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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.

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Notice of Proposed Rulemaking

Tracking number

2018-00522

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-4

Rule title

SALES AND USE TAX

Rulemaking Hearing

Date

10/30/2018

Time

09:00 AM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Repeal the Doing Business in this State rule in accordance with changes made to Regulations 39-26-105 and 39-26-204(2), 1 CCR 201-4 regarding the criteria that determine a retailers liability and responsibility to collect sales and use tax

Statutory authority

§§ 39-21-112(1) and 39-26-102(3), C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

SALES AND USE TAX

1 CCR 201-4

~~**REGULATION 39- 26-102.3**~~

~~1) "Doing business in this state" under C.R.S. 39-26-102(3)(a) requires that the person both (1) sell, lease, or deliver tangible personal property in this state, and (2) maintain, directly or indirectly, an office, salesroom, warehouse, or similar place of business within the state. A person meeting these requirements must obtain a Colorado Sales Tax License. "Doing business in this state" under C.R.S. 39-26-102(3)(b) requires that the person both (1) sell, lease, or deliver tangible personal property in this state, and (2) regularly or systematically make solicitations in this state. A person meeting these requirements should obtain a Colorado Retailer's Use Tax License or a Colorado Sales Tax License.~~

~~2) The solicitation required by (3)(b)(I) of section 39-26-102 C.R.S. may be by any means whatsoever, including advertising by catalogues, newspapers, radio, television, e-mail, or Internet. The solicitation need not originate in this state. It is sufficient that the vendor purposefully direct the advertising into the state, which includes national or international advertising that includes Colorado.~~

~~3)~~

~~a) Any retailer that does not collect Colorado tax (the "remote retailer") and is a component member of a controlled group of corporations, which controlled group also contains a retailer with a physical presence in this state (the "in-state retailer"), is presumed to be doing business in the state at a level sufficient to require the collection of Colorado sales tax. The remote retailer is required to register with the department and is required to collect Colorado sales tax.~~

~~b) The presumption articulated in a) may be rebutted by the remote retailer by a showing that the in-state retailer did not engage in any constitutionally sufficient solicitation on behalf of the remote retailer.~~

~~c) A retailer that does not collect Colorado tax is a retailer that sells taxable property or services to customers who are not exempt from sales tax, but does not collect sales or use tax.~~

~~d) In-state retailer includes any member of the controlled group of corporations that has a controlling interest in any in-state retailer regardless of the form of doing business of the in-state retailer.~~

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Doing Business in This State
39-26-102.3
1 CCR 201-4

Basis

The bases for this rule are §§ 39-21-112(1) and 39-26-102(3), C.R.S.

Purpose

The purpose of the amendment is to repeal the rule in accordance with changes made to Regulations 39-26-105 and 39-26-204(2), 1 CCR 201-4 regarding the criteria that determine a retailer's liability and responsibility to collect sales and use tax.

Notice of Proposed Rulemaking

Tracking number

2018-00527

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-4

Rule title

SALES AND USE TAX

Rulemaking Hearing

Date

10/30/2018

Time

09:00 AM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Amend the Remittance of Tax rule to clarify the criteria that determine a retailers liability and responsibility to collect sales tax and to conform the rule to the U.S. Supreme Courts decision in South Dakota v. Wayfair, Inc., 138 S. Ct. 2080 (2018).

Statutory authority

§§ 39-21-112(1) and 119, C.R.S. and §§ 39-26-105, 107, 109, 112, 118, and 704(2), C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

SALES AND USE TAX

1 CCR 201-4

~~Rule~~ Regulation 39-26-105. Remittance of Tax.

Basis and Purpose. The statutory bases for this rule are §§ 39-21-112(1) and 39-21-119, ~~C.R.S. and §§~~ 39-26-105, 39-26-107, 39-26-109, 39-26-112, ~~and~~ 39-26-118, and 39-26-704(2). C.R.S. The purpose of this rule is to clarify sales tax remittance requirements and conditions under which a retailer is eligible to deduct a retailer's service fee from the sales tax they remit.

(1) **Retailer Requirements.**

(a) A retailer is liable and responsible for tax on the retailer's taxable sales made during the tax period prescribed for the retailer pursuant to 1 CCR 201-4, Rule 39-26-109, calculated using the tax rate in effect at the time of the sale and applied to all taxable sales, including all taxable sales made for less than the minimum amount subject to tax pursuant to § 39-26-106, C.R.S. A retailer is also liable and responsible, pursuant to § 39-26-112, C.R.S., for the payment of any tax collected in excess of the tax rate in effect at the time of the sale and must remit such excess amount to the Department.

(b) A retailer shall file with the Department a return reporting its sales, including any sales exempt from taxation under article 26 of title 39, C.R.S., made during the preceding tax period. If a retailer makes no retail sales during its preceding tax period, the retailer must file a return reporting zero sales. Returns and any required supplemental forms must be completed in full.

(c) A retailer must file returns and remit any tax due to the Department in accordance with the filing schedules prescribed by 1 CCR 201-4, Rule 39-26-109.

(2) **Due Date of Returns.** Sales tax returns and payments of tax reported thereon are due the twentieth day of the month following the close of the tax period. If the twentieth day of the month following the close of the tax period is a Saturday, Sunday, or legal holiday, the due date shall be the next business day.

(3) **Retailer's Service Fee.** Except as provided in this paragraph (3), a retailer may, in the remittance of collected sales tax, deduct and retain a retailer's service fee in the amount prescribed by § 39-26-105(1)(c), C.R.S.

(a) If the retailer is delinquent in remitting any portion of the tax due, other than in unusual circumstances shown to the satisfaction of the executive director, the retailer shall not retain a retailer's service fee for any portion of the tax for which the retailer is delinquent.

(b) If a retailer has retained a retailer's service fee pursuant to paragraph (3) of this rule and, subsequent to the applicable due date, owes additional tax for the filing period as the result of an amended return or an adjustment made by the Department, the retailer shall not be permitted to retain a retailer's service fee with respect to the additional tax, but the

retailer may retain the retailer's service fee associated with the original return, so long as the retailer filed the original return in good faith.

(4) **Application.**

(a) The liability and responsibility imposed by § 39-26-105, C.R.S. and this rule apply to any retailer that has substantial nexus with Colorado and is doing business in this state, as defined in § 39-26-102(3), C.R.S. Retailers are considered to have a substantial nexus with Colorado for sales tax purposes if they meet any of the following criteria:

(I) the retailer maintains a physical presence in Colorado pursuant to §§ 39-26-102(3)(a), (d), and (e), C.R.S.; or

(II) in the previous calendar year or the current calendar year:

(A) the retailer's gross revenue from the sale of tangible personal property or services delivered into Colorado exceeds one hundred thousand dollars; or

(B) the retailer sold tangible personal property or services for delivery into Colorado in two hundred or more separate transactions.

(b) Paragraph (4)(a)(II) of this rule shall not apply in determining a retailer's liability and responsibility for tax pursuant to § 39-26-105, C.R.S. and this rule for any sale made prior to December 1, 2018.

(c) A retailer that has substantial nexus with Colorado as defined in paragraph (4)(a) of this rule is not a "remote seller" as defined in § 39-26-102(7.7), C.R.S. and sales made by any such retailers are not "remote sales" as defined in § 39-26-102(7.6), C.R.S.

Cross Reference(s):

1. Forms, returns, and instructions can be found online at www.colorado.gov/tax.

2. For additional information about excess tax collected by a retailer, see § 39-26-112, C.R.S. and Rule 39-26-106, 1 CCR 201-4.

3. For information about electronic funds transfer (EFT) requirements and the timeliness of payments made via EFT, see Special Rule 1 Electronic Funds Transfer, 1 CCR 201-1.

4. For information about dates payments or returns are deemed to have been made, see § 39-21-119, C.R.S. and Rule 39-21-119, 1 CCR 201-1.

5. For information about electronic filing, see § 39-21-120, C.R.S. and Rule 39-21-120, 1 CCR 201-1.

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Remittance of Tax
39-26-105
1 CCR 201-4

Basis

The statutory bases for this rule are §§ 39-21-112(1) and 119, C.R.S. and §§ 39-26-105, 107, 109, 112, 118, and 704(2), C.R.S.

Purpose

The purpose of the amendment is to clarify the criteria that determine a retailer's liability and responsibility to collect sales tax and to conform the rule to the U.S. Supreme Court's decision in *South Dakota v. Wayfair, Inc*., 138 S. Ct. 2080 (2018).

Notice of Proposed Rulemaking

Tracking number

2018-00528

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-4

Rule title

SALES AND USE TAX

Rulemaking Hearing

Date

10/30/2018

Time

09:00 AM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Repeal the Tax Rate rule so that the rule will not be inconsistent with changes made to Regulation 39-26-102(9) regarding the sourcing of sales.

Statutory authority

§§ 39-21-112(1) and 39-26-105, 106, and 107, C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

SALES AND USE TAX

1 CCR 201-4

Regulation 39-26-105(1)(A) TAX RATE

(1) **General Rule.** A retailer shall collect the state sales tax and any applicable state-administered local sales taxes in effect at the time of the sale. If the retailer's filing period does not end on the day preceding the effective date of a new tax rate, the retailer must compute the amount of sales tax on its sales tax return using both tax rates.

(a) **Leases and Credit Sales.** Retailers who enter into leases or credit sales subject to Colorado sales or use taxes must collect for each such payment the tax at the rate in effect when the credit sale or lease was first made.

(i) Retailers who receive payments for a lease or credit sale after the effective date of a change in the tax rate must continue to collect the tax at the original rate. If the tax rate decreases and the retailer collects tax at the old rate on payments made after the effective date of the new tax rate, the retailer must report on their sales tax return the difference between the old tax rate and the new tax rate on the "Excess tax collected" line that is applicable to the tax jurisdiction whose tax rate has changed. Retailers cannot distribute the excess tax to the reporting columns of tax jurisdictions whose rate has not changed. If the tax rate increases and the retailer collects tax at the old rate on payments made after the effective date of the new tax rate, the retailer should contact the Department for instructions on filing the return.

(A) Retailers who renew or extend a lease must collect on each subsequent payment the tax rate in effect on the effective date of such renewal or extension.

(b) **Deferred Transactions.** Retailers who have conditional sales contracts or who remit tax on a cash basis for sales that occurred before a change in the tax rate must continue to collect the tax related to all payments made after the effective date of the new tax rate at the rate in effect at the time the contract or sale was originally made.

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Tax Rate
39-26-105(1)(A)
1 CCR 201-4

Basis

The bases for this rule are §§ 39-21-112(1) and 39-26-105, 106, and 107, C.R.S.

Purpose

The purpose of the amendment is to conform the rule to changes made to Regulation 39-26-102(9) regarding the sourcing of sales.

Notice of Proposed Rulemaking

Tracking number

2018-00521

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-4

Rule title

SALES AND USE TAX

Rulemaking Hearing

Date

10/30/2018

Time

09:00 AM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Amend the Auctioneers rule to conform the rule to changes made to Regulation 39-26-102(9) regarding the sourcing of sales.

Statutory authority

§§ 39-21-112(1); 39-26-102(1.3), (8), (9), and (10); 39-26-104; 39-26-105; and 39-26-106, C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

SALES AND USE TAX

1 CCR 201-4

Regulation 39-26-102(1.3). Auctioneers. ~~UCTIONEERS~~

(1) Auctioneer's Duty to Collect Tax

(a) Definitions

(i) *Auction sale*. An auction sale is a sale conducted by an auctioneer who solicits offers to purchase tangible personal property or services until the highest offer is made.

(ii) *Auctioneer*. An auctioneer is a person who sells an interest in tangible personal property or taxable services owned by the auctioneer or another person at an auction sale. An auctioneer has the legal authority to accept on behalf of the seller an offer to buy. An interest in property or services includes a lease and license. A person selling goods on consignment for another is an auctioneer if the sale is made at an auction sale. An auctioneer includes a person who is a lienholder, such as storageman, pawnbroker, motor vehicle mechanic, or artisan, and is selling the property at an auction sale to foreclose such lien.

(b) *General Rule*. An auctioneer is a retailer and, therefore, must collect, report, and remit Colorado sales tax and state-administered local sales taxes to the Department, even if the auctioneer is a disclosed agent of the owner.

(c) *Calculation of Tax*. Sales tax is calculated on the gross price paid by the buyer for the purchase of taxable tangible personal property or a taxable service, including any non-optional fee that only successful bidders must pay in order to purchase taxable goods or services, even if the non-optional fee is separately stated from the bid price paid for the auctioned item.

(i) *Examples.*

(A) Auctioneer sells restaurant equipment at auction for $10,000 and charges a fee of ten percent of the selling price, which is deducted from the total sale proceeds paid by the purchaser(s). Sales tax is calculated on the selling price paid by a successful bidder ($10,000), which includes the ten percent auctioneer's fee. Similarly, the fee is included in the sales tax calculation if the purchaser is required to pay the fee in addition to the successful bid price (i.e., tax calculated on $11,000) because the fee is included in the overall purchase price of the item.

(B) Auctioneer charges owners or bidders a flat “entrance” fee which compensates auctioneer for its cost to rent the auction facilities,

advertising, insurance, and/or auctioneer's administrative overhead. The fee is collected from sellers and bidders regardless of whether the owner's good(s) sells or the bidder purchases auctioned property or a service. The fee is not included in the calculation of sales tax because the fee is charged regardless of whether there is a taxable sale of goods or services. However, the fee is included in the calculation of sales tax if the fee (whether a flat or percentage fee) is due and payable only when goods or services are sold.

(C) Auctioneer charges buyer a fee for additional services that buyer has the option, but is not required, to purchase as part of buyer's purchase of auctioned property or services, such as an optional fee for auctioneer's or seller's service of delivering the auctioned goods to buyer. The optional fee paid by buyer is not included in the sales tax calculation if, and only if, the fee is separately stated on the buyer's invoice.

(d) *Local Sales Taxes*. ~~The location where the auction sale is conducted determines what, if any, state-administered local sales taxes apply, except as otherwise noted below.~~ Auctioneers must collect any applicable state-administered local sales taxes. For motor vehicles sold at auction, an auctioneer, who is required to collect sales tax (see paragraph (2)(b), below), must collect ~~the sales taxes of those~~any applicable state-administered local sales taxes, unless the motor vehicle is exempted from such local sales tax by § 29-2-105(1)(e), C.R.S. ~~jurisdictions in which the location of the sale and the location where the motor vehicle will be registered are the same.~~

~~(i) *Examples.*~~

~~(A) Auctioneer conducts auction sale of office equipment at its sale yard located in Weld County. The seller is located in Arapahoe County. To facilitate the auction, the equipment is moved to the auctioneer's sale yard in Weld County. Buyers take possession of and title to the equipment at the auctioneer's Weld County auction yard. Except for motor vehicles, a sale takes place, for purposes of sales tax, where and when the purchaser takes possession of, or title to, the property. Because both possession and title are transferred in Weld County, the sale takes place in Weld County and auctioneer must collect Weld County sales tax. Auctioneer does not collect Arapahoe County sales tax, even though the seller is located in Arapahoe County because the sale takes place in Weld County.~~

(B) Auctioneer has a sale yard in Weld County but conducts an auction sale of restaurant equipment, including a motor vehicle owned by the restaurant, at the restaurant's place of business, which is located in Berthoud, Larimer County. Buyers take possession of and title to the restaurant equipment in Berthoud. The purchaser of the motor vehicle resides in Arapahoe County, which is where the vehicle will be registered. Auctioneer collects Berthoud city sales tax and Larimer County sales tax on all the restaurant equipment because the sale takes place in those state-administered local tax jurisdictions. Auctioneer does not collect Weld County sales tax on any of the property because the sale occurred in Berthoud, Larimer County. If the auctioneer is not a licensed automotive dealer, then the auctioneer does not collect any tax for the sale of the vehicle. If the auctioneer is a licensed automotive dealer, the auctioneer does not collect Berthoud city sales tax or Larimer county sales tax on the motor vehicle because the city and county in which the sale occurs (Berthoud / Larimer) is not the same city or county in which the vehicle will be registered (Arapahoe County).

(ii) *Exceptions*. An auctioneer does not collect the state-administered local taxes applicable to the place of sale if purchaser takes possession of the property (including possession by an agent of the purchaser, such as a transportation company engaged by buyer to pick up the property) outside the local jurisdiction where the sale takes place and in which the auctioneer does not have a business presence. See, §29-2-105(1)(b), C.R.S. (Retailer does not collect local sales tax if the property is delivered outside retailer's local tax jurisdiction).

(A) *Examples.*

(I) Auctioneer conducts an auction at its sale yard in Weld County. Purchaser A, who is located in Larimer County, uses its own vehicle to pick up the property at the auctioneer's sale yard. Purchaser B, who is located in Arapahoe County, requests auctioneer to arrange the delivery of the property by common carrier to Purchaser B. Auctioneer collects state-administered Weld County sales tax for Purchaser A because Purchaser A takes possession of the property in Weld County (i.e., the sale occurs in Weld County). For Purchaser B, auctioneer does not collect Weld County sales tax because the sale occurs where Purchaser B takes possession (and presumably title) in Arapahoe County. Auctioneer does not have sale yard or other business presence in Arapahoe County and, therefore, has no obligation to collect Arapahoe County sales tax.

(II) Same facts as example (I) above, but auctioneer has a sale yard in both Weld County and a satellite office in Arapahoe County. Same result as example (I), except auctioneer must collect Arapahoe County sales tax from Purchaser B because the sale takes place in Arapahoe County and auctioneer has a business presence in Arapahoe County.

~~(III) Auctioneer conducts an auction at its place of business in Weld County but the property is stored at the owner's warehouse, which is located in Pueblo County. Purchasers take delivery (and title) of the auctioned property in Pueblo County. Auctioneer does not have a satellite office in Pueblo County, but auctioneer sent three employees to Pueblo County to inventory, arrange, and label the property and to supervise a pre-auction viewing by prospective bidders. Because the sale takes place where delivery or title pass to purchasers, the sale occurs in Pueblo County where purchasers take possession (and presumably title), not Weld County where the auctioneer and bidders are located at the time of sale. Even though auctioneer does not have an office in Pueblo County, auctioneer has sufficient business activity in Pueblo County to be required to collect Pueblo County sales tax.~~

(2) **Exceptions to Auctioneer's Duty to Collect**

(a) *Licensed Owners.* An auctioneer is not required to collect sales tax if the auctioneer sells taxable tangible personal property or services on behalf of a seller who, at the time of the sale, holds a current Colorado sales tax license issued by the Department. The licensed owner is responsible for collecting, remitting, and filing a sales tax return, even if the auctioneer was contractually obligated to the owner to collect the sales tax from the purchaser(s) and report and remit the tax to the Department, or if the auctioneer was contractually required to remit such collected tax to the licensed owner. An auctioneer, who is not legally required to collect tax because the owner is a licensed retailer but is collecting such tax on behalf of the owner, must disclose to the successful bidder the owner's name and owner's retail license number. An auctioneer who is not legally responsible to collect sales tax because the owner is a licensed retailer, but who nevertheless collects sales tax from a purchaser must hold the same in trust on behalf of the State of Colorado, and is liable for such tax if the tax is not remitted to the licensed seller or the Department.

(b) *Sales of motor vehicles.* An auctioneer is not required to collect sales taxes due on the sale of a motor vehicle, unless the auctioneer is licensed by Colorado as an automotive dealer pursuant to §12-6-101, et seq., C.R.S and the sale or use of the vehicle is subject to tax. § §39-26-113(7)(a) and (b), C.R.S.

(c) *Property Exempt from Sales Tax*. An auctioneer does not collect sales tax if the property is exempt from sales tax, such as an exempt farm close-out sale.

(d) *Burden of Proof*. An auctioneer has the burden of establishing with objective, verifiable documentation an exception or exemption from collecting, reporting, and remitting sales tax. An auctioneer selling on behalf of a licensed seller or to a purchaser with a sales tax exemption certificate must obtain a copy of the owner's sales tax license or, in the case of an exempt sale, the sales tax license number or the purchaser's sales tax exemption certificate, and verify that such license or certificate is valid at the time of the sale.

Cross Reference(s):

1. Please visit the Department's website (www.colorado.gov/revenue/tax) for online services available for verifying tax licenses and exemption certificates.

2. See ~~Department~~ Rule 39-26-716.4(a), 1 CCR 201-4 regarding an auctioneer's duties for an exempt farm close-out sale.

3. See ~~Department~~ Regulation 39-26-718, 1 CCR 201-4 for information on charitable entities conducting fundraising by auction sales.

4. See Regulation 39-26-102.9, 1 CCR 201-4 for the sourcing of sales for state and local sales tax purposes.

5~~4~~. See, Department Publication FYI Sales 56, “Sales Tax on Leases of Motor Vehicles and Other Tangible Personal Property” for additional information about when local sales taxes must be collected by retailers on sales of motor vehicles.

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Auctioneers
39-26-102(1.3)
1 CCR 201-4

Basis

The bases for this rule are §§ 39-21-112(1); 39-26-102(1.3), (8), (9), and (10); 39-26-104; 39-26-105; and 39-26-106, C.R.S.

Purpose

The purpose of the amendment is to conform the rule to changes made to Regulation 39-26-102(9) regarding the sourcing of sales.

Notice of Proposed Rulemaking

Tracking number

2018-00523

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-4

Rule title

SALES AND USE TAX

Rulemaking Hearing

Date

10/30/2018

Time

09:00 AM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Amend the Retail Sales rule to establish rules to determine the location to which a retail sale is sourced within Colorado.

Statutory authority

§§ 29-2-105(1)(b), 39-21-112(1), 39-26-102(9), 39-26-102(10), 39-26-104, 39-26-107, 39-26-204(2), and 39-26-713, C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

SALES AND USE TAX

1 CCR 201-4

Regulation 39-26-102.(9). Retail Sales.

Basis and Purpose. The bases for this rule are §§ 29-2-105(1)(b), 39-21-112(1), 39-26-102(9), 39-26-102(10), 39-26-104, 39-26-107, 39-26-204(2), and 39-26-713, C.R.S. The purpose of this rule is to establish the location to which a retail sale is sourced within Colorado.

(1) "Retail sale" " includes all sales on which sales tax is imposed under § 39-26-104, C.R.S. of tangible personal property and the sales of those services specifically enumerated in the Act as rooms and accommodations, gas and electric service, steam, and telephone and telegraph service, and all such sales are subject to the tax imposed by this Act. A retail sale is a sale to the user or consumer of such tangible personal property or service. "Retail sale" does not include a wholesale sale.

(2) For the purposes of this Article, aA retail sale is a sale to the user or consumer of such tangible personal property or service whether such the sale is made by a licensed vendor or is between private parties.

(3) "Retail sale" includes only those sales made within Colorado. For purposes of determining whether a sale of tangible personal property or services, other than leases or rentals controlled by subparagraphs (4), (5), or (6) below, and sales of mobile telecommunications services under §39-26-104(1)(c), C.R.S., is made within Colorado, the following rules apply:

(a) When tangible personal property or services are received by the purchaser at a business location of the seller, the sale is sourced to that business location.

(b) When tangible personal property or services are not received by the purchaser at a business location of the seller, the sale is sourced to the location where receipt by the purchaser (or the purchaser's donee, designated as such by the purchaser) occurs, including the location indicated by instructions for delivery to the purchaser (or donee), if that location is known to the seller.

(c) When subparagraphs (3)(a) and (3)(b) do not apply, the sale is sourced to the location indicated by an address for the purchaser that is available from the business records of the seller that are maintained in the ordinary course of the seller's business when use of this address does not constitute bad faith.

(d) When subparagraphs (3)(a) through (3)(c) do not apply, the sale is sourced to the location indicated by an address for the purchaser obtained during the consummation of the sale, including the address of a purchaser's payment instrument, if no other address is available, when use of this address does not constitute bad faith.

(e) When subparagraphs (3)(a) through (3)(d) do not apply, including the circumstance in which the seller is without sufficient information to apply the previous rules, then the

location will be determined by the address from which tangible personal property was shipped.

(f) For the purpose of applying subparagraphs (3)(a) through (3)(e), the terms "receive" and "receipt" mean:

(i) Taking possession of tangible personal property; or

(ii) Making first use of services; but not

(iii) Possession by a shipping company on behalf of the purchaser.

(4) The lease or rental of tangible personal property, other than property identified in subparagraphs (5) or (6) shall be sourced as follows:

(a) For a lease or rental that requires recurring periodic payments, the first periodic payment is sourced the same as a retail sale in accordance with subparagraph (3) of this rule. Periodic payments made subsequent to the first payment are sourced to the primary property location for each period covered by the payment. The primary property location shall be as indicated by an address for the property provided by the lessee that is available to the lessor from its records maintained in the ordinary course of business, when use of this address does not constitute bad faith. The property location shall not be altered by intermittent use at different locations, such as use of business property that accompanies employees on business trips and service calls.

(b) For a lease or rental that does not require periodic payments, the payment is sourced the same as a retail sale in accordance with the provisions of subparagraph (3) of this rule.

(c) This subparagraph does not affect the imposition or computation of sales or use tax on leases or rentals based on a lump sum or accelerated basis, or on the acquisition of property for lease.

(5) The lease or rental of motor vehicles, trailers, semi-trailers, or aircraft that do not qualify as transportation equipment, as defined in subparagraph (6), shall be sourced as follows:

(a) For a lease or rental that requires recurring periodic payments, each periodic payment is sourced to the primary property location. The primary property location shall be as indicated by an address for the property provided by the lessee that is available to the lessor from its records maintained in the ordinary course of business, when use of this address does not constitute bad faith. The location shall not be altered by intermittent use at different locations.

(b) For a lease or rental that does not require recurring periodic payments, the payment is sourced the same as a retail sale in accordance with the provisions of subparagraph (3).

(c) This subparagraph does not affect the imposition or computation of sales or use tax on leases or rentals based on a lump sum or accelerated bases, or on the acquisition of property for lease.

(6) The retail sale, including the lease or rental, of transportation equipment shall be sourced the same as a retail sale in accordance with the provisions of subparagraph (3), notwithstanding the exclusion of lease or rental in subparagraph (3). "Transportation equipment" means any of the following:

(a) Locomotives and railcars that are utilized for the carriage of persons or property in interstate commerce.

(b) Trucks and truck-tractors with a Gross Vehicle Weight Rating (GVWR) of 10,001 pounds or greater, trailers, semi-trailers, or passenger buses that are:

(i) Registered through the International Registration Plan; and

(ii) Operated under authority of a carrier authorized and certificated by the U.S. Department of Transportation or another federal or a foreign authority to engage in the carriage of persons or property in interstate or foreign commerce.

(c) Aircraft that are operated by air carriers authorized and certificated by the U.S. Department of Transportation or another federal or foreign authority to engage in the carriage of persons or property in interstate or foreign commerce.

(d) Containers designed for use on and component parts attached or secured on the items set forth in subparagraphs (6)(a) through (6)(c).

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Retail Sales
39-26-102(9)
1 CCR 201-4

Basis

The bases for this rule are §§ 29-2-105(1)(b), 39-21-112(1), 39-26-102(9), 39-26-102(10), 39-26-104, 39-26-107, 39-26-204(2), and 39-26-713, C.R.S.

Purpose

The purpose of this rule is to establish the location to which a retail sale is sourced within Colorado.

Notice of Proposed Rulemaking

Tracking number

2018-00529

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-4

Rule title

SALES AND USE TAX

Rulemaking Hearing

Date

10/30/2018

Time

09:00 AM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Amend the Retailer's Use Tax rule to clarify the criteria that determine a retailers obligation to collect use tax and to conform the rule to the U.S. Supreme Courts decision in South Dakota v. Wayfair, Inc., 138 S. Ct. 2080 (2018).

Statutory authority

§§ 39-21-112(1) and 39-26-204(2), C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

SALES AND USE TAX

1 CCR 201-4

~~**Retailer's Use Tax**~~

Regulation 39-26-~~-~~204.(2). Retailer's Use Tax

(1) Every retailer that has substantial nexus with Colorado and is doing business in this state, as defined in § 39-26-102(3), C.R.S., shall collect retailer's use tax, pursuant to § 39-26-204(2), C.R.S., with respect to any sale of tangible personal property for storage, use, or consumption in Colorado for which the retailer was not, under state and federal law, required to collect sales tax. Retailers are considered to have a substantial nexus with Colorado for sales tax purposes if they meet any of the following criteria:

(a) the retailer maintains a physical presence in Colorado pursuant to §§ 39-26-102(3)(a), (d), and (e), C.R.S.; or

(b) in the previous calendar year or the current calendar year:

(I) the retailer's gross revenue from the sale of tangible personal property or services delivered into Colorado exceeds one hundred thousand dollars; or

(II) the retailer sold tangible personal property or services for delivery into Colorado in two hundred or more separate transactions.

(2) Paragraph (1)(b) of this rule shall not apply in determining a retailer's obligation to collect tax under § 39-26-204(2), C.R.S. and this rule for any sale made prior to December 1, 2018.

(3) A retailer that has substantial nexus with Colorado as defined in paragraph (4)(a) of this rule is not a "remote seller" as defined in § 39-26-102(7.7), C.R.S. and sales made by any such retailers are not "remote sales" as defined in § 39-26-102(7.6), C.R.S.

~~Effective January 1, 1999, all entries on the retailer's use tax return must be rounded to the nearest dollar. Amounts less than fifty cents must be rounded down to zero cents and amounts from fifty to ninety-nine must be rounded to the nearest dollar. Rounding is required on the tax return only; books, records, invoices and other retailer's use tax documents must reflect actual tax amounts.~~

~~**Any out-of-state retailer who is engaged in selling at retail and who does not maintain a location in this state, as specified in C.R.S. 39-26-102 (3)(a), shall impose, collect, and remit to the department, a "Retailer's Use Tax" on such sales, instead of collecting the retail sales tax provided in Part 1 of the Act. Such retailer, upon application, shall be issued a "Retailer's Use Tax License" which is issued without charge.**~~

~~Every outstate retailer who is doing business in this state is required to collect retailer's use tax from the purchaser regardless of whether title to the goods passes within or without this state, if the sale of tangible personal property is subject to taxation due to the storage, use or consumption of that property within this state.~~

~~All sales subject to the retailer's use tax must be reported on the forms supplied by this department, "Retailer's Use Tax Return", subject to the provisions of Part 1 of this Act.~~

~~Any retailer collecting sales or use tax thereby becomes a trustee for any such tax collected and is responsible as an agent of the State of Colorado.~~

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Retailer's Use Tax
39-26-204.2
1 CCR 201-4

Basis

The statutory bases for this rule are §§ 39-21-112(1) and 39-26-204(2), C.R.S.

Purpose

The purpose of the amendment is to clarify the criteria that determine a retailer's obligation to collect use tax and to conform the rule to the U.S. Supreme Court's decision in *South Dakota v. Wayfair, Inc*., 138 S. Ct. 2080 (2018).

Notice of Proposed Rulemaking

Tracking number

2018-00525

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-4

Rule title

SALES AND USE TAX

Rulemaking Hearing

Date

10/30/2018

Time

09:00 AM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Amend the Direct Payment Permit rule to conform the rule to changes made to Regulation 39-26-102(9) regarding the sourcing of sales.

Statutory authority

§§ 39-21-112(1); 39-26-102(8), (9), and (10); and 39-26-103.5, C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

SALES AND USE TAX

1 CCR 201-4

Regulation 39-26-103.5. Direct Payment Permit~~DIRECT PAYMENT PERMIT.~~

(1) **General Rule.** A purchaser who holds a direct payment permit ("Qualified Purchaser") shall remit sales and use taxes directly to the Colorado Department of Revenue ("Department") and not to the retailer. Retailers who sell taxable goods or services to a Qualified Purchaser shall not collect sales tax from such purchasers.

(2) **Qualified Purchaser Qualifications.** An applicant, which can be an entity or individual, for a direct payment permit must meet the following conditions.

(a) *Dollar Threshold*. An applicant must have had a minimum of $7,000,000 in purchases on which Colorado state sales or use tax was owed during the twelve months preceding the application. The dollar threshold excludes purchases that are exempt from Colorado state sales and use tax, even if such purchases are subject to state-administered local sales or use taxes. See, §29-2-105, C.R.S. for a description of the local tax base. For example, the dollar threshold excludes exempt wholesale purchases of inventory. Additionally, commodities or tangible personal property that are to be erected upon or affixed to real property, such as building and construction materials and fixtures, are not included in the dollar threshold. See, §39-26-103.5(1)(a), C.R.S.

(b) Good Standing. If an applicant has been subject to any tax administered by the Department for at least three years prior to the date of the application, an applicant cannot have been delinquent in collecting, remitting, or reporting any sales, use, income, or other tax administered by the Department for the immediate three years prior to the date applicant submits its application. If an applicant has not been subject to any tax administered by the Department for at least three years, the applicant cannot have been delinquent in collecting, remitting, or reporting taxes for any period after the date the applicant was first obligated to collect, remit, and report such taxes. The Department can waive this requirement if an applicant demonstrates to the satisfaction of the director or their designee that the failure to comply with the collecting, remitting, and reporting requirements was due to reasonable cause. In determining whether reasonable cause exists, the Department will consider, among other relevant aggravating and mitigating factors, whether:

(i) the failure was due to willful or reckless disregard of applicant's tax obligations;

(ii) the applicant failed to comply on more than one occasion;

(iii) the magnitude of the failure was significant in terms of dollars or time; and

(iv) the applicant made subsequent efforts to avoid future failures.

(c) *Accounting Systems and Practices*. An applicant must have in place an accounting system and set of practices that are acceptable to the Department. The accounting

system and practices must fully and accurately report the amount of sales or use tax to be reported on the appropriate sales or use tax return(s), including state-administered local tax jurisdictions. The Department may revoke a direct payment permit and may make assessments of tax, penalties, or interest if such system or practices are not adequate to enable the Department to fully and accurately collect and allocate to cities, counties, and other local taxing entities all the sales and use taxes that the Department collects on behalf of such entities.

(d) A Qualified Purchaser is not required to be subject to the collection, remittance, and reporting requirements for sales taxes in order to obtain such a permit. Rather, a Qualified Purchaser can be subject to the collection, remittance, and reporting requirements for any tax administered by the Department.

(3) **Effective Date.** A direct payment permit is effective from the date of issuance until December 31 of the third year following the year in which it is issued unless sooner revoked.

(4) **Purchaser's Funds.** When a Qualified Purchaser uses a direct payment permit, the Qualified Purchaser must use its own funds when paying a retailer for a transaction to which the direct payment permit applies. Retailers cannot accept payment from persons other than the Qualified Purchaser, including payment from the personal funds of an individual if the permit is held in the name of an entity. Retailers must collect tax if a Qualified Purchaser is making a purchase with funds other than the Qualified Purchaser's funds and will be liable for unpaid taxes for transactions paid in contravention of this subsection (4).

(5) **Revocation of Permits.**

(a) The Department may revoke a direct payment permit if the Qualified Purchaser violates any statute or rule governing the administration of sales and use taxes, or if in the opinion of the Department the Qualified Purchaser becomes otherwise unable to meet any of the conditions for holding a direct payment permit. The Department shall provide written notice of the revocation by first-class mail to the last known address of the Qualified Purchaser thirty days prior to the effective date of such revocation. The notice of revocation shall set forth:

(i) the factual and legal basis for revocation,

(ii) advise the Qualified Purchaser of its right to appeal, and

(iii) the date the Department issued the notice.

The Department will issue a denial of a direct payment permit application in the same manner.

(b) An applicant who is denied a permit or a Qualified Purchaser whose permit was revoked, may appeal the decision by submitting to the Department's executive director a written request for hearing. The notice of appeal must be received by the Department within thirty days of the date of issuance of the notice of revocation or denial and contain the permit holder's name, address, permit account number (for revocations), and the legal and factual basis explaining why the permit should not be revoked or denied. Qualified Purchaser's notice of appeal shall suspend the effective date of the revocation until a final order resolving the appeal is issued by the executive director or the director's designee. The executive director or director's designee shall conduct a hearing and issue a final ruling on such appeal within a reasonable time.

(6) **Reporting Requirements.**

(a) A Qualified Purchaser holding a direct payment permit must directly remit to the Department all state and state-administered city, county and special district sales taxes that would have been collected by the retailer had the Qualified Purchaser purchased such goods or services without a direct payment permit.

(i) *Exceptions.* A Qualified Purchaser holding a direct payment permit cannot pay county lodging taxes, county short-term rental taxes, and local marketing district taxes directly to the Department because such taxes are not sales taxes. Retailer must collect such taxes from the Qualified Purchaser and remit them to the Department. See, §30-11-107.5 and §30-11-107.7, C.R.S.

(b) A Qualified Purchaser must report and remit state and state-administered local taxes on or before the 20th day of each month following the month the Qualified Purchaser purchases taxable goods or services with a direct payment permit.

(c) The vendor must retain a copy of Qualified Purchaser's direct pay permit.

~~(7) **Determining Local Sales Taxes.**~~

~~(a) *Service fees*. With regard to sales taxes only, a Qualified Purchaser may deduct from its remittance to the Department the service fee for state sales tax and any local service fee(s).~~

~~(b) A sale occurs when and where a Qualified Purchaser takes title or possession of the good(s) or where a taxable service is performed.~~

~~(c) If the Qualified Purchaser takes title or delivery of any taxable good(s) within the State of Colorado, then the Qualified Purchaser shall remit the state-administered local sales taxes for the local jurisdiction(s) in which the Qualified Purchaser took the title or delivery.~~

~~(d) If the Qualified Purchaser takes title or delivery of any taxable good(s) outside the State of Colorado, then the Qualified Purchaser shall remit use tax for the location where the Qualified Purchaser first uses, stores, or consumes the goods.~~

~~(e) Sales and use taxes of home rule cities and counties cannot be paid by direct payment permit to the Department, unless the Department has agreed to collect such taxes.~~

~~(f) *Examples*.~~

~~(i) Qualified Purchaser takes delivery of goods at seller's store which is located in the City and County of Denver, Regional Transportation District (RTD) and Scientific and Cultural Facilities District (CD). Qualified Purchaser remits state sales tax and RTD/CD sales taxes to the Department because purchaser took possession in these state-administered local tax jurisdictions. Qualified Purchaser does not remit the City and County of Denver sales taxes to the Department because Denver is a home rule city and county and the Department does not administer their local taxes.~~

~~(ii) Seller, who is located in Arapahoe County and in RTD/CD special districts, ships goods with its own vehicle, or engages a common carrier (e.g., United States Postal Service, UPS, or other common carrier), to Qualified Purchaser which is located in that portion of El Paso County that also includes the Pikes Peak Rural Transportation Authority. Qualified Purchaser does not remit Arapahoe County or RTD/CD special districts sales taxes because the sale does not occur in those local tax jurisdictions. Qualified Purchaser remits Colorado state, El Paso~~

~~County, and Pikes Peak Rural Transportation Authority sales taxes because the sale takes place in those state-administered local tax jurisdictions.~~

~~(iii) The same facts occur as in Example ii, except Qualified Purchaser engages a third-party transportation company to pick up the goods from seller's store. The Department will presume the third-party transportation company is acting as Qualified Purchaser's agent and the sale occurs in the local tax jurisdiction in which the third-party takes delivery from seller. Therefore, Qualified Purchaser remits Colorado state, Arapahoe County, RTD, and CD special district sales taxes to the Department.~~

Cross References

1. See Rule 39-26-102.9, 1 CCR 201-4 for the sourcing of sales for state and local sales tax purposes.

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Direct Payment Permit
39-26-103.5
1 CCR 201-4

Basis

The bases for this rule are §§ 39-21-112(1); 39-26-102(8), (9), and (10); and 39-26-103.5, C.R.S.

Purpose

The purpose of the amendment is to conform the rule to changes made to Regulation 39-26-102(9) regarding the sourcing of sales.

Notice of Proposed Rulemaking

Tracking number

2018-00526

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-4

Rule title

SALES AND USE TAX

Rulemaking Hearing

Date

10/30/2018

Time

09:00 AM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Amend the Exchanged Tangible Personal Property rule to conform the rule to changes made to Regulation 39-26-102(9) regarding the sourcing of sales.

Statutory authority

§§ 39-21-112(1) and 39-26-104(1)(b)(I), C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

SALES AND USE TAX

1 CCR 201-4

Regulation 39-26-104(1)(bB)(I). ExchangedXCHANGED TangibleANGIBLE PersonalERSONAL PropertyROPERTY.

(1) **General Rule.** When tangible personal property is received by a retailer as part or full payment for the sale of tangible personal property, sales tax shall be calculated upon the purchase price of the tangible personal property sold, minus the fair market value of the tangible personal property exchanged by the purchaser, provided the property taken by the retailer in the exchange is to be resold in the usual course of the retailer's trade or business. The general rule applies to exchanges that occur both inside and outside Colorado (e.g., motor vehicles exchanged in another state and one or both cars are subsequently registered in Colorado).

