2023,** beginning **at 8:00 a.m.***

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FINAL REGULATIONS

PARK REGULATIONS

Chapter P-1 - "Parks and Outdoor Recreation Lands" 2 CCR 405-1

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Open for final consideration of regulations including, but not limited to, the following:

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WILDLIFE REGULATIONS

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Notice of Proposed Rulemaking

Tracking number

2023-00348

Department

400 - Department of Natural Resources

Agency

406 - Colorado Parks and Wildlife (406 Series, Wildlife)

CCR number

2 CCR 406-3

Rule title

CHAPTER W-3 - FURBEARERS AND SMALL GAME, EXCEPT MIGRATORY BIRDS

Rulemaking Hearing

Date

08/24/2023

Time

08:00 AM

Location

Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487

Subjects and issues involved

Chapter W-3 - Furbearers and Small Game, Except Migratory Birds 2 CCR 406-3 - see attached

Statutory authority

See attached

Contact information

Name

Hilary Hernandez

Title

Regulations Manager

Telephone

3032917226

Email

hilary.hernandez@state.co.us

June 30, 2023

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Open for annual review of the entire chapter including, but not limited to, consideration of regulations regarding river outfitter requirements.

WILDLIFE REGULATIONS

Chapter W-0 – "General Provisions" – 2 CCR 406-0

Open for consideration of regulations including, but not limited to, importation, transportation, and possession of crayfish.

Chapter W-1- "Fishing" 2 CCR 406-1 and those related provisions of Chapter W-0 ("General Provisions" 2 CCR 406-0) and Chapter W-9 ("Wildlife Properties" 2 CCR 406-9) necessary to accommodate changes to or ensure consistency with Chapter W-1

Open for annual review of the entire chapter including, but not limited to, consideration of regulations regarding season dates, bag and possession limits, licensing requirements, manner of take provisions and special conditions or restrictions applicable to waters of the state.

Chapter W-3 - "Furbearers and Small Game, except Migratory Birds" 2 CCR 406-3

Open for annual review of regulations regarding turkey hunting, including but not limited to, license areas, season dates, and manner of take provisions for the 2024 turkey hunting seasons.

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Notice of Proposed Rulemaking

Tracking number

2023-00349

Department

400 - Department of Natural Resources

Agency

406 - Colorado Parks and Wildlife (406 Series, Wildlife)

CCR number

2 CCR 406-9

Rule title

CHAPTER W-9 - WILDLIFE PROPERTIES

Rulemaking Hearing

Date

08/24/2023

Time

08:00 AM

Location

Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487

Subjects and issues involved

Chapter W-9 - Wildlife Properties 2 CCR 406-9 - see attached

Statutory authority

See attached

Contact information

Name

Hilary Hernandez

Title

Regulations Manager

Telephone

3032917226

Email

hilary.hernandez@state.co.us

June 30, 2023

RULE-MAKING NOTICE
PARKS AND WILDLIFE COMMISSION MEETING
August 24-25, 2023

In accordance with the State Administrative Procedure Act, section 24-4-103, C.R.S., the Parks and Wildlife Commission gives notice that regulations will be considered for adoption at their next meeting on **August 24-25, 2023 with a virtual participation option. The Parks and Wildlife Commission meeting will be held at Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, 80487. For up-to-date information on the meeting, please refer to the Parks and Wildlife Commission website: https://cpw.state.co.us/aboutus/Pages/CommissionMeetings.aspx. The public is encouraged to comment before the meeting by submitting written comments to the Commission's email address at: dnr_cpwcommission@state.co.us.**

Comment deadlines: Written comments will be accepted at any time. However, to ensure sufficient time for consideration prior to the meeting, **comments should be provided to the Division of Parks and Wildlife by noon on the following date:**

August 10, 2023, for mailing by the Division of Parks and Wildlife to the Parks and Wildlife Commission on **August 11, 2023.**

Comments received by the Division between noon on **August 10, 2023** and noon on **August 18, 2023,** will be provided to the Commission two business days before the meeting. Comments received after noon on **August 18, 2023** will be held and shared with the Commission as part of the subsequent meeting mailing.

More information on submitting public comments is available at: https://cpw.state.co.us/aboutus/Pages/Submit-Public-Comments.aspx.

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FINAL REGULATORY ADOPTION – **August 24-25, 2023,** beginning **at 8:00 a.m.***

EFFECTIVE DATE OF REGULATIONS approved during the August 2023 Parks and Wildlife Commission meeting: October 1, 2023, unless otherwise noted.

FINAL REGULATIONS

PARK REGULATIONS

Chapter P-1 - "Parks and Outdoor Recreation Lands" 2 CCR 405-1

**Please reference the Commission agenda, to be posted on or after August 14, 2023, to ensure when each regulatory item will be addressed by the Commission. The agenda will be posted at https://cpw.state.co.us/aboutus/Pages/CommissionMeetings.aspx.*

Open for final consideration of regulations including, but not limited to, the following:

- Extending the pilot testing of the timed entry reservation system at Eldorado Canyon State Park.
- Updating the property specific regulations for Fishers Peak as the park is developed.

WILDLIFE REGULATIONS

Chapter W-2 - "Big Game" 2 CCR 406-2

Open for consideration of any necessary corrections or administrative clean-ups to regulations previously adopted by the Parks and Wildlife Commission for the 2023 big game seasons, including, but not limited to, the season dates for over-the-counter hunt code BE087U6R from 09/01/2023 - 11/26/2023 to 09/02/2023 - 11/26/2023.

Chapter W-9 - "Wildlife Properties" 2 CCR 406-9

Open for consideration of any necessary corrections or administrative clean-ups to regulations previously adopted by the Parks and Wildlife Commission, including, but not limited to:

- Removing the public access prohibition from March 1-Aug. 14 at San Luis Hills SWA.
- Moving Williams Hill SWA back to #900 from #902.

DRAFT REGULATIONS

WILDLIFE REGULATIONS

Chapter W-0 - "General Provisions" 2 CCR 406-0, and those related provisions of Chapter W-2 ("Big Game" 2 CCR 406-2), Chapter W-3 ("Furbearers and Small Game, Except Migratory Birds" 2 CCR 406-3), Chapter W-11 ("Wildlife Parks and Unregulated Wildlife" 2 CCR 406-11), Chapter W-15 ("Division Agents" 2 CCR 406-15), and Chapter P-7 ("Passes, Permits and Registrations" – 2 CCR 405-7) necessary to accommodate changes to or ensure consistency with Chapter W-0

Open for consideration of regulations including, but not limited to, adjusting license fees and license agent commission rates according to adjustments to the Denver-Aurora-Lakewood Consumer Price Index.

ISSUES IDENTIFICATION

PARK REGULATIONS

Chapter P-3 – "River Outfitters" – 2 CCR 405-3

Open for annual review of the entire chapter including, but not limited to, consideration of regulations regarding river outfitter requirements.

WILDLIFE REGULATIONS

Chapter W-0 – "General Provisions" – 2 CCR 406-0

Open for consideration of regulations including, but not limited to, importation, transportation, and possession of crayfish.

Chapter W-1- "Fishing" 2 CCR 406-1 and those related provisions of Chapter W-0 ("General Provisions" 2 CCR 406-0) and Chapter W-9 ("Wildlife Properties" 2 CCR 406-9) necessary to accommodate changes to or ensure consistency with Chapter W-1

Open for annual review of the entire chapter including, but not limited to, consideration of regulations regarding season dates, bag and possession limits, licensing requirements, manner of take provisions and special conditions or restrictions applicable to waters of the state.

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Notice of Proposed Rulemaking

Tracking number

2023-00350

Department

400 - Department of Natural Resources

Agency

406 - Colorado Parks and Wildlife (406 Series, Wildlife)

CCR number

2 CCR 406-11

Rule title

CHAPTER W-11 - WILDLIFE PARKS AND UNREGULATED WILDLIFE

Rulemaking Hearing

Date

08/24/2023

Time

08:00 AM

Location

Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487

Subjects and issues involved

Chapter W-11 - Wildlife Parks and Unregulated Wildlife 2 CCR 406-11 - see attached

Statutory authority

See attached

Contact information

Name

Hilary Hernandez

Title

Regulations Manager

Telephone

3032917226

Email

hilary.hernandez@state.co.us

June 30, 2023

RULE-MAKING NOTICE
PARKS AND WILDLIFE COMMISSION MEETING
August 24-25, 2023

In accordance with the State Administrative Procedure Act, section 24-4-103, C.R.S., the Parks and Wildlife Commission gives notice that regulations will be considered for adoption at their next meeting on **August 24-25, 2023 with a virtual participation option. The Parks and Wildlife Commission meeting will be held at Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, 80487. For up-to-date information on the meeting, please refer to the Parks and Wildlife Commission website: https://cpw.state.co.us/aboutus/Pages/CommissionMeetings.aspx. The public is encouraged to comment before the meeting by submitting written comments to the Commission's email address at: dnr_cpwcommission@state.co.us.**

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FINAL REGULATORY ADOPTION – **August 24-25, 2023,** beginning **at 8:00 a.m.***

EFFECTIVE DATE OF REGULATIONS approved during the August 2023 Parks and Wildlife Commission meeting: October 1, 2023, unless otherwise noted.

FINAL REGULATIONS

PARK REGULATIONS

Chapter P-1 - "Parks and Outdoor Recreation Lands" 2 CCR 405-1

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Open for final consideration of regulations including, but not limited to, the following:

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WILDLIFE REGULATIONS

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Open for consideration of any necessary corrections or administrative clean-ups to regulations previously adopted by the Parks and Wildlife Commission for the 2023 big game seasons, including, but not limited to, the season dates for over-the-counter hunt code BE087U6R from 09/01/2023 - 11/26/2023 to 09/02/2023 - 11/26/2023.

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Open for consideration of any necessary corrections or administrative clean-ups to regulations previously adopted by the Parks and Wildlife Commission, including, but not limited to:

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DRAFT REGULATIONS

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ISSUES IDENTIFICATION

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Notice of Proposed Rulemaking

Tracking number

2023-00351

Department

400 - Department of Natural Resources

Agency

406 - Colorado Parks and Wildlife (406 Series, Wildlife)

CCR number

2 CCR 406-15

Rule title

CHAPTER W-15 - DIVISION AGENTS

Rulemaking Hearing

Date

08/24/2023

Time

08:00 AM

Location

Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487

Subjects and issues involved

Chapter W-15 - Division Agents 2 CCR 406-15 - see attached

Statutory authority

See attached

Contact information

Name

Hilary Hernandez

Title

Regulations Manager

Telephone

3032917226

Email

hilary.hernandez@state.co.us

June 30, 2023

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Open for annual review of regulations regarding turkey hunting, including but not limited to, license areas, season dates, and manner of take provisions for the 2024 turkey hunting seasons.

Except for the day and time indicated for when the meeting is scheduled to begin, the order indicated for each agenda item is approximate and subject to change when necessary to accommodate the Commission's schedule.

For Viewing of Proposed Rules or Questions: copies of the proposed rules (together with a proposed statement of basis and purpose and specific statutory authority), will be available for inspection online at https://cpw.state.co.us/aboutus/pages/commission.aspx and copies can be obtained from the Colorado Division of Parks and Wildlife, Office of the Regulations Manager by emailing **dnr_cpw_planning@state.co.us** at least five (5) days prior to the date of hearing. Such copies, however, are only proposals to be submitted to the Commission by the Division of Parks and Wildlife. Questions may be sent to the Colorado Division of Parks and Wildlife, Office of the Regulations Manager by emailing **dnr_cpw_planning@state.co.us** as well.

Modification of Proposed Rules prior to adoption: subject to the provisions of Section 24-4-103, C.R.S., modification of these proposals may be made by the Division of Parks and Wildlife or the Commission before the Commission promulgates final rules and regulations on the above topics.

Opportunity to submit alternate proposals and provide comment: the Commission will afford all interested persons an opportunity to submit alternate proposals, written data, views or arguments and to present them orally, if time permits, at the meeting unless it deems such oral presentation unnecessary. Written alternate proposals, data, views or arguments and other written statements should be e-mailed to **dnr_cpwcommission@state.co.us**.

Use of Consent Agenda:
In order to increase the Parks and Wildlife Commission's efficiency and allow more time for consideration of parks and wildlife policy and contested issues, some or all of this regulatory agenda may be listed for action by the Commission as part of a "Consent Agenda" for this meeting.

The process for placing matters on the Consent Agenda is as follows:
The Director identifies matters where the recommended action follows established policy or precedent, there has been agreement reached or the matter is expected to be uncontested and non-controversial.

Regulatory Matters on the Consent Agenda are noticed for hearing at the same time and in the same manner as other Consent Agenda items. If a member of the Commission requests further consideration of an item on the Consent Agenda, that item will be withdrawn from the Consent Agenda and discussed at the end of the meeting or at the next meeting. The Consent Agenda may be voted on without the necessity of reading individual items. Any Commission member may request clarification from the Director of any matter on the Consent Agenda.

OTHER AGENDA ITEMS: The Parks and Wildlife Commission may consider and make policy, program implementation, and other non-regulatory decisions, which may be of public interest at this meeting. A copy of the complete meeting agenda can be viewed on the Division of Parks and Wildlife's internet home page at **https://cpw.state.co.us**, on or after **August 14, 2023**.

Notice of Proposed Rulemaking

Tracking number

2023-00355

Department

700 - Department of Regulatory Agencies

Agency

702 - Division of Insurance

CCR number

3 CCR 702-4 Series 4-2

Rule title

LIFE, ACCIDENT AND HEALTH, Series 4-2 Accident and Health (General)

Rulemaking Hearing

Date

08/01/2023

Time

02:00 PM

Location

Webinar or 1560 Broadway, STE 850, Denver CO 80202

Subjects and issues involved

The purpose of this regulation is to establish rules for the required premium reduction methodology for the Colorado Option standardized bronze, silver and gold health benefit plans to be offered by all carriers offering individual and small group health benefits plans issued or renewed on or after January 1, 2024.

Statutory authority

§§ 10-1-108(7), 10-1-109(1), 10-16-109, 10-16-1304, 10-16-1305, 10-16-1306, 10-16-1312, C.R.S.

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DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

DRAFT Proposed Amended Regulation 4-2-85

CONCERNING THE METHODOLOGY FOR CALCULATING PREMIUM RATE REDUCTIONS FOR COLORADO OPTION STANDARDIZED HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-16-109, 10-16-1304, 10-16-1305, 10-16-1306, 10-16-1312, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules for the required premium reduction methodology for the Colorado Option standardized bronze, silver and gold health benefits plans to be offered by all carriers offering individual and small group health benefits plans issued or renewed on or after January 1, 2024.

Section 3 Applicability

This regulation applies to all carriers offering individual and small group health benefit plans subject to the individual and group laws of Colorado and the requirements of federal law.

If Colorado's Section 1332 Innovation Waiver Request for the Colorado Option is not approved by the U.S. Department of Health and Human Services and Department of Treasury, then these premium reductions will not go into effect.

Section 4 Definitions

A. "Actuarial value" and "AV" means, for the purposes of this regulation, the percentage of total average costs for covered benefits that a health benefit plan will cover, with calculations based on the provision of essential health benefits to a standard population.

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B. “Baseline Plan” or “2021 Baseline Plan” means, for the purposes of this regulation, the health benefit plan with the carrier’s lowest 21-year-old non-tobacco use premium rate, by metal level, in the applicable county from the 2021 Benefit Year, regardless of whether the health benefit plan is sold in the entire county or a partial county. The Baseline Plan shall only consider on-exchange health benefit plans for the Individual market and be determined prior to the impact of the Colorado reinsurance program. The Baseline Plan shall only consider off-exchange health benefit plans for the Small Group market.

C. “Benefit Year” means, for the purposes of this regulation, the calendar year for individual health benefit plans, or the twelve month period beginning with the health benefit plan contract date for small group health benefit plans.

D. “Calibrated Plan Adjusted Index Rate” means, for the purpose of this regulation, line 3.14 on Worksheet 2 of the URRT.

E. “Carrier” shall have the same meaning as found at § 10-16-102(8), C.R.S.

F. “Colorado Option Standardized Plan” or “Standardized Plan” or shall have the same meaning as found at § 10-16-1303(14), C.R.S.

G. “CSR” means, for the purposes of this regulation, a cost-sharing reduction health benefit plan variation defined in 45 C.F.R. 156.420(a).

H. “CSR Load” means, for the purposes of this regulation, the load in the silver plan premiums necessary to cover the cost of providing the CSR benefit to qualified consumers in the on-exchange silver health benefit plans.

I. “CPI-U” means, for the purposes of this regulation, the ~~c~~Consumer ~~p~~Price ~~i~~Index for all urban consumers~~customers~~, U.S. city average, and all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.

J. “Essential health benefits” and “EHB” shall have the same meaning as found at § 10-16-102(22), C.R.S.

K. “Exchange” shall have the same meaning as found at § 10-16-102(26), C.R.S.

L. “Expanded bronze” means, for the purposes of this regulation, a bronze health benefit plan that provides coverage for at least one (1) major service, other than preventive services, prior to meeting the deductible, or meets the requirements to qualify as a high deductible health plan under 26 U.S.C 223(c)(2), as established at 45 CFR 156.140(c), with a bronze actuarial value of 60%.

M. “Federal Actuarial Value Calculator” or “Federal AV Calculator” means, for the purposes of this regulation, the AV Calculator required pursuant to 45 C.F.R. 156.135(a).

N. “Federal law” shall have the same meaning as found at § 10-16-102(29), C.R.S.

O. “Health benefit plan” shall have the same meaning as found at § 10-16-102(32), C.R.S.

P. “Healthcare coverage cooperative” shall have the same meaning as found at § 10-16-1002(2), C.R.S.

Q. “Induced demand factor” means, for the purposes of this regulation, the anticipated induced demand associated with the health benefit plan’s cost sharing (metal) level.

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R. “Medical Inflation” shall have the same meaning as found at § 10-16-1303(10), C.R.S.

S. “Metal Level" means, for the purposes of this regulation, the bronze, silver, and gold health benefit plans available in the individual and small group market as found at § 10-16-103.4, C.R.S.

T. “Non-EHB” means, for the purposes of this regulation, any benefit in a health benefit plan that is not an EHB as found at § 10-16-102(22), C.R.S.

U. “Plans and Benefits Template” or “PBT” means, for the purpose of this regulation, the Plans & Benefits Template created by the Centers for Medicare & Medicaid Services (CMS).

V. “Premium” shall have the same meaning as found at § 10-16-102(51), C.R.S.

W. “Reinsurance” shall have the same meaning as found at § 10-16-1103(12), C.R.S.

X. “SERFF” means, for the purposes of this regulation, System for Electronic Rate and Form Filing.

Y. “Supplemental Template” shall have the same meaning as found at Colorado Insurance Regulation 4-2-39 Section (6)(C)(3).

Z. “Substantially Similar Plan” means, for the purposes of this regulation, the silver level health benefit plan that is substantially similar to the on-exchange CSR-loaded silver health benefit plan, but without the CSR load, for those off-exchange consumers who do not qualify for advanced premium tax credits or CSRs.

AA. “URRT” means, for the purpose of this regulation, the Unified Rate Review Template created by the Centers for Medicare & Medicaid Services.

Section 5 Premium Rate Reduction Methodology for Colorado Option Standardized Health Benefit Plan

A. Pursuant to § 10-16-1305(2)(a)-(c), C.R.S., carriers offering a Standardized Plan at the bronze, silver, and gold metal levels must offer standardized plans with a premium that is reduced by a specified percent relative to their 2021 premiums, after adjustments for ~~national~~ medical inflation. The Division will define the allowable adjustments for the calculation of the premium rate reduction methodology required for the Colorado Option. The required premium reductions are:

1. Five percent premium reduction for the Benefit Year beginning in 2023;

2. Ten percent premium reduction for the Benefit Year beginning in 2024; and

3. Fifteen percent premium reduction for the Benefit Year beginning in 2025.

B. Pursuant to § 10-16-1305(2)(d), C.R.S., for the Benefit Year beginning on or after January 1, 2026, and each year thereafter, each carrier and healthcare coverage cooperative shall limit any annual premium rate increase to a rate that is no more than medical inflation, relative to the previous year.

C. The Division will calculate whether a carrier meets the premium reductions specified in Sections 5.A. and 5.B. using the following methodology.

1. Bronze and Expanded Bronze health benefit plans will be combined to determine the lowest cost premium rate for the Bronze Colorado Option Standardized Plan.

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2. The 2021 Baseline Plan Unadjusted Premium will be calculated on a county, metal level, and market basis for each carrier. The 2021 Baseline Plan Unadjusted Premium will be calculated as follows:

a. For the Individual Market:

i. 2021 Baseline Plan Unadjusted Premium =

(minimum 2021 Calibrated Plan Adjusted Index Rate offered in the county for the metal level) x (1.0 age factor) x (2021 Geographic Rating Factor for the applicable county)

ii. The Minimum 2021 Calibrated Plan Adjusted Index Rate will be determined using the carrier's 2021 "No Reinsurance" URRT.

b. For the Small Group Market:

i. 2021 Baseline Plan Unadjusted Premium =

(minimum annual filing 2021 Calibrated Plan Adjusted Index Rate offered in the county for the metal level) x ((fourth quarter rate of 2021 Baseline Plan) / (first quarter rate of 2021 Baseline Plan)) x (1.0 age factor) x (2021 Geographic Rating Factor for the applicable county)

ii. If a carrier submitted quarterly rate filing(s) subsequent to the annual filing, the last filing submitted will be used to determine the fourth quarter rate for the Baseline plan.

3. An adjustment factor will be applied to reflect changes in the member cost sharing from the 2021 Baseline Plan to the applicable Colorado Option Standardized Plan design and underlying data changes in the 2023 and 2024 federal AV calculator, including meaningfully different changes across the various metal levels beyond the impact of claim cost and utilization trends and trend leveraging. The Changes in Member Cost Sharing Adjustment will be calculated as follows:

(Colorado Option Standardized Plan AV) x (CY2023 AV Calculator Adjustment) x (Pricing AV Adjustment) x (CY2024 AV Calculator Adjustment)

÷

(2021 Baseline Plan AV)

a. Colorado Option Standardized Plan AV for the applicable metal level.

b. The CY2023 AV Calculator Adjustment will be:

i. 0.992 for Gold Metal Level Plans

ii. 0.971 for Silver Metal Level Plans

iii. 1.002 for Bronze Metal Level Plans

c. The Pricing AV Adjustment will be consistent across carriers and determined using information provided to the Division in a data call.

d. The CY2024 AV Calculator Adjustment will be:

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i. 1.017 for Gold Metal Level Plans

ii. 1.019 for Silver Metal Level Plans

iii. 1.020 for Bronze Metal Level Plans

e. The 2021 Baseline Plan AV will be determined by the value entered in the carrier's PBT for the 2021 Baseline Plan.

4. An adjustment factor will be applied to reflect changes in the loading applied to Individual market Silver health benefit plans for CSR payments. The CSR load will be calculated for both the Colorado Option Standardized Plan and the 2021 Baseline Plan using the ratio of the on-Exchange silver health benefit plan and the off-Exchange Substantially Similar Plan. The CSR Load Adjustment will be calculated as follows:

(Colorado Option Standardized Plan CSR Load) ÷

(2021 Baseline Plan CSR Load)

a. The Colorado Option Standardized Plan CSR Load will be calculated using the Calibrated Plan Adjusted Index Rate for the on-exchange Colorado Option Standardized Silver Plan divided by the Calibrated Plan Adjusted Index Rate of the ~~s~~Substantially ~~S~~similar off-~~E~~exchange Colorado Option Standardized Silver Plan.

b. The 2021 Baseline Plan CSR Load will be calculated using the Calibrated Plan Adjusted Index Rate for the 2021 Baseline Plan divided by the Calibrated Plan Adjusted Index Rate of the ~~s~~Substantially ~~s~~similar off-~~e~~exchange plan of the 2021 Baseline Plan.

5. An adjustment factor will be applied to reflect changes in the induced demand factor applied in 2021 and the applicable Colorado Option Standardized Plan design. The Induced Demand Factor Adjustment will be calculated as follows:

(Colorado Option Standardized Plan Induced Demand Factor) ÷

(2021 Baseline Plan Induced Demand Factor)

a. The Colorado Option Standardized Plan Induced Demand Factor will be determined by the following formula:

Colorado Option Standardized Plan Induced Demand Factor =

$1.24 - (AV) + (AV)^2$

b. The 2021 Baseline Plan Induced Demand Factor will be determined by the value supplied to the Division in a data call regarding 2021 plans. The 2021 Baseline Plan Induced Demand Factors are normalized based on the projected membership carriers assumed for the 2021 Benefit Year. To ensure the induced demand adjustment is consistent, a normalization factor will be developed and applied to the Induced Demand Factor using the formula in (a). This normalization factor will be developed separately for each carrier and ensure that the shift from carrier-specific induced demand factor to

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the federal induced demand formula is revenue-neutral across each carrier's 2021 rate filing.

6. The Adjustment for EHB Changes of 1.0016 will be applied to reflect the changes in the EHB-benchmark plan, which will be in effect starting with the 2023 Benefit Year. This adjustment will be based on the cost impact of the benefit changes in the actuarial analysis submitted to CMS for approval of these changes.

7. If the Baseline Plan has non-EHBs not reflected in the Colorado Option Standardized Plan, an adjustment will be made based on the EHB Percent of Total Premium in the Plan & Benefits Template for 2021. Additionally, if the 2021 Baseline Plan did not include any non-EHB benefits but the carrier chooses to offer allowable non-EHB benefits in the Colorado Option Standardized Plan, an adjustment would also be made based on the EHB Percent of Total Premium in the Plan & Benefits Template for the Benefit Year. The Adjustment for non-EHB Changes will be calculated as follows:

("EHB Percent of Total Premium" for 2021 Baseline Plan) ÷

("EHB Percent of Total Premium" for the Colorado Option Standardized Plan)

a. The "EHB Percent of Total Premium" for the Colorado Option Standardized Plan will be determined by the value entered in the carrier's PBT for the Colorado Option Standardized Plan.

b. The "EHB Percent of Total Premium" for the Baseline Plan will be determined by the value entered in the carrier's 2021 PBT.

8. The Medical Inflation Trend will be calculated as follows:

(1 + "Medical Inflation3~~10 Year Average CPI-U for Medical Services, Annualized"~~) ^ (Months of Trend/12)

a. ~~The~~ "Medical Inflation3~~10 Year Average CPI-U for Medical Services, Annualized~~" will be based on ~~medical inflation. This will be calculated based on~~ the latest CPI-U for Medical Care for the Denver-Aurora-Lakewood, CO Core Based Statistical Area published 30 days prior to the issuance ~~publication~~ of a Division bulletin by June 30~~April 1~~, 2023~~2~~ for the 2024~~3~~ Benefit Year, and January 1 of each year thereafter.

b. Months of Trend will be calculated as the difference between the midpoint of the Colorado Option Standardized Plan Benefit Year and the midpoint of the effective period of the 2021 Baseline Plan.

9. The Required Rate Reduction Factor will be calculated as follows:

(1 – Benefit Year Required Rate Reduction Percentage)

The Benefit Year Required Rate Reduction will equal 5% for Benefit Year 2023, 10% for Benefit Year 2024 and 15% for Benefit Years 2025 and all subsequent Benefit Years.

10. The Colorado Option Standardized Plan premium rate for a 21-year-old non-tobacco user, calculated on a county, metal level, and market basis for each carrier must be less than or equal to the Maximum Colorado Option Standardized Premium. The

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Maximum Colorado Option Standardized Plan Premium will be calculated as follows:

a. For Colorado Option Standardized Gold and Bronze Plans in the Individual and Small Group markets, and Colorado Option Standardized Silver Plans in the Small Group Market:

i. Maximum Colorado Option Standardized Plan Premium =

(2021 Baseline Plan Unadjusted Premium) x (Changes in Member Cost Sharing Adjustment) x (Induced Demand Factor Adjustment) x (Adjustment for EHB Changes) x (Adjustment for non-EHB Changes) x (Medical Inflation Trend) x (Required Rate Reduction Factor)

ii. The Maximum Colorado Option Standardized Plan Premium for the Small Group Market is the maximum allowable premium for all plans commencing during the applicable benefit year, irrespective of whether the rates are based on an annual or quarterly rate filing.

b. For On-Exchange Colorado Option Standardized Silver Plans in the Individual Market:

i. Maximum Colorado Option Standardized Plan Premium =

(2021 Baseline Plan Unadjusted Premium) x (Changes in Member Cost Sharing Adjustment) x (CSR Load Adjustment) x (Induced Demand Factor Adjustment) x (Adjustment for EHB Changes) x (Adjustment for non-EHB Changes) x (Medical Inflation Trend) x (Required Rate Reduction Factor)

ii. A separate calculation will not be required for the Off-Exchange Colorado Option Standardized Silver Plan.

c. If a carrier is offering the Standardized Plan in a county where the carrier did not sell plans in 2021, the Maximum Colorado Option Standardized Plan Premium will be the weighted average, using enrollment as of April 1, 2021, of the Maximum Colorado Option Standardized Plan Premiums, across all carriers, that offered plans in the applicable county in 2021, regardless of whether plans are sold in the entire county or a partial part of the county. If a county did not have enrollment in any plans in the applicable metal level as of April 1, 2021, the Maximum Colorado Option Standardized Plan Premium will be the average of all plans in the applicable county in 2021, regardless of whether plans are sold in the entire county or a partial part of the county.

D. Carrier-filed Colorado Option Standardized Plan premiums submitted as part of rate filings pursuant to § 10-16-1306(1), C.R.S., must be at or below the rates set forth in Section 5.C.10. in order to be compliant with the required premium rate reductions pursuant to § 10-16-1305(2), C.R.S.

Section 6 Filing Requirements

A. Carriers shall notify the commissioner whether the carrier's Colorado Option Standardized Plan will comply with the required premium rate reductions set forth in § 10-16-1305(2), C.R.S., and calculated pursuant to Section 5.

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1. For premium rates applicable in 2023, the carrier shall notify the commissioner. If a carrier's Colorado Option Standardized Plan fails to comply with the required premium rate reductions set forth in § 10-16-1305(2), C.R.S., and calculated pursuant to this Section 5, the carrier shall notify the commissioner of the reasons why the carrier is unable to meet the requirements in compliance with § 10-16-1306(2), C.R.S.

2. For premium rates applicable in 2024 or any subsequent year, the carrier shall notify the commissioner by March 1 of the preceding year.

B. Format of Filings

1. Carriers shall submit the notification of whether Colorado Option Standardized Plans will meet the required premium rate reductions through the "Colorado Option Standardized Plan Premium Rate Reduction" template supplied by the Division.

2. Carriers shall submit the "Colorado Option Standardized Plan Premium Rate Reduction" template in SERFF through an "Colorado Option Rate Reduction Notice" filing. This filing shall be submitted separately from any rate, form, annual certification, binder or network adequacy filing.

3. For the Individual market, Carriers shall use January 1 of the Benefit Year for which the filing applies for the "Effective Date" in SERFF.

4. For the small group market, Carriers shall use January 1 of the Benefit Year for the annual filing period as the "Effective Date" in SERFF. For other periods, the carrier shall use April 1, July 1 or October 1 of the Benefit Year for which the filing applies for the "Effective Date" in SERFF.

5. Carriers shall use "Informational" for the "Requested Filing Mode" in SERFF.

6. Carriers shall complete the SERFF Form Schedule tab to specify the forms to which this filing applies.

7. Carriers shall provide a filing description, including the Benefit Year the filing will support.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Incorporation by Reference

45 C.F.R. § 156.420(a) published by the Government Printing Office shall mean 45 C.F.R. § 156.420(a) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.420(a). A copy of 45 C.F.R. § 156.420(a) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 C.F.R. § 156.420(a) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 CFR 156.140(c) published by the Government Printing Office shall mean 45 CFR 156.140(c) as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR 156.140(c). A copy of 45 CFR 156.140(c) may be examined during regular business hours at the

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Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 CFR 156.140(c) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

45 CFR 156.135(a) published by the Government Printing Office shall mean 45 CFR 156.135(a) as published on the effective date of this regulation and does not include later amendments to or editions of 45 CFR 156.135(a). A copy of 45 CFR 156.135(a) may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of 45 CFR 156.135(a) may be requested from the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202. A charge for certification or copies may apply. A copy may also be obtained online at www.ecfr.gov.

Section 9 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 10 Effective Date

This regulation shall be effective September 30, 2023~~June 15~~, 2023.

Section 11 History

New regulation effective June 15, 2023.

Amended regulation effective September 30, 2023.

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Notice of Proposed Rulemaking

Tracking number

2023-00326

Department

1100 - Department of Labor and Employment

Agency

1101 - Division of Workers' Compensation

CCR number

7 CCR 1101-3 Rule 18

Rule title

Rule 18, MEDICAL FEE SCHEDULE (Rule 18 exhibits published separately)

Rulemaking Hearing

Date

08/15/2023

Time

10:00 AM

Location

Virtual hearing via zoom - preregistration REQUIRED

Subjects and issues involved

These proposed rule amendments will update, revise or clarify previous Workers Compensation Rules of Procedure. The revisions identify and clarify procedures and requirements, update and clarify language, fees, forms, and payments contained within the rules. Further the rules will update policy and reflect statutory changes.

Statutory authority

Sections 8-47-107 and 8-42-101(3)(a)(I), C.R.S.

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DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation
7 CCR 1101-3
WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 18 MEDICAL FEE SCHEDULE

CONTENTS

18.1 INTRODUCTION

Pursuant to § 8-42-101(3)(a)(I) and § 8-47-107, the Director promulgates this Medical Fee Schedule to review and establish maximum fees for healthcare services falling within the purview of the Workers' Compensation Act of Colorado. This Rule applies to services rendered on or after January 1, 2024. All other bills shall be reimbursed in accordance with the fee schedule in effect on the date of service. This Rule shall be read together with Rule 16, Utilization Standards, and Rule 17, the Medical Treatment Guidelines (MTGs).

The unofficial copies of Rule 18, other Colorado Workers' Compensation Rules of Procedure, and Interpretive Bulletins are available on the Division's website. The rules also may be purchased from LexisNexis. An official copy of this Rule is available on the Colorado Secretary of State's webpage, 7 CCR 1101-3.

18.2 INCORPORATION BY REFERENCE

The Director adopts and incorporates by reference the following materials:

(A) National Physician Fee Schedule Relative Value file (RBRVS-Resource Based Relative Value Scale), as modified and published by Medicare in April 2023.

(B) The Current Procedural Terminology CPT® 2023, Professional Edition, published by the American Medical Association (AMA). All CPT® modifiers are adopted, unless otherwise specified in this Rule.

(C) Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 40.1 using MS-DRGs from CMS-1771-F Table 5. MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems.

(D) Hospital Outpatient Prospective Payment System (OPPS) Addenda A and B, January 2023; 2023 NFRM OPPS Addendum J; Table 3 (The OPPS Imaging Families and Multiple Imaging Procedure Composite APCs of the 2023 OPPS Final Rule); and Table 2 of the 2023 NFRM OPPS Claims Accounting.

(E) Medicare Part B April 2023 Average Sales Price (ASP) Pricing File.

(F) Health Care Common Procedure Coding System (HCPCS) Level II Professional 2023, published by the AMA.

(G) Medicare's Clinical Laboratory Fee Schedule File, CY 2023 Q2 Release.

(H) The Current Dental Terminology, CDT® 2023, published by the American Dental Association.

(I) Medicare's 2022 Anesthesia Base Units by CPT® Code.

All guidelines and instructions in the referenced materials are adopted, unless otherwise specified in this Rule. The incorporation is limited to the specific editions named and does not include later revisions or additions.

The Division shall make available for public review and inspection the copies of all materials incorporated by reference in Rule 18. Please contact the Medical Services Manager, 633 17th Street, Suite 400, Denver, Colorado 80202-3626. These materials also are available at any state publications depository library. All users are responsible for the timely purchase and use of these materials.

18.3 GENERAL POLICIES

(A) BILLING CODES AND FEE SCHEDULE:

(1) The Division establishes the Medical Fee Schedule based on RBRVS, as modified by Rule 18 and its Exhibits.

(2) The Division incorporates CPT®, HCPCS, CDT® and National Drug Code (NDC) codes and values, unless otherwise specified in Rule 18. The providers may use CPT® Category III codes listed in the RBRVS with Payer agreement. Payment for the Category III codes shall comply with Rule 16 policy for unpriced codes.

(3) Division-created codes and values (DoWC ZXXXX) supersede CPT®, HCPCS, CDT®, and NDC codes and values. The CPT® mid-point rule for attaining a unit of time applies to these codes, unless otherwise specified in this Rule.

(4) Codes listed with values of "BR" (by report), not listed, or listed with a zero value and not included by Medicare in another procedure(s), require prior authorization.

(B) PLACE OF SERVICE CODES:

The table below lists the place of service codes corresponding to the RBRVS facility RVUs. All other maximum fee calculations shall use the non-facility RVUs listed in the RBRVS.

Place of Service Code	Place of Service Code Description
21	Inpatient Hospital
22	On Campus - Outpatient Hospital
23	Emergency Room-Hospital
24	Ambulatory Surgery Center (ASC)
26	Military Treatment Facility
31	Skilled Nursing Facility
34	Hospice
41	Ambulance - Land
42	Ambulance - Air or Water
51	Inpatient Psychiatric Hospital
52	Psychiatric Facility-Partial Hospitalization
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Facility

(C) CORRECT REPORTING AND PAYMENT POLICIES:

(1) Providers shall report codes and number of units based on all applicable code descriptions and this Rule. In addition, providers shall document all services/ procedures in the medical record.

(2) Providers shall report the most comprehensive code that represents the entire service.

(3) Providers shall report only the primary services and not the services that are integral to the primary services.

(4) Providers shall document the time spent performing all time-based services or procedures in accordance with applicable code descriptions.

(5) Providers shall apply modifiers to clarify services rendered and/or adjust the maximum allowances as indicated in this Rule. When correcting a modifier, Payers shall comply with Rule 16.

18.4 PROFESSIONAL FEES AND SERVICES

(A) GENERAL INSTRUCTIONS

(1) Conversion Factors (CFs):

Maximum allowances are determined by multiplying the following CFs by the established facility or non-facility total relative value units (RVUs) found in the corresponding RBRVS sections:

RBRVS SECTION	CF
Anesthesia	$44.00
Surgery/Radiology/Pathology/Medicine (SRPM)	$68.00
Physical Medicine and Rehabilitation	$49.00
(Includes Medical Nutrition Therapy and Acupuncture)	
Evaluation & Management (E&M)	$55.20

(2) Maximum Allowance:

(a) Maximum allowance for most providers shall be 100% of the Medical Fee Schedule unless otherwise specified in this Rule.

(b) The maximum allowance for Physician Assistants (PAs) and Nurse Practitioners (NPs) shall be 85% of the Medical Fee Schedule. However, PAs and NPs are allowed 100% of the Medical Fee Schedule if the requirements of Rule 16 have been met and one of the following conditions applies:

(i) The service is provided in a rural area. Rural area means:

- a county outside a Metropolitan Statistical Area (MSA) or
- a Health Professional Shortage Area, located either outside of an MSA or in a rural census tract, as determined by the Office of Rural Health Policy, Health Resources and Services Administration, United States Department of Health and Human Services.

(ii) The PA or NP is Level I Accredited.

(c) The Payer may negotiate reimbursement of travel expenses not addressed in the fee schedule (including transit time) with providers traveling to a rural area to serve an injured worker. Rural area is defined in subsection (2)(b)(i) above. This reimbursement shall be in addition to the maximum allowance for services addressed in the fee schedule.

(3) The Division adopts the following RBRVS attributes or modifies them as follows:

(a) HCPCS (Healthcare Common Procedure Coding System) – including any CPT® codes, Level I (CPT®), and Level II (HCPCS) Modifiers (listed and unlisted).

(b) Description – short description as listed in the file and long description as specified in CPT®.

(c) Status Code:

Status	Meaning
A	Separately Payable
B & P	Bundled Code
C	Priced per Rule 16-10-1
E	HCPCS J0120 to J9999 and CPT® 90296-90750 are payable. HCPCS Q4074-Q4255 require prior authorization for payment.

	All other codes are not payable unless otherwise specified in this Rule.
I	HCPCS A0021-A0998 and S0012-S0199 (see section 18-4(B)(6)(c)) are payable. Dental codes are paid per Exhibit #3; All other codes are not payable unless otherwise specified in this Rule. There may be another code for reporting and payment of these services.
J	Anesthesia Code
M & Q	Measurement or Functional Information Codes - No Value
N	HCPCS A4210-A9300 are payable when these supplies are issued for home use. Dental codes are paid per Exhibit #3. HCPCS V2025-V5290 are payable per section 18-6(A). There may be another code for reporting and payment of services associated with V-codes. Codes found in the Medicine Section of CPT® with an assigned RBRVS value (section 18-2(A)) are payable. All other codes are not payable unless otherwise specified in this Rule.
R	Dental codes are paid per Exhibit #3. All other codes require prior authorization for payment unless otherwise specified in this Rule.
T	Paid When It Is the Only Payable Service Performed
X	Codes with an assigned RBRVS or DMEPOS value (section 18-2(A)) are payable. All other codes are not payable unless otherwise specified in this Rule.

(d) Increment of Service/Billable (when specified).

(e) Anesthesia Base Unit(s), see section 18-4(C).

(f) Non-Facility (NF) Total RVUs.

(g) Facility (F) Total RVUs.

(h) Professional Component/Technical Component Indicators.

Indicator	**Meaning**
0	Physician Service Codes – professional component/ technical component (PC/TC) distinction does not apply.

1	Diagnostic Radiology Tests - may be billed with or without modifiers 26 or TC.
2	Professional Component Only Codes – standalone professional service code (no modifier is appropriate because the code description dictates the service is professional only).
3	Technical Component Only Codes - standalone technical service code (no modifier is appropriate because the code description dictates the service is technical only).
4	Global Test Only Codes - modifiers 26 and TC cannot be used because the values equal to the sum of the total RVUs (work, practice expense, and malpractice).
5	Incident To Codes - do not apply.
6	Laboratory Physician Interpretation Codes – separate payments may be made (these codes represent the professional component of a clinical laboratory service and cannot be billed with modifier TC).
7	Physical Therapy Service – not recognized.
8	Physician Interpretation Codes – separate payments may be made only if a physician interprets an abnormal smear for a hospital inpatient.
9	Concept of PC/TC distinction does not apply.

(i) Global Days: a period of time starting with the preoperative period of a surgical procedure and ending some period of time after the procedure was performed.

Indicator	**Meaning**
000	Endoscopies or some minor surgical procedures, typically a zero day post-operative period. E&M visits on the same day as procedures generally are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
010	Other minor procedures, 10-day post-operative period. E&M visits on the same day as procedures and during the 10-day post-operative period generally are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.

090	Major surgeries, 90-day post-operative period. E&M visits the day before and on same day as procedures, as well as during the 90-day post-operative period generally are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
MMM	Global service days concept does not apply (see Medicare's Global Maternity Care reporting rule).
XXX	Global concept does not apply.
YYY	Identifies primarily "BR" procedures where "global days" need to be determined by the Payer.
ZZZ	Code is related to another service and always included in the global period of the other service. Identifies "add-on" codes.

(j) Pre-Operative Percentage Modifier: percentage of the global surgical package payable when pre-operative care is rendered by a provider other than the surgeon.

Indicator	**Meaning**
%	The physician shall append modifier 56 when performing only the pre-operative portion of any surgical procedure. This modifier can be combined with either modifier 54 or 55, but not both. This column lists the allowed percentage of the total surgical relative value unit.

(k) Intra-Operative Percentage Modifier: percentage of the global surgical package payable when the surgeon renders only intra-operative care.

Indicator	**Meaning**
%	The surgeon shall append modifier 54 when performing only the intra-operative portion of a surgical procedure. This modifier can be combined with either modifier 55 or 56, but not both. This column lists the allowed percentage of the total surgical relative value unit.

(l) Post-Operative Percentage Modifier: percentage of the global surgical package payable when post-operative care is rendered by a provider other than the surgeon.

Indicator	Meaning
%	The surgeon shall append modifier 55 when performing only the post-operative portion of a surgical procedure. This modifier can be combined with either modifier 54 or 56, but not both. This column lists the allowed percentage of the total surgical relative value unit.

(m) Multiple Procedure Modifier: the maximum allowance for the highest-valued procedure is 100% of the fee schedule, even if the provider appends modifier 51. The maximum allowance for the lesser-valued procedures performed in the same operative setting is 50% of the fee schedule.

Indicator	Meaning
0	No payment adjustment for multiple procedures applies. These codes are generally identified as “add-on” codes in CPT®.
1, 2, or 3	Standard payment reduction applies (100% for the highest-valued procedure and 50% for all lesser-valued procedures performed during the same operative setting).
4, 5, 6, or 7	Not subject to the multiple procedure adjustments.
9	Multiple procedure concept does not apply.

(n) Bilateral Procedure Modifier.

Indicator	Meaning
0	Not eligible for the bilateral payment adjustment. Either the procedure cannot be performed bilaterally due to the anatomical constraints or another code more adequately describes the procedure.
1	Eligible for bilateral payment adjustment and shall be reported on one line with modifier 50 and “1” in the units box. Providers performing the same bilateral procedure during the same operative setting on multiple sites shall report the second and subsequent procedures with modifiers 50 and 59. Report on one line with one unit for each bilateral procedure performed. The maximum allowance is increased to 150%. If provider performs multiple bilateral procedures during the same setting, Payer shall apply the bilateral payment adjustment rule first, and then apply other applicable payment adjustments (e.g., multiple surgery).

2	Not eligible for the bilateral payment adjustment. These procedure codes are already bilateral.
3	Not eligible for the bilateral payment adjustment. Report these codes on two lines with RT and LT modifiers. There is one payment per line.
9	Not eligible for the bilateral payment adjustment because the concept does not apply.

(o) Assistant Surgeon, Modifiers 80, 81, 82, or AS: the designation of "almost always" for a surgical code in the Physicians as Assistants at Surgery: 2023 Update (February 2023), published by the American College of Surgeons shall indicate that separate payment for an assistant surgeon is allowed for that code. If that publication does not make a recommendation on a surgical code or lists it as "sometimes" or "almost never," then RBRVS indicators shall determine whether separate payment for assistant surgeons is allowed.

Indicator	**Meaning**
0	Documentation of medical necessity and prior authorization is required to allow an assistant at surgery.
1	No assistant at surgery is allowed.
2	Assistant at surgery is allowed.
9	Concept does not apply.

No separate assistant surgeon or minimum assistant fees shall be paid if a co-surgeon is paid for the same operative procedure during the same surgical episode. See section 18-4(D)(1) for additional payment policies.

(p) Co-Surgeon, Modifier 62.

Indicator	**Meaning**
1 or 2	Indicators may require two primary surgeons performing two distinct portions of a procedure. Modifier 62 is used with the procedure and maximum allowance is increased to 125% of the fee schedule value. The payment is apportioned to each surgeon in relation to the individual responsibilities and work, or it is apportioned equally between the co-surgeons.
0 or 9	Not eligible for co-surgery fee allowance adjustment. These procedures are either straightforward or only one surgeon is required, or the concept does not apply.

(q) Team Surgeon, Modifier 66.

Indicator	Meaning
0	Team surgery adjustments are not allowed.
1	Prior authorization is required for team surgery adjustments.
2	Team surgery adjustments may occur as a "BR." Each team surgeon must bill modifier 66. Payer must adjust the values in consultation with the billing surgeon(s).
9	Concept does not apply.

(r) Endoscopy base codes are not recognized for payment adjustments except when other modifiers apply.

(s) All other fields are not recognized.

(B) EVALUATION AND MANAGEMENT (E&M)

(1) E&M codes may be billed by Physicians, NPs, and PAs, as defined in Rule 16. To justify the billed level of E&M service, medical records shall utilize CPT® E&M Services Guidelines and Exhibit #1 for office or other outpatient services.

To justify the level of E&M service billed based on time, the provider shall not count the time spent on other reportable codes.

(2) New or Established Patients:

An E&M visit shall be billed as a "new" patient service for each new injury or new Colorado workers' compensation claim even if the provider has seen the injured worker within the last three years.

Any subsequent E&M visits for the same injury billed by the same provider or another provider of the same specialty or subspecialty in the same group practice shall be billed as an "established patient" visit.

Transfer of care from one physician to another with the same tax ID and specialty or subspecialty shall be billed as an "established patient" regardless of location.

(3) Number of Office Visits:

All providers are limited to one office visit per injured worker, per day, per workers' compensation claim, unless prior authorization is obtained.

(4) Treating Physician Telephone or On-line Services:
Minimum required documentation elements include:

(a) Total time spent on medical discussion and date;

(b) The injured worker, family member, or healthcare provider spoken with; and

(c) Specific discussion and/or decision(s) made during the discussion.

Telephone or on-line services may be billed even if performed within the one day and seven day timelines listed in CPT®.

(5) Consultation/Referrals/Transfers of Care/Independent Medical Examinations:

A consultation occurs when a treating Physician seeks an opinion from another

Physician regarding an injured worker's diagnosis and/or treatment beyond the treating Physician's expertise. CPT® 99242-99245 are payable codes.

To bill for a consultation, the Physician must document the following:

(a) Identity of the Physician requesting the opinion;

(b) The need for a consultant's opinion;

(c) Statement that the report was submitted to the requesting Physician.

A transfer of care occurs when one Physician turns over the responsibility for the comprehensive care of an injured worker to another Physician.

An independent medical exam (IME) occurs when a Physician is requested to evaluate an injured worker by any party or party's representative and is billed in accordance with section 18-7(G).

(6) Prolonged Services:

Providers shall document the medical necessity of prolonged services utilizing patient-specific information. Providers shall comply with all applicable CPT® requirements and the following additional requirements.

(a) Physicians or other qualified healthcare professionals (MDs, DOs, DCs, DMPs, NPs, and PAs) billing for extensive record review shall document the names of providers and dates of service reviewed, as well as briefly summarize each record reviewed.

(b) Prolonged clinical staff services (RNs or LPNs) with physician or other qualified healthcare professional supervision:

(i) The supervising physician or other qualified healthcare professional may not bill for the time spent supervising clinical staff.

(ii) Clinical staff services cannot be provided in an urgent care or emergency department setting.

(c) Providers shall bill the CPT® code for prolonged services.

CPT® 99417	Non-facility RVU is .92, facility RVU is .89
CPT® 99418	Non-facility and facility RVUs are 1.16

(C) ANESTHESIA

(1) All anesthesia base values are set forth in Medicare's Anesthesia Base Units by CPT® code, as incorporated by 18-2. Anesthesia services are only reimbursable if the anesthesia is administered by a Physician, a Certified Registered Nurse Anesthetist (CRNA), or an Anesthesiologist Assistant (AA) who remains in constant attendance during the procedure for the sole purpose of rendering anesthesia.

When a CRNA or AA administers anesthesia:

(a) CRNAs not under the medical direction of an Anesthesiologist shall be reimbursed 90% of the maximum anesthesia value;

(b) If billed separately, CRNAs and AAs under the medical direction of an Anesthesiologist shall be reimbursed 50% of the maximum anesthesia value. The other 50% is payable to the Anesthesiologist providing the medical direction to the CRNA or AA;

(c) Medical direction for administering anesthesia means the Anesthesiologist performs the following:

(i) examines and evaluates the injured worker before administering

anesthesia;

(ii) prescribes the anesthesia plan;

(iii) personally participates in the most demanding procedures in the anesthesia plan including, if applicable, induction and emergence;

(iv) ensures that any procedure in the anesthesia plan is performed by a qualified anesthetist;

(v) monitors anesthesia administration at frequent intervals;

(vi) remains physically present and available for immediate diagnosis and treatment of emergencies; and

(vii) provides indicated post-anesthesia care.

(2) HCPCS Level II modifiers are required when billing for anesthesia services. Modifier AD shall be used when an Anesthesiologist supervises more than four concurrent (occurring at the same time) anesthesia service cases. Maximum allowance for supervising multiple cases is calculated using three base anesthesia units for each case, regardless of the number of base anesthesia units assigned to each specific anesthesia episode of care.

(3) Physical status modifiers are reimbursed as follows, using the Anesthesia CF:

P-1	Healthy patient	0 RVUs
P-2	Patient with mild systemic disease	0 RVUs
P-3	Patient with severe systemic disease	1 RVU
P-4	Patient with severe systemic disease that is a constant threat to life	2 RVUs
P-5	A moribund patient who is not expected to survive without the operation	3 RVUs
P-6	A declared brain-dead patient whose organs are being removed for donor purposes	0 RVUs

(4) Qualifying circumstance codes are reimbursed using the Anesthesia CF:

Anesthesia complicated by extreme age (under one or over 70 yrs)	1 RVU
Anesthesia complicated by utilization of total body hypothermia	5 RVUs
Anesthesia complicated by utilization of controlled hypotension	5 RVUs
Anesthesia complicated by emergency conditions (specify)	2 RVUs

(5) Multiple procedures are billed in accordance with CPT®. When more than one surgical procedure is performed during a single episode, only the highest-valued base anesthesia procedure value is added to the total anesthesia time for all procedures.

(6) Total minutes are reported for reimbursement. Each 15-minutes of anesthesia time

equals one additional RVU. Five minutes or more is considered significant time and adds one RVU to the payment calculation.

(7) Calculation of Maximum Allowance for Anesthesia:

(a) Add the anesthesia base units, one unit for each 15 minutes of anesthesia time, and any physical status modifier units to calculate total relative value anesthesia units;

(b) Multiply the total relative value anesthesia units by the Anesthesia CF to calculate the total maximum anesthesia allowance.

(8) Non-time based anesthesia procedures shall be billed with modifier 47.

(D) SURGERY

(1) Assistant Surgeons Payment Policies and Modifiers:

(a) The use of assistant surgeons shall be limited according to the American College of Surgeons' Physicians as Assistants at Surgery: 2023 Update (February 2023), available from the American College of Surgeons, Chicago, IL, or from its web page.

Provider shall document the medical necessity for any assistant surgeon in the operative report.

(b) Payment for more than one assistant surgeon or minimum assistant surgeon requires prior authorization.

(c) Maximum allowance for an assistant surgeon reported by a physician, as indicated by modifier 80, 81, or 82 is 20% of the fee schedule allowance.

(d) Maximum allowance for a minimum assistant surgeon, reported by a non-physician, as indicated by modifier AS is 10% of the fee schedule allowance (the 85% adjustment in section 18-4(A)(2)(b) does not apply).

(e) The services performed by registered surgical technologists are bundled fees and are not separately payable.

See section 18-4(A)(3) for additional payment policies applicable to assistant surgeons.

(2) Global Package:

(a) Global surgical package rules apply in any setting, including inpatient and outpatient hospitals, ambulatory surgical centers, and physicians' offices. The payment rules for global surgical packages apply to surgical procedure codes with global surgery indicators of 000, 010, 090, and sometimes YYY. In addition to the services included pursuant to CPT®, the following services, when provided within the global period by a provider with the same specialty reporting the same Federal Employer Identification Number (FEIN), are included in the global surgical package:

(i) Pre-operative services performed within the global period (the day before surgery for procedures with global surgery indicators of 090, and the day of the surgery for all other procedures);

(ii) Complications following a procedure that require services of the physician, but not a return trip to the operating room;

(iii) Post-operative visits, including follow-up E&Ms, related to the patient recovery;

(iv) Post-surgical pain management;

(v) Supplies related to the procedure, unless otherwise addressed in this Rule;

(vi) Miscellaneous services related to the procedure such as dressing changes; local incision care; removal of operative pack; removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, and nasogastric and rectal tubes; and changes/removal of tracheostomy tubes.

(b) Services not included in the global surgical package:

(i) Services by a provider who is not the same specialty unless the surgeon and the other provider agree on the transfer of care (for transfers of care, see pre-, intra-, and post- operative percentage modifiers);

(ii) The E&M service that resulted in the initial decision to perform the surgery. billed with modifier 57;

(iii) Visits that are unrelated to the diagnosis for which the procedure was performed, billed with modifier 24 or 25;

(iv) Diagnostic tests and procedures (including lab and x-ray);

(v) Staged or related procedures or services that occur on the same day or staged over a couple of days, billed with modifier 58. The maximum allowance is 100% of the fee schedule.

(vi) Clearly distinct procedures during the post-operative period that are not re-operations or treatment for complications;

(vii) Treatment for post-operative complications requiring a return trip to the operating room or another place of service specifically equipped and staffed for the sole purpose of performing procedures, billed with modifier 78. The maximum allowance is the intra-operative value of the procedure(s) performed only and the original post-operative global days continue from the initial surgical procedure(s).

(viii) Increased procedural services (the work required to provide a service is substantially greater than typically required), billed with modifier 22. The Payer and Provider shall negotiate the value based on the fee schedule and the amount of additional work.

(ix) Significant and separately identifiable services, billed with modifier 24 or 25. These services are not considered part of the surgical procedure, but may be necessary to stabilize the patient for the procedure. These services may involve unusual circumstances, complications, exacerbations, or recurrences; and/or unrelated diseases or injuries. This category also includes an E&M visit by an ATP for disability management. Disability management for the same diagnosis requires the physician to identify specific disability management detail performed during that visit.

(x) Casting supplies if a related fracture or surgical care code is not billed. The HCPCS Level II “Q” code(s) are used for reporting any associated DMEPOS fees.

(xi) Immunosuppressive therapy for organ transplants.

(3) General Surgical Payment Policies:

(a) Exploration of a surgical site is not separately payable except in cases of a traumatic wound or an exploration performed in a separate anatomic location.

(b) An arthroscopy performed as a “scout” procedure to assess the surgical field or extent of disease is bundled into the surgical procedure performed on the same body part during the same surgical encounter and is not separately payable.

(c) An arthroscopy converted to an open procedure is bundled into the open procedure and is not separately payable. In this circumstance, providers shall not report either a surgical arthroscopy or a diagnostic arthroscopy code.

(d) Only the joints/compartments listed in subsections (4) through (6) below are recognized for separate payment purposes.

(e) Providers shall report only one removal code for removal of implants through the same incision, same anatomical site, or a single implant system during the same episode of care.

(4) Knee Arthroscopies:

(a) Medial, lateral, and patella are the knee compartments recognized for purposes of separate payment of debridement and synovectomies.

(b) Chondroplasty is separately payable with another knee arthroscopy only if performed in a different knee compartment or to remove a loose/foreign body during a meniscectomy. The separate payment must comply with all applicable CPT® guidelines.

(c) Limited synovectomy involving one knee compartment is not separately payable with another arthroscopic procedure on the same knee.

(d) Separate payment for a major synovectomy procedure requires a synovial diagnosis and two or more knee compartments without any other arthroscopic surgical procedures performed in the same compartment.

(5) Shoulder Arthroscopies:

CPT® 29822 is not separately payable when another shoulder arthroscopy procedure is billed and paid on the same shoulder at the same encounter. CPT® 29823 is bundled with CPT® 29806 and 29807.

(6) Spine and Nervous System:

(a) Spinal manipulation is integral to spinal surgical procedures and is not separately payable.

(b) Surgeon performing a spinal procedure shall not report intra-operative neurophysiology monitoring/testing codes.

(c) If multiple procedures from the same CPT® code family are performed at contiguous vertebral levels, provider shall append modifier 51 to all lesser-valued primary codes. See section 18-4(A)(3) for applicable payment policies.

(d) Fluoroscopy is separately payable with spinal procedures only if indicated by a specific CPT® instruction.

(e) Lumbar laminotomies and laminectomies performed with arthrodesis at the same interspace are separately payable if the surgeon identifies the

additional work performed to decompress the thecal sac and/or spinal nerve(s). If these procedures are performed at the same level, provider shall append modifier 51 to the lesser-valued procedure(s). If procedures are performed at different interspaces, provider shall append modifier 59 to the lesser-valued procedure(s). See section 18-4(A)(3) for applicable payment policies.

(f) Only one anterior or posterior instrumentation performed through a single skin incision is payable.

(g) Anterior instrumentation performed to anchor an inter-body biomechanical device to the intervertebral disc space is not separately payable.

(h) Anterior instrumentation unrelated to anchoring the device is separately payable with modifier 59 appended.

(7) Venipuncture maximum fee allowance is addressed in section 18-4(F)(2).

(8) Platelet Rich Plasma (PRP) Injections:

The maximum allowance includes and applies to all body parts, imaging guidance, harvesting, preparation, the injection itself, kits, and supplies.

CPT® 0232T Non-facility RVU is 11.16, facility RVU is 4.04

(9) Functional Assessments:

If all requirements of the Medical Treatment Guidelines for pre- and post- injection functional assessments have been met and documented, the billing codes and maximum allowances are as follows:

DOWC Z0811, $64.26, per episode for the initial functional assessment of pre-injection care, related to spinal or SI joint injections (may be performed by injectionist or non-injectionist no more than seven days prior to the injection).

DOWC Z0812, $35.29, for a subsequent visit of therapeutic post-injection care (preferably done by a non-injectionist and at least seven days after the injection), billed along with the appropriate E&M code, related to follow-up care of spinal or SI joint injections. The injured worker should provide post injection data.

DOWC Z0814, $35.29, for post-diagnostic injection care (repeat functional assessment within the time period for the effective agent given).

(E) RADIOLOGY

(1) Payments:

(a) The Division recognizes the value of accreditation for quality and safe radiological imaging. Only offices/facilities that have attained accreditation from American College of Radiology (ACR), Intersocietal Accreditation Commission (IAC), RadSite, or The Joint Commission (TJC) may bill the technical component for Advanced Diagnostic Imaging (ADI) procedures (magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine scan). Providers reporting technical or total component of these services certify accreditation status. The provider shall supply proof of accreditation upon Payer request.

(b) The cost of dye and contrast materials shall be reimbursed in accordance with section 18-6(A).

(c) Copying charges for X-rays and MRIs shall be $15.00/film regardless of the size of the film.

(d) Providers using film instead of digital X-rays shall append the FX modifier.

The allowance is 80% of the Maximum Fee Schedule.

If a physician interprets the same radiological image more than once, or if multiple physicians interpret the same radiological image, only one interpretation shall be reimbursed.

If an X-ray consultation is requested, the consultant's report shall include the name of the requesting provider, the reason for the request, and documentation that the report was sent to the requesting provider.

The maximum allowance for an X-ray consultation shall be no greater than the maximum allowance for the professional component of the original X-ray.

The time a physician spends reviewing and/or interpreting an existing radiological image is considered a part of the physician's E&M service code.

(2) Thermography:

(a) The provider supervising and interpreting the thermographic evaluation shall be certified by the examining board of one of the following national organizations and follow their recognized protocols, or have equivalent documented training:

(i) American Academy of Thermology;

(ii) American Chiropractic College of Infrared Imaging; or

(iii) American Academy of Infrared Imaging.

(b) Thermography Billing Codes:

DoWC Z0200 Upper Body w/ Autonomic Stress Testing	$980.00
DoWC Z0201 Lower Body w/Autonomic Stress Testing	$980.00

(c) Documentation must include:

(i) Method of stress thermography supporting it was accomplished in a guideline-consistent fashion (cold water stress test, warm water stress test, or whole body thermal stress);

(ii) Temperature readings via infrared thermography and their locations on the affected and contralateral extremity and/or copies of any pictures or graphics obtained; and

(iii) Interpretation of the results.

(F) PATHOLOGY

(1) Clinical Laboratory Improvement Amendments (CLIA):

Only laboratories with a CLIA certificate of waiver may perform tests cleared by the Food and Drug Administration (FDA) as waived tests. Laboratories with a CLIA certificate of waiver, or other providers billing for services performed by these laboratories, shall bill using the QW modifier.

Laboratories with a CLIA certificate of compliance or accreditation may perform non- waived tests. Laboratories with a CLIA certificate of compliance or accreditation, or other providers billing for services performed by these laboratories, do not append the QW modifier.

(2) Payments:

All clinical pathology laboratory tests, except as allowed by this Rule, are reimbursed at 170% of the rate listed in the CMS Clinical Diagnostic Laboratory Fee Schedule, as incorporated by section 18-2.

Technical or professional component maximum split is not separately payable, and therefore should be negotiated between billing parties when applicable.

When a physician clinical pathologist is required for consultation and interpretation, and a separate written report is created, the maximum allowance is determined by using RBRVS values and the Pathology CF. The Pathology CF also determines the maximum allowance when the Pathology CPT® code description includes "interpretation" and "report" or when billing CPT® codes for the following services:

(a) physician blood bank services;

(b) cytopathology and cell marker study interpretations;

(c) cytogenics or molecular cytogenics interpretation and report;

(d) surgical pathology gross and microscopic and special stain groups 1 and 2 and histochemical stain, blood or bone marrow interpretations; and

(e) skin tests for unlisted antigen each, coccidoidomycosis, histoplasmosis, TB intradermal.

When ordering automated laboratory tests, the ordering physician may seek verbal consultation with the pathologist in charge of the laboratory's policy, procedures and staff qualifications. The consultation with the ordering physician is not payable unless the physician requested additional medical interpretation, judgment, and a separate written report. Upon such a request, the pathologist may bill using the appropriate CPT® code, not DoWC Z0755.

The maximum allowance for CPT® 80050 is $39.95 (equal to the total allowance for CPT® 80053, 85004, and 85027).

(3) Clinical Drug Screening and Testing:

Clinical drug screening and testing may be appropriate for therapeutic drug monitoring, to assess compliance, or to identify illicit or non-prescribed drug use.

(a) Billing requirements for clinical drug testing:

(i) documentation of medical necessity by the ordering Physician.

(ii) the ordering Physician shall specify which drugs require definitive testing to meet the injured worker's medical needs.

(iii) a Physician order for quantification of illicit or non-prescribed drugs or drug classes.

(b) Presumptive Tests:

All drug class immunoassays or enzymatic methods are considered presumptive. Payers shall only pay for one presumptive test per date of service, regardless of the number of drug classes tested.

(c) Definitive qualitative or quantitative tests identify specific drug(s) and any associated metabolites, providing sensitive and specific results expressed as a concentration in ng/mL or as the identity of a specific drug.

- These tests may be billed using G0480-G0483.
- Providers may only bill one definitive HCPCS Level II code per day.

A Physician must order definitive quantitative tests. The reasons for ordering a definitive quantification drug test may include:

- Unexpected positive presumptive or qualitative test results inadequately explained by the injured worker.

- Unexpected negative presumptive or qualitative test results and suspected medication diversion.
- Differentiate drug compliance:
  - Buprenorphine vs. norbuprenorphine
  - Oxycodone vs. oxymorphone and noroxycodone
- Need for quantitative levels to compare with established benchmarks for clinical decision-making, such as tetrahydro-cannabinol quantitation to document discontinuation of a drug.
- Chronic opioid management:
  - Drug testing shall be done prior to the implementation of the initial long-term drug prescription and randomly repeated at least annually.
  - While the injured worker receives chronic opioid management, additional drug screens with documented justification may be conducted (see section 18-9(A) for examples).

CPT® lists definitive drug classes and examples of individual drugs within each class. Each class of drug can only be billed once per day.

(G) MEDICINE

(1) Biofeedback:

Licensed medical and mental health professionals who provide biofeedback must practice within the scope of their training. Non-licensed biofeedback providers must hold Clinical Certification from the Biofeedback Certification International Alliance (BCIA), practice within the scope of their training, and receive prior approval of their biofeedback treatment plan from the injured worker's authorized treating Physician, or Psychologist. Professionals integrating biofeedback with any form of psychotherapy must be a Psychologist, a Clinical Social Worker, a Marriage and Family Therapist, or a Professional Counselor.

All biofeedback providers shall document biofeedback instruments used during each visit (including, but not limited to, surface electromyography (SEMG), heart rate variability (HRV), electroencephalogram (EEG), or temperature training), placement of instruments, and patient response if sufficient time has passed.

The modified RVUs for biofeedback are:

CPT® 90901	Non-facility RVU is 1.78, facility RVU is 1.76
CPT® 90875	Non-facility RVU is 2.13, facility RVU is 1.82

Psychophysiological therapy incorporating biofeedback is not subject to a reduction when performed by non-physician providers.

(2) Appendix J of CPT® identifies mixed, motor, and sensory nerve conduction studies and applicable billing requirements. For purposes of Appendix J, each nerve branch listed in that appendix counts as a separate nerve. Electromyography (EMG) and nerve conduction velocity values generally include an E&M service. However, an E&M service may be separately payable if the requirements listed in Appendix A of CPT® for billing modifier 25 have been met.

(3) Manipulation -- Chiropractic (DC), Medical (MD) and Osteopathic (DO):

(a) Prior authorization shall be obtained before billing for more than four body regions in one visit.

(b) Osteopathic Manipulative Treatment and Chiropractic Manipulative Treatment codes include manual therapy techniques, unless the Physician performs manual therapy in a separate region and meets modifier 59 requirements.

(c) The modified RVUs for chiropractic spinal manipulative treatment are:

CPT® 98940	Non-facility RVU is 1.03, facility RVU is 0.81
CPT® 98941	Non-facility RVU is 1.48, facility RVU is 1.26

(4) Psychiatric/Psychological Services:

(a) The maximum allowance for services performed by a Psychologist is 100% of the Medical Fee Schedule. The maximum allowance for psychological/ psychiatric services performed by other non-physician providers is 85% of the Medical Fee Schedule.

(b) Psychological diagnostic evaluation code(s) are limited to one per provider, per admitted claim, unless it is authorized by the Payer or is necessary to complete an impairment rating recommendation as determined by the ATP.

(c) Central Nervous System (CNS) Assessments/Tests:

When testing, evaluation, administration, and scoring services are provided across multiple dates of service, all codes should be billed on the last date of service when the evaluation process is completed. A base code shall be billed only for the first unit of service of the evaluation process, and add-on codes shall be used to capture services provided during subsequent dates of service. The limit for these services is 16 hours unless the provider obtains prior authorization.

Documentation shall include the total time and the approximate time spent on each of the following activities, when performed:

- face-to-face time with the patient;
- reviewing and interpreting standardized test results and clinical data;
- integrating patient data;
- clinical decision-making and treatment planning;
- report preparation.

If there is a delay in scheduling the feedback session, the provider may incorporate feedback into the first psychotherapy session.

The modified RVUs for psychological and neuropsychological services are:

CPT® 96116	Non-facility RVU is 3.50, facility RVU is 3.07
CPT® 96127	Non-facility and facility RVUs are 0.19
CPT® 96130	Non-facility RVU is 3.74, facility RVU is 3.50
CPT® 96131	Non-facility RVU is 3.00, facility RVU is 2.81
CPT® 96132	Non-facility RVU is 4.23, facility RVU is 3.29
CPT® 96133	Non-facility RVU is 3.20, facility RVU is 2.51
CPT® 96146	Non-facility and facility RVUs are 0.10
CPT® 90791	Non-facility RVU is 10.2, facility RVU is 8.80
CPT® 90792	Non-facility RVU is 11.45, facility RVU is 10.3

(d) The limit for psychotherapy services is 60 minutes per visit, unless provider obtains prior authorization. The time for internal record review/ documentation is included in this limit.

Psychotherapy for work-related conditions continuing for more than three months after the initiation of therapy requires prior authorization unless the MTGs recommend a longer duration.

(e) When billing an E&M code in addition to psychotherapy:

(i) both services must be separately identifiable;

(ii) the level of E&M is based on history, exam, and medical decision-making;

(iii) time may not be used as the basis for the E&M code selection; and

(iv) add-on psychotherapy codes are to be used by psychiatrists to indicate both services were provided.

Non-medical disciplines cannot bill most E&M codes.

(f) A provider billing for any stored clinical or physiological data analysis must obtain prior authorization.

(g) Upon request of a party to a workers' compensation claim and pursuant to HIPAA regulations, a psychiatrist, psychologist or other qualified healthcare professional may generate a separate report and bill for that service as a special report.

(5) Telephone or On-Line Services:

Reimbursement for coordination of care between medical professionals is limited to professionals outside of the provider's practice.

Telephone services, including those listed in Appendix T and Telephone Services section of CPT®, shall be billed with a modifier 93.

The modified RVUs for the telephone and on-line services are:

CPT® 99421	Non-facility and facility RVUs are 0.38
CPT® 99422	Non-facility and facility RVUs are 0.75
CPT® 99423	Non-facility and facility RVUs are 1.19
CPT® 99441	Non-facility and facility RVUs are 1.03
CPT® 99442	Non-facility and facility RVUs are 1.95
CPT® 99443	Non-facility and facility RVUs are 2.86
CPT® 98966	Non-facility and facility RVUs are 0.27
CPT® 98967	Non-facility and facility RVUs are 0.53
CPT® 98968	Non-facility and facility RVUs are 0.75

For reimbursement of face-to-face or telephonic meetings by a treating Physician or Psychologist with employer, claim representative, or attorney, see section 18-7(A)(1).

(6) Quantitative Autonomic Testing Battery (ATB) and Autonomic Nervous System Testing:

(a) Quantitative Sudomotor Axon Reflex Test (QSART) is a diagnostic test used to diagnose Complex Regional Pain Syndrome. This test is performed on a minimum of two extremities and encompasses the

following components:

(i) Resting Sweat Test;

(ii) Stimulated Sweat Test;

(iii) Resting Skin Temperature Test; and

(iv) Interpretation of clinical laboratory scores. Physician must evaluate the patient specific clinical information generated from the test and quantify it into a numerical scale. The data from the test and a separate report interpreting the results of the test must be documented.

(b) DoWC Z0401 QSART, $1,066.00, is billed when all of the services outlined above are completed and documented. This code may only be billed once per workers' compensation claim, regardless of the number of limbs tested.

(7) Intra-Operative Monitoring (IOM):

IOM identifies compromise to the nervous system during certain surgical procedures. Evoked responses are constantly monitored for changes that could imply damage to the nervous system.

(a) Clinical Services:

(i) Technical staff: A qualified technician shall set up the monitoring equipment in the operating room. The technician shall be in constant attendance in the operating room with the physical or electronic capacity for real-time communication with the supervising neurologist or other physician trained in neurophysiology. The technician shall be specifically trained in/registered with:

- the American Society of Neurophysiologic Monitoring; or
- the American Society of Electrodiagnostic Technologists

(ii) Professional/Supervisory/Interpretive:

A Colorado-licensed Physician trained in neurophysiology shall monitor the patient's nervous system throughout the surgical procedure. The monitoring Physician's time is billed based upon the actual time the Physician devotes to the individual patient, even if the Physician is monitoring more than one patient. The monitoring Physician's time does not have to be continuous for each patient and may be cumulative. The Physician shall not monitor more than three surgical patients at one time. The Physician shall provide constant neuromonitoring at critical points during the surgical procedure as indicated by the surgeon or any unanticipated testing responses. There must be a neurophysiology-trained Colorado licensed Physician backup available to continue monitoring the other two patients if one of the patients being monitored has complications and/or requires the monitoring Physician's undivided attention. There is no additional payment for the back-up neuro-monitoring Physician, unless utilized.

(b) Procedures and Time Reporting:

Physicians shall include an interpretive written report for all primary billed procedures.

(c) Billing Restrictions:

Intra-operative neurophysiology codes do not have separate professional and technical components. However, certain tests performed in conjunction with these services have separate professional and technical components, which may be separately payable if documented and otherwise allowed in this Rule.

The neuromonitoring Physician is the only party allowed to report these codes.

The maximum allowance for CPT® 95941 is equal to the maximum allowance for CPT® 95940.

(8) Speech-language therapy/pathology or any care rendered under a speech-language therapy/pathology plan of care shall be billed with a GN modifier.

(9) Hearing and vision services are separately payable with a code from the Medicine Section of CPT®, in addition to the supplies payable per section 18-6(A)(1)(f). The maximum allowances for the following codes are as follows:

CPT® 92590	Non-facility value is $165.90, facility value is $93.80
CPT® 92591	Non-facility value is $248.78, facility value is $140.56
CPT® 92592	Non-facility value is $60.31, facility value is $34.07
CPT® 92593	Non-facility value is $90.46, facility value is $51.11
CPT® 92594	Non-facility value is $60.31, facility value is $34.07
CPT® 92595	Non-facility value is $90.46, facility value is $51.11

(10) Vaccines, toxoids, immune globulins (including those with status “I”), serums, or recombinant products shall be billed using the appropriate J code or CPT® code listed in the Medicare Part B Drug Average Sale Price (ASP), as incorporated by Rule 18-2, unless the ASP value does not exist for the drug or the provider’s actual cost exceeds the ASP. In these circumstances, the provider may request reimbursement based on the actual cost, after taking into account any discounts/rebates the provider may have received.

The maximum allowance for CPT® 90371 is $800.

(11) IV infusion therapy performed in a Physician’s office or sent home with the injured worker shall be billed under the “Therapeutic, Prophylactic, and Diagnostic Injections and Infusions” and the “Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration” in the Medicine Section of CPT®. The maximum allowance for infused therapeutic drugs shall be at cost to the billing provider.

Maximum allowance for supplies and medications provided by a Physician's office for self-administered home care infusion therapy are covered in section 18-6(B).

(12) Moderate (Conscious) Sedation:

Providers billing for moderate sedation services shall comply with all applicable CPT® billing instructions. The maximum allowance is determined using the Medicine CF.

(H) PHYSICAL MEDICINE AND REHABILITATION (PM&R)

(1) General Policies:

(a) Modifiers:

(i) Physical therapy or any care provided under a Physical Therapist's plan of care shall be billed with a GP modifier. Occupational therapy or any care provided under an Occupational Therapist's plan of care shall be billed with a GO modifier.

(ii) Services provided in whole or in part by a Physical Therapist Assistant shall be billed with a CQ modifier. Services provided in whole or in part by an Occupational Therapist Assistant shall be billed with a CO modifier. "In part" is defined as exceeding the CPT® mid-point. The CQ and CO modifiers shall be billed in addition to the GP or GO modifiers.

(b) Each PM&R billed service must be clearly identifiable. The provider must clearly document the time spent performing each service and the beginning and end time for each session.

(c) Functional objectives shall be included in the PM&R plan of care for all injured workers. Any request for additional treatment must be supported by evidence of positive objective functional gains or PM&R treatment plan changes. The ordering ATP must also agree with the PM&R continuation or changes to the treatment plan.

(d) The injured worker shall be re-evaluated by the prescribing provider within 30 calendar days from the initiation of the prescribed treatment and at least once every month thereafter.

(2) Medical nutrition therapy requires prior authorization.

(3) Interdisciplinary Rehabilitation Programs:

As defined in the MTGs, interdisciplinary rehabilitation programs may include, but are not limited to: chronic pain, spinal cord, or brain injury programs.

All billing providers shall detail the services, frequency of services, duration of the program, and proposed fees for the entire program. The billing Provider and Payer shall attempt to agree upon billing code(s) and fee(s) for each interdisciplinary rehabilitation program.

If there is a single billing provider for the entire interdisciplinary rehabilitation program and a daily per diem rate is mutually agreed upon, use code Z0500.

Individual professionals billing separately for their participation in an interdisciplinary rehabilitation program shall use the applicable CPT® codes.

(4) Procedures and Modalities:

(a) Definitions:

(i) Procedure is any treatment listed in the Medicine/Physical Medicine and Rehabilitation section of CPT® under the sub-heading "Therapeutic Procedures." For purposes of this rule, the term "procedure" includes acupuncture.

The billing maximums listed below are per discipline per day, unless medical necessity is documented and prior authorization is obtained. The total amount of time spent performing the procedures shall determine the appropriate number of time based units for a particular visit.

(ii) Modality is any treatment listed in the Medicine/Physical Medicine and Rehabilitation section of CPT® under the sub-heading "Modalities."

(b) Billing Restrictions:

(i) Provider may bill no more than two separate modality codes and no more than 60 minutes or four units of procedure codes on the same visit. This restriction does not apply to Special Tests referenced in subsection (6) below.

(ii) The maximum allowance for services billed by a Massage Therapist shall be 72% of the fee schedule.

(iii) The maximum allowance for services billed with a CQ or CO modifier shall be 85% of the fee schedule.

(iv) If provider performs another service concurrently with a time-based service, the time associated with the concurrent service shall not be included in the time used for reporting the time-based service.

(v) Electrical stimulation is not payable when billed with dry needling and performed on the same body part.

(vi) Providers shall specify all unlisted treatment in the medical record.

CPT® 97139	Non-facility and facility RVUs are 0.87
CPT® 97039	Non-facility and facility RVUs are 0.42

(c) Acupuncture:

(i) All non-physician acupuncture providers must be Licensed Acupuncturists (L.Ac). Both Physician and L.Acs must provide evidence of training, and licensure upon request of the Payer.

(ii) New or established patient evaluation services are payable if the medical record specifies the appropriate history, physical examination, treatment plan, or evaluation of the treatment plan. Only evaluation services directly performed by a Physician or a L.Ac are payable. All evaluation notes or reports must be written and signed by the Physician or the L.Ac.

L.Ac new patient visit:	DOWC Z0800, $103.84
L.Ac established patient visit:	DOWC Z0801, $70.33

(5) Evaluation Services for Physical Therapists (PTs), Occupational Therapists (OTs) and Athletic Trainers (ATs):

(a) All evaluation services must be supported by the appropriate history, physical examination documentation, treatment goals, and treatment plan or re-evaluation of the treatment plan, as outlined in CPT®. The provider shall clearly state the reason for the evaluation, the nature and results of the physical examination, and the reason for recommending the continuation or adjustment of the treatment protocol. The re-evaluation codes shall not be billed for routine pre-treatment patient assessment.

If a new problem or abnormality is encountered that requires a new evaluation and treatment plan, the provider may perform and bill for another initial evaluation. A new problem or abnormality may be caused by a surgical procedure being performed after the initial evaluation has been completed.

A re-examination, re-evaluation, or re-assessment is different from a progress note. Providers shall not bill these codes for a progress note.

Providers may bill a re-evaluation code only if:

(i) professional assessment indicates a significant improvement or decline or change in the injured worker's condition or a functional status that was not anticipated in the plan of care for that time interval;

(ii) new clinical findings become known; or

(iii) the injured worker fails to respond to the treatment outlined in the current plan of care.

(b) A PT or OT may utilize a Rehabilitation Communication Form (WC 196) in addition to a progress note no more than every two weeks for the first six weeks, and once every four weeks thereafter.

The WC 196 form shall not be used for an evaluation, re-evaluation, or re-assessment. The form must be completed and specify which validated functional tool was used for assessing the injured worker. The form shall be sent to the referring physician before or at the injured worker's follow-up appointment with the physician.

DoWC Z0817 $15.61.

(c) Only evaluation services directly performed by a PT, OT, or AT are payable. All evaluation notes or reports must be written and signed by the PT, OT, or AT.

(d) An injured worker may be seen by more than one healthcare professional on the same day. Each professional may charge an evaluation service with appropriate documentation per patient, per day.

(e) The RVU for evaluation services performed by ATs shall be equal to the RVU for evaluation services performed by PTs.

(6) Special Tests:

(a) The following are considered special tests:

(i) Job Site Evaluation

(ii) Functional Capacity Evaluation

(iii) Assistive Technology Assessment

(iv) Speech

(v) Physical performance test or measurement

(b) Billing Restrictions:

(i) The following services require prior authorization: Job site evaluations exceeding two hours; Assistive Technology Assessments and Work Tolerance Screenings for more than four hours per test or more than three tests per claim; and Functional Capacity Evaluations for more than four hours per test or two tests per claim.

(ii) The provider shall specify the time required to perform the test in 15-minute increments.

(iii) The analysis and the written report is included in the code's value.

(iv) No E&M services or PT, OT, or acupuncture evaluations shall be

charged separately for these tests.

(v) Data from computerized equipment shall always include the supporting analysis developed by the PM&R professional before it is payable as a special test.

(c) All special tests must be fully supervised by a Physician, PT, OT, CCC-SLP, or Audiologist. Final reports must be written and signed by the Physician, PT, OT, CCC-SLP, or Audiologist.

(7) Non-Medical Facility Fees:

Gyms, pools, etc., and training or supervision by non-medical providers require prior authorization and a written negotiated fee for every three month period.

(8) Work Hardening, Conditioning and Simulation:

These programs and recommendations for coverage are defined in the MTGs. All procedures must be performed by or under the onsite supervision of a Physician, Psychologist, PT, OT, CCC-SLP, or Audiologist.

CPT® 97545	Non-facility and facility RVUs are 3.39
CPT® 97546	Non-facility and facility RVUs are 1.7

(9) Wound Care:

Wound care is separately payable only when devitalized tissue is debrided using a recognized method (chemical, water, vacuums).

(I) TELEMEDICINE

(1) In addition to the healthcare services listed in Appendix P of CPT®, and Division Z-codes (when appropriate), the following CPT® codes may be provided via telemedicine: G0396, G0397, G0406-G0408, G0425-G0427, G0447, G0459, G0508, G0509, 97129, 97130, 97150, 97542, and 97763. Additional services may be provided via telemedicine with prior authorization. The provider shall append modifier 95 to the appropriate CPT® code(s) to indicate synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.

All treatment provided through telemedicine shall comply with the applicable requirements found in the Colorado Medical Practice Act and Colorado Mental Health Practice Act, as well as the rules and policies adopted by the Colorado Medical Board and the Colorado Board of Psychologist Examiners and shall follow applicable laws, rules and regulations for informed consent.

(2) HIPAA privacy and electronic security standards are required for the originating site and the rendering provider.

(3) Reimbursement:

(a) The rendering provider may be the only provider involved in the provision of telemedicine services. The rendering provider shall bill place of service (POS) code 02 or 10. Maximum allowance is the appropriate CPT® code's non- facility relative weight from RBRVS multiplied by the appropriate CF, unless only a facility weight is established.

(b) An originating site fee may only be billed when the injured worker is receiving services at an authorized originating site. The originating site is responsible for verifying the injured worker and rendering provider's identities. Originating site must bill with the appropriate facility POS code. Authorized originating sites include:

- A Hospital (inpatient or outpatient)
- A Critical Access Hospital (CAH)
- A Rural Health Clinic (RHC)
- A federally qualified health center (FQHC)
- A hospital based renal dialysis center (including satellites)
- A Skilled Nursing Facility (SNF)
- A community mental health center (CMHC)

Maximum allowance for Q3014 is $35.00 per 15 minutes. (Equipment, supplies, and professional fees of supporting providers at the originating site are not separately payable.)

(4) Documentation:

Documentation requirements are the same as for a face-to-face encounter and shall also include the location of both the rendering provider and the injured worker at the time of service, and a statement on how the treatment was rendered through telemedicine (such as secured video).

18.5 FACILITY FEES

(A) INPATIENT FACILITY FEES

(1) Billing:

(a) Inpatient facility fees shall be billed on a UB-04 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-04.

(b) Hospitals reimbursed based on MS-DRGs shall indicate the MS-DRG code FL 71 of the UB-04 billing form and maintain documentation on file showing how the MS-DRG was determined. The hospital shall determine the MS-DRG using the MS-DRGs Definitions Manual in effect per section 18-2 at the time of discharge. The attending Physician shall not be required to certify this documentation unless a dispute arises between the hospital and the Payer regarding MS-DRG assignment. The Payer may deny payment for services until the appropriate MS-DRG code is supplied.

(2) Reimbursement:

(a) The following types of inpatient facilities, as defined in Rule 16, are allowed a reasonable charge as negotiated by the Provider and Payer:

(i) Children’s Hospitals

(ii) Veterans Administration Hospitals

(iii) State-run Psychiatric Hospitals

(iv) Psychiatric Hospitals

The provider has the burden of proving reasonableness of reimbursement sought. Veterans Administration Hospital payments must comply with applicable rules promulgated by the United States Department of Veterans Affairs.

(b) The following inpatient facilities, as defined in Rule 16, are allowed a daily rate:

(i) Skilled Nursing Facilities (SNFs) are allowed $663 per day.

(ii) Rehabilitation Hospitals are allowed $1,479 per day.

(iii) Long Term Acute Care Hospitals (LTACHs) are allowed $3,417 per day.

Each of the daily rates listed above is all-inclusive for services related to the injured worker's compensable conditions. Physician's professional services, ambulance services, and chemotherapy drugs or radioisotopes may be billed separately. In the rare case extraordinary medical care is required, or for treatment of traumatic brain injuries or spinal cord injuries, there shall be an additional payment of $306 on a per day basis.

All charges shall be submitted on a final bill, unless the parties agree on interim billing. The rate in effect on the last date of service covered by an interim or final bill shall determine payment.

The total length of stay includes the date of admission but not the date of discharge. Typically, bed hold days or temporary leaves are not subtracted from the total length of stay.

(c) All other inpatient facilities:

The maximum allowance is determined by the relative weights for the assigned MS-DRG from Table 5 in effect per section 18-2 at the time of discharge and the hospital's base rate in Exhibit #2, calculated as follows:

(MS-DRG Relative Wt x Specific hospital base rate x 160%) + (trauma center activation allowance) + (organ acquisition, when appropriate)

(i) For trauma center activation allowance, (revenue codes 680-684) see subsection (B)(7)(c);

(ii) For organ acquisition allowance, (revenue codes 810-819) see subsection (A)(2)(g).

Table 5 establishes the maximum length of stay (LOS) using the "arithmetic mean LOS." However, there is no additional allowance for exceeding this LOS, other than through the cost outlier criteria.

An admission requiring the use of both an acute care hospital (admission/discharge) and its Rehabilitation Hospital (admission/discharge) is considered as one admission and MS-DRG.

(d) Outliers for inpatient hospitals identified in Exhibit #2:

Outliers are admissions with extraordinary cost warranting additional reimbursement beyond the maximum allowance. To calculate the additional reimbursement, if any:

(i) Determine the hospital's cost by multiplying total billed charges (excluding any trauma center activation or organ acquisition billed charges) by the hospital's cost-to-charge ratio located in Exhibit #2;

(ii) The difference = hospital's cost – maximum allowance excluding any trauma center activation or organ acquisition allowance;

(iii) If the difference is greater than $38,859, additional reimbursement is warranted. The additional allowance is determined by multiplying the difference by .80.

(e) If an injured worker is admitted to a hospital through the emergency department (ED), the ED fee is included in the inpatient allowance.

(f) If an injured worker is admitted to one hospital and is subsequently

transferred to another hospital, the payment to each hospital will be based upon a per diem value of the MS-DRG maximum allowance. The per diem value is calculated based upon the individual hospital's MS-DRG relative weight multiplied by the hospital's specific base rate divided by the MS-DRG geometric mean LOS established in Table 5. This per diem amount is multiplied by the actual LOS. If the patient is admitted and transferred on the same day, or transferred and discharged on the same day, the actual LOS equals one. If the LOS is greater than or equal to the geometric mean LOS for the MS-DRG, then the maximum MS-DRG is allowed for that hospital.

(g) The Payer shall compare each billed charge type:

(i) The MS-DRG adjusted billed charges to the MS-DRG allowance (including any outlier allowance);

(ii) The trauma center activation billed charge to the trauma center activation allowance; and

(iii) The organ acquisition billed charges to the organ acquisition allowance.

The MS-DRG adjusted billed charges are determined by subtracting the trauma center activation billed charge and the organ acquisition billed charges from the total billed charges. The final payment is the sum of the lesser of each of these comparisons.

The organ acquisition allowance is calculated using the most recent filed computation of organ acquisition costs and charges for hospitals that are certified transplant centers (CMS Worksheet D-4 or subsequent form) plus 20%.

(B) OUTPATIENT FACILITY FEES

(1) Provider Restrictions:

(a) All non-emergency outpatient surgeries require prior authorization unless the MTGs recommend a surgery for the particular condition. All outpatient surgical procedures performed in an ASC shall warrant performance at an ASC level.

(b) A facility fee is payable only if the facility is licensed as a hospital or an ASC by the Colorado Department of Public Health and Environment (CDPHE) or applicable out of state governing agency or statute.

(2) Types of Bills for Service:

(a) Outpatient facility fees shall be billed on a UB-04 and require summary level billing by revenue code. The provider must submit itemized bills along with the UB-04.

(b) All professional charges (professional services including, but not limited to, PT, OT, CCC-SLP, anesthesia, etc.) are subject to the RBRVS and Dental Fee Schedules as incorporated by this Rule. These fee schedules apply to professional services performed in all facilities.

(c) Outpatient hospital facility bills include all outpatient surgery, ED, clinics, Urgent Care, and diagnostic testing in the Radiology, Pathology or Medicine Section of CPT®/RBRVS.

(3) General Reimbursement Instructions:

(a) The following outpatient facilities, as defined in Rule 16, are allowed a

reasonable charge, as negotiated by the Provider and Payer, except for any associated professional fees that are reimbursed per section 18-4:

(i) Children's Hospitals

(ii) Veterans Administration Hospitals

(iii) State-run Psychiatric Hospitals

The Provider has the burden of proving reasonableness of reimbursement sought. Veterans Administration Hospital payments must comply with applicable rules promulgated by the United States Department of Veterans Affairs.

(b) The maximum allowance for Ambulatory Payment Classifications (APC) is calculated at the following percentages of the payment rates listed in Medicare's OPPS Addendum A, as incorporated by 18-2:

(i) Outpatient hospital is 160%

(ii) CAH is 200%

(iii) ASC is 150%

To identify which APC grouper is aligned with a CPT® code and dollar value, use Medicare's Addendum B, as incorporated by 18-2. For comprehensive APCs (C-APCs), see 18-5(B)(6).

(c) CPT® codes listed with a "C" status indicator in Medicare's Addendum B shall align to the APC codes as listed in Exhibit #4. The status indicator assigned to the Exhibit #4 APC code, as identified in Medicare's Addendum A, shall apply. These codes are not eligible for complexity-adjusted APC payments.

(d) Facilities receive the lesser of the actual charge or the fee schedule allowance. A line-by-line comparison of charges is not appropriate.

(4) APC values include the services and revenue codes listed in Table 2 of the 2022 NFRM OPPS Claims Accounting, as incorporated by Rule 18-2; therefore, these are generally not separately payable. Drugs and devices having a status indicator of G and H receive a pass-through payment. In some instances, the procedure code may have an APC code assigned. These are separately payable based on APC values, if given, or at cost to the facility.

Services and items included in the APC value:

(a) nursing, technician, and related services;

(b) use of the facility where the surgical procedure(s) was performed;

(c) drugs and biologicals for which separate payment is not allowed;

(d) medical and surgical supplies, durable medical equipment and orthotics not listed as a "pass through";

(e) surgical dressings;

(f) equipment;

(g) splints, casts and related devices;

(h) radiology services for which separate payment is not allowed;

(i) administrative, record keeping, and housekeeping items and services;

(j) materials, including supplies and equipment for the administration and monitoring of anesthesia;

(k) supervision of the services of an anesthetist by the operating surgeon;

(l) post-operative pain blocks; and

(m) implanted items.

(5) Status Indicators from Medicare's Addendum B apply as follows:

Indicator	Meaning
A	Use another fee schedule instead of Addendum B, such as conversion factors listed in section 18-4, RBRVS RVUs, Ambulance Fee Schedule, or section 18-4(F)(2).
B	Is not recognized for Outpatient Hospital Services bill type (12x and 13x) and therefore is not separately payable unless separate fees are applicable under another section of this Rule.
C	The Division recognizes these procedures on an outpatient basis with prior authorization.
E	Not generally reimbursable when submitted on any outpatient bill type. However, services could still be reasonable and necessary, thus requiring hospital or ASC level of care. The billing party shall submit documentation to substantiate the billed service codes and any similar established codes with fees in Addendum A, as incorporated by 18-2.
F	Corneal tissue acquisition, certain CRNA services, and Hepatitis B vaccines are allowed at a reasonable cost to the facility. The facility must provide a separate invoice identifying its cost.
G	"Pass-Through Drugs and Biologicals"; separate APC payment.
H	"Pass-Through Device"; separate APC payment based on cost to the facility.
J1 or J2	The services are paid through a comprehensive APC.
K	"Nonpass-Through Drug or Biological or Device" for therapeutic radiopharmaceuticals, brachytherapy sources, blood and blood products; separate APC payment.
L	Influenza Vaccine/Pneumococcal Pneumonia Vaccine and therefore is generally considered to be unrelated to work injuries.
M	Not separately payable.
N	Items and services packaged into APC rates; not separately payable.
P	Partial hospitalization paid based on observation fees outlined in this section.
Q1-Q4	Packaged services subject to separate payment criteria.

R	Blood and blood products; separate APC payment.
S	Significant procedure, not discounted when multiple.
T	Significant procedure, multiple procedure reduction applies.
U	Brachytherapy source; separate APC payment.
V	Clinic or an ED visit; separate APC payment.
Y	Non-implantable Durable Medical Equipment paid pursuant to Medicare's Durable Medical Equipment Regional Carrier fee schedule for Colorado.

(6) Multiple Procedures

(a) A comprehensive APC treats all individually reported codes as representing components of the comprehensive service, resulting in a single prospective payment.

As defined by status indicator J1, all covered outpatient services on the claim are packaged with the primary J1 service for payment, except services with a status indicator of F, G, H, L, or U; ambulance services; diagnostic and screening mammography; rehabilitation therapy services reported on a separate claim; new technology services; and self-administered drugs.

When multiple codes with J1 status indicators are included on the claim, services are packaged with the primary (highest APC value) J1 code. Certain J1 codes, when billed together, may be eligible for a complexity adjusted APC payment listed on Medicare's Addendum J, as incorporated by 18-2.

Services with a status indicator J2 are assigned to a comprehensive APC (8011) when specific combinations of services are reported on the claim. All levels of emergency department (ED) and clinic visits, if billed in combination with observation time, can trigger this comprehensive composite rate. Payment of APC 8011 requires a minimum of eight units of G0378 *hospital observation service, per hour*; no status T procedure on the claim; and either an E&M visit on the same day or day before the G0378 date of service; or G0379 *direct admit to observation*.

All covered services on the claim shall be considered adjunct to APC 8011 and packaged into a single payment, except those items excluded by rule. Other excluded services include covered screening procedures, preventative services, pass-through drugs and devices (status indicator G or H), PT, OT, and SLP services reported on a separate claim, certain vaccines (status indicator L or F), cornea tissue acquisition, and new technology APCs with status indicator S. If the claim contains a J1 primary service, the J1 C-APC will be the composite under which the services will be paid. There is no complexity adjustment for J2 occurring on the same claim as J1.

If services with a J2 status indicator are provided during an extended assessment and management encounter, including observation care, and do not meet all the requirements for APC 8011 listed above, the usual APC logic will apply.

(b) Codes with a status Q1 indicator are packaged with the APC payment if billed on the same claim as a HCPCS code assigned status indicator S, T, or V. Otherwise, payment is made through a separate APC.

Codes with a Q2 indicator are packaged with the APC payment if billed on the same claim as a HCPCS code assigned status indicator T. Otherwise, payment is made through a separate APC. When multiple codes with status Q1 or Q2 are billed together, only one unit of the highest-valued Q1 or Q2 code is payable.

Codes with a status Q3 indicator may be paid through a composite APC if billed with another code in the same family listed in Table 3 of the OPPS Imaging Families and Multiple Procedure Composite APCs, of the 2023 OPPS Final Rule. The five multiple imaging composite APCs are:

- APC 8004 (Ultrasound Composite);
- APC 8005 (CT and CTA without Contrast Composite);
- APC 8006 (CT and CTA with Contrast Composite);
- APC 8007 (MRI and MRA without Contrast Composite); and
- APC 8008 (MRI and MRA with Contrast Composite).

Each imaging composite APC is defined as having two or more imaging procedures from the same family performed on the same date of service. If a “without contrast” procedure is performed during the same session as a “with contrast” procedure from the same family, payment would be based on the “with contrast” composite APC. Standard APC assignments apply for single imaging procedures and multiple imaging procedures performed across families.

Codes with a status Q4 indicator are packaged with the APC payment if billed on the same claim as a HCPCS code assigned status indicator S, T, V, Q1, Q2, or Q3. Otherwise, payment is made through a separate APC.

(c) The maximum allowance for multiple procedures with a T status indicator is limited to four procedure codes per episode. The highest valued APC code is allowed at 100% of the maximum allowance, plus 50% of the maximum allowance for the following three highest valued codes.

(i) The use of modifier 51 is not a factor in determining which codes are subject to multiple procedure reductions.

(ii) Bilateral procedures require each procedure to be billed on separate lines using RT and LT modifier(s).

(iii) When a code is billed with multiple units, multiple procedure reductions apply to the second through fourth units as appropriate. Units may also be subject to other maximum frequency per day policies.

(7) Other surgical payment policies:

(a) All surgical procedures performed in one operating room, regardless the number of surgeons, are considered one outpatient surgical episode of care for payment purposes.

(b) Discontinued surgeries require the use of modifier 73 (discontinued prior to the administration of anesthesia) or modifier 74 (discontinued after administration of anesthesia). Modifier 73 results in an allowance of 50% of the APC value for the primary procedure only. Modifier 74 allows 100%

of the primary procedure value only. If a comprehensive APC procedure is discontinued or reduced and modifier 52, 73 or 74 is reported, complexity adjustment will not apply to the claim.

(c) Facilities shall report G0260 when billing for sacroiliac joint injections, not CPT® 27096.

(8) Emergency Department (ED) Visits:

(a) Types of ED Visits:

(i) Hospitals billing type "A" ED visits must be physically located within a hospital licensed by the CDPHE as a general hospital or meet the out-of-state facility's state's licensure requirements, and be open 24 hours a day, seven days a week. These EDs bill using revenue code 450 and applicable CPT® codes;

(ii) A freestanding type "B" ED must have operations and staffing equivalent to a licensed ED, be physically located inside a hospital, and meet Emergency Medical Treatment and Active Labor Act (EMTALA) regulations. All type "B" outpatient ED visits must be billed using revenue code 456 with level of care HCPCS codes G0380-G0384, even though the facility may not be open 24 hours a day, seven days a week.

(b) ED level of care is identified based upon one of five levels of care for either a type "A" or type "B" ED visit. The level of care is defined by CPT® E&M code descriptions and internal level of care guidelines developed by the hospital in compliance with Medicare regulations. The hospital's guidelines should establish an appropriate gradation of hospital resources (ED staff and other resources) as the level of service increases. Upon request, the provider shall supply a copy of its level of care guidelines to the Payer. (Only the higher one of any ED levels or critical care codes shall be paid).

(c) Trauma activation means a trauma team has been activated, not just alerted. Trauma activation is billed with 068X revenue codes. The level of trauma activation shall be determined by CDPHE's assigned hospital trauma level designation. Trauma activation fees are in addition to ED and inpatient fees and are not paid for alerts. APC 5045, Trauma Response with Critical Care, is not recognized for separate payment.

Trauma activation allowances are as follows:

Revenue Code 681	$5,534.00
Revenue Code 682	$2,298.00
Revenue Code 683	$1,289.00
Revenue Code 684	$954.00

(9) Ancillary Services:

(a) Any diagnostic testing, clinical labs, or therapies with a status indicator of "A" shall be reimbursed using section 18-4(F)(2) or the appropriate CF to the unit values for the specific CPT® code as listed in the RBRVS. Hospital bill types 13x are allowed payment for any clinical laboratory services (even if the SI is "N" for the specific clinical laboratory CPT® code) when these laboratory services are unrelated to any other outpatient services performed that day. Off-campus freestanding imaging centers are reimbursed using the RBRVS TC value(s).

(b) Professional fees are reimbursed in accordance with section 18-4

regardless of the facility type. Additional reimbursement is payable for the following services not included in the APC values, as incorporated by 18-2:

(i) ambulance services (revenue code 540), see section 18-6(E)

(ii) blood, blood plasma, platelets (revenue codes 380X)

(iii) physician or physician assistant services

(iv) nurse practitioner services

(v) licensed clinical psychologist

(vi) licensed social workers

(vii) rehabilitation services (PT, OT, respiratory or CCC-SLP, revenue codes 420, 430,440)

(c) Any prescription for a drug supply to be used for longer than 24 hours, filled at any clinic, shall be reimbursed in accordance with section 18-6(C).

(d) Clinic facility fees are not separately payable unless otherwise specified in this Rule.

(e) IV infusion therapy performed in an outpatient hospital facility is separately payable in accordance with this section.

(10) Rural Health Clinics:

Rural Health Clinics are allowed a single separate clinic facility fee at 80% of billed charges per date of service.

Allowed revenue codes for clinic fees are 521 for physical health services and 900 for behavioral health services.

(C) URGENT CARE FACILITIES

(1) Provider Restrictions:

Facility fees are only payable if the facility qualifies as an Urgent Care facility. All Urgent Care facilities shall be accredited or certified by the Urgent Care Association (UCA) or accredited by the Joint Commission to be recognized for a separate facility payment for the initial visit.

(2) Billing and Maximum Allowances:

(a) Facility Fees:

(i) No separate facility fees are allowed for follow-up care. To receive a separate facility fee, a subsequent diagnosis shall be based on a new acute care situation and not the initial diagnosis.

(ii) No facility fee is appropriate when the injured worker is sent to the employer's designated provider for a non-urgent episode of care during regular business hours of 8 am to 5 pm, Monday through Friday.

(iii) Hospitals may bill on a UB-04 using revenue code 516 or 526 and the facility HCPCS code S9088, $76.50, with one unit. All maximum allowances for other services billed on the UB-04 shall be in accordance with CPT® relative weights from RBRVS, multiplied by the appropriate CF.

(iv) Hospital and non-hospital based urgent care facilities may bill for the facility fee, HCPCS code S9088, $76.50, on the CMS-1500 with professional services. All other services and procedures

provided in an urgent care facility, including a freestanding facility, are allowed according to the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate CF.

(b) All professional fees shall be billed on a CMS-1500 with a Place of Service Code 20 and reimbursed in accordance with section 18-4.

(c) All supplies are included in the facility fee.

(d) Any prescription for a drug to be used for longer than 24 hours, filled at any clinic, shall be reimbursed in accordance with section 18-6(C).

18-6 ANCILLARY SERVICES

(A) DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

(1) Durable Medical Equipment (DME):

DME equipment withstands repeated use and allows injured workers accessibility in the home, work, and community. DME can be categorized as:

(a) Purchased Equipment/Capped Rental:

(i) Items that cost $100.00 or less may not be rented.

(ii) Rented items must be purchased or discontinued after ten months of continuous use or once the total fee schedule allowance has been reached.

(iii) The monthly rental rate cannot exceed 10% of the DMEPOS fee schedule, or if not available, the cost of the item to the provider or the supplier (after taking into account any discounts/rebates the supplier or the provider may have received). When the item is purchased, all rental fees shall be deducted from the total fee scheduled price. If necessary, the parties should use an invoice to establish the purchase price.

(iv) Purchased items may require maintenance/servicing agreements or fees. The fees are separately payable. Rented items typically include these fees in the monthly rental rates.

(v) Modifier NU shall be appended for new, UE for used purchased items or modifier RR for rented items.

(b) Take Home Exercise Equipment:

Items with a total invoice cost of $50 or less may be billed using A9300 at no more than 120% of actual cost, without an invoice. Reimbursement shall be based on billed charges. Payers reserve the right to retroactively review invoices to validate the provider's cost, per Rule 16. Home exercise supplies can include, but are not limited to the following items: therabands, theratubes, band/tube straps, theraputty, bow-tie tubing, fitness cables/trainers, overhead pulleys, exercise balls, cuff weights, dumbbells, ankle weight bands, wrist weight bands, hand squeeze balls, flexbars, digiflex hand exercisers, power webs, plyoballs, spring hand grippers, hand helper rubber band units, ankle stretchers, rocker boards, balance paws, and aqua weights.

(c) Electrical Stimulators:

Electrical stimulators are bundled kits that include the portable unit(s), two to four leads and pads, initial battery, electrical adapters, and carrying case. Kits that cost more than $300.00 shall be rented for the first month of use and require documentation of effectiveness prior to purchase (effectiveness means functional improvement and decreased pain).

(i) TENS (Transcutaneous Electric Nerve Stimulator) machines/kits, IF (Interferential) machines/kits, and any other type of electrical stimulator combination kits: E0720 for a kit with two leads or E0730 for a kit with four leads.

(ii) Electrical Muscle Stimulation machines/kits: E0744 for scoliosis; or E0745 for neuromuscular stimulator, electric shock unit.

(iii) Osteogenesis electrical stimulators (E0747-E0760) are not required to be rented before purchase when used in accordance with MTG recommendations.

(iv) Replacement supplies are limited to once per month and are not eligible with a first month rental.

A4595 - electrical stimulator supplies, two leads.
A4557 - lead wires, pair (reimbursable once every 12 months).

(v) Conductive Garments: E0731.

(d) Continuous Passive Motion Devices (CPMs):

These devices are bundled into the facility fees and not separately payable, unless the MTGs recommend their use after discharge for the particular condition.

E0935 – continuous passive motion exercise device for use on the knee only.

E0936 – continuous passive motion exercise device for use on body parts other than knee.

(e) Intermittent Pneumatic Devices:

These devices (including, but not limited to, cold with compression) are bundled into facility fees and are not separately payable. The use of these devices after discharge requires prior authorization.

E0650-E0676 – Codes based on body part(s), segmental or not, gradient pressure and cycling of pressure, and purpose of use.

A4600 – Sleeve for intermittent limb compression device, replacement only, per each limb.

(f) Hearing and Vision Supplies:

These items are purchased. The maximum allowance is 120% of the cost to the provider as indicated by invoice. The maximum allowance for V2623 (prosthetic eye) and L8045 (auricular prosthesis) shall be based on 120% of the cost of the item as indicated by invoice.

(2) Orthotics:

Maximum allowance for any orthotic created using casting materials shall be determined using Medicare's Q codes and values listed under Medicare's DMEPOS fee schedule. The therapist time necessary to create the orthotic shall be billed using CPT® 97760.

Payment for professional services associated with the fabrication and/or modification of orthotics, custom splints, adaptive equipment, and/or adaptation and programming of communication systems and devices shall be paid in accordance with the Colorado Medicare HCPCS Level II values.

(3) Supplies:

Supplies necessary to perform a service or procedure are not separately reimbursable. Only supplies that are not an integral part of a service or procedure are considered to be over and above those usually included in the service or procedure. Allowances for supplies to facilities shall comply with the appropriate section of this Rule.

(4) Reimbursement:

Unless other limitations exist in this Rule, the maximum allowance for DMEPOS suppliers and medical providers shall be based on Medicare's HCPCS Level II codes, when one exists, as established in the January 2023 DMEPOS schedule for rural (R) or non-rural (NR) areas.

If no Medicare value exists, the maximum allowance shall be based on the total allowable amount listed in Medicaid's Health First Colorado Fee Schedule Effective January 1, 2023.

If no Medicaid fee schedule value exists, the maximum allowance is based on 120% of the cost of the item as indicated by invoice. For inventorial items, "invoice" means a statement given to the Provider by its supplier showing the Provider's cost of obtaining the item. For fabricated/customized items, "invoice" means a statement prepared by the Provider showing the amount due after accounting for fabrication and necessary customization. Shipping and handling charges are not separately payable. Payers shall not recognize the KE modifier.

Auto-shipping of monthly DMEPOS is not allowed. An affirmative request by the injured worker or prescribing provider is required.

(5) Complex Rehabilitation Technology dispensed and billed by Non-Physician DMEPOS Suppliers:

(a) Complex rehabilitation technology (CRT) items, including complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, standing frames, and gait trainers enable individuals to maximize their function and minimize the extent and costs of their medical care.

(b) Complex Rehabilitation Technology products must be provided by suppliers who are specifically accredited by a Center for Medicare and Medicaid Services (CMS) deemed accreditation organization as a supplier of CRT and licensed as a DMEPOS Supplier with the Colorado Secretary of State.

(B) HOME CARE SERVICES

Prior authorization is required for all home care services, unless otherwise specified. All skilled home care service providers shall be licensed by the Colorado Department of Public Health and Environment (CDPHE) as Type A or B providers. The Payer and the home health entity should agree in writing on the type of care, the type and skill level of provider, frequency of care, duration of care at each visit, and any financial arrangements to prevent disputes.

(1) Home Infusion Therapy:

The per day or refill rates for home infusion therapy shall include all reasonable and necessary products, equipment, IV administration sets, supplies, supply management, and delivery services necessary to perform the infusion therapy. Per diem rates are only payable when licensed professionals (RNs) are providing "reasonable and necessary" skilled assessment and evaluation services in the injured worker's home.

Skilled Nursing fees are separately payable when the nurse travels to the injured worker's home to perform initial and subsequent evaluation(s), education, and coordination of care.

(a) Parenteral Nutrition:

Code	Quantity	Max Bill Frequency	Daily Rate
S9364	<1 Liter	once per day	$160.00
S9365	1 liter	once per day	$174.00
S9366	1.1 - 2.0 liter	once per day	$200.00
S9367	2.1 - 3.0 liter	once per day	$227.00
S9368	> 3.0 liter	once per day	$254.00

The daily rate includes the standard total parenteral nutrition (TPN) formula. Lipids, specialty amino acid formulas, and drugs other than those in standard formula are separately payable under section 18-6(C).

(b) Antibiotic Therapy is allowed a daily rate by professional + drug cost at Medicare's Average Sale Price (ASP), as incorporated by Rule 18-2. If ASP is not available, use Average Wholesale Price (AWP) (see section 18-6(C)).

Code	Time	Max Bill Frequency	Daily Rate
S9494	Per diem	once per day	$158.00
S9497	once every 3 hours	once per day	$152.00
S9500	every 24 hours	once per day	$97.00
S9501	once every 12 hours	once per day	$110.00
S9502	once every 8 hours	once per day	$122.00
S9503	once every 6 hours	once per day	$134.00
S9504	once every 4 hours	once per day	$146.00

(c) Chemotherapy is allowed a daily rate + drug cost at ASP, as incorporated by Rule 18-2. If ASP is not available, use AWP.

Code	Description	Max Bill Frequency	Daily Rate
S9329	Administrative Services	once per day	$0.00
S9330	Continuous (24 hrs. or more) chemotherapy	once per day	$91.00
S9331	Intermittent (less than 24 hrs.)	once per day	$103.00

(d) Enteral nutrition (enteral formula and nursing services are separately payable):

Code	Description	Max Bill Frequency	Daily Rate
S9341	Via Gravity	once per day	$44.09
S9342	Via Pump	once per day	$24.23
S9343	Via Bolus	once per day	$24.23

(e) Pain Management per day or refill + drug cost at ASP, as incorporated by Rule 18-2. If ASP is not available, use AWP.

Code	Description	Max Bill Frequency	Daily Rate
S9326	Continuous (24 hrs. or more)	once per day	$79.00
S9327	Intermittent (less than 24 hrs.)	once per day	$103.00
S9328	Implanted pump	per diem	$116.00/refill.

(f) Fluid Replacement is allowed a daily rate + drug cost at ASP, as incorporated by Rule 18-2. If ASP is not available, use AWP.

Code	Quantity	Max Bill Frequency	Daily Rate
S9373	< 1 liter per day	once per day	$61.00
S9374	1 liter per day	once per day	$85.00
S9375	>1 but <2 liters per day	once per day	$85.00
S9376	>2 liters but <3 liters	once per day	$85.00
S9377	>3 liters per day	once per day	$85.00

(g) Multiple Therapies:

Highest cost per day or refill only + drug cost at ASP, as incorporated by Rule 18-2. If ASP is not available, use AWP.

(2) Nursing Services are limited to two hours without prior authorization, unless otherwise indicated in the MTGs:

Code	Type of Nurse	Max Bill Frequency	Hourly Rate
S9123	RN	2 hours	$127.50
S9124	LPN	2 hours	$127.50
S9122	CNA	The amount of time spent with the injured worker must be specified in the medical records and on the bill.	$51.00

(3) Physical medicine procedures are payable in accordance with section 18-4(H).

(4) Mileage:

The parties should agree upon travel allowances and the mileage rate shall not exceed 59 cents per mile, portal to portal. DoWC Z0772.

(5) Travel Time:

Travel is typically included in the fees listed. Travel time greater than one hour one-way is allowed additional reimbursement not to exceed $35.37 per hour. DoWC Z0773.

(6) Drugs/Supplies/DME/Orthotics/Prosthetics Used For At-Home Care:

As defined in section 18-6(A), any drugs/supplies/DME/Orthotics/Prosthetics integral to a professional's service are not separately payable.

The maximum allowance for non-integral drugs/supplies/DME/Orthotics/Prosthetics used during a professional's home care visits are listed in section 18-6(A). All IV infusion supplies are included in the per diem or refill rates listed in this Rule.

(C) DRUGS AND MEDICATIONS

(1) All medications must be reasonably needed to cure and relieve the injured worker from the effects of the injury. Prior authorization is required for:

(a) Medications "not recommended" in the MTGs for a particular diagnosis; or

(b) Any non-steroidal anti-inflammatory drug (NSAID), muscle relaxant, or topical agent for which a significantly lower-cost therapeutic equivalent is available, including commercially or over-the-counter (OTC), even in a different strength/dosage. Significantly lower cost means the therapeutic equivalent costs at least $100 less, for the same number of days' supply. For example, prior authorization would be required to dispense diclofenac gel 1.5% at an average wholesale price (AWP) of $689 when diclofenac 1% is available OTC for $10, or to dispense more than one unit of lidocaine 4.5%-menthol 5% patch at an AWP of $49 when a lidocaine 4%-menthol 5% patch can be obtained OTC for $2.

(2) Prescription Writing:

(a) This Rule applies to all pharmacies, whether located in or out of state.

(b) Physicians shall indicate on the prescription form that the medication is related to a workers' compensation claim.

(c) All prescriptions shall be filled with bio-equivalent generic drugs unless the physician indicates "Dispense As Written" (DAW) on the prescription. In addition to the Rule 16 requirements, providers prescribing a brand name with a DAW indication shall provide a written medical justification explaining the reasonableness and necessity of the brand name over the generic equivalent.

(d) The provider shall not exceed a 60-day supply per prescription.

(e) Opioids/scheduled controlled substances, including benzodiazepines, shall only be provided through a pharmacy. The prescriber shall comply with applicable provisions of Title 12 and other statutes and rules.

(3) Billing:

(a) Drugs (brand name or generic) shall be reported on bills using the applicable identifier from the National Drug Code (NDC) Directory as published by the Food and Drug Administration (FDA).

(b) All parties shall use one (1) of the following forms:

(i) CMS-1500 – dispensing provider shall bill by using the metric quantity (number of tablets, grams, or mls) in column 24.G and NDC number of the drug being dispensed or, if one does not exist, the HCPCS supply code. For repackaged drugs, dispensing provider shall list the "repackaged" and the "original" NDC numbers in field 24 of the CMS- 1500. The dispensing provider shall list the "repackaged" NDC number of the actual dispensed medication first and the "original" NDC number second, with the prefix 'ORIG' appended. Billing providers shall include the units and days supply for all dispensed medications in field 19, example: '60UN/30DY.'

(ii) With the agreement of the Payer, the National Council for Prescription Drug Programs (NCPDP) or ANSI ASC 837 (American National Standards Institute Accredited Standards Committee) electronic billing transaction containing the same information as above may be used for billing. NCPDP Workers' Compensation/Property and Casualty (P&C) Universal Claim Form, version 1.1, for prescription drugs billed on paper shall be used by dispensing pharmacies and pharmacy benefit managers.

(c) Dispensing provider shall keep a signature on file indicating the injured worker or the injured worker's authorized representative has received the prescription.

(4) Average Wholesale Price (AWP):

(a) AWP for brand name and generic pharmaceuticals may be determined using such monthly publications as Red Book Online or Medispan. In case of a dispute on AWP values for a specific NDC, the parties shall take the lower of their referenced published values.

(b) If published AWP data becomes unavailable, substitute Wholesale Acquisition Cost (WAC) + 20% for AWP everywhere in this Rule.

(5) Reimbursement for Prescription Drugs & Medications:

(a) For prescription medications, except topical compounds, reimbursement shall be AWP + $4.00. If drugs have been repackaged, use the original

AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

(b) The entity packaging two or more products together makes an implied claim that the products are safe and effective when used together and shall be billed as individual line items identified by their original AWP and NDC. This original AWP and NDC shall be used to determine reimbursement. Supplies are considered integral to the package are not separately reimbursable.

(c) Reimbursement for an opiate antagonist prescribed or dispensed under §12- 30-110, to an injured worker at risk of experiencing an opiate-related drug overdose event, or to a family member, friend, an employee or volunteer of a harm reduction organization, or other person in a position to assist the injured worker shall be AWP plus $4.00.

(d) Injectables shall be reimbursed at Medicare's Part B Drug Average Sale Price (ASP), as incorporated by Rule 18-2, unless the ASP value does not exist for the drug or the provider's actual cost exceeds the ASP. In this circumstance, provider may request reimbursement based on the actual cost, after taking into account any discounts/rebates the provider may have received.

(e) The provider may bill for the discarded portion of drug from a single use vial or a single use package, appending the JW modifier to the HCPCS Level II code. The provider shall bill for the discarded drug amount and the amount administered to the injured worker on two separate lines. The provider must document the discarded drug in the medical record.

(6) Prescription-Strength Topical Compounds:

In order to qualify as a compound under this section, the medication must require a prescription; the ingredients must be combined, mixed, or altered by a licensed pharmacist or a pharmacy technician being overseen by a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist; and it must create a medication tailored to the needs of an individual patient. All topical compounds shall be billed using the DoWC Z code corresponding with the applicable category as follows:

Category I Z0790, $83.23 per 30 day supply

Any anti-inflammatory medication or any local anesthetic single agent.

Category II Z0791, $166.46 per 30 day supply

Any anti-inflammatory agent or agents in combination with any local anesthetic agent or agents.

Category III Z0792, $275.71 per 30 day supply

Any single agent other than anti-inflammatory agent or local anesthetic, either alone, or in combination with anti-inflammatory or local anesthetic agents.

Category IV Z0793, $384.95 per 30 day supply

Two or more agents that are not anti-inflammatory or local anesthetic agents, either alone or in combination with other anti-inflammatory or local anesthetic agents.

All ingredient materials must be listed by quantity used per prescription. If the MTGs approve some but not all of the active ingredients for a particular diagnosis, the insurer shall count only the number of the approved ingredients to determine the applicable category. In addition, initial prescription containing the approved ingredients shall be reimbursed without a medical review. Continued use (refills)

may require documentation of effectiveness including functional improvement.

Category allowances include materials, shipping and handling, and time. Regardless of how many ingredients or what type, compounded drugs cannot be reimbursed higher than the Category IV allowances. The 30 day maximum allowance value shall be fractioned down to the prescribed and dispensed amount given to the injured worker. Automatic refilling is not allowed.

(7) Over-the-Counter Medications:

(a) Medications that are available for purchase by the general public without a prescription and listed as over-the-counter in publications such as RedBook Online or Medispan, are reimbursed at NDC/AWP and are not eligible for dispensing fees. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

(b) The maximum allowance for any topical agent containing only active ingredients available without a prescription shall be at cost to the billing provider up to $30.60 per 30 day supply for any application (excludes patches). The maximum allowance for a patch is cost to the billing provider up to $71.40 per 30 day supply. When less than a 30 day supply is prescribed, these allowances shall be pro-rated to the amount dispensed to the injured worker.

DoWC Z0794 per 30 day supply for any application (excludes patches).
DoWC Z0795 per 30 day supply for patches.

See subsection (6) for prescription-strength topicals and patches.

(8) Dietary Supplements, Vitamins, and Herbal Medicines:

Reimbursement for outpatient dietary supplements, vitamins, and herbal medicines is authorized only by prior agreement of the Payer or if specifically indicated in the MTGs. Reimbursement shall be at cost to the injured worker (see subsection (9) below).

(9) Injured Worker Reimbursement:

In the event the injured worker has directly paid for authorized medications (prescription or over-the-counter), the Payer shall reimburse the injured worker for the amount actually paid within 30 days after submission of the injured worker's receipt. See Rule 16.

(D) COMPLEMENTARY INTEGRATIVE MEDICINE

Complementary integrative medicine describes a broad range of treatment modalities, some of which are generally accepted in the medical community and others that remain outside the accepted practice of conventional western medicine. Non-physician providers of complementary integrative medicine that are not listed in Rule 16 must have completed training in one or more forms of therapy and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in Chinese herbology.

(E) AMBULANCE TRANSPORTATION

(1) Maximum Allowance:

The maximum allowance for medical transportation consists of a base rate and a payment for mileage. Both the transport of the injured worker and all items and services associated with such transport are included in the base rate and mileage rate.

(2) General Claims Submission:

(a) All hospitals billing for ground or air ambulance services shall bill on the UB-04. All other providers shall bill on the CMS-1500.

(b) Providers shall use HCPCS codes and origin/destination modifiers.

(c) Providers shall list their name, complete address, and NPI number.

(d) Providers shall list the zip code for the place of origin in Item 23 of the CMS- 1500 or FL 39-41 of the UB-04 with an "AO" code. If billing for multiple trips and the zip code for each origin is the same, services can be submitted on the same claim. If the zip codes are different, a separate claim must be submitted for each trip.

(3) Ground Ambulance Services Billing Codes and Fees:

The selection of the base code is based upon the condition of the injured worker at the time of transport, not the vehicle used and includes services and supplies used during the transport.

HCPCS	Base Rate	URBAN BASE RATE/ URBAN MILEAGE	RURAL BASE RATE/ RURAL MILEAGE	RURAL BASE RATE/ SUPER RURAL MILEAGE	RURAL GROUND MILES
A0425	$17.08	$17.42	$17.60	n/a	$26.40
A0426	$531.08	$672.80	$679.38	$832.92	n/a
A0427	$531.08	$1,065.26	$1,075.70	$1,318.80	n/a
A0428	$531.08	$560.66	$566.16	$694.12	n/a
A0429	$531.08	$897.06	$905.86	$1,110.58	n/a
A0432	$531.08	$981.16	$990.78	n/a	n/a
A0433	$531.08	$1,541.82	$1,556.94	$1,908.80	n/a
A0434	$531.08	$1,822.14	$1,840.02	$2,255.86	n/a

The "urban" base rate(s) and mileage rate(s) shall apply to all relevant/applicable ambulance services unless the zip code range area is "Rural" or "Super Rural." Medicare MSA zip code grouping is listed on Medicare's webpage with an "R" indicator for "Rural" and "B" indicator for "Super Rural." See Medicare's Zip Code to Carrier Locality File, revised May 2023.

(4) Modifiers:

HCPCS modifiers identify place of origin and destination of the trip. The modifier is to be placed next to the HCPCS code billed. Each of the modifiers may be utilized to make up the first and/or second half of a two-letter modifier. The first letter describes the origin of the transport, and the second letter describes the destination.

(5) Mileage:

Charges for mileage must be based on loaded mileage only, i.e., from pickup to destination.

18-7 DIVISION-ESTABLISHED CODES AND VALUES

(A) FACE-TO-FACE OR TELEPHONIC MEETINGS

(1) Face-to-face or telephonic meeting by a treating Physician or a Psychologist with an employer, claim representative, or any attorney, and with or without the injured worker. Claim representatives include physicians or other qualified medical personnel performing Payer-initiated medical treatment reviews, but this Rule does not apply to provider-initiated requests for prior authorization. The Physician or Psychologist may bill for the time spent attending the meeting and preparing the report (no travel time or mileage is separately payable). The fee includes the cost of the report for all parties, including the injured worker.

Before a meeting is separately payable, the following requirements must be met:

(a) Each meeting (including the time to document) shall be a minimum of 8 minutes.

(b) A report or written record signed by the Physician or Psychologist is required and shall include the following:

(i) Who was present at the meeting and their role at the meeting;

(ii) Purpose of the meeting;

(iii) A brief statement of recommendations and actions at the conclusion of the meeting;

(iv) Documented time (both start and end times).

(c) DoWC Z0701, $44.22, is payable in 8-minute increments. The CPT® mid-point rule for attaining a unit of time does not apply to this code. The Physician or Psychologist may bill multiple units of this code per date of service.

(d) For reimbursement to qualified non-physician providers for coordination of care with medical professionals, see section 18-4(H).

(2) Face-to-face or telephonic meeting by a non-treating physician with the employer, claim representatives, or any attorney in order to provide a medical opinion on a specific workers' compensation case, which is not accompanied by a specific report or written record.

DoWC Z0601, $76.99 per 15 minutes billed to the requesting party.

(3) Face-to-face or telephonic meeting by a non-treating physician with the employer, claim representatives, or any attorney to provide a medical opinion on a specific workers' compensation case, which is accompanied by a report or written record, shall be billed as a special report (see section 18-7(G)(4)).

(4) Peer-to-peer review by a treating physician with a medical reviewer, following the treating physician's complete prior authorization request pursuant to Rule 16.

DoWC Z0602, $76.99 per 15 minutes billed to the requesting party.

(B) CANCELLATION FEES FOR PAYER-MADE APPOINTMENTS

(1) A cancellation fee is payable only when a Payer schedules an appointment the injured worker fails to keep, and the Payer has not canceled five days prior to the appointment.

The Payer shall pay one-half of the usual fee for the scheduled services, or $187.27, whichever is less:

DoWC Z0720. The provider shall indicate the code corresponding to the service that has been cancelled in Box 19 of the CMS-1500 form or electronic billing equivalent.

For Payer-made appointments scheduled for four hours or longer, the Payer shall pay one-half of the usual fee for the scheduled service.

DoWC Z0740. The Provider shall indicate the code corresponding to the service that has been cancelled in Box 19 of the CMS-1500 form or electronic billing equivalent.

(2) Missed Appointments:

When an injured worker fails to keep a scheduled appointment, the Provider should contact the Payer within five days. Upon reporting the missed appointment, the Provider may inquire if the Payer wishes to reschedule the appointment for the injured worker. If the injured worker fails to keep the Payer's rescheduled appointment, the Provider may bill for a cancellation fee according to this section.

(C) REQUESTS FOR MEDICAL RECORDS AND COPYING FEES

The Payer, Payer's representative, injured worker, and injured worker's representative shall pay a reasonable fee for the reproduction of the injured worker's medical record. Copying charges do not apply for the initial submission of records that are part of the required documentation for billing. If records are readily producible electronically and appropriate security is in place, including but not limited to compatible encryption, the provider shall provide the requestor with an electronic copy (e.g., email). If the requester and Provider agree, the copy may be provided by fax, on paper, or by disc. Provider may not charge a fee for a records search and retrieval. All records shall be provided no later than 30 days from the date the request is received.

Copying Fee Billing Codes and Maximum Fees:

DoWC Z0721, $18.53 for first 10 or fewer paper page(s), including faxed documents

DoWC Z0725, $0.85 per paper page for the next 11-40 paper page(s), including faxed documents

DoWC Z0726, $0.57 per paper page for remaining paper page(s), including faxed documents

DoWC Z0727, $1.50 per microfilm page

DoWC Z0728, $14.00 per computer disc

DoWC Z0729, $6.50 per electronic copy

DoWC Z0802, actual postage paid

(D) DEPOSITION AND TESTIMONY FEES

(1) When requesting deposition or testimony from any Provider, guidance should be obtained from the Interprofessional Code, prepared by the Colorado Bar Association, the Denver Bar Association, the Colorado Medical Society, and the Denver Medical Society. If the parties cannot agree upon lesser fees for the

deposition or testimony services, or cancellation time periods and/or fees, the deposition and testimony rules and fees listed below shall be used.

If a party shows good cause to an Administrative Law Judge (ALJ) for exceeding the Medical Fee Schedule allowance, that ALJ may allow a greater fee.

(2) Preparation Time:

By prior agreement, the Provider may charge for preparation time for a deposition or testimony, for reviewing and signing the deposition, or for preparation time for testimony.

Treating or non-treating Physician or Psychologist:

DoWC Z0730, $190.74, billed in half-hour increments. Other Providers are allowed 85% of this fee.

(3) Deposition:

Payment for testimony at a deposition shall not exceed $190.74, billed in half-hour increments, for a treating or non-treating Physician or a Psychologist. DoWC Z0734, calculating the Provider’s time from "portal to portal." Other Providers are allowed 85% of this fee.

If requested, the Provider is entitled to a full hour deposit in advance in order to schedule the deposition.

If the Provider is notified of the cancellation of the deposition at least ten days prior to the scheduled deposition, the Provider shall be paid the number of hours that have been reasonably spent in preparation, less any deposit paid by the deposing party. DoWC Z0731, $190.74, in half-hour increments.

If the Provider is notified less than ten days in advance of a cancellation or rescheduling, or the deposition is shorter than the time scheduled, the Provider shall be paid the number of hours that have been reasonably spent in preparation and have been scheduled for the deposition. DoWC Z0733, $190.74, in half-hour increments.

(4) Testimony:

Treating or non-treating Physician or Psychologist:

DoWC Z0738, $264.18, billed in half-hour increments. Other Providers are allowed 85% of this fee.

Calculation of the Provider’s time shall be "portal to portal” (includes travel time and mileage in both directions).

For testifying at a hearing, if requested, the Provider is entitled to a four-hour deposit in advance in order to schedule the testimony.

If the Provider is notified of the cancellation of the testimony at least ten days prior to the scheduled testimony, the Provider shall be paid the number of hours that have been reasonably spent in preparation, less any deposit paid by the requesting party. DoWC Z0735, $264.18, in half-hour increments.

If the Provider is notified less than ten days in advance of a cancellation or rescheduling, or the testimony is shorter than the time scheduled, the Provider shall be paid the number of hours that have been reasonably spent in preparation and has scheduled for the testimony. DoWC Z0737, $264.18, in half-hour increments.

(E) INJURED WORKER TRAVEL EXPENSES

The Payer shall advance or reimburse the injured worker for reasonable and necessary mileage expenses for travel to and from medical appointments. The injured worker shall submit a request to the Payer showing the date(s) of travel and mileage, incurred or anticipated, and explain any other reasonable and necessary travel expenses. The number of miles shall be in whole numbers and calculated using the most direct route available on the date of service. Advance mileage is available for eligible travel greater than 100 miles round trip, and shall be approved when requested by the injured worker at least seven days in advance.

Mileage Pre-paid Expense:	DoWC Z0722, 59 cents per mile
Mileage Expense:	DoWC Z0723, 59 cents per mile
Other Travel Expenses:	DoWC Z0724, actual paid

(F) PERMANENT IMPAIRMENT RATING

(1) The Payer is only required to pay for one combined whole-person permanent impairment rating per claim, except as otherwise provided in the Workers' Compensation Rules of Procedures. Exceptions that may require payment for an additional impairment rating include, but are not limited to, reopened cases, as ordered by the Director or an Administrative Law Judge, or a subsequent request to review apportionment. The ATP is required to submit in writing all permanent restrictions and future maintenance care related to the injury or occupational disease.

(2) Provider Restrictions:

The Physician determining the permanent impairment rating must be Level II accredited and comply with Rule 5 as applicable.

(3) Maximum Medical Improvement (MMI) Determined Without any Permanent Impairment:

If a Physician determines the injured worker is at MMI and has no permanent impairment, the Physician should be reimbursed for the examination at the appropriate level of E&M service. The ATP managing the total workers' compensation claim should complete the Physician's Report of Workers' Compensation Injury (Closing Report), WC 164 (see section 18-7(G)(2)).

(4) MMI Determined with a Calculated Permanent Impairment Rating

(a) Calculated Impairment: The total fee includes the office visit, a complete physical examination, complete history, review of all medical records except when the amount of medical records is extensive (see below), determining MMI, completing all required measurements, referencing all tables used to determine the rating, using all report forms from the AMA's Guide to the Evaluation of Permanent Impairment, Third Edition (Revised), (AMA Guides), and completing the Physician's Report of Workers' Compensation Injury (Closing Report) WC 164.

Extensive medical records take longer than one hour to review and require a separate report. The separate report must document each record reviewed, specific details of the records reviewed, and the dates represented by the records reviewed. The separate record review can be billed as a special report and requires prior authorization.

(b) Impairments Requiring Multiple Providers:

All Physicians and Psychologists (including Level II Accredited Physicians) providing consulting services for the completion of a whole person

impairment rating shall bill using the appropriate E&M consultation code, or psychological diagnostic evaluation code, and shall forward their portion of the rating to the Physician determining the combined whole person rating.

A return visit for a range of motion (ROM) validation shall be billed with the appropriate code in the Medicine Section of CPT®.

The date the Physician sees the injured worker shall be the date of service billed.

DoWC Z0759, $612.00, for the Level II Accredited Authorized Treating Physician providing primary care.

DoWC Z0760, $822.12, for the Referral, Level II Accredited Authorized Physician (the claimant is not a previously established patient to that physician for that workers' compensation injury).

DoWC Z0764. If the injured worker fails to attend the impairment rating appointment or if the parties notify the Physician of a cancellation or rescheduling five days or less prior to the appointment, the Physician shall be paid one-half of the fee for the scheduled service. The Physician shall indicate the code corresponding to the scheduled service in Box 19 of the CMS-1500 form or electronic billing equivalent.

(G) REPORT PREPARATION

(1) Routine Reports:

Providers shall submit routine reports free of charge as directed in Rule 16 and by statute. Requests for additional copies of routine reports and for reports not in Rule 16 or statute are reimbursable under the copying fee section of this Rule. Routine reports include:

(a) Diagnostic testing

(b) Procedure reports

(c) Progress notes

(d) Office notes

(e) Operative reports

(f) Supply invoices, if requested by the Payer

(2) Completion of the Physician's Report of Workers' Compensation Injury:

(a) Initial Report WC 164:

The ATP and ED/urgent care physician when applicable, shall complete the first report of injury. Items 1-7 and 11 must be complete, however item 2 may be omitted if not known by the Provider. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0750 Initial Report $51.00

(b) Closing Report WC 164:

The ATP managing the workers' compensation claim must complete the WC 164 closing report when the injured worker is at maximum medical improvement (MMI) for all covered injuries or diseases, with or without a permanent impairment. Items 1-5, 6 B-C, 7 (if applicable), and 8-11 must be complete. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0752 Closing Report $51.00

If the injured worker has sustained a permanent impairment, the following additional information must be attached to the bill when MMI is determined:

(i) All necessary permanent impairment rating reports, medical reports, and narrative relied upon by the ATP, when the ATP managing the workers' compensation claim is Level II Accredited; or

(ii) The name of the Level II Accredited Physician requested to perform the permanent impairment rating when a rating is necessary and the ATP managing the workers' compensation claim is not determining the permanent impairment rating.

(c) Initial and Closing Report WC 164 completed on the same form for the same date of service: DoWC Z0753 $51.00

(d) Progress Report WC 164:

Any request from the Payer or the employer for the information provided on this form is deemed authorization for payment. The Provider shall document the name of the person who made the request and the date of the request on the WC 164; complete items 1, 2, 4-7, and 11; and send it to all parties within five days of the request. If completed by a PA or NP, the ATP must countersign the form.

DoWC Z0751 Progress Report $51.00

(3) Form Completion:

The requesting party shall pay for its request for a physician to complete additional forms requiring 15 minutes or less, including forms sent by a Payer or an employer. This code also may be billed when completing the requirements outlined in § 8-43-404(10)(a) or Desk Aid 15 for a non-medical discharge.

DoWC Z0754 Form Completion $51.00

(4) Special Reports:

The term special report includes any form, questionnaire, letter or report with variable content not otherwise addressed in Rule. Examples include:

(a) treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise addressed, or

(b) meeting with and reviewing another Provider's written record, and amending or signing that record.

The content and total payment shall be agreed upon by the Provider and the report's requester before the Provider begins the report.

Advance Payment: If requested, the Provider is entitled to a two hour deposit in advance in order to schedule a patient exam associated with a special report.

DoWC Z0755 Written Report, $95.37 billable in 15 minute increments

DoWC Z0757 Lengthy Form, $95.37 billable in 15 minute increments

DoWC Z0758 Meeting and Report with Non-treating Physician, $95.37 billable in 15 minute increments

In cases of cancellation for special reports not requiring a scheduled patient exam, the Provider shall be paid for the time reasonably spent in preparation up to the date of cancellation.

DoWC Z0761 Report Preparation with Cancelled Patient Exam, $95.37 billable in

15 minute increments

(5) Independent Medical Examinations (IMEs):

An IME is an objective medical examination of an injured worker performed by a Physician who has not previously treated the injured worker, in order to evaluate prior, current, or proposed treatment, or current condition. The Physician may refer a psychological component of the IME to a Psychologist and incorporate that evaluation into the IME report. In some circumstances, the IME Physician must be Level I or Level II accredited.

RIME: Respondent-requested Independent Medical Examination

DoWC Z0756 RIME Report with patient exam, $95.37 billable in 15 minute increments

Section 8-43-404 requires RIMEs to be recorded in audio in their entirety and retained by the examining Physician for 12 months and made available by request to any party to the case.

DoWC Z0766 RIME Audio Recording, $35.70 per exam

DoWC Z0767 RIME Audio Copying Fee, $24.48 per copy

CIME: Claimant-requested Independent Medical Examination, $95.37 billable in 15 minute increments to the injured worker, DoWC Code Z0770

DIME: Division Independent Medical Examination - see Rule 11

All IME reports must be served concurrently to all parties no later than 20 days after the examination. All IME reports must include an attestation that the billed charges comply with § 8-42-101(3)(a)(I) and Rule 16-8, as well as document the total time spent.

Cancellations:

In cases of a cancelled or rescheduled RIME or CIME, the Provider shall be paid the following fees:

If the Provider is notified of the cancellation of the RIME or CIME at least fourteen days prior to the scheduled examination, the Provider shall be paid the number of hours reasonably spent in preparation, less any deposit paid by the requesting party. DoWC Z0762, $95.37 billable in 15 minute increments.

If the Provider is notified less than fourteen days in advance of a cancelled or rescheduled RIME or CIME, the Provider shall be paid the number of hours reasonably spent in preparation and scheduled for the examination. DoWC Z0763, $95.37 billable in 15 minute increments.

(H) USE OF AN INTERPRETER

(1) Payers shall reimburse for the services of an interpreter when interpretation is reasonable and necessary to provide access to medical benefits. Interpreter services provided in a hospital or ambulatory surgery center are included in the facility reimbursement and are not separately payable.

An interpreter may be provided on-site or via video or audio remote interpreting service, based on availability and the preference of the treating Provider.

(2) Providers are prohibited from relying on minor children and should refrain from using adult family members and friends as interpreters, except in an emergency.

(3) Payment requirements:

(a) Interpreters for certifiable languages must be listed as certified on the Certification Commission for Healthcare Interpreters or National Board of Certification for Medical Interpreters website directory. Certifiable languages are:

- Spanish
- Cantonese
- Mandarin
- Russian
- Korean
- Vietnamese
- Arabic

(b) For all other languages, or in the event a certified interpreter is unavailable, the interpreter shall be qualified. Qualified means the interpreter has documentation showing completion of at least 40 hours of healthcare interpreter training.