(2) **Exceptions**. The general rule does not apply if:

(a) The property transferred from purchaser, or by a third party on behalf of the purchaser, to seller is not tangible personal property.

(i) *Examples.*

(A) Intangible property, such as stock certificates, and real property are not subject to sales or use tax.

(B) Services (because they are not property).

(b) Retailer does not resell, in the usual course of its business, the property transferred from purchaser.

(i) *Examples.*

(A) Retailer does not resell the property in a commercially reasonable period.

(B) Retailer takes a used computer from buyer in exchange for the sale of a new computer to buyer. Retailer then donates the used computer to a school. A donation does not constitute a sale and, therefore, the initial exchange does not qualify under the general rule.

(C) Retailer is in the business of selling only construction equipment. Buyer exchanges a boat as partial payment of its purchase of a large compressor. Retailer cannot reduce the price on which sales tax is calculated for the compressor by the fair market value of the boat even if the seller resells the boat. The resale of boats is not part of the retailer's usual course of business. Retailer and buyer also do not qualify for the vehicle exchange, even though the boat qualifies as a vehicle, because both the buyer and retailer must exchange vehicles. Therefore, both the retailer, as a licensed vendor, and buyer are liable for the sales tax on

the purchase of the equipment and the retailer, as a buyer, is liable for sales tax on the fair market value of the boat (buyer would also be liable for the sales tax on the boat if buyer is a licensed retailer).

(ii) *Exception to the Resale Requirement - Vehicles.* The resale requirement does not apply if the property transferred (exchanged) by the seller to buyer is a vehicle and the property transferred (exchanged) by the buyer to the seller is a vehicle. Both vehicles must be subject to licensing, registration, or certification by the laws of Colorado. "Vehicles" include:

(A) Trailers, semi-trailers, trailer coach,

(B) Special mobile machinery (except such machinery used solely on property of the owner),

(C) Vehicles designed primarily to be operated or drawn on public highways, (§§ 42-3-103(1) and 104, C.R.S.),

(D) Watercraft (§ 33-13-103, C.R.S.),

(E) Aircraft (Colorado does not license aircraft but Colorado law requires aircraft possessed in this state be licensed by FAA) (§ 43-10-114(1), C.R.S.).

Purchaser, on whom the obligation to pay sales tax is levied, is the person who pays money or other consideration in addition to the exchanged vehicle. If the seller is a licensed retailer, then the retailer must collect sales tax from the purchaser. Persons who engage in three or more such exchanges may be required to obtain a motor vehicle dealer's license

(c) Exchanges that do not occur at the same time and place. See, § 39-26-104(1)(b).

(i) *Examples.*

(A) Motor vehicle dealer sells a motor vehicle to buyer, who pays cash. Two weeks later, buyer decides to sell another vehicle he owns to the dealer. Buyer cannot claim a refund for taxes paid for the first purchase because the second vehicle was not exchanged as part of the first sale.

(B) Retailer is in the business of leasing equipment. Customer rents a forklift for 30 days and retailer and customer agree at the time the lease is signed that customer will give retailer, as part of the payment, a used compressor that retailer intends to lease to third parties. The exchange does not qualify because the use of the forklift occurs over thirty days and does not occur at the same time and place as the exchange of the compressor. In contrast, a finance lease is treated as a credit sale and not as a true lease. An exchange involving a finance lease is treated as occurring at the same time and place as the other party's exchange of property.

Cross Reference(s):

1. For additional requirements regarding the collection of tax for motor vehicles, see § 39-26-113, C.R.S.

2. See, § 39-26-104(1)(b)(I)(B), C.R.S. and § 12-6-101, et seq., C.R.S. for laws governing motor vehicle dealer licensing.

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Exchanged Tangible Personal Property
39-26-104(1)(b)(I)
1 CCR 201-4

Basis

The bases for this rule are §§ 39-21-112(1) and 39-26-104(1)(b)(I), C.R.S.

Purpose

The purpose of the amendment is to conform the rule to changes made to Regulation 39-26-102(9) regarding the sourcing of sales.

Notice of Proposed Rulemaking

Tracking number

2018-00530

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-4

Rule title

SALES AND USE TAX

Rulemaking Hearing

Date

10/30/2018

Time

09:00 AM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Amend Regulation 39-26-704(2) to conform the rule to changes made to Regulation 39-26-102(9) regarding the sourcing of sales.

Statutory authority

§§ 39-21-112(1) and 39-26-704, C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

SALES AND USE TAX

1 CCR 201-4

Regulation 39-26-704(.2).

(1) All sales which the state of Colorado is prohibited from taxing under the constitution or laws of the United States or the state of Colorado are exempt, including sales to ambassadors, consuls, and their employees who are citizens of the nation they are representing.

(2) Sales involving interstate commerce are exempt only in cases where the tax would be unconstitutional.

~~(3) Sales of tangible personal property located within this state at the time of sale and delivered within this state are taxable, irrespective of the ultimate destination of the property sold, or where the parties to the contract of sale are located, or where the contract was made or accepted or the funds paid.~~

~~(4) Sales of tangible personal property located within this state at the time of sale and delivered to the purchaser by the vendor or by common carrier to a destination outside this state for use outside this state are not taxable. Vendor's shipping records, bills of lading, or other proof satisfactory to the executive director must be retained to substantiate any exemption allowed for such sales in interstate commerce. On single sales of tangible personal property in excess of $25,000.00, the purchaser shall execute and the vendor shall furnish the department "A Certificate of Out of State Sale" on forms furnished by the department.~~

~~(5) Sales of merchandise ordered for delivery in this state are not necessarily exempt, even though the merchandise may be shipped from outside this state directly to the purchaser or indirectly through the vendor.~~

(3~~6~~) All sales to railroads, except as provided in C.R.S. 1973, 39-26-710(1)(a) and to other common carriers doing an interstate business, to telephone and telegraph companies, and to all other agencies engaged in interstate commerce are taxable in the same manner as are sales to other persons.

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Miscellaneous Sales Tax Exemptions
39-26-704.2
1 CCR 201-4

Basis

The bases for this rule are §§ 39-21-112(1) and 39-26-704, C.R.S.

Purpose

The purpose of the amendment is to conform the rule to changes made to Regulation 39-26-102(9) regarding the sourcing of sales.

Notice of Proposed Rulemaking

Tracking number

2018-00531

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-13

Rule title

ENTERPRISE ZONE REGULATIONS

Rulemaking Hearing

Date

10/30/2018

Time

02:00 PM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Amend Credit for Enterprise Zone Contributions rule to conform the rule to statute and to clarify qualifications and limitations for the enterprise zone contribution credit. The amendment:

clarifies the criteria for determining whether a contribution is a monetary contribution or an in-kind contribution;
clarifies statutory provisions limiting (1) the total credit to $100,000 and (2) the credit for in-kind contributions to 50% of the total credit; and
clarifies that contributions made to donor advised funds, as defined under the Internal Revenue Code, do not qualify for the enterprise zone contribution credit.

Statutory authority

§§ 39-21-112(1), 39-30-103.5, and 39-30-108(1), C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

ENTERPRISE ZONE REGULATIONS

1 CCR 201-13

~~**ENTERPRISE ZONE REGULATIONS**~~

Regulation 39-30-103.5. Credit ~~allowed against income tax~~ for Enterprise Zone C~~c~~ontribution~~s to enterprise zone administrator to implement economic development plan.~~

Basis and Purpose. The statutory basis for this rule are §§ 39-21-112, 39-30-103.5, and 39-30-108, C.R.S. The purpose of the rule is to provide clarification regarding the credit for contributions to certified enterprise zone programs, projects, or organizations.

(1~~a~~) **General Rule.** ~~Credit allowed.~~ Subject to the limitations prescribed by paragraph (3) of this rule, any taxpayer who makes a qualifying contribution is allowed a~~A~~ credit ~~is allowed~~ against Colorado income tax equal to twenty-five percent of the total value of the contribution as certified by the enterprise zone administrator.

(2) **Qualifying Contributions.** A qualifying contribution is ~~for~~a monetary or in-kind contribution~~s~~ made for the purpose of implementing the economic development plan for the enterprise zone to an enterprise zone administrator or to a project, program, or organization certified by an enterprise zone administrator ~~to receive such contributions~~.

~~(b) Use of contribution. No credit will be allowed for a contribution that is used for a purpose that directly benefits the contributor. The contribution must be used for a purpose that is directly related to job creation, job preservation, or the promotion of temporary, emergency, or transitional housing programs for the homeless. Effective January 1, 2003, contributions used to promote community development projects will also qualify.~~

(a) *Monetary Contributions.* Monetary contributions are donations of cash or any payment of funds by check, electronic funds transfer (EFT), debit card, credit card, or any similar form of payment. A distribution of funds in the form of cash, check, or electronic funds transfer (EFT) from an individual retirement account, 401(k) plan account, or other similar qualified or nonqualified retirement or savings account qualifies as a monetary contribution.

(b) *In-Kind Contributions.* An in-kind contribution is any contribution other than a monetary contribution. In-kind contributions include contributions of stocks, bonds, and other similar intangible property.

(~~c~~3) **~~Computation of the c~~Credit Limitations.** The credit allowed and determined pursuant to § 39-30-103.5(1)(a), C.R.S. and paragraph (1) of this rule is reduced by:

(a) the amount by which the credit determined pursuant to § 39-30-103.5(1)(a), C.R.S. and paragraph (1) of this rule exceeds $100,000; and

(b) the amount by which the credit for in-kind contributions, calculated in accordance with § 39-30-103.5(1)(a), C.R.S. and paragraph (1) of this rule, exceeds fifty percent of the total

credit calculated pursuant to § 39-30-103.5(1)(a), C.R.S. and paragraphs (1) and (3)(a) of this rule.

(4) **Donor Advised Funds.** A donor who contributes to a donor advised fund, as defined in I.R.C. §4966(d)(2)(A) cannot claim the enterprise zone contribution credit for such contribution, even if the donor instructed the donor advised fund to contribute the funds to a Certified Program.

~~(1) The contribution credit for taxable years beginning prior to 1996 was limited to 50% of the value of the contribution. For taxable years beginning on or after January 1, 1996, the credit is limited to 25% of the value of the contribution.~~

~~(2) Credit for in-kind contributions are allowed at one-half the rate that would have been allowed for a monetary contribution of the same value. Thus where a 50% cash contribution credit would have been allowed, an in-kind contribution will create a credit of 25% of the value of the contribution; or where a 25% credit would have been allowed for a cash contribution, an in-kind credit will be 12.5% of the value of the contribution.~~

~~(3) Combined cash and in-kind contributions will generate credits at rates ranging from the cash credit to the in-kind credit rate depending on the proportions of the components. The credit will be the smaller of: (A) 100% of the cash contribution plus 12.5% of the total value of the combined contribution or $50,000; (B) 25% of the total value of the combined contribution; or (C) $100,000.~~

~~(d) Limitation on amount of credit that may be generated. Carryovers. The amount of credit that may be generated in any one tax year may not exceed $100,000. The amount of credit that may be generated in any one tax year by inkind contributions may not exceed $50,000. If the amount of credit generated in one tax year exceeds the amount of tax, the excess may be carried forward for up to five tax years.~~

~~(e) Examples:~~

~~(1) Under the 25% credit limitation rules, the contribution of inkind property with a value of $100,000 will create a credit of $12,500.~~

~~(2) If in addition to the $100,000 of in-kind property, $10,000 in cash is contributed, the credit becomes $23,750 computed as follows:~~

~~Cash~~	~~$10,000~~
~~In-Kind @ 12.5% of total contribution~~	~~$13,750~~
~~Total credit~~	~~$23,750~~

(3) However, once the credit for in-kind contributions hits the $50,000 limitation, the effect of additional cash contributions becomes limited:

	~~$400,000 In-Kind Contribution plus:~~	~~No Cash~~	~~$ 10,000 Cash~~	~~$ 100,000 Cash~~
~~1.~~	~~Cash Contribution~~	~~$ 0~~	~~$ 10,000~~	~~$ 100,000~~
~~2.~~	~~In-Kind Contribution~~	~~$ 400,000~~	~~$ 400,000~~	~~$ 400,000~~

3.	Total Contribution	$ 400,000	$ 410,000	$ 500,000
4.	Smaller of 50% or $ 100,000	$ 100,000	$ 100,000	$ 100,000
5.	Limitation on In-Kind Credit	$ 50,000	$ 50,000	$ 50,000
6.	Allowable In-Kind Credit	$ 50,000	$ 50,000	$ 50,000
7.	Limitation on Cash Credit	$ 50,000	$ 50,000	$ 50,000
8.	Allowable Cash Credit	$ 0	$ 10,000	$ 50,000
9.	Total Credit	$ 50,000	$ 60,000	$ 100,000

(f) Contributions to promote employment for the homeless.

(1) Contributions made to enterprise zone administrators or to projects, programs, or organizations certified to receive direct donations for the purpose of promoting employment for homeless persons in enterprise zones may qualify for the enterprise zone contribution tax credit.

(2) To be eligible to receive assistance from tax-credited contributions to enterprise zone administrators, an organization must meet the following criteria:

(A) Housing - An organization must offer temporary, emergency, or transitional housing for the homeless.

(B) Support services - In addition, a participating organization must have a regular on-going program offering child care, job placement, counseling, and/or other services appropriate to its clientele which support placement of the homeless in permanent employment.

(C) Referrals - The law allows an organization to meet the requirement for support services by offering referrals to such services. In this case, there should be a written agreement or letter substantiating the status of the relationship between the referring homeless provider and the referred-to support service organization. The agreement or letter should indicate that such referrals are appropriate and accepted subject to the same general conditions that would apply to other potential clientele of the referred-to organization.

(3) The statute authorizes the contributions "for the purpose of promoting employment for homeless persons in the enterprise zones." The required connection to the geography of an existing zone may be met by:

(A) The location within a zone of an organization's housing and employment support services.

(B) If the housing is not within a zone, demonstration to the enterprise zone administrator's satisfaction of a significant level of service in the zone. This may be shown by the location within the zone of an organization's facility offering employment referrals, counseling, and training; and/or clientele drawn from within the zone.

(C) In the case of an organization that provides services both within and outside of a zone, documentation to the enterprise zones administrator's satisfaction that the prorated or allocated costs providing services within the zone equal or exceed the amount of funds derived from enterprise zone contributions.

(g) Certificate of value and use. Any income tax return filed with the Department of Revenue wherein the taxpayer is claiming a credit for contribution to an enterprise zone administrator of $250 or more must contain a certificate signed by the enterprise zone administrator or an official of the project, program, or organization certified to receive direct donations showing the value of the contribution and the use to which the contribution will be put.

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Credit for Enterprise Zone Contributions
39-30-103.5
1 CCR 201-13

Basis

The bases for this rule are §§ 39-21-112(1), 39-30-103.5, and 39-30-108(1), C.R.S.

Purpose

The purpose of the amendment is to conform the rule to statute and to clarify qualifications and limitations for the enterprise zone contribution credit. The amendment:

- clarifies the criteria for determining whether a contribution is a monetary contribution or an in-kind contribution;
- clarifies statutory provisions limiting (1) the total credit to $100,000 and (2) the credit for in-kind contributions to 50% of the total credit; and
- clarifies that contributions made to donor advised funds, as defined under the Internal Revenue Code, do not qualify for the enterprise zone contribution credit.

Notice of Proposed Rulemaking

Tracking number

2018-00532

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-13

Rule title

ENTERPRISE ZONE REGULATIONS

Rulemaking Hearing

Date

10/30/2018

Time

02:00 PM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Repeal Enterprise Zone Qualified Job Training Program Investment Credit rule as it provides no additional clarification of the related statute.

Statutory authority

§§ 39-21-112(1), 39-30-104(4), and 39-30-108(1), C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

ENTERPRISE ZONE REGULATIONS

1 CCR 201-13

~~Regulation 39-30-104(4). Enterprise Zone Qualified Job Training Program Investment Credit.~~

~~(a) Credit allowed.~~

~~For income tax years beginning on or after January 1, 1997, a ten percent credit is allowed with respect to the total current year investment in a qualified job training program.~~

~~(b) Credit carryforward.~~

~~Excess credits may be carried forward for up to twelve years. The credits may not be carried back.~~

~~(c) Relocation facility.~~

~~No enterprise zone qualified jobs training program credit will be allowed for any expenditures resulting from the relocation of a facility from a location in Colorado to a location in an enterprise zone. This rule shall not apply if during the relocation, the new facility meets one of the criteria for determining an expansion facility: a $1,000,000 or 100% investment increase or a 10 employee or 10% employee increase.~~

~~(d) Definitions.~~

~~(1) "Qualified job training program" means a structured training or basic education program conducted on-site or off-site by the taxpayer or another entity to improve the job skills of employees who are employed by the taxpayer. These employees must be working predominantly within an enterprise zone. On the job training is not a qualified job training program.~~

~~(2) "Total investment" means~~

~~A) Land, building, real property improvement, leasehold improvement, or space lease costs and the cost of any capital equipment purchased or leased by the taxpayer and used entirely within an enterprise zone primarily for qualified job training program purposes or to make a training site accessible to the extent such investments or costs do not qualify for the enterprise zone investment tax credit; and~~

~~B) Expenses for a qualified job training program, whether incurred within or outside of an enterprise zone, including expensed equipment, supplies, training staff wages or fees, training contract costs, temporary space rental, travel expenses, and other expense costs of qualified job training programs for employees working predominantly within an enterprise zone. Wages of employees being trained are not includible expenses.~~

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Enterprise Zone Qualified Job Training Program Investment Credit
39-30-104(4)
1 CCR 201-13

Basis

The bases for this rule are §§ 39-21-112(1), 39-30-104(4), and 39-30-108(1), C.R.S.

Purpose

The purpose of the amendment is to repeal the rule as it provides no additional clarification of the related statute.

Notice of Proposed Rulemaking

Tracking number

2018-00533

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-13

Rule title

ENTERPRISE ZONE REGULATIONS

Rulemaking Hearing

Date

10/30/2018

Time

02:00 PM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Repeal Enterprise Zone Research and Experimental Expenditures Credit rule as it provides no additional clarification of the related statute.

Statutory authority

§§ 39-21-112(1), 39-30-105.5, and 39-30-108(1), C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

ENTERPRISE ZONE REGULATIONS

1 CCR 201-13

Regulation 39-30-105.5. Enterprise zone research and experimental expenditures credit,

(a) Credit allowed.

(1) For income tax years beginning on or after January 1, 1989, taxpayers may claim an income tax credit with respect to expenditures made for research and experimental activities conducted in a Colorado enterprise zone. The credit is three percent of the amount of such expenditures allowed to be expensed (or which could have been expensed, had the taxpayer so elected) under the provisions of section 174 of the internal revenue code for the current tax year over the average of such amounts for the two preceding tax years.

(2) Research and experimental expenditures are expenditures incurred in the taxpayer's trade or business, which represent research and development costs in the experimental or laboratory sense. The term includes generally all such costs incident to the development of an experimental or pilot model, a plant process, a product, a formula, an invention, or similar property. Qualifying expenditures include not only costs paid or incurred by the taxpayer for research or experimentation undertaken directly by him but also to expenditures paid or incurred for experimentation carried out in his behalf by another person or organization. Expenditures by the taxpayer for the acquisition or improvement of land or property that is subject to an allowance for depreciation under section 167 or depletion under section 611 of the Internal Revenue Code are not qualifying expenditures for the purposes of determining this credit. The following expenditures also do not qualify:

(i) expenditures for ordinary testing or inspection of material for quality control, management, advertising or consumer studies, efficiency surveys, or promotions;

(ii) cost of acquiring another person's patent, model, process, etc.;

(iii) costs incurred in connection with literary, historical and similar projects;

(iv) expenditures to ascertain the existence, location, extent or quality of mineral deposits, including oil and gas; and

(v) amounts paid from funds furnished by a governmental agency.

(b) Limitation on credit; carryover.

(1) The amount of enterprise zone research and experimental credit allowed with respect to expenditures made during a given year is allowed over a four year period. One-fourth of the credit is allowed for the year during which the expenditure was made and one-fourth for each of the next three years. To the extent the credit for any year exceeds the tax liability for such year after other credits have been claimed, the excess may be carried forward and claimed until it is used up.

~~(2) Example of provisions of paragraph (b).~~

~~Example: The Spacerace Corporation had qualifying enterprise zone research and experimental activities expenditures during 1989 of $618,000. The average of such expenditures for the two preceding tax years was $370,000. The allowable credit is 3% of $248,000 or $7,440. One-fourth of this amount or $1,860 may be claimed in each of the tax years, 1989, 1990, 1991 and 1992. If the 1989 tax were $1,500, the $360 excess could be carried to 1990 and added to the allowable credit for that year.~~

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Enterprise Zone Research and Experimental Expenditures Credit
39-30-105.5
1 CCR 201-13

Basis

The bases for this rule are §§ 39-21-112(1), 39-30-105.5, and 39-30-108(1), C.R.S.

Purpose

The purpose of the amendment is to repeal the rule as it provides no additional clarification of the related statute.

Notice of Proposed Rulemaking

Tracking number

2018-00534

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-13

Rule title

ENTERPRISE ZONE REGULATIONS

Rulemaking Hearing

Date

10/30/2018

Time

02:00 PM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Repeal the Credit for Rehabilitation of Vacant Enterprise Zone Buildings rule as it provides no additional clarification of the related statute.

Statutory authority

§§ 39-21-112(1), 39-30-105.6, and 39-30-108(1), C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

ENTERPRISE ZONE REGULATIONS

1 CCR 201-13

~~Regulation 39-30-105.6. Credit for rehabilitation of vacant enterprise zone buildings.~~

~~(a) Credit allowed.~~

~~(1) The building must be at least twenty years old and must have been unoccupied with no business activity for at least two years prior to the time the rehabilitation is begun.~~

~~(2) The $50,000 per building limitation applies with respect to each owner, tenant, or group of owners or tenants. Taxpayer Brown may rehabilitate a building and claim a $50,000 credit. He may later sell the building to taxpayer Green who may make additional rehabilitation and claim additional credit. In the case of an ownership or tenant group, the $50,000 limitation applies to the group, and each partner, member or shareholder thereof is limited to his proportionate share of the overall limitation.~~

~~(3) If a taxpayer elects to claim the federal section 38 rehabilitation credit, he may not claim the Colorado enterprise zone credit for rehabilitation of a vacant building with respect to the same expenditures.~~

~~(b) Credit carryover. If the credit allowed for the rehabilitation of a vacant enterprise zone building exceeds the tax liability after reduction for previous credits claimed, the excess credit may be carried forward for a period of up to five years.~~

~~(c) Building defined. For purposes of the rehabilitation credit, the term building means any structure built for permanent use, as a house, factory, etc., which is valued separately for general property tax purposes.~~

~~(d) Qualifying expenditures defined.~~

~~(1) Qualified expenditures means expenditures associated with exterior improvements, structural improvements, mechanical improvements, or electrical improvements necessary to put the building into a proper condition for the operation of a commercial enterprise. Qualified expenditures may include expenditures associated with demolition, carpentry, sheetrock, plaster, painting, ceilings, fixtures, doors, windows, sprinkler systems installed for fire protection purposes, roofing and flashing, exterior repair, cleaning, tuckpointing, and cleanup.~~

~~(3) Qualified expenditures does not include soft costs such as the cost of appraisals, architectural, engineering, and interior design fees; legal, accounting, and realtor fees; loan fees; sales and marketing; closing; building permit, use, and inspection fees; bids; insurance; project signs and phones; temporary power; bid bonds; copying; and rent loss during construction. Qualifying expenditures does not include costs associated with the acquisition; interior furnishings; new additions except as may be required to comply with building and safety codes; excavation; grading; paving; landscaping, and repairs to outbuildings.~~

~~(c) Certification of qualified nature of expenditures. Any taxpayer claiming credit for the rehabilitation of an enterprise zone building must attach to his income tax return a certification from the enterprise zone administrator attesting to the qualified nature of the expenditures. He shall submit upon request copies of receipts, bills or any other documentation he may have that will verify the amount of the qualifying expenditures.~~

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Credit for Rehabilitation of Vacant Enterprise Zone Buildings
39-30-105.6
1 CCR 201-13

Basis

The bases for this rule are §§ 39-21-112(1), 39-30-105.6, and 39-30-108(1), C.R.S.

Purpose

The purpose of the amendment is to repeal the rule as it provides no additional clarification of the related statute.

Notice of Proposed Rulemaking

Tracking number

2018-00535

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-13

Rule title

ENTERPRISE ZONE REGULATIONS

Rulemaking Hearing

Date

10/30/2018

Time

02:00 PM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Repeal Enterprise Zone Machinery and Machine Tool Sales Tax Exemption rule as it provides no additional clarification of the related statute.

Statutory authority

§§ 39-21-112(1), 39-30-106, and 39-30-108(1), C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

ENTERPRISE ZONE REGULATIONS

1 CCR 201-13

~~**Regulation 39-30-106. Enterprise zone machinery and machine tool sales tax exemption.**~~

~~(1) Exemption provided. An exemption from Colorado sales tax is provided with respect to the purchase of machinery, machine tools, or parts thereof, or material for the construction or repair of machinery or machine tools, in excess of $500 to the extent the machinery or machine tools is used exclusively in a manufacturing process carried on in a Colorado enterprise zone. This exemption applies to machinery, machine tools and parts purchased on or after January 1, 1988, and to material for the construction or repair of machinery or machine tools purchased on or after June 7, 1989. Machinery, machine tools, and parts purchased prior to June 7, 1989 did not qualify for this exemption unless it/they were capitalized on the taxpayer's books and met the definition of "qualifying property" as contained in section 48 of the internal revenue code as such section existed prior to the enactment of the "Revenue Reconciliation Act of 1990".~~

~~(2) Declaration of entitlement. Whenever a taxpayer making a purchase of machinery, machine tools, parts thereof, or material for the construction or repair of machinery or machine tools which qualifies for the exemption provided for by section 39-30-106 wishes to claim such exemption, he must complete two copies of Form 1191, "sales tax exemption on purchases of machinery and machine tools", give one copy to the vendor and send the other copy to the department of revenue within 20 days of the date of the purchase. The department of revenue will then determine whether or not the exemption claim is valid.~~

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Enterprise Zone Machinery and Machine Tool Sales Tax Exemption
39-30-106
1 CCR 201-13

Basis

The bases for this rule are §§ 39-21-112(1), 39-30-106, and 39-30-108(1), C.R.S.

Purpose

The purpose of the amendment is to repeal the rule as it provides no additional clarification of the related statute.

Notice of Proposed Rulemaking

Tracking number

2018-00536

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-13

Rule title

ENTERPRISE ZONE REGULATIONS

Rulemaking Hearing

Date

10/30/2018

Time

02:00 PM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Repeal the Certifications rule as it provides no additional clarification of the related statute.

Statutory authority

§§ 39-21-112(1) and 39-30-108, C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

ENTERPRISE ZONE REGULATIONS

1 CCR 201-13

~~**Regulation 39-30-108**~~

~~(a) The local government, with jurisdiction over the enterprise zone, shall annually certify on the form specified by the Director to the taxpayer claiming the exemption and credits under Part 1 of Article 30, Title 39, C.R.S. that the taxpayer's permanent place of business is located within the boundaries of the zone. In the case of a contribution to the zone administrator, the enterprise zone administrator, or an official of the project, program, or organization certified to receive direct donations shall certify on the form specified by the Director the value of the contribution and the use to which the contribution will be put. The taxpayer shall file a copy of this certification document with the Department of Revenue at the time of the tax return claiming the credits.~~

~~(b) The certification document is not required to claim a credit for contribution to an enterprise zone administrator of less than $250, an investment tax credit of less than $450, or a new business facility employee credit of less than $450.~~

~~(c) Any electronically filed income tax return must include requested information from the certification and the certification form must be submitted to the Department of Revenue upon request.~~

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Certifications
39-30-108
1 CCR 201-13

Basis

The bases for this rule are §§ 39-21-112(1) and 39-30-108, C.R.S.

Purpose

The purpose of the amendment is to repeal the rule as it provides no additional clarification of the related statute.

Notice of Proposed Rulemaking

Tracking number

2018-00537

Department

200 - Department of Revenue

Agency

201 - Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-14

Rule title

RURAL TECHNOLOGY ENTERPRISE ZONES

Rulemaking Hearing

Date

10/30/2018

Time

02:00 PM

Location

1313 Sherman Street, Room 220, Denver, CO 80203

Subjects and issues involved

Repeal the Rural Technology Enterprise Zone Income Tax Credit rule because the credit was last allowed in 2004 and could be carried forward for no more than 10 years.

Statutory authority

§§ 39-21-112(1) and 39-32-105, C.R.S.

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DEPARTMENT OF REVENUE

Taxpayer Service Division - Tax Group

RURAL TECHNOLOGY ENTERPRISE ZONES

1 CCR 201-14

~~Regulation 39-32-105(1) - Rural Technology Enterprise Zone Income Tax Credit.~~

~~1) The credit for approved investments in a rural technology enterprise zone is available in years ending on or after March 30, 2001 and beginning prior to January 1, 2005. March 30, 2001 is the date the Public Utilities Commission's rules became effective specifying what investments would qualify for the credit. See, 4 CCR 723-53 (pages 1 to 7).~~

~~2) The credit is limited as follows:~~

~~a) The credit claimed shall not exceed $100,000 per year. Qualified investments in excess of $1 million in any tax year cannot earn a credit and cannot be carried forward.~~

~~b) A partnership, S corporation, or other similar pass-through entity or a disregarded entity may pass through up to $100,000 in total credit to its partners/shareholders/members. Each partner/shareholder/member's portion of the credit is determined according to the ratio in which profits/losses of the entity are allocated.~~

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Rural Technology Enterprise Zone Income Tax Credit
39-32-105(1)
1 CCR 201-14

Basis

The bases for this rule are §§ 39-21-112(1) and 39-32-105, C.R.S.

Purpose

The purpose of the amendment is to repeal the rule because the credit was last allowed in 2004 and could be carried forward for no more than 10 years.

Notice of Proposed Rulemaking

Tracking number

2018-00498

Department

200 - Department of Revenue

Agency

203 - Division of Liquor Enforcement

CCR number

1 CCR 203-2

Rule title

LIQUOR CODE

Rulemaking Hearing

Date

11/01/2018

Time

09:00 AM

Location

1707 Cole Blvd., Golden, CO 80401, Suite 300, Marijuana Enforcement Division "Red Rocks" Conference Room.

Subjects and issues involved

Rules pursuant to annual rule review as listed in the regulatory agenda. General rules review and clarity revisions along with compliance for legislative bills.

Statutory authority

Pursuant to authority granted in section 44-3-202 C.R.S. of the Colorado Liquor Code and section 24-3-103 C.R.S. of the Administrative Procedure Act.

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DEPARTMENT OF REVENUE

~~Division of~~ Liquor Enforcement DIVISION

1 CCR 203-2

Liquor ~~Code~~ RULES

EFFECTIVE JANUARY 1, 2019

Regulation 47-002. ~~Fermented Malt Beverages - Advertising Practices~~ REPEALED.

~~Basis and Purpose. The statutory authority for this regulation is located at subsections 44-3-202(1)(b), 44-3-202(2)(a)(I)(G), and 44-3-202(2)(a)(I)(H), C.R.S. The purpose of this regulation is to establish certain prohibited advertising practices of fermented malt beverage licensees pertaining to the alcohol content of beverages sold on the licensed premises.~~

~~No licensee for the retail sale or distribution of fermented malt beverages shall, upon or in proximity to, or referring to the licensed premises, use, publish or exhibit, or permit to be used, published or exhibited, any sign, advertisement, display, notice, symbol or other device which advertises, indicates, implies or infers that beverages containing more than 3.2% alcohol by weight (wt) or four percent by volume (vl), are sold, distributed or dispensed upon or from said premises.~~

Regulation 47-004. Fermented Malt Beverages - Possession of Alcohol Liquors.

Basis and Purpose. The statutory authority for this regulation is located at subsections 44-3-202(1)(b) and 44-3-202(2)(a)(I)(A), C.R.S. The purpose of this regulation is to prohibit possession and consumption of ~~alcohol beverages containing alcohol in excess of fermented malt beverage standards~~ MALT, VINOUS, OR SPIRITUOUS LIQUORS on a fermented malt beverage licensee's licensed premises.

~~No person shall possess or consume on the licensed premises of a fermented malt beverage licensee, any beverages containing alcohol in excess of three and two-tenths percent by weight or four-percent alcohol by volume.~~

A. EXCEPT AS PROVIDED BY SUBSECTION 44-3-107(2), C.R.S., NO SUPPLIER, WHOLESALER, OR RETAILER LICENSED PURSUANT TO ARTICLE 4 OF TITLE 44, C.R.S., SHALL ALLOW THE SALE, POSSESSION, OR CONSUMPTION OF MALT, VINOUS, OR SPIRITUOUS LIQUOR ON ITS LICENSED PREMISES.

B. EXCEPT AS PROVIDED IN SUBSECTION 44-3-107(2), C.R.S., NO PERSON SHALL POSSESS OR CONSUME MALT, VINOUS, OR SPIRITUOUS LIQUOR ON THE LICENSED PREMISES OF A SUPPLIER, WHOLESALER, OR RETAILER LICENSED PURSUANT TO ARTICLE 4 OF TITLE 44, C.R.S.

Regulation 47-006. ~~Fermented Malt Beverages - Identification and Labeling~~ REPEALED.

~~Basis and Purpose. The statutory authority for this regulation is located at subsections 44-3-202(1)(b) and 44-3-202(2)(a)(I)(N), C.R.S. The purpose of this regulation is to establish labeling standards required for the sale, offering, exposure for sale, or distribution of fermented malt beverages.~~

~~A. No licensee for the sale of fermented malt beverages shall sell, offer, expose for sale, or distribute within this state any canned or bottled fermented malt beverages in case or carton lots unless such beverages be contained in a case or carton bearing the phrase "3.2%" or "4.0%~~

~~ABV" followed by a word indicating the type of beverage, such as beer or ale. The designation "3.2% BEER," "3.2% ALE," or "4.0% ABV Beer," "4.0% ABV Ale," etc., as the case may be, shall be composed of legible symbols of not less than ¼ of one inch in height, and shall be indelibly stamped or imprinted on top of the case or carton or upon the sealing strip thereof. Notwithstanding the above, cartons or unsealed returnable cases need no external markings if such container allows direct view of the individual cans or bottles which indicates the percent and type of beverage therein.~~

~~B. No licensee shall sell, offer or expose for sale or distribute within this state any fermented malt beverages in kegs, casks or other containers except bottles and cans of less than 33 ounces capacity unless such containers bear thereon the phrase "3.2%" followed by a word indicating the type of beverage, such as beer or ale. The designation "3.2% BEER", "3.2% ALE," etc., as the case may be, shall be composed of legible symbols of not less than one inch in height, shall clearly and visibly appear on the container which is intended to be opened and shall be indelibly stamped or imprinted either upon the container itself or upon a label affixed thereto and sealed with a transparent water repellent material. Nothing shall prohibit the division from approving materials other than water repellent material used for labeling if the division finds the material is suitable for maintaining the required information on the container.~~

~~C. No such licensee shall sell, offer or expose for sale or distribute within the state any fermented malt beverages in bottles or cans of less than thirty-three (33) ounces capacity unless said containers, or a label attached thereto, shall carry thereon, in clear legible and indelible print a statement which clearly indicates that the beverage therein contains not more than 3.2% alcohol by weight or 4% alcohol by volume.~~

Regulation 47-008. Fermented Malt Beverages - Limitations of License.

A. EXCEPT AS PROVIDED BY SUBSECTION 44-3-107(2), C.R.S., ~~No~~ NO person licensed for on-premises consumption ~~only,~~ pursuant to section 44-4-107(1)(b), C.R.S., shall sell fermented malt beverages in sealed containers, or permit the removal from the licensed premises of any fermented malt beverages in either sealed or unsealed containers.

B. EXCEPT AS PROVIDED BY SUBSECTION 44-3-901(6)(K)(II)(B), C.R.S., ~~No~~ NO person licensed for off-premises consumption ~~only,~~ pursuant to section 44-4-107(1)(a), C.R.S., shall sell~~, by the drink,~~ any open container of fermented malt beverage, or permit the consumption of any fermented malt beverages within the licensed premises.

Regulation 47-010. Items Approved for Sale in Fermented Malt Beverage Off-Premises Licenses.

BASIS AND PURPOSE. THE STATUTORY AUTHORITY FOR THIS REGULATION IS FOUND AT SUBSECTIONS 44-3-202(1)(B), 44-3-202(2)(A)(I)(A), 44-3-202(2)(A)(I)(D), AND 44-3-202(2)(A)(I)(O), C.R.S. THE PURPOSE OF THIS REGULATION IS TO DEFINE HOW APPLICABLE LICENSEES MUST REPORT AND DEMONSTRATE COMPLIANCE CONCERNING THIS SPECIFIC STATUTORY REQUIREMENT.

A. TO DEMONSTRATE COMPLIANCE WITH SUBSECTION 44-4-107(3), C.R.S., IF APPLICABLE, THE APPLICANT OR LICENSEE MUST AFFIRM ON ITS NEW AND ANNUAL RENEWAL APPLICATION THAT THE LICENSE DERIVES OR WILL DERIVE AT LEAST TWENTY (20) PERCENT OF ITS GROSS ANNUAL REVENUES FROM TOTAL SALES FROM THE SALE OF FOOD ITEMS FOR CONSUMPTION OFF THE PREMISES.

B. NOTHING WITHIN THIS REGULATION SHALL LIMIT THE AUTHORITY OF THE STATE LICENSING AUTHORITY TO INSPECT BOOKS AND RECORDS PURSUANT TO REGULATION 47-700, 1 C.C.R. 203-2, TO VERIFY THIS AFFIRMATION OR COMPLIANCE WITH THIS STATUTORY REQUIREMENT.

Regulation 47-100. Definitions.

A. "Licensed, ~~Licensee~~ LICENSEE, and ~~Licensed Premises~~ LICENSED PREMISES" mean persons or premises issued a license or permit under Articles 3, Articles 4 and Article 5 of Title 44.

B. "Manufacturer" means a Colorado licensed brewery, winery, limited winery, distillery, vintner's restaurant, distillery pub or ~~brewpub~~ BREW PUB as defined by C.R.S. 44-4-104 and 44-3-103.

C. "Nonresident ~~Manufacturer~~ MANUFACTURER" means a ~~manufacturer of~~ COLORADO LICENSEE THAT MANUFACTURES malt liquor or fermented malt beverages ~~that is located~~ outside the state of Colorado and has been issued a Brewer's Notice by the ~~Bureau of Alcohol, Tobacco and Firearms~~ ALCOHOL AND TOBACCO TAX AND TRADE BUREAU.

D. "~~Product Sales Promotion~~ ON-SITE PRODUCT SALES PROMOTION" means a sales promotion, featuring a particular brand of alcohol beverage, that is conducted on a retailer's licensed premises by an alcohol beverage supplier. ~~Product sales promotions~~ ON-SITE PRODUCT SALES PROMOTION may include drink specials, product sampling and the giveaway of consumer goods.

E. "Sponsored ~~Event~~ EVENT" means an event supported in whole or in part by a licensed supplier that is conducted at a retail licensed establishment.

F. "Supplier" means a Colorado licensed ~~manufacturer,~~ BREWERY, WINERY, DISTILLERY, ~~brewpub~~ BREW PUB, distillery pub, ~~vintners~~ VINTNER'S restaurant, limited winery, ~~non-resident~~ NONRESIDENT manufacturer, wholesaler or importer of alcohol beverages.

H. "Unreasonable ~~or Undue Noise~~ NOISE" means a level of noise that violates local noise ordinance standards, or where no local noise ordinance standard exists, a level of noise that would violate ~~the provisions of~~ SECTION 25-12-103, C.R.S.

I. "Wholesaler" means those entities authorized to sell alcohol beverages at wholesale to licensed retailers, including wholesalers of ~~malt liquors and fermented malt beverages, wholesalers of~~ FERMENTED MALT BEVERAGES, MALT LIQUORS, vinous and spirituous liquors, limited wineries, ~~brewpubs~~ BREW PUBS, distillery pubs, and vintner's restaurants.

K. "COLORADO LIQUOR CODE" OR "LIQUOR CODE" MEANS ARTICLE 3 OF TITLE 44, C.R.S.

L. "COLORADO BEER CODE" OR "BEER CODE" MEANS ARTICLE 4 OF TITLE 44, C.R.S.

M. "SPECIAL EVENT CODE" MEANS ARTICLE 5 OF TITLE 44, C.R.S.

N. "COLORADO LIQUOR RULES" MEANS THIS REGULATORY ARTICLE, 1 C.C.R. 203-2.

O. "DIVISION" MEANS THE STATE OF COLORADO DEPARTMENT OF REVENUE'S LIQUOR ENFORCEMENT DIVISION, EXCEPT AS PROVIDED OTHERWISE.

REGULATION 47-104. WINERY DIRECT SHIPPER'S PERMITS.

BASIS AND PURPOSE. THE STATUTORY AUTHORITY FOR THIS REGULATION IS LOCATED AT SUBSECTIONS 44-3-202(1)(B), 44-3-202(2)(A)(I)(A), AND 44-3-104(6), C.R.S. THE PURPOSE OF THIS REGULATION IS TO CLARIFY THE SCOPE OF A WINERY DIRECT SHIPPER'S PERMITTEE'S PRIVILEGES.

A. FOR PURPOSES OF THIS REGULATION, THE TERM "PERMIT" OR "PERMITTEE" MEANS THE NATURAL PERSON OR ENTITY HOLDING A WINERY DIRECT SHIPPER'S PERMIT AND ANY MANAGER, AGENT, SERVANT, OFFICER, OR EMPLOYEE THEREOF.

B. FOR PURPOSES OF THIS REGULATION, THE TERM "PERSONAL CONSUMER" HAS THE MEANING SET FORTH IN SECTION 44-3-103(36).

C. SUBJECT TO THE REQUIREMENTS AND LIMITATIONS IN SECTION 44-3-104, C.R.S., A PERMITTEE MAY SHIP OR DELIVER ONLY WINE THAT IT PRODUCED OR BOTTLED TO A PERSONAL CONSUMER LOCATED IN COLORADO.

D. A WINERY DIRECT SHIPPER'S PERMITTEE SHALL NOT ENGAGE IN ANY IN-PERSON SALE (AS DEFINED IN SECTION 44-3-103(52), C.R.S.) OF WINE TO BE SHIPPED OR DELIVERED TO A CONSUMER IN THE STATE OF COLORADO, EXCEPT AT THE LICENSED PREMISES OF A PERMITTEE'S LICENSED WINERY OR LIMITED WINERY, OR AT AN APPROVED SALES ROOM OF A LICENSED WINERY OR LIMITED WINERY THAT ALSO HAS RECEIVED A WINERY DIRECT SHIPPER'S PERMIT.

Regulation 47-200. Petitions for Statements of Position and Declaratory Orders Concerning the Colorado Liquor CODE, COLORADO Beer CODE, ~~or~~ Special Event ~~Codes~~ CODE, OR COLORADO LIQUOR RULES.

A. Statements of Position. Any person may petition the ~~Liquor Enforcement~~ Division of the Colorado Department of Revenue for a statement of position concerning the applicability to the petitioner of any provision of the ~~Colorado Liquor, Beer, or Special Events Codes or any regulation of the state licensing authority~~ COLORADO LIQUOR CODE, COLORADO BEER CODE, SPECIAL EVENT CODE, OR COLORADO LIQUOR RULES.

B. Service of Petition for Statement of Position. A letter for petition for a statement of position shall be served on the ~~Liquor Enforcement~~ Division by mailing or emailing such petition to the Division with a copy sent on the same date to the local licensing authority in the county or municipality where the petitioner's licensed premises or proposed licensed premises are located, ~~(~~if applicable~~)~~. Each petition for a statement of position shall contain a certification that the service requirements of this paragraph have been met.

D. Declaratory Orders. Any person who has petitioned the Division for a statement of position and who is dissatisfied with the statement of position MAY PETITION THE STATE LICENSING AUTHORITY WITHIN FORTY-FIVE (45) DAYS OF THE ISSUANCE OF THE STATEMENT OF POSITION FOR A DECLARATORY ORDER PURSUANT TO SECTION 24-4-105(11), C.R.S. ~~or~~ FURTHERMORE, ANY PERSON who has not received a response within forty-five (45) days, may petition the state licensing authority for a declaratory order pursuant to section 24-4-105(11), C.R.S. The parties to any petition for a declaratory order pursuant to this regulation shall be the petitioner and the ~~Liquor Enforcement~~ Division.

~~E. Time to Petition for a Declaratory Order. If a petitioner is dissatisfied with a statement of position, a petition for declaratory order must be filed within forty-five (45) days after issuance of the statement of position. Any petitioner who has not received a statement of position within forty-five (45) days may petition the state licensing authority at any time thereafter.~~

~~F~~E. Requirements of Petition for Declaratory Order. Each petition for a declaratory order shall set forth the following:

1. The name and address of the petitioner; whether the petitioner is licensed pursuant to the Colorado Liquor CODE, Beer CODE, or Special Events ~~Codes~~ CODE and if so, the type of ~~license/permit~~ LICENSE OR PERMIT and address of the licensed premises.

~~G~~F. Service~~:~~. A petition for a declaratory order shall be served on the ~~State Licensing Authority~~ STATE LICENSING AUTHORITY by mailing such petition to the ~~State Licensing Authority~~ STATE LICENSING AUTHORITY with a copy of the petition sent on the same date to the ~~Liquor Enforcement~~ Division,

the local licensing authority in the county or municipality where the petitioner's licensed premises or proposed licensed premises are located, and to the Revenue & Utilities Section of the Colorado Department of Law. Each petition for a declaratory order shall contain a certification that the service requirements of this paragraph have been met.

~~H~~G. Acceptance~~:~~. The state licensing authority will determine~~, in its discretion without prior notice to the petitioner,~~ whether to entertain any petition FOR DECLARATORY ORDER. If the state licensing authority decides it will not entertain a petition FOR DECLARATORY ORDER, it shall promptly notify the petitioner in writing of its decision and the reasons for that decision. Any of the following grounds may be sufficient reason to refuse to entertain a petition:

3. The petition involves a subject, question or issue which is currently involved in a ~~pending hearing~~ COURT ACTION, AN ADMINISTRATIVE ACTION before the state or any local licensing authority, ~~or which is involved in~~ an ~~on – going~~ ONGOING investigation conducted by the Division or ~~which is involved in~~ a written complaint ~~previously~~ filed with the state ~~liquor~~ licensing authority OR DIVISION.

~~I~~H. Determination~~:~~. If the state licensing authority determines that it will entertain the petition for declaratory order, it shall promptly so notify all parties involved, and the following procedures shall apply:

1. The state licensing authority may expedite the hearing, where the interests of the petitioner will not be substantially prejudiced thereby, by ruling on the basis of the facts and legal authority presented in the petition, or by requesting the petitioner or the ~~Liquor Enforcement~~ Division to submit additional evidence and legal argument in writing. Any such request for additional information shall be ~~copied~~ SERVED on all parties.

~~J~~I. Record Retention and Reliability~~:~~. Files of all requests, statements of position, and declaratory orders will be maintained and relied upon by the ~~Liquor Enforcement~~ Division for a period of five (5) years, unless the statement of position or declaratory order is superseded by a statutory or regulatory change, or amended or reversed by the ~~State Licensing Authority~~ STATE LICENSING AUTHORITY. Except with respect to any material required by law to be kept confidential, such files shall be available for public inspection.

Regulation 47-301. Undue Concentration of Licenses.

A. For purposes of determining if the issuance of a new tavern or retail liquor store license would result in or add to an undue concentration of the same class of license and, as a result, require the use of additional law enforcement resources, the state or local licensing authority may consider factors, including, but not limited to:

1. Whether the ratio of the number of tavern or retail liquor store licenses within the ~~county/s~~ COUNTY OR COUNTIES of the neighborhood to be served where application has been made to the ~~county/s~~ COUNTY OR COUNTIES population exceeds the ratio of the statewide number of licenses of the same class to the state population;

B. For purposes of this regulation:

2. The population shall be the estimate published by the most recent United ~~states~~ STATES decennial or special census (for state, census tract, and census division data) or the most recent estimates published by the Department of Local Affairs (for county and municipal data).

Regulation 47-302 Changing, Altering, or Modifying Licensed Premises.

Basis and Purpose. The statutory authority for this regulation is located at subsections 44-3-202(1)(b), ~~and~~ 44-3-202(2)(a)(I)(A), AND 44-3-202(2)(A)(I)(D), C.R.S. The purpose of this regulation is to establish procedures for a licensee seeking to make material or substantial alterations to the licensed premises, and provide factors the licensing authority must consider when evaluating such alterations for approval or rejection.

A. After issuance of a license, the licensee shall make no physical change, alteration or modification of the licensed premises that materially or substantially alters the licensed premises or the usage of the licensed premises from the LATEST APPROVED plans and specifications ~~submitted at the time of obtaining the original license~~ ON FILE WITH THE STATE AND LOCAL LICENSING AUTHORITIES without application to, and the approval of, the ~~local and state~~ RESPECTIVE licensing authorities.

For purposes of this regulation, physical changes, alterations or modifications of the licensed premises, or in the usage of the premises requiring prior approval, shall include, but not be limited to, the following:

3. Any substantial or material enlargement of a bar, ~~or~~ relocation of a bar, or addition of a separate bar. However, the temporary addition of bars or service areas to accommodate seasonal operations shall not require prior approval unless the additional service areas are accompanied by an enlargement of the licensed premises.

4. A TEMPORARY OUTSIDE SERVICE AREA LOCATED ON A SIDEWALK OWNED BY A MUNICIPALITY, AND THAT THE LICENSEE POSSESSES IN ACCORDANCE WITH SUBSECTION (B)(2) OF THIS REGULATION, MAY BE APPROVED BY THE STATE AND LOCAL LICENSING AUTHORITIES UPON THE ANNUAL FILING OF A TEMPORARY MODIFICATION OF PREMISES APPLICATION, DUE AT THE TIME OF INITIAL APPLICATION OR AT THE TIME OF RENEWAL, ON A FORM APPROVED BY THE STATE LICENSING AUTHORITY, AND PAYMENT OF THE ASSOCIATED FEE AS SET FORTH IN REGULATION 47-506, PROVIDED THAT:

   A. THE PROPOSED TEMPORARY OUTSIDE SERVICE AREA LOCATED ON A SIDEWALK IS IMMEDIATELY ADJACENT TO THE LICENSED PREMISES;

   B. THE LICENSED PREMISES, AS TEMPORARILY MODIFIED, WILL COMPRISE A DEFINITE CONTIGUOUS AREA; AND

   C. PLANS AND SPECIFICATIONS IDENTIFYING THE TEMPORARY OUTSIDE SERVICE AREA LOCATED ON A SIDEWALK ACCOMPANY THE FORM AND FEE.

~~4~~5. Any material change in the interior of the premises that would affect the basic character of the premises or the physical structure ~~that existed in the plan on file with the latest application~~ DETAILED IN THE LATEST APPROVED PLANS AND SPECIFICATIONS ON FILE WITH THE STATE AND LOCAL LICENSING AUTHORITIES. However, the following types of modifications will not require prior approval, even if a local building permit is required: painting and redecorating of premises; the installation or replacement of electric fixtures or equipment, plumbing, refrigeration, air conditioning or heating fixtures and equipment; the lowering of ceilings; the installation and replacement of floor coverings; the replacement of furniture and equipment; and any non structural remodeling where the remodel does not expand or reduce the existing area designed for the display or sale of alcohol beverage products.

~~5~~6. The destruction or demolition, and subsequent reconstruction, of a building that contained the retailer's licensed premises shall require the filing of new building plans with the local licensing authority, or in the case of manufacturers and wholesalers, with the state licensing authority. However, reconstruction shall not require an application to modify the premises unless the proposed plan for the newly-constructed premises materially or substantially alters the licensed premises or the usage of the licensed premises from the plans and specifications ~~submitted at the time of obtaining the original~~

~~license~~ DETAILED IN THE LATEST APPROVED PLANS AND SPECIFICATIONS ON FILE WITH THE STATE AND LOCAL LICENSING AUTHORITIES.

~~6~~7. Nothing herein shall prohibit a licensee, who is otherwise not eligible for an optional premises permit or optional premises license, from modifying its licensed premises to include in the licensed premises a public thoroughfare, if the following conditions are met:

C. If permission to change, alter or modify the licensed premises is denied, the licensing authority shall give notice in writing and shall state grounds upon which the application was denied. The licensee shall be entitled to a hearing on the denial if a request in writing is made to the licensing authority within fifteen (15) days after the date of notice.

D. This regulation shall be applicable to the holder of a manufacturer's license as specifically defined in Section 44-3-402, C.R.S., or a limited winery defined in section 44-3-403, C.R.S, only if the physical change, alteration, or modification involves any increase or decrease in the total size of the licensed premises~~ or sales room locations~~. EXCEPT, ANY CHANGE, ALTERATION, OR MODIFICATION OF A SALES ROOM, SHALL BE REPORTED IN ACCORDANCE WITH SUBSECTION (A).

E. Neither the state or local licensing authority shall impose any additional fees for the processing or review of an application for a modification of premises for the holder of a manufacturer's license.

REGULATION 47-302(A)(4) IS EFFECTIVE APRIL 1, 2019.

Regulation 47-303. License Renewal.

A. ~~Only the license holder may exercise the privilege of license renewal.~~ No one other than the license holder, or their duly-authorized representative, may file an application to renew the license with local and state licensing authorities.

B. A complete renewal application shall include evidence that the licensee remains in possession of the licensed premises, by ownership, lease, rental, or other arrangement at the time of application. ~~Lease agreements~~ AN AGREEMENT that ~~include a provision that a lease period~~ may lapse within the new license year ~~do not automatically disqualify~~ NEITHER AUTOMATICALLY DISQUALIFIES the licensee from renewing, nor automatically ~~invalidate~~ INVALIDATES the license. However, this provision does not preclude ~~a~~ THE STATE OR LOCAL licensing authority from initiating any action as provided by law to suspend or revoke a license for loss of possession of the licensed premises.

C. NOTHING HEREIN AUTHORIZES A LICENSEE TO PURCHASE, SELL, OR SERVE ALCOHOL BEVERAGES WITH AN EXPIRED LICENSE, EXCEPT AS AUTHORIZED IN SUBSECTIONS D, E(2), AND F(3) OF THIS REGULATION. LICENSED PRIVILEGES ARE NOT RESTORED UNTIL AND UNLESS THE APPLICABLE REQUIREMENTS OF SECTION E(2) AND/OR F(3) OF THIS REGULATION ARE MET.

~~C~~D. Application for the renewal of an existing license shall be made to the local licensing authority not less than forty-five (45) days prior to the date of expiration and to the state licensing authority not less than thirty (30) days prior to the date of expiration. The state or local licensing authority may waive these requirements for good cause. Once an application for renewal has been filed with the local licensing authority, OR THE STATE LICENSING AUTHORITY FOR STATE ONLY LICENSES, the licensee may continue to operate~~ up and~~ until final agency action~~, if final action by both authorities has not been completed before the date of license expiration.~~

~~D~~E. LICENSE EXPIRED FOR NOT MORE THAN NINETY (90) DAYS.

1. ~~No application for renewal of a license shall be accepted by the local licensing authority after the date of expiration; except that, a~~ A licensee whose license has not been expired for more than ninety (90) days may file a late renewal application upon the payment of a non-refundable late application fee to the local licensing authority, AND/OR THE STATE LICENSING AUTHORITY.

2. A licensee who files a late renewal application and pays the requisite fees may resume operation until ~~both~~ THE state and/OR local licensing authorities have taken final AGENCY action to approve or deny such licensee's late renewal application.

~~E. Nothing herein authorizes a licensee to purchase, sell, or serve alcohol beverages with an expired license after expiration, except as otherwise authorized in this regulation. Licensed privileges are not restored until the renewal application and requisite fees have been duly filed with the local licensing authority, in the case of a retail license, and with the state licensing authority for all others.~~

~~F~~F. LICENSE EXPIRED FOR MORE THAN NINETY (90) DAYS, BUT LESS THAN ONE HUNDRED EIGHTY (180) DAYS.

1. ~~Pursuant to section 44-3-302(2), C.R.S, any~~ ANY licensee whose license has been expired more than ninety (90) but less than one hundred eighty (180) days, may submit to the local licensing authority, or state licensing authority ~~(~~for ~~state-only issued~~ STATE ONLY licenses~~)~~, an application:

   A. FOR A NEW LICENSE, SUBJECT TO SECTION ~~44-3-311~~ 44-3-301, C.R.S., OR

   B. ~~for~~ FOR a reissued license, subject to ~~44-3-302, C.R.S.~~ SUBSECTION 44-3-302(2)(D), C.R.S.

2. THE LOCAL LICENSING AUTHORITY, OR STATE LICENSING AUTHORITY FOR STATE-ONLY LICENSES, SHALL HAVE SOLE DISCRETION TO DETERMINE WHETHER TO ALLOW A LICENSEE TO APPLY FOR A REISSUED LICENSE. IF THE LOCAL LICENSING AUTHORITY, OR STATE LICENSING AUTHORITY FOR STATE-ONLY LICENSES, DOES NOT ALLOW THE LICENSEE TO APPLY FOR A REISSUED LICENSE, THEN THE LICENSEE MUST APPLY FOR A NEW LICENSE.

3. A LICENSEE MAY RESUME OPERATION UNTIL BOTH THE STATE AND LOCAL LICENSING AUTHORITIES HAVE TAKEN FINAL AGENCY ACTION TO APPROVE OR DENY THE LICENSEE'S APPLICATION ONLY IF THE LOCAL LICENSING AUTHORITY, OR STATE LICENSING AUTHORITY FOR STATE-ONLY LICENSES:

   A. ALLOWS A LICENSEE TO APPLY FOR A REISSUED LICENSE~~,~~; AND

   B. ACCEPTS THE REISSUED LICENSE APPLICATION AND REQUIRED FEES AND FINES.

~~G~~G. Any licensee whose license has been expired for ~~more than~~ one hundred eighty (180) days OR MORE must apply for a new license pursuant to section 44-3-311, C.R.S., and shall not purchase or sell any alcohol beverage until all required licenses have been obtained, unless otherwise authorized under these regulations.

Regulation 47-304. Transfer of Ownership and Changes in Licensed Entities.

Basis and Purpose. The statutory authority for this regulation is located at subsections 44-3-202(1)(b), 44-3-202(2)(a)(I)(J), 44-3-301(7), ~~44-3-301(9),~~ and section 44-3-308, C.R.S. The purpose of this regulation is to establish reporting and disclosure requirements for the identification of applicants, licensees, and their relevant financial interests to promote transparency and prevent the occurrence of statutorily prohibited financial interests between the manufacturing, wholesale, and retail tiers.

D. All reports required by this regulation shall be made on forms supplied by the ~~Department of Revenue, Liquor Enforcement~~ Division.

Regulation 47-305. Transfers – Wholesaler Confirmation.

A. In accordance with section 44-3-303(1)(d), C.R.S., the ~~Applicant~~ APPLICANT shall deliver a confirmation to each wholesaler licensed under this article, ~~(to include brewpubs~~ INCLUDING BREW PUBS, distillery pubs, vintner's restaurants and limited wineries~~)~~, who has sold alcohol beverages to the transferor-licensee within the preceding one hundred eighty (180) calendar days, in the form and substance approved by the ~~Liquor Enforcement~~ Division.

C. Upon delivery of a confirmation to a wholesaler, the transferor-licensee shall not purchase alcohol beverage on credit or accept an offer or extension of credit from the wholesaler and shall effect payment upon delivery of the alcohol beverage from the wholesaler. Allowed payments include cash, ~~credit/debit~~ CREDIT OR DEBIT cards, check, money orders, certified check, EFT transfer and any other method OF payment approved by the ~~Liquor Enforcement~~ Division.

D. A wholesaler shall have fifteen (15) business days upon receipt of a confirmation to complete and return the confirmation to the ~~Applicant~~ APPLICANT, in the same manner and extent as ~~allowed~~ SPECIFIED in ~~Section~~ SECTION B ~~above~~ OF THIS REGULATION. If a wholesaler does not complete and return the confirmation within the ~~15-day~~ FIFTEEN (15) BUSINESS DAY period of time, the wholesaler shall be deemed paid in full solely for purposes of transferring the license.

E. Nothing within this ~~Regulation~~ REGULATION shall prohibit or restrict a local licensing authority from issuing a temporary permit or from processing the transfer application. However, a transfer shall not be approved unless the transferor-licensee is in compliance with this regulation.

F. The ~~Applicant~~ APPLICANT, transferor-licensee and/or its agent and assign, and each wholesaler shall act in good faith and fair dealing with each other.

Regulation 47-306. Change of Trade Name.

A. No licensee shall ~~change~~ USE A NEW ~~the~~ BUSINESS name or trade name ~~of the licensed premises~~ without submitting written notice to the local and state licensing authorities, not less than ten (10) days prior to the ~~change~~ USE of A NEW BUSINESS NAME OR TRADE name.

B. Exterior signage or advertising OF the business NAME OR ~~(~~trade~~)~~ name is not required, but if used, must accurately reflect the current BUSINESS NAME OR trade name on file with the ~~Liquor Enforcement~~ Division.

Regulation 47-307. Master Files.

B. An applicant for master file can meet the minimum requirements of this regulation by having an interest in separate licensed ~~entities~~ LOCATIONS, as long as there are a minimum of five (5) total licenses issued and/or applications pending.

Regulation 47-310. Application - General Provisions.

A. All applications for state licenses for the manufacture or sale of alcohol beverages shall be made upon forms prescribed by the ~~Department of Revenue, Liquor Enforcement~~ Division. No

application will be considered which is not complete in every material detail, or which is not accompanied by a remittance in full for the whole amount of the annual state license fee, and eighty five percent of the local license fee. Each application for a new retail license shall contain a report from the local licensing authority of the town, city, county, or city and county, in which the applicant proposes to conduct its business, which report shall show the opinion of the local licensing authority concerning the reasonable requirements of the neighborhood and the desires of the adult inhabitants with respect to the issuance of the license applied for and the character of a new applicant.

REGULATION 47-313. TASTINGS.

BASIS AND PURPOSE. THE STATUTORY AUTHORITY FOR THIS REGULATION IS FOUND AT SUBSECTIONS 44-3-202(1)(B) AND 44-3-202(2)(A)(I)(A), C.R.S. THE PURPOSE OF THIS REGULATION IS TO CLARIFY WHO MAY CONDUCT TASTINGS AND HOW OPEN AND UNCONSUMED SAMPLES MUST BE APPROPRIATELY TREATED AFTER A TASTING.

A. TASTINGS.

1. A TASTING SHALL BE CONDUCTED ONLY BY A PERSON WHO HAS COMPLETED SELLER-SERVER TRAINING THAT MEETS THE STANDARDS ESTABLISHED BY THE DIVISION, AND IS:

   a. A RETAIL LIQUOR STORE OR LIQUOR-LICENSED DRUGSTORE LICENSEE OR EMPLOYEE; OR

   b. A REPRESENTATIVE, EMPLOYEE, OR AGENT OF ONE OF THE FOLLOWING SUPPLIERS LICENSED BY THE STATE LICENSING AUTHORITY:

      i. WHOLESALER,

      ii. BREW PUB,

      iii. DISTILLERY PUB,

      iv. MANUFACTURER,

      v. LIMITED WINERY,

      vi. IMPORTER, OR

      vii. VINTNER'S RESTAURANT.

B. FOLLOWING A TASTING, THE LICENSEE SHALL PROMPTLY REMOVE ALL OPEN AND UNCONSUMED ALCOHOL BEVERAGE SAMPLES FROM THE LICENSED PREMISES, DESTROY THE SAMPLES IMMEDIATELY FOLLOWING THE COMPLETION OF THE TASTING, OR STORE ANY OPEN CONTAINERS OF UNCONSUMED ALCOHOL BEVERAGES IN A SECURE AREA OUTSIDE THE SALES AREA OF THE LICENSED PREMISES FOR USE ONLY AT A TASTING CONDUCTED AT A LATER TIME OR DATE. A SECURE AREA MEANS:

   1. A DESIGNATED AREA, INCLUDING, BUT NOT LIMITED TO, A CLOSET, CABINET, OR SAFE;

   2. THAT IS UPON THE LICENSED PREMISES AND NOT ACCESSIBLE TO CONSUMERS; AND

   3. IS SECURED BY A LOCKING MECHANISM AT ALL TIMES WHILE ANY OPEN CONTAINERS OF UNCONSUMED ALCOHOL BEVERAGES ARE STORED FOR USE AT A FUTURE TASTING.

Regulation 47-314. Limited Liability Company.

B. Each Limited Liability Company licensed pursuant to this Article or Article 4, of Title 44, shall report changes of any of its managers within 30 days from the date of the change, and shall submit said information to the respective local or state licensing authorities on forms approved by the ~~Department of Revenue, Liquor Enforcement~~ Division. A report shall also be required for changes of any member having a 10% or more interest in the licensee.

REGULATION 47-315. LODGING AND ENTERTAINMENT LICENSE.

BASIS AND PURPOSE. THE STATUTORY AUTHORITY FOR THIS REGULATION IS LOCATED AT SUBSECTIONS 44-3-202(1)(B), 44-3-202(2)(A)(I)(A), 44-3-202(2)(A)(I)(C), 44-3-202(2)(A)(I)(L), AND 44-3-202(2)(A)(I)(R), C.R.S. THE PURPOSE OF THIS REGULATION IS TO DESCRIBE THOSE SPORTS AND ENTERTAINMENT ACTIVITIES WHICH QUALIFY AN ESTABLISHMENT AS AN ENTERTAINMENT FACILITY. ADDITIONALLY, THE PURPOSE OF THIS REGULATION IS TO DESCRIBE HOW TO DETERMINE THE PRIMARY BUSINESS OF A LODGING AND ENTERTAINMENT FACILITY.

A. IN ADDITION TO OTHER STATUTORY REQUIREMENTS, A LODGING AND ENTERTAINMENT LICENSE MAY BE ISSUED TO A QUALIFYING LODGING AND ENTERTAINMENT FACILITY. A "LODGING AND ENTERTAINMENT FACILITY" IS AN ESTABLISHMENT THAT IS EITHER:

1. A "LODGING FACILITY," THE PRIMARY BUSINESS OF WHICH IS TO PROVIDE THE PUBLIC WITH SLEEPING ROOMS AND MEETING FACILITIES; OR

2. AN "ENTERTAINMENT FACILITY," THE PRIMARY PURPOSE OF WHICH IS TO PROVIDE THE PUBLIC WITH SPORTS OR ENTERTAINMENT ACTIVITIES WITHIN ITS LICENSED PREMISES.

B. TO QUALIFY AS AN ENTERTAINMENT FACILITY, THE APPLICANT OR LODGING AND ENTERTAINMENT LICENSEE MUST DEMONSTRATE THAT ITS PRIMARY BUSINESS IS TO PROVIDE QUALIFYING SPORTS OR ENTERTAINMENT ACTIVITIES WITHIN ITS LICENSED PREMISES.

1. TO QUALIFY AS A SPORTS ACTIVITY, THE ACTIVITY MUST PROVIDE THE PUBLIC WITH AN OPPORTUNITY TO PARTICIPATE IN, OR TO OBSERVE OTHERS WHO PARTICIPATE IN, AN ACTIVITY SUCH AS A GAME, RECREATION, TEAM OR INDIVIDUAL SPORT, OR AN ACTIVITY OF A SIMILAR NATURE. EXAMPLES OF QUALIFYING SPORTS ACTIVITIES INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING:

   a. ARCADE GAMES;

   b. BILLIARDS;

   c. BOWLING;

   d. GOLF; OR

   e. LASER TAG.

2. TO QUALIFY AS AN ENTERTAINMENT ACTIVITY, THE ACTIVITY MUST PROVIDE THE PUBLIC WITH AN OPPORTUNITY TO PARTICIPATE IN OR OBSERVE OTHERS WHO PARTICIPATE IN AN ACTIVITY THAT IS PRIMARILY ARTISTIC, CULTURAL, EDUCATIONAL, OR ENTERTAINING, OR AN ACTIVITY OF A SIMILAR NATURE. EXAMPLES OF QUALIFYING ENTERTAINMENT ACTIVITIES INCLUDE, BUT ARE NOT LIMITED TO, THE FOLLOWING:

   a. ARTISTIC EXHIBITIONS, FILMS, OR PERFORMANCES;

   b. ARTS AND CRAFTS CLASSES;

   c. COOKING CLASSES;

d. Amusement rides; or

e. Spa experiences.

i. For purposes of this regulation, to qualify as a "spa experience" the facility must offer at least three (3) of the following treatments and experiences:

A. Facials;

B. Massage therapy;

C. Skin treatment;

D. Body wraps; or

E. Body waxing.

3. The following activities shall not qualify as entertainment activities for purposes of an entertainment facility:

a. Any activity not described in subparagraphs (B)(1) or (B)(2) of this regulation; and

b. Shopping for or receiving goods or personal services, including but not limited to hair care or nail care services.

C. An activity that would otherwise qualify under subparagraphs (B)(1) and (B)(2) of this regulation, shall not qualify if the activity involves the use of a deadly weapon as defined by subsection 18-1-901(3)(e), C.R.S., or creates a substantial health and safety risk to any person.

D. Determining the primary business of a lodging and entertainment facility.

1. To satisfy the requirement that the primary business of a lodging facility is to provide the public with sleeping rooms and meeting facilities, and that serving and selling alcohol beverages is incidental thereto, the lodging facility's annual gross revenues from the sale of sleeping rooms and meeting facilities must exceed fifty (50) percent of the lodging facility's total annual gross sales revenues.

2. To satisfy the requirement that the primary business of an entertainment facility is to provide the public with sports or entertainment activities, and that serving and selling alcohol beverages is incidental thereto, the entertainment facility's annual gross revenues from the sale of sports or entertainment activities must exceed fifty (50) percent of the entertainment facility's total annual gross sales revenues.

Regulation 47-316. Advertising Practices

A. Consumer Advertising Specialties

1. "Consumer advertising specialties" shall mean those items designed to advertise or promote a specific alcohol beverage brand or supplier, that have a utilitarian function to

the consumer in addition to product promotion and that are intended and designed to be carried away by the consumer. Consumer advertising specialties shall include: t-shirts, caps, visors, bottle or can openers, cork screws, printed recipes, pencils, pens, pins, buttons, matches, computer flash and jump drives (not to exceed 8 GB), computer mouse pads, shopping bags, key chains, paper or plastic cups and plates, and similar items of negligible value, as approved by the ~~Liquor Enforcement~~ Division. For purposes of this regulation, glassware and plates do not qualify as consumer advertising specialties.

B. Point-of-Sale Advertising

2. Suppliers may provide the following point-of-sale advertising materials to licensed retailers free of charge for use within retail premises: display decorations of negligible value, table tents, table tent holders, sports schedules and brackets, case cards, serving trays, condiment trays, bar utensil caddies, stir rods, strainers, presses, check and credit card holders, shakers, pitchers, table mats, bar mats, alcohol beverage lists or menus, menu cards, menu holders, calendars, napkins, napkin holders, coasters, stir sticks, and similar items of negligible value, as approved by the ~~Liquor Enforcement~~ Division.

5. Supplier Give-A-Ways and Displays

d. The actual item(s) that is(are) part or the Consumer Contest shall be delivered to the retail license premises together with an invoice made out to the retail licensee for not less than the actual cost of the item(s). The retail licensee shall be responsible for and required to pay the invoice cost for the item unless the retail licensee can establish to the satisfaction of the ~~Liquor Enforcement~~ Division that the item(s) was(were) in fact presented to the winning consumer in accordance with the rules of the Consumer Contest. Both the retail licensee and the supplier of the item shall each maintain in their respective records proof establishing that the item(s) was(were) delivered to the winning consumer. Such records shall include but not be limited to a signed acknowledgement of receipt of the item(s) by the winning consumer which acknowledgment shall include a valid form of identification proving the identity of the consumer, the consumer's name, address, phone number, e-mail address (if available) and the date on which the item was presented to the consumer. In addition, the records shall include the name and position of the person or persons presenting the item to the consumer sufficient so that the ~~Liquor Enforcement~~ Division can verify that the item was presented to the Consumer Contest winner.

C. Media Advertising

1. Except as provided in Regulations 47-322(B) and 47-322(C) ~~for on-site sales promotions and Sponsored Events~~, AND SUBSECTION (C)(3) OF THIS REGULATION, no supplier shall directly or indirectly furnish or pay for any advertising for or with respect to any one or more retail licensee by means of the internet, device applications (apps), radio or television broadcast, magazines, newspapers, pamphlets, or similar media, or by means of any sign not located on or in the licensed premises of the retailer which is advertised.

2. Except as provided in Regulations 47-322(B) and 47-322(C) ~~for on-site sales promotions and Sponsored Events~~, suppliers that purchase internet, device applications (apps), radio or television advertising packages from third party advertising agencies:

a. May not authorize the advertising agency to apply any value attributable to the supplier's advertising package toward the advertising or promotion of any licensed retailer or their location.

b. May not authorize the advertising agency to combine supplier-purchased advertising packages with those purchased by licensed retailers, for the purpose and benefit of cooperative advertising.

3. ~~For purposes of this paragraph C, a supplier's~~ A SUPPLIER MAY DIRECTLY OR INDIRECTLY ADVERTISE FOR OR WITH RESPECT TO ANY ONE (1) OR MORE RETAILERS THAT SELL THE SUPPLIER'S ALCOHOL BEVERAGES, VIA THE SUPPLIER'S internet websites (including forums such as a supplier's Facebook page, blog or device applications (apps)) and electronic advertising messages delivered directly to consumers' private electronic devices.~~, shall not be construed as "similar media."~~

Regulation 47-318. Owner-Manager.

B. Owners may hire managers, and managers may be compensated on the basis of profits made, gross or net. In such cases, (except through an I.R.S. qualified retirement account), the financial interests of the manager(s) must be reported on the forms prescribed by the ~~Liquor Enforcement~~ Division. The manager may be required to complete an individual history report and be subject to a background check. A license may not be held in the name of the manager.

Regulation 47-319. Liquor-Licensed Drugstore Manager Permit.

C. A liquor-licensed drugstore licensee must submit an application for each permitted manager with the ~~Liquor Enforcement~~ Division on forms approved by the State Licensing Authority. The manager permit is an annual permit that is renewed every year.

REGULATION 47-321. BONA FIDE LOYALTY OR REWARDS PROGRAMS – DISCONTINUED SALES – CLOSE-OUT SALES.

BASIS AND PURPOSE. THE STATUTORY AUTHORITY FOR THIS REGULATION IS FOUND AT SUBSECTIONS 44-3-202(1)(B), 44-3-202(2)(A)(I)(A), 44-3-202(2)(A)(I)(D), AND 44-3-202(2)(A)(I)(O), C.R.S. THE PURPOSE OF THIS REGULATION IS TO CLARIFY HOW APPLICABLE LICENSEES MAY SELL ALCOHOL BEVERAGES BELOW COST UNDER LIMITED STATUTORY EXCEPTIONS.

A. A RETAILER LICENSED PURSUANT TO SECTION 44-3-409 OR 44-3-410, OR SUBSECTION 44-4-107(1)(A), C.R.S., SHALL NOT SELL ALCOHOL BEVERAGES TO CONSUMERS AT A PRICE THAT IS BELOW THE RETAILER'S COST, AS LISTED ON THE INVOICE, UNLESS THE SALE IS OF DISCONTINUED OR CLOSE-OUT ALCOHOL BEVERAGES. FOR PURPOSES OF THIS SUBSECTION:

1. "DISCONTINUED" MEANS WHEN A MANUFACTURER OR IMPORTER DISCONTINUES THE PRODUCTION, IMPORTATION, OR MARKET AVAILABILITY OF A SPECIFIC ALCOHOL BEVERAGE PRODUCT. A RETAILER'S DECISION TO STOP MAKING AVAILABLE THE ALCOHOL BEVERAGE PRODUCT FOR PURCHASE BY A CONSUMER DOES NOT QUALIFY AS A DISCONTINUED PRODUCT.

2. TO QUALIFY AS A "CLOSE-OUT" SALE, THE FOLLOWING CONDITIONS MUST BE SATISFIED:

   A. THE CLOSE-OUT SALE MUST INCLUDE AND LIQUIDATE, BY SALE OR DESTRUCTION, ALL OF THE RETAILER'S CURRENT INVENTORY OF A SPECIFIC ALCOHOL BEVERAGE PRODUCT AS OF THE DATE THE CLOSE-OUT SALE BEGINS.

   B. THE RETAILER IS PROHIBITED FROM SELLING THE SPECIFIC ALCOHOL BEVERAGE PRODUCT THAT WAS INVOLVED IN THE CLOSE-OUT SALE AT A PRICE BELOW COST FOR A PERIOD OF TWO (2) YEARS COMMENCING ON THE DATE THE LAST ITEM INCLUDED IN THE CLOSE-OUT SALE IS LIQUIDATED.

B. A retailer licensed pursuant to section 44-3-409 or 44-3-410, or subsection 44-4-107(1)(a), C.R.S., shall not be prohibited from operating a bona fide loyalty or rewards program for alcohol beverages the retailer is licensed to sell so long as the price for the product is not below the retailer's costs as listed on the invoice. For purposes of subsections (B) and (C) of this regulation:

1. "Bona fide loyalty or rewards program" means a structured program used by a retailer licensed pursuant to section 44-3-409 or 44-3-410, or subsection 44-4-107(1)(a), C.R.S., to encourage participants to continue to shop at the retailer's licensed business by allowing participants to accrue program benefits, through the purchase of alcohol beverages, to be redeemed in the form of a discount upon a subsequent sales transaction on alcohol beverage products only.

2. "Retailer's cost" means the actual proportionate invoice price charged by the wholesaler, per item, including applicable state and federal taxes. All invoices must clearly designate a price paid for each product, which shall not be less than the wholesaler's laid-in cost for each product.

3. "Price" means the amount an alcohol beverage product is listed for sale to consumers by the retailer, before applicable taxes, and before application of bona fide loyalty or rewards program benefits in the form of a discount.

4. A supplier shall not provide to a retailer, and a retailer shall not accept from a supplier, any financial assistance in connection with a bona fide loyalty or rewards program.

5. bona fide loyalty rewards program benefits shall be structured so that both the accrual and redemption of benefits is applied without discrimination across all brands and labels of alcohol beverages.

C. A retailer described in subsection (B) of this regulation shall maintain and make available those business records regarding all bona fide loyalty or rewards program transactions consistent with Regulation 47-700, 1 C.C.R. 203-2. A retailer described in subsection (B) of this regulation must maintain, at a minimum, the following records regarding its bona fide loyalty or rewards program:

1. Documentation regarding the value of loyalty or rewards program benefits and how those benefits may be accrued and redeemed by participants;

2. Documentation showing the loyalty or rewards program benefits actually accrued and redeemed by each participant, organized by a unique customer identification number assigned to each participant;

3. Invoices showing the retailer's cost of the individual alcohol beverage product to which any consumer loyalty or rewards benefit was applied or redeemed; and

4. Receipts for every alcohol beverage sale to which loyalty or rewards program benefits are redeemed, showing the price for every alcohol beverage and the amount of such benefits.

Regulation 47-322. Unfair Trade Practices and Competition.

A. Sales of alcohol beverages.

5. Certain sales of alcohol beverages below cost are not designed or intended to influence or control a retailer's product selection. The following exceptions to below cost product sales are therefore permitted:

c. Products for use, but not for resale by the drink, by a non-profit organization or similar group, as defined in section 44-5-102, C.R.S., on a retailer's licensed premises, may be invoiced to a retailer at no cost. The invoice for said products must detail the products provided and the group for whose benefit it is provided. At the conclusion of the organization's event any unused product must be returned to the ~~manufacturer,~~ wholesaler, ~~brewpub~~ BREW PUB, distillery pub, or vintner's restaurant, or invoiced at a minimum of laid in cost to the retailer.

B. On-site sales promotions

2. ON-PREMISES SAMPLING. ~~Supplier-sponsored~~ A SUPPLIER-SPONSORED consumer sampling of alcohol beverages ~~that is~~ MAY BE held ~~in establishments licensed for on-premises consumption~~ AT A RETAILER'S PREMISES LICENSED FOR ON-PREMISES CONSUMPTION for the purpose of product sales promotion~~, are permitted~~ under the following conditions:

A. A SUPPLIER-SPONSORED CONSUMER SAMPLING HELD AT THE LICENSED PREMISES OF A RETAILER LICENSED FOR ON-PREMISES CONSUMPTION SHALL INCLUDE ONLY THE ALCOHOL BEVERAGES THE RETAILER IS LICENSED TO SELL.

B. THE SUPPLIER SHALL ONLY OFFER ITS ALCOHOL BEVERAGE PRODUCT TO CONSUMERS DURING A SUPPLIER-SPONSORED CONSUMER SAMPLING.

C. A RETAILER OR SUPPLIER SHALL NOT IMPOSE ANY CHARGE TO THE CONSUMER TO ENTER OR PARTICIPATE IN THE SAMPLING.

~~a~~D. Product used for sampling must be invoiced by ~~a~~ THE supplier, who is authorized to sell THE alcohol beverages to licensed retailers pursuant to article 3 or 4 of title 44, as if sold to the retailer.

~~b. A retailer may not impose any charge to the consumer to enter or participate in the sampling.~~

~~c~~E. If all product listed in the sales invoice is consumed as permitted herein, the supplier may issue the retailer a credit against the entire amount of the original invoice.