(c) When a qualified interpreter is used in lieu of a certified interpreter, Payers must document a good faith effort was made to obtain a certified interpreter and submit this documentation to the Division upon request. By way of example, the payer may document a good faith effort by contacting at least two certified interpreters who are unavailable for the requested date and time.

(d) Prior authorization is required for on-site interpreters except for initial and emergency treatment.

(4) Interpreters shall submit claims using the Interpreter Invoice Form or electronic data interchange (EDI). The codes and maximum allowances are:

(a) DoWC Z0710, Certified Spanish Interpreter, on-site, $15.00, billable in 15 minute increments with a minimum of one hour;

(b) DoWC Z0711, Qualified Spanish Interpreter, on-site, $11.25, billable in 15 minute increments with a minimum of one hour;

(c) DoWC Z0712, Interpreter for languages other than Spanish, on-site, rates shall be negotiated;

(d) HCPCS T1013, Sign Language, rates shall be negotiated;

(e) DoWC Z0713, On-Demand Video or Audio Remote Interpreting, all languages, $1.35 per minute, with no minimum.

(f) DoWC Z0773, Travel time for distances 50 miles or greater one-way is separately payable to on-site interpreters and shall not exceed $35.37 per hour.

(g) DoWC Z0772, Mileage is separately payable to on-site interpreters, and shall not exceed 59 cents per mile. The reimbursement shall be calculated based on the actual number of miles driven portal to portal or the most direct route available on the date of service, whichever is less.

(h) If a prior authorized interpreter receives a cancellation notice less than 24 hours prior to the scheduled service, the Payer shall pay one-half of the usual fee for the scheduled service, or $187.27, whichever is less. DoWC Z0720, plus full reimbursement for incurred mileage and eligible travel time.

(I) GUARDIAN AD LITEM AND CONSERVATOR SERVICES

When reasonably necessary for employees who are legally incapacitated as a result of a work-related injury or occupational disease, the following services are allowed reasonable fees and costs as agreed upon by the parties:

Guardian ad litem
Conservator
Attorney/Paralegal

The parties may submit an invoice or other agreed upon form for these services. If the parties are unable to agree on a reasonable fee, the parties may bring the matter before the Director for resolution.

18.8 DENTAL FEE SCHEDULE

The dental fee schedule is adopted using the American Dental Association's CDT® as incorporated by 18-2. However, surgical treatment for dental trauma and subsequent related procedures shall be billed using medical codes from RBRVS. If billed using RBRVS, reimbursement shall be in accordance with the values listed in the Surgery/Anesthesia section and the corresponding CF. See Exhibit #3 for the listing and maximum allowance for CDT® codes.

Regarding prosthetic appliances, the Provider may bill and be reimbursed for 50% of the allowed fee at the time the master casts are prepared for removable prosthodontics or the final impressions are taken for fixed prosthodontics. The remaining 50% may be billed on insertion of the final prosthesis.

18.9 QUALITY INITIATIVES

(A) OPIOID MANAGEMENT

(1) Codes and maximum allowances are payable to the prescribing ATP for a written report with all the following opioid review services completed and documented:

(a) ordering and reviewing drug tests for subacute or chronic opioid management;

(b) ordering and reviewing Colorado Prescription Drug Monitoring Program (PDMP) results;

(c) reviewing the medical records;

(d) reviewing the injured worker's current functional status;

(e) evaluating the risk of misuse and abuse initially and periodically; and

(f) determining what actions, if any, need to be taken.

In determining the prescribed levels of medications, the ATP shall review and integrate the drug screening results required for subacute and chronic opioid management, as appropriate; the PDMP and its results; an evaluation of compliance with treatment and risk for addiction or misuse; as well as the injured worker's past and current functional status. A written report also must document the treating physician's assessment of the injured worker's past and current functional status of work, leisure, and activities of daily living.

The injured worker should initially and periodically be evaluated for risk of misuse or addiction. The ATP may consider whether the injured worker experienced an opiate- related drug overdose event that resulted in an opiate antagonist being prescribed or dispensed pursuant to § 12-30-110. If the injured worker is deemed

to be at risk for an opiate overdose, an opioid antagonist may be prescribed (see section 18- 6(C)(5)(c)).

Opioid Management Billing Codes:

Acute Phase:	DoWC Z0771, $86.70, per 15 minutes, maximum of 30 minutes per report
Subacute/Chronic Phase:	DoWC Z0765, $86.70, per 15 minutes, maximum of 30 minutes per report

(2) Definitions:

(a) Acute opioid use refers to the prescription of opioid medications (single or multiple) for duration of 30 days or less for non-traumatic injuries, or six weeks or less for traumatic injuries or post-operatively.

(b) Subacute opioid use refers to the prescription of opioid medications for longer than 30 days for non-surgical cases and longer than six weeks for traumatic injuries or post-operatively.

(c) Chronic opioid use refers to the prescription of opioid medications for longer than 90 days.

(3) Acute opioid prescriptions generally should be limited to three to seven days and 50 morphine milliequivalents (MMEs) per day. Providers considering repeat opioid refills at any time during treatment are encouraged to perform the actions in this section and bill accordingly.

(4) When long-term opioid treatment is prescribed, the ATP shall comply with the Division's Chronic Pain Disorder MTG (Rule 17, Exhibit #9), and review the Colorado Medical Board Policy #40-26, "Policy for Prescribing and Dispensing Opioids."

(5) Urine drug tests are required for subacute and chronic opioid management and shall employ testing methodologies that meet or exceed industry standards for sensitivity, specificity, and accuracy. The test methodology must be capable of identifying and quantifying the parent compound and relevant metabolites of the opioid prescribed. In-office screening tests designed to screen for drugs of abuse are not appropriate for subacute or chronic opioid compliance monitoring. Refer to section 18-4(F)(3) for clinical drug screening testing codes and values.

(a) Drug testing shall be done prior to the initial long-term drug prescription being implemented and randomly repeated at least annually.

(b) While the injured worker is receiving opioid management, additional drug screens with documented justification may be conducted. Examples of documented justification include:

(i) Concern regarding the functional status of the injured worker;

(ii) Abnormal results on previous testing;

(iii) Change in management of dosage or pain; and

(iv) Chronic daily opioid dosage above 50 MMEs.

(B) QUALITY PERFORMANCE AND OUTCOMES PAYMENTS (QPOP)

(1) Medical Providers who are Level I or II Accredited, or who have completed the Division-sponsored Level I or II Accreditation program and have successfully completed the QPOP training may bill separately for documenting functional progress made by the injured worker. The medical Providers must utilize both a Division-approved psychological screen and a Division-approved functional tool.

The psychological screen and the functional tool are approved by the Division and are validated for the specific purpose for which they have been created. The medical Provider also must document whether the injured worker's perception of function correlates with clinical findings. The documentation of functional progress should assist the Provider in preparing a successful plan of care, including specific goals and expected time frames for completion, or for modifying a prior plan of care. The documentation must include:

(a) Specific testing that occurred, interpretation of testing results, and the weight given to these results in forming a reasonable and necessary plan of care;

(b) Explanation of how the testing goes beyond the evaluation and management (E&M) services typically provided by the Provider;

(c) Meaningful discussion of actual or expected functional improvement between the Provider and the injured worker.

(2) Billing codes and maximum fees:

DOWC Z0815, $83.23, for the initial assessment during which the injured worker provides functional data and completes the validated psychological screen, which the Provider considers in preparing a plan of care. This code also may be used for the final assessment that includes review of the functional gains achieved during the course of treatment and documentation of MMI.

DOWC Z0816, $41.62, for subsequent visits during which the injured worker provides follow-up functional data that could alter the treatment plan. The Provider may use this code if the analysis of the data leads to a modification of the treatment plan. The Provider should not bill this code more than once every two to four weeks.

(3) QPOP for post-MMI patients requires prior authorization based on clearly documented functional goals.

(C) APP-BASED INTERVENTIONS

Providers may write an order for app-based interventions for the purpose of patient education and training to aid in curing and/or relieving the injured worker from the effects of the work injury. A duration for use shall be designated on the order and may be reordered as clinically indicated. If ordered, the app must be payable by invoice and billed directly to the Payer. Providers who write such orders are not permitted to receive any remuneration from the service Provider for the referral. The maximum allowable charge is $25 per month and may be billed for a maximum duration of three months, or $75 per order. App-based interventions that exceed this allowance require prior authorization. Examples of app-based interventions include apps that utilize artificial intelligence to educate the user about pain neuroscience, chronic pain management, weight loss, mental well-being, glucose management, and home exercise routines.

(D) PILOT PROGRAMS

Payers may submit a proposal to conduct a pilot program(s) to the Director for approval. Pilot programs authorized by this Rule shall be designed to improve quality of care, determine the efficacy of clinic or payment models, and to provide a basis for future development and expansion of such models.

The proposal for a pilot program shall meet the minimum standards set forth in § 8-43-602 and shall include:

(1) beginning and end date for the pilot program;

(2) population to be managed (e.g. size, specific diagnosis codes);

(3) Provider group(s) participating in the program;

(4) proposed codes and fees; and

(5) process for evaluating the program's success.

Participating Payers must submit data and other information as required by the Division to examine such issues as the financial implications for Providers and injured workers, enrollment patterns, utilization patterns, impact on health outcomes, system effects and the need for future health planning.

18-10 LIST OF EXHIBITS

Exhibit #1 - Evaluation and Management (E&M)

Exhibit #2 - Hospital Base Rates and Cost to Charge Ratios (CCRs)

Exhibit #3 - Dental Fee Schedule

Exhibit #4 – APCs for Procedures with Status Indicator C When Performed in an OP Hospital or ASC

Exhibit #1
Evaluation and Management - Medical Decision Making – Effective 1/1/2024

Number/Complexity of Problems Addressed **(Chart A)** *See examples on page 6*
Only problems directly related to the injury and pertinent to the visit or treatment are counted.

Minimal	☐ 1 Self-limited / minor problem
Low	☐ 2+ Self-limited/minor problems; or ☐ 1 Stable chronic illness; or ☐ 1 Acute uncomplicated illness/injury; may or may not require hospital level care ☐ 1 Stable acute illness
Moderate	☐ 1+ Chronic illness w/ exacerbation, progression, or Tx side effects; or ☐ 2+ Stable chronic illnesses; or ☐ Undiagnosed new problem w/ uncertain prognosis; or ☐ Acute illness w/ systemic symptoms; or

Self-limited or Minor Problem – A problem that runs a definite and prescribed course, is temporary in nature, and is not likely to permanently affect health status.

Stable, Chronic Illness - A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not the stage or the severity changes (e.g., uncontrolled diabetes and controlled diabetes are a single chronic condition). 'Stable' for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at their treatment goal is not stable, even if the condition has not changed and there is no short- term threat to life or bodily function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity without treatment is significant.

Acute, Uncomplicated Illness or Injury - A recent or new short-term problem with low risk of morbidity for which a treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Chronic Illness with Exacerbation, Progression or Side Effects of Tx - A chronic illness that is actually worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or attention to treatment for side effects but that does not require consideration of hospital level care.

Undiagnosed New Problem with Uncertain Prognosis - A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without medical intervention.

Acute Illness with Systemic Symptoms - An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms such as fever, body aches, or fatigue in a minor illness that may be treated to

	□ Acute complicated injury	alleviate symptoms, shorten the course of illness or to prevent complications, see the definitions for 'self-limited or minor' or 'acute, uncomplicated.' Systemic symptoms may not be general, but may be a single system.
High	□ Chronic illness w/ severe exacerbation, progression, or Tx side effects; or □ Acute/chronic illness/injury that poses threat to life or bodily function	Acute, Complicated Injury – An injury which requires treatment that includes evaluation of other body systems that are not directly related to the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. Chronic Illness with Severe Exacerbation, Progression, or Side Effects of Treatment – The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospitalization. Acute or Chronic Illness or Injury that Poses a Threat to Life or Bodily Function - An acute illness with systemic symptoms (symptoms affecting one or more organ systems), an acute complicated injury, or a chronic illness or injury with exacerbation

Amount and/or Complexity of **Data to be Reviewed and Analyzed (Chart B)**

Tests & Documents (T&D)				**T&D pts**	**Level of Data**
Review of prior **external note(s)** from each unique source*		x 1 =			❑ 2 pts from at least 2 T&D **or** ❑ 1 pt from IHX If at least 1 box is checked, the level of data is **LIMITED** If not, the level of data is **MINIMAL** or **NONE**
Review of the **result(s)** of each unique test*		x 1 =			
Ordering of each unique test* or **Discussion with the patient** of possible test alternatives (documented)		x 1 =			
Assessment requiring an independent historian(s)(IHx)				**IHx pts**	
An individual who provides a history in addition to patient		0 or 1 max =			
Independent interpretation of tests (Intpr)				**Intpr pts**	

Independent interpretation of a test performed by another physician/ other qualified health care professional (not separately reported);	0 or 1 max =			❑ 3 pts from 3 T&D/IHX **or** ❑ 1 pt from Intpr **or** ❑ 1 pt from DISC If at least 1 box is checked, the level of data is **MODERATE** If not, the level of data is **LIMITED or MINIMAL/NONE**

Discussion of management or test interpretation (DISC)			**DISC pts**	
Discussion of management or test interpretation **with external physician**/other qualified health care professional/appropriate source (not separately reported)	0 or 1 max =			If at least 2 of the 3 boxes above are checked, the level of data is **EXTENSIVE**

*Each unique test, order, or document contributes to the combination of T&D category below. If the test is being billed on the same date, T&D does not apply

Test – Laboratory services, diagnostic imaging, psychometric, or physiologic data. A clinical laboratory panel (e.g., basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT® code set.

External – External records, communications and/or test results are from an external physician, other qualified health care professional, facility or health care organization.

External Physician or Other Qualified Healthcare Professional - An individual who is in a different group practice or who is of a different specialty or subspecialty. It includes licensed professionals that are practicing independently (e.g. PT, OT, nurse case manager.) It may also be a facility or organizational provider such as a hospital, nursing facility, or home health care agency.

Independent Historian(s)- An individual such as a parent, guardian, surrogate, spouse, caregiver, witness, supervisor, or co-worker who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history due to developmental stage of the patient, or another mental condition(s) or because a confirmatory history is determined to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.

Independent Interpretation - The interpretation of a test for which there is a CPT® code and an interpretation or report is expected. This does not apply when the provider is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented, but need not conform to the usual standards of a complete report for the test.

Appropriate Source – Individuals who are not health care professionals, but may be involved in the management of the patient (e.g., lawyer, parole officer, power of attorney, case manager, clergy, teacher). It does not include discussion with family or informal caregivers.

Risk of complications and/or Morbidity or Mortality of Patient Management (Chart C) *see examples on following page*

Minimal	☐ Minimal risk of morbidity from additional diagnostic testing or treatment
Low	☐ Low risk of morbidity from additional diagnostic testing or treatment
Moderate	☐ Moderate risk of morbidity from additional diagnostic testing or Treatment
High	☐ High risk of morbidity from additional diagnostic testing or treatment

Risk – The probability and/or consequences of an event (an event is the medical intervention or treatment). The assessment of the level of risk is affected by the nature of the event under consideration. *For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk.* Definitions of risk are based upon the usual behavior and thought processes of a provider in the same specialty. Trained clinicians apply common language usage meanings to terms such as 'high', 'medium', 'low', or 'minimal' risk and do not require quantification for these definitions, (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of calculating medical decision making, level of risk is based upon consequences of the problems(s) addressed at the visit when appropriately treated. Risk also includes medical decision making related to the need to initiate or forego further testing, treatment and/or hospitalization.

Morbidity – A state of illness or functional impairment that is expected to be long-term duration in which function is limited, quality of life is impaired, or there is organ damage that may not be temporary despite treatment.

Level of the Presenting Problem (from Chart A) _____

Level of Data (from Chart B) _____

Level of Risk (from Chart C) _____

Minimal	**99202/99212**
Low	**99203/99213**
Moderate	**99204/99214**
High	**99205-99215**

Overall level of MDM-two of three categories above must be at a specific level in order to claim overall MDM at that level _____

Examples of patient management or conditions	**Level of Risk**

❑ Rest ❑ Gargles ❑ Insect bite ❑ Contusion ❑ Bruise	❑ Elastic bandages ❑ Superficial dressings ❑ Minor non-sutured laceration ❑ Abrasion	**MINIMAL**
❑ Over-the-counter drugs ❑ Minor surgery with no identified risk factors ❑ PT/OT ❑ Superficial burn ❑ Simple sprain/strain ❑ Stable chronic low back pain	❑ IV fluids w/o additives ❑ Simple or layered closure ❑ Vaccine injection ❑ Simple laceration repair ❑ Superficial foreign body	**LOW**
❑ Minor surgery, with identified risk factors ❑ Elective major surgery (open, percutaneous, or endoscopic), with no identified risk factors ❑ Prescription drug management (new, increase, decrease, discontinue, decision to refill) ❑ Therapeutic nuclear medicine ❑ IV fluids with additives ❑ Head injury with brief loss of consciousness ❑ New neurologic complaints in extremity (numbness, tingling) ❑ Partial thickness burn < 10% total body surface area	❑ Closed fracture(s) or dislocation(s), without manipulation ❑ Disability counseling and/or work restrictions ❑ Inability to return the injured worker to work and requiring detailed functional improvement plan ❑ Diagnosis or treatment significantly limited by social determinants of health ❑ Chronic pain with exacerbation &/or side effects of tx ❑ Intermediate laceration repair ❑ Torn ligament ❑ Deep foreign body	**MODERATE**
❑ Elective major surgery (open, percutaneous, endoscopic), with identified risk factors ❑ Emergency major surgery or trauma ❑ Parenteral controlled substances ❑ Drug therapy requiring intensive monitoring for toxicity ❑ Initial treatment of open fracture ❑ Head injury with prolonged loss of consciousness ❑ Partial thickness burn ≥ 10% total body surface areas ❑ Full-thickness burn ❑ Complex laceration repair ❑ Initial loss of limb/digit	❑ Decision not to resuscitate, or to de- escalate care because of poor prognosis ❑ Potential for significant permanent work restrictions or total disability which would significantly restrict employment opportunities ❑ Management of addiction behavior or other significant psychiatric condition ❑ Treatment plan for patients with symptoms causing severe functional deficits without supporting physiological findings or verified related medical diagnosis. ❑ Abrupt change in neurological status	**HIGH**

Time-Based Coding

Total Time on the Date of the Visit – (99202-99205, 99212-99215) - For calculation purposes, time for these services is the total time on the date of the visit. It includes both the face-to-face and non-face-to-face time personally spent by the provider(s) on the day of the visit and includes time in activities that require the provider but does not include time in activities normally performed by clinical staff.

Provider time includes the following activities, when performed and documented:

- Preparing to see the patient such as reviewing the pt's record
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate history and examination
- Counseling and educating the patient, family, and/or caregiver
- Ordering prescription medications, tests, or procedures
- Referring and communicating with other health care providers when not separately reported during the visit
- Documenting clinical information in the electronic or other health record
- Independently interpreting and communicating results to the patient/family/caregiver
- Coordinating the care of the patient (case manager; discharge; instructions for post-op care)
- Time spent communicating with patient, family and/or caregiver through an interpreter
- Time spent on causation or apportionment analysis

Provider time does not include:

- Completing a WC-164
- Activities related to QPOP
- Activities not included in the documentation
- Time associated with any other billed code

Code	Time	Code	Time
99202	15-29	99212	10-19
99203	30-44	99213	20-29
99204	45-59	99214	30-39
99205	60-74	99215	40-54

Exhibit # 2
Base Rates and Cost-to-Charge Ratios – Effective 1/1/2024
Source: Medicare FY 2023 IPPS Impact File – Correcting Amendment (November 2022)

Provider Number	Name	Total CCR	Individual Hospital Base Rate
060001	North Colorado Medical Center	0.253	$7,913.40
060003	Centura Longmont United Hospital	0.26	$7,202.19
060004	Platte Valley Medical Center	0.373	$7,111.39
060006	Montrose Regional Health	0.364	$7,106.37
060008	San Luis Valley Health	0.405	$7,111.39
060009	Lutheran Medical Center	0.212	$7,216.63
060010	Poudre Valley Hospital	0.235	$7,447.82
060011	Denver Health Medical Center	0.257	$9,220.64
060012	Centura St Mary-Corwin Hospital	0.311	$7,996.66
060013	Centura Mercy Hospital	0.245	$8,888.69
060014	Presbyterian St Luke's Medical Center	0.126	$7,606.67
060015	Centura St Anthony Hospital	0.183	$7,276.71
060020	Parkview Medical Center, Inc	0.129	$8,039.39
060022	University Colo Health Memorial Hospital Central	0.177	$7,294.42
060023	St Marys Medical Center	0.253	$7,742.79
060024	University Of Colorado Hospital Authority	0.152	$9,036.21
060027	Foothills Hospital	0.195	$7,036.98
060028	Saint Joseph Hospital	0.189	$7,899.49
060030	Mckee Medical Center	0.351	$7,135.92

060031	Centura Penrose Hospital	0.178	$7,221.57
060032	Rose Medical Center	0.112	$7,350.05
060034	Swedish Medical Center	0.087	$7,525.57
060044	Centura St Elizabeth Hospital	0.298	$7,329.90
060049	Uchealth Yampa Valley Medical Center	0.455	$10,736.66
060054	Community Hospital	0.207	$7,111.39
060064	Centura Porter Adventist Hospital	0.215	$7,114.28
060065	North Suburban Medical Center	0.092	$7,466.27
060071	Delta County Memorial Hospital	0.416	$7,027.86
060075	Valley View Hospital Association	0.398	$9,187.74
060076	Sterling Regional Medcenter	0.49	$8,716.57
060096	Vail Health Hospital	0.568	$13,453.27
060100	Medical Center Of Aurora, The	0.101	$7,632.39
060103	Centura Avista Adventist Hospital	0.256	$7,272.33
060104	Centura St Anthony North Hospital	0.163	$8,038.53
060107	National Jewish Health	0.185	$6,918.48
060112	Sky Ridge Medical Center	0.081	$7,965.33
060113	Centura Littleton Adventist Hospital	0.179	$6,981.62
060114	Centura Parker Adventist Hospital	0.192	$7,021.58
060116	Good Samaritan Medical Center	0.183	$6,982.54
060117	Animas Surgical Hospital, Llc	0.394	$6,918.48
060118	Centura St Anthony Summit Hospital	0.351	$7,111.39

060119	Medical Center Of The Rockies	0.244	$7,005.97
060124	Orthocolorado Hospital At St Anthony Med Campus	0.173	$6,918.48
060125	Centura Castle Rock Adventist Hospital	0.211	$7,016.61
060126	Banner Fort Collins Medical Center	0.417	$7,111.39
060128	Longs Peak Hospital	0.246	$7,111.39
060129	Uchealth Broomfield Hospital	0.313	$7,111.39
060130	Uchealth Grandview Hospital	0.304	$6,976.35
060131	Uchealth Greeley Hospital	0.327	$7,121.16
060132	Uchealth Highlands Ranch Hospital	0.269	$6,978.09
*	Critical Access Hospitals	0.568	$13,453.27
069999	Any New Hospital	0.256	$6,859.53

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*	Critical Access Hospitals	0.568	$13,453.27
069999	Any New Hospital	0.256	$6,859.53

Exhibit #4 – Effective 1/1/2024
APCs for Procedures with Status Indicator C When Performed in an OP Hospital or ASC

Proc	Description	APC
0202T	Post vert arthrplst 1 lumbar	5115
0219T	Plmt post facet implt cerv	5115
0220T	Plmt post facet implt thor	5115
20802	Replantation arm complete	5116
20805	Replant forearm complete	5116
20808	Replantation hand complete	5116
20816	Replantation digit complete	5114
20824	Replantation thumb complete	5114
20827	Replantation thumb complete	5114
20838	Replantation foot complete	5116
20955	Fibula bone graft microvasc	5114
20956	Iliac bone graft microvasc	5114
20957	Mt bone graft microvasc	5114
20962	Other bone graft microvasc	5114
20969	Bone/skin graft microvasc	5114
20970	Bone/skin graft iliac crest	5114
21045	Extensive jaw surgery	5165
21145	Lefort i-1 piece w/ graft	5165
21146	Lefort i-2 piece w/ graft	5165
21147	Lefort i-3/> piece w/ graft	5165
21151	Lefort ii w/bone grafts	5165
21154	Lefort iii w/o lefort i	5165
21155	Lefort iii w/ lefort i	5165
21159	Lefort iii w/fhdw/o lefort i	5165
21160	Lefort iii w/fhd w/ lefort i	5165
21179	Reconstruct entire forehead	5165
21180	Reconstruct entire forehead	5165
21182	Reconstruct cranial bone	5165

21183	Reconstruct cranial bone	5165
21184	Reconstruct cranial bone	5165
21188	Reconstruction of midface	5165
21247	Reconstruct lower jaw bone	5165
21268	Revise eye sockets	5165
21343	Open tx dprsd front sinus fx	5165
21344	Open tx compl front sinus fx	5165
21348	Opn tx nasomax fx w/graft	5165
21423	Treat mouth roof fracture	5165
21431	Treat craniofacial fracture	5165
21432	Treat craniofacial fracture	5165
21433	Treat craniofacial fracture	5165
21435	Treat craniofacial fracture	5165
21436	Treat craniofacial fracture	5165
21510	Drainage of bone lesion	5114
21602	Exc ch wal tum w/o lymphadec	5114
21603	Exc ch wal tum w/lymphadec	5114
21615	Removal of rib	5114
21616	Removal of rib and nerves	5114
21620	Partial removal of sternum	5114
21627	Sternal debridement	5114
21630	Extensive sternum surgery	5114
21632	Extensive sternum surgery	5114
21705	Revision of neck muscle/rib	5114
21740	Reconstruction of sternum	5114
21750	Repair of sternum separation	5114
21825	Treat sternum fracture	5114
22010	I&d p-spine c/t/cerv-thor	5114
22015	I&d abscess p-spine l/s/ls	5114
22110	Remove part of neck vertebra	5114
22112	Remove part thorax vertebra	5114

22114	Remove part lumbar vertebra	5114
22206	Incis spine 3 column thorac	5114
22207	Incis spine 3 column lumbar	5114
22210	Incis 1 vertebral seg cerv	5114
22212	Incis 1 vertebral seg thorac	5114
22214	Incis 1 vertebral seg lumbar	5114
22220	Osteot dsc ant 1 vrt sgm crv	5114
22222	Osteot dsc ant 1vrt sgm thrc	5114
22224	Osteot dsc ant 1vrt sgm lmbr	5114
22318	Treat odontoid fx w/o graft	5115
22319	Treat odontoid fx w/graft	5115
22325	Treat spine fracture	5115
22326	Treat neck spine fracture	5115
22327	Treat thorax spine fracture	5115
22532	Arthrd lat xtrcvtry tq thrc	5116
22533	Arthrd lat xtrcvtry tq lmbr	5116
22548	Arthrd ant toral/xoral c1-c2	5116
22556	Arthrd ant ntrbd min dsc thc	5116
22558	Arthrd ant ntrbd min dsc lum	5116
22586	Arthrd pre-sac ntrbdy l5-s1	5116
22590	Arthrd pst tq craniocervical	5116
22595	Arthrd pst tq atlas-axis	5116
22600	Arthrd pst tq 1ntrspc crv	5116
22610	Arthrd pst tq 1ntrspc thrc	5116
22800	Arthrd pst dfrm<6 vrt sgm	5116
22802	Arthrd pst dfrm 7-12 vrt sgm	5116
22804	Arthrd pst dfrm 13+ vrt sgm	5116
22808	Arthrd ant dfrm 2-3 vrt sgm	5116
22810	Arthrd ant dfrm 4-7 vrt sgm	5116
22812	Arthrd ant dfrm 8+ vrt sgm	5116
22818	Kyphectomy 1-2 segments	5116

22819	Kyphectomy 3 or more	5116
22830	Exploration of spinal fusion	5115
22849	Reinsert spinal fixation	5116
22850	Remove spine fixation device	5115
22852	Remove spine fixation device	5115
22855	Remove spine fixation device	5115
22857	Tot disc arthrp ant lumbar	5116
22861	Revise cerv artific disc	5116
22862	Revise lumbar artif disc	5116
22864	Remove cerv artif disc	5115
22865	Remove lumb artif disc	5115
23200	Resect clavicle tumor	5114
23210	Resect scapula tumor	5114
23220	Resect prox humerus tumor	5114
23335	Shoulder prosthesis removal	5073
23474	Revis reconst shoulder joint	5115
23900	Amputation of arm & girdle	5115
23920	Amputation at shoulder joint	5115
24900	Amputation of upper arm	5115
24920	Amputation of upper arm	5115
24930	Amputation follow-up surgery	5114
24931	Amputate upper arm & implant	5115
24940	Revision of upper arm	5115
25900	Amputation of forearm	5115
25905	Amputation of forearm	5115
25915	Amputation of forearm	5114
25920	Amputate hand at wrist	5114
25924	Amputation follow-up surgery	5114
25927	Amputation of hand	5113
26551	Great toe-hand transfer	5114
26553	Single transfer toe-hand	5114

26554	Double transfer toe-hand	5114
26556	Toe joint transfer	5114
26992	Drainage of bone lesion	5114
27005	Incision of hip tendon	5114
27025	Incision of hip/thigh fascia	5114
27030	Drainage of hip joint	5114
27036	Excision of hip joint/muscle	5114
27054	Removal of hip joint lining	5113
27070	Part remove hip bone super	5114
27071	Part removal hip bone deep	5114
27075	Resect hip tumor	5114
27076	Resect hip tum incl acetabul	5114
27077	Resect hip tum w/innom bone	5115
27078	Rsect hip tum incl femur	5115
27090	Removal of hip prosthesis	5073
27091	Removal of hip prosthesis	5073
27120	Reconstruction of hip socket	5115
27122	Reconstruction of hip socket	5115
27125	Partial hip replacement	5115
27132	Total hip arthroplasty	5115
27134	Revise hip joint replacement	5115
27137	Revise hip joint replacement	5115
27138	Revise hip joint replacement	5115
27140	Transplant femur ridge	5115
27146	Incision of hip bone	5114
27147	Revision of hip bone	5114
27151	Incision of hip bones	5114
27156	Revision of hip bones	5114
27158	Revision of pelvis	5114
27161	Incision of neck of femur	5114
27165	Incision/fixation of femur	5114

27170	Repair/graft femur head/neck	5114
27175	Treat slipped epiphysis	5114
27176	Treat slipped epiphysis	5115
27177	Treat slipped epiphysis	5114
27178	Treat slipped epiphysis	5114
27181	Treat slipped epiphysis	5114
27185	Revision of femur epiphysis	5114
27187	Reinforce hip bones	5114
27226	Treat hip wall fracture	5114
27227	Treat hip fracture(s)	5114
27228	Treat hip fracture(s)	5114
27232	Treat thigh fracture	5112
27236	Treat thigh fracture	5114
27240	Treat thigh fracture	5112
27244	Treat thigh fracture	5114
27245	Treat thigh fracture	5114
27248	Treat thigh fracture	5114
27253	Treat hip dislocation	5113
27254	Treat hip dislocation	5113
27258	Treat hip dislocation	5113
27259	Treat hip dislocation	5113
27268	Cltx thigh fx w/mnpj	5113
27269	Optx thigh fx	5112
27280	Fusion of sacroiliac joint	5116
27282	Fusion of pubic bones	5115
27284	Fusion of hip joint	5116
27286	Fusion of hip joint	5116
27290	Amputation of leg at hip	5116
27295	Amputation of leg at hip	5116
27303	Drainage of bone lesion	5114
27365	Resect femur/knee tumor	5114

27445	Revision of knee joint	5115
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Notice of Proposed Rulemaking

Tracking number

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1100 - Department of Labor and Employment

Agency

1107 - Division of Family and Medical Leave Insurance

CCR number

7 CCR 1107-1

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REGULATIONS CONCERNING PAID FAMILY MEDICAL LEAVE PROGRAM

Rulemaking Hearing

Date

08/01/2023

Time

10:15 AM

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Online: Zoom: https://us02web.zoom.us/meeting/register/tZMofuGoqzosGtG9_jIHjjv3sjKY1R4uHPty

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Statutory authority

C.R.S. 8-13.3-516

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DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Family and Medical Leave Insurance~~AMLI~~

REGULATIONS CONCERNING PREMIUMS AND INDIVIDUALS ELECTING COVERAGE~~AID FAMILY MEDICAL LEAVE PROGRAM~~

7 CCR 1107-1

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

1.1. Statements of Authority, Purpose, and Incorporation by Reference

1. This regulation is adopted pursuant to the authority in section C.R.S. 8-13.3-501 et seq. and is intended to be consistent with the requirements of the State Administrative Procedures Act, C.R.S. 24-4-101 et seq. (the "APA"), and the Paid Family and Medical Leave Insurance Act, C.R.S. 8-13.3-501 through 524 (the "FAMLI Act").

2. The general purpose of these rules is to exercise the authority of this Division to enforce and implement the Paid Family and Medical Leave Insurance Act (C.R.S. 8-13.3-501 et seq.) with regard to premiums and individuals electing coverage.

3. Title 8 Articles 4, 13.3, and 70 of the Colorado Revised Statutes (2023), 26 U.S.C. § 1402 (2023), 42 U.S.C. § 430 (2023), 38 U.S.C. §§ 4301-4334 (2023), 7 CCR 1103-1 (2023), 7 CCR 1107-4 (2023), and 7 CCR 1107-8 (2023) are hereby incorporated by reference. Earlier versions of such laws may apply to events that occurred in prior years. Such incorporation excludes later amendments to or editions of the statutes. These statutes and regulations are available for public inspection at the Colorado Department of Labor and Employment, Division of Family and Medical Leave Insurance, 633 17th Street, Denver CO 80202. Copies may be obtained from this Division at a reasonable charge, or can be accessed electronically from the website of the Colorado Secretary of State. Pursuant to C.R.S. § 24-4-103(12.5)(b), the agency shall provide certified copies of the statutes and regulations incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency originally issuing the statutes. All Division Rules are available to the public at famli.colorado.gov. Where these Rules have provisions different from or contrary to any incorporated or referenced material, the provisions of these Rules govern so long as these are consistent with Colorado statutory and constitutional provisions.

4. If any part of these rules is held invalid, the remainder shall remain valid, and if any part is held not wholly invalid, but in need of narrowing, it will be retained in narrowed form.

~~**1.2 Scope and Purpose**~~

~~**A. This regulation implements the procedural and substantive provisions for the Family and Medical Leave Insurance program pursuant to C.R.S. 8-13.3-507, concerning the establishment, collection, and administration of premium collections.**~~

~~**B. This regulation does not apply to any other premiums, fees, taxes, or collections outlined in unemployment insurance, worker compensation, private temporary disability insurance or private family leave insurance programs or other programs not administered by the Division.**~~

~~**1.3 Applicability**~~

~~**The provision of this Section will apply to employers as defined in C.R.S. 8-13.3-503(8) who are operating within the State of Colorado, no matter what State, county, or territory the employer is physically located in or claims as a base of operations, unless otherwise specified by exemptions in C.R.S. 8.13.3-503(8) or federal law.**~~

~~**The provisions of this Section will be applicable to self-employed persons who elect coverage under C.R.S. 8-13.3-514 and employees of any local government who elect coverage under C.R.S. 8-13.3-514.**~~

~~**If any part of these rules is held invalid, the remainder shall remain valid, and if any part is held not wholly invalid, but in need of narrowing, it will be retained in narrowed form.**~~

1.24 Definitions and Clarifications

1. Unless otherwise indicated, terms used here that are defined in the FAMLI Act have the same definition as they do under the FAMLI Act.

2. "Calendar Quarter" has the same definition as C.R.S. 8-70-103(6).

3. "Gross income from self-employment" means the gross income derived by an individual from any trade or business carried on by such individual, as used in 26 U.S.C. § 1402.~~has the same meaning as defined at 26 CFR § 1.61-1 through 1.61-14.~~

~~"Division" has the same definition as C.R.S. 8-13.3-503(5).~~

~~"Employee" has the same definition as C.R.S. 8-13.3-503(7).~~

~~"Employee share" is defined as 50 percent of the premium required for an employee by section C.R.S. 8-13.3-507(3).~~

~~"Employer" has the same definition as C.R.S. 8-13.3-503(8).~~

~~"Employer share" is defined as 50 percent of the premium required for an employee by section C.R.S. 8-13.3-507(3).~~

~~"FAMLI" is defined as the Paid Family and Medical Leave Insurance Act, C.R.S. 8-13.3-501 through 524 (the "Act").~~

~~"Net earnings from self-employment" has the same meaning as in the Internal Revenue Code at 26 U.S.C. § 1402(a), in effect for the taxable year, and the implementing regulations at 26 CFR 1.1402(a).~~

4. "Individual electing coverage" means either an employee of a local government that has declined participation in the family and medical leave insurance program or a self-employed person, who elects family and medical leave insurance~~individual who elects FAMLI~~ coverage pursuant to C.R.S. 8-13.3-514.

5. "My FAMLI+ Employer" means the online portal through which employers and individuals will interact with the FAMLI Division. Activities completed through this portal include, but are not limited to, electing coverage, declining coverage, reporting wages, and remitting premiums pursuant to the FAMLI Act and its implementing regulations.

6. "Premium" is defined as the money payments required pursuant to C.R.S. 8-13.3-507 to finance the payment of family and medical leave insurance benefits and administer the family and medical leave insurance program.

7. "Self-Employed Person" or "self-employed individual," means an individual who either: (1) carries on a trade or business as a sole proprietor or an independent contractor; (2) is a member of a partnership that carries on a trade or business; or (3) is otherwise in business for himself or herself (including a part-time business or a "gig worker"). An individual as used in the FAMLI Act and its implementing regulations includes individuals who does not meet the FAMLI Act's two-prong exception to the definition of "employee" at C.R.S. 8-13.3-503(7) is not a self-employed person or individual.

8. "Tax transcript" means a full copy of the individual's "record of account transcript" from the Internal Revenue Service ("IRS").

9. "Wages" as used in the FAMLI Act and its implementing regulations means "gross wages," and includes monetary compensation described by C.R.S. 8-4-101(14)(a), employer-provided paid leave pursuant to 7 CCR 1107-4 Section 4.2.2., and leave from a separate bank of time off solely for the purpose of paid family and medical leave as described by 7 CCR 1107-4 Section 4.2.5., if such leave is paid to the employee by the employer and not by a third party. "Wages" does not include compensation described by C.R.S. 8-4-101(14)(b), compensation described by C.R.S. 8-4-103(3), or any non-monetary payment except for the portion of any non-monetary payment used as credit toward the minimum wage pursuant to 7 CCR 1103-1 Sections 6.2.1 and 6.2.2. "Wages" for self-employed individuals who elected coverage means "gross income from self-employment" as defined in these rules. has the same meaning as C.R.S. 8-70-141 and its implementing regulations at 7 CCR 1101-2, and excludes remuneration described by C.R.S. 8-70-142.

1.35 Individuals Electing CoverageAssessing and Collecting Premiums

1.5.1 Election, Withdrawal, and Cancellation of Coverage for Individuals Electing Coverage

A1. Individuals electing coverage may elect coverage under C.R.S. 8-13.3-514 for an initial period of coverage of three years.

A1. Notice of election of coverage must be submitted to the Division via My FAMLI+ Employer. For self-employed individuals, the notice of election must include a copy of their most recent tax transcript, and no communication from a self-employed individual will constitute a notice of election without it.

B2. Elective coverage becomes effective on:

1. Tthe date of filing the notice of election;, or

2. If the individual so chooses, the first day of one of the five most recent closed calendar quarters.

C3. A period of coverage is defined as:

1.(a) The three years following the first day of elective coverage or any gap in coverage; and

2.(b) Each subsequent year.

D4. Any individual electing coverage may file a notice of withdrawal within thirty calendar days after the end of a each period of coverage.

E. The notice of withdrawal must include an effective date of the withdrawal, which must be no sooner than thirty days after the filing of the notice of withdrawal.

F5. A notice of withdrawal from coverage must be submitted to the Division online or in another format approved by the Division.

G~~6~~. Upon termination of coverage, due and unpaid premiums must be paid, as well as any interest or~~,~~ fines~~, or penalties~~ assessed.

2. Provisions specific to self-employed individuals electing coverage:

A. When the Division receives a completed notice of election from a self-employed individual, it will review the tax transcript to confirm gross income from self-employment.

B. If the tax transcript includes gross income from self-employment:

1. The Division will presume that the tax transcript reflects four quarters of gross income from self-employment.

2. The Division will determine prospective quarterly gross income from self-employment by dividing the tax transcript's total gross income from self-employment by four.

3. If the individual submits evidence sufficient for the Division to conclude that the tax transcript reflects fewer than four quarters of gross income from self-employment, the Division will adjust its calculation accordingly in order to determine prospective quarterly gross income from self-employment. For example, if the Division concludes that an individual's tax transcript reflects only two quarters of gross income from self-employment, then the Division will determine prospective quarterly gross income from self-employment by dividing the tax transcript's total gross income from self-employment by two.

4. The individual's premium liability and wage replacement benefits will be based on the prospective quarterly gross income from self-employment until the individual submits subsequent tax transcripts in accordance with these rules, at which point the Division will make any necessary adjustments to prior premium liability and wage replacement benefits, and will recalculate prospective quarterly gross income from self-employment for the following year.

C. If the tax transcript does not include gross income from self-employment, then the individual's premium liability and wage replacement benefits will be based on actual gross income reported quarterly in accordance with these rules. The individual must submit invoices, payment records, and bank records to verify actual gross income reported. After the individual submits subsequent tax transcripts in accordance with these rules, the individual's premium liability and wage replacement benefits will be based on prospective gross income from self-employment, calculated by the Division in accordance with these rules.

D. In addition to the tax transcript required in the notice of election, a self-employed individual electing coverage must annually submit to the Division a tax transcript by June 1 or within fourteen (14) days after filing their income tax return with the IRS, whichever is later. The Division may accept a tax transcript outside of these timeframes upon a showing of good cause by a self-employed individual.

3. All individuals electing coverage must report wages and remit premium payments no later than the last day of the month immediately following the end of the calendar quarter for which the premiums have accrued. The Division may require additional information or documentation from any individual electing coverage when such information is necessary to accurately calculate and administer premiums obligations and benefit entitlements. The Division may require additional information or documentation from any individual electing coverage when such information is necessary to accurately calculate and administer premiums obligations and benefit entitlements.

~~1.5.2 Determining Wages Earned for Self-Employed Persons Regarding Premium Assessment~~

~~A. An individual electing coverage must submit earnings reports and remit premium payments no later than the last day of the month immediately following the end of the calendar quarter for which the premiums have accrued.~~

~~B. Pursuant to C.R.S. 8-13.3-507(4)(a), an individual electing coverage is required to submit only 50 percent of the premium required for an employee by section C.R.S. 8-13.3-507(3) on that individual's income.~~

~~C. Upon electing coverage, self-employed individuals shall choose between reporting gross income or net earnings from self-employment, for purposes of calculating premiums and benefits.~~

~~D. A self-employed individual may elect to change their premium and benefit calculation basis between gross and net one time within a coverage period.~~

~~E. The Division may require copies of tax returns, bank records, self-attestations, or any other documents deemed necessary by the Division to verify or determine the income of an individual electing coverage.~~

1.~~45.3~~ Premiums ~~Remitted by an Employer~~

~~A~~1. Premiums must be paid not less than quarterly in the form and manner determined by the Division. Quarterly payments must include all premiums with respect to wages paid during the calendar quarter.

2~~1. Due Date of Premiums.~~ Premiums must be paid no later than the last day of the month immediately following the end of the calendar quarter for which the premiums have accrued.~~(a)~~ Payment will be considered timely if postmarked or received electronically on or before the due date. If the due date of premiums falls on a Saturday, Sunday, or legal holiday, payment will be considered timely if postmarked or received in person or electronically on the next business day that is not a Saturday, Sunday, or legal holiday.

~~(b) Quarterly payment will not be required when the total amount of any premiums due, including any penalties and interest accrued for an untimely or incorrect report, is less than five dollars.~~

3. ~~2. Erroneous Rate Notice.~~ If, as a result of an incorrect notification or computation by the Division of premiums due, an employer is required to make an additional payment of premiums, such additional payment will not accrue interest until thirty days after notification by the Division that such additional payments are due.

~~3~~4. U~~First payment of a new employer, u~~nless stated otherwise by exemption:

A~~(a)~~ The first premium payment of any person or entity~~employing unit~~ that becomes an employer subject to C.R.S. 8.13.3-501 et seq., at any time during a calendar year must be paid on or before the last day of the month immediately following the calendar quarter in which such person or entity~~an employing unit~~ becomes an employer.

B ~~(b)~~ Said payment must include ~~the FAMLI~~ premiums with respect to wages paid beginning the first day the person or entity becomes an employer.~~for employment occurring on and from the first day of the calendar year through all payroll periods that end within the calendar quarter in which the employing unit becomes an employer.~~

5. ~~1.~~ An employer required to remit premiums pursuant to C.R.S. 8-13.3-507 may not deduct more than the maximum allowable employee share of the premium from wages paid for a pay period.

~~B. Employers ability to deduct premiums from employees~~

A~~(a)~~ If an employer fails to deduct the maximum allowable employee share of the premium from wages paid for a pay period, the employer is considered to have elected to pay that portion of the employee share under C.R.S. 8-13.3-507, and the employer cannot deduct this amount from a future

paycheck of the employee for a different pay period. However, ~~(b) Notwithstanding Rule 1.5.3.B.1(a) above,~~ where there is a lack of sufficient employee wages to cover the employee share of premiums for a pay period, the employer may deduct the uncollected portion of the employee share from one or more paychecks for future pay periods.

B~~(c)~~ In the payment of any premiums to the Division, and in the collection of any premium contributions from an employee, a fractional part of a cent will be disregarded unless it amounts to one-half cent or more, in which case it will be increased to one cent.

~~2. Employers not required to pay the Employer share of the FAMLI premium due to employer size of business pursuant to C.R.S. 8-13.3-507(5) must remit the employees' share of the premium in the manner outlined by the Division. Such employers may deduct up to 50 percent of the premium required for an employee by C.R.S. 8-13.3-507(3), from the employee's wages and must remit 50 percent of the premium required by C.R.S. 8-13.3-507(3), to the Division.~~

~~C~~6. Premium payments to the Division will be applied in the following order:

A. Premiums owed for the current calendar quarter; and

B. Then beginning with the oldest quarter to the most recent past calendar quarter in which a balance is owed:

1. Fines;

2. Fees;

3. Interest charges;

4. Premiums; and

5. Any other debt owed to the Division.

7. If the Division receives payment in an amount that exceeds the total of any premiums, fines, interest, or other debt owed to the Division, then:

A. ~~Application of payments made to premiums~~

~~1. A payment received by the Division as a premium payment will be applied to the quarter for which the premium assessment applies.~~

~~(a) A payment exceeding the legal fees, fines, penalties, interest and premiums due for that quarter will be applied to any other debt owed to the Division in accordance with these rules.~~

~~(b) If no debt exists, premium overpayments of~~If the amount in excess is less than fifty dollars, it will be credited to future payments due; and~~.~~

B. If the amount in excess is~~(c) If no debt exists, premium overpayments of~~ fifty dollars or more, it may be refunded to the employer at the employer's request. Otherwise, it~~such overpayments~~ will be credited to future payments due.

8. If an employer or an individual electing coverage fails to remit premiums by the due dates described in these rules, the Division may assess upon the employer or individual a fine of up to $50.00 per individual whose premiums were not timely paid.

9. D. Pursuant to C.R.S. 8-13.3-507(6), premiums will not be required for wages~~, gross income, or net earnings from self-employment~~ above the contribution and benefit base limit established annually for the federal social security administration for purposes of the federal old-age survivors, and disability insurance program limits pursuant to 42 U.S.C. § 430.

~~2. Payments received will be applied in the following order of priority:~~

~~(a) Current quarter balance;~~

~~(b) Any previous quarter premium balance due starting with the oldest quarter;~~

~~(c) Then beginning with the oldest quarter in which a balance is owed:~~

~~(1) Penalties;~~

~~(2) Fines;~~

~~(3) Fees; and~~

~~(4) Interest charges.~~

1.5.4 Calculating Employer Size ~~Related To Premium Exemptions~~

~~A~~1. For determining employer size for the purpose of determining premium liability pursuant to C.R.S. 8-13.3-507(5), an employee counts toward the total number of employees if he or she is employed in any state of the United States, the District of Columbia, or any territory or possession of the United States during 20 or more workweeks in the preceding calendar year. A person is considered "employed" during a workweek for the purpose of determining premium liability if: (1) he or she performs any work for the employer during the workweek; or (2) he or she is on any type of paid or unpaid leave during the workweek, and the employer has a reasonable expectation that the employee will later return to active employment, including leave taken under the Uniformed Services Employment and Reemployment Rights Act of 1994, 38 U.S.C. §§ 4301-4334.

~~A~~1. ~~If the Division determines the employer's status has changed as it relates to premium liability, the Division will notify the employer as to their premium liability.2.~~ An employer's size for purposes of this ~~rule~~regulation 1.5.4 will be calculated upon registration with the My FAMLI+ Employer portal and annually thereafter during the first calendar quarter of the year. Any change to premium liability as a result of a change in employer size will happen no more frequently than one time per calendar year.

B. If the Division determines the employer's status has changed as it relates to premium liability, the Division will notify the employer as to their premium liability.

1.6. ~~B.~~ Colorado Localization of Employees

1. ~~Determining in-state status of employees1.~~ An employee is localized to Colorado, and their~~'s~~ wages will be subject to premiums, if

A.~~(a)~~ The employee's entire service is performed within Colorado;

B.~~(b)~~ The employee's service is performed both within and outside of Colorado, but the service performed outside the state is incidental to the employee's work within Colorado or, for example is, temporary or transitory in nature and consists of isolated transactions; or

C.~~(c)~~ Services are not localized in any state, but some of the services are performed in Colorado, and

1.~~(1)~~ The employee's base of operations is in Colorado, or if there is no base of operations, then the place from which such services are directed or controlled is in Colorado as established in C.R.S. 8-70-117, or

2.~~(2)~~ The base of operations or place from which some part of the service is directed or controlled is not in any state in which part of the service is performed, but the employee's residence is in Colorado.

2. ~~Payment to Another Jurisdiction.~~ An employer who has ~~erroneously~~ paid to another jurisdiction an amount as premiums properly payable to Colorado will not be delinquent if premiums properly payable to Colorado are paid within thirty days of the date on which the Division determines that such premiums are payable to Colorado.

1.~~75.5.~~ Assessments and Recomputations of FAMLI Premiums

1~~A~~. If~~, in the judgment of the Division or upon its information and knowledge,~~ the report of wages included in an employer's ~~FAMLI~~ premium report is incomplete or in error, the Division may require~~, and the employer shall respond within the time allotted,~~ a further report, may examine the employer's relevant books and records, or may use other reasonable measures to the extent necessary to obtain an accurate report.

2~~B~~. If an ~~contributing~~ employer is delinquent in filing a wage report within the time prescribed by the Division, or fails to provide the Division with additional records needed to make a proper determination of an amount of indebtedness, the Division may, in its discretion:

~~1~~A. Use the information and knowledge available to the Division to estimate the ~~amount of chargeable~~ wages paid by an ~~contributing~~ employer during the premium period or periods. The amount of ~~chargeable~~ wages so determined will be deemed to have been paid by the employer ~~and will be used to determine the annual payroll~~;

~~2~~B. Assess the employer for ~~FAMLI~~ premiums calculated on the basis of the estimated wages; and

~~3~~C. Issue a subpoena duces tecum to compel an employer to release books and records to the Division for use in obtaining the required information.

~~C~~3. The Division will notify an ~~A contributing~~ employer who is delinquent in filing reports or paying ~~FAMLI~~ premiums by sending a determination letter to the employer's correct address ~~will be promptly notified of the assessment by the communication method the employer elected during FAMLI registration. Premiums will not be considered delinquent if paid within thirty days after the date on which the Division notifies the employer of the delinquent payment~~. Any outstanding premiums past due shall accrue interest pursuant to 7 CCR 1107-8 Section 8.10.

~~D~~4. The Division may correct errors of computation whenever such erroneous computations are found or brought to the Division's attention.

~~**1.6 Notification of FAMLI Premium Liability**~~

~~**A. The Division will notify employers and individuals electing coverage of their expected premium amount on the first business day of the calendar month the premium is due to be paid.**~~

~~**1. Notification will be sent electronically, either via My FAMLI+ Employer or to the email address provided to the Colorado Department of Labor and Employment.**~~

~~(a) Employers, including self-employed persons may choose a business representative such as a payroll service provider, attorney, or accountant to receive notification on their behalf.~~

~~(b) Local governments that have declined participation in the FAMLI program pursuant to C.R.S. 8-13.3-522, but which have agreed to withhold and remit the employee share of premiums for employees who elect coverage under C.R.S. 8-13.3-514, will be provided a quarterly list of employees who have elected coverage pursuant to C.R.S. 8-13.3-514. Local governments which have declined participation in the FAMLI program pursuant to section C.R.S. 8-13.3-522, and have declined to withhold and remit the employee share of premiums for employees who elect coverage under C.R.S. 8-13.3-514, will receive no such quarterly list.~~

~~2. A schedule of due dates as well as guidance as to how to remit premiums will be posted by the Division on the FAMLI website and will remain publicly available.~~

~~B. Employers not subject to a premium liability due to coverage through a pre-approved substitute private plan under C.R.S. 8-13.3-521 will not receive quarterly notifications of premium liability from the Division.~~

Editor's Notes

History

New rule eff. 01/01/2022.

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Family and Medical Leave Insurance

REGULATIONS CONCERNING PREMIUMS AND INDIVIDUALS ELECTING COVERAGE

7 CCR 1107-1

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

1.1. Statements of Authority, Purpose, and Incorporation by Reference

1. This regulation is adopted pursuant to the authority in section C.R.S. 8-13.3-501 et seq. and is intended to be consistent with the requirements of the State Administrative Procedures Act, C.R.S. 24-4-101 et seq. (the "APA"), and the Paid Family and Medical Leave Insurance Act, C.R.S. 8-13.3-501 through 524 (the "FAMLI Act").

2. The general purpose of these rules is to exercise the authority of this Division to enforce and implement the Paid Family and Medical Leave Insurance Act (C.R.S. 8-13.3-501 et seq.) with regard to premiums and individuals electing coverage.

3. Title 8 Articles 4, 13.3, and 70 of the Colorado Revised Statutes (2023), 26 U.S.C. § 1402 (2023), 42 U.S.C. § 430 (2023), 38 U.S.C. §§ 4301-4334 (2023), 7 CCR 1103-1 (2023), 7 CCR 1107-4 (2023), and 7 CCR 1107-8 (2023) are hereby incorporated by reference. Earlier versions of such laws may apply to events that occurred in prior years. Such incorporation excludes later amendments to or editions of the statutes. These statutes and regulations are available for public inspection at the Colorado Department of Labor and Employment, Division of Family and Medical Leave Insurance, 633 17th Street, Denver CO 80202. Copies may be obtained from this Division at a reasonable charge, or can be accessed electronically from the website of the Colorado Secretary of State. Pursuant to C.R.S. § 24-4-103(12.5)(b), the agency shall provide certified copies of the statutes and regulations incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency originally issuing the statutes. All Division Rules are available to the public at famli.colorado.gov. Where these Rules have provisions different from or contrary to any incorporated or referenced material, the provisions of these Rules govern so long as these are consistent with Colorado statutory and constitutional provisions.

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1.2 Definitions and Clarifications

1. Unless otherwise indicated, terms used here that are defined in the FAMLI Act have the same definition as they do under the FAMLI Act.

2. "Calendar Quarter" has the same definition as C.R.S. 8-70-103(6).

3. "Gross income from self-employment" means the gross income derived by an individual from any trade or business carried on by such individual, as used in 26 U.S.C. § 1402.

4. "Individual electing coverage" means either an employee of a local government that has declined participation in the family and medical leave insurance program or a self-employed person, who elects family and medical leave insurance coverage pursuant to C.R.S. 8-13.3-514.

5. "My FAMLI+ Employer" means the online portal through which employers and individuals will interact with the FAMLI Division. Activities completed through this portal include, but are not limited to, electing coverage, declining coverage, reporting wages, and remitting premiums pursuant to the FAMLI Act and its implementing regulations.

6. "Premium" is defined as the money payments required pursuant to C.R.S. 8-13.3-507 to finance the payment of family and medical leave insurance benefits and administer the family and medical leave insurance program.

7. "Self-Employed Person" or "self-employed individual" means an individual who either: (1) carries on a trade or business as a sole proprietor or an independent contractor; (2) is a member of a partnership that carries on a trade or business; or (3) is otherwise in business for himself or herself (including a part-time business or a "gig worker"). An individual who does not meet the FAMLI Act's two-prong exception to the definition of "employee" at C.R.S. 8-13.3-503(7) is not a self-employed person or individual.

8. "Tax transcript" means a full copy of the individual's "record of account transcript" from the Internal Revenue Service ("IRS").

9. "Wages" as used in the FAMLI Act and its implementing regulations means "gross wages," and includes monetary compensation described by C.R.S. 8-4-101(14)(a), employer-provided paid leave pursuant to 7 CCR 1107-4 Section 4.2.2., and leave from a separate bank of time off solely for the purpose of paid family and medical leave as described by 7 CCR 1107-4 Section 4.2.5., if such leave is paid to the employee by the employer and not by a third party. "Wages" does not include compensation described by C.R.S. 8-4-101(14)(b), compensation described by C.R.S. 8-4-103(3), or any non-monetary payment except for the portion of any non-monetary payment used as credit toward the minimum wage pursuant to 7 CCR 1103-1 Sections 6.2.1 and 6.2.2. "Wages" for self-employed individuals who elected coverage means "gross income from self-employment" as defined in these rules.

1.3 Individuals Electing Coverage

1. Individuals electing coverage may elect coverage under C.R.S. 8-13.3-514 for an initial period of coverage of three years.

   A. Notice of election of coverage must be submitted to the Division via My FAMLI+ Employer. For self-employed individuals, the notice of election must include a copy of their most recent tax transcript, and no communication from a self-employed individual will constitute a notice of election without it.

   B. Elective coverage becomes effective on:

      1. The date of filing the notice of election; or

      2. If the individual so chooses, the first day of one of the five most recent closed calendar quarters.

   C. A period of coverage is defined as:

      1. The three years following the first day of elective coverage or any gap in coverage; and

2. Each subsequent year.

D. Any individual electing coverage may file a notice of withdrawal within thirty calendar days after the end of a period of coverage.

E. The notice of withdrawal must include an effective date of the withdrawal, which must be no sooner than thirty days after the filing of the notice of withdrawal.

F. A notice of withdrawal from coverage must be submitted to the Division online or in another format approved by the Division.

G. Upon termination of coverage, due and unpaid premiums must be paid, as well as any interest or fines assessed.

2. Provisions specific to self-employed individuals electing coverage:

A. When the Division receives a completed notice of election from a self-employed individual, it will review the tax transcript to confirm gross income from self-employment.

B. If the tax transcript includes gross income from self-employment:

1. The Division will presume that the tax transcript reflects four quarters of gross income from self-employment.

2. The Division will determine prospective quarterly gross income from self-employment by dividing the tax transcript's total gross income from self-employment by four.

3. If the individual submits evidence sufficient for the Division to conclude that the tax transcript reflects fewer than four quarters of gross income from self-employment, the Division will adjust its calculation accordingly in order to determine prospective quarterly gross income from self-employment. For example, if the Division concludes that an individual's tax transcript reflects only two quarters of gross income from self-employment, then the Division will determine prospective quarterly gross income from self-employment by dividing the tax transcript's total gross income from self-employment by two.

4. The individual's premium liability and wage replacement benefits will be based on the prospective quarterly gross income from self-employment until the individual submits subsequent tax transcripts in accordance with these rules, at which point the Division will make any necessary adjustments to prior premium liability and wage replacement benefits, and will recalculate prospective quarterly gross income from self-employment for the following year.

C. If the tax transcript does not include gross income from self-employment, then the individual's premium liability and wage replacement benefits will be based on actual gross income reported quarterly in accordance with these rules. The individual must submit invoices, payment records, and bank records to verify actual gross income reported. After the individual submits subsequent tax transcripts in accordance with these rules, the individual's premium liability and wage replacement benefits will be based on prospective gross income from self-employment, calculated by the Division in accordance with these rules.

D. In addition to the tax transcript required in the notice of election, a self-employed individual electing coverage must annually submit to the Division a tax transcript by June

1 or within fourteen (14) days after filing their income tax return with the IRS, whichever is later. The Division may accept a tax transcript outside of these timeframes upon a showing of good cause by a self-employed individual.

3. All individuals electing coverage must report wages and remit premium payments no later than the last day of the month immediately following the end of the calendar quarter for which the premiums have accrued. The Division may require additional information or documentation from any individual electing coverage when such information is necessary to accurately calculate and administer premiums obligations and benefit entitlements. The Division may require additional information or documentation from any individual electing coverage when such information is necessary to accurately calculate and administer premiums obligations and benefit entitlements.

1.4 Premiums

1. Premiums must be paid not less than quarterly in the form and manner determined by the Division. Quarterly payments must include all premiums with respect to wages paid during the calendar quarter.

2. Premiums must be paid no later than the last day of the month immediately following the end of the calendar quarter for which the premiums have accrued. Payment will be considered timely if postmarked or received electronically on or before the due date. If the due date of premiums falls on a Saturday, Sunday, or legal holiday, payment will be considered timely if postmarked or received in person or electronically on the next business day that is not a Saturday, Sunday, or legal holiday.

3. If, as a result of an incorrect notification or computation by the Division of premiums due, an employer is required to make an additional payment of premiums, such additional payment will not accrue interest until thirty days after notification by the Division that such additional payments are due.

4. Unless stated otherwise by exemption:

   A. The first premium payment of any person or entity that becomes an employer subject to C.R.S. 8.13.3-501 et seq., at any time during a calendar year must be paid on or before the last day of the month immediately following the calendar quarter in which such person or entity becomes an employer.

   B. Said payment must include premiums with respect to wages paid beginning the first day the person or entity becomes an employer.

5. An employer required to remit premiums pursuant to C.R.S. 8-13.3-507 may not deduct more than the maximum allowable employee share of the premium from wages paid for a pay period.

   A. If an employer fails to deduct the maximum allowable employee share of the premium from wages paid for a pay period, the employer is considered to have elected to pay that portion of the employee share under C.R.S. 8-13.3-507, and the employer cannot deduct this amount from a future paycheck of the employee for a different pay period. However, where there is a lack of sufficient employee wages to cover the employee share of premiums for a pay period, the employer may deduct the uncollected portion of the employee share from one or more paychecks for future pay periods.

   B. In the payment of any premiums to the Division, and in the collection of any premium contributions from an employee, a fractional part of a cent will be disregarded unless it amounts to one-half cent or more, in which case it will be increased to one cent.

6. Premium payments to the Division will be applied in the following order:

   A. Premiums owed for the current calendar quarter; and

   B. Then beginning with the oldest quarter to the most recent past calendar quarter in which a balance is owed:

      1. Fines;

      2. Fees;

      3. Interest charges;

      4. Premiums; and

      5. Any other debt owed to the Division.

7. If the Division receives payment in an amount that exceeds the total of any premiums, fines, interest, or other debt owed to the Division, then:

   A. If the amount in excess is less than fifty dollars, it will be credited to future payments due; and

   B. If the amount in excess is fifty dollars or more, it may be refunded to the employer at the employer's request. Otherwise, it will be credited to future payments due.

8. If an employer or an individual electing coverage fails to remit premiums by the due dates described in these rules, the Division may assess upon the employer or individual a fine of up to $50.00 per individual whose premiums were not timely paid.

9. Pursuant to C.R.S. 8-13.3-507(6), premiums will not be required for wages above the contribution and benefit base limit established annually for the federal social security administration for purposes of the federal old-age survivors, and disability insurance program limits pursuant to 42 U.S.C. § 430.

1.5. Calculating Employer Size

1. For determining employer size for the purpose of determining premium liability pursuant to C.R.S. 8-13.3-507(5), an employee counts toward the total number of employees if he or she is employed in any state of the United States, the District of Columbia, or any territory or possession of the United States during 20 or more workweeks in the preceding calendar year. A person is considered “employed” during a workweek for the purpose of determining premium liability if: (1) he or she performs any work for the employer during the workweek; or (2) he or she is on any type of paid or unpaid leave during the workweek, and the employer has a reasonable expectation that the employee will later return to active employment, including leave taken under the Uniformed Services Employment and Reemployment Rights Act of 1994, 38 U.S.C. §§ 4301-4334.

   A. An employer's size for purposes of this rule will be calculated upon registration with the My FAMLI+ Employer portal and annually thereafter during the first calendar quarter of the year. Any change to premium liability as a result of a change in employer size will happen no more frequently than one time per calendar year.

   B. If the Division determines the employer's status has changed as it relates to premium liability, the Division will notify the employer as to their premium liability.

1.6. Colorado Localization of Employees

1. An employee is localized to Colorado, and their wages will be subject to premiums, if:

    A. The employee's entire service is performed within Colorado;

    B. The employee's service is performed both within and outside of Colorado, but the service performed outside the state is incidental to the employee's work within Colorado or, for example is, temporary or transitory in nature and consists of isolated transactions; or

    C. Services are not localized in any state, but some of the services are performed in Colorado, and

        1. The employee's base of operations is in Colorado, or if there is no base of operations, then the place from which such services are directed or controlled is in Colorado as established in C.R.S. 8-70-117, or

        2. The base of operations or place from which some part of the service is directed or controlled is not in any state in which part of the service is performed, but the employee's residence is in Colorado.

2. An employer who has paid to another jurisdiction an amount as premiums properly payable to Colorado will not be delinquent if premiums properly payable to Colorado are paid within thirty days of the date on which the Division determines that such premiums are payable to Colorado.

1.7. Assessments and Recomputations of FAMLI Premiums

1. If the report of wages included in an employer's premium report is incomplete or in error, the Division may require a further report, may examine the employer's relevant books and records, or may use other reasonable measures to the extent necessary to obtain an accurate report.

2. If an employer is delinquent in filing a wage report within the time prescribed by the Division, or fails to provide the Division with additional records needed to make a proper determination of an amount of indebtedness, the Division may, in its discretion:

    A. Use the information and knowledge available to the Division to estimate the wages paid by an employer during the premium period or periods. The amount of wages so determined will be deemed to have been paid by the employer;

    B. Assess the employer for premiums calculated on the basis of the estimated wages; and

    C. Issue a subpoena duces tecum to compel an employer to release books and records to the Division for use in obtaining the required information.

3. The Division will notify an employer who is delinquent in filing reports or paying premiums by sending a determination letter to the employer's correct address. Any outstanding premiums past due shall accrue interest pursuant to 7 CCR 1107-8 Section 8.10.

4. The Division may correct errors of computation whenever such erroneous computations are found or brought to the Division's attention.

Editor's Notes

History

New rule eff. 01/01/2022.

Notice of Proposed Rulemaking

Tracking number

2023-00361

Department

1100 - Department of Labor and Employment

Agency

1107 - Division of Family and Medical Leave Insurance

CCR number

7 CCR 1107-2

Rule title

REGULATIONS CONCERNING LOCAL GOVERNMENT PARTICIPATION WITH THE PAID FAMILY MEDICAL LEAVE PROGRAM

Rulemaking Hearing

Date

08/01/2023

Time

10:15 AM

Location

Online: Zoom: https://us02web.zoom.us/meeting/register/tZMofuGoqzosGtG9_jIHjjv3sjKY1R4uHPty

Subjects and issues involved

Edits to 7 CCR 1107-2 for further clarification and alignment to the Colorado Paid Family and Medical Leave Insurance Act C.R.S. 8-13.3-501 et seq. C.R.S. 8-13.3-516.

Statutory authority

C.R.S. 8-13.3-516

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DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Family and Medical Leave Insurance

REGULATIONS CONCERNING LOCAL GOVERNMENT PARTICIPATION WITH THE PAID FAMILY MEDICAL LEAVE PROGRAM

7 CCR 1107-2

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

2.1 Statements of Authority, Purpose, and Incorporation by Reference

1. This regulation is adopted pursuant to the authority in section C.R.S. 8-13.3-501 et seq. and is intended to be consistent with the requirements of the State Administrative Procedures Act, C.R.S. 24-4-101 et seq. (the "APA"), and the Paid Family and Medical Leave Insurance Act, C.R.S. 8-13.3-501 through 524 (the "FAMLI Act").

2. The general purpose of these rules is to exercise the authority of this Division to enforce and implement the FAMLI Act with regard to local governments.

3. Article XII Section 13 of the Colorado Constitution (2023); Title 29 Article 1, Title 8 Article 13.3, and Title 24 Article 50 of the Colorado Revised Statutes (2023); and 7 CCR 1107-1 (2023) are hereby incorporated by reference. Earlier versions of such laws may apply to events that occurred in prior years. Such incorporation excludes later amendments to or editions of the statutes. These statutes and regulations are available for public inspection at the Colorado Department of Labor and Employment, Division of Family and Medical Leave Insurance, 633 17th Street, Denver CO 80202. Copies may be obtained from this Division at a reasonable charge, or can be accessed electronically from the website of the Colorado Secretary of State. Pursuant to C.R.S. § 24-4-103(12.5)(b), the agency shall provide certified copies of the statutes and regulations incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency originally issuing the statutes. All Division Rules are available to the public at famli.colorado.gov. Where these Rules have provisions different from or contrary to any incorporated or referenced material, the provisions of these Rules govern so long as these are consistent with Colorado statutory and constitutional provisions.

4. If any part of these rules is held invalid, the remainder shall remain valid, and if any part is held not wholly invalid, but in need of narrowing, it will be retained in narrowed form.

~~**2.2**~~

~~**This regulation is adopted pursuant to the authority in section C.R.S. 8-13.3-522, and is intended to be consistent with the requirements of the State Administrative Procedures Act, C.R.S. 24-4-101 et seq. (the "APA"), and the Paid Family and Medical Leave Insurance Act, C.R.S. 8-13.3-501, et seq. (the "Act").**~~

~~**2.2 Scope and Purpose**~~

~~**A. This regulation will govern the Family and Medical Leave Insurance program pursuant to C.R.S. 8-13.3-522, concerning the process for local government employers to decline participation in the program.**~~

~~**B. This regulation will govern the process of a local government electing into the FAMLI Program, after initial declination.**~~

~~**C. This regulation will govern the notification requirements of local government employers to their employees regarding any vote to decline FAMLI coverage, the outcome of such a vote, and the ability of local government employees to voluntarily elect coverage as individuals.**~~

~~**D. This regulation does not apply to any other employer classifications within the State of Colorado, including but not limited to people who are self-employed.**~~

~~**2.3 Applicability**~~

~~**The provisions of this section will be applicable to all local government entities within the State of Colorado.**~~

~~**If any part of these rules is held invalid, the remainder shall remain valid, and if any part is held not wholly invalid, but in need of narrowing, it will be retained in narrowed form.**~~

~~**2.4**~~ **Definitions** and Clarifications

1. Unless otherwise indicated, terms used here that are defined in the FAMLI Act have the same definition as they do under the FAMLI Act.

2. "Governing Body" has the same meaning as in C.R.S. 29-1-102(12).

~~"FAMLI" is defined as the Paid Family and Medical Leave Insurance Act, C.R.S. 8-13.3-501 through 524 (the "Act").~~

~~"Division" has the same definition as C.R.S. 8-13.3-503(5) as created in C.R.S. 8-13.3-508.~~

3. "Local Government" has the same meaning as defined at C.R.S. 8-13.3-503(14), and is limited to Colorado local governments. "Local government" does not include: (1) a governmental entity with one or more employees in the state personnel system pursuant to Art. XII Section 13 of the Colorado Constitution and the State Personnel System Act, C.R.S. 24-50-101 *et seq.;* or (2) a governmental entity for which premiums were paid pursuant to C.R.S. 8-13.3-518(4)(b).

4. "Premium" has the same meaning as in 7 CCR 1107-1 Section 1.2.6~~is defined as the money payments required pursuant to C.R.S. 8-13.3-507, to finance the payment of family and medical leave insurance benefits and administer the family and medical leave insurance program~~.

2.3. Process and Notification of Program Declination

1. Local government employers are permitted to decline participation in the family and medical leave insurance program after a written notice has been delivered to the Division memorializing the decision by an affirmative vote of the local government's governing body to decline participation in the program. Such a vote must follow the local government's procedures for other votes of the governing body for similar decisions.

   A. If a local government participates in the family and medical leave program on or after January 1, 2024, and later votes to decline participation, the declination will not take effect until at least 180 days after the vote, to allow individual employees the opportunity to opt into the benefits program pursuant to C.R.S. 8-13.3-514, should individuals choose to elect coverage.

B. Public notice must be given in the same manner as any similar business before the governing body, and the local government must take/hear testimony prior to the vote if the local government has established procedures for public testimony for similar business. The local government's employees must also be notified in writing prior to the vote and provided both information regarding the vote process and the opportunity to submit comments through a public process to the governing body.

C. Within 30 days following a local government declination vote, the local government must provide its local government employees with a written individual notice of the local government's declination vote and the impact toward coverage under the FAMLI Act, or other paid family and leave insurance coverage. The written notice, must at a minimum, explain the differences between benefits offered by the state program and any other paid leave plan offered by the local government. The notice must also state which employees, if any, are eligible for job protection under the federal Family and Medical Leave Act (FMLA) benefits or other local provisions where applicable. The notice must also be delivered to all new employees hired after the date of the declination vote.

D. The written notice described at Section 2.3.1.C must contain information regarding the right of local government employees to voluntarily elect coverage pursuant to C.R.S. 8-13.3-514, and the contact information for the Division. In addition to providing written notices to individual employees in accordance with Section 2.3.1.C. of this rule, local government employers must also post a notice containing the information in a conspicuous and accessible place in each establishment where employees are employed; provided, however, in cases where the local government employer does not maintain a physical workplace, or an employee teleworks or performs work through a web-based or app-based platform, notification must be sent via electronic communication or through a conspicuous posting in the web-based or app-based platform. The individual and posted notices required in Sections 2.3.1.C. and 2.3.1.D. must be in English and in any language representing the first language spoken by at least five percent of the local government employer's workforce. The Division will create and make available to local government employers posters and notices containing the information required in this regulation, and local government employers may use the posters and notices to comply with the requirements of this section.

1. It is the responsibility of the local government employer to request printed materials from the Division. Local government employers may be responsible for the printing and mailing costs of such materials.

2. It is the responsibility of the local government to provide written notification to the Division of the local government employers interpretation needs of printed notices for languages other than English or Spanish.

2. Local governments without employees are not employers, and as such, do not need to register, vote, decline coverage, or otherwise participate in the family and medical leave insurance program.

2.~~4.~~5 Local Government Employer Participation

~~A~~1. L~~Pursuant to 7 CCR 1107-2 Section 2.6, l~~ocal government employers are required to formally notify the Division in writing and provide both the date of the vote, and the local government's decision to decline participation in the family and medical leave insurance~~FAMLI~~ program.

~~1~~A. Local governments which have previously declined participation in the family and medical leave insurance~~FAMLI~~ program pursuant to C.R.S. 8-13.3-522, may subsequently elect coverage at any time by a vote of the governing body.

~~2~~B. A local government may not decline participation in the family and medical leave insurance~~FAMLI~~ program in part. Any declination by a local government is a full declination of family and medical leave insurance~~FAMLI~~ program participation for that local government employer, except such an employer may enter into an agreement with an employee who elects coverage pursuant to C.R.S. 8-13.3-514, whereby the employer agrees to provide administrative support to the employee with regard to the employee's program ~~FAMLI~~ obligations, including but not limited to deducting premiums from the employee's wages and remitting premiums and wage reports to the Division on behalf of the employee.

2.~~B.~~ ~~Local government employers which have previously declined coverage and now wish to elect coverage of FAMLI benefits for their employees pursuant to C.R.S. 8-13.3-522(3)(b), may subsequently elect coverage by a vote of the governing body~~. ~~C.~~ A vote to decline coverage is not permanent. A local government which has previously declined coverage may vote to renew the declination ~~through a similar vote process and margin~~ no later than every eight years. The Division will notify the local government of the end of the eight-year declination period one year in advance. In the absence of a vote further declining coverage, the local government will become a covered employer immediately after the end of the eight-year declination period. The local government must inform the Division of a declination vote in writing which includes the date the vote was taken.

~~D~~3. When a local government employer returns to coverage pursuant to these rules~~7 CCR 1107-2 Sections 2.5.B or 2.5.C~~, the employer will be covered and subject to premium liability beginning on the earlier of: (1) the effective date specified by the local government employer in its notification to the Division~~,~~; or (2) the first day after the local government employer's deadline to renew its declination has passed.

4~~E~~. ~~Employees of local governments who elect coverage pursuant to C.R.S. 8-13.3-514 are eligible for benefits immediately upon electing coverage.~~ ~~F.~~ Local government employers that have previously declined participation and then subsequently elect or otherwise return to coverage under the family and medical leave insurance~~FAMLI~~ program pursuant to these regulations must remain in the program for a minimum of twelve complete calendar quarters after the elected coverage begins. If such an employer chooses to again decline ~~FAMLI~~ participation, notice of such declination must be delivered in writing to the Division at least one complete calendar quarter in advance of the end of the twelve calendar quarter cycle pursuant to this regulation.

~~G~~5. Employees must also be notified directly in writing, and at least 180 days before the pending or upcoming return to or withdrawal of coverage pursuant to this regulation.

A. Local government employers must display a notice containing the information required in this regulation in a conspicuous and accessible place in each establishment where employees are employed; provided, however, in cases where the local government employer does not maintain a physical workplace, or an employee teleworks or performs work through a web-based or app-based platform, notification must be sent via electronic communication or through a conspicuous posting in the web-based or app-based platform.

~~2~~B. The written notice and posting must contain an explanation of employee rights under the FAMLI program including but not limited to program requirements, benefits, claims process, payroll deductions and premiums, the right to job protection and benefit continuation under C.R.S. 8-13.3-509, protection against retaliatory personnel actions or other discrimination, relevant contact information for the Division, and other pertinent information.

~~3~~C. The notice and poster required by this regulation must be in English and in any language representing the first language spoken by at least five percent of the local governments employer's workplace. The Division will create and make available to local government employers posters and notices containing information required in this regulation, and local government employers may use the posters and notices to comply with the requirements of this section.

2.6~~5~~ ~~Process and Notification of FAMLI Program Declination~~

~~A. Local government employers are permitted to decline to participate in the FAMLI program after a written notice has been delivered to the FAMLI Division memorializing the decision by an affirmative vote of the local government's governing body to decline participation in the program. Such a vote must follow the local government's procedures for other votes of the governing body.~~

~~1. A declination vote that occurs after a period of FAMLI coverage will not take effect until at least 180 days after the vote, to allow individual employees the opportunity to opt into the benefits program pursuant to C.R.S. 8-13.3-514, should individuals choose to elect coverage.~~

~~2. Public notice must be given in the same manner as any other business before the governing body, and the local government must take/hear testimony prior to the vote if the local government has established procedures for public testimony. The local government's employees must also be notified in writing prior to the vote and provided both information regarding the vote process and the opportunity to submit comments through a public process to the governing body.~~

~~3. Within 30 days following a local government declination vote, the local government must provide its local government employees with a written individual notice of the local government's declination vote and the impact toward FAMLI coverage, or other paid family and leave insurance coverage. The written notice, must at a minimum, explain the differences between benefits offered by the FAMLI program and any other paid leave plan offered by the local government. The notice must also state which employees, if any, are eligible for job protection under the federal Family and Medical Leave Act (FMLA) benefits or other local provisions where applicable.~~

~~4. Written notices must contain information regarding the right of local government employees to voluntarily elect coverage pursuant to C.R.S. 8-13.3-514, and the contact information for the Division. Local government employers must display a notice containing the information in a conspicuous and accessible place in each establishment where employees are employed; provided, however, in cases where the local government employer does not maintain a physical workplace, or an employee teleworks or performs work through a web-based or app-based platform, notification must be sent via electronic communication or through a conspicuous posting in the web-based or app-based platform. The notice and poster required in this regulation must be in English and in any language representing the first language spoken by at least five percent of the local government employer's workforce. The Division will create and make available to local government employers posters and notices containing the information required in this regulation, and local government employers may use the posters and notices to comply with the requirements of this section.~~

~~(a) It is the responsibility of the local government employers to request printed materials from the Division. Local government employers may be responsible for the printing and mailing costs of such materials.~~

~~**(b) It is the responsibility of the local government to provide written notification to the Division of the local government employers interpretation needs of printed notices for languages other than English or Spanish.**~~

~~**B. The declination period is not permanent and participation must be reconsidered, and the Division notified at a minimum of every 8 years.**~~

~~2.7~~ Overpayments

In the event of an overpayment of premiums by a local government employee whose employer elects coverage after having previously declined ~~FAMLI~~ coverage, any overpaid premiums will be repaid to the employee by the Division. The Division will ensure a continuation of coverage for local government employees who have individually opted into the benefits program pursuant to C.R.S. 8-13.3-514, and ensure there is not a lapse in coverage prior to the local government's reinstatement of coverage.

Editor's Notes

History

New rule eff. 03/17/2022.

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Family and Medical Leave Insurance

REGULATIONS CONCERNING LOCAL GOVERNMENT PARTICIPATION WITH THE PAID FAMILY MEDICAL LEAVE PROGRAM

7 CCR 1107-2

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

2.1 Statements of Authority, Purpose, and Incorporation by Reference

1. This regulation is adopted pursuant to the authority in section C.R.S. 8-13.3-501 et seq. and is intended to be consistent with the requirements of the State Administrative Procedures Act, C.R.S. 24-4-101 et seq. (the "APA"), and the Paid Family and Medical Leave Insurance Act, C.R.S. 8-13.3-501 through 524 (the "FAMLI Act").

2. The general purpose of these rules is to exercise the authority of this Division to enforce and implement the FAMLI Act with regard to local governments.

3. Article XII Section 13 of the Colorado Constitution (2023); Title 29 Article 1, Title 8 Article 13.3, and Title 24 Article 50 of the Colorado Revised Statutes (2023); and 7 CCR 1107-1 (2023) are hereby incorporated by reference. Earlier versions of such laws may apply to events that occurred in prior years. Such incorporation excludes later amendments to or editions of the statutes. These statutes and regulations are available for public inspection at the Colorado Department of Labor and Employment, Division of Family and Medical Leave Insurance, 633 17th Street, Denver CO 80202. Copies may be obtained from this Division at a reasonable charge, or can be accessed electronically from the website of the Colorado Secretary of State. Pursuant to C.R.S. § 24-4-103(12.5)(b), the agency shall provide certified copies of the statutes and regulations incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency originally issuing the statutes. All Division Rules are available to the public at famli.colorado.gov. Where these Rules have provisions different from or contrary to any incorporated or referenced material, the provisions of these Rules govern so long as these are consistent with Colorado statutory and constitutional provisions.

4. If any part of these rules is held invalid, the remainder shall remain valid, and if any part is held not wholly invalid, but in need of narrowing, it will be retained in narrowed form.

2.2 Definitions and Clarifications

1. Unless otherwise indicated, terms used here that are defined in the FAMLI Act have the same definition as they do under the FAMLI Act.

2. "Governing Body" has the same meaning as in C.R.S. 29-1-102(12).

3. "Local Government" has the same meaning as defined at C.R.S. 8-13.3-503(14), and is limited to Colorado local governments. "Local government" does not include: (1) a governmental entity with one or more employees in the state personnel system pursuant to Art. XII Section 13 of the Colorado Constitution and the State Personnel System Act, C.R.S. 24-50-101 et seq.; or (2) a governmental entity for which premiums were paid pursuant to C.R.S. 8-13.3-518(4)(b).

4. "Premium" has the same meaning as in 7 CCR 1107-1 Section 1.2.6.

2.3. Process and Notification of Program Declination

1. Local government employers are permitted to decline participation in the family and medical leave insurance program after a written notice has been delivered to the Division memorializing the decision by an affirmative vote of the local government's governing body to decline participation in the program. Such a vote must follow the local government's procedures for other votes of the governing body for similar decisions.

   A. If a local government participates in the family and medical leave program on or after January 1, 2024, and later votes to decline participation, the declination will not take effect until at least 180 days after the vote, to allow individual employees the opportunity to opt into the benefits program pursuant to C.R.S. 8-13.3-514, should individuals choose to elect coverage.

   B. Public notice must be given in the same manner as any similar business before the governing body, and the local government must take/hear testimony prior to the vote if the local government has established procedures for public testimony for similar business. The local government's employees must also be notified in writing prior to the vote and provided both information regarding the vote process and the opportunity to submit comments through a public process to the governing body.

   C. Within 30 days following a local government declination vote, the local government must provide its local government employees with a written individual notice of the local government's declination vote and the impact toward coverage under the FAMLI Act, or other paid family and leave insurance coverage. The written notice, must at a minimum, explain the differences between benefits offered by the state program and any other paid leave plan offered by the local government. The notice must also state which employees, if any, are eligible for job protection under the federal Family and Medical Leave Act (FMLA) benefits or other local provisions where applicable. The notice must also be delivered to all new employees hired after the date of the declination vote.

   D. The written notice described at Section 2.3.1.C must contain information regarding the right of local government employees to voluntarily elect coverage pursuant to C.R.S. 8-13.3-514, and the contact information for the Division. In addition to providing written notices to individual employees in accordance with Section 2.3.1.C. of this rule, local government employers must also post a notice containing the information in a conspicuous and accessible place in each establishment where employees are employed; provided, however, in cases where the local government employer does not maintain a physical workplace, or an employee teleworks or performs work through a web-based or app-based platform, notification must be sent via electronic communication or through a conspicuous posting in the web-based or app-based platform. The individual and posted notices required in Sections 2.3.1.C. and 2.3.1.D. must be in English and in any language representing the first language spoken by at least five percent of the local government employer's workforce. The Division will create and make available to local government employers posters and notices containing the information required in this regulation, and local government employers may use the posters and notices to comply with the requirements of this section.

      1. It is the responsibility of the local government employer to request printed materials from the Division. Local government employers may be responsible for the printing and mailing costs of such materials.

2. It is the responsibility of the local government to provide written notification to the Division of the local government employers interpretation needs of printed notices for languages other than English or Spanish.

2. Local governments without employees are not employers, and as such, do not need to register, vote, decline coverage, or otherwise participate in the family and medical leave insurance program.

2.4. Local Government Employer Participation

1. Local government employers are required to formally notify the Division in writing and provide both the date of the vote, and the local government's decision to decline participation in the family and medical leave insurance program.

   A. Local governments which have previously declined participation in the family and medical leave insurance program pursuant to C.R.S. 8-13.3-522, may subsequently elect coverage at any time by a vote of the governing body.

   B. A local government may not decline participation in the family and medical leave insurance program in part. Any declination by a local government is a full declination of family and medical leave insurance program participation for that local government employer, except such an employer may enter into an agreement with an employee who elects coverage pursuant to C.R.S. 8-13.3-514, whereby the employer agrees to provide administrative support to the employee with regard to the employee's program obligations, including but not limited to deducting premiums from the employee's wages and remitting premiums and wage reports to the Division on behalf of the employee.

2. A vote to decline coverage is not permanent. A local government which has previously declined coverage may vote to renew the declination no later than every eight years. The Division will notify the local government of the end of the eight-year declination period one year in advance. In the absence of a vote further declining coverage, the local government will become a covered employer immediately after the end of the eight-year declination period. The local government must inform the Division of a declination vote in writing which includes the date the vote was taken.

3. When a local government employer returns to coverage pursuant to these rules, the employer will be covered and subject to premium liability beginning on the earlier of: (1) the effective date specified by the local government employer in its notification to the Division; or (2) the first day after the local government employer's deadline to renew its declination has passed.

4. Local government employers that have previously declined participation and then subsequently elect or otherwise return to coverage under the family and medical leave insurance program pursuant to these regulations must remain in the program for a minimum of twelve complete calendar quarters after the elected coverage begins. If such an employer chooses to again decline participation, notice of such declination must be delivered in writing to the Division at least one complete calendar quarter in advance of the end of the twelve calendar quarter cycle pursuant to this regulation.

5. Employees must also be notified directly in writing, and at least 180 days before the pending or upcoming return to or withdrawal of coverage pursuant to this regulation.

   A. Local government employers must display a notice containing the information required in this regulation in a conspicuous and accessible place in each establishment where employees are employed; provided, however, in cases where the local government employer does not maintain a physical workplace, or an employee teleworks or performs

work through a web-based or app-based platform, notification must be sent via electronic communication or through a conspicuous posting in the web-based or app-based platform.

B. The written notice and posting must contain an explanation of employee rights under the FAMLI program including but not limited to program requirements, benefits, claims process, payroll deductions and premiums, the right to job protection and benefit continuation under C.R.S. 8-13.3-509, protection against retaliatory personnel actions or other discrimination, relevant contact information for the Division, and other pertinent information.

C. The notice and poster required by this regulation must be in English and in any language representing the first language spoken by at least five percent of the local governments employer's workplace. The Division will create and make available to local government employers posters and notices containing information required in this regulation, and local government employers may use the posters and notices to comply with the requirements of this section.

2.5 Overpayments

In the event of an overpayment of premiums by a local government employee whose employer elects coverage after having previously declined coverage, any overpaid premiums will be repaid to the employee by the Division. The Division will ensure a continuation of coverage for local government employees who have individually opted into the benefits program pursuant to C.R.S. 8-13.3-514, and ensure there is not a lapse in coverage prior to the local government’s reinstatement of coverage.

Editor’s Notes

History

New rule eff. 03/17/2022.

Notice of Proposed Rulemaking

Tracking number

2023-00344

Department

1505 - Department of State

Agency

1505 - Secretary of State

CCR number

8 CCR 1505-1

Rule title

ELECTIONS

Rulemaking Hearing

Date

08/03/2023

Time

01:00 PM

Location

Please see the Additional Information section for details.

Subjects and issues involved

The Colorado Department of State is considering amendments to the election rules to ensure uniform and proper administration, implementation, and enforcement of Colorado election law, improve elections administration in Colorado, increase transparency and security of the election process, and implement amendments to the election laws made during the 2023 regular session of the 74th General Assembly. Specifically, the Department proposes permanent rule revisions necessary to: implement SB23-276, which concerned modifications to laws regarding elections; ensure proper staffing by bipartisan teams of election judges; strengthen signature verification procedures, training, assignment, and monitoring; update requirements for video surveillance and security of drop boxes, secure areas, and voting equipment; set new licensing requirements for petition entities; update requirements for the review of signatures on petitions; clarify intercounty ballot transfer requirements; clarify procedures for ballots for UOCAVA voters; specify requirements for tracking ballots delivered to voters who are confined in a county jail; establish naming conventions for ballot races; eliminate obsolete provisions; simplify existing rule language; remove language that is duplicative of statute; and ensure consistency with Department rulemaking standards. The Department may consider additional rule amendments. Please see attached Notice of Proposed Rulemaking including a Draft Statement of Basis.

Statutory authority

Senate Bills 23-276 & 22-153. Sections 1-1-107(2)(a), 1-1-110(1), 1-1-301, 1-1.5-104(1)(b) & (1)(e), 1-1.5-105, 1-2-217.7(7), 1-4-101(2)(c), 1-4-905.5(4)(a), 1-4-908(1) & (1.5)(b)(III), 1-5-102.9(5)(d)(I), 1-5-616(1) & (4), 1-5-623(4), 1-7-510(6), 1-7-511(4), 1-7-512(2), 1-7-513(2), 1-7-513.5(6), 1-7-515(4)(a), 1-7.5-104, 1-7.5-105(2)(c) & (3), 1-7.5-106(2), 1-7.5-107(1), (4.3)(a)(I) & (6), 1-8.3-104(3), 1-10-104.5, 1-10.5-102(2), 1-40-116(3) & (4)(a), 1-40-132, & 1-40-135(4), C.R.S.

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Preliminary Draft of Proposed Rules

Colorado Department of State
Election Rules
8 CCR 1505-1

June 30, 2023

Disclaimer:
In accordance with the State Administrative Procedure Act, this draft is filed with the Department of State and submitted to the Department of Regulatory Agencies.[1]

This is a preliminary draft of the proposed rules that may be revised before the August 3, 2023, rulemaking hearing. If changes are made, a revised copy of the proposed rules will be available to the public and a copy will be posted on the Department of State's website no later than **July 29, 2023**.[2]

Please note the following formatting key:

Font effect	Meaning
Sentence case	Retained/modified current rule language
SMALL CAPS	New language
~~Strikethrough~~	Deletions
Italic blue font text	Annotations

Amendments to 8 CCR 1505-1 follow:

Amendments to Rule 1:

Amendments to Rule 1.1.4 removing language for outdated technology:

1.1.4 "Ballot image" means a digitally captured image of a paper ballot~~ or a representation in electronic form of the marks or vote positions of a cast ballot on a DRE~~.

Amendments to Rule 1.1.5 fixing a grammatical issue for consistency:

1.1.5 "Ballot marking device" OR "~~(~~BMD"~~)~~ means a device that may integrate components such as a ballot scanner, printer, touch-screen monitor, audio output, and a navigational keypad and uses electronic technology to:

[Not shown: no changes to sections (a) through (d).]

Amendments to Rule 1.1.42 clarifying the candidate that must be placed on a ballot for an organization to be considered a "qualified political organization":

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[1] Sections 24-4-103(2.5) and (3)(a), C.R.S. (2022). A draft must be submitted to the Department at the time that a notice of proposed rulemaking is filed with the Secretary of State.
[2] Section 24-4-103(4)(a), C.R.S. (2022). "[A]ny proposed rule or revised proposed rule by an agency which is to be considered at the public hearing…shall be made available to any person at least five days prior to said hearing."

1.1.42 “Qualified political organization” means an organization that has placed a PARTISAN candidate, CERTIFIED TO THE BALLOT BY THE SECRETARY OF STATE, for congressional or state office on the ballot in a congressional vacancy or general election, whose officers have filed proof of organization with the Secretary of State, and that continues to meet the requirements of Rules 3.3 and 3.4.

Amendments to Rule 1.1.62 fixing a grammatical issue for consistency:

1.1.62 “Voting system” as defined in section 1-1-104(50.8), C.R.S., means:

[Not shown: no changes to sections (a) and (b).]

(c) “Voting system” does not include any other component of election administration, such as voter registration applications or systems, electronic pollbooks, ballot delivery and retrieval systems, signature verification and envelope sorting devices, ~~ballot on demand~~BALLOT-ON-DEMAND printers, election night reporting and other election reporting systems, and other components used throughout the election process that do not capture and tabulate votes.

Amendments to Rule 1.1.63 fixing a grammatical issue for consistency:

1.1.63 “Voting system test laboratory” OR “~~(~~VSTL”~~)~~ means a federally accredited entity that conducts certification testing for voting systems.

Repeal of Rule 1.1.64 to recodify sections (a) through (c) into Rule 8.1:

~~1.1.64 “Watcher” has the same meaning as in section 1-1-104(51), C.R.S.~~

~~(a) Watchers may be appointed for a recall election by each qualified successor candidate, the proponents and opponents of the recall ballot question, and each participating political party for a partisan recall election.~~

~~(b) For the purpose of appointing a watcher, the proponent or opponent of a ballot measure means a registered issue committee supporting or opposing the ballot measure.~~

~~(c) A designated watcher need not be a resident of the county he or she is designated in as long as he or she is an eligible elector in the State of Colorado.~~

[Not shown: current Rules 1.1.65 through 1.1.67 are renumbered to Rules 1.1.64 to 1.1.66.]

Amendments to Rule 2:

Amendments to Rule 2.1.2 updating a reference to a form no longer in use:

2.1.2 If any portion of a ~~mail application~~ VOTER REGISTRATION FORM is illegible, the county clerk must notify the applicant of the additional information required in accordance with section 1-2-509, C.R.S.

Amendments to Rule 2.5.3 removing outdated language:

2.5.3 If an elector submits a change to his or her voter registration record and leaves the affiliation ~~or ballot preference~~ section blank, the county clerk may not change the voter’s existing affiliation ~~or ballot preference~~ in the registration record.

New Rule 2.5.5 concerning changes to a covered voter's status as a covered voter:

2.5.5 A COVERED VOTER, AS DEFINED IN SECTION 1-8.3-102(2), C.R.S., WHO PROVIDES AN ADDRESS CHANGE TO THE DEPARTMENT OF REVENUE WHICH INDICATES THE VOTER IS NO LONGER OVERSEAS OR SERVING IN THE MILITARY OUT OF STATE MAY NOT HAVE THEIR STATUS AS A COVERED VOTER REMOVED DUE TO THE CHANGE. THE CLERK MUST INSTEAD SEND A NOTIFICATION VIA MAIL AND EMAIL, IF AVAILABLE, TO THE ELECTOR NOTIFYING THEM THAT A CHANGE OF ADDRESS WAS RECEIVED AND ASKING THE VOTER TO CONFIRM THAT THEY ARE NO LONGER A COVERED VOTER. IF NO RESPONSE IS RECEIVED, THE CLERK MAY NOT MAKE REMOVE THE ELECTOR'S COVERED VOTER STATUS.

Repeal of Rule 2.8 which is duplicative of section 1-2-102, C.R.S.:

~~2.8 Registration of homeless electors~~

~~2.8.1 For the purpose of voter registration residence, a homeless elector must identify a specific location that the applicant considers his or her home base in accordance with section 1-2-102(1)(a)(II), C.R.S.~~

~~2.8.2 For an elector whose home is in foreclosure, the elector may register to vote or remain registered to vote at the foreclosed address until the elector establishes a new permanent residence.~~

~~2.8.3 A post office box or general delivery at a post office is not a home base.~~

Amendments to current Rule 2.9, renumbered to Rule 2.8, to clarify the residential address that can be used by covered voters:

~~2.9~~2.8 Registered electors absent from the state

~~2.9.1~~2.8.1 A registered elector who is absent from the state but who maintains Colorado residency is eligible to be registered and to vote without holding a property interest in a fixed habitation in the state.

~~2.9.2~~2.8.2 An absent elector's voter registration address is the elector's last residence address or the address AN ELECTOR PREVIOUSLY RESIDED AT THAT the elector intends to return to in the state. A COVERED VOTER AS DEFINED IN SECTION 1-8.3-102(2), C.R.S., WHO IS ABSENT AND HAS NEVER RESIDED IN THE UNITED STATES MAY USE THE RESIDENCE ADDRESS OF THEIR PARENT, LEGAL GUARDIAN, SPOUSE, OR CIVIL UNION PARTNER AS REQUIRED BY SECTION 1-8.3-102(2)(D), C.R.S.

Current Rule 2.10 is repealed because it is contradictory to statute, which requires convicted felons to have their voter registration records cancelled in accordance with sections 1-2-302 (3.5)(b) and 1-2-606, C.R.S.:

~~2.10 A county clerk may cancel a registration record based upon information from a local law enforcement agency only if:~~

~~2.10.1 The information states that the individual is currently serving a sentence of detention or confinement in a correctional facility, jail, or other location for a felony conviction; and~~

~~2.10.2 Minimum matching criteria outlined in Rule 2.7 are met.~~

[Not shown: current Rule 2.11 is renumbered to Rule 2.9.]

Repeal of current Rule 2.12 concerning information provided by the Department of State to state parties prior to caucus:

~~2.12~~2.10 Voter registration confidentiality

[Not shown: current Rules 2.12.1 and 2.12.2 renumbered to Rules 2.10.1 and 2.10.2.]

Repeal of Rule 2.12.3:

~~2.12.3 Before precinct caucuses, the Secretary of State will provide to each major state political party a list of confidential voters, which includes only the information necessary to determine eligibility. The list will only be provided if the major party agrees in writing to limit and protect that data in accordance with Secretary of State requirements. This rule does not apply to records held confidential as part of the Address Confidentiality Program.~~

[Not shown: current Rule 2.12.4 is renumbered to Rule 2.10.3.]

Amendments to current Rule 2.13 including necessary renumbering and concerning a technical change regarding the update of a change of address and stylistic change:

~~2.13~~2.11 List ~~M~~Maintenance under section 8 of the National Voter Registration Act of 1993

~~2.13.1~~2.11.1 The Secretary of State's OFFICE will provide monthly National Change of Address (NCOA) data under section 1-2-302.5, C.R.S., to the county clerk ~~by the fifth business day of each~~ ONCE A month.

[Not shown: current Rules 2.13.2 through 2.13.5 are renumbered to Rules 2.11.2 through 2.11.5.]

Amendments to current Rule 2.14 including necessary renumbering and clarifying that a state employee in this context is from the Secretary of State's office:

~~2.14~~2.12 Voter registration at a voter service and polling center. A person registering voters or updating voter registration information in a voter service and polling center must:

~~2.14.1~~2.12.1 Be an election judge, a permanent or temporary county employee, state employee OF THE DEPARTMENT OF STATE, or temporary staff hired by the county clerk; and

[Not shown: current Rule 2.14.2 is renumbered to Rule 2.12.2.]

Amendments to current Rule 2.15 including necessary renumbering and removing language of outdated practices regarding the charge of a fee for county voter information reports and related services:

~~2.15~~2.13 Voter registration records and data

[Not shown: current Rules 2.15.1 and 2.15.2 are renumbered to Rules 2.13.1 and 2.13.2.]

~~2.15.3~~2.13.3 The county clerk of each county may charge fees for county voter information reports and related services~~, such as label printing provided by the centralized statewide registration system. But in accordance with federal requirements governing the use of federal funds, fees must not exceed county direct and indirect costs for providing such reports and services~~.

[Not shown: current Rules 2.15.4 through 2.15.7 are renumbered to Rules 2.13.4 and 2.13.7.]

Repeal of current Rule 2.16 removing references to ballot preference due to the passage of SB23-276:

~~2.16 If an unaffiliated elector indicates a political party ballot preference at any time up to and including the twenty-second day before a primary election, the county clerk must record the selection in SCORE and mail only the ballot of that political party to the elector in the upcoming primary election. An elector's political party ballot preference is only effective for a single primary election even if there is more than one primary election in a single year.~~

[Not shown: current Rules 2.17 and 2.18 are renumbered to Rules 2.14 and 2.15.]

Amendments to Rule 3:

Repeal of Rules 3.8 and 3.9 concerning outdated language that separates the treatment of qualified political organizations from minor parties:

~~3.8 Except for the precinct caucus list furnished to major political parties, a qualified political organization may obtain print-outs, lists, and tapes, of voter registration records at the same rate as political parties.~~

~~3.9 A voter registration summary report must include major political parties, minor political parties, qualified political organizations, and unaffiliated categories.~~

Amendments to Rule 4:

Amendments to Rule 4.1.2 concerning intergovernmental agreements regarding ballot contest length and format:

4.1.2 A coordinating political subdivision must enter into an intergovernmental agreement with the county clerk that delineates which tasks are the responsibility of the designated election official of the political subdivision and which are the responsibility of the county clerk.

[Not shown: no changes to sections (a) and (b).]

(c) THE INTERGOVERNMENTAL AGREEMENT MAY ALSO ADDRESS LIMITATIONS ON, OR REQUIREMENTS FOR, BALLOT CONTEST LENGTH AND FORMATTING OR ANY OTHER LAWFUL TOPIC.

Amendments to Rule 4.5.1(b) removing outdated language concerning the text limit on a ballot:

4.5.1 Each political subdivision must prepare the list of candidates and the ballot title and text for ballot issues and ballot questions, as required by law.

[Not shown: no changes to section (a).]

(b) Political subdivisions may only require the coordinated election official to print the entire text of a ballot issue or ballot question on the ballot if the political subdivision pays for any additional cost associated with printing ~~and if sufficient space is on the voting equipment to print the entire text given the other issues, questions, and candidates on the ballot. The coordinated election official must tell the political subdivision how much space is available for text for each position on the ballot. If the required ballot title and text is too long for the voting equipment, the coordinated election official may choose to conduct the election with a different form of ballot~~.

Amendments to Rule 5:

Repeal of Rule 5.3 concerning an outdated practice:

~~5.3 If a political subdivision coordinates with the county clerk, the designated election official is not required to submit a separate election plan for the election.~~

[Not shown: current Rules 5.4 through 5.6 renumbered to Rules 5.3 through 5.5.]

Amendments to Rule 6:

Amendments to Rule 6.1 clarifying the appointment process of election judges between county clerks and political parties:

6.1 Appointment of election judges under section 1-6-104, C.R.S.

6.1.1 The county clerk must request an updated list of election judges from each major party before each election the clerk conducts under the Uniform Election Code.

6.1.2 ~~The county clerk must reasonably attempt to exhaust the updated list provided by the major parties before supplementing with additional major party judges or minor party or unaffiliated judges. When the county clerk is filling election judge vacancies under section 1-6-113 (1), C.R.S., the clerk may choose from any of the available lists.~~ NO LATER THAN THE FRIDAY BEFORE PRECINCT CAUCUSES, THE CLERK MUST PROVIDE EACH MAJOR PARTY WITH AN ESTIMATE OF THE NUMBER OF JUDGES NEEDED FOR EACH POSITION, AND THE DATES AND TIMES THE CLERK WILL REQUIRE ELECTIONS JUDGES TO WORK IN THOSE POSITIONS IN ELECTIONS FOR THE UPCOMING 2-YEAR CYCLE. THE CLERK MAY UPDATE THIS ESTIMATE FOR EACH MAJOR PARTY PRIOR TO AN ELECTION.

6.1.3 THE COUNTY CLERK MUST REASONABLY ATTEMPT TO EXHAUST THE PRECINCT CAUCUS AND UPDATED LIST PROVIDED BY THE MAJOR PARTIES BY THE 60TH DAY BEFORE AN ELECTION. If, BY THE 60TH DAY BEFORE AN ELECTION, a major political party fails to provide ~~an adequate~~ A SUFFICIENT list of election judges WHO ARE AVAILABLE FOR THE COUNTY TO STAFF ALL OF THE ELECTION JUDGE POSITIONS, DATES, AND TIMES NEEDED BY THE COUNTY FOR THAT ELECTION ~~by the 60th day before election day~~, the county clerk may consider a supplemental list from ~~a~~ THAT major political party. IF THAT SUPPLEMENTAL LIST IS STILL NOT SUFFICIENT, THE CLERK MAY SUPPLEMENT WITH ADDITIONAL MAJOR PARTY, MINOR PARTY, OR UNAFFILIATED JUDGES.

6.1.4 WHEN THE COUNTY CLERK IS FILLING ELECTION JUDGE VACANCIES UNDER SECTION 1-6-113(1), C.R.S., THE CLERK MAY CHOOSE FROM ANY OF THE AVAILABLE MAJOR PARTY, MINOR PARTY, OR UNAFFILIATED JUDGES.

~~6.1.4~~6.1.5 The county clerk must provide a list of election judges, including political party affiliations and assignments, if known, to each appointing party no later than 35 days before election day. Upon request by an appointing party, the clerk must provide a supplemental list no later than seven days before the date on which the county will open its first ~~V~~voter ~~S~~service and ~~P~~polling ~~C~~center.

~~6.1.5~~6.1.6 The county clerk may not ask an election judge or county staff member to change his or her party affiliation to achieve the bipartisan balance required under section 1-6-109, C.R.S.

Amendments to Rule 6.2 concerning the assignment of election judges and including a stylistic change:

6.2 Assignment of ~~E~~Election ~~J~~Judges

[Not shown: no changes to Rule 6.2.1.]

New Rule 6.2.2 requiring a county clerk to review any data available from an election judge's previous election's signature verification work before assigning that election judge to perform signature verification:

6.2.2 PRIOR TO ASSIGNING AN ELECTION JUDGE TO PERFORM SIGNATURE VERIFICATION, THE COUNTY CLERK MUST REVIEW ANY DATA AVAILABLE FROM THAT JUDGE'S SIGNATURE VERIFICATION WORK IN A PREVIOUS ELECTION. IF THE JUDGE HAD AN UNEXPLAINED, IRREGULAR ACCEPTANCE OR REJECTION RATE THE CLERK MAY NOT ASSIGN THAT JUDGE TO CONDUCT SIGNATURE VERIFICATION.

[Not shown: current Rule 6.2.2 renumbered to Rule 6.2.3.]

Amendments to Rule 6.7 clarifying that supervisor judge training content is only valid for one year and requires yearly re-approval:

6.7 A supervisor judge in a voter service and polling center must complete a training course conducted by the county clerk. The Secretary of State must provide or approve the training content. TRAINING CONTENT WHICH IS APPROVED BY THE SECRETARY OF STATE IS ONLY VALID FOR ONE YEAR AFTER APPROVAL.

Amendments to Rule 6.8 specifying that signature verification judge training must be successfully completed prior to each election and from the Department:

6.8 A signature verification judge must SUCCESSFULLY complete a training course conducted by the county clerk PRIOR TO EACH ELECTION~~ at least once per election cycle~~. The county clerk must use the Secretary of State provided training AND MAY PROVIDE ADDITIONAL~~ or provide their own~~ training. If the county clerk provides their own training, it must be approved by the Secretary of State EACH YEAR before its first use.

Amendments to Rule 7:

Amendments to Rule 7.2 concerning ballots and ballot packets:

7.2 Ballots and ballot packets

[Not shown: no change to Rules 7.2.1 through 7.2.3.]

Amendments to Rule 7.2.4 removing language regarding primary ballots which have been printed before a primary election and other technical changes.

7.2.4 Voiding ballots due to timely changes in address or affiliation.

(a) If an elector timely changes his or her address or affiliation after the county mails ballots or sends the voter file to the vendor, the county must void the first ballot and generate a second ballot.

~~(1)~~ If the county processes the change to the elector's record after it sends the voter file to the vendor but before the vendor prints ballots, the county must provide the vendor a voided ballot file to prevent the vendor from printing and preparing voided ballots for mailing.

~~(2) If the county processes the change to the elector's record after the vendor has printed ballots but before the vendor mails ballots, the county must work with the vendor to make every reasonable effort to remove voided ballots before they enter the mail stream.~~

~~(A)~~(B) If the county mails its own ballots, the county clerk must remove all voided ballots before mailing.

~~(B)~~(C) If the county processes the change to the elector's record after it mails ballots, the county must count the first ballot returned by the elector in accordance with section 1-7.5-107(6), C.R.S., except where an elector ~~changed his or her affiliation~~ AFFILIATED WITH A POLITICAL PARTY, the county ~~must~~ MAY ONLY count the ballot issued for the elector's new party affiliation.

[Not shown: no change to Rule 7.2.5.]

Repeal of Rule 7.2.6 regarding an optional statement that could be included on an envelope but is not required by law:

~~7.2.6 Each mail ballot return envelope may include the following statement: "I am voluntarily giving my ballot to (name and address) for delivery on my behalf." If the county clerk includes this statement on their return envelopes they must include an explanation in their voter instructions that the voter is not required to fill this statement out to return their ballot. If the voter leaves the fillable portion of the statement blank, the county clerk must accept the ballot for counting if it is otherwise valid.~~

[Not shown: current Rules 7.2.7 through 7.2.9 are renumbered to Rules 7.2.6 through 7.2.8.]

Amendments to current Rule 7.2.10 including necessary renumbering and concerning the update of an outdated process due to the passage of SB23-276:

~~7.2.10~~7.2.9 An unaffiliated voter who wants to receive the mail ballot of a participating minor political party in the mail must ~~declare a mail ballot preference for that party in accordance with section 1-2-204(2)(j.5), C.R.S.~~ REQUEST A REPLACEMENT MAIL BALLOT OR IN-PERSON BALLOT OF THAT MINOR POLITICAL PARTY.

Repeal of Rule 7.2.11 due to elimination of ballot preference with the passage of SB23-276:

~~7.2.11 If an unaffiliated voter selects a mail ballot preference for a major or minor political party that is not participating or that prohibits unaffiliated voters from voting in its primary election, the county clerk must send the voter the mail ballot packet described in Rule 7.2.9. The packet must include a notice explaining why the voter is receiving the packet or provide an alternative method for the voter to obtain this information.~~

Amendments to current Rule 7.2.12 including necessary renumbering and a stylistic change:

~~7.2.12~~7.2.10 A voter affiliated with a ~~Q~~Qualified ~~P~~Political ~~O~~Organization is considered an unaffiliated voter for the purposes of ~~this~~ Rule 7.2.

[Not shown: current Rules 7.2.13 and 7.2.14 are renumbered to Rules 7.2.11 and 7.2.12.]

Amendments to current Rule 7.2.15 including necessary renumbering and removing outdated language due to the passage of SB23-276:

~~7.2.15~~7.2.13 Each mail ballot return envelope and mail ballot instruction for an unaffiliated voter ~~who has not declared a preference in a primary election~~ must include a statement instructing the voter to return only one ballot.

Amendments to current Rule 7.2.16 including necessary renumbering, removing of outdated practices due to the passage of SB23-276, and permitting unaffiliated voters to receive a minor party ballot in a primary, if allowed by the minor party:

~~7.2.16~~7.2.14 The county clerk must issue a replacement mail ballot packet THAT CONTAINS BALLOTS OF ALL PARTICIPATING MAJOR POLITICAL PARTIES to an unaffiliated elector WHO REQUIRES OR IS ELIGIBLE FOR A REPLACEMENT BALLOT. IF AN UNAFFILIATED VOTER REQUESTS A BALLOT FOR A MINOR POLITICAL PARTY THAT IS PARTICIPATING IN THE PRIMARY ELECTION AND ALLOWS UNAFFILIATED VOTERS TO VOTE, THE UNAFFILIATED ELECTOR MUST BE ISSUED A REPLACEMENT BALLOT WITH ONLY THAT PARTY'S BALLOT INCLUDED. ~~in a primary election as follows:~~

~~(a) If the elector has not declared a mail ballot preference, the county clerk must issue a packet containing the ballots of all participating major political parties.~~

~~(b) If the Elector has timely declared a mail ballot preference, the county clerk must issue the elector's preferred political party's ballot; or upon the elector's request, a packet containing the ballots of all participating major political parties.~~

[Not shown: current Rule 7.2.17 renumbered to Rule 7.2.15.]

New Rule 7.2.16 concerning the mailing of a property-owner ballot when coordinating a mail ballot election with a special district:

7.2.16 A COUNTY COORDINATING A MAIL BALLOT ELECTION WITH A SPECIAL DISTRICT IN WHICH PROPERTY OWNERS ARE ELIGIBLE TO VOTE UNDER SECTION 32-1-103(5)(A)(II), C.R.S., MUST AUTOMATICALLY MAIL PROPERTY OWNER BALLOTS TO ACTIVE, REGISTERED VOTERS WHO ARE CERTIFIED AS- ELIGIBLE BY THE DISTRICT'S DESIGNATED ELECTION OFFICIAL.

Amendments to Rule 7.4.1 updating the retention of the surveillance records at drop box locations:

7.4.1 The county clerk must adequately light all drop box locations and use a DROP BOX video ~~security surveillance~~ recording system ~~as defined in Rule 1.1.61~~ to monitor each location. THE SYSTEM MUST CONTINUOUSLY RECORD THE BOX A SYSTEM USING MOTION DETECTION THAT RECORDS ONE FRAME, OR MORE, PER MINUTE UNTIL DETECTION OF MOTION TRIGGERS CONTINUOUS RECORDING.

[Not shown: no changes to section (a) through (d).]

(e) ~~Video security surveillance~~ DROP BOX VIDEO RECORDINGS must be retained by the county clerk through ~~60~~120 days following the deadline to certify the election, or until the conclusion of any election contest, whichever is later; except that if the county clerk knows or reasonably should know that there is a potential violation of law where the surveillance could be used as evidence, it must be retained through the applicable statute of limitations or the conclusion of any judicial proceeding related to the election, whichever is later.

Amendments to Rule 7.4.5 repealing language duplicative to statute and introducing language regarding pickup schedules of drop boxes in response to SB23-276:

7.4.5 The county clerk must arrange for the collection of ballots by bipartisan teams, of election judges and/or staff, from each drop box location once it is open and receive the ballots into SCORE~~:~~.

~~(a) If applicable, at least once every 72 hours after non-UOCAVA ballots are mailed until the date that voter service and polling centers must open;~~

~~(b) If applicable, at least once every 24 hours during the days that voter service and polling centers must be open; and~~

~~(c)~~(A) FOR COUNTIES WITH LESS THAN 250,000 ACTIVE ELECTORS AS OF THE PREVIOUS GENERAL ELECTION, AT ~~At~~ least twice on election day, at approximately 1:00 p.m. and 7:00 p.m.

~~(d)~~(B) The county clerk may meet the requirements of this Rule by~~:~~

~~(1) Collecting and transporting the ballots to the central counting location for receipt into SCORE; or~~

~~(2) Collecting and transporting the ballots to the nearest voter service and polling center for receipt into SCORE.~~ FOLLOWING THE REQUIREMENTS OF SECTION 1-7.5-107 (4.3)(C)(II), C.R.S.

Repeal of Rule 7.4.6 due to the passage of SB23-276 which mandates that all drop boxes in Colorado must have ballots picked up on a specific schedule:

~~7.4.6 The county clerk may request a waiver from the Secretary of State for remote drop box locations in the county's election plan or amended election plan, exempting them from the ballot collection requirements in Rule 7.5.5. If the Secretary of State grants the waiver:~~

~~(a) The county clerk must arrange for the collection of ballots by bipartisan teams of election judges from all exempt drop box locations once they are open as often as necessary, but at least:~~

~~(1) Once each week after the initial mailing of non-UOCAVA ballots until the Friday before election day; and~~

~~(2) On the Friday and Monday before election day and on election day at 7:00 p.m. MT.~~

~~(b) The county clerk must post a notice on each exempt drop box of the dates and approximate times ballots will be collected.~~

~~(c) If the Secretary of State determines that the county failed to collect ballots from a remote drop box location as often as necessary, the Secretary of State may revoke or modify the waiver.~~

[Not shown: current Rules 7.4.7 through 7.4.10 are renumbered to Rules 7.4.6 through 7.4.9.]

Repeal and replacement of current Rule 7.4.11 for clarity, including necessary renumbering and concerning intercounty transfer process of ballots if an elector delivers a ballot to a county in which they do not reside:

~~7.4.11~~7.4.10 ~~If an elector delivers a ballot to the wrong county, that county must date stamp the ballot envelope and timely forward it to the correct county. Beginning the Monday before election day, the county must notify the correct county of receipt by secure electronic transmission with a scanned image of the outside of the mail ballot envelope including the signature, and forward it to the correct county no later than the next business day. A county that physically delivers ballots to another county no later than the next business day, or immediately transmits them by next-day delivery, is not required to scan the envelope. The~~

~~correct county must treat the ballot as received as of the date and time of the date stamp. The county receiving the image may perform signature verification upon receipt of the image.~~ INTERCOUNTY TRANSFER OF BALLOTS

(A) IF AN ELECTOR DELIVERS A BALLOT TO THE COUNTY IN WHICH THEY DO NOT RESIDE, THE COUNTY WHO INITIALLY RECEIVED THE BALLOT MUST TAKE THE FOLLOWING ACTIONS:

(1) IF RECEIVED BEFORE 7:00 P.M. ON ELECTION DAY, DATE STAMP THE BALLOT ENVELOPE WITH A STAMP THAT IDENTIFIES THAT THE BALLOT WAS RECEIVED BEFORE 7:00 P.M. ON ELECTION DAY, AND NOTING THE COUNTY WHERE THE BALLOT WAS RECEIVED;

(2) FORWARD THE BALLOT TO THE CORRECT COUNTY;

(A) ON AND AFTER ELECTION DAY, THE BALLOT MUST BE PHYSICALLY DELIVERED BY THE COUNTY WHO RECEIVED THE BALLOT TO THE CORRECT COUNTY, SENT BY NEXT-DAY DELIVERY IF AVAILABLE, OR SENT BY FIRST CLASS MAIL IF NEXT-DAY DELIVERY IS NOT AVAILABLE.

(B) BALLOTS MUST BE PHYSICALLY DELIVERED OR MAILED NO LATER THAN 2 DAYS AFTER ELECTION DAY.

(C) BALLOTS THAT ARE MAILED MUST BE SENT TO THE MAILING ADDRESS PRESENT ON THE BALLOT ENVELOPE.

(3) CREATE AN ENTRY IN A LOG WHICH RECORDS THE DATE THE BALLOT WAS RECEIVED, THE VOTER IDENTIFICATION NUMBER FOR THE BALLOT, THE COUNTY THE BALLOT WILL BE DELIVERED TO, THE METHOD OF DELIVERY TO THE CORRECT COUNTY, THE DELIVERY TRACKING NUMBER, IF ANY, AND THE DATE THE BALLOT WAS MAILED OR PHYSICALLY DELIVERED TO THE CORRECT COUNTY;

(4) IF THE BALLOT WILL BE MAILED, NOTIFY THE COUNTY WHERE THE BALLOT WILL BE SENT VIA EMAIL WHEN THE BALLOT HAS BEEN PLACED IN THE MAIL, THE VOTER IDENTIFICATION NUMBER OF THE BALLOT, AND THE METHOD OF DELIVERY FOR THE BALLOT; AND

(5) BEGINNING THE DAY BEFORE ELECTION DAY, SEND, BY SECURE ELECTRONIC TRANSMISSION, A SCANNED IMAGE OF THE OUTSIDE OF THE MAIL BALLOT ENVELOPE, INCLUDING THE SIGNATURE, TO THE COUNTY WHERE THE BALLOT WILL BE SENT. A COUNTY THAT PHYSICALLY DELIVERS BALLOTS TO ANOTHER COUNTY NO LATER THAN THE NEXT BUSINESS DAY, OR IMMEDIATELY TRANSMITS THEM BY NEXT-DAY DELIVERY, IS NOT REQUIRED TO SCAN THE ENVELOPE. THE COUNTY RECEIVING THE IMAGE MAY PERFORM SIGNATURE VERIFICATION UPON RECEIPT OF THE IMAGE.

(B) THE CORRECT COUNTY MUST TREAT THE BALLOT AS RECEIVED AS OF THE DATE AND TIME OF THE DATE STAMP.

Repeal of Rule 7.4.12 as a result of the amendments to current Rule 7.4.11:

~~7.4.12 The county clerk must date stamp each ballot envelope as received on or before 7:00 PM on election day and immediately forward it to the correct county. The correct county must treat the ballot as received as of the date and time of the date stamp.~~

Amendments to current Rule 7.4.13, including necessary renumbering and concerning the tracking of ballots delivered or received from electors who are confined in a county jail as a result of the passage of SB23-276:

~~7.4.13~~7.4.11 County clerks who deliver or receive ballots from electors who are confined in a county jail or detention facility must MAINTAIN A log OF the number of ballots delivered and received from each facility and provide the log to the Secretary of State's office following ~~the~~ AN election THAT IS NOT CONDUCTED IN NOVEMBER. THE COUNTY CLERK MUST SEPARATELY MAINTAIN A LOG OF THE NUMBER OF VOTER REGISTRATION FORMS RECEIVED FROM THE COUNTY JAIL OR DETENTION FACILITY, OR SUBMITTED TO COUNTY CLERK PERSONNEL WHO ARE ON-SITE AT THE JAIL OR FACILITY.

[Not shown: current Rules 7.4.14 and 7.4.15 are renumbered to Rules 7.4.12 through 7.4.13.]

Amendments to Rule 7.5 organizing the structure for clarity:

7.5 Ballot returned in unofficial envelope~~.~~

7.5.1 If the county timely receives a mail ballot from an eligible elector in an envelope that is missing or lacks the correct self-affirmation, the county must contact the elector by mail and by electronic mail, if available, within three calendar days of receiving the ballot but no later than two calendar days after election day. The county must use the letter and affidavit prescribed by the Secretary of State and keep a copy as part of the official election record.

7.5.2 If the county receives the completed affidavit no later than the eighth day after election day, the county must count the ballot.

7.5.3 A county that receives a ballot from a voter with a disability covered under section 1-5-706, C.R.S., in an unofficial envelope must accept the ballot for processing if the envelope also contains a signed application from the voter.

Amendments to Rule 7.7 concerning signature verification procedures:

7.7 Signature verification procedures

Amendments to Rule 7.7.1 clarifying the use of signature verification judges for the levels of review of signatures:

7.7.1 When reviewing signatures through the use of signature verification judges, ~~a single election judge must conduct the first level of signature verification.~~ THE COUNTY CLERK MUST FOLLOW THE REQUIREMENTS OF SECTION 1-7.5-107.3 (2), C.R.S., FOR THE INITIAL AND SECOND LEVEL REVIEW OF SIGNATURES, INCLUDING:

(A) THE REQUIREMENT THAT A SINGLE ELECTION JUDGE CONDUCT THE FIRST LEVEL OF SIGNATURE VERIFICATION; AND

(B) THE REQUIREMENT THAT A BI-PARTISAN TEAM OF ELECTION JUDGES REVIEW A REJECTED SIGNATURE. THAT BI-PARTISAN TEAM MAY NOT INCLUDE THE ELECTION JUDGE WHO MADE THE FIRST DECISION TO REJECT A SIGNATURE.

[Not shown: no changes to Rule 7.7.2.]

Amendments to Rule 7.7.3 concerning standards for accepting or rejecting a signature on a mail ballot envelope:

7.7.3 An election judge conducting signature verification must compare the signature on the self-affirmation on each ballot return envelope with the elector's signature in SCORE in accordance with the Secretary of State's Signature Verification Guide. A SIGNATURE ON A MAIL BALLOT ENVELOPE THAT IS CONSISTENT WITH THE SIGNATURES FOR THE VOTER IN SCORE IS ONE THAT IS MORE LIKELY THAN NOT TO BE THE SIGNATURE OF THE VOTER. A SIGNATURE THAT IS CONSISTENT MUST BE ACCEPTED AS A MATCH.

[Not shown: no changes to Rules 7.7.4 through 7.7.7.]

Amendments to Rule 7.7.8 establishing additional monitoring of signature verification judges by the county clerk:

7.7.8 SIGNATURE VERIFICATION JUDGE MONITORING

(A) THE COUNTY CLERK MUST KEEP REAL-TIME RECORDS OF EACH SIGNATURE VERIFICATION TRANSACTION, INCLUDING:

(1) EACH DECISION MADE BY AN ELECTION JUDGE AT TIER 1 TO ACCEPT OR REJECT A SIGNATURE; AND

(2) EACH DECISION MADE BY AN ELECTION JUDGE TEAM AT TIER 2 TO ACCEPT OR REJECT A SIGNATURE;

(3) THE SIGNATURES ASSOCIATED WITH EACH DECISION MADE BY AN ELECTION JUDGE AT TIER 1 OR TIER 2;

(4) AGGREGATE ACCEPTANCE AND REJECTION RATE DATA FOR EACH TIER 1 ELECTION JUDGE; AND

(5) SIGNATURES REJECTED BY AN ELECTION JUDGE TEAM AT TIER 2 WHICH ARE LATER CURED BY THE VOTER.

(B) THE RECORDS CREATED BY THIS RULE ARE AN ELECTION RECORD WHICH MUST BE MADE AVAILABLE TO THE SECRETARY OF STATE UPON REQUEST.

(C) USING THE DATA COLLECTED IN RULE 7.7.8, EACH DAY SIGNATURE VERIFICATION IS CONDUCTED, THE ~~The~~ county clerk must ~~periodically audit~~ TRACK THE ACCEPTANCE AND REJECTION RATE OF signature verification judges. If a judge or team of judges has an unexplained, irregular acceptance, ~~or~~ rejection, OR OVERTURN rate, the county clerk must retrain or remove that judge or team of judges from conducting signature verification.

[Not shown: no changes to Rule 7.7.9.]

Amendments to Rule 7.7.10 concerning the capture of the image of the full back of a mail ballot envelope for signature verification:

7.7.10 If the county uses a ballot sorting and signature capture device, the county clerk must test the device before using it in an election to ensure that it properly sorts envelopes, and accurately and clearly captures the signature on the envelope for comparison to the correct voter record. BEGINNING ON JANUARY 1, 2024, THE DEVICE MUST ALSO CAPTURE AN IMAGE OF THE FULL BACK OF THE MAIL BALLOT ENVELOPE.

Amendments to Rule 7.8.1to clarify the elections that this rule applies to:

7.8.1 The county clerk must designate and open the minimum number of voter service and polling centers as required in section 1-5-102.9, C.R.S., for a general election and section 1-7.5-107(4.5), C.R.S., for all ~~other elections~~ PRIMARY AND COORDINATED ELECTIONS.

[Not shown: no changes to sections (a) through (d).]

Repeal and replacement of Rule 7.8.2 concerning the use of the voter center siting tool, provided by the Department, during the placement process of voter service and polling centers and drop boxes:

7.8.2 ~~Voter service and polling center materials include sufficient computer stations for SCORE access, HAVA information, signature cards, paper ballots, voting booths and a ballot box.~~ WHEN DETERMINING WHERE IN A COUNTY A VOTER SERVICE AND POLLING CENTER OR DROP BOX SHOULD BE PLACED IN A GENERAL ELECTION, A COUNTY CLERK MUST TAKE INTO CONSIDERATION THE RECOMMENDATIONS GIVEN BY THE VOTER CENTER SITING TOOL. THE TOOL WILL BE PROVIDED FOR USE BY THE DEPARTMENT OF STATE.

Amendments to Rule 7.8.3 concerning a grammatical change:

7.8.3 In order to assist applicants and electors efficiently, a county clerk must configure voter service and polling centers with sufficient election judges, WebSCORE workstations, voting equipment, and sufficient numbers of mail and in-person ballots that can be tabulated by the county's voting system without further duplication, and other supplies. A county may satisfy this Rule by providing a sufficient number of ballot marking devices or ~~ballot on demand~~ BALLOT-ON-DEMAND printers.

Amendments to Rule 7.9 removing an outdated reference:

7.9 The county clerk must complete an accessibility survey for all drop box and voter service and polling center locations annually before designating a location for use, and no later than 120 days before an election, the county clerk must designate drop-off, drop box, and voter service and polling center locations. In a presidential election year, the county clerk's accessibility survey for the presidential primary election serves as the annual survey for that voter service and polling center or drop box through the following general election.

[Not shown: no changes to Rules 7.9.1 and 7.9.2.]

7.9.3 ~~The Secretary of State may deny an application for accessibility grant funds if a county clerk fails to assess locations, timely file complete accessibility surveys, or develop and implement necessary barrier removal plans in accordance with this Rule.~~ The DEPARTMENT OF STATE will conduct site visits to assess compliance and identify accessibility barriers. The Secretary will seek injunctive action or other penalties under section 1-1-107(2)(d), C.R.S., as necessary to remedy violations of this Rule.

Amendments to Rule 7.11 concerning a stylistic change:

7.11 At each ~~V~~voter ~~S~~service and ~~P~~polling ~~C~~center, election judges and, if appropriate, election staff, must:

New Rule 7.17 concerning data entry standards for district, position, and ballot style names in SCORE:

7.17 DATA ENTRY STANDARDS FOR DISTRICT, POSITION, AND BALLOT STYLE NAMES IN SCORE. AUTHORIZED SCORE USERS MUST COMPLY WITH THE DATA ENTRY STANDARDS SET FORTH IN THIS RULE WHEN NAMING DISTRICTS, POSITIONS, AND BALLOT STYLES IN SCORE'S DISTRICTS & PRECINCTS AND ELECTION MANAGEMENT MODULES.

7.17.1 DISTRICT NAMES: COUNTY CLERKS MUST NAME LOCAL DISTRICTS IN SCORE'S DISTRICTS & PRECINCTS MODULE EXACTLY THE SAME AS THEY ARE NAMED IN THE DEPARTMENT OF LOCAL AFFAIRS' LOCAL GOVERNMENT INFORMATION SYSTEM (LGIS), WITH TWO EXCEPTIONS:

(A) LGIS LISTS MUNICIPALITIES BY NAME FOLLOWED BY A COMMA AND THE MUNICIPALITY TYPE. SCORE USERS MUST ENTER THE NAMES OF MUNICIPALITIES IN SCORE ACCORDING TO COMMON USAGE, SO THAT THE MUNICIPALITY TYPE PRECEDES MUNICIPALITY'S NAME. BY WAY OF EXAMPLE, IF LGIS LISTS *AVON, TOWN OF*, THE COUNTY MUST NAME THE MUNICIPALITY IN SCORE AS *TOWN OF AVON*.

(B) LGIS LISTS SCHOOL DISTRICTS BY THE STATE BOARD OF EDUCATION'S TRUNCATED ORGANIZATION NAME WITH THE WORDS "SCHOOL DISTRICT" APPENDED AT THE END OF THE DISTRICT'S NAME. COUNTIES MUST ENTER THE DISTRICT'S NAME INTO SCORE ACCORDING TO COMMON USAGE. BY WAY OF EXAMPLE, IF LGIS LISTS A SCHOOL DISTRICT AS *LAS ANIMAS RE-1 SCHOOL DISTRICT*, THE COUNTY MUST NAME THE DISTRICT IN SCORE AS *LAS ANIMAS SCHOOL DISTRICT RE-1*.

7.17.2 POSITION NAMES: COUNTIES MUST NAME POSITIONS IN SCORE SO THAT THE FULL NAME OF THE DISTRICT PRECEDES THE POSITION OR OFFICE NAME FOLLOWED BY THE POSITION DISTRICT NUMBER OR TERM OF YEARS, IF ANY. THE COUNTY CLERK MAY DELETE THE FULL DISTRICT NAME FROM THE POSITION OR OFFICE NAME ON BALLOT ART IF A BALLOT HEADER OR CONTEST HEADING SUFFICIENTLY IDENTIFIES THE PARTICIPATING DISTRICT, BUT THE POSITION MUST BE NAMED IN ACCORDANCE WITH THIS RULE TO ENSURE IT IS INCLUDED IN THE COUNTY'S ELECTION DEFINITION EXPORT, ELECTION RESULTS EXPORTS, AND CAST VOTE RECORD FILES. FOR EXAMPLE:

(A) COUNTY POSITION NAMES: ADAMS COUNTY BOARD OF COUNTY COMMISSIONERS – DISTRICT 1; ADAMS COUNTY CLERK AND RECORDER; ADAMS COUNTY TREASURER; ADAMS COUNTY ASSESSOR; ADAMS COUNTY SHERIFF; ADAMS COUNTY CORONER; ADAMS COUNTY SURVEYOR

(B) MUNICIPAL POSITION NAMES: CITY OF ASPEN CITY COUNCIL – AT LARGE; CITY OF ASPEN CITY COUNCIL – WARD 2; TOWN OF MANCOS BOARD OF TRUSTEES – WARD 1; CITY OF LITTLETON MAYOR

(C) SCHOOL DISTRICT POSITION NAMES: ALAMOSA SCHOOL DISTRICT RE-11J BOARD OF DIRECTORS – DISTRICT 2; KIT CARSON SCHOOL DISTRICT R-1 BOARD OF DIRECTORS – DISTRICT A

(D) SPECIAL DISTRICT POSITION NAMES: ALLISON VALLEY METROPOLITAN DISTRICT NO. 2 BOARD OF DIRECTORS – 2-YEAR TERM; DENVER SOUTHEAST SUBURBAN WATER & SANITATION DISTRICT BOARD OF DIRECTORS – 4-YEAR TERM.

7.17.2 BALLOT STYLE NAMES:

(A) IF A COUNTY REPORTS RESULTS FOR ANY ELECTION BY PRECINCT, THE COUNTY MUST RENAME ITS BALLOT STYLES IN SCORE ACCORDING TO THE CONVENTION OF XXX-Y OR XXX-YY, WHERE XXX IS THE FINAL THREE DIGITS OF THE TEN-DIGIT PRECINCT NUMBER, AND Y OR YY IS THE ONE- OR TWO-DIGIT DISTRICT STYLE NUMBER. BY WAY OF EXAMPLE, IF SCORE GENERATES A SINGLE DISTRICT STYLE AND THE COUNTY HAS 3 PRECINCTS, THE COUNTY MUST NAME THE PRECINCT STYLES AS 001-1, 002-1, AND 003-1.

(B) IF THE COUNTY REPORTS RESULTS OF AN ELECTION BY BALLOT STYLE, THE COUNTY MUST NAME THE BALLOT STYLE WITH THE BALLOT STYLE NUMBER GENERATED BY SCORE. BY WAY OF EXAMPLE, IF SCORE GENERATES THREE DIFFERENT DISTRICT STYLES FOR AN ELECTION OTHER THAN A GENERAL ELECTION, THE COUNTY MUST NAME THE BALLOT

STYLES 1, 2, AND 3. IF SCORE GENERATES MORE THAN NINE DISTRICT STYLES FOR AN ELECTION, THE COUNTY MUST NAME THEM WITH A TWO-DIGIT NUMBER, SUCH AS 01 THROUGH 09, 10, 11, ETC.

Amendments to Rule 8:

Amendments to Rule 8.1 including the recodification of sections (a) through (c) of Rule 1.1.64 to Rules 8.1.2 through 8.1.4 and necessary renumbering:

8.1 A watcher must affirm that he or she is qualified to act as a watcher under Colorado law. The county clerk must accept the appointment of all eligible watchers duly certified by a political party, candidate, or issue committee under sections 1-1-104(51), 1-7-105, 1-7-106, or 1-7-107, C.R.S.

8.1.1 The registered agent or designated filing agent for an issue committee is the authorized representative to appoint watchers for the issue committee.

~~(a)~~8.1.2 Watchers may be appointed for a recall election by each qualified successor candidate, the proponents and opponents of the recall ballot question, and each participating political party for a partisan recall election.

~~(b)~~8.1.3 For the purpose of appointing a watcher, the proponent or opponent of a ballot measure means a registered issue committee supporting or opposing the ballot measure.

~~(c)~~8.1.4 A designated watcher need not be a resident of the county they are designated in as long as they are an eligible elector in the State of Colorado.

[Not shown: current Rules 8.1.2 through 8.1.6 are renumbered to Rules 8.1.5 through 8.1.9.]

Amendments to Rule 8.8 specifying the use of watchers in a non-partisan, coordinated election since the passage of SB23-276 incorporates these requirements for watchers in other elections and stylistic changes to Rule 8.8.3:

8.8 The minimum number of watchers the county clerk must accommodate for each appointing entity IN A NON-PARTISAN, COORDINATED ELECTION is as follows:

[Not shown: no changes to Rules 8.8.1 and 8.8.2.]

8.8.3 At each ~~V~~Voter ~~S~~Service and ~~P~~Polling ~~C~~Center, one watcher, or one watcher per ~~V~~Voter ~~S~~Service and ~~P~~Polling ~~C~~Center process.

[Not shown: no changes to Rules 8.8.4 and 8.8.5.]

Amendments to Rule 8.10.2 including a stylistic change in section (a)(1) and new section (d).]

8.10.2 Watchers must be permitted access that would allow them to attest to the accuracy of election-related activities. This includes personal visual access at a reasonable proximity to read documents, writings or electronic screens and reasonable proximity to hear election-related discussions between election judges and electors.

(a) Election activities include:

(1) Setup and breakdown of ~~V~~Voter ~~S~~Service and ~~P~~Polling ~~C~~Centers.

[Not shown: no changes to subsections (2) through (12).]

[Not shown: no changes to sections (b) and (c).]

(D) THE COUNTY CLERK MUST ALLOW A WATCHER TO POSSESS A PHONE TO SEND OR RECEIVE TEXT MESSAGES WHILE WATCHING ELECTION ACTIVITIES AS LONG AS THE WATCHER IS NOT LOCATED WHERE PERSONALLY IDENTIFIABLE INFORMATION IS WITHIN VIEW AS REQUIRED BY SECTION 1-7-108(4), C.R.S.

Amendments to Rule 9:

Amendments to Rule 9.1.4 removing outdated language, due to the passage of SB23-276, regarding voters under the age of 18:

9.1.4 Age. ~~For a primary election, the election judge must ask the elector, "Are you at least 17 years of age and will you be 18 years of age or older on or before the date of the next general election?" For any other election,~~ The election judge must ask the elector, "Will you be 18 years of age or older on election day?"

Amendments to Rule 10:

Amendments to Rule 10.3.2 removing outdated language pertaining to complaints about random audits which are no longer conducted in Colorado:

10.3.2 The canvass board's only duties are to:

(a) Conduct the canvass and certify the official abstract of votes in accordance with section 1-10-101.5, C.R.S., by:

(1) Reconciling the number of ballots counted to the number of ballots cast; and

(2) Reconciling the number of ballots cast to the number of voters who voted.

(b) Observe the post-election audit in accordance with section 1-7-514(4), C.R.S., and Election Rule 25.2 or 25.3; AND

~~(c) In coordination with the county clerk, investigate and report discrepancies found in the audit under section 1-7-514(2), C.R.S.; and~~

(C)~~(d)~~ Conduct any recount in accordance with section 1-10.5-107, C.R.S., and this Rule. ~~The canvass board's role in conducting a recount includes selecting ballots for the random test, observing the recounting of ballots, and certifying the results.~~

Repeal of Rule 10.5.3 which pertains to complaints made about voting devices, which are no longer used in Colorado:

~~10.5.3 Written Complaints~~

~~(a) The designated election official must provide the canvass board with any written complaint submitted by a registered elector about a voting device.~~

~~(b) If the complaint is resolved, the designated election official must provide the details of the resolution.~~

~~(c) If the complaint is pending resolution when the board meets to conduct the canvass, the designated election official must provide a proposal for how the issue will be resolved.~~

Amendments to Rule 10.6 concerning a grammatical change:

10.6 Official ~~A~~Abstract and ~~R~~Reporting to the Secretary of State

Repeal of Rule 10.6.3 which has been superseded with the passage of SB22-153, and replacement with notification requirements for canvass board meetings:

10.6.3 ~~If a majority of the canvass board votes not to certify the abstract of votes cast or does not make a final determination by the deadline to certify the abstract of votes cast, the county clerk must forward the abstract that has not been certified to the Secretary of State along with a report from the canvass board describing why the abstract has not been certified. Upon receiving an abstract under this rule, or if the county clerk does not provide the abstract to the Secretary of State by the deadline to certify the abstract of votes cast, the Secretary of State will consider whether to canvass the returns under section 1-10-104, C.R.S.~~ A COUNTY MUST NOTIFY THE SECRETARY OF STATE IMMEDIATELY AFTER THE MEETING OF THE CANVASS BOARD IF:

(A) THE CANVASS BOARD VOTES NOT TO CERTIFY THE ABSTRACT OF VOTES CAST;

(B) THE CANVASS BOARD OTHERWISE FAILS TO TAKE ACTION TO CERTIFY THE ABSTRACT OF VOTES CAST; OR

(C) IN A PARTISAN ELECTION, THE COMPOSITION OF THE CANVASS BOARD DID NOT CONSIST OF:

(1) AN EQUAL NUMBER OF BOARD MEMBERS APPOINTED FROM EACH OF THE OPPOSING MAJOR PARTIES; AND

(2) THE COUNTY CLERK OR DEPUTY CLERK.