~~d~~F. Any remaining product must be returned to the wholesaler, or sold to the retailer at a minimum of the ~~seller's~~ WHOLESALER'S cost.

~~e~~G. THE SUPPLIER MUST BE PRESENT AND SHALL BE THE PERSON WHO PROVIDES THE SAMPLE TO A CONSUMER WHO IS TWENTY-ONE (21) YEARS OF AGE OR OLDER.~~, Supplier representatives or their authorized agents may provide alcohol beverage samples directly to the consumer, if the product has been delivered to the retail premises pursuant to the conditions described herein, and the retailer has so consented.~~

~~f~~H. Suppliers may provide or pay for any media announcement of a ~~supplier sponsored~~ SUPPLIER-SPONSORED consumer sampling that primarily advertises the product, the location, and the date and time of the sampling. The name of the retail outlet may also be mentioned.

3. OFF-PREMISES GIVEAWAY. A supplier-sponsored consumer ~~give-a-way~~ GIVEAWAY of SEALED malt ~~liquors~~ LIQUOR OR FERMENTED MALT BEVERAGES MAY BE held ~~in retail establishments licensed for off-premises consumption~~ AT A RETAILER'S PREMISES LICENSED FOR OFF-PREMISES CONSUMPTION for the purpose of product sales promotion~~, are permitted~~ under the following conditions:

A. A SUPPLIER-SPONSORED CONSUMER GIVEAWAY HELD AT THE LICENSED PREMISES OF A RETAILER LICENSED FOR OFF-PREMISES CONSUMPTION IS LIMITED TO EITHER SEALED MALT LIQUOR OR FERMENTED MALT BEVERAGES, WHICHEVER THE RETAILER IS LICENSED TO SELL.

B. THE SUPPLIER SHALL ONLY OFFER ITS MALT LIQUOR OR FERMENTED MALT BEVERAGES PRODUCT TO CONSUMERS DURING A SUPPLIER-SPONSORED CONSUMER GIVEAWAY.

C. A RETAILER OR SUPPLIER SHALL NOT IMPOSE ANY CHARGE TO THE CONSUMER TO ENTER OR PARTICIPATE IN THE GIVEAWAY.

a~~D~~. ~~The supplier must purchase the malt liquors from the retailer at the retail price of the product to be given away, including sales tax.~~ PRODUCT USED FOR THE GIVEAWAY MUST BE INVOICED BY A SUPPLIER, WHO IS AUTHORIZED TO SELL MALT LIQUOR OR FERMENTED MALT BEVERAGE TO LICENSED RETAILERS PURSUANT TO ARTICLE 3 OR 4 OF TITLE 44, AS IF SOLD TO THE RETAILER.

~~b. A retailer/supplier may not impose any charge to the consumer to enter or participate in the give-a-way.~~

E. IF ALL PRODUCT LISTED IN THE SALES INVOICE IS GIVEN AWAY AS PERMITTED HEREIN, THE SUPPLIER MAY ISSUE THE RETAILER A CREDIT AGAINST THE ENTIRE AMOUNT OF THE ORIGINAL INVOICE.

F. ANY REMAINING PRODUCT MUST BE RETURNED TO THE WHOLESALER, OR SOLD TO THE RETAILER AT A MINIMUM OF THE WHOLESALER'S COST.

~~c. The product purchased must be of the supplier's brands and currently offered by the supplier.~~

~~d~~G. The supplier must be present and shall be the person who gives the ~~product~~ SEALED CONTAINER to consumers. The supplier ~~representative~~ must verify that each consumer is of lawful age prior to ~~giving the item to them~~ GIVING AWAY THE SEALED CONTAINER.

~~e. The supplier and retailer must keep records of all items purchased from a retail liquor store to be used as a free give-a-way to consumers. The records must include the date, retailer/supplier name, amount paid, and name of products purchased.~~

~~f. Supplier representatives or their authorized agents may give-a-way sealed malt liquor products directly to the consumer (for off premises consumption only), if the product has been purchased in accordance to this regulation and the retailer has so consented. The retail licensee or their employee(s) are not eligible to receive free malt liquor samples.~~

~~g. The maximum amount of malt liquor beverages given to each consumer is limited to twenty-four (24) ounces.~~

~~h~~H. Suppliers may provide or pay for any media announcement of a ~~supplier-sponsored~~ SUPPLIER-SPONSORED consumer ~~give-a-way~~ GIVEAWAY that primarily advertises the product, the location, and the date and time of the ~~give-a-way~~ GIVEAWAY. The name of the retail outlet may also be mentioned.

~~i. All items purchased by the supplier representative for the give-a-way must be given away to the consumer or the retailer must purchase back any remaining items not given away at the original purchase price.~~

I. THE MAXIMUM AMOUNT OF MALT LIQUOR OR FERMENTED MALT BEVERAGES GIVEN TO EACH CONSUMER SHALL NOT EXCEED TWENTY-SIX (26) OUNCES.

J. Other goods

Suppliers may not provide a retailer with any other goods below ~~a supplier's cost~~ FAIR MARKET VALUE except those items expressly permitted by articles 3, 4, or 5 of title ~~44~~, C.R.S, and related regulations.

L. Value of labor

~~1. Suppliers may provide labor at no cost as it relates to product delivery, price stamping, rotation and stocking. The cleaning of beverage dispensing equipment and supplier-provided displays may also be provided at no cost.~~

~~2. Suppliers may, upon retail premises, organize, construct, and maintain displays of those alcohol beverages that they sell. Such supplier-constructed displays shall be accessible by the consumer.~~

~~3. Cost of labor provided to a retailer for services such as the installation of dispensing systems and the pouring or serving of alcohol beverages (except as allowed by regulation 47-322(B)(2)) shall be at least at a minimum of that employee's hourly wage.~~

1. FOR PURPOSES OF THIS SUBSECTION (L):

A. "DELIVER" OR "DELIVERING" IS THE ACT OF A WHOLESALER BRINGING AND UNLOADING ITS ALCOHOL BEVERAGE PRODUCT FROM ITS DELIVERY VEHICLE ONTO THE RETAILER'S LICENSED PREMISES OR PERMITTED RETAIL WAREHOUSE STORAGE LOCATION. "DELIVER" OR "DELIVERING" DOES NOT MEAN A WHOLESALER BRINGING AND UNLOADING ITS ALCOHOL BEVERAGE PRODUCT FROM A PERMITTED RETAIL WAREHOUSE STORAGE LOCATION TO A RETAILER'S LICENSED PREMISES.

B. "STOCK" OR "STOCKING" IS THE ACT OF A SUPPLIER PLACING OR REPLENISHING ITS ALCOHOL BEVERAGE PRODUCT ON ANY SHELF, REFRIGERATOR, OR SIMILAR LOCATION WITHIN THE RETAILER'S LICENSED PREMISES.

C. "ROTATE" OR "ROTATING" IS THE ACT OF A SUPPLIER MOVING ITS ALCOHOL BEVERAGE PRODUCT FROM THE REAR TO THE FRONT OF ANY SHELF, REFRIGERATOR, OR SIMILAR LOCATION WITHIN THE RETAILER'S LICENSED PREMISES, SO THAT OLDER ALCOHOL BEVERAGE PRODUCT WILL SELL FIRST.

D. "PRICE STAMP" OR "PRICE STAMPING" IS THE ACT OF A SUPPLIER AFFIXING THE RETAIL PRICE OF ITS ALCOHOL BEVERAGE PRODUCT TO ITS RESPECTIVE SHELF, REFRIGERATOR, OR ANY OTHER SIMILAR LOCATION WITHIN THE RETAILER'S LICENSED PREMISES.

e. "Merchandise" or "merchandising" is the act of a supplier organizing, constructing, or maintaining a temporary display of alcohol beverage product including a sign, interior display, consumer advertising specialty, or point-of-sale advertising, within the retailer's licensed premises, for the purpose of increased product visibility to consumers.

2. Except as otherwise provided by this subsection (L)(2), the Colorado Liquor Code, the Colorado Beer Code, or the Colorado Liquor Rules, a supplier is prohibited from providing any labor to a retailer at no cost or conducting an on-site sales promotion pursuant to subsection (B) of this regulation, for the purpose of altering or influencing a retailer's product selection. A retailer is prohibited from requiring a supplier to provide any labor to the retailer or to conduct an on-site sales promotion pursuant to subsection (B) of this regulation, as an express or implied condition of the delivery, purchase, or future purchases between the supplier and the retailer.

a. A wholesaler may deliver its alcohol beverage product at no cost to the retailer.

b. In a supplier's sole discretion, a supplier may stock, rotate, price stamp, and merchandise its alcohol beverage product on the retailer's licensed premises at no cost to the retailer.

i. Except as provided by subsection (L)(2)(B)(ii) of this regulation, no single licensed supplier, nor any combination of licensed suppliers of any given alcohol beverage product may perform the activities listed in subsection (L)(2)(B) of this regulation upon any retailer's licensed premises more than four (4) days in a calendar week. A calendar week, for purposes of this subsection, will commence on Sunday and end on Saturday.

ii. Twelve (12) times per calendar year, any single licensed supplier, or combination of licensed suppliers of any given alcohol beverage product shall be permitted to perform the activities listed in subsection (L)(2)(B) of this regulation for a total of five (5) days in a calendar week. Nothing in this subsection shall be construed to permit a single licensed supplier, or any combination of licensed suppliers of any given alcohol beverage product to perform these activities more than five (5) days in a calendar week.

iii. A supplier is prohibited from disturbing another supplier's alcohol beverage product while stocking, rotating, price stamping, and/or merchandising.

iv. For purposes of this subsection (L)(2)(b), the retailer's licensed premises shall not include a permitted retail warehouse storage location.

v. Both the retail licensee and each licensed supplier shall maintain, in their respective records, pursuant to 44-3-701, C.R.S., a log for each calendar week that documents every instance in which a licensed supplier performed any of the activities listed in subsection (L)(2)(B) of this regulation.

A. The log shall include the licensed supplier name, the date the activities were performed, and the name of at least one person who performed the activities on behalf of the supplier.

B. These records shall be maintained by each licensee in accordance with regulation 47-700.

C. Failure to maintain accurate or complete records shall be a violation of this regulation.

c. A supplier may clean the retailer's alcohol beverage dispensing equipment at no cost to the retailer. A supplier may only clean the portion of the retailer's alcohol beverage dispensing equipment used for dispensing its alcohol beverage product.

3. A supplier is prohibited from providing to a retailer, and a retailer is prohibited from requiring from a supplier, any acts of labor other than those acts described in subsection (L)(2) of this regulation. Such prohibited acts of labor shall include, but are not limited to:

a. Cleaning, sweeping, mopping, or maintaining the retailer's licensed premises;

b. Cleaning the retailer's shelves or refrigerators;

c. Operating the retailer's powered mechanical equipment; or

d. Performing inventory for the retailer's records.

4. A representative, employee, or agent of one of the following suppliers licensed by the state licensing authority may pour or serve only its own alcohol beverage products as part of a tasting at no cost to the retailer:

a. Wholesaler,

b. Brew pub,

c. Distillery pub,

d. Manufacturer,

e. Limited winery,

f. Importer, or

g. Vintner's restaurant.

M. Prohibition.

1. Except as otherwise provided by the Colorado Liquor Code, Colorado Beer Code, or Colorado Liquor Rules, a supplier is prohibited from disturbing another supplier's alcohol beverage product.

Regulation 47-326. Distance Restriction – Applicability and Measurement.

A. Except as provided for in this regulation, no RETAIL license shall be issued to or held by any person where ~~malt, vinous, or spirituous liquor is~~ ALCOHOL BEVERAGES ARE sold if the licensed premises is located within 500 feet of any public or parochial school or the principal campus of any college, university or seminary~~;~~. ~~said~~ SAID distance ~~to~~ SHALL be computed by direct measurement from the nearest property line of the land used for school purposes to the nearest portion of the building in which ~~malt, vinous, or spirituous liquors~~ ALCOHOL BEVERAGES are to be sold, using a route of direct pedestrian access, measured as a person would walk safely and properly, without trespassing, with right angles at crossings and with the observance of traffic regulations and traffic signals.

B. The restriction stated herein shall not be applicable to the following:

7. A RETAILER LICENSED PURSUANT TO SUBSECTION 44-4-107(1)(B), C.R.S.

Regulation 47-407. Liquor-Licensed Drugstore.

E. Additional liquor-licensed drugstore locations:

1. After January 1, 2017, a liquor-licensed drugstore licensee may apply for additional liquor-licensed drugstore licenses as long as they meet the requirements of section 44-3-410(1)(b)(I-IV), C.R.S. The application for an additional liquor-licensed drugstore will be a single application form approved by the ~~Liquor Enforcement~~ Division. The application process will include the transfer of ownership of at least two retail liquor stores, the change of location to the new licensed premises and the merger and conversion of a new liquor-licensed drugstore.

F. On or after January 1, 2017, a liquor-licensed drugstore licensee shall not purchase malt, vinous or spirituous liquors from a wholesaler on credit and shall effect payment upon delivery of the alcohol beverages. Allowed payments include cash, credit/debit cards, check, money orders, certified check, EFT transfer and any other method of payment approved by the ~~Liquor Enforcement~~ Division.

H. Wholesalers, including ~~brewpubs~~ BREW PUBS, ~~distiller's~~ DISTILLERY pubs, vintner's restaurants and limited wineries shall take orders for alcohol beverage sales to a liquor-licensed drugstore only from a permitted manager of such liquor-licensed-drugstore who has a valid manager's permit under section 44-3-427, C.R.S.

Regulation 47-418. Restaurants.

D. Restaurants must be maintained in a clean and sanitary condition, and shall maintain such food service license issued by the Colorado Department of Public Health and Environment OR THE DENVER DEPARTMENT OF EXCISE AND LICENSES in full force and effect at all times while selling alcohol beverages for consumption therein.

Regulation 47-426. Delivery of Alcohol Beverages.

Basis and Purpose. The statutory authority for this regulation is located at subsections 44-4-107(1)(c), 44-3-202(1)(b), 44-3-202(2)(a)(I)(A), 44-3-409(3), and 44-3-410(3), C.R.S. The purpose of this regulation is

to permit fermented malt beverage ~~on-off premises~~ OFF-PREMISES licensees, retail liquor stores, and liquor licensed drug stores to deliver alcohol beverage products to consumers within the requirements, restrictions, and limitations outlined in the regulation in accordance with the statutory provisions under which limited retail delivery activities are authorized.

~~A. Delivery Prohibited.~~

~~No retail liquor licensee, licensed to sell malt, vinous, and spirituous liquor for off-premises consumption or fermented malt beverages for on and off premises consumption, shall conduct a delivery only business, or permit the delivery of such alcohol beverages beyond the customary parking area for the customers of the retail outlet except as permitted in paragraph B of this regulation.~~

~~B~~A. Delivery Permitted.

~~A retail liquor licensee, licensed to sell malt, vinous, and spirituous liquor, for off-premises consumption or fermented malt beverages for on and off premises consumption, may,~~ RETAILER LICENSED PURSUANT TO SECTION 44-3-409 OR 44-3-410, OR SUBSECTION 44-4-107(1)(A), C.R.S., MAY deliver such alcohol beverages AUTHORIZED BY ITS LICENSE to any location off the licensed premises, pursuant to the following restrictions:

1. ORDER.

   A. The order for the alcohol beverages which are to be delivered, must be taken by the licensee or an ordering service acting as an agent of the licensee pursuant to a written agreement entered into with the licensee. Licensee shall provide a copy of said agreement to the ~~Liquor Enforcement~~ Division prior to any orders being accepted by licensee's agent.

   B. The order may be taken by written order, by telephone, in person, or via internet communication with the licensee or its agent.

   C. The person placing the order must provide the licensee with their name, ~~address,~~ date of birth, AND DELIVERY ADDRESS ~~and a valid form of identification, including the identification number~~. Under no circumstances shall a person under TWENTY-ONE (21) years of age be permitted to place an order for alcohol beverages.

2. DELIVERY.

   A. Delivery of alcohol beverages shall only be made to a person TWENTY-ONE (21) years of age or older at the address specified in the order.

   B. Delivery must be made by the licensee~~, an employee of the licensee, or a delivery service acting as an agent of the licensee pursuant to a written agreement entered into with the licensee. A copy of said agreement shall be maintained by the licensee~~ OR THE LICENSEE'S EMPLOYEE WHO IS AT LEAST TWENTY-ONE (21) YEARS OF AGE AND IS USING A VEHICLE OWNED OR LEASED BY THE LICENSEE TO MAKE THE DELIVERY.

   C. The licensee or ~~his~~ THE LICENSEE'S employee~~, or a representative of a delivery service~~ who delivers the alcohol beverages shall note and log~~,~~ at the time of delivery~~;~~ the name~~, address, date of birth and the valid form of identification, including the~~ AND identification number, of the person the alcohol beverages are

delivered to. Under no circumstances shall a person under TWENTY-ONE (21) years of age be permitted to receive a delivery of alcohol beverages.

D. A LICENSEE MUST DERIVE NO MORE THAN FIFTY (50) PERCENT OF ITS GROSS ANNUAL REVENUES FROM TOTAL SALES OF ALCOHOL BEVERAGES THAT THE LICENSEE DELIVERS.

3. Licensees who deliver alcohol beverages shall maintain as a part of their required records, pursuant to 44-3-701, C.R.S., all records of delivery including~~; delivery agreements,~~ delivery orders, receipt logs and journals. These records shall be maintained by the licensee for the current and three prior calendar years. Failure to maintain accurate or complete records shall be a violation of this regulation.

4. Have a licensed premises with the following conditions:

~~A~~A. Open to the public a minimum of three (3) days a week; and

~~B~~B. Open to the public a minimum of five (5) hours each day the business is open; and

~~C~~C. Have signage viewable from a public road.

5. PERMIT REQUIRED.

A. EFFECTIVE JULY 1, 2019, THE STATE LICENSING AUTHORITY WILL ACCEPT COMPLETE DELIVERY PERMIT APPLICATIONS FROM ANY APPLICANT OF OR RETAILER LICENSED PURSUANT TO SECTION 44-3-409 OR 44-3-410, OR SUBSECTION 44-4-107(1)(A), C.R.S.

B. EFFECTIVE JULY 1, 2020, ANY RETAILER LICENSED PURSUANT TO SECTION 44-3-409 OR 44-3-410, OR SUBSECTION 44-4-107(1)(A), C.R.S., MUST HOLD A VALID DELIVERY PERMIT ISSUED BY THE STATE LICENSING AUTHORITY TO DELIVER ALCOHOL BEVERAGES PURSUANT TO THE COLORADO LIQUOR CODE, THE COLORADO BEER CODE, AND THIS REGULATION.

C. THE APPLICANT MUST AFFIRM ON ITS DELIVERY PERMIT APPLICATION THAT THE APPLICANT DERIVES OR WILL DERIVE NO MORE THAN FIFTY (50) PERCENT OF ITS GROSS ANNUAL REVENUES FROM TOTAL SALES OF ALCOHOL BEVERAGES THAT THE APPLICANT DELIVERS. HOWEVER, NOTHING WITHIN THIS SUBSECTION (A)(5)(C) SHALL LIMIT THE AUTHORITY OF THE STATE LICENSING AUTHORITY TO INSPECT BOOKS AND RECORDS PURSUANT TO REGULATION 47-700, 1 C.C.R. 203-2, TO VERIFY THIS AFFIRMATION OR COMPLIANCE WITH THIS STATUTORY REQUIREMENT.

D. A DELIVERY PERMITTEE SHALL DISPLAY ITS DELIVERY PERMIT AT ALL TIMES IN A PROMINENT PLACE ON ITS LICENSED PREMISES. A DELIVERY PERMITTEE SHALL NOT BE REQUIRED TO HOLD OR CARRY A COPY OF ITS DELIVERY PERMIT IN THE DELIVERY VEHICLE.

E. A DELIVERY PERMIT SHALL NOT BE REQUIRED FOR A RETAILER TO DELIVER ALCOHOL BEVERAGES WITHIN ITS CUSTOMARY PARKING AREA.

~~C~~B. ~~Suspension/Revocation~~ SUSPENSION OR REVOCATION.

Any delivery made in violation of Title 44, Articles 3 and Article 4, or in violation of this regulation may be grounds for suspension or revocation OF THE LICENSEE'S LICENSE AND/OR DELIVERY PERMIT by the ~~State Licensing Authority~~ STATE LICENSING AUTHORITY as provided for in section 44-3-601, C.R.S.

Regulation 47-428. ~~Manufacturer~~ Sales Rooms.

B. The applicant must send a copy of the application for the sales room concurrently to the state licensing authority and to the local licensing authority in the jurisdiction in which such sales room is proposed. All applications for VINOUS OR SPIRITUOUS LIQUOR sales rooms to be operated for no more than three (3) consecutive days shall be filed with both the local and state licensing authorities not less than ten (10) business days prior to the proposed opening date.

D. The local licensing authority may submit a response to the application to the state licensing authority including its determination whether or not the approval of the proposed sales room will impact traffic, noise, or other neighborhood concerns in a manner that is inconsistent with local regulations or ordinances, which may be determined by the local licensing authority without requiring a public hearing, or that the applicant cannot sufficiently mitigate any potential impacts identified by the local licensing authority. ~~the~~ THE local licensing authority submission to the state licensing authority shall be done in a manner that provides proof of date of delivery. This includes, but not limited to, email, facsimile, or certified mail.

J. Neither the state or local licensing authority shall impose any additional fees for the processing or review of an application for a sales room

Regulation 47-432. Colorado Manufacturers– Alternating Proprietor Licensed Premises.

A. Definitions

3. "Alternating Proprietor Agreement" shall mean a written agreement between a host manufacturer and an alternating proprietor that, at minimum, conveys possession of specific alternating proprietor licensed premises within a host manufacturer's licensed premises to specific alternating proprietors, establishes the general time frame for possession of alternating proprietor licensed premises, and the manner in which each alternating proprietor will maintain control over its manufacturing operations as an independent producer. Such agreement must be approved by the ~~Liquor Enforcement~~ Division, and any changes, modifications, or termination of such agreement must also be reported to the ~~division~~ DIVISION within the time frame specified within paragraph C of this regulation.

B. Requirements of Alternating Proprietor Licensed Premises in Colorado Wineries, Breweries, and ~~Brewpubs~~ BREW PUBS

C. Application for Alternating Proprietor Licensed Premises

1. When a host manufacturer elects to alternate its licensed premises by designating a portion of its licensed premises as alternating proprietor licensed premises, it shall file notification with the ~~Liquor Enforcement~~ Division, within ten (10) days after alternation has commenced.

2. Notification shall be filed on forms prepared by the ~~Liquor Enforcement~~ Division, and shall include all applicable fees, an alternating proprietor agreement, color-coded diagrams delineating those sections of the licensed premises that are to be operated as alternating proprietor licensed premises and those sections that are to remain designated premises, and the manner in which alcohol beverage stock ownership will be identified and segregated.

Regulation 47-500. Excise Tax Audits.

Basis and Purpose. The statutory authority for this regulation is located at subsections 44-3-202(1)(b) and 44-3-503(2), C.R.S. The purpose of this regulation is to establish a regular audit for ~~brewpubs~~ BREW PUBS, distillery pubs, manufacturers, and wholesalers, and associated credits and liabilities consequential to this audit

The Department of Revenue shall cause each original monthly summary report to be audited.

A. If the audit reveals that the reporting ~~brewpub~~ BREW PUB, distillery pub, manufacturer or wholesaler shall have paid more tax, penalty, or interest than was actually due, the Department of Revenue shall issue to that ~~brewpub~~ BREW PUB, distillery pub, manufacturer or wholesaler a tax credit form reflecting the amount of overpayment. The ~~brewpub~~ BREW PUB, distillery pub, manufacturer or wholesaler may deduct the tax credit from any succeeding monthly report by attaching tax credit forms to the report.

B. If such audit reveals that the reporting ~~brewpub~~ BREW PUB, distillery pub, manufacturer or wholesaler shall have paid less tax, penalty, or interest than was actually due, the Department of Revenue shall issue to that ~~brewpub~~ BREW PUB, distillery pub, manufacturer or wholesaler a notice of assessment form reflecting the amount of underpayment. The ~~brewpub~~ BREW PUB, distillery pub, manufacturer or wholesaler must return the assessment form, along with the remittance, payable to the Department of Revenue.

Regulation 47-506. Fees.

Basis and Purpose. The statutory authority for this regulation is located at subsections 44-3-202(1)(b) and 44-3-501(3)-(4), C.R.S. The purpose of this regulation is to establish fees for certain applications, notices, reports, and services.

Below are the fees set by the State Licensing Authority pursuant to sections 44-3-501(3) and 44-3-501(4), C.R.S.

Alternating Proprietor Licensed Premises.....$150.00
Application for New License.....$1,100.00
Application for Transfer License.....$1,100.00
Application for Transfer & Conversion for an Additional Liquor-Licensed Drugstore.....$1,300.00
Branch Warehouse or Warehouse Storage Permit.....$100.00
Change of Corporate or Trade Name.....$50.00
Change of Location.....$150.00
Concurrent Review.....$100.00
Corporate/LLC Change (Per Person) $100.00
Duplicate Liquor License.....$50.00
Limited Liability Change.....$100.00
Manager Permit Registration (Liquor-Licensed Drugstore).....$100.00
Master File Background.....$250.00
Master File Location Fee (Per Location) $25.00
Modification of License Premises (City or County) $150.00
(EXCEPT THAT A TEMPORARY MODIFICATION OF LICENSED PREMISES TO ACCOMMODATE AN OUTSIDE SERVICE AREA LOCATED ON A SIDEWALK SHALL ONLY INCUR AN ANNUAL FEE OF $75.00, AS OUTLINED IN REGULATION 47-302(A)(4)).
New Product Registration (Per Unit) $0.00
Optional Premises Added to H&R License (Per Unit).....$100.00
Retail Warehouse Storage Permit.....$100.00
Sole Source Registration.....$100.00

Winery Direct Shipment Permit.....$100.00
Subpoena Testimony (Per Hour) $50.00

Regulation 47-600. Complaints against Licensees - Suspension and Revocation of Licenses.

A. Whenever a written complaint shall be filed with a licensing authority, ~~charging~~ ALLEGING A VIOLATION BY any licensee for the manufacture or sale of alcohol beverages with a violation of any law or of any of the rules or regulations adopted by the ~~State Licensing Authority~~ STATE LICENSING AUTHORITY, the licensing authority shall ~~determine by investigation or otherwise~~ INVESTIGATE, AS DEEMED APPROPRIATE, the ~~probable truth of such charges~~ ALLEGATIONS.

B. If it shall appear therefrom or shall otherwise come to the attention of the licensing authority APPEARS FROM AN INVESTIGATION that there is probable cause to believe that a licensee has violated any such law, rule or regulation, the licensing authority shall MAY issue and cause to be served upon such licensee a notice of hearing and order to show cause why its license should not be suspended or revoked.

Regulation 47-601. Assurance of Voluntary Compliance.

A. The ~~Liquor Enforcement~~ Division Director ~~or Local Licensing Authority~~ OR LOCAL LICENSING AUTHORITY may accept an Assurance of Voluntary Compliance regarding any act or practice alleged to violate Articles 3, 4 or 5 of title 44, C.R.S., or the rules and regulations thereunder, by a licensee who has engaged in, is engaging in, or is about to engage in such acts or practices.

B. The Assurance OF VOLUNTARY COMPLIANCE must be in writing and may include a stipulation for the voluntary payment of the costs of the investigation.

C. An Assurance of Voluntary Compliance may not be considered an admission of a violation for any purpose by the ~~State or Local~~ STATE OR LOCAL licensing ~~authority~~ AUTHORITY~~:~~. ~~however~~ HOWEVER, proof of failure to comply with the Assurance of Voluntary Compliance is prima facie evidence of a violation of articles 3, 4 or 5 of title 44, C.R.S., or the rules and regulation thereunder~~,~~.

D. AN ASSURANCE OF VOLUNTARY COMPLIANCE SHALL not ~~to~~ exceed nine (9) months from the date of executed agreement.

E. The ~~State Licensing Authority or Local Licensing Authority~~ STATE OR LOCAL LICENSING AUTHORITY may approve or review an Assurance of Voluntary Compliance executed by their respective agencies.

Regulation 47-605. Responsible Alcohol Beverage Vendor and Permitted Tastings by Retail Liquor Stores and ~~Liquor Licensed~~ LIQUOR-LICENSED Drugstores

C) Information for Owners and Managers

2) State Licensing and Enforcement

a) ~~How to~~ ~~contact~~ CONTACT INFORMATION FOR the ~~Liquor Enforcement~~ Division

F. Records Retention The certified seller – server training program providers for the Responsible Alcohol Beverage Vendor Program must keep proof of attendance and records of successful completion of the training for a minimum of three (3) years and make the records available to the ~~Liquor Enforcement~~ Division upon request.

Regulation 47-700. Inspection of the Licensed Premises.

A. The licensed premises, including any places of storage where alcohol beverages are stored or dispensed, shall be subject to inspections by the State or Local Licensing Authorities and their duly authorized representatives (which include investigators or peace officers) during all business hours and all other times of apparent activity, for the purpose of determining compliance with the provisions of articles 3, 4, or 5 of title 44, C.R.S., and regulations promulgated thereunder. For examination of ~~any inventory or~~ books and records required to be kept by licensees, access shall only be required during business hours. Where any part of the licensed premises consists of a locked area (for example, closets, filing cabinets, desks, safes), upon demand to the licensee, such area shall be made available for inspection without unreasonable delay; and upon request by authorized representatives of the licensing authority or peace officers, such licensee shall open said area for inspection.

Regulation 47-900. Conduct of Establishment.

B. Attire and conduct of employees and patrons.

No person licensed under Article 3, Article 4, and Article 5 of Title ~~4~~44, nor any employee or agent of such person licensed under these Articles shall engage in or permit the following:

1. Employment or use of any person in the sale or service of alcohol beverages in or upon the licensed premises while such person is unclothed or in such attire, costume or clothing as to expose to view any portion of the female breast below the top of the areola or of any portion of the ~~public~~ PUBIC hair, anus, cleft of the buttocks, vulva or genitals.

REGULATION 47-901. PUBLIC CONSUMPTION OF ALCOHOL BEVERAGES.

BASIS AND PURPOSE. THE STATUTORY AUTHORITY FOR THIS REGULATION IS FOUND AT SUBSECTIONS 44-3-202(1)(B), 44-3-202(2)(A)(I)(A), AND 44-3-202(2)(A)(I)(D), C.R.S. THE PURPOSE OF THIS REGULATION IS ESTABLISH A MECHANISM FOR AN APPROPRIATE AUTHORITY TO NOTIFY THE STATE LICENSING AUTHORITY WHEN PUBLIC CONSUMPTION ORDINANCES, RESOLUTIONS, OR RULES ARE PROMULGATED WITHIN THE APPLICABLE JURISDICTION SO THAT THE STATE LICENSING AUTHORITY IS AWARE OF THE VARYING ORDINANCES, RESOLUTIONS, OR RULES.

A. A LOCAL LICENSING AUTHORITY OR THE PARKS AND WILDLIFE COMMISSION, AS APPLICABLE, SHALL NOTIFY THE DIVISION OF ANY NEW OR AMENDED ORDINANCE, RESOLUTION, OR RULE WHICH AUTHORIZES THE PUBLIC CONSUMPTION OF ALCOHOL BEVERAGES. SUCH NOTIFICATION MUST INCLUDE A COPY OF AND CITATION TO THE ORDINANCE, RESOLUTION, OR RULE.

Regulation 47-904. Product Labeling, Substitution, Sampling and Analysis.

E. All licensees for the sale of alcohol beverages for consumption on the premises where sold shall, upon request of the ~~Department of Revenue, Liquor Enforcement~~ Division or any of its officers, make available to the person so requesting a sufficient quantity of such alcohol beverage to enable sampling or analysis thereof. The licensee shall be notified of the results of the sampling or analysis without delay.

F. The manufacturer or importer of any alcohol beverage product sold in or shipped to Colorado must register said product with the ~~Liquor Enforcement~~ Division prior to the date of the product's initial intended date of sale or shipment. If required by applicable Federal laws or regulations, alcohol beverages sold in Colorado must have obtained either a “Certificate of Label Approval” or a “Certificate of Exemption” from the Alcohol and Tobacco Tax and Trade Bureau (“TTB”).

THE MATERIAL INCORPORATED BY REFERENCE SHALL BE THOSE EFFECTIVE AS OF JANUARY 1, 2019. MATERIAL INCORPORATED BY REFERENCE IN THIS RULE DOES NOT INCLUDE LATER AMENDMENTS TO OR EDITIONS OF THE INCORPORATED MATERIAL. Copies of the material incorporated by reference may be obtained by contacting the Director of the Colorado Liquor Enforcement Division of the Department of Revenue, ~~1881 Pierce Street, Suite 108A, Lakewood, Colorado Tel: 303-205-2300~~ 1697 COLE BOULEVARD, SUITE 200, GOLDEN, COLORADO, 80401, and copies of the material may be examined at any state publication depository library.

Regulation 47-905. Colorado Wineries – Labeling and Records

D. A Colorado winery shall maintain records of the purchase and harvest of agricultural produce used in the manufacture of each of its vinous liquors. Such records shall be sufficient to verify the source of agricultural produce used in the manufacture of vinous liquors. These records shall be available for inspection by the ~~Liquor Enforcement~~ Division for a period of three years after the first sale of each vinous liquor, or longer if required by other applicable statutes or regulations.

F. A Colorado limited winery shall, on or before February 28, annually declare on a form provided by the ~~Liquor Enforcement~~ Division that it did not manufacture more than 100,000 gallons of vinous liquor in the preceding calendar year.

Regulation 47-913. Age of Employees.

~~This regulation provides guidance as to the acceptable age of employees employed in the manufacture, sale, and/or distribution of alcohol beverages.~~

A. ~~However, nothing herein~~ NOTHING WITHIN THIS REGULATION shall authorize a licensee to permit ~~an employee~~ A PERSON under the age of eighteen (18) to sell, DISPENSE, ~~or~~ serve, OR PARTICIPATE IN THE SALE, DISPENSING, OR SERVICE OF alcohol beverages ~~under any circumstances,~~.

B. EXCEPT AS OTHERWISE PROVIDED BY THIS REGULATION, ~~nor to~~ A LICENSEE SHALL NOT permit a person WHO IS at least eighteen (18) YEARS of age but less than twenty-one (21) years of age ~~to possess alcohol beverages except as part of the person's employment responsibilities authorized herein~~ TO SELL, DISPENSE, OR SERVE ALCOHOL BEVERAGES UNLESS THE EMPLOYEE IS SUPERVISED BY ANOTHER PERSON WHO IS ON THE LICENSED PREMISES AND IS AT LEAST TWENTY-ONE (21) YEARS OF AGE.

~~A~~C. ~~Retail liquor stores, liquor-licensed drug stores, taverns that do not regularly serve meals,~~ TAVERN and lodging and entertainment ~~facilities~~ LICENSEES that do not regularly serve meals:.

1. Employees or agents of the licensee who are at least twenty-one (21) years of age may handle and otherwise act with respect to malt, vinous, and spirituous liquors in the same manner as that person does with other items sold at retail and may sell such alcohol beverages or check identification of the customers of the retail outlet.

D. RETAIL LIQUOR STORE AND LIQUOR-LICENSED DRUGSTORE LICENSEES.

1. RETAIL LIQUOR STORE AND LIQUOR-LICENSED DRUGSTORE LICENSEES MAY PERMIT A PERSON WHO IS AT LEAST EIGHTEEN (18) YEARS OF AGE TO SELL, SERVE, OR PARTICIPATE IN THE SALE OR SERVICE OF MALT, VINOUS, AND SPIRITUOUS LIQUOR.

2. RETAIL LIQUOR STORE AND LIQUOR-LICENSED DRUGSTORE LICENSEES SHALL NOT PERMIT A PERSON WHO IS LESS THAN TWENTY-ONE (21) YEARS OF AGE TO DELIVER MALT, VINOUS, AND SPIRITUOUS LIQUOR PURSUANT TO REGULATION 47-426, 1 C.C.R. 203-2.

~~B~~E. ~~3.2% beer licensees (On-premises, Off-premises, and On/Off Premises) and 3.2% special event permit holders:~~ FERMENTED MALT BEVERAGE LICENSEES.

1. ~~Employees or agents of the licensee who are at least eighteen (18) years of age may handle and otherwise act with respect to fermented malt beverages in the same manner as such person would with other items sold at retail, without the supervision of persons who are at least twenty-one (21) years of age, including the sale of fermented malt beverage and checking identification of the customers of the retail outlet.~~ FERMENTED MALT BEVERAGE LICENSEES MAY PERMIT A PERSON WHO IS AT LEAST EIGHTEEN (18) YEARS OF AGE TO SELL, SERVE, OR PARTICIPATE IN THE SALE OR SERVICE OF FERMENTED MALT BEVERAGES.

2. FERMENTED MALT BEVERAGE LICENSEES FOR SALES FOR CONSUMPTION OFF THE LICENSED PREMISES SHALL NOT PERMIT A PERSON WHO IS LESS THAN TWENTY-ONE (21) YEARS OF AGE TO DELIVER FERMENTED MALT BEVERAGES PURSUANT TO REGULATION 47-426, 1 C.C.R. 203-2.

~~C~~F. ~~Except as provided in paragraph A of this regulation, retailers licensed for on-premises consumption pursuant to article 3 of title 44, C.R.S., and special~~ SPECIAL event permit holders:

~~1. Employees or agents of the licensee who are at least twenty-one (21) years of age may handle and otherwise act with respect to alcohol beverages in the same manner as that person does with other items sold at retail and may sell such alcohol beverages or check identification of the customers of the retail outlet.~~

~~2. Employees or agents of the licensee who are at least eighteen (18) years of age may handle and otherwise act with respect to alcohol beverages in the same manner as such person would with other items sold at retail and may sell such alcohol beverages or check identification of the customers of the retail outlet, as long as they are under the direct supervision of a person who is at least 21 years of age.~~

1. NO PERSON UNDER EIGHTEEN (18) YEARS OF AGE MAY SELL, SERVE, DISPENSE OR HANDLE ALCOHOL BEVERAGES.

2. MALT, VINOUS, AND SPIRITUOUS LIQUORS SPECIAL EVENT PERMITTEES MAY PERMIT A PERSON WHO IS AT LEAST EIGHTEEN (18) YEARS OF AGE BUT LESS THAN TWENTY-ONE (21) YEARS OF AGE TO SELL, SERVE, DISPENSE, OR HANDLE ALCOHOL BEVERAGES WHEN SAID PERSON IS UNDER THE DIRECT SUPERVISION OF A PERSON WHO IS AT LEAST TWENTY-ONE (21) YEARS OF AGE.

3. FERMENTED MALT BEVERAGE SPECIAL EVENT PERMITTEES MAY PERMIT A PERSON WHO IS AT LEAST EIGHTEEN (18) YEARS OF AGE TO SELL, SERVE, DISPENSE, OR HANDLE FERMENTED MALT BEVERAGES.

~~D~~G. Wholesalers and manufacturers licensed pursuant to article 3, of title ~~4~~4, C.R.S.

1. Employees or agents of the licensee who are at least twenty-one (21) years of age may handle and otherwise act with respect to alcohol beverages ~~liquors~~ in the same manner as that person does with other items sold at wholesale and may sell and/or deliver such alcohol beverages to retail outlets.

2. Employees or agents of the licensee who are at least eighteen (18) years of age may handle and otherwise act with respect to alcohol beverages in the same manner as such person would with other items sold at wholesale, as long as they are under the direct supervision of a person who is at least TWENTY-ONE (21) years of age. However, persons under the age of TWENTY-ONE (21) shall not sell malt, vinous, or spirituous liquors or check identification of the customers of the ~~retail outlet~~ PERMITTED SALES ROOM.

Regulation 47-914. Unlicensed Possession of Beverages.

EXCEPT AS PROVIDED BY SUBSECTION 44-3-107(2), C.R.S., ~~No~~ NO licensee shall possess, maintain or permit the possession, on the licensed premises, of any alcohol beverage which it is not licensed to sell or possess for sale.

Regulation 47-918. Removal of Alcohol Beverages from Premises.

A. ~~Other than those licensees described in section 44-3-423(2)(a), C.R.S. who may permit a patron to reseal a partially consumed bottle of vinous liquor (not to exceed 750 ml) which was originally sold for on-premises consumption;~~ EXCEPT AS PROVIDED BY SECTION 44-3-423, C.R.S., OR SUBSECTION 44-3-107(2), C.R.S., no licensee, manager or agent of any establishment licensed for on-premises consumption shall knowingly or recklessly permit the removal from the licensed premises of any alcohol beverages in sealed or unsealed containers.

1. Licensees that post signs as specified in ~~Section~~ SUBSECTION 44-3-901(10)(a)(II)(A), C.R.S., must post the signs at all exits in a location that can be easily identified and read by patrons using those exits.

2. Regardless of whether a licensee posts a sign as specified in ~~Section~~ SUBSECTION 44-3 901(10)(a)(II)(A), C.R.S., the licensee may be charged with knowingly permitting the removal of an alcohol beverage from the licensed premises if the licensee shows reckless disregard for the prohibition against alcohol beverage removal from the licensed premises, which may include permitting the removal of an alcohol beverage from the licensed premises three times within a twelve-month period, regardless of whether the three incidents occur on the same day or separate days. A licensee may be charged with knowingly permitting the removal of an alcohol beverage from the licensed premises upon the third occurrence of alcohol beverage removal from the licensed premises.

B. Licensees ~~described in paragraph A of this regulation~~ who MAY permit a patron to remove a partially consumed bottle of vinous liquor PURSUANT TO SECTION 44-3-423, C.R.S., shall reseal the bottle with a cork or other commercially manufactured stopper.

C. Patrons transporting a partially consumed bottle of vinous liquor in a motor vehicle shall comply with the requirements of SECTION 42-4-1305, C.R.S.

Regulation 47-924. Importation and Sole Source of Supply/Brand Registration.

B. ~~At least thirty (30) days prior~~ PRIOR to the sale or shipment of any alcohol beverages into the State of Colorado, each licensed manufacturer, non-resident manufacturer or importer shall submit to the state licensing authority a complete AND APPROVED report, on forms prepared and furnished by the state licensing authority, which shall detail: the licensee's name and license number; the designated Colorado licensed wholesaler(s); the name of the United States primary source of supply; the products to be imported, including the brand name, class or type, and fanciful name; and evidence of compliance with federal labeling requirements found in the "Federal Alcohol Administration Act" 27 CFR Subchapter A-Liquors Part 4, Subpart D; Part 5, subpart D; and Part 7, Subpart C. The import licensee, if not the product manufacturer, shall also include with said form a separate letter from the primary source of supply designating such import licensee as the primary source in the United States or the sole source of supply in Colorado. A separate form is required for each primary source. Each non-resident manufacturer, manufacturer and importer shall also remit with said form the appropriate brand registration and/or sole source fee(s). A separate sole source fee is required for each primary source that an importer represents.

THE MATERIAL INCORPORATED BY REFERENCE SHALL BE THOSE EFFECTIVE AS OF JANUARY 1, 2019. Material incorporated by reference in this rule does not include later amendments to or editions of the incorporated material. Copies of the material incorporated by reference may be obtained by contacting the Director of the Colorado Liquor Enforcement Division of the Department of Revenue, ~~1881 Pierce Street, Suite 108A, Lakewood, Colorado Tel: 303-205-2300~~ 1697 COLE BOULEVARD, SUITE 200, GOLDEN, COLORADO, 80401, and copies of the material may be examined at any state publication depository library.

Regulation 47-926. Interference with Officers.

No licensee or person shall by force or threat of force, including any letter or other communication threatening such force, endeavor to intimidate, obstruct or impede inspectors of the ~~Liquor Enforcement~~ Division, their supervisors or peace officers from exercising their duties under the provisions of this article. The term "threat of force" includes the threat of bodily harm to the officer or to a member of his/her family.

Regulation 47-930. ~~Testing of Alcohol Content – Malt Liquor and Fermented Malt Beverage.~~ REPEALED.

~~Basis and Purpose. The statutory authority for this regulation is located at subsections 12-47-202(1)(b), 12-47-202(2)(a)(I)(M), and 12-47-202(2)(a)(I)(S), C.R.S. The purpose of this regulation is to require licensees to make malt liquor and fermented malt beverage available for sampling and analysis to the Department of Revenue, Liquor Enforcement Division upon its request to assist with compliance and enforcement of alcohol content limits on fermented malt beverages.~~

~~All licensees for the sale of malt liquor and fermented malt beverage shall, upon request of the Department of Revenue, Liquor Enforcement Division, make available a sufficient quantity of such malt liquor or fermented malt beverage to enable sampling or analysis thereof. The licensee shall be notified of the results of the sampling or analysis without delay.~~

Regulation 47-1000. Qualifications for Special Event Permit.

Organizations qualifying for special events permit are described as follows:

A. Organizations that are incorporated under the laws of this state ~~for nonprofit purposes, including but not limited to,~~ for social, fraternal, patriotic, political, educational, or athletic purposes, and not for pecuniary gain.

B. ~~Local governmental entities, including~~ MUNICIPALITIES, COUNTIES, OR special districts.

C. Any ~~non-profit~~ NONPROFIT or charitable organization that is incorporated or registered with the Colorado secretary of state.

D. A regularly chartered branch, lodge, or chapter of a national organization or society organized for ~~such~~ SOCIAL, FRATERNAL, PATRIOTIC, POLITICAL, EDUCATIONAL, OR ATHLETIC purposes and ~~being~~ IS nonprofit in nature.

I. ~~Any municipality owning arts facilities at which productions or performances of an artistic or cultural nature are presented for use at such facilities.~~ REPEALED.

Regulation 47-1002. Application for Special Event Permit.

B. A local authority may elect not to notify the state licensing authority for the purpose of obtaining the state licensing authority's approval or disapproval of an application for special event permit.

Any local authority electing not to notify the state licensing authority shall promptly act upon each application for special event permit.

1. The local licensing authority acting as the sole reviewer of the application shall report to the ~~Liquor Enforcement~~ Division, within ten (10) days from issuance of a permit, the name of the permitted organization, the address of the permitted location, and the permitted dates of alcohol beverage service.

2. The ~~Liquor Enforcement~~ Division shall maintain on its public website the statewide permitting activity, which the local authority shall review prior to its approval and issuance of permits in order to ensure compliance with section 44-5-105(3), C.R.S. regarding the maximum number of permits that may be issued to an organization each calendar year.

Regulation 47-1010. Special Event Permit - Possession of Beverages.

A. No SPECIAL EVENT permittee shall allow the sale, possession, or consumption of any ALCOHOL beverages on the licensed premises when OR WHERE the sale, possession or consumption of such ALCOHOL beverages is prohibited by the permit.

B. EXCEPT AS PROVIDED BY SUBSECTION 44-3-107(2), C.R.S., ~~No~~ NO person shall possess or consume on the licensed premises any beverage other than that allowed by the type of special events permit as issued.

C. ~~Permittees may~~ SPECIAL EVENT PERMITTEES SHALL ONLY sell licensed beverages by the drink ~~only~~ to persons for consumption on the licensed premises ~~only~~.

Regulation 47-1012. Special Event Permit – Permitted Age of Servers.

Basis and Purpose. The statutory authority for this regulation is located at subsections 44-3-202(1)(b) and 44-3-202(2)(a)(I)(A), C.R.S. The purpose of this regulation is to establish age requirements for alcohol beverage ~~servers~~ EMPLOYEES, AGENTS, OR VOLUNTEERS under a special event permit.

A. No person under eighteen (18) years of age may sell, serve, dispense or ~~distribute~~ HANDLE alcohol beverages.

B. ~~Except as provided by Regulation 47-913(B), 1 C.C.R. 203-2, a~~ MALT, VINOUS, AND SPIRITUOUS LIQUORS SPECIAL EVENT PERMITTEES MAY PERMIT A person who is ~~between~~ AT LEAST eighteen (18) YEARS OF AGE ~~and twenty (20)~~ BUT LESS THAN TWENTY-ONE (21) years of age ~~may~~ TO sell, SERVE, ~~and~~ dispense, OR HANDLE alcohol beverages when said person is under the direct supervision of a person who is at least twenty-one (21) years of age.

C. Fermented malt beverage special event permittees may permit a person who is at least eighteen (18) years of age to sell, serve, dispense, or handle fermented malt beverages.

Regulation 47-1014. Special Event Permit - Complaint against Permittee- Cancellation-Revocation of Permit.

~~Whenever a written complaint is filed with the state or local licensing authority or shall otherwise come to the attention of the licensing authority, that a violation of the provisions of article 5 occurred, and the special event permittee, its agents, employees, or its members, violated the provisions of articles 3, 4, or~~

~~5, of title 44, C.R.S., upon proper investigation of such charges~~ UPON INSPECTION, NOTICE, AND HEARING, the STATE OR LOCAL licensing authority may ~~upon notice and hearing,~~ suspend or revoke ~~such~~ A special event permit and may further order the denial of future applications for another special event permit ~~to be~~ submitted by the same organization.

Regulation 47-1016. Special Event Permittee - Purchase and Storage of Alcohol Beverages.

A. Special event permittees may purchase ~~the kinds of~~ alcohol beverages ~~they are~~ authorized by such permits ~~to sell~~ from a licensed wholesaler, ~~brewpub~~ BREW PUB, distillery pub, limited winery, vintner's restaurant, retail liquor store, or liquor-licensed drugstore.

B. ~~Permit holders~~ SPECIAL EVENT PERMITTEES may store alcohol beverage stock in areas outside the designated event area approved by the ~~respective licensing authorities~~ STATE OR LOCAL LICENSING AUTHORITY under the following conditions:

~~A~~1. The application included the address of proposed storage locations and a diagram of said premises.

~~B~~2. The application included evidence of the ~~permit holder's~~ SPECIAL EVENT PERMITTEE'S lawful possession of the storage premises by way of deed, lease, rental, or other arrangement and specifying the terms of storage.

~~C~~3. The proposed location is not a location licensed pursuant to articles 3 or 4 of title ~~44~~, C.R.S.

~~D~~4. ~~The applicant acknowledges that state~~ STATE and local law enforcement authorities have the right ~~of inspection of~~ TO INSPECT each storage area that is used for permitted events.

~~E~~5. ~~The applicant acknowledges that storage~~ STORAGE areas may only be maintained in anticipation of scheduled events. Nothing herein shall authorize long-term storage of alcohol beverages that have no nexus to events.

~~F~~6. A licensed wholesaler may deliver alcohol beverages purchased by a special event permittee to the storage location in accordance to ~~paragraphs A, B, C and D,~~ SUBSECTIONS (B)(1), (B)(2), (B)(3), AND (B)(4) OF THIS REGULATION, but such storage cannot be more than two (2) business days prior to the date for the special event. If a licensed wholesaler donates alcohol to the special event permittee, the wholesaler may pick up such unused donated alcohol beverage products from the storage area in accordance to ~~paragraphs A, B, C and D~~ SUBSECTIONS (B)(1), (B)(2), (B)(3), AND (B)(4) OF THIS REGULATION. Such removal of unused donated alcohol beverage products must occur within two (2) business days after the end of the special event permit.

Regulation 47-1018. Special Event Permittee - Supplier Financial Assistance.

A. Licensed suppliers may furnish financial support and/or services to organizations, ~~as defined by article 5 of title 44, C.R.S~~ that qualify for a special events permit. ~~Support~~ ANY FURNISHED FINANCIAL SUPPORT AND/OR SERVICES shall be in connection with public service or non-profit ~~fund raising~~ FUNDRAISING activities including, but not limited to, events such as:

1. ~~fairs~~ FAIRS,

2. ~~sporting~~ SPORTING events,

3. ~~agricultural~~ AGRICULTURAL exhibitions,

4. ~~educational~~ EDUCATIONAL clinics,

5. ~~concerts~~ CONCERTS, and

6. ~~other~~ OTHER similar events.

B. A supplier may furnish or share the cost of advertisements, signs, promotional materials and items of a similar nature used in connection with a non-profit special events permit.

C. Support shall not be conditioned, directly or indirectly, upon the present or future purchase of an alcohol beverage ~~or fermented malt beverage~~ or the exclusive sale of a supplier's product at such events.

Regulation 47-1020. Alcohol Beverage Donations.

A. For purposes of this regulation, “wholesaler” means an entity licensed to sell alcohol beverages at wholesale to special event permit holders, including wholesalers of malt liquor and fermented malt beverages, wholesalers of vinous and spirituous liquors, limited wineries, ~~brewpubs~~ BREW PUBS, distillery pubs and vintner’s restaurants.

B. A wholesaler may donate alcohol beverages to a special event permittee at no cost if such ALCOHOL beverages are used for hospitality or ~~fund raising~~ FUNDRAISING purposes, including resale by the drink. The wholesaler shall provide an invoice documenting the donation of ~~such products~~ ALCOHOL BEVERAGES to the permittee and shall ensure that all applicable state excise taxes are paid pursuant to section 44-3-503, C.R.S.

C. Nothing herein shall prohibit a retailer licensed for off-premises consumption to make a donation of alcohol beverage to a special event ~~permit holder~~ PERMITTEE, as long as such donation is taken from the retailer’s existing inventory.

D. Wholesalers and retailers licensed for off-premises consumption may make a donation of alcohol beverages to organizations that would otherwise qualify for a special events permit but are exempted under section 44-5-108, C.R.S. The wholesaler shall provide an invoice documenting the donation of ~~such products~~ ALCOHOL BEVERAGES to the organization and shall ensure that all applicable state excise taxes are paid pursuant to section 44-3-503, C.R.S. However, nothing herein shall authorize a wholesale licensee to deliver such alcohol beverages to premises that are not licensed pursuant to articles 3 or 4 of title 44, C.R.S.

E. When an event, for which the alcohol donations are solicited, is held at a retail location licensed for on-premises consumption pursuant to article 3 or 4 of title 44~~,~~;

1. ~~the~~ THE wholesaler shall invoice the retailer at no cost for alcohol ~~beverage products~~ BEVERAGES intended for the event, if the retail licensee consents to such an arrangement.

2. Any such donated ~~product~~ ALCOHOL BEVERAGES which ~~is~~ ARE unused must be returned by the retailer to the wholesaler as soon as practicable after the event.

3. If the unused ~~product is~~ ALCOHOL BEVERAGES ARE not returned, then the wholesaler must charge the retailer at least the ~~minimum of~~ LAID-IN cost for those ~~products~~ ALCOHOL BEVERAGES.

4. The retail value of any donation OF ALCOHOL BEVERAGES from a retailer licensed for off-premises consumption to a non-profit event held at a retail location licensed for on-

premises consumption will count against the on-premises licensee's statutory dollar limit of alcohol BEVERAGES purchased from an off-premises retailer.

REGULATION 47-1022. DONATED ALCOHOL BEVERAGES IN SEALED CONTAINERS FOR AUCTION FOR FUNDRAISING PURPOSES.

A. FOR PURPOSES OF SUBSECTION 44-3-107(2), C.R.S., "DONATED" OR "OTHERWISE LAWFULLY OBTAINED" ALCOHOL BEVERAGES MEAN:

1. ALCOHOL BEVERAGES DONATED PURSUANT TO REGULATION 47-1020, 1 C.C.R. 203-2; OR

2. ALCOHOL BEVERAGES DONATED BY A PRIVATE INDIVIDUAL WHO IS AT LEAST TWENTY-ONE (21) YEARS OF AGE AND LAWFULLY OBTAINED THE ALCOHOL BEVERAGES SHE OR HE IS DONATING; OR

3. ALCOHOL BEVERAGES DONATED BY AN ENTITY THAT DOES NOT HOLD A LIQUOR LICENSE PURSUANT TO ARTICLES 3 OR 4 OF TITLE 44, C.R.S. AND LAWFULLY OBTAINED THE ALCOHOL BEVERAGES IT IS DONATING. THE AGENT OR REPRESENTATIVE OF THE DONATING ENTITY MUST BE A PRIVATE INDIVIDUAL WHO IS AT LEAST TWENTY-ONE (21) YEARS OF AGE AND LAWFULLY OBTAINED THE ALCOHOL BEVERAGES SHE OR HE IS DONATING.

NOTICE OF RULEMAKING HEARING

Department of Revenue
Liquor Enforcement Division

The State Licensing Authority of the Colorado Department of Revenue, Liquor Enforcement Division, will consider the promulgation of amendments to its Rules and Regulations as authorized by the Colorado Liquor Code, sections 44-3-101 *et seq.*, C.R.S. For specific information and language concerning the proposed changes, please refer to the contents of this Notice and to the proposed rules that are set forth following this notice and are also at the Colorado Department of Revenue, Liquor Enforcement Division's website at www.colorado.gov/enforcement/liquor.

STATUTORY AUTHORITY FOR RULEMAKING

The State Licensing Authority promulgates these rules pursuant to the authority granted in section 44-3-202, C.R.S., of the Colorado Liquor Code and section 24-4-103, C.R.S., of the Administrative Procedure Act.

SUBJECT OF RULEMAKING

The proposed rules and relevant information are posted on the Colorado Department of Revenue, Liquor Enforcement Division's website at www.colorado.gov/enforcement/liquor. In addition, the proposed rules attached to this Notice are fully incorporated herein.

The State Licensing Authority will consider the promulgation of the following list of new rules and/or existing rules with changes proposed. For specific information and language concerning the proposed changes, please refer to the proposed rules that are set forth with this notice, at the Colorado Department of Revenue, Liquor Enforcement Division's website, and on the Colorado Secretary of State's website.

RULES TO BE CONSIDERED FOR AMENDMENT OR ADOPTION

The Rules to be considered for amendment or adoption are described as follows:

Regulation 47-002. Fermented Malt Beverages – Advertising Practices.
Regulation 47-004. Fermented Malt Beverages – Possession of Alcohol Liquors.
Regulation 47-006. Fermented Malt Beverages – Identification and Labeling.
Regulation 47-008. Fermented Malt Beverages – Limitations of License.
Regulation 47-010. Items Approved for Sale in Fermented Malt Beverage Off-Premises Licenses
Regulation 47-100. Definitions.
Regulation 47-104. Winery Direct Shipper's Permits.
Regulation 47-200. Petitions for Statements of Position and Declaratory Orders Concerning the Colorado Liquor, Beer or Special Event Codes.
Regulation 47-301. Undue Concentration of Licenses.

Regulation 47-302. Changing, Altering, or Modifying Licensed Premises.
Regulation 47-303. License Renewal.
Regulation 47-304. Transfer of Ownership and Changes in Licensed Entities.
Regulation 47-305. Transfers – Wholesaler Confirmation.
Regulation 47-306. Change of Trade Name.
Regulation 47-307. Master Files
Regulation 47-310. Application – General Provisions.
Regulation 47-313. Tastings.
Regulation 47-314. Limited Liability Company.
Regulation 47-315. Lodging and Entertainment License.
Regulation 47-316. Advertising Practices.
Regulation 47-318. Owner-Manager.
Regulation 47-319. Liquor-Licensed Drugstore Manager Permit.
Regulation 47-321. Bona Fide Loyalty or Rewards Programs – Discontinued Sales – Close-Out Sales.
Regulation 47-322. Unfair Trade Practices and Competition.
Regulation 47-326. Distance Restriction – Applicability and Measurement.
Regulation 47-407. Liquor-Licensed Drugstore.
Regulation 47-418. Restaurants.
Regulation 47-426. Delivery of Alcohol Beverages.
Regulation 47-428. Sales Rooms.
Regulation 47-432. Colorado-Manufacturers – Alternating Proprietor Licensed Premises.
Regulation 47-500. Excise Tax Audits.
Regulation 47-506. Fees.
Regulation 47-600. Complaints against Licensees – Suspension and Revocation of Licenses.
Regulation 47-601. Assurance of Voluntary Compliance.
Regulation 47-605. Responsible Alcohol Beverage Vendor and Permitted Tastings by Retail Liquor Stores and Liquor Licensed Drugstores.
Regulation 47-700. Inspection of the Licensed Premises.
Regulation 47-900. Conduct of Establishment.
Regulation 47-901. Public Consumption of Alcohol Beverages.
Regulation 47-904. Product Labeling, Substitution, Sampling and Analysis.
Regulation 47-905. Colorado Wineries – Labeling and Records.
Regulation 47-913. Age of Employees.
Regulation 47-914. Unlicensed Possession of Beverages.
Regulation 47-918. Removal of Alcohol Beverages from Premises.
Regulation 47-924. Importation and Sole Source of Supply/Brand Registration.
Regulation 47-926. Interference with Officers.
Regulation 47-930. Testing of Alcohol Content – Malt Liquor and Fermented Malt Beverage.
Regulation 47-1000. Qualifications for Special Event Permit.
Regulation 47-1002. Application for Special Event Permit.
Regulation 47-1010. Special Event Permit – Possession of Beverages.
Regulation 47-1012. Special Event Permit – Permitted Age of Severs.

Regulation 47-1018. Special Event Permmittee – Supplier Financial Assistance.
Regulation 47-1020. Alcohol Beverage Donations.
Regulation 47-1022. Donated Alcohol Beverages in Sealed Containers for Auction for Fundraising Purposes.

RULEMAKING RECORD AND PUBLIC PARTICIPATION

1. Official Rulemaking Record. The official record for purposes of the rulemaking hearing to be held on November 1, 2018 will include any written comments or oral testimony submitted or presented.

2. Written Comments. The State Licensing Authority encourages interested parties to submit written comments on the proposed rules, including alternate proposals, by October 25, 2018 so that the State Licensing Authority can review comments prior to the rulemaking hearing. Written comments will also be accepted after that date. The deadline to submit written comments is 5:00 P.M. on November 8, 2018.

   Written comments may be emailed to: dor_led@state.co.us. In addition, you may submit written comments to:

   Liquor Enforcement Division – Room 108
   Attn: Rules
   1881 Pierce Street, Suite 108
   Lakewood, Colorado 80214

   Written comments will be accepted at the rulemaking hearing as well.

3. Oral Comments. At his/her discretion, the State Licensing Authority may afford interested parties an opportunity to make brief oral presentations at the rulemaking hearing.

   If allowed, oral presentations will likely be limited to two minutes or less per person. Individuals will not be allowed to cede their time to another person (for instance, one person speaking on behalf of five people will not be given ten minutes to speak). Organized groups of individuals are urged to identify one spokesperson and to be concise. The State Licensing Authority encourages interested parties to avoid duplicating previously-submitted material and testimony.

HEARING SCHEDULE

Date:	November 1, 2018
Time:	9:00 a.m.
Location:	1707 Cole Blvd, Golden, CO 80401, Suite 300, Marijuana Enforcement Division "Red Rocks" Conference room

Location of the rulemaking hearing will also be posted on the Liquor Enforcement Division's website and the Secretary of State's website.

The hearing may be continued at such place and time as the State Licensing Authority may announce.

The State Licensing Authority shall deliberate upon testimony and written submissions presented at this hearing, as well as applicable legal provisions and any related matters properly submitted before the hearing record is closed. Pursuant to said hearing, in the above-entitled matter at the time and place aforesaid, or at any adjourned meeting, the State Licensing Authority will adopt such rules as in its judgment are justified by the rulemaking record and applicable legal provisions.

If you are an individual with a disability who needs a reasonable accommodation in order to participate in this rulemaking hearing, please contact Chris Manning at Chris.Manning@state.co.us no later than October 25, 2018.

Dated this 26th day of September, 2018.

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

Michael S. Hartman
State Licensing Authority
Colorado Department of Revenue

Notice of Proposed Rulemaking

Tracking number

2018-00496

Department

200 - Department of Revenue

Agency

204 - Division of Motor Vehicles

CCR number

1 CCR 204-10

Rule title

TITLE AND REGISTRATION SECTION

Rulemaking Hearing

Date

11/19/2018

Time

09:30 AM

Location

1881 Pierce Street Room 110

Subjects and issues involved

The purpose of this rule is to establish criteria for the Retirement of Group Special and Alumni License Plates.

Rule 20

Statutory authority

Added below to comments (over 500 char)

Contact information

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Title

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Notice of Proposed Rulemaking

Tracking number

2018-00497

Department

200 - Department of Revenue

Agency

204 - Division of Motor Vehicles

CCR number

1 CCR 204-10

Rule title

TITLE AND REGISTRATION SECTION

Rulemaking Hearing

Date

11/19/2018

Time

09:30 AM

Location

1881 Pierce Street Room 110

Subjects and issues involved

The purpose of this rule is to establish criteria for the application, responsibilities, and processes for Alumni License Plates.

Rule 45

Statutory authority

42-1-204, and 42-3-214 C.R.S.

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DEPARTMENT OF REVENUE

Division of Motor Vehicles – Title and Registration Sections

1 CCR 204-10

RULE 45. ALUMNI LICENSE PLATES

Basis: The statutory bases for this rule are 42-1-204, and 42-3-214 C.R.S.

Purpose: ~~This~~ The purpose of this rule is ~~promulgated~~ to establish criteria for the ~~and clarify~~ application, responsibilities, and processes ~~and responsibilities~~ for ~~the issuance and maintenance of~~ Alumni License Plates.

1.0 Definitions

1.1 "Alumni License Plate" means a special license plate issued to recognize an alumni association of a private or public college or university that is located within Colorado pursuant to section 42-3-214, C.R.S.

1.2 "Notice of Approval" means written notice issued by the Department approving establishment of a new Alumni License Plate.

1.3 "Certificate" for the purpose of this rule means the Department approved-letter, voucher, or other document issued by an alumni association as evidence that a person is qualified to receive an Alumni License Plate. A Certificate may be issued in electronic or digital format instead of paper, if approved by the Department.

1.4 "Pre-Certification Qualifier" means a condition(s) that must be met in order to qualify for issuance of an Alumni License Plate.

1.5 "Registered" for the purpose of this rule means a vehicle with an unexpired registration as provided in sections 42-3-102 and 42-3-114, C.R.S., that is currently issued the Alumni License Plate, unless the context otherwise requires.

1.6 "Retire" or "Retirement" means the discontinuation of the production of the Alumni License Plate.

1.7 "Secure and Verifiable Identification" means a form of identification listed on form DR 2841 Secure and Verifiable ID.

2.0 Application for Creation of Alumni License Plates

2.1 An alumni association that meets the requirements of section 42-3-214, C.R.S., and this rule may apply for the creation of an Alumni License Plate.

2.2 A college or university may have only one Alumni License Plate. If an alumni association is able to demonstrate that a college or university is independent from its parent college or university, either by statute, separate accreditation by a nationally recognized accrediting agency or association, or other bases, then the alumni association may apply for an Alumni License Plate pursuant to section 42-3-214, C.R.S., and this rule.

2.3 An alumni association may apply for the creation of an Alumni License Plate by submitting an application supplied by the Department to the Title and Registration Section, Division of Motor Vehicles. Applications may be submitted in paper or electronic form. Incomplete applications will not be accepted or retained.

a. Applications must be signed by the alumni association's designated representative, who shall affirm that the alumni association has complied with the requirements of section 42-3-214, C.R.S. and this rule. In addition to the signed application, the alumni association must submit:

1. Commitments from at least five hundred persons to purchase an Alumni License Plate, including the name, addresses of residence, signature, and ~~county of residence~~ date signed for each person.

A. Purchase commitments may be submitted in either paper, electronic, or digital format, as required by the Department.

B. Purchase commitments are not transferable between applications for different Alumni License Plates.

C. Purchase commitments are valid for two years from the date ~~they are~~ signed prior to being submitted with the application to the Department.

D. With prior approval of the Department, the alumni association may use electronic or digital methods to collect purchase commitments. Electronic or digital methods may include, but are not limited to, web petitions or electronic mail.

2. Proof that the college or university is: (1) an institution of higher education that offers at least a bachelor's degree; (2) accredited by a nationally recognized accrediting agency or association; and (3) located in Colorado.

3. A sample Certificate (paper, electronic, or digital) with a written description of security features (serialization, watermarks, holograms, etc.) incorporated into the Certificate. Sample Certificates must be provided to the Department prior to issuing Certificates to qualified individuals. An individual's name on a Certificate must be identical to that listed on the individual's Secure and Verifiable Identification. Certificates are not transferable and are valid for issuance and registration of one set (single if a motorcycle) of Alumni License Plates. The Department will destroy the Certificate upon issuing the Alumni License Plate. The Certificate must contain an area in which the alumni association ~~will~~ may place a Department system generated serial number/PIN.

4. Proof that the alumni association has the legal right to use all logos, designs, colors and other intellectual property in the proposed design of the Alumni License Plate.

5. A description of the qualifications the alumni association has established for eligibility to obtain a Certificate. The qualifications may be either membership in the alumni association or specified levels of monetary contributions to the college or university. If the alumni association has no qualifications, the alumni association must provide a written statement of this fact.

A. If the qualifications include monetary contributions to the college or university, the application must specify what monetary level of contributions are required.

6. ~~If the alumni association has established qualifications to use alumni license plates, a description of how the one-time fee required for qualification for the Alumni License Plate will be used. The use may be~~ If a monetary donation is required, the alumni association must provide a document that demonstrates the use of those funds to be for either scholarships for students attending the college or university or support of academic programs at the college or university.

2.4 ~~Upon receipt of the Notice of Approval, the alumni association must submit~~ Proof of payment for the ~~costs of the plate~~ design was submitted ~~in the form of a~~ by check or money order directly to Colorado Correctional Industries. The design fee becomes non-refundable upon the receipt of the Approval Notification from the Department.

2.5 The alumni association must meet all requirements under section 42-3-214, C.R.S. and this rule prior to the production and issuance of the Alumni License Plate.

3.0 Approved Alumni License Plates: Responsibilities and Processes

3.1 Alumni License Plates must be designed within the parameters established by the Department. The Department may deny any design violating such parameters.

a. Design changes requested after the design has been approved must be submitted in writing to the Department by the alumni association, and signed by its designated representative. Supporting documentation for the design change is required and may include, but is not limited to, issuance trends, current inventory levels, and costs associated with changes. If the change request is approved, the alumni association must prepay all design costs directly to Colorado Department of Corrections Division of Correctional Industries prior to production of the new design. Design changes are effective upon approval by the Department. If approval is granted while existing inventory is available, and the alumni association requests that the new plates be implemented prior to the sale of such inventory, the alumni association must pay all costs associated with the recall, collection, and destruction of existing inventory. Registered vehicle owners may continue to use their current alumni license plate regardless of any subsequent design change; provided that such plate will not be replaced if the inventory is destroyed, exhausted, or the Department has determined not to issue additional plates of the prior design or designs.

3.2 Upon completion of the proposed Alumni License Plate design, the alumni association will receive one sample of the approved plate design. Sample plates used in the design approval process are the property of the Department. The alumni association may request up to five samples for marketing and display purposes upon payment of material fees for each sample plate, as established in section 42-3-301, C.R.S. Sample plates will be produced using the standard passenger size license plate with the standard sample plate numbers assigned by the Department. Non-standard plate number requests will not be accepted.

a. The Department must be given at least one business day in advance notice from the alumni association of all news releases, interviews, or mass communications that reference the Alumni License Plate.

3.3 Alumni License Plates ~~typically~~ are produced through a print on demand process, which does not require pre-stocking of inventory. However, the Department may use methods other than print on demand if the Department deems it appropriate.

3.4 The Department will not distribute thank you notes, requests for contributions, or other materials on behalf of the alumni association.

3.5 The college or university for which an alumni association applies to establish an Alumni License Plate must continuously be located in Colorado, offer at least a bachelor degree in an educational program, and be accredited by a nationally recognized accrediting agency or association pursuant to sections 42-3-214(2)(a) and 42-3-214(2)(c), C.R.S.

a. If a college or university no longer meets this requirement, the Department may Retire the Alumni License Plate pursuant to Code of Colorado Regulations 1 CCR 204-10 Rule 20. License Plate Retirement, and, if Retired, the alumni association must eliminate the Pre-Certification Qualifier, if any. ~~At that time the alumni association must cease to associate itself in any way with the Alumni License Plate.~~

3.6 If an alumni association has Pre-Certification Qualifiers, it ~~must~~ may enter information for each individual who the alumni association has approved to be issued the Alumni License Plate into Department maintained systems and record the system generated serial number/PIN on the Certificate. If the alumni association enters the system generated serial number/PIN on the Certificate the ~~The~~ Department ~~will~~ may use the serial number/PIN to authenticate the Certificate.

3.7 The alumni association must notify the Department in writing if its right to use the Alumni License Plate is transferred to a successor alumni association. The successor alumni association must meet all statutory and regulatory requirements.

3.8 An alumni association may request changes to its Certificate. Requests must be submitted in writing, and any change must be approved by the Department prior to issuing the new Certificate. Any changes must meet the requirements of this rule. Upon approval, the Department will work with the alumni association to establish an effective date upon which the alumni association may begin to issue the new Certificate. Only new Certificates will be accepted by the Department after the effective date of the new Certificate; provided, however, that the Department will accept an old Certificate if it was issued by the alumni association before the effective date of the new Certificate.

3.9 Alumni License Plates will be issued beginning on the issuance date specified in the Notice of Approval.

3.10 The Department may audit an alumni association. The audit may include, but is not limited to, a review of accounting, financial, tax, and Pre-Certification Qualifiers.

a. If the Department determines that the college or university or the alumni association has violated or no longer meets the requirements of section 42-3-214, C.R.S., or this rule, the Department may require additional information or, at the Department's discretion, may Retire the Alumni License Plate pursuant to Code of Colorado Regulations 1 CCR 204-10 Rule 20. License Plate Retirement.

b. If the Department requires additional information, and the information is not provided or does not change the Department's determination that the college or university or the alumni association has violated or no longer meets the requirements of section 42-3-214, C.R.S, the Department may Retire the Alumni License Plate pursuant to Code of Colorado Regulations 1 CCR 204-10 Rule 20. License Plate Retirement.

3.11 Alumni associations with Alumni License Plates established prior to this rule must meet the requirements of this rule except as otherwise provided herein and/or pursuant to a contract between the alumni association and the Department that establishes requirements that differ from this rule.

4.0 Denial and Retirement Appeals

4.1 If an alumni association's application for an Alumni License Plate has been denied, it may request a hearing, in writing, within 60 days after a notice of denial is issued. Written hearing requests shall be submitted to the Department of Revenue, Hearings Section.

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

4.3 An Alumni License Plate will be Retired pursuant to Code of Colorado Regulations 1 CCR 204-10 Rule 20. License Plate Retirement.

Notice of Proposed Rulemaking

Tracking number

2018-00495

Department

200 - Department of Revenue

Agency

204 - Division of Motor Vehicles

CCR number

1 CCR 204-10

Rule title

TITLE AND REGISTRATION SECTION

Rulemaking Hearing

Date

11/19/2018

Time

09:30 AM

Location

1881 Pierce Street Room 110

Subjects and issues involved

The purpose of this rule is to establish criteria for the application, responsibilities, and processes for group special license plates.

Statutory authority

42-1-102(41.5), 42-1-204, 42-3-207, 42-3-208 and 42-3-301, C.R.S.

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DEPARTMENT OF REVENUE

Division of Motor Vehicles – Title and Registration Section

1 CCR 204-10

Rule 16. GROUP SPECIAL LICENSE PLATES

Basis: The statutory bases for this rule are 42-1-102(41.5), 42-1-204, 42-3-207, 42-3-208 and 42-3-301, C.R.S.

Purpose: ~~This~~ The purpose of this rule is ~~promulgated~~ to establish criteria for the application, responsibilities, and processes for group special license plates.

1.0 Definitions

1.1 "Approval Notification" means written notification by the Executive Director of the Department of Revenue to a Nonprofit confirming that the Nonprofit has complied with the statutory and regulatory requirements necessary to seek legislative action to authorize a new group special license plate.

1.2 "Certificate" for the purpose of this rule means a Department approved-letter, voucher, or other document issued by a Nonprofit to a person as evidence that the person is qualified to receive a group special license plate. A Certificate may be in electronic or digital format instead of paper, if approved by the Department.

1.3 "Group Special License Plate Created through Rule" means the Air Force Commemorative, Columbine, Firefighters, Greyhound Lovers, Pioneer, and Raptor Education Foundation license plates.

1.4 "Group Special License Plate Created through Statute" means a group special license plate created on or after January 1, 2001 through its authorizing legislation.

1.5 "Nonprofit" means an entity that is a 501(c)(3) corporation under the Internal Revenue Code or an entity holding charitable nonprofit status with the Colorado Secretary of State.

1.6 "Pre-Certification Qualifier" means a condition(s) that must be met in order to qualify for issuance of a group special license plate by the Department.

1.7 "Registered" for the purpose of this rule means a vehicle with an unexpired registration as provided in sections 42-3-102 and 42-3-114, C.R.S., that is currently issued the group special license plate, unless the context otherwise requires.

1.8 "Retire" or "Retirement" means the discontinuation of the production of the group special license plate.

1.9 "Secure and Verifiable Identification" means an identification document listed on form DR 2841 Secure and Verifiable ID.

2.0 Application for Approval to Seek Creation of Group Special License Plates

2.1 Any Nonprofit may apply for an Approval Notification authorizing the Nonprofit to seek legislation to create a group special license plate.

2.2 A Nonprofit that has satisfied all statutory and regulatory requirements for proposing the creation of a group special license plate may submit an application supplied by the Department to the Title and Registration Section, Division of Motor Vehicles. Incomplete applications will not be accepted or retained.

a. Applications must be signed by the Nonprofit's designated representative. In addition to the signed application, the Nonprofit must submit:

1. Petition sheets with the names, addresses~~, counties~~ of residence, date signed, and signatures of at least three thousand (3,000) Colorado registered vehicle owners who have committed to purchase the proposed group special license plate. Petition sheets must be submitted in either paper, electronic, or digital format, as required by the Department. Petitions are not transferable between applications for different group special license plates. Petition~~s~~ signatures are valid for two years from the date signed prior to being submitted with the application to the Department. Petition sheets are valid for two consecutive legislative sessions from the date submitted with the application to the Department.

A. With prior approval of the Department, a Nonprofit may use electronic or digital methods to obtain commitments to purchase the group special license plate.

B. Electronic or digital methods may include, but are not limited to, web petitions, or electronic mail.

2. Proof of Nonprofit status by submitting a current letter from the Internal Revenue Service confirming 501(c)(3) status or a document from the Colorado Secretary of State confirming the Nonprofit is holding charitable nonprofit status.

3. A sample Certificate (paper, electronic, or digital) with a written description of security features (serialization, watermarks, holograms, etc.) incorporated into the Certificate. The Nonprofit must provide a sample Certificate to the Department for approval before the Nonprofit can issue Certificates to qualified individuals. A Nonprofit may not issue a Certificate prior to the effective date of the enabling legislation. An individual's name on a Certificate must be identical to that listed on the individual's Secure and Verifiable Identification. Certificates are not transferable and are valid for issuance and registration of one set (single if a motorcycle) of group special license plates. The Department will destroy the Certificate upon issuing the group special license plate. The Certificate must contain an area in which the Nonprofit ~~will~~ may place a Department system generated serial number/PIN.

4. Proof that the Nonprofit has the legal right to use all logos, designs, colors and other intellectual property in the proposed design of the group special license plate.

5. Proof that payment for the design was submitted by check or money order directly to Colorado Correctional Industries. The design fee becomes non-refundable upon the receipt of the Approval Notification from the Department.

6. A list of Pre-Certification Qualifiers required by the Nonprofit. If there are no Pre-Certification Qualifiers, the Nonprofit must provide a written statement that the Nonprofit will not require Pre-Certification Qualifiers for persons to be issued the group special license plate.

A. If a monetary donation is required, the Nonprofit must provide a document that demonstrates that the use of those funds meets statutory and regulatory requirements.

2.3 Upon receipt of the Approval Notification, the Nonprofit is solely responsible for obtaining a bill sponsor to propose legislation. The Department will retain the application for two ~~years~~ consecutive legislative sessions from the date of the Approval Notification.

a. If the Nonprofit fails to obtain a bill sponsor within two years of issuance of the Approval Notification, and it desires to continue to seek creation of the group special license plate, the Nonprofit must re-apply, submit a new application and documents, and meet all statutory and regulatory requirements in effect at that time. Applications, documents, and other materials previously submitted to satisfy the application requirements are not transferable to the new application.

3.0 Enacted Group Special License Plates Responsibilities and Processes

3.1 A group special license plate must be designed within the parameters established by the Department. The Department may deny any design violating such parameters.

a. A group special license plate design shall not include a logo or other image copyrighted, trademarked, registered, or otherwise commonly associated with a for-profit entity, whether or not the Nonprofit is a division of or otherwise associated with the for-profit entity. Use of symbols not subject to trademark, copyright, or other legal protection may be approved if such use does not violate the parameters established by the Department. The Department shall have final approval authority on all logo designs and placement on the group special license plate.

b. Design change requests after the design has been approved must be submitted in writing to the Department by the Nonprofit. The Department may require supporting documentation, including, but not limited to, issuance trends, current inventory levels, and costs associated with changes. If the change request is approved, the Nonprofit shall prepay all design costs directly to Colorado Department of Corrections Division of Correctional Industries prior to production of the new design. Design changes are effective upon approval by the Department. If approval is granted while existing inventory is available and the Nonprofit requests that the new plates be issued prior to the sale of such inventory, the Nonprofit shall pay all costs associated with the recall, collection, and destruction of existing inventory. Registered vehicle owners may continue to use their current group special license plate regardless of any subsequent design change, provided such plate will not be replaced if the inventory is destroyed, exhausted, or the Department has determined not to issue additional plates.