Amendments to Rule 10.8.1 concerning a technical change:

10.8.1 As part of the Secretary's duties under section 1-1-107, C.R.S., the Secretary may provide guidance and investigate imperfections ~~as outlined below~~.

Amendments to Rule 10.9 concerning mandatory and discretionary recounts and including technical changes:

10.9 Recount generally

[Not shown: no changes to Rule 10.9.1.]

10.9.2 A county that has successfully completed a comparison audit under Rule 25.2 and reported no discrepancies in the recount contest need not re-scan ballots during a REQUESTED recount, except as provided in Rule 10.9.3. In all cases, the county must re-adjudicate ballot images for voter intent in accordance with Rule 10.13.3.

10.9.3 ~~The losing candidate with the most votes, or an~~ AN interested party as defined in section 1-10.5-106, C.R.S., may request that the county re-scan ballots. The request is due no later than ~~the day after the deadline to order a mandatory recount or~~ the day ~~after the deadline to request~~ a recount IS PAID FOR~~, whichever is applicable~~.

[Not shown: no changes to Rules 10.9.4 and 10.9.5.]

~~10.9.6 If all losing candidates who received enough votes to trigger a mandatory recount submit letters of withdrawal to the DEO in accordance with section 1-4-1001, C.R.S., the DEO must immediately notify the county clerk and the county clerk need not conduct the recount.~~

Amendments to Rule 10.10.2 concerning requested recounts and updating cost estimate requirements due to the passage of SB23-276:

10.10.2 Requested recounts

[Not shown: no changes to section (a).]

(b) In preparing a cost estimate for a requested recount, the county must use the Secretary of State approved form. The estimate must include reasonable itemized costs for conducting the recount AND MUST DISTINGUISH THE COST FOR CONDUCTING THE RECOUNT WITH AND WITHOUT RESCANNING THE BALLOTS. ~~The county may not request reimbursement for normal overhead costs.~~

Repeal of Rule 10.12.2 because it is duplicative to statute with the passage of SB23-276:

~~10.12.2 If the county re-scans ballots during the recount, the county clerk must test all ballot scanners that will be used. The purpose of the test is to ensure that the voting system accurately tabulates votes in the recounted contest.~~

~~(a) The county must prepare and tabulate the following test decks:~~

~~(1) The county recount test deck must include every ballot style and, where applicable, precinct style containing the recounted contest. It must consist of enough ballots to mark every vote position and every possible combination of vote positions, and include overvotes, undervotes, and blank votes in the recounted contest.~~

~~(2) In a requested recount, the person requesting the recount may mark up to 10 ballots. Any other candidate in the contest, or person or organization who could have requested the recount, may also mark up to 10 ballots.~~

~~(3) In a mandatory recount, at least two canvass board members of different party affiliations must each mark an additional 10 ballots containing the recounted contest.~~

~~(b) A bipartisan team, of election judges and/or staff, must hand tally the recounted contest on the test ballots and verify that the hand tally matches the voting system's tabulation.~~

~~(c) The test is limited to the race or measure that is recounted.~~

Repeal of Rule 10.13.1 because it is duplicative to statute with the passage of SB23-276:

10.13 Counting ballots during a recount

~~10.13.1 In accordance with section 1-10.5-102(3)(b), C.R.S., if there are no discrepancies in the test under Rule 10.12, the recount must be conducted in the same manner as the ballots were counted in the election except as outlined in this Rule. If there are unresolvable~~

~~discrepancies in the test, the recount must be conducted as a hand count under Rule 10.13.5.~~

[Not shown: current Rules 10.13.2 through 10.3.6 are renumbered to Rules 10.13.1 through 10.13.5.]

Amendments to Rule 10.14.1 updating the requirements for results reporting following a recount:

10.14 Canvass and reporting results for a recount

10.14.1 Totals of recounted ballots must be reported AS ~~in summary form as follows:~~

~~(a) Sum~~ COMBINED total of votes for each race or measure recounted, under-votes, BLANK VOTES, VALID WRITE-IN VOTES, and over-votes FOR THE RACE RECOUNTED ~~for each location;~~

~~(b) The totals must be a combined total, not totaled by individual precincts or location, unless the tabulation system allows~~.

Amendments to Rule 11.2 concerning a stylistic change:

11.2 Voting ~~S~~system ~~I~~inventory

[Not shown: no changes to Rules 11.2.1 and 11.2.2.]

Amendments to Rule 11.2.3 concerning a technical revision to reflect current practice:

11.2.3 The designated election official must file ~~a complete~~ THE voting system inventory REQUIRED BY RULE 11.2.1, noting which equipment will be used for the election, with the Secretary of State no later than ten days before the election.

[Not shown: no changes to Rule 11.2.4.]

Amendments to Rule 11.6 concerning a stylistic change:

11.6 ~~Rules Concerning~~ Accessible ~~V~~voting ~~S~~systems. A political subdivision may not purchase or lease voting systems for use by people with disabilities unless the system is certified by the Secretary of State.

Amendments to Rule 11.7 concerning a stylistic change:

11.7 ~~Rules Concerning~~ Notice of ~~V~~voting ~~S~~system ~~M~~malfunction

Amendments to Rule 11.7.1 requiring a voting systems provider to submit an incident report in the event of an incident:

11.7.1 The voting system provider must submit a software or hardware incident report to the Secretary of State no later than 72 hours after ~~a software~~ AN incident has occurred. SUBMISSION OF THIS INCIDENT REPORT BY THE PROVIDER IS REQUIRED EVEN IF THE DESIGNATED ELECTION OFFICIAL ALSO SUBMITS A REPORT OF THE SAME INCIDENT.

Amendments to Rule 11.8, including Rule 11.8.2(f), concerning stylistic and grammatical changes:

11.8 Purchases and ~~C~~contracts

[Not shown: no changes to Rule 11.8.1.]

11.8.2 The Secretary of State will approve a political subdivision's application to purchase, lease, or use the voting system, device, or related component, after considering all relevant factors, including without limitation:

[Not shown: no changes to sections (a) through (e).]

(f) The voting system's compatibility with dependent systems that are not directly related to the tabulation of votes and ballots, but are nevertheless utilized by designated election officials in conducting elections in Colorado, including:

(1) Ballot-on-demand systems,

(2) Election Night Reporting systems,

(3) Electronic ballot delivery systems,

(4) Election definition data exported from SCORE~~.~~, and

(5) The Secretary of State's RLA software~~.~~;

[Not shown: no changes to sections (g) through (q).]

[Not shown: no changes to Rules 11.8.3 through 11.8.7.]

Amendments to Rule 11.9:

11.9 Election Night Reporting. The county must use the Secretary of State's Election Night Reporting (ENR) system to report results for all primary, general, coordinated, and recall elections in accordance with this Rule.

[Not shown: no changes to Rule 11.9.1.]

New Rule 11.9.2 concerning a requirement that a county clerk must provide data to the voting systems team in advance of an election:

11.9.2 NO LATER THAN 45 DAYS BEFORE THE ELECTION, A COUNTY CLERK MUST PROVIDE THEIR SCORE ELECTION_DETAILS_TO_DOMINION EXPORT TO THE SECRETARY OF STATE'S OFFICE BY SENDING AN EMAIL TO VOTING.SYSTEMS@COLORADOSOS.GOV.

[Not shown: current Rule 11.9.2 renumbered to Rule 11.9.3.]

Amendments to current Rule 11.9.3 requiring a county to check the totals and content configuration reflected on the ENR website after uploading their LAT results file and necessary renumbering:

~~11.9.3~~11.9.4 No later than 21 days before the election, a data entry county must upload the LAT results file to ENR. At a minimum, the LAT results file must contain the results of the complete county test deck required under Rule 11.3.2(c)(1). THE COUNTY MUST CHECK THE TOTALS AND CONTENT CONFIGURATION REFLECTED ON THE ENR WEBSITE AT THE TIME OF UPLOADING THE LAT RESULTS FILE. THE COUNTY MUST SEND AN EMAIL TO VOTING.SYSTEMS@COLORADOSOS.GOV ONCE VERIFICATION OF THE ENR WEBSITE IS COMPLETE.

[Not shown: current Rules 11.9.4 through 11.9.6 are renumbered to Rules 11.9.5 through 11.9.7.]

Amendments to Rule 13:

Amendments to Rule 13.1.3 concerning the Department's processing and docketing of election complaints:

13.1.3 Processing and docketing election complaints

(a) Within three business days of receiving a complaint, the Secretary's designee will review the complaint to determine if it satisfies Rule 13.1.2 and sufficiently alleges a violation of the Uniform Election Code of 1992. THE SECRETARY'S DESIGNEE MAY EXTEND THIS DEADLINE IN THE EVENT THAT THERE ARE EXTENUATING CIRCUMSTANCES WHICH WOULD INHIBIT THE DESIGNEE'S ABILITY TO MEET THE DEADLINE.

[Not shown: no changes to section (1).]

(2) If a complaint meets the criteria, the Secretary's designee will ~~assign a complaint number,~~ notify the complainant, and send a copy of the complaint to the person or entity alleged to have committed a violation.

[Not shown: no changes to section (b).]

Amendments to Rule 13.2.9 concerning a grammatical change:

13.2.9 Hearing and ~~R~~Resolution of HAVA complaints

[Not shown: no changes to sections (a) and (b).]

Amendments to Rule 13.2.10 updating the complaint process for a HAVA complaint from the Office of Administrative Courts to a hearing officer and grammatical changes:

13.2.10 Alternative ~~D~~Dispute ~~R~~Resolution under section 1-1.5-105(2)(j), C.R.S.

(a) If the Secretary of State does not resolve the complaint within 90 days of the date that it was filed and the complainant does not consent to an extension of time, the Secretary of State will transfer the complaint to A HEARING OFFICER ~~the Office of Administrative Courts (OAC)~~.

(b) The Secretary of State will provide the record and any other materials from the proceedings to the ~~OAC~~ HEARING OFFICER.

(c) The Secretary of State will consider the initial determination by the ~~OAC~~ HEARING OFFICER and issue a final determination within 60 days of the date the determination is received by the Secretary.

Amendments to Rule 15.1.2 concerning the review of petition submissions which do not include required information and technical changes:

15.1.2 Petition submission

(a) The ~~Secretary~~ DEPARTMENT of State or DEO will not accept or count additional signatures after the initial submission of the petition, even if additional signatures are offered before the deadline.

(b) The ~~Secretary~~ DEPARTMENT of State or DEO will inspect each petition section for evidence of disassembly. If it appears that the section was disassembled, the Secretary or DEO will reject all signatures in the section.

(c) The ~~Secretary~~ DEPARTMENT of State or DEO will NOT consider ~~any~~ A signer line ~~with writing on it~~ as a reviewable line, ~~even~~ if the line is incomplete or partially crossed out AND THE INFORMATION MISSING OR CROSSED OUT IS THE NAME, SIGNATURE, OR ADDRESS OF THE SIGNER.

(d) The ~~Secretary~~ DEPARTMENT of State or DEO will not review lines that are blank or completely crossed-out.

Amendments to section (e) concerning a technical error and change:

~~(~~(e) If the number of lines submitted is less than the number of signatures required to access the ballot, the ~~Secretary~~ DEPARTMENT of State or DEO will issue a statement of insufficiency and will not review signer lines or apply duplicates to future candidate petition submissions for the same office or recall petitions of the same officeholder.

Amendments to section (f) concerning a technical change:

(f) The ~~Secretary~~ DEPARTMENT of State or DEO will review and process candidate petitions for the same office in the order in which they are received.

Amendments to Rule 15.1.4(c) for grammatical consistency within these rules:

15.1.4 Verifying individual entries

[Not shown: no changes to sections (a) and (b).]

(c) If an entry does not match the ~~signor's~~ SIGNER'S current information in SCORE, staff must check the ~~signor's~~ SIGNER'S information in SCORE as of the date the ~~signor~~ SIGNER signed the petition.

Amendments to Rule 15.1.4(d) concerning standards for the rejection of a signature on an initiative petition and technical changes:

(d) Secretary of State or DEO staff will reject the entry if:

[Not shown: no changes to subsections (1) through (9).]

(10) The entry is a duplicate of a previously accepted entry on the same petition; ~~or~~

(11) For a candidate petition where an elector may sign only one petition for the same office, the entry is a duplicate of a previously accepted entry on a petition that was declared sufficient or insufficient after lines were reviewed for the same office; ~~.~~

(12) The signer's information appears outside of a numbered signature block on a petition section; ~~.~~

(13) For a candidate petition, the address on the entry does not match the current residential or mailing address for the elector in SCORE ~~.~~; OR

(14) FOR AN INITIATIVE PETITION, A NAME SUFFIX IS PRESENT ON THE ENTRY BUT NOT IN SCORE, OR PRESENT IN SCORE BUT NOT ON THE ENTRY, AND MORE THAN ONE PERSON WITH THAT NAME IS REGISTERED TO VOTE AT THE SAME ADDRESS.

Amendments to Rule 15.1.4(e) concerning standards for the review of petitions, necessary renumbering, and grammatical changes:

(e) ~~Secretary~~ THE DEPARTMENT of State or DEO staff will not use any of the following discrepancies as the sole reason to reject an entry:

(1) The name on an entry matches or is substantially similar to the information in SCORE, or if the signature on an entry is a common variant of the name;

(2) A middle initial or middle name is present on the entry but not in SCORE, or present in SCORE but not on the entry;

(3) A name suffix is present on the entry but not in SCORE, or present in SCORE but not on the entry AND ONLY ONE PERSON WITH THAT NAME IS REGISTERED TO VOTE AT THAT ADDRESS;

(4) FOR A CANDIDATE PETITION, A NAME SUFFIX IS PRESENT ON THE ENTRY BUT NOT IN SCORE, OR PRESENT IN SCORE BUT NOT ON THE ENTRY, MORE THAN ONE PERSON WITH THAT NAME IS REGISTERED TO VOTE AT THE SAME ADDRESS, BUT THE SIGNATURE MATCHES FOR ONE PERSON REGISTERED TO VOTE AT THAT ADDRESS;

~~(4)~~(5) The printed name is missing or illegible but the signature can be read;

~~(5)~~(6) The address on the entry is missing an apartment letter or number or a street direction, or the address entry contains an apartment letter or number or a street direction that is missing in the voter registration record;

~~(6)~~(7) The CITY OR county name is missing, abbreviated, or wrong;

~~(7)~~(8) For candidate and recall petitions, the address provided did not match the current residence address information in SCORE, but did match the current mailing address information in SCORE;

~~(8)~~(9) On a signer line, the date is missing but a line above and below has an acceptable date; ~~or~~

~~(9)~~(10) For Secretary of State STAFF reviewed petitions only, the year of the date is missing or wrong; OR~~.~~

(11) INFORMATION REQUIRED FOR THE SIGNER IS PRESENT ON A PETITION LINE BUT IS WRITTEN IN THE WRONG FIELD.

Amendments to Rule 15.2.1 concerning the information to be included on a petition entity's license application and necessary renumbering:

15.2 Petition entity license, registration, filing, and circulation

15.2.1 A petition entity that intends to pay petition circulators must obtain a petition entity license, pay a fee, and register with the Secretary of State's OFFICE before circulating initiative, candidate, and recall petitions. The license application must include:

(a) The petition entity's name, address, telephone number, and email address;

(b) The designated agent's name;

(c) The name of all owners and chief officers of the entity;

(D) FOR THOSE APPLICATIONS SUBMITTED AFTER DECEMBER 31, 2024, THE FOLLOWING INFORMATION REGARDING PETITION CIRCULATORS:

(1) THE NAME, ADDRESS, AND SIGNATURE OF ANY PETITION CIRCULATORS THE ENTITY HAS HIRED OR CONTRACTED WITH TO CIRCULATE A PETITION IN COLORADO; AND

(2) THE PETITIONS EACH CIRCULATOR WILL CIRCULATE IN COLORADO; and

~~(d)~~(E) An affirmation that:

(1) The designated agent has read and understands Article 4, Article 12, and Article 40 of Title 1, C.R.S.;

(2) The designated agent has completed the Secretary of State's circulator training program AND WILL COMPLETE THE TRAINING BEFORE REGISTERING THE ENTITY TO CIRCULATE ANY PETITION IN COLORADO;

(3) THE PETITION ENTITY HAS OR WILL PROVIDE TO ALL CIRCULATORS, PAID OR UNPAID, THE CIRCULATOR TRAINING OFFERED BY THE COLORADO SECRETARY OF STATE AS ONE WAY FOR THE CIRCULATOR TO COMPLY WITH THE REQUIREMENT THAT A CIRCULATOR READ AND UNDERSTAND THE LAWS PERTAINING TO PETITION CIRCULATION; ~~and~~

~~(3)~~(4) The entity, ~~and~~ none of its owners or chief officers, AND NO ENTITY OR PRINCIPAL OF A PETITION ENTITY THAT THE ENTITY HAS OR WILL CONTRACT WITH, has ever been found in a judicial or administrative hearing in Colorado or any other state of authorizing or knowingly permitting:

(A) Forgery of a registered elector's signature;

(B) Circulation of a petition section, in whole or in part, by anyone other than the circulator;

(C) Use of a false circulator name or address in a circulator affidavit;

(D) Payment of money or a thing of value to any person for the purpose of inducing the person to sign or withdraw his or her name from a petition; or

(E) A notary public's notarization of a circulator affidavit outside of the physical presence of the circulator or without the production of the required identification for notarization of a petition section.; AND

(5) NEITHER THE ENTITY NOR ITS OWNERS OR OFFICERS HAVE BEEN FOUND IN A JUDICIAL OR ADMINISTRATIVE HEARING IN COLORADO OR ANY OTHER STATE OF:

(A) VIOLATING A PETITION LAW;

(B) COMMITTING ELECTION FRAUD;

(C) COMMITTING ANY OTHER ELECTION OFFENSE; OR

(D) COMMITTING AN OFFENSE WITH AN ELEMENT OF FRAUD.

Amendments to Rule 15.2.2 requiring the completion of the Department's circulator training program after license application but before the registration of a petition:

15.2.2 Before compensating a circulator, the designated agent must register with the Secretary of State's OFFICE by submitting a signed form that includes a list of the proposed initiatives and/or the candidate or candidate committee's name the petition entity will circulate. A DESIGNATED AGENT MUST COMPLETE THE SECRETARY OF STATE'S CIRCULATOR TRAINING PROGRAM AFTER APPLYING FOR A LICENSE AND PRIOR TO REGISTERING A PETITION ENTITY TO CIRCULATE ANY PETITION.

[Not shown: no changes to Rules 15.2.3 and 15.2.4.]

New Rule 15.2.5 clarifies that petition entity licenses expire after two years and require a new license application and fee after expiration:

15.2.5 BEGINNING JANUARY 1, 2024, A PETITION ENTITY LICENSE IS ONLY VALID FOR TWO YEARS FROM THE DATE THE LICENSE WAS APPROVED BY THE SECRETARY OF STATE. ONCE A LICENSE EXPIRES, A PETITION ENTITY MUST SUBMIT A NEW LICENSE APPLICATION AND FEE.

New Rule 15.2.6 clarifies when a petition entity must update their entity license in accordance with sections 1-4-905.5(4)(a) and 1-40-135(5)(a), C.R.S.:

15.2.6 IN ACCORDANCE WITH SECTIONS 1-4-905.5(4)(A) AND 1-40-135(5)(A), C.R.S., A PETITION ENTITY MUST UPDATE THEIR ENTITY LICENSE NO LATER THAN 20 DAYS AFTER A CHANGE TO ANY INFORMATION PROVIDED IN THEIR INITIAL APPLICATION.

Amendments to Rule 15.3.2 concerning technical revisions that reflect current Colorado law and grammatical changes:

15.3.2 The petition circulator must provide a permanent residence address on the circulator affidavit.

(a) For purposes of Article 40 of Title 1, C.R.S., and this Rule, a circulator's permanent "residence" ~~or "domicile"~~ means ~~his or her~~ THEIR principal or primary home or place of abode in which a circulator's habitation is fixed and to which the circulator, whenever absent, has the present intention of returning after a departure or absence, regardless of the duration of the absence. A permanent "residence" ~~or "domicile"~~ is a permanent building or part of a building and may include a house, condominium, apartment, room in house, or mobile home. Except as provided in paragraph (b) of this Rule, a vacant lot, business address, or post office box is not a permanent "residence" ~~or "domicile"~~.

(b) A homeless circulator must provide the address or location where ~~he or she is~~ THEY ARE living the date the affidavit is signed. The circulator must provide a physical location THEY RETURN TO REGULARLY WHICH MAY INCLUDE A PARK, CAMPGROUND, VACANT LOT, BUSINESS ADDRESS OR ANY OTHER PHYSICAL LOCATION; a post office box may not be provided.

[Not shown: no changes to section (c).]

Amendments to Rule 15.4.1 concerning technical revisions to the approval process for statewide initiative petitions:

15.4.1 The ~~Secretary~~ DEPARTMENT of State will not accept a petition that lists ~~proponents~~ DESIGNATED REPRESENTATIVES other than those ~~authorized by law~~ LISTED ON THE AFFIDAVIT OF DESIGNATED REPRESENTATIVES FILED WITH THE STATE TITLE BOARD.

Amendments to Rule 15.5.1 concerning technical changes to the verification by random sample in accordance with section 1-40-116, C.R.S.:

15.5 Statewide initiative petition verification

15.5.1 Verification by random sample.

[Not shown: no changes to section (a).]

(b) The database will generate a series of random numbers equal to 4,000 signatures or five percent of the total number of signatures, whichever is greater. Staff will ~~check the validity of the random signatures in accordance with this Rule~~ REVIEW THE RANDOMLY SELECTED SIGNATURE LINES IN ACCORDANCE WITH SECTION 1-40-116, C.R.S., AND THIS RULE. Staff will maintain a master record of each accepted and rejected entry, along with the reason code for each rejected entry.

Amendments to Rule 15.6.1 concerning the review of signatures on state candidate and recall petitions and technical changes:

15.6.1 The ~~Secretary~~ DEPARTMENT of State will compare the signature on each petition entry with the elector's signature in SCORE in accordance with the Secretary of State's Signature Verification Guide. The Secretary of State may use an automated signature verification device.

(a) If the signatures match and the entry is otherwise valid, the ~~Secretary~~ DEPARTMENT of State must accept the entry.

(b) If upon initial review the signatures do not match, The ~~Secretary~~ DEPARTMENT of State must conduct further review of the entry. A team of two staff members who are not affiliated with the same political party, OR WHO ARE UNAFFILIATED, must review the signatures, conduct additional research in SCORE if necessary, and, unless both staff members agree that the signatures do not match, accept the entry if it is otherwise valid. IN THE EVENT THAT A STAFF MEMBER IS NOT REGISTERED TO VOTE, THAT STAFF MEMBER WILL BE CONSIDERED UNAFFILIATED FOR THE PURPOSE OF THIS RULE.

Amendments to Rule 15.7.4 concerning stylistic changes:

15.7.4 Each referendum petition section must consist of the following, in the order listed:

(a) The warning as specified in section 1-40-110, C.R.S.;

(b) The heading "Referendum Petition",~~"~~ followed by the demand upon the Secretary of State in substantially the following form, in which the underlined material is only for example:

"To: The Honorable _____, Secretary of State of the State of Colorado

We, the undersigned electors of the State of Colorado, do hereby respectfully petition, order, and demand that Sections 1 to 12, inclusive (being the entire Act), of House Bill No. 02-1010, by Representatives Abel, Baker, and Cain, and

Senators Smith, Thomas, and Jones, entitled "Concerning registration requirements for motor vehicles, and, in connection therewith, authorizing two- and five-year registration periods and authorizing discretionary vehicle identification number inspections, and making an appropriation", passed by the Sixty-third General Assembly of the State of Colorado, at its regular session in the year 2002,shall be submitted to the voters for their adoption or rejection at the next biennial regular general election, to be held on Tuesday, the ~~5th~~ 5TH day of November, 2002, and each of the signers of this petition says:

I sign this petition in my own proper person only, and I am a registered elector of the State of Colorado, my residence address and the date of my signing this petition are correctly written immediately after my name, and I do hereby designate the following persons to represent me in all matters affecting this petition:";

(c) The name and mailing address of two persons who are designated to represent the signers thereof in all matters;~~.~~

(d) The ballot title and submission clause;~~.~~

(e) The text of the Act, or the item, section, or part of the Act, on which the referendum is demanded;~~.~~

(f) Succeeding pages that each contain the warning, the ballot title, and submission clause, and ruled lines numbered consecutively for signatures; AND~~.~~

(g) A final page that contains the circulator's affidavit required by section 1-40-111(2), C.R.S.

Amendments to Rule 16:

Amendments to Rule 16.1 concerning a stylistic change:

16.1 ~~General Rules concerning v~~Voting by military and overseas electors

Amendments to Rule 16.1.6 concerning county communication with UOCAVA electors:

16.1.6 The county clerk must send a minimum of one correspondence no later than 60 days before the first primary OR COORDINATED election ~~in an even numbered~~ EACH year to each ~~elector whose record is marked "Inactive~~ COVERED VOTER.~~"~~ The correspondence may be sent by email or mail and, at a minimum, must notify the electors of:

(a) The status of the elector's record and ballot request;

(b) The upcoming federal AND STATE elections;

(c) How to update the elector's mailing information and request a ballot; and

(d) Any other information the county clerk deems appropriate.

New Rule 16.2.5 regarding transmitting a mail ballot packet to a covered voter who has already received a ballot by fax or email:

16.2.5 A COUNTY CLERK THAT HAS SUCCESSFULLY TRANSMITTED A BALLOT PACKET TO A COVERED VOTER BY FAX OR EMAIL MAY NOT SEPARATELY MAIL THAT ELECTOR A BALLOT UNLESS LATER REQUESTED BY THAT ELECTOR, OR AS A RESULT OF A CHANGE OF THAT VOTER'S STATUS.

[Not shown: current Rules 16.2.5 through 16.2.8 are renumbered to Rules 16.2.6 through 16.2.9.]

Amendments to Rule 17:

Amendments to Rule 17.5 concerning technical changes:

17.5 Processing provisional ballot affidavits in the SCORE. Before closing an election, the county clerk must:

17.5.1 Enter all provisional ballot affidavits into the SCORE provisional module;~~.~~

17.5.2 Process all voter registration updates; AND~~.~~

17.5.3 Link all provisional ballot affidavits to the appropriate elector's record.

Amendments to Rule 18:

Repeal of Rule 18.3 and Rule 18.3.1 due to this technology no longer being in use in Colorado:

~~18.3 Standards for counting paper ballots on ballot scanners~~

~~18.3.1 Procedures for counting paper ballots on ballot scanners at polling locations~~

~~(a) To the extent permitted by its voting system, the county must program ballot scanners to sort ballots with write-in votes to a segregated bin of the ballot box or digital media and to initially reject blank ballots and ballots with overvotes.~~

~~(b) Voters whose ballots are initially rejected by a ballot scanner as a blank or overvoted ballot must be given the opportunity to review and correct their ballot. If after review, a voter requests to submit the blank or overvoted ballot as originally marked, an election judge must assist the voter by overriding the initial rejection setting on the ballot scanner.~~

~~(c) At the conclusion of voting, ballots with write-in votes must be delivered to the central count location in a secure container for resolution in accordance with Rule 18.5.3.~~

Amendments to Rule 18.3.2 including the recodification to Rule 18, necessary renumbering, and removing language which no longer applies to Colorado voting system components:

~~18.3.2~~18.3 Procedures for counting paper ballots on ballot scanners at central count locations

~~(a)~~18.3.1 Before tabulation, a resolution board must duplicate damaged ballots, and may duplicate ballots with marks that may identify the voter, in accordance with Rule 18.4. Election judges may visually inspect every ballot for the limited purpose of segregating damaged ballots and ballots with marks that may identify the voter.

~~(b)~~18.3.2 A county must sort ballots requiring resolution according to the capabilities of its voting system.

~~(1)~~ If a county's voting system supports digital ballot resolution, the county must program the voting system to digitally queue for resolution blank ballots, ballots with write-in votes, and ballots with overvotes. Ballots with marginal or ambiguous markings must be sorted according to the system provider's specifications, or, if different, the applicable Conditions of Use issued by the Secretary of State. The

digitally queued ballots must be resolved by election judges in accordance with Rule 18.5.

~~(2) If a county's voting system does not support digital ballot resolution, the county must program the central count ballot scanners to reject or sort blank ballots and ballots with overvotes, and to sort ballots with write-in votes. The resolution board must resolve all ballots initially rejected and sorted by the central count ballot scanners in accordance with Rule 18.5.~~

~~(c)~~18.3.3 A resolution board must resolve ballots sorted or rejected for resolution.

~~(1)~~(A) In partisan elections, a resolution board must consist of at least two election judges affiliated with different major political parties.

~~(2)~~(B) In nonpartisan elections, a resolution board must consist of at least two election judges.

~~(3) In counties with a voting system that does not support digital resolution, the county must have at least one resolution board.~~

~~(4)~~(C) ~~In counties with a voting system that supports digital resolution, a~~ A resolution board must work at each resolution workstation.

~~(5)~~(D) The members of a resolution board for an election may change, but all members of the resolution board at any particular time must satisfy the eligibility requirements specified in ~~this~~ Rule ~~18.3.2(c)~~ 18.3.3.

Amendments to Rule 18.4 concerning a stylistic change:

18.4 Ballot ~~D~~Duplication

Amendments to Rule 18.4.1 due to the passage of SB23-276 requiring a county clerk to review of the duplication process of ballots with a separate team of two election judges:

18.4.1 A resolution board must duplicate a voter's choices or selections on a damaged ballot onto a blank ballot of the same ballot style in accordance with Rule 18.4. During the duplication process, and to the extent necessary, the resolution board must also resolve overvotes, write-in votes, and ambiguous markings in accordance with Rule 18.5. ~~During ballot duplication, two election judges must observe or review the work of each resolution board. In a partisan election, the observing election judges must be representatives of each major political party~~ THE COUNTY CLERK MUST PERIODICALLY REVIEW DUPLICATED BALLOTS WITH A SEPARATE TEAM OF TWO ELECTION JUDGES TO ENSURE DUPLICATION IS BEING CONDUCTED CONSISTENT WITH THE LAW AND RULE 18.4.

[Not shown: no changes to Rules 18.4.2 through Rules 18.4.5.]

New Rule 18.4.6 regarding the organization of ballots which have been duplicated by a county clerk:

18.4.6 A COUNTY CLERK MUST BATCH DUPLICATED BALLOTS SEPARATELY FROM ALL OTHER BALLOTS.

[Not shown: current Rule 18.4.6 is renumbered to Rule 18.4.7.]

Amendments to Rule 18.5 concerning a stylistic change:

18.5 Ballot ~~R~~Resolution

[Not shown: no changes to Rule 18.5.1.]

Amendments to Rule 18.5.2 removing requirements which no longer apply to voting system components used in Colorado and technical changes for clarity:

18.5.2 Resolution of blank ballots.

(A) A resolution board must examine blank ballots to determine if the ballot is a true blank ballot or one that has been marked in a manner or medium that was not detected by the voting system.

~~(a) Counties without digital resolution capability. If the ballot is truly blank, the resolution board must re-scan the ballot and override the initial rejection setting. If the ballot is marked in a manner or medium that can be discerned by the resolution board but cannot be tabulated by the voting system, the resolution board must duplicate the ballot in accordance with Rule 18.4 and, to the extent necessary, resolve the ballot in accordance with Rule 18.5.~~

(b) ~~Counties with digital resolution capability.~~ If the ballot is truly blank, the resolution board must record the ballot as a blank ballot in the voting system's resolution application.

(C) If the ballot is marked in a manner or medium that can be discerned by the resolution board but cannot be tabulated by the voting system, the resolution board must resolve the ballot in the voting system's resolution application in accordance with Rules 18.5.2(b) and 18.5.3.

Amendments to Rule 18.5.3(c) removing outdated language to the digital adjudication process:

18.5.3 Resolution of write-in votes

[Not shown: no changes to sections (a) and (b).]

(c) In counties using voting systems that ~~do not have digital resolution capability, or the digital resolution feature is~~ ARE not capable of detecting voter markings on or in a write-in line or area if the corresponding target area is not also marked, and if the voter does not mark any other target area in a particular contest, the resolution board must count as valid votes for eligible write-in candidates those instances in which the voter both marks the applicable target area and writes in the name of a certified write-in candidate. During any recount, if the number of undervotes in a ballot contest could change the outcome if attributed to an eligible write-in candidate, votes for that candidate must be counted whether or not the target area designating the selection of a write-in candidate has been marked, provided that the number of candidates chosen does not exceed the number permitted in that office.

Amendments to Rule 19:

Amendments to Rule 19.1.3 updating the definition of "persons required to complete certification" due to the passage of SB22-153:

19.1.3 "Persons required to complete certification" means:

(a) The county clerk; ~~and~~

(b) Employees in the county clerk's office who are directly responsible for overseeing election activities, including but not limited to: voter registration, candidate qualifications and ballot certification, poll worker training, ballot design and setup, ballot counting, and canvassing~~.~~;

(C) OTHER EMPLOYEES IN THE CLERK AND RECORDER'S OFFICE AT THE DISCRETION OF THE CLERK AND RECORDER;

(D) A DESIGNATED ELECTION OFFICIAL FOR A COUNTY AND A COORDINATED ELECTION OFFICIAL FOR A COUNTY; AND

(E) EMPLOYEES IN THE ELECTIONS DIVISION OF THE DEPARTMENT OF STATE AT THE DISCRETION OF THE SECRETARY OF STATE.

~~(Section 1-1-302, C.R.S.)~~

Amendments to Rule 19.3.4 requiring that in-person certification training must be completed every two years:

19.3.4 To maintain Colorado certification, a person must complete at least four Continuing Elections Education courses by July 31 of every year and complete at least one in-person class every ~~four~~ TWO years.

Amendments to Rule 20:

Amendments to Rule 20.2.2 concerning background checks for election judges:

20.2.2 The county clerk must perform a background check FOR ALL ELECTION JUDGES. IN ACCORDANCE WITH SECTION 1-6-101, C.R.S., AN INDIVIDUAL CONVICTED OF ELECTION FRAUD, ANY OTHER ELECTION OFFENSE, OR FRAUD MAY NOT SERVE AS AN ELECTION JUDGE.~~in accordance with this Rule for each election judge if the judge requires access to:~~

~~(a) The statewide voter registration database;~~

~~(b) Elector's confidential or personally identifiable information; or~~

~~(c) Voter registration applications or other list maintenance activities.~~

Amendments to Rule 20.4.2 concerning the surveillance of secure areas due to the passage of SB22-153:

20.4.2 Surveillance of secure areas

(a) The county clerk must make video security surveillance recordings of secure equipment areas, as defined by Rule 1.1.49, ~~beginning at least 60 days before election day and continuing uninterrupted through at least 30 days after election day. If a recount or contest occurs, the recording must continue through the conclusion of all related activity~~ IN ACCORDANCE WITH THE REQUIREMENTS OF SECTION 1-7-513.5, C.R.S.

(b) The county clerk of a county with 50,000 or more registered voters must also make video security surveillance recordings of secure ballot areas, as defined by Rule 1.1.48, IF THOSE AREAS DO NOT CONTAIN ANY COMPONENTS OF A VOTING SYSTEM, beginning at least 35 days before election day and continuing uninterrupted through at least 30 days after election day. If a recount or contest occurs, the recording must continue through the conclusion of all related activity.

[Not shown: no changes to sections (c) and (d).]

New Rule 20.4.2(e) concerning planned maintenance of video surveillance systems:

(E) PLANNED MAINTENANCE OF VIDEO SURVEILLANCE

(1) IF NECESSITY REQUIRES IT, A COUNTY CLERK MAY TEMPORARILY CEASE VIDEO SURVEILLANCE OF VOTING SYSTEM COMPONENTS OR OTHER AREAS FOR PLANNED MAINTENANCE OF THE VIDEO SURVEILLANCE SYSTEM, BUT ONLY FOR SO LONG AS THE INTERRUPTION OF SURVEILLANCE IS REQUIRED.

(2) BEFORE THE PLANNED OUTAGE, THE COUNTY CLERK MUST NOTIFY AND SUBMIT DETAILED PLANS TO THE SECRETARY OF STATE WHICH DESCRIBE SECURITY MEASURES THE CLERK WILL TAKE TO ENSURE THE SECURITY OF THE VOTING SYSTEM COMPONENTS OR AREAS DURING THE PLANNED OUTAGE.

(3) AFTER REVIEW OF THE PLANS, THE SECRETARY OF STATE MAY REQUIRE A COUNTY CLERK TO TAKE ADDITIONAL OR DIFFERENT ACTIONS TO ENSURE THE SECURITY OF VOTING SYSTEM COMPONENTS OR AREAS DURING THE PLANNED OUTAGE.

Amendments to Rule 20.4.3 concerning access logs to secure areas and necessary renumbering and stylistic changes:

20.4.3 Access logs to secure areas

~~(a)~~ THE COUNTY CLERK MUST MAINTAIN A LOG OF EACH PERSON WHO ENTERS A LOCATION WHICH CONTAINS COMPONENTS OF A VOTING SYSTEM IN ACCORDANCE WITH THE REQUIREMENTS OF SECTION 1-7-513.5, C.R.S.

(B) The county clerk must OTHERWISE maintain a log of each person who enters a secure ballot area, as defined by Rule 1.1.48, IF THAT AREA DOES NOT CONTAIN ANY COMPONENTS OF A VOTING SYSTEM ~~or secure equipment area, as defined by Rule 1.1.49~~. This does not include members of the public who access areas of a county clerk's office that are regularly available to the public outside of an election.

[Not shown: sections (b) and (c) are recodified to sections (c) and (d).]

Amendments to Rule 20.5.2(c)(3) concerning election judges accessing the voting system under a single user account:

20.5.2 Accessing the voting system

[Not shown: no changes to sections (a) and (b).]

(c) Accounts and passwords

[Not shown: no changes to subsections (1) and (2).]

(3) The county clerk must create individual user accounts that are associated and identified with each individual authorized user of the operating system of the voting system, election management system, or election project. IF A PARTICULAR ELECTION ACTIVITY REQUIRES TWO ELECTION JUDGES TO INTERACT WITH A VOTING SYSTEM ON THE SAME ACTIVITY, THEN THE COUNTY MAY ASSIGN A SINGLE USER ACCOUNT TO BOTH ELECTION JUDGES FOR THAT

ACTIVITY. BOTH ELECTION JUDGES MUST STILL COMPLY WITH THE LOG REQUIREMENTS OF RULE 20.5.2(D).

[Not shown: no changes to section (d).]

Amendments to Rule 20.5.4 concerning the transportation of voting system components and necessary renumbering:

20.5.4 Transporting voting system

(a) The county clerk must submit detailed plans to the Secretary of State before ~~an election regarding~~ the transportation of voting system components FROM A COUNTY ELECTION FACILITY TO ANOTHER LOCATION, INCLUDING A VOTER SERVICE AND POLLING CENTER ~~to remote voting sites and back to the central elections office or storage facility~~. AFTER REVIEW OF THE PLANS, THE SECRETARY OF STATE MAY REQUIRE A COUNTY CLERK TO TAKE ADDITIONAL OR DIFFERENT ACTIONS TO ENSURE THE SECURITY OF VOTING SYSTEM COMPONENTS DURING TRANSIT.

(b) During or after transportation, if there is any evidence of possible tampering with a seal, or if the seal numbers do not match those listed in the chain-of-custody log, the county clerk must be immediately notified and must file an incident report required by Rule 20.12.2(a).

(C) VOTING SYSTEM COMPONENTS ARE NOT REQUIRED TO BE UNDER VIDEO SECURITY SURVEILLANCE WHILE IN TRANSIT. IN THE PLAN REQUIRED BY RULE 20.5.4(A), THE COUNTY CLERK MUST DESCRIBE HOW THEY WILL MAINTAIN BI-PARTISAN CHAIN-OF-CUSTODY WHILE THE COMPONENTS ARE NOT UNDER VIDEO SURVEILLANCE.

(D) PERSONNEL REQUIREMENTS FOR TRANSPORTATION

~~(c)~~(1) Transportation by county personnel

~~(1)~~(A) County personnel must at all times display identification provided by the county.

~~(2)~~(B) Two employee signatures and the date are required at the departure location verifying that the equipment is sealed to detect tampering. Upon delivery of equipment, at least two election officials must verify, and indicate by signing and dating the chain-of-custody log, that all seals are intact and that the seal numbers match the logged seal numbers.

~~(d)~~(2) Transportation by election judges

~~(1)~~(A) Two election judges of different party affiliations that are receiving or transporting equipment must inspect all voting devices and verify the specific seal numbers by signature and date on the chain-of-custody log for the device.

~~(e)~~(3) Transportation by contract

~~(1)~~(A) If a county clerk contracts for the delivery of equipment ~~to remote voting locations~~, each individual delivering equipment must successfully pass a criminal background check as required by Rule 20.2.1.

~~(2)~~(B) Two election officials must verify the specific seal numbers by device, sign, and date the chain-of-custody log upon release of the equipment to the individuals delivering the equipment. If the equipment is delivered by a truck capable of being locked by using a padlock or other similar device from the outside, the county clerk must provide a lock for the truck to be used during delivery. The county clerk must maintain the key or combination to the lock to be used to open the truck upon delivery. Upon delivery of equipment, at least two election officials must verify, and indicate by signing and dating the chain-of-custody log, that all seals are intact and that the seal numbers match the logged seal numbers.

~~(3)~~(C) A county clerk must require a contractor to deliver equipment ~~to a remote location~~ on the day the equipment is picked up from the county clerk.

Amendments to Rule 20.6 specifying the trusted build procedures at a county:

20.6 Trusted build procedures AT A COUNTY

Amendments to Rule 20.6.2(a) concerning attendance at a trusted build:

20.6.2 Attendance at trusted build

(a) The only individuals who may be present at a trusted build in a county include:

(1) Secretary of State staff, designees of the Secretary of State, or other individuals approved by the Secretary of State;

(2) Voting system vendor staff for the voting system for which trusted build is being installed. AT LEAST ONE INDIVIDUAL LISTED IN RULE 20.6.2(A)(2) MUST BE PRESENT DURING THE TRUSTED BUILD, UNLESS EXEMPTED BY THE DEPARTMENT OF STATE; and

[Not shown: no changes to subsection (3).]

[Not shown: no changes to sections (b) through (e).]

Amendments to Rule 20.9.2(a)(4) concerning ballot-on-demand and mobile ballot production printers:

20.9.2 Ballot-on-demand and mobile ballot production printers

(a) Software access, security, and storage

[Not shown: no changes to subsections (1) through (3).]

(4) The county clerk must store the ballot-on-demand and mobile ballot production printer, laptop, and unused paper ballot stock in a locked storage area WHICH IS ACCESSIBLE ONLY TO ELECTION OFFICIALS when the printer is not in use.

[Not shown: no changes to subsection (5).]

Amendments to Rule 20.11.1 concerning new section (f) that requires a county clerk to develop a contingency plan in cases of an unexpected outage of required video surveillance:

20.11.1 Contingency plans

[Not shown: no changes to sections (a) through (e).]

(f) THE COUNTY CLERK MUST DEVELOP CONTINGENCY PLANS WHICH ADDRESS AN UNEXPECTED OUTAGE OF ANY REQUIRED VIDEO SURVEILLANCE. THE PLAN MUST INCLUDE REGULAR INTERVALS AT WHICH THE COUNTY WILL CONFIRM THAT ALL REQUIRED VIDEO SURVEILLANCE IS OPERATIONAL.

Amendments to Rule 21:

Amendments to Rule 21.1.3 to clarify the exemption of some counties to use paper ballot tabulation devices after the passage of SB22-153:

21.1.3 The certification of a voting system is not a requirement that a county purchase or lease all of the components of the voting system. Counties may choose to configure and use a subset of the certified voting system and may use the services of a vendor or third party to provide ballot definition and election programming of memory cards. Counties are not required to use a paper ballot tabulation device if they ARE EXEMPTED BY LAW AND choose to manually tabulate the election results.

New Rule 21.1.4 concerning notification requirements for certification or modification applications:

21.1.4 A VOTING SYSTEM VENDOR APPLYING FOR CERTIFICATION OR MODIFICATION MUST NOTIFY THE SECRETARY OF STATE AT THE TIME OF APPLICATION IF ANY COMPONENT PREVIOUSLY CERTIFIED FOR USE IN COLORADO IS NOT INCLUDED IN THE APPLICATION FOR CERTIFICATION OR MODIFICATION.

Amendments to Rule 21.2 concerning stylistic changes:

21.2 Certification ~~P~~Process ~~O~~Overview and ~~T~~Timeline

[Not shown: no changes to Rule 21.2.1.]

Amendments to Rule 21.2.2 concerning the certification process of a voting system:

21.2.2 For a voting system to be certified, the voting system provider must successfully complete all phases of the certification process. The certification process includes: submission of a complete application, a documentation review, a public demonstration of the system, ~~and~~ functional testing, AND ESCROW OF STATE CERTIFIED ELECTION SOFTWARE.

Amendments to Rule 21.2.3 concerning each phase of certification and updated requirements:

21.2.3 The flow of each phase of certification is as follows:

[Not shown: no changes to sections (a) through (d).]

(e) Phase V – The Secretary of State will review the test results and determine whether the voting system substantially meets the requirements for certification. BEFORE THE SECRETARY OF STATE WILL MAKE A FINAL DETERMINATION OF WHETHER THE SYSTEM SUBSTANTIALLY MEETS THE REQUIREMENTS, THE VOTING SYSTEM PROVIDER MUST ESCROW IN COMPLIANCE WITH SECTION 1-7-511, C.R.S. Within 30 days of a decision, the Secretary of State will post the certification test report for the voting system on its website.

[Not shown: no changes to Rule 21.2.4.]

Amendments to Rule 21.3 concerning the application procedure and stylistic change:

21.3 Application ~~P~~Procedure

21.3.1 Any voting system provider ~~may apply to the Secretary of State~~ THAT WANTS TO APPLY for certification ~~at any time~~ MUST COMMUNICATE THEIR TIMING AND INTENT TO APPLY WITH THE VOTING SYSTEMS TEAM PRIOR TO SUBMITTING A COMPLETE APPLICATION PACKAGE. IF THE TIMING OF THE SUBMISSION WOULD PRESENT A HARDSHIP FOR THE SECRETARY OF STATE, THE SECRETARY MAY REQUEST THE PROVIDER TO DELAY SUBMISSION OF THE APPLICATION TO A LATER DATE AGREED UPON BY ALL PARTIES.

[Not shown: no changes to Rules 21.3.2 through 21.3.7.]

Amendments to Rule 21.4.9 concerning a stylistic change and a specific technical change in Rule 21.4.9(a)(4):

21.4.9 Audit ~~C~~capacity

(a) The voting system must track and maintain read-only audit information of the following election management system events:

[Not shown: no changes to subsections (1) through (3).]

(4) Election events – set for election, unset for election, open polls, close polls, end election, upload devices, download devices, create ballots, create precincts, create districts, create voter service and polling centers, initialize devices, backup devices, and voting activity; and

[Not shown: no changes to subsection (5).]

[Not shown: no changes to sections (b) through (l).]

Amendments to Rule 21.5.1 concerning demonstrations of voting system components by voting system providers:

21.5.1 Voting system provider demonstration

[Not shown: no changes to section (a).]

(b) The demonstration period does not have a predetermined agenda for the voting system provider to follow; however, presentations should be prepared to address and demonstrate the following items as they pertain to each area and use within the voting system, if applicable:

[Not shown: no changes to subsections (1) through (8).]

(9) Accessible use, including a full demonstration of all functionality using accessible voter interface devices and the audio ballot~~;~~. THIS INCLUDES A VIDEO SUBMITTED WITH THE DEMONSTRATION WHICH SHOWS:

(A) A DEMONSTRATION OF THE FULL FUNCTIONALITY OF THE VOTER INTERFACE DEVICES AVAILABLE FOR USE WITH A BALLOT MARKING DEVICE; AND

(B) A DEMONSTRATION OF A VOTING SESSION FROM BEGINNING TO END, WHICH INCLUDES THE AUDIO WHICH WILL ACCOMPANY VOTING ON A BALLOT MARKING DEVICE, AND WHICH DESCRIBES THE ACTIONS AVAILABLE TO THE VOTER TO TAKE AT EVERY STEP ON THE DEVICE. THE DEMONSTRATION MUST ALLOW FOR AN INDIVIDUAL WHO IS VISUALLY IMPAIRED TO FOLLOW EACH STEP TAKEN DURING A VOTING SESSION.

[Not shown: no changes to sections (c) through (i).]

Amendments to Rule 21.10 concerning the escrow of voting system software, repealing of Rules 21.10.2, 21.10.9, and 21.10.10, and necessary renumbering:

21.10 Escrow of voting system software and firmware by voting system provider. The voting system provider must meet the requirement for ELECTION MANAGEMENT software escrow per the following:

[Not shown: no change to Rule 21.10.1.]

~~21.10.2 Within ten days of the voting system provider receiving notification of the certification, the voting system provider must arrange for the completion of escrow requirements as indicated by this Rule.~~

[Not shown: current Rules 21.10.3 through 21.10.8 are renumbered to Rules 21.10.2 through 21.10.7.]

Repeal of Rules 21.10.9 and 21.10.10 because this information is already otherwise provided during the certification process of a voting system or is no longer required due to the passage of SB23-276:

~~21.10.9 System documentation will include technical architecture design, analysis, detail design, testing and an installation and configuration guide.~~

~~21.10.10 A set of schematics and drawings on electronic vote casting and counting equipment purchased or in use by the county clerk must be filed with the Secretary of State.~~

[Not shown: current Rule 21.10.11 renumbered to Rule 21.10.8.]

Repeal and replacement of current Rule 21.10.12 due to the passage of SB23-276 and now requiring a voting system provider to notify the Department that a certified election management software has been placed in escrow and necessary renumbering:

~~21.10.12~~21.10.9 ~~Copies of electronic media and supporting documentation for escrow within the Secretary of State will be sent to:~~

~~Colorado Secretary of State~~
~~Attn: Voting Systems~~
~~1700 Broadway – Suite 550~~
~~Denver, CO 80290~~ THE PROVIDER MUST NOTIFY THAT SECRETARY OF STATE VIA EMAIL THAT THE ELECTION MANAGEMENT SOFTWARE BEING CERTIFIED HAS BEEN PLACED IN ESCROW.

[Not shown: current Rule 21.10.13 renumbered to Rule 21.10.10.]

Amendments to Rules 21.11.1 and 21.11.6 concerning stylistic changes:

21.11.1 Results reporting requirements

-(a) The voting system must be capable of generating a summary report that lists the total number of votes for each candidate in each round. The report must include:

[Not shown: no changes to sections (b) and (c).]

[Not shown: no changes to Rules 21.11.2 through 21.11.5.]

21.11.6 Ballot adjudication requirements

(a) The voting system must allow the user to queue ballots with the following conditions for adjudication by election judges:

(1) Any ambiguous mark in any ranking;~~.~~

(2) Any ranking that results in an overvote;~~.~~

(3) Any skipped ranking;~~.~~

(4) Any duplicate ranking; AND~~.~~

(5) Any contest in which a voter has ranked fewer candidates than the contest's maximum permitted number of rankings.

Amendments to Rule 25:

Amendments to Rule 25.2.2 concerning the selection of races to audit during a primary and other stylistic change:

25.2.2 Preparing for the audit

[Not shown: no changes to sections (a) through (i).]

-(j) Selection of target contests. No later than 5:00 p.m. MT on the Friday after election day, the Secretary of State will select the target contests. In a general or coordinated election, the Secretary of State will select at least one statewide contest, and for each county at least one other contest. The Secretary of State will select other ballot contests for audit if in any particular election there is no statewide contest. In a primary election, the Secretary of State will select at least one ~~countywide~~ contest of each major political party in each county. The Secretary of State will publish a complete list of all target contests on the Audit Center. The Secretary of State will consider at least the following factors in selecting the target contests:

[Not shown: no changes to subsections (1) through (6).]

[Not shown: no changes to sections (k) and (l).]

STATE OF COLORADO
Department of State
1700 Broadway, Suite 550
Denver, CO 80290

Jena M. Griswold
Secretary of State
Christopher P. Beall
Deputy Secretary of State

Notice of Proposed Rulemaking

Colorado Department of State
Election Rules
8 CCR 1505-1

Date of notice: June 30, 2023
Date and time of public hearing: August 3, 2023, at 1:00 p.m.

I. Hearing Notice

As required by the State Administrative Procedure Act,[1] the Colorado Department of State gives notice of proposed rulemaking. The hearing is scheduled for August 3, 2023, at 1:00 p.m**.** in the Red Rocks Conference Room on the 5th floor of the Department of State's office at 1700 Broadway, Denver, CO 80290. This meeting will be conducted in person and via webinar. Details regarding how to join the webinar and testify online during the hearing are outlined in section VI of this notice.

II. Subject

The Colorado Department of State is considering amendments to the election rules[2] to ensure uniform and proper administration, implementation, and enforcement of Colorado election law[3], improve elections administration in Colorado, increase transparency and security of the election process, and implement amendments to the election laws made during the 2023 regular session of the 74th General Assembly.

Specifically, the Department proposes permanent rule revisions necessary to: implement Senate Bill 23-276, which concerned modifications to laws regarding elections; ensure proper staffing by bipartisan teams of election judges; strengthen signature verification procedures, training, assignment, and monitoring; update the requirements for video surveillance and security of drop boxes, secure areas, and voting equipment; set new licensing requirements for petition entities; update requirements for the review of signatures on initiative and candidate petitions; clarify the intercounty ballot transfer requirements; clarify procedures for ballots for overseas and military voters; specify requirements for tracking ballots delivered to voters who are confined in a county jail; establish naming conventions for ballot races; specify the permissible use of a phone for text-

[1] Section 24-4-103(3)(a), C.R.S. (2022).
[2] 8 CCR 1505-1.
[3] Article VII of the Colorado Constitution, Title 1 of the Colorado Revised Statutes, and the Help America Vote Act of 2002 ("HAVA"), P.L. No. 107-252.

message communication by a watcher while watching election activities; eliminate obsolete provisions; simplify the language of existing rules; remove language that is duplicative of statute or constitutional provisions; and ensure consistency with Department rulemaking standards. The Department may consider additional rule amendments as a result of the public comment and hearing process.

A detailed Statement of Basis, Purpose, and Specific Statutory Authority follows this notice and is incorporated by reference.

III. Statutory authority

The Department proposes the rule revisions and amendments in accordance with the following statutory provisions:

- Senate Bill 23-276, enacted June 6, 2023.

- Senate Bill 22-153, enacted June 2, 2022.

- Section 1-1-107(2)(a), C.R.S., (2022), which authorizes the Secretary of State "[t]o promulgate, publish and distribute…such rules as the secretary finds necessary for the proper administration and enforcement of the election laws."

- Section 1-1-110(1), C.R.S., (2022), which requires county clerks to, "follow the rules and order promulgated by the secretary of state pursuant to this code."

- Section 1-1-301, C.R.S., (2022), which requires the secretary of state to "establish and operate" a certification program for local election officials on the conduct of elections, to establish by rule a, "curriculum for the certification program . . . and methods for continuing education," and to prescribe the continuing education requirements for the program by rule.

- Section 1-1.5-104(1)(b), C.R.S., (2022), which authorizes the Secretary of State to "[p]romulgate, oversee, and implement changes in the statewide voter registration system as specified in part 3 of article 2 of this title."

- Section 1-1.5-104(1)(e), C.R.S., (2022), which gives the Secretary of State the power to "[p]romulgate rules…as the secretary finds necessary for the proper administration, implementation, and enforcement of HAVA and of [Article 1.5]."

- Section 1-1.5-105, C.R.S., (2022), which authorizes the Secretary of State to establish by rule "a uniform administrative complaint procedure to remedy grievances brought under Title III of HAVA," and which allows the Secretary of State to establish an alternative dispute resolution procedure.

- Section 1-2-217.7(7), C.R.S., (2022), which states that "[t]he secretary of state shall promulgate rules in accordance with article 4 of title 24, C.R.S., as may be necessary to implement this section" concerning registration on or immediately before election day.

- Section 1-4-101(2)(c), C.R.S., (2022), which allows the Secretary of State to adopt by rule ballot requirements "necessary to avoid voter confusion in voting in primary elections."

- Section 1-4-905.5(4)(a), C.R.S., (2022), which requires a petition entity to submit an application on a form "prescribed by the secretary."

- Section 1-4-908(1), C.R.S., (2022), which authorizes the Secretary of State, "to establish guidelines for verifying petition entries," for candidate petitions.

- Section 1-4-908(1.5)(b)(III), C.R.S., (2022), which authorizes the Secretary of State to "promulgate rules, in accordance with article 4 of title 24, to implement [review of candidate petition signatures]."

- Section 1-5-102.9(5)(d)(I), C.R.S., (2022), which requires counties to follow, "the secretary of state's current security rules . . ." regarding drop boxes.

- Section 1-5-616(1), C.R.S., (2022), which requires the Secretary of State to adopt rules "that establish minimum standards for electronic and electromechanical voting systems." This includes the authority to adopt rules regarding "documentation requirements", "security requirements", and "accessibility" for those voting systems.

- Section 1-5-616(4), C.R.S., (2022), which requires the Secretary of State to "adapt the standards for certification of electronic or electromechanical voting systems established by rule . . . to ensure that new technologies that meet the requirements for such systems are certified in a timely manner…"

- Section 1-5-623(4), C.R.S., (2022), which requires the Secretary of State to promulgate rules necessary "to specify permissible conditions of use governing electronic voting devices or systems or related components of such devices or systems…"

- Section 1-7-510(6), C.R.S., (2022), which requires the Secretary of State to promulgate rules to implement the section regarding election setup records.

- Section 1-7-511(4), C.R.S., (2022), which requires the Secretary of State to adopt rules "prescribing the manner and procedures that voting system providers shall follow to [escrow voting system software]."

- Section 1-7-512(2), C.R.S., (2022), which requires the Secretary of State to promulgate rules establishing procedures for voting system providers to: notify the Secretary of State of changes to software; place software in escrow; and notify the Secretary of State and designated election official of any defect in the system.

- Section 1-7-513(2), C.R.S., (2022), which requires the Secretary of State to promulgate rules "prescribing the manner of maintenance of records required by this section" regarding voting equipment.

- Section 1-7-513.5(6), C.R.S., (2022), which requires the Secretary of State to promulgate rules necessary to implement the section regarding voting system equipment security and surveillance.

- Section 1-7-515(4)(a), C.R.S., (2022), which requires the Secretary of State to promulgate rules "necessary to implement and administer by this section" regarding risk-limiting audits.

- Section 1-7.5-104, C.R.S., (2022), which requires the county clerk and recorder to conduct a mail ballot election "under the supervision of, and subject to rules promulgated in accordance with article 4 of title 24, C.R.S., by, the secretary of state."

- Section 1-7.5-105(2)(c), C.R.S., (2022), allowing the Secretary of State to adopt rules concerning the "submission and approval of election plans."

- Section 1-7.5-105(3), C.R.S., (2022), which requires the county clerk and recorder to "supervise the distribution, handling, and counting of ballots and the survey of returns in accordance with rules promulgated by the secretary of state..."

- Section 1-7.5-106(2), C.R.S., (2022), which authorizes the Secretary of State to "adopt rules governing procedures and forms necessary to implement [Article 7.5 of Title 1, C.R.S.]."

- Section 1-7.5-107(1), C.R.S., (2022), which requires ballots to be prepared, "by law or rules promulgated by the secretary of state."

- Section 1-7.5-107(4.3)(a)(I), C.R.S., (2022), which requires drop boxes to "comply with the secretary of state's current security rules."

- Section 1-7.5-107(6), C.R.S., (2022), which requires that mail ballots be counted as provided in "rules promulgated by the secretary of state."

- Section 1-8.3-104(3), C.R.S., (2022), which authorizes the secretary of state to establish an electronic transmission system through which a UOCAVA voter may apply for and receive ballots and other associated materials.

- Section 1-10-104.5, C.R.S., (2022), which requires the Secretary of State to promulgate rules, "for the purpose of establishing equitable uniformity in the appointment and operation of canvass boards."

- Section 1-10.5-102(2), C.R.S., (2022), which requires the Secretary of State to "promulgate and provide each county clerk and recorder with the necessary rules and regulations to conduct the recount in a fair, impartial, and uniform manner…"

- Section 1-40-116(3), C.R.S., (2022), which allows the Secretary of State to adopt rules for the examination and verification of signer lines on an initiative petition.

- Section 1-40-116(4)(a), C.R.S., (2022), which authorizes the Secretary of State to "engage in rule-making to establish the appropriate methodology" to review initiative petitions by random sample.

- Section 1-40-132, C.R.S., (2022), which charges the Secretary of State with the administration and enforcement of initiatives and referred measures, including the authority to "promulgate rules as may be necessary to administer and enforce any provisions of [Article 40] . . ."

- Section 1-40-135(4), C.R.S., (2022), which requires petition entities to apply for a license "on a form prescribed by the secretary of state."

IV. Copies of draft rules

A preliminary draft of the proposed rules is posted on the Department of State's rules and notices of rulemaking website at: https://www.coloradosos.gov/pubs/rule_making/hearings/2023/ElectionRulesHearing20230803.html.

You may also contact our office to request an editable electronic copy of the draft rules.

As required by the State Administrative Procedures Act,[4] if changes are made before the hearing, revised proposed draft rules will be available to the public and posted on the website by **July 29, 2023**.

V. Opportunity to testify and submit written comments

The Department values your feedback in our rulemaking process, and we would very much like to hear your thoughts on the proposed amendments. Please review and consider the attached proposed draft rules.

Everyone will have the opportunity to testify and provide written comments concerning the rule amendments. You may submit written comments to SoS.Rulemaking@coloradosos.gov any time before and during the hearing. If you attend the hearing in person, you may submit written comments to the hearing panel as well. An additional opportunity to comment in writing will be announced at the conclusion of the hearing. Information regarding how to testify via webinar during the hearing is provided in section VI of this notice.

All written comments will be posted online on the Department of State's website: https://www.coloradosos.gov/pubs/rule_making/hearings/2023/ElectionRulesHearing20230803.html.

[4] Section 24-4-103(3)(a), C.R.S. (2022). "Any proposed rule or revised proposed rule by an agency which is to be considered at the public hearing…shall be made available to any person at least five days prior to said hearing."

We will redact apparent personal contact information, including home address, email address, and telephone number(s), from submissions before posting the information online, unless otherwise directed by the contributor. All written comments will be added to the official rulemaking record.

VI. Webinar and audio recording of hearing

Register to attend online
To join and listen to the hearing, you must register for the webinar: https://attendee.gotowebinar.com/register/7739541944876240221.

When you register, you must provide your full name and email address. Please provide additional contact information, including your address and telephone number. You may also provide your job title and organization. Lastly, indicate whether you plan to testify during the hearing. When you submit your registration, you should receive a confirmation email including details about how to join the webinar.

Hybrid hearing procedures
After the introduction and a brief summary of the rulemaking, we will open the hearing to testimony as follows:

- For the sake of efficiency, in-person attendees will be called upon first to provide their public comment. We will reference the sign-in sheet provided and individually call upon attendees who wish to provide their testimony. Once we have exhausted the in-person sign-in sheet, we will move forward with the testimony of online attendees.

- Referencing webinar registration records, we will identify and individually unmute online attendees who indicated their intent to testify during the hearing.

- Once we have exhausted that list, we will ask whether any additional attendees wish to testify. In-person attendees may raise their hands to indicate their intention to testify, and online attendees may raise/lower their hand by clicking the icon in their control panel.

- To ensure that the hearing is prompt and efficient, oral testimony may be time limited.

Before the hearing concludes, we will announce an additional opportunity to submit written comments and the associated deadline.

Webinar audio requirements
Please be advised: we strongly encourage attendees to join the webinar through their computer or the GoToWebinar app, even if they use their telephone to dial in for audio. To testify during the hearing, you must use a computer or the GoToWebinar app to be unmuted and to utilize the "raise hand" feature within the webinar. If you access the webinar only by telephone, you may not appear in our webinar attendee list, meaning we will not be able to unmute you. Moreover, the raise your hand feature is only available to attendees who access the webinar by computer or by app. For the best audio, it is best to use your computer microphone and speakers or a headset or headphones, if you choose to testify. As outlined above, we will first receive online testimony from attendees

whose registration indicates that they plan to provide testimony and then we will offer attendees the option to raise their hand.

Audio recording
After the hearing concludes, a recording will be available on our audio broadcasts page here: https://www.coloradosos.gov/pubs/info_center/audioBroadcasts.html.

Office contact

If you have any questions or would like to submit written comments, please contact the Rulemaking and Legislative Policy Analyst at SoS.Rulemaking@coloradosos.gov or (303) 894-2200 ext. 6124.

Dated this 30th of June 2023.

Christopher P. Beall
Colorado Deputy Secretary of State

For

Jena Griswold
Colorado Secretary of State

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Draft Statement of Basis, Purpose, and Specific Statutory Authority

Colorado Department of State
Election Rules
8 CCR 1505-1

June 30, 2023

I. Basis and Purpose

This statement explains proposed amendments to the Colorado Department of State Election Rules [8 CCR 1505-1]. The amendments are intended to ensure uniform and proper administration, implementation, and enforcement of federal and Colorado election laws,[1] improve elections administration in Colorado, increase the transparency and security of the election process, and implement amendments required by Senate Bills 23-276, enacted June 6, 2023, and 22-153, enacted June 2, 2022.

Specific proposed changes include:

- Amendments to Rule 1 concerning definitions.
    - Amendments to Rule 1.1.4 to remove language for outdated technology.
    - Amendments to Rule 1.1.42 clarify that the candidate must be placed on a ballot for an organization to be considered a "qualified political organization".
    - Repeal of Rule 1.1.64 which has been recodified in Rule 8.1.
- Amendments to Rule 2 concerning voter registration.
    - Amendments to Rule 2.1.2 update a reference to a form no longer in use in Colorado.
    - Amendments to Rule 2.5.3 remove the "ballot preference" language as it is no longer applicable due to the passage of SB23-276.
    - New Rule 2.5.5 requires a county clerk to refrain from changing a covered voter's status as a covered voter due to a change of address submitted by the Colorado

[1] Article VII of the Colorado Constitution, Title 1 of the Colorado Revised Statutes, and the Help America Vote Act of 2002 ("HAVA"), P.L. No. 107-252.

Department of Revenue. The proposed rule also requires a county clerk to contact a covered voter in this situation.

  - Repeal of Rule 2.8 because it is duplicative of section 1-2-102, C.R.S.

  - Amendments to current Rule 2.9, including renumbering to Rule 2.8, clarify what residential address can be used by a covered voter.

  - Repeal of Rule 2.10 because it is contradictory to Colorado law, which requires convicted felons to have their voter registration records cancelled in accordance with sections 1-2-302(3.5)(b) and 1-2-606, C.R.S.

  - Repeal of Rule 2.12.3 which requires the Department of State to provide a list of confidential voters to state parties prior to that party's caucus meeting.

  - Amendments to current Rule 2.13, including renumbering to Rule 2.11, clarify that National Change of Address (NCOA) data will be provided to county clerks once per month, as required by law.

  - Amendments to current Rule 2.14, including renumbering to Rule 2.12, to clarify that a state employee registering voters at a voter service and polling center must be an employee of the Department of State.

  - Amendments to current Rule 2.15 include renumbering to Rule 2.13 and remove language of outdated practices regarding the charge of a fee for county voter information reports and related services.

  - Repeal of Rule 2.16 removing references to ballot preference due to the passage of SB23-276.

- Repeal of Rules 3.8 and 3.9 concerning outdated practices of treating a qualified political organization differently from a minor party. Qualified political organizations may already obtain voter registration records using the same process as other minor parties. Qualified political organizations are also treated as minor parties in all voter registration summary reports.

- Amendments to Rule 4 concerning coordinated elections.

  - Amendments to Rule 4.1.2 gives additional authority to county clerks to include in an intergovernmental agreement a restriction on the size and formatting of ballot contests submitted to them by coordinating districts.

  - Amendments to Rule 4.5.1 remove outdated language as there are no technical or mechanical limitations in Colorado voting systems to the text amount on a ballot.

- Repeal of Rule 5.3 to remove reference to an outdated practice no longer used in Colorado. Rules 5.4 through 5.6 are renumbered to Rules 5.3 through 5.5.

- Amendments to Rule 6 concerning election judges.
    - Amendments to Rule 6.1.2 require county clerks to provide information to county parties regarding the needs that county has for election judges for the upcoming election cycle.
    - Amendments to Rule 6.1.3 clarifies the process county clerks must use to exhaust the list of election judges submitted to them by their local major political parties before hiring election judges who are unaffiliated or are members of a minor party.
    - New Rule 6.1.4 has been renumbered but otherwise is unchanged from language repealed from Rule 6.1.2.
    - Current Rules 6.1.4 and 6.1.5 are renumbered to Rules 6.1.5 and 6.1.6.
    - New Rule 6.2.2 concerns the assignment of elections judges to perform signature verification. The amendments require county clerks to consider past election judge performance of signature verification duties before hiring that judge to conduct signature verification in a new election. Current Rule 6.2.2 is renumbered to Rule 6.2.3.
    - Amendments to Rule 6.7 require that election judge training content approved by the Department of State is valid for one year from approval.
    - Amendments to Rule 6.8 require election judges who conduct signature verification to take training provided by the Department of State prior to each election and to successfully complete that training. The amendments also clarify that additional signature verification training approved by the Department of State would only be valid for one year from approval.
- Amendments to Rule 7 concerning elections conducted by the county clerk and recorder.
    - Amendments to Rule 7.2 concerning ballots and ballot packets.
        - Amendments to Rule 7.2.4 remove language regarding primary ballots which have been printed before a primary election. This change no longer requires a county to attempt to remove ballots which have been printed by a vendor if a voter changes their affiliation after that ballot has been printed before a primary.
        - Repeal of Rule 7.2.6 which currently allows a county clerk to include a section on a mail ballot envelope which designates who is delivering the ballot for that voter. This change is being made because Colorado law allows any voter to return another voter's ballot as long as no person returns more than 10 ballots in an election and does not require a voter to identify

who is returning that ballot. The inclusion of this optional statement on a mail ballot envelope unnecessarily causes voter confusion. Current Rules 7.2.7 through 7.2.8 are renumbered to Rules 7.2.6 through 7.2.8.

- Amendments to current Rule 7.2.10, including renumbering to Rule 7.2.9, removing a reference to ballot preference due to the passage of SB23-276, and clarifying how an unaffiliated candidate may receive a minor party ballot if a minor party has a primary and allows unaffiliated voters to participate in that primary.

- Repeal of current Rule 7.2.11 due to the passage of SB23-276 which removed the ability for unaffiliated voters to select a ballot preference.

- Amendments to current Rule 7.2.12, including renumbering to Rule 7.2.10, fix a grammatical error. Current Rules 7.2.13 and 7.2.14 are renumbered to Rules 7.2.11 and 7.2.12.

- Amendments to current Rule 7.2.15, including renumbering to Rule 7.2.13, and removing language related to ballot preference which is no longer in practice in Colorado after the passage of SB23-276.

- Amendments to current Rule 7.2.16 include renumbering to Rule 7.2.14, removing outdated practices due to the passage of SB23-276, and permitting unaffiliated voters to receive a minor party ballot in a primary, if allowed by the minor party.

- New Rule 7.2.16 requires a county clerk who is coordinating an election for a special district to automatically mail property owner ballots to eligible property owners.

- Amendments to Rule 7.4 concern the receipt and processing of ballots.

  - Amendments to Rule 7.4.1 remove the requirement that drop box video be retained as an election record, and instead require county clerks to retain drop box video recordings for 120 days following the deadline to certify an election. Video surveillance of drop boxes will still need to remain on while drop boxes are open for receiving ballots.

  - Amendments to Rule 7.4.5 repeals language that is now duplicative of statute due to the passage of SB23-276 and clarifies that counties with less than 250,000 active voters must pick up ballots at least twice on election day, as was previously required.

  - Repeal of Rule 7.4.6 repeals the drop box waiver provision that is no longer allowed under Colorado law due to the passage of SB23-276. Colorado law

now requires all drop boxes in the state to have ballots picked up on a set schedule that the Department of State may not waive. Current Rules 7.4.7 through 7.4.10 are renumbered to Rules 7.4.6 through 7.4.9.

- Amendments to current Rule 7.4.11 include the repeal and replacement of original language and renumbering to Rule 7.4.10. This new rule language requires county clerks to take several steps when they receive a ballot for a voter who does not reside in their county. The actions the county must take includes logging that the ballot was received and where it will be delivered to, transferring the ballot by a set deadline and method, notifying the voter's home county that a ballot will be delivered, and sending an image of a signature to the voter's home county. Rule 7.4.12 is repealed and reincorporated in Rule 7.4.10.

- Amendments to current Rule 7.4.13, include renumbering to Rule 7.4.11 and adding requirements for logging information regarding voter registration and ballot delivery and receipt to eligible voters in county jails. This is required due to the passage of SB23-276.

- Amendments to Rule 7.5 include organizing the structure of the rule to include New Rules 7.5.1 through 7.5.3 for clarity.

- Amendments to Rule 7.7

  - Amendments to Rule 7.7.1 clarify that county clerks must review signatures following the two-tiered review process required by section 1-7.5-107.3, C.R.S.

  - Amendments to Rule 7.7.3 clarify that a signature on an envelope which is consistent with a voter's signature in SCORE is one that is more likely than not to be the signature of the voter. The rule also clarifies that a consistent signature must be accepted as a matching signature.

  - Amendments to Rule 7.7.8 requires county clerks to keep additional real-time data for election judges who are conducting signature verification. County clerks are required to review this data on a daily basis to determine if any signature verification judges have an irregular acceptance, rejection, or overturn rate and remove those election judges who do.

  - Amendments to Rule 7.7.10 require ballot sorting and signature capture devices to take an image of the full back of a mail ballot envelope. This requirement would begin on January 1, 2024.

- Amendments to Rule 7.8 concerning voter service and polling centers (VSPCs).

        - Amendments to Rule 7.8.1 clarify that clerks must open voter service and polling centers in accordance with section 1-704-107(4.5), C.R.S., for primary and coordinated elections.

        - Repeal and replacement of Rule 7.8.2. The current language is duplicative of statute. The new language requires county clerks to consider the recommendations made by the voter center siting tool when determining where to place voter service and polling centers and drop boxes in a general election.

    - Amendments to Rule 7.9.3 remove references to procedures no longer in place in Colorado.

    - New Rule 7.17 requires county clerks to follow specific data entry standards when naming districts, positions, and ballot styles in SCORE's Districts and Precincts and Election Management modules.

- Amendments to Rule 8 concerning watchers.

    - Amendments to Rule 8.1 include the recodification of sections (a) through (c) of Rule 1.1.64 into Rules 8.1.2 through 8.1.4 and necessary renumbering.

    - Amendments to Rule 8.8 specify that the rule is for use in non-partisan, coordinated elections. The passage of SB23-276 incorporated into law the requirements of the current rule in all other elections.

    - Amendments to Rule 8.10.2 clarify that watchers may possess a phone to send or receive text messages as long as no personally identifiable information is within view of the watcher.

- Amendments to Rule 9.1.4 remove a challenge question related to 17-year-olds voting in primary elections. 17-year-olds may no longer vote in primary elections after the passage of Amendment 76 in 2020.

- Amendments to Rule 10 concerning canvassing and recounts.

    - Amendments to Rule 10.3.2 remove outdated language that relates to random audits which are no longer conducted in Colorado. It also removes language which is duplicative of other election rules.

    - Repeal of Rule 10.5.3 removes language which is only applicable to "voting devices" which are devices no longer in use in Colorado.

    - Repeal and replacement of Rule 10.6.3. The previous language is being removed because it has been superseded by the passage of SB22-153. The new language

requires a county clerk to notify the Secretary of State if the canvass board voted not to certify the abstract of votes cast, failed to take action, or was not composed in a way required by Colorado law.

- Amendments to Rule 10.8.1 make a technical change.
- Amendments to Rule 10.9 concerning recounts generally.
  - Amendments to Rules 10.9.2 limit the ability to conduct a re-adjudication only recount to recounts requested by a candidate.
  - Amendments to rule 10.9.3 alter the deadline to request a re-adjudication recount to the day after the recount is paid for by the candidate.
  - Repeal of Rule 10.9.6 removes the ability for a mandatory recount to be cancelled by the withdrawal of the losing candidate in a race.
- Amendments to Rule 10.10.2(b) require county clerks to provide cost estimates for a requested recount for both a rescan recount and a re-adjudication recount. The amendments also allow a county to charge for normal overhead costs, which is now explicitly allowed after the passage of SB23-276.
- Repeal of Rule 10.12.2 because it is now duplicative of statute after the passage of SB23-276.
- Repeal of Rule 10.13.1 because it is now duplicative of statute after the passage of SB23-276.
- Amendments to Rule 10.14.1 update the results reporting requirements following a recount.

- Amendments to Rule 11 concerning voting systems.
  - Amendments to Rules 11.6 and 11.7 include technical changes that are consistent with Department rulemaking standards.
    - Amendments to Rule 11.7.1 require a voting system vendor to file an incident report for a software or hardware incident, even if a separate report was filed by the designated election official (DEO).
    - Amendments to Rule 11.8.2(f) concern technical changes that are consistent with Department rulemaking standards.
  - New Rule 11.9.2 requires a county clerk to provide the election details report separately to the voting systems team 45 days in advance of the election.

- Amendments to current Rule 11.9.3, including renumbering to Rule 11.9.4, require a county clerk to check the total and content configuration reflected on the Election Night Reporting (ENR) website after uploading their LAT results file. County clerks are required to separately notify the voting systems team that the check had occurred.

- Amendments to Rule 13 concerning election and Help America Vote Act (HAVA) complaints.

    - Amendments to Rule 13.1.3 permit the Secretary's designee to extend the deadline for an initial review of an election complaint if extenuating circumstances do not allow the review to be completed in three business days.

    - Amendments to Rule 13.2.10 update that the alternative dispute resolution of a HAVA complaint should be sent to a hearing officer instead of the Office of Administrative Courts.

- Amendments to Rule 15 concerning the preparation, filing, and verification of petitions.

    - Amendments to Rule 15.1.2 clarify that the Department or DEO will not consider a signature line to be a reviewable line if that line is missing the name, signature, or address of the signer.

    - Amendments to Rule 15.1.4 alter language for grammatical consistency. Additional changes require the Department to reject a petition entry if a name suffix is present on the entry but not in SCORE, or present in SCORE but not in the entry and more than one person with that name is registered to vote at that address. Additionally, the changes clarify that the Department and DEOs will not reject a petition entry solely for a variety of circumstances including if the city is missing, information is written in the wrong field, or a suffix is missing on the petition or in SCORE but the signature matches for a candidate petition.

    - Amendments to Rule 15.2 concerning petition submission.

        - Amendments to Rule 15.2.1 require petition entities to include additional information on applications submitted to the Department. This includes information regarding petition circulators working for that entity, beginning on January 1, 2025. Some of these changes to the information present on the application are required as a result of SB23-276.

        - Amendments to Rule 15.2.2 require petition entity designated agents to complete the Department of State's circulator training program after applying for a license but before registering the entity to circulate a petition.

        - New Rule 15.2.5 requires a new application to be submitted after that license expires and clarifies that petition entity licenses expire after two years, beginning on January 1, 2024.

        - New Rule 15.2.6 clarifies that petition entities must update any application information that changes within 20 days after the change.

    - Amendments to Rule 15.3.2 make technical changes to reflect current Colorado law regarding homeless petition circulators.

    - Amendments to Rule 15.4.1 make technical changes which clarify that the designated representatives must be listed on petitions submitted to the Department.

    - Amendments to Rule 15.5.1(b) make technical changes to clarify that Department staff reviews randomly selected signature lines for initiative petitions submitted to the Department.

    - Amendments to Rule 15.6.1(b) clarify that a bi-partisan review of candidate petitions includes two reviewers who are of different parties or are unaffiliated. It also allows an individual who is not registered to vote to be treated as unaffiliated for the purpose of the rule.

    - Amendments to Rule 15.7.4 concern a stylistic change to reflect Department rulemaking standards.

- Amendments to Rule 16 concerning military and overseas voters (UOCAVA).

    - Amendments to Rule 16.1.6 require county clerks to send correspondence to each UOCAVA voter in the county once per year before the first primary or coordinated election of the year.

    - New Rule 16.2.5 restricts county clerks from sending a mail ballot to a voter if that clerk has already successfully transferred a fax or email ballot to that voter, unless requested by that voter or as a result of a change, and necessary renumbering.

- Amendments to Rule 17.5 concern a stylistic change to reflect Department rulemaking standards.

- Amendments to Rule 18 concerning uniform counting standards for paper ballots.

    - Repeal of Rule 18.3.1 (and title section of Rule 18.3) because the rule refers to technology no longer in use in Colorado.

    - Amendments to current Rule 18.3.2 include recodifying to Rule 18.3 and removing language that refers to technology no longer in use in Colorado.

- Amendments to Rule 18.4 to reflect Department rulemaking standards.
    - Amendments to Rule 18.4.1 removes language which is now contrary to statute after the passage of SB23-276 and adds language which requires the county clerk to assign bi-partisan election judges to periodically review the ballot duplication process being conducted by other election judges in the county.
    - New Rule 18.4.6 requires a county clerk to separately batch duplicated ballots, and necessary renumbering.
- Amendments to Rule 18.5 concerning ballot resolution.
    - Amendments to Rule 18.5.2 remove language which is no longer necessary due to the fact that all Colorado voting systems certified for use must have digital resolution capability.
    - Amendments to Rule 18.5.3(c) remove language which is no longer necessary due to the fact that all Colorado voting systems certified for use must have digital resolution capability.

- Amendments to Rule 19 concerning the certification and education of designated election officials (DEOs).
    - Amendments to Rule 19.1.3 include additional groups of people who are required to complete certification classes after the passage of SB22-153.
    - Amendments to Rule 19.3.4 require a person to take an in-person class every two years to maintain their election certification.

- Amendments to Rule 20 concerning county security procedures.
    - Amendments to Rule 20.2.2 require county clerks to conduct a background check on all election judges.
    - Amendments to Rule 20.4.2 alter language which is no longer applicable due to the passage of SB22-153. New section (e) allows a county clerk to temporarily cease video surveillance of their voting system components if planned maintenance requires video surveillance to be temporarily brought down.
    - Amendments to Rule 20.4.3 alter language which is no longer applicable due to the passage of SB22-153.

- Amendments to Rule 20.5.2(c)(3) allow county clerks to assign a single user account and password to a team of election judges who are engaging in an activity that requires them both to interact with the voting system on the same activity.

- Amendments to Rule 20.5.3(c) to include a new subsection (6) which allows a county clerk to insert a removable storage device into a voting system component if the device contains only the virus definition updates retrieved from the Secretary of State's SFTP website.

- Amendments to Rule 20.5.4 clarify that county clerks must take security precautions required by rule any time voting system components are being transported. The amendments also clarify that voting system components are not required to be under video surveillance when in transit.

- Amendments to Rule 20.6 clarify that the rule applies to trusted builds conducted on-site at a county.

    - Amendments to Rule 20.6.2(a)(2) require a member of the voting system vendor to be present during a trusted build on site.

- Amendments to Rule 20.9.2 clarify that ballot-on-demand equipment must be stored in a location that is accessible only to election officials when not in use.

- Amendments to Rule 20.11.1 require a county clerk to develop a contingency plan to address an unexpected outage of any required video surveillance, including how often the county clerk will confirm that all required video surveillance is operational.

- Amendments to Rule 21 concerning voting system standards for certification.

    - Amendments to Rule 21.1.3 clarify that county clerks must use a ballot tabulation system unless they are exempted by law. This change is required after the passage of SB22-153.

    - New Rule 21.1.4 requires a voting system vendor to identify any equipment which was previously certified for use but is not in a new application for certification.

    - Amendments to Rule 21.2.2 clarify that the escrow of voting system software is a step in the certification process for voting systems in Colorado.

    - Amendments to Rule 21.2.3 require a voting system vendor to escrow their software in compliance with section 1-7-511, C.R.S., before the Department will make a final determination of whether or not a system is certified.

- Amendments to Rule 21.3.1 allow the Department to request a voting system vendor to delay submission of an application for certification if the timing of the application would present a hardship for the Department.

- Amendments to Rule 21.5 require a voting system vendor to include a video demonstration of the accessible aspects of their voting system when submitting an application.

- Amendments to Rule 21.10, include the repeal of Rules 21.10.2, 21.10.9, and 21.10.10, necessary renumbering. These amendments are because the current rules have been incorporated elsewhere in these Rules, the information is already otherwise provided during the certification process, or the information is no longer necessary due to the passage of SB23-276.

- Amendments to Rule 20.10.12, including necessary renumbering, due to the passage of SB23-276 which requires voting system vendors to escrow their software with a third party. Additional amendments require the voting system vendor to notify the Department when software has been placed in escrow.

- Amendments to Rule 25.2.2 allow the Department to choose at one contest of each party in each county for auditing during a primary and would not require that the contest picked be countywide.

Other changes to rules not specifically listed are non-substantive and necessary for consistency with Department rulemaking format and style. Cross-references in rules are also corrected or updated.

II. Rulemaking Authority

The statutory authority is as follows:

- Senate Bill 23-276, enacted June 6, 2023.

- Senate Bill 22-153, enacted June 2, 2022.

- Section 1-1-107(2)(a), C.R.S., (2022), which authorizes the Secretary of State "[t]o promulgate, publish and distribute…such rules as the secretary finds necessary for the proper administration and enforcement of the election laws."

- Section 1-1-110(1), C.R.S., (2022), which requires county clerks to, "follow the rules and order promulgated by the secretary of state pursuant to this code."

- Section 1-1-301, C.R.S., (2022), which requires the secretary of state to "establish and operate" a certification program for local election officials on the conduct of elections, to establish by rule a, "curriculum for the certification program . . . and methods for

continuing education," and to prescribe the continuing education requirements for the program by rule.

- Section 1-1.5-104(1)(b), C.R.S., (2022), which authorizes the Secretary of State to "[p]romulgate, oversee, and implement changes in the statewide voter registration system as specified in part 3 of article 2 of this title."

- Section 1-1.5-104(1)(e), C.R.S., (2022), which gives the Secretary of State the power to "[p]romulgate rules…as the secretary finds necessary for the proper administration, implementation, and enforcement of HAVA and of [Article 1.5]."

- Section 1-1.5-105, C.R.S., (2022), which authorizes the Secretary of State to establish by rule "a uniform administrative complaint procedure to remedy grievances brought under Title III of HAVA," and which allows the Secretary of State to establish an alternative dispute resolution procedure.

- Section 1-2-217.7(7), C.R.S., (2022), which states that "[t]he secretary of state shall promulgate rules in accordance with article 4 of title 24, C.R.S., as may be necessary to implement this section" concerning registration on or immediately before election day.

- Section 1-4-101(2)(c), C.R.S., (2022), which allows the Secretary of State to adopt by rule ballot requirements "necessary to avoid voter confusion in voting in primary elections."

- Section 1-4-905.5(4)(a), C.R.S., (2022), which requires a petition entity to submit an application on a form "prescribed by the secretary."

- Section 1-4-908(1), C.R.S., (2022), which authorizes the Secretary of State, "to establish guidelines for verifying petition entries," for candidate petitions.

- Section 1-4-908(1.5)(b)(III), C.R.S., (2022), which authorizes the Secretary of State to "promulgate rules, in accordance with article 4 of title 24, to implement [review of candidate petition signatures]."

- Section 1-5-102.9(5)(d)(I), C.R.S., (2022), which requires counties to follow, "the secretary of state's current security rules . . ." regarding drop boxes.

- Section 1-5-616(1), C.R.S., (2022), which requires the Secretary of State to adopt rules "that establish minimum standards for electronic and electromechanical voting systems." This includes the authority to adopt rules regarding "documentation requirements", "security requirements", and "accessibility" for those voting systems.

- Section 1-5-616(4), C.R.S., (2022), which requires the Secretary of State to "adapt the standards for certification of electronic or electromechanical voting systems established by rule . . . to ensure that new technologies that meet the requirements for such systems are certified in a timely manner…"

- Section 1-5-623(4), C.R.S., (2022), which requires the Secretary of State to promulgate rules necessary "to specify permissible conditions of use governing electronic voting devices or systems or related components of such devices or systems…"

- Section 1-7-510(6), C.R.S., (2022), which requires the Secretary of State to promulgate rules to implement the section regarding election setup records.

- Section 1-7-511(4), C.R.S., (2022), which requires the Secretary of State to adopt rules "prescribing the manner and procedures that voting system providers shall follow to [escrow voting system software]."

- Section 1-7-512(2), C.R.S., (2022), which requires the Secretary of State to promulgate rules establishing procedures for voting system providers to: notify the Secretary of State of changes to software; place software in escrow; and notify the Secretary of State and designated election official of any defect in the system.

- Section 1-7-513(2), C.R.S., (2022), which requires the Secretary of State to promulgate rules "prescribing the manner of maintenance of records required by this section" regarding voting equipment.

- Section 1-7-513.5(6), C.R.S., (2022), which requires the Secretary of State to promulgate rules necessary to implement the section regarding voting system equipment security and surveillance.

- Section 1-7-515(4)(a), C.R.S., (2022), which requires the Secretary of State to promulgate rules "necessary to implement and administer by this section" regarding risk-limiting audits.

- Section 1-7.5-104, C.R.S., (2022), which requires the county clerk and recorder to conduct a mail ballot election "under the supervision of, and subject to rules promulgated in accordance with article 4 of title 24, C.R.S., by, the secretary of state."

- Section 1-7.5-105(2)(c), C.R.S., (2022), allowing the Secretary of State to adopt rules concerning the "submission and approval of election plans."

- Section 1-7.5-105(3), C.R.S., (2022), which requires the county clerk and recorder to "supervise the distribution, handling, and counting of ballots and the survey of returns in accordance with rules promulgated by the secretary of state..."

- Section 1-7.5-106(2), C.R.S., (2022), which authorizes the Secretary of State to "adopt rules governing procedures and forms necessary to implement [Article 7.5 of Title 1, C.R.S.]."

- Section 1-7.5-107(1), C.R.S., (2022), which requires ballots to be prepared, "by law or rules promulgated by the secretary of state."

- Section 1-7.5-107(4.3)(a)(I), C.R.S., (2022), which requires drop boxes to "comply with the secretary of state's current security rules."

- Section 1-7.5-107(6), C.R.S., (2022), which requires that mail ballots be counted as provided in "rules promulgated by the secretary of state."

- Section 1-8.3-104(3), C.R.S., (2022), which authorizes the secretary of state to establish an electronic transmission system through which a UOCAVA voter may apply for and receive ballots and other associated materials.

- Section 1-10-104.5, C.R.S., (2022), which requires the Secretary of State to promulgate rules, "for the purpose of establishing equitable uniformity in the appointment and operation of canvass boards."

- Section 1-10.5-102(2), C.R.S., (2022), which requires the Secretary of State to "promulgate and provide each county clerk and recorder with the necessary rules and regulations to conduct the recount in a fair, impartial, and uniform manner…"

- Section 1-40-116(3), C.R.S., (2022), which allows the Secretary of State to adopt rules for the examination and verification of signer lines on an initiative petition.

- Section 1-40-116(4)(a), C.R.S., (2022), which authorizes the Secretary of State to "engage in rule-making to establish the appropriate methodology" to review initiative petitions by random sample.

- Section 1-40-132, C.R.S., (2022), which charges the Secretary of State with the administration and enforcement of initiatives and referred measures, including the authority to "promulgate rules as may be necessary to administer and enforce any provisions of [Article 40] . . ."

- Section 1-40-135(4), C.R.S., (2022), which requires petition entities to apply for a license "on a form prescribed by the secretary of state."

Preliminary Draft of Proposed Rules

Colorado Department of State
Election Rules
8 CCR 1505-1

June 30, 2023

Disclaimer:
In accordance with the State Administrative Procedure Act, this draft is filed with the Department of State and submitted to the Department of Regulatory Agencies.[1]

This is a preliminary draft of the proposed rules that may be revised before the August 3, 2023, rulemaking hearing. If changes are made, a revised copy of the proposed rules will be available to the public and a copy will be posted on the Department of State's website no later than **July 29, 2023**.[2]

Please note the following formatting key:

Font effect	Meaning
Sentence case	Retained/modified current rule language
SMALL CAPS	New language
~~Strikethrough~~	Deletions
Italic blue font text	Annotations

Amendments to 8 CCR 1505-1 follow:

Amendments to Rule 1:

Amendments to Rule 1.1.4 removing language for outdated technology:

1.1.4 "Ballot image" means a digitally captured image of a paper ballot~~ or a representation in electronic form of the marks or vote positions of a cast ballot on a DRE~~.

Amendments to Rule 1.1.5 fixing a grammatical issue for consistency:

1.1.5 "Ballot marking device" OR "~~(~~BMD"~~)~~ means a device that may integrate components such as a ballot scanner, printer, touch-screen monitor, audio output, and a navigational keypad and uses electronic technology to:

[Not shown: no changes to sections (a) through (d).]

Amendments to Rule 1.1.42 clarifying the candidate that must be placed on a ballot for an organization to be considered a "qualified political organization":

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[1] Sections 24-4-103(2.5) and (3)(a), C.R.S. (2022). A draft must be submitted to the Department at the time that a notice of proposed rulemaking is filed with the Secretary of State.
[2] Section 24-4-103(4)(a), C.R.S. (2022). "[A]ny proposed rule or revised proposed rule by an agency which is to be considered at the public hearing…shall be made available to any person at least five days prior to said hearing."

1.1.42 “Qualified political organization” means an organization that has placed a PARTISAN candidate, CERTIFIED TO THE BALLOT BY THE SECRETARY OF STATE, for congressional or state office on the ballot in a congressional vacancy or general election, whose officers have filed proof of organization with the Secretary of State, and that continues to meet the requirements of Rules 3.3 and 3.4.

Amendments to Rule 1.1.62 fixing a grammatical issue for consistency:

1.1.62 “Voting system” as defined in section 1-1-104(50.8), C.R.S., means:

[Not shown: no changes to sections (a) and (b).]

(c) “Voting system” does not include any other component of election administration, such as voter registration applications or systems, electronic pollbooks, ballot delivery and retrieval systems, signature verification and envelope sorting devices, ~~ballot on demand~~BALLOT-ON-DEMAND printers, election night reporting and other election reporting systems, and other components used throughout the election process that do not capture and tabulate votes.

Amendments to Rule 1.1.63 fixing a grammatical issue for consistency:

1.1.63 “Voting system test laboratory” OR “~~(~~VSTL”~~)~~ means a federally accredited entity that conducts certification testing for voting systems.

Repeal of Rule 1.1.64 to recodify sections (a) through (c) into Rule 8.1:

~~1.1.64 “Watcher” has the same meaning as in section 1-1-104(51), C.R.S.~~

~~(a) Watchers may be appointed for a recall election by each qualified successor candidate, the proponents and opponents of the recall ballot question, and each participating political party for a partisan recall election.~~

~~(b) For the purpose of appointing a watcher, the proponent or opponent of a ballot measure means a registered issue committee supporting or opposing the ballot measure.~~

~~(c) A designated watcher need not be a resident of the county he or she is designated in as long as he or she is an eligible elector in the State of Colorado.~~

[Not shown: current Rules 1.1.65 through 1.1.67 are renumbered to Rules 1.1.64 to 1.1.66.]

Amendments to Rule 2:

Amendments to Rule 2.1.2 updating a reference to a form no longer in use:

2.1.2 If any portion of a ~~mail application~~ VOTER REGISTRATION FORM is illegible, the county clerk must notify the applicant of the additional information required in accordance with section 1-2-509, C.R.S.

Amendments to Rule 2.5.3 removing outdated language:

2.5.3 If an elector submits a change to his or her voter registration record and leaves the affiliation ~~or ballot preference~~ section blank, the county clerk may not change the voter’s existing affiliation ~~or ballot preference~~ in the registration record.

New Rule 2.5.5 concerning changes to a covered voter's status as a covered voter:

2.5.5 A COVERED VOTER, AS DEFINED IN SECTION 1-8.3-102(2), C.R.S., WHO PROVIDES AN ADDRESS CHANGE TO THE DEPARTMENT OF REVENUE WHICH INDICATES THE VOTER IS NO LONGER OVERSEAS OR SERVING IN THE MILITARY OUT OF STATE MAY NOT HAVE THEIR STATUS AS A COVERED VOTER REMOVED DUE TO THE CHANGE. THE CLERK MUST INSTEAD SEND A NOTIFICATION VIA MAIL AND EMAIL, IF AVAILABLE, TO THE ELECTOR NOTIFYING THEM THAT A CHANGE OF ADDRESS WAS RECEIVED AND ASKING THE VOTER TO CONFIRM THAT THEY ARE NO LONGER A COVERED VOTER. IF NO RESPONSE IS RECEIVED, THE CLERK MAY NOT MAKE REMOVE THE ELECTOR'S COVERED VOTER STATUS.

Repeal of Rule 2.8 which is duplicative of section 1-2-102, C.R.S.:

~~2.8 Registration of homeless electors~~

~~2.8.1 For the purpose of voter registration residence, a homeless elector must identify a specific location that the applicant considers his or her home base in accordance with section 1-2-102(1)(a)(II), C.R.S.~~

~~2.8.2 For an elector whose home is in foreclosure, the elector may register to vote or remain registered to vote at the foreclosed address until the elector establishes a new permanent residence.~~

~~2.8.3 A post office box or general delivery at a post office is not a home base.~~

Amendments to current Rule 2.9, renumbered to Rule 2.8, to clarify the residential address that can be used by covered voters:

~~2.9~~2.8 Registered electors absent from the state

~~2.9.1~~2.8.1 A registered elector who is absent from the state but who maintains Colorado residency is eligible to be registered and to vote without holding a property interest in a fixed habitation in the state.

~~2.9.2~~2.8.2 An absent elector's voter registration address is the elector's last residence address or the address AN ELECTOR PREVIOUSLY RESIDED AT THAT the elector intends to return to in the state. A COVERED VOTER AS DEFINED IN SECTION 1-8.3-102(2), C.R.S., WHO IS ABSENT AND HAS NEVER RESIDED IN THE UNITED STATES MAY USE THE RESIDENCE ADDRESS OF THEIR PARENT, LEGAL GUARDIAN, SPOUSE, OR CIVIL UNION PARTNER AS REQUIRED BY SECTION 1-8.3-102(2)(D), C.R.S.

Current Rule 2.10 is repealed because it is contradictory to statute, which requires convicted felons to have their voter registration records cancelled in accordance with sections 1-2-302 (3.5)(b) and 1-2-606, C.R.S.:

~~2.10 A county clerk may cancel a registration record based upon information from a local law enforcement agency only if:~~

~~2.10.1 The information states that the individual is currently serving a sentence of detention or confinement in a correctional facility, jail, or other location for a felony conviction; and~~

~~2.10.2 Minimum matching criteria outlined in Rule 2.7 are met.~~

[Not shown: current Rule 2.11 is renumbered to Rule 2.9.]

Repeal of current Rule 2.12 concerning information provided by the Department of State to state parties prior to caucus:

~~2.12~~2.10 Voter registration confidentiality

[Not shown: current Rules 2.12.1 and 2.12.2 renumbered to Rules 2.10.1 and 2.10.2.]

Repeal of Rule 2.12.3:

~~2.12.3 Before precinct caucuses, the Secretary of State will provide to each major state political party a list of confidential voters, which includes only the information necessary to determine eligibility. The list will only be provided if the major party agrees in writing to limit and protect that data in accordance with Secretary of State requirements. This rule does not apply to records held confidential as part of the Address Confidentiality Program.~~

[Not shown: current Rule 2.12.4 is renumbered to Rule 2.10.3.]

Amendments to current Rule 2.13 including necessary renumbering and concerning a technical change regarding the update of a change of address and stylistic change:

~~2.13~~2.11 List ~~M~~Maintenance under section 8 of the National Voter Registration Act of 1993

~~2.13.1~~2.11.1 The Secretary of State's OFFICE will provide monthly National Change of Address (NCOA) data under section 1-2-302.5, C.R.S., to the county clerk ~~by the fifth business day of each~~ ONCE A month.

[Not shown: current Rules 2.13.2 through 2.13.5 are renumbered to Rules 2.11.2 through 2.11.5.]

Amendments to current Rule 2.14 including necessary renumbering and clarifying that a state employee in this context is from the Secretary of State's office:

~~2.14~~2.12 Voter registration at a voter service and polling center. A person registering voters or updating voter registration information in a voter service and polling center must:

~~2.14.1~~2.12.1 Be an election judge, a permanent or temporary county employee, state employee OF THE DEPARTMENT OF STATE, or temporary staff hired by the county clerk; and

[Not shown: current Rule 2.14.2 is renumbered to Rule 2.12.2.]

Amendments to current Rule 2.15 including necessary renumbering and removing language of outdated practices regarding the charge of a fee for county voter information reports and related services:

~~2.15~~2.13 Voter registration records and data

[Not shown: current Rules 2.15.1 and 2.15.2 are renumbered to Rules 2.13.1 and 2.13.2.]

~~2.15.3~~2.13.3 The county clerk of each county may charge fees for county voter information reports and related services~~, such as label printing provided by the centralized statewide registration system. But in accordance with federal requirements governing the use of federal funds, fees must not exceed county direct and indirect costs for providing such reports and services~~.

[Not shown: current Rules 2.15.4 through 2.15.7 are renumbered to Rules 2.13.4 and 2.13.7.]

Repeal of current Rule 2.16 removing references to ballot preference due to the passage of SB23-276:

~~2.16 If an unaffiliated elector indicates a political party ballot preference at any time up to and including the twenty-second day before a primary election, the county clerk must record the selection in SCORE and mail only the ballot of that political party to the elector in the upcoming primary election. An elector's political party ballot preference is only effective for a single primary election even if there is more than one primary election in a single year.~~

[Not shown: current Rules 2.17 and 2.18 are renumbered to Rules 2.14 and 2.15.]

Amendments to Rule 3:

Repeal of Rules 3.8 and 3.9 concerning outdated language that separates the treatment of qualified political organizations from minor parties:

~~3.8 Except for the precinct caucus list furnished to major political parties, a qualified political organization may obtain print-outs, lists, and tapes, of voter registration records at the same rate as political parties.~~

~~3.9 A voter registration summary report must include major political parties, minor political parties, qualified political organizations, and unaffiliated categories.~~

Amendments to Rule 4:

Amendments to Rule 4.1.2 concerning intergovernmental agreements regarding ballot contest length and format:

4.1.2 A coordinating political subdivision must enter into an intergovernmental agreement with the county clerk that delineates which tasks are the responsibility of the designated election official of the political subdivision and which are the responsibility of the county clerk.

[Not shown: no changes to sections (a) and (b).]

(c) THE INTERGOVERNMENTAL AGREEMENT MAY ALSO ADDRESS LIMITATIONS ON, OR REQUIREMENTS FOR, BALLOT CONTEST LENGTH AND FORMATTING OR ANY OTHER LAWFUL TOPIC.

Amendments to Rule 4.5.1(b) removing outdated language concerning the text limit on a ballot:

4.5.1 Each political subdivision must prepare the list of candidates and the ballot title and text for ballot issues and ballot questions, as required by law.

[Not shown: no changes to section (a).]

(b) Political subdivisions may only require the coordinated election official to print the entire text of a ballot issue or ballot question on the ballot if the political subdivision pays for any additional cost associated with printing ~~and if sufficient space is on the voting equipment to print the entire text given the other issues, questions, and candidates on the ballot. The coordinated election official must tell the political subdivision how much space is available for text for each position on the ballot. If the required ballot title and text is too long for the voting equipment, the coordinated election official may choose to conduct the election with a different form of ballot~~.

Amendments to Rule 5:

Repeal of Rule 5.3 concerning an outdated practice:

~~5.3 If a political subdivision coordinates with the county clerk, the designated election official is not required to submit a separate election plan for the election.~~

[Not shown: current Rules 5.4 through 5.6 renumbered to Rules 5.3 through 5.5.]

Amendments to Rule 6:

Amendments to Rule 6.1 clarifying the appointment process of election judges between county clerks and political parties:

6.1 Appointment of election judges under section 1-6-104, C.R.S.

6.1.1 The county clerk must request an updated list of election judges from each major party before each election the clerk conducts under the Uniform Election Code.

6.1.2 ~~The county clerk must reasonably attempt to exhaust the updated list provided by the major parties before supplementing with additional major party judges or minor party or unaffiliated judges. When the county clerk is filling election judge vacancies under section 1-6-113 (1), C.R.S., the clerk may choose from any of the available lists.~~ NO LATER THAN THE FRIDAY BEFORE PRECINCT CAUCUSES, THE CLERK MUST PROVIDE EACH MAJOR PARTY WITH AN ESTIMATE OF THE NUMBER OF JUDGES NEEDED FOR EACH POSITION, AND THE DATES AND TIMES THE CLERK WILL REQUIRE ELECTIONS JUDGES TO WORK IN THOSE POSITIONS IN ELECTIONS FOR THE UPCOMING 2-YEAR CYCLE. THE CLERK MAY UPDATE THIS ESTIMATE FOR EACH MAJOR PARTY PRIOR TO AN ELECTION.

6.1.3 THE COUNTY CLERK MUST REASONABLY ATTEMPT TO EXHAUST THE PRECINCT CAUCUS AND UPDATED LIST PROVIDED BY THE MAJOR PARTIES BY THE 60TH DAY BEFORE AN ELECTION. If, BY THE 60TH DAY BEFORE AN ELECTION, a major political party fails to provide ~~an adequate~~ A SUFFICIENT list of election judges WHO ARE AVAILABLE FOR THE COUNTY TO STAFF ALL OF THE ELECTION JUDGE POSITIONS, DATES, AND TIMES NEEDED BY THE COUNTY FOR THAT ELECTION ~~by the 60th day before election day~~, the county clerk may consider a supplemental list from ~~a~~ THAT major political party. IF THAT SUPPLEMENTAL LIST IS STILL NOT SUFFICIENT, THE CLERK MAY SUPPLEMENT WITH ADDITIONAL MAJOR PARTY, MINOR PARTY, OR UNAFFILIATED JUDGES.

6.1.4 WHEN THE COUNTY CLERK IS FILLING ELECTION JUDGE VACANCIES UNDER SECTION 1-6-113(1), C.R.S., THE CLERK MAY CHOOSE FROM ANY OF THE AVAILABLE MAJOR PARTY, MINOR PARTY, OR UNAFFILIATED JUDGES.

~~6.1.4~~6.1.5 The county clerk must provide a list of election judges, including political party affiliations and assignments, if known, to each appointing party no later than 35 days before election day. Upon request by an appointing party, the clerk must provide a supplemental list no later than seven days before the date on which the county will open its first ~~V~~voter ~~S~~service and ~~P~~polling ~~C~~center.

~~6.1.5~~6.1.6 The county clerk may not ask an election judge or county staff member to change his or her party affiliation to achieve the bipartisan balance required under section 1-6-109, C.R.S.

Amendments to Rule 6.2 concerning the assignment of election judges and including a stylistic change:

6.2 Assignment of ~~E~~Election ~~J~~Judges

[Not shown: no changes to Rule 6.2.1.]

New Rule 6.2.2 requiring a county clerk to review any data available from an election judge's previous election's signature verification work before assigning that election judge to perform signature verification:

6.2.2 PRIOR TO ASSIGNING AN ELECTION JUDGE TO PERFORM SIGNATURE VERIFICATION, THE COUNTY CLERK MUST REVIEW ANY DATA AVAILABLE FROM THAT JUDGE'S SIGNATURE VERIFICATION WORK IN A PREVIOUS ELECTION. IF THE JUDGE HAD AN UNEXPLAINED, IRREGULAR ACCEPTANCE OR REJECTION RATE THE CLERK MAY NOT ASSIGN THAT JUDGE TO CONDUCT SIGNATURE VERIFICATION.

[Not shown: current Rule 6.2.2 renumbered to Rule 6.2.3.]

Amendments to Rule 6.7 clarifying that supervisor judge training content is only valid for one year and requires yearly re-approval:

6.7 A supervisor judge in a voter service and polling center must complete a training course conducted by the county clerk. The Secretary of State must provide or approve the training content. TRAINING CONTENT WHICH IS APPROVED BY THE SECRETARY OF STATE IS ONLY VALID FOR ONE YEAR AFTER APPROVAL.

Amendments to Rule 6.8 specifying that signature verification judge training must be successfully completed prior to each election and from the Department:

6.8 A signature verification judge must SUCCESSFULLY complete a training course conducted by the county clerk PRIOR TO EACH ELECTION~~ at least once per election cycle~~. The county clerk must use the Secretary of State provided training AND MAY PROVIDE ADDITIONAL~~ or provide their own~~ training. If the county clerk provides their own training, it must be approved by the Secretary of State EACH YEAR before its first use.

Amendments to Rule 7:

Amendments to Rule 7.2 concerning ballots and ballot packets:

7.2 Ballots and ballot packets

[Not shown: no change to Rules 7.2.1 through 7.2.3.]

Amendments to Rule 7.2.4 removing language regarding primary ballots which have been printed before a primary election and other technical changes.

7.2.4 Voiding ballots due to timely changes in address or affiliation.

(a) If an elector timely changes his or her address or affiliation after the county mails ballots or sends the voter file to the vendor, the county must void the first ballot and generate a second ballot.

~~(1)~~ If the county processes the change to the elector's record after it sends the voter file to the vendor but before the vendor prints ballots, the county must provide the vendor a voided ballot file to prevent the vendor from printing and preparing voided ballots for mailing.

~~(2) If the county processes the change to the elector's record after the vendor has printed ballots but before the vendor mails ballots, the county must work with the vendor to make every reasonable effort to remove voided ballots before they enter the mail stream.~~

~~(A)~~(B) If the county mails its own ballots, the county clerk must remove all voided ballots before mailing.

~~(B)~~(C) If the county processes the change to the elector's record after it mails ballots, the county must count the first ballot returned by the elector in accordance with section 1-7.5-107(6), C.R.S., except where an elector ~~changed his or her affiliation~~ AFFILIATED WITH A POLITICAL PARTY, the county ~~must~~ MAY ONLY count the ballot issued for the elector's new party affiliation.

[Not shown: no change to Rule 7.2.5.]

Repeal of Rule 7.2.6 regarding an optional statement that could be included on an envelope but is not required by law:

~~7.2.6 Each mail ballot return envelope may include the following statement: "I am voluntarily giving my ballot to (name and address) for delivery on my behalf." If the county clerk includes this statement on their return envelopes they must include an explanation in their voter instructions that the voter is not required to fill this statement out to return their ballot. If the voter leaves the fillable portion of the statement blank, the county clerk must accept the ballot for counting if it is otherwise valid.~~

[Not shown: current Rules 7.2.7 through 7.2.9 are renumbered to Rules 7.2.6 through 7.2.8.]

Amendments to current Rule 7.2.10 including necessary renumbering and concerning the update of an outdated process due to the passage of SB23-276:

~~7.2.10~~7.2.9 An unaffiliated voter who wants to receive the mail ballot of a participating minor political party in the mail must ~~declare a mail ballot preference for that party in accordance with section 1-2-204(2)(j.5), C.R.S.~~ REQUEST A REPLACEMENT MAIL BALLOT OR IN-PERSON BALLOT OF THAT MINOR POLITICAL PARTY.

Repeal of Rule 7.2.11 due to elimination of ballot preference with the passage of SB23-276:

~~7.2.11 If an unaffiliated voter selects a mail ballot preference for a major or minor political party that is not participating or that prohibits unaffiliated voters from voting in its primary election, the county clerk must send the voter the mail ballot packet described in Rule 7.2.9. The packet must include a notice explaining why the voter is receiving the packet or provide an alternative method for the voter to obtain this information.~~

Amendments to current Rule 7.2.12 including necessary renumbering and a stylistic change:

~~7.2.12~~7.2.10 A voter affiliated with a ~~Q~~Qualified ~~P~~Political ~~O~~Organization is considered an unaffiliated voter for the purposes of ~~this~~ Rule 7.2.

[Not shown: current Rules 7.2.13 and 7.2.14 are renumbered to Rules 7.2.11 and 7.2.12.]

Amendments to current Rule 7.2.15 including necessary renumbering and removing outdated language due to the passage of SB23-276:

~~7.2.15~~7.2.13 Each mail ballot return envelope and mail ballot instruction for an unaffiliated voter ~~who has not declared a preference in a primary election~~ must include a statement instructing the voter to return only one ballot.

Amendments to current Rule 7.2.16 including necessary renumbering, removing of outdated practices due to the passage of SB23-276, and permitting unaffiliated voters to receive a minor party ballot in a primary, if allowed by the minor party:

~~7.2.16~~7.2.14 The county clerk must issue a replacement mail ballot packet THAT CONTAINS BALLOTS OF ALL PARTICIPATING MAJOR POLITICAL PARTIES to an unaffiliated elector WHO REQUIRES OR IS ELIGIBLE FOR A REPLACEMENT BALLOT. IF AN UNAFFILIATED VOTER REQUESTS A BALLOT FOR A MINOR POLITICAL PARTY THAT IS PARTICIPATING IN THE PRIMARY ELECTION AND ALLOWS UNAFFILIATED VOTERS TO VOTE, THE UNAFFILIATED ELECTOR MUST BE ISSUED A REPLACEMENT BALLOT WITH ONLY THAT PARTY'S BALLOT INCLUDED. ~~in a primary election as follows:~~

~~(a) If the elector has not declared a mail ballot preference, the county clerk must issue a packet containing the ballots of all participating major political parties.~~

~~(b) If the Elector has timely declared a mail ballot preference, the county clerk must issue the elector's preferred political party's ballot; or upon the elector's request, a packet containing the ballots of all participating major political parties.~~

[Not shown: current Rule 7.2.17 renumbered to Rule 7.2.15.]

New Rule 7.2.16 concerning the mailing of a property-owner ballot when coordinating a mail ballot election with a special district:

7.2.16 A COUNTY COORDINATING A MAIL BALLOT ELECTION WITH A SPECIAL DISTRICT IN WHICH PROPERTY OWNERS ARE ELIGIBLE TO VOTE UNDER SECTION 32-1-103(5)(A)(II), C.R.S., MUST AUTOMATICALLY MAIL PROPERTY OWNER BALLOTS TO ACTIVE, REGISTERED VOTERS WHO ARE CERTIFIED AS- ELIGIBLE BY THE DISTRICT'S DESIGNATED ELECTION OFFICIAL.

Amendments to Rule 7.4.1 updating the retention of the surveillance records at drop box locations:

7.4.1 The county clerk must adequately light all drop box locations and use a DROP BOX video ~~security surveillance~~ recording system ~~as defined in Rule 1.1.61~~ to monitor each location. THE SYSTEM MUST CONTINUOUSLY RECORD THE BOX A SYSTEM USING MOTION DETECTION THAT RECORDS ONE FRAME, OR MORE, PER MINUTE UNTIL DETECTION OF MOTION TRIGGERS CONTINUOUS RECORDING.

[Not shown: no changes to section (a) through (d).]

(e) ~~Video security surveillance~~ DROP BOX VIDEO RECORDINGS must be retained by the county clerk through ~~60~~120 days following the deadline to certify the election, or until the conclusion of any election contest, whichever is later; except that if the county clerk knows or reasonably should know that there is a potential violation of law where the surveillance could be used as evidence, it must be retained through the applicable statute of limitations or the conclusion of any judicial proceeding related to the election, whichever is later.

Amendments to Rule 7.4.5 repealing language duplicative to statute and introducing language regarding pickup schedules of drop boxes in response to SB23-276:

7.4.5 The county clerk must arrange for the collection of ballots by bipartisan teams, of election judges and/or staff, from each drop box location once it is open and receive the ballots into SCORE~~:~~.

~~(a) If applicable, at least once every 72 hours after non-UOCAVA ballots are mailed until the date that voter service and polling centers must open;~~

~~(b) If applicable, at least once every 24 hours during the days that voter service and polling centers must be open; and~~

~~(c)~~(A) FOR COUNTIES WITH LESS THAN 250,000 ACTIVE ELECTORS AS OF THE PREVIOUS GENERAL ELECTION, AT ~~At~~ least twice on election day, at approximately 1:00 p.m. and 7:00 p.m.

~~(d)~~(B) The county clerk may meet the requirements of this Rule by~~:~~

~~(1) Collecting and transporting the ballots to the central counting location for receipt into SCORE; or~~

~~(2) Collecting and transporting the ballots to the nearest voter service and polling center for receipt into SCORE.~~ FOLLOWING THE REQUIREMENTS OF SECTION 1-7.5-107 (4.3)(C)(II), C.R.S.

Repeal of Rule 7.4.6 due to the passage of SB23-276 which mandates that all drop boxes in Colorado must have ballots picked up on a specific schedule:

~~7.4.6 The county clerk may request a waiver from the Secretary of State for remote drop box locations in the county's election plan or amended election plan, exempting them from the ballot collection requirements in Rule 7.5.5. If the Secretary of State grants the waiver:~~

~~(a) The county clerk must arrange for the collection of ballots by bipartisan teams of election judges from all exempt drop box locations once they are open as often as necessary, but at least:~~

~~(1) Once each week after the initial mailing of non-UOCAVA ballots until the Friday before election day; and~~

~~(2) On the Friday and Monday before election day and on election day at 7:00 p.m. MT.~~

~~(b) The county clerk must post a notice on each exempt drop box of the dates and approximate times ballots will be collected.~~

~~(c) If the Secretary of State determines that the county failed to collect ballots from a remote drop box location as often as necessary, the Secretary of State may revoke or modify the waiver.~~

[Not shown: current Rules 7.4.7 through 7.4.10 are renumbered to Rules 7.4.6 through 7.4.9.]

Repeal and replacement of current Rule 7.4.11 for clarity, including necessary renumbering and concerning intercounty transfer process of ballots if an elector delivers a ballot to a county in which they do not reside:

~~7.4.11~~7.4.10 ~~If an elector delivers a ballot to the wrong county, that county must date stamp the ballot envelope and timely forward it to the correct county. Beginning the Monday before election day, the county must notify the correct county of receipt by secure electronic transmission with a scanned image of the outside of the mail ballot envelope including the signature, and forward it to the correct county no later than the next business day. A county that physically delivers ballots to another county no later than the next business day, or immediately transmits them by next-day delivery, is not required to scan the envelope. The~~

~~correct county must treat the ballot as received as of the date and time of the date stamp. The county receiving the image may perform signature verification upon receipt of the image.~~ INTERCOUNTY TRANSFER OF BALLOTS

(A) IF AN ELECTOR DELIVERS A BALLOT TO THE COUNTY IN WHICH THEY DO NOT RESIDE, THE COUNTY WHO INITIALLY RECEIVED THE BALLOT MUST TAKE THE FOLLOWING ACTIONS:

(1) IF RECEIVED BEFORE 7:00 P.M. ON ELECTION DAY, DATE STAMP THE BALLOT ENVELOPE WITH A STAMP THAT IDENTIFIES THAT THE BALLOT WAS RECEIVED BEFORE 7:00 P.M. ON ELECTION DAY, AND NOTING THE COUNTY WHERE THE BALLOT WAS RECEIVED;

(2) FORWARD THE BALLOT TO THE CORRECT COUNTY;

(A) ON AND AFTER ELECTION DAY, THE BALLOT MUST BE PHYSICALLY DELIVERED BY THE COUNTY WHO RECEIVED THE BALLOT TO THE CORRECT COUNTY, SENT BY NEXT-DAY DELIVERY IF AVAILABLE, OR SENT BY FIRST CLASS MAIL IF NEXT-DAY DELIVERY IS NOT AVAILABLE.

(B) BALLOTS MUST BE PHYSICALLY DELIVERED OR MAILED NO LATER THAN 2 DAYS AFTER ELECTION DAY.

(C) BALLOTS THAT ARE MAILED MUST BE SENT TO THE MAILING ADDRESS PRESENT ON THE BALLOT ENVELOPE.

(3) CREATE AN ENTRY IN A LOG WHICH RECORDS THE DATE THE BALLOT WAS RECEIVED, THE VOTER IDENTIFICATION NUMBER FOR THE BALLOT, THE COUNTY THE BALLOT WILL BE DELIVERED TO, THE METHOD OF DELIVERY TO THE CORRECT COUNTY, THE DELIVERY TRACKING NUMBER, IF ANY, AND THE DATE THE BALLOT WAS MAILED OR PHYSICALLY DELIVERED TO THE CORRECT COUNTY;

(4) IF THE BALLOT WILL BE MAILED, NOTIFY THE COUNTY WHERE THE BALLOT WILL BE SENT VIA EMAIL WHEN THE BALLOT HAS BEEN PLACED IN THE MAIL, THE VOTER IDENTIFICATION NUMBER OF THE BALLOT, AND THE METHOD OF DELIVERY FOR THE BALLOT; AND

(5) BEGINNING THE DAY BEFORE ELECTION DAY, SEND, BY SECURE ELECTRONIC TRANSMISSION, A SCANNED IMAGE OF THE OUTSIDE OF THE MAIL BALLOT ENVELOPE, INCLUDING THE SIGNATURE, TO THE COUNTY WHERE THE BALLOT WILL BE SENT. A COUNTY THAT PHYSICALLY DELIVERS BALLOTS TO ANOTHER COUNTY NO LATER THAN THE NEXT BUSINESS DAY, OR IMMEDIATELY TRANSMITS THEM BY NEXT-DAY DELIVERY, IS NOT REQUIRED TO SCAN THE ENVELOPE. THE COUNTY RECEIVING THE IMAGE MAY PERFORM SIGNATURE VERIFICATION UPON RECEIPT OF THE IMAGE.

(B) THE CORRECT COUNTY MUST TREAT THE BALLOT AS RECEIVED AS OF THE DATE AND TIME OF THE DATE STAMP.

Repeal of Rule 7.4.12 as a result of the amendments to current Rule 7.4.11:

~~7.4.12 The county clerk must date stamp each ballot envelope as received on or before 7:00 PM on election day and immediately forward it to the correct county. The correct county must treat the ballot as received as of the date and time of the date stamp.~~

Amendments to current Rule 7.4.13, including necessary renumbering and concerning the tracking of ballots delivered or received from electors who are confined in a county jail as a result of the passage of SB23-276:

~~7.4.13~~7.4.11 County clerks who deliver or receive ballots from electors who are confined in a county jail or detention facility must MAINTAIN A log OF the number of ballots delivered and received from each facility and provide the log to the Secretary of State's office following ~~the~~ AN election THAT IS NOT CONDUCTED IN NOVEMBER. THE COUNTY CLERK MUST SEPARATELY MAINTAIN A LOG OF THE NUMBER OF VOTER REGISTRATION FORMS RECEIVED FROM THE COUNTY JAIL OR DETENTION FACILITY, OR SUBMITTED TO COUNTY CLERK PERSONNEL WHO ARE ON-SITE AT THE JAIL OR FACILITY.

[Not shown: current Rules 7.4.14 and 7.4.15 are renumbered to Rules 7.4.12 through 7.4.13.]

Amendments to Rule 7.5 organizing the structure for clarity:

7.5 Ballot returned in unofficial envelope~~.~~

7.5.1 If the county timely receives a mail ballot from an eligible elector in an envelope that is missing or lacks the correct self-affirmation, the county must contact the elector by mail and by electronic mail, if available, within three calendar days of receiving the ballot but no later than two calendar days after election day. The county must use the letter and affidavit prescribed by the Secretary of State and keep a copy as part of the official election record.

7.5.2 If the county receives the completed affidavit no later than the eighth day after election day, the county must count the ballot.

7.5.3 A county that receives a ballot from a voter with a disability covered under section 1-5-706, C.R.S., in an unofficial envelope must accept the ballot for processing if the envelope also contains a signed application from the voter.

Amendments to Rule 7.7 concerning signature verification procedures:

7.7 Signature verification procedures

Amendments to Rule 7.7.1 clarifying the use of signature verification judges for the levels of review of signatures:

7.7.1 When reviewing signatures through the use of signature verification judges, ~~a single election judge must conduct the first level of signature verification.~~ THE COUNTY CLERK MUST FOLLOW THE REQUIREMENTS OF SECTION 1-7.5-107.3 (2), C.R.S., FOR THE INITIAL AND SECOND LEVEL REVIEW OF SIGNATURES, INCLUDING:

(A) THE REQUIREMENT THAT A SINGLE ELECTION JUDGE CONDUCT THE FIRST LEVEL OF SIGNATURE VERIFICATION; AND

(B) THE REQUIREMENT THAT A BI-PARTISAN TEAM OF ELECTION JUDGES REVIEW A REJECTED SIGNATURE. THAT BI-PARTISAN TEAM MAY NOT INCLUDE THE ELECTION JUDGE WHO MADE THE FIRST DECISION TO REJECT A SIGNATURE.

[Not shown: no changes to Rule 7.7.2.]

Amendments to Rule 7.7.3 concerning standards for accepting or rejecting a signature on a mail ballot envelope:

7.7.3 An election judge conducting signature verification must compare the signature on the self-affirmation on each ballot return envelope with the elector's signature in SCORE in accordance with the Secretary of State's Signature Verification Guide. A SIGNATURE ON A MAIL BALLOT ENVELOPE THAT IS CONSISTENT WITH THE SIGNATURES FOR THE VOTER IN SCORE IS ONE THAT IS MORE LIKELY THAN NOT TO BE THE SIGNATURE OF THE VOTER. A SIGNATURE THAT IS CONSISTENT MUST BE ACCEPTED AS A MATCH.

[Not shown: no changes to Rules 7.7.4 through 7.7.7.]

Amendments to Rule 7.7.8 establishing additional monitoring of signature verification judges by the county clerk:

7.7.8 SIGNATURE VERIFICATION JUDGE MONITORING

(A) THE COUNTY CLERK MUST KEEP REAL-TIME RECORDS OF EACH SIGNATURE VERIFICATION TRANSACTION, INCLUDING:

(1) EACH DECISION MADE BY AN ELECTION JUDGE AT TIER 1 TO ACCEPT OR REJECT A SIGNATURE; AND

(2) EACH DECISION MADE BY AN ELECTION JUDGE TEAM AT TIER 2 TO ACCEPT OR REJECT A SIGNATURE;

(3) THE SIGNATURES ASSOCIATED WITH EACH DECISION MADE BY AN ELECTION JUDGE AT TIER 1 OR TIER 2;

(4) AGGREGATE ACCEPTANCE AND REJECTION RATE DATA FOR EACH TIER 1 ELECTION JUDGE; AND

(5) SIGNATURES REJECTED BY AN ELECTION JUDGE TEAM AT TIER 2 WHICH ARE LATER CURED BY THE VOTER.

(B) THE RECORDS CREATED BY THIS RULE ARE AN ELECTION RECORD WHICH MUST BE MADE AVAILABLE TO THE SECRETARY OF STATE UPON REQUEST.

(C) USING THE DATA COLLECTED IN RULE 7.7.8, EACH DAY SIGNATURE VERIFICATION IS CONDUCTED, THE ~~The~~ county clerk must ~~periodically audit~~ TRACK THE ACCEPTANCE AND REJECTION RATE OF signature verification judges. If a judge or team of judges has an unexplained, irregular acceptance, ~~or~~ rejection, OR OVERTURN rate, the county clerk must retrain or remove that judge or team of judges from conducting signature verification.

[Not shown: no changes to Rule 7.7.9.]

Amendments to Rule 7.7.10 concerning the capture of the image of the full back of a mail ballot envelope for signature verification:

7.7.10 If the county uses a ballot sorting and signature capture device, the county clerk must test the device before using it in an election to ensure that it properly sorts envelopes, and accurately and clearly captures the signature on the envelope for comparison to the correct voter record. BEGINNING ON JANUARY 1, 2024, THE DEVICE MUST ALSO CAPTURE AN IMAGE OF THE FULL BACK OF THE MAIL BALLOT ENVELOPE.

Amendments to Rule 7.8.1to clarify the elections that this rule applies to:

7.8.1 The county clerk must designate and open the minimum number of voter service and polling centers as required in section 1-5-102.9, C.R.S., for a general election and section 1-7.5-107(4.5), C.R.S., for all ~~other elections~~ PRIMARY AND COORDINATED ELECTIONS.

[Not shown: no changes to sections (a) through (d).]

Repeal and replacement of Rule 7.8.2 concerning the use of the voter center siting tool, provided by the Department, during the placement process of voter service and polling centers and drop boxes:

7.8.2 ~~Voter service and polling center materials include sufficient computer stations for SCORE access, HAVA information, signature cards, paper ballots, voting booths and a ballot box.~~ WHEN DETERMINING WHERE IN A COUNTY A VOTER SERVICE AND POLLING CENTER OR DROP BOX SHOULD BE PLACED IN A GENERAL ELECTION, A COUNTY CLERK MUST TAKE INTO CONSIDERATION THE RECOMMENDATIONS GIVEN BY THE VOTER CENTER SITING TOOL. THE TOOL WILL BE PROVIDED FOR USE BY THE DEPARTMENT OF STATE.

Amendments to Rule 7.8.3 concerning a grammatical change:

7.8.3 In order to assist applicants and electors efficiently, a county clerk must configure voter service and polling centers with sufficient election judges, WebSCORE workstations, voting equipment, and sufficient numbers of mail and in-person ballots that can be tabulated by the county's voting system without further duplication, and other supplies. A county may satisfy this Rule by providing a sufficient number of ballot marking devices or ~~ballot on demand~~ BALLOT-ON-DEMAND printers.

Amendments to Rule 7.9 removing an outdated reference:

7.9 The county clerk must complete an accessibility survey for all drop box and voter service and polling center locations annually before designating a location for use, and no later than 120 days before an election, the county clerk must designate drop-off, drop box, and voter service and polling center locations. In a presidential election year, the county clerk's accessibility survey for the presidential primary election serves as the annual survey for that voter service and polling center or drop box through the following general election.

[Not shown: no changes to Rules 7.9.1 and 7.9.2.]

7.9.3 ~~The Secretary of State may deny an application for accessibility grant funds if a county clerk fails to assess locations, timely file complete accessibility surveys, or develop and implement necessary barrier removal plans in accordance with this Rule.~~ The DEPARTMENT OF STATE will conduct site visits to assess compliance and identify accessibility barriers. The Secretary will seek injunctive action or other penalties under section 1-1-107(2)(d), C.R.S., as necessary to remedy violations of this Rule.

Amendments to Rule 7.11 concerning a stylistic change:

7.11 At each ~~V~~voter ~~S~~service and ~~P~~polling ~~C~~center, election judges and, if appropriate, election staff, must:

New Rule 7.17 concerning data entry standards for district, position, and ballot style names in SCORE:

7.17 DATA ENTRY STANDARDS FOR DISTRICT, POSITION, AND BALLOT STYLE NAMES IN SCORE. AUTHORIZED SCORE USERS MUST COMPLY WITH THE DATA ENTRY STANDARDS SET FORTH IN THIS RULE WHEN NAMING DISTRICTS, POSITIONS, AND BALLOT STYLES IN SCORE'S DISTRICTS & PRECINCTS AND ELECTION MANAGEMENT MODULES.

7.17.1 DISTRICT NAMES: COUNTY CLERKS MUST NAME LOCAL DISTRICTS IN SCORE'S DISTRICTS & PRECINCTS MODULE EXACTLY THE SAME AS THEY ARE NAMED IN THE DEPARTMENT OF LOCAL AFFAIRS' LOCAL GOVERNMENT INFORMATION SYSTEM (LGIS), WITH TWO EXCEPTIONS:

(A) LGIS LISTS MUNICIPALITIES BY NAME FOLLOWED BY A COMMA AND THE MUNICIPALITY TYPE. SCORE USERS MUST ENTER THE NAMES OF MUNICIPALITIES IN SCORE ACCORDING TO COMMON USAGE, SO THAT THE MUNICIPALITY TYPE PRECEDES MUNICIPALITY'S NAME. BY WAY OF EXAMPLE, IF LGIS LISTS *AVON, TOWN OF*, THE COUNTY MUST NAME THE MUNICIPALITY IN SCORE AS *TOWN OF AVON*.

(B) LGIS LISTS SCHOOL DISTRICTS BY THE STATE BOARD OF EDUCATION'S TRUNCATED ORGANIZATION NAME WITH THE WORDS "SCHOOL DISTRICT" APPENDED AT THE END OF THE DISTRICT'S NAME. COUNTIES MUST ENTER THE DISTRICT'S NAME INTO SCORE ACCORDING TO COMMON USAGE. BY WAY OF EXAMPLE, IF LGIS LISTS A SCHOOL DISTRICT AS *LAS ANIMAS RE-1 SCHOOL DISTRICT*, THE COUNTY MUST NAME THE DISTRICT IN SCORE AS *LAS ANIMAS SCHOOL DISTRICT RE-1*.

7.17.2 POSITION NAMES: COUNTIES MUST NAME POSITIONS IN SCORE SO THAT THE FULL NAME OF THE DISTRICT PRECEDES THE POSITION OR OFFICE NAME FOLLOWED BY THE POSITION DISTRICT NUMBER OR TERM OF YEARS, IF ANY. THE COUNTY CLERK MAY DELETE THE FULL DISTRICT NAME FROM THE POSITION OR OFFICE NAME ON BALLOT ART IF A BALLOT HEADER OR CONTEST HEADING SUFFICIENTLY IDENTIFIES THE PARTICIPATING DISTRICT, BUT THE POSITION MUST BE NAMED IN ACCORDANCE WITH THIS RULE TO ENSURE IT IS INCLUDED IN THE COUNTY'S ELECTION DEFINITION EXPORT, ELECTION RESULTS EXPORTS, AND CAST VOTE RECORD FILES. FOR EXAMPLE:

(A) COUNTY POSITION NAMES: ADAMS COUNTY BOARD OF COUNTY COMMISSIONERS – DISTRICT 1; ADAMS COUNTY CLERK AND RECORDER; ADAMS COUNTY TREASURER; ADAMS COUNTY ASSESSOR; ADAMS COUNTY SHERIFF; ADAMS COUNTY CORONER; ADAMS COUNTY SURVEYOR

(B) MUNICIPAL POSITION NAMES: CITY OF ASPEN CITY COUNCIL – AT LARGE; CITY OF ASPEN CITY COUNCIL – WARD 2; TOWN OF MANCOS BOARD OF TRUSTEES – WARD 1; CITY OF LITTLETON MAYOR

(C) SCHOOL DISTRICT POSITION NAMES: ALAMOSA SCHOOL DISTRICT RE-11J BOARD OF DIRECTORS – DISTRICT 2; KIT CARSON SCHOOL DISTRICT R-1 BOARD OF DIRECTORS – DISTRICT A

(D) SPECIAL DISTRICT POSITION NAMES: ALLISON VALLEY METROPOLITAN DISTRICT NO. 2 BOARD OF DIRECTORS – 2-YEAR TERM; DENVER SOUTHEAST SUBURBAN WATER & SANITATION DISTRICT BOARD OF DIRECTORS – 4-YEAR TERM.

7.17.2 BALLOT STYLE NAMES:

(A) IF A COUNTY REPORTS RESULTS FOR ANY ELECTION BY PRECINCT, THE COUNTY MUST RENAME ITS BALLOT STYLES IN SCORE ACCORDING TO THE CONVENTION OF XXX-Y OR XXX-YY, WHERE XXX IS THE FINAL THREE DIGITS OF THE TEN-DIGIT PRECINCT NUMBER, AND Y OR YY IS THE ONE- OR TWO-DIGIT DISTRICT STYLE NUMBER. BY WAY OF EXAMPLE, IF SCORE GENERATES A SINGLE DISTRICT STYLE AND THE COUNTY HAS 3 PRECINCTS, THE COUNTY MUST NAME THE PRECINCT STYLES AS 001-1, 002-1, AND 003-1.

(B) IF THE COUNTY REPORTS RESULTS OF AN ELECTION BY BALLOT STYLE, THE COUNTY MUST NAME THE BALLOT STYLE WITH THE BALLOT STYLE NUMBER GENERATED BY SCORE. BY WAY OF EXAMPLE, IF SCORE GENERATES THREE DIFFERENT DISTRICT STYLES FOR AN ELECTION OTHER THAN A GENERAL ELECTION, THE COUNTY MUST NAME THE BALLOT

STYLES 1, 2, AND 3. IF SCORE GENERATES MORE THAN NINE DISTRICT STYLES FOR AN ELECTION, THE COUNTY MUST NAME THEM WITH A TWO-DIGIT NUMBER, SUCH AS 01 THROUGH 09, 10, 11, ETC.

Amendments to Rule 8:

Amendments to Rule 8.1 including the recodification of sections (a) through (c) of Rule 1.1.64 to Rules 8.1.2 through 8.1.4 and necessary renumbering:

8.1 A watcher must affirm that he or she is qualified to act as a watcher under Colorado law. The county clerk must accept the appointment of all eligible watchers duly certified by a political party, candidate, or issue committee under sections 1-1-104(51), 1-7-105, 1-7-106, or 1-7-107, C.R.S.

8.1.1 The registered agent or designated filing agent for an issue committee is the authorized representative to appoint watchers for the issue committee.

~~(a)~~8.1.2 Watchers may be appointed for a recall election by each qualified successor candidate, the proponents and opponents of the recall ballot question, and each participating political party for a partisan recall election.

~~(b)~~8.1.3 For the purpose of appointing a watcher, the proponent or opponent of a ballot measure means a registered issue committee supporting or opposing the ballot measure.

~~(c)~~8.1.4 A designated watcher need not be a resident of the county they are designated in as long as they are an eligible elector in the State of Colorado.

[Not shown: current Rules 8.1.2 through 8.1.6 are renumbered to Rules 8.1.5 through 8.1.9.]

Amendments to Rule 8.8 specifying the use of watchers in a non-partisan, coordinated election since the passage of SB23-276 incorporates these requirements for watchers in other elections and stylistic changes to Rule 8.8.3:

8.8 The minimum number of watchers the county clerk must accommodate for each appointing entity IN A NON-PARTISAN, COORDINATED ELECTION is as follows:

[Not shown: no changes to Rules 8.8.1 and 8.8.2.]

8.8.3 At each ~~V~~Voter ~~S~~Service and ~~P~~Polling ~~C~~Center, one watcher, or one watcher per ~~V~~Voter ~~S~~Service and ~~P~~Polling ~~C~~Center process.

[Not shown: no changes to Rules 8.8.4 and 8.8.5.]

Amendments to Rule 8.10.2 including a stylistic change in section (a)(1) and new section (d).]

8.10.2 Watchers must be permitted access that would allow them to attest to the accuracy of election-related activities. This includes personal visual access at a reasonable proximity to read documents, writings or electronic screens and reasonable proximity to hear election-related discussions between election judges and electors.

(a) Election activities include:

(1) Setup and breakdown of ~~V~~Voter ~~S~~Service and ~~P~~Polling ~~C~~Centers.

[Not shown: no changes to subsections (2) through (12).]

[Not shown: no changes to sections (b) and (c).]

(D) THE COUNTY CLERK MUST ALLOW A WATCHER TO POSSESS A PHONE TO SEND OR RECEIVE TEXT MESSAGES WHILE WATCHING ELECTION ACTIVITIES AS LONG AS THE WATCHER IS NOT LOCATED WHERE PERSONALLY IDENTIFIABLE INFORMATION IS WITHIN VIEW AS REQUIRED BY SECTION 1-7-108(4), C.R.S.

Amendments to Rule 9:

Amendments to Rule 9.1.4 removing outdated language, due to the passage of SB23-276, regarding voters under the age of 18:

9.1.4 Age. ~~For a primary election, the election judge must ask the elector, "Are you at least 17 years of age and will you be 18 years of age or older on or before the date of the next general election?" For any other election,~~ The election judge must ask the elector, "Will you be 18 years of age or older on election day?"

Amendments to Rule 10:

Amendments to Rule 10.3.2 removing outdated language pertaining to complaints about random audits which are no longer conducted in Colorado:

10.3.2 The canvass board's only duties are to:

(a) Conduct the canvass and certify the official abstract of votes in accordance with section 1-10-101.5, C.R.S., by:

(1) Reconciling the number of ballots counted to the number of ballots cast; and

(2) Reconciling the number of ballots cast to the number of voters who voted.

(b) Observe the post-election audit in accordance with section 1-7-514(4), C.R.S., and Election Rule 25.2 or 25.3; AND

~~(c) In coordination with the county clerk, investigate and report discrepancies found in the audit under section 1-7-514(2), C.R.S.; and~~

(C)~~(d)~~ Conduct any recount in accordance with section 1-10.5-107, C.R.S., and this Rule. ~~The canvass board's role in conducting a recount includes selecting ballots for the random test, observing the recounting of ballots, and certifying the results.~~

Repeal of Rule 10.5.3 which pertains to complaints made about voting devices, which are no longer used in Colorado:

~~10.5.3 Written Complaints~~

~~(a) The designated election official must provide the canvass board with any written complaint submitted by a registered elector about a voting device.~~

~~(b) If the complaint is resolved, the designated election official must provide the details of the resolution.~~

~~(c) If the complaint is pending resolution when the board meets to conduct the canvass, the designated election official must provide a proposal for how the issue will be resolved.~~

Amendments to Rule 10.6 concerning a grammatical change:

10.6 Official ~~A~~Abstract and ~~R~~Reporting to the Secretary of State

Repeal of Rule 10.6.3 which has been superseded with the passage of SB22-153, and replacement with notification requirements for canvass board meetings:

10.6.3 ~~If a majority of the canvass board votes not to certify the abstract of votes cast or does not make a final determination by the deadline to certify the abstract of votes cast, the county clerk must forward the abstract that has not been certified to the Secretary of State along with a report from the canvass board describing why the abstract has not been certified. Upon receiving an abstract under this rule, or if the county clerk does not provide the abstract to the Secretary of State by the deadline to certify the abstract of votes cast, the Secretary of State will consider whether to canvass the returns under section 1-10-104, C.R.S.~~ A COUNTY MUST NOTIFY THE SECRETARY OF STATE IMMEDIATELY AFTER THE MEETING OF THE CANVASS BOARD IF:

(A) THE CANVASS BOARD VOTES NOT TO CERTIFY THE ABSTRACT OF VOTES CAST;

(B) THE CANVASS BOARD OTHERWISE FAILS TO TAKE ACTION TO CERTIFY THE ABSTRACT OF VOTES CAST; OR

(C) IN A PARTISAN ELECTION, THE COMPOSITION OF THE CANVASS BOARD DID NOT CONSIST OF:

(1) AN EQUAL NUMBER OF BOARD MEMBERS APPOINTED FROM EACH OF THE OPPOSING MAJOR PARTIES; AND

(2) THE COUNTY CLERK OR DEPUTY CLERK.