3.2. Upon completion of the proposed group special license plate design, the Nonprofit will receive one sample of the approved plate design. Sample plates used in the design approval process are the property of the Department. The Nonprofit may request up to five samples for marketing and display purposes upon payment of material fees for each sample plate, as established in section 42-3-301, C.R.S. Sample plates will be produced using the standard passenger size license plate with the standard sample plate numbers assigned by the Department. Requests for non-standard sample plate number will not be accepted. The Department must be given at least one business day in advance notice from the Nonprofit of all news releases, interviews, or mass communications that reference the group special license plate.

3.3 Group special license plates ~~typically~~ are produced through a print on demand process, which does not require pre-stocking of inventory. However, the Department may utilize methods other than print on demand if the Department deems it appropriate.

3.4 The Department will not distribute thank you notes, requests for contributions, or other materials on behalf of the Nonprofit.

3.5 The Nonprofit must continuously maintain its Nonprofit status. A letter from the Internal Revenue Service confirming 501(c)(3) status or a document from the Colorado Secretary of State's Office confirming that the Nonprofit is holding charitable nonprofit statute must be submitted to the Department annually on or before June 1st.

a. If at any time it is determined that an entity no longer has Nonprofit status, the group special license plate will be Retired pursuant to Code of Colorado Regulations 1 CCR 204-10 Rule 20. License Plate Retirement. Upon Retirement, the entity must cease seeking any donation authorized pursuant to its respective authorizing statute, and must cease to associate itself in any way with the group special license plate.

3.6 If a Nonprofit has Pre-Certification Qualifiers, it ~~must~~ may enter into systems maintained by the Department information for each individual who has been approved for the receipt of a group special license plate and, for each, record the system generated serial number/PIN on the Certificate. If the Nonprofit enters the system generated serial number/PIN on the Certificate the ~~The~~ Department ~~will~~ may use the serial number/PIN to authenticate the Certificate.

3.7 The Nonprofit must notify the Department in writing if its authority regarding the group special license plate is transferred to a successor Nonprofit, as provided in the group special license plates respective authorizing statute. The successor Nonprofit must meet all statutory and regulatory requirements.

3.8 A Nonprofit may request changes to its Certificate. Requests must be submitted in writing, and any change must be approved by the Department before the Nonprofit can issue the new Certificate. Any changes must meet the requirements of this rule. Upon approval, the Department will work with the Nonprofit to establish an effective date upon which the Non-Profit may begin to issue the new Certificate. After the effective date of the new Certificate, only a new Certificate will be accepted by the Department; provided, however, that the Department will accept an old Certificate if it was issued by the Nonprofit prior to the effective date of the new Certificate.

3.9 If a group special license plate's respective authorizing statute provides that the Department "may" stop issuing the group special license plate if the group special license plate has not met the minimum issuance requirement, the Department may Retire the group special license plate or may continue to issue the plate until the existing inventory is exhausted. If the Department elects to Retire the group special license plate, the plate will be Retired pursuant to subsection 3.12 of this rule and Code of Colorado Regulations 1 CCR 204-10 Rule 20. License Plate Retirement.

3.10 If a group special license plate's respective authorizing statute provides that the Department "shall" retire the plate if the plate has not met its minimum issuance requirement as provided in that statute, then the group special license plate will be Retired pursuant to the group special license plate's respective authorizing statute and Code of Colorado Regulations 1 CCR 204-10 Rule 20. License Plate Retirement.

3.11 The Department may audit the Nonprofit associated with a group special license plate. The audit may include, but is not limited to, accounting, financial, tax, and Pre-Certification Qualifiers.

a. If the Department determines that the Nonprofit has violated its respective authorizing statute, or no longer qualifies as a Nonprofit under this rule, the Department may require additional information or at the Department's discretion may Retire the group special license plate pursuant to Code of Colorado Regulations 1 CCR 204-10 Rule 20. License Plate Retirement.

b. If the Department requires additional information, and such information is not provided or does not change the Department's determination that the Nonprofit has violated its respective authorizing statute, or that the Nonprofit no longer qualifies as a Nonprofit under this rule, the Department may Retire the group special license plate pursuant to Code of Colorado Regulations 1 CCR 204-10 Rule 20. License Plate Retirement.

c. Upon Retirement, the Nonprofit must cease seeking any donation authorized pursuant to the group special license plates respective authorizing statute~~, and must cease to associate itself in any way with the group special license plate~~.

3.12 If the Department Retires a group special license plate:

a. The Department will immediately cease producing the group special license plate, and may stop issuing the plate prior to exhausting the plate's inventory.

b. The Department will provide written notice of Retirement, via certified mail, to the Nonprofit associated with the group special license plate. This notice will be mailed to the last address provided by the Nonprofit in writing to the Department. This notice shall also act as official notice that the Nonprofit can no longer associate itself with the group special license plate. Upon receipt of the Retirement notice, the Nonprofit must:

1. Immediately cease collecting donations and issuing Certificates.

2. Within 72 hours, remove any reference to the Nonprofit's Pre-Certification Qualifier, if applicable, for the group special license plate from the Nonprofit's website, newsprint, or other publicly accessible media.

c. A person whose vehicle is Registered with a Retired group special license plate may continue to register with the group special license plate so long as the license plate is not damaged, lost, or stolen. The Department will not replace a Retired group special license plate if the inventory is destroyed, exhausted, or the Department has determined not to issue additional plates.

3.13 Nonprofits associated with Group Special License Plates Created through Rule must meet the requirements of this rule except as otherwise provided herein and/or pursuant to a contract between the Nonprofit and the Department that establishes requirements that differ from this rule.

3.14 A Nonprofit associated with a Group Special License Plate Created through Statute must meet the requirements of its respective authorizing statute and this rule.

3.15 An Approval Notification issued by the Department does not constitute an agreement to create the proposed group special license plate nor support legislation that would create the proposed group special license plate.

4.0 Denial and Retirement Appeals

4.1 If a Nonprofit's application for a group special license plate has been denied, it may request a hearing, in writing, within 60 days after the date of the notice of denial. Written hearing requests shall be submitted to the Department of Revenue Hearings Section.

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

4.3 A group special license plate will be Retired pursuant to Code of Colorado Regulations 1 CCR 204-10 Rule 20. License Plate Retirement.

Notice of Proposed Rulemaking

Tracking number

2018-00489

Department

300 - Department of Education

Agency

301 - Colorado State Board of Education

CCR number

1 CCR 301-68

Rule title

RULES FOR STUDENT POSSESSION AND ADMINISTRATION OF ASTHMA, ALLERGY AND ANAPHYLAXIS MANAGEMENT MEDICATIONS OR OTHER PRESCRIPTION MEDICATIONS

Rulemaking Hearing

Date

11/14/2018

Time

03:30 PM

Location

201 E. Colfax Ave., Room 101 - State Board Room

Subjects and issues involved

This notice of rulemaking is a direct result of the passage of both HB 18-1286 and HB 16-1373. HB 16-1373 directs school districts to adopt policies regarding the administration of medical marijuana by a primary caregiver to students with a medical marijuana registry card. HB 18-1286 requires the state board to establish the written documentation required should a district choose to allow school personnel to administer medical marijuana to a student.

Statutory authority

22-1-119.5, C.R.S, 22-1-119.5), C.R.S., and 22-2-135, C.R.S.

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DEPARTMENT OF EDUCATION

Colorado State Board of Education

RULES FOR ~~STUDENT~~ POSSESSION ~~AND ADMINISTRATION~~ OF ~~ASTHMA, ALLERGY AND ANAPHYLAXIS MANAGEMENT MEDICATIONS OR OTHER PRESCRIPTION~~ MEDICATIONS

1 CCR 301-68

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

Statement of Basis and Purpose

The statutory basis for the enactment of the Rules, adopted by the State Board of Education ~~on December 8, 2005 and re-adopted on April 6, 2006~~ is found in sections 22-1-119.5, C.R.S, 22-1-119.5 ~~(2)(b)(IV) & (8~~), C.R.S., and 22-2-135, C.R.S. The Colorado Schoolchildren's Asthma and Anaphylaxis Act and its subsequent revisions requires the State Board of Education to promulgate rules on determining students' qualifications, contract requirements and treatment plan requirements as well as the implementation for student possession and administration of prescription medication and use of stock epinephrine auto-injectors.

~~**Statement of Basis and Purpose**~~

~~The statutory basis for the revision of these Rules is found in SB09-226, section 22-2-135(3)(a), C.R.S. The Colorado School Children's Food Allergy and Anaphylaxis Management Act requires the State Board of Education to promulgate rules for the management of food allergies and anaphylaxis among students enrolled in public schools of the state.~~

~~The statutory basis for the revision of these Rules is found in S.B. 11-12, section 22-1-119.3 (4), C.R.S. allowing the State Board of Education to promulgate rules for the implementation of the student possession and administration of prescription medication.~~

~~The statutory basis for the revision of these Rules is found in H.B. 13-1171, section 22-1-119.5 (8) C.R.S. allowing the State Board of Education to promulgate rules for the management of students with life-threatening allergies and use of stock epinephrine auto-injectors in emergency situations in school settings.~~

1.00 Definitions

~~1.01 "Health Care Plan" hereinafter referred to as the "Plan" is a plan for a specific student that addresses the administration of medications and/or treatments for the student, including emergency treatment, and is based on the student's Healthcare Practitioner's orders for the administration of medications and/or treatments for the student and includes input from the parents or legal guardian..~~

1.01~~2~~ "Appropriate Staff" means employees of the school whom the principal or equivalent executive, in consultation with the School Nurse, determines to be appropriate recipients of emergency anaphylaxis treatment training, which employees shall include, but need not be limited to, employees who are directly involved during the school day with a student who has a known food allergy.

~~1.03 "Designated Personnel" means employees of the school who have current CPR/1st Aid certification, have received additional training on the recognition of anaphylaxis, and are~~

~~delegated by the School Nurse or a Healthcare Practitioner to administer an epinephrine auto-injector in the event of anaphylaxis.~~

1.0~~2~~4 "Contract" means the written contract between the student, the student's parents or legal guardian, and the School Nurse or the school administrator in consultation with the School Nurse, which clearly defines responsibility for the student to self-carry his/her emergency medication.

1.03 "Delegation" of a Medical or Nursing Task is the transfer of responsibility for the performance of a task from one individual to another while retaining accountability for the outcome.

1.04 "Designated Personnel" means employees of the school who have current CPR/1st Aid certification, have received additional training on the recognition of anaphylaxis, and are delegated by the School Nurse or a Healthcare Practitioner to administer an epinephrine auto-injector in the event of anaphylaxis.

1.05 "Health Care Plan" hereinafter referred to as the "Plan" is a plan for a specific student that addresses the administration of medications and/or treatments for the student, including emergency treatment, and is based on the student's Healthcare Practitioner's orders for the administration of medications and/or treatments for the student and includes input from the parents or legal guardian..

1.0~~6~~5 "Healthcare Practitioner" means a physician, nurse practitioner, or physician assistant who has prescriptive authority and is licensed to practice in the State of Colorado.

1.0~~7~~6 "School Nurse" means a nurse licensed to practice as a registered nurse in Colorado who is licensed as a Special Service Provider – School Nurse by the Colorado Department of Education.

1.08 "School Personnel" means school personnel designated by agreement between the principal or his or her designee and a parent or legal guardian.

1.0~~8~~7 "Standing Order and Protocol" is a written plan developed by a Healthcare Practitioner that authorizes specific medical action and includes the administration of selected medication.

~~1.08 "Delegation" of a Medical or Nursing Task is the transfer of responsibility for the performance of a task from one individual to another while retaining accountability for the outcome.~~

2.00 Policy for Management of Food Allergy and Anaphylaxis in the School for Students with a Known Allergy

Each school district board of education, including the Charter School Institute, shall adopt and implement a policy for the management of food allergies and anaphylaxis among students enrolled in the public schools of the school district. This policy, at a minimum, shall address the following requirements.

2.01 The management of food allergies and anaphylaxis in the school setting shall be a collaboration between the school district, parents, Healthcare Practitioner, and student, as appropriate.

2.02 The School Nurse or school administrator, in consultation with the School Nurse, shall be responsible for the development and implementation of the Plan for each student with the diagnosis of a potential life-threatening food allergy after reviewing the information provided by the student's parent or legal guardian and Healthcare Practitioner on the allergy and anaphylaxis standard form developed by the Colorado Department of Public Health and Environment pursuant to section 25-1.5-109, C.R.S. and referenced in section 22-2-135, C.R.S. If a student qualifies as a student with a disability in accordance with federal law, including but not limited to Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, or the Individuals with Disabilities Education Act, the development of a Health Care Plan and/or other plan as

appropriate, in accordance with such federal laws, shall be deemed to meet the requirements of these rules.

2.03 The school shall have a plan in place for communication between the school and emergency medical services, including instructions for emergency medical responders.

2.04 Reasonable accommodations shall be made to reduce the student's exposure to agents that may cause anaphylaxis within the school environment as set forth in section 22-2-135(3)(a)(II), C.R.S. The School Nurse, school personnel, Healthcare Practitioner, the student's parent or legal guardian, and student as appropriate, shall work in partnership to develop reasonable accommodations to reduce the risk of the student's exposure to agents that cause anaphylaxis. If a student qualifies as a student with a disability in accordance with federal law, including but not limited to Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, or the Individuals with Disabilities Education Act, the development of a Health Care Plan and/or other plan as appropriate, in accordance with such federal laws, shall be deemed to meet the requirements of these rules.

2.05 Training shall be done for Appropriate Staff as outlined below in section 3.00 of these rules.

2.06 Emergency medications shall be kept in a secure location easily accessible for designated staff.

2.07 The parent or legal guardian of the student shall be responsible, to supply to the school in a timely fashion the medication needed for treatment of food allergies or anaphylaxis unless the student is authorized to self-carry.

2.08 Prior to the beginning of each school year, each school district shall provide notice to the parent or legal guardian of each student enrolled in a public school of the policy adopted by the school district pursuant to section 22-32-139, C.R.S. The notice shall direct the parent or legal guardian how to access the standard form referred to in section 22-2-135(3)(b), C.R.S. and developed by the Colorado Department of Public Health and Environment pursuant to section 25-1.5-109, C.R.S.

3.00 Appropriate Staff Training

3.01 The principal or an equivalent school administrator, in consultation with the School Nurse, shall determine the appropriate recipients of emergency anaphylaxis treatment training, including Appropriate Staff directly involved during the school day with a student who has a known food allergy.

3.02 Training shall, at a minimum, prepare Appropriate Staff to have a basic understanding of food allergies and the importance of reasonable avoidance of agents that may cause anaphylaxis, the ability to recognize symptoms of anaphylaxis, and the ability to respond appropriately in the event of the student experiencing anaphylaxis including how to administer an epinephrine auto-injector if delegated. The training shall also include awareness of the ability of the student to carry and self-administer an epinephrine auto-injector.

3.03 Staff training and delegation of emergency medications by the School Nurse shall be done in accordance with ~~the State of Colorado Guide for Medication Administration: An Instructional Program for Training Unlicensed Persons to Give Medications in Out of Home Childcare, School and Camp Settings, (Qualistar Pub., Revised 2008) and~~ the Colorado Nurse Practice Act, section 12-38-103(10) C.R.S.

4.00 Requirements for Students to Self-Carry Asthma/Anaphylaxis Medication

4.01 In order to determine whether a student is eligible to administer his/her own medication, the School Nurse or administrator in consultation with the School Nurse and in collaboration with the parent or legal guardian and Healthcare Practitioner shall make an assessment of the student's knowledge of his/her condition and his/her ability to self-administer medication. The skill level assessment shall include, but not be limited to, the following areas: ability to identify the correct medication, a demonstration of the correct administration technique, knowledge of the dose required, the frequency of use, and the ability to recognize when to take the medication.

4.02 A Contract between the School Nurse or school administrator in consultation with the School Nurse, the student, and the student's parents or legal guardian shall be established assigning levels of responsibility for each individual. This Contract shall accompany orders for the medication from a Healthcare Practitioner. There must be agreement by all parties that noncompliance with the Contract may result in withdrawal of the privilege.

4.03 The Contract for the student shall include, but not be limited to: the ability to demonstrate competency in taking his/her medication, the ability to demonstrate asthma/allergy management and self-care skills, notify school staff if emergency medication has been administered or when having more difficulty than usual with his/her condition, and the express prohibition against allowing another person to use his/her medication.

4.04 The Contract for the parent or legal guardian shall include, but not be limited to: the provision of a written order by the Healthcare Practitioner; the provision of a written authorization by the parent or legal guardian; the assurance that the container is appropriately labeled by a pharmacist or Healthcare Practitioner; that the medication device contains the medication; that the medication has not expired, that backup medication will be provided to the Health Office for emergencies, and that, on a regular basis, the status of the student's asthma/allergy is reviewed with the student.

4.05 The Contract for the School Nurse or the school administrator, in consultation with the School Nurse, shall include but not be limited to: the review with the student of the correct technique for use of the medication device(s); an understanding of the order for time and dosages; and an understanding of the appropriate use of the medication; a review of the status of the student's asthma/allergy with the student on a regular basis; a requirement to notify school staff that needs to know whether the student has asthma, or a life-threatening allergy and has permission to carry and self-administer the medication, and the assignment of a designee to make a 911 emergency call if the student has an exposure that results in the need to use epinephrine.

5.00 Use of Stock Epinephrine Auto-injectors in Emergency Situations in School Settings

5.01 A local school board may adopt and implement a policy permitting its schools to acquire and maintain a stock supply of epinephrine auto-injectors for use in emergency anaphylaxis events that occur on school grounds.

5.02 For local school boards that elect to adopt such a policy, the school district shall meet the following requirements:

5.02(a) The school district must have a Standing Order and Protocol regarding the administration of epinephrine auto-injectors. The Standing Order and Protocol shall include the dosage of epinephrine, indications for use, route of medication and follow-up procedures. Standing Orders must be renewed annually and with any change in prescriber.

5.02(b) Building level administrators in consultation with the School Nurse shall identify at least two employees who are CPR/1 st Aid certified to be trained and delegated in the

administration of stock epinephrine auto-injectors ("Designated Personnel"). Schools with larger populations are encouraged to train additional staff as Designated Personnel.

5.02(c) Training of Designated Personnel must be conducted by a School Nurse or Healthcare Practitioner using a state approved course. Training must include the components identified in Section 3.02 and shall also include: defining anaphylaxis, recognizing symptoms of anaphylaxis, understanding standards and procedures for storage, the correct methods for administering an epinephrine auto-injector, and follow up procedures. Such training and delegation are encouraged to be conducted on an annual basis

5.02(d) Delegation by the school nurse or healthcare practitioner, in accordance with state legislation and rules concerning his or her practice, may only occur after Designated Personnel have received the training described in Section 5.02(c).

6.00 Reporting Requirements

6.01 Schools must submit a report to the State School Nurse Consultant at the Department of Education within 10 days regarding any incident at the school or a school-related event involving a severe allergic reaction, the administration of an epinephrine auto-injector, or both. Such report shall be on a form developed by the Department of Education. This reporting requirement applies to any nonpublic school that maintains a stock supply of epinephrine auto-injectors and to all public schools, regardless of whether they maintain a stock supply of epinephrine auto-injectors.

6.02 In school districts with a board-adopted policy allowing for the administration of stock epinephrine auto-injectors, the School Nurse must report to the State School Nurse Consultant at the Department of Education whether training and delegation has occurred and, if so, the number of employees in the school or school district that have been trained and delegated to administer epinephrine auto-injectors.

76.00 Policy for Management of Student Possession and Administration of Prescription Medication

A local school board of education may continue to adhere to the policy for management of food allergy and anaphylaxis management, as described in section 2.00 of these rules above, or may adopt a policy that applies to other prescription medications. In the event the local school board adopts a policy for student possession and administration of prescription medication, the local school board shall be exempt from the requirements for students to self-carry asthma/anaphylaxis medications, described in section 3.00 of these rules above. A policy for management of student possession and administration of prescription medication shall address the following requirements.

76.01 The parent or legal guardian of a student for whom prescription medication is required shall notify the school's administration or School Nurse of the student's medical needs and that he/she will be in possession of the medication. . The policy may require the notification to include a Plan developed by the Healthcare Practitioner for any qualifying student or as deemed appropriate by the School Nurse or the school administrator in consultation with the School Nurse.

76.02 There shall be a process by which a School Nurse or school administrator in consultation with the school nurse, with input from the prescribing Healthcare Practitioner, and parent or legal guardian, to determine any restrictions for a student to possess and self-administer his/her medication, Factors to be considered include the age and/or maturity of the student, the degree of responsibility of the student, the type of medication, and whether the student's possession or self-administration poses a significant risk of harm to the student or to other students. The School District may limit a student's ability to possess and carry medication in the event the student's possession of the medication becomes a disruption or danger to the student or learning environment.

76.03 If a prescription medication is carried for a life-threatening condition, the parent or legal guardian of the student shall provide a sufficient supply to be kept at the school and be accessible for emergencies.

76.04 A student shall carry only one day's dose of a prescription medication and the medication shall be kept in the original container with the prescription label that includes the student's name, name of medication, dosage and the name of the prescribing Healthcare Practitioner. This restriction shall not apply to medication that is contained in a multi-dose device including but not limited to asthma inhaler or insulin pump.

76.05 A student shall not possess or self-administer c~~C~~ontrolled substances, including medical marijuana, as defined in section 12-22-303, C.R.S., ~~shall not be permitted to be in possession by the student~~ on school grounds, on a school bus, or at any school sponsored event. Exceptions to the restriction against controlled substances, other than medical marijuana, may be determined by the school administrator and parents or legal guardian in consultation with the School Nurse. The sale or sharing of any drug or controlled substance may be grounds for suspension or expulsion according to section 22-33-106(1)(d)(I), C.R.S.

7.06 A primary caregiver may possess, and administer to a student who holds a valid recommendation for medical marijuana, medical marijuana in a nonsmokeable form upon the grounds of the preschool or primary or secondary school in which the student is enrolled, or upon a school bus or at a school-sponsored event. The primary caregiver shall not administer the nonsmokeable medical marijuana in a manner that creates disruption to the educational environment or causes exposure to other students. After the primary caregiver administers the medical marijuana in a nonsmokeable form, the primary caregiver shall remove any remaining medical marijuana in a nonsmokeable form from the grounds of the preschool or primary or secondary school, the school bus, or school-sponsored event.

7.06(a) Nothing in this section requires the school district staff to administer medical marijuana.

7.06(b) A school district board of education or charter school may adopt policies regarding who may act as a primary caregiver pursuant to section 7.06 and the reasonable parameters of the administration and use of medical marijuana in a nonsmokeable form upon the grounds of the preschool or primary or secondary school in which the student is enrolled, or upon a school bus or at a school-sponsored event.

7.06(c) This section 7.06 does not apply to a school district or charter school if:

7.06(c)(I) The school district or charter school loses federal funding as a result of implementing this section 7.06;

7.06(c)(II) The school district or charter school can reasonably demonstrate that it lost federal funding as a result of implementing this section 7.06; and

7.06(c)(III) The school district or charter school posts on its website in a conspicuous place a statement regarding its decision not to comply with this section 7.06.

7.06(d) Student possession, use, distribution, or sale or being under the influence of a cannabinoid product inconsistent with this section 7.06 is not permitted.

7.06(e) Notwithstanding the provisions of section 22-33-106 (1)(d)(II), C.R.S., a school district or charter school may not discipline a student who holds a valid recommendation for medical marijuana solely because the student requires medical marijuana in a nonsmokeable form as a reasonable accommodation necessary for the child to attend school.

7.06(f) A school district or charter school may not deny eligibility to attend school to a student who holds a valid recommendation for medical marijuana solely because the student requires medical marijuana in a nonsmokeable form as a reasonable accommodation necessary for the child to attend school.

8.00 Requirements for the Administration of Medical Marijuana by School Personnel

8.01 If consistent with local school board policy, school personnel may possess and administer to a student who holds a valid recommendation for medical marijuana, medical marijuana in a nonsmokeable form upon the grounds of the preschool or primary or secondary school in which the student is enrolled, or upon a school bus or at a school-sponsored event subject to the requirements outlined in section 22-1-119.3(3)(d.5), C.R.S. Nothing in this section shall require a local school board to adopt a policy permitting school personnel to possess and administer medical marijuana.

8.02 Prior to the administration of the medical marijuana in a nonsmokeable form at school, the student's parent or legal guardian shall complete and submit to the school the following documentation:

8.02(a) A written medical marijuana recommendation that includes the signature of one of the recommending physicians and the purpose, recommended dosage, frequency, and length of time between dosages of the medical marijuana in a nonsmokeable form to be administered. Such recommendation shall be renewed by the recommending physicians on an annual basis; and

8.02(b) A written statement from the student's parent or legal guardian releasing the school, and employees and volunteers of the school, from liability, except in cases of willful or wanton conduct or disregard of the criteria of the treatment plan outlined in section 8.02(a).

8.03 Nothing in this section shall require any school personnel to possess or administer medical marijuana, even if such action is permitted by the employing local school board.

~~**7.00 Reporting Requirements**~~

~~7.01 Schools must submit a report to the State School Nurse Consultant at the Department of Ed u cation within 10 days regarding any incident at the school or a school-related event involving a severe allergic reaction, the administration of an epinephrine auto-injector, or both. Such report shall be on a form developed by the Department of Education. This reporting requirement applies~~

~~to any nonpublic school that maintains a stock supply of epinephrine auto-injectors and to all public schools, regardless of whether they maintain a stock supply of epinephrine auto-injectors.~~

~~7.02 In school districts with a board-adopted policy allowing for the administration of stock epinephrine auto-injectors, the School Nurse must report to the State School Nurse Consultant at the Department of Education whether training and delegation has occurred and, if so, the number of employees in the school or school district that have been trained and delegated to administer epinephrine auto-injectors.~~

Editor's Notes

History

Entire rule eff. 12/31/2009.

Entire rule eff. 04/30/2012.

Entire rule eff. 01/30/2014.

DEPARTMENT OF EDUCATION

Colorado State Board of Education

RULES FOR POSSESSION OF MEDICATIONS

1 CCR 301-68

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

Statement of Basis and Purpose

The statutory basis for the enactment of the Rules, adopted by the State Board of Education is found in sections 22-1-119.5, C.R.S, 22-1-119.5), C.R.S., and 22-2-135, C.R.S. The Colorado Schoolchildren's Asthma and Anaphylaxis Act and its subsequent revisions requires the State Board of Education to promulgate rules on determining students' qualifications, contract requirements and treatment plan requirements as well as the implementation for student possession and administration of prescription medication and use of stock epinephrine auto-injectors.

1.00 Definitions

1.01 "Appropriate Staff" means employees of the school whom the principal or equivalent executive, in consultation with the School Nurse, determines to be appropriate recipients of emergency anaphylaxis treatment training, which employees shall include, but need not be limited to, employees who are directly involved during the school day with a student who has a known food allergy.

1.02 "Contract" means the written contract between the student, the student's parents or legal guardian, and the School Nurse or the school administrator in consultation with the School Nurse, which clearly defines responsibility for the student to self-carry his/her emergency medication.

1.03 "Delegation" of a Medical or Nursing Task is the transfer of responsibility for the performance of a task from one individual to another while retaining accountability for the outcome.

1.04 "Designated Personnel" means employees of the school who have current CPR/1 st Aid certification, have received additional training on the recognition of anaphylaxis, and are delegated by the School Nurse or a Healthcare Practitioner to administer an epinephrine auto-injector in the event of anaphylaxis.

1.05 "Health Care Plan" hereinafter referred to as the "Plan" is a plan for a specific student that addresses the administration of medications and/or treatments for the student, including emergency treatment, and is based on the student's Healthcare Practitioner's orders for the administration of medications and/or treatments for the student and includes input from the parents or legal guardian..

1.06 "Healthcare Practitioner" means a physician, nurse practitioner, or physician assistant who has prescriptive authority and is licensed to practice in the State of Colorado.

1.07 "School Nurse" means a nurse licensed to practice as a registered nurse in Colorado who is licensed as a Special Service Provider – School Nurse by the Colorado Department of Education.

1.08 "School Personnel" means school personnel designated by agreement between the principal or his or her designee and a parent or legal guardian.

1.09 "Standing Order and Protocol" is a written plan developed by a Healthcare Practitioner that authorizes specific medical action and includes the administration of selected medication.

2.00 Policy for Management of Food Allergy and Anaphylaxis in the School for Students with a Known Allergy

Each school district board of education, including the Charter School Institute, shall adopt and implement a policy for the management of food allergies and anaphylaxis among students enrolled in the public schools of the school district. This policy, at a minimum, shall address the following requirements.

2.01 The management of food allergies and anaphylaxis in the school setting shall be a collaboration between the school district, parents, Healthcare Practitioner, and student, as appropriate.

2.02 The School Nurse or school administrator, in consultation with the School Nurse, shall be responsible for the development and implementation of the Plan for each student with the diagnosis of a potential life-threatening food allergy after reviewing the information provided by the student's parent or legal guardian and Healthcare Practitioner on the allergy and anaphylaxis standard form developed by the Colorado Department of Public Health and Environment pursuant to section 25-1.5-109, C.R.S. and referenced in section 22-2-135, C.R.S. If a student qualifies as a student with a disability in accordance with federal law, including but not limited to Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, or the Individuals with Disabilities Education Act, the development of a Health Care Plan and/or other plan as appropriate, in accordance with such federal laws, shall be deemed to meet the requirements of these rules.

2.03 The school shall have a plan in place for communication between the school and emergency medical services, including instructions for emergency medical responders.

2.04 Reasonable accommodations shall be made to reduce the student's exposure to agents that may cause anaphylaxis within the school environment as set forth in section 22-2-135(3)(a)(II), C.R.S. The School Nurse, school personnel, Healthcare Practitioner, the student's parent or legal guardian, and student as appropriate, shall work in partnership to develop reasonable accommodations to reduce the risk of the student's exposure to agents that cause anaphylaxis. If a student qualifies as a student with a disability in accordance with federal law, including but not limited to Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, or the Individuals with Disabilities Education Act, the development of a Health Care Plan and/or other plan as appropriate, in accordance with such federal laws, shall be deemed to meet the requirements of these rules.

2.05 Training shall be done for Appropriate Staff as outlined below in section 3.00 of these rules.

2.06 Emergency medications shall be kept in a secure location easily accessible for designated staff.

2.07 The parent or legal guardian of the student shall be responsible, to supply to the school in a timely fashion the medication needed for treatment of food allergies or anaphylaxis unless the student is authorized to self-carry.

2.08 Prior to the beginning of each school year, each school district shall provide notice to the parent or legal guardian of each student enrolled in a public school of the policy adopted by the school district pursuant to section 22-32-139, C.R.S. The notice shall direct the parent or legal guardian how to access the standard form referred to in section 22-2-135(3)(b), C.R.S. and developed by the Colorado Department of Public Health and Environment pursuant to section 25-1.5-109, C.R.S.

3.00 Appropriate Staff Training

3.01 The principal or an equivalent school administrator, in consultation with the School Nurse, shall determine the appropriate recipients of emergency anaphylaxis treatment training, including Appropriate Staff directly involved during the school day with a student who has a known food allergy.

3.02 Training shall, at a minimum, prepare Appropriate Staff to have a basic understanding of food allergies and the importance of reasonable avoidance of agents that may cause anaphylaxis, the ability to recognize symptoms of anaphylaxis, and the ability to respond appropriately in the event of the student experiencing anaphylaxis including how to administer an epinephrine auto-injector if delegated. The training shall also include awareness of the ability of the student to carry and self-administer an epinephrine auto-injector.

3.03 Staff training and delegation of emergency medications by the School Nurse shall be done in accordance with the Colorado Nurse Practice Act, section 12-38-103(10) C.R.S.

4.00 Requirements for Students to Self-Carry Asthma/Anaphylaxis Medication

4.01 In order to determine whether a student is eligible to administer his/her own medication, the School Nurse or administrator in consultation with the School Nurse and in collaboration with the parent or legal guardian and Healthcare Practitioner shall make an assessment of the student's knowledge of his/her condition and his/her ability to self-administer medication. The skill level assessment shall include, but not be limited to, the following areas: ability to identify the correct medication, a demonstration of the correct administration technique, knowledge of the dose required, the frequency of use, and the ability to recognize when to take the medication.

4.02 A Contract between the School Nurse or school administrator in consultation with the School Nurse, the student, and the student's parents or legal guardian shall be established assigning levels of responsibility for each individual. This Contract shall accompany orders for the medication from a Healthcare Practitioner. There must be agreement by all parties that noncompliance with the Contract may result in withdrawal of the privilege.

4.03 The Contract for the student shall include, but not be limited to: the ability to demonstrate competency in taking his/her medication, the ability to demonstrate asthma/allergy management and self-care skills, notify school staff if emergency medication has been administered or when having more difficulty than usual with his/her condition, and the express prohibition against allowing another person to use his/her medication.

4.04 The Contract for the parent or legal guardian shall include, but not be limited to: the provision of a written order by the Healthcare Practitioner; the provision of a written authorization by the parent or legal guardian; the assurance that the container is appropriately labeled by a pharmacist or Healthcare Practitioner; that the medication device contains the medication; that the medication has not expired, that backup medication will be provided to the Health Office for emergencies, and that, on a regular basis, the status of the student's asthma/allergy is reviewed with the student.

4.05 The Contract for the School Nurse or the school administrator, in consultation with the School Nurse, shall include but not be limited to: the review with the student of the correct technique for use of the medication device(s); an understanding of the order for time and dosages; and an understanding of the appropriate use of the medication; a review of the status of the student's asthma/allergy with the student on a regular basis; a requirement to notify school staff that needs to know whether the student has asthma, or a life-threatening allergy and has permission to carry

and self-administer the medication, and the assignment of a designee to make a 911 emergency call if the student has an exposure that results in the need to use epinephrine.

5.00 Use of Stock Epinephrine Auto-injectors in Emergency Situations in School Settings

5.01 A local school board may adopt and implement a policy permitting its schools to acquire and maintain a stock supply of epinephrine auto-injectors for use in emergency anaphylaxis events that occur on school grounds.

5.02 For local school boards that elect to adopt such a policy, the school district shall meet the following requirements:

5.02(a) The school district must have a Standing Order and Protocol regarding the administration of epinephrine auto-injectors. The Standing Order and Protocol shall include the dosage of epinephrine, indications for use, route of medication and follow-up procedures. Standing Orders must be renewed annually and with any change in prescriber.

5.02(b) Building level administrators in consultation with the School Nurse shall identify at least two employees who are CPR/1 st Aid certified to be trained and delegated in the administration of stock epinephrine auto-injectors ("Designated Personnel"). Schools with larger populations are encouraged to train additional staff as Designated Personnel.

5.02(c) Training of Designated Personnel must be conducted by a School Nurse or Healthcare Practitioner using a state approved course. Training must include the components identified in Section 3.02 and shall also include: defining anaphylaxis, recognizing symptoms of anaphylaxis, understanding standards and procedures for storage, the correct methods for administering an epinephrine auto-injector, and follow up procedures. Such training and delegation are encouraged to be conducted on an annual basis

5.02(d) Delegation by the school nurse or healthcare practitioner, in accordance with state legislation and rules concerning his or her practice, may only occur after Designated Personnel have received the training described in Section 5.02(c).

6.00 Reporting Requirements

6.01 Schools must submit a report to the State School Nurse Consultant at the Department of Education within 10 days regarding any incident at the school or a school-related event involving a severe allergic reaction, the administration of an epinephrine auto-injector, or both. Such report shall be on a form developed by the Department of Education. This reporting requirement applies to any nonpublic school that maintains a stock supply of epinephrine auto-injectors and to all public schools, regardless of whether they maintain a stock supply of epinephrine auto-injectors.

6.02 In school districts with a board-adopted policy allowing for the administration of stock epinephrine auto-injectors, the School Nurse must report to the State School Nurse Consultant at the Department of Education whether training and delegation has occurred and, if so, the number of employees in the school or school district that have been trained and delegated to administer epinephrine auto-injectors.

7.00 Policy for Management of Student Possession and Administration of Prescription Medication

A local school board of education may continue to adhere to the policy for management of food allergy and anaphylaxis management, as described in section 2.00 of these rules above, or may adopt a policy that applies to other prescription medications. In the event the local school board adopts a policy for student possession and administration of prescription medication, the local school board shall be exempt from the requirements for students to self-carry asthma/anaphylaxis medications, described in section

3.00 of these rules above. A policy for management of student possession and administration of prescription medication shall address the following requirements.

7.01 The parent or legal guardian of a student for whom prescription medication is required shall notify the school's administration or School Nurse of the student's medical needs and that he/she will be in possession of the medication. . The policy may require the notification to include a Plan developed by the Healthcare Practitioner for any qualifying student or as deemed appropriate by the School Nurse or the school administrator in consultation with the School Nurse.

7.02 There shall be a process by which a School Nurse or school administrator in consultation with the school nurse, with input from the prescribing Healthcare Practitioner, and parent or legal guardian, to determine any restrictions for a student to possess and self-administer his/her medication, Factors to be considered include the age and/or maturity of the student, the degree of responsibility of the student, the type of medication, and whether the student's possession or self-administration poses a significant risk of harm to the student or to other students. The School District may limit a student's ability to possess and carry medication in the event the student's possession of the medication becomes a disruption or danger to the student or learning environment.

7.03 If a prescription medication is carried for a life-threatening condition, the parent or legal guardian of the student shall provide a sufficient supply to be kept at the school and be accessible for emergencies.

7.04 A student shall carry only one day's dose of a prescription medication and the medication shall be kept in the original container with the prescription label that includes the student's name, name of medication, dosage and the name of the prescribing Healthcare Practitioner. This restriction shall not apply to medication that is contained in a multi-dose device including but not limited to asthma inhaler or insulin pump.

7.05 A student shall not possess or self-administer controlled substances, including medical marijuana, as defined in section 12-22-303, C.R.S., on school grounds, on a school bus, or at any school sponsored event. Exceptions to the restriction against controlled substances, other than medical marijuana, may be determined by the school administrator and parents or legal guardian in consultation with the School Nurse. The sale or sharing of any drug or controlled substance may be grounds for suspension or expulsion according to section 22-33-106(1)(d)(I), C.R.S.

7.06 A primary caregiver may possess, and administer to a student who holds a valid recommendation for medical marijuana, medical marijuana in a nonsmokeable form upon the grounds of the preschool or primary or secondary school in which the student is enrolled, or upon a school bus or at a school-sponsored event. The primary caregiver shall not administer the nonsmokeable medical marijuana in a manner that creates disruption to the educational environment or causes exposure to other students. After the primary caregiver administers the medical marijuana in a nonsmokeable form, the primary caregiver shall remove any remaining medical marijuana in a nonsmokeable form from the grounds of the preschool or primary or secondary school, the school bus, or school-sponsored event.

7.06(a) Nothing in this section requires the school district staff to administer medical marijuana.

7.06(b) A school district board of education or charter school may adopt policies regarding who may act as a primary caregiver pursuant to section 7.06 and the reasonable parameters of the administration and use of medical marijuana in a nonsmokeable form upon the grounds of the preschool or primary or secondary school in which the student is enrolled, or upon a school bus or at a school-sponsored event.

7.06(c) This section 7.06 does not apply to a school district or charter school if:

7.06(c)(I) The school district or charter school loses federal funding as a result of implementing this section 7.06;

7.06(c)(II) The school district or charter school can reasonably demonstrate that it lost federal funding as a result of implementing this section 7.06; and

7.06(c)(III) The school district or charter school posts on its website in a conspicuous place a statement regarding its decision not to comply with this section 7.06.

7.06(d) Student possession, use, distribution, or sale or being under the influence of a cannabinoid product inconsistent with this section 7.06 is not permitted.

7.06(e) Notwithstanding the provisions of section 22-33-106 (1)(d)(II), C.R.S., a school district or charter school may not discipline a student who holds a valid recommendation for medical marijuana solely because the student requires medical marijuana in a nonsmokeable form as a reasonable accommodation necessary for the child to attend school.

7.06(f) A school district or charter school may not deny eligibility to attend school to a student who holds a valid recommendation for medical marijuana solely because the student requires medical marijuana in a nonsmokeable form as a reasonable accommodation necessary for the child to attend school.

8.00 Requirements for the Administration of Medical Marijuana by School Personnel

8.01 If consistent with local school board policy, school personnel may possess and administer to a student who holds a valid recommendation for medical marijuana, medical marijuana in a nonsmokeable form upon the grounds of the preschool or primary or secondary school in which the student is enrolled, or upon a school bus or at a school-sponsored event subject to the requirements outlined in section 22-1-119.3(3)(d.5), C.R.S. Nothing in this section shall require a local school board to adopt a policy permitting school personnel to possess and administer medical marijuana.