Amendments to Rule 10.8.1 concerning a technical change:

10.8.1 As part of the Secretary's duties under section 1-1-107, C.R.S., the Secretary may provide guidance and investigate imperfections ~~as outlined below~~.

Amendments to Rule 10.9 concerning mandatory and discretionary recounts and including technical changes:

10.9 Recount generally

[Not shown: no changes to Rule 10.9.1.]

10.9.2 A county that has successfully completed a comparison audit under Rule 25.2 and reported no discrepancies in the recount contest need not re-scan ballots during a REQUESTED recount, except as provided in Rule 10.9.3. In all cases, the county must re-adjudicate ballot images for voter intent in accordance with Rule 10.13.3.

10.9.3 ~~The losing candidate with the most votes, or an~~ AN interested party as defined in section 1-10.5-106, C.R.S., may request that the county re-scan ballots. The request is due no later than ~~the day after the deadline to order a mandatory recount or~~ the day ~~after the deadline to request~~ a recount IS PAID FOR~~, whichever is applicable~~.

[Not shown: no changes to Rules 10.9.4 and 10.9.5.]

~~10.9.6 If all losing candidates who received enough votes to trigger a mandatory recount submit letters of withdrawal to the DEO in accordance with section 1-4-1001, C.R.S., the DEO must immediately notify the county clerk and the county clerk need not conduct the recount.~~

Amendments to Rule 10.10.2 concerning requested recounts and updating cost estimate requirements due to the passage of SB23-276:

10.10.2 Requested recounts

[Not shown: no changes to section (a).]

(b) In preparing a cost estimate for a requested recount, the county must use the Secretary of State approved form. The estimate must include reasonable itemized costs for conducting the recount AND MUST DISTINGUISH THE COST FOR CONDUCTING THE RECOUNT WITH AND WITHOUT RESCANNING THE BALLOTS. ~~The county may not request reimbursement for normal overhead costs.~~

Repeal of Rule 10.12.2 because it is duplicative to statute with the passage of SB23-276:

~~10.12.2 If the county re-scans ballots during the recount, the county clerk must test all ballot scanners that will be used. The purpose of the test is to ensure that the voting system accurately tabulates votes in the recounted contest.~~

~~(a) The county must prepare and tabulate the following test decks:~~

~~(1) The county recount test deck must include every ballot style and, where applicable, precinct style containing the recounted contest. It must consist of enough ballots to mark every vote position and every possible combination of vote positions, and include overvotes, undervotes, and blank votes in the recounted contest.~~

~~(2) In a requested recount, the person requesting the recount may mark up to 10 ballots. Any other candidate in the contest, or person or organization who could have requested the recount, may also mark up to 10 ballots.~~

~~(3) In a mandatory recount, at least two canvass board members of different party affiliations must each mark an additional 10 ballots containing the recounted contest.~~

~~(b) A bipartisan team, of election judges and/or staff, must hand tally the recounted contest on the test ballots and verify that the hand tally matches the voting system's tabulation.~~

~~(c) The test is limited to the race or measure that is recounted.~~

Repeal of Rule 10.13.1 because it is duplicative to statute with the passage of SB23-276:

10.13 Counting ballots during a recount

~~10.13.1 In accordance with section 1-10.5-102(3)(b), C.R.S., if there are no discrepancies in the test under Rule 10.12, the recount must be conducted in the same manner as the ballots were counted in the election except as outlined in this Rule. If there are unresolvable~~

~~discrepancies in the test, the recount must be conducted as a hand count under Rule 10.13.5.~~

[Not shown: current Rules 10.13.2 through 10.3.6 are renumbered to Rules 10.13.1 through 10.13.5.]

Amendments to Rule 10.14.1 updating the requirements for results reporting following a recount:

10.14 Canvass and reporting results for a recount

10.14.1 Totals of recounted ballots must be reported AS ~~in summary form as follows:~~

~~(a) Sum~~ COMBINED total of votes for each race or measure recounted, under-votes, BLANK VOTES, VALID WRITE-IN VOTES, and over-votes FOR THE RACE RECOUNTED ~~for each location;~~

~~(b) The totals must be a combined total, not totaled by individual precincts or location, unless the tabulation system allows~~.

Amendments to Rule 11.2 concerning a stylistic change:

11.2 Voting ~~S~~system ~~I~~inventory

[Not shown: no changes to Rules 11.2.1 and 11.2.2.]

Amendments to Rule 11.2.3 concerning a technical revision to reflect current practice:

11.2.3 The designated election official must file ~~a complete~~ THE voting system inventory REQUIRED BY RULE 11.2.1, noting which equipment will be used for the election, with the Secretary of State no later than ten days before the election.

[Not shown: no changes to Rule 11.2.4.]

Amendments to Rule 11.6 concerning a stylistic change:

11.6 ~~Rules Concerning~~ Accessible ~~V~~voting ~~S~~systems. A political subdivision may not purchase or lease voting systems for use by people with disabilities unless the system is certified by the Secretary of State.

Amendments to Rule 11.7 concerning a stylistic change:

11.7 ~~Rules Concerning~~ Notice of ~~V~~voting ~~S~~system ~~M~~malfunction

Amendments to Rule 11.7.1 requiring a voting systems provider to submit an incident report in the event of an incident:

11.7.1 The voting system provider must submit a software or hardware incident report to the Secretary of State no later than 72 hours after ~~a software~~ AN incident has occurred. SUBMISSION OF THIS INCIDENT REPORT BY THE PROVIDER IS REQUIRED EVEN IF THE DESIGNATED ELECTION OFFICIAL ALSO SUBMITS A REPORT OF THE SAME INCIDENT.

Amendments to Rule 11.8, including Rule 11.8.2(f), concerning stylistic and grammatical changes:

11.8 Purchases and ~~C~~contracts

[Not shown: no changes to Rule 11.8.1.]

11.8.2 The Secretary of State will approve a political subdivision's application to purchase, lease, or use the voting system, device, or related component, after considering all relevant factors, including without limitation:

[Not shown: no changes to sections (a) through (e).]

(f) The voting system's compatibility with dependent systems that are not directly related to the tabulation of votes and ballots, but are nevertheless utilized by designated election officials in conducting elections in Colorado, including:

(1) Ballot-on-demand systems,

(2) Election Night Reporting systems,

(3) Electronic ballot delivery systems,

(4) Election definition data exported from SCORE~~.~~, and

(5) The Secretary of State's RLA software~~.~~;

[Not shown: no changes to sections (g) through (q).]

[Not shown: no changes to Rules 11.8.3 through 11.8.7.]

Amendments to Rule 11.9:

11.9 Election Night Reporting. The county must use the Secretary of State's Election Night Reporting (ENR) system to report results for all primary, general, coordinated, and recall elections in accordance with this Rule.

[Not shown: no changes to Rule 11.9.1.]

New Rule 11.9.2 concerning a requirement that a county clerk must provide data to the voting systems team in advance of an election:

11.9.2 NO LATER THAN 45 DAYS BEFORE THE ELECTION, A COUNTY CLERK MUST PROVIDE THEIR SCORE ELECTION_DETAILS_TO_DOMINION EXPORT TO THE SECRETARY OF STATE'S OFFICE BY SENDING AN EMAIL TO VOTING.SYSTEMS@COLORADOSOS.GOV.

[Not shown: current Rule 11.9.2 renumbered to Rule 11.9.3.]

Amendments to current Rule 11.9.3 requiring a county to check the totals and content configuration reflected on the ENR website after uploading their LAT results file and necessary renumbering:

~~11.9.3~~11.9.4 No later than 21 days before the election, a data entry county must upload the LAT results file to ENR. At a minimum, the LAT results file must contain the results of the complete county test deck required under Rule 11.3.2(c)(1). THE COUNTY MUST CHECK THE TOTALS AND CONTENT CONFIGURATION REFLECTED ON THE ENR WEBSITE AT THE TIME OF UPLOADING THE LAT RESULTS FILE. THE COUNTY MUST SEND AN EMAIL TO VOTING.SYSTEMS@COLORADOSOS.GOV ONCE VERIFICATION OF THE ENR WEBSITE IS COMPLETE.

[Not shown: current Rules 11.9.4 through 11.9.6 are renumbered to Rules 11.9.5 through 11.9.7.]

Amendments to Rule 13:

Amendments to Rule 13.1.3 concerning the Department's processing and docketing of election complaints:

13.1.3 Processing and docketing election complaints

(a) Within three business days of receiving a complaint, the Secretary's designee will review the complaint to determine if it satisfies Rule 13.1.2 and sufficiently alleges a violation of the Uniform Election Code of 1992. THE SECRETARY'S DESIGNEE MAY EXTEND THIS DEADLINE IN THE EVENT THAT THERE ARE EXTENUATING CIRCUMSTANCES WHICH WOULD INHIBIT THE DESIGNEE'S ABILITY TO MEET THE DEADLINE.

[Not shown: no changes to section (1).]

(2) If a complaint meets the criteria, the Secretary's designee will ~~assign a complaint number,~~ notify the complainant, and send a copy of the complaint to the person or entity alleged to have committed a violation.

[Not shown: no changes to section (b).]

Amendments to Rule 13.2.9 concerning a grammatical change:

13.2.9 Hearing and ~~R~~Resolution of HAVA complaints

[Not shown: no changes to sections (a) and (b).]

Amendments to Rule 13.2.10 updating the complaint process for a HAVA complaint from the Office of Administrative Courts to a hearing officer and grammatical changes:

13.2.10 Alternative ~~D~~Dispute ~~R~~Resolution under section 1-1.5-105(2)(j), C.R.S.

(a) If the Secretary of State does not resolve the complaint within 90 days of the date that it was filed and the complainant does not consent to an extension of time, the Secretary of State will transfer the complaint to A HEARING OFFICER ~~the Office of Administrative Courts (OAC)~~.

(b) The Secretary of State will provide the record and any other materials from the proceedings to the ~~OAC~~ HEARING OFFICER.

(c) The Secretary of State will consider the initial determination by the ~~OAC~~ HEARING OFFICER and issue a final determination within 60 days of the date the determination is received by the Secretary.

Amendments to Rule 15.1.2 concerning the review of petition submissions which do not include required information and technical changes:

15.1.2 Petition submission

(a) The ~~Secretary~~ DEPARTMENT of State or DEO will not accept or count additional signatures after the initial submission of the petition, even if additional signatures are offered before the deadline.

(b) The ~~Secretary~~ DEPARTMENT of State or DEO will inspect each petition section for evidence of disassembly. If it appears that the section was disassembled, the Secretary or DEO will reject all signatures in the section.

(c) The ~~Secretary~~ DEPARTMENT of State or DEO will NOT consider ~~any~~ A signer line ~~with writing on it~~ as a reviewable line, ~~even~~ if the line is incomplete or partially crossed out AND THE INFORMATION MISSING OR CROSSED OUT IS THE NAME, SIGNATURE, OR ADDRESS OF THE SIGNER.

(d) The ~~Secretary~~ DEPARTMENT of State or DEO will not review lines that are blank or completely crossed-out.

Amendments to section (e) concerning a technical error and change:

~~(~~(e) If the number of lines submitted is less than the number of signatures required to access the ballot, the ~~Secretary~~ DEPARTMENT of State or DEO will issue a statement of insufficiency and will not review signer lines or apply duplicates to future candidate petition submissions for the same office or recall petitions of the same officeholder.

Amendments to section (f) concerning a technical change:

(f) The ~~Secretary~~ DEPARTMENT of State or DEO will review and process candidate petitions for the same office in the order in which they are received.

Amendments to Rule 15.1.4(c) for grammatical consistency within these rules:

15.1.4 Verifying individual entries

[Not shown: no changes to sections (a) and (b).]

(c) If an entry does not match the ~~signor's~~ SIGNER'S current information in SCORE, staff must check the ~~signor's~~ SIGNER'S information in SCORE as of the date the ~~signor~~ SIGNER signed the petition.

Amendments to Rule 15.1.4(d) concerning standards for the rejection of a signature on an initiative petition and technical changes:

(d) Secretary of State or DEO staff will reject the entry if:

[Not shown: no changes to subsections (1) through (9).]

(10) The entry is a duplicate of a previously accepted entry on the same petition; ~~or~~

(11) For a candidate petition where an elector may sign only one petition for the same office, the entry is a duplicate of a previously accepted entry on a petition that was declared sufficient or insufficient after lines were reviewed for the same office; ~~.~~

(12) The signer's information appears outside of a numbered signature block on a petition section; ~~.~~

(13) For a candidate petition, the address on the entry does not match the current residential or mailing address for the elector in SCORE ~~.~~; OR

(14) FOR AN INITIATIVE PETITION, A NAME SUFFIX IS PRESENT ON THE ENTRY BUT NOT IN SCORE, OR PRESENT IN SCORE BUT NOT ON THE ENTRY, AND MORE THAN ONE PERSON WITH THAT NAME IS REGISTERED TO VOTE AT THE SAME ADDRESS.

Amendments to Rule 15.1.4(e) concerning standards for the review of petitions, necessary renumbering, and grammatical changes:

(e) ~~Secretary~~ THE DEPARTMENT of State or DEO staff will not use any of the following discrepancies as the sole reason to reject an entry:

(1) The name on an entry matches or is substantially similar to the information in SCORE, or if the signature on an entry is a common variant of the name;

(2) A middle initial or middle name is present on the entry but not in SCORE, or present in SCORE but not on the entry;

(3) A name suffix is present on the entry but not in SCORE, or present in SCORE but not on the entry AND ONLY ONE PERSON WITH THAT NAME IS REGISTERED TO VOTE AT THAT ADDRESS;

(4) FOR A CANDIDATE PETITION, A NAME SUFFIX IS PRESENT ON THE ENTRY BUT NOT IN SCORE, OR PRESENT IN SCORE BUT NOT ON THE ENTRY, MORE THAN ONE PERSON WITH THAT NAME IS REGISTERED TO VOTE AT THE SAME ADDRESS, BUT THE SIGNATURE MATCHES FOR ONE PERSON REGISTERED TO VOTE AT THAT ADDRESS;

~~(4)~~(5) The printed name is missing or illegible but the signature can be read;

~~(5)~~(6) The address on the entry is missing an apartment letter or number or a street direction, or the address entry contains an apartment letter or number or a street direction that is missing in the voter registration record;

~~(6)~~(7) The CITY OR county name is missing, abbreviated, or wrong;

~~(7)~~(8) For candidate and recall petitions, the address provided did not match the current residence address information in SCORE, but did match the current mailing address information in SCORE;

~~(8)~~(9) On a signer line, the date is missing but a line above and below has an acceptable date; ~~or~~

~~(9)~~(10) For Secretary of State STAFF reviewed petitions only, the year of the date is missing or wrong; OR~~.~~

(11) INFORMATION REQUIRED FOR THE SIGNER IS PRESENT ON A PETITION LINE BUT IS WRITTEN IN THE WRONG FIELD.

Amendments to Rule 15.2.1 concerning the information to be included on a petition entity's license application and necessary renumbering:

15.2 Petition entity license, registration, filing, and circulation

15.2.1 A petition entity that intends to pay petition circulators must obtain a petition entity license, pay a fee, and register with the Secretary of State's OFFICE before circulating initiative, candidate, and recall petitions. The license application must include:

(a) The petition entity's name, address, telephone number, and email address;

(b) The designated agent's name;

(c) The name of all owners and chief officers of the entity;

(D) FOR THOSE APPLICATIONS SUBMITTED AFTER DECEMBER 31, 2024, THE FOLLOWING INFORMATION REGARDING PETITION CIRCULATORS:

(1) THE NAME, ADDRESS, AND SIGNATURE OF ANY PETITION CIRCULATORS THE ENTITY HAS HIRED OR CONTRACTED WITH TO CIRCULATE A PETITION IN COLORADO; AND

(2) THE PETITIONS EACH CIRCULATOR WILL CIRCULATE IN COLORADO; and

~~(d)~~(E) An affirmation that:

(1) The designated agent has read and understands Article 4, Article 12, and Article 40 of Title 1, C.R.S.;

(2) The designated agent has completed the Secretary of State's circulator training program AND WILL COMPLETE THE TRAINING BEFORE REGISTERING THE ENTITY TO CIRCULATE ANY PETITION IN COLORADO;

(3) THE PETITION ENTITY HAS OR WILL PROVIDE TO ALL CIRCULATORS, PAID OR UNPAID, THE CIRCULATOR TRAINING OFFERED BY THE COLORADO SECRETARY OF STATE AS ONE WAY FOR THE CIRCULATOR TO COMPLY WITH THE REQUIREMENT THAT A CIRCULATOR READ AND UNDERSTAND THE LAWS PERTAINING TO PETITION CIRCULATION; ~~and~~

~~(3)~~(4) The entity, ~~and~~ none of its owners or chief officers, AND NO ENTITY OR PRINCIPAL OF A PETITION ENTITY THAT THE ENTITY HAS OR WILL CONTRACT WITH, has ever been found in a judicial or administrative hearing in Colorado or any other state of authorizing or knowingly permitting:

(A) Forgery of a registered elector's signature;

(B) Circulation of a petition section, in whole or in part, by anyone other than the circulator;

(C) Use of a false circulator name or address in a circulator affidavit;

(D) Payment of money or a thing of value to any person for the purpose of inducing the person to sign or withdraw his or her name from a petition; or

(E) A notary public's notarization of a circulator affidavit outside of the physical presence of the circulator or without the production of the required identification for notarization of a petition section.; AND

(5) NEITHER THE ENTITY NOR ITS OWNERS OR OFFICERS HAVE BEEN FOUND IN A JUDICIAL OR ADMINISTRATIVE HEARING IN COLORADO OR ANY OTHER STATE OF:

(A) VIOLATING A PETITION LAW;

(B) COMMITTING ELECTION FRAUD;

(C) COMMITTING ANY OTHER ELECTION OFFENSE; OR

(D) COMMITTING AN OFFENSE WITH AN ELEMENT OF FRAUD.

Amendments to Rule 15.2.2 requiring the completion of the Department's circulator training program after license application but before the registration of a petition:

15.2.2 Before compensating a circulator, the designated agent must register with the Secretary of State's OFFICE by submitting a signed form that includes a list of the proposed initiatives and/or the candidate or candidate committee's name the petition entity will circulate. A DESIGNATED AGENT MUST COMPLETE THE SECRETARY OF STATE'S CIRCULATOR TRAINING PROGRAM AFTER APPLYING FOR A LICENSE AND PRIOR TO REGISTERING A PETITION ENTITY TO CIRCULATE ANY PETITION.

[Not shown: no changes to Rules 15.2.3 and 15.2.4.]

New Rule 15.2.5 clarifies that petition entity licenses expire after two years and require a new license application and fee after expiration:

15.2.5 BEGINNING JANUARY 1, 2024, A PETITION ENTITY LICENSE IS ONLY VALID FOR TWO YEARS FROM THE DATE THE LICENSE WAS APPROVED BY THE SECRETARY OF STATE. ONCE A LICENSE EXPIRES, A PETITION ENTITY MUST SUBMIT A NEW LICENSE APPLICATION AND FEE.

New Rule 15.2.6 clarifies when a petition entity must update their entity license in accordance with sections 1-4-905.5(4)(a) and 1-40-135(5)(a), C.R.S.:

15.2.6 IN ACCORDANCE WITH SECTIONS 1-4-905.5(4)(A) AND 1-40-135(5)(A), C.R.S., A PETITION ENTITY MUST UPDATE THEIR ENTITY LICENSE NO LATER THAN 20 DAYS AFTER A CHANGE TO ANY INFORMATION PROVIDED IN THEIR INITIAL APPLICATION.

Amendments to Rule 15.3.2 concerning technical revisions that reflect current Colorado law and grammatical changes:

15.3.2 The petition circulator must provide a permanent residence address on the circulator affidavit.

(a) For purposes of Article 40 of Title 1, C.R.S., and this Rule, a circulator's permanent "residence" ~~or "domicile"~~ means ~~his or her~~ THEIR principal or primary home or place of abode in which a circulator's habitation is fixed and to which the circulator, whenever absent, has the present intention of returning after a departure or absence, regardless of the duration of the absence. A permanent "residence" ~~or "domicile"~~ is a permanent building or part of a building and may include a house, condominium, apartment, room in house, or mobile home. Except as provided in paragraph (b) of this Rule, a vacant lot, business address, or post office box is not a permanent "residence" ~~or "domicile"~~.

(b) A homeless circulator must provide the address or location where ~~he or she is~~ THEY ARE living the date the affidavit is signed. The circulator must provide a physical location THEY RETURN TO REGULARLY WHICH MAY INCLUDE A PARK, CAMPGROUND, VACANT LOT, BUSINESS ADDRESS OR ANY OTHER PHYSICAL LOCATION; a post office box may not be provided.

[Not shown: no changes to section (c).]

Amendments to Rule 15.4.1 concerning technical revisions to the approval process for statewide initiative petitions:

15.4.1 The ~~Secretary~~ DEPARTMENT of State will not accept a petition that lists ~~proponents~~ DESIGNATED REPRESENTATIVES other than those ~~authorized by law~~ LISTED ON THE AFFIDAVIT OF DESIGNATED REPRESENTATIVES FILED WITH THE STATE TITLE BOARD.

Amendments to Rule 15.5.1 concerning technical changes to the verification by random sample in accordance with section 1-40-116, C.R.S.:

15.5 Statewide initiative petition verification

15.5.1 Verification by random sample.

[Not shown: no changes to section (a).]

(b) The database will generate a series of random numbers equal to 4,000 signatures or five percent of the total number of signatures, whichever is greater. Staff will ~~check the validity of the random signatures in accordance with this Rule~~ REVIEW THE RANDOMLY SELECTED SIGNATURE LINES IN ACCORDANCE WITH SECTION 1-40-116, C.R.S., AND THIS RULE. Staff will maintain a master record of each accepted and rejected entry, along with the reason code for each rejected entry.

Amendments to Rule 15.6.1 concerning the review of signatures on state candidate and recall petitions and technical changes:

15.6.1 The ~~Secretary~~ DEPARTMENT of State will compare the signature on each petition entry with the elector's signature in SCORE in accordance with the Secretary of State's Signature Verification Guide. The Secretary of State may use an automated signature verification device.

(a) If the signatures match and the entry is otherwise valid, the ~~Secretary~~ DEPARTMENT of State must accept the entry.

(b) If upon initial review the signatures do not match, The ~~Secretary~~ DEPARTMENT of State must conduct further review of the entry. A team of two staff members who are not affiliated with the same political party, OR WHO ARE UNAFFILIATED, must review the signatures, conduct additional research in SCORE if necessary, and, unless both staff members agree that the signatures do not match, accept the entry if it is otherwise valid. IN THE EVENT THAT A STAFF MEMBER IS NOT REGISTERED TO VOTE, THAT STAFF MEMBER WILL BE CONSIDERED UNAFFILIATED FOR THE PURPOSE OF THIS RULE.

Amendments to Rule 15.7.4 concerning stylistic changes:

15.7.4 Each referendum petition section must consist of the following, in the order listed:

(a) The warning as specified in section 1-40-110, C.R.S.;

(b) The heading "Referendum Petition",~~"~~ followed by the demand upon the Secretary of State in substantially the following form, in which the underlined material is only for example:

"To: The Honorable _____, Secretary of State of the State of Colorado

We, the undersigned electors of the State of Colorado, do hereby respectfully petition, order, and demand that Sections 1 to 12, inclusive (being the entire Act), of House Bill No. 02-1010, by Representatives Abel, Baker, and Cain, and

Senators Smith, Thomas, and Jones, entitled "Concerning registration requirements for motor vehicles, and, in connection therewith, authorizing two- and five-year registration periods and authorizing discretionary vehicle identification number inspections, and making an appropriation", passed by the Sixty-third General Assembly of the State of Colorado, at its regular session in the year 2002,shall be submitted to the voters for their adoption or rejection at the next biennial regular general election, to be held on Tuesday, the ~~5th~~ 5TH day of November, 2002, and each of the signers of this petition says:

I sign this petition in my own proper person only, and I am a registered elector of the State of Colorado, my residence address and the date of my signing this petition are correctly written immediately after my name, and I do hereby designate the following persons to represent me in all matters affecting this petition:";

(c) The name and mailing address of two persons who are designated to represent the signers thereof in all matters;~~.~~

(d) The ballot title and submission clause;~~.~~

(e) The text of the Act, or the item, section, or part of the Act, on which the referendum is demanded;~~.~~

(f) Succeeding pages that each contain the warning, the ballot title, and submission clause, and ruled lines numbered consecutively for signatures; AND~~.~~

(g) A final page that contains the circulator's affidavit required by section 1-40-111(2), C.R.S.

Amendments to Rule 16:

Amendments to Rule 16.1 concerning a stylistic change:

16.1 ~~General Rules concerning v~~Voting by military and overseas electors

Amendments to Rule 16.1.6 concerning county communication with UOCAVA electors:

16.1.6 The county clerk must send a minimum of one correspondence no later than 60 days before the first primary OR COORDINATED election ~~in an even numbered~~ EACH year to each ~~elector whose record is marked "Inactive~~ COVERED VOTER.~~"~~ The correspondence may be sent by email or mail and, at a minimum, must notify the electors of:

(a) The status of the elector's record and ballot request;

(b) The upcoming federal AND STATE elections;

(c) How to update the elector's mailing information and request a ballot; and

(d) Any other information the county clerk deems appropriate.

New Rule 16.2.5 regarding transmitting a mail ballot packet to a covered voter who has already received a ballot by fax or email:

16.2.5 A COUNTY CLERK THAT HAS SUCCESSFULLY TRANSMITTED A BALLOT PACKET TO A COVERED VOTER BY FAX OR EMAIL MAY NOT SEPARATELY MAIL THAT ELECTOR A BALLOT UNLESS LATER REQUESTED BY THAT ELECTOR, OR AS A RESULT OF A CHANGE OF THAT VOTER'S STATUS.

[Not shown: current Rules 16.2.5 through 16.2.8 are renumbered to Rules 16.2.6 through 16.2.9.]

Amendments to Rule 17:

Amendments to Rule 17.5 concerning technical changes:

17.5 Processing provisional ballot affidavits in the SCORE. Before closing an election, the county clerk must:

17.5.1 Enter all provisional ballot affidavits into the SCORE provisional module;~~.~~

17.5.2 Process all voter registration updates; AND~~.~~

17.5.3 Link all provisional ballot affidavits to the appropriate elector's record.

Amendments to Rule 18:

Repeal of Rule 18.3 and Rule 18.3.1 due to this technology no longer being in use in Colorado:

~~18.3 Standards for counting paper ballots on ballot scanners~~

~~18.3.1 Procedures for counting paper ballots on ballot scanners at polling locations~~

~~(a) To the extent permitted by its voting system, the county must program ballot scanners to sort ballots with write-in votes to a segregated bin of the ballot box or digital media and to initially reject blank ballots and ballots with overvotes.~~

~~(b) Voters whose ballots are initially rejected by a ballot scanner as a blank or overvoted ballot must be given the opportunity to review and correct their ballot. If after review, a voter requests to submit the blank or overvoted ballot as originally marked, an election judge must assist the voter by overriding the initial rejection setting on the ballot scanner.~~

~~(c) At the conclusion of voting, ballots with write-in votes must be delivered to the central count location in a secure container for resolution in accordance with Rule 18.5.3.~~

Amendments to Rule 18.3.2 including the recodification to Rule 18, necessary renumbering, and removing language which no longer applies to Colorado voting system components:

~~18.3.2~~18.3 Procedures for counting paper ballots on ballot scanners at central count locations

~~(a)~~18.3.1 Before tabulation, a resolution board must duplicate damaged ballots, and may duplicate ballots with marks that may identify the voter, in accordance with Rule 18.4. Election judges may visually inspect every ballot for the limited purpose of segregating damaged ballots and ballots with marks that may identify the voter.

~~(b)~~18.3.2 A county must sort ballots requiring resolution according to the capabilities of its voting system.

~~(1)~~ If a county's voting system supports digital ballot resolution, the county must program the voting system to digitally queue for resolution blank ballots, ballots with write-in votes, and ballots with overvotes. Ballots with marginal or ambiguous markings must be sorted according to the system provider's specifications, or, if different, the applicable Conditions of Use issued by the Secretary of State. The

digitally queued ballots must be resolved by election judges in accordance with Rule 18.5.

~~(2) If a county's voting system does not support digital ballot resolution, the county must program the central count ballot scanners to reject or sort blank ballots and ballots with overvotes, and to sort ballots with write-in votes. The resolution board must resolve all ballots initially rejected and sorted by the central count ballot scanners in accordance with Rule 18.5.~~

~~(c)~~18.3.3 A resolution board must resolve ballots sorted or rejected for resolution.

~~(1)~~(A) In partisan elections, a resolution board must consist of at least two election judges affiliated with different major political parties.

~~(2)~~(B) In nonpartisan elections, a resolution board must consist of at least two election judges.

~~(3) In counties with a voting system that does not support digital resolution, the county must have at least one resolution board.~~

~~(4)~~(C) ~~In counties with a voting system that supports digital resolution, a~~ A resolution board must work at each resolution workstation.

~~(5)~~(D) The members of a resolution board for an election may change, but all members of the resolution board at any particular time must satisfy the eligibility requirements specified in ~~this~~ Rule ~~18.3.2(c)~~ 18.3.3.

Amendments to Rule 18.4 concerning a stylistic change:

18.4 Ballot ~~D~~Duplication

Amendments to Rule 18.4.1 due to the passage of SB23-276 requiring a county clerk to review of the duplication process of ballots with a separate team of two election judges:

18.4.1 A resolution board must duplicate a voter's choices or selections on a damaged ballot onto a blank ballot of the same ballot style in accordance with Rule 18.4. During the duplication process, and to the extent necessary, the resolution board must also resolve overvotes, write-in votes, and ambiguous markings in accordance with Rule 18.5. ~~During ballot duplication, two election judges must observe or review the work of each resolution board. In a partisan election, the observing election judges must be representatives of each major political party~~ THE COUNTY CLERK MUST PERIODICALLY REVIEW DUPLICATED BALLOTS WITH A SEPARATE TEAM OF TWO ELECTION JUDGES TO ENSURE DUPLICATION IS BEING CONDUCTED CONSISTENT WITH THE LAW AND RULE 18.4.

[Not shown: no changes to Rules 18.4.2 through Rules 18.4.5.]

New Rule 18.4.6 regarding the organization of ballots which have been duplicated by a county clerk:

18.4.6 A COUNTY CLERK MUST BATCH DUPLICATED BALLOTS SEPARATELY FROM ALL OTHER BALLOTS.

[Not shown: current Rule 18.4.6 is renumbered to Rule 18.4.7.]

Amendments to Rule 18.5 concerning a stylistic change:

18.5 Ballot ~~R~~Resolution

[Not shown: no changes to Rule 18.5.1.]

Amendments to Rule 18.5.2 removing requirements which no longer apply to voting system components used in Colorado and technical changes for clarity:

18.5.2 Resolution of blank ballots.

(A) A resolution board must examine blank ballots to determine if the ballot is a true blank ballot or one that has been marked in a manner or medium that was not detected by the voting system.

~~(a) Counties without digital resolution capability. If the ballot is truly blank, the resolution board must re-scan the ballot and override the initial rejection setting. If the ballot is marked in a manner or medium that can be discerned by the resolution board but cannot be tabulated by the voting system, the resolution board must duplicate the ballot in accordance with Rule 18.4 and, to the extent necessary, resolve the ballot in accordance with Rule 18.5.~~

(b) ~~Counties with digital resolution capability.~~ If the ballot is truly blank, the resolution board must record the ballot as a blank ballot in the voting system's resolution application.

(C) If the ballot is marked in a manner or medium that can be discerned by the resolution board but cannot be tabulated by the voting system, the resolution board must resolve the ballot in the voting system's resolution application in accordance with Rules 18.5.2(b) and 18.5.3.

Amendments to Rule 18.5.3(c) removing outdated language to the digital adjudication process:

18.5.3 Resolution of write-in votes

[Not shown: no changes to sections (a) and (b).]

(c) In counties using voting systems that ~~do not have digital resolution capability, or the digital resolution feature is~~ ARE not capable of detecting voter markings on or in a write-in line or area if the corresponding target area is not also marked, and if the voter does not mark any other target area in a particular contest, the resolution board must count as valid votes for eligible write-in candidates those instances in which the voter both marks the applicable target area and writes in the name of a certified write-in candidate. During any recount, if the number of undervotes in a ballot contest could change the outcome if attributed to an eligible write-in candidate, votes for that candidate must be counted whether or not the target area designating the selection of a write-in candidate has been marked, provided that the number of candidates chosen does not exceed the number permitted in that office.

Amendments to Rule 19:

Amendments to Rule 19.1.3 updating the definition of "persons required to complete certification" due to the passage of SB22-153:

19.1.3 "Persons required to complete certification" means:

(a) The county clerk; ~~and~~

(b) Employees in the county clerk's office who are directly responsible for overseeing election activities, including but not limited to: voter registration, candidate qualifications and ballot certification, poll worker training, ballot design and setup, ballot counting, and canvassing~~.~~;

(C) OTHER EMPLOYEES IN THE CLERK AND RECORDER'S OFFICE AT THE DISCRETION OF THE CLERK AND RECORDER;

(D) A DESIGNATED ELECTION OFFICIAL FOR A COUNTY AND A COORDINATED ELECTION OFFICIAL FOR A COUNTY; AND

(E) EMPLOYEES IN THE ELECTIONS DIVISION OF THE DEPARTMENT OF STATE AT THE DISCRETION OF THE SECRETARY OF STATE.

~~(Section 1-1-302, C.R.S.)~~

Amendments to Rule 19.3.4 requiring that in-person certification training must be completed every two years:

19.3.4 To maintain Colorado certification, a person must complete at least four Continuing Elections Education courses by July 31 of every year and complete at least one in-person class every ~~four~~ TWO years.

Amendments to Rule 20:

Amendments to Rule 20.2.2 concerning background checks for election judges:

20.2.2 The county clerk must perform a background check FOR ALL ELECTION JUDGES. IN ACCORDANCE WITH SECTION 1-6-101, C.R.S., AN INDIVIDUAL CONVICTED OF ELECTION FRAUD, ANY OTHER ELECTION OFFENSE, OR FRAUD MAY NOT SERVE AS AN ELECTION JUDGE.~~in accordance with this Rule for each election judge if the judge requires access to:~~

~~(a) The statewide voter registration database;~~

~~(b) Elector's confidential or personally identifiable information; or~~

~~(c) Voter registration applications or other list maintenance activities.~~

Amendments to Rule 20.4.2 concerning the surveillance of secure areas due to the passage of SB22-153:

20.4.2 Surveillance of secure areas

(a) The county clerk must make video security surveillance recordings of secure equipment areas, as defined by Rule 1.1.49, ~~beginning at least 60 days before election day and continuing uninterrupted through at least 30 days after election day. If a recount or contest occurs, the recording must continue through the conclusion of all related activity~~ IN ACCORDANCE WITH THE REQUIREMENTS OF SECTION 1-7-513.5, C.R.S.

(b) The county clerk of a county with 50,000 or more registered voters must also make video security surveillance recordings of secure ballot areas, as defined by Rule 1.1.48, IF THOSE AREAS DO NOT CONTAIN ANY COMPONENTS OF A VOTING SYSTEM, beginning at least 35 days before election day and continuing uninterrupted through at least 30 days after election day. If a recount or contest occurs, the recording must continue through the conclusion of all related activity.

[Not shown: no changes to sections (c) and (d).]

New Rule 20.4.2(e) concerning planned maintenance of video surveillance systems:

(E) PLANNED MAINTENANCE OF VIDEO SURVEILLANCE

(1) IF NECESSITY REQUIRES IT, A COUNTY CLERK MAY TEMPORARILY CEASE VIDEO SURVEILLANCE OF VOTING SYSTEM COMPONENTS OR OTHER AREAS FOR PLANNED MAINTENANCE OF THE VIDEO SURVEILLANCE SYSTEM, BUT ONLY FOR SO LONG AS THE INTERRUPTION OF SURVEILLANCE IS REQUIRED.

(2) BEFORE THE PLANNED OUTAGE, THE COUNTY CLERK MUST NOTIFY AND SUBMIT DETAILED PLANS TO THE SECRETARY OF STATE WHICH DESCRIBE SECURITY MEASURES THE CLERK WILL TAKE TO ENSURE THE SECURITY OF THE VOTING SYSTEM COMPONENTS OR AREAS DURING THE PLANNED OUTAGE.

(3) AFTER REVIEW OF THE PLANS, THE SECRETARY OF STATE MAY REQUIRE A COUNTY CLERK TO TAKE ADDITIONAL OR DIFFERENT ACTIONS TO ENSURE THE SECURITY OF VOTING SYSTEM COMPONENTS OR AREAS DURING THE PLANNED OUTAGE.

Amendments to Rule 20.4.3 concerning access logs to secure areas and necessary renumbering and stylistic changes:

20.4.3 Access logs to secure areas

~~(a)~~ THE COUNTY CLERK MUST MAINTAIN A LOG OF EACH PERSON WHO ENTERS A LOCATION WHICH CONTAINS COMPONENTS OF A VOTING SYSTEM IN ACCORDANCE WITH THE REQUIREMENTS OF SECTION 1-7-513.5, C.R.S.

(B) The county clerk must OTHERWISE maintain a log of each person who enters a secure ballot area, as defined by Rule 1.1.48, IF THAT AREA DOES NOT CONTAIN ANY COMPONENTS OF A VOTING SYSTEM ~~or secure equipment area, as defined by Rule 1.1.49~~. This does not include members of the public who access areas of a county clerk's office that are regularly available to the public outside of an election.

[Not shown: sections (b) and (c) are recodified to sections (c) and (d).]

Amendments to Rule 20.5.2(c)(3) concerning election judges accessing the voting system under a single user account:

20.5.2 Accessing the voting system

[Not shown: no changes to sections (a) and (b).]

(c) Accounts and passwords

[Not shown: no changes to subsections (1) and (2).]

(3) The county clerk must create individual user accounts that are associated and identified with each individual authorized user of the operating system of the voting system, election management system, or election project. IF A PARTICULAR ELECTION ACTIVITY REQUIRES TWO ELECTION JUDGES TO INTERACT WITH A VOTING SYSTEM ON THE SAME ACTIVITY, THEN THE COUNTY MAY ASSIGN A SINGLE USER ACCOUNT TO BOTH ELECTION JUDGES FOR THAT

ACTIVITY. BOTH ELECTION JUDGES MUST STILL COMPLY WITH THE LOG REQUIREMENTS OF RULE 20.5.2(D).

[Not shown: no changes to section (d).]

Amendments to Rule 20.5.4 concerning the transportation of voting system components and necessary renumbering:

20.5.4 Transporting voting system

(a) The county clerk must submit detailed plans to the Secretary of State before ~~an election regarding~~ the transportation of voting system components FROM A COUNTY ELECTION FACILITY TO ANOTHER LOCATION, INCLUDING A VOTER SERVICE AND POLLING CENTER ~~to remote voting sites and back to the central elections office or storage facility~~. AFTER REVIEW OF THE PLANS, THE SECRETARY OF STATE MAY REQUIRE A COUNTY CLERK TO TAKE ADDITIONAL OR DIFFERENT ACTIONS TO ENSURE THE SECURITY OF VOTING SYSTEM COMPONENTS DURING TRANSIT.

(b) During or after transportation, if there is any evidence of possible tampering with a seal, or if the seal numbers do not match those listed in the chain-of-custody log, the county clerk must be immediately notified and must file an incident report required by Rule 20.12.2(a).

(C) VOTING SYSTEM COMPONENTS ARE NOT REQUIRED TO BE UNDER VIDEO SECURITY SURVEILLANCE WHILE IN TRANSIT. IN THE PLAN REQUIRED BY RULE 20.5.4(A), THE COUNTY CLERK MUST DESCRIBE HOW THEY WILL MAINTAIN BI-PARTISAN CHAIN-OF-CUSTODY WHILE THE COMPONENTS ARE NOT UNDER VIDEO SURVEILLANCE.

(D) PERSONNEL REQUIREMENTS FOR TRANSPORTATION

~~(c)~~(1) Transportation by county personnel

~~(1)~~(A) County personnel must at all times display identification provided by the county.

~~(2)~~(B) Two employee signatures and the date are required at the departure location verifying that the equipment is sealed to detect tampering. Upon delivery of equipment, at least two election officials must verify, and indicate by signing and dating the chain-of-custody log, that all seals are intact and that the seal numbers match the logged seal numbers.

~~(d)~~(2) Transportation by election judges

~~(1)~~(A) Two election judges of different party affiliations that are receiving or transporting equipment must inspect all voting devices and verify the specific seal numbers by signature and date on the chain-of-custody log for the device.

~~(e)~~(3) Transportation by contract

~~(1)~~(A) If a county clerk contracts for the delivery of equipment ~~to remote voting locations~~, each individual delivering equipment must successfully pass a criminal background check as required by Rule 20.2.1.

~~(2)~~(B) Two election officials must verify the specific seal numbers by device, sign, and date the chain-of-custody log upon release of the equipment to the individuals delivering the equipment. If the equipment is delivered by a truck capable of being locked by using a padlock or other similar device from the outside, the county clerk must provide a lock for the truck to be used during delivery. The county clerk must maintain the key or combination to the lock to be used to open the truck upon delivery. Upon delivery of equipment, at least two election officials must verify, and indicate by signing and dating the chain-of-custody log, that all seals are intact and that the seal numbers match the logged seal numbers.

~~(3)~~(C) A county clerk must require a contractor to deliver equipment ~~to a remote location~~ on the day the equipment is picked up from the county clerk.

Amendments to Rule 20.6 specifying the trusted build procedures at a county:

20.6 Trusted build procedures AT A COUNTY

Amendments to Rule 20.6.2(a) concerning attendance at a trusted build:

20.6.2 Attendance at trusted build

(a) The only individuals who may be present at a trusted build in a county include:

(1) Secretary of State staff, designees of the Secretary of State, or other individuals approved by the Secretary of State;

(2) Voting system vendor staff for the voting system for which trusted build is being installed. AT LEAST ONE INDIVIDUAL LISTED IN RULE 20.6.2(A)(2) MUST BE PRESENT DURING THE TRUSTED BUILD, UNLESS EXEMPTED BY THE DEPARTMENT OF STATE; and

[Not shown: no changes to subsection (3).]

[Not shown: no changes to sections (b) through (e).]

Amendments to Rule 20.9.2(a)(4) concerning ballot-on-demand and mobile ballot production printers:

20.9.2 Ballot-on-demand and mobile ballot production printers

(a) Software access, security, and storage

[Not shown: no changes to subsections (1) through (3).]

(4) The county clerk must store the ballot-on-demand and mobile ballot production printer, laptop, and unused paper ballot stock in a locked storage area WHICH IS ACCESSIBLE ONLY TO ELECTION OFFICIALS when the printer is not in use.

[Not shown: no changes to subsection (5).]

Amendments to Rule 20.11.1 concerning new section (f) that requires a county clerk to develop a contingency plan in cases of an unexpected outage of required video surveillance:

20.11.1 Contingency plans

[Not shown: no changes to sections (a) through (e).]

(f) THE COUNTY CLERK MUST DEVELOP CONTINGENCY PLANS WHICH ADDRESS AN UNEXPECTED OUTAGE OF ANY REQUIRED VIDEO SURVEILLANCE. THE PLAN MUST INCLUDE REGULAR INTERVALS AT WHICH THE COUNTY WILL CONFIRM THAT ALL REQUIRED VIDEO SURVEILLANCE IS OPERATIONAL.

Amendments to Rule 21:

Amendments to Rule 21.1.3 to clarify the exemption of some counties to use paper ballot tabulation devices after the passage of SB22-153:

21.1.3 The certification of a voting system is not a requirement that a county purchase or lease all of the components of the voting system. Counties may choose to configure and use a subset of the certified voting system and may use the services of a vendor or third party to provide ballot definition and election programming of memory cards. Counties are not required to use a paper ballot tabulation device if they ARE EXEMPTED BY LAW AND choose to manually tabulate the election results.

New Rule 21.1.4 concerning notification requirements for certification or modification applications:

21.1.4 A VOTING SYSTEM VENDOR APPLYING FOR CERTIFICATION OR MODIFICATION MUST NOTIFY THE SECRETARY OF STATE AT THE TIME OF APPLICATION IF ANY COMPONENT PREVIOUSLY CERTIFIED FOR USE IN COLORADO IS NOT INCLUDED IN THE APPLICATION FOR CERTIFICATION OR MODIFICATION.

Amendments to Rule 21.2 concerning stylistic changes:

21.2 Certification ~~P~~Process ~~O~~Overview and ~~T~~Timeline

[Not shown: no changes to Rule 21.2.1.]

Amendments to Rule 21.2.2 concerning the certification process of a voting system:

21.2.2 For a voting system to be certified, the voting system provider must successfully complete all phases of the certification process. The certification process includes: submission of a complete application, a documentation review, a public demonstration of the system, ~~and~~ functional testing, AND ESCROW OF STATE CERTIFIED ELECTION SOFTWARE.

Amendments to Rule 21.2.3 concerning each phase of certification and updated requirements:

21.2.3 The flow of each phase of certification is as follows:

[Not shown: no changes to sections (a) through (d).]

(e) Phase V – The Secretary of State will review the test results and determine whether the voting system substantially meets the requirements for certification. BEFORE THE SECRETARY OF STATE WILL MAKE A FINAL DETERMINATION OF WHETHER THE SYSTEM SUBSTANTIALLY MEETS THE REQUIREMENTS, THE VOTING SYSTEM PROVIDER MUST ESCROW IN COMPLIANCE WITH SECTION 1-7-511, C.R.S. Within 30 days of a decision, the Secretary of State will post the certification test report for the voting system on its website.

[Not shown: no changes to Rule 21.2.4.]

Amendments to Rule 21.3 concerning the application procedure and stylistic change:

21.3 Application ~~P~~Procedure

21.3.1 Any voting system provider ~~may apply to the Secretary of State~~ THAT WANTS TO APPLY for certification ~~at any time~~ MUST COMMUNICATE THEIR TIMING AND INTENT TO APPLY WITH THE VOTING SYSTEMS TEAM PRIOR TO SUBMITTING A COMPLETE APPLICATION PACKAGE. IF THE TIMING OF THE SUBMISSION WOULD PRESENT A HARDSHIP FOR THE SECRETARY OF STATE, THE SECRETARY MAY REQUEST THE PROVIDER TO DELAY SUBMISSION OF THE APPLICATION TO A LATER DATE AGREED UPON BY ALL PARTIES.

[Not shown: no changes to Rules 21.3.2 through 21.3.7.]

Amendments to Rule 21.4.9 concerning a stylistic change and a specific technical change in Rule 21.4.9(a)(4):

21.4.9 Audit ~~C~~capacity

(a) The voting system must track and maintain read-only audit information of the following election management system events:

[Not shown: no changes to subsections (1) through (3).]

(4) Election events – set for election, unset for election, open polls, close polls, end election, upload devices, download devices, create ballots, create precincts, create districts, create voter service and polling centers, initialize devices, backup devices, and voting activity; and

[Not shown: no changes to subsection (5).]

[Not shown: no changes to sections (b) through (l).]

Amendments to Rule 21.5.1 concerning demonstrations of voting system components by voting system providers:

21.5.1 Voting system provider demonstration

[Not shown: no changes to section (a).]

(b) The demonstration period does not have a predetermined agenda for the voting system provider to follow; however, presentations should be prepared to address and demonstrate the following items as they pertain to each area and use within the voting system, if applicable:

[Not shown: no changes to subsections (1) through (8).]

(9) Accessible use, including a full demonstration of all functionality using accessible voter interface devices and the audio ballot~~;~~. THIS INCLUDES A VIDEO SUBMITTED WITH THE DEMONSTRATION WHICH SHOWS:

(A) A DEMONSTRATION OF THE FULL FUNCTIONALITY OF THE VOTER INTERFACE DEVICES AVAILABLE FOR USE WITH A BALLOT MARKING DEVICE; AND

(B) A DEMONSTRATION OF A VOTING SESSION FROM BEGINNING TO END, WHICH INCLUDES THE AUDIO WHICH WILL ACCOMPANY VOTING ON A BALLOT MARKING DEVICE, AND WHICH DESCRIBES THE ACTIONS AVAILABLE TO THE VOTER TO TAKE AT EVERY STEP ON THE DEVICE. THE DEMONSTRATION MUST ALLOW FOR AN INDIVIDUAL WHO IS VISUALLY IMPAIRED TO FOLLOW EACH STEP TAKEN DURING A VOTING SESSION.

[Not shown: no changes to sections (c) through (i).]

Amendments to Rule 21.10 concerning the escrow of voting system software, repealing of Rules 21.10.2, 21.10.9, and 21.10.10, and necessary renumbering:

21.10 Escrow of voting system software and firmware by voting system provider. The voting system provider must meet the requirement for ELECTION MANAGEMENT software escrow per the following:

[Not shown: no change to Rule 21.10.1.]

~~21.10.2 Within ten days of the voting system provider receiving notification of the certification, the voting system provider must arrange for the completion of escrow requirements as indicated by this Rule.~~

[Not shown: current Rules 21.10.3 through 21.10.8 are renumbered to Rules 21.10.2 through 21.10.7.]

Repeal of Rules 21.10.9 and 21.10.10 because this information is already otherwise provided during the certification process of a voting system or is no longer required due to the passage of SB23-276:

~~21.10.9 System documentation will include technical architecture design, analysis, detail design, testing and an installation and configuration guide.~~

~~21.10.10 A set of schematics and drawings on electronic vote casting and counting equipment purchased or in use by the county clerk must be filed with the Secretary of State.~~

[Not shown: current Rule 21.10.11 renumbered to Rule 21.10.8.]

Repeal and replacement of current Rule 21.10.12 due to the passage of SB23-276 and now requiring a voting system provider to notify the Department that a certified election management software has been placed in escrow and necessary renumbering:

~~21.10.12~~21.10.9 ~~Copies of electronic media and supporting documentation for escrow within the Secretary of State will be sent to:~~

~~Colorado Secretary of State~~
~~Attn: Voting Systems~~
~~1700 Broadway – Suite 550~~
~~Denver, CO 80290~~ THE PROVIDER MUST NOTIFY THAT SECRETARY OF STATE VIA EMAIL THAT THE ELECTION MANAGEMENT SOFTWARE BEING CERTIFIED HAS BEEN PLACED IN ESCROW.

[Not shown: current Rule 21.10.13 renumbered to Rule 21.10.10.]

Amendments to Rules 21.11.1 and 21.11.6 concerning stylistic changes:

21.11.1 Results reporting requirements

-(a) The voting system must be capable of generating a summary report that lists the total number of votes for each candidate in each round. The report must include:

[Not shown: no changes to sections (b) and (c).]

[Not shown: no changes to Rules 21.11.2 through 21.11.5.]

21.11.6 Ballot adjudication requirements

(a) The voting system must allow the user to queue ballots with the following conditions for adjudication by election judges:

(1) Any ambiguous mark in any ranking;~~.~~

(2) Any ranking that results in an overvote;~~.~~

(3) Any skipped ranking;~~.~~

(4) Any duplicate ranking; AND~~.~~

(5) Any contest in which a voter has ranked fewer candidates than the contest's maximum permitted number of rankings.

Amendments to Rule 25:

Amendments to Rule 25.2.2 concerning the selection of races to audit during a primary and other stylistic change:

25.2.2 Preparing for the audit

[Not shown: no changes to sections (a) through (i).]

-(j) Selection of target contests. No later than 5:00 p.m. MT on the Friday after election day, the Secretary of State will select the target contests. In a general or coordinated election, the Secretary of State will select at least one statewide contest, and for each county at least one other contest. The Secretary of State will select other ballot contests for audit if in any particular election there is no statewide contest. In a primary election, the Secretary of State will select at least one ~~countywide~~ contest of each major political party in each county. The Secretary of State will publish a complete list of all target contests on the Audit Center. The Secretary of State will consider at least the following factors in selecting the target contests:

[Not shown: no changes to subsections (1) through (6).]

[Not shown: no changes to sections (k) and (l).]

Notice of Proposed Rulemaking

Tracking number

2023-00362

Department

1507 - Department of Public Safety

Agency

1507 - Division of Homeland Security and Emergency Management

CCR number

8 CCR 1507-47

Rule title

COLORADO NONPROFIT SECURITY GRANT PROGRAM

Rulemaking Hearing

Date

08/07/2023

Time

10:00 AM

Location

Virtual Zoom Meeting https://us02web.zoom.us/meeting/register/tZMpf-6tqzMrG9F8-CqvDHaullNIzGtmpTVP

Subjects and issues involved

Proposed rule revision to make the timeline more generic due to continued funding for the grant so that the rules do not need to be updated each year. Rule section 5.3 Time Frames for Application will be revised to change specific deadline and notification calendar dates to days within specific calendar months. Rule section 4 Definitions, Grant program will correct the C.R.S. statute number implementing the grant program established by this rule.

Statutory authority

24-33.5-1622 (2) (d), C.R.S. via House Bill 22-1077

Contact information

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DEPARTMENT OF PUBLIC SAFETY
DIVISION OF HOMELAND SECURITY AND EMERGENCY MANAGEMENT

Colorado Nonprofit Security Grant

Program 8 CCR 1507-47

STATEMENT OF BASIS, STATUTORY AUTHORITY, AND PURPOSE

The General Assembly enacted section 24-33.5-1622 (2) (d), C.R.S. via House Bill 22-1077 to create the Colorado Nonprofit Security Grant Program. The bill was signed into law on June 7, 2022. The statute mandated that by August 30, 2022, "the Director of the Division of Homeland Security and Emergency Management shall promulgate rules and regulations concerning the administration, applicable costs, application and award criteria, reporting requirements, and time frames for applying for and distributing funds associated with the grant program." DHSEM adopted emergency rules on June 30, 2022, in order to meet this statutory deadline.

The purpose of this rule making is to establish permanent rules to supercede the emergency rules adopted on June 30, 2022. The absence of implementing permanent rules to carry out the purpose of the statute would be contrary to the statute.

~~19 August 2022~~

Kevin Klein — Date of Adoption

Director, Division of Homeland Security and Emergency Management

Colorado Department of Public Safety

Division of Homeland Security and Emergency

Management 24 CCR 33.5-1622

Colorado Nonprofit Security Grant Program

1. Authority

This regulation is adopted pursuant to the authority in section 24-33.5-1622 (2) (d), C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, section 24-4-101 et seq. (the "APA").

2. Scope and Purpose

This regulation shall govern the implementation of the Colorado Nonprofit Security Grant Program, which includes the time frames for applying for these grants, the form of the grant program application, and the time frames for distributing grant funds.

3. Applicability

The provisions of these rules shall be applicable to all eligible applicants and recipients of grant funds as provided by law.

4. Definitions

"Grant program" means the Colorado Nonprofit Security Grant Program that provides grants to nonprofits as set forth in 24-33.5-1622 (2)(b).

"Project Implementation Plan" means a written form or other document determined by the state agency to outline the steps necessary to achieve grant objectives.

"Quarterly Progress Report" means a written form or other document determined by the state agency to indicate and report the operational and financial activity of the recipient during the time period specified.

"Summary Report" means a written form or other document determined by the state agency allowing the grant award recipients to report the final operational and financial activity of the awarded grant funds.

"Reimbursement Request" means a written form or other document determined by the state agency to be used by the grant recipient to request reimbursement from grant award funds for approved expenditures.

"Financial Need" means the inability of a nonprofit organization to meet the financial requirements from the organization's general operating funds for the security related activities requested as part of the grant application process.

"The Federal Program" means the Nonprofit Security Grant Program (NSGP) administered by the Department of Homeland Security Federal Emergency Management Agency (FEMA).

"Recipient" means an eligible applicant receiving an award.

"Award" means a financial assistance grant that provides support to accomplish a public purpose given by the state to an eligible recipient.

"Period of Performance" means the period of time during which the recipient is required

to complete the grant activities and to receive and expend approved funds.

5. **Program Requirements**

5.1 Eligibility

A. Applicant must be a nonprofit entity meeting the federal requirements as described in the Notice of Funding Opportunity for the Federal Nonprofit Security Grant Program with the primary place of business in the state of Colorado in order to apply.

B. Eligible applicants are required to have submitted an application for the Federal Program, but not yet selected to receive a grant under the Federal Program to be eligible to apply.

C. Eligible applicants must submit an application developed by the Division of Homeland Security and Emergency Management Office of Grants Management in conformance with the application and the terms of the program guidance described below.

D. Eligible applicants must indicate in the application that the grant funds will be used for the following security related activities and purposes (including by not limited to):

1. The installation of security equipment on real property owned or leased by the nonprofit organization;
2. Security-related planning, exercises, training, and contracted security personnel;
3. New or existing infrastructure; except that priority must be given to existing infrastructure projects;
4. Any other security enhancements approved by the division and in accordance with the allowable costs under the federal program.

E. The grant agreement between the State and the recipient(s) of the grant program will specify additional requirements, including, but not limited to: performance measures, reporting requirements, and monitoring of recipient's activities and expenditures.

5.2 **Award Details**

A. Period of Performance: 7 months

B. Funding Instrument: Discretionary Grant

5.3 **Time Frames for Application**

A. Time ~~Frames~~Timeline for any year that the state legislature allocates funding for the program ~~Year 1~~:
Application Submission Deadline: ~~October 10~~Second Monday in October~~, 2022;~~ at ~~5~~11:~~00~~ 59 PM MDT
Grant Awarded to Applicants Deadline: ~~October 31, 2022~~First Monday in November
Grant Award Notification on Website: ~~November 5, 2022~~5 business days after the first Monday in November
Grant Fund Distribution Deadline: ~~November 30, 2022~~Thirty days after the first Monday in November
Period of Performance ~~7 months~~: ~~December 1, 2022 – June 30, 2023~~7 Months

B. Restrictions

1. Applications that are not submitted by the stated Application Submission Deadline will not be reviewed or considered for funding.
2. Pre-Award Costs are NOT allowed under this program (costs incurred or work completed prior to the award date)

5.4 **Application Submissions**

A. Applicants must submit their acceptable signed application via email or other delivery methods as listed and allowed in the grant application and accompanying guidance.

5.5 **Grant Guidance**

The DHSEM Office of Grants Management is responsible for the implementation of this grant program and will develop and publish a grant application and guidance. Grant guidance will include the following reporting requirements:

1. A Project Implementation Plan
2. Quarterly Progress Reports
3. A Summary Report upon completion of the project
4. Reimbursement Requests

Notice of Proposed Rulemaking

Tracking number

2023-00363

Department

500,1008,2500 - Department of Human Services

Agency

2503 - Income Maintenance (Volume 3)

CCR number

9 CCR 2503-7

Rule title

LOW-INCOME ENERGY ASSISTANCE PROGRAMS (LEAP)

Rulemaking Hearing

Date

08/04/2023

Time

08:30 AM

Location

1575 Sherman Street, Denver, CO 80203

Subjects and issues involved

To move rule language from definition to a more appropriate place in the manual under determining eligibility. To amend a rule regarding countable unearned income as the current rule, as written causes the eligibility technicians and QA techs too much confusion. To add the new citation for the new Income Guidelines for the new program year. To add clarifying language to the wood and propane bulk fuel purchases to address that the rule applies to any bulk purchase To change the processing timelines for emergency applications, based on the seasonality of the program and the high volume at the beginning of the heating season more time is needed to address emergency applications. Processing timelines have been extended by 3 days.

Statutory authority

26-1-107, C.R.S.; 40-8.5-101, C.R.S.; § 40-8.7-109, C.R.S.

Contact information

Name

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Title of Proposed Rule: Revisions to the Low Income Energy Assistance Program (LEAP)

CDHS Tracking Number: 23-04-13-01

Office, Division & Program: OES, FEAD, LEAP

Rule Author: Theresa Kullen Phone: 720-788-8050 Email Address: Theresa.kullen.state@co.us

Title of Proposed Rule: Revisions to the Low Income Energy Assistance Program (LEAP) –

CDHS Tracking #

		Office, Division,		Rule
		Author:	**Phone Number:**	**Email**
		Address:		
		OES, FEAD, LEAP		**Theresa**
Kullen	**720-788-8050**	**Theresa.kullen@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)*

[ ] 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
	New Rules
	Repealed Rules
	Reviewed Rules

What month is being requested for this rule to first go before the State Board?	August, 2023

What date is being requested for this rule to be effective?	10-1-23

Title of Proposed Rule: Revisions to the Low Income Energy Assistance Program (LEAP)

CDHS Tracking Number: 23-04-13-01

Office, Division & Program: OES, FEAD, LEAP

Rule Author: Theresa Kullen Phone: 720-788-8050 Email Address: Theresa.kullen.state@co.us

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 _____ 2nd Board _____ Effective Date _____

Title of Proposed Rule: Revisions to the Low Income Energy Assistance Program (LEAP)

CDHS Tracking Number: 23-04-13-01

Office, Division & Program: OES, FEAD, LEAP

Rule Author: Theresa Kullen Phone: 720-788-8050 Email Address: Theresa.kullen.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***

To move rule language from definition to a more appropriate place in the manual under determining eligibility.
To amend a rule regarding countable unearned income as the current rule, as written causes the eligibility technicians and QA techs too much confusion.
To add the new citation for the new Income Guidelines for the new program year.
To add clarifying language to the wood and propane bulk fuel purchases to address that the rule applies to any bulk purchase
To change the processing timelines for emergency applications, based on the seasonality of the program and the high volume at the beginning of the heating season more time is needed to address emergency applications. Processing timelines have been extended by 3 days.

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. (2015)	State department to administer or supervise all forms of public assistance and welfare activities that are vested in the state department pursuant to law. The LEAP program administration is vested in the state department under 40-8.5-101

Program Authority for Rule: *Give federal and/or state citations and a summary of the language authorizing the rule-making <u>function</u> AND <u>authority.</u>*

Code	Description
§ 40-8.5-101, C.R.S. (2020)	LEAP, established in the department of human services to determine the need for assistance to indigent, elderly, and persons with disabilities
§ 40-8.7-109, C.R.S. (2020)	LEAP eligibility for individuals must be certified by the state department and priority for eligibility is given to persons receiving certain public assistance benefits from other state department public assistance programs.

Title of Proposed Rule: Revisions to the Low Income Energy Assistance Program (LEAP)

CDHS Tracking Number: 23-04-13-01

Office, Division & Program: OES, FEAD, LEAP

Rule Author: Theresa Kullen Phone: 720-788-8050 Email Address: Theresa.kullen.state@co.us

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

If yes, please explain.

Title of Proposed Rule: Revisions to the Low Income Energy Assistance Program (LEAP)

CDHS Tracking Number: 23-04-13-01

Office, Division & Program: OES, FEAD, LEAP

Rule Author: Theresa Kullen Phone: 720-788-8050 Email Address: Theresa.kullen.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?

This rule will benefit applicants easing restrictions on verification of cash purchase bulk fuel verifications to reduce unnecessary restrictions on the verification. This rule will benefit the eligibility technicians by adding clarifying language to the rule. This rule contains a technical clean up moving a rule to a more appropriate place in the rules. This rule contains the updated federal citation to the Federal State Median Income limits.

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?

It is difficult to predict how many applicants this will impact. The easing of restrictions of unnecessary verification elements being required for bulk fuel applicants will reduce client barriers. Adding clarifying language for the eligibility technicians will ease application processing questions.

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)*

No fiscal impact to the State as the program is funded through the U.S. Department of Health and Human Services and the program is administered within the allotted allocation.

County Fiscal Impact

No fiscal impact to counties/contractor as the State allocates the funds necessary to administer the program.

Federal Fiscal Impact

No fiscal impact as LEAP is funded through a federal block grant administered by the U.S. Department of Health and Human Services.

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

No fiscal impact as energy providers are paid on behalf of eligible clients with allocated federal funds.

4. Data Description

Title of Proposed Rule: Revisions to the Low Income Energy Assistance Program (LEAP)

CDHS Tracking Number: 23-04-13-01

Office, Division & Program: OES, FEAD, LEAP

Rule Author: Theresa Kullen Phone: 720-788-8050 Email Address: Theresa.kullen.state@co.us

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

The rule updates the citation to the federal State Median Income Guidelines.

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…"**

No alternatives were considered because rulemaking is the only method available to update income guidelines and/or revise language for the upcoming program year.

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.*		
3.751.1	3.751.1 Definitions Strike Old Language	"Emergency Applicant": This is a household which has had heat service discontinued or is threatened with discontinuance, or is out of fuel or will run out of fuel within fourteen calendar days or the client is responsible for heating costs that are included in rent and has received an eviction notice to vacate the premises within thirty (30) calendar days. Emergency applications for households approved in these situations shall be processed expeditiously and eligibility determined within fourteen calendar days of notification of the emergency by the applicant to the county department. Emergency applications being denied for failure to provide the requested verifications shall be processed and eligibility determined within fifteen calendar days. If the fourteenth or fifteenth day falls on a weekend or holiday the eligibility determination shall be processed by the close of business the next business day.	"Emergency Applicant": This is a household which has had heat service discontinued or is threatened with discontinuance, or is out of fuel or will run out of fuel within fourteen calendar days or the client is responsible for heating costs that are included in rent and has received an eviction notice to vacate the premises within thirty (30) calendar days. ~~Emergency applications for households approved in these situations shall be processed expeditiously and eligibility determined within fourteen calendar days of notification of the emergency by the applicant to the county department. Emergency applications being denied for failure to provide the requested verifications shall be processed and eligibility determined within fifteen calendar days. If the fourteenth or fifteenth day falls on a weekend or holiday the eligibility determination shall be processed by the close of business the next business day.~~	The second paragraph of this definition is better suited under reference 3.756.14 as it pertains to the time frame in which emergency applications need to be addressed rather than defining what an emergency application is.	No
3.752.21 B	Strike Old Language	B. Dividends and interest paid out or withdrawn on savings bonds, leases, bank accounts, 401Ks, IRAs, savings bonds, etc.;	B. Dividends and interest paid out or withdrawn on savings bonds, leases, bank accounts~~, 401ks, IRAs, savings bonds, etc~~.;	The language causes too much confusion for QA and eligibility technicians.	No
3.752.22 D	Strike Old Language and Add New Language.	All applicant households whose countable income for the eligibility period is up to and including 60 percent (60%) of the state median income level released by the U.S. Department of Health and Human Services for federal fiscal year 2023 shall meet the income requirements for the Heating Fuel Assistance Program. The State Department shall adjust the income limits annually based on funds available and the state median income	All applicant households whose countable income for the eligibility period is up to and including 60 percent (60%) of the state median income level released by the U.S Department of Health and Human Services for federal fiscal year 2023 shall meet the income requirements for the heating fuel assistance program. The state department shall adjust the income limits annually based on funds available and the state median income guidelines. State median income level means the income level for a		

		guidelines. State median income level means the income level for a household as set forth in the federal register 86 FR 7732, 7732-7734, as of February 1, 2022. This rule does not contain any later amendments or editions. These guidelines are available for no cost at https://www.federalregister.gov/. These guidelines are also available for public inspection and copying at the Colorado Department of Human Services, Director of the Food and Energy Assistance Division,1575 Sherman Street, Denver, Colorado, 80203, or at any state publications library during regular business hours.	household as set forth in the federal register 86 fr 7732, 7732-7734, as of ~~February 1, 2022.~~ INSERT NEW REFERENCE ONCE RECEIVED. This rule does not contain any later amendments or editions. These guidelines are available for no cost at https://www.federalregister.gov/. These guidelines are also available for public inspection and copying at the Colorado department of human services, director of the food and energy assistance division,1575 Sherman Street, Denver, Colorado, 80203, or at any state publications library during regular business hours.		
3.755.44	3.755.44 Add new Language	3.755.44 Wood Purchase [Eff. 12/1/14]	3.755.44 Wood Purchase/OTHER BULK FUELS [Eff. 12/1/14]	To add language that other bulk fuels besides wood purchases are also covered in this situation.	No
3.755.45	Add New Language	Applicants who use propane or other bulk fuels, referred to in definitions in these rules, as their primary heating fuel must provide a receipt or statement from their vendor. Receipts must include the vendor's name, date, and the name and service address of the buyer. Applicants, who utilize propane bottles, as described in definitions in these rules or purchase propane as a cash account, are required to provide a copy of a receipt of purchase only from a retail store or other propane provider.	Applicants who use propane or other bulk fuels, referred to in definitions in these rules, as their primary heating fuel must provide a receipt or statement from their vendor. Receipts must include the vendor's name, date, and the name and service address of the buyer. Applicants, who utilize propane bottles/OTHER BULK FUELS, as described in definitions in these rules or purchase propane as a cash account, are required to provide a copy of a receipt of purchase only from a retail store or other propane provider.	To add language that other bulk fuels besides propane purchases are also covered in this situation.	No
3.756.12 D	Add New Language and Strike Old Language	D. The applicant household shall be provided two (2) calendar weeks from the date the notice is postmarked to provide the requested information and/or verification. Clients who fail to submit the required verification shall have their application denied within processing timelines for emergency and regular applications. However, the county department may extend the period for submission by the applicant of the information requested by the county department/Contractor to complete the	D. The applicant household shall be provided two (2) calendar weeks from the date the notice is postmarked to provide the requested information and/or verification. Clients who fail to submit the required verification shall have their application denied within processing timelines for emergency and regular applications. However, the county department may extend the period for submission by the applicant of the information requested by the county department/contractor to complete the application upon a showing of good cause for the applicant's failure to provide the necessary information or verification within the two (2)	To shorten the time frame when reopens need to occur. The number one complaint that the state received this program year was how long it takes counties/contractor to reopen applications when the verification was submitted untimely.	No

		application upon a showing of good cause for the applicant's failure to provide the necessary information or verification within the two (2) week period. The extended period shall not exceed two weeks. The term “good cause” as used above is defined as conditions outside the control of the individual such as sudden illness, hospitalization, fire, theft, acts of God, and natural disasters. If the requested verification is provided after the application is denied, the county or contractor shall reopen and complete processing of the application within 30 days of receipt. The requested verification must be received by June 15th of the current program year.	week period. The extended period shall not exceed two weeks. The term “good cause” as used above is defined as conditions outside the control of the individual such as sudden illness, hospitalization, fire, theft, acts of God, and natural disasters. If the requested verification is provided after the application is denied, the county or contractor shall reopen and complete processing of the application within ~~30~~ 15 CALENDAR days of receipt. The requested verification must be received by June 15th of the current program year.		
3.756.14	Add New Language	A county department/contractor shall have up to thirty (30) calendar days from the date of application as defined in section 3.751.1 of these rules to determine eligibility. The date of application is considered day zero. If the thirtieth day falls on a weekend or a holiday, the county/contractor shall have until close of business on the following business day to determine eligibility.	A county department/contractor shall have up to thirty (30) calendar days from the date of application as defined in section 3.751.1 of these rules to determine eligibility. The date of application is considered day zero. If the thirtieth day falls on a weekend or a holiday, the county/contractor shall have until close of business on the following business day to determine eligibility. EMERGENCY APPLICATIONS FOR HOUSEHOLDS APPROVED IN THESE SITUATIONS SHALL BE PROCESSED EXPEDITIOUSLY AND ELIGIBILITY DETERMINED WITHIN ~~FOURTEEN~~ EIGHTEEN CALENDAR DAYS OF NOTIFICATION OF THE EMERGENCY BY THE APPLICANT TO THE COUNTY DEPARTMENT. CASES THAT ARE PENDING VERIFICATION MUST NOT BE DENIED FOR FAILURE TO PROVIDE REQUESTED INFORMATION PRIOR TO THE 15TH DAY AFTER THE REQUEST FOR INFORMATION IS MAILED OUT TO ALLOW FOR THE FULL 2-WEEKS TO RETURN THE REQUIRED VERIFICATIONS. IF THE EIGHTEENTH DAY FALLS ON A WEEKEND OR HOLIDAY THE ELIGIBILITY DETERMINATION SHALL BE PROCESSED BY THE CLOSE OF BUSINESS THE NEXT BUSINESS DAY. EMERGENCY APPLICATIONS FOR HOUSEHOLDS SHALL BE PROCESSED AS EXPEDITIOUSLY AS POSSIBLE NOT TO EXCEED 18 CALENDAR DAYS	THIS IS THE PARAGRAPH BEING MOVED FROM DEFINITIONS AND IT LENGHTENS THE TIME FRAME FOR EMERGENCY APPLICATIONS TO BE DETERMINED TO 18 DAYS FROM 14 DAYS AS THE VOLUME OF APPLICATIONS AT THE BEGINNING OF THE HEATING SEASON IS TOO HIGH TO HANDLE THIS IS 14 CALENDAR DAYS.	

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):

A subcommittee comprised of LEAP county stakeholders/contractor met in March and April 2023 to review existing rule and recommend updates. The changes will be presented to the larger LEAP county stakeholder group in May 2023 to ensure there are no more suggested changes. All counties/contractors were invited to be on the Rule Revision Committee.

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:

Colorado Legal Services, Economic Security Sub-PAC, Economic Security PAC, Energy Outreach Colorado (EOC), Colorado Energy Office (CEO), County LEAP managers, and the County Human Services Directors Association have been or will be informed.

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	Economic Security Sub-PAC		
Date presented	Will be presented June 8, 2023 for vote		
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.	It is in the future		

PAC

Have these rules been approved by PAC?

[ ] Yes [X] No

Date presented	It will be presented for vote at the July 2023 PAC Meeting		
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.

DEPARTMENT OF HUMAN SERVICES
Income Maintenance (Volume 3)
LOW-INCOME ENERGY ASSISTANCE PROGRAMS (LEAP)
9 CCR 2503-7

3.751 GENERAL PROVISIONS

3.751.1 DEFINITIONS [Rev. eff. 12/1/14]

****

"Emergency Applicant": This is a household which has had heat service discontinued or is threatened with discontinuance, or is out of fuel or will run out of fuel within fourteen calendar days or the client is responsible for heating costs that are included in rent and has received an eviction notice to vacate the premises within thirty (30) calendar days. ~~Emergency applications for households approved in these situations shall be processed expeditiously and eligibility determined within fourteen calendar days of notification of the emergency by the applicant to the county department. Emergency applications being denied for failure to provide the requested verifications shall be processed and eligibility determined within fifteen calendar days. If the fourteenth or fifteenth day falls on a weekend or holiday the eligibility determination shall be processed by the close of business the next business day.~~

3.752.21 Countable Unearned Income [Rev. eff. 12/1/14]

B. Dividends and interest paid out or withdrawn on savings bonds, leases, bank accounts~~, 401Ks, IRAs, savings bonds, etc.~~;

****

3.752.22 Income and Household Size Criteria [Rev. eff. 11/1/15]

D. All applicant households whose countable income for the eligibility period is up to and including 60 percent (60%) of the state median income level released by the U.S. Department of Health and Human Services for federal fiscal year 2023 shall meet the income requirements for the Heating Fuel Assistance Program. The State Department shall adjust the income limits annually based on funds available and the state median income guidelines.

State median income level means the income level for a household as set forth in the federal register 86 FR 7732, 7732-7734, as of ~~February 1, 2022.~~ INSERT NEW CITATION ONCE INCOME GUIDELINES HAVE BEEN RELEASED COMING SOON. This rule does not contain any later amendments or editions. These guidelines are available for no cost at https://www.federalregister.gov/. These guidelines are also available for public inspection and copying at the Colorado Department of Human Services, Director of the Food and Energy Assistance Division,1575 Sherman Street, Denver, Colorado, 80203, or at any state publications library during regular business hours.

3.755.44 Wood Purchase/OTHER BULK FUELS [Eff. 12/1/14]

3.755.45 Propane Purchase/Other Bulk Fuels [Eff. 11/1/15]

Applicants who use propane or other bulk fuels, referred to in definitions in these rules, as their primary heating fuel must provide a receipt or statement from their vendor. Receipts must include the vendor's name, date, and the name and service address of the buyer.

Applicants, who utilize propane bottles/OTHER BULK FUELS, as described in definitions in these rules or purchase propane as a cash account, are required to provide a copy of a receipt of purchase only from a retail store or other propane provider.

3.756.12 Application Processing [Rev. eff. 11/1/13]

D. The applicant household shall be provided two (2) calendar weeks from the date the notice is postmarked to provide the requested information and/or verification. Clients who fail to submit the required verification shall have their application denied within processing timelines for emergency and regular applications. However, the county department may extend the period for submission by the applicant of the information requested by the county department/Contractor to complete the application upon a showing of good cause for the applicant's failure to provide the necessary information or verification within the two (2) week period. The extended period shall not exceed two weeks. The term “good cause” as used above is defined as conditions outside the control of the individual such as sudden illness, hospitalization, fire, theft, acts of God, and natural disasters.

If the requested verification is provided after the application is denied, the county or contractor shall reopen and complete processing of the application within ~~30~~ 15 CALENDAR days of receipt. The requested verification must be received by June 15th of the current program year.

3.756.14 Determination of Eligibility [Rev. eff. 11/1/93]

A county department/contractor shall have up to thirty (30) calendar days from the date of application as defined in section 3.751.1 of these rules to determine eligibility. The date of application is considered day zero. If the thirtieth day falls on a weekend or a holiday, the county/contractor shall have until close of business on the following business day to determine eligibility.

A county department/contractor shall have up to thirty (30) calendar days from the date of application as defined in section 3.751.1 of these rules to determine eligibility. The date of application is considered day zero. If the thirtieth day falls on a weekend or a holiday, the county/contractor shall have until close of business on the following business day to determine eligibility.

EMERGENCY APPLICATIONS FOR HOUSEHOLDS APPROVED IN THESE SITUATIONS SHALL BE PROCESSED EXPEDITIOUSLY AND ELIGIBILITY DETERMINED WITHIN EIGHTEEN CALENDAR DAYS OF NOTIFICATION OF THE EMERGENCY BY THE APPLICANT TO THE COUNTY DEPARTMENT. CASES THAT ARE PENDING VERIFICATION MUST NOT BE DENIED FOR FAILURE TO PROVIDE REQUESTED INFORMATION PRIOR TO THE 15TH DAY AFTER THE REQUEST FOR INFORMATION IS MAILED OUT TO ALLOW FOR THE FULL 2-WEEKS TO RETURN THE REQUIRED VERIFICATIONS. IF THE EIGHTEENTH DAY FALLS ON A WEEKEND OR HOLIDAY THE ELIGIBILITY DETERMINATION SHALL BE PROCESSED BY THE CLOSE OF BUSINESS THE NEXT BUSINESS DAY.

EMERGENCY APPLICATIONS FOR HOUSEHOLDS SHALL BE PROCESSED AS EXPEDITIOUSLY AS POSSIBLE NOT TO EXCEED 18 CALENDAR DAYS

Notice of Proposed Rulemaking

Tracking number

2023-00343

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

08/11/2023

Time

09:00 AM

Location

303 East 17th Avenue, 11th Floor, Denver, CO 80203

Subjects and issues involved

see attachment

Statutory authority

Sections 25.5-1-301 through 25.5-1-303 (2023)

Contact information

Name

Chris Sykes

Title

Medical Services Board Administrator

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chris.sykes@state.co.us

COLORADO
Department of Health Care Policy & Financing
Medical Services Board

NOTICE OF PROPOSED RULES

The Medical Services Board of the Colorado Department of Health Care Policy and Financing will hold a public meeting on Friday, August 11, 2023, beginning at 9:00 a.m., in the eleventh floor conference room at 303 E 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 23-06-29-A, Revision to the Medical Assistance Act Rule concerning Dental Health Care Program for Low-Income Seniors Procedure Increase, Section 8.960

Medical Assistance. Current rule states the max program fees of the Dental Health Program for Low-Income Seniors must not fall below Medicaid dental rates. Medicaid received a 3% increase for the dental rates for FY2023-24. This made some of the program rates in Schedule A fall below the Medicaid rate. This change is necessary to stay in compliance with rule.

The authority for this rule is contained in Sections 25.5-1-301 through 25.5-1-303 (2023).

MSB 23-06-29-B, Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers, Sections 8.511 & 8.535

Medical Assistance. An increase to the currently approved direct care worker Base Wage has been approved by the General Assembly effective July 1, 2023. The Base Wage rule will be amended to remove exact dates and rates, so that future increases can be implemented quickly without further amendments. Additionally, the rule has been simplified and reorganized. For example, the Department will remove Base Wage regulations from the Pediatric Personal Care Rule (8.535) and reference the main Base Wage rule within 8.511. Future notices of Base Wage increases will be posted on the Provider Rates and Fee Section of the website.

The authority for this rule is contained in Senate Bill 23-214; 25.5-6-18 C.R.S. (2021) and Sections 25.5-1-301 through 25.5-1-303 (2023).

MSB 23-06-29-C, Revision to the Medical Assistance Act Rule concerning Cost Sharing, Section 8.754.1

Medical Assistance. Current rule states the max program fees of the Dental Health Program for Low-Income Seniors must not fall below Medicaid dental rates. Medicaid received a 3% increase for the dental rates for FY2023-24. This made some of the program rates in Schedule A fall below the Medicaid rate. This change is necessary to stay in compliance with rule.

The authority for this rule is contained in Sections 25.5-1-301 through 25.5-1-303 (2023).

MSB 23-06-29-D, Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443

Medical Assistance. House Bill (H.B.) 23-1228 increases nursing home reimbursement starting in state fiscal year (SFY) 2023-24. The proposed rule increases the SFY 2023-24 statewide average nursing home per-diem reimbursement rate by 10%, compared to a limited 2% or 3% increase in previous years. The proposed rule also increases the Cognitive Performance Scale (CPS) and Preadmission Screening and Resident Review (PASRR) II supplemental payment starting in SFY 2023-24, reimbursement for providing care to residents with cognitive and/or behavioral disabilities. The propose rule also makes necessary changes to the case mix adjustment applied to nursing home per diem reimbursement rates due to the current Resource Utilization Group (RUG) tool no longer utilized by the Center for Medicare & Medicaid Services (CMS) after October 1, 2023.

The authority for this rule is contained in Senate Bill 23-214; 25.5-6-18 C.R.S. (2021) and Sections 25.5-1-301 through 25.5-1-303 (2023).

MSB 23-06-29-E, Revision to the Medical Assistance Rule concerning Dental Therapists, Section 8.201.1

Medical Assistance. This rule clarifies that dental therapists are dental provider types who can be reimbursed by Medicaid, as part of implementing Colorado Senate Bill 22-219.

The authority for this rule is contained in Sections 25.5-1-301 through 25.5-1-303 (2023).

MSB 23-02-09-A, Revision to the Medical Assistance Act Rule concerning Electronic Consultation (eConsults), Section 8.095

Medical Assistance. The proposed rule will authorize Electronic Consultation (eConsults), which is an asynchronous dialogue initiated by a Primary Care Medical Provider (PCMP) or other qualified health care professional seeking a Specialty Provider's expert opinion without a face-to-face member encounter with the Specialty Provider. eConsults must be initiated by a PCMP, and responded to by a Specialty Provider, through the Department's authorized eConsults Platform. The eConsult Platform is a web-based and application-based electronic system authorized by the Department that allows for an asynchronous exchanges between PCMPs and Specialty Providers to securely share health information and discuss member care. Specialty Providers are reimbursed only for closed eConsults that are delivered, and responded to, through the eConsult Platform.

The authority for this rule is contained in CRS §§ 25.5-4-103 (25.7), 25.5-5-321.5 and Sections 25.5-1-301 through 25.5-1-303 (2023).

MSB 23-04-12-B, Revision to the Medical Assistance Rules Mental Health Transitional Living Homes, Section 8.509.50

Medical Assistance. The Department has worked with the Colorado Department of Human Services (CDHS) in the development of the new residential settings. There are two levels of service that will be provided within these settings. Under the Community Mental Health Supports (CMHS) Home and Community Based Services (HCBS) waiver, the Department has developed a new residential service titled "Mental Health Transitional Living homes (MHTL). This residential service will include protective oversight and supervision; assistance with medication; community participation; recreational and social activities; intensive case management/care coordination; housing planning and navigation services as appropriate for clients experiencing homelessness/at risk for homelessness; life skills training/ADL support as needed; and therapeutic services, which may include but is not limited to individual and group therapy, medication management, etc. Only the Level 1 homes will be an HCBS benefit and available only to members who are on the CMHS waiver.

This benefit has been added to the Department's waiver agreement with the Centers for Medicare and Medicaid Services (CMS). In order to operationalize the MHTL homes, the Department must promulgate regulations for the service and align with the waiver agreement. These rules outline member eligibility, provider requirements, environmental standards, and reimbursement information.

The authority for this rule is contained in 27-71-101 C.R.S. (2022) and Sections 25.5-1-301 through 25.5-1-303 (2023).

Permanent Rules Adopted

Department

Department of Natural Resources

Agency

Colorado Parks and Wildlife (406 Series, Wildlife)

CCR number

2 CCR 406-9

Rule title

2 CCR 406-9 CHAPTER W-9 - WILDLIFE PROPERTIES 1 - eff 08/01/2023

Effective date

08/01/2023

FILING 06/30/2023

FINAL REGULATIONS - CHAPTER W-9 - WILDLIFE PROPERTIES

ARTICLE I - GENERAL PROVISIONS

#900 - REGULATIONS APPLICABLE TO ALL WILDLIFE PROPERTIES, EXCEPT STATE TRUST LANDS

A. DEFINITIONS

1. “Aircraft” means any machine or device capable of atmospheric flight, including, but not limited to, airplanes, helicopters, gliders, dirigibles, hot air balloons, rockets, hang gliders and parachutes, parasails, kite boards, kite tubes, wingsuits, zip lines and other similar devices or equipment.

2. “Camping” means the erecting of a tent or shelter of natural or manmade material, the placing of a sleeping bag or other bedding material on the ground, the parking of a motor vehicle, motor home, travel trailer or other similar equipment for the apparent purpose of overnight occupancy.

3. “Camping Unit” is defined as one of the following:
    a. Two tents and a passenger vehicle; or
    b. One tent plus one motorhome (Class A, B, C), motor vehicle, vehicle, trailer, slide-in truck camper, pop-up camper/trailer, boat, or other equipment of any description manufactured and/or used for the purposes of overnight occupancy; or
    c. A camping unit may include additional tents only in a campsite with a tent pad; provided the tents are contained on the pad and other camping unit and camping group limits are observed; or
    d. One passenger vehicle in addition to the above descriptions is authorized only if available parking space exists.

4. “Vessel” means every description of watercraft used or capable of being used as a means of transportation of persons and/or property on water. This includes but is not limited to single and multi-chambered stand-up paddleboards, float tubes, and tubes.

5. "Water contact activities" means swimming, wading (except for the purpose of fishing or hunting), waterskiing, surfing, sailboarding, scuba diving, and other water-related activities which put a person in contact with the water (without regard to the clothing worn or equipment used).

6. “Youth mentor hunting” means hunting by youths under 18 years of age. Youth hunters under 16 years of age shall at all times be accompanied by a mentor when hunting on youth mentor properties. A mentor must be 18 years of age or older and hold a valid hunter education certificate or be born before January 1, 1949.

B. Public Access to State Wildlife Areas

1. Only properties listed in this chapter are open for public access.
2. The Director may open newly acquired properties for public access for a period not to exceed nine (9) months pending adoption of permanent regulations. In addition, the Director may establish and post restrictions based upon consideration of the following criteria:
   a. The location and size of the area.
   b. The location, type and condition of roads, vehicle parking areas and the number and type of sanitary facilities available.
   c. The number of users and vehicles the area will tolerate without significant degradation to wildlife resources, and public or private property.
   d. Opportunity to assure public safety, health and welfare.

3. If a property is opened for public access pursuant to this provision, the property shall be posted with a list of applicable access restrictions. It shall be unlawful for any person or vehicle to enter any such property, except in accordance with its posting and the applicable restrictions.

C. Prohibited Activities

Except as specifically authorized in 901.B of these regulations or specifically authorized by contractual agreement, official document, public notice, permit, or posted sign, the following activities are prohibited on all lands, waters, the frozen surface of waters, rights-of-way, buildings, and other structures or devices owned, operated, or under the administrative control of Colorado Parks and Wildlife:

1. To enter, use or occupy any State Wildlife Area or portion thereof for all persons 16 years of age and older without:
   a. a hunting license valid for the current license year,
   b. a valid fishing license, or
   c. a valid Colorado State Wildlife Area pass.

   Annual hunting licenses, including all big game hunting licenses, small game hunting licenses, turkey hunting licenses, annual fishing licenses, and annual Colorado State Wildlife Area passes are only valid for the individual specified on the license or pass, and authorize such individual to enter, use or occupy any State Wildlife Area or portion thereof from March 1 through March 31 of the following year, also known as the current license year. Daily Colorado State Wildlife Area passes and daily or multi-day fishing and small game licenses are only valid for the individual specified on the license or pass, and authorize such individual to enter, use or occupy any State Wildlife Area or portion thereof only on the date(s) indicated on the license or pass.

2. To enter, use, or occupy any area or portion thereof for any purpose when posted against such entry, use, or occupancy.

3. To enter, use, or occupy any area for any commercial purpose or to conduct land, water, oil, gas, or mineral investigations, surveys, or explorations of any kind.

4. To operate any form of vehicle, or bicycle (motorized or non-motorized) except on established roads open to public motor vehicle use or within designated camping or parking areas. All motor vehicles and the operators thereof must comply with all Colorado statutes and regulations pertaining to motor vehicle operation. This regulation does not prohibit the use of non-motorized game carts.

5. To operate any motor vehicle, snowmobile, off highway vehicle or bicycle in excess of posted speed limits or in excess of 25 miles per hour where not posted.

6. To camp recreationally. To use or occupy a state wildlife area as a residence. Where camping is specifically authorized to leave a camp, pitched tent, shelter, motor vehicle, or trailer unattended for more than 48 hours, or to camp or to park a travel trailer or camper on any one state wildlife area for more than 14 days in any 45-day period.

7. To build, erect, or establish any permanent structure or to plant any vegetation. Only portable blinds or treestands and steps may be erected by the public on state wildlife areas. No nails may be driven into trees. Portable blinds or tree stands intended for use to hunt any big game or waterfowl during an established season may be erected on state wildlife areas no earlier than 30 days prior to the season in which they are used. All man-made materials used for blinds or tree stands during big game or waterfowl seasons must be removed within 10 days after the end of the season in which they are used. Any other portable blind or tree stand used for any other purpose must be removed at the end of the day in which they are used. The Customer Identification Number of the owner and the date(s) to be used must be displayed on the outside of all portable blinds and on the underside of all tree stands in a readily visible area. However, the erection or placement of any blind or tree stand by any person does not reserve the blind or tree stand for personal use. All such blinds and tree stands remain available for use to the general public on a first come, first-served basis.

8. To remove, modify, adjust, deface, destroy, or mutilate any building, structure, water control device, fence, gate, poster, notice, sign, survey or section marker, tree, shrub or other vegetation or any object of archaeological, geological, or historical value or interest.

9. To place fixed or permanent rock climbing hardware, unless the climber first obtains written permission from the Area Wildlife Manager pursuant to regulation #900.H. Removal of previously placed fixed or permanent climbing hardware is prohibited.

10. To litter in any form, to leave fish, fish entrails, human excrement, waste water, containers or cartons, boxes or other trash, garbage or toxic substance on any area or to bring any household or commercial trash, garbage or toxic substance to a Division-controlled area for disposal, or to dump trailer waste into any toilet or sanitary facility.

11. To set, build, or tend a fire. Where fires are specifically authorized, to allow a fire to burn in a careless manner; to leave any fire unattended; or to fail to completely extinguish any fire.

12. To release or allow livestock to graze or range on any area, except that horses, mules, llamas, and burros may be used when in direct association with wildlife recreational activities.

13. To possess, use or apply explosives (other than lawful firearm ammunition), fireworks, poisons, herbicides, insecticides or other pesticides.

14. To release wildlife or privately-owned game birds, except privately-owned game birds released for field trials, including group dog training, or on those state wildlife areas where release for dog training is specifically authorized.

15. To allow dogs, cats, or other domestic pets on any area, except dogs lawfully used while actively hunting, or while training dogs for hunting, or during Division licensed field trials. Service animals, as defined by 28 C.F.R. § 35.104(2016) are permitted. Later amendments to the definition of service animal are not incorporated. Copies of the definition may be obtained at Colorado Parks and Wildlife, 6060 Broadway, Denver CO 80216 or via the U.S. Department of Justice, Civil Rights Division, Disability Rights Section, 950 Pennsylvania Avenue, NW, Washington, D.C. 20530-0001.

16. To excavate or dig trenches, holes, or pits.

17. To launch, or take out vessels, except those being actively used for fishing and/or hunting. To leave vessels beached, at anchor, moored or docked overnight, except in areas designated for that purpose.

18. To fish from, block or impede any Division-controlled boat ramps or boat docks when in conflict with boaters or as posted.

19. To snorkel, scuba dive, or spearfish with the aid of diving mask, swim fins, snorkel, and/or air tanks, except in waters where swimming is permitted, when location is properly identified by a "divers down flag," and when the scuba diver has a valid S.C.U.B.A. diver's certificate issued by a recognized S.C.U.B.A. training organization.

20. To engage in any unlawful conduct or act as defined in Title 18, C.R.S.

21. To promote, sponsor, conduct or participate in boat regattas, paintball shooting, questing, or other non-wildlife oriented activities.

22. To launch or land any aircraft.

23. To launch, land or operate any unmanned aerial vehicle including but not limited to drones, and model airplanes.

24. To leave any decoys or anything used as decoys set up in the field or on the water overnight.

25. To engage in water contact activity, except where specifically authorized.

26. To discharge a firearm or bow within designated parking, camping, or picnic areas.

27. To possess the following types of ammunition and/or firearms: tracer rounds, armor-piercing rounds, military hardened rounds with explosive or radioactive substances, .50 caliber BMG rounds, or fully automatic firearms.

28. To possess, store, or use hay, straw, or mulch which has not been certified as noxious weed free in accordance with the Weed Free Forage Crop Certification Act, Sections 35-27.5-101 to 108, C.R.S., or any other state or province participating in the Regional Certified Weed Free Forage Program. See Appendix A of this chapter. All materials so certified shall be clearly marked as such by the certifying state or province. Exempted from this prohibition are persons transporting such materials on Federal, State, or County roads that cross Division property; and hay produced on the property where it is being used.

29. Upon notification by authorized Colorado Parks and Wildlife personnel of a violation of any of the above (or any other law of the State of Colorado) and where the unlawful activity is not immediately and permanently discontinued or if it is of a continuing nature, the violator(s) may be required to leave Colorado Parks and Wildlife property for a minimum of 72 hours.

30. To trap, unless such trapping is done in accordance with the provisions of 33-6-204 (General Exemptions), 33-6-205 (Exemptions for Departments of Health), 33-6-206 (Nonlethal Methods Exemptions), #901 and Chapter W-3 of these regulations. Persons wishing to use the above-mentioned exemptions must have prior authorization from Colorado Parks and Wildlife.

31. To conduct field trials or group dog training without first obtaining a field trial license, in accordance with the provisions of Chapter W-8 of these regulations.

32. Consumption of alcoholic beverages on lands and waters under the supervision, administration, and/or jurisdiction of the Division is permitted with the following exceptions:
    a. It shall be prohibited to consume alcoholic beverages on any archery or firearm range unless specifically authorized by a concession contract, cooperative agreement or special activities permit, and then only allowed in areas specifically designated by the contract, agreement, or permit.
    b. It shall be prohibited to sell and/or dispense alcoholic beverages on any lands and waters under the supervision, administration, and/or jurisdiction of the Division unless specifically authorized by a concession contract, cooperative agreement, or special activities permit, and then only allowed in areas specifically designated by the contract, agreement, or permit and the applicant party has obtained all appropriate licenses and permits to sell and/or dispense alcoholic beverages.
    c. It shall be prohibited to be present on any lands and waters under the supervision, administration, and/or jurisdiction of the Division when under the influence of alcohol or any controlled substance to the degree that may endanger oneself or another person, damage property or resources, or may cause unreasonable interference with another person’s enjoyment of any lands or waters under the supervision, administration, and/or jurisdiction of the Division.

D. Limitation of People and Vehicle Usage

1. The Director of Colorado Parks and Wildlife may establish and enforce a limitation not to exceed sixty (60) days, on public occupancy of the land and water areas owned or leased by the Division.

   The Director shall use only the following criteria when establishing such limitation:
   a. The location and size of the area.
   b. The location, type and condition of roads, vehicle parking areas and the number and type of sanitary facilities available.
   c. The number of users and vehicles the area will tolerate without significant degradation to wildlife resources, and public or private property.
   d. Opportunity to assure public safety, health and welfare.

2. Whenever such limitation is exercised, the area(s) involved shall be posted indicating the specific number of persons or vehicles permitted within the area at all times when such area is posted. It shall be unlawful for any person or vehicle to enter any such area(s) posted as being fully occupied or after being advised by an officer of the Division that the area is full.

3. The Division may waive these restrictions for daytime use during a specified period of time for organized supervised groups whose numbers exceed the limitations set forth. Written approval must first be obtained from the appropriate Regional Manager.

E. Closure of Properties to Public Use

1. The Director of Colorado Parks and Wildlife may establish and enforce temporary closures of, or restrictions on, lands or waters owned or leased by the Division, or portions thereof, for a period not to exceed nine months, when any one of the following criteria apply:

   a. The property has sustained a natural or man-made disaster such as drought, wildfire, flooding, or disease outbreak which makes public access unsafe, or where access by the public could result in additional and significant environmental damage.
   b. The facilities on the property are unsafe.
   c. To protect threatened or endangered wildlife species, protect wildlife resources from significant natural or manmade threats, such as the introduction or spread of disease or nuisance species, changing environmental conditions or other similar threats, protect time-sensitive wildlife use of lands or waters, or facilitate Division-sponsored wildlife research projects or management activities.

2. Whenever such closure is instituted, the area(s) involved shall be posted indicating the nature and purpose of the closure. It shall be unlawful for any person or vehicle to enter any such area(s) posted as closed.

F. Criteria for Activities Requiring Express Authorization - Whenever an activity requires expressed authorization (e.g. target practice) the Division shall grant or deny permission based on consideration of public safety and wildlife resource protection.

G. Commercial Use of State Wildlife Areas

1. Except as provided herein, commercial use of state wildlife areas, including, but not limited to, the provision of any goods or services to members of the general public using the state wildlife area, is prohibited. However, commercial uses of state wildlife areas may be allowed by the Division when:
   a. such commercial use will not adversely impact wildlife resources or habitat;
   b. there is a demonstrated need for the goods or services to be provided as part of such commercial use;
   c. such commercial use will not unreasonably interfere with the primary wildlife related recreational uses of the state wildlife area by members of the general public;
   d. the state wildlife area, and its existing facilities, can safely accommodate such commercial use; and
   e. Such commercial uses may be exclusive or nonexclusive, as determined by the Division to be necessary for the proper management of the state wildlife area in light of the criteria set forth above and the compensation provided to the Division.

2. Prior to making any commercial use of a state wildlife area, a person must receive a permit from the Division or enter into a commercial use agreement with the Division providing for such use. Any person accessing a State Wildlife Area under such authority is not required to have a valid hunting or fishing license, or Colorado State Wildlife Area pass. Such permit or agreement shall, at a minimum, include provisions regarding:
   a. the specific goods or services to be provided;
   b. user number restrictions;
   c. seasonal or time restrictions;
   d. record-keeping requirements, including, but not limited to, a requirement that the authorized user maintain records regarding the goods and services provided, the date(s) and time(s) the person provided these goods and services on the property, and the number of goods or services provided, by user day, for a period of at least three years. Such records shall be available for inspection by the Division;
   e. compensation to the Division: a minimum fee equal to 5% of the gross income generated by the activity shall be paid to the Division, but in no event shall any fee for a commercial use permit or agreement be less than $100. The $100 minimum shall be paid at the time the permit is issued or the agreement is signed. The Division may impose additional items, conditions and charges in connection with the permit or agreement as reasonably necessary to offset the administrative burden, costs or risks associated with the proposed activities;
   f. the Division may retain third party consultants to evaluate the potential adverse impacts of the proposed activity and develop appropriate strategies to offset or mitigate such risks. The applicant shall be notified if the Division decides to retain a consultant and shall be given the opportunity to provide input concerning consultant selection and scope of work. The applicant shall be responsible for the actual costs associated with this consultant review.
   g. the term or length of the permit or agreement, and a provision providing for cancellation or termination of such permit or agreement for any failure to comply with its terms and conditions and any applicable laws;
   h. any other provision necessary to protect wildlife resources, habitat or public safety, to prevent conflict with primary wildlife related recreational uses of the state wildlife area

by the general public or to properly administer the commercial use and the commercial use permit or agreement, including bonding requirements.

3. Incidental commercial services such as the renting of pack animals or their services to remove harvested animals; emergency vehicle repairs or tow services; or other similar incidental services may be provided to wildlife recreational users without a commercial use permit or agreement when the service is relatively infrequent, the provider does not advertise for or solicit business specifically for a state wildlife area and maintains a separate place of business, and the service is not one for which the provider is required by law to obtain a guide or outfitter license.

H. Special (Non-Wildlife Related) Use of State Wildlife Areas

1. Except for uses or activities otherwise specifically prohibited by these regulations, the Division may allow special (non-wildlife related) uses of state wildlife areas. Special uses may only be allowed if:
   a. such use will not adversely impact wildlife resources or habitat;
   b. such use will not interfere with wildlife-related recreational uses of the state wildlife area by members of the general public;
   c. such use is non-commercial in nature; and
   d. the state wildlife areas, and its existing facilities, can safely accommodate such use.

2. Prior to making any special use of a state wildlife area, a person must receive a permit from the Division or enter into a special use agreement with the Division. Any person accessing a State Wildlife Area under such authority is not required to have a valid hunting or fishing license, or Colorado State Wildlife Area pass. Such permit or agreement shall, at a minimum, include provisions regarding:
   a. the nature of the special use;
   b. user number restrictions;
   c. time and date restrictions;
   d. compensation to the Division: A minimum fee of $100 shall apply to all special use permits and agreements, but in no event shall the compensation received by the Division be less than the costs of administering such use, including, but not limited to, staff time;
   e. cancellation or termination of the permit or agreement for any failure to comply with the terms and conditions of the permit or agreement and any applicable laws; and
   f. any other provision necessary to protect wildlife resources, habitat or public safety, to prevent conflict with primary wildlife related recreational uses of the state wildlife area by the general public or to properly administer the special use and the special use permit or agreement, including bonding requirements.

I. Utility and Road Easements

1. The Director may grant easements, for a term not to exceed twenty-five (25) years, on properties owned in fee title by the Division after consideration of the following:

   a. financial consideration for the easement represents fair market value and is no more than $100,000;
   b. the easement is customary or minor in nature, or is a replacement, modification or

confirmation of an existing easement;

c. the easement is not detrimental to wildlife habitat, water resources, or the operation of a hatchery, fish rearing facility or administrative facility and is in the public interest; and
d. the businesses or persons involved in or maintaining the utility or road easements are not required to have a valid hunting or fishing license, or Colorado State Wildlife Area pass.

J. Leases

1. The Director may execute documents related to existing leases wherein the Division is either the lessor or lessee, after consideration of the following:

   a. the document is a renewal, extension or amendment of an existing lease;
   b. the renewal or extension is for a term not to exceed twenty-five (25) years;
   c. total consideration for the entire potential term of the renewal, extension or amendment represents fair market value and is no more than $100,000;
   d. the renewal, extension or amendment supports, protects, enhances or is not detrimental to wildlife habitat, water resources or the operation of a hatchery, fish rearing facility or administrative facility and is in the public interest; and
   e. the businesses or persons involved in or maintaining the lease are not required to have a valid hunting or fishing license, or Colorado State Wildlife Area pass.

2. The Director may execute a new lease for staff housing for a term not to exceed twelve (12) months.

ARTICLE II - PROPERTY-SPECIFIC PROVISIONS

#901 - PROPERTY-SPECIFIC REGULATIONS

See Appendix B for a list of properties without property-specific regulations, to which only restrictions in #900 apply)

A. On all Division properties which have reservations available or required, those reservations may be made by phone or online (cpw.state.co.us). Reservations for small game and waterfowl hunting may not be made more than 14 days in advance of the hunt date, nor after 12:00 noon on the day before the hunt date. Reservations for big game hunting may not be made more than 45 days in advance of the start of the season for which the reservation is being made. Unless otherwise specified, reservations for big game hunting are valid throughout the season designated by the license. Hunters who wish to cancel a reservation must do so no later than 12:00 noon on the day before the hunt date. Failure to hunt a reserved area without prior cancellation, or follow check station procedures, may cause forfeiture of the privilege to make reservations for the remainder of the hunting season. Hunters are limited to a maximum of one reservation per hunt date. Hunters must possess a valid license for the species to be hunted in order to make a reservation. Reservations are not transferable. The individual named on the reservation must be at the property on the day of the hunt. Hunters with reservations may only hunt the hunt area specified on the reservation. Any exceptions to the above restrictions will be listed under property specific regulations.

B. In addition to or in place of those restrictions listed in regulation #900, the following provisions or restrictions apply:

1. **Adams State Wildlife Area - Routt County**

a. Public access is prohibited from December 1 through July 15.
b. Discharge of firearms or bows is prohibited, except while hunting.

2. **Adobe Creek Reservoir State Wildlife Area - Bent and Kiowa Counties**

a. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise, except while camping, while hunting, or while fishing.

b. Public access to the frozen surface of the lake is prohibited.
c. Public access to the dams, inlets, and outlet structures is prohibited, except while fishing.
d. Launching and use of all vessels is allowed.
e. Water contact activities are allowed.
f. Camping is allowed in designated and established camping areas only.
g. Fires are allowed within an established containment structure in designated areas.

3. **Alberta Park Reservoir State Wildlife Area - Mineral County**

a. Launching and use of all vessels is allowed.
b. Operating a vessel in a manner that creates a whitewater wake is prohibited.

4. **Almont Triangle State Wildlife Area - Gunnison County**

a. Public access is prohibited from December 1 through April 30.

5. **Andrews Lake State Wildlife Areas - San Juan**

a. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand.

6. **Andrick Ponds State Wildlife Area - Morgan County**

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. Public access is limited to Saturdays, Sundays, Wednesdays, and state and federal holidays.
c. From June 1 through August 31 wildlife viewing is allowed from designated area only.
d. From September 1 through the dark goose season, only migratory bird hunting within designated areas is permitted. Reservations are required and valid until sunrise, and are limited to three (3) per hunter annually. Reservations must be made in accordance with #901.A of these regulations.
e. Hunters must check-in and out at check stations. Hunters may not check-in until 4:00 a.m. and can only hunt the area reserved. Hunters may check-in on a first-come, first-serve basis after a hunter checks out or after sunrise if a hunter has not checked-in. Maximum of four (4) hunters allowed per hunting area.
f. From the end of the dark goose season through the spring turkey season, only turkey hunting is permitted. During spring turkey season, reservations are required and valid until sunrise. Hunters must check-in and out at the check station on CR AA, but may hunt the entire property.

g. During waterfowl and turkey seasons, scouting is prohibited, except on Thursdays from 10:00 a.m. – 2:00 p.m. All persons must check-in and out at check stations. All firearms and dogs are prohibited while scouting.
h. Hunting with centerfire rifles is prohibited.
i. Hunting on Clark Lake is prohibited.
j. Discharge of firearms or bows is prohibited, except while hunting.
k. Fishing is prohibited.
l. Dogs are allowed but must be kept under control on a physical leash by the handler at all times.
m. Dog training is prohibited.

7. Apishapa State Wildlife - Las Animas County

a. Public access is prohibited from June 1 through August 15.
b. Camping is allowed in designated parking areas by licensed hunters during an established big game, spring turkey, and fall turkey season plus three (3) days before and three (3) days after each season.

8. Arkansas River/Big Bend State Wildlife Area (Fishing Easement) - Chaffee County

a. Public access is prohibited, except while fishing.
b. Parking and access is allowed from designated parking areas only.
c. Dogs are prohibited.

9. Atwood State Wildlife Area - Logan County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. All recreational activities, except deer hunting, are prohibited on opening weekend of the regular plains rifle deer season and on the opening day and first weekend of the late plains rifle deer season.
c. The launching or takeout of vessels is prohibited during waterfowl seasons.
d. Dog training is prohibited.
e. Horse use is prohibited.

10. Badger Basin State Wildlife Area (Fishing Easement) - Park County

a. Public access is prohibited, except while fishing.
b. Public access is allowed within the fenced and posted easement only.
c. Parking and access is allowed from designated parking areas only.
d. Hunting is prohibited

11. Banner Lakes State Wildlife Area - Weld County

a. Public access is prohibited north of Colo 52 from April 1 through July 15
b. Public access is restricted to foot traffic only.
c. Parking and access is allowed from designated parking areas only.
d. Public access is prohibited from the first day of the regular waterfowl season to the day before the first day of pheasant season, except for waterfowl hunting on Saturdays, Sundays, Mondays and state and federal holidays. During this period reservations are available for waterfowl, but not required. Reservations are valid throughout the reserved day until the hunter with the reservation checks out. Hunters may check-in on a first come, first served basis after a hunter with a reservation checks out, or if no reservation exists for a hunt area after 12:00 midnight immediately preceding the hunt, or if a reserved area is not claimed by

legal sunrise. Reservations may be made in accordance with #901.A of these regulations. No more than four hunters are allowed per reservation. Hunters with reservations may only hunt the hunt area specified on the reservation.

e. Waterfowl hunters must check-in and check out at the designated check station.
f. Discharge of firearms or bows is prohibited, except while hunting, training hunting dogs, or bowfishing.
g. Fishing is prohibited from October 1 through the end of February.
h. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand when used as an aid for fishing or hunting or dog training.
i. Horse use is prohibited.
j. Bicycles are prohibited.
k. Dog training is allowed north of Colo 52 during February, March and July 16 to August 31 only. Dog training is allowed south of Colo 52 from February 1 through August 31 only.
l. Field trials may be authorized during February, March, and August only. No more than four (4) field trials will be allowed per year, except that the number of group training events will not be limited.
m. Domestic birds, feral birds, or privately owned game birds may be released for field trials and for dog training south of Colo 52 by permit only, in accordance with the provisions of this chapter and other applicable regulations, including, but not limited to, #007, #008, #009, #801 and #804 of these regulations. All such birds taken during training activities shall be removed from the State Wildlife Area by the dog training permittee and all privately owned game birds shall be prepared for human consumption.
n. The Division is authorized to implement a dog training reservation system should overcrowding become an issue on the State Wildlife Area.

12. <u>Basalt State Wildlife Area - Eagle and Pitkin Counties</u>

a. From March 15 through October 14, firearms may only be discharged on the shooting range on Monday, Tuesday, Thursday, and Friday from 7:00 a.m. until 7:00 p.m., and on Saturday and Sunday from 9:00 a.m. until 5:00 p.m. From October 15 through March 14, firearms may only be discharged on the shooting range on Monday, Tuesday, Thursday, and Friday from 9:00 a.m. until 4:00 p.m., and on Saturday and Sunday from 9:00 a.m. until 4:00 p.m.
b. With the exception of Christine Lake and the Basalt Shooting Range, public access is prohibited from December 1 through July 15, except while spring turkey hunting.
c. Discharge of firearms or bows is prohibited, except while hunting or on the designated shooting range.
d. Vessel use is prohibited.
e. Camping is allowed by licensed hunters during an established big game or turkey season plus three (3) days before and three (3) days after each season.
f. Camping is prohibited within one-quarter (1/4) mile of the Frying Pan River.
g. Dogs are prohibited.

13. <u>Bayfield Lions Club Shooting Range - La Plata County</u>

a. Public access is allowed April 1 through November 30.
b. Public access is allowed from 9:00 a.m. to 8:00 p.m. from April 1 through October 31.

c. Public access is allowed from 10:00 a.m. to 5:00 p.m. from November 1 through November 30.
d. Pistol or rifle shooting is prohibited on the shotgun trap range.
e. Shotguns, shooting slugs only, are allowed on the pistol-rifle range.
f. Except for muzzleloaders, rifles are restricted to those smaller than .50 caliber.
g. Except for clay targets, glass or other breakable targets are prohibited.
h. Public access to Bayfield Lions Club Shooting Range is exempt from requirements set forth in section #900(C)1 of these regulations.

14. Beaver Creek Reservoir State Wildlife Area - Rio Grande County

a. Discharge of firearms or bows is prohibited.
b. Launching and use of all vessels is allowed.
c. Operating a vessel in a manner that creates a whitewater wake is prohibited.

15. Beaver Creek State Wildlife Area - Fremont County

a. Public access is prohibited from August 15 through April 30, except while hunting or fishing or while wildlife viewing from established parking areas.
b. Dogs are prohibited.

16. Beaver Lake State Wildlife Area (Marble) - Gunnison County

a. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand when used as an aid for fishing.
b. Motor vehicles are prohibited on the dam.
c. Discharge of firearms or bows is prohibited.

17. Bellaire Lake State Wildlife Area - Larimer County

a. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand, wind or electric motor.
b. Public access to Bellaire Lake State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

18. Bergen Peak State Wildlife Area - Clear Creek and Jefferson Counties

a. Discharge of firearms of bows is prohibited, except while hunting.
b. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

19. Big Meadows State Wildlife Area - Mineral County

a. Launching and use of all vessels is allowed.
b. Operating a vessel in a manner that creates a whitewater wake is prohibited.

20. Big Thompson Ponds State Wildlife Area - Larimer County

a. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise daily, except while fishing or when authorized by a night hunting permit.
b. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand when used as an aid for fishing or hunting.
c. Discharge of firearms or bows is prohibited, except while hunting or bowfishing.
d. Horse use is prohibited.
e. Bicycles are prohibited.
f. Dog training and field trials are prohibited.

21. Bighorn Springs State Wildlife Area (Fishing Easement) - Chaffee County

a. Public access is prohibited, except while fishing.
b. Public access is prohibited from one-half (1/2) hour after sunset to sunrise.
c. Parking and access is allowed from designated parking areas only.
d. Dogs are prohibited

22. Bill Patterson State Wildlife Area – Garfield County

a. Waterfowl hunting is allowed from designated blinds only.
b. Hunting is allowed with shotguns only.
c. Discharge of firearms or bows is prohibited, except while hunting.
d. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).

23. Billy Creek State Wildlife Area - Ouray and Montrose Counties

a. Camping is allowed by licensed hunters during an established big game season plus (3) days before and (3) days after each season.
b. Public access is prohibited from January 1 through April 30, except for hunting, fishing, and trapping along the Uncompahgre River corridor from US Hwy 550 to 100 feet from the east bank of the river.
c. Launching and take out of non-motorized vessels is allowed.

24. Bitterbrush State Wildlife Area - Moffat County

a. Public access is prohibited from January 15 through April 30.
b. Motor vehicle access is restricted to Moffat Co Rds 59 and 143.
c. The placing of any portable blind, marker, stand or related structure is prohibited prior to August 1 annually and must be removed within 24 hours after harvesting an animal or within seven (7) days after the end of the archery pronghorn season, whichever comes first.

25. Blacktail Conservation Easement - Routt County

a. Public access is prohibited from December 1 through July 15.
b. Discharge of firearms or bows is prohibited, except while hunting.

26. Bliss State Wildlife Area - Larimer County

a. Vessel use is prohibited.

27. Blue River State Wildlife Area - Summit County

a. Overnight parking is prohibited.
b. Discharge of firearms or bows is prohibited.

28. Bob Terrell State Wildlife Area - Garfield County

a. Launching and use of vessels is allowed, except that launching and take out of personal watercraft (PWC) is prohibited.
b. Discharge of firearms or bows is prohibited.

29. Bodo State Wildlife Area - La Plata County

a. Public access is prohibited from December 1 through April 30, except that:
    1. Small game hunting is allowed south of CR 210.

2. Public access to the Smelter Mountain Trail is allowed by foot only from 10:00 a.m. - 2:00 p.m.

b. Discharge of firearms or bows is prohibited, except while hunting.
c. Launching of paragliders is allowed from the Smelter Mountain Trail, subject to the restrictions listed in a.2 above.
d. Dogs are allowed from May 1 through September 30 but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).
e. Dogs are allowed pursuant to #900(C)(15) from October 1 through November 30.

30. Boedecker Reservoir State Wildlife Area - Larimer County

a. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise except while fishing.
b. Fishing is prohibited from vessels from November 1 through the last day of the migratory waterfowl season.
c. Launching and use of all vessels is allowed.
d. Operating a vessel in a manner that creates a whitewater wake is prohibited.
e. Sail surfboards are prohibited.
f. Discharge of firearms or bows is prohibited, except while hunting or bowfishing.
g. Horse use is prohibited.

31. Bosque del Oso State Wildlife Area - Las Animas County

a. Public access is prohibited from December 1 through April 30, except for properly licensed big game and spring turkey hunters and one non-hunting companion.
b. Fishing is prohibited on the South Fork of the Purgatoire River within the boundaries of the Bosque del Oso State Wildlife Area from the first day after the Labor Day holiday weekend to the first day of the Memorial Day holiday.
c. Parking and access is allowed from designated parking areas only.
d. Discharge of firearms or bows is prohibited, except while hunting or bowfishing.
e. Camping is allowed by licensed hunters during an established big game, spring turkey, and fall turkey season plus three (3) days before and three (3) days after each season.
f. Fires are allowed within a containment structure in designated camping areas.
g. Leaving any unattended food or trash is prohibited unless it is being stored in a bear resistant manner or container.

32. Bravo State Wildlife Area - Logan County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. All recreational activities, except deer hunting, are prohibited on the opening weekend of the regular plains rifle deer season and on the opening day and first weekend of the late plains rifle deer season.
c. The launching or takeout of vessels is prohibited during waterfowl seasons.
d. Horse use is prohibited.
e. Field trials are prohibited.

33. Brower State Wildlife Area - Weld County

a. Public access is prohibited from the day after the spring turkey season through August 31. Additionally, public access is prohibited from the day after the close of

the regular goose season through the day before the opening of the spring turkey season.

b. Public access is prohibited, except while hunting.
c. Public access is prohibited one (1) hour after sunset to 4:00 a.m.
d. Parking is allowed in the designated parking area only.
e. Fishing is prohibited.
f. Discharge of firearms or bows is prohibited, except shotguns or bows may only be used while hunting.
g. Horse use is prohibited.

34. Brownlee State Wildlife Area (Fishing Lease) - Jackson County

a. Public access is prohibited, except while fishing.
b. Discharge of firearms or bows is prohibited.

35. Brownlee II State Wildlife Area (Fishing Lease) - Jackson County

a. Public access is prohibited, except while fishing.
b. Discharge of firearms or bows is prohibited.

36. Browns Park State Wildlife Area - Moffat County

a. Public use is prohibited within the posted administrative area of the Calloway Unit.
b. Public access on the Wiggins Unit is allowed by foot or horseback only except along the main road that runs east and west on the south end of the property.
c. Camping is allowed in the Cold Springs Mountain Unit and west of Beaver Creek in the Beaver Creek Unit except as posted.
d. Fires are allowed within a containment structure.

37. Brush State Wildlife Area - Morgan County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. All recreational activities, except deer hunting, are prohibited on the opening weekend of regular plains rifle deer season and on the opening day and first weekend of the late plains rifle deer season.
c. The launching or takeout of vessels is prohibited during waterfowl seasons.

38. Brush Hollow State Wildlife Area - Fremont County

a. Operating a vessel in a manner that creates a whitewater wake is prohibited.
b. Hunting and the discharge of firearms or bows is prohibited.

39. Brush Prairie Ponds State Wildlife Area - Morgan County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. From September 1 through the dark goose season, only hunting allowed. Hunters must check-in and out at the check station.
c. From September 1 through November 30, only migratory bird hunting within designated areas is allowed, and only on Saturdays, Sundays, Wednesdays, and state and federal holidays. Reservations are required and valid until sunrise, and are limited to three (3) per hunter annually. Reservations must be made in accordance with #901.A of these regulations.

d. Hunters may not check-in until 4:00 a.m. and can only hunt the area reserved or which they check into. Hunters may check-in on a first-come, first-serve basis after a hunter checks out or after sunrise if a hunter has not checked-in. Maximum of four (4) hunters and two (2) vehicles allowed per hunting area.
e. From September 1 through November 30, scouting is prohibited, except on Thursdays from 10:00 a.m. – 2:00 p.m. All persons must check-in and out at the check station. All firearms and dogs are prohibited while scouting.
f. From December 1 through the dark goose season, hunters may check-in on a first-come, first-serve basis after 4:00 a.m. or after a hunter checks out. Five (5) hunting areas are open for check-in. Hunters properly checked in may hunt anywhere on the property.
g. Up to two (2) hunting areas are reserved each year for residents with a physical address of Brush, CO. Applications to enter the drawing are available at the CPW Brush Service Center in mid-August. Hunters must possess a valid license to hunt waterfowl to enter the drawing. Hunters may apply for one hunt area per day, but can list multiple requests on one application. Hunters successful in the drawing are required to comply with all hunting restrictions listed in regulation #901.A of these regulations.
h. Discharge of a firearm or bow is prohibited, except while hunting.

40. Buena Vista State Wildlife Area - Chaffee County

a. Public access to Buena Vista State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

41. Burry State Wildlife Area (Fishing Lease) - Garfield County

a. Public access is prohibited, except while fishing.
b. Public access is limited to designated points as posted.
c. Dogs are prohibited.

42. Centennial State Wildlife Area - Gunnison County

a. Public access is prohibited from December 1 through June 30.
b. Dog training and field trials are prohibited.

43. Centennial Valley State Wildlife Area – Weld County

a. Public access is prohibited from one (1) hour after sunset – 4:00 a.m.
b. Public access is prohibited from the day after the last day of the spring turkey season through August 31.
c. During the spring turkey season, public access is prohibited except for licensed turkey hunters that have a turkey hunting reservation. A total of ten (10) reservation slots per day will be available for spring turkey hunters during the spring turkey season. Turkey hunters with a reservation may hunt the entire property. There is no annual limit on the number of turkey reservations. Reservations must be made in accordance with #901.A of these regulations. A maximum of four (4) hunters are allowed per turkey hunting reservation slot.
d. During the regular duck seasons, public access is limited to Saturdays, Sundays, Wednesdays, and state and federal holidays. Reservations are required to hunt waterfowl and small game, and are limited to three (3) per hunter annually. Waterfowl and small game hunters may only hunt the areas specified on their reservation. Reservations must be made in accordance with #901.A of these

regulations.

e. All reservation hunters must check out at one of the check stations located in each parking lot of the property.
f. Small game and waterfowl hunting is prohibited on the opening weekend of the regular plains rifle deer season and the opening day and first weekend of the late plains rifle deer season.
g. Discharge of firearms or bows is prohibited, except while hunting.
h. Hunting with centerfire rifles is prohibited.
i. Horse use is prohibited.

44. Cerro Summit State Wildlife Area - Montrose County

a. Public access is prohibited, except while fishing and hunting only.
b. Public access is allowed by foot only.
c. Parking and public access to the property is allowed from designated parking areas only.
d. Hunting is prohibited from December 1 to August 14.
e. Fishing is prohibited from December 1 to February 28.
f. Dogs are allowed as an aid in small game hunting only. Dogs are prohibited from entering the water.
g. Vessel use and water contact activity is prohibited, except for launching and use of float tubes (with waders) for fishing only.

45. Chaffee County Shooting Range State Wildlife Area - Chaffee County

a. Public access is prohibited from sunset to sunrise.

46. Champion State Wildlife Area (Fishing Easement) - Chaffee County

a. Public access is prohibited, except while fishing.
b. Parking and access is allowed from designated parking areas only.

47. Chance Gulch State Wildlife Area – Gunnison County

a. Public access is prohibited from March 1 through June 30, except for through traffic on Gunnison Co Rd 42a and established roads connecting to designated BLM roads.

48. Cherokee State Wildlife Area (Upper Unit, Middle Unit, Lower Unit, Lone Pine Unit, Roy Brown Unit) - Larimer County

a. Public access is prohibited from September 1 to May 1, except while hunting and fishing.
b. Hunting and fishing access after the close of the last big game season is by foot only.
c. Horse use is restricted to designated roads and trails, except for horses used as an aid in hunting big game.
d. Horse use is prohibited while hunting mountain lion.
e. Horse use is allowed on the Rattlesnake Loop on the Lone Pine Unit from May 2 through August 31.
f. Camping is allowed.
g. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

49. Chesmore State Wildlife Area - Chaffee County

a. Public access to Chesmore State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

50. Christina State Wildlife Area (Elk River Fishing Easement) - Routt County

a. Public access is prohibited, except while fishing.
b. Discharge of firearms or bows is prohibited.

51. Chubb Park Ranch State Wildlife Area - Chaffee County

a. Discharge of firearms or bows is prohibited, except while hunting.

52. Chuck Lewis State Wildlife Area - Routt County

a. Public access is prohibited from sunset to sunrise except while hunting or fishing.
b. Overnight parking is prohibited.
c. Big game and small game hunting are prohibited.
d. Waterfowl hunting is allowed, except for within 50 yards of the bridge on Routt Co Rd 14F.
e. Horses are allowed in the parking area.
f. Discharge of firearms or bows is prohibited, except while hunting.

53. Cimarron State Wildlife Area - Montrose and Gunnison Counties

a. Snowmobile use is prohibited.
b. Overnight parking is prohibited.
c. Public access is prohibited from January 1 through June 30.

54. Clear Creek Reservoir State Wildlife Area - Chaffee County

a. Camping is allowed in designated areas only.
b. Fires are allowed within a containment structure in designated camping areas.
c. Fishing is prohibited from the dam, spillway, outlet structures and downstream to US 24.

55. Cline Ranch State Wildlife Area - Park County

a. Public access is allowed in designated parking area only.
b. Overnight parking is prohibited
c. Fishing access is restricted to designated fishing areas (beats) only. Access to each fishing beat is restricted to occupants of the vehicle parked in the parking stall assigned to that beat (determined by corresponding number). No more than four anglers are allowed per vehicle, and only one vehicle is allowed per stall.
d. Fishing is prohibited from October 1 through the end of February.
e. Hunting access is limited to occupants of vehicles parked in designated parking stalls with a maximum of four hunters per vehicle.
f. Discharge of firearms or bows is prohibited, except while hunting.
g. Dog training and field trials are prohibited.

56. Coal Creek Ranch State Wildlife Area (Access Easement) - Rio Blanco County

a. Public access allowed from May 1 through November 30 while fishing only.
b. Public access is allowed while deer and elk hunting during the archery and muzzleloader season only.

c. Public access is limited to four hunters per day and hunters must sign in and out of property as posted.
d. Parking and access is allowed from designated parking areas only.

57. Coalbed Canyon State Wildlife Area – Dolores County

a. Discharge of firearms or bows is prohibited, except while hunting.

58. Cochetopa State Wildlife Area - Saguache County

a. Public access is allowed by foot only from designated parking areas.
b. Public access is prohibited from one (1) hour after sunset until one (1) hour before sunrise, except when a hunter is retrieving downed game.
c. Big game hunting is prohibited north of the posted east/west center line of Section 27, Range 2 East, Township 46 North.
d. Dogs are prohibited.

59. Coller State Wildlife Area - Rio Grande and Mineral Counties

a. Overnight parking is prohibited.
b. Snowmobile use is prohibited.c. Vessel use is prohibited, except for launching and take out of vessels that are propelled by hand.

d. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

60. Collins Mountain Ranch State Wildlife Area (Access Easement) – Rio Blanco County

a. Public access is prohibited, except while deer or elk hunting.
b. Hunting allowed by reservation only.
c. All hunters must comply with the Hunter Reservation System and reservations must be made through the Hunter Reservation System in accordance with #901.A of these regulations.
d. Motor vehicle use is prohibited, except for on designated roadways or through permission of the ranch owners. All other access is restricted to walk-in access only.
e. Discharge of firearms or bows prohibited, except while hunting.
f. Fishing is prohibited.

61. Colorado River Island State Wildlife Area - Mesa County

a. Hunting is prohibited, except for waterfowl hunting from designated blinds.
b. Waterfowl hunting is allowed by reservation only.
c. All hunter must comply with the Hunter Reservation System and reservations must be made through the Hunter Reservation System in accordance with #901.A of these regulations.
d. Discharge of firearms or bows is prohibited, except while hunting.

62. Colorow Mountain State Wildlife Area - Rio Blanco County

a. Public access is prohibited from February 1 through April 30.
b. Motorized vehicles are prohibited in the Scenery Gulch Unit.
c. Motorized vehicles are prohibited in the Tschuddi Unit north of the designated camping area.

d. Parking and access is allowed from designated parking areas only.
e. Discharge of firearms or bows is prohibited within 200 yards of camping or parking areas or any structure.
f. Discharge of firearms or bows is prohibited, except while hunting.
g. Camping is allowed in designated areas only.
h. Fires are allowed within a containment structure.

63. Columbine State Wildlife Area - Douglas County

a. Discharge of firearms is prohibited.
b. Fishing is prohibited.
c. Hunting is prohibited.
d. Public access is prohibited in riparian areas for the protection of Preble's meadow jumping mouse, as posted.

64. Cottonwood State Wildlife Area - Morgan County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. All recreational activities, except deer hunting, are prohibited on the opening weekend of the regular plains rifle deer season and on the opening day and first weekend of the late plains rifle deer season.
c. The launching or takeout of vessels is prohibited during waterfowl seasons.

65. Cottonwood Creek State Wildlife Area - Chaffee County

a. Public access to Cottonwood Creek State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

66. Cowdrey Lake State Wildlife Area - Jackson County

a. Operating a vessel in a manner that creates a whitewater wake is prohibited.
b. Discharge of firearms or bows is prohibited, except while hunting.
c. Camping is allowed in designated areas only.
d. Fires are allowed within an established containment structure in designated areas.
e. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).

67. Creede State Wildlife Area – Mineral County

a. Hatchery Tract
    1. Hunting and the discharge of firearms or bows is prohibited.
    2. Dogs are allowed but must be kept under control on a physical leash by the handler at all times.
    3. Overnight parking is prohibited.
b. Mountain Views RV Park Fishing Easement
    1. Public access is allowed from designated access points as posted.
    2. Public access within the high water mark of the Rio Grande River is prohibited, except while fishing.
c. Deep Creek Bridge Tract
    1. Hunting and the discharge of firearms or bows is prohibited.
    2. Dogs are allowed but must be kept under control on a physical leash by the handler at all times.
    3. Overnight parking is prohibited.

d. Vessel use is prohibited, except for launching and take out of vessels that are propelled by hand.

68. Crooked Wash Ranch State Wildlife Area (Access Easement) – Moffat County

a. Public access is prohibited, except while elk hunting.
b. Hunting allowed by reservation only.
c. All hunters must comply with the Hunter Reservation System and reservations must be made through the Hunter Reservation System in accordance with #901.A of these regulations.
d. Discharge of firearms or bows is prohibited, except while hunting.
e. Motor vehicle use is prohibited, except for on designated roadways or through permission of the ranch owners. All other access is restricted to walk-in access only.
f. Fishing is prohibited.

69. Cross Canyon State Wildlife Area - Dolores County

a. Public access during the first two days of the rifle deer and elk seasons is restricted to youth and a non-hunting mentor.
b. Parking is allowed in designated parking areas only.
c. Discharge of firearms or bows is prohibited, except while hunting.
d. Dog training and field trials are prohibited.

70. Dan Noble State Wildlife Area - San Miguel County

a. Miramonte Reservoir Tract
    1. Camping is allowed in designated areas only.
    2. Discharge of firearms or bows is prohibited, except while hunting.
    3. Launching and use of all vessels is allowed. Trailered vessels must be launched from boat ramps.
    4. Waterskiing and personal watercraft (PWC) are allowed in designated areas only on the western half of the reservoir. Waterskiing is allowed from 10:00 a.m. to sunset.
    5. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).
b. Greager Tract
    1. Public access is prohibited from March 1 through May 15, except under permit issued by AWM/DWM for viewing purposes.
    2. Public access is allowed by foot or horseback only.
    3. Viewing site is limited to area selected by Division personnel.
    4. Viewing parties will abide by all restrictions and conditions on the permit.
    5. Snowmobile use is prohibited.
c. John Kane Tract
    1. Public access is prohibited from March 1 through May 15.
    2. Public access is allowed by foot or horseback only.
    3. Snowmobile use is prohibited.

71. Dawn Pond State Wildlife Area - Bent County

a. Public access is prohibited, except while fishing; hunting is by landowner permission only.
b. Parking and access is allowed from designated parking areas only.

c. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand or electric motors are allowed when used as an aid in fishing or hunting.

72. Delaney Butte Lakes State Wildlife Area - Jackson County

a. Operating a vessel in a manner that creates a whitewater wake is prohibited.
b. Discharge of firearms or bows is prohibited, except while hunting.
c. Fires are allowed within an established containment structure in designated areas.
d. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).

73. Devil Creek State Wildlife Area - Archuleta County

a. Snowmobile use is prohibited.
b. Discharge of firearms or bows is prohibited, except while hunting.

74. Deweese Reservoir State Wildlife Area – Custer County

a. Vessel use is prohibited, except while fishing. Any other water recreation use, other than fishing, is restricted to owners with deeded recreation rights on Deweese Reservoir.
b. OHV use is prohibited. Snowmobile use is allowed only as an aid in ice fishing.
c. Camping is allowed by reservation only in designated and established camping areas.
d. Fires are allowed within an established containment structure in designated camping areas.
e. Glass containers are prohibited.
f. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

75. Diamond J State Wildlife Area (Hunting and Fishing Lease) - Jackson County

a. Public access is allowed while fishing, small game hunting, and waterfowl hunting only.
b. Hunting is allowed with shotguns or by falconry only.
c. Discharge of firearms or bows is prohibited, except while hunting.

76. Dolores River State Wildlife Area - Montezuma County

a. Parking is allowed in designated parking areas only.
b. Fishing is prohibited in the rearing ponds.

77. Dome Lakes State Wildlife Area - Saguache County

a. Discharge of firearms or bows is prohibited in the designated safety zones or as posted.
b. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except when used as an aid in hunting waterfowl.
c. Camping is allowed in designated areas.
d. Fires are allowed within a containment structure in designated camping areas.

78. Dome Rock State Wildlife Area - Teller County

a. Public access is prohibited from December 1 through July 15 in the area bounded on the east by the Sand Creek Trail, on the north by the Dome Rock

Trail, and on the west and south by the property boundaries. The Dome Rock Trail west of the Jack Rabbit Lodge is closed from December 1 through July 15.

b. Parking and public access is allowed from designated parking lots and connecting trails from Mueller State Park only.
c. Horse and pack animal use is allowed on designated roads and trails only, except when used as an aid to big game hunting.
d. Rock climbing is prohibited.
e. Dogs are prohibited.

79. <u>Douglas Reservoir - Larimer County</u>

a. Public access is prohibited from one (1) hour after sunset until one (1) hour before sunrise, except while fishing.
b. Hunting and the discharge of firearms or bows is prohibited.
c. The use of any vessel or single compartment air or gas filled flotation device and all water contact is prohibited, unless actively fishing.
d. Operating a vessel in a manner that creates a whitewater wake is prohibited.
e. Sailboards, sailboats and ice skating is prohibited.
f. OHV and snowmobile use is prohibited.
g. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

80. <u>Dowdy Lake State Wildlife Area - Larimer County</u>

a. Launching and use of all vessels is allowed.
b. Operating a vessel in a manner that creates a whitewater wake is prohibited.
c. Public access to Dowdy Lake State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

81. <u>Dry Creek Basin State Wildlife Area - San Miguel County</u>

a. Snowmobile use is prohibited.
b. Camping is allowed in designated areas by licensed hunters during an established big game season plus three (3) days before and three (3) days after each season.

82. <u>Duck Creek State Wildlife Area - Logan County</u>

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. One field trial per year in February, March, or August may be authorized.

83. <u>Dune Ridge State Wildlife Area - Logan County</u>

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. All recreational activities, except deer hunting, are prohibited on the opening weekend of the regular plains rifle deer season and on the opening day and first weekend of the late plains rifle deer season.
c. The launching or takeout of vessels is prohibited during waterfowl seasons.

84. <u>Dutch Gulch State Wildlife Area - Gunnison County</u>

a. Public access is prohibited from March 1 through June 30, except for through traffic on Gunnison Co. Rd 42 and on established roads connecting to designated BLM roads.

85. Eagle River State Wildlife Area (Fishing Leases) - Eagle County

a. Public access is prohibited, except while fishing.
b. Public access is limited to designed points as posted.
c. Dogs are prohibited

86. Eagle Rock State Wildlife Area - Yuma County

a. Public access prohibited from 9 p.m. - 4 a.m.
b. Public access is allowed by foot traffic only.
c. Horse use is prohibited, except while used in hunting.
d. Dog training is prohibited.

87. Echo Canyon Reservoir State Wildlife Area - Archuleta County

a. Launching and use of all vessels is allowed.
b. Operating a vessel in a manner that creates a whitewater wake is prohibited.
c. Discharge of firearms or bows is prohibited, except while hunting.
d. Snowmobile use is prohibited.
e. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

88. Elk Springs Ranch State Wildlife Area - Moffat County

a. Public access is prohibited from March 1 through August 14.

89. Elliott State Wildlife Area - Morgan County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. All recreational activities, except deer hunting, are prohibited on the opening weekend of the regular plains rifle deer season and on the opening day and first weekend of the late plains rifle deer season.
c. Landowner permission is required to hunt deer on access easement.
d. The launching or takeout of vessels is prohibited during waterfowl seasons.
e. Lonetree Tract:
    1. From September 1 through the regular duck seasons, hunters must check-in and out at check station. Hunters may not check-in until 4:00 a.m.
f. Hamlin Tract:
    1. From September 1 through the regular duck seasons, hunters must check-in and out at check stations. Hunters may check-in on a first-come, first-serve basis after 4:00 a.m. or after another hunter checks out. Hunters may only hunt the area they check into, and must comply with youth-mentor only area restrictions as posted. Maximum of four (4) hunters allowed per hunting area.
g. Union Tract:
    1. Only waterfowl hunting allowed from designated blinds or areas, and only on Saturdays, Sundays, Wednesdays, and state and federal holidays. Reservations are required and valid until sunrise, and are limited to three (3) per hunter annually. Reservations must be made in accordance with #901.A of these regulations.
    2. All hunters must check-in and out at check station. Hunters may not check-in until 4:00 a.m. and can only hunt the area reserved or which they check into. Hunters may check-in on a first-come, first-serve basis after a hunter checks out or after sunrise. A maximum of four (4) hunters allowed per hunting area.

3. During waterfowl seasons, scouting is prohibited, except on Thursdays from 10:00 a.m. until 2:00 p.m. All persons must check-in and out at the check station. All firearms and dogs prohibited while scouting.

90. Emerald Mountain State Wildlife Area - Routt County

a. Public access is prohibited from December 1 through July 15.
b. Public access is prohibited from sunset to sunrise except while fishing.
c. Public access is allowed by foot and horseback only.
d. Discharge of firearms of bows is prohibited.
e. Dogs are prohibited.

91. Escalante State Wildlife Area - Mesa, Delta & Montrose Counties

a. Public access is prohibited on the Hamilton and Lower Roubideau tracts from March 15 through July 31.
b. Public access is prohibited in the Lower Roubideau tract youth area as posted from August 1 through March 14 except for youth fishing and hunting. No more than one mentor per youth hunter may engage in hunting.
c. Field trials may be authorized during February, March, August, and September only.
d. Dog training is prohibited on the Hamilton and Lower Roubideau tracts during any upland game bird or migratory bird season.
e. Game birds listed in #009(B) of these regulations may be released by the Division or its agent for educational or training purposes without seasonal or numerical restrictions.

92. Fish Creek State Wildlife Area - Dolores County

a. Public access is prohibited from December 1 through June 30.
b. Camping is allowed in designated parking areas by licensed hunters during an established big game season plus three (3) days before and three (3) days after each season.

93. Flagler Reservoir State Wildlife Area - Kit Carson County

a. Hunting is prohibited, except for youth mentor hunting only. No more than one mentor per youth hunter may engage in hunting.
b. Camping is allowed by licensed hunters during an established big game season or spring and fall turkey season plus three (3) days before and three (3) days after each season or while actively fishing.
c. Fires are allowed within an established containment structure in designated areas.

94. Flanders Ranch State Wildlife Area (Hunting and Fishing Easement) – Routt County

a. Public access is allowed by foot only.
b. Public access is allowed from designated parking areas only.
c. Fishing is prohibited during established big game hunting seasons.
d. Waterfowl and big game hunting is allowed by reservation only.

e. All hunters must comply with the Hunter Reservation System and reservations must be made through the Hunter Reservation System in accordance with #901.A of these regulations.
f. Discharge of firearms or bows is prohibited, except while hunting.
g. Launching and take out of vessels is prohibited.
h. Dogs are allowed but must be kept under control on a physical leash by the handler, except as authorized in #900(C)(15).

95. Frank State Wildlife Area - Weld and Larimer counties

a. Public access, including fishing and wildlife-related recreation, is prohibited north of the Poudre River.
b. Discharge of firearms or bows is prohibited, except while bowfishing.
c. Hunting is prohibited.
d. Operating a vessel in a manner that creates a whitewater wake is prohibited.
e. Bicycles are allowed.

96. Franklin Island State Wildlife Area - Mesa County

a. Hunting is prohibited, except for waterfowl hunting from designated blinds.
b. Waterfowl hunting is allowed by reservation only
c. All hunters must comply with the Hunter Reservation System and reservations must be made through the Hunter Reservation System in accordance with #901.A of these regulations.
d. Discharge of firearms or bows is prohibited. except while hunting.