8.02 Prior to the administration of the medical marijuana in a nonsmokeable form at school, the student's parent or legal guardian shall complete and submit to the school the following documentation:

8.02(a) A written medical marijuana recommendation that includes the signature of one of the recommending physicians and the purpose, recommended dosage, frequency, and length of time between dosages of the medical marijuana in a nonsmokeable form to be administered. Such recommendation shall be renewed by the recommending physicians on an annual basis; and

8.02(b) A written statement from the student's parent or legal guardian releasing the school, and employees and volunteers of the school, from liability, except in cases of willful or wanton conduct or disregard of the criteria of the treatment plan outlined in section 8.02(a).

8.03 Nothing in this section shall require any school personnel to possess or administer medical marijuana, even if such action is permitted by the employing local school board.

Editor's Notes

History

Entire rule eff. 12/31/2009.

Entire rule eff. 04/30/2012.

Entire rule eff. 01/30/2014.

Notice of Proposed Rulemaking

Tracking number

2018-00487

Department

300 - Department of Education

Agency

301 - Colorado State Board of Education

CCR number

1 CCR 301-95

Rule title

RULES FOR THE ADMINISTRATION OF THE SCHOOL TRANSFORMATION GRANT PROGRAM

Rulemaking Hearing

Date

11/14/2018

Time

01:30 PM

Location

201 E. Colfax Ave., Room 101 - State Board Room

Subjects and issues involved

The purpose of this notice of rulemaking is to incorporate technical changes that were enacted during the 2018 legislative session with the passage of House Bill 18-1355. The changes are being made to the previously named School Turnaround Leadership Development Grant, which is now called the School Transformation Grant and which has an expanded scope. In addition to leadership development grant activities, schools and districts in Priority Improvement or Turnaround in the immediate or preceding school year will be able to apply for grant funds to support educator professional development, implement activities geared towards instructional transformation, or plan for or implement one of the statutory options for schools and districts with persistent low performance.

Statutory authority

22-13-103, C.R.S.

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DEPARTMENT OF EDUCATION

Colorado State Board of Education

RULES FOR THE ADMINISTRATION OF THE SCHOOL ~~TURNAROUND LEADERS DEVELOPMENT~~TRANSFORMATION GRANT ~~PROGRAM~~

1 CCR 301-95

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

Authority: Article IX, Section 1, Colorado Constitution. 22-2-106(1)(a) and (c); 22-2-107(1)(c); 22-7409(1.5); 22-13-103 of the Colorado Revised Statutes (C.R.S.).

1.00 Statement of Basis and Purpose.

The statutory basis for these rules is Sec 22-13-103, C.R.S., which requires the State Board of Education to promulgate rules to implement and administer the School Transformation Grant Program.

~~The statutory basis for these emergency rules adopted on September 11, 2014 is found in 22-2-106(1)(a) and (c), State Board Duties; 22-2-107(1)(c), State Board Powers; and 22-13-103, C.R.S., School Turnaround Leaders Development Transformation Grant Program – Rules.~~

~~The School Turnaround Leaders Development Transformation Grant Program, 22-13-103, C.R.S., requires the State Board of Education to promulgate rules to implement and administer the program. At a minimum, the rules must include criteria for approving providers who respond to any request for proposal. The rules must also include timelines for the application and approval process, grant application content requirements, and criteria for selecting grant recipients. : Criteria for identifying approved providers from among those that respond to the request for proposals pursuant to section 22-13-104, C.R.S.; Timelines for the design grant application and approval process; Criteria for awarding design grants to identified providers to partially offset the design and development costs of creating or expanding high-quality turnaround leadership development programs; Timelines for the school turnaround leadertransformation grant application and approval process; The requirements for a school turnaround leadertransformation grant application, including but not limited to the goals that the applicant expects to achieve through the grant; and Criteria for selecting school turnaround leader transformation grant recipients.~~

2.0 Definitions.

2.00(1) Charter School: A charter school authorized by a school district pursuant to part 1 of article 30.5 of title 22 or an institute charter school authorized by the state charter school institute pursuant to part 5 of article 30.5 of title 22 of the Colorado Revised Statutes.

2.00(2) Department: The Department of Education created and existing pursuant to section 24-1-~~-~~115, C.R.S.

2.00(3) Institute: The State Charter School Institute established in section 22-30.5-503, C.R.S.

2.00(4) Program: The School ~~Turnaround Leaders Development~~ Transformation Grant program created in section 22 13-103.

2.00(5) Provider: A public or private entity that offers a high-quality turnaround leadership development program for Colorado educators.

2.00(6) School District: A school district organized pursuant to article 30 of title 22, C.R.S.

2.00(7) School Turnaround Leader: A principal or teacher leader in a school that is required to adopt a priority improvement plan or turnaround plan pursuant to section 22-11-210, C.R.S. or a district-level administrator or employee of the State Charter School Institute that coordinates and supports turnaround efforts in schools of the School District or Institute Charter schools that implement priority improvement plans or turnaround plans.

~~2.00(8) Turnaround plan: The lowest plan type assigned to a school in Colorado based on the percentage of points earned on the School Performance Framework. A Turnaround plan puts a school on the "five-year accountability clock" per the Education Accountability Act of 2009.~~

~~2.00(9) Priority Improvement plan: The second-lowest plan type assigned to a school in Colorado based on the percentage of points earned on the School Performance Framework. A Priority Improvement plan puts a school on the "five-year accountability clock" per the Education Accountability Act of 2009.~~

2.00(~~8~~10) State Board: The State Board of Education created pursuant to Section 1 of Article IX of the Colorado Constitution.

2.1 Turnaround Leadership Development Pro~~vider~~sgrams ~~grams~~ Request for Proposals

The Department ~~will~~must ~~must~~ issue a request for proposals (RFP) from providers who seek to participate in the program. Based on the criteria outlined below, the Department will identify one or more providers to provide turnaround leadership development programs for school districts, the Institute, and charter schools that receive ~~School Turnaround Leader G~~grants. ~~Providers that respond to the RFP may request a one-time design grant to offset the costs incurred in creating or expanding the provider's Turnaround Leadership Development Programs or may apply to be an identified approved Provider without seeking funding.~~

2.01(1) Criteria for identifying approved Turnaround Leadership Development Providers ~~and awarding Design Grants.~~

The Department ~~will~~ must develop an RFP, ~~according to the Department's competitive grants and awards RFP process,~~ which consists of ~~use of~~ an ~~standard grant~~ application and scoring rubric template. Thereafter, the Department must undertake~~; and~~ a fair and equitable application review. In such review, the Department must consider the following ~~The following criteria will be considered~~for identifying providers from among those that respond to the RFP:

2.01(1)(a) Each Provider's experience in developing successful, effective leadership in low-performing schools and school districts;

2.01(1)(b) The leadership qualities that each Provider's turnaround leadership development program is expected to develop;

2.01(1)(c) A Provider's capacity to implement identified program components that make up a comprehensive leadership development experience; and

2.01(1)(d) The availability of turnaround leadership development programs for school turnaround leaders in public schools throughout the state. The grant program shall seek to ensure approved providers are available for leaders in all regions of the state.

~~2.01(2) Additional Criteria for Design Grants~~

~~Applicants for one-time design grants shall also provide persuasive evidence of the need for additional design grant funding, above and beyond operating revenues generated by participant tuition, in order to build the organization's capacity as a School Turnaround Leaders Development provider. Applicants should also include potential uses of design grant funds, such as, but not limited to:~~

~~2.01(2)(a) Additional staff to develop the program~~

~~2.01(2)(b) Staff training~~

~~2.01(2)(c) Curricula or material development~~

2.01(~~2~~3) Timeline for approving new Turnaround Leadership Development Providers ~~and design grants. During the 2014-15 school year, the Department will provide funding to identify providers to offset the costs incurred in creating or expanding the provider's Turnaround Leadership Development Programs. Applications will be due to the Department on or before January 1, 2015. Application decision notification will occur on or before February 1, 2015. For the 2015-16 school year and each year thereafter, subject to available appropriations, Turnaround Leadership Development Program Design Grant applications will be due each year by November 30.~~ Applications for new providers to apply will open at the Department's discretion and a decision notification will occur ~~within 90 days of the closing application date directly after State Board approval by the December meeting~~.

2.01(3) Review of approved Turnaround Leadership Development Providers. The department, on a regular basis, shall review each provider's turnaround leadership development programs, including the success achieved by the persons who complete the programs, and revise the list of identified providers as appropriate to ensure that the turnaround leadership development programs that are available through the program are of the highest quality.

~~2.01(4) Duration of Design Grant Awards. During the first three years that the program receives appropriations, an identified provider may apply as provided by rule for a onetime design grant to offset the costs incurred in creating or expanding the Provider's turnaround leadership development programs.~~

2.01(~~4~~5) Reporting requirements for ~~All Identified~~ approved Turnaround Leadership Development Providers. Each ~~identified~~approved provider shall track the effectiveness of persons who are engaged in and who complete a turnaround leadership development program and report the effectiveness to the department on or before July 1 of the year following the training. The report must use department ~~rubrics~~ surveys to measure the effectiveness of persons who complete the turnaround leadership development program. Each grant recipient must report on the following:

2.01(5)(a) Number of participants in program;

2.01(5)(b) Schools served; and

2.01(5)(c) Change in principals' or aspiring leaders' actions/behavior (as data is available).

2.2 School ~~Turnaround Leader~~Transformation Grants.

2.02(1) Use of funds for School Transformation Grants. Subject to available appropriations, the State Board shall award School ~~Turnaround Leader~~Transformation Grants to one or more school districts or charter schools or the Institute to use in:

2.02(1)(a) Identifying and recruiting practicing and aspiring school turnaround leaders;

2.02~~1~~(1)(b) Subsidizing the costs incurred for school turnaround leaders and their staff, if appropriate, to participate in turnaround leadership development programs offered by identified providers ~~(both funded and non-funded)~~; ~~and~~

2.02(1)~~1~~(c) Reimbursing the school turnaround leaders for costs they incur in completing turnaround leadership development programs offered by identified providers; ~~(both funded and non-funded).~~

2.02(1)~~1~~(d) ~~———~~Providing educator professional development for educators working in public schools that are required to adopt priority improvement or turnaround plans for the immediate or preceding school year;

2.02(1)(e) ~~———~~Providing services, support, and materials to transform instruction in public schools that are required to adopt priority improvement or turnaround plans for the immediate or preceding school year; and

2.02(1)(f) ~~———~~Planning for and implementing one or more of the following rigorous school redesign strategies:

(I) Converting a district public school to a charter school if it is not already authorized as a charter school;

(ii) Granting innovation school status to a district public school pursuant to section 22-32.5-104;

(iii) With regard to a district or institute charter school, replacing the school's operator or governing board;

(iv) Contracting with a public or private entity other than the school district to partially or wholly manage a district public school, which entity is accepted by the department and the local school board as using research-based strategies and having a proven record of success working with schools under similar circumstances; or

(v) Closing a public school or revoking the charter for a district or institute charter school.

2.02(2~~1~~) Timeline for School ~~Turnaround Leader~~Transformation Grants. ~~During the 2014-2015 school year, the Department will conduct an initial School Turnaround Leader Grant competition. Applications will be due to the Department on or before February 1, 2015. Application decision notification will occur on or before, April 1, 2015.~~ For the 201~~85~~-19~~6~~ school year and each year thereafter, subject to available appropriations, School ~~Turnaround Leader~~ Transformation Grant applications will be due each year ~~by February 5~~no later than January 15. Application decision notification will occur directly after State Board approval, no later than by the following April meeting.

2.02(3~~2~~) Application procedures for School ~~Turnaround Leader~~Transformation Grants. The Department ~~will~~ must develop a~~n RFP, according to the Department's competitive grants and awards RFP process, which consists of: use of a standard~~ grant application and scoring rubric template. Thereafter, the Department must undertake ~~; and~~ a fair and equitable application review.

2.02(4~~3~~) Application requirements for School Transformation Grants—turnaround leadership development applicants. The following~~criteria~~ minimum ~~-~~requirements will be ~~considered for~~

~~identifying~~included in applications for School ~~Turnaround Leader~~Transformation Grants for turnaround leadership development programs:

2.02(42)(a) The goals that the applicant expects to achieve through the grant;

2.02(432)(b) The number of individuals to participate in leadership programs, including: existing leaders, aspiring leaders, district managers or support staff;

2.02(432)(c) A clear plan for leadership development, implementation, and application of skills in the schools and district; and

2.02(432)(d) A plan to evaluate impact of program.

2.02(54) Application requirements for School Transformation Grants—all other applicants. The following minimum requirements will be included in all other applications for School Transformation Grants:

2.02(54)(a) The goals that the applicant expects to achieve through the grant;

2.02(54)(b) A clear action plan and corresponding budget for grant activities comprised of reasonable and necessary requests for funding; and

2.02(54)(c) A plan for monitoring and reporting on the effectiveness of grant funds.

2.02(63) Criteria for selecting recipients of School ~~Turnaround Leader~~Transformation Grants. The following minimum criteria will be considered in selecting School ~~Turnaround Leader~~ Transformation Grant recipients:

2.02(63)(a) For applying school districts, the concentration of schools of the school district or, for the Institute, the concentration of Institute charter schools, that must implement priority improvement or turnaround plans. For applying charter schools, those that are implementing priority improvement or turnaround plans will be prioritized.

2.02(63)(b) Quality of grant applications and demonstrated need, based on the applicant's:

(i) Goals to be achieved through the grant;

(ii) Action plan and corresponding budget for grant activities comprised of reasonable and necessary requests for funding; and

(iii) A plan for monitoring and reporting on the effectiveness of grant funds.

2.02(74) Duration of School ~~Turnaround Leader~~Transformation Grant awards. Each ~~gschool turnaround leader g~~rant may continue for up to three budget years. The Department shall annually review each grant recipient's use of the grant money~~s~~ and may rescind the grant if the Department finds that the grant recipient is not making adequate progress toward achieving the goals identified in the grant application.

2.02(85) Reporting requirements for School ~~Turnaround Leader~~Transformation Grant~~—turnaround leadership development~~. ~~Each grant recipient will annually track the effectiveness of persons who complete a turnaround leadership development program and report the effectiveness to the department on or before July 1 of the year following the training. The report must use department rubrics to measure the effectiveness of persons who complete the turnaround leadership~~

~~development program.~~ Each grant recipient ~~will~~ annually track the effectiveness of persons who complete a turnaround leadership development program and report the effectiveness to the department on or before July 1 of the year following the training. The report must use department surveys to measure the effectiveness of persons who complete the turnaround leadership development program and include the following information, at a minimum~~must report on the following~~:

2.02(~~85~~)(a) Number of people who participated and in which programs;

2.02(~~85~~)(b) Schools served;

2.02(~~85~~)(c) Impact of the grant on raising student achievement and establishing a positive school culture; and

2.02(~~85~~)(d) Change in principals' or aspiring leaders' actions/behavior.

2.02(~~96~~) Reporting requirements for School Transformation Grant— all other grantees. Each grant recipient will annually report the following at a minimum:

2.02(~~96~~)(a) Impact of the grant on raising student achievement and establishing a positive school culture.

2.02(~~106~~) Evaluation of School ~~Turnaround Leader~~ Transformation Grant Program. The Department will analyze and summarize the reports received from grant recipients and annually submit to the State Board, the Governor, and the Education Committees of the Senate and the House of Representatives, or any successor committees, a report of the effectiveness of the School ~~Turnaround Leader~~Transformation Grants awarded pursuant to this section. The Department will also post the annual report on its web site.

Editor's Notes

History

Entire rule emer. rule eff. 09/10/2014; expired 01/08/2015.

Entire rule eff. 01/15/2015.

Entire rule eff. 01/30/2016.

Sections 2.01(2)-2.01(5) eff. 01/30/2017.

DEPARTMENT OF EDUCATION

Colorado State Board of Education

RULES FOR THE ADMINISTRATION OF THE SCHOOL TRANSFORMATION GRANT PROGRAM

1 CCR 301-95

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

Authority: Article IX, Section 1, Colorado Constitution. 22-2-106(1)(a) and (c); 22-2-107(1)(c); 22-7409(1.5); 22-13-103 of the Colorado Revised Statutes (C.R.S.).

1.00 Statement of Basis and Purpose.

The statutory basis for these rules is Sec 22-13-103, C.R.S., which requires the State Board of Education to promulgate rules to implement and administer the School Transformation Grant Program.

2.0 Definitions.

2.00(1) Charter School: A charter school authorized by a school district pursuant to part 1 of article 30.5 of title 22 or an institute charter school authorized by the state charter school institute pursuant to part 5 of article 30.5 of title 22 of the Colorado Revised Statutes.

2.00(2) Department: The Department of Education created and existing pursuant to section 24-1-115, C.R.S.

2.00(3) Institute: The State Charter School Institute established in section 22-30.5-503, C.R.S.

2.00(4) Program: The School Transformation Grant program created in section 22 13-103.

2.00(5) Provider: A public or private entity that offers a high-quality turnaround leadership development program for Colorado educators.

2.00(6) School District: A school district organized pursuant to article 30 of title 22, C.R.S.

2.00(7) School Turnaround Leader: A principal or teacher leader in a school that is required to adopt a priority improvement plan or turnaround plan pursuant to section 22-11-210, C.R.S. or a district-level administrator or employee of the State Charter School Institute that coordinates and supports turnaround efforts in schools of the School District or Institute Charter schools that implement priority improvement plans or turnaround plans.

2.00(8) State Board: The State Board of Education created pursuant to Section 1 of Article IX of the Colorado Constitution.

2.1 Turnaround Leadership Development Providers Request for Proposals

The Department must issue a request for proposals (RFP) from providers who seek to participate in the program. Based on the criteria outlined below, the Department will identify one or more providers to provide turnaround leadership development programs for school districts, the Institute, and charter schools that receive grants.

2.01(1) Criteria for identifying approved Turnaround Leadership Development Providers

The Department must develop an RFP, which consists of an application and scoring rubric template. Thereafter, the Department must undertake a fair and equitable application review. In such review, the Department must consider the following for identifying providers from among those that respond to the RFP:

2.01(1)(a) Each Provider's experience in developing successful, effective leadership in low-performing schools and school districts;

2.01(1)(b) The leadership qualities that each Provider's turnaround leadership development program is expected to develop;

2.01(1)(c) A Provider's capacity to implement identified program components that make up a comprehensive leadership development experience; and

2.01(1)(d) The availability of turnaround leadership development programs for school turnaround leaders in public schools throughout the state. The grant program shall seek to ensure approved providers are available for leaders in all regions of the state.

2.01(2) Timeline for approving new Turnaround Leadership Development Providers. Applications for new providers to apply will open at the Department's discretion and a decision notification will occur within 90 days of the closing application date.

2.01(3) Review of approved Turnaround Leadership Development Providers. The department, on a regular basis, shall review each provider's turnaround leadership development programs, including the success achieved by the persons who complete the programs, and revise the list of identified providers as appropriate to ensure that the turnaround leadership development programs that are available through the program are of the highest quality.

2.01(4) Reporting requirements for approved Turnaround Leadership Development Providers. Each approved provider shall track the effectiveness of persons who are engaged in and who complete a turnaround leadership development program and report the effectiveness to the department on or before July 1 of the year following the training. The report must use department surveys to measure the effectiveness of persons who complete the turnaround leadership development program. Each grant recipient must report on the following:

2.01(5)(a) Number of participants in program;

2.01(5)(b) Schools served; and

2.01(5)(c) Change in principals' or aspiring leaders' actions/behavior (as data is available).

2.2 School Transformation Grants.

2.02(1) Use of funds for School Transformation Grants. Subject to available appropriations, the State Board shall award School Transformation Grants to one or more school districts or charter schools or the Institute to use in:

2.02(1)(a) Identifying and recruiting practicing and aspiring school turnaround leaders;

2.02(1)(b) Subsidizing the costs incurred for school turnaround leaders and their staff, if appropriate, to participate in turnaround leadership development programs offered by identified providers;

2.02(1)(c) Reimbursing the school turnaround leaders for costs they incur in completing turnaround leadership development programs offered by identified providers;

2.02(1)(d) Providing educator professional development for educators working in public schools that are required to adopt priority improvement or turnaround plans for the immediate or preceding school year;

2.02(1)(e) Providing services, support, and materials to transform instruction in public schools that are required to adopt priority improvement or turnaround plans for the immediate or preceding school year; and

2.02(1)(f) Planning for and implementing one or more of the following rigorous school redesign strategies:

(I) Converting a district public school to a charter school if it is not already authorized as a charter school;

(ii) Granting innovation school status to a district public school pursuant to section 22-32.5-104;

(iii) With regard to a district or institute charter school, replacing the school's operator or governing board;

(iv) Contracting with a public or private entity other than the school district to partially or wholly manage a district public school, which entity is accepted by the department and the local school board as using research-based strategies and having a proven record of success working with schools under similar circumstances; or

(v) Closing a public school or revoking the charter for a district or institute charter school.

2.02(2) Timeline for School Transformation Grants. For the 2018-19 school year and each year thereafter, subject to available appropriations, School Transformation Grant applications will be due each year no later than January 15. Application decision notification will occur directly after State Board approval, no later than by the following April meeting.

2.02(3) Application procedures for School Transformation Grants. The Department must develop a grant application and scoring rubric template. Thereafter, the Department must undertake a fair and equitable application review.

2.02(4) Application requirements for School Transformation Grants—turnaround leadership development applicants. The following minimum requirements will be included in applications for School Transformation Grants for turnaround leadership development programs:

2.02(4)(a) The goals that the applicant expects to achieve through the grant; 2.02(4)

(b) The number of individuals to participate in leadership programs, including: existing leaders, aspiring leaders, district managers or support staff;

2.02(4)(c) A clear plan for leadership development, implementation, and application of skills in the schools and district; and

2.02(4)(d) A plan to evaluate impact of program.

2.02(5) Application requirements for School Transformation Grants—all other applicants. The following minimum requirements will be included in all other applications for School Transformation Grants:

2.02(5)(a) The goals that the applicant expects to achieve through the grant;

2.02(5)(b) A clear action plan and corresponding budget for grant activities comprised of reasonable and necessary requests for funding; and

2.02(5)(c) A plan for monitoring and reporting on the effectiveness of grant funds.

2.02(6) Criteria for selecting recipients of School Transformation Grants. The following minimum criteria will be considered in selecting School Transformation Grant recipients:

2.02(6)(a) For applying school districts, the concentration of schools of the school district or, for the Institute, the concentration of Institute charter schools, that must implement priority improvement or turnaround plans. For applying charter schools, those that are implementing priority improvement or turnaround plans will be prioritized.

2.02(6)(b) Quality of grant applications and demonstrated need, based on the applicant's:

(i) Goals to be achieved through the grant;

(ii) Action plan and corresponding budget for grant activities comprised of reasonable and necessary requests for funding; and

(iii) A plan for monitoring and reporting on the effectiveness of grant funds.

2.02(7) Duration of School Transformation Grant awards. Each grant may continue for up to three budget years. The Department shall annually review each grant recipient's use of the grant money and may rescind the grant if the Department finds that the grant recipient is not making adequate progress toward achieving the goals identified in the grant application.

2.02(8) Reporting requirements for School Transformation Grant—turnaround leadership development. Each grant recipient will annually track the effectiveness of persons who complete a turnaround leadership development program and report the effectiveness to the department on or before July 1 of the year following the training. The report must use department surveys to measure the effectiveness of persons who complete the turnaround leadership development program and include the following information, at a minimum:

2.02(8)(a) Number of people who participated and in which programs;

2.02(8)(b) Schools served;

2.02(8)(c) Impact of the grant on raising student achievement and establishing a positive school culture; and

2.02(8)(d) Change in principals' or aspiring leaders' actions/behavior.

2.02(9) Reporting requirements for School Transformation Grant— all other grantees. Each grant recipient will annually report the following at a minimum:

2.02(9)(a) Impact of the grant on raising student achievement and establishing a positive school culture.

2.02(10) Evaluation of School Transformation Grant Program. The Department will analyze and summarize the reports received from grant recipients and annually submit to the State Board, the Governor, and the Education Committees of the Senate and the House of Representatives, or any successor committees, a report of the effectiveness of the School Transformation Grants awarded pursuant to this section. The Department will also post the annual report on its web site.

Editor's Notes

History

Entire rule emer. rule eff. 09/10/2014; expired 01/08/2015.

Entire rule eff. 01/15/2015.

Entire rule eff. 01/30/2016.

Sections 2.01(2)-2.01(5) eff. 01/30/2017.

Notice of Proposed Rulemaking

Tracking number

2018-00491

Department

300 - Department of Education

Agency

301 - Colorado State Board of Education

CCR number

1 CCR 301-102

Rule title

RULES FOR THE ADMINISTRATION OF THE RETAINING TEACHERS GRANT PROGRAM

Rulemaking Hearing

Date

11/15/2018

Time

10:30 AM

Location

201 E. Colfax Ave., Room 101 - State Board Room

Subjects and issues involved

This is a new grant program authorized during the 2018 legislative session under House Bill 18-1412. The retaining teachers grant program is created to assist local education providers in retaining teachers by implementing one or more initiatives designed to improve the ability of a local education provider to retain teachers.

Statutory authority

22-98-101 et seq., C.R.S.

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DEPARTMENT OF EDUCATION

Colorado State Board of Education

RULES FOR THE ADMINISTRATION OF THE RETAINING TEACHERS GRANT PROGRAM

1 CCR 301-102

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

AUTHORITY: ARTICLE IX, SECTION 1, COLORADO CONSTITUTION. 22-98-101 ET SEQ. OF THE COLORADO REVISED STATUTES (C.R.S.).

0.0 STATEMENT OF BASIS AND PURPOSE

The Retaining Teachers Grant Program, 22-98-101 et seq., C.R.S., requires the State Board of Education to promulgate rules as necessary to implement the program. At a minimum, the rules must include: the application process, including requirements; criteria for the award of grants, including award priorities; the duration of the grants; and the approved uses of the grant.

1.0 DEFINITIONS

1.1 "Board of Cooperative Services" means a board of cooperative services created pursuant to article 5 of this title 22.

1.2 "Department" means the department of education created and existing pursuant to section 24-1- 115, C.R.S.

1.3 "Fund" means the retaining teachers fund created in section 22-98-104.

1.4 "Grant Program" means the retaining teachers grant program created in section 22-98-103.

1.5 "Local Education Provider" means a school district, a board of cooperative services that operates a public school, a charter school that is authorized by a school district pursuant to part 1 of article 30.5 of this title 22, or an institute charter school that is authorized pursuant to part 5 of article 30.5 of this title 22.

1.6 "Postsecondary Institution" means an area technical college, a local district college, or a state institution of higher education, as defined in section 23-18-102.

1.7 "School District" means a school district in Colorado that is organized and existing pursuant to law but does not include a local college district.

1.8 "State Board" means the state board of education created pursuant to section 1 of article IX of the state constitution.

1.9 "Teacher" means any person employed to instruct students in any school in the state, including licensed special service providers.

2.0 RETAINING TEACHERS GRANT PROGRAM

2.1 The department shall create and administer the retaining teachers grant program to assist local education providers in retaining teachers by implementing one or more of the following initiatives designed to improve the ability of a local education provider to retain teachers.

2.1.1 Job-sharing for teachers;

2.1.2 Providing on-site early childhood care services for family members of educators;

2.1.3 Robust multi-year teacher induction and mentoring programs for new teachers;

2.1.4 Peer review and mentorship programs and other career development and advancement strategies;

2.1.5 Programs to provide professional development for the creation and implementation of career advancement pathways for master teacher and teacher leadership positions for effective teachers;

2.1.6 Incentive programs to recognize and retain highly effective teachers;

2.1.7 Reduced teacher-student contact hours and increased planning, mentoring, and collaboration time for new teachers and mentor teachers; and

2.1.8 Increased use of technology in blended learning initiatives to create opportunities and financial incentives for teacher development and career advancement and cost savings to support salary increases.

3.0 APPLICATION PROCESS AND REQUIREMENTS

3.1 The department shall provide information to the local education providers concerning the grant program, the requirements for applying for a grant, the initiatives that local education providers may implement using grant money, and the availability of assistance in writing grant applications.

3.2 On an annual basis on a date determined by the department, local education providers interested in obtaining funding shall submit a retaining teacher's grant application electronically to the department, using the application form provided by the department.

3.3 Local education providers must assure that grant funds are used to supplement local education provider funding and is not used to supplant funding.

3.4 Each application submitted shall include, but need not be limited to the following:

3.4.1 Evidence describing the level of difficulty that the applicant encounters in retaining teachers, including teacher turnover and retention rates, the specific reasons for the difficulty, and a specific accounting of the grade levels and subjects for which the applicant is unable to retain teachers;

3.4.2 An accounting of the existing monetary or other resources available to the applicant to use in implementing initiatives to retain teachers;

3.4.3 A description of the initiative to retain teachers that the applicant intends to implement using the grant, how the initiative is designed to address the specific issues causing the difficulty with retaining teachers, and the applicant's strategy to build capacity;

3.4.4 The specific, measurable goals that the applicant expects to achieve in implementing the initiative, an explanation of the applicant's capacity to achieve the goals, and how the applicant expects to measure attainment of the goals; and

3.4.5 The cost, including cost-effectiveness, of implementing the initiative and the applicant's plan for sustaining the initiative after the grant money is no longer available

3.5 Local education providers are encouraged to partner with other local education providers, nonprofit entities, or postsecondary institutions to apply for a grant.

3.6 Upon request, the department shall provide technical assistance in writing the grant application described above and in complying with the annual review requirements described in section 6.0.

4.0 APPLICATION EVALUATION

4.1 In reviewing grant applications to determine which applicants should receive grant funding, the department and the state board shall prioritize applicants meeting the following criteria:

4.1.1 A high number of positions for which an applicant is unable to retain teachers; and

4.1.2 Evidence of a high rate of teacher turnover if the applicant is a low-performing school or within the low-performing schools operated by the applicant.

4.2 In addition, the department and the state board shall consider:

4.2.1 The applicant's capacity to successfully implement the proposed initiative and the likelihood that the proposed initiative will increase the applicant's ability to retain teachers;

4.2.2 The cost-effectiveness and quality of the proposed initiative; and

4.2.3 The applicant's plan for sustaining implementation of the initiative after the grant money is no longer available.

5.0 AWARD PROCESS

5.1 On an annual basis, the department shall make recommendations for grant awards to the state board.

5.2 Subject to available appropriations, the state board, taking into account the recommendations of the department, shall award the grants from money appropriated to the fund.

5.3 Each grant awarded through the grant program continues for three budget years, subject to annual review by the department and renewal by the state board as described in section 6.0.

6.0 ANNUAL REVIEW AND REPORTING

6.1 The department shall annually review the progress achieved by each grant recipient in attaining the goals of the initiative funded by the grant and recommend to the state board that the grant be extended or revoked.

6.2 For the annual review, grant recipients shall submit, at a minimum, the following information to the department:

6.2.1 How the grant money was used to fund the initiative;

6.2.2 Narrative explanation and evidence of grant outcomes against the goals set in the beginning of the year and in the grant proposal; and

6.2.3 Updates to the goals set in the grant proposal based on the progress made.

6.3 Taking into consideration the recommendations of the department, the state board shall extend the grant only if it is determined that the grand recipient is making adequate progress toward achieving the goals of the initiative.

6.4 On or before January 15, 2019, and each year thereafter, the department shall submit annually to the state board, the joint budget committee, and the education committees of the senate and house of representatives, or any successor committees, a report concerning the implementation of the grant program, including, at a minimum, the following information:

6.4.1 The name of each grant recipient and the amount of each grant;

6.4.2 A description of the initiative to be implemented with each grant and a report of the progress made by each grant recipient in achieving the goals of the initiative;

6.4.3 For the reports submitted in 2021 and 2022, an evaluation of the effect of the grant program in improving teacher retention by local education providers and in reducing the overall teacher shortage in the state;

6.4.4 Any recommendations for legislative changes to improve the effectiveness of the grant program; and

6.4.5 For the report submitted in 2022, a recommendation concerning whether to continue the grant program.

Editor's Notes

History

Notice of Proposed Rulemaking

Tracking number

2018-00506

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

11/15/2018

Time

08:30 AM

Location

Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807

Subjects and issues involved

CHAPTER P-1 - PARKS AND OUTDOOR RECREATION LANDS - SEE ATTACHED

Statutory authority

SEE ATTACHED

Contact information

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September 28, 2018

RULE-MAKING NOTICE
PARKS AND WILDLIFE COMMISSION MEETING
November 15-16, 2018

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 **November 15-16, 2018. The Parks and Wildlife Commission meeting will be held at Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807. 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, 33-1-106, 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 - **November 15-16, 2018,** beginning **at 8:30 a.m.***

EFFECTIVE DATE OF REGULATIONS approved during the November 2018 Parks and Wildlife Commission meeting: January 1, 2019, unless otherwise noted.

FINAL REGULATIONS

PARK REGULATIONS

Chapter P-1 - "Parks and Outdoor Recreation Lands" 2 CCR 405-1 and those related provisions of Chapter W-9 ("Wildlife Properties" 2 CCR 406-9) and Chapter W-16 ("Parks and Wildlife Procedural Rules" 2 CCR 406-16) necessary to accommodate changes to, or ensure consistency with, Chapter P-1

Open for consideration of final regulations regarding the consumption and sale of alcohol on state parks, state wildlife areas, and Division-leased state trust lands based on implementation of Senate Bill 18-243.

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

Open for consideration of final regulations making park fee adjustments based on implementation of the Hunting, Fishing, and Parks for Future Generations Act (Senate Bill 18-143), including, but not limited to, the following:

- Addition of a transferable annual state parks pass pilot program.
- Increases to daily and annual parks pass fees.
- Increases to camping, yurts, cabins, and group picnic fees.
- Expansion of the individual daily pass requirement to additional state parks.
- Modifications to camping reservation, special activity, and replacement park pass fees.

**Please reference the Commission agenda, to be posted on or after November 5, 2018, to ensure when each regulatory item will be addressed by the Commission. The agenda will be posted at http://cpw.state.co.us/aboutus/Pages/CommissionMeetings.aspx.*

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-15 ("License 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 final regulations related to license fees adjustments based on implementation of the Hunting, Fishing, and Parks for Future Generations Act (Senate Bill 18-143) including, but not limited to, the following:

- Adjusting wildlife license fees based on prices provided in statute.
- Increasing the Wildlife Council surcharge from .75 cents to $1.50.
- Considering wildlife license combinations, as well as adjustments to application and preference point fees.
- Adjusting commission rates applicable to the sale of licenses by license agents.

Chapter W-1- "Fishing" 2 CCR 406-1

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

- Extension of special fishing regulations on the upper Rio Grande River from Masonic Park to the Highway 149 bridge.
- Decreasing the bag and possession limit at Upper Seepage Lake in Mineral County, and limiting fishing to artificial flies and lures only.
- Implementing catch and release regulations at Dry Gulch in Clear Creek County.
- Adjusting the start date of the spring walleye spawning fishing closure on the dams at Chatfield, Cherry Creek, and Pueblo Reservoirs to March 1st. Also removing the time of day stipulations for the Pueblo Reservoir walleye spawning closure.
- Adjusting the bag and possession limit, and implementing a minimum size requirement for crappie at Pueblo Reservoir.
- Adjusting the bag and possession limit for wiper at Pueblo Reservoir, including allowing no more than one wiper greater than 21 inches to be taken per day.

Chapter W-3 - "Furbearers and Small Game, except Migratory Birds" 2 CCR 406-3, and those related provisions of Chapter W-0 – ("General Provisions" 2 CCR 406-0) necessary to accommodate changes to, or ensure consistency with, Chapter W-3

Open for final consideration of annual changes regarding turkey hunting, including but not limited to, license areas and license numbers, season dates, manner of take provisions and adopting new preference point application hunt codes for the 2019 fall and spring turkey seasons.

CITIZEN PETITIONS:

Final action may be taken on rule-making petitions at any step of the Commission's generally applicable two-step rule-making process.

WILDLIFE REGULATIONS

Chapter W-17 - "Damage Caused by Wildlife" 2 CCR 406-17

At its November meeting, the Parks and Wildlife Commission will consider a Citizen Petition for Rulemaking related to Damage Caused by Wildlife, as follows:

- A Citizen Petition for Rulemaking requesting that the Commission allow dogs to haze geese year-round on private property in order to prevent or alleviate damage.

The Commission may accept all or a portion of this petition for final action, further consideration or otherwise reject the petition at the November Commission Meeting. A copy of any petition may be obtained by contacting Danielle Isenhart, Regulations Manager, Colorado Parks and Wildlife at (303) 866-3203 ext. 4625.

ISSUES IDENTIFICATION

WILDLIFE REGULATIONS

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

Open for annual review of the entire chapter, including but not limited to, Game Management Unit boundary modifications, regulations relating to fish management, health, importation, prohibited species, and other annual changes.

Chapter W-2 - "Big Game" 2 CCR 406-2 and those related provisions of Chapter W-0 ("General Provisions" 2 CCR 406-0) necessary to accommodate changes to or ensure consistency with Chapter W-2

Open for annual review of the entire chapter, including, but not limited to:

- Annual changes to season dates, limited license areas, license numbers, and manner of take provisions for bighorn sheep and mountain goat.
- Annual changes to season dates, limited license areas and manner of take provisions for deer, elk, pronghorn antelope, moose, mountain lion, and bear.
- Annual changes to limited license application and drawing processes.

Except for the days 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.

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Notice of Proposed Rulemaking

Tracking number

2018-00508

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

11/15/2018

Time

08:30 AM

Location

Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807

Subjects and issues involved

CHAPTER P-7 - PASSES, PERMITS AND REGISTRATIONS - SEE ATTACHED

Statutory authority

SEE ATTACHED

Contact information

Name

Danielle Isenhart

Title

Regulations Manager

Telephone

303-866-3203 x4625

Email

Danielle.Isenhart@state.co.us

September 28, 2018

RULE-MAKING NOTICE
PARKS AND WILDLIFE COMMISSION MEETING
November 15-16, 2018

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 **November 15-16, 2018. The Parks and Wildlife Commission meeting will be held at Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807. 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, 33-1-106, 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 - **November 15-16, 2018,** beginning **at 8:30 a.m.***

EFFECTIVE DATE OF REGULATIONS approved during the November 2018 Parks and Wildlife Commission meeting: January 1, 2019, unless otherwise noted.

FINAL REGULATIONS

PARK REGULATIONS

Chapter P-1 - "Parks and Outdoor Recreation Lands" 2 CCR 405-1 and those related provisions of Chapter W-9 ("Wildlife Properties" 2 CCR 406-9) and Chapter W-16 ("Parks and Wildlife Procedural Rules" 2 CCR 406-16) necessary to accommodate changes to, or ensure consistency with, Chapter P-1

Open for consideration of final regulations regarding the consumption and sale of alcohol on state parks, state wildlife areas, and Division-leased state trust lands based on implementation of Senate Bill 18-243.

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

Open for consideration of final regulations making park fee adjustments based on implementation of the Hunting, Fishing, and Parks for Future Generations Act (Senate Bill 18-143), including, but not limited to, the following:

- Addition of a transferable annual state parks pass pilot program.
- Increases to daily and annual parks pass fees.
- Increases to camping, yurts, cabins, and group picnic fees.
- Expansion of the individual daily pass requirement to additional state parks.
- Modifications to camping reservation, special activity, and replacement park pass fees.

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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-15 ("License 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 final regulations related to license fees adjustments based on implementation of the Hunting, Fishing, and Parks for Future Generations Act (Senate Bill 18-143) including, but not limited to, the following:

- Adjusting wildlife license fees based on prices provided in statute.
- Increasing the Wildlife Council surcharge from .75 cents to $1.50.
- Considering wildlife license combinations, as well as adjustments to application and preference point fees.
- Adjusting commission rates applicable to the sale of licenses by license agents.

Chapter W-1- "Fishing" 2 CCR 406-1

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

- Extension of special fishing regulations on the upper Rio Grande River from Masonic Park to the Highway 149 bridge.
- Decreasing the bag and possession limit at Upper Seepage Lake in Mineral County, and limiting fishing to artificial flies and lures only.
- Implementing catch and release regulations at Dry Gulch in Clear Creek County.
- Adjusting the start date of the spring walleye spawning fishing closure on the dams at Chatfield, Cherry Creek, and Pueblo Reservoirs to March 1st. Also removing the time of day stipulations for the Pueblo Reservoir walleye spawning closure.
- Adjusting the bag and possession limit, and implementing a minimum size requirement for crappie at Pueblo Reservoir.
- Adjusting the bag and possession limit for wiper at Pueblo Reservoir, including allowing no more than one wiper greater than 21 inches to be taken per day.

Chapter W-3 - "Furbearers and Small Game, except Migratory Birds" 2 CCR 406-3, and those related provisions of Chapter W-0 – ("General Provisions" 2 CCR 406-0) necessary to accommodate changes to, or ensure consistency with, Chapter W-3

Open for final consideration of annual changes regarding turkey hunting, including but not limited to, license areas and license numbers, season dates, manner of take provisions and adopting new preference point application hunt codes for the 2019 fall and spring turkey seasons.