97. Frantz Lake State Wildlife Area - Chaffee County

a. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand, wind or electric motor.
b. Hunting and the discharge of firearms or bows is prohibited.
c. Water contact activities are allowed.
d. Bicycles are allowed.
e. Dogs are allowed but must be kept under control on a physical leash by the handler at all times.

98. Frenchman Creek State Wildlife Area - Phillips County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.

99. Frying Pan State Wildlife Area (Fishing Lease) - Eagle County

a. Public access is prohibited except while fishing.
b. Public access is limited to designated point as posted.
c. Dogs are prohibited.

100. Garfield Creek State Wildlife Area - Garfield County

a. Public access is prohibited from December 1 through July 15, except for spring turkey hunters.
b. Grouse hunting is prohibited on the Upper Baldy Unit.
c. Hunting is prohibited within 75 yards of the center line of Garfield Co Rds 312 and 328.

d. Discharge of firearms or bows is prohibited in the designated safety zones, or as posted.
e. Discharge of firearms or bows is prohibited, except while hunting.
f. Camping is allowed by licensed hunters during an established big game season plus three (3) days before and three (3) days after each season.
g. Fires are allowed within a containment structure while camping.

101. Granada State Wildlife Area - Prowers County

a. Parking and access is allowed from designated parking areas only.
b. Public access is prohibited from one (1) hour after sunset until one (1) hour before sunrise, except while actively hunting or fishing.
c. Midwestern Farms Tract
    1. Hunting is prohibited, except in the area south of the river road.
    2. Operating a vessel in a manner that creates a whitewater wake is prohibited.

102. Granby Ranch Conservation Easement - Grand County

a. Public access (Gazebo and associated Gazebo trail excluded) is prohibited from November 15 through April 14.
b. Public access is allowed on designated trails only.
c. Bicycles are allowed on designated trails only.
d. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).
e. Public access to Granby Ranch Conservation Easement is exempt from requirements set forth in section #900(C)1 of these regulations.

103. Grand Junction - West Lake State Wildlife Area - Mesa County

a. Public access is prohibited from 9:00 p.m. – 6:00 a.m.
b. Vessel use is prohibited.
c. Hunting is prohibited.
d. Dogs are allowed.
e. Public access to Grand Junction - West Lake State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

104. Granite State Wildlife Area (Fishing Easement) - Chaffee County

a. Public access is prohibited, except while fishing.
b. Launching and take out of vessels is prohibited.
c. Dogs are prohibited.
d. Mining activities and panning are prohibited.

105. Grieve Ranch Conservation Easement - Routt County

a Public access is prohibited on the hay meadows north of Routt County Road 129.
b. Public access to the Little Snake River while fishing is only allowed on the river corridor plus 20 feet above the high water line on either bank.
c. Discharge of firearms or bows is prohibited except while hunting.
d. OHV and snowmobile use is prohibited.
e. Camping is allowed in designated areas only.
f. Fires are allowed within a containment structure in designated campgrounds.

106. Groundhog Reservoir State Wildlife Area - Dolores County

a. Launching and use of vessels may be allowed as posted. Contact the Durango CPW office for current information. When allowed, trailered vessels must be launched from CPW boat ramp. When allowed, operating a vessel in a manner that creates a whitewater wake is prohibited.
b. Snowmobiles are allowed only as an aid in ice fishing.
c. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).
d. Public access to Groundhog Reservoir State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

107. Gunnison River State Wildlife Area (Van Tuyl and Redden) - Gunnison County

a. Public access to the Gunnison River is by foot only from the Van Tuyl trail intersection at the Y-gate.
b. Discharge of firearms or bows is prohibited, except for waterfowl hunting on the Van Tuyl tract only.
c. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except when used as an aid in hunting waterfowl.

108. Gunnison State Wildlife Area - Gunnison County

a. Public access is prohibited from December 1 through April 30.
b. Public access to the Blinberry Gulch parcel is prohibited from December 1 through June 30.
c. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise, except for lawful hunting activities.
d. Beaver Creek Trail is restricted to foot and horseback travel only.
e. Camping is allowed in designated areas by licensed hunters during an established big game season plus three (3) days before and three (3) days after each season.
f. Fires are allowed within a containment structure in designated camping areas.
g. Archery range users must comply with archery range rules as posted.

109. Gypsum Ponds State Wildlife Area - Eagle County

a. Public access is prohibited between sunset and sunrise, except while hunting or fishing.
b. Parking and public access is allowed through designated points as posted only.
c. Launching and take out of vessels prohibited.
d. Dogs are prohibited from March 15 through July 15.When allowed dogs must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).

110. Hardeman State Wildlife Area (Fishing Easement) – Lake County

a. Public access is prohibited, except while fishing.
b. Launching and take out of vessels is prohibited.
c. Hunting and the discharge of firearms or bows is prohibited.
d. Dogs are prohibited.
e. Mining activities and panning are prohibited.

111. Harmon State Wildlife Area (Fishing Easement) - Chaffee County

a. Public access is prohibited, except while fishing.

b. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise.
c. Hunting and the discharge of firearms or bows is prohibited.
d. Dogs are prohibited.

112. Haviland Lake State Wildlife Area - La Plata County

a. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand, wind or electric motor.
b. Discharge of firearms or bows is prohibited, except while hunting.

113. Hayden Shooting Range – Routt County

a. Public access is prohibited from sunset to sunrise.
b. Exploding targets and any targets other than paper and cardboard are prohibited.
c. All rounds must impact designated berms, except for shotguns using bird shot.

114. Headwaters Ranch State Wildlife Fishing Easement – Lake County

a. Public access is prohibited, except while fishing.
b. Parking and access is allowed from designated parking areas only.
c. Dogs are prohibited.

115. Heckendorf State Wildlife Area - Chaffee County

a. Parking and access is allowed from designated parking areas only.
b. Public access is prohibited from August 15 through April 30, except while hunting or while wildlife viewing from established parking areas.

116. Hereford Haven State Wildlife Area – Routt County

a. Public access is allowed by foot only.
b. Waterfowl hunting is allowed by reservation only.
c. All hunters must comply with the Hunter Reservation System and reservations must be made through the Hunter Reservation System in accordance with #901.A of these regulations.
d. Big game and small game hunting prohibited.
e. Discharge of firearms or bows is prohibited, except while hunting.
f. Fishing is prohibited during established big game seasons.
g. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except when used as an aid in hunting.

117. Higel State Wildlife Area - Alamosa County

a. Public access is prohibited from September 1 through February 14, except on Saturdays, Sundays, Wednesday, and state and federal holidays.
b. From September 1 through February 14, a valid access permit must be obtained. A maximum of 25 permits will be issued per day and are available at no charge on a first-come, first-served basis. Permits may be obtained by emailing montevista.wildlife@state.co.us or by calling (719) 587-6900.
    1. Reservations may be made up to 14 days in advance, but not less than two days before the date requested.
c. Public access is prohibited from February 15 through July 15 annually.

d. The Area Wildlife Manager may authorize special use of the area during closures to accommodate educational or scientific uses if it will not be detrimental to nesting or migrating water birds.

118. Hohnholz Lakes State Wildlife Area - Larimer County

a. Boating is prohibited, except for craft propelled by hand, wind or electric motor.
b. Camping is prohibited, except within the Laramie River camping area.
c. Public access is prohibited on the Grace Creek access road except to licensed hunters, beginning August 16 through the last day of the fourth rifle season.
d. Sail surfboards are prohibited.

119. Holbrook Reservoir State Wildlife Area - Otero County

a. Discharge of firearms or bows is prohibited in the designated safety zones, or as posted.
b. Launching and use of all vessels is allowed.
c. Water contact activities are allowed.
d. Camping is allowed in designated and established camping areas.
e. Fires are allowed within an established containment structure in designated areas.

120. Holly State Wildlife Area - Prowers County

a. Discharge of firearms or bows is prohibited in the designated safety zones, or as posted.

121. Holyoke State Wildlife Area - Phillips County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.

122. Home Lake State Wildlife Area - Rio Grande County

a. Public access is prohibited from sunset to sunrise, except for fishing.
b. Hunting and the discharge of firearms or bows is prohibited.
c. Vessel use is prohibited, except for launching and use of vessels that are propelled by hand, wind, electric motor, or motorboats up to 10 horsepower.
d. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).
e. Public access to Home Lake State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

123. Horse Creek Reservoir State Wildlife Area (Timber Lake) - Bent & Otero Counties

a. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise daily, except while fishing.
b. Public access to the frozen surface of the lake is prohibited.
c. Public access to the dams, inlets, and outlet structures is prohibited, except while fishing.

124. Horsethief Canyon State Wildlife Area - Mesa County

a. Public access is prohibited from March 15 through July 15 as posted except while spring turkey hunting.
b. Public access is prohibited between sunset and sunrise, except while fishing and hunting.

c. All turkey hunting; and waterfowl hunting west of Blind #1 south of the Colorado River are allowed by reservation only.
d. All turkey hunters; and waterfowl hunters west of Blind #1 south of the Colorado River must comply with the Hunter Reservation System and reservations must be made through the Hunter Reservation System in accordance with #901.A of these regulations.
e. Waterfowl hunting is prohibited from Wednesday through Friday of each week, except for on Thanksgiving Day, Christmas Day, and New Year's Day.
f. Hunting is allowed with shotguns, hand-held bows, and muzzle-loading rifles or by falconry.
g. Quail hunting is prohibited.
h. Discharge of firearms or bows is prohibited in the designated safety zones, or as posted.
i. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).
j. Public access to Horsethief Canyon State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

125. Hot Creek State Wildlife Area - Conejos County

a. Vehicles are prohibited from January 1 through April 30.
b. Snowmobile use is prohibited.
c. Camping is allowed by licensed hunters during an established big game season plus three (3) days before and three (3) days after each season.
d. Fires are allowed within a containment structure.

126. Hot Sulphur Springs State Wildlife Area - Grand County

a. Public access is prohibited on the Byers Canyon Rifle Range, except between sunrise and sunset.
b. Public access on the Byers Canyon Rifle Range is prohibited from January 1 through April 30.
c. Discharge of firearms or bows is prohibited, except while hunting or on the designated shooting range.
d. Camping is allowed in designated campgrounds, in designated sites from May 15 through December 15.
e. Fires are allowed within an established containment structure in designated areas.
f. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).

127. Huerfano State Wildlife Area - Huerfano County

a. Camping is allowed by licensed hunters during an established big game season or spring and fall turkey season plus three (3) days before and three (3) after each season or when engaged in fishing activities.

128. Hugo State Wildlife Area - Lincoln County

a. Camping is allowed by licensed hunters during an established big game season or spring and fall turkey season plus three (3) days before and three (3) days after each season or while actively fishing.

b. Fires are allowed within an established containment structure in designated areas.

129. Indian Run State Wildlife Area - Routt County

a. Discharge of firearms or bows is prohibited, except while hunting.
b. Discharge of firearms or bows is prohibited in designated safety zones, or as posted.
c. Camping is allowed in designated areas only.
d. Fires are allowed within a containment structure.

130. Jackson Lake State Wildlife Area - Morgan County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m., except while fishing.
b. Fishing is prohibited from October 1 through the dark goose season.
c. Ice fishing is prohibited.
d. Discharge of firearms or bows is prohibited, except while hunting.
e. Hunting with centerfire rifles is prohibited.
f. Vessels and hunting are prohibited on frozen surface of lake.
g. During the teal season and the first split of the regular duck season, reservations are required on Saturdays, Sundays, and state and federal holidays to hunt waterfowl. Reservations are valid until sunrise and are limited to three (3) per hunter annually. Reservations must be made through the Hunter Reservation System in accordance with #901.A of these regulations. Reservations are not required Monday through Friday, except state and federal holidays, and hunters may check-in on a first-come, first-served basis.
h. Waterfowl hunters must check-in and out at the check station. Hunters may not check-in until 4:00 a.m. and can only hunt the area reserved. Hunters may check-in on a first-come, first-served basis after a hunter checks out or after sunrise if a hunter has not checked in. A maximum of four (4) hunters are allowed per hunting area.

131. Jackson State Wildlife Area (Fishing Lease) - Garfield County

a. Public access is prohibited, except while fishing.
b. Public access is allowed from designated points as posted only.
c. Dogs are prohibited.

132. James M. John State Wildlife Area - Las Animas County

a. Public access is prohibited from December 1 through June 30.
b. Hunting access is prohibited during the regular rifle deer and elk seasons, except for licensed big game hunters that have a hunting access permit. Permits are issued through a drawing process. Applications for fall hunting access permits are available July 1 online. Applications are due July 21. Permit holders must comply with all provisions of the hunting access permit.
c. Camping is allowed by licensed hunters during an established big game or turkey season plus three (3) days before and three (3) days after each season.
d. Camping is prohibited within one-hundred (100) feet of any stream.
e. Dogs are prohibited.

133. James Mark Jones State Wildlife Area - Park County

a. Public access is prohibited January 1 through May 1.

b. Camping is allowed from May 2 through August 13.
c. Camping is allowed by licensed hunters from August 14 through the end of the late elk season.
d. Fires are allowed within an established containment structure in designated areas.
e. Dog training and field trials are prohibited.

134. Jean K. Tool State Wildlife Area - Morgan County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. All recreational activities, except deer hunting, are prohibited on the opening weekend of the regular plains rifle deer season and on the opening day and first weekend of the late plains rifle deer season.
c. The launching or takeout of vessels is prohibited during waterfowl seasons.

135. Jensen State Wildlife Area - Rio Blanco County

a. Public access is prohibited from January 1 through July 15.
b. Discharge of firearms or bows is prohibited, except while hunting.
c. Camping is allowed in designated areas only.
d. Fires are allowed within a containment structure.

136. Jerry Creek Reservoirs State Wildlife Area (Jerry Creek Reservoirs #1 and #2) - Mesa County

a. Public access to the frozen surface of the lake is prohibited.
b. Vessel use is prohibited, except for launching and use of float tubes for fishing.
c. Hunting is prohibited.
d. Discharge of firearms or bows is prohibited.

137. Jim Olterman/Lone Cone State Wildlife Area - Dolores County

a. Snowmobile use is prohibited.
b. Camping is allowed in designated areas by licensed hunters during an established big game season or spring turkey season plus (3) days before and (3) days after each season.

138. Joe Moore Reservoir State Wildlife Area - Montezuma County

a. Launching and use of vessels may be allowed as posted. Contact the Durango CPW office for current information. When allowed, operating a vessel in a manner that creates a whitewater wake is prohibited.
b. Discharge of firearms or bows is prohibited, except while hunting.
c. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

139. John Martin Reservoir State Wildlife Area - Bent County

a. Field trials may be authorized during February, March, August, and September only.
b. Vessels are prohibited from November 1 through the last day of the migratory waterfowl season as posted on U.S. Army Corps of Engineer property under lease by Colorado Parks and Wildlife, except to retrieve downed waterfowl only.
c. Camping is allowed in designated and established camping areas.

d. Fires are allowed within an established containment structure in designated areas.

140. <u>Jumbo (Julesburg) Reservoir State Wildlife Area - Logan and Sedgwick Counties</u>

a. Property is limited to 250 vehicles.
b. Hunting is prohibited from the frozen surface of the lake.
c. Discharge of firearms or bows is prohibited, except while hunting.
d. Launching and use of all vessels is allowed.
e. Waterskiing is prohibited from 7:00 p.m. – 10:00 a.m., Friday through Monday of Memorial Day weekend.
f. Vessels are prohibited within 50 feet of outlet structure.
g. Launching of motorized vessels or sailboats is prohibited if the Aquatic Nuisance Species (ANS) inspection station is closed.
h. Hand-launched and hand-powered vessels shall only be used for fishing, to set-up/pick-up decoys or retrieve downed waterfowl after the ANS inspection station closes for the year or until the reservoir is frozen.
i. Camping is allowed in designated areas in designated number sites.
j. One camping unit is allowed per campsite.
k. Quiet hours will be enforced from 10:00 p.m. – 6:00 a.m. Legal hunting activities are except from quite hours.
l. Fires are allowed within a containment structure in designated camping areas.
m. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).

141. <u>Jumping Cow State Wildlife Area - Elbert County</u>

a. Hunting access is allowed by permit only. Hunters must have a valid license for their activity prior to applying for a permit. Permit holders shall have their permit on their person at all times while on the property. Permits may designate specific geographic hunting zones; in this case permits are restricted to the listed zone and are not valid property-wide. Access permits for hunters will be issued free of charge. Permits may be obtained via a drawing process. Permits on the Woodard Unit will be issued with priority given to mobility-impaired hunters and youth (accompanied by one hunting mentor). Applications are available from the CPW in Denver (303)291-7227. Application due dates are as follows:
    1. Applications for fall hunting access are due the 3rd Monday in August.
    2. Spring turkey applications are due the 3rd Monday in March.
b. Hunting is restricted to dove, turkey, doe pronghorn, antlerless elk, antlerless white-tailed deer, and antlerless mule deer. Hunting on the Woodard Unit is restricted to waterfowl, small game (excluding dove, turkey, and coyote), doe pronghorn, antlerless mule deer, and antlerless white-tailed deer.
c. Permitted hunters may take one other person (an observer) who is not hunting with them onto the property; however that person must remain with the permit holder at all times. On the Woodard Unit, a mobility-impaired person may bring two non-hunting companions.
d. Permitted hunters may not enter the property prior to the first Monday after the opening day of their individual season. Permits valid for hunting dove, wild turkey, or that are valid for the Woodard Unit only, may access the property on opening day of their season.

e. Vehicular access to the property is restricted. Motor vehicle use is only allowed on marked existing roadways that lead to marked parking areas. All other access is restricted to foot and horseback only. On the Woodard Unit, mobility-impaired hunters are allowed to use an Off-highway vehicle (OHV) for hunting and game retrieval as specified on their permit.
f. All gates on the property shall be left in the condition in which they are found after passing through the gateway.
g. Public access is allowed from two hours prior to sunrise to one hour after sunset except that when an animal is harvested the successful hunter is allowed to remain as long as is necessary to remove the animal.
h. Dogs are prohibited on the Woodard Unit.

142. Junction Butte State Wildlife Area - Grand County

a. Vehicles are prohibited, except from the day after Labor Day through December 31.

143. Karney Ranch State Wildlife Area - Bent County

a. Public access is prohibited from one (1) hour after sunset until one (1) hour before sunrise, except when an animal is harvested the successful hunter may remain as long as necessary to remove the animal.
b. Public access is prohibited in the designated safety zones, or as posted.
c. Parking and access is allowed from designated parking areas only.
d. Ornate box turtle collection and/or release is prohibited.
e. Night hunting with artificial light may be permitted as provided in regulation #303.E.10.

144. Karval Reservoir State Wildlife Area - Lincoln County

a. Camping is allowed by licensed hunters during an established big game season or spring and fall turkey season plus three (3) days before and three (3) days after each season or while actively fishing.
b. Fires are allowed within an established containment structure in designated areas.

145. Kemp-Breeze State Wildlife Area - Grand County

a. Public access on the Breeze Unit hay meadow wetland is prohibited from March 15 through July 15.
b. Fishing at the Breeze Unit Kids Pond is restricted to youth fishing only and those anglers with mobility impairments.
c. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).

146. Kinney Lake State Wildlife Area- Lincoln County

a. Camping is allowed by licensed hunters during an established big game season or spring and fall turkey season plus three (3) days before and three (3) days after each season or while actively fishing.
b. Fires are allowed within an established containment structure in designated areas.

147. Knight-Imler State Wildlife Area - Park County

a. Public access is prohibited beyond 25 feet from the center line of the stream.

148. Knudson State Wildlife Area - Logan County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. All recreational activities, except deer hunting, are prohibited on the opening weekend of the regular plains rifle deer season and on the opening day and first weekend of the late plains rifle deer season.
c. Landowner permission required to hunt deer on access easement.
d. Discharge of firearms or bows is prohibited, except while hunting.
e. Horse use is prohibited, except when used as an aid in hunting.
f. The launching or takeout of vessels is prohibited during waterfowl seasons.

149. La Jara Reservior State Wildlife Area - Conejos County

a. Camping is allowed, except during established big game seasons when camping is allowed only by licensed big game hunters plus three (3) days before and three (3) days after each season.
b. Fires are allowed within a containment structure.

150. La Jara Creek State Wildlife Area - Conejos County

a. Vehicles are prohibited from January 1 through the last Thursday prior to Memorial Day.
b. Snowmobile use is prohibited.
c. Camping is allowed while engaged in hunting or fishing activities.
d. Fires are allowed within a containment structure.

151. Lake Beckwith State Wildlife Area - Pueblo County

a. Ice fishing and all public access to the frozen surface of the lake is prohibited.
b. Hunting and the discharge of firearms or bows is prohibited.
c. Vessel use is prohibited except for hand-launched vessels that are propelled by hand, wind or electric motor.
d. Dogs are allowed but must be kept under control on a physical leash by the handler at all times.
e. Public access to Lake Beckwith State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

152. Lake Dorothey State Wildlife Area - Las Animas County

a. Public access to trails A & B is allowed by foot, bicycle, and horseback use only.
b. Public access to trails C & D is allowed by foot and horseback only. Public access to these trails is prohibited from December 1 through April 30 and from May 15 through June 30, except for licensed spring turkey hunters.
c. Parking and access is allowed from designated parking areas only.
d. Hunting access is prohibited during the regular rifle deer and elk seasons, except for licensed big game hunters that have a hunting access permit. Permits are issued through a drawing process. Applications for fall hunting access permits are available July 1 online. Applications are due July 21. Permit holders must comply with all provisions of the hunting access permit.
e. Trapping is prohibited.

f. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand when used as an aid for fishing.
g. Camping is allowed by licensed hunters during an established big game, spring and fall turkey season plus three (3) days before and three (3) days after each season.
e. Camping is prohibited within two hundred (200) yards of Lake Dorothey or one-hundred (100) feet of any stream, except in designated areas.

153. Lake John State Wildlife Area - Jackson County

a. Discharge of firearms or bows is prohibited, except while hunting.
b. Camping is allowed west of Lake John Dam.
c. Fires are allowed within an established containment structure in designated areas.
d. Dogs are allowed but must be kept under control on a physical leash by the handler at all time except as authorized in #900(C)(15).

154. Lake Pueblo State Wildlife Area - Pueblo County

a. Discharge of firearms or bows is prohibited, except shotguns or bows may be used while hunting or bowfishing.
b. Launching and use of all vessels is allowed.
c. Water contact activities are allowed.
d. Jumping, diving, or swinging from cliffs, ledges or man-made structures is prohibited, including, but not limited to, boat docks, marina infrastructure, and the railroad trestle in Turkey Creek.
e. Bicycles are prohibited.
f. Field trials may be authorized during February, March, August, and September only.

155. Leatha Jean Stassen State Wildlife Area - Mesa County

a. Public access is prohibited between sunset and sunrise except while fishing.
b. Hunting is prohibited.

156. Lennartz State Wildlife Area - Logan County

a. Public access is prohibited.

157. Little Snake State Wildlife Area - Moffat County

a. The placing of a portable blind, marker, stand or related structure is prohibited prior to August 1 annually.
b. Camping is allowed in self-contained camping trailers or campers by licensed hunters during any deer, elk, or pronghorn season plus three (3) days before and (3) days after each season.

158. Loma Boat Launch State Wildlife Area - Mesa County

a. Parking and access is allowed from designated areas only.
b. Launching and use of vessels is allowed, except that the launching and take out of personal watercraft (PWC) is prohibited.
c. Discharge of firearms or bows is prohibited.
d. Dogs are allowed.

159. Lon Hagler State Wildlife Area - Larimer County

a. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise, except while fishing.
b. Parking is allowed in designated parking areas only.
c. Fishing is prohibited in the inlet structure and the annex pond.
d. Vessel use is prohibited, except when used as an aid for fishing. Sailboats are prohibited.
e. Operating a vessel in a manner that creates a whitewater wake is prohibited.
f. Horse use is prohibited.
g. Target practice is prohibited.
h. Dogs are allowed but must be kept under control on physical leash by the handler at all times unless on a vessel.
i. Dogs are prohibited west of the lake side parking lots except between September 1 and the last day of February when used as an aid to hunting.
j. Dogs are prohibited on the annex pond and adjacent lands, as posted, to protect wildlife habitat and nesting wildlife.

160. Lone Dome State Wildlife Area - Montezuma and Dolores counties

a. Overnight parking is prohibited, except in designated areas.

161. Louisiana Purchase Ranch State Wildlife Area (Access Easement) – Moffat County

a. Public access is prohibited, except while deer or elk hunting.
b. Hunting allowed by reservation only.
c. All hunters must comply with the Hunter Reservation System and reservations must be made through the Hunter Reservation System in accordance with #901.A of these regulations.
d. Discharge of firearms or bows is prohibited, except while hunting.
e. Vehicle use is prohibited, except for on designated roadways or through permission of the ranch owners. All other access is allowed by foot only.
f. Fishing is prohibited.

162. Love Meadow Watchable Wildlife Area - Chaffee County

a. Public access is prohibited, except while wildlife viewing from established parking area.
b. Public access to Love Meadow Watchable Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

163. Manville State Wildlife Area (Fishing Lease) - Jackson County

a. Public access is prohibited, except while fishing.
b. Discharge of firearms or bows is prohibited.

164. Mason Family State Wildlife Area – Hinsdale County

a. Camping is allowed in designated areas only.
b. Fires are allowed within a containment structure in designated camping areas.
c. Food, trash or other attractants must be stored or secured in bear-resistant containers or inside vehicles.
d. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

165. McCluskey State Wildlife Area - Delta County

a. Public access is prohibited, except while hunting or trapping.
b. Public access is prohibited from the day after the conclusion of the annual big game seasons through April 30.
c. Dogs are prohibited.

166. Meeker Pastures State Wildlife Area - Rio Blanco County

a. Hunting big game is allowed with archery equipment only.

167. Melon Valley State Wildlife Area - Otero County

a. Hunting is prohibited on weekends, except for youth mentor hunting only. No more than one mentor per youth hunter may engage in hunting.
b. Camping is allowed from August 15 through May 31.

168. Messex State Wildlife Area - Washington and Logan Counties

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. All recreational activities, except deer hunting, are prohibited on the opening weekend of the regular plains rifle deer season and on the opening day and first weekend of the late plains rifle deer season.
c. Landowner permission required to hunt deer on access easement.
d. The launching or takeout of vessels is prohibited during waterfowl seasons.

169. Mike Higbee State Wildlife Area - Prowers County

a. Public access is prohibited from one (1) hour after sunset until one (1) hour before sunrise, except while camping or while actively hunting or fishing.
b. Game birds listed in #009(B) of these regulations may be released by the Division or its agent for educational or training purposes without seasonal or numerical restrictions.
c. Camping is allowed in designated and established camping areas.

170. Miller Ranch State Wildlife Area - Gunnison County

a. Public access is prohibited from March 1 through June 30.
b. Hunting is prohibited north of Gunnison Co Rd 7 except for mentored youth hunting by permit only. A maximum of four free permits will be available daily on a first-come, first-served basis. Permits are available by reservation through the Gunnison Service Center at 300 W. New York Ave., Gunnison, CO, or by calling 970-641-7060. Reservations may be made up to 30 days in advance but not less than two days before the requested hunt date. Upon reservation, the youth hunter and mentor will be provided a map with access points and restrictions. Mentors are not allowed to hunt.
c. Discharge of firearms or bows is prohibited in the designated safety zones, or as posted.
d. Dogs are prohibited.

171. Mitani-Tokuyasu State Wildlife Area - Weld County

a. Public access is prohibited from one (1) hour after sunset through 4:00 a.m.
b. Public access prohibited from the day after the close of the spring turkey season through August 31.
c. Hunting access is limited to occupants of vehicles legally parked in 1 of 4 spaces

in the designated parking area. A reservation is required to occupy a parking space from 4:00 a.m. until noon. Reservations may be made in accordance with #901.A of these regulations. After noon each day, parking spaces are available on a first-come, first-serve basis.

d. Discharge of firearms or bows is prohibited, except while hunting.
e. Horse use is prohibited.

172. Mogensen Ponds State Wildlife (Fishing) Area - Mesa County

a. Hunting is prohibited, except for waterfowl hunting from designated blinds.
b. Discharge of firearms or bows is prohibited, except while hunting.

173. Mountain Home Reservoir State Wildlife Area - Costilla County

a. Launching and use of all vessels is allowed.
b. Operating a vessel in a manner that create a whitewater wake is prohibited.
c. Camping is allowed in designated areas.
d. Fires are allowed within an established containment structure in designated camping areas.
e. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except when used as an aid in hunting.

174. Mount Evans State Wildlife Area - Clear Creek County

a. Public access is prohibited from January 1 through June 14.
b. Public access is restricted to only fishing and hunting activities from the day after Labor Day through the end of the 4th regular rifle season.
c. Vehicles are prohibited from the day after Labor Day through June 14, except during regular rifle deer and elk seasons.
d. Groups of 25 or more people must obtain a permit prior to use. Permits shall be issued to limit access to no more than one group at one time.
e. Camping is allowed but limited to five (5) days in any 45 day period, except during established big game seasons when camping is restricted to licensed big game hunters.
f. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

175. Mount Ouray State Wildlife Area - Chaffee County

a. Parking and access is allowed from designated parking areas only.
b. Hunting with centerfire rifles is prohibited.

176. Mount Shavano State Wildlife Area - Chaffee County

a. Public access is prohibited south of Chaffee Co. Rd. 154 and west of Colorado State Highway 291.
b. From the west end of the Mount Shavano SFU, upstream to the marked property boundary, discharge of firearms or bows is prohibited, except while hunting. Hunting with centerfire rifles is prohibited.
c. From the east end of the Mount Shavano SFU, downstream to the Colo. Hwy 291 Bridge, discharge of firearms or bows is prohibited except while hunting. Hunting is allowed with hand-held bows only.
d. Hunting is prohibited from the Colorado State Highway 291 Bridge downstream to Chaffee County Road 175.

e. Bicycles are allowed.
f. Dogs are allowed but must be kept under control on a physical leash by the handler at all times.

177. Mount Werner State Wildlife Area (Fishing Easement) – Routt County

a. Public access is prohibited, except while fishing.
b. Discharge of firearms or bows is prohibited.

178. Murphy State Wildlife Area (Fishing Lease) - Jackson County

a. Public access is prohibited, except while fishing.
b. Discharge of firearms or bows is prohibited.

179. Nakagawa State Wildlife Area - Weld County

a. Discharge of firearms or bows is prohibited, except when hunting.

180. Narraguinnep Reservoir State Wildlife Area - Montezuma County

a. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise, except while fishing.
b. Launching and use of vessels may be allowed as posted. Contact the Durango CPW office for current information.
c. Glass containers are prohibited.
d. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).
e. Public access to Narraguinnep Reservoir State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

181. North Fork State Wildlife Area - Larimer County

a. Public access is prohibited, except while fishing.
b. Public access to North Fork State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

182. North Lake State Wildlife Area - Las Animas County

a. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand, wind or electric motor when used as an aid to fishing.

183. Oak Ridge State Wildlife Area - Rio Blanco County

a. Public access is prohibited on the Oak Ridge Unit from December 1 through July 15 except for CPW youth outreach turkey hunts April 1 through 30 and valid GMU 23 turkey license holders and their companion May 1 through 31.
b. Public access is prohibited on Sleepy Cat Ponds Unit and Sleepy Cat Fishing Easement, except while fishing.
c. Discharge of firearms or bows is prohibited, except while hunting.
d. Hunting is allowed south of Rio Blanco Co Rd 8, west of Rio Blanco Co Rd 17, and north and east of Rio Blanco Co Rd 10 by archery equipment only.
e. Launching and use of vessels not associated with fishing or hunting activities are allowed in designated areas only.
f. Operating a vessel in a manner that creates a whitewater wake is prohibited on Lake Avery.
g. Water contact activities are allowed in designated areas only.

h. Camping is allowed in designated areas only.
i. Dogs are allowed but must be kept under control on a physical leash by the handler at all times on the Lake Avery Unit except as authorized in #900(C)(15).

184. Ogden-Treat State Wildlife Area (Fishing Easement) - Fremont County

a. Public access is prohibited, except while fishing.
b. Parking and access is allowed from designated parking areas only.
c. Dogs are prohibited.

185. Orchard Mesa Wildlife Area - Mesa County

a. Public access is allowed only from the parking area located on "C" Road between 30 and 31 Roads.
b. Public access is allowed by foot only.
c. Public access is prohibited from March 15 through July 15.
d. Small game hunting is prohibited, except for waterfowl hunting.
e. Big game and waterfowl hunting is allowed by reservation only.
f. Big game hunting is allowed with archery equipment only.
g. Waterfowl hunting is allowed from designated blinds only.
h. All hunters must comply with the Hunter Reservation System and reservations must be made through the Hunter Reservation System in accordance with #901.A of these regulations.
i. Discharge of firearms or bows is prohibited, except while hunting.

186. Orient Mine State Wildlife Area – Saguache County

a. Public access to adjacent public lands through the property for hunting purposes is allowed October 1 through May 31 annually. Hunters wishing to gain access across the property to adjacent federal lands must contact the Orient Land Trust and adhere to their check-in/out procedures.
b. Public access through the property for all purposes is prohibited three (3) hours before sunrise and three (3) hours after sunset, except when an animal has been harvested on adjacent public lands.
c. Public access to the property is allowed by foot only from adjacent public lands.
d. Hunting and the discharge of firearms or bows is prohibited.
e. Public access to Orient Mine State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

187. Overland Trail State Wildlife Area - Logan County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. All recreational activities, except deer hunting, are prohibited on the opening weekend of the regular plains rifle deer season and on the opening day and first weekend of the late plains rifle deer season.
c. The launching or takeout of vessels is prohibited during waterfowl seasons.

188. Owl Mountain State Wildlife Area - Jackson County

a. Discharge of firearms prohibited, except while hunting.

189. Paddock State Wildlife Area - Lake County

a. Public access is prohibited from August 15 through November 30, except while hunting with a valid bighorn sheep, deer, elk or bear license.

b. Fishing access is prohibited, except in Iowa Gulch and Upper Empire Gulch.
c. Dogs are prohibited.

190. Parachute Ponds State Wildlife Area - Garfield County

a. Public access to the frozen surface of the lake is prohibited.
b. Vessel use is prohibited, except for launching and use of float tubes for fishing only.
c. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).

191. Parvin Lake State Wildlife Area - Larimer County

a. Vessel use is prohibited, except for launching and use of float tubes for fishing only.
b. Anglers must enter the area on foot through the gate at the check station and must check-in and out at the check station when open.

192. Pastorius Reservoir State Wildlife Area - La Plata County

a. Vessel use is prohibited, except for launching and use of vessels that are propelled by hand, wind or electric motor.
b. Discharge of firearms or bows is prohibited, except while hunting.
c. Hunting is prohibited, except on Saturdays, Sundays, and Wednesdays.
d. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

193. Perins Peak State Wildlife Area - La Plata County

a. Public access is prohibited west of La Plata County Road 208 from December 1 through April 30, except turkey hunters.
b. Public access is prohibited east of La Plata Co Rd 208 from December 1 through July 31.
c. Camping is allowed by licensed hunters during an established big game season plus three (3) days before and three (3) days after each season.
d. Discharge of firearms or bows is prohibited, except while hunting.
e. Snowmobile use is prohibited.
f. Dogs are allowed but must be kept under control on a physical leash by the handler at all times from May 1 through September 30 west of CR 208 and from August 1 through September 30 east of CR 208, except as authorized in #900(C)(15).
g. Dogs are allowed pursuant to #900(C)(15) from October 1 through November 30.

194. Perkins State Wildlife Area (Access Easement) - Grand County

a. Public access is prohibited, except while hunting.

195. Piceance State Wildlife Area - Garfield/Rio Blanco County

a. Discharge of firearms or bows is prohibited in the designated safety zones, or as posted on the Little Hills Unit.
b. Camping is allowed.
c. Camping is allowed in designated areas only on the Yellow Creek and Square S Units.
d. Fires are allowed within in a containment structure.

196. Pikes Peak State Wildlife Area - Teller County

a. Public access is prohibited from April 1 through July 15.
b. Dogs are prohibited.

197. Plateau Creek State Wildlife Area - Mesa County

a. Public access is prohibited from December 1 through April 30, except for on the shooting range.
b. Discharge of firearms or bows is prohibited, except while hunting or on the designated shooting range.
c. Camping is allowed by licensed hunters during an established big game season plus three (3) days before and three (3) days after each season.
d. Fires are allowed within a containment structure while camping.

198. Playa Blanca State Wildlife Area - Alamosa County

a. Public access is prohibited from February 15 through July 15.
b. Public access is allowed in designated areas on Tuesdays, Thursdays, and Saturdays from July 16 through February 14.
c. Camping is allowed during waterfowl hunting seasons by licensed waterfowl hunters and only in parking areas with self-contained camping trailers or campers.

199. Pony Express State Wildlife Area - Sedgwick County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. All recreational activities, except deer hunting, are prohibited on the opening weekend of the regular plains rifle deer season and on the opening day and first weekend of the late plains rifle deer season.
c. The launching or takeout of vessels is prohibited during waterfowl seasons.

200. Pot Creek State Wildlife Area (Access Easement) – Moffat County

a. Public access is prohibited, except while elk hunting.
b. Hunting allowed by reservation only.
c. All hunters must comply with the Hunter Reservation System and reservations must be made through the Hunter Reservation System in accordance with #901.A of these regulations.
d. Discharge of firearms or bows is prohibited, except while hunting.
e. Motor vehicle use is prohibited, except on designated roadways or through permission of the ranch owners. All other public access is allowed by foot only.
f. Fishing is prohibited.

201. Pothook Ranch State Wildlife Area (Fishing Easement) – (Slater Creek) Moffat County

a. Public access is prohibited, except for fishing, wildlife viewing and hunting with a limited Ranching for Wildlife big game license valid for this property.
b. Public access is allowed by foot only from the designated parking areas/access points only.
c. Public fishing is allowed within 20 feet of the high water line of both banks of Slater Creek only.

d. Discharge of firearms or bows is prohibited, except while hunting.
e. Overnight parking is prohibited.

202. Poudre River State Wildlife Area - Larimer County

a. Discharge of firearms or bows is prohibited, except when hunting or bowfishing.
b. Public access to Poudre River State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

203. Prewitt Reservoir State Wildlife Area - Logan and Washington Counties

a. Property limited to 250 vehicles.
b. From October 1 through the dark goose season, fishing is restricted to the dam, ice fishing is restricted to 50 yards of the dam, and boating is prohibited, except for craft propelled by hand or electric motor used to set and pick up decoys and retrieve downed waterfowl.
c. Hunting prohibited as posted, including hunting from floating devices.
d. Discharge of firearms or bows is prohibited, except while hunting.
e. OHV and snowmobile use is prohibited.
f. Launching and use of all vessels is allowed. Sailing and windsurfing prohibited, except in July and August.
g. Operating a vessel in a manner that creates a whitewater wake is prohibited.
h. Waterskiing and personal watercraft (PWC) use is prohibited.
i. Camping is allowed only in camping areas at designated campsite markers.
j. Only one camping unit is allowed per campsite.
k. Quite hours will be enforced from 10:00 p.m. – 6:00 a.m. Legal hunting activities are exempt from quite hours.
l. Fires are allowed within a containment structure in designated camping areas.
m. Glass containers are prohibited.
n. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).

204. Pridemore State Wildlife Area (Fishing Lease) - Chaffee County

a. Public access is prohibited, except while fishing.
b. Launching and take out of vessels is prohibited.
c. Dogs are prohibited.

205. Puett Reservoir State Wildlife Area - Montezuma County

a. Launching and use of vessels may be allowed as posted. Contact the Durango CPW office for current information. When allowed, operating a vessel in a manner that creates a whitewater wake is prohibited.
b. Dogs are allowed but must be kept under control on a physical leash by the handler at all time, except as authorized in #900(C)(15).

206. Queens State Wildlife Area (Nee Noshe, Nee So Pah, Nee Gronda, Upper Queens and Lower Queens (Neeskah)) - Kiowa County

a. Operating a vessel in a manner that creates a whitewater wake in the channel between Upper Queens and Lower Queens (Neeskah) is prohibited.
b. Swimming is allowed.

c. Hunters must check-in and out of fields/pits at the check station during waterfowl season.
d. Camping is allowed in designated and established camping areas.
e. Fires are allowed within an established containment structure in designated areas.
f. Nee Noshe
    1. From December 1 through the last day of migratory waterfowl season, vessel use is allowed, as posted, only to retrieve downed waterfowl.
    2. Launching and use of all vessels is allowed.
    3. All water contact activities are allowed.

207. Radium State Wildlife Area - Grand, Routt, and Eagle Counties

a. Hunting is prohibited in the designated safety zone, or as posted.
b. Camping is allowed except as posted.
c. Fires are allowed within a containment structure.

208. Ralston Creek State Wildlife Area - Jefferson County

a. Discharge of firearms or bows is prohibited except while hunting.

209. Ramah State Wildlife Area - El Paso County

a. Discharge of firearms or bows is prohibited, except while hunting or bowfishing. Discharge of archery equipment is allowed on the established archery shooting range.
b. Hunting with centerfire rifles is prohibited.
c. Game birds listed in #009(B) of these regulations may be released by the Division or its agent for educational or training purposes without seasonal or numerical restrictions.

210. Red Lion State Wildlife Area - Logan County

a. From September 1 through the regular duck seasons, hunters must check-in and out at check station. Hunters may not check-in until 4:00 a.m.
b. Hunting prohibited from floating devices and frozen surface of the lake.
c. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand, wind or electric motor when used as an aid for fishing, or to set and pick up decoys, and retrieve downed waterfowl. Vessels must be launched from a designated area as posted.

211. Red Mountain State Wildlife Area - Grand County

a. Public access is prohibited from December 1 through April 14.
b. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).

212. Reddy State Wildlife Area (Fishing Easement) - Lake County

a. Public access is allowed while fishing only.
b. Public access is allowed only within 30 feet of the high water line, or as otherwise posted.
c. Parking and access is allowed from designated parking areas only.
d. Dogs are prohibited.

213. Richard State Wildlife Area (Hunting and Fishing Lease) - Jackson County

a. Public access is prohibited, except while hunting and fishing.
b. Hunting is prohibited within two hundred (200) yards of any building.
c. Discharge of firearms or bows is prohibited, except while hunting.

214. Rio Blanco Lake State Wildlife Area - Rio Blanco County

a. Public access to the Roselund Unit is allowed for day use only.
b. Parking and public access is allowed from designated parking areas only.
c. Hunting big game is allowed with archery equipment only.
d. Launching and use of all vessels is allowed.
e. Water contact activities are allowed.
f. Camping is allowed.
g. Fires are allowed within a containment structure.
h. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).

215. Rio Grande River State Wildlife Area (Del Norte Fishing Easements) - Rio Grande County

a. Public access is prohibited, except while fishing.
b. Vessel use is prohibited, except for launching and take out of vessels propelled by hand is allowed at the CR 17 ramp.

216. Rio Grande State Wildlife Area - Rio Grande County

a. Public access is prohibited from February 15 through July 15. The Area Wildlife Manager may authorize access during this closure if the proposed access will not adversely impact nesting or wintering bird populations.
b. From July 16 through February 14, hiking, horseback riding, and dogs kept under control on a physical leash by the handler are allowed on established roads.
c. The Area Wildlife Manager may post area specific closures to manage waterfowl hunting pressure during established waterfowl seasons, to protect maintenance and construction equipment and to protect human health and safety.
d. Camping is allowed during waterfowl hunting seasons by licensed waterfowl hunters in those parking areas with toilet facilities.

217. Rito Hondo Reservoir State Wildlife Area - Hinsdale County

a. Vessel use is prohibited, except for launching and use of vessels that are propelled by hand, wind or electric motor when used as an aid for fishing or hunting.

218. Road Canyon Reservoir State Wildlife Area - Hinsdale County

a. Operating a vessel in a manner that creates a whitewater wake is prohibited.

219. Roaring Fork/Gianinetti State Wildlife Area (Fishing Lease) - Garfield County

a. Public access is prohibited, except while fishing.
b. Public access is allowed from designated points as posted only.
c. Dogs are prohibited.

220. Rock Creek State Wildlife Area - Grand County

a. Camping is allowed.

b. Fires are allowed within an established containment structure.

221. Rocky Ford State Wildlife Area - Otero County

a. Camping is allowed from August 15 through May 31.

222. Roeber State Wildlife Area - Delta County

a. Public access is prohibited, except while hunting and fishing.
b. Public access is prohibited from the day after the conclusion of the annual big game seasons through April 30.
c. Hunting and the discharge of firearms or bows is prohibited in the open space easement area.
d. Dogs are prohibited.

223. Rosemont Reservoir State Wildlife Area - Teller County

a. Public access is prohibited in the dam area, vicinity of the caretaker's house, and north side of the reservoir or as posted.
b. Parking and access is allowed from designated parking areas only.
c. Vessel use is prohibited, except launching and use of float tubes for fishing only.
d. Fishing is prohibited from 9:00 p.m. until 5:00 a.m.
e. Ice fishing is prohibited.
f. Discharge of firearms is prohibited.
g. Dogs are prohibited.

224. Runyon/Fountain Lakes State Wildlife Area - Pueblo County

a. Public access is prohibited from 9:30 p.m. - 7:30 a.m., except while fishing.
b. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand, wind, or electric motor when used as an aid in fishing.
c. Bicycles are allowed.
d. Dogs are allowed but must be kept under control on a physical leash by the handler at all times.

225. Russell Lakes State Wildlife Area - Saguache County

a. Public access is prohibited from February 15 through July 15.
b. Public access is prohibited, except as posted, to protect wintering and nesting waterfowl, and to protect administrative areas of the property.
c. Section 29 (Herrance Lake and Island Lake) shall be closed during waterfowl hunting season.
d. During the first split waterfowl season, Russell Lakes SWA shall close at 1:00 p.m. daily to all recreation.
e. Parking is allowed in designated parking areas only.
f. Camping is allowed during waterfowl hunting seasons by licensed waterfowl hunters and only in parking areas with self-contained camping trailers or campers.
g. Field trials may be authorized during February, March, August, and September only.
h. Public access to established restroom facilities is exempt from requirements set forth in section #900(C)1 of these regulations.

226. Sam Caudill State Wildlife Area - Garfield County

a. Launching and use of vessel is allowed, except that the launching and take out of personal watercraft (PWC) is prohibited.
b. Discharge of firearms or bows is prohibited.

227. Sanchez Reservoir State Wildlife Area - Costilla County

a. Public access is prohibited, except while fishing.
b. Discharge of firearms of bows is prohibited.
c. Camping is allowed.

228. Sand Draw State Wildlife Area - Sedgwick County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. Hunting is allowed for youth/mentor hunting only. A maximum of one (1) mentor per youth hunter may hunt.

229. Sands Lake State Wildlife Area - Chaffee County

a. Hunting and the discharge of firearms or bows is prohibited.
b. Bicycles are allowed.
c. Dogs are allowed but must be kept under control on a physical leash by the handler at all times.

230. Sandsage State Wildlife Area - Yuma County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. Discharge of firearms or bows is prohibited, except shotguns with birdshot or bows may be used while hunting.

231. Sandy Bluffs State Wildlife Area - Yuma County

a. Public access is prohibited from June 1 through August 31.
b. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
c. Dog training is prohibited.

232. San Luis Hills SWA - Costilla County

a. Public access is prohibited from March 1 through August 14.
b. Camping is allowed while engaged in hunting or fishing activities.
c. Fires are allowed within a containment structure when associated with hunting or fishing activities.

233. San Luis Lakes State Wildlife Area - Alamosa County

a. Public access north of the buoy line and east-west fence line is prohibited from February 15 through July 15. From July 16 through February 14:
    1. Public access is allowed by foot or horseback only.
    2. Bicycles are allowed as an aid in hunting and fishing only.
    3. Game carts are allowed.
b. Operating a vessel north of the buoy line is prohibited.
c. Camping is allowed in designated areas.
d. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).

234. Sarvis Creek State Wildlife Area - Routt County

a. Discharge of firearms or bows is prohibited, except while hunting.

b. Camping is allowed by licensed hunters during an established big game season plus three (3) days before and three (3) days after each season.
c. Fires are allowed within a containment structure while camping.

235. Sawhill Ponds – Boulder County

a. Public access is prohibited between midnight and 5:00 a.m.
b. Other activities may be prohibited as posted, to implement the management agreement between Colorado Parks and Wildlife and the City of Boulder.
c. Vessel use is prohibited.
d. Hunting is prohibited.
e. Horseback riding is allowed on established maintenance roads.
f. Dogs are allowed but must be kept under control on a physical leash by the handler at all times.
g. Public access to Sawhill Ponds State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

236. Sedgwick Bar State Wildlife Area - Sedgwick County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. All recreational activities, except deer hunting, are prohibited on the opening weekend of the regular plains rifle deer season and on the opening day and first weekend of the late plains rifle deer season.
c. The launching or takeout of vessels is prohibited during waterfowl seasons.

237. Sego Springs State Wildlife Area - Conejos County

a. Public access is prohibited from February 15 through July 15.
b. Camping is allowed while engaged in hunting or fishing activities.
c. Fires are allowed within a containment structure while engaged in hunting or fishing activities.
d. Field trials may be authorized during August and September only.

238. Seymour Lake State Wildlife Area - Jackson County

a. Operating a vessel in a manner that creates a whitewater wake is prohibited.
b. Discharge of firearms or bows is prohibited, except while hunting.
c. Camping is allowed in designated areas only.
d. Fires are allowed within an established containment structure in designated areas.
e. Dogs are allowed but must be kept under control on a physical leash by the handler at all times except as authorized in #900(C)(15).

239. Sharptail Ridge State Wildlife Area - Douglas County

a. Public access is allowed from sunrise to sunset.
b. Public access is allowed by foot only.
c. Hunting is prohibited except for deer and elk hunting only.
d. Deer and elk hunting is only allowed by permit with a Sharptail Ridge SWA hunting permit obtained by a separate drawing. Hunters must have a limited deer or elk license for unit 51 before applying. No more than two hunters will be permitted daily. Group applications are allowed for a maximum of two (2) applicants per group. Permits will be valid for a minimum of two (2) days and a maximum of three (3) days beginning after Labor Day, and will be based on the

length of the underlying season and maximization of individual hunter opportunity. Permit applications are available from the Division in Denver 303-291-7227.

e. Permitted hunters may take one other person (an observer) who is not hunting with them while hunting, however that person must remain with the hunter at all times.
f. Permitted hunters may park inside in the parking area behind the gate during the times for which they are permitted. Driving anywhere else on the property is prohibited.
g. Public access to Sharptail Ridge State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

240. <u>Shriver-Wright State Wildlife Area - Rio Grande County</u>

a. Hunting with centerfire rifles is prohibited.
b. Discharge of firearms or bows is prohibited except while hunting or bows used on the archery range.
c. Bows used on the archery range must adhere to the following:
    1. Target and field point only (no broadheads).
    2. Crossbows are prohibited.
    3. All persons must adhere to range safety rules as posted.
d. Camping is allowed during waterfowl hunting seasons by licensed waterfowl hunters and only in parking areas with self-contained camp trailers or campers.
e. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized by #900(C)(15).
f. Public access to Shriver-Wright State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

241. <u>Sikes Ranch State Wildlife Area - Baca and Las Animas Counties</u>

a. Public access is prohibited from one (1) hour after sunset until one (1) hour before sunrise, except when an animal is harvested the successful hunter may remain as long as necessary to remove the animal or when authorized by a night hunting permit.
b. Public access is prohibited in the building envelope and designated safety zones, or as posted.
c. Parking and access is allowed from designated parking areas only.
d. Trapping is prohibited, except by permit only. Permit holders shall have their permit on their person at all times while trapping. Permits may be obtained by calling the Lamar Service Center.

242. <u>Simmons State Wildlife Area - Yuma County</u>

a. Public access is prohibited from June 1 through August 31.
b. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
c. Dog training is prohibited.

243. <u>Simpson Ponds State Wildlife Area - Larimer County</u>

a. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise except while fishing or when authorized by a night hunting permit.
b. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand when used as an aid for fishing or hunting.

c. Discharge of firearms or bows is prohibited, except while hunting or bowfishing.
d. Horse use is prohibited.
e. Bicycle riding is prohibited.

244. Skaguay Reservoir State Wildlife Area - Teller County

a. Operating a vessel in a manner that creates a whitewater wake is prohibited.

245. SKCK State Wildlife Area (Fishing Access) – Routt County

a. Public access is prohibited, except while fishing.
b. Public access is allowed in the designated "Fishing Access Area" and "Public Access Detour" highlighted on the posted property map.
c. Public access is allowed to walk-in access only.
d. Public access is prohibited from one (1) hour after sunset to sunrise daily.
e. Public access is prohibited from December 1 through March 31.
f. Hunting and discharge of firearms or bows is prohibited.

246. Smith Lake State Wildlife Area - Larimer County

a. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise, except while fishing.
b. Hunting and the discharge of firearms or bows is prohibited.
c. Operating a vessel in a manner that creates a whitewater wake is prohibited.
d. OHV and snowmobile use is prohibited.
e. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

247. Smith Reservoir State Wildlife Area - Costilla County

a. Public access is prohibited from February 15 through July 15 on the north and east shore areas.
b. Fishing is prohibited from November 1 through the last day of the waterfowl season, except within two-hundred (200) yards of the dam.
c. Motor vehicles are prohibited within fifty (50) feet of the water.
d. Field trials may be authorized during February, March, August and September only.

248. South Republican State Wildlife Area - Yuma County

a. Parking and access is allowed from designated parking areas only.
b. Field trials may be authorized during February, March, August, and September only. No more than two trials may be authorized during the February-March period and no more than one field trial may be authorized during the August-September period.
c. Waterfowl hunting is prohibited as posted. Waterfowl hunting access is prohibited on the downstream face of the dam.
d. Camping is allowed in designated and established camping areas.
e. Fires are allowed within an established containment structure in designated areas.

249. Spanish Peaks State Wildlife Area - Las Animas County

a. Parking and access is allowed from designated parking areas only.

b. Camping is allowed by licensed hunters during an established big game, spring and fall turkey season plus three (3) days before and three (3) days after each season.
c. Fires are allowed within an established containment structure in designated camping areas.

250. Stalker Lake State Wildlife Area - Yuma County

a. After October 31, hunting is prohibited, except in areas east of Stalker Lake dam.
b. Hunting on the western half of Stalker Lake is prohibited.
c. Discharge of firearms or bows is prohibited, except for bows on the designated archery range.
d. Discharge of firearms or bows is prohibited, except shotguns with birdshot, or bows may be used while hunting.
e. Vessel use is prohibited, except for launching and use of vessels that are propelled by hand or electric motor.

251. Steamboat Springs State Wildlife Area (Fishing Easement) – Routt County

a. Public access is prohibited, except while fishing.
b. Discharge of firearms or bows is prohibited.

252. Storm Mountain Access Road - Larimer County

a. Public access is prohibited as posted.
b. Off-highway vehicles (OHV) must be trailered until on US Forest Service land.
c. Public access to the Storm Mountain Access Road is exempt from requirements set forth in section #900(C)1 of these regulations.

253. Summit Reservoir State Wildlife Area - Montezuma County

a. Launching of vessels may be allowed as posted. Contact the Durango CPW office for current information. When allowed, operating a vessel in a manner that creates a whitewater wake is prohibited.
b. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

254. Tamarack Ranch State Wildlife Area - Logan County

a. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
b. All recreational activities, except deer hunting, are prohibited on the opening weekend of the regular plains rifle deer season and on the opening day and first weekend of the late plains rifle deer season.
c. All hunters must check-in and out at the check station, and must park at the hunting area they are checked into. After 9:00 a.m., hunters may hunt adjacent areas. Deer and turkey hunters are only required to check into East, West, or South Tamarack Area.
d. From October 25 through the regular duck seasons, reservations are available, but not required, on weekends and state and federal holidays. Reservations must be made in accordance with #901.A of these regulations.
e. A maximum of three (3) field trials may be authorized during February, March, or August, and one (1) in September.
f. Vessel use is prohibited during waterfowl seasons.
g. Camping is allowed in designated areas only.

h. Augmentation Ponds:
    1. From the first day of the second duck season through the dark goose season, waterfowl hunting is allowed only through a lottery drawing.
    2. Hunting is limited to a specific pond/hunt area on each day.
    3. To enter drawing, hunters must send a letter or postcard postmarked by September 30 to the CPW Brush Service Center, with name, address, phone number, CID number, and desired reservation dates. Hunters must possess a valid license to hunt waterfowl to enter drawing. Hunters may apply for multiple hunt dates on one postcard.
    4. Hunters successful in the drawing are required to comply with all hunting restrictions in #901.A of these regulations. All hunters must check-in and out at the check station. Maximum of four (4) hunters allowed per group per day. Hunters must park in designated parking areas, but are allowed to drop off decoys via existing four-wheel-drive only roads, as posted. Hunters must remain on existing roads as posted.
    5. During the light goose conservation order season, all hunters must check-in and out at check station.

255. Tarryall Reservoir State Wildlife Area - Park County

a. Public access is prohibited from the dam, spillway and outlet structures.
b. Operating a vessel in a manner that creates a whitewater wake is prohibited.
c. OHV and snowmobiles use is prohibited.
d. Discharge of firearms, pellet guns, or bows is prohibited in established campgrounds.
e. Camping is allowed in designated campgrounds in designated number sites.
f. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

256. Taylor River State Wildlife Area - Gunnison County

a. Public access is prohibited from Taylor Dam to 325 yards downstream.
b. Parking is allowed in designated parking areas only.
c. Hunting and the discharge of firearms or bows is prohibited.

257. Thurston Reservoir State Wildlife Area - Prowers County

a. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise daily, except while fishing.
b. Public access to the frozen surface of the lake is prohibited.
c. Public access to the dams, inlets, and outlet structures is prohibited, except while fishing.
d. Operating a vessel in a manner that creates a whitewater wake is prohibited from November 1 through the last day of the migratory waterfowl season.

258. Tilman Bishop State Wildlife Area - Mesa County

a. Public access is prohibited from March 15 through July 15.
b. Public access is allowed by foot only.
c. Hunting is allowed with archery equipment and shotguns with shot-shells or by falconry only.
d. Big game and waterfowl hunting is allowed by reservation only.
e. Waterfowl hunting is allowed from designated blinds only.

f. All hunters must comply with the Hunter Reservation System and reservations must be made through the Hunter Reservation System in accordance with #901.A of these regulations.
g. Discharge of firearms or bows is prohibited, except while hunting.

259. Timpas Creek State Wildlife Area - Otero County

a. Camping is allowed from August 15 through May 31.

260. Tomahawk State Wildlife Area - Park County

a. Dog training and field trials are prohibited.

261. Tomichi Creek State Wildlife Area - Gunnison County

a. Public access is prohibited from the end of the waterfowl season through June 30, except while fishing.
b. Dog training and field trials are prohibited.

262. Totten Reservoir State Wildlife Area - Montezuma County

a. Public access is prohibited along the north shore from March 1 through May 31, as posted
b. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise, except while fishing.
c. Glass containers are prohibited.
d. Hunting is prohibited in the inlet area as posted.
e. Launching and use of vessels may be allowed as posted. Contact the Durango CPW office for current information. When allowed, operating a vessel in a manner that creates a whitewater wake is prohibited.
f. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).
g. Public access to Totten Reservoir State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

263. Trujillo Meadows State Wildlife Area - Conejos County

a. Launching and use of all vessels is allowed.
b. Operating a vessel in a manner that creates a whitewater wake is prohibited.

264. Turk's Pond State Wildlife Area - Baca County

a. Vessel use is prohibited, except for launching and use of vessels that are propelled by hand, or electric motor when used as an aid in fishing or hunting.
b. All human activity is prohibited within a one-quarter (1/4) mile of the high water line around Turk's Pond including the administrative buildings, from the opening day of the regular duck season through the last day of the regular dark goose season as posted. Hunters are allowed inside the closure only to retrieve downed waterfowl. Hunters must leave firearms outside of the closure.

265. Twenty Mile Pond State Wildlife Area (Fishing Easement) – Routt County

a. Public access is prohibited, except while fishing.
b. Discharge of firearms or bows is prohibited.

266. Twin Spruce Ponds State Wildlife Area- Montezuma County

a. Public access is prohibited from sunset to sunrise.
b. Parking and public access is allowed from designated parking areas only.
c. Glass containers are prohibited.
d. Hunting and discharge of firearms or bows is prohibited.
e. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand.

267. Two Buttes Reservoir State Wildlife Area - Baca and Prowers Counties

a. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand, or electric motor in the ponds below the dam.
b. Launching and use of all vessels is allowed on the reservoir.
c. Water contact activities are allowed on the reservoir only.
d. Camping is allowed in designated and established camping areas.
e. Fires are allowed within an established containment structure in designated areas.

268. Upper Red Cliff Ranch State Wildlife Area - Custer County

a. Public access is prohibited from December 1 through April 30, except for properly licensed hunters and one non-hunting companion.
b. Parking and access is allowed from designated parking areas only.
c. Hunting access is allowed by reservation only.
d. All hunters must comply with the Hunter Reservation System and reservations must be made through the Hunter Reservation System in accordance with #901.A of these regulations.
e. Discharge of firearms or bows is prohibited, except while hunting.
f. Camping is allowed by licensed hunters during an established big game or turkey season plus three (3) days before and three (3) days after each season. Camping is prohibited within one hundred (100) feet of any stream.
g. Dog training and field trials are prohibited.

269. Vail Deer Underpass State Wildlife Area - Eagle County

a. Public access is prohibited.

270. Verner State Wildlife Area (Fishing Lease) - Jackson County

a. Public access is prohibited, except while fishing.
b. Discharge of firearms or bows is prohibited.

271. Wahatoya State Wildlife Area - Huerfano County

a. Hunting and the discharge of firearms or bows is prohibited.
b. Vessel use is prohibited, except for hand-launched vessels that are propelled by hand, wind or electric motor when used as an aid for fishing.
c. Dogs are allowed but must be kept under control on a physical leash by the handler at all times.

272. Walker State Wildlife Area - Mesa County

a. Public access is prohibited between sunset and sunrise except for on the paved portion of the Riverfront trail and while fishing.
b. Overnight parking is prohibited.
c. Discharge of firearms or bows is prohibited, except while bowfishing.

d. Hunting is prohibited.
e. Dogs are allowed on the paved portion of the Riverfront Trail, but must be kept under control on a physical leash by the handler at all times.

273. Watson Lake State Wildlife Area - Larimer County

a. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise, except while fishing.
b. Public access onto the fish passage structure located on the northeast side of Watson Lake State Wildlife Area is prohibited.
c. Public access is prohibited to the northwest side as posted to prevent access to the water outtake and fish disposal area.
d. Fishing from the walls of the fish passage or fishing in the fish passage is prohibited.
e. The use or possession of live minnows is prohibited.
f. Vehicle parking is prohibited on the South Dam.
g. Launching and take out of vessels is prohibited.
h. Hunting and discharge of firearms or bows is prohibited.
i. Ice fishing is prohibited.
j. Ice skating is prohibited.
k. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

274. Waunita Watchable Wildlife Area - Gunnison County

a. Public access is allowed from April 1 through April 30 annually only, except during the second full week (Sunday through Sunday) of the month when public access is prohibited. Public access is prohibited at all other times.
b. Discharge of firearms or bows is prohibited.
c. Dogs are prohibited.

275. Webster State Wildlife Area - Weld County

a. Public access is prohibited, except from September 1 through the last day of spring turkey season.
b. Public access is allowed only for licensed hunters or members of a hunting party, and only on Saturdays, Sundays, Wednesdays and state and federal holidays.
c. Public access is prohibited from one (1) hour after sunset to 4:00 a.m.
d. Hunters may only access the property by parking in a designated, numbered parking spot inside the parking lot. Parking along the access road or Weld Co Rd 394 is prohibited.
e. Discharge of firearms or bows is prohibited, except while hunting.
f. Hunting with centerfire rifles and muzzleloaders is prohibited.
g. Hunting is prohibited in the inflow or outflow canals.
h. Horse use is prohibited.

276. Wellington State Wildlife Area - Larimer and Weld Counties

a. Public access is prohibited on the Wellington and Schware Units from March 15 through July 15.
b. Public access is prohibited on the Wellington Unit from the first day of the regular waterfowl season to the first day of the pheasant season, except on Saturday, Sundays, Wednesday and state and federal holidays.

c. Hunting with centerfire rifles is prohibited.
d. Target practice is prohibited, except when authorized by the area wildlife manager.
e. Vessel use is prohibited, except for launching and use of vessels that are propelled by hand and used for waterfowl hunting, dog training or field trials.
f. Field trials may be authorized on the Wellington and Schware units during February, March 1 through 14, and August only. Field trials may be authorized on the Cobb Lake Unit year-round.
g. Game birds listed in #009(B) of these regulations may be released on the Cobb Lake Unit by the Division or its agent for educational or training purposes without seasonal or numerical restrictions.
h. Domestic birds, feral birds, or privately-owned game birds may be released year-round for dog training on the Cobb Lake Unit by permit only, in accordance with the provisions of this chapter and other applicable regulations, including, but not limited to, #007, #008, #009, #801 and #804 of these regulations. All such birds taken during training activities shall be removed from the State Wildlife Area by the dog training permittee and all privately-owned game birds shall be prepared for human consumption.
i. Horse use is prohibited, except at the Cobb Lake Unit, where horses may be used during field trials.
j. The Division is authorized to implement a dog training reservation system should overcrowding become an issue on the State Wildlife Area.

277. <u>West Lake State Wildlife Area - Larimer County</u>

a. Vessel use is prohibited, except for launching and use of vessels that are propelled by hand, wind or electric motor.
b. Public access to West Lake State Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

278. <u>West Rifle Creek State Wildlife Area - Garfield County</u>

a. Public access is prohibited on the designated shooting range between sunset and sunrise.
b. Discharge of firearms or bows is prohibited, except while hunting or on the designated shooting range.
c. Camping is allowed by licensed hunters during an established big game season plus three (3) days before and three (3) days after each season.
d. Fires are allowed within a containment structure while camping.

279. <u>Whitehorse State Wildlife Area - Adams County</u>

a. Public access is limited to youth and mentors who have received certification to use the property as participants in the youth hunting program.
b. Public access is limited to dates specified by the program.
c. Parking and access is allowed from designated parking areas only.
d. Reservations are available to authorized participants for waterfowl hunting. Reservations must be made in accordance with #901.A of these regulations. Hunters with reservations may only hunt the area specified on the reservation, except when hunting areas which are unreserved and unoccupied.
e. Waterfowl hunters must check-in and check-out at the designated check station and the reservation holder must be present while hunting.

280. Williams Creek Reservoir State Wildlife Area - Hinsdale County

a. Launching and use of all vessels is allowed.
b. Operating a vessel in a manner that creates a whitewater wake is prohibited.
c. Discharge of firearms or bows is prohibited, except while hunting.
d. Snowmobiles are allowed only as an aid in ice fishing.
e. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

281. Willow Creek State Wildlife Area (Fishing and Hunting Lease) - Yuma County

a. Public access is prohibited from June 1 through August 31.
b. Public access is prohibited from 9:00 p.m. – 4:00 a.m.
c. Dog training is prohibited.
d. Horse use is prohibited.

282. Willow Creek Reservoir State Wildlife Area (Fishing/Hunting Lease) - Grand County

a. Public access is prohibited, except while fishing, small game, and waterfowl hunting.
b. Public access is allowed only through designated access points as posted.
c. Hunting with centerfire rifles prohibited.

283. Wind in the Willows State Wildlife Area - Hinsdale County

a. Public access to the Easement Area is allowed from a single point located at the southerly end of the property, just north of the bridge on Hinsdale Co Rd 33, near the intersection of Hinsdale Co Rd 33 and Hinsdale Co Rd 30. Public access to the Easement Area from any other portion of the property is prohibited.
b. Public access is prohibited, except while fly fishing only.
c. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise.
d. Public access is allowed by foot only.
e. Fishing access is allowed only on the Lake Fork of the Gunnison River, including twenty (20) feet on either side of the riverbank.
f. Dogs are prohibited.

284. Windy Gap Watchable Wildlife Area - Grand County

a. Public access is prohibited outside of the viewing area.
b. Public access is prohibited from sunset to sunrise.
c. Discharge of firearms or bows is prohibited.
d. Hunting is prohibited.
e. Fishing is prohibited.
f. Dogs are allowed but must be kept under control on a physical leash by the handler at all times.
g. Public access to Windy Gap Watchable Wildlife Area is exempt from requirements set forth in section #900(C)1 of these regulations.

285. Woods Lake State Wildlife Area - San Miguel County

a. Vessel use is prohibited, except for launching and use of vessels that are propelled by hand, wind or electric motor.

b. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except as authorized in #900(C)(15).

286. Yampa River State Wildlife Area - Routt County

a. Discharge of firearms or bows is prohibited, except while hunting.
b. Launch or take out of vessels, except those being actively used for fishing, hunting or wildlife viewing is prohibited.

287. Yarmony Ranch State Wildlife Area (Hunting and Fishing Easement) - Jackson County

a. Public access is prohibited, except while hunting or fishing.
b. Hunting is allowed for elk, moose and pronghorn with a limited public access permit only.
c. Limited public access permits may be obtained by contacting the CPW Steamboat Springs Service Center at 970-870-3333.
d. To obtain a limited public access permit, hunters must already possess a big game license for one of the specific hunt codes permitted on the property.
e. Limited access permits will be valid starting the 1st day of the season of the license.
f. Hunters may only access the property during the dates specified on their limited public access permit and may be accompanied by up to two (2) people who are not hunting.
g. Public access by hunters with a limited public access permit is prohibited prior to two (2) hours before sunrise and after one (1) hour following sunset, except that when an animal has been harvested, the successful hunter and their non-hunter companion shall be allowed to remain as long as necessary to remove it.
h. Fishing is prohibited during established big game hunting seasons.
i. Parking and public access is allowed from designated parking areas only.
j. Public access is allowed by foot and horseback only.
k. Discharge of firearms or bows is prohibited in the designated safety zones, or as posted.
l. Discharge of firearms or bows is prohibited, except while hunting.
m. Building blinds is prohibited.

ARTICLE IV - STATE FISH UNITS

#905 - PROPERTY SPECIFIC REGULATIONS

E. Roaring Judy State Fish Unit - Gunnison County

1. Public access is prohibited from one (1) hour after sunset to one (1) hour before sunrise.
2. Public access is prohibited from December 1 through April 30 on that portion of the property east of Hwy 135.
3. West of Hwy 135, hunting is allowed with archery equipment for big game and shotguns utilizing birdshot for small game and waterfowl only.
4. Discharge of firearms or bows is prohibited in the designated safety zones, or as posted.

5. Fishing is prohibited in the fishing ponds and the connecting hatchery discharge stream to the hatchery outlet (on the East River) from the day after Labor Day through November 15.
6. Dogs are allowed but must be kept under control on a physical leash by the handler at all times, except when used as an aid in hunting.

APPENDIX B

1. State Wildlife Areas governed by regulation #900

Wildlife properties governed by general provisions contained in regulation #900 include those listed in the following table and any new properties acquired during the year for which property specific regulations have not been adopted:

Property Name	**County**
Alma SWA	Park
Blanca SWA	Alamosa
Brackenbury SWA	Larimer
Brown Lakes SWA	Hinsdale
Brush Creek SWA	Eagle
Burchfield SWA	Baca
Cabin Creek SWA	Gunnison
Charlie Meyers SWA	Park
Coke Oven SWA	Pitkin
Deadman SWA	Prowers
Droney Gulch SWA	Chaffee
Fort Lyon SWA	Bent
Four Mile SWA	Douglas
Georgetown SWA	Clear Creek
Jackson SWA	Garfield
Johnson Village SWA (Fishing Easement)	Chaffee
Lake Fork Gunnison SWA (Fishing Easement)	Hinsdale
Leaps Gulch SWA	Gunnison
Masonic Park Fishing Easement	Rio Grande
Middle Taylor Creek SWA	Custer
Purgatoire River SWA	Bent
Oxbow SWA	Otero
Pioneer Park SWA	Grand
Red Dog SWA	Prowers
Saguache Park	Saguache
San Miguel SWA	San Miguel
Sapinero SWA	Gunnison
Seaman Reservoir SWA	Larimer
Setchfield SWA	Bent
Spinney Mountain SWA	Park
63 Ranch SWA	Park
Terrace Reservoir SWA	Conejos
Teter-Michigan Creek SWA	Park
Twin Sisters SWA	Larimer
Van Tuyl SWA (Cabin Creek and Lost Canyon Units)	Gunnison
Wheeler SWA	Garfield

Wright's Lake SWA	Chaffee

2. State Trust Lands governed by regulation #902

Properties leased from the State Land Board (state trust lands) governed by general provisions contained in regulation #902 include those listed in the following table and any new properties acquired during the year for which property specific regulations have not been adopted:

Property Name	**County**
Adelaide	Fremont
Agate Mountain	Park
Agua Ramon	Rio Grande
Alamosa Canyon	Conejos
Alkali Arroyo	Otero
Alta	Conejos
American Gulch	Rio Grande
Antelope Flats	Morgan
Antelope Tank	Las Animas
Arrowhead	Larimer
Aspen Ridge	Chaffee
Aubury Creek	Baca
Badger Basin	Park
Badger Flats	Park
Badito	Huerfano
Bear Creek	Huerfano
Beaver Brook	Clear Creek
Beecher Island	Yuma
Ben Morgan Canyon	Moffat
Black Wolf Creek	Yuma
Bloom Hills	Otero
Bonny Creek	Yuma
Box Elder	Moffat
Boxelder North	Moffat
Brammer	Morgan
Briggsdale	Weld
Brush Hollow	Fremont
Buffalo Gulch	Park
Bull Pasture	Otero
Burns Canyon	Chaffee
Bustos Flat	Huerfano
Carrica	Otero
Chiquito Peak	Conejos
Cimarron River	Baca
Citadel	Moffat
Copper Mountain	Grand
Crooked Arroyo	Otero

Property Name	County
Cross Mountain	Moffat
Crow Valley	Weld
David Canyon	Otero
Dead Horse Creek	San Miguel
Dearfield	Weld
Delmonica Gulch	Lake
Disappointment Creek	Dolores
Disappointment Valley	San Miguel
Dixie Bluffs	Otero
Dry Creek Basin	San Miguel
Dry Creek North	Larimer
Eagle Canyon	Larimer
East Alamosa	Alamosa
East Bend	Conejos
East Carrizo Creek	Las Animas
East Timpas	Otero
Eastman Basin	Weld
Ecklund	Yuma
Edler	Baca
Eleven Mile	Park
Elk Springs #1	Moffat
Flagler	Kit Carson
Flying A	Pueblo
Foster Gulch	Custer
Gallegos	Conejos
Geary Creek	Weld
Gerrard	Rio Grande
Guillermo Ranch	Huerfano
Haight	Otero
Hamilton Mesa	San Miguel
Hartsel	Park
Hartsel South	Park
Hay Gulch Overlook	Yuma
Higbee Canyon	Otero
Howard Creek	Weld
Hungerford	Pueblo
Iles Grove	Moffat
Iron Springs	Otero
Jack Canyon	Otero
Jacks Creek	Saguache
Jeffway Gulch	Moffat
Jimmy Creek	Larimer
Johnson Gulch	Custer
Jubb Creek	Moffat
Juniper Hot Springs	Moffat
Keller	Bent

Property Name	County
Keota	Weld
Kerber Creek	Saguache
Kinney Lake	Lincoln
Kirkwell	Baca
Klondike Basin	San Miguel
La Junta	Otero
Las Mesitas	Conejos
Laughlin Gulch	Saguache
Lazy D	Weld
Little Muddy	Adams
Little Snake	Moffat
Lone Rock	Baca
Maitland	Huerfano
Manhattan Creek	Larimer
McKenna Peak	San Miguel
Middle Creek	Saguache
Miner’s Draw	Moffat
Mirage	Saguache
Moore Draw	Baca
Morgan Gulch	Moffat
North Devils Canyon	Otero
North Pawnee Creek	Weld
Oil Well Flats	Fremont
Old Man’s Gulch	Eagle
Old Woman Creek	Saguache
Orchard	Weld
Oritz	Conejos
Packers Gap	Otero
Pawnee Coal Creek	Weld
Pawnee Valley	Logan
Pine Arroyo	Huerfano
Pinon Ridge	Moffat
Point of Rocks	Weld
Poison Spyder	San Miguel
Poitrey Canyon	Las Animas
Poitrey Creek	Las Animas
Poncha Pass	Chaffee
Punche Valley	Conejos
Queens	Kiowa
Railroad Gulch	Chaffee
Rattlesnake	Huerfano
Red Mountain	Grand
Red Rock	Otero
Robinson Creek	Weld
Rock Creek	Saugache
Rock Fall	Otero

Property Name	County
Romeo	Conejos
Rosener	Morgan
Round Top	Otero
Russell Creek	Saguache
Rye Slough	Park
Saddle Mountain	Park
San Antonito	Conejos
Sand Arroyo	Baca
Sand Canyon	Baca
Sand Creek Central	Chaffee
Sand Creek South	Baca
Savory East	Las Animas
Settlement	Kit Carson
Shelf Road	Teller
Simmons	Yuma
Simsberry Draw	Moffat
Sixteen Ditch	Jackson
Skull Creek	Moffat
Sleeping Giant	Routt
Slide Mountain	Grand
Snyder Prairie	Washington
South Duffy Mountain	Moffat
South Fork Republican	Kit Carson, Yuma
South Fork Spring Canyon	Yuma
South Gardner	Huerfano
South Mountain	Dolores
South Pawnee Creek	Weld
South Pinon Hills	Conejos
South Roggen	Weld
Spinney	Park
Spring Creek Basin	San Miguel
Spring Gulch	Saguache
Spring Valley	Kit Carson
Sterling Prairie	Logan
Steven’s Gulch	Larimer
Stone Corral	Weld
Sugar Loaf	Conejos
Sultan Creek	San Juan
Sunny Moon	Baca
Taos Valley	Conejos
Tarryall Creek	Park
Tecolote Creek	Las Animas
Temple Canyon	Moffat
Texas Creek #2	Fremont
The Hogback	Huerfano
The Poso	Conejos

Property Name	County
Thornburg Draw	Moffat
Three Mile Mountain	Park
Timberlake	Otero
Tinaja Canyon	Huerfano
Tobe Creek	Las Animas
Treasurevault Mountain	Park
Treetop	Bent
Triangle	Moffat
Troublesome Valley Ranch	Grand
Trujillo Canyon	Conejos
Tunnel Drive	Fremont
Turkey Ridge	Pueblo, Huerfano
Two Buttes	Prowers
Twomile Creek	Weld
Utleyville	Baca
Villa Grove	Saguache
Weldon Valley	Morgan
West Lime Creek	San Juan
Whiskey Creek	Eagle
Whiterock	Otero, Pueblo
Wild Horse	Weld
Williams Hill	Pitkin

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Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado Parks and Wildlife (406 Series, Wildlife)

on 06/22/2023

2 CCR 406-9

CHAPTER W-9 - WILDLIFE PROPERTIES

The above-referenced rules were submitted to this office on 06/22/2023 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.

June 26, 2023 11:24:46

Philip J. Weiser
Attorney General
by Kurtis Morrison
Deputy Attorney General

Permanent Rules Adopted

Department

Department of Human Services

Agency

Behavioral Health

CCR number

2 CCR 502-1

Rule title

2 CCR 502-1 BEHAVIORAL HEALTH 1 - eff 07/30/2023

Effective date

07/30/2023

(2 CCR 502-1, 21.800-21.900 Behavioral Health)

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DEPARTMENT OF LAW

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Office of the Attorney General

Tracking number: 2023-00200

Opinion of the Attorney General rendered in connection with the rules adopted by the

Behavioral Health

on 06/09/2023

2 CCR 502-1

BEHAVIORAL HEALTH

The above-referenced rules were submitted to this office on 06/14/2023 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.

June 26, 2023 11:46:28

Philip J. Weiser
Attorney General
by Kurtis Morrison
Deputy Attorney General

Permanent Rules Adopted

Department

Department of Human Services

Agency

Office of Civil and Forensic Mental Health

CCR number

2 CCR 505-1

Rule title

2 CCR 505-1 Civil and Forensic Mental Health 1 - eff 07/30/2023

Effective date

07/30/2023

(2 CCR 505-1, CIVIL AND FORENSIC MENTAL HEALTH)

21.800 UNIFORM METHOD OF DETERMINING ABILITY TO PAY FOR ANY PERSON WHO RECEIVES SERVICES FROM ANY PUBLIC INSTITUTION SUPERVISED BY THE DEPARTMENT OF HUMAN SERVICES FOR THE CARE, SUPPORT, MAINTENANCE, EDUCATION OR TREATMENT OF THE MENTALLY ILL OR DEVELOPMENTALLY DISABLED

21.810 STATUTORY AUTHORITY

The statutory authority for these rules and regulations is found at Sections 27-92-101 through 27-92-109,
C.R.S.

21.820 DEFINITIONS

“Ability to Pay” is the amount of the legally responsible person's income and assets available to pay for the individual cost of care, support, maintenance, treatment, and education at the institution.

“Adjusted Assets” is the balance of the assets of the legally responsible person(s) after allowed asset deductions.

“Adjusted Charge” is the charge for hospital care, support, maintenance and treatment, up to but not exceeding the ability to pay of the responsible person(s).

“Adjusted Income” is the balance of the total gross monthly income of the legally responsible person(s) after allowed income deductions.

“Allowed Asset Deduction” includes liabilities; the value of the equity in the home; assets which are specifically targeted for retirement and which are not available for other purposes; and the Supplemental Security Income (SSI) asset allowance for each legally responsible parent, patient, spouse, and other dependent.

“Allowed Income Deduction” includes withholding taxes, employee union or association dues, mandatory retirement deductions, health insurance premiums, conservator fees, one-twelfth of the federal personal exemption allowance for each dependent, and child support and/or alimony payments.

“Colorado Net Taxable Income” refers to the calculation on the State of Colorado Income Tax Form, and reportable under Colorado law, which is used as the base against which state tax liability is determined.

“Cost of Care” refers to the full rate multiplied by the number of days of care provided.

“Department” refers to the Colorado Department of Human Services.

“Dependent” is an individual who qualifies as a dependent under Internal Revenue Service (IRS) regulations for federal income tax purposes.

“Executive Director” refers to the Executive Director of the Department.

“Federal Personal Exemption Allowance” refers to the dollar amount allowed by the IRS for each dependent.

“Full Rate” refers to the institution's daily rate, which is determined periodically, based on the cost for care, support, maintenance, treatment and education of patients, as approved by the Executive Director.

“Institution” refers to any public institution of this state supervised by the Department of Human Services for the care, support, maintenance, education, or treatment of the mentally ill or developmentally disabled.

“Insurance and Other Benefits” includes all insurance, health maintenance organizations, Medicare, Medicaid, and any other resources covering the cost of care, support, maintenance, or treatment by the institution.

“Legally Responsible Person(s)” is the patient, fiduciary, spouse, and parent(s) of children under 18 years of age, as applicable.

“Patient” refers to any person admitted, committed or transferred to any public institution of this state supervised by the Department of Human Services for the care, support, maintenance, education or treatment of the mentally ill or developmentally disabled.

“Personal Needs Allowance” refers to the uniform dollar amount determined by the Department to be available to each patient receiving income from a benefit or employment, which may be used for items not provided by the institution.

“SSI Asset Allowance” refers to the maximum dollar amount of assets that an individual is allowed to retain and still qualify for the Supplemental Security Income (SSI) Program.

21.830 INTRODUCTION

These rules are intended to provide the method used to assess charges at the public institutions under the supervision of the Department of Human Services for the care, support, maintenance, education, or treatment of the mentally ill or developmentally disabled. No person shall be denied admission because of inability to pay. These rules and regulations do not apply to individuals at these institutions who are receiving services under federally funded programs whose rules conflict with these rules.

21.840 PROCESS OF DETERMINING ABILITY TO PAY AND ADJUSTED CHARGE

A. Insurance and Other Benefits

Insurance and other benefits shall be applied first to the cost of care. Insurance and other benefits for any patient shall be billed at the cost of care. A legally responsible person who fails to cooperate in making existing insurance and other benefits available for payment will nevertheless be considered as having benefits available for payment.

B. Calculation of Ability to Pay

The ability to pay shall be calculated taking into consideration the factors in Section 27-92-104, C.R.S., and using the schedule in Section 21.860 of these rules and regulations.

C. Determination of Adjusted Charge

The adjusted charge shall be the balance of the cost of care after insurance and other benefits have been deducted, or the ability to pay, whichever is less. If the legally responsible person(s) does not cooperate in making insurance and other benefits available, the legally responsible person(s) will be billed for the amount equal to the dollar value of the insurance or benefits in addition to the lesser of the balance of the cost of care or the ability to pay. If the dollar value of insurance and other benefits cannot be determined, the legally responsible person(s) will be billed the full cost of care.

D. Modifications

A legally responsible person whose income is substantially reduced as a result of changed financial circumstances after the ability to pay has been determined, may request a redetermination and provide the hospital with evidence of financial change so that a new ability to pay may be determined based on current income and assets. Should there be an increase in income, assets, insurance or other benefits, this information must be reported to the institution within sixty (60) calendar days of the changed financial circumstances so that an appropriate redetermination of the ability to pay can be made.

21.850 FACTORS AFFECTING THE DETERMINATION OF ABILITY TO PAY

The following factors are considered in the determination of ability to pay, in accord with Section 27-92-104, C.R.S.

A. Length of a Patient's Care and Treatment

To avoid undue hardship on patients and/or their families, the ability to pay is reduced after the sixth calendar month of treatment.

B. Medical and Physical Condition of Dependents

To avoid undue hardship on families, monthly payments for medical services for dependents with serious mental or physical conditions may be deducted from income when the adjusted income is determined, provided adequate supporting documentation is submitted to the institution.

21.860 SCHEDULE FOR DETERMINING THE ABILITY TO PAY

The ability to pay of the legally responsible person(s) is the sum of the monthly adjusted income and the monthly adjusted assets available to pay for the cost of care, support, maintenance, treatment, and education at the institution.

The monthly adjusted assets considered available to pay for care, support, maintenance and treatment is one (1) percent of adjusted assets.

The following table is used to calculate the monthly adjusted income considered available to pay for care, support, maintenance, treatment, and education.

MONTHLY ADJUSTED INCOME AVAILABLE TO PAY FOR CARE, SUPPORT, MAINTENANCE, TREATMENT AND EDUCATION

Adjusted Income	1st - 6th Calendar Months	7th and Subsequent Calendar Months
	Percent of Adjusted Income Available	
$0-$ 499	20%	15%
$500-$ 999	30%	25%
$1,000 - $1,499	35%	30%
$1,500 - $1,999	40%	35%
$2,000 and above	45%	40%

21.870 ADDITIONAL FACTORS AFFECTING THE ABILITY TO PAY AND THE ADJUSTED CHARGE

A. For legally responsible parents of children under eighteen (18) years of age, the monthly adjusted income available in the seventh and subsequent calendar months shall be one percent of Colorado Net Taxable Income.

B. For single patients receiving only fixed income benefits, or when a husband and wife both reside in an institution or other health care facility and receive only fixed income benefits, the monthly adjusted income available will be the amount of these benefits, less the personal needs allowance and any other applicable deductions.

21.900 COMPETENCY EVALUATIONS IN CRIMINAL CASES

These rules are established to create standards for psychologists and psychiatrists wishing to become approved as evaluators of competency to proceed.

21.910 DEFINITIONS

“Approved evaluator” means an evaluator who is currently employed by CDHS; or has completed the application process through the Court Services Division and is providing services under an active purchase order or a personal services contract, or as a fellow in forensic psychology or psychiatry training.

“Board Certification” in forensic psychiatry or forensic psychology means recognition of specialized training and knowledge in the field of forensic psychiatry by the American Board of Psychiatry and Neurology (ABPN), or in the field of forensic psychology by the American Board of Forensic Psychology (ABFP); no amendments or editions are incorporated.

“Competency Evaluator” means a licensed physician who is a psychiatrist or a licensed psychologist, each of whom is trained in forensic competency assessments, or a psychiatrist who is in forensic training and practicing under the supervision of a psychiatrist with expertise in forensic psychiatry and who is an approved evaluator, or a psychologist who is in forensic training and is practicing under the supervision of a licensed psychologist with expertise in forensic psychology and who is an approved evaluator.

“Competent to Proceed” means that the defendant does not have a mental disability or developmental disability that prevents the defendant from having sufficient present ability to consult with the defendant's lawyer with a reasonable degree of rational understanding in order to assist in the defense, or prevents the defendant from having a rational and factual understanding of the criminal proceedings.

“Court-Ordered Competency Evaluation” means a court-ordered examination of a defendant either before, during, or after trial, directed to developing information relevant to a determination of the defendant’s competency to proceed at a particular stage of the criminal proceeding, that is performed by a competency evaluator and includes evaluations concerning restoration to competency.

“Forensic” means relating to or dealing with the application of scientific knowledge to the legal issues of defendants in criminal proceedings.

“Incompetent to proceed” means that, as a result of a mental disability or developmental disability, the defendant does not have sufficient present ability to consult with the defendant's lawyer with a reasonable degree of rational understanding in order to assist in the defense, or that, as a result of a mental disability or developmental disability, the defendant does not have a rational and factual understanding of the criminal proceedings.

21.920 APPLICATION PROCESS

Individuals other than independent contractors or those providing services under an active purchase order or personal services contract wishing to become an approved

evaluator shall contact the Director of Court Services for application information, and the following shall be submitted:

A. A completed application form;

B. Verification of licensure as a psychiatrist or psychologist;

C. Verification of board certification in forensic psychiatry from the ABPN or board certification in forensic psychology from the ABFP, when relevant;

D. Proof of current malpractice insurance;

E. A minimum of two work samples, preferably forensic reports;

F. A minimum of three professional references.

21.930 TRAINING

21.931 APPROVED EVALUATORS

A. All approved evaluators shall have received training as specified in these rules, consisting of at least six hours of instruction. This initial training shall, at a minimum, cover the following elements:

1. Legal background and legal standards for competency to proceed and competency to stand trial;

2. Forensic versus clinical evaluation, ethical issues and challenges in competency evaluations, dual relationships, constitutional protections for defendants, informed consent in defendants with severe mental illnesses, and communication with attorneys;

3. Interviewing for competency to proceed;

4. Assessment of malingering;

5. Use of third-party (collateral) data and resources;

6. Working with the difficult defendant;

7. Evaluating developmentally delayed defendants;

8. Special issues in evaluating juveniles;

9. Writing the competency or restoration report;

10. Acting as an expert witness; and,

11. Unique requests from the court, such as for evaluations for competency to waive the right to counsel.

B. Exemptions to Initial Training

1. Evaluators who are board certified in forensic psychiatry by the ABPN or board certified in forensic psychology by the ABFP shall be considered exempt from this initial training requirement.

2. Evaluators who are in forensic training and practicing under the supervision of a licensed psychiatrist who is an approved evaluator and who has expertise in forensic psychiatry, or a licensed psychologist who is an approved evaluator and who has expertise in forensic psychology, may practice without the initial training; however, it is expected that these evaluators will receive equivalent education during the course of their training programs.

3. Independent contractors or individuals providing services under an active purchase order or personal services contract are not subject to the training requirements in Section 21.931, A.

C. Ongoing Training

Approved evaluators other than independent contractors or individuals providing services under an active purchase order or personal services contract shall participate in at least four hours of ongoing training annually. Training will be made available at least annually by staff of the Court Services Division; alternative training to fulfill this requirement may be substituted for that offered by the Court Services Division, with prior approval from the Director of Court Services.

21.932 MENTORING

Mentoring shall be made available to approved CDHS-employed evaluators. Mentoring will be provided by senior clinical staff whenever possible.

A. Approved CDHS-employed evaluators wishing to participate in mentoring will be provided the opportunity to observe one or more evaluations being conducted by senior clinical staff, and to conduct one or more evaluations while being observed by senior clinical staff.

21.940 STANDARDS FOR CONDUCTING EVALUATIONS AND ESTABLISHING A REPORT

Each report shall conform with the requirements for report content as set forth in Section 16-8.5-105(5), C.R.S., and in accordance with best practices for forensic assessment of competency to stand trial.

21.950 QUALITY ASSURANCE

All approved evaluators shall have one or more of their competency or restoration reports reviewed at least annually by a senior Court Services Division evaluator or his or her designee.

A. All approved evaluators shall have their first two reports reviewed by the senior Court Services Division evaluator, or his or her designee, with additional reports being reviewed as necessary.

B. Any and all reports submitted by approved evaluators are subject to review.

PHIL WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

SHANNON STEVENSON
Solicitor General

TANJA WHEELER
Associate Chief Deputy Attorney General

STATE OF COLORADO
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Office of the Attorney General

Tracking number: 2022-00763

Opinion of the Attorney General rendered in connection with the rules adopted by the

Office of Civil and Forensic Mental Health

on 06/09/2023

2 CCR 505-1

Civil and Forensic Mental Health

The above-referenced rules were submitted to this office on 06/14/2023 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.

June 26, 2023 11:44:24

Philip J. Weiser
Attorney General
by Kurtis Morrison
Deputy Attorney General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - State Electrical Board

CCR number

3 CCR 710-1

Rule title

3 CCR 710-1 STATE ELECTRICAL BOARD RULES AND REGULATIONS 1 - eff 07/30/2023

Effective date

07/30/2023

DEPARTMENT OF REGULATORY AGENCIES

State Electrical Board

STATE ELECTRICAL BOARD RULES AND REGULATIONS

3 CCR 710-1

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

…

1.5 INCORPORATION BY REFERENCE

This Rule is promulgated pursuant to sections 12-20-204, 12-115-107(2)(a), and 24-4-103(12.5), C.R.S.

A. The Board hereby incorporates by reference the National Fire Protection Association standard number 70, hereafter known as the National Electrical Code, 2023 Edition, and as may be amended by the Board. These standards are incorporated by reference as the minimum standards governing the planning, laying out, and installing or the making of additions, alterations, and repairs in the installation of wiring apparatus and equipment for electric light, heat, and power in this state. This Rule does not include later amendments to or editions of the National Electrical Code, 2023 Edition. The effective date shall be August 1, 2023. The incorporated code is available for public inspection at 1560 Broadway, Suite 1350, Denver, CO, 80202.

B. A copy of the provisions of the National Electrical Code, 2023 edition is available for public inspection during regular business hours at the Board office at the Division of Professions and Occupations, Department of Regulatory Agencies, 1560 Broadway, Suite 110, Denver, Colorado, 80202, and at any state publications depository library. For further information regarding how this material can be obtained or examined, contact the Program Director for the Board ("Program Director") at 1560 Broadway, Suite 110, Denver, Colorado, 80202, (303) 894-2300. The National Electric Code, 2023 Edition, is available directly from the National Fire Protection Association (NFPA), 1 Batterymarch Park, Quincy MA 02169-7471, phone 1-800-344-3555. Copies are also available from the NFPA website at NFPA.org, as well as most online and retail book vendors.

…

1.10 ENFORCEMENT

This Rule is promulgated pursuant to sections 12-20-204, 12-115-107(2)(a), and 12-115-122, C.R.S.

…

D. Fine Schedule. The following is the current fine schedule adopted by the Board pursuant to section 12-115-122(3)(a), C.R.S.

Violation	Statutory Provision	1st Offense	2nd Offense	Subsequent Offense
Engaging in the business, trade, or calling of a journeyman electrician without a license	12-115-109(1)	$225	$600	Up to $2,000 per day
Engaging in the business, trade, or calling of a master electrician without a license	12-115-109(1)	$300	$600	Up to $2,000 per day
Engaging in the business, trade, or calling of a residential wireman without a license	12-115-109(2)	$150	$375	Up to $2,000 per day
Performing electrical work beyond the authorization of a residential wireman license	12-115-109(1)	$375	$750	Up to $2,000 per day
Failure of an electrical contractor to register an apprentice	12-115-115(3) 12-115-122(1)(a)	$225	$600	Up to $2,000 per day
Failure of a licensee or registered apprentice to produce a license or registration as required by Rule 7.3	12-115-122(1)(b)	$50	$200	Up to $2,000 per day
Employment by an electrical contractor of unlicensed persons doing electrical work	12-115-122(1)(k)	$300	$600	Up to $2,000 per day
Engaging in the business of an electrical contractor without obtaining registration from the Board	12-115-110(5)(a)	$750	$1,500	Up to $2,000 per day
Applying for an electrical permit if not qualified applicant	12-115-113(1)(r) 12-115-122(1)(q)	$375	$900	Up to $2,000 per day
Failure of a licensed electrician to supervise an apprentice	12-115-115(1), 12-115-115(3)(b) 12-115-122(1)(j)	$375	$600	Up to $2,000 per day
Failure of an electrical contractor to maintain a supervisory ratio of one licensed electrician to three apprentices	12-115-115(1)	$375	$600	Up to $2,000 per day
Failure to obtain a permit and/or failure to obtain an inspection	12-115-120 12-115-122(1)(a)	$375	$900	Up to $2,000 per day
Failure to remove a cause for disapproval of any electrical installation within a reasonable time	12-115-122(1)(c)	$450	$900	Up to $2,000 per day

Advertising by a licensee or registrant which is false or misleading	12-115-122(1)(h)	$375	$750	Up to $2,000 per day
Deception, misrepresentation or fraud in obtaining or attempting to obtain a license (includes loaning a license)	12-115-122(1)(i)	$1,000	$2,000	Up to $2,000 per day
Failure to comply with other state or federal law (safety, health, insurance, tax)	12-115-122(1)(p)	$375	$750	Up to $2,000 per day
Other violations of the state electrical statutes, rules, or Board orders.	12-115-122(1)	Up to $1,000	Up to $2,000	Up to $2,000 per day

…

Editor's Notes

History

Entire rule eff. 08/01/2008.

Rules 3.7, 5.0-5.2, 9.0-10.0 eff. 08/01/2010.

Entire rule eff. 03/17/2011.

Rules 8.1, 9.7 m eff. 09/15/2011.

Rules 3.0-10.7 eff. 07/15/2012.

Entire rule eff. 07/01/2014.

Rules 2.2, 3.1, 4.4.1.2.B, 4.4.1.3.A eff. 01/30/2015.

Entire rule eff. 03/17/2017.

Rule 2.0 eff. 06/01/2017.

Rules 6.0, 11.0 eff. 07/15/2017.

Rules 7.2.5.9, 8.3.3, 11.2 eff. 03/17/2018. Rule 11.3.7 repealed eff. 03/17/2018.

Rule 8.3.3. eff. 11/14/2018.

Rule 1.2 eff. 07/15/2020.

Rule 1.3 E eff. 07/15/2021.

Rule 1.11 G.2 eff. 11/30/2021.

Entire rule eff. 07/15/2022.

Rule 1.14 emer. rule eff. 09/28/2022.

Rule 1.14 eff. 11/30/2022.

PHIL WEISER
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Office of the Attorney General

Tracking number: 2023-00238

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - State Electrical Board

on 05/31/2023

3 CCR 710-1

STATE ELECTRICAL BOARD RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 06/13/2023 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.

June 20, 2023 09:50:06

Philip J. Weiser
Attorney General
by Kurtis Morrison
Deputy Attorney General

Permanent Rules Adopted

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

CCR number

10 CCR 2505-10

Rule title

10 CCR 2505-10 MEDICAL ASSISTANCE - STATEMENTS OF BASIS AND PURPOSE AND RULE HISTORY 1 - eff 07/30/2023

Effective date

07/30/2023

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Care and Case Management System, Sections 8.390, 8.393, 8.400, 8.500 & 8.615 .
Rule Number: MSB 23-01-13-A
Division / Contact / Phone: Office of Community Living / Michelle Topkoff / 303-866-3659

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 23-01-13-A, Revision to the Medical Assistance Act Rule concerning Care and Case Management System, Sections 8.390, 8.393, 8.400, 8.500 & 8.615 .

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.390, 8.393, 8.400, 8.500 and 8.614, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.390.1 with the proposed text beginning at 8.390.1 through the end of 8.390.1. Replace the current text at 8.393.1.M with the proposed text beginning at 8.393.1.M through the end of 8.393.1.M. Replace the current text at 8.393.2 with the proposed text beginning at 8.393.2.B through the end of 8.393.2.H. Replace the current text at 8.393.5 with the proposed text beginning at 8.393.5 through the end of 8.393.6.B. Replace the current text at 8.400 beginning at 8.400.12 through the end of

*to be completed by MSB Board Coordinator

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8.400.17. Replace the current text at 8.401 with the proposed text beginning at 8.401 through the end of 8.401.16. Replace the current text at 8.402.10 with the proposed text beginning at 8.402.10 through the end of 8.402.54. Replace the current text at 8.405.2 with the proposed text beginning at 8.405.2 through the end of 8.405.4. Replace the current text at 8.470.2 with the proposed text beginning at 8.470.2 through the end of 8.470.5.D. Replace the current text at 8.485.50 with the proposed text beginning at 8.485.50 through the end of 8.485.90. Replace the current text at 8.486 with the proposed text beginning at 8.486.20 through the end of 8.486.40. Replace the current text at 8.486.200 with the proposed text beginning at 8.486.200 through the end 8.486.500. Replace the current text at Section 8.400-499, Appendix A with the proposed text beginning at Section 8.400-499, Appendix A through the end of Section 8.400-499, Appendix A. Replace the current text at 8.500 with the proposed text beginning at 8.500.1 through the end of 8.500.4.A. Replace the current text at 8.500.90 with the proposed text beginning at 8.500.90 through the end of 8.500.91.F. Replace the current text at 8.500.93 with the proposed text beginning at 8.500.93.A through the end of 8.500.93.A. Replace the current text at 8.500.103 with the proposed text beginning at 8.500.103.A through the end of 8.500.103.A. Replace the current text at 8.501 with the preposed text beginning at 8.501.A through the end of 8.501.A. Replace the current text at 8.503 with the proposed text beginning at 8.503.QQ. Replace the current text at 8.503.30 with the proposed text beginning at 8.503.30 through the end of 8.503.30. Replace the current text at 8.503.60 with the proposed text beginning at 8.503.60 through the end of 8.503.80. Replace the current text at 8.504 with the proposed text beginning at 8.504.1 through the end of 8.504.1. Replace the current text at 8.504.5 with the proposed text beginning at 8.504.5 through the end of 8.504.5. Replace the current text 8.506 with the preposed text beginning at 8.506.2 through the end of 8.506.4. Replace the current text at 8.506.6 with the proposed text beginning at 8.506.6.A through the end of 8.506.6.A. Replace the current text at 8.506.7 with the proposed text beginning at 8.506.7.H through the end of 8.506.7.H. Replace the current text at 8.506.10 with the proposed text beginning at 8.506.10 through the end of 8.506.10.H. Replace the current text at 8.508 with the proposed text beginning at 8.508.20 through the end of 8.508.20. Replace the current text at 8.508 with the proposed text beginning at 8.508.40 through the end of 8.508.70. Replace the current text at 8.508.121 with the proposed text beginning at 8.508.121 through the end of 8.508.121.A. Replace the current text at 8.509 with the proposed text beginning at 8.509.14 through the end of 8.509.16. Replace the current text at 8.509.31 with the proposed text beginning at 8.509.31 through the end of 8.509.33.A.1. Replace the current text at 8.510 with the proposed text beginning at 8.510.1 through the end of 8.510.1. Replace the current text at 8.515 with the proposed text beginning at 8.515.3 through the end of 8.515.85.B. Replace the current text at 8.517 with the proposed text beginning at 8.517.6 through the end of 8.517.6. Replace the current text

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

beginning at 8.519 with the proposed text beginning at 8.519.1 through the end of 8.519.1. Remove the current text at 8.519.6. Replace the text at 8.550.6.B with the proposed text beginning at 8.550.6.B through the end 8.500.6.B. Replace the current text at 8.600 with the proposed text beginning at 8.600.4 through the end of 8.600.4. Replace the current text at 8.615 with the proposed text beginning at 8.615.1 through the end of 8.615.1. This rule is effective July 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Care and Case Management System, Sections 8.390, 8.393, 8.400, 8.500 & 8.615 .
Rule Number: MSB 23-01-13-A
Division / Contact / Phone: Office of Community Living / Michelle Topkoff / 303-866-3659

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This proposed rule amends Sections 8.390, 8.393, 8.400, 8.500 and 8.614 in anticipation of adoption of a new assessment instrument, the Colorado Single Assessment Level of Care Eligibility Determination Screen. The current rule identifies by name the ULTC 100.2 as the instrument used to determine eligibility for Long Term Services and Supports (LTSS) and incorporates the instrument in its entirety into the regulations. The amendments to rule update terminology and language to allow for use of a second instrument, which will be used concurrently with the ULTC 100.2 during the phase in of the use of the new Colorado Single Assessment Level of Care Eligibility Determination Screen. During the phase in period, only one of the two instruments will used on any one member for any single certification period. This is in preparation for the eventual complete phase out of the ULTC 100.2 and replacement with the Colorado Single Assessment Level of Care Eligibility Determination Screen.

   An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

2. Federal authority for the Rule, if any:

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, 25.5-6-104, C.R.S. (2023);

Initial Review **05/12/23** Final Adoption **06/09/23**
Proposed Effective Date **07/30/23** Emergency Adoption

DOCUMENT #08

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Care and Case Management System, Sections 8.390, 8.393, 8.400, 8.500 & 8.615 .
Rule Number: MSB 23-01-13-A
Division / Contact / Phone: Office of Community Living / Michelle Topkoff / 303-866-3659

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   This proposed rule will affect Case Management Agencies and Medicaid LTSS members. Case management agencies and members will benefit from the proposed rule changes because it will allow the Department to phase in the implementation of the new Colorado Single Assessment, which is a new comprehensive level of care and needs assessment housed in the new Care and Case Management system. The new assessment process is required by SB 16-192 (codified at Section 25.5-6-104, C.R.S.)

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

   The new assessment has automated features that will streamline the assessment process for members and reduce duplication in administrative work for case managers. It is also more objective and standardized.

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

   Initial cost associated with the change have been addressed through the fiscal note for SB 16-192. Enforcement costs are not anticipated to change. No other agency will incur any costs and there will be no effect on state revenues as a result of this rule change.

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

   Funding for the initial costs for the development and implementation of the new assessment instrument was allocated in a fiscal note for SB 16-192. The benefits of the proposed rule are that clients and case managers

will benefit from the streamlined assessment process and the more objective and standardized Colorado Single Assessment Level of Care Eligibility Determination Screen. The cost of inaction is that the Department will fail comply with statute and clients and case managers will be deprived of the efficiency, objectivity and standardization of the Colorado Single Assessment Level of Care Eligibility Determination Screen. No benefits of inaction have been identified.

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

   Because the current rules identify and incorporate the ULTC 100.2 as the single instrument to be used for assessments, the rule must be changed to allow use of the Colorado Single Assessment Level of Care Eligibility Determination Screen.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   No alternative methods for achieving the purpose of the proposed rule change were considered.

8.390 LONG TERM CARE SINGLE ENTRY POINT SYSTEM

The long-term care Single Entry Point system consists of Single Entry Point Agencies, representing geographic districts throughout the state, for the purpose of enabling persons in need of long-term services and supports to access appropriate services and supports.

8.390.1 DEFINITIONS

A. Applicant means an individual who is seeking a long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in a Level of Care Eligibility Determination Screen.

C. Assessment means a comprehensive evaluation of an Applicant or Member, including but not limited to the individual's level of care, service needs, available resources, and potential funding resources using Department prescribed instrument(s), as required by the program for which they are applying or in which they are enrolled.

D. Case Management means the Assessment of an individual seeking or receiving long-term services and supports' needs, the development and implementation of a Person-Centered Support Plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness, and the periodic Reassessment of such individual's needs.

E. Corrective Action Plan means a written plan by the CMA, which includes a detailed description of actions to be taken to correct non-compliance with waiver requirements, regulations, and direction from the Department, and which sets forth the date by which each action shall be completed and the persons responsible for implementing the action.

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

G. Department means the Colorado Department of Health Care Policy and Financing, the Single State Medicaid Agency.

HF. Failure to Satisfy the Scope of Work means acts or failures to act by the Single Entry Point Agency that constitute nonperformance or breach of the terms of its contract with the Department.

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

J. Home and Community Based Services (HCBS) waivers means services and supports authorized through a waiver under Section 1915(c) of the Social Security Act and provided in home- and community-based settings to individuals who require a level of care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

K. Information Management System (IMS) means an automated data management system prescribed by the Department to document case management activities and information for each individual seeking or receiving long-term and/or State General Fund services as well as to compile and generate standardized or custom summary reports.

L. Intake, Screening and Referral means the initial contact with individuals by the Single Entry Point Agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term services and supports; an individual's need for referral to other programs or services; an individual's need for financial and program assistance; and the need for an Assessment of the individual seeking services.

M. Level of Care Eligibility means an individual requires the level of care that is provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities, as determined by the Department prescribed Level of Care Eligibility Determination Screen.

O. Level of Care Eligibility Determination means the outcome of the LOC Screen,

P. Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation of the Applicant or Member using a Department prescribed assessment instrument as outlined in section 8.401.

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

R. LTSS Program means any of the following: publicly funded programs, Home and Community-Based Services Elderly, Blind and Disabled Waiver (HCBS-EBD), Home and Community-Based Services Complementary and Integrative Health Waiver (HCBS-CIH), Home and Community-Based Services Brain Injury Waiver (HCBS-BI), Home and Community-Based Services Community Mental Health Supports Waiver (HCBS-CMHS), Home and Community-Based Services Children with a Life Limiting Illness Waiver (HCBS-CLLI), Medicaid Nursing Facility Care, Program for All-Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU) and Adult Long-Term Home Health (LTHH).

S. Member means an individual who meets long-term services and support eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).

T. Person-Centered Support Planning means the process of collaborating with the individual receiving services and other people of their choosing to identify goals, needed services, individual choices and preferences, and service providers. This is based on Assessment and knowledge of the individual and of community resources and includes informing the individual of their rights and responsibilities.

U. Person-Centered Support Plan (PCSP) means the documentation of the Person-Centered Planning Process in the Department prescribed IMS using the Department prescribed format, including but not limited to the individual’s chosen goals, services and providers.

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

W. Professional Medical Information Page (PMIP) means the medical information form signed by a licensed medical professional used to verify the individual’s medical necessity for Long-Term Care Services.

X. Reassessment means a comprehensive reevaluation of an Applicant or Member, including but not limited to the individual’s level of care, service needs, available resources, and potential

funding resources using Department prescribed instrument(s), as required by the program for which they are applying or in which they are enrolled.

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

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

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

BB. Single Entry Point District means one or more counties that have been designated as a geographic region in which one agency serves as the Single Entry Point for persons in need of LTSS.

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

8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.1.M. Functions of the Case Manager.

1. The SEP Agency's case manager(s) shall be responsible for: intake, screening and referral, Assessment/Reassessment, development of Person-Centered Support Plans, ongoing case management, monitoring of individuals' health and welfare, documentation of contacts and case management activities in the Department-prescribed IMS, resource development, and case closure.

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

    b. The case manager shall have in-person monitoring at least one (1) time during the PCSP year. The case manager shall ensure one required monitoring is conducted in-person with the Member, in the Member's place of residence. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which in-person meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

    c. The case manager shall complete a new LOC Screen during a in-person Reassessment annually, or more frequently if warranted by the individual's

condition or if required by the rules of the LTSS Program in which the individual is enrolled. Upon Department approval, Reassessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which in-person meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

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

   i. The quality of services and supports provided;

   ii. The health and safety of the individual; and

   iii. The utilization of services.

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

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

   ii. Overall level of functioning;

   iii. Mental status or cognitive functioning;

   iv. Duration of disabilities;

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

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

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

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

8.393.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.2.B. Intake, Screening and Referral

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

   a. The completion and documentation of the intake, screening and referral functions using the Department prescribed intake, screening and referral instruments in the IMS;

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

b. The provision of information and referral to other agencies, as needed, and the documentation of those referrals in the IMS;

c. A screening to determine whether a LOC Screen is indicated;

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

e. The implementation of a SEP Agency procedure for prioritizing urgent inquiries.

2. When LTSS are to be reimbursed through one or more of the publicly funded LTSS Programs served by the SEP system:

a. The SEP Agency shall verify the individual's demographic information collected during the intake;

b. The SEP Agency shall coordinate the completion of the financial eligibility determination by:

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

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

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

iv. Conducting and documenting follow-up activities to complete the LOC Screen and facilitate the completion of the financial eligibility determination, as needed.

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

d. Individuals shall be notified by the SEP Agency at the time of their application for publicly funded LTSS that they have the right to appeal actions of the SEP Agency, the Department, and contractors acting on behalf of the Department. The notification shall include the right to request a fair hearing before an Administrative Law Judge.

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

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

8.393.2.C. Initial Level of Care Eligibility Determination

1. The SEP Agency shall complete the LOC Screen within the following time frames:

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

department of social services, unless a different time frame specified below applies.

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

c. For a resident who is being admitted to the nursing facility from the hospital, the SEP Agency shall complete the LOC Screen, including a PASRR Level 1 Screen within two (2) working days after notification, as required by Section 8.401.18 .PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

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

e. For an individual who is being transferred from a hospital to an HCBS program, the SEP Agency shall complete the LOC Screen within two (2) working days after notification from the hospital.

2. The start date of the Level of Care Eligibility Determination shall not be back dated by the SEP. Neither the state nor its agent(s) will approve late PAR revisions. See Section 8.486.30 LEVEL OF CARE ELIGIBILITY DETERMINATION and Section 8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES.

3. A trained SEP Agency Case Manager shall complete the LOC Screen for LTSS programs, in accordance with Section 8.401.1.

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

4. The SEP Agency shall assess the individual's level of care in-person, in the location where the person currently resides. Upon Department approval, the LOC Screen may be conducted by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which in-person meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

5. The Applicant may choose to have family members, advocates, friends and/or caregivers, as appropriate, participate as respondents in the assessment process either by attending with the Applicant or separate interviews with the case manager.

5. The SEP Agency shall conduct the following activities for a Level of Care Eligibility Determination of an Applicant:

a. Obtain supporting diagnostic information, including but not limited to, the Professional Medical Information Page (PMIP) form from the individual's medical provider for individuals in nursing facilities, HCBS Community Mental Health Supports Waiver (HCBS-CMHS), Brain Injury Waiver (HCBS-BI), Elderly, Blind and Disabled Wavier (HCBS-EBD), Complementary and Integrated Health

Waiver (HCBS-CHI) and Children with a Life Limiting Illness Waiver (HCBS-CLLI).

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

b. Determine the individual's level of care during an evaluation, with observation of the individual and family, if appropriate, in his or her residential setting using a Department prescribed instrument as outlined in Section 8.401.1.

c. Determine the length of stay for individuals seeking/receiving nursing facility care using the Nursing Facility Length of Stay Assignment Form in accordance with Section 8.402.10.15.

d. Assess the need for LTSS services using a Department prescribed instrument.

e. For HCBS Programs and admissions to nursing facilities from the community, a copy of the LOC Eligibility Determination shall be sent to the prospective provider agency and a copy shall be retained in the agency's case record for the individual. If there are changes in the individual's condition which significantly change the payment or services amount, a copy of the LOC Eligibility Determination documenting the change must be sent to the provider agency and a copy is to be maintained in the agency's case record for the individual.

f. When the SEP Agency assesses the individual's level of care using the Department's prescribed instrument, the Assessment is not an adverse action that is directly appealable. The individual's right to appeal arises only when an individual is denied enrollment into an LTSS Program by the SEP based on the thresholds for Level of Care Eligibility Determination as outlined in Section 8.401.1. The appeal process is governed by the provisions of Section 8.057.

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

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

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

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

i. If the end date for the nursing facility is indefinite, the SEP Agency shall assign an end date not past one (1) year from the date of the most recent Level of Care Eligibility Determination.

ii. If the Level of Care Eligibility Determination is less than six (6) months, the SEP Agency shall generate a new Level of Care Determination that reflects the end date that was assigned to the nursing facility.

iii. The SEP Agency shall complete a new LOC Screen if the current completion date is six (6) months old or older. The assessment results shall be used to determine level of care and the new length of stay.

iv. The SEP Agency shall provide the Level of Care Determination to the eligibility enrollment specialist at the county department of social services.

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

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

a. Coordinate the admission date with the facility;

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

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

d. If appropriate, assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the Level of Care Eligibility Determination is not six (6) months old or older.

8.393.2.D. Ongoing Level of Care Eligibility Determination

1. The case manager shall determine level of care eligibility on an ongoing basis by completing the LOC Screen at least one (1) but no more than three (3) months before the required completion date. The case manager shall complete a LOC Screen of an individual receiving services within twelve (12) months of the initial or most recent LOC screen.

2. A Level of Care Eligibility Determination shall be completed sooner if the individual's condition changes or if required by program criteria. The case manager shall document changes utilizing the LOC Screen.

3. Ongoing Level of Care Determination assessments shall be made according to 8.393.2.C.4 and shall include the following activities**:**

a. Review Person-Centered Support Plan, service agreements and provider contracts or agreements;

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

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

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

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

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

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

4. The SEP Agency shall be responsible for completing Level of Care Eligibility Determination Reassessments of individuals receiving care in a nursing facility. A Reassessment shall be completed if the nursing facility determines there has been a significant change in the resident's physical/medical status, if the individual requests a Reassessment or if the case manager assigns a definite determination end date. The nursing facility shall be responsible to send the SEP Agency a referral for a Reassessment, as needed.

5. In order to assure quality of services and supports and the health and welfare of the individual, the case manager shall ask for permission from the individual to observe the individual's residence as part of the reassessment process, but this shall not be compulsory of the individual. Upon Department approval, observation may be completed using virtual technology methods or delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

8.393.2.E. Person-Centered Support Plan

1. The nursing facility shall be responsible for developing a Support Plan for individuals residing in nursing facilities.

2. The SEP Agency shall develop the Person-Centered Support Plan (PCSP) for individuals not residing in nursing facilities within fifteen (15) working days after determination of program eligibility.

3. The SEP Agency shall:

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

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

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

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

e. Formalize the Person-Centered Support Plan agreement, including appropriate physical or digital signatures, in accordance with program requirements;

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

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

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

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

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

k. Explain the appeals process to the individual.

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

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

b. Is led by the individual, the individual's parent's (if the individual is a minor), and/or the individual's authorized representative;

c. Includes people chosen by the individual;

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

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

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

5. Prudent purchase of services:

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

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

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

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

6. In order to assure quality of services and supports and health and welfare of the individual, the case manager shall observe the individual's residence prior to completing and submitting the individual's Person-Centered Support Plan. Upon Department

approval, observation may be completed using virtual technology methods may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

8.393.2.F. Cost Containment

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

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

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

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

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

8.393.2.G. Ongoing Case Management

1. The functions of the ongoing case manager shall be:

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

    b. Person Centered Support Plan (PCSP) Development: The case manager shall work with individuals to design and update a PCSP that address individuals' goals and assessed needs and preferences;

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

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

        1. Be performed when necessary to address health and safety and services in the PCSP.

        2. Include activities to ensure:

            A. Services are being furnished in accordance with the individual's PCSP

            B. Services in the PCSP are adequate; and

C. Necessary adjustments in the PCSP and service arrangements with providers are made if the needs of the individual have changed;

3. Include an in-person contact and observation with the individual in their place of residence, at least once per certification period. Additional in person monitoring shall be performed when required by the individual's condition or circumstance. Upon Department approval, observation may be completed using virtual technology methods or delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.)

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

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

3. The case manager may require the Contractor to revise the PCSP and Prior Authorization if the results of the monitoring indicate that the plan is inappropriate, the services as described in the plan are untimely, or the amount of services need to be changed to meet the Client’s needs.

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

a. Review of the individual’s PCSP and service agreements;

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

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

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

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

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

g. Referral to community resources as needed.

5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment or mis-utilization of any public assistance benefit and shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with Department of Human Services Income Maintenance Rules at 9 C.C.R. 2503-8, Section 3.810 and Section 8.076.

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

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

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

9. The case manager shall contact the service providers, as well as the individual, to monitor service delivery as determined by the individual's needs and as required by the authorities applicable to the service.

10. Case Managers shall report critical incidents within 24 hours of notification within the State Approved IMS.

    a. Critical Incident reporting is required when the following occurs

        i. Injury/Illness;

        ii. Missing Person;

        iii. Criminal Activity;

        iv. Unsafe Housing/Displacement;

        v. Death;

        vi. Medication Management Issues;

        vii. Other High-Risk Issues;

        viii. Allegations of Abuse, Mistreatment, Neglect, or Exploitation;

        ix. Damage to the Consumer's Property/Theft.

    b. Allegations of abuse, mistreatment, neglect and exploitation, and injuries which require emergency medical treatment or result in hospitalization or death shall be reported immediately to the Agency administrator or designee.

    c. Case Managers shall comply with mandatory reporting requirements set forth at Section 18-6.5-108, C.R.S, Section 19-3-304, C.R.S and Section 26-3.1-102, C.R.S.

    d. Each Critical Incident Report must include:

        i. incident type

            a. Mistreatment, Abuse, Neglect or Exploitation (MANE) as defined at Section 19-1-103, 26-3.1-101, 16-22-102 (9), and 25.5-10-202 C.R.S.

            b. Non-Mane: A Critical Incident, including but not limited to, a category of criminal activity, damage to a consumer's property, theft, death, injury, illness, medication management issues,

missing persons, unsafe housing or displacement, other high-risk issues.

ii. Date and time of incident;

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

iv. Individuals involved;

v. Description of incident, and

vi. Resolution of incident, if applicable.

e. The Case Manager shall complete required follow up activities and reporting in the State approved IMS within assigned timelines.

8.393.2.H. Case Recording/Documentation

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

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

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

   b. All State-required forms; and

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

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

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

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

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

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

   e. The person making each entry must be identified;

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

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

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

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

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

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

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

8.393.4. COMMUNICATION

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

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

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

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

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

8.393.5 LEVEL OF CARE ELIGIBILITY DETERMINATION

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

1. Ensuring that the Level of Care Screen is completed in the IMS in accordance with Section 8.401.1 and justifies that the individual seeking or receiving services is eligible or ineligible for admission to or continued stay in an applicable LTSS program.

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

3. If the assessment indicates approval, the SEP Agency shall notify the appropriate parties.

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

5. If the individual or individual's legally authorized representative appeals, the SEP Agency shall process the appeal request, according to Section 8.057.

8.393.6. INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES

8.393.6.A. Intercounty Transfers

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

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

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

    c. In order to assure quality of services and supports and health and welfare of the individual, the case manager must observe and evaluate the condition of the individual's residence. Upon Department approval, observation may be completed using virtual technology methods. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

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

        i. Level of Care Eligibility Determination.

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

        iii. Verification of Medicaid eligibility status.

8.393.6.B. Inter-district Transfers

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

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

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

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

d. If the individual is moving from one SEP District to another SEP District to enter an ACF, the transferring SEP Agency shall forward copies of the individual's records to the ACF prior to the individual's admission to the facility, in accordance with section 8.393.6.A.

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

f. The receiving SEP Agency shall complete an in person meeting with the individual in the individual's residence and a case summary update within ten (10) working days after the individual's relocation, in accordance with assessment procedures for individuals served by SEP Agencies. Upon Department approval, meeting may be completed using virtual technology methods or may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.)

g. The receiving SEP Agency shall review the PCSP and the LOC Screen and change or coordinate services and providers as necessary.

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

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

8.400 LONG-TERM CARE

.12 Home and Community Based Services under the Medicaid Waivers include distinct service programs designed as alternatives to standard Medicaid nursing facility or hospital services for discrete categories of clients. These waivers are Home and Community Based Services Waiver for Persons Who Are Elderly, Blind and Disabled (HCBS-EBD), Home and Community Based Services Waiver for Complementary and Integrative Health (HCBS-CHI), Community Mental Health Supports Waiver (HCBS-CMHS), Home and Community Based Services Waiver for Persons With Brain Injury (HCBS-BI); Home and Community Based Services Waiver for Persons with Developmental Disabilities (HCBS-DD), Supportive Living Services Waiver (HCBS-SLS); Home and Community Based Services Waiver for Children with Autism (HCBS-CWA), Children with Life-limiting Illness Waiver (HCBS-CLLI), Children's Habilitation Residential Program Waiver (HCBS-CHRP), Children Extensive Supports Waiver (HCBS-CES), Children's Home and Community Based Services Waiver (HCBS-CHCBS) and Home and Community Based Services for those inappropriately residing in nursing facilities (OBRA '87).

.13 Unless specified by reference to the specific programs described above, the term Home and Community Based Services where it appears in these rules and regulations shall refer to the programs described herein above, and the rules and regulations within this section shall be applicable to all Home and Community Based Services programs.

.14 Nursing facilities are prohibited from admitting any new client who has mental illness or intellectual or developmental disability, as defined in Section 8.401.18 Determination Criteria for

Mentally Ill or Individuals with an Intellectual or Developmental Disability unless that client has been determined to require the level of services provided by a nursing facility as defined in Section 8.401.19.

.15 Clients eligible for Home and Community Based Services are eligible for all Medicaid services including home health services.

.16 Target Population Definitions. For purposes of determining appropriate type of long-term services, including home and community-based services, as well as providing for a means of properly referring clients to the appropriate community agency, the following target group designations are established:

A. Developmentally Disabled - includes all clients whose need for long-term care services is based on a diagnosis of Developmental Disability and Related Conditions, as defined in Section 8.401.18.

B. Mentally Ill - includes all clients whose need for long-term care is based on a diagnosis of mental disease as defined in Section 8.401.18.

C. Functionally Impaired Elderly - includes all clients who meet the level of care for SNF or ICF care, as determined by the LOC Screen and who are age 65 or over.

D. Physically Disabled or Blind Adult - includes all clients who meet the level of care for SNF or ICF care, as determined by the LOC Screen and who are age 18 through 64. E. Persons Living with AIDS - includes all clients of any age who meet either the nursing home level of care or acute level of care for nursing facilities or hospitals and have the diagnosis of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS). Clients who are diagnosed with HIV or AIDS may alternatively request to be designated as any other target group for which they meet the definitions above.

.17 Services in Home and Community Based Services programs established in accordance with federal waivers shall be provided to clients in accordance with the URC determined target populations as defined herein above.

8.401 LEVEL OF CARE SCREEN

.01 The client must have been found by the Case Management Agency to meet the applicable level of care for the type of services to be provided.

.02 The Case Management Agency shall not make a Level of Care Eligibility Determination unless the recipient has been determined to be Medicaid eligible or an application for Medicaid services has been filed with the County Department of Social/Human services.

.03 Payment for skilled (SNF) and intermediate nursing home care (ICF) Payment for skilled (SNF) and intermediate nursing home care (ICF) will only be made for clients whose Level of Care Eligibility Determination and frequency of need for skilled and maintenance services meet the level of care for long-term care.

.04 Payment for care in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) will only be made for developmentally disabled clients whose programmatic and/or health care needs meet the level of care for the appropriate class of ICF/IIDs.

.05 Services provided by nursing facilities are available to those individuals who meet the level of care below and are not identified as mentally ill or individuals with an intellectual or

developmental disability by the Determination Criteria for Mentally Ill or Individuals with an Intellectual or Developmental Disability in Section 8.401.18.

8.401.1 LONG-TERM SERVICES AND SUPPORTS LEVEL OF CARE ELIGIBILITY DETERMINATION (CLASS I SNF AND ICF FACILITIES, *HCBS-EBD, HCBS-CMHS, HCBS-BI, Children's HCBS, HCBS-SCI, HCBS-CLLI, HCBS-CES, HCBS-DD, HCBS-SLS, HCBS-CHRP*, PACE and Long-term Home Health)

.11 Eligibility for long-term care is based on a LOC Screen, as defined in Section 8.390.1, in which an individual's needs are evaluated in at least the following areas of activities of daily living:

- Mobility
- Bathing
- Dressing
- Eating
- Toileting
- Transferring
- Need for supervision

.12 Skilled services shall be defined as those services which can only be provided by a skilled person such as a nurse or licensed therapist or by a person who has been extensively trained to perform that service.

.13 Maintenance services shall be defined as those services which may be performed by a person who has been trained to perform that specific task, e.g., a family member, a nurses' aide, a therapy aide, visiting homemaker, etc.

.14 Skilled and maintenance services are performed in the following areas:

- Skin care
- Medication
- Nutrition
- Activities of daily living
- Therapies
- Elimination
- Observation and monitoring

.15

A. The case management agency shall certify as to the need for the nursing facility level of care, as demonstrated by the Level of Care Eligibility Determination Screen outcome using criteria outlined in 10 CCR 2505-10 Section 8.401.

B. A person's need for Medicaid state plan benefits is not a proper consideration in determining whether a person needs long-term care services (including Home and Community Based Services).

.16 LONG-TERM CARE ELIGIBILITY ASSESSMENTS

The Department is implementing a new Level of Care Eligibility Determination Screen instrument- the Colorado Single Assessment Level of Care Screen, or CSA LOC Screen. The new LOC Screen will replace the current instrument, the Uniform Long-Term Care (ULTC) 100.2. The intent of the new instrument is to better understand individual needs, obtain objective and consistent assessment data, including standardized Functional Assessment Standardized Items (FASI), and is not intended to reduce eligibility or services. The Department will implement the new LOC Screen gradually, meaning the ULTC 100.2 and the new CSA LOC Screen instruments will both be in use concurrently for Level of Care Eligibility Determination Screens until the new CSA LOC Screen has been fully implemented across Colorado. During the transition, Case Management Agencies will use one of the two instruments, as determined by the Department, for initial and ongoing Level of Care Eligibility Determinations.

A. UNIFORM LONG-TERM CARE 100.2

To qualify for Medicaid long-term care services using the ULTC 100.2, the member/Applicant must have deficits in 2 of 6 Activities of Daily Living (ADL), (2+ score) or require at least moderate (2+ score) in Behaviors or Memory/Cognition under Supervision as outlined below. The needs of an individual ages 18 and under shall be assessed in accordance with Appendix A, the Age-Appropriate Guidelines for the Use of ULTC 100.2 on Children. Specific ULTC scoring criteria is as follows:

BATHING

Definition: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene.

ADL SCORING CRITERIA

☐0=The client is independent in completing the activity safely.

☐1=The client requires oversight help or reminding; can bathe safely without assistance or supervision, but may not be able to get into and out of the tub alone.

☐2=The client requires hands on help or line of sight standby assistance throughout bathing activities in order to maintain safety, adequate hygiene and skin integrity.

☐3=The client is dependent on others to provide a complete bath.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	☐Open Wound
☐Pain	☐Stoma Site
☐Sensory Impairment	Supervision:
☐Limited Range of Motion	☐Cognitive Impairment
☐Weakness	☐Memory Impairment
☐Balance Problems	☐Behavior Issues
☐Shortness of Breath	☐Lack of Awareness
☐Decreased Endurance	☐Difficulty Learning
☐Falls	☐Seizures

☐ Paralysis ☐ Neurological Impairment ☐ Oxygen Use ☐ Muscle Tone ☐ Amputation	Mental Health: ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia

Comments:

DRESSING

Definition: The ability to dress and undress as necessary. This includes the ability to put on prostheses, braces, anti-embolism hose or other assistive devices and includes fine motor coordination for buttons and zippers. Includes choice of appropriate clothing for the weather. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit.

ADL SCORING CRITERIA

☐ 0=The client is independent in completing activity safely.

☐ 1= The client can dress and undress, with or without assistive devices, but may need to be reminded or supervised to do so on some days.

☐ 2= The client needs significant verbal or physical assistance to complete dressing or undressing, within a reasonable amount of time.

☐ 3= The client is totally dependent on others for dressing and undressing.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments: ☐ Pain ☐ Sensory Impairment ☐ Limited Range of Motion ☐ Weakness ☐ Balance Problems ☐ Shortness of Breath ☐ Decreased Endurance ☐ Fine Motor Impairment ☐ Paralysis ☐ Neurological Impairment ☐ Bladder Incontinence ☐ Bowel Incontinence ☐ Amputation ☐ Oxygen Use	☐ Open Wound Supervision: ☐ Cognitive Impairment ☐ Memory Impairment ☐ Behavior Issues ☐ Lack of Awareness ☐ Difficulty Learning ☐ Seizures Mental Health: ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia

☐ Muscle Tone	

Comments:

TOILETING

Definition: The ability to use the toilet, commode, bedpan or urinal. This includes transferring on/off the toilet, cleansing of self, changing of apparel, managing an ostomy or catheter and adjusting clothing.

ADL SCORING CRITERIA

☐ 0=The client is independent in completing activity safely.

☐ 1=The client may need minimal assistance, assistive device, or cueing with parts of the task for safety, such as clothing adjustment, changing protective garment, washing hands, wiping and cleansing.

☐ 2=The client needs physical assistance or standby with toileting, including bowel/bladder training, a bowel/bladder program, catheter, ostomy care for safety or is unable to keep self and environment clean.

☐ 3=The client is unable to use the toilet. The client is dependent on continual observation, total cleansing, and changing of garments and linens. This may include total care of catheter or ostomy. The client may or may not be aware of own needs.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	
☐ Pain	☐ Ostomy
☐ Sensory Impairment	☐ Catheter
☐ Limited Range of Motion	Supervision Need:
☐ Weakness	☐ Cognitive Impairment
☐ Shortness of Breath	☐ Memory Impairment
☐ Decreased Endurance	☐ Behavior Issues
☐ Fine Motor Impairment	☐ Lack of Awareness
☐ Paralysis	☐ Difficulty Learning
☐ Neurological Impairment	☐ Seizures
☐ Bladder Incontinence	Mental Health:
☐ Bowel Incontinence	☐ Lack of Motivation/Apathy
☐ Amputation	☐ Delusional
☐ Oxygen Use	☐ Hallucinations
☐ Physiological defect	☐ Paranoia
☐ Balance	
☐ Muscle Tone	
☐ Impaction	

Comments:

MOBILITY

Definition: The ability to move between locations in the individual's living environment inside and outside the home. Note: Score client's mobility without regard to use of equipment other than the use of prosthesis.

ADL SCORING CRITERIA

☐0=The client is independent in completing activity safely.

☐1=The client is mobile in their own home but may need assistance outside the home.

☐2=The client is not safe to ambulate or move between locations alone; needs regular cueing, stand-by assistance, or hands on assistance for safety both in the home and outside the home.

☐3=The client is dependent on others for all mobility.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	Supervision Need:
☐Pain	☐Cognitive Impairment
☐Sensory Impairment	☐Memory Impairment
☐Limited Range of Motion	☐Behavior Issues
☐Weakness	☐Lack of Awareness
☐Shortness of Breath	☐Difficulty Learning
☐Decreased Endurance	☐Seizures
☐Fine or Gross Motor Impairment	☐History of Falls
☐Paralysis	Mental Health:
☐Neurological Impairment	☐Lack of Motivation/Apathy
☐Amputation	☐Delusional
☐Oxygen Use	☐Hallucinations
☐Balance	☐Paranoia
☐Muscle Tone	

Comments:

TRANSFERRING

Definition: The physical ability to move between surfaces: from bed/chair to wheelchair, walker or standing position; the ability to get in and out of bed or usual sleeping place; the ability to use assisted devices, including properly functioning prosthetics, for transfers. Note: Score Client's ability to transfer without regard to use of equipment.

ADL SCORING CRITERIA

☐0=The client is independent in completing activity safely.

☐1=The client transfers safely without assistance most of the time, but may need standby assistance for cueing or balance; occasional hands on assistance needed.

☐2=The client transfer requires standby or hands on assistance for safety; client may bear some weight.

☐3=The client requires total assistance for transfers and/or positioning with or without equipment.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	Supervision Need:
☐Pain	☐Cognitive Impairment
☐Sensory Impairment	☐Memory Impairment
☐Limited Range of Motion	☐Behavior Issues
☐Weakness	☐Lack of Awareness
☐Balance Problems	☐Difficulty Learning
☐Shortness of Breath	☐Seizures
☐Falls	Mental Health:
☐Decreased Endurance	☐Lack of Motivation/Apathy
☐Paralysis	☐Delusional
☐Neurological Impairment	☐Hallucinations
☐Amputation	☐Paranoia
☐Oxygen Use	

Comments:

EATING

Definition: The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew and swallow food. Note: If a person is fed via tube feedings or intravenously, check box 0 if they can do independently, or box 1, 2, or 3 if they require another person to assist.

ADL SCORING CRITERIA

☐0=The client is independent in completing activity safely.

☐1=The client can feed self, chew and swallow foods but may need reminding to maintain adequate intake; may need food cut up; can feed self if food brought to them, with or without adaptive feeding equipment.

☐2=The client can feed self but needs line of sight standby assistance for frequent gagging, choking, swallowing difficulty; or aspiration resulting in the need for medical intervention. The client needs reminder/assistance with adaptive feeding equipment; or must be fed some or all food by mouth by another person.

☐3=The client must be totally fed by another person; must be fed by another person by stomach tube or venous access.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments: ☐ Pain ☐ Sensory Impairment ☐ Limited Range of Motion ☐ Weakness ☐ Shortness of Breath ☐ Decreased Endurance ☐ Paralysis ☐ Neurological Impairment ☐ Amputation ☐ Oxygen Use ☐ Fine Motor Impairment ☐ Poor Dentition ☐ Tremors ☐ Swallowing Problems ☐ Choking ☐ Aspiration	☐ Tube Feeding ☐ IV Feeding Supervision Need: ☐ Cognitive Impairment ☐ Memory Impairment ☐ Behavior Issues ☐ Lack of Awareness ☐ Difficulty Learning ☐ Seizures Mental Health: ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia

Comments:

SUPERVISION- Behaviors

Definition: The ability to engage in safe actions and interactions and refrain from unsafe actions and interactions (Note, consider the client's inability versus unwillingness to refrain from unsafe actions and interactions).

SCORING CRITERIA

☐ 0=The client demonstrates appropriate behavior; there is no concern.

☐ 1=The client exhibits some inappropriate behaviors but not resulting in injury to self, others and/or property. The client may require redirection. Minimal intervention is needed.

☐ 2=The client exhibits inappropriate behaviors that put self, others or property at risk. The client frequently requires more than verbal redirection to interrupt inappropriate behaviors.

☐ 3=The client exhibits behaviors resulting in physical harm to self or others. The client requires extensive supervision to prevent physical harm to self or others.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	Supervision needs:
☐ Chronic Medical Condition ☐ Acute Illness ☐ Pain ☐ Neurological Impairment ☐ Choking ☐ Sensory Impairment ☐ Communication Impairment (not inability to speak English) Mental Health: ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia ☐ Mood Instability	☐ Short Term Memory Loss ☐ Long Term Memory Loss ☐ Agitation ☐ Aggressive Behavior ☐ Cognitive Impairment ☐ Difficulty Learning ☐ Memory Impairment ☐ Verbal Abusiveness ☐ Constant Vocalization ☐ Sleep Deprivation ☐ Self-Injurious Behavior ☐ Impaired Judgment ☐ Disruptive to Others ☐ Disassociation ☐ Wandering ☐ Seizures ☐ Self Neglect ☐ Medication Management

Comments:

SUPERVISION- Memory/Cognition Deficit

Definition: The age appropriate ability to acquire and use information, reason, problem solve, complete tasks or communicate needs in order to care for oneself safely.

SCORING CRITERIA

☐ 0= Independent no concern

☐ 1= The client can make safe decisions in familiar/routine situations, but needs some help with decision making support when faced with new tasks, consistent with individual's values and goals.

☐ 2= The client requires consistent and ongoing reminding and assistance with planning, or requires regular assistance with adjusting to both new and familiar routines, including regular monitoring and/or supervision, or is unable to make safe decisions, or cannot make his/her basic needs known.

☐ 3= The client needs help most or all of time.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments: ☐ Metabolic Disorder ☐ Medication Reaction ☐ Acute Illness ☐ Pain ☐ Neurological Impairment ☐ Alzheimer's/Dementia ☐ Sensory Impairment ☐ Chronic Medical Condition ☐ Communication Impairment (does not include ability to speak English) ☐ Abnormal Oxygen Saturation ☐ Fine Motor Impairment Supervision Needs: ☐ Disorientation ☐ Cognitive Impairment ☐ Difficulty Learning ☐ Memory Impairment	☐ Self-Injurious Behavior ☐ Impaired Judgment ☐ Unable to Follow Directions ☐ Constant Vocalizations ☐ Perseveration ☐ Receptive Expressive Aphasia ☐ Agitation ☐ Disassociation ☐ Wandering ☐ Lack of Awareness ☐ Seizures ☐ Medication Management Mental Health: ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia ☐ Mood Instability

Comments:

B. CSA LEVEL OF CARE SCREEN

The Level of Care Eligibility Determination outcome is based on an individual's performance level as documented in the LOC Screen, in areas including, but not limited to, completing Activities of Daily Living, memory and cognition, sensory and communication, and behavior, as well as other criteria specific to applicable program. The eligibility criteria and thresholds are as follows:

1. Nursing Facility Level of Care Eligibility for ages four (4) and older

    a. Participants four (4) years of age or older must meet the Nursing Facility Level of Care criteria and thresholds outlined in 10 CCR 2505-10 Section 8.401.16.B.1 to be determined eligible for Long-Term Services and Supports.
        i. Eligibility Criteria
            1. Meets one or more ADL and Health Condition criteria thresholds in at least two areas to include Mobility, Transferring, Bathing, Dressing, Toileting, Eating (ADLs) or Health Condition; or
            2. Meets one or more Behavior threshold(s); or
            3. Meets one or more Memory and Cognition threshold(s); or
            4. Meets the Sensory & Communication threshold.
        ii. Criteria Thresholds
            1. ADL and Health Condition criteria thresholds are as follows:

a. Mobility threshold is met with either of the following:
    i. Participant does not walk but walking is indicated in the future or Participant does not walk and walking is not indicated in the future; or
    ii. Participant requires a cane or walker during all mobility activities; or
    iii. Participant uses a wheelchair or scooter as their primary mechanism for mobility; or
    iv. Participant requires, at minimum, partial moderate assistance to walk (once standing) 10 feet indoors; or
    v. Participant requires, at minimum, supervision or touching assistance to walk (once standing) 150 feet indoors; or
    vi. Participant requires, at minimum, supervision or touching assistance to walk 10 feet outside of the home; or
    vii. Participant requires, at minimum, supervision or touching assistance to walk 150 feet outside of the home.
b. Transferring threshold is met with either of the following:
    i. Participant requires use of a cane or walker during all transfer activities; or
    ii. Participant requires, at minimum, partial/moderate assistance for the ability to roll left and right: from lying on back to left and right side, and return to lying on back on the bed; or
    iii. Participant requires, at minimum, partial/moderate assistance for the ability to complete a sit to stand transfer: safely come to a standing position from sitting in a chair or on the side of the bed.
c. Bathing threshold is met with the following:
    i. Participant requires, at minimum, partial/moderate assistance for the ability to shower/bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower
d. Dressing threshold is met with either of the following:
    i. Participant requires, at minimum, partial/moderate assistance with upper body dressing; or
    ii. Participant requires, at minimum, partial/moderate assistance with lower body dressing; or
    iii. Participant requires, at minimum, partial/moderate assistance with putting on/taking off footwear.
e. Toileting threshold is met with either of the following:
    i. Participant requires, at minimum, partial/moderate assistance with toilet hygiene; or
    ii. Participant requires, at minimum, partial/moderate assistance with toilet transfers; or
    iii. Participant requires, at minimum, partial/moderate assistance with menses care; or
    iv. Participant requires assistance with managing *equipment* related to bladder incontinence; or
    v. Participant is currently using a bladder program to manage participant's bladder continence; or

vi. Participant requires assistance with managing *equipment* related to bowel incontinence; or
vii. Participant is currently using a bowel program to manage the participant's bowel continence.

f. Eating threshold is met with either of the following:
i. Participant requires, at minimum, partial/moderate assistance for eating; or
ii. Participant requires, at minimum, partial/moderate assistance for tube feeding.

g. Health Condition threshold is met with the following:
i. Participant has a diagnosis of paralysis; or
ii. A missing limb.

2. **Behavior** criteria thresholds are as follows:
a. Behavior threshold area one is as follows:
i. Participant's behavior status previously or currently requires interventions or presents symptoms for Injury to Self, Physical Aggression or Property Destruction; and
ii. One or more of the following are met:
1. Cueing frequency, at minimum, is required more than once per month and up to weekly; or
2. Physical intervention frequency, at minimum, is required more than once per month up to weekly; or
3. Planned intervention frequency, at minimum, is required less than monthly up to once per month.

b. Behavior criteria threshold area two is as follows:
i. Participant's behavior status for Verbal Aggression currently requires interventions or presents symptoms for this behavior; and
ii. Participant presents threat(s) to own or other's safety; and
iii. One or more of the following are met:
1. Cueing frequency, at minimum, is required more than once per month and up to weekly; or
2. Physical intervention frequency, at minimum, is required more than once per month up to weekly; or
3. Planned intervention frequency, at minimum, is required less than monthly up to once per month.

c. Behavior criteria threshold area three is as follows:
i. Injurious to Self, property destruction, physical aggression, or verbal aggression behavior status currently requires intervention and/or displays symptoms and
ii. Likelihood behavior would occur and/or escalate if HCBS services were withdrawn is likely or highly likely.

3. Memory and Cognition criteria thresholds are as follows:
a. Participant has a Level of Impairment of moderately or higher in at least one area (Memory, Attention, Problem Solving, Planning, or Judgment); or

b. Participant has a level of impairment of mildly or higher in at least two areas (Problem Solving, Planning, Judgment).

4. Sensory and Communication criteria threshold is as follows:
    a. Participant frequently exhibits difficulty expressing needs and/or ideas with individuals they are familiar with; or
    b. Participant rarely or never expresses themself or is very difficult to understand.

2. Nursing Facility Level of Care Eligibility Criteria for individuals zero to three (0-3) years of age
    a. Participants zero to three (0-3) years of age must meet the Nursing Facility Level of Care criteria and thresholds outlined in 10 CCR 2505-10 Section 8.401.16.B.2, according to age, to be determined eligible for Long-Term Services and Supports.
        i. Eligibility Criteria
            1. The participant must meet the criteria threshold for two or more Activities of Daily Living, based on participant age.
            2. If the participant meets one or more of the two required ADL thresholds by selecting only “Other Concerns,” a second level review is required to determine eligibility.
            3. Participants may also meet LOC using the behavior criteria for adults in Section 8.401.16.B.1.ii.2.
        ii. Activities of Daily Living thresholds by age 0-5 months
            1. Bathing:
                a. Needs adaptive equipment, or
                b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., or
                c. Other concerns that may affect the amount of support the child needs and
                d. at least one of the bathing impairments above is expected to last for at least one year from the date of assessment.
            2. Dressing:
                a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., or
                b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., or
                c. Other concerns that may affect the amount of support the child needs and
                d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
            3. Eating:
                a. Requires more than one hour per feeding, or
                b. Receives tube feedings or TPN, or
                c. Requires more than three hours per day for feeding or eating, or
                d. Other concerns that may affect the amount of support the child needs and
                e. at least one of the impairments above is expected to last for at least one year from the date of assessment.
        iii. Activities of Daily Living thresholds by age 6-11 months
            1. Bathing:
                a. Needs adaptive equipment, or
                b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
                c. Other concerns that may affect the amount of support the child needs AND

d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:
    a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
    b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR
    c. Other concerns that may affect the amount of support the child needs AND
    d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
3. Eating:
    a. Requires more than one hour per feeding, OR
    b. Receives tube feedings or TPN, OR
    c. Requires more than three hours per day for feeding or eating, OR
    d. Other concerns that may affect the amount of support the child needs AND
    e. at least one of the impairments above is expected to last for at least one year from the date of assessment.
4. Mobility:
    a. Unable to maintain a sitting position when placed, OR
    b. Unable to move self by rolling, crawling, or creeping, OR
    c. Other concerns that may affect the amount of support the child needs AND
    d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

iv. Activities of Daily Living thresholds by age 12-17 months

1. Bathing:
    a. Needs adaptive equipment, OR
    b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
    c. becomes agitated requiring alternative bathing methods OR
    d. Other concerns that may affect the amount of support the child needs AND
    e. at least one of the impairments above is expected to last for at least one year from the date of assessment.
2. Dressing:
    a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
    b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR
    c. Other concerns that may affect the amount of support the child needs AND
    d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
3. Eating:
    a. Requires more than one hour per feeding, OR
    b. Receives tube feedings or TPN, OR
    c. Requires more than three hours per day for feeding or eating, OR
    d. Other concerns that may affect the amount of support the child needs AND

e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Mobility:
    a. Unable to sit alone, OR
    b. Requires a stander or someone to support the child's weight in a standing position, OR
    c. Unable to crawl or creep, OR
    d. Other concerns that may affect the amount of support the child needs AND
    e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

v. Activities of Daily Living thresholds by age 18-23 months
    1. Bathing:
        a. Needs adaptive equipment, OR
        b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
        c. becomes agitated requiring alternative bathing methods OR Other concerns that may affect the amount of support the child needs AND
        d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
    2. Dressing:
        a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
        b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., Does not assist with dressing by helping to place arms in sleeves or legs into pants, OR
        c. Other concerns that may affect the amount of support the child needs AND
        d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
    3. Eating:
        a. Receives tube feedings or TPN, OR
        b. Requires more than three hours per day for feeding or eating, OR
        c. Other concerns that may affect the amount of support the child needs AND
        d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
    4. Mobility:
        a. Requires a stander or someone to support the child's weight in a standing position, OR
        b. Uses a wheelchair or other mobility device not including a single cane, OR
        c. Unable to take steps holding on to furniture, OR
        d. other concerns that may affect the amount of support the child needs AND
        e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

vi. Activities of Daily Living thresholds by age 24-35 months
    1. Bathing:
        a. Needs adaptive equipment, OR
        b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR

c. becomes agitated requiring alternative bathing methods OR Other concerns that may affect the amount of support the child needs AND
d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:
    a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
    b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., Does not assist with dressing by helping to place arms in sleeves or legs into pants, OR
    c. Unable to pull hats, socks, and mittens, OR
    d. Other concerns that may affect the amount of support the child needs AND
    e. at least one of the impairments above is expected to last for at least one year from the date of assessment.
3. Eating:
    a. Receives tube feedings or TPN, OR
    b. Requires more than three hours per day for feeding or eating, OR
    c. Cannot pick up appropriate foods with hands and bring them to his/her mouth, OR
    d. Other concerns that may affect the amount of support the child needs AND
    e. at least one of the impairments above is expected to last for at least one year from the date of assessment.
4. Mobility:
    a. Requires a stander or someone to support the child's weight in a standing position, OR
    b. Does not walk or needs physical help to walk, OR
    c. Uses a wheelchair or other mobility device not including a single cane, OR
    d. Other concerns that may affect the amount of support the child needs AND
    e. at least one of the impairments above is expected to last for at least one year from the date of assessment.
5. Transfers:
    a. Requires transfer assistance due to physical or cognitive deficits, OR
    b. Other concerns that may affect the amount of support the child needs AND
    c. at least one of the impairments above is expected to last for at least one year from the date of assessment.

vii. Activities of Daily Living thresholds by age 36-47 months

1. Bathing:
    a. Needs adaptive equipment, OR
    b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
    c. Is combative during bathing (e.g., flails, takes two caregivers to accomplish task), OR
    d. Other concerns that may affect the amount of support the child needs AND
    e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Grooming:
    a. Is combative during grooming (e.g., flails, clamps mouth shut, takes two caregivers to accomplish task), OR
    b. Has physical limitations that prevent completing the task (e.g. limited range of motion, unable to grasp brush), OR
    c. Other concerns that may affect the amount of support the child needs AND
    d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
3. Dressing:
    a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
    b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR
    c. Is combative during dressing (e.g., flails, resists efforts to put clothes on, takes two caregivers to accomplish task), OR
    d. Does not or cannot assist with dressing by helping to place arms in sleeves or legs into pants, OR
    e. Unable to undress self independently, OR
    f. Other concerns that may affect the amount of support the child needs AND
    g. at least one of the impairments above is expected to last for at least one year from the date of assessment.
4. Eating:
    a. Is combative while eating (e.g., flails, throws food so will not have to eat, takes two caregivers to accomplish task), OR
    b. Receives tube feedings or TPN, OR
    c. Requires more than three hours per day for feeding or eating, OR
    d. Needs to be fed by another individual, OR
    e. Needs one-on-one monitoring to prevent choking, aspiration, or other serious complications, OR
    f. Other concerns that may affect the amount of support the child needs AND
    g. at least one of the impairments above is expected to last for at least one year from the date of assessment.
5. Toileting:
    a. Is combative during toileting (e.g., flails, takes two caregivers to accomplish task), OR
    b. Has no awareness of being wet or soiled, OR
    c. Requires caregiver assistance to be placed onto the toilet/potty chair, OR
    d. Does not use toilet/potty chair when placed there by a caregiver, OR
    e. Other concerns that may affect the amount of support the child needs AND
    f. at least one of the impairments above is expected to last for at least one year from the date of assessment.
6. Mobility:
    a. Does not walk or needs physical help to walk, OR
    b. Uses a wheelchair or other mobility device not including a single cane, OR
    c. Other concerns that may affect the amount of support the child needs AND

d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

7. Transfers:
    a. Needs physical help with transfers, OR
    b. Uses a mechanical lift, OR
    c. Other concerns that may affect the amount of support the child needs AND
    d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Nursing Facility Level of Care Eligibility Alternative Criteria
    a. Alternative ADL criteria shall be applicable for participants four (4) and older whose level of support for Activities of Daily Living (Mobility, Transferring, Bathing, Dressing Toileting, Eating) has varied over the last 30 days; and
        i. Meet the following alternate ADL thresholds in two or more ADL areas (Mobility, Transferring, Bathing, Dressing Toileting, Eating):
            1. Participant's performance level is, at minimum, scored at partial/moderate assistance or higher AND
            2. Frequency of enhanced support is scored, at minimum, 1-2 times per month in the past 30 days, or
        ii. Meets at least one Nursing Facility Level of Care ADL (Mobility, Transferring, Bathing, Dressing Toileting, Eating) thresholds as required at 10 CCR 2505-10 Section 8.401.16.B.1.a.ii.1., and
        iii. Meets the alternate ADL thresholds in at least one ADL area.
    b. If the alternative LOC criteria is used, a second level review is required to determine eligibility.
4. Hospital Level of Care Eligibility Criteria
    a. Complementary and Integrative Health (CIH), Brain Injury (BI), Children's Home and Community Based Services (CHCBS), and Children with Life Limiting Illness (CLLI) have a Hospital Level of Care (H-LOC)).
        i. CIH and BI may be met through NF-LOC and H-LOC Criteria.
        ii. CHCBS and CLLI have distinct criteria.
    b. H-LOC for SCI and BI participants must meet in at least one of the following areas:
        i. Transfers:
            1. Participant has met Nursing Facility Level of Care (NF-LOC) AND
            2. Participant's performance level is, at minimum, substantial/maximum assistance for Chair/Bed -to-Chair Transfers-the ability to safely transfer to and from a bed to a chair.
        ii. Bathing:
            1. Participant has met NF-LOC AND
            2. Participant's performance level is, at minimum, substantial/maximum assistance for Shower/bathe self-the ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
        iii. Dressing:
            1. Participant has met NF-LOC AND
            2. Participant's performance level is, at minimum, substantial/maximum assistance for Upper Body Dressing-the ability to put on and remove shirt or pajama top. Includes buttoning, if applicable OR
            3. Participant's performance level is, at minimum, substantial/maximum for Lower Body Dressing-the ability to dress and undress below the waist, including fasteners. Does not include footwear.
        iv. Toileting:
            1. Participant has met NF-LOC AND
            2. Participant's performance level is, at minimum, substantial/maximum assist for Toilet hygiene-the ability to maintain perineal/feminine hygiene, adjust clothes before and after using toilet, commode,

bedpan, urinal. If managing ostomy, include wiping opening but not managing equipment. OR

3. Participant's performance level is, at minimum, substantial/maximum assistance for Toilet Transfers: the ability to safely get on and off a toilet or commode.

v. Eating:

1. Participant has met NF-LOC AND
2. Participant's performance level is, at minimum, substantial/maximum assistance for Eating - the ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. This includes modified food consistency OR
3. Participant's performance level is, at minimum, substantial/maximum assistance for Tube feeding - the ability to manage all equipment/supplies related to obtaining nutrition.

c. H-LOC for CLLI participants must meet in at least ONE of the following threshold areas:

i. Threshold Area 1:

1. Participant has met NF-LOC or Alt-LOC AND
2. Participant has been diagnosed with a life limiting illness by a medical professional.

ii. Threshold Area 2:

1. Participant has NOT met NF-LOC or Alt-LOC AND
2. Participant has been diagnosed with a life limiting illness by a medical professional AND
3. ONE of the following conditions apply to the participant:
    a. Technologically dependent for life or health-sustaining functions OR
    b. Complex medication regimen or medical interventions to maintain or improve health status, OR
    c. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health or development at risk
4. A second-level review is required to verify whether the conditions documented justify a H-LOC.

d. H-LOC for CHCBS participants must meet in at least ONE of the following threshold areas:

i. Threshold Area 1:

1. Transferring:
    a. Participant met NF-LOC or Alt-LOC AND
    b. Participant's performance level is, at minimum, substantial/maximum assistance for Chair/Bed -to-Chair Transfer -The ability to safely transfer to and from a bed to a chair.
2. Bathing:
    a. Participant has met NF-LOC or Alt-LOC AND
    b. Participant's performance level is, at minimum, substantial/maximum assistance for Shower/bathe self- The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
3. Dressing:
    a. Participant has met NF-LOC or Alt-LOC AND
    b. Participant's performance level is, at minimum, substantial/maximum assistance for Upper Body Dressing - The ability to put on and remove shirt or pajama top. Includes buttoning, if applicable OR

c. Participant's performance level is, at minimum, substantial/maximum assistance for Lower Body Dressing - The ability to dress and undress below the waist, including fasteners. Does not include footwear.

4. Toileting:
    a. Participant has met NF-LOC or Alt-LOC AND
    b. Participant's performance level is, at minimum, substantial/maximum assistance for toilet hygiene-The ability to maintain perineal/feminine hygiene, adjust clothes before and after using toilet, commode, bedpan, urinal. If managing ostomy, include wiping opening but not managing equipment. OR
    c. Participant's performance level is, at minimum, substantial/maximum assistance for Toilet Transfer: The ability to safely get on and off a toilet or commode.
5. Eating:
    a. Participant has met NF-LOC or Alt-LOC AND
    b. Participant's performance level is, at minimum, substantial/maximum assistance for Eating - The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. This includes modified food consistency OR
    c. Participant's performance level is, at minimum, substantial/maximum assistance for Tube feeding - The ability to manage all equipment/supplies related to obtaining nutrition.

ii. Threshold Area 2:
1. Participant has not met NF-LOC or Alt-LOC AND
2. One of the following conditions apply to the participant:
    a. Technologically dependent for life or health-sustaining functions, OR
    b. Complex medication regimen or medical interventions to maintain or improve health status, OR
    c. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health or development at risk.
3. A second-level review is required to verify whether the conditions documented justify a H-LOC.

8.402.10 ADMISSION PROCEDURES FOR CLASS I NURSING FACILITIES

.11 The URC/Single Entry Pointy (SEP) shall certify a client for nursing facility admission after a client is determined to meet the level of care and passes the PASRR Level 1 screen requirements for long-term care. However, the URC/SEP shall not certify a client for nursing facility admission unless the client has been advised of long-term care options including Home and Community Based Services as an alternative to nursing facility care.

.12 The medically licensed provider must complete the necessary documentation prior to the client's admission.

.13 The Level of Care Eligibility Determination Screen and other transfer documents concerning medical information as applicable, must accompany the client to the facility.

.14 The nursing facility or hospital shall notify the URC/SEP agency of the pending admission by faxing or emailing the appropriate form. The date the form is received by the URC/SEP agency shall be the effective start date if the client meets all eligibility requirements for Medicaid long-term care services.

.15 The URC/SEP case manager shall determine the client's length of stay using the appropriate form developed by the Department. The length of stay shall be less than a year, one year or indefinite. All indefinite lengths of stay shall be approved by the case manager's supervisor.

.16 The URC/SEP agency shall notify in writing all appropriate parties of the initial length of stay assigned. Appropriate parties shall include, but are not limited to, the client or the client's designated representative, the attending physician, the nursing facility, the Fiscal Agent, the appropriate County Department of Social/Human Services, the appropriate community agency, and for clients within the developmentally disabled or mentally ill target groups, the Department of Human Services or its designee.

.17 The nursing facility shall be responsible for tracking the length of stay end date so that a timely Reassessment is completed by the URC/SEP.

.18 The URC will determine the start date for nursing facility services. The start date of eligibility for nursing facility services shall not precede the date that all the requirements (functional level of care, financial eligibility, disability determination) have been met.

8.402.30 ADMISSION PROCEDURES FOR HOME AND COMMUNITY BASED SERVICES

.31 When the client meets the level of care requirements for long-term care, is currently living in the community, and could possibly be maintained in the community, the URC/SEP agency shall immediately communicate with the appropriate community agency, according to the URC/SEP agency-determined target group, for an evaluation for alternative services. The URC/SEP agency shall forward a copy of the worksheet plus a State prescribed disposition form to the agency either immediately after the telephone referral, or in place of the telephone referral.

.32 Based upon information obtained in the pre-admission review, the URC/SEP case manager shall make the referral to the appropriate community agency based on the client's target group designation, as defined below:

A. Individuals determined by the URC/SEP agency to be in the Mentally Ill target group, regardless of source, shall be referred to the appropriate community mental health center or clinic.

B. Individuals determined by the URC to be in the Functionally Impaired Elderly target group, or the Physically Disabled or Blind target group shall be referred to the appropriate Single Entry Point Agency for evaluation for Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD).

C. Individuals identified by the URC to be in the Developmentally Disabled target group shall be referred to the appropriate Community Centered Board.

D. Individuals determined by the URC to be in the Persons Living with AIDS target group shall be referred to the appropriate Single Entry Point Agency for evaluation for HCBS-EBD.

E. The URC shall notify any clients referred to case management agencies of the referral, the provisions of the program, and shall inform them of the complaint procedures.

.33 The case management agency or community mental health center or clinic shall complete an evaluation for alternative services within five (5) working days of the referral by the URC.

.34 Single Entry Point Agencies shall conduct the evaluation in accordance with the procedures at 10 CCR 2505-10 Sections 8.486 and 8.390.

.35 Community Centered Boards shall conduct the evaluation in accordance with procedures at 10 CCR 2505-10 Section 8.500.

.36 Community mental health centers and clinics shall conduct the evaluation in accordance with Standards/Rules and Regulations for Mental Health 2 CCR 502-1 Section 21.940 and Rules and Regulations Concerning Care and Treatment of the Mentally Ill, 2 CCR 502-1 Section 21.280.

.37 If the community agency develops an approved plan for long-term care services, the URC will approve one (1) certification for long-term care services and the client shall be placed in alternative services. Following receipt of the fully completed LOC Screen the URC will review the information submitted and make a certification decision. If certification is approved, the URC shall assign an initial length of stay for alternative services. If certification is denied, the decision of the URC may be appealed in accordance with 10 CCR 2505-10 Section 8.057 through 8.057.8.

.38 If the appropriate community agency cannot develop an approved plan for long-term care services, the URC will approve certification for long-term care services and utilize the procedure for nursing home admissions described previously in this section.

8.402.40 ADMISSION TO NURSING FACILITY WITH REFERRAL FOR COMMUNITY SERVICES

.41 When a client who meets the level of care requirements for long-term care is currently hospitalized but could possibly be maintained in the community, certification shall be issued. The client may be placed in the nursing facility, given a short length of stay and immediately referred to the appropriate community agency for evaluation for alternative services in accordance with the procedure described in the preceding section.

8.402.50 DENIALS (ALL TARGET GROUPS)

.51 When, based on the pre-admission review, the client does not meet the level of care requirements for skilled and maintenance services, certification shall not be issued. The client shall be notified in writing of the denial.

.52 If the URC denied long-term care certification based upon the information on the LOC Screen written notification of the denial shall be sent to the client, the attending physician, and the referral source (hospital, nursing facility, etc.).

If the information provided on the LOC Screen indicates the client does meet the level of care requirements, the URC shall proceed with the admission and/or referral procedures described above.

.53 Denials of certification for long-term care may be appealed in accordance with the procedures described at 10 CCR 2505-10 Section 8.057 through 8.057.8.

.54 Denial of designation into a specifically requested target group may also be appealed in accordance with 10 CCR 2505-10 Section 8.057 through 8.057.8.

8.405.2 ADMISSION PROCEDURES FOR ICF/IID FACILITIES

.21 When the client, based on CCB review, cannot reasonably be expected to make use of ICF/IID or HCBS-DD, the CCB shall notify the physician and the URC. The physician and the URC/Community Center Board (URC/CCB) agency then proceed with the SNF or ICF placement under the provisions set forth at 10 CCR 2505-10 Section 8.402.10.

22 When the CCB determines that a client is not appropriately served through HCBS-DD services or, in accordance with provisions permitting the client or the client's designated representative to choose institutional services as an alternative to HCBS-DD services, the CCB shall recommend placement to an ICF/IID facility. The CCB shall seek the approval of the client's physician. The physician shall notify the URC/CCB agency of the proposed placement. Based on information provided by the CCB and the client's physician, the URC/SEP agency may certify the client for long-term care prior to ICF/IID admission.

.23 The URC/CCB agency shall advise the County Department of Social/Human Services of the certification to enable the County Department staff to assist with the placement arrangements.

24. The LOC Screen and other transfer documents concerning medical information as applicable must accompany the client to the facility.

.25 Following receipt of the fully completed LOC Screen, the URC/CCB shall review the information and make a final certification decision. If certification is approved, the URC/CCB shall assign an initial length of stay according to 10 CCR 2505-10 Section 8.404.1. If certification is denied, the decision of the URC/CCB may be appealed in accordance with the appeals process at 10 CCR 2505-10 Section 8.057.

8.405.30 ADMISSION PROCEDURES FOR HCBS-DD

.31 CCBs may evaluate clients for HCBS-DD services if, in the judgment of the CCB, such services represent a viable alternative to SNF, ICF, or ICF/IID services. The evaluation shall be carried out in accordance with the procedures set forth in 2 CCR Section 503-1.

.32 If the CCB recommends HCBS-DD placement, then the URC/CCB will approve certification for services for the developmentally disabled at the level of care recommended by the CCB. The client will be placed in alternative service.

Following receipt of the completed LOC Screen and any other supporting information, the URC/CCB will review the information and make a final certification determination.

If certification is approved, the URC/CCB shall assign an initial length of stay for HCBS-DD services.

If certification is denied, the decision of the URC/CCB may be appealed in accordance with Section 8.057.

8.405.4 CONTINUED STAY REVIEW PROCEDURES; SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

.41 Continued Stay Reviews shall be conducted by the URC for all intellectually and clients in ICF/IID services, in accordance with 42 CFR Part 456 Subpart F.

.42 As a result of the Continued Stay Review, the URC shall renew or deny certification.

8.470 HOSPITAL BACK UP LEVEL OF CARE

8.470.1 DEFINITION

The Hospital Back Up (HBU) Program is a long-term care program that provides hospital level care in a skilled nursing facility (SNF) setting. Clients who no longer need acute care in a hospital but require 24-hour monitoring and life sustaining technology for complex medical conditions may apply to receive long-term care in an HBU certified facility.

8.470.2 PROGRAM ELIGIBILITY

In order to be eligible for the hospital back up program, a client shall:

1. Meet LOC Screen level of care eligibility for long term care as determined by the appropriate single-entry point agency (SEP); and

2. Meet the client clinical eligibility requirements as identified in 10 CCR 2505-10 Section 8.470.3 as determined by the State Utilization Review Contractor (SURC);

3. Be medically stable in a chronically acute state;

4. Be in a hospital or **long-term** acute care facility prior to approval; or

5. Be in An HBU skilled facility under a qualified Medicare stay

8.470.3 CLIENT CLINICAL ELIGIBILITY

All prospective clients must meet the requirements of at least one of the following three categories in the clinical eligibility criteria in to participate in the Hospital Back Up Program:

1. Complex Wound as outlined in 8.470.3.A;

2. Ventilator Dependent as outlined in 8.470.3.B; or

3. Medically Complex as outlined in 8.470.3.C

8.470.3.A. Complex Wound Care means the client must meet all the following criteria:

1. At least one stage 3-4 pressure ulcer or injury, second- or third-degree burns, or a Medicare “pressure relieving support surface” rating of 2-3 to heal or prevent skin breakdown;

2. Documentation of extensive skin loss, active infection, compromised blood flow, sloughing, tunneling, fistulae, or undermining of surrounding tissue or necrosis with potential extension to underlying fascia;

3. Documentation of nutritional deficiencies including:

    a. Identification of diagnostic markers and specific nutritional deficiencies;

    b. A plan of treatment to address underlying conditions such as malabsorption or excess loss of nutrients; and

    c. The modality of supplementation: oral, intramuscular or intravenous, and

4. Documentation of <u>at least one</u> of the following:

    a. Full thickness wound graft surgery;

b. Negative pressure wound therapy, electromagnetic therapy, compression therapy or hyperbaric oxygen therapy;

c. Debridement (surgical, mechanical, chemical, autolytic or larval biotherapy); or

d. Advanced dressings with growth factors, silver/alginates, hyaluronic acid or collagens.

8.470.3.B. Ventilator dependent clients must meet all requirements in at least one of the following three subsections:

1. If the client is actively weaning off the ventilator, the client must:

a. Require direct assessment and monitoring of weaning at least 2 hours each day by a respiratory therapist;

b. Require supportive care at least 12 hours a day by a respiratory therapist or pulmonary trained nurse (under the supervision of a respiratory therapist) for ventilator management;

c. Require physical therapy, occupational therapy, speech therapy, or a combination of such therapies at least 5 days per week;

d. Have documented rehabilitation potential and a plan of treatment by a respiratory therapist in place at the time of the HBU referral; and

e. Have clinical documentation including (but not limited to) arterial bloods gas labs, standard breathing and capping trial results, pulmonary function tests, capnography, respiratory and speech language pathology progress notes and any other documentation to support active weaning efforts.

2. If active weaning fails, the client must:

a. Have documentation of failed weaning efforts by a respiratory therapist and a plan of treatment with prognosis for liberation from a respiratory therapist or pulmonologist;

b. Require continuous ventilator support at least 8 hours per day and skilled respiratory care at least 3.5 hours per day to remain medically stable;

c. Have difficulty communicating needs to others and/or requires assistance from skilled staff to set up adaptive equipment, or is unable to speak due to physical or cognitive impairment; and

d. Meet Nursing Facility Level of Care as determined by the LOC Screen.

3. If the client has been successfully weaned off the ventilator and is actively working to reduce oxygen levels and/or removal of the tracheostomy tube, the client must:

a. Meet Nursing Facility Level of Care as determined by the LOC Screen.

b. Have documentation from a respiratory therapist and pulmonologist verifying the client has been weaned off active ventilation and/or is working to have a further reduction to standard home oxygen levels (1-6 LPM);

c. Require the support of a respiratory therapist under the supervision of a pulmonologist at least 3.5 hours a day to remain medically stable and/or show progress toward decannulation; and

d. Be capable of:

i. Communicating needs and following simple commands; and/or

ii. Managing basic tracheostomy care or respiratory hygiene.

8.470.3.C. Medically complex clients include ventilator dependent individuals and individuals successfully weaned off the ventilator with co-morbidities. To be deemed medically complex under the HBU program, clients must meet all of the following requirements:

1. Meet Nursing Facility Level of care as determined by the LOC Screen.

2. Have difficulty communicating needs to others and requires assistance from skilled staff to set up adaptive equipment or be unable to seek assistance due to cognitive or physical impairment;

3. Require on-site assessment by a rounding physician or subspecialist at least once a week to remain stable;

4. Require artificial nourishment to be administered by registered nurse, including but not limited to a gastro-intestinal tube (G tube or NG tube) and/or jejunostomy tube (J tube), total parenteral nutrition (TPN) with or without lipids, or central line in active use for fluids or medication (excluding TPN);

5. Require documentation of rehabilitative therapies including physical, occupational and speech language therapy, and/or skilled nursing notes documenting assessment, monitoring and intervention at a greater frequency than is provided in a class 1 nursing facility;

6. Require suctioning and/or airway maintenance at least every four hours by a respiratory therapist or pulmonary trained nurse under the supervision of a respiratory therapist for ventilator dependent clients or clients with a tracheostomy;

7. Physician documentation of life limiting disease which will require ongoing care in the HBU skilled nursing facility; and

8. Documentation of quarterly updates to plan of treatment, prognosis, status evaluation, care conference and/or palliative consult.

8.470.4 INITIAL ELIGIBILITY DETERMINATION AND ADMISSION

8.470.4.A. SURC Review for Initial Hospital Eligibility Determination

Upon receipt of the completed Hospital Back Up Application, patient choice form and the LOC Screen, the SURC nurse reviewer shall:

1. Conduct a program eligibility review to determine whether the client meets the hospital back up level of care criteria and may successfully be treated in the requested skilled nursing facility;

2. Review the LOC Screen by the SEP;

3. Provide initial assessment for secondary review by SURC physician reviewer;

4. Request additional medical documentation deemed necessary to make such determination;

5. Notify the Department of final eligibility determination;

6. Document all final physician determinations and maintain these records for the Department;

7. Issue a denial letter to the Department and referring provider within 10 business days of determination if the prospective client does not meet HBU level of care;

8. Notify the Department in writing within 10 days of determination if the SURC determines the Client meets HBU level of care; and

9. Issue a 90-day initial length of stay letter to the client and skilled nursing facility within 24 hours of approval from the Department, in accordance with the criteria specified below in subsection 8.470.4.C.

8.470.5.D. Annual Continued Stay Review

1. The SURC nurse shall conduct an on-site continued stay review for each hospital back up client 15 days prior to the end of the client's currently approved annual stay.

2. The SURC may conduct an unscheduled on-site review at any time during the length of stay for client clinical change of condition or at the request of the Department.

3. The SURC shall observe the same review criteria and determination requirements as outlined in 8.470.4.C of the 90-day initial eligibility criteria for determining ongoing annual eligibility.

4. A new LOC Screen must be completed annually by the SEP agency. The nursing facility shall provide a current LOC Screen to the SURC as part of the annual eligibility assessment.

5. If the SURC determines that the client no longer meets the hospital back up level of care criteria or the nursing facility fails to provide documentation to support level of care and services provided, the SURC shall notify the Department within 24 hours of completion of the eligibility review.

6. The SURC shall observe the same determination and notification requirements as outlined in 8.470.4.C.6-7 of the 90-day initial eligibility criteria for determining ongoing annual eligibility.

8.485 HOME AND COMMUNITY BASED SERVICES FOR THE ELDERLY, BLIND AND DISABLED (HCBS-EBD) GENERAL PROVISIONS

8.485.50 GENERAL DEFINITIONS

A. Agency shall be defined as any public or private entity operating in a for-profit or nonprofit capacity, with a defined administrative and organizational structure. Any sub-unit of the agency that is not geographically close enough to share administration and supervision on a frequent and adequate basis shall be considered a separate agency for purposes of certification and contracts.

B. Assessment shall be as defined at Section 8.390.1..

C. Case Management shall be as defined at Section 8.390.1. including the calculation of client payment and the determination of individual cost-effectiveness.

D. Categorically eligible shall be defined in the HCBS-EBD program as any client eligible for medical assistance (Medicaid), or for a combination of financial and medical assistance; and who retains eligibility for medical assistance even when the client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, but not for medical assistance, or persons who are eligible for HCBS-EBD as three hundred percent eligible persons, as defined at Section 8.485.50.T.

E. Congregate facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.

F. Uncertified Congregate Facility shall be a facility as defined at Section 8.485.50.E. that is not certified as an Alternative Care Facility. See Section 8.495.1.

G. Continued Stay Review shall be a Reassessment as defined at 10 CCR 2505-10 Sections 8.402.60 and 8.390.1.

H. Corrective Action Plan shall be as defined at Section 8.390.1.

I. Cost containment shall be defined as the determination that, on an individual client basis, the cost of providing care in the community is less than the cost of providing care in an institutional setting. The cost of providing care in the community shall include the cost of providing HCBS-EBD services and long-term home health services.

J. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility type services reimbursed by Medicaid, within forty-five (45) calendar days of admission to HCBS-EBD. These include hospitalized clients who were in a nursing facility immediately prior to inpatient hospitalization and who would have returned to the nursing facility if they had not elected HCBS-EBD.

K. Diverted shall be defined as HCBS-EBD waiver recipients who were not deinstitutionalized.

L. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) shall be defined as services provided in a home or community setting to clients who are eligible for Medicaid reimbursement for long-term care, who would require nursing facility or hospital care without the provision of HCBS-EBD, and for whom HCBS-EBD services can be provided at no more than the cost of nursing facility or hospital care.

M. Intake/Screening/Referral shall be as defined 10 CCR 2505-10 Section 8.390.1.K.

N. Level of Care Screen shall be as defined as an assessment conducted in accordance with 10 CCR 2505-10 Section 8.401.

O. Provider agency shall be defined as an agency certified by the Department and which has a contract with the Department to provide one or more of the services listed at Section 8.485.40. A Single Entry Point Agency is not a provider agency, as case management is an administrative activity, not a service. Single Entry Point Agencies may become service providers if the criteria in Sections 8.390-8.393 are met.

P. Reassessment shall be as defined at 10 CCR 2505-10 Section 8.390.1.

Q. Person-Centered Support Plan means as defined in 10 CCR 2505-10 Section 8.390.1.

R. Single Entry Point Agency shall be defined as an organization described at Section 8.390.1.U.

S. The Department shall be defined described in 8.390.1.F.

T. Three hundred percent (300%) eligible shall be defined as persons:

1) Whose income does not exceed 300% of the SSI benefit level; and

2) Who, except for the level of their income, would be eligible for an SSI payment; and

3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program or are in a nursing facility or hospitalized for thirty consecutive days.

8.485.60 ELIGIBLE PERSONS

.61 HCBS-EBD services shall be offered to persons who meet the eligibility requirements below provided the individual can be served within the capacity limits in the federal waiver:

A. Financial Eligibility

Clients shall meet the eligibility criteria as stated at 10 CCR 2505-10 Section 8.100. Clients must also meet criteria specified in the Colorado Department of Human Services Income Maintenance Staff Manual, 9 CCR 2503-1, (2018).

B. Level of Care and Target Group

Clients who have been determined to meet the level of care and target group criteria shall be certified by a Single Entry Point Agency as eligible for HCBS-EBD. The Single Entry Point Agency shall only certify HCBS-EBD eligibility for those clients:

1. Determined by the Single Entry Point Agency to meet the target group definition for functionally impaired elderly, or the target group definition for physically disabled or blind adult; and

2. Determined by a LOC Screen to require the Nursing Facility Level of Care, according to 10 CCR 2505-10 Section 8.401.11 through 8.401.15; or

3. Determined by a LOC Screen to require hospital level of care;

4. A length of stay shall be assigned by the Single Entry Point Agency for approved admissions, according to guidelines at Section 8.402.60.

C. Receiving HCBS-EBD Services

1. Only clients who receive HCBS-EBD services, or who have agreed to accept HCBS-EBD services as soon as all other eligibility criteria have been met, are eligible for the HCBS-EBD program.

2. Case management is not a service and shall not be used to satisfy this requirement

3. Desire or need for home health services or other Medicaid services that are not HCBS-EBD services, as listed at Section 8.485.30, shall not satisfy this eligibility requirement

4. HCBS-EBD clients who have received no HCBS-EBD services for one month must be discontinued from the program.

D. Institutional Status

1. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-EBD services while residing in such institutions unless the Single Entry Point Agency determines the client is eligible for EBD as described in Section 8.486.33.

2. A client who is already an HCBS-EBD recipient and who enters a hospital for treatment may not receive HCBS-EBD services while in the hospital. If the hospitalization continues for 30 days or longer, the case manager must terminate the client from the HCBS-EBD program.

3. A client who is already an HCBS-EBD recipient and who enters a nursing facility may not receive HCBS-EBD services while in the nursing facility.

(a) The case manager must terminate the client from the HCBS-EBD program if Medicaid pays for all or part of the nursing facility care, or if there is a URC-certified LOC Screen for the nursing facility placement, as verified by telephoning the URC.

(b) A client receiving HCBS-EBD services who enters a nursing facility for respite care as a service under the HCBS-EBD program shall not be required to obtain a nursing facility LOC Screen and shall be continued as an HCBS-EBD client in order to receive the HCBS-EBD service of respite care in a nursing facility.

E. Cost-effectiveness

Only clients who can be safely served within cost containment, as defined at Section 8.485.50, are eligible for the HCBS-EBD program.

F. Waiting List

Persons who are determined eligible for services under the HCBS-EBD waiver, who cannot be served within the capacity limits of the federal waiver, shall be eligible for placement on a waiting list.

1. The waiting list shall be maintained by the Department.

2. The date used to establish the person’s placement on the waiting list shall be the date on which eligibility for services under the HCBS-EBD waiver was initially determined.

3. As openings become available within the capacity limits of the federal waiver, persons shall be considered for services based on the following priorities:

a. Clients being deinstitutionalized from nursing facilities.

b. Clients being discharged from a hospital who, absent waiver services, would be discharged to a nursing facility at a greater cost to Medicaid.

c. Clients who receive long-term home health benefits who could be served at a lesser cost to Medicaid.

d. Clients requiring nursing facility level of care and who are at risk of imminent nursing facility placement.

8.485.70 START DATE

.71 The start date of eligibility for HCBS-EBD services shall not precede the date that all of the requirements at Section 8.485.60 have been met. The first date for which HCBS-EBD services can be reimbursed shall be the later of any of the following:

A. Financial: The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.

B. Level of Care: This date is determined by the official assigned start date on the LOC Screen.

C. Receiving Services: This date shall be determined by the date on which the client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept services.

D. Institutional Status: HCBS-EBD eligibility cannot precede the date of discharge from the hospital or nursing facility.

.72 The start date for CTS may precede HCBS-EBD enrollment when a client meets the conditions set forth at Section 8.486.33. The start date for CTS shall be no more than 180 calendar days before a client’s discharge from a nursing facility.

8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES

.91 The Department or its agent shall develop the Prior Authorization Request (PAR) form in compliance with all applicable regulations, and determine whether services requested are (a) consistent with the client's documented medical condition and Level of Care, (b) reasonable in amount, frequency and duration, (c) not duplicative, (d) not services for which the client is receiving funds to purchase, and (e) do not total more than twenty four (24) hours per day of care.

A. The case manager shall submit prior authorization approvals for all HCBS-EBD services to the fiscal agent within one (1) calendar month after the URC's assigned start date and approval of financial eligibility.

B. The Department or its fiscal agent will approve, deny or return for additional information home modification PARs over $1,000 within ten (10) working days of receipt.

.92 When home modifications are denied, in whole or in part, the Single Entry Point Agency shall notify the client or the client's designated representative of the adverse action and their appeal rights on a state-prescribed form, according to Section 8.057, et. seq.

.93 Revisions requested by providers six months or more after the end date shall always be disapproved.

.94 Approval of the PAR by the Department or its agent shall authorize providers of services under the PCSP to submit claims to the fiscal agent and to receive payment for authorized services

provided during the period of time covered by the PAR. Payment is also conditional upon the client's financial eligibility for long-term care medical assistance (Medicaid) on the dates of service; and upon provider's use of correct billing procedures.

.95 Every PAR shall be supported by information on the PCSP, the LOC Screen and written documentation from the income maintenance technician of the client's current monthly income. All units of service requested on the PAR shall be listed on the PCSP.

.96 If a PAR is for an Alternative Care Facility client who is 300% eligible, all medical and remedial care requested as deductions shall be listed on the Client Payment form.

.97 The start date on the Prior Authorization Request form shall not precede the start date of eligibility for HCBS-EBD services, according to Section 8.485.70, except for CTS. A TCA may provide CTS up to 180 days prior to nursing facility discharge when authorized by the Single Entry Point Agency. The TCA is eligible for reimbursement beginning on the first day of the client's HCBS-EBD enrollment.

.98 The PAR shall not cover a period longer than the length of stay assigned by the URC.

Note: Sections 8.485.100 - 8.485.101 were deleted effective 7/1/02.

8.486 HCBS-EBD CASE MANAGEMENT FUNCTIONS

8.486.10 HCBS-EBD PROGRAM REQUIREMENTS FOR SINGLE ENTRY POINT AGENCIES

Single entry point agencies shall comply with single entry point rules at 10 CCR 2505-10 section 8.390, et. seq., governing case management functions, and shall comply with all HCBS-specific requirements in the rest of this section on HCBS-EBD case management functions.

8.486.20 INTAKE

.21 Refer to Section 8.393.2.B for single entry point intake procedures. The intake form shall be completed before a LOC Screen is initiated. The intake form may also be used as a preliminary case plan form when signed by the Applicant, for purposes of establishing a start date.

.22 Based upon information gathered on the intake form, the case manager shall determine the appropriateness of a referral for a LOC Screen and shall explain the reasons for the decision on the Intake form. The client shall be informed of the right to request a LOC Screen if the client disagrees with the case manager's decision.

8.486.30 LEVEL OF CARE ELIGIBILITY DETERMINATION

.31 If the client is being discharged from a hospital or other institutional setting, the discharge planner shall contact the URC/SEP agency for assessment by emailing or faxing the initial intake and screening form.

.32 The URC/SEP case manager shall view and document the current Personal Care Boarding Home license, if the client lives, or plans to live, in a congregate facility as defined at Section 8.485.50, in order to ensure compliance with Section 8.485.20.

.33 A SEP may determine that a client is eligible for HCBS-EBD while the client resides in a nursing facility when the client meets the eligibility criteria as established at Section 8.400, et seq., the .client requests CTS and the SEP includes CTS in the client's long-term care plan. If the client has been evaluated with the LOC Screen and has been assigned a length of stay that has not lapsed, the SEP shall not conduct another review when CTS is requested.

8.486.40 HCBS-EBD DENIALS

.41 If a client is determined, at any point in the Level of Care Eligibility Determination process, to be ineligible for HCBS-EBD according to any of the requirements at Section 8.485.60, the client or the client's designated representative shall be notified of the denial and the client's appeal rights in accordance with Long-term Care Single Entry Point System regulations at Section 8.393.3.A.

8.486.200 REASSESSMENT

.201 The case manager shall complete a Reassessment of each SEP-managed waiver client before the end of the length of stay assigned by the Utilization Review Contractor at the last level of care determination. The case manager shall initiate a Reassessment more frequently if required by single entry point regulations at 10 CCR 2505-10 section 8.393.25, or when warranted by significant changes that may affect HCBS-EBD eligibility.

.202 The case manager shall submit a continued stay review PAR, in accordance with requirements at 10 CCR 2505-10 section 8.485.90. For clients who have been denied by the Utilization Review Contractor at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the approved LOC Screen. Acceptable documentation of an appeal includes: (a) a copy of the request for reconsideration or the request for appeal, signed by the client and sent to the Utilization Review Contractor or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by the Utilization Review Contractor or the Office of Administrative Courts to the client; or (c) a copy of the notice of a scheduled court date. Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed and shall not be accepted as a substitute for the approved LOC Screen. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

8.486.300 TERMINATION

.301 In accordance with Long-term Care Single Entry Point System regulations at Section 8.393.28, clients shall be terminated from any SEP-managed waiver whenever they no longer meet one or more of the eligibility requirements at Section 8.485.60. Clients shall also be terminated from the waiver if they die, move out of state or voluntarily withdraw from the waiver.

8.486.400 COMMUNICATION

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

A. The case manager shall inform all Alternative Care Facility clients of their obligation to pay the full and current State-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.

B. Within five (5) working days of receipt of the approved PAR form, from the fiscal agent, the case manager shall provide copies to all the HCBS-EBD providers in the care plan.

C. Within five (5) working days of Level of Care Eligibility Determination the case manager shall send a copy of the Level of Care Eligibility Determination the to all personal care, and adult day services provider agencies on the care plan and to alternative care facilities listed on the care plan.

D. The case manager shall notify the URC, on a form prescribed by the Department, within thirty (30) calendar days, of the outcome of all non-diversions, as defined at Section 8.485.50.

8.486.500 CASE RECORDING/DOCUMENTATION

.501 Case management documentation shall meet all of the standards found at Sections 8,393.2.H.

10 CCR 2505-10, Section 8.400-499, Appendix A: Age Appropriate Guidelines for the Use of ULTC 100.2 Assessment on Children

These guidelines provide instructions for using the Uniform Long Term Care (ULTC) – 100.2 assessment to assess the needs of children for the following Home and Community-Based Services (HCBS) Waivers: Children's Extensive Support (CES), Children's HCBS (CHCBS), Children's Habilitation Residential Program (CHRP), Children with Life Limiting Illness (CLLI) and Children with Autism (CWA). Each individual and their circumstances must be considered when completing the assessment. Case Managers must score each child according to his/her age and individual needs.

Please consult evidence based resources and references to further your understanding of child development.

A. What is child development?

1. Child development refers to the various stages of physical, biological, social, intellectual and psychological changes that occur from birth through the end of adolescence.

2. Growing process refers to the process of becoming physically larger in size and more mature through natural development.

3. The following are child development categories:

    a. Gross Motor Skill: The ability to coordinate and control large muscles of the body. Some examples of gross motor control are sitting upright, balancing, walking, lifting, kicking and throwing a ball.

    b. Fine Motor Skill: The ability to coordinate small muscles for precise small movements involving the hands, wrists, feet, toes, lips and tongue. Some examples of fine motor control are handwriting, drawing, grasping objects, dressing, cutting and controlling a computer mouse.

    c. Speech and Language: The ability to both understand and use language to communicate thoughts and feelings through speaking, body language and gestures.

    d. Cognitive: The ability to learn, understand, remember, reason, and solve problems.

    e. Social and Emotional: The ability to interact with others, have relationships with family, friends, and teachers, exercise self-control, cooperate and respond to the feelings of others.

B. What are developmental milestones?

1. Developmental milestones refer to abilities achieved by most children by a certain age.

    Milestones are used to gauge how a child is developing. Each milestone is associated with a specific age, however, the age when a developing child actually reaches each milestone may vary.

C. What is the Uniform Long Term Care (ULTC) 100.2 Assessment?

The ULTC 100.2 is an assessment to determine the Level of Care of a client by evaluating the client's ability to independently complete Activities of Daily Living (ADLs). ADLs are activities performed in the course of a typical day in a person's life such as: bathing, dressing, toileting, mobility, transferring, and

eating. ADLs also include behavior and memory supervision activities needed for daily life. The ULTC 100.2 is a foundational component of the Person-Centered Support Planning process that helps:

1. Determine the appropriate services

2. Determine the care that is necessary to meet clients' needs, and

3. Assist in the selection of long-term care supports and services that meet clients' needs.

The assessment measures what the child is able to do, not what he/she prefers to do. In other words, assess the child's ability to do particular activities, even if he/she doesn't usually do the activity.

Consider age-appropriate behavior when assessing the child's ability to complete any ADL. If the child is not able to complete the ADL due to his or her age, then the child will not score in the ADL. However, if a child needs assistance in completing an ADL that is above and beyond the assistance a typically developing peer would require, then a score above 0 may be warranted.

D. Scoring

The ULTC 100.2 asks you to give the child a score between 0 and 3 based on the child's abilities in eight ADL areas. Scoring is completed as follows:

0 = Independent:

The child requires no greater assistance to successfully complete this task than would a child of similar age and stage that does not have a disability or impairment. The child has age-appropriate independence and reliability in the use of adaptive equipment necessary to complete this task, if needed.

1 = Minimal Assistance:

The child is able to perform all essential components of the activity with some impairment, with or without assistive device within a reasonable amount of time.

A score of 1 indicates the child is able to perform most of the essential components of the activity within a reasonable amount of time and may require:

a. Minimal assistance to successfully complete the task compared to a child of similar age and stage.

b. Minimal assistance with adaptation and assistive device(s)/medical equipment(s).

c. Minimal interventions such as occasional standby assistance, oversight and/or cueing.

2 = Moderate Assistance:

The child is unable to perform most of the essential components of the activity even with assistive device, requires a great deal of supervision or exceeds a reasonable amount of time to perform the activity with or without assistive device.

A score of 2 indicates that the child is unable to perform essential components of the activity due to requiring:

a. Hands-on assistance.

b. Hands-on assistance to use assistive device(s)/medical equipment(s).

c. Interventions such as regular line of sight.

d. Significant prompting or step by step cueing to begin a task and to complete it successfully.

3 = Total Assistance:

The child is totally unable to perform the essential components of the activity and needs extensive assistance.

A score of 3 indicates that the child is unable to perform the essential components of the activity due to requiring (but not limited to):

a. Assistance with complex assistive device(s)/medical equipment(s).

b. Extensive for hands-on assistance.

c. A trained attendant to perform ADLs or prevent complications.

E. Justification of Scoring (Due To's)

All scores must be justified through one or more of the following conditions. Select all applicable "due to's" to support the ADL score.

1. Physical Impairment

   a. Example: client requires assistance due to paralysis

2. Supervision

   a. Example: client requires assistance due to lack of awareness

3. Mental Health

   a. Example: client requires assistance due to hallucinations

F. Comment Box (Narratives)

Narratives are required in the "Comment box" to support each score and to help others who read the assessment understand a client's over all need. Descriptions should be person-centered, meaningful and should justify level of assistance required based on "due to's." Comment descriptions should include:

a. How/Source: How the information obtained: Individual/caregiver, Case Manager Observation, or other?

b. What: What type of assistance is required to complete the task and how does the child manage to complete the task?

c. Who: Who is providing assistance?

d. When: How often is the child able or not able to complete the task each day?

e. Why: Why is the child able or not able to complete the activity (task)?

In May 2015, the Department published information on the best practices for what to include in narrative statements in the assessment in the Departments training website as well as in a Dear Administrator Letter. For additional information or examples of narrative statements, please find these resources on our website:

a. Writing Narrative Statements in the Assessment

b. Dear Administrator Letter – May 11, 2015

G. Activities of Daily Living (ADL)

1. BATHING

Definition: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene.

For older children, this includes the ability to get in and out of the tub and/or shower, the ability to turn the faucets on and off, regulate water temperature and to wash and dry.

A child should be able to physically and/or cognitively perform all essential components of the task safely and without assistance at 10 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child the same age without a disability or impairment.

Considerations for a child from birth to 59 months:

a. A child younger than 12 months is dependent on a caregiver for bathing.

b. A child 12-24 months can typically sit-up in the bath and begin to participate, however, the child still requires assistance and supervision.

c. A child 24-59 months typically participates in bathing, however, still requires assistance and supervision.

Considerations for a child from 5 to 18 years:

a. A child 5-18 years old typically has the ability to bathe and does not require assistance, supervision, and/or help transferring in and out of the tub.

A child may score if the child has a unique medical reason or cognitive impairment that impacts bathing, needs adaptive equipment or skilled/medical care during bathing. Please remember that all children under 4 years of age need some assistance in bathing.

2. DRESSING

Definition: The ability to dress and undress as appropriate.

This includes the ability to put on and remove basic garments such as underwear, shirts, sweaters, pants, socks, hats, and jackets. It also includes fine motor coordination for buttons, snaps, zippers, and the ability to choose appropriate clothing for the weather. For older children, this activity includes the ability to put on prostheses, braces, anti-embolism hose or other assistive devices.

A child should be able to physically and/or cognitively perform all essential components of the task safely and without assistance at 5 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child the same age without a disability or impairment.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for dressing.

b. A child 12-24 months can typically pull off hat, socks, and mittens.

c. A child 24-35 months can typically begin to help dress self.

d. A child 36-47 months can typically put on shoes (but cannot tie laces) and dress self with some help (buttons, snaps, zippers).

A child 48-59 months can typically dress self without much help.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-18 years old typically participates in dressing and may require supervision or reminders with selecting appropriate clothing.

A child may score if the child has physical characteristics that makes dressing difficult such as contractures, hypotonia/hypertonia causing a lack of endurance or range of motion, or paralysis. Consider safety and the need to assist with dressing due to seizure activity, lack of balance or cognitive impairment when scoring a child. Difficulties with a zipper or buttons at the back of a garment is not unusual and does not mean there is a functional deficit.

3. TOILETING

Definition: The ability to use the toilet, commode, bedpan, or urinal.

This includes independent transferring on and off the toilet, cleansing appropriately, and adjusting clothes. In older children, this activity could include managing their ostomy or catheter.

A child should be able to physically and cognitively perform all essential components of the task safely and without assistance at 5 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child the same age without a disability or impairment.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for toileting.

b. A child 12-42 months typically requires the use of diapers, though begins to gain some control of bowels/bladder.

c. A child 43-59 months is typically toilet trained; however occasional night time bedwetting or accidents may occur.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-6 years old may need to have intermittent supervision, cueing, or minor physical assistance and/or; have occasional night time bedwetting or accidents during waking hours.

b. A child age 7-18 years old should have the ability to toilet without assistance.

A child may score if he/she has cognitive impairment or skilled/medical care needs that affect toileting, such as ostomy, suppositories, or frequent infections. Children younger than 4 years old may still require diapers or need to have intermittent supervision, cueing, or minor physical assistance, or they may have occasional night time bedwetting or accidents during waking hours. Children should have an awareness of being wet or soiled and show interest in toilet training and/or appliances such as ostomies or urinary catheters.

4. MOBILITY

Definition: The ability to move between locations in the child's environment inside and outside the home.

This includes the ability to safely maneuver (ambulate) without assistance, go up/down the stairs, kneel without support, and assume a standing position.

A child should be able to physically and/or cognitively perform all essential components of the task safely and without assistance at 3 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child the same age without a disability or impairment.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 6 months is dependent on a caregiver for mobility.

b. A child 6-12 months can typically maintain a sitting position, may begin to move by rolling or crawling, and may begin to pull self up using furniture.

c. A child 12-18 months can typically pull self to standing position, sit or stand alone, and move by crawling and/or walking with or without the use of furniture for balance.

d. A child 18-59 months can typically stand and walk without assistance.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-18 years old should be totally mobile and have the ability to move between locations without assistance.

A child may score if the child is unable to maintain seated balance, unable to bear weight on one or both legs, has a high risk of falling and/or uses mobility devices. Consideration is given to safety and the need to assist with mobility due to visual concerns, seizure activity, frequent falls, and/or lack of balance.

5. TRANSFERS

Definition: The physical ability to move between surfaces.

This includes the physical ability to get in/out of bed or usual sleeping place; to transfer from a bed/chair to a wheelchair, walker or standing position; to transfer on/off the toilet; and the ability to use assisted devices for transfers.

A child should be able to physically and/or cognitively perform all essential components of the task safely and without assistance at 3 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child without a disability or impairment at the same age.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for transfers.

b. A child 12-36 months may require physical assistance with transfers.

c. A child 36-59 months should require minimal assistance with transfers.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-6 years old may still require minimal assistance with transfers.

b. A child age 7-18 years old should be independent and be able to transfer without physical assistance.

A child may score if the child has limited ability to independently move between two nearby surfaces and/or use assisted devices to transfer. Consideration is given to safety and the need to assist with transfer due to visual concerns, seizure activity, and awareness to surrounding and/or lack of balance.

6. *EATING*

Definition: The ability to eat and drink using routine or adaptive utensils.

This includes the ability to cut, regulate the amount of intake, chew, swallow foods, and use utensils. Note other forms of feeding such as a tube or intravenous on the assessment.

A child should typically be able to physically and cognitively perform all essential components of the task safely and without assistance if 5 years of age or older.

Consider what the parent or caregiver is doing that is above and beyond the requirements of another child without a disability or impairment at the same age.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for feeding.

b. A child 12-24 months can typically eat finger foods and begin to use a utensils and cup.

c. A child 24-47 months can typically feed self solid foods and begin to try new flavors of foods.

d. A child 48-59 months can typically use spoon, fork, and dinner knife independently.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-6 years old should physically participate in eating, and may need some supervision and/or assistance.

b. A child age 7-18 years old should have the ability to eat without assistance.

A child may score if the child requires more than one hour per feeding, tube feedings (or TPN), or requires more than three hours per day for feeding or eating. Consideration is given to safety and the need to assist with eating due to choking, dietary restrictions, allergies and eating disorders. Children younger than 5 years of age may require verbal prompting and assistance with cutting food.

7. SUPERVISION: (Behavioral)

Definition: The ability to engage in safe actions and interactions and refrain from unsafe actions and interactions.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 48 months requires supervision and surveillance.

b. A child 18-36 months often gets physically aggressive when frustrated.

c. A child 36-59 months should begin to understand and refrain from unsafe actions and interactions.

Considerations for a Child from 5 to 18 Years:

a. A child 5-18 years old should begin to understand and refrain from unsafe actions and interactions with occasional reminders.

A child may score if the ultimate responsibility for the safety, care, wellbeing, and behavior of dependent children remains with the parent or caregiver. Consideration should be given if the child is not able to manage appropriate behaviors and requires constant supervision/prompting.

Examples of behaviors that may justify scoring a functional deficiency for children over 36 months include:

a. Verbal or physical threats and/or actions against self and/or others.

b. Socially inappropriate or sexually aggressive behaviors.

c. Wandering with little safety awareness.

d. Removing or destroying property.

8. SUPERVISION: (Memory/Cognition)

Definition: The ability to acquire and use information, communicate, reason, complete tasks, and problem-solve needs in order to care for oneself safely.

Considerations for a Child from Birth to 59 Months:

a. A child 12-18 months typically says 8-20 words, identifies objects in a book, and follows simple one step directions.

b. A child 18-24 months typically uses two to three word phrases, refers to self by name, and points to parts of face when asked.

c. A child 25-36 months typically enjoys simple make-believe games and enjoys simple stories or songs.

d. A child 36-59 months typically begins counting; identifying colors and letters; and can follow simple rules of a game.

Considerations for a Child from 5 to 18 years:

a. A child 5-9 years old may require occasional supervision necessary to acquire and use information, reason, problem-solve, complete tasks, or communicate needs in order to care for oneself safely.

b. A child 5-18 years old has the ability to recognize and adjust to daily routines, interact with peers and others appropriately, understand directions, understand basic home safety and stranger awareness.

A child may score if the child requires consistent reminding, planning or adjusting for both new and familiar routines; if the child needs preparation and assistance when transitioning between activities; or if the child has impaired ability to assure his or her safety in a strange environment (for example, the child cannot give name or address or would not be aware of dangerous situations).

Examples of behaviors that may justify scoring a functional deficiency for children over 59 months include:

a. Failure to recognize and adjust to daily routines.

b. Inappropriate interactions with peers and other.

c. Lack of basic home safety understanding and stranger awareness.

H. Activities of Daily Living Scores

To be eligible for waiver services a child must have deficits in a minimum of two out of six ADLs (2+ score) or a moderate score (2+ score) in Behaviors or Memory/Cognition under Supervision category.

I. Assessment Demographic

Check the appropriate box that best identifies the client situation. If one of the categories does not apply, select 'Other' and enter a description for the different categories in Assessment Demographics.

J. Summary

Summarize the assessment findings and enter any additional comments that provide more information about the client's situation such as background information, current status, hospital visits, surgeries, seizure activities/frequency or police interactions. Comments can address issues not already identified by

the assessment or expand on information presented in the assessment document. Please do not copy and paste entire assessment in this space.

8.500 HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES(HCBS-DD) WAIVER

8.500.1 This Section hereby incorporates the terms and provisions of the federally approved Home and Community-based Services for Individuals with Intellectual or Developmental Disabilities (HCBS-DD) waiver. To the extent that the terms of that federally approved waiver are inconsistent with the provisions of this Section, the waiver will control.

8.500.1 DEFINITIONS

A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and needing supervision to support behavior, medical needs and memory/cognition.

B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-DD waiver or a HCBS waiver service.

C. APPLICANT means as defined in Section 8.390.1.

D. AUDITABLE means the information represented on the wavier cost report can be verified by reference to adequate documentation as required by generally accepted auditing standards.

E. AUTHORIZED REPRESENTATIVE means an individual designated by a Client, or by the parent or guardian of the Client receiving services, if appropriate, to assist the Client receiving services in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined at Section 8.510.1.

F. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

G. CLIENT means an individual who meets long-term services and support eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).

H. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the Client's behalf. A Client Representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the Client to speak for or act on the Client's behalf.

I. COMMUNITY CENTERED BOARD means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

J. COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing home and community-based services and Medicaid state plan benefits including long-term home health services and targeted case management.

K. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Client.

L. DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means as defined in 8.280.1.

P. FAMILY means a relationship as it pertains to the Client and is defined as:

A mother, father, brother, sister; or,

Extended blood relatives such as grandparent, aunt, uncle, cousin; or

An adoptive parent; or,

One or more individuals to whom legal custody of a Client with an intellectual or developmental disability has been given by a court; or,

A spouse; or,

The Client's children.

Q. GROUP RESIDENTIAL SERVICES AND SUPPORTS (GRSS) means residential habilitation provided in group living environments of four (4) to eight (8) Clients receiving services who live in a single residential setting, which is licensed by the Colorado Department of Public Health and Environment as a residential care facility or residential community home for persons with developmental disabilities.

R. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem S, as set forth in Section 15-14-102 (4), C.R.S.

S. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in Article 33 of Title 22, C.R.S.

T. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IDD)

U. INDIVIDUAL RESIDENTIAL SERVICES AND SUPPORTS (IRSS) means residential habilitation services provided to three (3) or fewer Clients in a single residential setting or in a host home setting that does not require licensure by the Colorado Department of Public Health and Environment.

V. INSTITUTION means a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IDD) for which the Department makes Medicaid payment under the Medicaid State Plan.

W. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a publicly or privately-operated facility that provides health and habilitation services to a Client with an intellectual or developmental disability or related conditions.

X LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse.

Y. LEVEL OF CARE (LOC) means the specified minimum amount of assistance a Client must require in order to receive services in an institutional setting under the Medicaid State Plan.

Z. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities.

AA. MEDICAID ELIGIBILE means an Applicant or Client meets the criteria for Medicaid benefits based on the Applicant's financial determination and disability determination when applicable.

BB. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

CC. MEDICATION ADMINISTRATION means assisting a Client in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

DD. NATURAL SUPPORTS means non-paid informal relationships that provide assistance and occur in the Client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

EE. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

FF. PERSON-CENTERED SUPPORT PLAN (PCSP) means as defined in Section 8.390.1 DEFINITIONS.

GG. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent or the Case Management Agency.

HH. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means as defined in Section 8.390.1 DEFINITIONS.

II PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined Section 8.600.4 et seq., that has received program approval to provide HCBS-DD waiver services.

JJ. PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use, including vehicles for hire.

KK. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or common law marriage.

LL. RETROSPECTIVE REVIEW means the Department or the Department's contractor's review after services and supports are provided to ensure the Client received services according to the support plan and that the Case Management Agency complied with the requirements set forth in statue, waiver and regulation.

MM. STATE AND LOCAL GOVERNMENT HCBS WAIVER PROVIDER means the state owned and operated agency providing HCBS waiver services to Clients enrolled in the HCBS-DD waiver.

NN. SUPPORT is any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

OO. SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

PP. TARGETED CASE MANAGEMENT (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 et seq, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; assessment and periodic Reassessment, development and periodic revision of a PCSP,, referral and related activities, and monitoring.

QQ. THIRD PARTY RESOURCES means services and supports that a Client may receive from a variety of programs and funding sources beyond natural supports or Medicaid. That may include, but are not limited to, community resources, services provided through private insurance, non-profit services and other government programs.

RR. WAIVER SERVICE means optional services defined in the current federally approved HCBS waiver documents and do not include Medicaid State Plan benefits.

8.500.2 HCBS-DD WAIVER ADMINISTRATION

8.500.2.A HCBS-DD shall be provided in accordance with the federally approved waiver document and these rules and regulations.

8.500.2.B The HCBS-DD waiver provides the necessary support to meet the daily living needs of a Client who requires access to 24-hour support in a community-based residential setting.

8.500.2.C HCBS-DD Waiver services are available only to address those needs identified in the LOC Screen and authorized in the PCSP and when the service or support is not available through the Medicaid state plan, EPSDT, natural supports or third-party resources.

8.500.4 CLIENT ELIGIBILITY

8.500.4.A To be eligible for the HCBS-DD waiver, an individual shall meet the target population criteria as follows:

1. Be determined to have an intellectual or developmental disability,

2. Be eighteen (18) years of age or older,

3. Require access to services and supports twenty-four (24) hours a day,

4. Meet ICF-IID level of care as determined by the LOC Screen, and

5. Meet the Medicaid financial determination for LTC eligibility as specified in Section 8.100, *et seq.*

8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

The section hereby incorporates the terms and provisions of the federally approved Home and Community-Based Supported Living Services (HCBS-SLS) waiver. To the extent that the terms of the federally approved waiver are inconsistent with the provisions of this section, the waiver shall control.

HCBS-SLS services and supports which are available to assist persons with intellectual or developmental disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an HCBS-SLS setting. HCBS-SLS waiver services are not intended to provide twenty-four (24) hours of paid support or meet all identified Client needs and are subject to the availability of appropriate services and supports within existing resources.

8.500.90 DEFINITIONS

A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and needing supervision to support behavior, medical needs and memory/cognition.

B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-SLS waiver or a specific HCBS-SLS waiver service(s).

C. APPLICANT means as defined in Section 9.390.1.

D. AUTHORIZED REPRESENTATIVE means an individual designated by a Client, or by the parent or guardian of the Client receiving services, if appropriate, to assist the Client receiving service in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined at Section 8.510.1.

E. CASE MANAGEMENT AGENCY(CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

F. CLIENT means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).

G. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the Client's behalf. A Client representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or, (B) an individual, family member or friend selected by the Client to speak for and/or act on the Client's behalf.

H. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

I CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care and homemaker activities.

J. COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community-Based Services, and Medicaid State Plan Benefits including long-term home health services, and targeted case management.

K. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Client.

L. DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means as defined in Section 8.280.1.

P. FAMILY means a relationship as it pertains to the Client and includes the following:

A mother, father, brother, sister; or,

Extended blood relatives such as grandparent, aunt, uncle, cousin; or

An adoptive parent; or,

One or more individuals to whom legal custody of a Client with an intellectual or developmental disability has been given by a court; or,

A spouse; or

The Client's children.

Q. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.

R. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in Article 33 of Title 22, C.R.S.

S HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

T. INSTITUTION means a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) for which the Department makes Medicaid payment under the Medicaid State Plan.

U. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a public or private facility that provides health and habilitation services to a Client with intellectual or developmental disabilities or related conditions.

V. LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse.

W. LEVEL OF CARE (LOC) means the specified minimum amount of assistance that a Client must require in order to receive services in an institutional setting under the state plan.

X. LEVEL OF CARE SCREEN means as defined in Section 8.390.1.

Y. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illness who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

Z. MEDICAID ELIGIBLE means an Applicant or Client meets the criteria for Medicaid benefits based on the Applicant's financial determination and disability determination when applicable.

AA. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the State covers, and how the State addresses additional Federal Medicaid statutory requirements concerning the operation of its Medicaid program.

BB. MEDICATION ADMINISTRATION means assisting a Client in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

CC. NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur in a Client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

DD. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-Based

Services for Persons with Developmental Disabilities (HCBS-DD), Home and Community-Based Services Supported Living Services (HCBS-SLS) and Home and Community-Based Services Children's Extensive Support (HCBS-CES) waivers.

EE. PERSON-CENTERED SUPPORT PLAN (PCSP) means as defined in Section 8.390.1 DEFINITIONS.

FF. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent or the Case Management Agency.

GG. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means as defined in Section 8.390.1 DEFINITIONS.

HH. PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in Section 8.600.4 *et seq.*, that has received program approval to provide HCBS-SLS services.

II. PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use including vehicles for hire.

JJ. REIMBURSMENT RATES means the maximum allowable Medicaid reimbursement to a provider for each unit of service.

KK. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or common law marriage.

LL. RETROSPECTIVE REVIEW means the Department or the Department's contractor review after services and supports are provided to ensure the Client received services according to the PCSP and that the Case Management Agency complied with requirements set forth in statute, waiver and regulation.

MM. SERVICE DELIVERY OPTION means the method by which direct services are provided for a Client and include a) by an agency and b) Client directed.

NN. SERVICE PLAN AUTHORIZATION LIMIT (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the Client's ongoing needs. Purchase of services not subject to the SPAL are set forth at Section 8.500.102.B. A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of Clients in each level, and projected utilization.

OO. SUPPORT is any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

PP. SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi- structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

QQ. SUPPORT LEVEL means a numeric value determined using an algorithm that places Clients into groups with other Clients who have similar overall support needs.

RR. TARGETED CASE MANAGEMENT (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 *et seq*, Targeted case

management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; Assessment and periodic Reassessment, development and periodic revision of a PCSP referral and related activities, and monitoring.

SS. THIRD PARTY RESOURCES means services and supports that a Client may receive from a variety of programs and funding sources beyond natural supports or Medicaid that may include, but are not limited to community resources, services provided through private insurance, non-profit services and other government programs.

TT. WAIVER SERVICE means optional services defined in the current federally approved HCBS waiver documents and do not include Medicaid State plan benefits.

8.500.91 HCBS-SLS WAIVER ADMINISTRATION

8.500.91.A HCBS-SLS shall be provided in accordance with the federally approved waiver document and these rules and regulations, and the rules and regulations of the Colorado Department of Human Services, Division for Developmental Disabilities, 2 CCR 503-1 and promulgated in accordance with the provision of Section 25.5-6-404 (4), C.R.S.

8.500.91.B In the event a direct conflict arises between the rules and regulations of the Department and the Operating Agency, the provisions of Section 25.5-6-404(4), C.R.S. shall apply and the regulations of the Department shall control.

8.500.10.C The HCBS-SLS waiver is operated by the Department of Health Care Policy and Financing.

8.500.910.E HCBS-SLS services are available only to address those needs identified in the LOC Screen and authorized in the PCSP when the service or support is not available through the Medicaid State plan, EPSDT, natural supports, or third party payment resources.

8.500.91.F The HCBS-SLS Waiver:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,

2. Shall be subject to annual appropriations by the Colorado General Assembly,

3. Shall ensure enrollments into the HCBS-SLS waiver do not exceed the federally approved waiver capacity, and

4. May limit the enrollment when utilization of the HCBS-SLS waiver program is projected to exceed the spending authority.

8.500.93 CLIENT ELIGIBILITY

8.500.93. A To be eligible for the HCBS-SLS waiver an individual shall meet the target population criteria as follows:

1. Be determined to have an intellectual or developmental disability

2. Be eighteen (18) years of age or older,

3. Does not require twenty-four (24) hour supervision on a continuous basis which is reimbursed as a HCBS-SLS service,

4. Is served safely in the community with the type or amount of HCBS-SLS waiver services available and within the federally approved capacity and cost containment limits of the waiver,

5. Meet ICF-IID level of care as determined by the LOC Screen.

6. Meet the Medicaid financial determination for LTC eligibility as specified at Section 8.100; and,

7. Reside in an eligible HCBS-SLS setting. SLS settings are the Client's residence, which is defined as the following:

   a. A living arrangement, which the Client owns, rents or leases in own name,

   b. The home where the Client lives with the Client's family or legal guardian, or

   c. A living arrangement of no more than three (3) persons receiving HCBS-SLS residing in one household, unless they are all members of the same family.

8. The Client shall maintain eligibility by continuing to meet the HCBS-SLS eligibility requirements and the following:

   a. Receives at least one (1) HCB-SLS waiver service each calendar month,

   b. Is not simultaneously enrolled in any other HCBS waiver, and

   c. Is not residing in a hospital, nursing facility, ICF-IID, correctional facility or other institution.

9. When the HCBS-SLS waiver reaches capacity for enrollment, a Client determined eligible for a waiver shall be placed on a wait list in accordance with these rules at Section 8.500.96.

8.500.103 RETROSPECTIVE REVIEW PROCESS

8.500.103.A Services provided to a Client are subject to a retrospective review by the Department and the Operating Agency. This retrospective review shall ensure that services:

1. Identified in the PCSP are based on the Client's identified needs as stated in the LOC Screen.

2. Have been requested and approved prior to the delivery of services,

3. Provided to a Client are in accordance with the PCSP and

4. Provided are within the specified HCBS service definition in the federally approved HCBS-SLS waiver,

8.501 State Funded Supported Living Services Program

The State Funded Supported Living Services (State-SLS) program is funded through an allocation from the Colorado General Assembly. The State-SLS program is designed to provide supports to individuals

with an intellectual or developmental disability to remain in their community. The State-SLS program shall not supplant Home and Community-Based services for those who are currently eligible.

8.501.A Definitions

1. APPLICANT means an individual who is seeking supports from State-SLS program.

2. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-Based Services waivers pursuant to section 25.5-10-209.5, C.R.S., has a valid provider participation agreement with the Department, and has a valid contract with the Department to provide these services.

3. CCB CASE MANAGER means the staff member of the Community Centered Board that works with individuals seeking services to develop and authorize services under the State-SLS program.

4. CLIENT means an individual who meets the DD Determination criteria and other State-SLS eligibility requirements and has been approved for and agreed to receive services in the State-SLS program.

5. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the Client's behalf. A Client Representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, or a spouse; or (B) an individual, family member or friend selected by the Client to speak for or act on the Client's behalf.

6. CORRECTIVE ACTION PLAN means a written plan, which includes the detailed description of actions to be taken to correct non-compliance with State-SLS requirements, regulations, and direction from the Department, and includes the date by which each action shall be completed and the individuals responsible for implementing the action.

7. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit that meets the requirements set forth in Section 25.5.-10-209, C.R.S. and is responsible for conducting level of care evaluations and determinations for State-SLS services specific to individuals with intellectual and developmental disabilities.

8. COMMUNITY RESOURCE means services and supports that a Client may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to, services provided through private insurance, non-profit services and other government programs.

9. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Client.

10. DEVELOPMENTAL DISABILITY (DD) DETERMINATION means the determination of a Developmental Disability as defined in section 8.607.2

11. DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

12. DEVELOPMENTAL DISABILITY means a disability that is defined in section 8.600.4.

13. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of Medicaid State Plan for Medicaid eligible children up to the age of twenty-one (21).

14. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

15. LONG-TERM CARE SERVICES AND SUPPORTS (LTSS) means the services and supports utilized by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

16. MEDICAID ELIGIBLE means an Applicant or Client meets the criteria for Medicaid benefits based on a financial determination and disability determination.

17. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses federal Medicaid statutory requirements concerning the operation of its Medicaid program.

18. NATURAL SUPPORTS means an informal relationship that provides assistance and occurs in the Client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

19. PERFORMANCE AND QUALITY REVIEW means a review conducted by the Department or its contractor at any time to include a review of required case management services performed by the CCB to ensure quality and compliance with all statutory and regulatory requirements.

20. PLAN YEAR mean a twelve (12) month period starting from the date when State-SLS Supports and Services where authorized.

21. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent.

22. PROGRAM APPROVED SERVICE AGENCY (PASA) means a developmental disabilities service agency or a service agency as defined in 8.602, that has received program approval, by the Department, to provide Medicaid Wavier services.

23. RELATIVE means a person related to the Client by virtue of blood, marriage, or adoption.

24. RETROSPECTIVE REVIEW means the Department’s review after services and supports are provided and the PASA is reimbursed for the service, to ensure the Client received services according to the PCSP and standards of economy, efficiency and quality of service.

25. STATE-SLS INDIVIDUAL SUPPORT PLAN means the written document that identifies an individual’s need and specifies the State-SLS services being authorized, to assist a Client to remain safely in the community.

26. STATE FISCAL YEAR means a 12-month period beginning on July 1 of each year and ending June 30 of the following calendar year. If a single calendar year follows the term, then it means the State Fiscal Year ending in the calendar year.

27. Services and Supports or Supports and Services means one or more of the following: Education, training, independent or supported living assistance, therapies, identification of natural supports, and other activities provided to

    a. To enable persons with intellectual and developmental disabilities to make responsible choices, exert greater control over their lives, experience presence and inclusion in their communities, develop their competencies and talents, maintain relationships, foster a sense of belonging, and experience person security and self-respect.

28. SUPPORT SERVICE means the service(s) established in the State SLS program that a CCB Case Manager may authorize to support an eligible Client to complete the identified tasks identified in the Client's Individualized Support Plan.

29. WAIVER SERVICE means optional services and supports defined in the current federally approved HCBS waiver documents and do not include Medicaid State Plan benefits.

8.503 CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM (HCBS-CES)

8.503 DEFINITIONS

A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, transferring, and needing supervision to support behavior, medical needs and memory cognition.

B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-CES waiver or a HCBS waiver service.

C. APPLICANT means as defined in Section 8.390.1.

D. AUTHORIZED REPRESENTATIVE means an individual designated by a Client, or by the parent or guardian of the Client receiving services, if appropriate, to assist the Client receiving service in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined at Section 8.510.1.

E. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the Department.

F. CLIENT means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-based Services (HCBS).

G. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the Client's behalf. A Client representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the Client to speak for or act on the Client's behalf.

H. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

I. COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community-based Services, and Medicaid State Plan benefits including long-term home health services and targeted case management.

J. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Client.

K. CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care and homemaker activities.

L. DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single state Medicaid agency.

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means as defined in Section 8.280.1.

P. FAMILY means a relationship as it pertains to the Client and is defined as:

A mother, father, brother, sister,

Extended blood relatives such as grandparent, aunt, uncle, cousin,

An adoptive parent,

One or more individuals to whom legal custody of a person with a developmental disability has been given by a court,

A spouse or,

The Client’s child.

Q. FISCAL MANAGEMENT SERVICE (FMS) means the entity contracted with the Department to complete employment related functions for CDASS attendants and track and report on individual Client allocations for CDASS.

R. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a

parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.

S. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under Title 19, C.R.S., or the "School Attendance Law of 1963," set forth in Article 33 of Title 22, C.R.S.

T. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

U. INSTITUTION means a hospital, nursing facility, or ICF-IID for which the Department makes Medicaid payments under the state plan.

V. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a publicly or privately operated facility that provides health and habilitation services to a Client with developmental disabilities or related conditions.

W. LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse

X. LEVEL OF CARE (LOC) means the specified minimum amount of assistance a Client must require in order to receive services in an institutional setting under the Medicaid State Plan.

Y. LEVEL OF CARE SCREEN means as defined in Section 8.391.1.

Z. LICENSED MEDICAL PROFESSIONAL means a person who has completed a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is limited to those who possess the following medical licenses: physician, physician assistant and nurse governed by the Colorado Medical License Act and the Colorado Nurse Practice Act.

AA. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities.

BB. MEDICAID ELIGIBLE means the Applicant or Client meets the criteria for Medicaid benefits based on the Applicant's financial determination and disability determination when applicable.

CC. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

DD. MEDICATION ADMINISTRATION means assisting a Client in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

EE. NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur in the Client's everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

FF. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts

with other qualified providers to furnish services authorized in Home and Community Services for persons with Developmental Disabilities (HCBS-DD), HCBS- Supported Living Services (HCBS-SLS) and HCBS- Children's Extensive Supports (HBCS-CES) waivers.

GG. PERSON-CENTERED SUPPORT PLAN (PCSP) means as defined in Section 8.390.1 DEFINITIONS.

HH. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the Case Management Agency.

II. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means as defined in Section 8.390.1 DEFINITIONS.

JJ. PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in Section 8.600.4 *et seq.*, that has received program approval to provide HCBS-CES waiver services.

KK. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or common law marriage.

LL. RETROSPECTIVE REVIEW means the Department or the Department's contractor review after services and supports are provided to ensure the Client received services according to the PCSP and that the Case Management Agency complied with the requirements set forth in statue, waiver and regulation.

MM. SUPPORT is any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

NN. TARGETED CASE MANAGEMENT (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 *et seq*, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; Assessment and periodic Reassessment, development and periodic revision of a PCSP, referral and related activities, and monitoring.

OO. THIRD PARTY RESOURCES means services and supports that a Client may receive from a variety of programs and funding sources beyond natural supports or Medicaid. They may include, but are not limited to community resources, services provided through private insurance, non-profit services and other government programs.

PP. UTILIZATION REVIEW CONTRACTOR (URC) means the agency contracted with the Department to review the HCBS-CES waiver applications for determination of eligibility based on the additional targeting criteria.

QQ. WAIVER SERVICE means optional services defined in the current federally approved waivers and do not include Medicaid State Plan benefits.

8.503.30 CLIENT ELIGIBILITY

A. To be eligible for the HCBS-CES waiver, an individual shall meet the target population criteria as follows:

1. Is unmarried and less than eighteen years of age,

2. Be determined to have a Developmental Disability which includes Developmental Delay if under five (5) years of age,

3. Can be safely served in the community with the type and amount of HCBS-CES waiver services available and within the federally approved capacity and Cost Containment limits of the HCBS-CES waiver,

4. Meet ICF-IID Level of Care as determined by the LOC Screen.

5. Meet the Medicaid financial determination for Long-term Care (LTC) eligibility as specified at Section 8.100 *et seq.* and,

6. Reside in an eligible HCBS-CES waiver setting as defined as the following:

   a. With biological, adoptive parent(s), or legal Guardian,

   b. In an out-of-home placement and can return home with the provision of HCBS-CES waiver services with the following requirement:

      i. The case manager will work in conjunction with the residential caregiver to develop a transition plan that includes timelines and identified services or Supports requested during the time the Client is not residing in the Family home. The case manager will submit the transition plan to the Department for approval prior to the start of services.

7. Be determined to meet the Federal Social Security Administration's definition of disability,

8. Be determined by the Department or its agent to meet the additional targeting criteria eligibility for HCBS-CES waiver. The additional targeting criterion includes the following:

   a. The individual demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically Age Appropriate and due to one or more of the following conditions:

      i. A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life-threatening condition or situation. Significant pattern is defined as the behavior or medical condition that is harmful to self or others as evidenced by actual events occurring within the past six (6) months,

      ii. A significant pattern of serious aggressive behavior toward self, others or property. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events occurring within the past six (6) months, or

iii. Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers. The term constant is defined as on the average of fifteen (15) minutes each waking hour.

b. In the instance of an annual Reassessment, the Reassessment must demonstrate in the absence of the existing interventions or preventions provided through Medicaid that the intensity and frequency of the behavior or medical condition would resume to a level that would meet the criterion listed above.

B. The Client shall maintain eligibility by meeting the HCBS-CES waiver eligibility as set forth in Section 8.503 and the following:

1. Receives at least one (1) HCBS-CES waiver service each calendar month,

2. Is not simultaneously enrolled in any other HCBS waiver, and

3. Is not residing in a hospital, nursing facility, ICF-IID, other Institution or correctional facility.

8.503.60 WAITING LIST PROTOCOL

A. When the HCBS-CES waiver reaches capacity for enrollment, a Client determined eligible for HCBS-CES waiver benefits shall be placed on a statewide waiting list in accordance with these rules and the Department's procedures.

1. The Community Centered Board shall determine if an Applicant has Developmental Delay if under age five (5), or Developmental Disability if over age five (5) , prior to submitting the HCBS-CES waiver application to the Department or its agent. Only a Client who is determined to have a Developmental Delay or Developmental Disability may apply for HCBS-CES waiver.

2. In the event a Client who has been determined to have a Developmental Delay is placed on the wait list prior to age five (5), and that Client turns five (5) while on the HCBS-CES waiver wait list, a determination of Developmental Disability must be completed in order for the Client to remain on the wait list.

3. The Case Management Agency shall complete the LOC Screen as defined in Department rules, to determine the Client's Level of Care.

4. The Case Management Agency shall complete the HCBS-CES waiver application (for use with the ULTC 100.2 only) with the participation of the Family. The completed application and a copy of the LOC Screen that determines the Client meets the ICF-IID Level of Care shall be submitted to the Department or its agent within fourteen (14) calendar days of parent signature.

5. Supporting documentation provided with the HCBS-CES waiver application shall not be older than six (6) months at the time of submission to the Department or its agent.

6. The Department or its agent shall review the HCBS-CES waiver application. In the event the Department or its agent needs additional information; the Case Management Agency shall respond within two (2) business days of request.

7. Any Client determined eligible for services under the HCBS-CES waiver when services are not immediately available within the federally approved capacity limits of the HCBS-CES waiver, shall be eligible for placement on a single statewide waiting list in the order

in which the Department or its agent received the eligible HCBS-CES waiver application. Applicants denied program enrollment shall be informed of the Client's appeal rights in accordance with Section 8.057.

8. The Case Management Agency will create or update the consumer record to reflect the Client is waiting for the HCBS-CES waiver with the waiting list date as determined by the Department or its agent.

8.503.70 ENROLLMENT

A. When an opening becomes available for an initial enrollment to the HCBS-CES waiver it shall be authorized in the order of placement on the waiting list. Authorization shall include an initial enrollment date and the end date for the initial enrollment period.

1. The Case Management Agency shall complete the HCBS-CES waiver application (with ULTC 100.2 only) and the LOC Screen in the Family home with the participation of the Family. The completed application, as applicable, and a copy of the LOC Screen shall be submitted to the Department or its agent within thirty (30) days of the authorized initial enrollment date.

a. If it has been less than six (6) months since the review to determine waiting list eligibility by the URC and there has been no change in the Client's condition, the Case Management Agency shall complete the LOC Screen and the parent may submit a letter to the Case Management Agency in lieu of the HCBS-CES waiver application stating there has been no change.

b. If there has been any change in the Client's condition the Case Management Agency shall complete a LOC Screen and the HCBS-CES waiver application, as applicable, which shall be submitted to the Department or its agent.

2. Services and Supports shall be implemented pursuant to the PCSP within 90 days of the parent or Guardian signature.

3. All continued stay review enrollments shall be completed and submitted to the Department or its agent at least thirty (30) days and not more than ninety (90) days prior to the end of the current enrollment period.

8.503.80 CLIENT RESPONSIBILITIES

A. The parent or legal Guardian of a Client is responsible to assist in the enrollment of the Client and cooperate in the provision of services. Failure to do so shall result in the Client's termination from the HCBS-CES waiver. The parent or legal Guardian shall:

1. Provide accurate information regarding the Client's ability to complete activities of daily living, daily and nightly routines and medical and behavioral conditions;

2. Cooperate with providers and Case Management Agency requirements for the HCBS-CES waiver enrollment process, Reassessment process and provision of services;

3. Cooperate with the local Department of Human Services in the determination of financial eligibility;

4. Complete the HCBS-CES waiver application with fifteen (15) calendar days of the authorized initial enrollment date as determined by the HCBS-CES waiver coordinator or

in the event of a Reassessment, at least thirty (30) days prior to the end of the current certification period;

5. Complete the PCSP within thirty (30) calendar days of determination of HCBS-CES waiver additional targeting criteria eligibility as determined by the Department or its agent.

6. Notify the case manager within thirty (30) days after changes:

    a. In the Client's Support system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements or ICF-IID placements;

    b. That may affect Medicaid financial eligibility such as prompt report of changes in income or resources;

    c. When the Client has not received an HCBS-CES waiver service for one calendar month;

    d. In the Client's care needs; and,

    e. In the receipt of any HCBS-CES waiver services.

8.504 HOME AND COMMUNITY BASED SERVICES for CHILDREN WITH LIFE LIMITING ILLNESS WAIVER

8.504.05 Legal Basis

The Home and Community-based Services for Children with Life Limiting Illness program (HCBS-CLLI) in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CLLI program is also authorized under state law at Section 25.5-5-305 C.R.S.

8.504.1 DEFINITIONS

A. Assessment shall be as defined at Section 8.390.1.DEFINITIONS.

B. Bereavement Counseling means counseling provided to the Client and/or family members in order to guide and help them cope with the Client's illness and the related stress that accompanies the continuous, daily care required by a child with a life-threatening condition. Enabling the Client and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies.

C. Case Management means as defined in Section 8.390.1 DEFINITIONS.

D. Continued Stay Review (CSR) means a Reassessment as defined in Section 8.390.1 DEFINITIONS.

E. Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital.

F. Curative Treatment means medical care or active treatment of a medical condition seeking to affect a cure.

G. Expressive Therapy means creative art, music or play therapy which provides children the ability to creatively and kinesthetically express their medical situation for the purpose of allowing the Client to express feelings of isolation, to improve communication skills, to decrease emotional suffering due to health status, and to develop coping skills.

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

I. Level of Care Screen means as defined in Section 8.391.1.

J. Life Limiting Illness means a medical condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the child reaches adulthood at age 19.

K. Massage Therapy means the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension.

L. Palliative/Supportive Care is a specific program offered by a licensed health care facility or provider that is specifically focused on the provision of organized palliative care services. Palliative care is specialized medical care for people with life limiting illnesses. This type of care is focused on providing Clients with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. The goal is to improve the quality of life for both the Client and the family. Palliative care is appropriate at any age (18 and under for this waiver) and at any stage in a life limiting illness and can be provided together with curative treatment. The services are provided by a Hospice or Home Care Agency who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss. For the purpose of this waiver, Palliative Care includes Care Coordination and Pain and Symptom Management.

1. Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the Client and central coordination of medical and psychological services. The Care Coordinator will organize the multifaceted array of services. This approach will enable the Client to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. Additionally, a key function of the Care Coordinator will be to assume the majority of responsibility, otherwise placed on the parents, for condensing, organizing, and making accessible to providers, critical information that is related to care and necessary for effective medical management. The activities of the Care Coordinator will allow for a seamless system of care. Care Coordination does not include utilization management, that is review and authorization of service requests, level of care determinations, and waiver enrollment, provided by the case manager at the Single Entry Point.

2. Pain and Symptom Management means nursing care in the home by a registered nurse to manage the Client's symptoms and pain. Management includes regular, ongoing pain and symptom assessments to determine efficacy of the current regimen and available options for optimal relief of symptoms. Management also includes as needed visits to provide relief of suffering, during which, nurses assess the efficacy of current pain management and modify the regimen if needed to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological and complementary/supportive therapies.

M. Person-Centered Support Planning means as defined in Section 8.390.1 DEFINITIONS.

Prior Authorization Request (PAR) means the Department's prescribed form to authorize services.

N. Professional Medical Information Page (PMIP) means as defined in Section 8.390.1 DEFINITIONS.

O. Respite Care means services provided to an eligible Client who is unable to care for himself/herself on a short-term basis because of the absence or the need for relief of those persons normally providing care. Respite Care may be provided through different levels of care depending upon the needs of the Client. Respite care may be provided in the Client's residence, in the community, or in an approved respite center location.

P. Therapeutic Life Limiting Illness Support means grief/loss or anticipatory grief counseling that assist the Client and family to decrease emotional suffering due to the Client's health status, to decrease feelings of isolation or to cope with the Client's life limiting diagnosis. Support is

intended to help the child and family in the disease process. Support is provided to the Client to decrease emotional suffering due to health status and develop coping skills. Support is provided to the family to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for limited lifespan, surrounding the failing health status of the Client, and impending death of a child. Support is provided to the Client and/or family members in order to guide and help them cope with the Client's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Support will include but is not limited to counseling, attending physician visits, providing emotional support to the family/caregiver if the child is admitted to the hospital or having stressful procedures, and connecting the family with community resources such as funding or transportation.

Q. Utilization Review means approving or denying admission or continued stay in the waiver based on level of care needs, clinical necessity, amount and scope, appropriateness, efficacy or efficiency of health care services, procedures or settings.

8.504.5 WAIT LIST

8.504.5.A. The number of Clients who may be served through the waiver at any one time during a year shall be limited by the federally approved HCBS-CLLI waiver document.

8.504.5.B. Applicants who are determined eligible for benefits under the HCBS-CLLI waiver, who cannot be served within the capacity limits of the federally approved waiver, shall be eligible for placement on a wait list maintained by the Department.

8.504.5.C. The SEP case manager shall ensure the Applicant meets all criteria as set forth in Section 8.504.4.A prior to notifying the Department to place the Applicant on the wait list.

8.504.5.D. The SEP case manager shall enter the Client's LOC Screen and Professional Medical Information Page data in the IMS and notify the Department by sending the Client's enrollment information, utilizing the Department's approved form, to the program administrator.

8.504.5.E. The date and time of notification from the SEP case manager shall be used to establish the order of an Applicant's place on the wait list.

8.504.5.F. Within five working days of notification from the Department that an opening for the HCBS-CLLI waiver is available, the SEP case manager shall:

1. Reassess the Applicant for level of care using the Department prescribed Level of Care Screen if the date of the last assessment is more than six months old.

2. Update the current LOC Screen if the date is less than six months old.

3. Reassess for the target population criteria.

4. Notify the Department of the Applicant's eligibility status.

8.506 CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM

8.506.1 Legal Basis:

The Children's Home and Community -based Services program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CHCBS program is also authorized under state law at Section 25.5-6-901, et seq. C.R.S.

8.506.2 Definitions of Services Provided

8.506.2.A Case Management means services as defined at Section 8.390.1 DEFINITIONS and the additional operations specifically defined for this waiver in Section 8.506.4.B.

8.506.2.B In Home Support Services (IHSS) means services as defined at Section 8.506.4.C and Section 8.552

8.506.3 General Definitions

A. Assessment means as defined at Section 8.390.1.DEFINITIONS.

B. Case Management Agency (CMA) means a public, private, or non-governmental non-profit agency.

C. Continued Stay Review means Reassessment as defined in Section 8.390.1 DEFINITIONS.

D. Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital or skilled nursing facility.

E. County Department means the Department of Human or Social Services in the county where the resident resides.

F. Department means the Department of Health Care Policy and Financing.

G. Extraordinary Care means an activity that a parent or guardian would not normally provide as part of a normal household routine.

H. Institutional Placement means residing in an acute care hospital or nursing facility.

I. Intake/Screening/Referral means the initial contact with individuals by the Case Management Agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term services and supports; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive functional assessment of the individual seeking services.

J. Level of Care Screen means as defined in Section 8.390.1.

K. Level of Care Eligibility Determination means as defined in Section 8.390.1.

L. Performance and Quality Review means a review conducted by the Department or its contractor at any time to include a review of required case management services performed by a Case

Management Agency to ensure quality and compliance with all statutory and regulatory requirements.

M. Person-Centered Support Planning means as defined in Section 8.390.1 DEFINITIONS.

N. Prior Authorization Request (PAR) means the Department prescribed form to authorize delivery and utilization of services.

O. Professional Medical Information Page (PMIP) means as defined in Section 8.390.1 DEFINITIONS.

P. Targeting Criteria means the criteria set forth in Section 8.506.6.A.1

Q. Utilization Review Contractor (URC) means the agency or agencies contracted with the Department to review the CHCBS waiver application for confirmation that Level of Care eligibility and targeting criteria are met.

8.506.4 Benefits

8.506.4.A Home and Community-based Services under the CHCBS waiver shall be provided within Cost Containment, as demonstrated in Section 8.506.12.

8.506.4.B Case Management:

1. Case Management Agencies must follow requirements and regulations in accordance with state statutes on Confidentiality of Information at Section 26-1-114, C.R.S.

2. Case Management Agencies will complete all administrative functions of a Client's benefits as described in HCBS-EBD Case Management Functions, Section 8.486.

3. Initial Referral:

    a. The Case Management Agency shall begin assessment activities within ten (10) calendar days of receipt of Client's information. Assessment activities shall consist of at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g., natural disaster, pandemic, etc.

    b. At the time of making the initial in person contact with the child and their parent/guardian, assess child's health and social needs to determine whether or not program services are both appropriate and cost effective. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g., natural disaster, pandemic, etc.

    c. Inform the parent(s) or guardian of the purpose of the Children's HCBS Waiver Program, the eligibility process, documentation required, and the necessary agencies to contact. Assist the parent(s) or guardian in completing the identification information on the assessment form.

d. Verify that the child meets the eligibility requirements outlined in Client Eligibility, Section 8.506.6.

e. Submit the LOC Screen and documentation to the URC to ensure the targeting criteria and level of care eligibility criteria are met. Minimum documents required:

ii. Department prescribed Professional Medical Information Page

f. Submit a copy of the Level of Care Determination to the County Department for activation of a Medicaid State Identification Number.

g. Develop the Person-Centered Support Plan in accordance with Section 8.506.4.B.7.

i. Following issuance of a Medicaid ID, submit a Prior Authorization Request in accordance with Section 8.506.10.

4. Continued Stay Review

a. Complete a LOC Screen Reassessment of each child, at a minimum, every twelve (12) months and before the end of the eligibility period approved. Upon Department approval, assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose documented safety risk to the case manager or Client (e.g., natural disaster, pandemic, etc.).

b. Submit the LOC Screen and documentation to the URC to ensure the targeting criteria and Level of Care eligibility criteria are met.

c. Review and revise the Person-Centered Support Plan document in accordance with Section 8.506.4.B.7.

d. Notify the county technician of the renewed Long-term Care certification.

5. Discharge/Withdrawal

a. At the time that the Client no longer meets all of the eligibility criteria outlined in Section 8.506.6 or chooses to voluntarily withdraw, the case management agency will:

i. Provide the child and their parent/guardian with a notice of action, on the Department designated form, within ten (10) calendar days before the effective date of discharge.

iii. Submit PAR termination to the Department's Fiscal Agent.

iv. Notify County Department of termination.

v. Notify agencies providing services to the Client that the child has been discharged from the waiver.

6. Transfers

a. Sending agency responsibilities:

i. Contact the receiving case management agency by telephone and provide notification that:

1) The child is planning to transfer, per the parent(s) or guardian choice.

2) Negotiate an appropriate transfer date.

3) Forward the case file, and other pertinent records and forms, to the receiving case management agency within five (5) working days of the child's transfer.

ii. Using a State designated form, notify the URC of the transfer within thirty (30) calendar days that includes the effective date of transfer, and the receiving case management agency.

iii. If the transfer is inter-county, notify the income maintenance technician to follow inter-county transfer procedures in accordance with the Colorado Department of Human Services, Income Maintenance Staff Manual 9 CCR 2503-5 Section 3.560 Case Transfers.

This rule incorporates by reference the Colorado Department of Human Services, Income Maintenance Staff Manual, Case Transfer Section at 9 CCR 2503-5, Section 3.560 is available at Pursuant to Section 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

b. Receiving agency responsibilities

i. Conduct an in person visit with the child within ten (10) working days of the child's transfer. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g., natural disaster, pandemic, etc.)., and

ii. Review and revise the Person-Centered Support Plan and change or coordinate services and providers as necessary.

8.506.6 Client Eligibility

8.506.6.A An eligible Client shall meet the following requirements:

1. Targeting Criteria:

a. Not have reached his/her eighteenth (18th) birthday.

b. Living at home with parent(s) or guardian and, due to medical concerns, is at risk of institutional placement and can be safely cared for in the home.

c. The child's parent(s) or guardian chooses to receive services in the home or community instead of an institution.

d. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs.

2. Level of Care Eligibility:

a. The URC certifies, through the Case Management Agency completed LOC Screen, that the child meets the Department's established minimum criteria for hospital or skilled nursing facility levels of care.

3. Enrollment of a child is cost effective to the Medicaid Program, as determined by the State as outlined in section 8.506.12.

4. Receive a waiver benefit, as defined in 8.506.2, on a monthly basis.

8.506.7 Waiting List

8.506.7.A The number of Clients who may be served through the CHCBS waiver during a fiscal year shall be limited by the federally approved waiver.

8.506.7.B Individuals who meet eligibility criteria for the CHCBS waiver and cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.

8.506.7.C The waiting list shall be maintained by the URC.

8.506.7.D The date that the Case Manager determines a child has met all eligibility requirements as set forth in Sections 8.506.6.A and 8.506.6.B is the date the URC will use for the individual's placement on the waiting list.

8.506.7.E When an eligible individual is placed on the waiting list for the CHCBS waiver, the Case Manager shall provide a written notice of the action in accordance with section 8.057 et seq.

8.506.7.F As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for CHCBS services in the order of the individual's placement on the waiting list.

8.506.7.G When an opening for the CHCBS waiver becomes available the URC will provide written notice to the Case Management Agency.

8.506.7.H Within ten business days of notification from the URC that an opening for the CHCBS waiver is available the Case Management Agency shall:

1. Reassess the individual using the Department's prescribed LOC Screen instrument if more than six months has elapsed since the previous assessment.

2. Update the existing Level of Care Screen in the official Client record.

3. Reassess for eligibility criteria as set forth at 8.506.6.

4. Notify the URC of the individual's eligibility status.

8.506.7.I A child on the waitlist shall be prioritized for enrollment onto the waiver if they meet any of the following criteria:

1. Have been in a hospital for 30 or more days and require waiver services in order to be discharged from the hospital.

2. Are on the waiting list for an organ transplant.

3. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.

4. Have received a terminally ill prognosis from their physician.

8.506.7.J Documentation that a child meets one or more of these criterion shall be received by the child's case manager prior to prioritization on the waiting list.

8.506.10 Prior Authorization Requests

8.506.10.A The Case Manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the waiver.

8.506.10.B All units of service requested shall be listed on the Person-Centered Support Plan.

8.506.10.C The first date for which services can be authorized is the latest date of the following:

1. The financial eligibility start date, as determined by the financial eligibility site.

2. The assigned start date on the Level of Care Eligibility Determination.

3. The date, on which the Client's parent(s) and/or legal guardian signs the Person-Centered Support Plan or Intake form, as prescribed by the Department, agreeing to receive services.

8.506.10.D The PAR shall not cover a period of time longer than the certification period assigned on the Level of Care Eligibility Determination.

8.506.10.E The Case Manager shall submit a revised PAR if a change in the Person-Centered Support Plan results in a change in services.

8.506.10.F The revised Person-Centered Support Plan shall list the service being changed and state the reason for the change. Services on the revised Person-Centered Support Plan, plus all services on the original document, shall be entered on the revised PAR.

8.506.10.G Revisions to the Person-Centered Support Plan requested by providers after the end date on a PAR shall be disapproved.

8.506.10.H The Long-Term Care Notice of Action Form (LTC-803) shall be completed in the Information Management System (IMS), as defined in Section 8.390.1 DEFINITIONS for all applicable programs at the time of initial eligibility, when there is a significant change in the individual's payment or services, an adverse action, or at the time of discontinuation.

8.508 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM

8.508.10 LEGAL BASIS

The Home and Community based Services- Children's Habilitation Residential Program (HCBS-CHRP) is authorized by waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. § 1396a. The waiver is granted by the United States Department of Health and Human Services under Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n.

8.508.20 DEFINITIONS

A. Abuse: As defined at § 16-22-102 (9) C.R.S., § 19-1-103, C.R.S., § 25.5-10-202 (1) (a)-(c), C.R.S., and § 26.3.1-101 C.R.S.

B. Adverse Action: A denial, reduction, termination, or suspension from a Long-Term Services and Supports (LTSS) program or service.

C. Applicant: A child or youth who is seeking a Long-Term Care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

D. Assessment: As defined in Section 8.390.1 DEFINITIONS.

E. Caretaker: As defined at Section 25.5-10-202 (1.6)(a)-(c), C.R.S.

F. Caretaker neglect: As defined at Section 25.5-10-202 (1.8)(a)-(c), C.R.S.

G. Case Management Agency (CMA): A public or private not-for-profit for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-based Services waivers pursuant to sections 25.5-10-209.5 C.R.S. and pursuant to a provider participation agreement with the state department.

H. Child Placement Agency: As defined at 12 CCR 2509-8; Section 7.701.2 (F).

I. Client: A child or youth who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-based Services (HCBS)

J. Client Representative: A person who is designated to act on the Client's behalf. A Client Representative may be: (a) a legal representative including, but not limited to a court-appointed guardian, or a parent of a minor child; or (b) an individual, family member or friend selected by the Client to speak for an/or act on the Client's behalf.

K. Community Centered Board: A private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-based Service waivers specific to individuals with intellectual and developmental disabilities, and management of state funded programs for individuals with intellectual and developmental disabilities.

L. Complex Behavior: Behavior that occurs related to a diagnosis by a licensed physician, psychiatrist, or psychologist that includes one or more substantial disorders of the cognitive, volitional or emotional process that grossly impairs judgment or capacity to recognize reality or to control behavior.

M. Complex Medical Needs: Needs that occur as a result of a chronic medical condition as diagnosed by a licensed physician that has lasted or is expected to last at least twelve (12) months, requires skilled care, and that without intervention may result in a severely life altering condition.

N. Cost Containment: Limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community-based Services, and Medicaid State Plan benefits including long- term home health services and targeted case management.

O. Criminal Activity: A criminal offense that is committed by a person; a violation of parole or probation; and any criminal offense that is committed by a person receiving services that results in immediate incarceration.

P. Crisis: An event, series of events, and/or state of being greater than normal severity for the Client and/or family that becomes outside the manageable range for the Client and/or their family and poses a danger to self, family, and/or the community. Crisis may be self-identified, family identified, and/or identified by an outside party.

Q. Critical Incident: Incidents of Mistreatment; Abuse; Neglect; Exploitation, Criminal Activity; Damage to Client's Property/Theft; Death unexpected or expected; Injury/Illness to Client; Medication Mismanagement; Missing Person; Unsafe Housing/Displacement; and/or Other Serious Issues.

R. Department: The Colorado Department of Health Care Policy and Financing the single state Medicaid agency.

S. Damage to Client's Property/Theft: Deliberate damage, destruction, theft or use a Client's belongings or money. If the incident involves Mistreatment by a Caretaker that results in damage tor Client's property or theft in the incident shall be listed as Mistreatment.

. Developmental Delay: A child who is:

1. Birth up to age five (5) and has a developmental delay defined as the existence of at least one of the following measurements:

    i. Equivalence of twenty-five percent (25%) or greater delay in one (1) or more of the five domains of development when compared with chronological age;

    ii. Equivalence of 1.5 standard deviations or more below the mean in one (1) or more of the five domains of development;

    iii. Has an established condition defined as a diagnosed physical or mental condition that, as determined by a qualified health professional utilizing appropriate diagnostic methods and procedures, has a high probability of resulting in significant delays in development, or

2. Birth up to age three (3) who lives with a parent who has been determined to have a developmental disability by a CCB.

T. Early and Periodic Screening Diagnosis and Treatment (EPSDT): As defined in Section 8.280.1.

U. Exploitation: As defined in Sections 25.5-10-202(15.5)(a)-(d) and 26.3.1-101 C.R.S.

V. Extraordinary Needs: A level of care due to Complex Behavior and/or Medical Support Needs that is provided in a residential child care facility or that is provided through community-based programs, and without such care, would place a child at risk of unwarranted child welfare involvement or other system involvement.

W. Family: As defined at Section 25.5-10-202 (16)(a)(I)-(IV)(b), C.R.S.

X. Foster Care Home: A family care home providing 24-hour care for a child or children and certified by either a County Department of Social/Human Services or a child placement agency. A Foster Care Home, for the purposes of this waiver, shall not include a family member as defined in Section 25.10-202 (16)(a)(I)-(IV)(b), C.R.S.

Y. Guardian: An individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a court. Guardianship may include a limited, emergency, and temporary substitute court appointed guardian but not guardian ad litem.

Z.. Guardian ad litem or GAL: A person appointed by a court to act in the best interests of a child involved in a proceeding under Title 19, C.R.S., or the "School Attendance Law of 1963", set forth in Article 33 of Title 22, C.R.S.

AA. Harmful Act: as defined at Section 25.5-10-202 (18.5) and 26.3.1-101 C.R.S.

BB. Home and Community-based Services (HCBS) Waivers: Services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

CC. Increased Risk Factors: Situations or events that when occur at a certain frequency or pattern historically have led to Crisis.

DD. Informed Consent: An assent that is expressed in writing, freely given, and preceded by the following:

1. A fair explanation of the procedures to be followed, including an identification of those which are experimental;

2. A description of the attendant discomforts and risks;

3. A description of the expected benefits;

4. A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts and risks;

5. An offer to answer any inquiries regarding the procedure(s);

6. An instruction that the person giving consent is free to withdraw such consent and discontinue participation in the project or activity at any time; and,

7. A statement that withholding or withdrawal of consent shall not prejudice future availability of services and supports.

EE. Injury/Illness to Client: An injury or illness that requires treatment beyond first aid which includes lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, and skin wounds; an injury or illness requiring immediate emergency medical treatment to preserve

life or limb; an emergency medical treatment that results in admission to the hospital; and a psychiatric crisis resulting in unplanned hospitalization.

FF. Institution: A hospital, nursing facility, or ICF-IID for which the Department makes Medicaid payments under the State Plan.

GG. Intellectual and Developmental Disability: A disability that manifests before the person reaches twenty-two (22) years of age, that constitutes a substantial disability to the affected person, and that is attributable to an intellectual and developmental disability or related conditions, including Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when the condition or conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of “developmental disability” found in 42 U.S.C. sec. 15001 et seq., does not apply.

“Impairment of general intellectual functioning” The person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. when an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.

“Adaptive behavior similar to that of a person with intellectual and developmental disabilities” The person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. These adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.

“Substantial intellectual deficits” An intellectual quotient that is between 71 and 75 assuming a scale with a mean of 100 and a standard deviation of 15, as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

HH. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID): A publicly or privately-operated facility that provides health and habilitation services to a Client with intellectual or developmental disabilities or related conditions.

II. Kin: As defined in 12 CCR 2509-1, Section 7.000.2.A.

JJ. Kinship Foster Care Home: As defined in 12 CCR 2509-1, Section 7.000.2.A.

KK. Level of Care (LOC): The specified minimum amount of assistance a Client must require in order to receive services in an institutional setting under the Medicaid State Plan.

LL. Level of Care Eligibility Determination: As defined in Section 8.390.1.

MM. Level of Care Eligibility Determination Screen: As defined in Section 8.390.1.

NN. Licensed Child Care Center (less than 24 hours): As defined in Section 26-6-102 (5), C.R.S. and as described in 12 CCR 2509-8; Section 7.701.

OO. Licensed Medical Professional: A physician, physician assistant, registered nurse, and advanced practice nurse. Long-Term Services and Supports (LTSS): The services and supports used by Clients of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

PP. Medicaid Eligible: The Applicant or Client meets the criteria for Medicaid benefits based on the financial determination and disability determination.

QQ. Medicaid State Plan: The federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

RR. Medication Mis-Management: Issues with medication dosage, scheduling, timing, set-up, compliance and administration or monitoring which results in harm or an adverse effect which necessitates medical care.

SS. Missing Person: A waiver participant is not immediately found, their safety is at serious risk, or there is a risk to public safety.

TT. “Mistreated” or “Mistreatment”: As defined at Section 25.5-10-202(29.5)(a)-(d) and 26.3.1-101.

UU. Natural Supports: Unpaid informal relationships that provide assistance and occur in the Client’s everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

VV. Other Serious Issues: Incidents that do not fall into one of the Critical Incident categories.

WW. Predictive Risk Factors: Known situations, events, and characteristics that indicate a greater or lesser likelihood of success of Crisis interventions.

XX. Prior Authorization: Approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the CMA.

YY. Professional: Any person, not including family, performing an occupation that is regulated by the State of Colorado and requires state licensure and/or certification.

ZZ. Professional Medical Information Page (PMIP): as defined in Section 8.390.1 DEFINITIONS.

AAA. Relative: A person related to the Client by blood, marriage, adoption or common law marriage.

BBB. Residential Child Care Facility: As defined in 12 CCR 2509-8, Section 7.705.1.

CCC. Retrospective Review: The Department’s review after services and supports are provided to ensure the Client received services according to the PCSP and standards of economy, efficiency and quality of service.

DDD. Separation: The restriction of a Client for a period of time to a designated area from which the is not physically prevented from leaving, for the purpose of providing the Client an opportunity to regain self-control.

EEE. Service Provider: A Specialized Group Facility, Residential Child Care Facility, Foster Care Home, Kinship Foster Care Home, Child Placement Agency, Licensed Child Care Facility (non-24 hours), and/or Medicaid enrolled provider.

FFF. Person-Centered Support Plan (PCSP): Defined in Section 8.390.1 DEFINITIONS.

GGG. Person-Centered Support Planning (PCSP): Defined in Section 8.390.1 DEFINITIONS.

HHH. Specialized Group Facility: As defined in 12 CCR 2509-8; Section 7.701.2(B).

III. Support: Any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

JJJ. Support Level: A numeric value determined by the Support Need Level Assessment that places Clients into groups with other Clients who have similar overall support needs.

KKK. Support Need Level Assessment: The standardized assessment tool used to identify and measure the support requirements for HCBS-CHRP waiver participants.

LLL. Targeted Case Management (TCM): Has the same meaning as in Section 8.761.

MMM. Third Party Resources: Services and supports that a Client may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to community resources, services provided through private insurance, non-profit services and other government programs.

NNN. Unsafe Housing/Displacement: An individual residing in an unsafe living condition due to a natural event (such as fire or flood) or environmental hazard (such as infestation) and is at risk of eviction or homelessness.

OOO. Waiver Service: Optional services defined in the current federally approved waivers and do not include Medicaid State Plan benefits.

PPP. Wraparound Facilitator: A person who has a bachelor's degree in a human behavioral science or related field of study and is certified in a wraparound training program. Experience working with LTSS populations in a private or public social services agency may substitute for the bachelor's degree on a year for year basis. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field. The wraparound certification must include training in the following:

Trauma informed care.

Youth mental health first aid.

Crisis supports and planning.

Positive Behavior Supports, behavior intervention, and de-escalation techniques.

Cultural and linguistic competency.

Family and youth serving systems.

Family engagement.

Child and adolescent development.

Accessing community resources and services.

Conflict resolution.

Intellectual and developmental disabilities.

Mental health topics and services.

Substance abuse topics and services.

Psychotropic medications.

Motivational interviewing.

Prevention, detection, and reporting of Mistreatment, Abuse, Neglect, and Exploitation.

QQQ. Wraparound Transition Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a Client and his or her family, including a transition to the family home after out of home placement.

RRR. Wraparound Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a Client and his or her family, including a plan to maintain stabilization, prevent Crisis, and/or for de-escalation of Crisis situations.

SSS. Wraparound Support Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the Client and his or her family.

TTT. Wraparound Transition Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the Client and his or her family.

8.508.40 ELIGIBILITY

A. Services shall be provided to Clients with an Intellectual and Developmental Disability who meet all of the following eligibility requirements:

1. A determination of developmental disability by a CCB which includes developmental delay if under five (5) years of age.

2. The Client has Extraordinary Needs that put the Client at risk of, or in need of, out of home placement.

3. Meet ICF-IID Level of Care as determined by a LOC Screen.

4. The income of the Client does not exceed 300% of the current maximum SSI standard maintenance allowance.

5. Enrollment of the Client in the HCBS- CHRP waiver will result in an overall savings when compared to the ICF/IID cost as determined by the State.

6. The Client receives at least one waiver service each month.

B. A Support Need Level Assessment must be completed upon determination of eligibility. The Support Need Level Assessment is used to determine the level of reimbursement for Habilitation and per diem Respite services.

C. Clients must first access all benefits available under the Medicaid State Plan and/or EPSDT for which they are eligible, prior to accessing funding for those same services under the HCBS-CHRP waiver.

D. Pursuant to the terms of the HCBS-CHRP waiver, the number of individuals who may be served each year is based on:

1. The federally approved capacity of the waiver;

2. Cost Containment requirements under section 8.508.80;

3. The total appropriation limitations when enrollment is projected to exceed spending authority.

8.508.50 WAITING LIST PROTOCOL

A. Clients determined eligible for HCBS-CHRP services who cannot be served within the appropriation capacity limits of the HCBS-CHRP waiver shall be eligible for placement on a waiting list.

1. The waiting list shall be maintained by the Department.

2. The date used to establish the Client's placement on the waiting list shall be the date on which all other eligibility requirements at Section 8.508.40 were determined to have been met and the Department was notified.

3. As openings become available within the appropriation capacity limits of the federal waiver, Clients shall be considered for services based on the date of their waiting list placement.

8.508.60 RESPONSIBILITIES OF THE CCB

A. The CCB shall make eligibility determinations for developmental disabilities services to include the Level of Care Eligibility Determination for any Applicant or Client being considered for enrollment in the HCBS-CHRP waiver.

B. Additional administrative responsibilities of CCBs as required in 8.601.

8.508.70 CASE MANAGEMENT FUNCTIONS

A. Case management services will be provided by a CMA as a Targeted Case Management service pursuant to sections 8.761.14 and 8.519 and will include:

1. Completion of a LOC Screen

2. Completion of a Person-Centered Support Plan (PCSP);

3. Referral for services and related activities;

4. Monitoring and follow-up by the CMA including ensuring that the SP is implemented and adequately addresses the Client's needs.

5. Monitoring and follow-up actions, which shall

   a. Be performed when necessary to address health and safety and services in the PCSP;

   b. Services in the PCSP are adequate; and

   c. Necessary adjustments in the PCSP and service arrangements with providers are made if the needs of the Client have changed.

6. Face to face monitoring to be completed at least once per quarter and to include direct contact with the Client in a place where services are delivered. Upon Department approval, monitoring may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g., natural disaster, pandemic, etc.).

8.508.121 REASSESSMENT AND REDETERMINATION OF ELIGIBILITY

A. The CMA shall conduct a Level of Care Eligibility Determination and redetermine or confirm a Client's eligibility for the HCBS-CHRP waiver, at a minimum, every twelve (12) months.

B. The CMA shall conduct a LOC Screen to redetermine or confirm a Client's individual needs, at a minimum, every twelve (12) months.

C. The CMA shall verify that the child or youth remains Medicaid Eligible at a minimum, every twelve (12) months.

8.509 HOME AND COMMUNITY-BASED SERVICES FOR COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS)

8.509.10 GENERAL PROVISIONS

8.509.11 LEGAL BASIS

A. The Home and Community-based Services for COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS) program in Colorado is authorized by a waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CMHS program is also authorized under state law at Sections 25.5-6-601 through 25.5-6-607, C.R.S. The number of recipients served in the HCBS-CMHS program is limited to the number of recipients authorized in the waiver.

B. All congregate facilities where any HCBS Client resides must be in possession of a valid Assisted Living Residence license issued under Section 25-27-105, C.R.S., and regulations of the Colorado Department of Public Health and Environment at 6 CCR 1011-1, Chapters 2 and 7.

8.509.14 GENERAL DEFINITIONS

A. Assessment shall be defined as a Client evaluation according to requirements at Section 8.390.1 DEFINITIONS.

B. Case Management shall be defined as administrative functions performed by a case management agency according to requirements at Section 8.509.30.

C. Case Management Agency shall be defined as an agency that is certified and has a valid contract with the state to provide HCBS-CMHS case management.

D. Categorically Eligible, shall be defined in the HCBS-CMHS Program, as any person who is eligible for Medical Assistance (Medicaid), or for a combination of financial and Medical Assistance; and who retains eligibility for Medical Assistance even when the Client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, or persons who are eligible for HCBS-CMHS as three hundred percent eligible persons, as defined at 8.509.14.S.

E. Congregate Facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.

F. Uncertified Congregate Facility is a facility as defined in Section 8.509.14.G that is not certified as an Alternative Care Facility, which is defined at Section 8.495.1.

G. Continued Stay Review shall be defined as a Reassessment as defined in Section 8.390.1 and conducted as described at Section 8.402.60.

H. Cost Containment shall be defined at Section 8.485.50(I)

I. Department shall be defined as the State Agency designated as the Single State Medicaid Agency for Colorado, or another state agency operating under the authority of a memorandum of understanding with the Single State Medicaid Agency.

J. Deinstitutionalized shall be defined as waiver Clients who were receiving nursing facility services reimbursed by Medicaid, within forty-five (45) calendar days of admission to HCBS-CMHS waiver. These include hospitalized Clients who were in a nursing facility immediately prior to inpatient hospitalization and who would have returned to the nursing facility if they had not elected the HCBS-CMHS waiver.

K. Diverted shall be define as HCBS-CMHS waiver recipients who were not deinstitutionalized, as defined at Section 8.485.50(K).

L. Home and Community-based Services for Community Mental Health Supports (HCBS-CMHS) shall be defined as services provided in a home or community-based setting to Clients who are eligible for Medicaid reimbursement for long-term care, who would require nursing facility care without the provision of HCBS-CMHS, and for whom HCBS-CMHS services can be provided at no more than the cost of nursing facility care.

M. Intake/Screening/Referral shall be as defined at Section 8.390.1(M) and as the initial contact with Clients by the case management agency. This shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term care services; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive long-term care Client assessment.

N. Level Ff Care Screen shall be defined as an assessment conducted in accordance with Section 8.401.16

O. Non-Diversion shall be defined as a Client who was certified by the URC as meeting the Level of Care Screen and target group for the HCBS-CMHS program, but who did not receive HCBS-CMHS services for some other reason.

P. Person-Centered Support Plan shall be as defined in Section 8.390.1 DEFINITIONS.

Q. Provider Agency shall be defined as an agency certified by the Department and which has a contract with the Department, in accordance with Section 8.487, HCBS-EBD PROVIDER AGENCIES, to provide one of the services listed at Section 8.509.13. A case management agency may also become a provider if the criteria at Sections 8.390-8.393 and 8.487 are met.

R. Reassessment shall be as defined in Section 8.390.1 DEFINITIONS.

S. Three Hundred Percent (300%) Eligible persons shall be defined as persons:

1) Whose income does not exceed 300% of the SSI benefit level, and

2) Who, except for the level of their income, would be eligible for an SSI payment; and

3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program or are in a nursing facility or hospitalized for thirty (30) consecutive days.

8.509.15 ELIGIBLE PERSONS

A. HCBS-CMHS services shall be offered to persons who meet all of the eligibility requirements below:

1. Financial Eligibility

Clients shall meet the eligibility criteria as specified in 9 CCR 2503-5, and the Section 8.100.

2. Level of Care AND Target Group.

Clients who have been determined to meet the level of care AND target group criteria shall be determined by the Utilization Review Contractor (URC) as meeting the level of care eligibility for HCBS-CMHS. The URC shall only determine HCBS-CMHS eligibility for those Clients:

a. Determined to meet the target group definition, defined as a person experiencing a severe and persistent mental health need that requires assistance with one or more Activities of Daily Living (ADL);

i. A person experiencing a severe and persistent mental health need is defined as someone who:

1) Is 18 years of age or older with a severe and persistent mental health need; and

2) Currently has or at any time during the past year leading up to assessment has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM -5); and

a) Has a disorder that is episodic, recurrent, or has persistent features, but may vary in terms of severity and disabling effects; and

b) Has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

ii. A severe and persistent mental health need does not include:

1) Intellectual or developmental disorders; or

2) Substance use disorder without a co-occurring diagnosis of a severe and persistent mental health need.

b. Determined by a formal LOC Screen to require the level of care available in a nursing facility, according to Section 8.401.11-15; and

c. A length of stay shall be assigned by the URC for approved admissions, according to guidelines at Section 8.402.50.

3. Receiving Services

a. Only Clients who receive HCBS-CMHS services, or who have agreed to accept HCBS-CMHS services as soon as all other eligibility criteria have been met, are eligible for the HCBS-CMHS program.

b. Case management is not a service and shall not be used to satisfy this requirement.

c. Desire or need for home health services or other Medicaid services that are not HCBS-CMHS services, as listed at Section 8.509.12, shall not satisfy this eligibility requirement.

d. HCBS-CMHS Clients who have not received HCBS-CMHS services for thirty (30) days shall be discontinued from the program.

4. Institutional Status

a. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-CMHS services while residing in such institutions.

b. A Client who is already an HCBS-CMHS recipient and who enters a hospital may not receive HCBS-CMHS services while in the hospital. If the hospitalization continues for 30 days or longer, the case manager must terminate the Client from the HCBS-CMHS program.

c. A Client who is already an HCBS-CMHS recipient and who enters a nursing facility may not receive HCBS-CMHS services while in the nursing facility;

1) The case manager must terminate the Client from the HCBS-CMHS program if Medicaid pays for all or part of the nursing facility care, or if there is a LOC Eligibility Determination for the nursing facility placement, as verified by telephoning the URC.

2) A Client receiving HCBS-CMHS services who enters a nursing facility for Respite Care as a service under the HCBS-CMHS program shall not be required to obtain a nursing facility LOC Screen and shall be continued as an HCBS-CMHS Client in order to receive the HCBS-CMHS service of Respite Care in a nursing facility.

8.509.16 START DATE

The start date of eligibility for HCBS-CMHS services shall not precede the date that all of the requirements at Section 8.509.15, have been met. The first date for which HCBS-CMHS services can be reimbursed shall be the LATER of any of the following:

A. Financial The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.

B. Level of Care This date is determined by the official URC-assigned start date on the LOC Eligibility Determination.

C. Receiving Services This date shall be determined by the date on which the Client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept HCBS-CMHS services.

D. Institutional Status HCBS-CMHS eligibility cannot precede the date of discharge from the hospital or nursing facility.

8.509.30 CASE MANAGEMENT FUNCTIONS

8.509.31 NEW HCBS-CMHS CLIENTS

A. INTAKE/SCREENING/REFERRAL

1. Case management agency staff shall complete a State-prescribed Intake form in accordance with the Single Entry Point Intake Procedures at Section 8.393.2 for each potential HCBS-CMHS Applicant. The Intake form must be completed before an assessment is initiated. The Intake form may also be used as a preliminary case plan form when signed by the Applicant for purposes of establishing a start date. Additionally, at intake, Clients shall be offered an opportunity to identify a third party to receive Client notices. This information shall be included on the intake form. This designee shall be sent copies of all notices sent to Clients.

2. Case management agency staff shall verify the individual's current financial eligibility status or refer the Client to the county department of social services of the Client's county of residence for application. This verification shall include whether the Applicant is in a category of assistance that includes financial eligibility for long-term care.

3. Based upon information gathered on the Intake form, the case manager shall determine the appropriateness of a referral for a Level of Care Eligibility Determination Screen and shall explain the reasons for the decision on the Intake form. The Client shall be informed of the right to request an LOC Screen if the Client disagrees with the case manager's decision.

4. If the case management agency staff has determined that a LOC Screen is needed, or if the Client requests one a case manager shall be assigned to schedule the assessment.

B. ASSESSMENT

1. The SEP case manager shall complete the LOC Screen in accordance with Section .C-D

2. The URC/SEP case manager shall begin and complete the LOC Screen within ten (10) days of notification of Client's need for assessment.

3. The SEP case manager shall complete the following activities for a LOC Screen:

   a. Obtain all required information from the Client's medical provider including information required for target group determination;

   b. Determine the Client's level of care needs during a face-to-face interview, preferably with the observation of the Client in his or her residential setting. Upon Department approval, the assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.).;

   c. Determine the ability and appropriateness of the Client's caregiver, family, or others , to provide the Client assistance in activities of daily living;

   d. Determine the Client's service needs, including the Client's need for services not provided under HCBS-CMHS

   e. If the Client is a resident of a nursing facility, determine the feasibility of deinstitutionalization;

   f. Review service options based on the Client's needs, the potential funding sources, and the availability of resources;

g. Explore the Client's eligibility for publicly funded programs, based on the eligibility criteria for each program, in accordance with state rules;

h. View and document the current Assisted Living Residence license, if the Client lives, or plans to live, in a congregate facility as defined at Section 8.509.14in order to assure compliance with the regulation at Section 5.509.11(B).

i. Determine and document Client preferences in program selection;

j. Complete documentation on the LOC Screen.

k. To de-institutionalize a Client who is in a nursing facility under payment by Medicaid, and with an existing nursing facility Level of Care Eligibility Determination with a completion date older than six (6) months, , the URC/SEP case manager shall complete a new LOC Screen and determine whether the client continues to meet the nursing facility level of care. The nursing facility staff shall notify the URC/SEP agency of the planned date of discharge and shall assign a new length of stay for HCBS if eligibility criteria are met. If a client leaves a nursing facility, and no one has notified the URC/SEP agency of the client's intent to apply for HCBS-CMHS, the case manager must complete a new LOC Screen and the Client shall be treated as an Applicant from the community rather than as a de-institutionalized Client.

l. It is the URC/SEP case manager's responsibility to assess the behaviors of the Client and assure that community placement is appropriate.

C. HCBS-CMHS DENIALS AND/OR DISCONTINUATIONS

1. If a Client is determined, at any point in the level of care eligibility determination process, to be ineligible for HCBS-CMHS according to any of the requirements at Section 8.509.15, the case manager shall refer the Client or the Client's designated representative to other appropriate services. Clients who are denied HCBS-CMHS services shall be notified of denials and appeal rights as follows:

a. Financial Eligibility

The income maintenance technician at the county department of social services shall notify the Applicant of denial for reasons of financial eligibility and shall inform the Applicant of appeal rights in accordance with Sections 3.840 and 3.850 of the Colorado Department of Human Services' Staff Manual Volume III at 9 CCR 2503-1. The case manager shall not attend the appeal bearing for a denial based on financial eligibility, unless subpoenaed, or unless requested by the state.

b. Level of Care AND Target Group

The URC shall notify the Applicant of denial for reasons related to determination of level of care AND target group eligibility and shall inform the Applicant of appeal rights in accordance with Section 8.057. The case manager shall not make judgments as to eligibility regarding level of care or target group and shall refer all Applicants who request a URC review to the URC, independently of any action that may be taken by the case manager in regard to other eligibility requirements, in accordance with the rest of this section. The case manager shall not attend the appeal hearing for a denial based on level of care or target group determination, unless subpoenaed, or unless requested by the state.

c. Receiving Services

The case manager shall notify the Applicant of denial, on Department-prescribed form, when the case manager determines that the Applicant does not meet the HCBS-CMHS eligibility requirements at Section 8.509.15 and shall inform the Applicant of appeal rights in accordance with Section 8.057, et. seq. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

d. Institutional Status

The case manager shall notify the Applicant of denial, on a Department-prescribed form, when the case manager determines that the Applicant does not meet the eligibility requirement at Section 8.509.15 and shall inform the Applicant of appeal rights in accordance with Section 8.057, et. seq. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

e. Cost-effectiveness

The case manager shall notify the Applicant of denial, on Department-prescribed form, when the case manager determines that the Applicant does not meet the eligibility requirement 8.509.15 and shall inform the Applicant of appeal rights in accordance with Section 8.057, et.seq. The case manager shall also attend the appeal hearing to defend this denial action. If the Applicant requests to receive less than the needed amount of services in order to become cost-effective, the case manager must assess the safety of the Applicant, and the competency of the Applicant to choose to live in an unsafe situation. If the case manager determines that the Applicant will be unsafe with the amount of services available and is not competent to choose to live in an unsafe situation, the case manager may deny HCBS-CMHS eligibility. To support a denial for safety reasons related to cost-effectiveness, the case manager must document the results of an Adult Protective Services assessment, a statement from the Client's physician attesting to the Client's mental competency status, and all other available information which will support the determination that the Client is unsafe and incompetent to make a decision to live in an unsafe situation; and, which will satisfy the burden of proof required of file case manager making the denial. Denials and appeals for reasons of cost-effectiveness, or safety related to cost-effectiveness, are independent of any action that may be taken by the URC in regard to level of care and target group determination.

f. Waiver Cap

The case manager shall notify the Applicant of denial, on a Department-prescribed form, when the waiver cap limiting the number of Clients who may be served under the terms of the approved waiver has been reached.

8.509.32 ONGOING HCBS-CMHS CLIENTS

A. COORDINATION, MONITORING AND EVALUATION OF SERVICES

1. The coordination, monitoring, and evaluation of services for HCBS-CMHS Clients shall be in accordance with Section 8.393.2. In addition, the case manager shall:

a. Contact each Client quarterly, or more frequently, as determined by the Client's assessed needs. Contact may be at the Client's place of residence, by telephone, or other appropriate setting as determined by the Client's needs.

b. Review the LOC Screen and the PCSP with the client every six (6) months in person. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.).

2. The case manager shall refer the Client for mental health services taking into account Client choice. The case manager shall coordinate case management activities for those Clients who are receiving mental health services from the Behavioral Health Organizations (BHO).

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

a. Review of the Client's case plan and service agreements;

b. Contact with the Client concerning whether services are being delivered according to the plan; and the Client's satisfaction with services provided;

c. Contact with service providers concerning service delivery, coordination, effectiveness, and appropriateness;

d. Contact with appropriate parties in the event any issues or complaints have been presented by the Client or others;

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

f. Informal assessment of changes in Client functioning, service effectiveness, service appropriateness, and service cost-effectiveness;

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

h. Referral to community resources, and arrangement for non-HCBS-CMHS services, as needed.

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

5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment, or mis-utilization of any public assistance or Medicaid benefit. The case manager shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with the Colorado Department of Human Services' Staff Manual Volume 3, Section 3.810.

C. REASSESSMENT

1. The case manager shall complete a level of care Reassessment of each HCBS-CMHS Client before the end of the length of stay assigned by the URC at the Level of Care Eligibility Determination. The case manager shall initiate a Reassessment more frequently when warranted by significant changes that may affect HCBS-CMHS eligibility.

2. The case manager shall complete the Reassessment, utilizing the Department prescribed instrument.

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

    a. Verify continuing Medicaid eligibility, including verification of an aid category that includes eligibility for long-term care benefits;

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

    c. Evaluate continuing need for the HCBS-CMHS program, and clearly document reasons for continuing HCBS; or terminate the Client's eligibility according to Section 8.509.32(E);

    d. Ensure that all information needed from the medical provider for the LOC Screen is included.

    e. Reassess the Client's level of care status, according to the procedures in Section 8.509.31(B);

    f. Review the PCSP, including verification of whether services have been delivered according to the PCSP, and write a new PCSP, according to procedures at Section 8.509.31(D);

    g. Refer the Client to community resources, as needed;

    h. Submit a continued stay review PAR, in accordance with requirements at Section 8.509.31(G). For Clients who have been denied by the URC at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the Level of Care Eligibility Determination. Acceptable documentation of an appeal include: (a) a copy of the request for reconsideration, or the request for appeal, signed by the Client and sent to the URC or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by the URC or the Office of Administrative Courts to the Client; or (c) a copy of the notice of a scheduled court date.

        Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed and shall not be accepted as a substitute for the Level of Care Eligibility Determination. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

8.509.33 OTHER CASE MANAGEMENT REQUIREMENTS

A. COMMUNICATION

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

1. The case manager shall inform the income maintenance technician of any and all changes in the Client's participation in HCBS-CMHS and shall provide the technician with copies the Level of Care Eligibility Determination.

8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.1 DEFINITIONS

A. Adaptive Equipment means one or more devices used to assist with completing activities of daily living.

B. Allocation means the funds determined by the Case Manager in collaboration with the Client and made available by the Department through the Financial Management Service (FMS) vendor for Attendant support services available in the Consumer Directed Attendant Support Services (CDASS) delivery option.

C. Assessment shall be as defined at Section 8.390.1.DEFINITIONS.

D. Attendant means the individual who meets qualifications in 8.510.8 who provides CDASS as described in 8.510.3 and is hired by the Client or Authorized Representative through the contracted FMS vendor.

E. Attendant Support Management Plan (ASMP) means the documented plan described in 8.510.5, detailing management of Attendant support needs through CDASS.

F. Authorized Representative (AR) means an individual designated by the Client or the Client's legal guardian, if applicable, who has the judgment and ability to direct CDASS on a Client's behalf and meets the qualifications contained in 8.510.6 and 8.510.7.

G. Case Management Agency (CMA) means a public or private entity that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-based Services waivers pursuant to §§ 25.5-10-209.5 and 25.5-6-106, C.R.S., and has a current provider participation agreement with the Department.

H. Case Manager means an individual employed by a Case Management Agency who is qualified to perform the following case management activities: determination of an individual Client's functional eligibility for one or more Home and Community-based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the Client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and periodic Reassessment of Client needs.

I. Consumer-Directed Attendant Support Services (CDASS) means the service delivery option that empowers Clients to direct their care and services to assist them in accomplishing activities of daily living when included as a waiver benefit. CDASS benefits may include assistance with health maintenance, personal care, and homemaker activities.

J. CDASS Certification Period Allocation means the funds determined by the Case Manager and made available by the Department for Attendant services for the date span the Client is approved to receive CDASS within the annual certification period.

K. CDASS Task Worksheet: A tool used by a Case Manager to indicate the number of hours of assistance a Client needs for each covered CDASS personal care services, homemaker services, and health maintenance activities.

L. CDASS Training means the required CDASS training and comprehensive assessment provided by the Training and Operations Vendor to a Client or Authorized Representative.

M. Department means the Colorado Department of Health Care Policy and Financing, the Single State Medicaid Agency.

N. Electronic Visit Verification (EVV) means the use of technology, including mobile device technology, telephony, or Manual Visit Entry, to verify the required data elements related to the delivery of a service mandated to be provided using EVV by the "21st Century Cures Act," P.L. No. 114-255, or this rule.

O. Family Member means any person related to the Client by blood, marriage, adoption, or common law as determined by a court of law.

P. Financial Eligibility means the Health First Colorado financial eligibility criteria based on Client income and resources.

Q. Financial Management Services (FMS) vendor means an entity contracted with the Department and chosen by the Client or Authorized Representative to complete employment-related functions for CDASS Attendants and to track and report on individual Client CDASS Allocations.

R. Fiscal/Employer Agent (F/EA) provides FMS by performing payroll and administrative functions for Clients receiving CDASS benefits. The F/EA pays Attendants for CDASS services and maintains workers' compensation policies on the Client-employer's behalf. The F/EA withholds, calculates, deposits and files withheld Federal Income Tax and both Client-employer and Attendant-employee Social Security and Medicare taxes.

S. Home and Community-based Services (HCBS) means a variety of supportive services delivered in conjunction with Colorado Medicaid Waivers to Clients in community settings. These services are designed to help older persons and persons with disabilities to live in the community.

T. Inappropriate Behavior means offensive behavior toward Attendants, Case Managers, the Training and Operations Vendor or the FMS, and which includes documented verbal, sexual and/or physical abuse. Verbal abuse may include threats, insults or offensive language.

U. Licensed Medical Professional means the primary care provider of the Client, who possesses one of the following licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN), as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.

V. Prior Authorization Request (PAR) means the Department-prescribed process used to authorize HCBS waiver services before they are provided to the Client.

W. Notification means a communication from the Department or its designee with information about CDASS. Notification methods include but are not limited to announcements via the Department's CDASS web site, Client account statements, Case Manager contact, or FMS vendor contact.

X. Stable Health means a medically predictable progression or variation of disability or illness.

Y. Training and Operations Vendor means the organization contracted by the Department to provide training and customer service for self-directed service delivery options to Clients, Authorized Representatives, and Case Managers.

8.515 HOME AND COMMUNITY BASED SERVICES FOR PERSONS WITH BRAIN INJURY (HCBS-BI)

8.515.1 LEGAL BASIS

The Home and Community-based Services for Persons with Brain Injury (HCBS-BI) program is authorized by waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. Section 1396a(a)(10)(B) (2018). This waiver is granted by the United States Department of Health and Human Services under Section 1915(c) of the Social Security Act, 42 U.S.C. Section 1396n (2018). This regulation is adopted pursuant to the authority in Section 25.5-1-303, C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, Sections 24-4-101 et seq., C.R.S. and the Home and Community-based Services for Persons with Brain Injury Act, Sections 25.5-6-701 et seq., C.R.S.

8.515.3 GENERAL DEFINITIONS

Brain Injury means an injury to the brain of traumatic or acquired origin which results in residual physical, cognitive, emotional, and behavioral difficulties of a non-progressive nature and is limited to the following broad diagnoses found within the most current version of the International Classification of Diseases (ICD) at the time of assessment:

1. Nonpsychotic mental disorders due to brain damage; or
2. Anoxic brain damage; or
3. Compression of the brain; or
4. Toxic encephalopathy; or
5. Subarachnoid and/or intracerebral hemorrhage; or
6. Occlusion and stenosis of precerebral arteries; or
7. Acute, but ill-defined cerebrovascular disease; or
8. Other and ill-defined cerebrovascular disease; or
9. Late effects of cerebrovascular disease; or
10. Fracture of the skull or face; or
11. Concussion resulting in an ongoing need for assistance with activities of daily living; or
12. Cerebral laceration and contusion; or
13. Subarachnoid, subdural, and extradural hemorrhage, following injury; or
14. Other unspecified intracranial hemorrhage following injury; or
15. Intracranial injury; or
16. Late effects of musculoskeletal and connective tissue injuries; or
17. Late effects of injuries to the nervous system; or

18. Unspecified injuries to the head resulting in ongoing need for assistance with activities of daily living.

Case Management Agency means the agency designated by the Department to provide the Single Entry Point Functions detailed at Section 8.393.

Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

Person-Centered Support Plan means as defined in Section 8.390.1 DEFINITIONS.

8.515.4 SCOPE AND PURPOSE

The HCBS-BI program provides those services listed at Section 8.515.2.A to eligible individuals with brain injury that require long-term supports and services in order to remain in a community-based setting.

8.515.5 ELIGIBLE PERSONS

HCBS-BI program enrollment and services shall be offered only to individuals determined by the Department or its agent to have met all eligibility requirements in this Section 8.515.5..

8.515.5.A LEVEL OF CARE

Eligible individuals shall be determined by the Department or its agent to require one of the following levels of care:

1. Hospital Level of Care as evidenced by:

    a. The individual shall have been:

        i. Referred to the Case Management Agency while receiving inpatient care in an acute care or rehabilitation hospital for the treatment of the individual's brain injury; or

        ii. Determined by the Department or its agent to have require a hospital level of care as determined using the Department prescribed LOC Screen.

    c. The individual shall require goal-oriented therapy with medical management by a physician; and

    d. The individual cannot be therapeutically managed in a community-based setting without significant supervision and structure, specialized therapy, and support services.

2. Nursing Facility Level of Care as evidenced by all the following:

    a. The individual shall have been determined by the Department or its agent to require nursing facility level of care as determined using the Department prescribed LOC Screen.

    b. The individual shall require long-term support services at a level comparable to those services typically provided in a nursing facility.

8.515.5.B TARGET GROUP

Eligible individuals shall be determined by the Department or its agent to meet all the following target group criteria:

1. The individual shall have a diagnosis of Brain Injury. This diagnosis must be documented on the individual's Professional Medical Information Page (PMIP) and the LOC Screen.

2. Age Limit

    a. Individuals enrolled in the Brain Injury waiver shall be aged 16 years and older and shall have sustained the brain injury prior to the age of 65.

8.515.5.C FINANCIAL ELIGIBILITY

Individuals must meet the financial requirements for long-term care medical assistance eligibility specified at Section 8.100.7.

8.515.5.D NEED FOR HCBS-BI SERVICES

1. Only Clients that currently receive HCBS-BI services, or that have agreed to accept HCBS-BI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-BI program.

    a. Case management is provided as an administrative function, not an HCBS-BI service, and shall not be used to satisfy this requirement.

    b. The desire or need for any Medicaid services other than HCBS-BI services, as listed at Section 8.515.1, shall not satisfy this eligibility requirement.

2. Clients that have not received an HCBS-BI service for a period greater than 30 consecutive days shall be discontinued from the program.

8.515.5.E EXCLUSIONS FROM ELIGIBILITY

1. Individuals who are residents of nursing facilities, hospitals, or other institutional settings are not eligible to receive HCBS-BI services.

2. HCBS-BI Clients that enter a nursing facility or hospital may not receive HCBS-BI services while admitted to the nursing facility or hospital.

    a. HCBS-BI Clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the HCBS-BI program.

    b. HCBS-BI Clients entering a nursing facility for Respite Care as an HCBS-BI service shall not be discontinued from the HCBS-BI program.

8.515.6 START DATE FOR SERVICES

8.515.6.A. The start date of eligibility for HCBS-BI services shall not precede the date that all of the requirements in Section 8.515.5 have been met. The first date for which HCBS-BI services may be reimbursed shall be the later the following:

1. The date at which financial eligibility is effective.

2. The date at which the Department or its agent has made a Level of Care Determination that the Client has met all level of care eligibility requirements at Section 8.515.5.

3. The date at which the Client agrees to accept services and signs all necessary intake and Person-Centered Support Planning forms.

4. The date of discharge from an institutional setting.

8.515.7 PRIOR AUTHORIZATION OF SERVICES

8.515.7.A. All HCBS-BI services must be prior authorized by the Department or its agent.

8.515.7.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.

8.515.7.C. The Department or its agent shall determine if the services requested are:

1. Consistent with the Client's documented medical condition and functional capacity;

2. Reasonable in amount, scope, frequency, and duration;

3. Not duplicative of the other services or supports included in the Client's PCSP;

4. Not for services for which the Client is receiving funds to purchase; and

5. Do not total more than 24 hours per day of care.

8.515.7.D. Revisions to the PAR that are requested six months or more after the end date shall be disapproved.

8.515.7.E. Approval of the PAR by the Department or its agent shall authorize providers of HCBS-BI services to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR.

1. Payment for HCBS-BI services is also conditional upon:

a. The Client's eligibility for HCBS-BI services;

b. The provider's certification status; and

c. The submission of claims in accordance with proper billing procedures.

8.515.7.F. The prior authorization of services does not constitute an entitlement to those services. All services provided and reimbursed must be delivered in accordance with regulation and be necessary to meet the Client's needs.

8.515.7.G. Services requested on the PAR shall be supported by information on the PCSP and the LOC Screen.

8.515.7.H. The PAR start date shall not precede the start date of HCBS-BI eligibility in accordance with Section 8.515.6.

8.515.7.I. The PAR end date shall not exceed the end date of the HCBS-BI eligibility certification period.

8.515.8 WAITING LIST

8.515.7.A. Persons determined eligible for HCBS-BI services that cannot be served within the capacity limits of the HCBS-BI waiver shall be eligible for placement on a waiting list.

1. The waiting list shall be maintained by the Department.

2. The date used to establish the person's placement on the waiting list shall be the date on which all other eligibility requirements at Section 8.515.5 were determined to have been met and the HCBS-BI Program Administrator was notified.

3. As openings become available within the capacity limits of the federal waiver, persons shall be considered for services based on the date of their waiting list placement.

8.515.85 SUPPORTIVE LIVING PROGRAM

8.515.85.A DEFINITIONS

1. Activities of Daily Living (ADLs) mean basic self-care activities, including mobility, bathing, toileting, dressing, eating, transferring, support for memory and cognition, and behavioral supervision.

2. Assistance means the use of manual methods to guide or assist with the initiation or completion of voluntary movement or functioning of an individual's body through the use of physical contact by others, except for the purpose of providing physical restraint.

3. Assistive Technology Devices means any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

4. Authorized Representative means an individual designated by the Client or the legal guardian, if appropriate, who has the judgment and ability to assist the Client in acquiring and utilizing supports and services.

5. Behavioral Management and Education means services as defined in § 8.516.40.A, and Inclusions as defined at § 8.516.40.B, provided as an individually developed intervention designed to decrease/control the Client's severe maladaptive behaviors which, if not modified, will interfere with the Client's ability to remain integrated in the community.

6. Case Management Agency (CMA) means an agency within a designated service area where an Applicant or Client can obtain Case Management services. CMAs include Single Entry Points (SEPs), Community Centered Boards (CCBs), and private case management agencies.

7. Case Manager means an individual employed by a CMA who is qualified to perform the following case management activities: determination of an individual Client's fLevel of Care Eligibility Determination for the Home and Community-based Services – Brain Injury (HCBS-BI) waiver, development and implementation of an individualized and Person-Centered Support Plan for the Client, coordination and monitoring of HCBS-BI waiver services delivery, evaluation of service effectiveness, and the periodic Reassessment of such Client's needs.

8. Critical Incident means an actual or alleged event or situation that creates a significant risk of substantial or serious harm to the health or welfare of a Client that could have, or has had, a negative impact on the mental and/or physical well-being of a Client in the short or long-term. A critical incident includes accidents, a suspicion of, or actual abuse, neglect, or exploitation, and criminal activity.

9. Department means the Department of Health Care Policy and Financing.

10. Health Maintenance Activities means those routine and repetitive health-related tasks which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if he/she were physically able, or that would be carried out by family members or friends if they were available. These activities include, but are not limited to, catheter irrigation, administration of medication, enemas, suppositories, and wound care.

11. Independent Living Skills Training means services designed and directed toward the development and maintenance of the Client's ability to independently sustain himself/herself physically, emotionally, and economically in the community.

12. Instrumental Activities of Daily Living (IADLs) means activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework and communication.

13. Interdisciplinary Team means a group of people responsible for the implementation of a Client's individualized care plan, which includes the Client receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by the Client's needs and preferences, who are assembled in a cooperative manner to develop or review the person-centered care plan.

14. Personal Care Services includes providing assistance with eating, bathing, dressing, personal hygiene or other activities of daily living. When specified in the service plan, Personal Care Services may also include housekeeping chores such as bed making, dusting, and vacuuming. Housekeeping assistance must be incidental to the care furnished or essential to the health and welfare of the individual rather than for the benefit of the individual's family.

15. Person-Centered Support Plan is as defined in Secgtion 8.390.1 DEFINITIONS.

16. Protective Oversight is defined as monitoring and guidance of a Client to assure his/her health, safety, and well-being. Protective oversight includes, but is not limited to: monitoring the Client while on the premises, monitoring ingestion and reactions to prescribed medications, if appropriate, reminding the Client to carry out activities of daily living, and facilitating medical and other health appointments. Protective oversight includes the Client's choice and ability to travel and engage independently in the wider community and providing guidance on safe behavior while outside the Supportive Living Program.

17. Room and Board is defined as a comprehensive set of services that include lodging, routine or basic supplies for comfortable living, and nutritional and healthy meals and food for the Client, all of which are provided by the Supportive Living Program provider, and are not included in the per diem.

18. Supportive Living Program (SLP) certification means documentation from the Colorado Department of Public Health and Environment (CDPHE) recommending certification to the Department after the SLP provider has met all licensing requirements found in 6 C.C.R. 1011-1; Chapter 2, and either Chapter 7 or 26, in addition to all requirements in § 8.515.85.

8.515.85.B CLIENT ELIGIBILITY

1. SLP services are available to individuals who meet all of the following requirements:

    a. Clients are determined to meet level of care eligibility for HCBS-BI waiver by a certified case management agency as outlined in Section 8.515.5.

    b. Clients are enrolled in the HCBS-BI waiver; and

    c. Clients require the specialized services provided under the SLP as determined by assessed need.

2. Person-Centered Care Planning

    SLP providers must comply with the Person-Centered Care Planning process. Providers must work with CMAs to ensure coordination of a Client's Person-Centered Care Plan. Additionally, SLP providers must provide the following actionable plans for all HCBS-BI waiver Clients, updated every six (6) months:

    a. Transition Planning; and

    b. Goal Planning.

    These elements of a Person-Centered Care Plan are intended to ensure the Client actively engages in his or her care and activities, as is able to transition to any other type of setting or service at any given time.

3. Exclusions

    The following are not included as components of the SLP:

    a. Room and board; and

    b. Additional services which are available as a State Plan benefit or other HCBS-BI waiver service. Examples include, but are not limited to physician visits, mental health counseling, substance abuse counseling, specialized medical equipment and supplies, physical therapy, occupational therapy, long-term home health, and private duty nursing.

8.517 HOME AND COMMUNITY-BASED SERVICES FOR THE COMPLEMENTARY AND INTEGRATIVE HEALTH WAIVER

8.517.1 HCBS-CIH WAIVER SERVICES

8.517.2 GENERAL DEFINITIONS

A. Acupuncture (CIHS) means the insertion of needles and/or manual, mechanical, thermal, electrical, and electromagnetic treatment to stimulate specific anatomical tissues for the promotion, maintenance and restoration of health and prevention of disease both physiological and psychological. During an acupuncture treatment, dietary advice and therapeutic exercises may be recommended in support of the treatment.

B. Chiropractic (CIHS) means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting and/or improving alignment, neurological function, and other musculoskeletal problems. During a chiropractic treatment, nutrition, exercise, and rehabilitative therapies may be recommended in support of the adjustment.

C. Complementary and Integrative Health Care Plan means the plan developed prior to the delivery of Complementary and Integrative Health Services in accordance with Section 8.517.11.D.

D. Complementary and Integrative Health Provider means an individual or agency certified annually by the Department to have met the certification standards listed at Section 8.517.11.

E. Complementary and Integrative Health Services (CIHS) means Acupuncture, Chiropractic, and Massage Therapy.

F. Emergency Systems means procedures and materials used in emergent situations and may include, but are not limited to, an agreement with the nearest hospital to accept patients; an Automated External Defibrillator; a first aid kit; and/or suction, AED, and first aid supplies.

G. Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

H. Massage Therapy (CIHS) means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about beneficial physiologic, mechanical, and/or psychological changes.

8.517.5 CLIENT ELIGIBILITY

8.517.5.A. ELIGIBLE PERSONS

Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver services shall be offered only to individuals who meet all of the following eligibility requirements:

1. Individuals shall be aged 18 years or older.

2. Individuals shall have a qualifying condition of a spinal cord injury (traumatic or nontraumatic), multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy with the inability for independent ambulation directly resulting from one of

these conditions as defined by broad diagnoses related to each condition within the most current version of the International Classification of Diseases (ICD) at the time of assessment.

3. Individuals must have been determined to have an inability for independent ambulation resulting from the qualifying condition as identified by the case manager through the assessment process. The inability for independent ambulation means:

   a. The individual does not walk, and requires use of a wheelchair or scooter in all settings, whether or not they can operate the wheelchair or scooter safely, on their own, OR;

   b. The individual does walk, but requires use of a walker or cane in all settings, whether or not they can use the walker or cane safely, on their own, OR;

   c. The individual does walk but requires “touch” or “stand-by” assistance to ambulate safely in all settings.

8.517.5.C LEVEL OF CARE CRITERIA

Individuals shall require long-term support services at a level of care comparable to services typically provided in a nursing facility or hospital.

8.517.6 WAITING LIST

9. Within ten business days of notification from the Department that an opening for the HCBS-CIH waiver is available the Case Management Agency shall:

   a. Reassess the individual for level of care using the Department’s prescribed instrument if more than six months has elapsed since the previous assessment.

   b. Update the existing level of care assessment in the official Client record if less than six months has elapsed since the date of the previous assessment.

   c. Reassess for eligibility criteria as set forth at 8.517.5.

   d. Notify the Department of the individual’s eligibility status.

8.519 Case Management

8.519.1 Definitions

A. Adverse Action means a denial, reduction, termination, or suspension from a long-term service and support program or service.

B. Algorithm means a formula that establishes a set of rules that precisely defines a sequence of operations. An algorithm is used to assign Clients into one of six support levels in the Home and Community-based Services for Persons with Developmental Disabilities (HCBS-DD) and Home and Community Based Services- Supported Living Services (HCBS-SLS) waivers.

C. Assessment means as defined in Section 8.390.1 DEFINITIONS.

D. Authorized Representative means an individual designated by a Client or by the parent or guardian of the Client, if appropriate, to assist the Client in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined in Section 8.510.1.

E. Business Day means any day in which the state is open and conducting business, but shall not include Saturday, Sunday, or any day in which the state observes on of the holidays listed in Section 24-11-101(1), C.R.S.

F. Case Manager means a person who provides case management services and meets all regulatory requirements for Case Managers.

G. Case Management means as defined in Section 8.390.1 DEFINITIONS.

H. Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for specific Home and Community-Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

I. Certification means the process by which an agency is approved by the Department to provide case management which includes the submission and approval of a Medicaid Provider Agreement along with submission of verification that the agency meets the qualifications as set forth in Section 8.519.

J. Client means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).

K. Client Representative means a person who is designated by the Client to act on the Client's behalf. A Client Representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the Client to speak for or act on the Client's behalf.

L. Community Centered Board means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

M. Conflict-Free Case Management means, pursuant to 42 CFR § 441.301(c)(1)(vi), case management services provided to a Client enrolled in a Home and Community-Based Services waiver that are provided by a Case Management Agency that is not the same agency that provides services and supports to that person.

N. Corrective Action Plan shall be as defined at Section 8.390.1.DEFINITIONS.

O. Critical Incident means incidents or allegations involving Clients receiving services to include mistreatment, abuse, neglect, exploitation, illness/injury, death, damage to consumer's property/theft, medication management issues, criminal activity, unsafe housing/displacement, and missing persons.

P. Department means the Colorado Department of Health Care Policy and Financing, the Single State Medicaid Agency.

Q. Developmental Delay means as defined in Section 8.600.4.

R. Developmental Disability means as defined in Section 8.600.4.

S. Executive Director means the Executive Director of the Colorado Department of Health Care Policy and Financing unless otherwise indicated.

T. Financial Eligibility means the eligibility criteria for a publicly funded program, based on the individual's financial circumstances, including income and resources, if applicable.

U. Guardian means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.

V. Guardian ad litem or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in article 33 of title 22, C.R.S.

W. Home and Community-based Services (HCBS) waivers means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a Level of Care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

X. Incident means an injury to a person receiving services; lost or missing persons receiving services; medical emergencies involving persons receiving services; hospitalizations of persons receiving services; death of persons receiving services; errors in medication administration; incidents or reports of actions by persons receiving services that are unusual and require review; allegations of abuse, mistreatment, neglect, or exploitation; use of safety control procedures; use of emergency control procedures; and stolen personal property belonging to a person receiving services.

Y. Information Management System (IMS) means as defined in Section 8.390.1 DEFINITIONS.

Z. Interdisciplinary Team (IDT) means a group of people convened by a certified Case Management Agency that includes the person receiving services, the parent or guardian of a minor, guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as chosen by the person receiving services, who are assembled to work in a cooperative manner to develop or review the PCSP.

AA. Legally Responsible Persons means the parent of a minor child, or the Client's spouse,

BB. Level of Care Eligibility Determination means as defined in Section 8.390.1 DEFINITIONS.

CC. Level of Care Eligibility Determination Screen means as defined in Section 8.390.1 DEFINITIONS.

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

EE. Medicaid Eligible means an Applicant or Client meets the criteria for Medicaid benefits based on the Applicant's financial determination and disability determination when applicable.

FF. Organized Health Care Delivery System (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-based Services for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

GG. Parent means the biological or adoptive parent.

HH. Performance and Quality Review means a review conducted by the Department or its contractor at any time but no less than the frequency as specified in the approved waiver application. To include a review of required case management services performed by the agency to ensure quality and compliance with all requirements. The agency shall provide all requested information and documents as requested by the Department or by its contractor.

II.. Person-Centered Support Plan (PCSP) means as defined in Section 8.390.1 DEFINITIONS.

JJ. Person-Centered Support Planning means as defined in Section 8.390.1 DEFINITIONS.

KK. Prior Authorization Requests (PAR) means approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the Case Management Agency.

LL. Professional Medical Information Page (PMIP) means as defined in Section 8.390.1 DEFINITIONS.

MM Provider for the purpose of this section means any person, group or entity approved to render services or provide items to a Client enrolled in an HCBS waiver program.

NN. Regional Center means a facility or program operated directly by the Department of Human Services which provides services and supports to Clients with intellectual and developmental disabilities.

OO. Retrospective Review means the Department or the Department's contractor's review after services and supports are provided to ensure the Client received services according to the PCSP and that the Case Management Agency complied with the requirements set forth in statute, waiver, and regulations.

PP. Service Plan Authorization Limit (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the Client's ongoing needs. Purchase of services not subject to the SPAL are set forth at Section 8.500.102.B. A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department

based on the annual appropriation for the HCBS-SLS waiver, the number of Clients in each level, and projected utilization.

QQ. Supports Intensity Scale (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with intellectual and developmental disabilities.

RR. Support Level means a numeric value determined using an algorithm that places Clients into groups with other Clients who have similar overall support needs.

SS. Targeted Case Management (TCM) means case management services provided to Clients enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 et seq, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities Assessment and periodic Reassessment, development and periodic revision of a PCSP, referral and related activities, and monitoring.

TT. Waiver Services means those optional Medicaid services defined in the current federally approved HCBS waiver document and do not include Medicaid state plan services.

8.550.6.B. Special Requirements

1. Eligibility for, and access to, Hospice Services does not fall within the purview of the long-term care Single Entry Point system for prior authorization.
2. Nursing facility placement for a Client who has Medicaid and has Elected Hospice Services in a nursing facility does not require a LOC Screen. The nursing facility must complete a Pre Admission Screening and Resident Review (PASRR).

8.600 Services for Individuals with Intellectual and Developmental Disabilities

8.600.4 Definitions

As used in these rules, unless the context requires otherwise:

“Abuse” is as defined at Sections 16-22-102 (9), 19-1-103, 25.5-10-202 (1) (a)-(c), and 26.3.1-101 C.R.S..

“Algorithm” means a formula that establishes a set of rules that precisely defines a sequence of operations. An algorithm is used to assign Clients into one of six support levels in the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) and Home and Community Based Services-Supported Living Services (HCBS-SLS) waivers.

“Assistive Technology Devices” means any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

“Assistive Technology Services” includes, but is not limited to, the evaluation of a person's need for assistive technology; helping to select and obtain appropriate devices; designing, fitting and customizing

those devices; purchasing, repairing or replacing the devices; and, training the individual, or if appropriate a family member, to use the devices effectively.

“Authorized Representative” means an individual designated by a Client or by the parent or guardian of the Client, if appropriate, to assist the Client in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined in 8.510.1.

“Authorized Services” means those services and supports authorized pursuant to Section 25.5-10-206, C.R.S., which the Department shall provide directly or purchase subject to available appropriations for persons who have been determined to be eligible for such services and supports and as specified in the eligible person's individualized plan.

“Caretaker” is as defined at Section 25.5-10-202(1.6)(a)-(c), C.R.S.

“Caretaker Neglect” is as defined at Section 25.5-10-202(1.8)(a)-(c), C.R.S.

“Case Management Agency” (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

“Challenging Behavior” means behavior that puts the person at risk of exclusion from typical community settings, community services and supports, or presents a risk to the health and safety of the person or others or a significant risk to property.

“Client” means an individual who has met Long-Term Services and Supports (LTSS) eligibility requirements and has been offered and agreed to receive Home and Community Based Services (HCBS) in the Children's Extensive Supports (HCBS-CES) waiver, the HCBS waiver for Children’s Habilitation Residential Program (CHRP), the HCBS waiver for Persons with Developmental Disabilities (HCBS-DD), Family Support Services Program (FSSP),or the Supported Living Services (HCBS-SLS) waiver.

“Community Centered Board” means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

“Comprehensive Review of the Person's Life Situation” means a thorough review of all aspects of the person's current life situation by the program approved service agency in conjunction with other members of the interdisciplinary team.

“Comprehensive Services” means habilitation services and supports that provide a full day (24 hours) of services and supports to ensure the health, safety and welfare of the individual, and to provide training and habilitation services or a combination of training and supports in the areas of personal, physical, mental and social development and to promote interdependence, self-sufficiency and community inclusion. Services include residential habilitation services and supports, day habilitation services and supports and transportation.

“Consent” means an informed assent, which is expressed in writing and is freely given. Consent shall always be preceded by the following:

A. A fair explanation of the procedures to be followed, including an identification of those which are experimental;

B. A description of the attendant discomforts and risks;

C. A description of the benefits to be expected;

D. A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts and risks;

E. An offer to answer any inquiries regarding the procedure;

F. An instruction that the person giving consent is free to withdraw such consent and discontinue participation in the project or activity at any time; and,

G. A statement that withholding or withdrawal of consent shall not prejudice future provision of appropriate services and supports to individuals.

“Developmental Delay” means that a child meets one or more of the following:

A. A child who is less than five (5) years of age at risk of having a developmental disability because of the presence of one or more of the following:

1. Chromosomal conditions associated with delays in development,

2. Congenital syndromes and conditions associated with delays in development,

3. Sensory impairments associated with delays in development,

4. Metabolic disorders associated with delays in development,

5. Prenatal and perinatal infections and significant medical problems associated with delays in development,

6. Low birth weight infants weighing less than 1200 grams, or

7. Postnatal acquired problems resulting in delays in development.

B. A child less than five (5) years of age who is significantly delayed in development in one or more of the following areas:

1. Communication,

2. Adaptive behavior,

3. Social-emotional,

4. Motor,

5. Sensory, or

6. Cognition.

C. A child less than three (3) years of age who lives with one or both parents who have a developmental disability.

“Critical Incident” means an actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; and it may endanger or negatively impact the mental and/or

physical well-being of an individual. Critical Incidents include, but are not limited to: Injury/illness; abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death

“Developmental Disabilities Professional” means a person who has at least a Bachelor’s Degree and a minimum of two (2) years’ experience in the field of developmental disabilities or a person with at least five (5) years of experience in the field of developmental disabilities with competency in the following areas:

A. Understanding of civil, legal and human rights;

B. Understanding of the theory and practice of positive and non-aversive behavioral intervention strategies;

C. Understanding of the theory and practice of non-violent crisis and behavioral intervention strategies.

“Developmental Disability” means a disability that:

A. Is manifested before the person reaches twenty-two (22) years of age;

B. Constitutes a substantial disability to the affected individual, as demonstrated by the criteria below at C, 1 and/or C, 2; and,

C. Is attributable to an intellectual and developmental disability or related conditions which include Prader-Willi syndrome, cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of “developmental disability” found 42 U.S.C. § 15002, et seq., shall not apply.

1. “Impairment of general intellectual functioning” means that the person has been determined to have a full scale intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15).

a. A secondary score comparable to the General Abilities Index for a Wechsler Intelligence Scale that is two or more standard deviations below the mean may be used only if a full scale score cannot be appropriately derived.

b. Score shall be determined using a norm-referenced, standardized test of general intellectual functioning comparable to a comprehensively administered Wechsler Intelligence Scale or Stanford-Binet Intelligence Scales, as revised or current to the date of administration. The test shall be administered by a licensed psychologist or a school psychologist.

c. When determining the intellectual quotient equivalent score, a maximum confidence level of ninety percent (90%) shall be applied to the full scale score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the Applicant being determined to have a developmental disability.

2. “Adaptive behavior similar to that of a person with intellectual disability “ means that the person has an overall adaptive behavior composite or equivalent score that is two or more standard deviations below the mean.

a. Measurements shall be determined using a norm-referenced, standardized assessment of adaptive behaviors that is appropriate to the person's living environment and comparable to a comprehensively administered Vineland Scale of Adaptive Behavior, as revised or current to the date of administration. The assessment shall be administered and determined by a professional qualified to administer the assessment used.

b. When determining the overall adaptive behavior score, a maximum confidence level of ninety percent (90%) shall be applied to the overall adaptive behavior score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the Applicant being determined to have a developmental disability.

D. A person shall not be determined to have a developmental disability if it can be demonstrated such conditions are attributable to only a physical or sensory impairment or a mental illness.

“Emergency”, as used in Section 8.608.3 regarding restraint, means a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to affect such bodily harm.

“Emergency Control Procedure” means an unanticipated use of a restrictive procedure or restraint in order to keep the person receiving services and others safe.

“Executive Director” means the Executive Director of the Colorado Department of Health Care Policy and Financing unless otherwise indicated.

“Exploitation” is as defined in Section 25.5-10-202(15.5)(a)-(d) and 26-3.1-101 C.R.S.

“Extreme Safety Risk to Self” means a factor in addition to specific Supports Intensity Scale (SIS) scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client:

A. Displays self-destructiveness related to self-injury, suicide attempts or other similar behaviors that seriously threaten the Client's safety; and,

B. Has a rights suspension in accordance with Section 8.604.3 or has a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits the ability of the Client to harm himself or herself.

“Family”, as used in rules pertaining to support services and the Family Support Services Program means a group of interdependent persons residing in the same household that consists of a family member with a developmental disability or a child under the age of five (5) years with a developmental delay, and one or more of the following:

A. A mother, father, brother(s), sister(s) or any combination; or,

B. Extended blood relatives such as grandparent(s), aunt(s) or uncle(s); or,

C. An adoptive parent(s); or,

D. One or more persons to whom legal custody of a person with a developmental disability has been given by a court; or,

E. A spouse and/or his/her children.

“Family Support Council” means the local group of persons within the Community Centered Board's designated service area who have the responsibility for providing guidance and direction to the Community Centered Board for the implementation of the Family Support Services Program.

“Family Support Plan (FSP)” means a plan which is written for the delivery of family support services as specified in Section 8.613.

“Functional Analysis” means a comprehensive analysis of the medical, social, environmental, and personal factors that may influence current behavior. This analysis shall also investigate the person's ability to communicate, analyze whether the current behavior is a means to communicate, and identify historical factors which may contribute to the understanding of the current behavior.

“Guardian” means a person who has qualified as a guardian of a minor or incapacitated person by testamentary or count appointment but excludes a Guardian Ad Litem.

“Harmful Act” is as defined at Section 25.5-10-202 (18.5) and 26.3.1-101 C.R.S.

“Home and Community-Based Services Waivers (HCBS)” means HCBS waiver programs, including the Home and Community Based Waiver for the Developmentally Disabled (HCBS-DD), Supported Living Services (SLS) and Children's Extensive Support (CES). “Host Home Provider” is an individual(s)who provides residential supports in his/her home to persons receiving comprehensive services who are not family members as defined in Section 25.5-10-202(16), C.R.S. A host home provider is not a developmental disabilities service agency pursuant to Section 8.602 of these rules.

“Human Rights Committee” means a third-party mechanism to adequately safeguard the legal rights of persons receiving services by participating in the granting of informed consent, monitoring the suspension of rights of persons receiving services, monitoring behavioral development programs in which persons with intellectual and developmental disabilities are involved, monitoring the use of psychotropic medication by persons with intellectual and developmental disabilities, and reviewing investigations of allegations of mistreatment of persons with intellectual and developmental disabilities who are receiving services or supports.

“Individual Service and Support Plan (ISSP)” means a plan of intervention or instruction which directly addresses the needs identified in the person's Individualized Plan and which provides specific direction and methodology to employees and contractors providing direct service to a person.

“Interdisciplinary Team (IDT)” means a group of people convened by a Community Centered Board which shall include the person receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by such person's needs and preferences, who are assembled in a cooperative manner to develop or review the individualized plan.

“Mechanical Restraint” means the use of devices intended to restrict the movement or normal functioning of a portion of an individual's body. Mechanical restraint does not include the use of protective devices used for the purpose of providing physical support or prevention of accidental injury.

“Minimum Effective Dose” means the smallest medication dosage necessary to produce the intended effect.

“Mistreated” or “Mistreatment” is as defined at Sections 25.5-10-202(29.5)(a)-(d) and 26-3.1-101 C.R.S.:

“Notice” means written notification hand delivered to or sent by first class mail that contains at least all of the following:

A. The proposed action;

B. The reason or reasons for that action;

C. The effective date of that action;

D. The specific law, regulation, or policy supporting the action;

E. The responsible agency with whom a protest of the action may be filed including the name and address of the director.

F. The dispute resolution procedure, including deadlines, in conformity with Section 8.605 and procedures on accessing agency records:

1. For disputes involving individuals as defined in Section 8.605.2, information on availability of advocacy assistance, including referral to publicly funded legal services, corporation, and other publicly or privately funded advocacy organizations, including the protection and advocacy system required under 42 U.S.C. 15001, the Developmental Disabilities Assistance and Bill of Rights Act; and,

2. For disputes involving individuals as defined in Section 8.605.2 an explanation of how the agency will provide services to a currently enrolled person during the dispute resolution period, including a statement that services will not be terminated during the appeal. Such explanation will include a description of services currently received.

“Parent” means the biological or adoptive parent.

“Person-Centered Support Plan” means as defined in Section 8.390.1 DEFINITIONS.

“Physical Restraint” means the use of manual methods to restrict the movement or normal functioning of a portion of an individual's body through direct physical contact by others except for the purpose of providing assistance/prompts. Assistance/prompts is the use of manual methods to guide or assist with the initiation or completion of and/or support the voluntary movement or functioning of an individual's body through the use of physical contact by others except for the purpose of providing physical restraint.

“PRN” (Pro Re Nata) means giving drugs on an “as needed” basis through a standing prescription or standing order.

“Program Approved Service Agency” means a developmental disabilities service agency or typical community service agency as defined in Section 8.602, which has received program approval by the Department pursuant to Section 8.603 of these rules.

“Program Services” means an organized program of therapeutic, habilitative, specialized support or remedial services provided on a scheduled basis to individuals with developmental disabilities.

“Prospective New Service Agency” means an individual or any publicly or privately operated program, organization or business that has completed and submitted an application with a Community Centered Board for selection and approval as a service agency to provide comprehensive services.

“Public Safety Risk-Convicted” means a factor in addition to specific SIS scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client has:

A. Been found guilty through the criminal justice system for a criminal action involving harm to another person or arson and who continues to pose a current risk of repeating a similar serious action; and,

B. A rights suspension in accordance with Section 8.604.3 or through parole or probation, or a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

“Public Safety Risk-Not Convicted” means a factor in addition to specific SIS scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client has:

A. Not been found guilty through the criminal justice system, but who does pose a current and serious risk of committing actions involving harm to another person or arson; and,

B. A rights suspension in accordance with Section 8.604.3or through parole or probation, or a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

“Rate” means the amount of money, determined by a standardized rate setting methodology, reimbursed for each unit of a defined waiver service provided to a Client by a qualified provider.

“Referral” means any notice or information (written, verbal, or otherwise) presented to a Community Centered Board which indicates that a person may be appropriate for services or supports provided through the developmental disabilities system and for which the Community Centered Board determines that some type of follow-up activity for eligibility is warranted.

“Request for Provider (RFP)” means a formal process for case managers to notify Program Approved Provider Agencies when a Client is seeking authorized services including, but not limited to, a non-identifying description of the client’s support and supervision needs.

“Regional Center” means a facility or program operated directly by the Department of Human Services, which provides services and supports to persons with developmental disabilities.

“Respondent” means a person participating in the SIS assessment who has known the Client for at least three months and has knowledge of the Client's skills and abilities. The respondent must have recently observed the Client directly in one or more places such as home, work, or in the community.

“Restrictive Procedure” means any of the following when the intent or plan is to bring an individual’s behavior into compliance:

A. Limitations of an individual's movement or activity against his or her wishes; or,

B. Interference with an individual's ability to acquire and/or retain rewarding items or engage in valued experiences.

“Request for Developmental Disability Determination” means written formal documentation, either handwritten or a signed standardized form, which is submitted to a Community Centered Board requesting that a determination of developmental disability be completed.

“Safety Control Procedure” means a restrictive procedure or restraint that is used to control a previously exhibited behavior which is anticipated to occur again and for which the planned method of intervention is developed in order to keep the person and others safe.

“Screening for Early Intervention Services” means a preliminary review of how a child is developing and learning in comparison to other similarly situated children. “Seclusion” means the placement of a Client alone in a closed room for the purpose of punishment. Seclusion for any purpose is prohibited.

“Service Agency” means an individual or any publicly or privately operated program, organization or business providing services or supports for persons with developmental disabilities.

“SIS Interviewer” means an individual formally trained in the administration and implementation of the Supports Intensity Scale by a Department approved trainer using the Department approved curriculum. SIS Interviewers must maintain a standard for conducting SIS assessments as measured through periodic interviewer reliability reviews.

“Statewide Database” means the state web-based system that contains consumer-related demographic and program data.

“Support Coordinating Agency” means a Community Centered Board which has been designated as the agency responsible for the coordination of support services (supported living services for adults and the children's extensive support program) within its service area.

“Supports Intensity Scale” (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

“Support Level” means a numeric value determined using an algorithm that places Clients into groups with other Clients who have similar overall support needs.

“Undue Influence” means use of influence to take advantage of a person with an intellectual or developmental disability’s vulnerable state of mind, neediness, pain, or emotional distress.

“Waiver Services” means those optional Medicaid services defined in the current federally approved HCBS waiver document and do not include Medicaid State Plan services.

8.615 TELEHEALTH DELIVERY OF HOME AND COMMUNITY-BASED SERVICES

8.615.1 DEFINITIONS

A. Assessment shall be as defined at Section 8.390.1.DEFINITIONS.

B. Case Management means as defined in Section 8.390.1 DEFINITIONS.

C. Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-Based Services waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

D. Community Centered Board (CCB) means a private corporation, for profit or not for profit, which when designated pursuant to Section 25.5-10-209, C.R.S., provides case management services to Members with developmental disabilities, is authorized to determine eligibility of such Members within a specified geographical area, serves as the single point of entry for Members to receive services and supports under Section 25.5-10-201, C.R.S. et seq , and provides authorized services and supports to such Members either directly or by purchasing such services and supports from service agencies.

E. Department means the Department of Health Care Policy and Financing.

F. Home and Community-Based Services (HCBS) means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Member who requires a level of institutional care that would otherwise be provided in an institutional setting.

G. Home and Community-Based Services Telehealth (HCBS Telehealth) is a method of service delivery of those HCBS services listed at Section 8.615.2.

H. Medicaid State Plan means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

I. Member means as defined in Section 8.390.1.

J. Prior Authorization Request (PAR) means the Department prescribed form to authorize the reimbursement for services.

K. Person-Centered Support Plan means as defined in Section 8.390.1 DEFINITIONS.

L. Person-Centered Support Planning means as defined in Section 8.390.1 DEFINITIONS.

M. Telehealth means the broad use of technologies to provide services and supports through HCBS waivers, when the Member is in a different location from the provider.

N. Waiver Service means optional services defined in the current federally approved waiver documents and do not include Medicaid State Plan benefits.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Adult Day Services Dementia Training, Section 8.491
Rule Number: MSB 23-03-14-B
Division / Contact / Phone: OCL / Kyra Acuna / 5666

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 23-03-14-B, Revision to the Medical Assistance Rule concerning Adult Day Services Dementia Training, Section 8.491

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections 8.491, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.491.4 with the proposed text beginning at 8.491.4 through the end of 8.491.4.K. This rule is effective July 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Adult Day Services Dementia Training, Section 8.491
Rule Number: MSB 23-03-14-B
Division / Contact / Phone: OCL / Kyra Acuna / 5666

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Senate Bill 22-079 was signed into Colorado law in May 2022, and codified, in part, at Section 25.5-6-314. This bill requires that by July 1, 2024, the State Board of Health shall adopt rules requiring all direct-care staff members at Adult Day Care Facilities to obtain dementia training pursuant to curriculum prescribed or approved by the State Department in collaboration with stakeholders that is consistent with the rules adopted pursuant to Colorado Revised Statutes 25.5-6-314(2). The proposed rules are necessary comply with Senate Bill 22-079 prior to the July 1, 2024 deadline. The new regulations ensure that all direct-care staff members of Adult Day Services providers are required to receive dementia training as outlined in Senate Bill 22-079.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, 25.5-6-314, C.R.S. (2022);

Initial Review **05/12/23** Final Adoption **06/09/23**
Proposed Effective Date **07/30/23** Emergency Adoption

DOCUMENT #09

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Title of Rule: Revision to the Medical Assistance Rule concerning Adult Day Services Dementia Training, Section 8.491
Rule Number: MSB 23-03-14-B
Division / Contact / Phone: OCL / Kyra Acuna / 5666

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The proposed rule will impact all Adult Day Services providers and those Home and Community-Based Services (HCBS) waiver members who receive Adult Day Services, which may include members on the Elderly, Blind, and Disabled (EBD), Brain Injury (BI), Complementary and Integrative Health (CIH), and Community Mental Health Supports (CMHS) waivers. The rule will benefit members served as it is estimated that about 31% of members receiving Adult Day Services have dementia diseases or related disabilities. There may be a budgetary or additional financial burden on Adult Day Services providers because of the new requirements, however this depends on the training entity selected by each provider agency. It is up to each provider agency to select the training entity that best meets the needs of the members they serve.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons. Approximately 2,500 members utilize Adult Day services across 50 service providers. This rule will impact all providers offering Adult Day services and all members served.

   The proposed rule will have a significant, positive impact on the quality of services for HCBS members by ensuring that all Adult Day Services direct-care staff members are specifically trained in working with individuals with dementia.

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

   There should be no additional cost to the Department or the Department of Public Health and Environment because of these rules. This training required by this rule will simply be added to the list of items surveyors review when at an Adult Day Services setting to monitor compliance.

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

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Implementing these rules ensures that the Department is compliant with state law. No budgetary impact is anticipated as a result of the passage of the rule. The cost of inaction is a failure to comply with state law, which puts the Department at risk of losing funding for these invaluable HCBS services. No benefits to inaction are identified.

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

   There are no other methods to achieve the purpose of this proposed rule. These regulations must be implemented to comply with Section 25.5-6-314, C.R.S.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   No alternative methods were considered.

8.491 ADULT DAY SERVICES

8.491.1 Definitions

Adult Day Services (ADS) Center is a certified center that provides Basic Adult Day Services and Specialized Adult Day Services to participants.

Adult Day Services (ADS) are provided in an Adult Day Services Center or through Non-Center-Based means including Telehealth, on a regularly scheduled basis, as specified in the Person Centered Care Plan, promoting social, recreational, physical, and emotional well-being that encompasses the supportive services needed to ensure the optimal wellness of the participant.

A. Basic Adult Day Services (ADS) Center means a community-based entity that provides basic Adult Day Services in conformance with all state established requirements as described in 10 CCR 2505-10 section 8.130 and 10 CCR 2505-10 section 8.491.

B. Center-Based Adult Day Services are services provided in a certified ADS Center.

C. Non-Center-Based Adult Day Services are services that may be provided outside of the certified ADS Center, where participants can engage in activities and community life, either in-person or through virtual means.

D. Specialized Adult Day Services (SADS) Center means a community-based entity providing Adult Day Services for participants with a primary diagnosis of dementia related diseases, Multiple Sclerosis, Brain Injury, chronic mental illness, Intellectual and Developmental Disabilities, Huntington's Disease, Parkinson's, or post-stroke participants, who require extensive rehabilitative therapies. To be designated as specialized, two-thirds of an ADS Center's population must have a diagnosis which is one of any of the above diagnoses. Each diagnosis must be verified by a Licensed Medical Professional, either directly or through Case Management Agency documentation, in accordance with Section 8.491.14.A.

E. Telehealth Adult Day Services are provided through virtual means in a group or on an individual basis. Telehealth ADS are ways for participants to engage in activities, with their community, and connect to staff and other ADS participants virtually or over the phone, only if a participant does not have access or the ability to use video chat technology. Services provided through Telehealth are not required to provide nutrition services.

Care Plan means the individualized goal-oriented plan of services, supports, and preferences developed collaboratively with the participant and/or the designated or legal representative and the service provider, as outlined in 10 CCR 2505-10 8.495.6.F.

Designated Representative means a representative who is designated by the participant to act on the participant's behalf, as defined in 10 CCR 2505-10 Section 8.500.1.

Direct Care Staff means staff who provide hands-on care and services, including personal care, to participants. Direct Care Staff must have the appropriate knowledge, skills and training to meet the individual needs of the participants before providing care and services. Training must be completed prior to the provision of services, as outlined in 10 CCR 2505-10 8.491.4.I.

Director means any person who owns and operates an ADS Center or SADS Center or is a managing employee with delegated authority by ownership to manage, control, or perform the day-to-day tasks of operating the Center as described in 10 CCR 2505-10 Section 8.491.

Licensed Medical Professional (LMP) means a medical professional that possesses one or more of the following Colorado licenses, which must be active and in good standing: Physician, Physician Assistant, Registered Nurse (RN) or Licensed Practical Nurse (LPN) governed by the Colorado Medical License Act, and as defined in 10 CCR 2505-10 Section 8.503.

Participant means any individual found to be eligible for and enrolled in Center-Based or Non-Center-Based Adult Day Services regardless of payment source.

Provider means a service agency enrolled with the Department to provide Center-Based and/or Non-Center-Based Adult Day Services.

Qualified Medication Administration Personnel (QMAP) means an individual that has completed training, passed a competency evaluation, and is included in the Colorado Department of Public Health and Environment's (CDPHE) public list of individuals who have passed the requisite competency evaluation, as outlined in 6 CCR 1011-1 Chapter 24.

Restraint means any physical or chemical device, application of force, or medication, which is designed or used for restricting freedom of movement, and/or modifying, altering, or controlling behavior, excluding medication prescribed by a physician as part of an ongoing treatment plan or pursuant to a diagnosis.

Staff means a paid or voluntary employee or contracted professional of the ADS Center or SADS Center.

Universal Precautions refers to a system of infection control that prevents the transmission of communicable diseases. Precautions include, but are not limited to, disinfecting of instruments, isolation and disinfection of environment, use of personal protective equipment, hand washing, and proper disposal of contaminated waste.

8.491.2 PARTICIPANT BENEFITS

8.491.2.A. Adult Day Services

1. Only participants whose needs can be met by the ADS provider within its certification category and populations served may be admitted by the ADS provider.

2. ADS shall include, but are not limited to, the following:

    a. Monitoring to ensure participants are maintaining activity levels and goals set forth in the Care Plan, pursuant to Section 8.491.4.E; and assistance with activities of daily living (ADL) as needed when ADS is provided in-person. (ADLs include but are not limited to eating, ambulation, positioning, transferring, toileting, and incontinence care).

    b. Services provided to monitor the participant's health status, monitor or administer medications (administration of medication only during the in-person delivery of services), and carry out physicians' orders as set forth in participant's individual Care Plan.

    c. Center-Based ADS must be provided in an integrated, community-based setting, which, supports participation and engagement in community life and gaining access to the greater community; participants may engage in meaningful activities in integrated and community settings.

    d. Emergency services including written procedures to meet medical crises.

e. Activities that assist in the development of self-care capabilities, personal hygiene, and social support services.

f. Nutrition services including therapeutic diets and snacks in accordance with the participant's individual Care Plan and hours of attendance. Nutrition services are not required during the delivery of Non-Center-Based ADS.

g. Social and recreational supportive services as appropriate for each participant and their needs, as documented in the participant's Care Plan. Activities shall take into consideration individual differences in age, health status, sensory deficits, religious affiliation, interests, abilities, and skills by providing opportunities for a variety of types and levels of involvement.

h. Participants have the right to choose not to participate in social and recreational activities.

8.491.2.B. Adult Day Service Requirements

1. The participant's Care Plan must include documentation of their diagnosis(es) and service goals.

2. A Specialized Adult Day Services (SADS) provider must verify all Medicaid participant's diagnosis(es) using the Professional Medical Information Page (PMIP) which shall be supplied by the case manager or documentation from the participant's Licensed Medical Professional (LMP). Documentation must be verified at the time of admission and whenever there is a significant change in the participant's condition. Any significant change must be recorded in the participant's record or Care Plan.

   a. For participants from other payment sources, diagnosis(es) must be documented in a care plan, or other admission form, and verified by the participant's physician or LMP. This documentation must be verified at the time of admission, and whenever there is a significant change in the participant's condition.

8.491.3 PROVIDER REQUIREMENTS

A. General

1. ADS providers shall conform to all provider participation requirements, as defined in 10 CCR 2505-10 Section 8.130. ADS Centers shall have in effect all required licenses, certifications, and insurance, as applicable. ADS Center providers shall comply with ADS Center regulations and Life Safety Code (LCS) regulations, as determined by the Colorado Division of Fire Protection and Control.

2. ADS providers shall be Medicaid certified by the Department as an ADS provider, in accordance with 10 CCR, 2505-10 Section 8.487.20. Proof of Medicaid certification consists of a completed Provider Agreement approved by the Department and the Department's fiscal agent, and recommendation for certification by CDPHE.

   a. Certification shall be denied, revoked, suspended, or terminated when a Provider is unable to meet, or adequately correct deficiencies relating to, certification standards as defined at 10 CCR 2505-10 section 8.491.

3. The Department or its designee will review an ADS Center's designation as a Specialized Adult Day Services (SADS) Center at the time of initial approval and during the recertification survey.

4. Denial, termination, or non-renewal of the Provider Agreement shall be for "Good Cause" as defined in 10 CCR 2505-10 section 8.076.

5. All providers of ADS shall operate in full compliance with all applicable federal, State and local laws, ordinances and regulations related to fire, health, safety, zoning, sanitation and other standards prescribed in law or regulations. This includes certification of building use occupancy.

8.491.4 PROVIDER ROLES AND RESPONSIBILITIES

A. Environment

1. All ADS providers must comply with the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Settings Final Rule requirements, 42 C.F.R. § 441.301(c)(4). This includes:

   a. ADS Center must be integrated in and supports full access of individuals to the greater community;

   b. ADS provider is selected by the individual from among setting options including non-disability specific settings;

   c. ADS provider ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;

   d. ADS provider optimizes individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact; and

   e. ADS provider facilitates individual choice regarding services and supports, and who provides them.

2. ADS Centers presumed to have institutional qualities will be subject to heightened scrutiny and reviewed by the Department and CMS, per 42 C.F.R. § 441.301(a)(2)(v). Settings in which this may apply include but are not limited to those where:

   a. The provision of inpatient institutional treatment within a publicly or privately-operated facility happens within the same building.

   b. Located on the grounds of, or adjacent to, a public institution.

   c. The effect of isolating participants receiving Medicaid Home and Community Based Services (HCBS) from the broader community.

2. If an ADS Center is subject to heightened scrutiny, Medicaid reimbursement by the Department may not be issued if the center fails CMS's heightened scrutiny review or until CMS approves the center.

3. ADS Centers shall provide a clean and sanitary environment that is free of obstacles that could pose a hazard to participant health and safety, allowing individuals the freedom to safely move about inside and outside the ADS Center.

4. ADS Centers shall provide lockers or a safe and secure place for participants' personal items.

5. ADS Centers shall provide recreational areas and recreational activities appropriate to the number and needs of the participants, at the times desired by the participants.

6. ADS Centers shall ensure the following are physically accessible to the participants at all times during hours of operation:

    a. Access to drinking water and other beverages;

    b. Bathrooms, sinks, and paper towel dispensers or hand dryers;

    c. Appliances and equipment used by or in the delivery of activities offered by the ADS Center, such as, tables/desks and chairs at a convenient height and location; and

    d. Free from obstructions such as steps, lips in doorways, narrow hallways, limiting individuals' mobility in the ADS Center. If obstructions are present, environmental adaptations are to be made to allow for participant access.

7. ADS Centers must provide for a private shower and/or bathing area located on site to address the emergency hygiene needs of participants as needed.

8. To accommodate the activities and program needs of the ADS Center, the center must provide eating and activity areas that are consistent with the number and needs of the participants being served, which is at a minimum of 40 square feet per participant.

9. ADS Centers shall maintain a comfortable temperature throughout the center. At no time shall the temperature fall outside the range of 68 degrees to 76 degrees Fahrenheit.

10. ADS Centers must provide an environment free from restraints.

11. ADS Centers, in accordance with 10 CCR 2505-10 section 8.491.4.A above, must provide a safe environment for all participants, including participants exhibiting behavioral problems, wandering behavior, or limitations in mental/cognitive functioning.

B. Food Safety Requirements

1. ADS providers shall comply with all applicable local food safety regulations. In addition, all ADS Centers must ensure:

    a. Access to a handwashing sink, soap and disposable paper towels;

    b. Food handlers, cooks and servers, including participants engaged in food preparation, properly wash their hands using proper hand-washing guidelines;

    c. The ADS Centers do not allow any staff or participants who are not in good health and free of communicable disease to handle, prepare or serve food or handle utensils;

    d. Refrigerated foods opened or prepared and not used within 24 hours are marked with a “use by” or “discard by” date. The “use by” or “discard by” date may not exceed 7 days following opening or preparation, or exceed or surpass the manufacturer’s expiration date for the product or its ingredients;

e. For food service, foods are maintained at the proper temperatures at all times. Foods that are stored cold must be held at or below 41 degrees Fahrenheit and foods that are stored hot must be held at or above 135 degrees Fahrenheit in order to control the growth of harmful bacteria;

f. Kitchen and food preparation equipment are maintained in working order and cleanable; and

g. Any equipment or surfaces used in the preparation and service of food are washed, rinsed and sanitized before use or at least every 4 hours of continual use. Dish detergent must be labeled for its intended purpose. Sanitizer must be approved for use as a no-rinse food contact sanitizer. Sanitizers must be registered with the Environmental Protection Agency (EPA) and used in accordance with labeled instructions.

C. Medication Administration and Monitoring

1. All medications shall be administered by Qualified Medication Administration Personnel (QMAP) staff, LMP staff or self-administered, regardless of the location where services are rendered.

2. Center-Based and Non-Center-Based ADS providers shall require each staff person who administers medication, that is not a LMP, to have completed training, passed a competency evaluation and be included in the Colorado Department of Public Health and Environment's (CDPHE) public list of individuals who have passed the QMAP competency evaluation, as outlined in 6 CCR 1011-1 Chapter 24.

3. All medication, when stored and administered by the ADS provider, shall be stored in a locked cabinet when unattended by QMAP or LMP staff.

4. Non-prescription medications, when stored by the ADS provider, shall be labeled with the recipient's name, and shall not be taken by any other participants.

5. A QMAP shall not conduct feeding or administer medication through a gastrostomy tube or administer intravenous, intramuscular or subcutaneous injections.

D. Records and Information

1. All ADS providers shall keep records and information necessary to document the services provided to participants receiving Adult Day Services. Records shall include but not be limited to:

a. Name, address, gender, and date of birth of each participant;

b. Name, address and telephone number of designated representative and/or emergency contact;

c. Name, address and telephone number of primary physician;

d. Documentation of the supervision and monitoring of services provided;

e. Documentation that all participants and their designated representatives (if any) were oriented to the ADS Center, their policies and procedures, to the services provided by the ADS provider, and delivery methods offered.;

f. A service agreement signed by the participant and/or the designated representative and appropriate staff; and

g. For SADS providers only, a copy of the PMIP, or diagnosis documentation from the participant's LMP;

h. Documentation specifically stating the types of services and monitoring that are provided when rendered via Telehealth, ensuring the integrity of the service provided and the benefit the service provides the participant.

E. Care Plan

1. The following information must be documented in the Care Plan and used to direct the participant's care and must be reviewed annually.

a. Medical Information:

i. All medications the participant is taking, including those while receiving Center-Based or Non-Center-Based ADS, and whether they are being self-administered;

ii. Special dietary considerations, instructions, or restrictions;

iii. Services that are administered to the participant while receiving Center-Based and/or Non-Center-Based ADS (may include nursing or medical interventions, speech therapy, physical therapy, or occupational therapy);

iv. Any restrictions on social and/or recreational activities identified by participant's LMP; and

v. Any other special health or behavioral management services or supports recommended to assist the participant by the participant's LMP.

b. Care Planning Documentation:

i. Documentation that the provider was selected by the individual and/or designated representative or legal representative;

ii. Individual choices, including location and delivery method for ADS, preferences, and needs shall be incorporated into the goals and services outlined in the Care Plan;

iii. All participant information and the Care Plan are considered protected health information and shall be kept confidential; and

iv. Participant and/or designated representative or legal representative must review and sign the Care Plan.

c. Modifications to the Care Plan must be supported by a specific and assessed need. Informed consent and proper documentation in the Care Plan are required for any changes including but not limited to:

i. Identification of the specific and individualized assessed need; and

ii. Documentation of any intervention and/or additional supports offered to support the participant appropriately.

d. Documentation that the participant and/or designated representative was provided with written information about the participant's right to establish an advance directive.

e. Documentation as to whether the participant has executed an advance directive or other declaration regarding medical decisions. Such documentation shall be maintained in the participant's record.

f. All entries into the record shall be legible, written in ink, dated, and signed with name and title designation, or records shall be maintained electronically with electronic signatures in accordance with standards for electronic medical record keeping practices.

F. Critical Incident Reporting

1. A Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a participant. A Critical Incident may endanger or negatively impact the mental and/or physical well-being of a participant. Critical Incidents include, but are not limited to:

a. Death;

b. Abuse/neglect/exploitation;

c. Serious injury to participant or illness of participant;

c. Damage or theft of participant's property;

d. Medication mismanagement;

e. Lost or missing person; and

f. Criminal activity.

2. A provider must submit a verbal or written report of a Critical Incident to the HCBS participant's Case Management Agency (CMA) case manager within 24 hours of discovery of the actual or alleged incident. The report must include:

a. Participant name;

b. Participant Medicaid identification number;

c. Waiver;

d. Incident type;

e. Date and time of incident;

f. Location of incident;

g. Persons involved;

h. Description of incident; and

i. Resolution, if applicable.

3. If any of the above information is not available within 24 hours of incident and not reported to the CMA case manager, a follow-up to the initial report must be completed.

G. Staff Requirements

1. In determining appropriate staffing levels, the ADS provider shall adjust staffing ratios based on the individual acuity and needs of the participants being served. At a minimum, staffing must be sufficient in number to provide the services outlined in the Care Plans, considering the individual needs, level of assistance, and risks of accidents. A staff person can have multiple functions, as long as they meet the definition of Direct Care Staff defined at 10 CCR 2505-10, Sections 8.491.1. Staff counted in the staff-participant ratio are those who are trained and able to provide direct services to participants.

   a. Staffing for Center-Based and in person Non-Center-Based ADS shall be no less than the following standard:

      i. A minimum of 1 staff to 8 participants with continuous supervision of participants during program operation.

   b. Staffing for Telehealth ADS shall be no less than the following standard:

      i. A minimum of 1 staff to 15 virtual participants with continuous virtual supervision of participants during Telehealth program operation.

   c. Staff shall provide the following:

      i. Immediate response to emergency situations to assure the safety, health and welfare of participants;

      ii. Activities that are planned to support the plans of care for the participants; and

      iii. Administrative, recreational, social, and supportive functions and duties.

   d. Nursing services for regular monitoring of the on-going medical needs of participants and the supervision of medications. These services must be available a minimum of two hours daily during Center-Based ADS, and as needed for Non-Center-Based ADS, and must be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Certified Nursing Assistant's (CNA) may provide nursing services under the direction of a RN or an LPN, in conformance with nurse delegation provisions outlined in CRS 12-38-132. Supervision of CNAs must include documented consultation and oversight on a weekly basis or more according to the participant's needs. If the supervising RN or LPN is an ADS provider staff member, with consultation and oversight of CNAs included in the member's job description, the supervising nurse's documented attendance shall be sufficient to document consultation and oversight.

2. In addition to the above services, Specialized Adult Day Services (SADS) Centers shall have sufficient staff to provide nursing services during all hours of operation.

a. Nursing services must be provided by a licensed RN or LPN or by a CNA under the supervision of an RN or LPN, as per 10 CCR 2505-10 section 8.491.4.G.1.e above and employed or contracted by the SADS Center.

3. The ADS provider shall require any individual seeking employment with that agency to submit to a criminal history record check to ascertain whether the individual seeking employment has been convicted of a felony or misdemeanor that involves conduct that the provider determines could pose a risk to the health, safety or welfare of participants.

4. The criminal history record check shall, at a minimum, include a search of criminal history in the State of Colorado and be conducted not more than 90 days prior to employment of the individual.

5. In assessing whether to employ an applicant with a felony or misdemeanor conviction, the ADS provider shall consider the following factors:

a. The history of convictions, pleas of guilty or no contest,

b. The nature and seriousness of the crimes;

c. The time that has elapsed since the conviction(s);

d. Whether there are any mitigating circumstances; and

e. The nature of the position for which the applicant would be employed.

6. The ADS provider shall develop and implement policies and procedures regarding the employment of any individual who is convicted of a felony or misdemeanor to ensure that the individual does not pose a risk to the health, safety and welfare of the consumer.

H. Director Qualifications

1. All Directors hired or designated after January 1, 2019, shall meet one of the following qualifications:

a. At least a bachelor’s degree from an accredited college or university and a minimum of two years of social services or health services experience and shall have demonstrated ability to perform all aspects of the position; or

b. A licensure by the state of Colorado as a Licensed Practical Nurse or Registered Nurse and completion of two years of paid or volunteer experience in planning or delivering health or social services including experience in supervision and administration; or

c. A high school diploma or GED equivalent, a minimum of four years of experience in a social services or health services setting, skills to work with aging adults or adults with functional impairment, and skills to supervise ADS Center staff persons.

I. Training Requirements

1. All ADS staff and volunteers must be trained in the ADS provider’s programmatic policies and procedures.

2. ADS providers providing medication administration as a service must have QMAP staff qualified in accordance with C.R.S. 6 CCR 1011-1 Chapter 24, unless medications are administered only by LMPs.

3. All staff and volunteers must be trained in the use of universal precautions and infection control, as defined at 10 CCR 2505-10 section 8.491.1.

4. The ADS Director and staff must receive training specific to the needs and diagnoses of the participants served. Training may include, but is not limited to: behavioral expression and management techniques, effective communication techniques, redirection, cardiopulmonary resuscitation, validation theory and communication, seizure response, and brain injuries.

    a. Documentation of staff member and Director trainings must include, but is not limited to: training provided, who completed trainings, who conducted trainings, and completion date.

5. All ADS staff must be trained in the handling of emergency services including written procedures to meet medical crises, and natural and manmade disasters.

6. All required training must be documented, and documentation must be maintained in individual staff's personnel files. Each staff person's training must be up-to-date.

J. Dementia Training Requirements

1. As of October 1, 2023, each Adult Day Services provider shall ensure that its Direct-Care Staff Members complete dementia training as required by Section 25.5-6-314, C.R.S.

2. Definitions applicable to Dementia Training Requirements:

    a. "Covered Facility" means a Assisted Living Residences, Nursing Care Facilities, and Adult Day Care Facilities as defined in Section 25.5-6-303(1), C.R.S.

    b. "Dementia diseases and related disabilities" is a condition where mental ability declines and is severe enough to interfere with an individual's ability to perform everyday tasks. Dementia diseases and related disabilities include Alzheimer's disease, mixed dementia, Lewy Body Dementia, vascular dementia, frontotemporal dementia, and other types of dementia.

    c. "Direct-Care Staff Member" means a staff member caring for the physical, emotional, or mental health needs of participants of an Adult Day Services provider and whose work involves regular contact with participants who are living with Dementia Diseases and related disabilities.

    d. "Staff member" means an individual, other than a volunteer, who is employed by an Adult Day Services provider.

    e. "Equivalent training" means any initial training provided by a Covered Facility that meets the requirements in Section 8.491.4.J.3.

3. Initial training: Each Adult Day Services provider is responsible for ensuring that all Direct-Care Staff Members are trained in dementia diseases and related disabilities.

    a. Initial training shall be available to Direct-Care Staff Members at no cost to them.

b. The training shall be competency-based and culturally competent and shall include a minimum of four hours of training in dementia topics including the following content:

1) Dementia diseases and related disabilities;

2) Person-centered care;

3) Care planning;

4) Activities of daily living; and

5) Dementia-related behaviors and communication.

c. For Direct-Care Staff Members already employed prior to October 1, 2023, the initial training must be completed as soon as practical, but no later than 120 days after October 1, 2023, unless an exception, as described in Section 8.491.4.J.4.a, applies.

d. For Direct-Care Staff Members hired or providing care on or after October 1, 2023, the initial training must be completed as soon as practical, but no later than 120 days after the start of employment or the provision of direct-care services, unless an exception, as described in Section 8.491.4.J.4.b, applies.

4. Exception to initial dementia training requirement

a. Any Direct-Care Staff Member who is employed by or providing direct-care services prior to the October 1, 2023, may be exempted from the provider's initial training requirement if all of the following conditions are met:

1) The Direct-Care Staff Member has completed Equivalent Training program, as defined in these rules, within the 24 months immediately preceding October 1, 2023; and

2) The Direct-Care Staff Member can provide documentation of the satisfactory completion of the Equivalent Training program.

3) If the Equivalent Training was provided more than 24 months prior to the date of hire, the individual must document participation in both the Equivalent Training and all required continuing education subsequent to the initial training.

b. Any Direct-Care Staff Member who is hired or begins providing direct-care services on or after October 1 ,2023, may be exempted from the provider's initial training requirement if the Direct-Care Staff Member:

1) Has completed an equivalent initial dementia training program, as defined in these rules, either:

a) Within the 24 months immediately preceding October 1, 2023; or

b) Within the 24 months immediately preceding the date of hire or the first date the Direct-Care Staff Member provides direct care services; and

2) Provides documentation of the satisfactory completion of the initial training program; and

3) Provides documentation of all required continuing education subsequent to the initial training.

c. Such exceptions shall not exempt a Direct-Care Staff Member from the requirement for dementia training continuing education as described in Section 8.491.4.J.5.

5. Dementia Training: Continuing Education

a. After completing the required initial training, all Direct-Care Staff Members shall have completed and documented a minimum of two hours of continuing education on dementia topics every two years.

b. Continuing education on this topic must be available to Direct-Care Staff Members at no cost to them.

c. This continuing education shall be culturally competent, include current information provided by recognized experts, agencies, or academic institutions, and include best practices in the treatment and care of persons living with dementia diseases and related disabilities.

6. Individuals conducting dementia training must meet the following minimum requirements:

a. Specialized training from recognized experts, agencies, or academic institutions in dementia disease, or

b. Successful completion of training which meets the minimum standards described herein; and

c. Two or more years of experience working with persons living with dementia diseases and related disabilities.

7. Documentation of initial dementia training and continuing education for Direct-Care Staff Members:

a. The provider shall maintain documentation that each Direct-Care Staff Member has completed initial dementia training and continuing education. Such records shall be made available upon request.

b. Completion shall be demonstrated by a certificate, attendance roster, or other documentation.

c. Documentation shall include the number of hours of training, the date on which it was received, and the name of the instructor and/or training entity.

d. Documentation of the satisfactory completion of an equivalent initial training program as defined in Section 8.491.4.J.2.e. shall include the information required in this Section 8.491.4.J.7.b. & c.

e. After the completion of training and upon request, such documentation shall be provided to the staff member for the purpose of employment at another Covered Facility.

K. Written Policies

1. The ADS provider shall have written policies and procedures relevant to its operation. Such policies shall include, but not be limited to, statements describing:

   a. Admission criteria for participants who can be appropriately served by the ADS provider;

   b. Intake procedures conducted for participants and/or designated representatives prior to admission with the ADS provider;

   c. The meals and nourishments including special diets that are provided;

   d. The hours and days that Center-Based ADS are open and available, and the days and times that Non-Center-Based ADS are available to participants, including the availability of nursing services;

   e. Medication administration and storage;

   f. The personal items that the participants may bring with them to the ADS Center;

   g. Emergency services including written procedures to meet medical crises, and natural and manmade disasters; and

   h. The administration of Telehealth Adult Day Services, if provided. This includes telehealth options, provision of services, and examples of virtually offered services.

2. There shall be a written, signed agreement between the participant and/or designated representative and the ADS provider outlining the rules and responsibilities of the ADS provider and the participant. Each party in the agreement shall be provided a copy.

L. Exclusions

1. The delivery of a meal, workbook, activity packet, etc. does not constitute rendered ADS and therefore are not reimbursable, unless in-person ADS service was provided in addition to the delivery of food or item.

8.491.5 REIMBURSEMENT METHOD FOR ADULT DAY SERVICES

A. Reimbursement for ADS for participants in the HCBS Elderly, Blind and Disabled (EBD) waiver, Community Mental Health Supports waiver (CMHS), and the Spinal Cord Injury (SCI) waiver is to be billed in accordance with the current rate schedule:

1. Providers may bill in 15-minute units or for 1-2 units of 3-5-hours depending on the participant's needs and how the service is delivered. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 12 units or three (3) hours per day of Basic Adult Day Services. A provider may bill the maximum of 15-minute units for ADS in combination with no more than 1 unit of 3-5 hour ADS on the same day, as long as services were rendered at separate times.

B. For persons in the HCBS waiver for Persons with a Brain Injury (BI), reimbursement for BI-ADS is to be billed in accordance with the current rate schedule.

1. A unit is defined as the following:

a. Providers may bill in units of 15 minutes or a unit of 2 or more hours depending on the participant's needs and how the service is delivered. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 8 units or two (2) hours per day of services. Units of 2 hours or more can only be delivered in-person. A provider cannot bill for 15-minute units of ADS if a unit of 2-hour BI ADS was provided on the same day.

C. ADS Centers are permitted to utilize funding from other Federal sources, such as the Child and Adult Care Food Program (CACFP), in addition to the Medicaid per diem. If such funding is utilized, a Center must acknowledge the use of multiple funding sources and demonstrate that Federal funds are not used in a duplicative manner to Medicaid-funded services.

D. Only providers certified as a Specialized Adult Day Services Center are permitted to receive the SADS reimbursement rate, for participants needing SADS. The SADS reimbursement rate applies to every participant at a SADS Center, even if the participant does not have a specialized diagnosis.

E. Certified SADS providers may provide Non-Center-Based Adult Day Services, including Telehealth ADS, billing only for Basic Adult Day Services using the 15-minute unit, up to 3 hours per day. The SADS provider may bill the maximum of 15-minute units for Basic ADS in combination with no more than 1 unit of 3-5 hour SADS on the same day, as long as services were rendered at separate times.

F. Providers shall not bill for services on the same day of service for a participant in an HCBS residential program, unless the following criteria have been met:

1. ADS and residential services have been authorized by the Department and are included on the prior authorization request (PAR);

2. Participant's diagnoses must meet the criteria for a SADS Center;

3. Documentation from the participant's physician demonstrating the required specialized services in the SADS Center are necessary because of the qualifying diagnosis(es), are essential to the care of the participant, and are not included in the residential per diem;

4. Documentation that the extensive rehabilitative therapies and therapeutic needs of the participant are not being met by the residential program and are not included in the residential per diem; and

5. Documentation from the participant's physician recommending SADS and how it will meet the previously mentioned needs.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 23-04-24-A
Division / Contact / Phone:Special Financing / Nancy Dolson / 303-866-3698

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 23-04-24-A, Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000.

3. This action is an adoption of: new rules

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) OP Pages, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.8000 with the proposed text beginning at 8.8000 through the end of 8.8000. This rule is effective July 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 23-04-24-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Create rules to administer the Rural Provider Access and Affordability Stimulus Grant Program established through the enactment of Senate Bill 22-200 including a methodology to determine which rural providers are qualified for grant funds, permissible uses of grant money, and reporting requirements for grant recipients.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   American Rescue Plan Act of 2021 (ARPA), Public Law 117-2

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
   Section 25.5-1-207 (5), C.R.S. (2022)

Initial Review — Final Adoption **06/09/23**
Proposed Effective Date **07/30/23** — Emergency Adoption

DOCUMENT #03

DO NOT PUBLISH THIS PAGE

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Rule Number: MSB 23-04-24-A
Division / Contact / Phone:Special Financing / Nancy Dolson / 303-866-3698

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Colorado hospitals in rural communities and their associated clinics will benefit from the proposed rule by helping these providers modernize their information technology systems which tend to lag behind their urban and suburban counterparts. Residents of rural Colorado will benefit as the program will support reducing health care costs in communities, add jobs, stimulate the economy, improve access to care, and mitigate rural health disparities.

   The funding for the Rural Provider Access and Affordability Stimulus Grant Program comes from federal funds with no cost to the state or local communities.

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

   The Rural Provider Access and Affordability Stimulus Grant Program will drive financial sustainability for hospitals and clinics in rural areas of Colorado by investing $9.6 million in health care affordability and health care access related projects:

   - $4.8 million in health care affordability projects, such as shared analytics platforms, telehealth supports, and enabling shared care management between rural providers

   - $4.8 million in health care access projects, such as extending hours for primary and behavioral health care, telemedicine including remote monitoring supports, new or expanded access sites including surgery, chemotherapy, and advanced imaging

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

The General Assembly appropriated $400,000 to the Department to administer the Rural Provider Access and Affordability Stimulus Grant Program when it enacted Senate Bill 22-200. These funds are sufficient to administer the program and no costs to other agencies are expected. The funds for the Rural Provider Access and Affordability Stimulus Grant Program are federal funds from the American Rescue Plan Act of 2021 (ARPA) and there is no impact on state revenues.

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

   Adopting the proposed rules to administer the Rural Provider Access and Affordability Stimulus Grant Program will allow the Department to grant $9.6 million of federal funds to rural providers as directed by the General Assembly to improve health care affordability and access and stimulate the economies in rural Colorado.

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, there are no benefits to inaction.

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

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, there are no less costly or intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, there are no alternatives to rule making than the proposed rule. The proposed rule includes those elements necessary to administer the grant program and were developed and supported by the Rural Provider Access and Affordability Advisory Committee established by the legislation.

8.8000 Rural Provider Access and Affordability Stimulus Grant Program

8.8000.A PURPOSE AND LEGAL BASIS

1. Pursuant to C.R.S. § 25.5-1-207, the Rural Provider Access and Affordability Stimulus Grant Program provides grants to qualified providers to improve health care affordability and access to health care services in rural communities and to drive financial sustainability for rural hospitals and clinics.

8.8000.B DEFINITIONS

1. Advisory Committee means the rural provider access and affordability advisory committee as defined in section 25.5-1-207 (3), C.R.S.

2. Department means the Colorado Department of Health Care Policy and Financing.

3. Health Care Access Project means a project that expands access to health care in Rural Communities including but not limited to:

    a. Extending hours for access to primary care or behavioral health services,

    b. Investing in dual track emergency department management,

    c. Expanding access to Telemedicine including remote monitoring support,

    d. Providing new or replacement Hospital beds,

    e. Expanding access to long term care and recovery care in skilled nursing facilities, and

    f. Creating or expanding sites that provide surgical care, chemotherapy, imaging, and advanced imagining including computerized tomography scans.

4. Health Care Affordability Project means a project that modernizes the information technology infrastructure of Qualified Rural Providers including but not limited to:

    a. Creating a shared analytics platform and care coordination platforms among Qualified Rural Providers, and

    b. Enabling technologies, including telehealth and e-consult systems, that allow Qualified Rural Providers to communicate, share clinical information, and consult electronically to manage patient care.

5. Hospital means a hospital licensed or certified pursuant to section 25-1.5-103 (1)(a), C.R.S. or an affiliate owned or controlled as defined in section 25.5-4-402.8 (1)(b), C.R.S., by the hospital.

6. Qualified Rural Provider means a Hospital located in a Rural Community in Colorado that has a lower net patient revenue or fund balance compared with other Rural Hospitals.

7. Rural Community means a county with a population of fewer than fifty thousand residents; or a municipality with a population of fewer than twenty-five thousand residents if the municipality is not contiguous to a municipality with a population of twenty-five thousand or more residents.

8. Rural Stimulus Grant means funding received from the rural provider access and affordability grant program established in section 25.5.1-207, C.R.S.

9. Telemedicine means the delivery of medical services as defined at section 12-240-104 (6), C.R.S.

8.8000.C GRANT AWARD PROCEDURES

1. Rural Stimulus Grants will be awarded through an application process.

    a. A request for grant application form shall be issued by the Department and posted for public access on the Department's website at https://hcpf.colorado.gov/research-data at least 30 days prior to the application due date.

    b. A Qualified Rural Provider may submit applications for more than one project or may submit a joint application with another Qualified Rural Provider.

2. The application will include:

        a. Project overview.

        b. Proposed budget including:

            i. Total funds requested not to exceed $650,000 per project per applicant,

            ii. Itemized direct expenses,

            iii. Indirect expenses limited to federal Negotiated Indirect Costs Rate Agreement (NICRA) or de minimis rate of 10 percent if the applicant does not have an NICRA,

            iv. If applicable, documentation of quotes or estimates for construction, equipment, or other expenditures, and

            v. If applicable other sources of funding that will be utilized to complete the proposed project.

        c. Project timeline to commence no earlier than July 1, 2023 and to conclude no later than December 31, 2026.

        d. Description of Qualified Rural Provider's diversity, equity, and inclusion strategy and how diverse community needs are met by the project.

        e. Demonstration of financial need.

            i. Qualified Rural Providers in the bottom 40% of net patient revenues for the three-year average of 2016, 2017, and 2018 or the bottom 6% fund balance for 2019 as determined by the Department's review of CMS 2552-10 Medicare Cost Reports are considered to meet the financial health requirement.

            ii. Other Qualified Rural Providers may submit additional financial supporting information to support their financial need.

        a. For capital investment projects, facility or equipment age.

        b. Impact to health care affordability or access to care.

i. Statement of need outlying underlying problem the funding will address.

ii. Description of how the project's goals and objectives will be sustained after the Rural Stimulus Grant funds have been expended.

iii. Description of how the project will increase access to specialty care, if applicable.

iv. Description of how project will improve care coordination, if applicable.

v. Description of partner engagement, if applicable.

3. The Advisory Committee will review Rural Stimulus Grant applications and recommend Rural Stimulus Grant awards to the Department's executive director based on the following criteria:

    a. Budget and financial need.

    b. Partner collaboration, support, or engagement.

    c. Completeness of response.

    d. Ability to execute and complete project.

    e. Reasonableness of timeline.

    f. Diversity, equity and inclusion and how diverse communities will be impacted by the project.

    g. County Medicare and Medicaid caseload percentage of population.

    h. Statement of need.

    i. Sustainability of project.

    j. Impact to health care affordability or access to care.

4. The Department's executive director or his or her designee shall make the final Rural Stimulus Grant awards to Qualified Rural Providers.

    a. The total funding for Rural Stimulus Grants is limited to no more than $9.6 million with no more than $4.8 million for Health Care Access Projects and no more than $4.8 million for Health Care Affordability Projects.

    b. The Department may change Rural Stimulus Grant amounts depending on the final number of Rural Stimulus Grants awarded, the availability of Rural Stimulus Grant funds, or the goals stated in the Rural Stimulus Grant application.

    c. Rural Stimulus Grant applicants may request reconsideration of Rural Stimulus Grant awards within 5 business days of award notification in writing to the Department's executive director. The executive director will respond to the request for reconsideration within 10 business days of receipt.

    d. The Department will execute a grant agreement with each Rural Stimulus Grant recipient.

5. The Department will disburse Rural Stimulus Grant funds no earlier than July 1, 2023 and no later than July 1, 2024. Any money not disbursed by July 1, 2024 will revert to the Economic Recovery and Relief Cash Fund created pursuant section 24-75-228 (2)(a), C.R.S.

6. Rural Stimulus Grant recipients will expend Rural Stimulus Grant funds by the timeline in their grant agreement and no later than December 31, 2026. Any Rural Stimulus Grant funds not expended by Rural Stimulus Grant recipients by December 31, 2026 will be recovered by the Department to be returned to the U.S. Department of the Treasury.

8.8000.D PERMISSIBLE USES OF GRANT AWARDS

1. Rural Stimulus Grant funds must be used for Health Care Affordability Projects or Health Care Access Projects to improve health care affordability and access in Rural Communities.

2. Rural Stimulus Grant funds may not be deposited into a pension fund and may not be used to service debt, satisfy a judgment or settlement, or contribute to a “rainy day” fund.

8.8000.E REPORTING REQUIREMENTS FOR GRANT RECIPIENTS

1. Recipients of Rural Stimulus Grant funds for capital expenditures must submit a written justification as set forth in 31 Code of Federal Regulations 35.6 (b)(4) to the Department.

2. For the duration of the grant agreement, Rural Stimulus Grant recipients must submit a quarterly report to the Department no later than the 10th day of the month following the end of each quarter including but not limited to a brief narrative and itemized expenditure and performance metric data.

3. Rural Stimulus Grant recipients will submit a final report to the Department within 30 calendar days following the end of the grant agreement including an overall narrative and itemization of all expenditures and performance metric data for the total Rural Stimulus Grant award.

8.8000.F RECORD RETENTION AND ACCESS

1. Rural Stimulus Grant recipients must maintain records of expenditures for a minimum of five years after funds have been expended or returned to the Department, whichever is later.

2. Rural Stimulus Grant recipients must allow the Department and state and federal auditors access to records related to the expenditure of Rural Stimulus Grant funds.

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Office of the Attorney General

Tracking number: 2023-00239

Opinion of the Attorney General rendered in connection with the rules adopted by the

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

on 06/09/2023

10 CCR 2505-10

MEDICAL ASSISTANCE - STATEMENTS OF BASIS AND PURPOSE AND RULE HISTORY

The above-referenced rules were submitted to this office on 06/09/2023 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.

June 23, 2023 09:44:33

Philip J. Weiser
Attorney General
by Kurtis Morrison
Deputy Attorney General

Permanent Rules Adopted

Department

Department of Human Services

Agency

Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)

CCR number

12 CCR 2509-4

Rule title

12 CCR 2509-4 CHILD WELFARE SERVICES 1 - eff 07/30/2023

Effective date

07/30/2023

7.306.4 Adoption Assistance Services

Colorado operates two adoption assistance programs: the Title IV-E program and the state and county-only (non-Title IV-E) program.

A. Applicable to Both Programs:

1. The federal government participates in adoption assistance agreements on behalf of children/youth who meet the eligibility criteria for the Title IV-E adoption assistance program.

2. The state and county departments participate in adoption assistance agreements on behalf of children/youth who are not eligible for the Title IV-E program.

3. Prospective adoptive parents must be informed of the adoption assistance program. Adoption assistance is a program that provides assistance to adoptive parent(s) in certain defined and limited ways to provide for the needs of an eligible adopted child/youth. Adoption assistance is intended to help or remove financial or other barriers to the adoption of eligible Colorado children/youth with identified needs by providing assistance to the parent(s) in caring for and raising the child/youth.

a. The county department may make adoption assistance payments and/or provide Medicaid or medical assistance at the time of adoptive placement, continue them after the adoption has been finalized and continue them until the adopted child/youth has reached the age of eighteen (18). As defined in section 7.306.54, adoption assistance may continue to the 21st birthday. In situations where adoption assistance continues through the 21st birthday of the adoptee, adoption Medicaid will still continue through the end of the month of the 21st birthday.

b. The determination for expiration of the agreement must be made and documented in the original negotiation and noted in the original paperwork for the adoption assistance agreement. The county department shall extend the adoption assistance agreement upon the approaching expiration date if the youth meets criteria for extension per section 7.306.54 and the extension is requested by the adoptive parent(s).

c. The county department must determine that in each case a reasonable, but unsuccessful, effort to place the child/youth for adoption without adoption assistance has been made before negotiating adoption assistance, unless the best interests of the child/youth would not be served by such an effort. Reasonable effort requires listing with the Colorado Adoption Resource Registry (CARR) and may include presentation in the media and consultation with the state. Exceptions to the requirement:

1) The current caregiver will be given priority as the prospective adoptive family, when appropriate.

2) In situations where it would be against the best interests of the child/youth, due to such factors as:

a. The existence of significant emotional ties with the prospective adoptive parents while in their care as a foster child/youth, or

b. Adoption by a kinship caregiver

c. The eligible child/youth is being placed by a birth parent with designated adoptive parents through a non-profit child placement agency.

d. Eligible child or youth means a child or youth who meets the medical and disability requirements for federal supplemental security income or is a child or youth with one or more specific factors or conditions that would make it reasonable to conclude that a child or youth cannot be adopted without providing benefits to assist in the adoption. Such factors may include but are not limited to:

1) A physical disability, that has been documented by a qualified licensed professional such as hearing, vision, or physical impairment; neurological conditions; disfiguring defects; metabolic disorder; a child or youth infected with the human immunodeficiency virus; or heart defects;

2) A mental, intellectual, or developmental disability that has been documented by a qualified licensed professional, such as a perceptual, speech, or language disability or any disability that results in educational delays or significant learning difficulties;

3) An emotional handicap, such as post-traumatic stress disorder, bipolar disorder, or other mental health disorder that has been documented by a qualified licensed professional;

4) Hereditary factors that have been documented by a qualified licensed professional;

5) An educational disability that qualifies for section 504 of the federal rehabilitation act of 1973, or special education services;

6) Factors that place a child or youth in a "high-risk" category, such as being drug- or alcohol-exposed in utero;

7) Other conditions that act as a barrier to the child's/youth's adoption, including but not limited to, a healthy child or youth over seven years of age or a sibling group that should remain intact and medical conditions that are likely to require further treatment; or,

8) Ethnic background or membership in a minority group which may be difficult to place.

e. The county department shall not use an income eligibility requirement (income means test) for the prospective adoptive parent(s) in determining eligibility for adoption assistance. Instead, the particular agreement that is negotiated shall be based on the child/youth's current and anticipated needs and the family circumstances.

f. Available public programs for which the child/youth is eligible shall be used first to address the child's/youth's needs before an adoption assistance agreement is negotiated.

g. The county department may authorize the following types of adoption assistance agreements:

1) "Long-Term Adoption Assistance Agreement" means to partially meet a child's/youth's daily needs unless the adoptive family's or child's/youth's circumstances

change or the agreement terminates as outlined in the termination of adoption assistance, section 7.306.48, of the adoption assistance agreement rules and as cited in C.R.S. § 26-7-109. A long-term agreement is made when the family's financial situation and/or the child's/youth's needs are unlikely to change or when a child's/youth's needs take an excessive toll on the family's financial resources.

2) "Time-Limited Adoption Assistance Agreement" means to partially meet the everyday needs of the child/youth for a specified period. Agreement partially covers unmet needs that are time limited.

3) "Dormant" or "Medicaid Only Adoption Assistance Agreement" means there is no adoption assistance payment provided at the time of the agreement. County departments shall document for the child's/youth's eligibility in the services record and in the Comprehensive Child Welfare Information System (CCWIS) that the potential need for financial adoption assistance exists and may need to be activated at a future time.

4. If the child/youth is legally available for adoption and reunited with their birth parent(s), the child/youth is not eligible for adoption assistance.

5. Medicaid is available to all Colorado children/youth who have an adoption assistance agreement.

6. Families who adopt children/youth who meet the criteria for adoption assistance are eligible for non-recurring adoption expenses.

7. Case services payments may be part of an adoption assistance agreement; these payments can be made directly to the service providers or to the adoptive parent(s).

B. Target Groups for Adoption Assistance Agreements:

1. Children/youth who meet the eligibility criteria to participate in one of Colorado's adoption assistance programs and whose identified needs are a barrier to their adoption are legally available for adoption and are in the custody of a county department and the county has guardianship of the child/youth with the right to consent for adoption; or,

2. Children/youth who are in the custody of a relative, tribe, person to whom custody of the child/youth has been given by proper order of a dependency and neglect court, or licensed non-profit child placement agency and meet the eligibility criteria to participate in one of Colorado's adoption assistance programs; and,

3. The county department, licensed non-profit child placement agency, tribe, person to whom custody of the child/youth has been given by proper order of a dependency and neglect court, or relative requesting the adoption assistance agreement is financially responsible for the care of the child/youth.

C. County Requirements for Adoption Assistance:

1. The county department shall obtain and document the diagnoses and prognoses of the child's/youth's

needs that are barriers to the adoption.

2.The documentation shall include specific eligibility factors used to determine eligibility factors as outlined in section 7.306.4 A.

A. Placement history

B. Eligible child/youth: if the county department determines that the child/youth is an eligible child/youth, with needs for whom services will be purchased, it must confirm the identified needs by a second opinion of a qualified licensed professional who is outside the department.

C. Other appropriate reports

3. The county department shall determine the child's/youth's Title IV-E status for adoption assistance in the Comprehensive Child Welfare Information System (CCWIS) prior to adoption finalization and no later than the calendar month the adoption petition is filed.

4. The county department shall ensure that all parties sign the adoption assistance agreement before the adoption is finalized.

5. At the time that the family is matched for adoption of a child/youth who is potentially eligible for adoption assistance benefits, the prospective adoptive family should be informed in writing, with the following information:

a. The availability of benefits, with an explanation of the differences between these benefits and foster care maintenance payments;

b. The availability of reimbursement for non-recurring expenses incurred in the adoption of an eligible child/youth not to exceed the federal limit;

c. The availability of mental health services through the state Medicaid assistance program or other programs;

d. The federal adoption tax credit for an individual who is adopting or is considering adopting a child/youth in foster care or through a nonprofit child placement agency;

e. Notice of the general right to request a negotiating meeting;

f. Notice of the general right to bring to the adoption assistance negotiation process:

1. Parties who possess relevant information about a child/youth's history and needs, including the child's guardian ad litem or the family's advocate; and

2. Legal representation for a child/youth or prospective adoptive family.

g. Notice of the right to an administrative appeal and be represented by legal counsel, at the prospective adoptive parent's expense.

h. The Colorado Adoption Assistance Negotiation Worksheet must be provided to all participants 5 business days prior to the negotiation meeting.

7.306.41 Title IV-E Adoption Assistance Program

A. Pathways to Eligibility

Title IV-E adoption assistance services may be provided to children/youth whose needs are a barrier to their adoption, who are legally available for adoption, and meet one of the following pathways:

1. A child/youth was removed from a specified relative by a court order that contains the requirements in Section 7.601.71.

a. For the purposes of Title IV-E adoption assistance only, there is no requirement for a "reasonable efforts" judicial determination at the time of the initial removal.

b. The Federal Applicable Child Criteria (delinking) allows for Title IV-E adoption assistance to child(ren)/youth who are two or turn two in the federal fiscal year in which the adoption is finalized.

c. For Title IV-E funding to be an option in adoption assistance a removal must have been entered and an initial Title IV-E foster care determination must have been entered into the CCWIS system.

2. Have Social Security Income (SSI) eligibility.

a. This factor must be met at any time prior to finalization of the adoption.

b. If eligible, the child/youth may simultaneously receive SSI and Title IV-E adoption assistance payments.

c. If a child/youth is SSI eligible, there are no requirements for the Federal Applicable Child Criteria or the statement regarding efforts to place the child/youth without adoption assistance.

3. Are IV-E eligible in a previous adoption and the adoptive parents have relinquished, had their parental rights terminated, or died and the child/youth are placed in a subsequent adoptive placement, then the child/youth retain Title IV-E eligibility for adoption assistance in their new adoptive placement. Additional requirements for this pathway to eligibility include:

a. A new determination regarding the child/youth's continuing needs.

b. Completion of a new adoption assistance agreement with the new prospective adoptive parent(s).

c. If the previous adoptive parent(s) is(are) deceased, a copy of the death certificate must be provided.

4. Is in mutual foster care placement with a county department.

a. The child must be placed with their teen parent; and,

b. The foster care payment included both the child and the teen parent.

5. Is in foster care by voluntary placement agreement with a county department (a tribe or another public agency with which the state/county has a Title IV-E agreement). The child/youth must meet the requirement outlined in section 7.601.71.

a. There must have been at least one Title IV-E foster care maintenance payment made on behalf of the child/youth under the voluntary placement agreement.

b. Under this factor, there is no specified amount of time that the child/youth must have been in foster care under the voluntary placement agreement.

6. A child/youth who was voluntarily relinquished to a public or private licensed non-profit agency must meet the requirements in section 7.601.71.F., and:

a. A petition was filed in court to place the child/youth outside of the home within six months of the time the child/youth lived with the relinquishing parent; and,

b. A subsequent order was issued which included findings that it is in the best interest of the child/youth to be placed out of the home; and,

c. Legal orders placing the child/youth in the custody of a public or private licensed non-profit child placement agency with authority to consent to the child/youth's adoption;

d. The agency must provide documentation of the efforts the agency made to place the child/youth for adoption without an adoption assistance agreement, except as provided in section 7.306.4.A.3.C., when the child/youth meets the Federal Applicable Child Criteria.

7. If the child/youth does not meet the Federal Applicable Child Criteria, has identified needs, and if they are between the ages of 2 and 18 years in the Federal Fiscal Year in which the adoption assistance agreement is signed by all parties, the child/youth will become categorically eligible for Title IV-E adoption assistance (delinking). A child/youth still must meet removal requirements of section 7.601.71. This requirement is in effect during the period of January 1, 2018, through June 30,2024. This includes children/youth who turn two during the current federal fiscal year in which they are adopted.

8. County Departments of Human/Social Services shall continue the adoption assistance agreement if the extension is requested by the adoptive parent(s) and claim Title IV-E funds for youth 18 years of age through the 21st birthday (adoption Medicaid will still continue through the end of the month of the 21st birthday) when one of the following criteria is met:

a. The county shall document in the record that the youth is enrolled full-time in high school or vocational training and is making progress in the program; or completing secondary education; or is enrolled in a program leading to an equivalent credential; or,

b. Enrolled in an institution that provides postsecondary or vocational education (section 7.306.54); or,

c. A youth who is identified in the original adoption assistance agreement as having an intellectual and or developmental disability or a physical handicap, is between the age of 18-21, and continues to live at home, may continue to be eligible for the adoption assistance program as long as these disabilities were identified and documented in the original agreement paperwork or is genetic in nature; or,

d. Participation in a program or activity designed to promote or remove barriers to employment; or,

e. Employed for at least eighty hours per month.

9. After a child/youth has been determined eligible for Title IV-E adoption assistance payments and/or Title IV-E Medicaid benefits, Title IV-E eligibility continues as long as there is an adoption assistance agreement in effect as outlined below:

a. The child/youth meet the requirements regardless of the family's state of residence.

b. Eligibility may continue even though no payments or Medicaid benefit is currently paid; therefore, maintaining the potential Title IV-E benefits if needed later.

c. Until the expiration of the original agreement unless all parties to the agreement are in concurrence in a subsequent written and signed document.

10. The county shall obtain annual documentation of school attendance or reasons for inability to attend. The documentation must demonstrate that each child/youth who is eligible for adoption assistance and who has attained the minimum age for compulsory school attendance is:

a. Enrolled or in the process of enrolling in an institution that provides elementary or secondary education, or,

b. Instructed in elementary or secondary education at home in accordance with the home school statute, or,

c. In an independent study elementary or secondary education program in accordance with statute, and which is administered by the local school, school district, or Board of Cooperative Education (BOCES), or,

d. Incapable of attending school on a full-time basis due to the medical condition of the youth or child. The reasons shall be supported by regularly updated information in the educational plan maintained by the school, school district, or Boards of Cooperative Educational Services (BOCES).

B. Out-of-Home Placement of a Child/Youth Who is in the Custody of the County While Receiving Adoption Assistance

1. Title IV-E eligibility must be determined when a child/youth is dually placed in foster care and adoption assistance. The child/youth does not automatically retain the Title IV-E eligibility while in foster care and out of home placement.

2. The State prescribed form must be completed using the adoptive parent(s)' income.

3. The child/youth, upon returning to the adoptive parent(s)' home, continues to be eligible for the Title IV-E adoption assistance agreement.

4. If the adoptive family does not reside in the state of Colorado this does not apply.

C. Assessment of Parental Fees for Placement Out of the Home for Children/Youth Receiving Title IV-E Adoption Assistance:

1. If the adoptive parent(s) are receiving Title IV-E adoption assistance and the child/youth is under the custody of the department and placed in out-of-home for a duration of over thirty (30) calendar days, the department and the family have two options:

a. To assess a parental fee (child support) from the family not to exceed the amount of the adoption assistance payment they are receiving under their adoption assistance agreement; or,

b. To execute an amended agreement, which would reduce the adoption assistance payment to $0 and place it on Medicaid-only status until such time that the child/youth returns to the custody of the parent(s).

2. The parental fee will not be discontinued because the child/youth returns to the home of the adoptive parents for holidays or visits while the child/youth is under the custody of the department.

3. During the time the adoption assistance payment is in Medicaid-only status, the parent(s) will not be assessed a parental share fee for the child/youth's out-of-home placement.

D. Eligibility Determination for Medicaid in Title IV-E Adoption Assistance

1. Children/youth with an effective adoption assistance agreement are eligible for Medicaid in the state they reside. See Medical Resources section, 7.402 Medicaid for children/youth covered by the Interstate Compact on Adoptions and Medical Assistance (ICAMA).

2. An adoption assistance payment is not required to extend Medicaid coverage.

3. Colorado is a member of the Interstate Compact to Adoption and Medicaid Assistance (ICAMA). Procedures for completing and complying with the compact are in the Medical Resources section, Children Moving from Colorado (Section 7.420.3, B.).

4. Medicaid eligibility shall be continued for IV-E eligible children/youth who are out of the home for more than thirty (30) calendar days unless it is determined that they are eligible for Medicaid under another program by completing the State approved form.

5. Medicaid eligibility for all children/youth receiving Medicaid shall be re-determined yearly only if the child/youth continues to be eligible for Medicaid. This can be done by completing the State prescribed form or completing a form letter that the children/youth continue to be eligible for Medicaid. This form letter shall be sent to the other states by the county department to

ensure continuation of Medicaid for a child/youth who is residing out of state.

6. Upon verification that Medicaid has been opened by the receiving state, the county department will ensure Colorado Medicaid is closed.

E. County Process for Title IV-E Adoption Assistance Agreements

1. Determine and document a child's/youth's identified needs and eligibility for adoption assistance.

2. Denial of assistance based solely on a means test of the adoptive family is not allowed and must not be substituted for the agreement.

a. The circumstances of the family, as defined in C.R.S. § 26-7-102(5), should be considered in negotiating the adoption assistance agreement. "Circumstances of the family" is defined as the capacity of the family, including but not limited to financial capacity, to meet the anticipated needs of the eligible child or youth. The county is entitled to request and receive financial information regarding the family, including assets, liabilities, and insurance benefits in negotiating the initial agreement and any subsequent increases in adoption assistance but may not be used as the sole factor.

3. The adoption assistance agreement shall be established in accordance with the state's written policy and is consistent with state and federal regulations. The policy shall outline the criteria used for determining the amount of adoption assistance.

a. County departments shall use the Colorado Adoption Assistance Negotiation Worksheet with the potential adoptive family for all adoption assistance determinations and negotiations.

1. If adoptive parent(s) choose(s) to refuse all adoption assistance including monthly cash assistance, Medicaid, and/or case services, they must sign the permanent refusal of adoption assistance form.

2. If adoption parent(s) request a Medicaid only adoption assistance agreement and/or non-recurring adoption expenses they may choose to decline completing the Adoption Assistance Negotiation Worksheet and sign the request for Medicaid only adoption assistance form. However, they still must sign an adoption assistance agreement.

b. County departments shall adopt the policies and procedures outlined in the State of Colorado's adoption assistance policy. A copy of the written policy shall be provided to adoptive parent(s) at least 5 business days prior to a negotiation meeting.

4. It is not permissible for a county to include a statement in the adoption assistance agreement that IV-E adoption assistance payments and/or services are subject to the appropriation of state funds.

5. The county department shall make a good faith effort to negotiate an adoption assistance agreement with the adoptive parent(s). The county shall base the negotiation on the current and anticipated needs of the child/youth and the circumstances of the adoptive parent(s).

a. A good faith negotiation means to deal honestly and fairly with one another. There must be a discussion between the county department and the adoptive parent(s).

b. At the negotiation meeting, the county department will explain all aspects of the program and the agreed-upon amount of assistance which considers the needs of the child/youth.

c. If the parties cannot come to an agreement, the county department shall establish the adoption assistance amount. If the family disagrees with the decision, a fair hearing can be requested.

6. Negotiate with the adoptive parents to request the amount that is needed by the family to meet the child's/youth's needs. This may be less than the amount for which the child/youth qualifies.

7. The county may negotiate up to the monthly foster care rate in appropriate cases. The amount shall be no more than the rate that is being paid for the child's/youth's current out-of-home care or that would have been paid if the child/youth were in paid out-of-home care today. The monthly respite care payment that is provided under the foster care program is not a benefit under the adoption assistance program. If the county and the prospective adoptive family do not agree to an amount, the county shall make an offer. The adoptive family may reject that offer and take the matter to a fair hearing.

8. If a child/youth with mental, intellectual or developmental disability that is documented and defined by a licensed medical professional is receiving an allowance in addition to the foster care payment at the time the child/youth is placed for adoption, the allowance may continue under the adoption assistance program if the child/youth continues to meet the criteria outlined in "Child with Adoption assistance" Section 7.306.4, A.

9. County departments who pay more than the child's/youth's foster care rate or in the event that the child/youth is not in foster care, the rate that would have been paid based on the child's/youth's original or amended adoption assistance agreement shall reimburse the state for ninety percent (90%) of the payment that is over the foster care rate.

10. Use the State prescribed forms to document the negotiated agreement for IV-E adoption assistance and attach supporting documentation.

11. Complete and sign the adoption assistance agreement form specifying:

a. The dollar amount of any adoption assistance and a summary of case services agreed upon being provided, if applicable.

b. The duration date of the agreement:

1. Until the adopted child/youth reaches the age of 18 years; or,

2. Up to 21 years in the case of a child/youth who has a physical, intellectual or developmental disability; or,

a. The county shall document in the record that the youth is enrolled full-time in high school or vocational training and is making progress in the program or completing secondary education or is enrolled in a program leading to an equivalent credential.

b. Enrolled in an institution that provides postsecondary or vocational

education.

c. A youth who is identified in the original adoption assistance agreement has an intellectual and or developmental disability or a physical handicap, is between the age of 18-21, and continues to live at home, may continue to be eligible for the adoption assistance program as long as these disabilities were identified;

d. Participating in a program or activity designed to promote or remove barriers to employment; or,

e. Employed for at least eighty hours per month.

3. On a case-by-case basis, the duration of an agreement may be sooner than this time. All parties must be in agreement with the earlier termination date.

4. The services and dates of services that are covered by an effective adoption assistance agreement.

5. Any reimbursement for non-recurring expenses incurred by or on behalf of the adoptive parent(s) in connection with the adoption.

c. That the adoption assistance agreement must be signed and dated by all parties prior to the effective date of the agreement and before the adoption is finalized. If the county fails to completely execute the initial adoption assistance agreement prior to the effective date and prior to the finalization of the adoption, the assistance payment will become non-reimbursable by the State and IV-E moneys.

12. The adoption assistance agreement must be reviewed at least every three years. The county department shall provide written notice of the upcoming review to the adoptive family.

a. The agreement may be adjusted after a good-faith negotiation and with the concurrence of the adoptive family. An adjustment is reviewable through the administrative law process upon the request of the family. Any party may request a review of the agreement prior to the three-year mandatory review if changes occur in the needs of the adoptive child or youth or in the circumstances of the family.

b. Benefits provided through the program must be continued if the adoptive parent(s) leave the state of Colorado with the adopted child or youth (for additional information regarding state-to-state Medicaid services see section 7.402.4 Medicaid for children and youth covered by the Interstate Compact on Adoptions and Medical Assistance (ICAMA)).

13. The county or adoptive family may request to renegotiate an existing adoption assistance agreement at any based on changes in the needs of the adopted child or youth or in the circumstances of the family related to the original eligibility criteria known and documented at the time of the finalization of the adoption.

a. Any new agreement must include the circumstances under which the county department may suspend adoption assistance payments.

b. The agreement may be adjusted after a good faith negotiation and with the concurrence of

the adoptive family. An adjustment is reviewable through the administrative law process upon the request of the family. Any party may request a review of the agreement prior to the three-year mandatory review if changes occur in the needs of the adoptive child or youth or in the circumstances of the family.

F. There are situations after finalization when adoptive parents can request a state level fair hearing before an Administrative Law Judge concerning the adopted child's/youth's eligibility for adoption assistance benefits or the amount of those benefits. These situations include but are not limited to:

1. Relevant facts regarding the child/youth that were known and not presented to the adoptive parent(s) prior to the finalization of the adoption.

2. Denial of assistance based upon a means test of the adoptive family.

3. Erroneous determination that a child/youth is ineligible for adoption assistance.

4. Denial of a request for a change in payment level due to a change in the child/youth's needs and/or in the adoptive parent(s)' circumstances.

5. Failure by the county or non-profit child placement agency to advise the adoptive parent(s) about the availability of adoption assistance for children/youth who have been identified with special needs.

6. Decrease in the amount of adoption assistance without the concurrence of the adoptive parent(s) (for Title IV-E adoption assistance agreements, only).

7.306.42 Non-Title IV-E Adoption Assistance

A. Pathways to Eligibility

The following are ways to become eligible for non-Title IV-E adoption assistance:

1. The county department has guardianship of the person(s) (children/youth) with the authority to consent to adoption.

2. The county department or non-profit child placement agency has guardianship of the person (children/youth) with the right to consent to adoption, but the current caregiver has physical custody of the children/youth.

3. The child(ren)/youth is not a citizen or a qualified citizen but is being adopted by a U.S. citizen or qualified citizen.

4. A person has custody of a child/youth given by proper order of a dependency and neglect court.

5. The child/youth was not Title IV-E eligible in foster care and does not meet the Federal Applicable Child Criteria (delinking).

6. All county departments of human/social services and Title IV-E eligibility staff are required to determine children and youth eligible for Title IV-E adoption assistance, if the following applies:

a. The child or youth was in the custody of relatives or kin at the time of termination of parental rights in a dependency and neglect action; and/or,

b. The child or youth was in the care or custody of a public or licensed private non-profit child placement agency or Indian tribal organization pursuant to:

1. An involuntary removal of the child or youth from the home in accordance with a judicial determination to the effect that continuation in the home would be contrary to the welfare of the child or youth; or,

2. A voluntary placement agreement or voluntary relinquishment; and,

3. The termination of parental rights/relinquishment orders contain the judicial determination to the effect that the county department/Indian tribal organization has guardianship of the child or youth to consent to that child or youth's adoption; and the child or youth has been determined by the county, pursuant to section 7.306.4. a. d. to be an eligible child or youth.

B. Foster Care Placement of a Child/Youth Under an Adoption Assistance Agreement

1. The State prescribed form must be completed to determine Title IV-E eligibility using the adoptive parent(s)' income.

2. The child/youth, upon returning to the adoptive parent(s)' home, returns to the previous non-IV-E adoption assistance agreement.

C. Eligibility Determination for Medicaid in Non-Title IV-E Eligible

1. Colorado children/youth who are eligible for an adoption assistance agreement, but are not Title IV-E are eligible for Medicaid in Colorado or reciprocal states, only.

2. An adoption assistance payment is not required to extend Medicaid coverage.

3. Medicaid eligibility may or may not be continued for non-IV-E eligible children/youth who are out of the home for more than thirty (30) calendar days.

4. Medicaid eligibility for all children/youth receiving Medicaid shall be redetermined yearly only if the child/youth continues to be eligible for Medicaid. This can be done by completing the State prescribed form.

D. Non-Title IV-E Adoption Assistance Payments

1. Determine and document a child's/youth's identified needs and eligibility for adoption assistance.

2. Denial of assistance based solely on a means test of the adoptive family is not allowed and must not be substituted for the agreement.

3. The adoption assistance agreement shall be established in accordance with the State's written policy.

a. County departments shall use the Colorado Adoption Assistance Negotiation Worksheet with the potential adoptive family for all adoption assistance determinations and negotiations.

1. If adoptive parent(s) choose to refuse all adoption assistance including monthly cash assistance, Medicaid, and/or case services, they must sign the permanent refusal of adoption assistance form.

2. If adoptive parent(s) request a Medicaid only adoption assistance agreement and/or non-recurring adoption expenses they may choose to decline completing the Adoption Assistance Negotiation Worksheet and sign the request for Medicaid only adoption assistance form. However, they still must sign an adoption assistance agreement.

b. County departments shall adopt the policies and procedures outlined in the State of Colorado's adoption assistance policy. a copy of the written policy shall be provided to adoptive parent(s) at least 5 business days prior to a negotiation meeting.

4. Make a good faith effort to negotiate an adoption assistance agreement with the adoptive parent(s). The county shall base the negotiation on the current and anticipated needs of the child/youth and the circumstances of the adoptive parent(s). If the parties cannot come to an agreement, the county department shall establish the adoption assistance amount. If the family disagrees with the decision, a fair hearing can be requested.

5. The monthly respite care payment that is provided under the foster care program is not a benefit under the adoption assistance program.

6. If a child/youth with physical, mental, intellectual and developmental disabilities is receiving an allowance in addition to the foster care payment at the time the child/youth is placed for adoption, the allowance may continue under the adoption assistance program if the child/youth continues to meet the criteria outlined in "Child with Adoption assistance", Section 7.306.4.A.e.d.

7. County departments who pay more than the county's foster care rate or in the event that the child/youth is not in foster care, the rate that would have been paid based on the child's/youth's original or amended adoption assistance agreement shall reimburse the State for ninety percent (90%) of the payment that is over the foster care rate.

8. Use the State prescribed forms to document the negotiated agreement for non-Title IV-E adoption assistance and attach supporting documentation.

9. Complete and sign the Adoption assistance Agreement form specifying:

a. The dollar amount of the adoption assistance being provided, if applicable.

b. Duration of the agreement:

1. In non-Title IV-E adoption assistance agreements, duration is decided by the State's written policy, according to the identified needs of the child/youth and family circumstances. The county department shall extend the adoption assistance agreement upon the approaching expiration date if the youth meets criteria for extension and the extension is requested by the adoptive parent(s). As defined in section 7.306.54, adoption assistance may continue to the 21st birthday. In situations where adoption assistance continues through the 21st birthday, adoption Medicaid will still continue

through the end of the month of the 21st birthday.

2. On a case-by-case basis, the duration of an agreement may be sooner than this time. All parties must be in agreement with the earlier termination date.

3. The adoption assistance agreement must be reviewed at least every three years. The county department shall provide written notice of the upcoming review to the adoptive family.

a. Any new agreement must include the circumstances under which the county department may suspend subsidy payments.

b. The agreement may be adjusted after good faith negotiation and with the written concurrence of the adoptive family. An adjustment is reviewable through the administrative law process upon the request of the family. Any party may request a review of the agreement prior to the three-year mandatory review if changes occur in the needs of the adoptive child/youth or in the circumstances of the family.

c. Benefits provided through the program must be continued if the adoptive parents leave the state of Colorado with the adoptive child or youth.

d. The services and dates that are covered by an effective adoption assistance agreement.

e. Any reimbursement for non-recurring adoption expenses incurred by or on behalf of the adoptive parent in connection with the adoption.

f. That the adoption assistance agreement must be signed and dated by all parties prior to the effective date of the agreement and before the adoption is finalized. If the county fails to completely execute the initial adoption assistance agreement prior to the effective data and prior to the finalization of the adoption, the assistance payment will become non-reimbursable by the State.

10. The adoption assistance agreement must be reviewed at least every three years. The county department shall provide written notice of the upcoming review to the adoptive family.

a. Any new agreement must include the circumstances under which the county department may suspend adoption assistance payments.

b. The agreement may be adjusted after good faith negotiation and with the written c concurrence of the adoptive family. An adjustment is reviewable through the administrative law process upon the request of the family. Any party may request a review of the agreement prior to the three-year mandatory review if changes occur in the needs of the adoptive child or youth or in the circumstances of the family.

c. Benefits provided through the program must be continued if the adoptive parent(s) leaves the state of Colorado with the adopted child or youth.

11. The county or adoptive family may at any time negotiate changes to an existing adoption assistance agreement based on information related to the child's/youth's current and/or anticipated needs or the family's circumstances.

7.306.43 Review Of Eligibility For All Ongoing Adoption Assistance Agreements

The state department will conduct reviews of county departments' adoption assistance programs as follows:

A. The county shall review the current adoption assistance agreement every three (3) years.

1. The county department shall initiate the written notice of the review for adoption assistance sixty (60) days prior to the three-year anniversary of the agreement.

2. The adoptive family may request a review of the agreement prior to the three-year review if changes in the needs of the child/youth or family circumstances occur.

3. The adoptive parents may request a review of the adoption assistance agreement if changes in the needs of the child/youth or family circumstances occur. Any changes in the agreement must be related to the original barriers identified at the time the decision was made that adoption assistance was needed or to the child's/youth's needs that are genetic in nature, regardless of whether those needs were identified prior to adoption.

B. The county shall annually review documentation of school attendance or reasons for inability to attend. The documentation must demonstrate that each child/youth who is eligible for adoption assistance and who has attained the minimum age for compulsory school attendance is:

1. Enrolled (or in the process of enrolling) in an institution that provides elementary or secondary education, or,

2. Instructed in elementary or secondary education at home in accordance with the homeschool statute, or,

3. In an independent study elementary or secondary education program in accordance with statute, and which is administered by the local school, school district, or board of cooperative education (BOCES), or,

4. Incapable of attending school on a full-time basis due to the medical condition of the child/youth. The reasons shall be supported by regularly updated information in the educational plan maintained by the school, school district, or BOCES.

7.306.44 Social Security Benefits for Children/Youth in Adoptive Placement

A. The county department shall inform adoptive parents of the potential eligibility for social security benefits of any child/youth placed with them for adoption.

B. In cases where the child/youth is eligible for both Supplemental Security Income (SSI) and Title IV-E adoption assistance, the prospective adoptive parents may make application for both programs and the child/youth, if eligible, may receive benefits from both programs. In considering the most appropriate choice of programs and deciding whether to make application for one or both, the prospective adoptive

parents should be made aware of the differences between SSI and the adoption assistance program by the county department of human/social services.

C. When a child/youth is receiving Supplemental Security Income prior to adoption, the adoptive parent(s) can seek a monthly adoption assistance payment from the county department of human/social services up to the foster care maintenance payment that has been paid or would have been paid if the eligible child or youth had been in foster care at the time of the eligible child or youth's adoption. In cases where the child/youth is eligible for both Supplemental Security Income (SSI) and Title IV-E adoption assistance the adoptive parent(s) cannot receive more than the maximum foster care rate. Nothing in this paragraph shall limit the county department of human/social services from providing case services when a child/youth is SSI eligible.

7.306.45 Accepting and Processing Applications for Adoption Assistance from Child Placement Agencies and Prospective Adoptive Parents Seeking a Private Adoption

A. Colorado non-profit licensed adoption agencies can access adoption assistance if the child/youth is in their custody and meets Title IV-E eligibility, as outlined in section.7.601.7. Prospective adoptive parent(s) can also access adoption assistance in a private adoption if the child/youth is determined to be eligible for Social Security Income or is in their custody through a court order of a dependency and neglect court, such as guardianship or allocation of parental responsibilities, and meets Title IV-E eligibility as outlined in section 7.601.7. The adoption assistance application, whether being made by a licensed adoption agency or prospective adoptive parent(s), should be made in the first instance to the Colorado Division of Child Welfare.

1. Upon receipt of the complete application, the Colorado Division of Child Welfare shall determine the overall eligibility of the child/youth. If the Division of Child Welfare determines there is an eligible child/youth, within ten (10) business days the Colorado Division of Child Welfare shall request financial Title IV-E eligibility from the county department of human/social services where the prospective adoptive family resides. The county department shall send verification of that determination to the Colorado Division of Child Welfare. Such determination by the county department shall be made within ten (10) business days.

2. Upon receipt of financial Title IV-E eligibility from the county department, the Colorado Division of Child Welfare Adoption Administrator shall provide the formal Title IV-E determination letter to the applicant within fourteen (14) business days. The Colorado Division of Child Welfare Adoption Administrator shall send the required documents to the Colorado county department of human/social services within fourteen (14) business days and the county department will start the adoption negotiation process with the prospective adoptive parents.

3. If the child/youth is determined to be non-Title IV-E eligible, the Colorado Division of Child Welfare Adoption Administrator will provide the adoptive family and county department of human/social services a denial letter of adoption assistance. If the child/youth is determined to be non-Title IV-E eligible, the family may consult with the county department on other services for which they or the child/youth may be eligible. It is at the discretion of the Colorado county department of human/social services if they choose to provide adoption assistance as all assistance, would be solely funded by the county. The provision of medical insurance for these children/youth can only occur through commercial insurance plans solely paid through county only funds. The only path for these child(ren)/youth is that the family meets Medicaid income

parameters, or the child(ren)/youth meets waiver, or children and disabilities buy-in parameters.

4. If it is determined that the child/youth is not eligible for Title IV-E adoption assistance, the Colorado Division of Child Welfare Adoption Administrator shall inform all parties in writing the basis for the denial and their right to appeal the state's decision.

B. If the child/youth is being placed in the state of Colorado with a prospective adoptive family working with a Colorado non-profit adoption agency, the Colorado Department of Human Services will process and approve adoption assistance funded by Colorado county departments if the child/youth meets the following criteria:

1. Have Social Security Income (SSI) eligibility; or,

2. If the child/youth meets the Federal Applicable Child Criteria (delinking), has identified needs, and meets the requirements in the federal fiscal year in which the adoption is finalized, the child/youth will become categorically eligible for Title IV-E adoption assistance.

C. If the child/youth is being placed out of the state of Colorado by a Colorado non-profit adoption agency, it is at the discretion of the other state to process and fund adoption assistance.

D. After the county department approves the adoption assistance and finalization has occurred, it shall open the case on the Comprehensive Child Welfare Information System (CCWIS).

E. Approved adoption assistance payments will begin on the date of adoption finalization. The child placement agency or the prospective adoptive parents, whichever is applicable, is responsible for any costs before the initiation of the adoption assistance agreement and prior to finalization.

F. Adoption assistance available to the eligible child/youth are:

1. Medicaid (Title XIX).
2. Adoption assistance payment.
3. Non-recurring adoption expenses.
4. Adoption case services.

G. Before finalization of the adoption, the child placement agency that arranged the adoption, if applicable, retains responsibility for continued services to the adoptive family should they be requested.

H. The county department shall terminate adoption assistance payments and eligibility for Medicaid as outlined in termination of adoption assistance (section 7.306.59).

7.306.46 Reinstatement of Adoption Assistance

A. Adoption assistance agreements may be reinstated if the services requested relate to the child's/youth's identified needs or family circumstances.

B. When adoptive parents have relinquished, have had their parental rights terminated, or have died and the child/youth is placed in a subsequent adoptive placement, then the child/youth retains Title IV-E eligibility for adoption assistance in their new adoptive placement. The only determination that must be made for adoption assistance eligibility prior to the finalization of the subsequent adoption is whether the child/youth is a child/youth with one or more specific factors or conditions as set forth in Colorado Revised Statutes section 26-7-102(8).

7.306.47 Suspension of Adoption Assistance

1. The county department may suspend the payment of adoption assistance available when contact with the adoptive family cannot be established and the county department cannot establish that the adoptive parent is providing any support, which includes financial support as determined by the Title IV-E agency.

2. Prior to suspension, the county department shall provide notice to the adoptive parent(s) of intent to suspend adoption assistance payments at least ten days prior to suspension and shall include in the notice:

a. A statement of the county department's intent to suspend adoption assistance payments, as well as the reasons and legal basis for the intended suspension;

b. A description of the adoptive parent(s)' right to request a fair hearing pursuant to 45 C.F.R. § 205.10; "(current through May 3, 2023) can be found in the Code of Federal Regulations. No later amendments or editions are incorporated. The Code of Federal Regulations are available at no cost from the U.S. Health Resources and Services Administration, Office of Communications 5600 FISHERS LANE, ROCKVILLE, MD 20857 or at https://www.ecfr.gov/. The regulations are also available for public inspection and copying by contacting the Colorado Department of Human Services, 1575 Sherman Street, Denver, Colorado 80203 during regular business hours."

c. A description of the circumstances under which adoption assistance must be continued if a hearing is requested; and

d. The circumstances under which a suspension may be reversed without a fair hearing.

3. When the adoption assistance payment is suspended, the eligible child or youth remains Title IV-E eligible, the Title IV-E agreement remains in effect, and the eligible child or youth remains eligible for, and in receipt of, medical assistance.

7.306.48 Termination of Adoption Assistance Agreement

1. The county department shall terminate the payment of adoption assistance available when any of the following situations occur:

a. The child or youth reaches eighteen (18) years of age; except that, in cases where the county department has determined that the youth meets eligibility for extension of the adoption

assistance agreement which warrants continued assistance, the payment of adoption assistance shall continue until the child or youth reaches twenty-one (21) years of age;

b. The adoptive parent or parents are no longer legally responsible for the support of the child or youth;

c. The child or youth is no longer receiving support from the adoptive family, which includes financial support as determined by the Title IV-E agency, or

d. The county department certifies the death, marriage, or enrollment in military service of the child or youth.

2. Adoptive parents who receive adoption assistance shall keep the county department that is administering the program informed of circumstances that would make them ineligible to continue to receive adoption assistance.

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Tracking number: 2023-00201

Opinion of the Attorney General rendered in connection with the rules adopted by the

Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)

on 06/09/2023

12 CCR 2509-4

CHILD WELFARE SERVICES

The above-referenced rules were submitted to this office on 06/14/2023 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.

June 26, 2023 11:48:19

Philip J. Weiser
Attorney General
by Kurtis Morrison
Deputy Attorney General

Permanent Rules Adopted

Department

Department of Human Services

Agency

Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)

CCR number

12 CCR 2509-4

Rule title

12 CCR 2509-4 CHILD WELFARE SERVICES 1 - eff 07/31/2023

Effective date

07/31/2023

7.301.22 Family Service Plan Participants

A. The county shall assure that the following parties participate in the development of the Family Services Plan and engagement activities, except in Foster Youth in Transition cases in which the youth and caseworker are the only required parties:

1. Caseworker;

2. Parent(s) or legal guardians;

3. Child/youth;

4. Immediate and extended family members as appropriate to the service needs of the family, child, and youth; and,

5. Service providers, including kin caregivers, out-of-home caregivers, and in-home providers.

B. In addition to all parties being encouraged to sign the plan, all parties shall be engaged in activities that indicate involvement in service planning, including, but not limited to:

1. Family engagement meetings; or,

2. Ongoing contacts, which could include, but are not limited to: face to face, visitation, email, texts, technology with face to face capacity, emerging technology, or through signature on the Family Services Plan.

C. Activities shall be documented in the State Department's automated system and may be located in the record of contact notes, the framework field, ninety (90) day reviews, and progress reports to the court. Documentation shall reflect the various ways in which attempts were made to engage parents, child/youth, and providers.

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7.301.24 Family Service Plan Out-of-Home Placement Documentation

For child(ren)/youth in out-of-home placement, the Family Services Plan documents:

A. The child/youth meets all of the out-of-home placement criteria listed in Section 7.304.3.

B. When the child/youth is part of a sibling group and the sibling group is being placed out of the home, it shall be presumed that placement of the entire sibling group in the joint placement is in the best interests of the children/youth in order to sustain family relationships. Such presumption may be rebutted by the county by a preponderance of the evidence that placement of the entire sibling group in the joint placement is not in the best interests of a child/youth or of the children/youth. The county shall make reasonable and continued efforts to locate a joint placement for all of the children/youth in the sibling group unless:

(1) it is not in the best interests of the children/youth to be placed as a group as determined by the county in consultation with the family, youth, and GAL(s) and/or counsel for youth when possible, and

(2) these efforts unreasonably delay permanency for any child/youth.

These efforts depend upon the county's ability to locate an appropriate, capable, willing, and available joint placement for all of the children/youth in the sibling group. As soon as practicable after making a decision affecting sibling placement, the county department shall notify the GAL(s) and/or counsel for youth appointed to the case. Efforts to place siblings as a group shall be documented in the Colorado child welfare information system (CCWIS).

C. The problems to be resolved in order to facilitate reunification of the child/youth and family, and to safely maintain the child/youth in the home.

D. A description of the type of facility in which the child/youth is placed and the reason(s) the placement is appropriate and safe for the child/youth.

E. A description of the county's efforts to place the child/youth in reasonable proximity to the home of the parents and to the "school of origin" as defined in § 22-32-138(g), C.R.S. For a child/youth placed a substantial distance from the home of the parent(s), from his or her "school of origin," or in out-of-state placement, the county shall document how the placement meets the best interests of the child/youth, including how the county took into account proximity to parents and school in making its placement decision (see sections 7.304.54, J and 7.301.241).

F. A summary of efforts to ensure educational stability as outlined in Section 7.301.241.

G. That the placement is the least restrictive, safe, and most appropriate setting available consistent with the best interests and specific needs of the child. This includes documentation of initial and on-going efforts to place the child/youth with kin.

If the child/youth is moved to a more restrictive placement after the initial placement, the Family Services Plan documents how the more restrictive placement meets the child/youth's needs.

H. Health and educational information shall be documented in the State Department's automated system and updated at the time of each case review, including addresses and other contact information about the child/youth's current:

1. Education providers, including school, school district, and Board of Cooperative Education Services (BOCES) contacts who assist in the coordination of enrollment and services, and the child/youth's academic progress.

2. Health care providers and the status of health care information.

I. Specific plans for how the county will carry out any court determinations or orders concerning the child/youth.

J. A description of the services and resources needed by the foster parents or kinship providers to meet the needs of the child/youth and how those services and resources will be provided.

K. A description of the services provided to reunite the family, including the plan for visitation, or to accomplish another permanency goal. The visitation plan shall specify the frequency, type of contact, and the person(s) who will make the visit. At a minimum the visitation plan shall provide the methods to meet the following:

1. The growth and development of the child/youth;

2. The child/youth's adjustment to placement;

3. The ability of the provider to meet the child/youth's needs;

4. The appropriateness of the parent and child/youth visitation, including assessment of risk;

5. The efforts to ensure the child/youth’s wishes as to sibling contact were considered;

6. The child/youth's contact with parents, siblings, and other family members; and

7. Visitation between the child/youth and his/her family shall increase in frequency and duration as the goal of reuniting the family is approached.

L. For child(ren) under the age of fourteen (14), a description of services and a plan for accomplishing tasks to prepare child(ren) to be age appropriately self-sufficient, when independent living services are provided.

M. For youth aged fourteen (14) and older, a roadmap to success as early in placement as possible but no later than sixty (60) calendar days after the youth's fourteenth (14th) birthday.

N. Reasonable efforts have been made to maintain the child/youth in the home, or prevent or eliminate the need for removal of the child/youth from the home, or make it possible for the child/youth to return to the home; or when applicable, documentation of the circumstances that exist in which reasonable efforts to prevent removal or reunite the child and the family are not required (see Section 7.304.53, B, 3).

O. The specified permanency goal for the child/youth shall be based on the individual needs and best interests of the child/youth. Permanency goals shall include one of the following:

- Remain home;
- Return home;
- Permanent placement with a relative through adoption;
- Permanent placement with a relative through legal guardianship or permanent custody;
- Adoption (non-relative);
- Legal guardianship/permanent custody (non-relative);
- Return home through reinstatement of parental rights;
- Other planned permanent living arrangement through emancipation;
- Other planned permanent living arrangement through relative long term foster care;
- Other planned permanent living arrangement through non-relative long term foster care.

Permanency goals shall include the projected date (month, day, and year) by which the goal is to be accomplished for each child/youth receiving services.

1. The initial permanency goal for the child/youth is to return home with the following exceptions:

   a. Children/youth whose parents are both deceased or have both voluntarily relinquished custody;

   b. Children/youth whose parents cannot be located after family search and engagement activities, which shall begin no later than three working days following placement and shall not exceed three months;

c. Children/youth whose parents have been guilty of repeated and/or severe abuse or neglect of the child/youth or the child/youth's siblings such that termination of parental rights of both parents is appropriate; ~~or,~~

d. Children/youth for whom it appears, after investigation, that a safe return home will not be possible even with the provision of reasonable efforts; or,

e. Youth who are participating in the Foster Youth in Transition program.

2. After twelve months, the child/youth's caseworker and supervisor shall include written justification on the Family Services Plan for continuation of the goal of return home.

3. After eighteen months, the extraordinary circumstances which exist and the reasons which support the permanency goal of return home shall be documented in the Family Services Plan. Approval of the return home permanency goal by the caseworker, supervisor and county administrative review is documented in the case record.

4. In concurrent planning cases the alternate permanency goal shall be documented.

5. The permanency goal of other planned permanent living arrangement through emancipation shall only be used for youth ages sixteen to twenty-one.

6. For a child/youth who has been in foster care under the responsibility of the state for fifteen (15) of the last twenty-two (22) months, the county shall either file a motion for termination of parental rights no later than the end of the fifteenth (15th) month or document and submit to the court at the next review the compelling reason why it is in the child/youth's best interest not to terminate parental rights.

P. The steps the agency is taking to find an adoptive or other permanent living arrangement for a child/youth for whom the permanency plan is adoption or placement in another permanent home.

Q. The permanency goal for the child would be to remain home barring case circumstances that would indicate the need for an alternative permanency goal when a teen mother and her child are placed together in the same foster home and if a case is opened on the child. The county must see the child when visiting the teen mother in the foster home.

R. Requirements for use of Other Planned Permanent Living Arrangement goals as follows:

1. The county department may consider Other Planned Permanent Living Arrangement (OPPLA) as a permanency goal:

   For youth who are sixteen (16) years of age or over and are demonstrating exceptional circumstances that prevent the youth from returning home, adoption, legal guardianship or permanent custody.

2. The goal shall be reviewed through the use of a family engagement meeting or equivalent team that reviews permanency needs. All of the following shall be submitted to and considered by the review team, and the recommendation shall be submitted to the court.

   a. Documentation pertaining to the completion of an intensive and ongoing examination of kin and permanent connections. This process shall also address:

      1) A comprehensive assessment of the youth's strengths and needs. In addition to updating the assessment of the youth's strengths and needs, the updated assessment or staffing shall address the youth's capacity to live within a family setting.

2) This review team shall also consider the youth's desired permanency outcome.

b. A detailed description of efforts made to achieve permanency through the other goals and identification of the barriers to achieve them.

c. A detailed description of how OPPLA is in the best interest of the youth.

3. The following is to be documented and made available to the court at each court review.

a. Documentation of the barriers to permanency to date and compelling reasons why the other permanency goals are not attainable.

b. Documentation of the youth's desired permanency outcome including giving the youth an opportunity to attend each hearing to voice his/her desired goal.

c. Documentation of intensive, ongoing, and as of the date of the hearing, unsuccessful efforts to return the youth home or secure a placement for the youth with a fit and willing relative (including adult siblings), a legal guardian, or an adoptive parent, including thorough efforts that utilize technology (including social media) to find biological family members for the youth.

d. Documentation of the steps taken to ensure that youth are being supported in-engaging in age or developmentally appropriate activities and social events including:

1) The youth's foster family home or other placement is following the reasonable and prudent parent standard; and,

2) The youth has regular, ongoing opportunities to engage in age or developmentally appropriate activities (including consulting with the youth in an age-appropriate manner about the opportunities of the youth to participate in the activities).

4. Documentation which includes the review team's reasons for approving Other Planned Permanent Living Arrangement (OPPLA) shall also be entered in the Family Service Plan as directed by the Division of Child Welfare.

5. The use of this goal shall be reviewed by a family engagement or equivalent review team at a minimum of every six (6) months. The county shall request that the court review the case every twelve (12) months to determine if the youth is demonstrating exceptional circumstances that prevent the youth from returning home, adoption, legal guardianship or permanent custody.

6. If this goal is not achieved through relative care, a family-like network of significant people shall be developed to provide the youth with a sense of belonging and with support expected to endure over a lifetime.

7. Youth who have an open case through the Foster Youth in Transition Program are presumed to meet the above requirements for a goal of other permanent planned living arrangement through emancipation. The goal shall be reviewed by the court on an annual basis pursuant to 19-7-311, C.R.S.

S. Reinstatement of Parental Rights

1. The county department of human or social services may explore the use of reinstatement of parental rights as a permanency option for:

a. Children twelve (12) years of age and older, or child(ren) younger than twelve (12) years of age if they are part of a sibling group where at least one of the child(ren) or youth is twelve (12) or older and is pursuing reinstatement of parental rights; and,

b. Child(ren) younger than twelve (12), if they are part of a sibling group where at least one of the child(ren) is twelve or older, and is pursuing reinstatement of parental rights; and,

c. Child(ren) who currently do not have a legal parent; and,

d. Child(ren) who currently are not in an adoptive placement and not likely to be adopted within a reasonable period of time; and,

e Child(ren) who had all other permanency options exhausted; and,

f. Cases when the termination of parental rights was ordered at least three-years-prior or when it is determined by the court to be in the best interest of the child(ren) when termination occurred less than three years prior to the date of the petition for reinstatement is being filed with the court; and,

g. Child(ren) and former parent(s) that consent to parental rights being reinstated; and,

h. Child(ren) where it is in their best interest, including the financial best interest, to have parental rights reinstated; and,

i. Former parent(s) who have remedied the issues that led to the termination and those issues did not involve founded allegations of sexual abuse or an incident of egregious abuse or neglect against a child, a near fatality, or a suspicious fatality; and,

j. The child is in the legal custody of a county department.

2. A county department of human or social services that identifies reinstatement as a permanency option shall complete an assessment of the former parent(s). Completion of the assessment and the results of the assessment will be documented in the statewide case management system. The assessment shall include all of the following:

a. Completing the Colorado family risk assessment tool, which must include a visit and inspection of the former parent's home;

b. Reviewing the reasons for the termination of parental rights and determining if the concerns identified have been remedied and do not currently exist or present a safety concern;

c. Conducting the following background checks on the former parent(s) and any other adults eighteen (18) years of age or older in their home and share the results with all parties to the case:

1) Child abuse/and/or neglect records check in every state where any adult residing in the home has lived in the five years preceding the filing of the petition for reinstatement;

2) Fingerprint-based criminal history checks from the Colorado Bureau of Investigation (CBI), or other state background check if the parent lives in another state, and the Federal Bureau of Investigation (FBI);

3) Review the state Judicial Department's case management system and include in the case record; and,

4) Review the CBI sex offender registry and the national sex offender public website operated by the United States Department of Justice for:

a) Known names and addresses of each adult residing in the home; and,

b) Address only of the home.

3. A safety assessment shall be completed.

4. Upon the decision to pursue reinstatement of parental rights; only the county department, guardian ad litem, or a child twelve (12) years of age or older may file the petition for reinstatement.

a. The petition for reinstatement of parental rights should be filed in the county who has custody of the child(ren) through the dependency and neglect court case.

b. The petition shall be filed in the dependency and neglect court case where the termination of parental rights occurred for the former parent(s) or in the event that the current open dependency and neglect case is a termination of the adoptive parent's rights, then the petition shall be filed in that court case, as it grants custody of the child(ren) to the county.

c. If the county is contacted by a former parent inquiring about reinstatement, the county must notify the guardian ad litem (GAL) and child twelve (12) years of age or older within thirty (30) calendar days after the contact and provide them with the name and address of the former parent(s).

d. Once the court sets an initial hearing, the county shall develop and report to the court the following:

1) Whether the former parent(s) has remedied the conditions that led to the termination;

2) Based on the assessment of the former parent, including the outcome of the Colorado family risk assessment tool, the transition plan shall include supports or treatment needed for the child(ren) and former parent(s) to help make the reinstatement a success;

3) Whether the former parent(s) can provide a safe and stable home for the child(ren);

4) A visitation or temporary placement plan with the former parent(s) for up to a six month trial period where custody remains with the department; this plan will be approved or modified at this initial hearing.

a) Updates about the visits, transition plan, and supports shall be provided at each review hearing and no later than thirty (30) calendar days prior to the expiration of the trial home period.

b) At any point the placement is deemed no longer safe or in the best interest of the child(ren), removal shall be in accordance with procedures outlined in Sections 19-3-401 and 19-3-403, C.R.S.

5) Whether the child(ren) will lose or gain any benefits or services (Medicaid, Chafee, etc.) as a result of the reinstatement being granted.

5. If the court grants the order, the county shall select reinstatement of parental rights as the closure reason, in the state automated case management system.

6. If the court denies the order the county department shall:

a. Arrange for immediate placement of the child(ren), if the child(ren) is still in the former parent's home;

b. Set a permanency hearing to determine a new permanency goal and plan for the child(ren).

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7.301.241 Education Requirements for Children/Youth in Out-of-Home Placement

A. Documentation shall be entered into the state automated case management system to address compliance with all requirements in this section, 7.301.241, including designation of responsibilities.

B. County departments shall coordinate with the local public school, school district, the State Charter School Institute, and/or board of cooperative education services (collectively referred to as "education provider" for the purposes of this section) to ensure educational stability for each "student in out-of-home placement" as defined in § 22-32-138(1)(e) and (h), C.R.S. including those attending public pre-school. County departments shall notify "education providers" upon each school-aged child/youth entering or changing out-of-home placement, even if no school change is being considered.

C. Each placement of a child/youth shall take into account the appropriateness of the current educational setting and the proximity to the "school of origin" as defined in § 22-32-138(1)(g), C.R.S. See Section 7.301.24, E.

D. It is presumed to be in a child/youth's best interest to remain in the "school of origin." If transportation is necessary to maintain the child/youth in the "school of origin," this shall be provided in accordance with section 7.301.241, E.

The county shall make a best interest determination prior to any school move resulting from a change in placements unless remaining in the "school of origin" poses a specific, documented threat to the child/youth's safety. The best interest determination process is as follows:

1. The best interest discussion and determination shall occur as an in-person meeting when warranted and possible. When an in-person meeting is not warranted or not possible, or for participants unable to attend the meeting, the county department shall consult participants by other means, such as phone or email.

2. The county department shall invite the following people to participate in the best interest determination. If a participant is unavailable or cannot be located, the county shall document the various ways in which attempts were made to engage that participant.

a. Child/youth,

b. Parents,

For purposes of this subsection 7.301.241, the term "parents" includes a natural parent having sole or joint custody, regardless of whether the parent is

designated as the primary residential custodian, or a parent allocated parental responsibilities with respect to a child, or an adoptive parent. Parent does not include a person whose parental rights have been terminated pursuant to the provisions of Title 19 of the Colorado Revised Statutes, the parent of an emancipated minor, or the parent of a youth participating in the Foster Youth in Transition program.

c. Caseworker or appropriate designee,

d. Guardian ad litem and/or counsel for youth if one is appointed,

e. Representative from the "school of origin" who knows the child/youth, as determined by the "education provider,"

f. Educational surrogate parent, if any, and

g. Others as relevant and appropriate as determined by the county, which may include but are not limited to future caregiver, court appointed special advocate (CASA), current caregiver, representatives from potential new school, support person for the child/youth.

3. Best interest determination meetings may be incorporated into family engagement meetings. The county department shall protect the family's confidentiality by including school personnel only in the portion of the meeting regarding the child/youth's educational needs, unless members consent to their ongoing participation in the meeting.

4. The best interest determination shall address whether it is in the child/youth's best interests to either:

   a. Remain in the same school, or

   b. Attend another appropriate school.

   The potential new school(s) to consider may include any school in which the child/youth may enroll pursuant to state law and "education provider" policy, including but not limited to C.R.S. § 22-1-102 (defining residence of child), C.R.S. § 22-32-116 (defining exception to exclusion of non- residents), or C.R.S. § 22-20-107.5 (defining residence of child who receives special education). The county department need not consider every possible school; rather the county should identify which school or schools they are considering so the attributes of the specific schools can be considered.

   If it is determined to be in the child/youth's best interest to attend a new school, the best interest determination shall also include the date when the child/youth will change schools. The child/youth shall remain in the "school of origin" until this date. It is presumed to be in a child/youth's best interest to be in the least restrictive environment and to transfer at natural transitions such as the beginning of the school year or academic term.

5. The county department shall make the best interest determination in collaboration with the "education provider" and other participants and in consideration of the following non-exhaustive factors, as relevant:

   a. Child/youth's wishes,

   b. Child/youth's safety,

   c. How the "school of origin" can meet the child/youth's academic and non-academic needs (including special education, extra-curricular activities, social,

emotional, and other needs). In considering the child/youth's needs, the county department shall give special weight to whether the child/youth has a meaningful and appropriate relationship with an adult at the "school of origin,"

d. How the potential new school could meet the child/youth's academic and non-academic needs, including special education, extra-curricular activities, social, emotional, and other needs,

e. How the decision impacts the child/youth's permanency goal(s), and

f. The length of travel and impact on the child/youth.

g. The cost of transportation is not a permissible consideration in determining the child/youth's best interest.

6. If the county determines that it is not in a child/youth's best interest to remain in the same school, the "education provider" shall immediately, on the date designated in the best interest determination, enroll the child/youth in a new school, even without records normally required for enrollment, pursuant to the Every Student Succeeds Act, 42 U.S.C. § 675(1)(G)(ii). In order to facilitate transfers at natural academic transitions whenever possible, "immediately" means the date designated in the best interest determination, not necessarily the date the determination is made.

7. The county department shall inform the CHILD/youth, parent(s), guardian ad litem and/or counsel for youth, and educational surrogate parent, if any, of the best interest determination within one business day of making the determination. The notification shall serve as the first day in the dispute resolution time frames described in section 7.301.24, D, 8.

a. Parents of a youth participating in the Foster Youth in transition program are not required to be notified.

8. Disputes regarding best interest determinations shall be handled in a manner that promotes the child/youth's safety and stability, as follows:

If the parent(s), guardian ad litem, child/youth twelve (12) years of age or older, and/or educational surrogate parent, if any, is a party to an accompanying court case and disagrees with the county department's best interest determination, he or she must file a motion with the juvenile court to seek judicial resolution. Such a motion must be filed within three business days of the notice of the county's determination. If the county receives such a motion, the child/youth shall remain in the "school of origin" pending dispute resolution, unless remaining in the school poses a specific, documented threat to the child/youth's safety. If such parties indicate their agreement to a school move, the county need not delay the move pending the three-day appeal period.

E. County departments and "education providers" shall collaborate to ensure that children in foster care needing transportation to the "school of origin" will promptly receive transportation in a cost-effective manner. County departments and "education providers" shall collaborate to develop systems-level transportation plans, including how transportation will be provided, arranged, and funded for the duration of time the child/youth is in out-of-home placement and, if accepted by the family, the remainder of the academic term during which a child/youth exits out-of-home placement. Transportation plans may be developed at the local and/or regional levels.

F. County departments shall document efforts to ensure the child/youth meets the state compulsory attendance requirements.

G. Procedures for special education evaluations when children are in out-of-home care:

1. If a child/youth is suspected to have a disability affecting his or her education, the caseworker shall make a written referral for a special education evaluation to the designated representatives of the child/youth's "education provider" of jurisdiction, which is the "education provider" where the child is a resident for educational purposes, before a non-emergency placement in a residential child care facility.

2. Upon any placement of a child/youth with a disability or suspected of having a disability into a residential child care facility, the caseworker shall make a verbal notification within five working days and a written notification within fifteen calendar days to the "education provider" of jurisdiction after the placement.

3. Educational costs of placements are not reimbursable to the county department until after notice of the placement is given to the "education provider" of jurisdiction.

4. If the special education evaluation results in a determination that the child/youth is disabled pursuant to section 504 of the Rehabilitation Act and/or the Individuals with Disabilities Education Act, which means that the child/youth qualifies for disability accommodations and/or special education services, the county and "education provider" of jurisdiction shall meet to determine if the educational needs of the child/youth can be met in the placement or the Core Services program.

5. If the child/youth is not eligible for disability accommodations and/or special education services, the county may be responsible for educational costs.

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7.303.4 HUMAN TRAFFICKING

A. In any open Program Area 4, 5 or 6, when the county department of human or social services has reason to believe a child/youth is, or is at risk of being, a victim of human trafficking, the county department shall:

1. screen the child/youth for risk of human trafficking using a state approved human trafficking screen;

2. determine service needs;

3. Document the details of the SCREEN, assessment, and services in the state automated case management system;

4. Report immediately, and no later than twenty-four (24) hours from when the county department becomes aware, to the local law enforcement agency; and,

5. Document the details of the report to law enforcement in the state automated case management system.

B. If a child/youth who is in the legal custody of the county department of human or social services or whom the county department of human or social services has authority for placement is missing, then the county departments shall:

1. Report immediately and no later than twenty-four (24) hours from when the county department receives notification that the child/youth is missing, to the local law enforcement agency and to the National Center for Missing and Exploited Children (NCMEC). The county department shall document the details of the reports in the state automated case management system.

2. Make reasonable efforts to locate a child/youth who is missing and document those efforts a minimum of once per month in the state automated case management system:

3. Upon the return of the child/youth, make reasonable efforts to complete the following activities and document those efforts in the state automated case management system:

   a. Determine the primary factors that contributed to the child/youth being missing;

   b. Determine the child/youth's experiences while missing, including conducting human trafficking screen to determine if the child/youth is a possible human trafficking victim; and,

   c. Respond to factors identified in 7.303.4.B.3 (a) AND (b), above, in current and subsequent services.

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7.304.53 Court-Related Procedures

A. County department staff shall work with the courts in order to best serve families, children, and adults. This includes, but is not limited to:

1. Providing competent and appropriate testimony. When the case involves the Indian Child Welfare Act, testimony shall be provided by a qualified expert witness (see Indian Child Welfare Act, "Definitions", Section 7.309.1, L).

2. Identifying witnesses and evidence to be presented.

3. Being in compliance with the Indian Child Welfare Act.

4. Working with the legal representative of the county department and all other attorneys involved to serve the best interest of the child(ren) and family.

5. Ensuring that the court is provided names and addresses of parents, foster parents, pre-adoptive parents, and kin who are providing out of home care for a child in order that the court can inform and allow these individuals an opportunity to be heard at all hearings and reviews involving the child.

B. The county department shall document the following court related procedures in the case file:

1. The child and family's legal status including custody, guardianship, parental rights, and other judgments issued by the court(s) of jurisdiction. The term "allocation of parental responsibilities" when used by the court shall be interpreted to mean custody for child welfare purposes. The term "allocation of parental responsibilities" shall not be used as a permanency goal.

2. Title IV-E related documents described in Section 7.601.71.

3. The reasonable efforts which have been made to prevent removal of the child from her/his home, the reasonable efforts that have been or will be made to return the child to her/his home, and the reasonable efforts to finalize a permanent plan. The specific actions taken shall be documented and submitted to the court. When the case involves the Indian Child Welfare Act, "active efforts" rather than "reasonable efforts" must be provided (see Indian Child Welfare Act, "Definitions", Section 7.309.1, A).

When applicable, the county department shall document and submit to the court existing circumstances in which the court may determine that reasonable efforts are not required to prevent a child's removal from the home or to reunify the child and family. These circumstances are:

a. A court has determined that the parent has subjected the child to aggravated circumstances as specified in Section 19-3-604(1) and (2), C.R.S.

b. A court has determined that the parent has been convicted of:

1) murder or voluntary manslaughter of another child of the parent; or,

2) aiding or abetting, attempting, conspiring, or soliciting to commit murder; or, voluntary manslaughter of another child of the parent; or,

3) felony assault that results in serious injury to the child or another child of the parent.

c. The parental rights of the parent with respect to a sibling have been terminated involuntarily unless the prior sibling termination resulted from a parent delivering a child to a firefighter or a hospital staff member pursuant to the provisions of Section 19-3-304.5, C.R.S.

d. Youth who are participating in the Foster Youth in Transition program as described in 12 CCR 2509-03, Section 7.203.4, et seq., pursuant to Section 19-7-307(2), C.R.S.

4. That the court and the parents are notified of any change in placement before the change unless the child is in immediate danger.

5. That a record is kept of all visits and of reasons planned visits did not occur.

6. That the court, the parents, and the child are given written notice ten days before any determination which affects the parent's visitation rights, unless the child's health or well being is endangered by delaying action or would be endangered if prior notice was given. The caseworker shall keep a copy of this notification in the case record.

7. The treatment plans, including the Family Services Plan and court ordered plan, that have been attempted to return the child to the family home.

8. That the county has requested the court, in its periodic reviews, to make findings regarding the continued necessity and appropriateness of placement, the extent of compliance with the case plan, the extent of progress which has been made toward alleviating or mitigating the causes necessitating the placement, and projecting a likely date by which the child may be returned home or placed in an alternate permanent living arrangement.

C. The county department shall file a dependency and neglect petition when there are protective service issues that either present imminent danger or indicate that the environment is injurious and the case requires court jurisdiction.

D. When protective issues are not significant, county departments may refer children with intellectual, physical, or emotional disabilities to community or home-based services. If home-based or community services are not sufficient or successful, the county department may offer voluntary out-of-home placements for children who meet the criteria. If voluntary out-of-home placements are not offered, the county department shall have a written policy stating that voluntary placements are not provided.

The county department shall ensure that a placement contract is signed before a voluntary placement is made. The county department shall:

1. File a Petition for Review of Need for Placement within 90 calendar days of placement, if the placement is expected to exceed 90 calendar days.

2. Ensure that the child's parents, guardian, and legal custodian are informed of the substance of the Petition for Review of Need for Placement.

3. File a review report with the court every six months, thereafter, or more frequently, when ordered by the court, until the placement is ended. When an Administrative Review conducted by the Administrative Review Division substitutes for a court review, a summary containing the same information as would be submitted to the court shall be completed and filed in the case record in accordance with 12 CCR 2509-7, Section 7.601.6, B. The county department shall submit this written summary with the Administrative Review findings to the court.

4. Ensure that a court decree giving the county placement and care responsibility is obtained within 180 calendar days of placement. The order must state that continued placement is in the best interests of the child and either that reasonable efforts have been made to reunite the child and family or that the plan is for the child not to return home.

5. Ensure that the permanency planning hearing order for voluntary placements conforms with the requirements discussed under that section.

E. When a child is returned to the home, the county shall request the court to return legal custody of the child to the parent or guardian, except in cases covered by the Interstate Compact for the Placement of Children.

F. When a child is removed from the home, the county department must initiate a request for temporary custody hearing per Sections 19-3-312,19-3-401, and 19-3-403, C.R.S. The Family Services Plan shall be used as an Interim Treatment Plan in Court involved cases, to be available 30 calendar days after the child's removal from the home or 30 calendar days after filing of the petition, whichever is earlier.

G. The county department shall notify the court of jurisdiction and other parties within 10 calendar days of receipt of a report that a child has run away from placement.

H. Copies of Administrative Review findings shall be filed in the case record and a summary of those findings shall be included in court reports. For those cases in which an Administrative Review substitutes for court reviews, counties shall submit a copy of the actual review findings to the court with the county's court report.

I. Recommendations to the court regarding out-of-home placement of a child who has been adjudicated a delinquent, shall contain specific facts and reasons supporting the recommendations and the cost of the recommended placement.

J. When a child is temporarily absent from placement because he or she is in detention, psychiatric or medical hospitalization, or on a trial visit home, the placement is considered to be continuous for up to six months for federal review purposes if the county retains legal custody or has placement and care responsibility through a voluntary placement agreement or Petition to Review the Need for Placement. If the child returns to out-of-home placement during this time, a new removal order is not needed. Within the trial home visit time period, when the agency determines it is in the best interest of the child to continue to live in the planned permanent home, the county agency shall request the court to consider relieving the department of custody in these cases.

K. A trial home visit shall occur when it is necessary to assess the child's or youth's safety and well-being while residing in the planned permanent home. The time period of the trial home visit shall

be determined by the agency and reviewed by the court as part of the reunification process prior to the permanent custodial return of the child or youth to the parents or planned caregivers.

1. Trial home visits shall be documented in the State Department's automated data system.

2. A trial home visit may exceed six months in duration if a court orders a longer trial home visit. If a trial home visit extends beyond six months and has not been authorized by the court or exceeds the time period the court has deemed appropriate, and the child is subsequently returned to foster care, that removal must then be considered a new removal and Title IV-E eligibility must be newly established. Under these circumstances, the judicial determination regarding contrary to the welfare and reasonable efforts to prevent removal are required.

L. Change in Venue procedures are outlined in Section 7.304.4, F, G, and H.

M. When court-ordered, the county department of human or social services shall share a foster care home, kinship foster care home, and/or non-certified kinship care home provider's reports of fingerprint-based criminal history record information check generated from the Colorado Bureau of Investigation (CBI) and Federal Bureau of Investigation (FBI) with the guardian ad litem, related to the placement of a child and/or youth in out-of-home care.

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7.304.65 Administrative Review

Definition:

Administrative Review means a review conducted by the Colorado Department of Human Services, Administrative Review Division, that is open to the participation of the parents of the child, the child (if age appropriate, as determined by the caseworker), and the out-of-home care provider, pre-adoptive parents, or relatives/kin who are providing out-of-home care for the child; and conducted by an Administrative Reviewer, who is not responsible for the case management of, or the delivery of services to, either the child or the parents who are the subject of the review. If there is no objection by any party to the action, the court may order that an Administrative Review substitute for a six (6) month periodic review. All attorneys of record must be invited to court ordered Administrative Reviews.

A. The county department shall participate in the statewide Administrative Review system for all children in foster care who meet the criteria for inclusion in the review system.

B. The county department shall provide all required case records, documentation and information to the Administrative Reviewer no later than 8:00 a.m. the day of the scheduled review to allow the reviewer sufficient time to read the case file in its entirety prior to each scheduled review. If the hard copy case record is not available to the reviewer by 8:00 a.m. the day of the scheduled review, case information shall be obtained through the Department's statewide automated system.

C. The county department shall provide office space for case record review and face-to-face reviews, access to the Department's statewide automated system, and teleconference capability.

D. The county department shall coordinate, with the Administrative Reviewer, timely scheduling of all initial and subsequent Administrative Reviews.

E. The county department shall invite the following to the administrative reviews, so that these individuals will have a right to be heard, and all invitees shall be encouraged to attend:

1. For out-of-home case reviews, the following shall be invited:

a. Parents,

b. The child (if age-appropriate as determined by the caseworker),

c. Out-of-home care providers,

d. Pre-adoptive parents,

e. Relatives/kin who are providing out-of-home care for the child, and,

f. Guardian ad Litem and/or counsel for youth.

2. For Foster Youth in Transition reviews, the youth and counsel for youth and guardian ad litem (if applicable) shall be invited to the review and the youth shall be offered the opportunity to invite the following:

a. Parents,

b. Out-of-home care providers,

c. Pre-adoptive parents,

d. Relatives/kin who are providing out-of-home care.

F. If an Administrative Review has been ordered by the court and no objection has been made to the substitution of the Administrative Review for the six (6) month periodic court review, the county department shall also invite to the review all attorneys of record in the case. When an Administrative Review substitutes for a six month periodic court review, the county department shall complete a case summary containing the same information that would be submitted in a court report as required in Section 7.601.6 B, and the county shall submit this written summary with the Administrative Review findings to the court.

G. The county department shall send letters of invitation to all review participants at least two weeks prior to scheduled reviews, and ensure that invited parties are properly documented in the Department's statewide automated system prior to the time of the review. The parent or Indian custodian and the Indian child's tribe shall be sent letter(s) of invitation at least two weeks prior to the scheduled review by certified or registered mail with return receipt requested. All other invitations may be sent by electronic mail. Invitations shall include date, time, location, and purpose of the review. If the case involves an Indian child, the requirements of the pending court proceedings section of the Indian Child Welfare Act of 1978, 25 U.S.C. § 1912(a), and § 19-1-126, C.R.S.

H. The county department shall encourage all invitees to attend Administrative Reviews (see Section 7.304.661.A, regarding, provider attendance). If an individual is unable to attend, participation by conference call shall be offered.

I. Administrative Reviews shall be held at the county department having custody of the child, irrespective of the location of the child's placement.

J. Administrative Review Findings

1. Copies of Administrative Review findings shall be maintained in the Department's statewide automated system and a summary of those findings shall be included in court reports. For those cases in which an Administrative Review substitutes for a six month periodic court review, counties shall submit a copy of the actual review findings to the court with the county's court report.

2. For all narrative findings that contain "Issues for County Administration", the county is required to respond to the Administrative Review Division within the time frame specified in the narrative depending on the issue identified.

a. A county response shall be sent to the Administrative Review Division.

b. If the county response is considered sufficient and timely, no further action is taken and the county shall be notified in writing within five (5) working days.

c. If the county's response is not timely or sufficient, notification will be given to the county and appropriate division(s) representative for further follow up/action.

d. An internal meeting will be held with the appropriate division(s) and their representatives within a maximum of twenty (20) working days to determine next steps and time frames for resolution.

e. If the issues are unresolved, a corrective action process may be pursued.

K. Confidentiality

1. The federal confidentiality requirements at Section 471(a)(8) of the Social Security Act provide safeguards which restrict the use of, or disclosure of, information concerning individuals served by the child welfare agency, and these same rules apply to the Administrative Review process.

2. Audio and/or video recording of Administrative Reviews shall not occur without releases of confidentiality forms signed by all parties to the case prior to recording.

****

7.305.2 SPECIFIC PROCEDURES

A. The county department shall assess all youth in foster care who have reached the age of fourteen (14) for services to prepare for adulthood and shall complete the Roadmap to Success part of the Family Services Plan (FSP). This is required regardless of the specified permanency goal of the case plan.

B. The county department's assessment shall include documentation of:

1. The youth's capacity for self-sufficiency and self-support by reviewing daily living skills, in consideration of their age and appropriate developmental expectations/milestones.

2. An evaluation of individual, family, community, and financial support resources available to promote emancipation or semi-independent living.

C. Following assessment, the Roadmap to Success (RTS) shall be developed in consultation with the youth, caseworker, care provider(s), and, at the option of the youth, up to two (2) other significant persons chosen by the youth who are not the foster parent or caseworker for the youth and documented in the FSP in the state automated system. If the county department of human or social services has good cause to believe an individual selected by the youth will not act in his or her best interest, the planning team may designate another advocate for the youth.

1. The case plan and court report following a staffing or meeting shall describe the services to help the youth transition to successful adulthood including, but not limited to, participation in ongoing opportunities to engage in age and developmentally appropriate activities, and, if the youth is pregnant and/or a parent, the parenting supports provided to the youth.

2. The case plan shall document the rights of the youth to education, health, visitation, court participation, the right to stay safe and avoid exploitation, and the right to receive a credit report annually. A signed acknowledgement that the youth was provided a copy of these rights and that they were explained in an age or developmentally appropriate way shall be included in the case plan.

D. A Supervised Independent Living Placement is an out-of-home placement.

1. The county department may utilize a supervised independent living placement for youth at least sixteen (16) years of age through the last day of the month of their twenty-first (21) birthday when the county has placement and care responsibility.

2. Approved supervised independent living placement settings may include an approved college dormitory, transitional living program, an apartment or other private housing, or another age or developmentally appropriate placement

3. The use of a supervised independent living placement for youth ages sixteen (16) up to eighteen (18) may only be utilized after considering the youth's developmental needs and assets, supports that are available to the youth, and documentation in case notes that all other options have been exhausted.

4. For youth ages sixteen (16) up to eighteen (18), placement in a supervised independent living placement must follow a period in out-of-home care.

5. When the placement is not a college dormitory operated by an institution of higher education, adults residing in the household with the youth shall be required to successfully complete background checks as described in 12 CCR 2509-5.

6. An update to the existing Roadmap to Success (RTS) must be completed, preferably within 30 days prior to, but no later than 30 days after, the start date of the supervised independent living placement.

7. The county department shall establish a written policy for the use of supervised independent living placement. The policy shall address the following:

a. Assessing each youth's readiness to be successful in a supervised independent living placement, the safety of the placement, the availability of supportive services and resources for youth transitioning into adulthood, any county-specific policies around caseworker contact with the youth, and the process for ongoing review.

b. Supervised independent living placement funds shall be provided to the youth and be sufficient to have their needs met as identified in 12 CCR 2509-8 Sections 7.708.26, 7.708.31, 7.708.41, 7.708.42, 7.708.43, and 7.708.44, as well as having access to a working telephone and internet.

c. Additional supervised independent living placement funds may be provided to the youth as an incentive for progress towards and/or achievement of goals.

d. Decisions to withhold supervised independent living placement funds provided to the youth per section (c) shall not reduce the amount provided per subsection (b) and must be according to defined guidelines found in the county policy.

e. Defined appeal process and notification procedures for youth whose supervised independent living placement funds under subsection (c) are withheld.

f. Defined process for how and when a supervised independent living placement may be terminated. The policy must address potential termination reasons

including, but not limited to, concerns for current or impending danger or court case closure.

8. A signed copy of the supervised independent living placement agreement and a signed expectations/acknowledgement that the youth was provided a copy of the county guidelines. These documents shall be explained in an age or developmentally appropriate way and shall be included in the case file.

E. Free Annual Credit Record Report for Youth Fourteen (14) Years of Age and Older in Foster Care

The following steps shall be taken:

1. The county department shall obtain free annual credit report information from the three credit reporting agencies designated by the Department for youth who are in foster care and are at least fourteen (14) years of age, and provide the information to the youth and Guardian ad Litem (GAL) and/or counsel for youth;

2. If the youth objects to obtaining the credit report, the county department shall inform the court and request that the court issue an order authorizing the county to obtain the credit report.

3. The county department shall maintain a copy of each credit report in the case record; and,

4. Should the annual report show evidence of any inaccuracies, the county department shall inform the court of the inaccuracies, refer the youth to a Colorado Department of Human Services approved governmental or non-profit entity to resolve the inaccuracies, and inform the GAL and/or counsel for youth of the referral.

F. The youth, county department caseworker, provider(s), and other representatives of the youth as appropriate, shall jointly develop a detailed, formal emancipation transition plan no more than ninety (90) days prior to the emancipation date of the youth. The plan, signed by all parties, shall include, but need not be limited to, the following:

1. Assurance that the plan meets the specific self-sufficiency/cost of living standard in the county or state where the youth plans to reside.

2. a plan shall be developed with the youth based on the information from the assessment and the youth’s goals.

3. Personalization at the direction of the youth to meet the individual emancipation needs in order to help prevent homelessness.

4. Copies of verifiable vital documents required in Section 7.305.5.

5. Specific options for:

   a. Housing,

   b. Health insurance and health care decision-making information,

   c. Education,

   d. Local opportunities for safe mentors,

   e. Continuing after-care support services, and

f. Work force supports and employment services.

6. The plan shall be documented in the State Department's automated system in the Family Services Plan, and a copy given to the youth free of charge.

PHIL WEISER
Attorney General

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Chief Deputy Attorney General

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Solicitor General

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Associate Chief Deputy Attorney General

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Office of the Attorney General

Tracking number: 2023-00202

Opinion of the Attorney General rendered in connection with the rules adopted by the

Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)

on 06/09/2023

12 CCR 2509-4

CHILD WELFARE SERVICES

The above-referenced rules were submitted to this office on 06/15/2023 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.

June 26, 2023 11:50:40

Philip J. Weiser
Attorney General
by Kurtis Morrison
Deputy Attorney General

Permanent Rules Adopted

Department

Department of Human Services

Agency

Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)

CCR number

12 CCR 2509-5

Rule title

12 CCR 2509-5 RESOURCES, REIMBURSEMENT, REPORTING, AND PROVIDER REQUIREMENTS 1 - eff 07/31/2023

Effective date

07/31/2023

7.406 GENERAL REIMBURSEMENT FOR CHILD WELFARE SERVICES

7.406.1 THE STATE REIMBURSES WHEN

A. The county's case record contains required program documentation. For out-of-home placement, documentation shall include the requirements listed under Section 7.304.51 (12 CCR 2509-4), Authority for Placement.

B. Care is provided after the case is open and before the case is closed.

C. The child is with a provider in possession of a valid certificate or license, when one is required.

D. Placement is with an in-state Residential Child Care Facility or Child Placement Agency on the state approved vendor list or with out of state placement providers as approved through the Interstate Compact on the Placement of Children.

E. A youth over eighteen (18) years of age is in placement only when the court had jurisdiction before the 18th birthday and the court orders out- of-home placement or the youth meets eligibility criteria for the Foster Youth in Transition Program and has an active voluntary services agreement.

F. A child is absent from an out-of-home placement and the county department elects to reimburse the provider during the absence period for the placement for one of the following reasons:

1. The absence does not exceed seven days per absence, with only one (1) seven-day total reimbursement within thirty (30) calendar days for the following reasons:

    a. The child has run away,

    b. Trial home visit,

    c. Trial provider visit,

    d. Child in detention; or,

    e. The child has been kidnapped.

2. Thirty (30) calendar day absences are allowed for the following reasons:

    a. Respite (unless care is being provided and it violates Section 7.708.31.1 C, ~~D~~ (12 CCR 2509-8) and causes a foster care home to be over capacity); or,

    b. The absence occurs during the first thirty (30) days of a hospitalization.

3. For children enrolled in the Children's Habilitation Residential Program Waiver (CHRP), the county may continue payment of the equivalent of the maximum federal Supplemental Security Income benefit during all absences.

G. The out-of-home placement duration for a voluntary Title IV-E child/youth does not exceed 180 calendar days when the county department has filed for a petition to review the need for placement, or petition to open a foster youth in transition case by the 90th calendar day and the county has a correctly worded court order issued, based on the request of the petition to review the need for placement; see Court-Related Procedures, Section 7.304.53 (12 CCR 2509-4).

H. The county department reports an out-of-home or Core Services Program care placement in the Department's automated reporting system within ninety (90) calendar days of its beginning. The State reimburses for retroactive payments not greater than the current and two (2) preceding months.

I. The county department places children in out-of-home care within the provider's licensed or certified capacity or if the licensed/certified capacity is exceeded with the placement of a sibling group. The county shall document that there are no other appropriate placements available.

J. A child is in a Child Placement Agency or Residential Child Care Facility within Colorado for longer than ten (10) working days and an agreement to purchase Child Placement Agency or Residential Child Care Facility services is completed for the child.

K. A child is in a Child Placement Agency or Residential Child Care Facility within Colorado for less than ten (10) working days and the facility has an emergency shelter contract with a county department.

L. Out-of-home placement occurs in facilities holding current certificates or licenses, including kinship foster care placement.

M. Children are placed in Child Placement Agencies and Residential Child Care Facilities outside of Colorado according to the rules for out of state placement and Interstate Compact on the Placement of Children.

N. Respite care is paid to providers of foster care homes. This includes county department or child placement agency foster care homes, or adoptive homes receiving a foster care payment and kinship family foster care providers. It does not include foster homes that provide receiving home care.

O. The child enters care (first day) but not for the last day in care.

P. The child is placed and removed on the same day.

Q. The state reimburses for supervised independent living placements as described in 12 CCR 2509-04; 7.305.2(D) for youth aged sixteen (16) through the end of the month of the youth’s twenty-first (21st) birthday, when the county has placement and care responsibility.

R. Child Welfare Child Care program criteria are met.

S. The Core Services Program is operated within applicable state rules and within the provisions of the county or multi-county state approved Core Services Plan and in accordance with the requirements governing the specific funding streams used.

T. Client travel costs for out-of-state placement and supervision activities are related to out-of-home placements approved through the Interstate Compact county liaison and the receiving state Interstate Compact on the Placement of Children office. Staff travel costs are reimbursed through county administration.

U. Payments for out-of-home care and rate adjustments are pro-rated using the foster care daily rate in the State Department's automated reporting system.

V. The developmental disability rate for children placed in foster care homes, kinship foster care homes, receiving home care, specialized group facilities, specialized foster care in county certified foster care homes, and homes in which a subsidized adoption maintenance payment is made.

W. Clothing is authorized to be purchased for a child/youth in out-of-home care. The state reimburses retroactive clothing payments not greater than the current and two preceding months.

X. The child is in out-of-home care and the county department lists a child who is available for adoption with the Colorado Adoption Resource Registry within ninety (90) calendar days following:

1. The date of relinquishment or termination of the parent-child relationship, or

2. The date of placement into out-of-home care following an adoption dissolution.

Y. The child is in out-of-home care, the county department requests and the State approves an exclusion from Colorado Adoption Resource Registry listing for a child who is available for adoption within ninety (90) calendar days following:

1. The date of relinquishment or termination of the parent-child relationship; or,

2. The date of placement into foster care following an adoption dissolution.

Z. A Colorado Adoption Resource Registry exclusion is approved by the state because the county finds an adoptive home, reimbursement for out-of-home care is limited to six months from the date the state department receives the request for exclusion.

AA. Costs are billed for the current and two (2) preceding months.

BB. The Early intervention and Prevention Program is operated within applicable state rules and within the provision of the county or multi- county state approved services plan.

CC. A child/youth with intellectual or developmental disabilities has been placed in a locked residential setting for treatment and the county has obtained a court order of legal imposition of disability pursuant to Section 27-10.5-110, C.R.S.

DD. A county department pays incentives to a consortium for meeting or exceeding agreed to outcomes.

EE. A county department may pay a consortium, if the consortium's outcome measures meet or exceed the agreed to standard.

FF. A county department purchases Transition Program services provided by a RCCF that is on the approved State RCCF vendor list. In no case shall the rate for transition services exceed the RCCF rate approved by the county department.

GG. Placement of a child in a provisionally certified foster care home that is fully certified within ninety (90) calendar days from the date of the application.

HH. If required by section 24-76.5-101, -102, OR -103 a county department shall document the lawful presence of children age eighteen (18) and over receiving services other than those excluded from the definition of a federal public benefit, state and local public benefits as those terms are defined at Section 24-76.5-102, C.R.S., or services excluded from this requirement as defined at section 24-76.5-103, C.R.S.

II. A county department pays a provider at or above the state-established base anchor rates. A county that negotiates provider rates shall use a request for proposal process, a draft of which shall be submitted to the Department, no later than March 1 of each calendar year. The Department shall approve or deny the draft proposal no later than April 1 of each calendar year. The request for proposal shall include the following:

1. The county department of human/social services’ policy for:

a. Determining the time frames for negotiation or re-negotiation of rates, services and outcomes; and,

b. Actions to be taken if services are not delivered or outcomes are not met.

2. The Department shall evaluate request for proposals submitted by county departments of human/social services using the following criteria:

a. Consideration of whether the county used an approved request for proposal process including, but not limited to, competitive bidding and negotiations;

b. Consideration of performance outcomes and whether they are tied to financial incentives.

JJ. Reasonable travel is provided to the school where the child is enrolled prior to out-of-home placement.

KK. Reasonable costs are provided for liability insurance for a child.

LL. Adoption Assistance and Relative Guardianship Assistance Program payments are made in compliance with requirements.

MM. Case services are authorized in adoption assistance agreements and relative guardianship assistance agreements.

NN. Non-recurring expenses are authorized for adoption assistance and relative guardianship assistance agreements.

OO. A child/youth is placed at the IDD facility, as described in 7.424.13, with the approval of the State Department. The approved placement period is the duration of treatment, as stated in the most recent approval letter from the State Department, and thirty (30) days after the completion of treatment/ discharge date.

PP. A county department makes foster care maintenance payments for children/youth placed with parents in a licensed residential family-based treatment facility for substance abuse in accordance with federal and state program and fiscal requirements. Reimbursement shall be eighty percent (80%) of the approved allowable cost, within the available allocation.

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7.416.1 REIMBURSEMENT FOR THE CHAFEE PROGRAM

A. The Chafee Program provides supplemental services that assist youth to successfully transition to adulthood for youth who are eligible through section 7.305.42. The state shall reimburse counties or programs for expenditures in approved Chafee plans to include the following:

1. Salaries, fringe, and operating costs directly related to the county- or program- funded positions;

2. Contracted services authorized by an approved program plan and contained in a written contract between the individual contractor and the county department. Contractors must perform as an independent business entity;

3. Program services purchased from an agency as outlined in an approved Chafee Foster Care Independence Program plan when a written contractual agreement exists between the provider agency and the county department;

4. Consultation, training, and staff development for Chafee Program service staff when necessary for the delivery of the Chafee Program;

5. Travel and per-diem expenses directly related to program delivery; and,

6. Room and board costs for young adults, ages 18 to 23, who were in out-of-home care on or after their 18th birthday.

B. Chafee Program expenditures not reimbursable by the state include:

1. Expenditures used to supplant, duplicate, or replace existing child welfare funds; and,

2. Other expenditures not permitted by the fiscal rules or procedures.

C. Any expenditure other than those defined in this section as reimbursable shall be nonreimbursable unless specifically identified in a state approved Chafee Program plan.

D. The county departments shall meet all state fiscal reporting requirements for expenditures in its plan. The state may withhold or reduce reimbursement to counties for expenditures not in compliance with the Chafee Program plan.

E. Youth Direct Services - County departments of social services may be reimbursed at 100% for directly funded services up to a maximum amount in each state fiscal year.

1. The amount shall be determined by the county departments of social services with approval by the state.

2. Youth Direct Services shall be used according to federal guidelines (Public Law No. 106-169) as incentives for completing goals in the plan for transition to independent living and other expenditures that will assist youth to emancipate and for which no other funding sources exist.

a. Amounts up to $100 shall be documented in the case notes.

b. Amounts of $100 or greater shall be documented in the Chafee plan that is created with the youth.

PHIL WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

SHANNON STEVENSON
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Office of the Attorney General

Tracking number: 2023-00203

Opinion of the Attorney General rendered in connection with the rules adopted by the

Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)

on 06/09/2023

12 CCR 2509-5

RESOURCES, REIMBURSEMENT, REPORTING, AND PROVIDER REQUIREMENTS

The above-referenced rules were submitted to this office on 06/14/2023 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.

June 26, 2023 11:51:57

Philip J. Weiser
Attorney General
by Kurtis Morrison
Deputy Attorney General

Emergency Rules Adopted

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

CCR number

10 CCR 2505-10

Rule title

10 CCR 2505-10 MEDICAL ASSISTANCE - STATEMENTS OF BASIS AND PURPOSE AND RULE HISTORY 1 - eff 06/09/2023

Effective date

06/09/2023

Expiration date

10/07/2023

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 23-06-01-A
Division / Contact / Phone:Special Financing / Nancy Dolson / 303-866-3698

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 23-06-01-A, Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000.

3. This action is an adoption of: new rules

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) OP Pages, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 06/09/23
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.8000 with the proposed text beginning at 8.8000 through the end of 8.8000. This rule is effective June 9, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 23-06-01-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Create rules to administer the Rural Provider Access and Affordability Stimulus Grant Program established through the enactment of Senate Bill 22-200 including a methodology to determine which rural providers are qualified for grant funds, permissible uses of grant money, and reporting requirements for grant recipients.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   The enabling legislation, Senate Bill 22-200, requires that the Medical Services Board promulgate rules for the administration of the Rural Provider Access and Affordability Stimulus Grant Program. The legislation also created the Rural Provider Access and Affordability Advisory Committee to begin meeting in September 2022 and charged the committee with making formal recommendations to the Department on the administration of the grant program including the proposed rule. The timeline for the advisory committee's work must meet the requirements set in legislation at Section 25.5-1-207 (5), C.R.S.

3. Federal authority for the Rule, if any:

   American Rescue Plan Act of 2021 (ARPA), Public Law 117-2

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
   Section 25.5-1-207 (5), C.R.S. (2022)

Initial Review — Final Adoption **06/09/23**
Proposed Effective Date **07/30/23** — Emergency Adoption

DOCUMENT #03

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 23-06-01-A
Division / Contact / Phone:Special Financing / Nancy Dolson / 303-866-3698

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Colorado hospitals in rural communities and their associated clinics will benefit from the proposed rule by helping these providers modernize their information technology systems which tend to lag behind their urban and suburban counterparts. Residents of rural Colorado will benefit as the program will support reducing health care costs in communities, add jobs, stimulate the economy, improve access to care, and mitigate rural health disparities.

   The funding for the Rural Provider Access and Affordability Stimulus Grant Program comes from federal funds with no cost to the state or local communities.

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

   The Rural Provider Access and Affordability Stimulus Grant Program will drive financial sustainability for hospitals and clinics in rural areas of Colorado by investing $9.6 million in health care affordability and health care access related projects:

   - $4.8 million in health care affordability projects, such as shared analytics platforms, telehealth supports, and enabling shared care management between rural providers

   - $4.8 million in health care access projects, such as extending hours for primary and behavioral health care, telemedicine including remote monitoring supports, new or expanded access sites including surgery, chemotherapy, and advanced imaging

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

The General Assembly appropriated $400,000 to the Department to administer the Rural Provider Access and Affordability Stimulus Grant Program when it enacted Senate Bill 22-200. These funds are sufficient to administer the program and no costs to other agencies are expected. The funds for the Rural Provider Access and Affordability Stimulus Grant Program are federal funds from the American Rescue Plan Act of 2021 (ARPA) and there is no impact on state revenues.

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

   Adopting the proposed rules to administer the Rural Provider Access and Affordability Stimulus Grant Program will allow the Department to grant $9.6 million of federal funds to rural providers as directed by the General Assembly to improve health care affordability and access and stimulate the economies in rural Colorado.

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, there are no benefits to inaction.

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

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, there are no less costly or intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, there are no alternatives to rule making than the proposed rule. The proposed rule includes those elements necessary to administer the grant program and were developed and supported by the Rural Provider Access and Affordability Advisory Committee established by the legislation.

8.8000 Rural Provider Access and Affordability Stimulus Grant Program

8.8000.A PURPOSE AND LEGAL BASIS

1. Pursuant to C.R.S. § 25.5-1-207, the Rural Provider Access and Affordability Stimulus Grant Program provides grants to qualified providers to improve health care affordability and access to health care services in rural communities and to drive financial sustainability for rural hospitals and clinics.

8.8000.B DEFINITIONS

1. Advisory Committee means the rural provider access and affordability advisory committee as defined in section 25.5-1-207 (3), C.R.S.

2. Department means the Colorado Department of Health Care Policy and Financing.

3. Health Care Access Project means a project that expands access to health care in Rural Communities including but not limited to:

    a. Extending hours for access to primary care or behavioral health services,

    b. Investing in dual track emergency department management,

    c. Expanding access to Telemedicine including remote monitoring support,

    d. Providing new or replacement Hospital beds,

    e. Expanding access to long term care and recovery care in skilled nursing facilities, and

    f. Creating or expanding sites that provide surgical care, chemotherapy, imaging, and advanced imagining including computerized tomography scans.

4. Health Care Affordability Project means a project that modernizes the information technology infrastructure of Qualified Rural Providers including but not limited to:

    a. Creating a shared analytics platform and care coordination platforms among Qualified Rural Providers, and

    b. Enabling technologies, including telehealth and e-consult systems, that allow Qualified Rural Providers to communicate, share clinical information, and consult electronically to manage patient care.

5. Hospital means a hospital licensed or certified pursuant to section 25-1.5-103 (1)(a), C.R.S. or an affiliate owned or controlled as defined in section 25.5-4-402.8 (1)(b), C.R.S., by the hospital.

6. Qualified Rural Provider means a Hospital located in a Rural Community in Colorado that has a lower net patient revenue or fund balance compared with other Rural Hospitals.

7. Rural Community means a county with a population of fewer than fifty thousand residents; or a municipality with a population of fewer than twenty-five thousand residents if the municipality is not contiguous to a municipality with a population of twenty-five thousand or more residents.

8. Rural Stimulus Grant means funding received from the rural provider access and affordability grant program established in section 25.5.1-207, C.R.S.

9. Telemedicine means the delivery of medical services as defined at section 12-240-104 (6), C.R.S.

8.8000.C GRANT AWARD PROCEDURES

1. Rural Stimulus Grants will be awarded through an application process.

    a. A request for grant application form shall be issued by the Department and posted for public access on the Department's website at https://hcpf.colorado.gov/research-data at least 30 days prior to the application due date.

    b. A Qualified Rural Provider may submit applications for more than one project or may submit a joint application with another Qualified Rural Provider.

2. The application will include:

        a. Project overview.

        b. Proposed budget including:

            i. Total funds requested not to exceed $650,000 per project per applicant,

            ii. Itemized direct expenses,

            iii. Indirect expenses limited to federal Negotiated Indirect Costs Rate Agreement (NICRA) or de minimis rate of 10 percent if the applicant does not have an NICRA,

            iv. If applicable, documentation of quotes or estimates for construction, equipment, or other expenditures, and

            v. If applicable other sources of funding that will be utilized to complete the proposed project.

        c. Project timeline to commence no earlier than July 1, 2023 and to conclude no later than December 31, 2026.

        d. Description of Qualified Rural Provider's diversity, equity, and inclusion strategy and how diverse community needs are met by the project.

        e. Demonstration of financial need.

            i. Qualified Rural Providers in the bottom 40% of net patient revenues for the three-year average of 2016, 2017, and 2018 or the bottom 6% fund balance for 2019 as determined by the Department's review of CMS 2552-10 Medicare Cost Reports are considered to meet the financial health requirement.

            ii. Other Qualified Rural Providers may submit additional financial supporting information to support their financial need.

        a. For capital investment projects, facility or equipment age.

        b. Impact to health care affordability or access to care.

i. Statement of need outlying underlying problem the funding will address.

ii. Description of how the project's goals and objectives will be sustained after the Rural Stimulus Grant funds have been expended.

iii. Description of how the project will increase access to specialty care, if applicable.

iv. Description of how project will improve care coordination, if applicable.

v. Description of partner engagement, if applicable.

3. The Advisory Committee will review Rural Stimulus Grant applications and recommend Rural Stimulus Grant awards to the Department's executive director based on the following criteria:

    a. Budget and financial need.

    b. Partner collaboration, support, or engagement.

    c. Completeness of response.

    d. Ability to execute and complete project.

    e. Reasonableness of timeline.

    f. Diversity, equity and inclusion and how diverse communities will be impacted by the project.

    g. County Medicare and Medicaid caseload percentage of population.

    h. Statement of need.

    i. Sustainability of project.

    j. Impact to health care affordability or access to care.

4. The Department's executive director or his or her designee shall make the final Rural Stimulus Grant awards to Qualified Rural Providers.

    a. The total funding for Rural Stimulus Grants is limited to no more than $9.6 million with no more than $4.8 million for Health Care Access Projects and no more than $4.8 million for Health Care Affordability Projects.

    b. The Department may change Rural Stimulus Grant amounts depending on the final number of Rural Stimulus Grants awarded, the availability of Rural Stimulus Grant funds, or the goals stated in the Rural Stimulus Grant application.

    c. Rural Stimulus Grant applicants may request reconsideration of Rural Stimulus Grant awards within 5 business days of award notification in writing to the Department's executive director. The executive director will respond to the request for reconsideration within 10 business days of receipt.

    d. The Department will execute a grant agreement with each Rural Stimulus Grant recipient.

5. The Department will disburse Rural Stimulus Grant funds no earlier than July 1, 2023 and no later than July 1, 2024. Any money not disbursed by July 1, 2024 will revert to the Economic Recovery and Relief Cash Fund created pursuant section 24-75-228 (2)(a), C.R.S.

6. Rural Stimulus Grant recipients will expend Rural Stimulus Grant funds by the timeline in their grant agreement and no later than December 31, 2026. Any Rural Stimulus Grant funds not expended by Rural Stimulus Grant recipients by December 31, 2026 will be recovered by the Department to be returned to the U.S. Department of the Treasury.

8.8000.D PERMISSIBLE USES OF GRANT AWARDS

1. Rural Stimulus Grant funds must be used for Health Care Affordability Projects or Health Care Access Projects to improve health care affordability and access in Rural Communities.

2. Rural Stimulus Grant funds may not be deposited into a pension fund and may not be used to service debt, satisfy a judgment or settlement, or contribute to a “rainy day” fund.

8.8000.E REPORTING REQUIREMENTS FOR GRANT RECIPIENTS

1. Recipients of Rural Stimulus Grant funds for capital expenditures must submit a written justification as set forth in 31 Code of Federal Regulations 35.6 (b)(4) to the Department.

2. For the duration of the grant agreement, Rural Stimulus Grant recipients must submit a quarterly report to the Department no later than the 10th day of the month following the end of each quarter including but not limited to a brief narrative and itemized expenditure and performance metric data.

3. Rural Stimulus Grant recipients will submit a final report to the Department within 30 calendar days following the end of the grant agreement including an overall narrative and itemization of all expenditures and performance metric data for the total Rural Stimulus Grant award.

8.8000.F RECORD RETENTION AND ACCESS

1. Rural Stimulus Grant recipients must maintain records of expenditures for a minimum of five years after funds have been expended or returned to the Department, whichever is later.

2. Rural Stimulus Grant recipients must allow the Department and state and federal auditors access to records related to the expenditure of Rural Stimulus Grant funds.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Cost Sharing, Section 8.754.1
Rule Number: MSB 23-04-26-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 23-04-26-A, Revision to the Medical Assistance Act Rule concerning Cost Sharing

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.754.1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 7/1/2023
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.754 with the proposed text beginning at 8.754.1 through the end of 8.754.1. This rule is effective July 1, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Cost Sharing, Section 8.754.1
Rule Number: MSB 23-04-26-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The proposed rule removes member copayments for the following services in accordance with the 2023 Colorado Long Bill (Senate Bill 23-214), effective July 1, 2023: outpatient hospital visits; physician (M.D. or D.O.) office or home visits; rural health clinic visits; brief, individual, group and partial care community mental health center visits (except services which fall under Home and Community Based Service programs); pharmacy prescription or refill; optometrist visits; podiatrist visits; psychiatric services; durable medical equipment/disposable supply services; laboratory services; and radiology services.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   The proposed rule is imperatively necessary to align Department rule with the statutory removal of certain member copayments in the 2023 Colorado Long Bill (Senate Bill 23-214), effective July 1, 2023

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
   Colorado Senate Bill 23-214

Initial Review — Final Adoption **08/11/23**
Proposed Effective Date **07/01/23** — Emergency Adoption **06/09/23**

DOCUMENT #08

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Cost Sharing, Section 8.754.1
Rule Number: MSB 23-04-26-A
Division / Contact / Phone: Health Policy Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Members will be affected by the proposed rule.

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

   Members will not be required to provide copayments for the affected services.

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

   The Department estimates that removal of member copayments from affected services will cost $9,429,686 in total funds annually.

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

   The costs of the proposed rule are provided in question three response above. The benefit of the proposed rule is aligning Department rule with Senate Bill 23-214. The cost of inaction is misalignment between Department rule and Senate Bill 23-214. There are no benefits to inaction.

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

   There are no less costly methods or less intrusive methods for aligning Department rule with Senate Bill 23-214.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

DO NOT PUBLISH THIS PAGE

There are no alternative methods to align Department rule with Senate Bill 23-214.

8.754 CLIENT CO-PAYMENT

8.754.1 CLIENT RESPONSIBILITY

Clients shall be responsible for the following co-payments:

8.754.1.A. Hospital outpatient, $0.00 per visit, effective July 1, 2023.

8.754.1.B. Physician (M.D. or D.O) office or home visit, $0.00 per visit, effective July 1, 2023.

8.754.1.C. Rural health clinic, $0.00 per visit, effective July 1, 2023.

8.754.1.D. Brief, individual, group and partial care community mental health center visits except services which fall under Home and Community Based Service programs, $0.00 per visit, effective July 1, 2023.

8.754.1.E. Pharmacy, $0.00 per prescription or refill, effective July 1, 2023.

8.754.1.F. Optometrist, $0.00 per visit, effective July 1, 2023.

8.754.1.G. Podiatrist, $0.00 per visit, effective July 1, 2023.

8.754.1.H. Inpatient hospital, $0.00 per admission, July 1, 2023.

8.754.1.I. Durable medical equipment/disposable supply services, $0.00 per date of service, effective July 1, 2023.

8.754.1.J. Laboratory services, $0.00 per date of service, July 1, 2023.

8.754.1.K. Radiology services, $0.00 per date of service, July 1, 2023.

8.754.1.L. Emergency services, $0.00 co-pay.

1. For services that continue to have a co-pay under Section 8.754.2, it is the provider's responsibility to identify emergency on the claim form so that the fiscal agent can exempt the service from co-payment.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers, Sections 8.511 & 8.535
Rule Number: MSB 23-04-11-A
Home and Community Based Services Division / Erin Thatcher / 5788

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 23-04-11-A, Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.511 and 8.535, Colorado Department of Health Care Policy and Financing, Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 06/09/23 for 07/01/23

   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.511 with the proposed text beginning at 8.511.1 through the end of 8.511.4. Replace the current text at 8.535 with the proposed text beginning at 8.535.2 through the end of 8.535.2. This rule is effective July 1, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers, Sections 8.511 & 8.535
Rule Number: MSB 23-04-11-A
Home and Community Based Services Division / Erin Thatcher / 5788

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   An increase to the currently approved direct care worker Base Wage has been approved by the General Assembly effective July 1, 2023. The Base Wage rule will be amended to remove exact dates and rates, so that future increases can be implemented quickly without further amendments. Additionally, the rule has been simplified and reorganized. For example, the Department will remove Base Wage regulations from the Pediatric Personal Care Rule (8.535) and reference the main Base Wage rule within 8.511. Future notices of Base Wage increases will be posted on the Provider Rates and Fee Section of the website.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   The Department's Budget Request R07 was approved on May 1, 2023, when Senate Bill 23-214 was signed into law. Within SB 23-214 the General Assembly approved "an increase for home and community-based waiver services to reflect a $15.75 per hour base wage for workers statewide and $17.29 per hour in Denver." An emergency rule to amend the existing Base Wage regulations is required to implement the increase effective July 1, 2023.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Senate Bill 23-214 approved May 1, 2023;

   25.5-6-18 C.R.S. (2021) & Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023)

Initial Review — Final Adoption **08/11/23**
Proposed Effective Date **07/01/23** — Emergency Adoption
06/09/23

DOCUMENT #09

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers, Sections 8.511 & 8.535
Rule Number: MSB 23-04-11-A
Home and Community Based Services Division / Erin Thatcher / 5788

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Direct Care Workers are the most impacted by this proposed rule. They continue to benefit from an increased base wage, which promotes stability for the workers themselves, HCBS providers and members receiving services. The Department has increased reimbursement rates to offset costs to HCBS provider agencies in implementation of this rule. Provider agencies and Department staff will be impacted in the effort to implement and monitor compliance with this rule.

2. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The Department received approval and funding to increase the Base Wage via Senate Bill 23-214. Providers will receive increased reimbursement rates and are responsible for ensuring Direct Care Workers' wages are compliant with the Base Wage. The Department has existing policies and mechanisms in place to monitor compliance of the Base Wage. HCBS provider agencies and Direct Care Workers will benefit from streamlined processes and simplified rules.

   The existing rule outlines that HCBS providers may incur penalties and recoupment if they do not comply with the necessary reporting requirements of this rule. This provision has not changed.

3. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The Department will utilize funding authorized through the General Assembly to fund the associated rate increases and complete the auditing requirements needed for the implementation of this rule. No additional budgetary impact is expected from the implementation of this rule.

   If this rule is not approved, the Department will be unable to hold providers accountable for ensuring Direct Care Workers receive an

increase to their Base Wage. This will further exacerbate workforce challenges and retention of staff, impacting members receiving these critical home and community-based services.

4. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   The Department is amending the rule to remove rates and dates that would require an amendment for every rate change impacting the Base Wage. This is the most effective way to ensure the Base Wage is enforced.

5. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no less costly solutions to achieve the purpose of this proposed rule.

8.511 BASE WAGE REQUIREMENT FOR DIRECT CARE WORKERS

8.511.1 DEFINITIONS

Definitions below only apply to Section 8.511.

A. Base Wage means the minimum hourly rate of pay of a Direct Care Worker for the provision of Home and Community-Based Services (HCBS) required by the Colorado Department of Health Care Policy and Financing. The Department shall publish current and previous Base Wage rates and related effective dates on the Provider Rates and Fee Schedule website.

B. Department means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

C. Direct Care Worker means a non-administrative employee or independent contractor of a Provider Agency or Participant Directed Program Employer of Record who provides hands-on care, services, and support to older adults and individuals with disabilities across the long-term services and supports continuum within home and community-based settings.

D. Minimum Wage means the rate of pay established in accordance with Section 15 of Article XVIII of the State Constitution and any other minimum wage established by federal or local laws or regulations. In addition to state wage requirements, federal or local laws or regulations may apply minimum, overtime, or other wage requirements to some or all Colorado employers and employees. If an employee is covered by multiple minimum or overtime wage requirements, the requirement providing a higher wage, or otherwise setting a higher standard, shall apply.

E. Plan of Correction means a formal, written response from a provider agency to the Department on identified areas of non-compliance with requirements listed in Section 8.511.4.

F. Participant Directed Program means a service model that provides participants who are eligible for Home and Community-Based Services the ability to manage their own in-home care, or have care managed by an authorized representative, provided by a direct care worker. Participant Directed Program participants, or their authorized representative, operate as Employers of Record with an established FEIN.

G. Provider means any person, public or private institution, agency, or business enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods. Pursuant to this rule, a provider that renders qualifying service(s) accepts responsibility to ensure qualifying Direct Care Workers currently under their employment are paid, at a minimum, the base wage.

H. Per Diem wage means daily rate of pay for Direct Care Workers for the provision of Home and Community-Based Services (HCBS). For purposes of this rule, the per diem wage shall apply to Direct Care Workers of residential service providers.

8.511.2 QUALIFYING SERVICES

A. When applicable, the Department will increase reimbursement rates for select services to support the base wage. Providers must use this increased funding to ensure all Direct Care Workers are paid the base wage or higher within the timeframe established by the Department. Services requiring Direct Care Workers to be paid at least the base wage include:

1. Adult Day Services

2. Alternative Care Facility (ACF)

3. Community Connector

4. Consumer Directed Attendant Support Services (CDASS)

5. Foster Care Home (Children's Habilitation Residential Program)

6. Group Home Habilitation (CHRP)

7. Group Residential Support Services (GRSS)

8. Homemaker

9. Homemaker Enhanced

10. Host Home (CHRP)

11. In-Home Support Services (IHSS)

12. Individual Residential Support Services (IRSS)

13. Job Coaching

14. Job Development

15. Mental Health Transitional Living Homes

16. Mentorship

17. Pediatric Personal Care

18. Personal Care

19. Prevocational Services

20. Respite

21. Specialized Habilitation

22. Supported Community Connections

23. Supported Living Program

B. In the event that a Direct Care Worker, based on state or local minimum wage laws, is eligible for a minimum wage that exceeds the base wage requirement, the Provider is required to compensate at the higher wage.

C. In the event that a Direct Care Worker is eligible for a per diem wage, the Provider is required to increase the Direct Care Worker's per diem wage by the percent of the Department's reimbursement rate increase.

D. The Department may add additional qualifying services that are applicable to this rule and not listed above.

8.511.3 PROVIDER RESPONSIBILITIES

A. The Provider must ensure that contact information on file with the Department is accurate; information shall be utilized by the Department to complete oversight responsibilities per Section 8.511.4.

B. Providers shall notify Direct Care Workers annually who are affected by the base wage requirement about Direct Care Worker rights, Direct Care Employer obligations, and the minimum state and local direct care employment standards.

C. Providers shall publish and make readily available the Department's designated contact for Direct Care Workers to submit questions, concerns or complaints regarding the base wage requirement.

D. Providers shall submit specific information for each Direct Care Worker regarding wage rates, working hours, benefits, work location, employment status, employment type, services provided, independent contractor agreements, and any other wage related information as requested by the Department. Providers shall submit the requested informationwithin the Department-specified timeframe.

E. Providers shall keep true and accurate records to support and demonstrate that all Direct Care Workers who performed the applicable services received at a minimum the base wage or a per diem wage increase.

F. Records shall be retained for no less than six (6) years and shall be made available for inspection by the Department upon request. Records may include, but are not limited to:

1. Payroll summaries and details, pay stubs with details
2. Timesheets
3. Paid time off records
4. Cancelled checks (front and back)
5. Direct deposit confirmations
6. Independent contractor documents or agreements
7. Per diem wage documents
8. Accounting records such as: accounts receivable and accounts payable

8.511.4 REPORTING & AUDITING REQUIREMENTS

A. The Department has ongoing discretion to request information from providers to demonstrate that all Direct Care Workers received the wage (base or per diem) increase. All records related to the base wage requirement received by the Provider for the applicable services shall be made available to the Department upon request, within specified deadlines.

B. Providers shall respond to the Department's request for records to demonstrate compliance within the timelines and format specified by the Department.

C. Failure to submit Direct Care Worker information as required or failure to provide adequate documents and timely responses may result in the Provider being required to submit a plan of

correction and/or recoupment of funds. The Department may suspend payment of claims until requested information is received and approved by the Department.

D. If a plan of correction is requested by the Department, the Provider shall submit the plan of correction by the date specified by the Department. The Provider must notify the Department in writing within five (5) business days of receipt of the request if they will not be able to meet the deadline. The Provider must explain the rationale for the delay and the Department may or may not grant an extension in writing.

E. Upon the Department's receipt of the plan of correction, the Department will accept, request modifications, or reject the proposed plan of correction. Modifications or rejections will be accompanied by a written explanation. If a plan of correction is rejected, the Provider must resubmit a new plan of correction along with any requested documentation to the Department for review within five (5) business days of notification.

F. The Department may recoup part or all of the funding resulting from the base wage increase if the Department determines the Provider is not in compliance with Section 8.511.

G. If such determination is made to recoup funds, the Provider will be notified by the Department. All recoupments will be conducted pursuant to C.R.S. Section 25.5-4-301 and 10 C.C.R. 2505-10, Section 8.050.6, Informal Reconsideration and Appeals of Overpayments Resulting from Review or Audit Findings.

8.535 PEDIATRIC PERSONAL CARE SERVICES

8.535.1 Pediatric Personal Care Services are provided in accordance with the provisions of Appendix A, which sets forth the coverage standards for the benefit.

8.535.2 Pediatric Personal Care providers are required to comply with all Base Wage requirements established in Section 8.511.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000
Rule Number: MSB 23-06-01-B
Division / Contact / Phone:Office of Community Living / Emily Walsh / 303-866-2549

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 23-06-01-B, Novel Coronavirus Disease (COVID-19) Rules
3. This action is an adoption of:	new rules

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.6000, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	June 9, 2023
Is rule to be made permanent? (If yes, please attach notice of hearing).	No

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text at 8.6000. This rule is effective June 9, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000
Rule Number: MSB 23-06-01-B
Division / Contact / Phone:Office of Community Living / Emily Walsh / 303-866-2549

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this emergency rule is to temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☒ for the preservation of public health, safety and welfare.

   Explain:

   The temporary changes to regulatory requirements in order to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic is imperatively necessary fo the preservation of public health safety, and welfare.

3. Federal authority for the Rule, if any:

   Social Security Act Section 1135, Social Security Act 1115 (Pending), and Social Security Act 1915(c), Appendix K.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2021); 25.5 Article 6, C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000
Rule Number: MSB 23-06-01-B
Division / Contact / Phone:Office of Community Living / Emily Walsh / 303-866-2549

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Individual's receiving services in community-based settings, provider-owned community-based residential settings, provider-owned facility settings, and case management will all be benefitting from an increase in available funding to respond to the COVID-19 crisis.

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

   Those rendering services in facilities, the community, or even remotely from their office or home may receive additional payment to do so during this critical time. Those receiving services are likely to continue with more likely to experience uninterrupted services as direct care workers/direct support professionals will be incentivized to continue to provide these services.

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

   Many of the changes the Department is asking for are cost neutral. Additionally, the Department has sought, and in some cases, received approval from the Centers for Medicare and Medicaid to increase payments or rates. However, the Department also must work with its partners at the Office for State Planning and Budget as well as prioritize the many different areas of Medicaid that are impacted by COVID-19. Accordingly, the Department continues to estimate potential costs.

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

   The comparison between direct cost and cost of inaction is hard to quantify. However, it is highly likely that the cost of doing nothing could

be higher costs associated with more costly forms of care, significant impact to member's quality of life, and, in some cases – the loss of life or limb.

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

   At this time, the Department is also pursuing additional alternatives to ensure health, safety, and welfare but a key component of this effort is to ensure providers, agencies, and direct support professionals have the money they need to continue to go out in a time of crisis and provide services.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   As mentioned above, the Department is also partnering with community organizations, non-profits, advocacy organizations, other executive agencies, and the governor's office to work towards prioritizing Colorado's most vulnerable citizens receiving long-term care health, safety, and welfare.

MEDICAL ASSISTANCE – SECTION 8.6000 Novel Coronavirus Disease (COVID-19) Rules

10 CCR 2505-10 8.6000

8.6000 COVID-19 EMERGENCY RULES

PURPOSE: To temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduced programmatic limitations, and alignment with existing federal guidance related to the COVID-19 pandemic.

8.6001 REGULATORY CHANGES

The following regulations require, as applicable, that funds be made available for payment, federal approval is received, and any conflicting state statutory requirements are suspended by Executive Order. Each regulation below is effective once the applicable prerequisites are satisfied and shall continue to be in effect as long as those prerequisites continue to be satisfied.

8.6001.1 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Section 8.420

> Temporarily waive the requirement that payments for ICF-IID are only allowed for facilities licensed by the Colorado Department of Public Health and Environment (CDPHE) to allow for potential inclusion of existing HCBS Group Homes.

Sections 8.404.3; 8.404.1; 8.405.2.22; 8.405.2.23; 8.405.2.24; 8.405.2.25.

> Temporarily allow emergency placement of eligible individuals into an ICF-IID. Individual would still need to be fully eligible in meeting placement requirements but would allow for Department to expedite process through existing layers of review.

Sections 8.443.16.A; 8.443.1.C-D.

> Temporarily allow payment beyond current limitation not to exceed COVID-19 emergency supplement payments.

8.6001.2 Nursing Facilities

Sections 8.443.10.B; 8.443.10.a; 8.443.11.A

> Temporarily allow Nursing Facilities to receive a supplemental payment for COVID-19 related activities, provided the Nursing Facility organization follows Departmental guidance and benchmarks for the assurance of the member's health, safety, and welfare and adherence to published guidelines for safety.

Section 8.443.12.B – Inclusion of the Following Language:

> COVID-19 Mitigation Emergency Supplemental Payment
>
> > Subject to available non-provider fee funding and Upper Payment Limit restrictions, the Department shall pay an additional supplemental payment to nursing facilities increasing measures to protect residents during the COVID-19 public health emergency.
> >
> > 1. In order to be eligible for this payment facilities must be:

a. Compliant with all emergency related reported measures required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

b. Implementing enhanced operational guidelines required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

c. Cooperative with State or National efforts to mitigate the emergency

2. The Department will use historical Medicaid patient data to calculate and issue supplemental payments.

3. All payments issued as an emergency supplemental payment due to COVID-19 must be reported as a revenue in the cost reporting period in which it is received.

Section 8.443.1.B Addition of the Following Language

In addition to the MMIS claims reimbursement and provider fee funded supplemental payments, the Department may issue additional supplemental payments necessary to protect the health, safety and welfare of nursing facility residents when additional state or federal funding is available.

Establishment of Section 8.430.6 – Temporary Medicaid Nursing Facility Expansion

1. 8.430.6.A The Department may issue temporary enrollments for the purposes of increasing bed capacity during a public health emergency.

2. Facilities seeking temporary enrollments must submit plans to discharge residents within 60 days of the emergency end date.

3. Facilities with temporary Medicaid beds will be reimbursed statewide average rate for nursing facilities.

4. The enrollment will be effective until 60 days after the COVID-19 emergency is lifted.

5. After the 60 days has expired, the facility will receive no further reimbursement.

8.6001.3 Case Management

Sections 8.763.C; 8.761.46

Authorize providers of targeted case management services to increase, supplement, exceed, or provide additional authorization of units and correlating payments to all long-term care case management entities including transitional services for individuals needing community-placement due to COVID-19.

8.6001.4 Level of Care Assessment

Sections 8.393.2.c.5.a; 8.393.2.D.3.a; 8.393.3.A.1.c.i.3; 8.401.183.B; 8.497; 8.401; 8.491.2.B.2; 8.500.1; 8.500.90; 8.503; 8.504.1; 8.504.5.D; 8.506.3; 8.506.4.e.ii; 8.508.20; 8.515.5.B.1; 8.517.5.A.2; 8.519.1;

Remove the Professional Medical Information Page (PMIP) from the level of care determination for HCBS waivers, Long-Term Care-Home Health, PACE, NF, and ICF/IID programs to enable additional capacity and expedite enrollment.

Sections 8.390.3.A.2; 8.393.1.M.1.C; 8.393.2.C.5.; 8.393.2.D.1-3; 8.401.11 through 8.401.15; 8.485.61.B; 8.485.71.C; 8.486.201; 8.603.5.D; 8.500.18.B.3; 8.500.108.B.1; 8.503.70.3; 8.503.80.A; 8.506.3;

8.506.4.B; 8.509.14; 8.508.121; 8.503.70.A.1; 8.503.80.A.4; 8.506.4.B; 8.506.12.F; 8.508.20; 8.509.14; 8.509.31.A; 8.515.6.A.3; 8.517.7.A.3; 8.603.5.D; 8.503.30.A; 8.503.30.A.8; 8.508.121.A

Modify the requirements for initial and continued stay review assessments. For initial assessments, the level of care assessment will be limited to the Activities of Daily living which determines the functional eligibility/LOC for the member. Members pursuing a Home and Community Based Services (HCBS) waiver enrollment will be issued a start date based on the date of referral to the Case Management Agency, with the Level of Care to be completed with the member thereafter via telephonic or virtual modality. Changes to transfers from nursing facility to nursing facility by not requiring an entirely new assessment be conducted. For yearly re-assessments, the members existing eligibility will continue through the duration of 1135. Then the yearly re-assessment set to occur within six (6) months following the conclusion of the Section 1135 Waiver.

8.6001.5 Termination from Waiver Eligibility - Adverse Action

Sections 8.393.3.A.1.a through 8.393.A.1.d; 8.485.61.A through 8.485.61.D.3.b; 8.500.16.A.1 through 8.500.16.A.4; 8.500.16.E.1 and E.2; 8.503.160.A.1 through 8.500.160.A.4; 8.503.160.E.1 through 8.503.160.E.9; 8.508.190.A.1-4; 8.508.190.E.1 and E.2 ; 8.508.190.H.1-4; 8.508.190.I.3 and I.4; 8.509.15.A.1 through 8.509.15.A.4.c.1; 8.555.5.D.2

Remove requirement to involuntarily terminate a member from their selected HCBS waiver program

8.6001.6 Preadmission Screening and Resident Review (PASRR)

Section 8.401.18.181.A

PASRR Level I Screening and Level II Evaluations will be suspended for 30 days in accordance with Section 1919(e)(7) for new admissions.

8.6001.7 Personal Care

Sections 8.485.61.D.2-3; 8.489.10.11; 8.510.4.A

Temporarily waive the restriction of personal care services provided in Hospital, Nursing Facility, or other acute-like setting.

Sections 8.510.18; 8.552.1.B

Temporarily allow legally responsible person to provide services using participant directed models (Consumer Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS)).

8.6001.8 Guidelines for Institutions for Mental Diseases (IMDs)

Section 8.401.4

Temporarily waive the IMD requirements for nursing facilities that exceed 50% of patient-census with a primary diagnosis of major mental illness.

8.6001.9 Retainer Payments

Sections 8.515.80.F; 8.500.14.B.3

Temporarily allow specified Brain Injury waiver providers to bill retainer payments for services not rendered.

MEDICAL ASSISTANCE – SECTION 8.6000 Novel Coronavirus Disease (COVID-19) Rules

10 CCR 2505-10 8.6000

8.6000 COVID-19 EMERGENCY RULES

PURPOSE: To temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduced programmatic limitations, and alignment with existing federal guidance related to the COVID-19 pandemic.

8.6001 REGULATORY CHANGES

The following regulations require, as applicable, that funds be made available for payment, federal approval is received, and any conflicting state statutory requirements are suspended by Executive Order. Each regulation below is effective once the applicable prerequisites are satisfied and shall continue to be in effect as long as those prerequisites continue to be satisfied.

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> Temporarily allow emergency placement of eligible individuals into an ICF-IID. Individual would still need to be fully eligible in meeting placement requirements but would allow for Department to expedite process through existing layers of review.

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> Temporarily allow Nursing Facilities to receive a supplemental payment for COVID-19 related activities, provided the Nursing Facility organization follows Departmental guidance and benchmarks for the assurance of the member's health, safety, and welfare and adherence to published guidelines for safety.

Section 8.443.12.B – Inclusion of the Following Language:

> COVID-19 Mitigation Emergency Supplemental Payment
>
> > Subject to available non-provider fee funding and Upper Payment Limit restrictions, the Department shall pay an additional supplemental payment to nursing facilities increasing measures to protect residents during the COVID-19 public health emergency.
> >
> > 4. In order to be eligible for this payment facilities must be:

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d. Compliant with all emergency related reported measures required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

e. Implementing enhanced operational guidelines required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

f. Cooperative with State or National efforts to mitigate the emergency

5. The Department will use historical Medicaid patient data to calculate and issue supplemental payments.

6. All payments issued as an emergency supplemental payment due to COVID-19 must be reported as a revenue in the cost reporting period in which it is received.

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6. 8.430.6.A The Department may issue temporary enrollments for the purposes of increasing bed capacity during a public health emergency.

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8.506.4.B; 8.509.14; 8.508.121; 8.503.70.A.1; 8.503.80.A.4; 8.506.4.B; 8.506.12.F; 8.508.20; 8.509.14; 8.509.31.A; 8.515.6.A.3; 8.517.7.A.3; 8.603.5.D; 8.503.30.A; 8.503.30.A.8; 8.508.121.A

Modify the requirements for initial and continued stay review assessments. For initial assessments, the level of care assessment will be limited to the Activities of Daily living which determines the functional eligibility/LOC for the member. Members pursuing a Home and Community Based Services (HCBS) waiver enrollment will be issued a start date based on the date of referral to the Case Management Agency, with the Level of Care to be completed with the member thereafter via telephonic or virtual modality. Changes to transfers from nursing facility to nursing facility by not requiring an entirely new assessment be conducted. For yearly re-assessments, the members existing eligibility will continue through the duration of 1135. Then the yearly re-assessment set to occur within six (6) months following the conclusion of the Section 1135 Waiver.

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DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.815 and 8.443
Rule Number: MSB 23-06-01-C
Division / Contact / Phone:Health Program Office / Christina Winship/303-866-5578

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 23-06-01-C, Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.815 and 8.443

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.815, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 06/09/2023

   Is rule to be made permanent? (If yes, please attach notice of hearing). No<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.815 with the proposed text beginning at 8.815.1 through the end of 8.815.1. Replace the current text at 8.815.3 with the proposed text beginning at 8.815.3.A through the end of 8.815.3.A. Replace the current text at 8.815.4 beginning at 8.815.4.A through the end of 8.815.4.C. Replace the current text at 8.815.6 with the proposed text beginning at 8.815.6 through the end of 8.815.6. Replace the current text at

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

8.443 with the proposed text beginning at 8.443.7.A.5 through the end of 8.443.7.A.5. This rule is effective June 9, 2023.

*to be completed by MSB Board Coordinator

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Rule Number: MSB 23-06-01-C
Division / Contact / Phone: Health Program Office / Christina Winship/303-866-5578

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule revision will allow the Department to reimburse pharmacies for administration of the COVID-19 vaccine in Long-term Care Facilities through the Centers for Disease Control and Prevention's (CDC's) Pharmacy Partnership for Long-term Care Program or other partnership between an LTC and a pharmacy.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   These revisions are required to facilitate administration of the forthcoming COVID-19 vaccine to nursing home facility residents.

3. Federal authority for the Rule, if any:

   Section 6008(b)(4) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), P.L. 116-136

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);

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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

Health First Colorado members residing in nursing facilities and pharmacy providers licensed to administer vaccines will benefit from the flexibility provided by this rule revision. Current policy limits reimbursement to vaccines ordered by the resident's own physician and administration is either included in the facility's rate or part of a regularly scheduled home health service.

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

This revision will help expedite administration of the COVID-19 vaccine to Health First Colorado members residing in nursing facilities. The rule will also allow nursing facility providers to utilize existing partnerships with pharmacies to administer the vaccine.

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

   The Department expects this change to cost approximately $60,000 in total funds, which will be incorporated through the regular budget process.

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

The proposed rule will facilitate the expeditious administration of the COVID-19 vaccine to this population.

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

   There are no less costly or intrusive methods to achieve the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose of the proposed rule.

8.815 IMMUNIZATION SERVICES

8.815.1 Definitions

8.815.1.A. Advisory Committee on Immunization Practices (ACIP) means the group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States. ACIP was established under Section 222 of the Public Health Service Act (42 U.S.C. § 2l7a).

8.815.1.B. Immunization means the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine.

8.815.1.C. School District means any board of cooperative services established pursuant to article 5 of title 22, C.R.S., any state educational institution that serves students in kindergarten through twelfth grade including, but not limited to, the Colorado School for the Deaf and Blind, created in article 80 of title 22, C.R.S., and any public School District organized under the laws of Colorado except a junior college district.

8.815.1.D. Vaccine means a biological preparation that improves immunity to a particular disease.

8.815.1.E. Vaccine Administration Services means the provision of an injection, nasal absorption, or oral administration of a vaccine product.

8.815.1.F. Vaccines for Children (VFC) means the federally funded program administered through the Centers for Disease Control for the purchase and distribution of pediatric vaccines to program-registered providers for the Immunization of vaccine-eligible children 18 years of age and younger.

8.815.2 Client Eligibility

8.815.2.A. All Colorado Medicaid clients are eligible for Immunization and Vaccine Administration Services.

8.815.3 Provider Eligibility

8.815.3.A. Rendering Providers

1. Colorado Medicaid enrolled providers are eligible to administer Vaccines and Vaccine Administration Services as follows:

    a. If it is within the scope of the provider's practice;

    b. In accordance with the requirements at 10 CCR 2505-10, Section 8.200.2.; and

    c. If the provider is administering Vaccines and Vaccine Administration Services to a client 18 years of age or younger, the provider is using Vaccines provided free of cost by the federal government, including through the VFC program.

8.815.3.B. Prescribing Providers

1. Colorado Medicaid enrolled providers are eligible to prescribe Vaccines and Vaccine Administration Services in accordance with Section 8.815.3.A.1.a.-b.

8.815.4 Covered Services

8.815.4.A. Vaccines identified in the ACIP Vaccine Recommendations and Guidelines are updated routinely and are covered as follows:

1. For clients 18 years of age and younger, Vaccines are either provided through the VFC program or are otherwise provided without cost by the federal government.

2. For clients 19 years of age and older, Vaccines are covered by Colorado Medicaid.

8.815.4.B. Administration of Vaccines identified in the ACIP Vaccine Recommendations and Guidelines is a covered service for all clients.

8.815.4.C. Immunization and Vaccine Administration Services that are provided by home health agencies, physicians, or other non-physician practitioners to clients at nursing facilities, group homes, or residential treatment centers are covered only as follows:

1. Immunization services for clients who are residents of nursing facilities and clients receiving home health services are covered only if ordered by their physician. The skilled nursing component for Immunization administration provided at a nursing facility is included in the facility's rate or part of a regularly scheduled home health service for clients receiving home health services.

    a. Administration of the COVID-19 vaccine will be reimbursed as specified at 10 CCR 2505-10, Section 8.443.7.A.5.a.

2. Clients who are residents of an Alternative Care Facility, as defined at Section 8.495.1, may receive Immunization services from their own physician. They may also receive Immunization services as part of a home health service in accordance with Section 8.815.4.C.1.

8.815.5 Prior Authorization Requirements

8.815.5.A. Prior authorization is not required for this benefit.

8.815.6 Non-covered Services

8.815.6.A. The following services are not covered by Colorado Medicaid:

1. For clients 18 years of age and younger, Vaccines that have been obtained from a source other than the federal government;

2. Immunization and Vaccine Administration Services provided by a School District provider; and

3. Travel-related Immunization and Vaccine Administration Services.

8.443 NURSING FACILITY REIMBURSEMENT

8.443.7 HEALTH CARE REIMBURSEMENT RATE CALCULATION

8.443.7.A Health Care Services Defined: Health Care Services means the categories of reasonable, necessary and patient-related support services listed below. No service shall be considered a health care service unless it is listed below:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of registered nurses, licensed practical nurses, restorative aides, nurse aides, feeding assistants, registered dietician, MDS coordinators, nursing staff development personnel, nursing administration (not clerical) case manager, patient care coordinator, quality improvement, clinical director. These personnel shall be appropriately licensed and/or certified, although nurse aides may work in any facility for up to four months before becoming certified.

   If a facility employee or a management company/home office employee or owner has dual health care and administrative duties, the provider must keep contemporaneous time records or perform time studies to verify hours worked performing health care related duties. If no contemporaneous time records are kept or time studies performed, total salaries, payroll taxes and benefits of personnel performing health care and administrative functions will be classified as administrative and general. Licenses are not required unless otherwise specified. Periodic time studies in lieu of contemporaneous time records may be used for the allocation. Time studies used must meet the following criteria:

   a. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

   b. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

   c. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

   d. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

   e. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

   f. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

2. The salaries, payroll taxes, workers compensation payments, training and other employee benefits of medical records librarians, social workers, central or medical supplies personnel and activity personnel.

Health Information Managers (Medical Records Librarians): Must work directly with the maintenance and organization of medical records.

Social Workers: Includes social workers, life enhancement specialists and admissions coordinators.

Central or Medical Supply personnel: Includes duties associated with stocking and ordering medical and/or central supplies.

Activity personnel: Personnel classified as “activities” must have a direct relationship (i.e., providing entertainment, games, and social opportunities) to residents. For instance, security guards and hall monitors do not qualify as activities personnel. Costs associated with security guards and hall monitors are classified as administrative and general.

3. If the provider’s chart of accounts directly identifies payroll taxes and benefits associated with health care versus administrative and general cost centers, the amounts directly identified will be appropriately allowed as either health care or administrative and general. If these costs are comingled in the chart of accounts, payroll taxes and benefits shall be allocated to the cost centers (health care and administrative and general) based on total employee wages reported in those cost centers. The reporting method for payroll taxes and benefits by cost center is required to be consistent from year to year. When a provider wishes to change its reporting method because it believes the change will result in more appropriate and a more accurate allocation, the provider must make a written request to the Department for approval of the change ninety (90) days prior to the end of that cost reporting period. The Department has sixty (60) days from receipt of the request to make a decision or the change is automatically accepted. The provider must include with the request all supporting documentation to establish that the new method is more accurate. If the Department approves the provider's request, the change must be applied to the cost reporting period for which the request was made and to all subsequent cost reporting periods. The approval will be for a minimum three year period. The provider cannot change methods until the three year period has expired.

4. Personnel licensed to perform patient care duties shall be reported in the administrative and general cost center if the duties performed by these personnel are administrative in nature.

5. Non-prescription drugs ordered by a physician that are included in the per diem rate, including costs associated with vaccinations.

    a. Pharmacies are eligible for reimbursement for administration of the COVID-19 vaccine

6. Consultant fees for nursing, medical records, registered dieticians, patient activities, social workers, pharmacies, physicians and therapies. Consultants shall be appropriately licensed and/or certified, as applicable and professionally qualified in the field for which they are consulting. The guidance provided in (1) above for employees also applies to consultants.

7. Purchases, rental, depreciation, interest and repair expenses of health care equipment and medical supplies used for health care services such as nursing care, medical records, social services, therapies and activities. Purchases, lease expenses or fees associated with computers and software (including the associated training and upgrades) used in departments within the facility that provide direct or indirect health care services to residents. Dual purpose software that includes both a health care and administrative and general component will be considered a health care service.

8. Purchase or rental of motor vehicles and related expenses, including salary and benefits associated with the van driver(s), for operating or maintaining the vehicles to the extent that they are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs if there is dual purpose. An example of the dual purpose vehicle is one used for both resident transport and maintenance activities.

9. Copier lease expense.

10. Salaries, fees, or other expenses related to health care duties performed by a facility owner or manager who has a medical or nursing credential. Note that costs associated with the Nursing Home Administrator are an administrative and general cost.

11. Related Party Management Fees and Home Office Costs

    Related party management fees and home office costs shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the related party which are listed in this section, may be included in the health care cost center equal to the actual costs incurred by the related party. Documentation supporting the cost and health care licenses must be maintained. Only salaries, payroll taxes and employee benefits associated with health care personnel will be considered as allowable in the health care cost center. No overhead expenses will be included. The amount allowable in the health care cost category will be calculated in one of two ways:

    a. Keeping contemporaneous time logs in 15 minute increments supporting the number of hours worked at each facility.

    b. Distributing the cost evenly across all facilities as follows: the amount allowable in each health care facility's health care costs shall be equal to the total salary, payroll taxes and benefits of the health care personnel divided by the number of facilities where the health care personnel worked during the year. For example, if a nurse's total salary, payroll taxes, and benefits total $80,000, and the nurse worked on five facilities during the year, $16,000 is allowable in each of the facility's health care costs.

    Auditable documentation supporting the number of facilities worked on during the year must be maintained. Even if a related party exception is granted in accordance with 10 CCR 2505-10 section 8.441.5.I.4, no mark-up or profit will be allowed in the health care cost center, only supported actual costs.

    Non-Related Party Management Fees

    Non-related party management fees shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the management company which are listed in this section, may be included in the health care cost center. Management contracts which specify percentages related to health care services will not be considered a direct charge from the management company.

12. Professional liability insurance, whether self-insurance or purchased, loss settlements, claims paid and insurance deductibles.

13. Medical director fees.

14. Therapies and services provided by an individual qualified to provide these services under Federal Medicare/Medicaid regulations including:

Utilization review
Dental care, when required by federal law
Audiology
Psychology and mental health services
Physical therapy
Recreational therapy
Occupational therapy
Speech therapy

15. Nursing licenses and permits, disposal costs associated with infectious material (medical or hazardous waste), background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.

16. Food Costs. Food costs means the cost of raw food, and shall not include the costs of property, staff, preparation or other items related to the food program.

8.443.7.B CLASS I HEALTH CARE STATE-WIDE MAXIMUM ALLOWABLE PER DIEM REIMBURSEMENT RATES (LIMIT)

For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem rate for direct and indirect health care services and raw food, the state department shall establish an annual maximum allowable rate (limit). In computing the health care per diem limit, each nursing facility provider shall annually submit cost reports, and actual days of care shall be counted, not occupancy-imputed days of care. The health care limit will be calculated as follows:

1. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed, in accordance with these regulations, by each facility on or before December 31 of the preceding year.

2. The MED-13 cost report shall be deemed filed if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before December 31.

3. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of the limit, the Department may:

   a. Exclude part, or all, of a provider's MED-13.

   b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) published by Global Insight, Inc. measured from the midpoint of the reporting period to the midpoint of the payment-setting period.

4. The health care limit and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

5. The health care limit shall not exceed one hundred twenty-five percent (125%) of the median costs of direct and indirect health care services and raw food as determined by an array of all class I facility providers; except that, for state veteran nursing homes, the health care limit will be one hundred thirty percent (130%) of the median cost.

   a. In determining the median cost, the cost of direct health care shall be case-mix neutral.

b. Actual days of care shall be counted, not occupancy-imputed days of care, for purposes of calculating the health care limit.

c. Amounts contained in cost reports used to determine the health care limit shall be adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

i). The percentage change shall be rounded at least to the fifth decimal point.

ii). The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

6. Annually, the state department shall redetermine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

7. The health care limit for health care reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

8.443.7.C. CLASS I HEALTH CARE PER DIEM LIMITATION ON HEALTH CARE GROWTH

For the fiscal year beginning July 1, 2009, and for each fiscal year thereafter, any increase in the direct and indirect health care services and raw food costs shall not exceed eight percent (8%) per year. The calculation of the eight percent per year limitation for rates effective on July 1, 2009, shall be based on the direct and indirect health care services and raw food costs in the as-filed facility's cost reports up to and including June 30, 2009. For the purposes of calculating the eight percent limitation for rates effective after July 1, 2009, the limitation shall be determined and indexed from the direct and indirect health care services and raw food costs as reported and audited for the rates effective July 1, 2009.

8.443.7.D. CLASS I HEALTH CARE PER DIEM REIMBURSEMENT RATES AND MEDICAID CASE MIX INDEX (CMI):

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of direct and indirect health care services and raw food, the State Department shall establish an annually readjusted schedule to pay each nursing facility provider the actual amount of the costs. This payment shall not exceed the health care limit described at 10 CCR 2505-10 section 8.443.7B. The health care per diem reimbursement rate is the lesser of the provider's acuity adjusted health care limit or the provider's acuity adjusted actual allowable health care costs.

The state department shall adjust the per diem rate to the nursing facility provider for the cost of direct health care services based upon the acuity or case-mix of the nursing facility provider's residents in order to adjust for the resource utilization of its residents. The state department shall determine this adjustment in accordance with each resident's status as identified and reported by the nursing facility provider on its federal Medicare and Medicaid minimum data set assessment. The state department shall establish a case-mix index for each nursing facility provider according to the resource utilization groups system, using only nursing weights. The state department shall calculate nursing weights based upon standard nursing time studies and weighted by facility population distribution and Colorado-specific nursing salary ratios. The state department shall determine an average case-mix index for each nursing facility provider's Medicaid residents on a quarterly basis

1. Acuity information used in the calculation of the health care reimbursement rate shall be determined as follows:

    a. A facility's cost report period resident acuity case mix index shall be the average of quarterly resident acuity case mix indices, carried to four decimal places, using the facility wide resident acuity case mix indices. The quarters used in this average shall be the quarters that most closely coincide with the cost reporting period.

    b. The facility's Medicaid resident acuity case mix index shall be a two quarter average, carried to four decimal places, of the Medicaid resident acuity average case mix indices. The two quarter average used in the July 1 rate calculation shall be the same two quarter average used in the rate calculation for the rate effective date prior to July 1.

    c. The statewide average case mix index shall be a simple average, carried to four decimal places, of the cost report period case mix indices for all Medicaid facilities calculated effective each July 1.

    d. The normalization ratio shall be determined by dividing the statewide average case mix index by the facility's cost report period case mix index.

    e. The facility Medicaid acuity ratio shall be determined by dividing the facility's Medicaid resident acuity case mix index by the facility cost report period case mix index.

    f. The facility overall resident acuity ratio shall be determined by dividing the facility cost report period case mix index by the statewide average case mix acuity index.

2. The annual facility specific direct health care maximum reimbursement rate shall be determined as follows:

    a. The percentage of the normalized per diem case mix adjusted nursing cost to total health care cost shall be determined by dividing the normalized per diem case mix adjusted nursing cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

    b. The statewide health care maximum allowable reimbursement rate (calculated at 10 CCR 2505-10 section 8.443.7B) shall be multiplied by the percentage established in the preceding paragraph to determine the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component.

    c. The facility specific maximum reimbursement rate for case mix adjusted nursing costs shall be determined by multiplying the facility specific overall acuity ratio by the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component as established in the preceding paragraph.

3. The annual facility specific indirect health care maximum allowable reimbursement shall be determined as follows:

    a. The percentage of the indirect health care per diem cost to total health care cost shall be determined by dividing the indirect health care per diem cost by the sum

of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

b. The facility specific in direct health care maximum reimbursement rate shall be determined by multiplying the statewide health care maximum allowable reimbursement rate by the percentage established in the preceding paragraph.

4. The case mix reimbursement rate component shall be determined as follows:

a. The case mix reimbursement rate component shall be established using the facility Medicaid resident acuity ratio.

b. This ratio shall be multiplied by the lesser of the facility's allowable case mix adjusted nursing cost or the facility specific maximum reimbursement rate for case mix adjusted nursing costs. The resulting calculation shall the case mix reimbursement rate component.

5. The indirect health care reimbursement rate shall be the lesser of the facility's allowable other health care cost or the facility specific other health care maximum reimbursement rate.

8.443.7.E DETERMINATION OF THE HEALTH CARE SERVICES MAXIMUM ALLOWABLE RATE (LIMIT) FOR CLASS II AND IV FACILITIES

1. For class II facilities, one hundred twenty-five percent (125%) of the median actual costs of all class II facilities;

2. For non-state administered class IV facilities, one hundred twenty-five percent (125%) of the median actual costs of all class IV facilities.

3. State-administered class IV facilities shall not be subject to the health care limit. The Med-13s of the state-administered class IV facilities shall be included in the health care limit calculation for other class IV facilities.

4. The determination of the reasonable cost of services shall be made every 12 months.

5. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed in accordance with these regulations, by each facility on or before May 2.

6. The MED-13 cost report shall be deemed submitted if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before May 2nd.

7. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the class, the Department may:

a. Exclude part, or all, of a provider's MED-13; or

b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the change in the "medical care" component of the Consumer Price Index published for all urban consumers (CPI-U) by the United States Department of Labor, Bureau of Labor Statistics over the time period from the provider's most recent audited cost report.

8. State-administered class IV facilities shall not be subject to the maximum reasonable rate ceiling. The Med-13s of the state-administered class IV facilities shall be included in the maximum rate calculation for other class IV facilities.

9. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

10. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Dental Health Care Program for Low-Income Seniors Procedure Increase, Section 8.960
Rule Number: MSB 23-05-18-A
Division / Contact / Phone:Special Financing Division / Chandra Vital / 303-866-5506

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 23-05-18-A, Revision to the Medical Assistance Act Rule concerning Dental Health Care Program for Low-Income Seniors Procedure Increase, Section 8.960

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 25.5-1-301 through 25.5-1-303, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: July 1, 2023
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.960 Appendix A with the proposed text beginning at 8.960 Appendix A through the end of 8.960 Appendix A. This rule is effective July 1, 2023.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Dental Health Care Program for Low-Income Seniors Procedure Increase, Section 8.960
Rule Number: MSB 23-05-18-A
Division / Contact / Phone:Special Financing Division / Chandra Vital / 303-866-5506

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Current rule states the max program fees of the Dental Health Program for Low-Income Seniors must not fall below Medicaid dental rates. Medicaid received a 3% increase for the dental rates for FY2023-24. This made some of the program rates in Schedule A fall below the Medicaid rate. This change is necessary to stay in compliance with rule.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   Current rule states that no program max rates will be below Medicaid dental rates.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);

Initial Review
Proposed Effective Date **07/01/23**
06/09/23

Final Adoption
Emergency Adoption

DOCUMENT #12

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Dental Health Care Program for Low-Income Seniors Procedure Increase, Section 8.960
Rule Number: MSB 23-05-18-A
Division / Contact / Phone:Special Financing Division / Chandra Vital / 303-866-5506

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The increase in program rates will not affect any classes and there will be no incurred costs for any classes.

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

   There will be no quantitative or qualitative impact to any classes.

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

   The Department will have no fiscal impact with this rule change. The funds for the Dental Health Care Program for Low-Income Seniors are appropriated, and this rule update will have no effect on the appropriation.

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

   There will be no costs to the Department. The benefits will be for the Department to be in compliance with current rule.

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

   The Department does not foresee any fiscal impact on this rule change and there are not any less costly methods that were considered.

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6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for staying in compliance with current rule.

8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

8.960.A Definitions

1. Arrange For or Arranging For means demonstrating established relations with Qualified Providers for any of the Covered Dental Care Services not directly provided by the applicant.

2. Covered Dental Care Services include Diagnostic Imaging, Emergency Services, Endodontic Services, Evaluation, Oral and Maxillofacial Surgery, Palliative Treatment, Periodontal Treatment, Preventive Services, Prophylaxis, Removable Prosthesis, and Restorative Services as listed by alphanumeric procedure code in Appendix A.

3. C.R.S. means the Colorado Revised Statutes.

4. Dental Health Professional Shortage Area or Dental HPSA means a geographic area, population group, or facility so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

5. Dental Prosthesis means any device or appliance replacing one or more missing teeth and associated structures if required.

6. Department means the Colorado Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. (2020).

7. Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation.

8. Economically Disadvantaged means a person whose Income is at or below 250% of the most recently published federal poverty level for a household of that size.

9. Eligible Senior or Client means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is not eligible for dental services under Medicaid or the Old Age Pension Health and Medical Care Program, and who does not have private dental insurance. An Eligible Senior or client is not ineligible solely because he/she is receiving dental benefits under Medicare or Medicare Advantage Plans.

10. Emergency Services means the need for immediate intervention by a Qualified Provider to stabilize an oral cavity condition.

11. Endodontic Services means services which are concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues, including pulpectomy.

12. Evaluation means an assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions.

13. Federally Qualified Health Center means a federally funded nonprofit health center or clinic that serves medically underserved areas and populations as defined in 42 U.S.C. section 1395x (aa) (4).

14. Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, or interest that are received by an individual or family. Income may be self-declared. Resources are not included in Income.

15. Max Allowable Fee means the total reimbursement listed by procedure for Covered Dental Care Services under the Colorado Dental Health Care Program for Low-Income Seniors in Appendix A. The Max Allowable Fee is the sum of the Program Payment and the Max Client Co-Pay.

16. Max Client Co-Pay means the maximum amount that a Qualified Provider may collect from an Eligible Senior listed by procedure in Appendix A for Covered Dental Services under the Colorado Dental Health Care Program for Low-Income Seniors.

17. Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S. (2020).

18. Medicare means the federal health insurance program for people who are 65 or older; certain younger people with disabilities; or people with End-Stage Renal Disease.

19. Medicare Advantage Plans mean the plans offered by Medicare-approved private companies that must follow rules set by Medicare and may provide benefits for services Medicare does not, such as vision, hearing, and dental care.

20. Old Age Pension Health and Medical Care Program means the program described at 10 CCR 2505-10, section 8.940 et. seq. and as defined in sections 25.5-2-101 and 26-2-111(2), C.R.S. (2020).

21. Oral and Maxillofacial Surgery means the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

22. Palliative Treatment for dental pain means emergency treatment to relieve the client of pain; it is not a mechanism for addressing chronic pain.

23. Periodontal Treatment means the therapeutic plan intended to stop or slow periodontal disease progression.

24. Preventive Services means services concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries.

25. Program Payment means the maximum amount by procedure listed in Appendix A for Covered Dental Care Services for which a Qualified Grantee may invoice the Department under the Colorado Dental Health Care Program for Low-Income Seniors. Program Payment must not be less than the reimbursement schedule for fee-for-service dental fees under the medical assistance program established in Articles 4, 5, and 6 of 10 CCR 2505-10.

26. Prophylaxis means the removal of dental plaque and calculus from teeth, in order to prevent dental caries, gingivitis and periodontitis.

27. Qualified Grantee means an entity that can demonstrate that it can provide or Arrange For the provision of Covered Dental Care Services and may include but is not limited to:

    a. An Area Agency on Aging, as defined in section 26-11-201, C.R.S. (2020);

    b. A community-based organization or foundation;

    c. A Federally Qualified Health Center, safety-net clinic, or health district;

    d. A local public health agency; or

e. A private dental practice.

28. Qualified Provider means a licensed dentist or dental hygienist in good standing in Colorado or a person who employs a licensed dentist or dental hygienist in good standing in Colorado and who is willing to accept reimbursement for Covered Dental Services. A Qualified Provider may also be a Qualified Grantee if the person meets the qualifications of a Qualified Grantee.

29. Removable Prosthesis means complete or partial Dental Prosthesis, which after an initial fitting by a dentist, can be removed and reinserted by the eligible senior.

30. Restorative Services means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic needs of the client.

31. Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3-406, C.R.S. (2020).

8.960.B Legal Basis

8.960.B.1 The Colorado Dental Health Care Program for Low-Income Seniors is authorized by state law at part 4 of article 3 of title 25.5, C.R.S. (2020).

8.960.C Request of Grant Proposals and Grant Award Procedures

8.960.C.1. Request for Grant Proposals

8.960.C.1.a Grant awards shall be made through an application process. The request for grant proposals form shall be issued by the Department and posted for public access on the Department's website at https://www.colorado.gov/hcpf/research-data-and-grants at least 30 days prior to the due date.

8.960.C.2 Evaluation of Grant Proposals

8.960.C.2.a Proposals submitted for the Colorado Dental Health Care Program for Low-Income Seniors will be evaluated by a review panel in accordance with the following criteria developed under the advice of the Senior Dental Advisory Committee.

1) The review panel will be comprised of individuals who are deemed qualified by reason of training and/or experience and who have no personal or financial interest in the selection of any particular applicant.

2) The sole objective of the review panel is to recommend to the Department's executive director those proposals which most accurately and effectively meet the goals of the program within the available funding.

3) Preference will be given to grant proposals that clearly demonstrate the applicant's ability to:

a) Outreach to and identify Eligible Seniors;

b) Collaborate with community-based organizations; and

c) Serve a greater number of Eligible Seniors or serve Eligible Seniors who reside in a geographic area designated as a Dental HPSA.

4) The review panel shall consider the distribution of funds across the state in recommending grant proposals for awards. The distribution of funds should be based on the estimated percentage of Eligible Seniors in the state by Area Agency on Aging region as provided by the Department.

8.960.C.3 Grant Awards

8.960.C.3.a The Department's executive director, or his or her designee, shall make the final grant awards to selected Qualified Grantees for the Colorado Dental Health Care Program for Low-Income Seniors.

8.960.C.4 Qualified Grantee Responsibilities

8.960.C.4.a A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors is required to:

1) Identify and outreach to Eligible Seniors and Qualified Providers;

2) Demonstrate collaboration with community-based organizations;

3) Ensure that Eligible Seniors receive Covered Dental Care Services efficiently without duplication of services;

4) Maintain records of Eligible Seniors serviced, Covered Dental Care Services provided, and moneys spent for a minimum of six (6) years;

5) For Eligible Seniors with dental coverage through a Medicare Advantage Plan, bill the Medicare Advantage Plan for dental procedures covered by the Medicare Advantage Plan prior to seeking payment from the Department. The Colorado Dental Health Care Program is secondary to the Medicare Advantage Plan dental coverage;

6) Distribute grant funds to Qualified Providers in its service area or directly provide Covered Dental Care Services to Eligible Seniors;

7) Expend no more than seven (7) percent of the amount of its grant award for administrative purposes; and

8) Submit an annual report as specified under section 8.960.3.F.

8.960.C.5 Invoicing

8.960.C.5.a A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors shall submit invoices on a form and schedule specified by the Department. Covered Dental Care Services shall be provided before a Qualified Grantee may submit an invoice to the Department.

1) Invoices shall include the number of Eligible Seniors served, the alphanumeric code and procedure description as listed in Appendix A, and any other information required by the Department.

2) The Department will pay no more than the established Program Payment per procedure rendered, as listed in Appendix A.

3) Eligible Seniors shall not be charged more than the Max Client Co-Pay as listed in Appendix A.

4) Qualified Grantees shall not bill the Department for any procedures covered by Medicare Advantage Plans that have been billed and paid by the Medicare Advantage Plans;

5) Qualified Grantees shall indicate on the invoice if the Eligible Senior has dental coverage through a Medicare Advantage Plan and any claim to the Medicare Advantage Plan was adjudicated prior to billing the Department;

6) Qualified Grantees may invoice for no more than seven (7) percent of the Program Payment for administrative costs.

8.960.C.6 Annual Report

8.960.C.6.a On or before September 1, 2016, and each September 1 thereafter, each Qualified Grantee receiving funds from the Colorado Dental Health Care Program for Low-Income Seniors shall submit a report to the Department following the state fiscal year contract period.

8.960.C.6.b The annual report shall be completed in a format specified by the Department and shall include:

1) The number of Eligible Seniors served;

2) The types of Covered Dental Care Services provided;

3) An itemization of administrative expenditures;

4) The procedures and amounts billed to Medicare Advantage Plans for Eligible Seniors; and

5) Any other information deemed relevant by the Department.

10 CCR 2505-10 § 8.960 APPENDIX A: COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS COVERED SERVICES AND PROCEDURE CODES

Capitalized terms within this appendix shall have the meaning specified in the Definitions section.

Procedure Description	**Alpha-numeric Code**	**Max Allowable Fee**	**Program Payment**	**Max Client Co-Pay**	**PROGRAM GUIDELINES**
Periodic oral evaluation - established client	D0120	$46.00	$46.00	$0.00	Evaluation performed on a client of record to determine any changes in the client's dental and medical health status since a previous comprehensive or periodic evaluation. This includes an oral cancer evaluation, periodontal screening where indicated, and may require interpretation of information acquired through additional diagnostic procedures. The findings are discussed with the client. Report additional diagnostic procedures separately. Frequency: One time per 6 month period per client.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Limited oral evaluation - problem focused	D0140	$62.00	$52.00	$10.00	This code must be used in association with a specific oral health problem or complaint and is not to be used to address situations that arise during multi-visit treatments covered by a single fee, such as, endodontic or post-operative visits related to treatments including prosthesis. Specific problems may include dental emergencies, trauma, acute infections, etc. Cannot be used for adjustments made to prosthesis provided within previous 6 months. Cannot be used as an encounter fee. Frequency: Two of D0140 per year per grantee. Not reimbursable on the same date as D0120 or D0150. Dental hygienists may only provide for an established client of record.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Comprehensive oral evaluation - new or established client	D0150	$81.00	$81.00	$0.00	Evaluation used by general dentist or a specialist when evaluating a client comprehensively. Applicable to new clients; established clients with significant health changes or other unusual circumstances; or established clients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues, and an evaluation and recording of the client's dental and medical history and general health assessment. A periodontal evaluation, oral cancer evaluation, diagnosis and treatment planning should be included. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0180.
Comprehensive periodontal evaluation - new or established client	D0180	$88.00	$88.00	$0.00	Evaluation for clients presenting signs & symptoms of periodontal disease & clients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the client's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0150.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - comprehensive series of radiographic images	D0210	$125.00	$125.00	$0.00	Radiographic survey of whole mouth, intended to display the crowns & roots of all teeth, periapical areas, interproximal areas and alveolar bone including edentulous areas. Panoramic radiographic image & bitewing radiographic images taken on the same date of service shall not be billed as a D0210. Payment for additional periapical radiographs within 60 days of a full month series or a panoramic film is not covered unless there is evidence of trauma. Frequency: 1 per 5 years per client. Any combination of x-rays taken on the same date of service that equals or exceeds the max allowable fee for D0210 must be billed and reimbursed as D0210. Should not be charged in addition to panoramic film D0330. Either D0330 or D0210 per 5 year period.
Intraoral - periapical first radiographic image	D0220	$25.00	$25.00	$0.00	Six of D0220 per 12 months per client. Report additional radiographs as D0230. Working and final endodontic treatment films are not covered. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - periapical each additional radiographic image	D0230	$23.00	$23.00	$0.00	D0230 must be utilized for additional films taken beyond D0220. Working and final endodontic treatment films are included in the endo codes. Not covered if billed with D3310, D3320, or D3330. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewing - single radiographic image	D0270	$26.00	$26.00	$0.00	Frequency: 1 in a 12 month period. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - two radiographic images	D0272	$42.00	$42.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - three radiographic images	D0273	$52.00	$52.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - four radiographic images	D0274	$60.00	$60.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Vertical bitewings – seven to eight radiographic images	D0277	$68.32	$68.32	$0.00	Frequency: 1 time in a 12-month period. Counts as an intraoral complete series. Any combination of D0220 through D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Panoramic radiographic image	D0330	$63.00	$63.00	$0.00	Frequency: 1 per 5 years per client. Cannot be charged in addition to full mouth series D0210. Either D0330 or D0210 per 5 years.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Prophylaxis - adult	D1110	$88.00	$88.00	$0.00	Removal of plaque, calculus and stains from the tooth structures with intent to control local irritational factors. Frequency: • 1 time per 6 calendar months; 2 week window accepted. • May be billed for routine prophylaxis. • D1110 may be billed with D4341 and D4342 one time during initial periodontal therapy for prophylaxis of areas of the mouth not receiving nonsurgical periodontal therapy. When this option is used, individual should still be placed on D4910 for maintenance of periodontal disease. D1110 can only be charged once, not per quadrant, and represents areas of the mouth not included in the D4341 or D4342 being reimbursed. • May be alternated with D4910 for maintenance of periodontally-involved individuals. • D1110 cannot be billed on the same day as D4346 • Cannot be used as 1 month re-evaluation following nonsurgical periodontal therapy.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Topical application of fluoride varnish	D1206	$52.00	$52.00	$0.00	Topical fluoride application is to be used in conjunction with prophylaxis or preventive appointment. Should be applied to whole mouth. Frequency: up to four (4) times per 12 calendar months. Cannot be used with D1208.
Topical application of fluoride - excluding varnish	D1208	$52.00	$52.00	$0.00	Any fluoride application, including swishing, trays or paint on variety, to be used in conjunction with prophylaxis or preventive appointment. Frequency: one (1) time per 12 calendar months. Cannot be used with D1206. D1206 varnish should be utilized in lieu of D1208 whenever possible.
Application of caries arresting medicament – per tooth	D1354	$5.88	$5.88	$0.00	Two of D1354 per 12 months per patient per tooth for primary and permanent teeth. Not to exceed 4 times per tooth in a lifetime. Cannot be billed on the same day as D1355 or any D2000 series code (D2140–D2954). Must Report tooth number.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Caries preventive medicament application – per tooth	D1355	$5.63	$5.63	$0.00	For primary prevention or remineralization. Medicaments applied do not include topical fluorides. Medicaments that may be applied during the delivery of D1355 procedure include Silver Diamine Fluoride (SDF), Silver Nitrate (SN), thymol-CHX varnish, and topical povidone iodine (PVP-I). Cannot be billed on the same day as: D1206, D1208, D1354, D0140, D9110, or any restoration codes on the same day or within 12 months of D2140 thru D2954. Maximum of four D1355 per tooth per lifetime. Must report tooth number.
Amalgam Restorations (including polishing): Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are included as part of the restoration. If pins are used, they should be reported separately (see D2951).					
Amalgam - one surface, primary or permanent	D2140	$117.86	$107.86	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - two surfaces, primary or permanent	D2150	$147.83	$137.83	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - three surfaces, primary or permanent	D2160	$179.02	$169.02	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - four or more surfaces, primary or permanent	D2161	$214.83	$204.83	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-Based Composite Restorations – Direct: Resin-based composite refers to a broad category of materials including but not limited to composites. May include bonded composite, light-cured composite, etc. Tooth preparation, acid etching, adhesives (including resin bonding agents), liners and bases, and curing are included as part of the restoration. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, they should be reported separately (see D2951).					
Resin-based composite - one surface, anterior	D2330	$115.00	$105.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Resin-based composite - two surfaces, anterior	D2331	$146.00	$136.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, anterior	D2332	$179.00	$169.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - four or more surfaces or involving incisal angle (anterior)	D2335	$212.00	$202.00	$10.00	Incisal angle to be defined as one of the angles formed by the junction of the incisal and the mesial or distal surface of an anterior tooth. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - one surface, posterior	D2391	$134.00	$124.00	$10.00	Used to restore a carious lesion into the dentin or a deeply eroded area into the dentin. Not a preventive procedure. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite -two surfaces, posterior	D2392	$176.00	$166.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, posterior	D2393	$218.00	$208.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - four or more surfaces, posterior	D2394	$268.00	$258.00	$10.00	Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - porcelain/ceramic	D2740	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to high noble metal	D2750	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to predominantly base metal	D2751	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to noble metal	D2752	$780.00	$730.00	$50.00	Only one the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - 3/4 cast predominantly base metal	D2781	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 cast noble metal	D2782	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 porcelain/ceramic	D2783	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast high noble metal	D2790	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - full cast predominantly base metal	D2791	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast noble metal	D2792	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - titanium	D2794	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910	$87.00	$77.00	$10.00	Not allowed within 6 months of placement.
Re-cement or re-bond crown	D2920	$89.00	$79.00	$10.00	Not allowed within 6 months of placement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Core buildup, including any pins when required	D2950	$225.00	$200.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation. Not payable on the same tooth and same day as D2951.
Pin retention per tooth	D2951	$50.00	$40.00	$10.00	Pins placed to aid in retention of restoration. Can only be used in combination with a multi-surface amalgam.
Cast post and core in addition to crown	D2952	$332.00	$307.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Prefabricated post and core in addition to crown	D2954	$269.00	$244.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Core is built around a prefabricated post. This procedure includes the core material and refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Endodontic Therapy (Including Treatment Plan, Clinical Procedures and Follow-Up Care) Includes primary teeth without succedaneous teeth and permanent teeth. Complete root canal therapy; pulpectomy is part of root canal therapy. Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images.					

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	$566.40	$516.40	$50.00	Frequency: One D3310 per lifetime per client per tooth. Teeth covered: 6-11 and 22-27.
Endodontic therapy, premolar tooth (excluding final restoration)	D3320	$661.65	$611.65	$50.00	Frequency: One D3320 per lifetime per client per tooth. Teeth covered: 4, 5, 12, 13, 20, 21, 28, and 29.
Endodontic therapy, molar tooth (excluding final restoration)	D3330	$786.31	$736.31	$50.00	Frequency: One D3330 per lifetime per client per tooth. Teeth covered: 2, 3, 14, 15, 18, 19, 30, and 31.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - four or more teeth per quadrant	D4341	$177.00	$167.00	$10.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as part of pre-surgical procedures in others.Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting. • Cannot be charged on same date as D4346. • Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - one to three teeth per quadrant	D4342	$128.00	$128.00	$0.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as part of pre-surgical procedures in. Current periodontal charting must be present in client chart documenting active periodontal disease. Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting.. Documentation of other treatment provided at same time will be requested. • Cannot be charged on same date as D4346. • Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	D4346	$102.00	$92.00	$10.00	The removal of plaque, calculus, and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures. Frequency: once in a lifetime. • Any follow-up and re-evaluation are included in the initial reimbursement. • Cannot be charged on the same date as D1110, D4341, D4342, or D4910.
Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	D4355	$98.27	$88.27	$10.00	One of (D4335) per 3 year(s) per patient. Prophylaxis D1110 is not reimbursable when provided on the same day of service as D4355. D4355 is not reimbursable if patient record indicates D1110 or D4910 have been provided in the previous 12 month period. Other D4000 series codes are not reimbursable when provided on the same date of service as D4355.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal maintenance procedures	D4910	$136.00	$136.00	$0.00	Procedure following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. It includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated and polishing the teeth. Frequency: • Up to four times per fiscal year per client. • Cannot be charged on the same date as D4346. • Cannot be charged within the first three months following active periodontal treatment.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - maxillary	D5110	$914.72	$834.72	$80.00	Reimbursement made upon delivery of a complete maxillary denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130 or D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - mandibular	D5120	$916.22	$836.22	$80.00	Reimbursement made upon delivery of a complete mandibular denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130, D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – maxillary	D5130	$914.72	$834.72	$80.00	Reimbursement made upon delivery of an immediate maxillary denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5130 can be reimbursed only once per lifetime per client. Complete denture, D5110, may be considered 5 years after immediate denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – mandibular	D5140	$916.22	$836.22	$80.00	Reimbursement made upon delivery of an immediate mandibular denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5140 can be reimbursed only once per lifetime per client. Complete dentures, D5120, may be considered 5 years after immediate denture was reimbursed – documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	D5211	$700.00	$640.00	$60.00	Reimbursement made upon delivery of a complete partial maxillary denture to the client. D5211 and D5212 are considered definitive treatments. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one resin maxillary per every 3 years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	D5212	$778.00	$718.00	$60.00	Reimbursement made upon delivery of a complete partial mandibular denture to the client. D5211 and D5212 are considered definitive treatment. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one resin mandibular per every 3 years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5213	$884.00	$824.00	$60.00	Reimbursement made upon delivery of a complete partial maxillary denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can also be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5214	$884.00	$824.00	$60.00	Reimbursement made upon delivery of a complete partial mandibular denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one mandibular per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	D5221	$635.32	$575.32	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5221 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	D5222	$635.32	$575.32	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5222 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5223	$884.00	$824.00	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5223 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5224	$884.0044.31	$824.00	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5224 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained. Immediate Denture Form must be on file.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	D5225	$784.34	$724.34	$60.00	Reimbursement made upon delivery of a partial maxillary denture to the client. D5225 and D5226 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial flexible base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial flexible base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every three years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)	D5226	$784.34	$724.34	$60.00	Reimbursement made upon delivery of a partial mandibular denture to the client. D5225 and D5226 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial flexible base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial flexible base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one mandibular per every three years - documentation that existing prosthesis cannot be made serviceable must be maintained.
Repair broken complete denture base, mandibular	D5511	$129.45	$119.45	$10.00	Repair broken complete mandibular denture base. Frequency: two of D5511 per 12 months per client.
Repair broken complete denture base, maxillary	D5512	$129.45	$119.45	$10.00	Repair broken complete maxillary denture base. Frequency: two of D5512 per 12 months per client.
Replace missing or broken teeth - complete denture (each tooth)	D5520	$97.11	$87.11	$10.00	Replacement/repair of missing or broken teeth. Teeth 1 – 32 and must report tooth number.
Repair resin partial denture base, mandibular	D5611	$97.79	$87.79	$10.00	Repair resin partial mandibular denture base. Frequency: two D5611 per 12 months per client.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Repair resin partial denture base, maxillary	D5612	$97.79	$87.79	$10.00	Repair resin partial maxillary denture base. Frequency: two D5612 per 12 months per client.
Repair cast partial framework, mandibular	D5621	$126.93	$116.93	$10.00	Repair cast partial mandibular framework. Frequency: two D5621 per 12 months per client.
Repair cast partial framework, maxillary	D5622	$126.93	$116.93	$10.00	Repair cast partial maxillary framework. Frequency: Two D5622 per 12 months per client.
Repair or replace broken retentive/clasping materials – per tooth	D5630	$137.12	$127.12	$10.00	Repair of broken clasp on partial denture base – per tooth. Teeth 1 – 32, report tooth number(s).
Replace broken teeth-per tooth	D5640	$98.27	$88.27	$10.00	Repair/replacement of missing tooth. Teeth 1 – 32, report tooth number(s).
Add tooth to existing partial denture	D5650	$109.00	$99.00	$10.00	Adding tooth to partial denture base. Documentation may be requested when charged on partial delivered in last 12 months. Teeth 1 – 32, report tooth number(s).
Add clasp to existing partial denture	D5660	$142.43	$132.43	$10.00	Adding clasp to partial denture base – per tooth. Documentation may be requested when charged on partial delivered in last 12 months. Teeth 1 – 32, report tooth number(s).
Rebase complete maxillary denture	D5710	$322.00	$297.00	$25.00	Frequency: one time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase complete mandibular denture	D5711	$322.00	$297.00	$25.00	Frequency: one time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Rebase maxillary partial denture	D5720	$304.00	$279.00	$25.00	Frequency: one time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase mandibular partial denture	D5721	$304.00	$279.00	$25.00	Frequency: one time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Reline complete maxillary denture (chairside)	D5730	$186.55	$176.55	$10.00	Frequency: One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (chairside)	D5731	$186.55	$176.55	$10.00	Frequency: One time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (chairside)	D5740	$184.21	$174.21	$10.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (chairside)	D5741	$185.97	$175.97	$10.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Reline complete maxillary denture (laboratory)	D5750	$248.66	$223.66	$25.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (laboratory)	D5751	$249.81	$224.81	$25.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (laboratory)	D5760	$246.89	$221.89	$25.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (laboratory)	D5761	$246.89	$221.89	$25.00	Frequency: one time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140	$116.93	$106.93	$10.00	Removal of tooth structure, minor smoothing of socket bone, and closure as necessary. Frequency: One D7140 per lifetime per client per tooth. Teeth 1 – 32.
Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	$181.12	$171.12	$10.00	Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure. Frequency: One of D7210 per lifetime per client per tooth. Teeth 1 - 32

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Removal of impacted tooth-soft tissue	D7220	$216.73	$196.73	$20.00	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Teeth 1-32. Frequency: One of D7220 per 1 lifetime per client per tooth.
Removal of impacted tooth-partially bony	D7230	$267.45	$247.45	$20.00	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7230 per 1 lifetime per patient per tooth
Removal of impacted tooth-completely bony	D7240	$310.37	$290.37	$20.00	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32. Frequency: One of D7240 per 1 lifetime per patient per tooth.
Removal of impacted tooth-completely boney, with unusual surgical complications	D7241	$407.88	$387.88	$20.00	Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Teeth 1-32. Frequency: One of D7241 per lifetime per patient per tooth.
Removal of residual tooth roots (cutting procedure)	D7250	$191.02	$181.02	$10.00	Includes cutting of soft tissue and bone, removal of tooth structure, and closure. Cannot be charged for removal of broken off roots for recently extracted tooth. Teeth 1 – 32 Frequency: One D7250 per lifetime per patient per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Primary closure of a sinus perforation	D7261	$476.03	$466.03	$10.00	Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fisulous tract. Narrative of medical necessity may be required and if the sinus perforation was caused by a current grantee or provider of the program.
Incisional biopsy of oral tissue-soft	D7286	$381.00	$381.00	$0.00	For partial removal of an architecturally intact specimen only. D7286 is not used at the same time as codes for apicoectomy/periradicular curettage and does not entail an excision. Treatment notes must include documentation and proof that biopsy was sent for evaluation.
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310	$150.00	$140.00	$10.00	D7310 is distinct (separate procedure) from extractions. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One D7310 or D7311 per lifetime per patient per quadrant. Reported per quadrant.
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	$145.97	$135.97	$10.00	D7311 is distinct (separate procedure) from extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One D7311 or D7310 per lifetime per patient per quadrant. Reported per quadrant.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	$210.11	$200.11	$10.00	No extractions performed in an edentulous area. See D7310 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7320 or D7321 per lifetime per patient per quadrant. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321	$210.11	$200.11	$10.00	No extractions performed in an edentulous area. See D7311 if teeth are being extracted concurrently with the alveoloplasty. Usually in preparation for prosthesis or other treatments such as radiation therapy and transplant surgery. Frequency: One of D7320 or D7321 per lifetime per patient per quadrant. Reported per quadrant.
Removal of lateral exostosis (maxilla or mandible)	D7471	$304.28	$294.28	$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Reported per arch (LA or UA)
Removal of torus palatinus	D7472	$357.83	$347.83	$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Must list quadrant.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Removal of torus mandibularis	D7473	$349.01	$339.01	$10.00	Limited to the removal of exostosis, including the removal of tori, osseous tuberosities, and other osseous protuberances, when the mass prevents the seating of denture and does not allow denture seal. Must list quadrant.
Incision & drainage of abscess - intraoral soft tissue	D7510	$193.00	$183.00	$10.00	Incision through mucosa, including periodontal origins. One of D7510 per lifetime per client per tooth. Report per tooth.
Palliative treatment of dental pain – per visit	D9110	$80.92	$55.92	$25.00	Emergency treatment to alleviate pain/discomfort. This code cannot be used for filing claims or writing or calling in a prescription to the pharmacy or to address situations that arise during multi-visit treatments covered by a single fee such as surgical or endodontic treatment. Report per visit, no procedure. Frequency: Limit 1 time per year. Maintain documentation that specifies problem and treatment.
Evaluation for moderate sedation, deep sedation or general anesthesia	D9219	$42.97	$42.97	$0.00	One of D9219 or D9310 per 12 month(s) per grantee
Deep sedation/general anesthesia-each 15 minute increment	D9223	$108.13	$98.13	$10.00	Nine of D9223 per 1 day per patient. Not allowed with D9243
Intravenous moderate (conscious) sedation/analgesia-first 15 minutes	D9239	$122.51	$112.51	$10.00	One of D9239 per 1 day per patient.
Intravenous moderate (conscious)sedation/analgesia-each 15 minute increment	D9243	$108.13	$98.13	$10.00	Thirteen of D9243 per 1 day per patient. Not allowed with D9223

EXPLANATION OF RESTORATIONS		
Location	Number of Surfaces	Characteristics
	1	Placed on one of the five surface classifications. .

Anterior - **Mesial, Distal, Incisal, Lingual, or Facial (or Labial)**	2	Placed, without interruption, on two of the surface classifications.
	3	Placed, without interruption, on three of the surface classifications.
	4 or more	Placed, without interruption, on four or more of the surface classifications.
Posterior – **Mesial, Distal, Occlusal, Lingual, or Buccal**	1	Placed on one of the five surface classifications.
	2	Placed, without interruption, on two of the surface classifications.
	3	Placed, without interruption, on three of the surface classifications.
	4 or more	Placed, without interruption, on four or more of the surface classifications.

NOTE: Tooth surfaces are reported using the letters in the following table.

Surface	Code
Buccal	B
Distal	D
Facial (or Labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443
Rule Number: MSB 23-03-02-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 23-03-02-A, Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.440 & 8.443, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Emergency

   If yes, state effective date: 7/1/2023

   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.440 with the proposed text beginning at 8.440.17 through the end of 8.440.39. Replace the current text at 8.443 with the proposed text beginning at 8.443 through the end of 8.443.1.B. Replace the current text at 8.443.6 with the text beginning at 8.443.6.A through the end of 8.443.6.B. Replace the current text at 8.443.10 with the proposed text beginning at 8.443.10.A through the end of 8.443.10.B. This rule is effective July 1, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443
Rule Number: MSB 23-03-02-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

House Bill (H.B.) 23-1228 increases nursing home reimbursement starting in state fiscal year (SFY) 2023-24. The proposed rule increases the SFY 2023-24 statewide average nursing home per-diem reimbursement rate by 10%, compared to a limited 2% or 3% increase in previous years. The proposed rule also increases the Cognitive Performance Scale (CPS) and Preadmission Screening and Resident Review (PASRR) II supplemental payment starting in SFY 2023-24, reimbursement for providing care to residents with cognitive and/or behavioral disabilities.

The propose rule also makes necessary changes to the case mix adjustment applied to nursing home per diem reimbursement rates due to the current Resource Utilization Group (RUG) tool no longer utilized by the Center for Medicare & Medicaid Services (CMS) after October 1, 2023.

2. An emergency rule-making is imperatively necessary

☒ to comply with state or federal law or federal regulation and/or
☐ for the preservation of public health, safety and welfare.

Explain: H.B. 23-1228 increases SFY 2023-24 (July 1, 2023 through June 30, 2024) nursing home reimbursement. Emergency rule-making is necessary to comply with state law allowing for the change to nursing home reimbursement to be effective July 1, 2023. The proposed rule was not presented at a previous MSB meeting as H.B. 23-1228 was sent to the Governor for signature May 17, 2023.

3. Federal authority for the Rule, if any:

42 CFR 433.68 and 42 U.S.C. § 1396b(w)

4. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);

25.5-4-402.4(4)(b), (g), C.R.S.

Initial Review — Final Adoption
Proposed Effective Date **07/01/23** — Emergency Adoption
06/09/23

DOCUMENT #13

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443
Rule Number: MSB 23-03-02-A
Division / Contact / Phone: Special Financing / Jeff Wittreich / 2456

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

Nursing homes will benefit from the proposed rule. The statewide average nursing home per-diem reimbursement rate will increase by 10% in SFY 2023-24, compared to previous years where the increase was limited to 2% or 3%. Nursing homes providing care to more residents with mental health conditions, cognitive dementia, and/or developmental disabilities will benefit as their CPS and PSRR supplemental payments will increase starting in SFY 2023-24.

Nursing homes providing care to less residents with mental health conditions, cognitive dementia, and/or developmental disabilities will bear the costs as other nursing home supplemental payments will be reduced to offset the CPS/PASRR supplemental payment increase. There are limited provider fee funds and an increase in one supplemental payment means a decrease to the other supplemental payments. The state and federal governments will bear the costs of the proposed rule by funding the increase to per-diem reimbursement rates to nursing homes.

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

The 10% increase in reimbursement rates equates to a $43 million reimbursement increase to nursing homes starting in SFY 2023-24. CPS and PASRR supplemental payments will increase by $5.75 million with a corresponding $5.75 million decrease to other supplemental payments.

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

The state funding obligation is approximately $21.5 million per SFY. Additional costs include an increased administrative burden on Department staff for the implementation of these changes.

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

The benefit of the proposed rule includes additional reimbursement to nursing homes. The cost of the proposed rule is the additional administrative burden on Department staff to implement these changes. The cost of the proposed rule also includes an increased state funding obligation.

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

There are no other methods that are less costly or intrusive that still achieve the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

No alternative methods were seriously considered by the Department to achieve the desired goal of the proposed rule.

8.440 NURSING FACILITY BENEFITS

Special definitions relating to nursing facility reimbursement:

1. "Acquisition Cost" means the actual allowable cost to the owners of a capital-related asset or any improvement thereto as determined in accordance with generally accepted accounting principles.

2. "Actual cost" or "cost" means the audited cost of providing services.

3. "Administration and General Services Costs" means costs as defined at Section 8.443.8.

4. "Appraised value" means the determination by a qualified appraiser who is a member of an institute of real estate appraisers, or its equivalent, of the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal shall be based on the valuation system as determined by the Department.

The depreciated cost of replacement appraisal shall be redetermined every four years by new appraisals of the nursing facilities. The new appraisals shall be based upon rules promulgated by the state board.

5. "Array of facility providers" means a listing in order from lowest per diem cost facility to highest for that category of costs or rates, as may be applicable, of all Medicaid-participating nursing facility providers in the state.

6. a. "Base value" means:

i. The appraised value of a capital-related asset for the fiscal year 1986-87 and every fourth year thereafter.

ii. The most recent appraisal together with fifty percent of any increase or decrease each year since the last appraisal, as reflected in the index, for each year in which an appraisal is not done pursuant to subparagraph (a) of this paragraph (1).

b. For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars per licensed bed at any participating facility, and, for each succeeding fiscal year, the base value shall not exceed the previous year's limitation adjusted by any increase or decrease in the index.

c. An improvement to a capital-related asset, which is an addition to that asset, as defined by rules adopted by the state board, shall increase the base value by the acquisition cost of the improvement.

7. "Capital-related asset" means the land, buildings, and fixed equipment of a participating facility.

8. "Case-mix" means a relative score or weight assigned for a given group of residents based upon their levels of resources, consumption, and needs.

9. "Case-mix adjusted direct health care services costs" means those costs comprising the compensation, salaries, bonuses, workers' compensation, employer-contributed taxes, and other employment benefits attributable to a nursing facility provider's direct care nursing staff whether employed directly or as contract employees, including but not limited to DONs, registered nurses, licensed practical nurses, certified nurse aides and restorative nurses.

10. “Case-mix index” means a numeric score assigned to each nursing facility resident based upon a resident’s physical and mental condition that reflects the amount of relative resources required to provide care to that resident.

11. “Case-mix neutral” means the direct health care costs of all facilities adjusted to a common case-mix.

12. “Case-mix reimbursement” means a payment system that reimburses each facility according to the resource consumption in treating its case-mix of Medicaid residents, which case-mix may include such factors as the age, health status, resource utilization, and diagnoses of the facility’s Medicaid residents as further specified in this section.

13. “Class I nursing facility provider” means a private for-profit or not-for-profit nursing facility provider or a facility provider operated by the state of Colorado, a county, a city and county, or special district that provides general skilled nursing facility care to residents who require twenty-four-hour nursing care and services due to their ages, infirmity, or health care conditions, including residents who are behaviorally challenged by virtue of severe mental illness or dementia. Swing bed facilities are not included as Class I nursing facility providers.

14. “Core Component per diem rate” means the per diem rate for direct and indirect health care services costs, administrative and general services costs, and fair rental allowance for capital-related assets for Class 1 nursing facility providers.

15. “Direct health care services costs” means those costs subject to case-mix adjusted direct health care services costs.

16. “Direct or indirect health care services costs” means the costs incurred for patient support services as defined at Section 8.443.7.

17. “Facility population distribution” means the number of Colorado nursing facility residents who are classified into each Case-Mix group as of a specific point in time.

18. “Fair rental allowance” means the product obtained by multiplying the base value of a capital-related asset by the rental rate.

19. “Improvement” means the addition to a capital-related asset of land, buildings, or fixed equipment.

20. “Index” means the R. S. Means construction systems cost index or an equivalent index that is based upon a survey of prices of common building materials and wage rates for nursing home construction.

21. “Index maximization” means classifying a resident who could be assigned to more than one category to the category with the highest case-mix index.

22. “Median per diem cost” means the daily cost of care and services per patient for the nursing facility provider that represents the middle of all of the arrayed facilities participating as providers or as the number of arrayed facilities may dictate, the mean of the two middle providers.

23. “Medicare patient day” means all days paid for by Medicare. For instance, a Medicare patient day includes those days where Medicare pays a Managed Care Organization for the resident’s care.

24. “Minimum data set” means a set of screening, clinical, and functional status elements that are used in the assessment of a nursing facility provider’s residents under the Medicare and Medicaid programs.

25. “MMIS per diem reimbursement rate” means the per diem rate used for Medicaid Management Information Systems (MMIS) claims-based reimbursement.

26. “Normalization ratio” means the statewide average case-mix index divided by the facility’s cost report period case-mix index.

27. “Normalized” means multiplying the nursing facility provider’s per diem case-mix adjusted direct health care services cost by its case-mix index normalization ratio for the purpose of making the per diem cost comparable among facilities based upon a common case-mix in order to determine the maximum allowable reimbursement limitation.

28. “Nursing facility provider” means a facility provider that meets the state nursing facility licensing standards established pursuant to C.R.S. §25-1.5-103, and is maintained primarily for the care and treatment of inpatients under the direction of a physician.

29. “Nursing salary ratios” means the relative difference in hourly wages of registered nurses, licensed practical nurses, and nurse’s aides.

30. “Nursing weights” means numeric scores assigned to each category of the Case-Mix groups that measure the relative amount of resources required to provide nursing care to a nursing facility provider’s residents.

31. “Occupancy-imputed days” means the use of a predetermined number for patient days rather than actual patient days in computing per diem cost.

32. “Per diem cost” means the daily cost of care and services per patient for a nursing facility provider.

33. “Per diem fee” means the dollar amount of provider fee that the Department shall charge a nursing facility provider per non-Medicare day.

34. “Provider fee” means a licensing fee, assessment, or other mandatory payment as specified under 42 C.F.R. § 433.55.

35. “Raw food” means the food products and substances, including but not limited to nutritional supplements, that are consumed by residents.

36. “Rental rate” means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent. The rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

37. “Statewide average per diem rate” means the average per diem rate for all Medicaid-participating nursing facility providers in the state.

38. “Substandard Quality of Care” means one or more deficiencies related to participation requirements under 42 C.F.R § 483.12 Freedom from abuse, neglect, and exploitation, 42 C.F.R. § 483.24 Quality of life, or 42 C.F.R. § 483.25, Quality of care that constitute either immediate jeopardy to resident

health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

39. “Supplemental Payment” means a lump sum payment that is made in addition to a nursing facility provider’s MMIS per diem reimbursement rate. A supplemental Medicaid payment is calculated on an annual basis using historical data and paid as a fixed monthly amount with no retroactive adjustment.

8.443 NURSING FACILITY PROVIDER REIMBURSEMENT

8.443.1.B CLASS 1 NURSING FACILITY PROVIDER REIMBURSEMENT

i. For state fiscal year (SFY) 2019-20, if the MMIS per diem reimbursement rate is less than ninety-five percent (95%) of the SFY 2018-19 MMIS per diem reimbursement rate, the SFY 2019-20 MMIS per diem reimbursement rate shall be the lesser of 95% of the SFY 2018-19 MMIS per diem reimbursement rate or the SFY 2019-20 Core Component per diem rate.

b. For SFY 2020-21 and SFY 2021-22, the percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by a two percent (2.00%) statutory limit.

c. For SFY 2023-24, the percent factor shall be a percentage such that the statewide average MMIS per diem reimbursement rate net of patient payment equals the previous year statewide average MMIS per diem reimbursement rate net of patient payment increased by a ten percent (10.00%) statutory limit.

The Core Component per diem rate shall be the sum of the following per diem rates:

a. Medicaid utilization supplemental payment described in Section 8.443.10.C,

b. Acuity Adjusted Core Component supplemental payment described in Section 8.443.11.B,

c. Pay-For-Performance supplemental payment described in Section 8.443.12,

d. Cognitive Performance Scale supplemental payment described in Section 8.443.10.A,

e. Preadmission Screening and Resident Review II Resident supplemental payment described in Section 8.443.10.B,

f. Preadmission Screening and Resident Review II Facility supplemental payment described in Section 8.443.10.B, and

g. Core Component supplemental payment described in Section 8.443.11.A.

8.443.6 CASE MIX ADJUSTMENTS

8.443.6.A A resident's case mix index shall be determined using a case mix classification system. The case mix classification system shall be maintained through public postings on the Department's website. The case mix classification system may be updated to reflect advances in resident assessment or classification subject to federal requirements.

8.443.6.B A resident's case mix index shall be determined on a Quarterly basis.

1. The Department shall distribute facility listings identifying current assessments for residents in the nursing facility on the 1st day of the first month of each quarter as reflected in the Department's MDS assessment database.

    a. The listings shall identify resident social security numbers, names, assessment reference date, the calculated case mix index, and the payor source as reflected on the prior full assessment and/or current claims data.

2. Resident listings shall be reviewed by the nursing facility for completeness and accuracy.

3. If data reported on the resident listings is in error or if there is missing data, facilities shall have until the last day of the second month of each quarter to correct data submissions, or until a later date if approved by the Department pursuant to 10 CCR 2505-10 section 8.442.2.

    a. Errors or missing data on the resident listings due to untimely submissions to the CMS database maintained by CDPHE shall be corrected by the nursing facility transmitting the appropriate assessments or tracking documents to CDPHE.

    b. Errors in key field items shall be corrected by following the CMS key field specifications through CDPHE

    c. Errors on the current payor source shall be noted on the resident listings prior to signing and returning to the Department.

4. Each nursing facility shall sign and return its resident listing to the Department no later than 15 calendar days after it was mailed by the Department.

5. Residents shall be assigned a case mix index based on their most current non-delinquent assessment available on the 1st day of the first month of each quarter as amended during the correction period.

    a. The RUG-III group shall be translated to the appropriate case mix index or weight.

    b. Two average case mix indices for each Medicaid nursing facility shall be determined from the individual case mix weights for the applicable quarter:

        i. The facility average case mix index shall be a simple average, carried to four decimal places, of all resident case mix indices.

        ii. The Medicaid average case mix index shall be a simple average, carried to four decimal places, of all residents where Medicaid is the per diem

payor source anytime during the 30 days prior to their current assessment.

c. Any incomplete assessments and current assessment in the database older than 122 days shall be included in the calculation of the averages using the case mix index established in these rules.

8.443.10 COGNITIVE PERFORMANCE SCALE, PREADMISSION SCREENING AND RESIDENT REVIEW II, AND MEDICAID UTILIZATION SUPPLEMENTAL PAYMENTS

8.443.10.A COGNITIVE PERFORMANCE SCALE SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers who have residents with moderate to very severe mental health conditions, cognitive dementia, or acquired brain injury, based upon the resident's score on the Cognitive Performance Scale (CPS).

1. Annually, the Department shall calculate the payment by multiplying a CPS per diem rate by CPS Medicaid days.

2. The CPS per diem rate is calculated based on the number of standard deviations a nursing facility provider's CPS percentage is above the statewide average CPS percentage. The CPS per diem rate shall be determined in accordance with the following table:

Standard Deviation Above Statewide Average	CPS Per Diem
Greater Than or Equal to Statewide Average + 1 Standard Deviation	1x
Greater Than or Equal to Statewide Average + 2 Standard Deviation	2x
Greater Than or Equal to Statewide Average + 3 Standard Deviation	3x

The CPS per diem rate multiplier (x) shall equal an amount such that the total statewide CPS supplemental payment divided by total statewide CPS Medicaid days equal two percent of the statewide average July 1 Core Component per diem rate.

3. The CPS percentage is the sum of Medicaid residents with a CPS score of 4, 5, or 6 divided by the sum of Medicaid residents.

   a. Medicaid residents with a CPS score of 4, 5, or 6 are determined using the Department utilized case mix classification system and reported on the MDS form.

   b. The determination of Medicaid residents with a CPS score of 4, 5, or 6 shall be made using the April MDS roster.

4. CPS Medicaid patient days shall equal the count of Medicaid residents with a CPS score of 4, 5, 6, or equivalent, multiplied by the days in the year.

5. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

8.443.10.B PREADMISSION SCREENING AND RESIDENT REVIEW II SUPPLEMENTAL PAYMENT

The Department shall pay a supplemental payment to nursing facility providers who have residents with severe mental health conditions or developmental disabilities that are classified at Level II by the Medicaid program's preadmission screening and resident review assessment tool (PASRR II).

1. Annually, the Department shall calculate the payment by multiplying a PASRR II per diem rate by Medicaid PASRR II days.

2. Medicaid PASRR II days shall equal the count of PASRR II residents on May 1, multiplied by the days in the year.

3. The PASRR II per diem rate shall equal four percent of the statewide July 1Core Component per diem rate.

4. The Department shall pay an additional PASRR II supplemental payment to facilities that offer specialized behavioral services to residents who have severe behavioral health needs. These services shall include enhanced staffing, training, and programs designed to increase the resident's skills for successful community reintegration.

5. The additional PASRR II supplemental payment for nursing facility providers that have an approved specialized behavioral services program shall be calculated using the methodology described in Section 8.443.10.B.1 through Section 8.443.10.B.3.

6. The Department shall perform these calculations annually to coincide with the July 1st rate setting process.

COLORADO
Department of Health Care Policy & Financing
Medical Services Board

JUNE 2023 EMERGENCY JUSTIFICATION FOR MEDICAL ASSISTANCE RULES ADOPTED AT THE JUNE 9, 2023 EMERGENCY MEDICAL SERVICES BOARD MEETING

MSB 23-06-01-A, Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. The enabling legislation, Senate Bill 22-200, requires that the Medical Services Board promulgate rules for the administration of the Rural Provider Access and Affordability Stimulus Grant Program. The legislation also created the Rural Provider Access and Affordability Advisory Committee to begin meeting in September 2022 and charged the committee with making formal recommendations to the Department on the administration of the grant program including the proposed rule. The timeline for the advisory committee's work must meet the requirements set in legislation at Section 25.5-1-207 (5), C.R.S. and is imperatively necessary for the preservation of public health safety, and welfare.

MSB 23-04-26-A, Revision to the Medical Assistance Act Rule concerning Cost Sharing, Section 8.754.1

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. The proposed rule is imperatively necessary to align Department rule with the statutory removal of certain member copayments in the 2023 Colorado Long Bill (Senate Bill 23-214), effective July 1, 2023 and is imperatively necessary for the preservation of public health safety, and welfare.

MSB 23-04-11-A, Revision to the Medical Assistance Rule regarding the Base Wage for Direct Care Workers, Sections 8.511 & 8.535

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. The Department's Budget Request R07 was approved on May 1, 2023, when Senate Bill 23-214 was signed into law. Within SB 23-214 the General Assembly approved "an increase for home and community-based waiver services to reflect a $15.75 per hour base wage for workers statewide and $17.29 per hour in

Denver.” An emergency rule to amend the existing Base Wage regulations is required to implement the increase effective July 1, 2023 and is imperatively necessary for the preservation of public health safety, and welfare.

MSB 23-06-01-B, Revision to the Medical Assistance Act Rule concerning Novel Corona Virus Disease (COVID-19) Rules, Section 8.6000

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. The temporary changes to regulatory requirements in order to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic is imperatively necessary for the preservation of public health safety, and welfare.

MSB 23-06-01-C, Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.443 and 8.815

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. This rule revision will allow the Department to reimburse pharmacies for administration of the COVID-19 vaccine in Long-term Care Facilities through the Centers for Disease Control and Prevention's (CDC's) Pharmacy Partnership for Long-term Care Program or other partnership between an LTC and a pharmacy. These revisions are required to facilitate administration of the forthcoming COVID-19 vaccine to nursing home facility residents and is imperatively necessary for the preservation of public health safety, and welfare.

MSB 23-05-18-A, Revision to the Medical Assistance Act Rule concerning Dental Health Care Program for Low-Income Seniors Procedure Increase, Section 8.960

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. Current rule states the max program fees of the Dental Health Program for Low-Income Seniors must not fall below Medicaid dental rates. Medicaid received a 3% increase for the dental rates for FY2023-24. This made some of the program rates in Schedule A fall below the Medicaid rate. This change is necessary to stay in compliance with rule and is imperatively necessary for the preservation of public health safety, and welfare.

MSB 23-03-02-A, Revisions to the Medical Assistance Act Rule Concerning Nursing Home Reimbursement, Sections 8.440 & 8.443

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. H.B. 23-1228 increases SFY 2023-24 (July 1, 2023 through June 30, 2024) nursing home reimbursement. Emergency rule-making is necessary to comply with state law allowing for the change to nursing home reimbursement to be effective July 1, 2023. The proposed rule was not presented at a previous MSB meeting as H.B. 23-1228 was sent to the Governor for signature May 17, 2023 and is imperatively necessary for the preservation of public health safety, and welfare.

PHIL WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

SHANNON STEVENSON
Solicitor General

TANJA WHEELER
Associate Chief Deputy Attorney General

STATE OF COLORADO
DEPARTMENT OF LAW

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Office of the Attorney General

Tracking number: 2023-00307

Opinion of the Attorney General rendered in connection with the rules adopted by the

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

on 06/09/2023

10 CCR 2505-10

MEDICAL ASSISTANCE - STATEMENTS OF BASIS AND PURPOSE AND RULE HISTORY

The above-referenced rules were submitted to this office on 06/09/2023 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.

June 23, 2023 10:09:41

Philip J. Weiser
Attorney General
by Kurtis Morrison
Deputy Attorney General

Nonrulemaking Public Notices and other Miscellaneous Rulemaking Notices

Filed on 07/05/2023

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

1915(c) Home and Community-Based Services (HCBS) Waiver Amendment

The Department of Health Care Policy & Financing (Department) intends to submit amendments for the following Home and Community-Based Services (HCBS) waivers:

- Persons with Brain Injury (BI)
- Children's Extensive Supports (CES)
- Children's Habilitation Residential Program (CHRP)
- Children with Life-Limiting Illness (CLLI)
- Community Mental Health Supports (CMHS)
- Complementary and Integrative Health (CIH)
- Developmental Disabilities (DD)
- Elderly, Blind, and Disabled (EBD)
- Supported Living Services (SLS)
- Children's Home and Community-Based Services (CHCBS)

Explanation of changes within the waiver applications can be found below.

- The Department is adding the Dental Assistant provider type which was approved through the passage of SB 22-219. (SLS, DD)
- Addition of the new residential service type, Mental Health Transitional Living (MHTL), to the CMHS waiver. MHTL will provide supportive intervention services to members who reside within the community and require 24/7 care to develop the skills necessary for daily living and to assist with successful integration into the community. (CMHS)
- The Department is deleting language formerly contained in Attachment #2: Home and Community-Based Settings Waiver Transition Plan and is updating Appendix C-5: Home and Community-Based Settings in the CMHS waiver to describe, for the settings that were previously public noticed and approved through the Statewide Transition Plan, (i) the services offered at each setting and (ii) the process for ongoing monitoring for compliance with HCBS Settings Final Rule requirements. The Department is also updating language in Appendix C-5 to note that effective November 11, 2023, the Department is adding a new service to the CMHS waiver, Mental Health Transitional Living (MHTL), that will be provided

in the new setting of Mental Health Transitional Living Homes (MHTLHs)

- The Department is updating Appendix J Average Cost/Unit to reflect rate increases approved during the recent legislative session through the Long Bill, SB 23-214. The rate includes a 3% increase, a base wage increase for services outside Denver County to $15.75/hour, a minimum wage increase to $17.29/hour for services inside Denver County, and Targeted Rate Increases (TRI) for Non-Medical Transportation in the DD and SLS waivers and Group Residential Support Services in the DD waiver. The increases will be effective on 07/01/2023 through an Appendix K Amendment. The State is updating Appendix J to reflect the Appendix K approval and for permanent ongoing approval in the waiver. The Department's rate sheet that reflects these increases is located at https://hcpf.colorado.gov/provider-rates-fee-schedule. (All waivers)

The Department will post the drafts of the waiver amendment applications for public notice from July 6, 2023, through August 4, 2023. The Department will ask for an effective date of November 11, 2023, for the amendments.

For a more detailed summary of all changes, please go to the Department's website https://hcpf.colorado.gov/hcbs-public-comment to view the full draft waivers and the waiver actions fact sheet. You may also obtain a paper or electronic copy by calling 303-866-3684 or by writing the Department 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: HCBS Waiver Amendments; or in-person at 1570 Grant Street, Denver, CO 80203.

Public Comments will be accepted July 6, 2023, through August 4, 2023.

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: HCBS Waiver Amendments, 1570 Grant Street, Denver, CO 80203.

Calendar of Hearings

Hearing Date/Time	Agency	Location
08/01/2023 08:00 AM	Colorado Lottery	Zoom Meeting
08/01/2023 08:00 AM	Colorado Lottery	Zoom Meeting
10/30/2023 09:00 AM	Marijuana Enforcement Division	1707 Cole Blvd., Ste. 300, Red Rocks Conference Room Lakewood, CO 80401
08/24/2023 08:00 AM	Colorado Parks and Wildlife (405 Series, Parks)	Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487
08/24/2023 08:00 AM	Colorado Parks and Wildlife (405 Series, Parks)	Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487
08/24/2023 08:00 AM	Colorado Parks and Wildlife (405 Series, Parks)	Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487
08/24/2023 08:00 AM	Colorado Parks and Wildlife (406 Series, Wildlife)	Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487
08/24/2023 08:00 AM	Colorado Parks and Wildlife (406 Series, Wildlife)	Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487
08/24/2023 08:00 AM	Colorado Parks and Wildlife (406 Series, Wildlife)	Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487
08/24/2023 08:00 AM	Colorado Parks and Wildlife (406 Series, Wildlife)	Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487
08/24/2023 08:00 AM	Colorado Parks and Wildlife (406 Series, Wildlife)	Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487
08/24/2023 08:00 AM	Colorado Parks and Wildlife (406 Series, Wildlife)	Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487
08/24/2023 08:00 AM	Colorado Parks and Wildlife (406 Series, Wildlife)	Colorado Mountain College, 1275 Crawford Ave, Steamboat Springs, CO 80487
08/01/2023 02:00 PM	Division of Insurance	Webinar or 1560 Broadway, STE 850, Denver CO 80202
08/15/2023 10:00 AM	Division of Workers' Compensation	Virtual hearing via zoom - preregistration REQUIRED
08/01/2023 10:15 AM	Division of Family and Medical Leave Insurance	Online: Zoom: https://us02web.zoom.us/meeting/register/tZMofuGoqzosGtG9_jIHjjv3sjKY1R4uHPty
08/01/2023 10:15 AM	Division of Family and Medical Leave Insurance	Online: Zoom: https://us02web.zoom.us/meeting/register/tZMofuGoqzosGtG9_jIHjjv3sjKY1R4uHPty
08/03/2023 01:00 PM	Secretary of State	Please see the Additional Information section for details.
08/07/2023 10:00 AM	Division of Homeland Security and Emergency Management	Virtual Zoom Meeting https://us02web.zoom.us/meeting/register/tZMpf-6tqzMrG9F8-CqvDHaullNIzGtmpTVP
08/04/2023 08:30 AM	Income Maintenance (Volume 3)	1575 Sherman Street, Denver, CO 80203
08/11/2023 09:00 AM	Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)	303 East 17th Avenue, 11th Floor, Denver, CO 80203