CITIZEN PETITIONS:

Final action may be taken on rule-making petitions at any step of the Commission's generally applicable two-step rule-making process.

WILDLIFE REGULATIONS

Chapter W-17 - "Damage Caused by Wildlife" 2 CCR 406-17

At its November meeting, the Parks and Wildlife Commission will consider a Citizen Petition for Rulemaking related to Damage Caused by Wildlife, as follows:

- A Citizen Petition for Rulemaking requesting that the Commission allow dogs to haze geese year-round on private property in order to prevent or alleviate damage.

The Commission may accept all or a portion of this petition for final action, further consideration or otherwise reject the petition at the November Commission Meeting. A copy of any petition may be obtained by contacting Danielle Isenhart, Regulations Manager, Colorado Parks and Wildlife at (303) 866-3203 ext. 4625.

ISSUES IDENTIFICATION

WILDLIFE REGULATIONS

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

Open for annual review of the entire chapter, including but not limited to, Game Management Unit boundary modifications, regulations relating to fish management, health, importation, prohibited species, and other annual changes.

Chapter W-2 - "Big Game" 2 CCR 406-2 and those related provisions of Chapter W-0 ("General Provisions" 2 CCR 406-0) necessary to accommodate changes to or ensure consistency with Chapter W-2

Open for annual review of the entire chapter, including, but not limited to:

- Annual changes to season dates, limited license areas, license numbers, and manner of take provisions for bighorn sheep and mountain goat.
- Annual changes to season dates, limited license areas and manner of take provisions for deer, elk, pronghorn antelope, moose, mountain lion, and bear.
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Notice of Proposed Rulemaking

Tracking number

2018-00511

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

11/15/2018

Time

08:30 AM

Location

Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807

Subjects and issues involved

CHAPTER W-0 - GENERAL PROVISIONS - SEE ATTACHED

Statutory authority

SEE ATTACHED

Contact information

Name

Danielle Isenhart

Title

Regulations Manager

Telephone

303-866-3203 x4625

Email

Danielle.Isenhart@state.co.us

September 28, 2018

RULE-MAKING NOTICE
PARKS AND WILDLIFE COMMISSION MEETING
November 15-16, 2018

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Notice of Proposed Rulemaking

Tracking number

2018-00515

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

11/15/2018

Time

08:30 AM

Location

Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807

Subjects and issues involved

CHAPTER W-1 - FISHING - SEE ATTACHED

Statutory authority

SEE ATTACHED

Contact information

Name

Danielle Isenhart

Title

Regulations Manager

Telephone

303-866-3203 x4625

Email

Danielle.Isenhart@state.co.us

September 28, 2018

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November 15-16, 2018

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

- Extension of special fishing regulations on the upper Rio Grande River from Masonic Park to the Highway 149 bridge.
- Decreasing the bag and possession limit at Upper Seepage Lake in Mineral County, and limiting fishing to artificial flies and lures only.
- Implementing catch and release regulations at Dry Gulch in Clear Creek County.
- Adjusting the start date of the spring walleye spawning fishing closure on the dams at Chatfield, Cherry Creek, and Pueblo Reservoirs to March 1st. Also removing the time of day stipulations for the Pueblo Reservoir walleye spawning closure.
- Adjusting the bag and possession limit, and implementing a minimum size requirement for crappie at Pueblo Reservoir.
- Adjusting the bag and possession limit for wiper at Pueblo Reservoir, including allowing no more than one wiper greater than 21 inches to be taken per day.

Chapter W-3 - "Furbearers and Small Game, except Migratory Birds" 2 CCR 406-3, and those related provisions of Chapter W-0 – ("General Provisions" 2 CCR 406-0) necessary to accommodate changes to, or ensure consistency with, Chapter W-3

Open for final consideration of annual changes regarding turkey hunting, including but not limited to, license areas and license numbers, season dates, manner of take provisions and adopting new preference point application hunt codes for the 2019 fall and spring turkey seasons.

CITIZEN PETITIONS:

Final action may be taken on rule-making petitions at any step of the Commission's generally applicable two-step rule-making process.

WILDLIFE REGULATIONS

Chapter W-17 - "Damage Caused by Wildlife" 2 CCR 406-17

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- A Citizen Petition for Rulemaking requesting that the Commission allow dogs to haze geese year-round on private property in order to prevent or alleviate damage.

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ISSUES IDENTIFICATION

WILDLIFE REGULATIONS

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

Open for annual review of the entire chapter, including but not limited to, Game Management Unit boundary modifications, regulations relating to fish management, health, importation, prohibited species, and other annual changes.

Chapter W-2 - "Big Game" 2 CCR 406-2 and those related provisions of Chapter W-0 ("General Provisions" 2 CCR 406-0) necessary to accommodate changes to or ensure consistency with Chapter W-2

Open for annual review of the entire chapter, including, but not limited to:

- Annual changes to season dates, limited license areas, license numbers, and manner of take provisions for bighorn sheep and mountain goat.
- Annual changes to season dates, limited license areas and manner of take provisions for deer, elk, pronghorn antelope, moose, mountain lion, and bear.
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or the Commission before the Commission promulgates final rules and regulations on the above topics.

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Notice of Proposed Rulemaking

Tracking number

2018-00512

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

11/15/2018

Time

08:30 AM

Location

Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807

Subjects and issues involved

CHAPTER W-2 - BIG GAME - SEE ATTACHED

Statutory authority

SEE ATTACHED

Contact information

Name

Danielle Isenhart

Title

Regulations Manager

Telephone

303-866-3203 x4625

Email

Danielle.Isenhart@state.co.us

September 28, 2018

RULE-MAKING NOTICE
PARKS AND WILDLIFE COMMISSION MEETING
November 15-16, 2018

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 **November 15-16, 2018. The Parks and Wildlife Commission meeting will be held at Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807. 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, 33-1-106, 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 - **November 15-16, 2018,** beginning **at 8:30 a.m.***

EFFECTIVE DATE OF REGULATIONS approved during the November 2018 Parks and Wildlife Commission meeting: January 1, 2019, unless otherwise noted.

FINAL REGULATIONS

PARK REGULATIONS

Chapter P-1 - "Parks and Outdoor Recreation Lands" 2 CCR 405-1 and those related provisions of Chapter W-9 ("Wildlife Properties" 2 CCR 406-9) and Chapter W-16 ("Parks and Wildlife Procedural Rules" 2 CCR 406-16) necessary to accommodate changes to, or ensure consistency with, Chapter P-1

Open for consideration of final regulations regarding the consumption and sale of alcohol on state parks, state wildlife areas, and Division-leased state trust lands based on implementation of Senate Bill 18-243.

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

Open for consideration of final regulations making park fee adjustments based on implementation of the Hunting, Fishing, and Parks for Future Generations Act (Senate Bill 18-143), including, but not limited to, the following:

- Addition of a transferable annual state parks pass pilot program.
- Increases to daily and annual parks pass fees.
- Increases to camping, yurts, cabins, and group picnic fees.
- Expansion of the individual daily pass requirement to additional state parks.
- Modifications to camping reservation, special activity, and replacement park pass fees.

**Please reference the Commission agenda, to be posted on or after November 5, 2018, to ensure when each regulatory item will be addressed by the Commission. The agenda will be posted at http://cpw.state.co.us/aboutus/Pages/CommissionMeetings.aspx.*

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-15 ("License 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 final regulations related to license fees adjustments based on implementation of the Hunting, Fishing, and Parks for Future Generations Act (Senate Bill 18-143) including, but not limited to, the following:

- Adjusting wildlife license fees based on prices provided in statute.
- Increasing the Wildlife Council surcharge from .75 cents to $1.50.
- Considering wildlife license combinations, as well as adjustments to application and preference point fees.
- Adjusting commission rates applicable to the sale of licenses by license agents.

Chapter W-1- "Fishing" 2 CCR 406-1

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

- Extension of special fishing regulations on the upper Rio Grande River from Masonic Park to the Highway 149 bridge.
- Decreasing the bag and possession limit at Upper Seepage Lake in Mineral County, and limiting fishing to artificial flies and lures only.
- Implementing catch and release regulations at Dry Gulch in Clear Creek County.
- Adjusting the start date of the spring walleye spawning fishing closure on the dams at Chatfield, Cherry Creek, and Pueblo Reservoirs to March 1st. Also removing the time of day stipulations for the Pueblo Reservoir walleye spawning closure.
- Adjusting the bag and possession limit, and implementing a minimum size requirement for crappie at Pueblo Reservoir.
- Adjusting the bag and possession limit for wiper at Pueblo Reservoir, including allowing no more than one wiper greater than 21 inches to be taken per day.

Chapter W-3 - "Furbearers and Small Game, except Migratory Birds" 2 CCR 406-3, and those related provisions of Chapter W-0 – ("General Provisions" 2 CCR 406-0) necessary to accommodate changes to, or ensure consistency with, Chapter W-3

Open for final consideration of annual changes regarding turkey hunting, including but not limited to, license areas and license numbers, season dates, manner of take provisions and adopting new preference point application hunt codes for the 2019 fall and spring turkey seasons.

CITIZEN PETITIONS:

Final action may be taken on rule-making petitions at any step of the Commission's generally applicable two-step rule-making process.

WILDLIFE REGULATIONS

Chapter W-17 - "Damage Caused by Wildlife" 2 CCR 406-17

At its November meeting, the Parks and Wildlife Commission will consider a Citizen Petition for Rulemaking related to Damage Caused by Wildlife, as follows:

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ISSUES IDENTIFICATION

WILDLIFE REGULATIONS

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Open for annual review of the entire chapter, including but not limited to, Game Management Unit boundary modifications, regulations relating to fish management, health, importation, prohibited species, and other annual changes.

Chapter W-2 - "Big Game" 2 CCR 406-2 and those related provisions of Chapter W-0 ("General Provisions" 2 CCR 406-0) necessary to accommodate changes to or ensure consistency with Chapter W-2

Open for annual review of the entire chapter, including, but not limited to:

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Notice of Proposed Rulemaking

Tracking number

2018-00513

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

11/15/2018

Time

08:30 AM

Location

Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807

Subjects and issues involved

CHAPTER W-3 - FURBEARERS AND SMALL GAME EXCEPT MIGRATORY BIRDS - SEE ATTACHED

Statutory authority

SEE ATTACHED

Contact information

Name

Danielle Isenhart

Title

Regulations Manager

Telephone

303-866-3203 x4625

Email

Danielle.Isenhart@state.co.us

September 28, 2018

RULE-MAKING NOTICE
PARKS AND WILDLIFE COMMISSION MEETING
November 15-16, 2018

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Notice of Proposed Rulemaking

Tracking number

2018-00509

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

11/15/2018

Time

08:30 AM

Location

Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807

Subjects and issues involved

CHAPTER W-9 - WILDLIFE PROPERTIES - SEE ATTACHED

Statutory authority

SEE ATTACHED

Contact information

Name

Danielle Isenhart

Title

Regulations Manager

Telephone

303-866-3203 x4625

Email

Danielle.Isenhart@state.co.us

September 28, 2018

RULE-MAKING NOTICE
PARKS AND WILDLIFE COMMISSION MEETING
November 15-16, 2018

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 **November 15-16, 2018. The Parks and Wildlife Commission meeting will be held at Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807. 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, 33-1-106, 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 - **November 15-16, 2018,** beginning **at 8:30 a.m.***

EFFECTIVE DATE OF REGULATIONS approved during the November 2018 Parks and Wildlife Commission meeting: January 1, 2019, unless otherwise noted.

FINAL REGULATIONS

PARK REGULATIONS

Chapter P-1 - "Parks and Outdoor Recreation Lands" 2 CCR 405-1 and those related provisions of Chapter W-9 ("Wildlife Properties" 2 CCR 406-9) and Chapter W-16 ("Parks and Wildlife Procedural Rules" 2 CCR 406-16) necessary to accommodate changes to, or ensure consistency with, Chapter P-1

Open for consideration of final regulations regarding the consumption and sale of alcohol on state parks, state wildlife areas, and Division-leased state trust lands based on implementation of Senate Bill 18-243.

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

Open for consideration of final regulations making park fee adjustments based on implementation of the Hunting, Fishing, and Parks for Future Generations Act (Senate Bill 18-143), including, but not limited to, the following:

- Addition of a transferable annual state parks pass pilot program.
- Increases to daily and annual parks pass fees.
- Increases to camping, yurts, cabins, and group picnic fees.
- Expansion of the individual daily pass requirement to additional state parks.
- Modifications to camping reservation, special activity, and replacement park pass fees.

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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-15 ("License 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 final regulations related to license fees adjustments based on implementation of the Hunting, Fishing, and Parks for Future Generations Act (Senate Bill 18-143) including, but not limited to, the following:

- Adjusting wildlife license fees based on prices provided in statute.
- Increasing the Wildlife Council surcharge from .75 cents to $1.50.
- Considering wildlife license combinations, as well as adjustments to application and preference point fees.
- Adjusting commission rates applicable to the sale of licenses by license agents.

Chapter W-1- "Fishing" 2 CCR 406-1

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

- Extension of special fishing regulations on the upper Rio Grande River from Masonic Park to the Highway 149 bridge.
- Decreasing the bag and possession limit at Upper Seepage Lake in Mineral County, and limiting fishing to artificial flies and lures only.
- Implementing catch and release regulations at Dry Gulch in Clear Creek County.
- Adjusting the start date of the spring walleye spawning fishing closure on the dams at Chatfield, Cherry Creek, and Pueblo Reservoirs to March 1st. Also removing the time of day stipulations for the Pueblo Reservoir walleye spawning closure.
- Adjusting the bag and possession limit, and implementing a minimum size requirement for crappie at Pueblo Reservoir.
- Adjusting the bag and possession limit for wiper at Pueblo Reservoir, including allowing no more than one wiper greater than 21 inches to be taken per day.

Chapter W-3 - "Furbearers and Small Game, except Migratory Birds" 2 CCR 406-3, and those related provisions of Chapter W-0 – ("General Provisions" 2 CCR 406-0) necessary to accommodate changes to, or ensure consistency with, Chapter W-3

Open for final consideration of annual changes regarding turkey hunting, including but not limited to, license areas and license numbers, season dates, manner of take provisions and adopting new preference point application hunt codes for the 2019 fall and spring turkey seasons.

CITIZEN PETITIONS:

Final action may be taken on rule-making petitions at any step of the Commission's generally applicable two-step rule-making process.

WILDLIFE REGULATIONS

Chapter W-17 - "Damage Caused by Wildlife" 2 CCR 406-17

At its November meeting, the Parks and Wildlife Commission will consider a Citizen Petition for Rulemaking related to Damage Caused by Wildlife, as follows:

- A Citizen Petition for Rulemaking requesting that the Commission allow dogs to haze geese year-round on private property in order to prevent or alleviate damage.

The Commission may accept all or a portion of this petition for final action, further consideration or otherwise reject the petition at the November Commission Meeting. A copy of any petition may be obtained by contacting Danielle Isenhart, Regulations Manager, Colorado Parks and Wildlife at (303) 866-3203 ext. 4625.

ISSUES IDENTIFICATION

WILDLIFE REGULATIONS

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

Open for annual review of the entire chapter, including but not limited to, Game Management Unit boundary modifications, regulations relating to fish management, health, importation, prohibited species, and other annual changes.

Chapter W-2 - "Big Game" 2 CCR 406-2 and those related provisions of Chapter W-0 ("General Provisions" 2 CCR 406-0) necessary to accommodate changes to or ensure consistency with Chapter W-2

Open for annual review of the entire chapter, including, but not limited to:

- Annual changes to season dates, limited license areas, license numbers, and manner of take provisions for bighorn sheep and mountain goat.
- Annual changes to season dates, limited license areas and manner of take provisions for deer, elk, pronghorn antelope, moose, mountain lion, and bear.
- Annual changes to limited license application and drawing processes.

Except for the days 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.

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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.

Comment deadlines: Comments will be accepted at any time prior to, or as part of the meeting. 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:**

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Notice of Proposed Rulemaking

Tracking number

2018-00514

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

11/15/2018

Time

08:30 AM

Location

Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807

Subjects and issues involved

CHAPTER W-15 - DIVISION AGENTS - SEE ATTACHED

Statutory authority

SEE ATTACHED

Contact information

Name

Danielle Isenhart

Title

Regulations Manager

Telephone

303-866-3203 x4625

Email

Danielle.Isenhart@state.co.us

September 28, 2018

RULE-MAKING NOTICE
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November 15-16, 2018

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FINAL REGULATIONS

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WILDLIFE REGULATIONS

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Notice of Proposed Rulemaking

Tracking number

2018-00510

Department

400 - Department of Natural Resources

Agency

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

CCR number

2 CCR 406-16

Rule title

CHAPTER W-16 - PARKS AND WILDLIFE PROCEDURAL RULES

Rulemaking Hearing

Date

11/15/2018

Time

08:30 AM

Location

Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807

Subjects and issues involved

CHAPTER W-16 - PARKS AND WILDLIFE PROCEDURAL RULES - SEE ATTACHED

Statutory authority

SEE ATTACHED

Contact information

Name

Danielle Isenhart

Title

Regulations Manager

Telephone

303-866-3203 x4625

Email

Danielle.Isenhart@state.co.us

September 28, 2018

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November 15-16, 2018

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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 may be viewed on the Division of Parks and Wildlife's internet home page at **http://cpw.state.co.us**, on or after **November 5, 2018**.

Notice of Proposed Rulemaking

Tracking number

2018-00517

Department

400 - Department of Natural Resources

Agency

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

CCR number

2 CCR 406-17

Rule title

CHAPTER W-17 - DAMAGE CAUSED BY WILDLIFE

Rulemaking Hearing

Date

11/15/2018

Time

08:30 AM

Location

Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807

Subjects and issues involved

CHAPTER W-17 - DAMAGE CAUSED BY WILDLIFE - SEE ATTACHED

Statutory authority

SEE ATTACHED

Contact information

Name

Danielle Isenhart

Title

Regulations Manager

Telephone

303-866-3203 x4625

Email

Danielle.Isenhart@state.co.us

September 28, 2018

RULE-MAKING NOTICE
PARKS AND WILDLIFE COMMISSION MEETING
November 15-16, 2018

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 **November 15-16, 2018. The Parks and Wildlife Commission meeting will be held at Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807. 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, 33-1-106, 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 - **November 15-16, 2018,** beginning **at 8:30 a.m.***

EFFECTIVE DATE OF REGULATIONS approved during the November 2018 Parks and Wildlife Commission meeting: January 1, 2019, unless otherwise noted.

FINAL REGULATIONS

PARK REGULATIONS

Chapter P-1 - "Parks and Outdoor Recreation Lands" 2 CCR 405-1 and those related provisions of Chapter W-9 ("Wildlife Properties" 2 CCR 406-9) and Chapter W-16 ("Parks and Wildlife Procedural Rules" 2 CCR 406-16) necessary to accommodate changes to, or ensure consistency with, Chapter P-1

Open for consideration of final regulations regarding the consumption and sale of alcohol on state parks, state wildlife areas, and Division-leased state trust lands based on implementation of Senate Bill 18-243.

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

Open for consideration of final regulations making park fee adjustments based on implementation of the Hunting, Fishing, and Parks for Future Generations Act (Senate Bill 18-143), including, but not limited to, the following:

- Addition of a transferable annual state parks pass pilot program.
- Increases to daily and annual parks pass fees.
- Increases to camping, yurts, cabins, and group picnic fees.
- Expansion of the individual daily pass requirement to additional state parks.
- Modifications to camping reservation, special activity, and replacement park pass fees.

**Please reference the Commission agenda, to be posted on or after November 5, 2018, to ensure when each regulatory item will be addressed by the Commission. The agenda will be posted at http://cpw.state.co.us/aboutus/Pages/CommissionMeetings.aspx.*

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-15 ("License 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 final regulations related to license fees adjustments based on implementation of the Hunting, Fishing, and Parks for Future Generations Act (Senate Bill 18-143) including, but not limited to, the following:

- Adjusting wildlife license fees based on prices provided in statute.
- Increasing the Wildlife Council surcharge from .75 cents to $1.50.
- Considering wildlife license combinations, as well as adjustments to application and preference point fees.
- Adjusting commission rates applicable to the sale of licenses by license agents.

Chapter W-1- "Fishing" 2 CCR 406-1

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

- Extension of special fishing regulations on the upper Rio Grande River from Masonic Park to the Highway 149 bridge.
- Decreasing the bag and possession limit at Upper Seepage Lake in Mineral County, and limiting fishing to artificial flies and lures only.
- Implementing catch and release regulations at Dry Gulch in Clear Creek County.
- Adjusting the start date of the spring walleye spawning fishing closure on the dams at Chatfield, Cherry Creek, and Pueblo Reservoirs to March 1st. Also removing the time of day stipulations for the Pueblo Reservoir walleye spawning closure.
- Adjusting the bag and possession limit, and implementing a minimum size requirement for crappie at Pueblo Reservoir.
- Adjusting the bag and possession limit for wiper at Pueblo Reservoir, including allowing no more than one wiper greater than 21 inches to be taken per day.

Chapter W-3 - "Furbearers and Small Game, except Migratory Birds" 2 CCR 406-3, and those related provisions of Chapter W-0 – ("General Provisions" 2 CCR 406-0) necessary to accommodate changes to, or ensure consistency with, Chapter W-3

Open for final consideration of annual changes regarding turkey hunting, including but not limited to, license areas and license numbers, season dates, manner of take provisions and adopting new preference point application hunt codes for the 2019 fall and spring turkey seasons.

CITIZEN PETITIONS:

Final action may be taken on rule-making petitions at any step of the Commission's generally applicable two-step rule-making process.

WILDLIFE REGULATIONS

Chapter W-17 - "Damage Caused by Wildlife" 2 CCR 406-17

At its November meeting, the Parks and Wildlife Commission will consider a Citizen Petition for Rulemaking related to Damage Caused by Wildlife, as follows:

- A Citizen Petition for Rulemaking requesting that the Commission allow dogs to haze geese year-round on private property in order to prevent or alleviate damage.

The Commission may accept all or a portion of this petition for final action, further consideration or otherwise reject the petition at the November Commission Meeting. A copy of any petition may be obtained by contacting Danielle Isenhart, Regulations Manager, Colorado Parks and Wildlife at (303) 866-3203 ext. 4625.

ISSUES IDENTIFICATION

WILDLIFE REGULATIONS

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

Open for annual review of the entire chapter, including but not limited to, Game Management Unit boundary modifications, regulations relating to fish management, health, importation, prohibited species, and other annual changes.

Chapter W-2 - "Big Game" 2 CCR 406-2 and those related provisions of Chapter W-0 ("General Provisions" 2 CCR 406-0) necessary to accommodate changes to or ensure consistency with Chapter W-2

Open for annual review of the entire chapter, including, but not limited to:

- Annual changes to season dates, limited license areas, license numbers, and manner of take provisions for bighorn sheep and mountain goat.
- Annual changes to season dates, limited license areas and manner of take provisions for deer, elk, pronghorn antelope, moose, mountain lion, and bear.
- Annual changes to limited license application and drawing processes.

Except for the days 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.

Viewing of Proposed Rules: Copies of the proposed rules (together with a proposed statement of basis and purpose and specific statutory authority), will be available for inspection and distribution at the Office of the Regulations Manager, Division of Parks and Wildlife, 1313 Sherman St., Denver, Colorado, 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.

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.

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Notice of Proposed Rulemaking

Tracking number

2018-00494

Department

500,1008,2500 - Department of Human Services

Agency

501 - Mental Health Services

CCR number

2 CCR 501-1

Rule title

UNIFORM METHOD OF DETERMINING ABILITY TO PAY [Repealed eff. 11/01/2013]

Rulemaking Hearing

Date

11/02/2018

Time

08:30 AM

Location

1575 Sherman Street, Denver, CO 80203

Subjects and issues involved

House Bill 18-1094 reauthorized, renamed, and updated the Child Mental Health Treatment Act (Act). The proposed rule revisions align the program regulations with the statutory changes to the Act from House Bill 18-1094. The renamed Children and Youth Mental Health Treatment Act allows families to access community, residential, and transitional treatment services for their child without requiring a dependency and neglect action, when there is no child abuse or neglect. To be eligible, a child must have a mental health disorder, be under the age of 21, and be at risk of out-of-home placement or at risk of further involvement with a county department of human/social services.

Statutory authority

26-1-107, C.R.S. (2018)
26-1-109, C.R.S. (2018)
26-1-111, C.R.S. (2018)
27-67-106, C.R.S. (2018)
27-67-107, C.R.S.

Contact information

Name

Ryan Templeton

Title

Rule Author

Telephone

303-866-7405

Email

ryantempleton@state.co.us

Title of Proposed Rule:	**Revisions to the Rules Implementing the Children and Youth Mental Health Treatment Act**	
CDHS Tracking #:	**18-08-15-01**	
Office, Division, & Program: Office of Behavioral Health, Division of Community Behavioral Health	Rule Author: Ryan Templeton	Phone: 303-866-7405 E-Mail: ryantempleton@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***

House Bill 18-1094 reauthorized, renamed, and updated the Child Mental Health Treatment Act (Act). The proposed rule revisions align the program regulations with the statutory changes to the Act from House Bill 18-1094. The renamed Children and Youth Mental Health Treatment Act allows families to access community, residential, and transitional treatment services for their child without requiring a dependency and neglect action, when there is no child abuse or neglect. To be eligible, a child must have a mental health disorder, be under the age of 21, and be at risk of out-of-home placement or at risk of further involvement with a county department of human/social services.

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

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

Justification for emergency:

Not applicable

State Board Authority for Rule:

Code	Description
26-1-107, C.R.S. (2018)	State Board to promulgate rules
26-1-109, C.R.S. (2018)	State department rules to coordinate with federal programs
26-1-111, C.R.S. (2018)	State department to promulgate rules for public assistance and welfare activities.

Program Authority for Rule: *Give federal and/or state citations and a summary of the language authorizing the rule-making function AND authority.*

Code	Description
27-67-106, C.R.S. (2018)	The state board of human services shall promulgate rules implementing a sliding scale for the payment of services.
27-67-107, C.R.S.	The state board of human services shall promulgate rules to assure that a grievance process is available to parents concerning the provision of mental health services and to assure that a dispute resolution process is available for disputes between the county departments and mental health agencies.

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

If yes, please explain. The rule reference Social Security Administration rules regarding the determination of ability to pay for services.

Title of Proposed Rule:	**Revisions to the Rules Implementing the Children and Youth Mental Health Treatment Act**	
CDHS Tracking #:	**18-08-15-01**	
Office, Division, & Program: Office of Behavioral Health, Division of Community Behavioral Health	Rule Author: Ryan Templeton	Phone: 303-866-7405 E-Mail: ryantempleton@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?

The proposed rule revisions align the Children and Youth Mental Health Treatment Act (CYMHTA) regulations with the updated statute. The statutorily required program regulations establish procedures for how CYMHTA shall be implemented in Colorado. CYMHTA benefits families with a child or youth at risk of out-of-home placement by allowing these families to access community, residential, and transitional mental health treatment services for their child without requiring a dependency or neglect action, in cases where this is no child abuse or neglect.

Entities providing the services, including entities assigned to participate in the dispute resolution process, under CYMHTA will be affected by these regulations, as these regulations update procedures for implementing CYMHTA to align with the changes made to the Act by House Bill 18-1094.

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?

For Fiscal Year 2017-18, the Child Mental Health Treatment Act had an appropriation of $1.1 million and provided services to 99 children located in 20 out of the 65 counties in Colorado. House Bill 18-1094 increased the appropriation to $3.2 million annually. The additional appropriation expands the age limit for program services from 18 years of age to 21 years of age; expands statewide utilization of the program; allows for training for communities; and provides family advocacy services from children.

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)*

With additional funding appropriated to the Children and Youth Mental Health Treatment Act (CYMHTA) pursuant to House Bill 18-1094, CYMHTA has an annual General Fund appropriation of $3,199,125.

The Department does not expect a fiscal impact as a result of the proposed rule changes. The changes do not include additional funding requirements to the Department or contracted agencies.

County Fiscal Impact

No County fiscal impact is expected with these proposed rules, as the services provided through CYMHTA is completed funded with Colorado General Funds.

Title of Proposed Rule:	**Revisions to the Rules Implementing the Children and Youth Mental Health Treatment Act**	
CDHS Tracking #:	**18-08-15-01**	
Office, Division, & Program: Office of Behavioral Health, Division of Community Behavioral Health	Rule Author: Ryan Templeton	Phone: 303-866-7405 E-Mail: ryantempleton@state.co.us

Federal Fiscal Impact

No Federal fiscal impact is expected with these proposed rules as this program is specific to Colorado.

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

Additional training requirements may be needed due to the changes House Bill 18-1094 made to CYMHTA. The Office of Behavioral Health has CMYHTA staff assigned to provide training and technical assistance regarding CYMHTA services. CYMHTA training and technical assistance would be provided at no cost, but providers and other entities may experience travel or related costs to attend trainings.

4. Data Description

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

House Bill 18-1094 including the fiscal note for House Bill 18-1094 were used when the Office of Behavioral Health collaborated with stakeholder in the development of the proposed rule revisions.

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 to rule-making were considered due to the authorizing statute requiring rule promulgation.

Title of Proposed Rule:	**Revisions to the Rules Implementing the Children and Youth Mental Health Treatment Act**	
CDHS Tracking #:	**18-08-15-01**	
Office, Division, & Program:	Rule Author: Ryan Templeton	Phone: 303-866-7405
Office of Behavioral Health, Division of Community Behavioral Health		E-Mail: ryantempleton@state.co.us

OVERVIEW OF PROPOSED RULE

Compare and/or contrast the content of the current regulation and the proposed change.

Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
7.000	*Incorrect Statutory Reference*	*Section 26.5.103 C.R.S.*	*Section 26.5-101(3) C.R.S.*		
21.200.4	Section needs updating to align with updated statute	These rules are intended to implement the mental health treatment services defined in the Child Mental Health Treatment Act, Sections 27-67-101 through 27-67-108, C.R.S., subject to available appropriations, to ensure the maximum use of appropriate least restrictive treatment services and to provide access to the greatest number of children. The purpose of the Child Mental Health Treatment Act is to provide access to mental health treatment for eligible children who are Medicaid eligible as well as those who are at risk of out-of-home placement, as defined below. In addition, the rules are intended to provide a sliding fee scale for responsible parties to offset the cost of care not covered by private insurance or Medicaid provided under the Child Mental Health Treatment Act. Appeal procedures for denial of residential and community mental health treatment are established in the rules as well as a dispute resolution process for county departments and mental health agencies.	These rules are intended to implement the mental health treatment services defined in the Children and Youth Mental Health Treatment Act, Sections 27-67-101 through 27-67-109, C.R.S., to ensure the maximum use of appropriate least restrictive treatment services and to provide access to the greatest number of children. The purpose of the Children and Youth Mental Health Treatment Act is to provide access to mental health treatment for eligible children who are Medicaid eligible as well as those who are at risk of out-of-home placement, as defined below. These rules are intended to provide a sliding fee scale for responsible parties to offset the cost of care not covered by commercial insurance or the family provided under the Children and Youth Mental Health Treatment Act. Appeal procedures for denial of Medicaid funded residential services, and denial of Children and Youth Mental Health Treatment Act funding are established in the rules as well as a dispute resolution process for county departments and mental health agencies.	Align with updated statute	No
21.200.41	Section needs updating to align with updated statute	“Ability to Pay” means the amount of income and assets of the legally responsible person(s) available to pay for the individual cost of community mental health treatment and room and board for a child in residential treatment. “BHO” means the Behavioral Health Organization responsible for implementing the Medicaid mental health capitation program through contract with the Colorado Department of Health Care Policy and Financing. “Care Management” means arranging for continuity of care and coordinating the array of service necessary for treating the child; communicating with responsible	"Ability to pay" means the amount of income and assets of the legally responsible person(s) available to pay for the individual cost of children and youth mental health treatment act funded services. "Care management" means arranging for continuity of care and coordinating the array of service necessary for appropriately treating the a child or youth; communicating verbally or in-person with responsible individuals, and funded providers at least every thirty (30) calendar days to assure services are being delivered as planned and adequate progress is being	Align with updated statute	Yes, requests to clarify definitions

		individuals, and providers at least every thirty (30) calendar days to assure services are being delivered as planned and adequate progress is being made; and the authority to rescind authorization for any treatment services with proper notice. “Child at Risk of Out-of-Home Placement” means a child between the ages of zero (0) and his/her eighteenth (18th) birthday who, although not otherwise categorically eligible for Medicaid, meets the following criteria: A. Has been diagnosed as a person with a mental illness, as defined in Section 27-65-102(14), C.R.S.; B. Requires a level of care that is provided in a residential child care facility pursuant to Section 25.5-5-306, C.R.S., or that is provided through in-home or community-based programs and who, without such care, is at risk of out of home placement; C. If determined to be in need of placement in a residential child care facility, is determined to be eligible for Supplemental Security Income; and, D. For whom it is inappropriate or unwarranted to file an action in dependency or neglect pursuant to Article 3 of Title 19, C.R.S. “Children who are categorically Medicaid eligible” means a child between the ages of zero (0) and his/her eighteenth (18th) birthday who, with a covered mental health diagnosis, is eligible for services through the Capitated Single Entry Point System for Mental Health Services Program described in Section 25.5-5411, C.R.S. “Community-Based Services” includes, but is not limited to, therapeutic foster care, intensive in-home treatment, intensive case management, and day treatment. “Community Mental Health Center, as defined in Section 27-66-101, C.R.S., means either a physical facility or a group of services under unified administration or affiliated with one another, and includes at least the following services for the prevention and treatment of mental illness in persons residing in a particular community in or near the community mental health center or group so situated: A. Inpatient services; B. Outpatient services;	made; discharge planning and development; and the authority to rescind authorization for any treatment services with proper notice. "child at risk of out-of-home placement" means a child or youth meets the following criteria: A. Has been diagnosed as a person with a mental health disorder, as defined in section 27-65-102(11.5), C.R.S.; B. Requires a level of care that is provided in a residential child care facility pursuant to section 25.5-5-306, C.R.S, or that is provided through community-based programs and who, without such care, is at risk of unwarranted child welfare involvement or other system involvement, as described in section 27-67-102, in order to receive funding for treatment; C. If determined to be in need of placement in a residential child care facility or psychiatric residential treatment facility, a child or youth shall apply for supplemental security income, but any determination for supplemental security income must not be a criterion for a child or youth to receive funding D. The child or youth is a person for whom there is no pending or current action in dependency or neglect pursuant to article 3 of title 19, C.R.S and; E. The child or youth is younger than eighteen years of age at time of applying, but he or she may continue to remain eligible for services until his or her twenty-first birthday. "Children who are categorically Medicaid eligible" has the same meaning as defined in section 25.5-5-101. "Community-based services" means any intervention that is designed to be an alternative to residential or hospital level of care in which the child or youth resides within a non-institutional setting and includes, but is not limited to, therapeutic foster care, intensive in-home treatment, intensive case management, and day treatment. "Community mental health center", has the same meaning as defined in section 27-66-101(2), C.R.S, "Cost of care" includes residential and community-		

		C. Partial hospitalization; D. Emergency services; and, E. Consultative and educational services. “Cost of Care” includes residential and community-based treatment not covered by private insurance or Medicaid, and room and board. “County Department” means the county, or district, department of human/social services. “Face to Face”, for the purpose of this Section 21.200.4, means that the child is physically in the same room as the professional person. If the child is out of state or otherwise unable to participate in a face to face assessment, video technology may be used. “Licensed Mental Health Professional” means a psychologist licensed pursuant to Section 12-43-301, et seq., C.R.S., a psychiatrist licensed pursuant to Section 12-36-101, et seq., C.R.S., a clinical social worker licensed pursuant to Section 12-43-401, et seq., C.R.S., a marriage and family therapist licensed pursuant to Section 12-43-501, et seq., a professional counselor licensed pursuant to Section 12-43-601, et seq., C.R.S., or a social worker licensed by pursuant to Section 12-43-401, et seq., C.R.S., that is supervised by a licensed clinical social worker. “Mental Health Agency” means the community mental health center serving children in a particular geographic area or the Behavioral Health Organization, serving children in a particular geographic area who are receiving Medicaid, under contract with the Colorado Department of Health Care Policy and Financing. “Plan of Care” is a Department developed document that at a minimum includes the anticipated frequency and costs of services to be provided for the duration of the plan of care. The plan of care is also a schedule of the fees to be paid by the responsible person including, but not limited to, the estimated amount of Supplemental Security Income payable to the residential treatment facility or other provider, and sliding scale fees payable to the contractor, if applicable. “Resident” means a child receiving residential mental health treatment under the Child Mental Health Treatment	based services not covered by the family, commercial insurance, or Medicaid. "County department" means the county or district department of human or social services. “Dependent” means a person who relies on the responsible person(s) for financial support. “Face to face clinical assessment”, for this section 21.200.4, means a formal and continuous process of collecting and evaluating information about an individual for service planning, treatment, referral, and funding eligibility. This information establishes justification for services and children and youth mental health treatment act funding. The child is physically in the same room as the professional person. If the child is out of state or otherwise unable to participate in a face to face assessment, video technology may be used. "Family advocate" has the same meaning as provided in section 27-69-102 (5). "Family systems navigator" has the same meaning as provided in section 27-69-102 (5.5). "First-level appeal" means the initial process a Medicaid member is required to enact to contest a benefit, service, or eligibility decision made by Medicaid or a Medicaid managed care entity. “Licensed mental health professional” means a psychologist licensed pursuant to section 12-43-301, et seq., C.R.S, a psychiatrist licensed pursuant to section 12-36-101, et seq., C.R.S, a clinical social worker licensed pursuant to section 12-43-401, et seq., C.R.S, a marriage and family therapist licensed pursuant to section 12-43-501, et seq., a professional counselor licensed pursuant to section 12-43-601, et seq., C.R.S, or a social worker licensed by pursuant to section 12-43-401, et seq., C.R.S, that is supervised by a licensed clinical social worker. “Medicaid child or youth who is at risk of out-of-home placement" means a child or youth who is categorically eligible for Medicaid but who otherwise meets the definition of a child or youth who is at risk of out-of-		

		Act. “Residential Treatment” means services provided by a residential child care facility or psychiatric residential treatment facility licensed as a residential child care facility pursuant to Section 26-6-102(8), C.R.S., which has been approved by the Department to provide mental health treatment. “Responsible Persons” means parent(s) or legal guardian(s) of a minor.	home placement as defined above. "Mental health agency" means a behavioral health services contractor through the state department of human services serving children and youth statewide or in a particular geographic area, including but not limited to community mental health centers, and with the ability to meet all expectations of 21.200.4 and 27-67-101. "Plan of care" is a state department developed document that at a minimum includes the anticipated frequency and costs of services to be provided for the duration of the plan of care. The plan of care is also a schedule of the fees to be paid by the responsible person including, but not limited to, the estimated amount of supplemental security income payable to the residential facility if awarded to the child at risk of out-of-home placement or another provider, and sliding scale fees payable to the contractor, if applicable. "Professional person" means a person licensed to practice medicine in this state, a psychologist certified to practice in this state, or a person licensed and in good standing to practice medicine in another state or a psychologist certified to practice and in good standing in another state who is providing medical or clinical services at a treatment facility in this state that is operated by the armed forces of the united states, the united states public health service, or the united states department of veterans affairs. "Residential treatment" means services provided by a residential child care facility or psychiatric residential treatment facility licensed as a residential child care facility pursuant to section 26-6-102(8), C.R.S., which has been approved by the state department to provide mental health treatment. "Responsible persons" means parent(s) or legal guardian(s) of a minor. “State department" means the state department of human services.		
21.200.42	Section needs updating to align	The Child Mental Health Treatment Act allows parents or guardians to apply to a mental health agency on behalf of	The Children and Youth Mental Health Treatment Act allows parents or guardians to apply to a mental health	Align with updated statute	Yes, ensure the rule

	with updated statute	their minor child for mental health treatment services whether the child is categorically eligible for Medicaid under the capitated mental health system, or whether the parents or guardians believe his or her child is at risk for out-of-home placement, as defined in Section 21.200.41. A. For children who are not categorically eligible at the time services are requested, the community mental health center is responsible for clinically assessing the child and providing care management and necessary treatment services, including any community-based mental health treatment, other family preservation services, residential treatment or any post-residential follow-up service that may be appropriate for the child's and family's needs. A dependency or neglect action pursuant to Article 3 of Title 19, C.R.S., shall not be required in order to allow a family access to residential or community-based mental health treatment services for a child. B. For children who are categorically eligible for Medicaid as defined in Section 21.200.41, the BHO is responsible for clinically assessing the child and providing care management and necessary treatment services, including any community based mental health treatment, other family preservation services, residential treatment or any post-residential follow-up service that may be appropriate for the child's and family's needs. C. The Child Mental Health Treatment Act, Sections 27-67-101 through 27-67-108, C.R.S., provides appeal processes for parents or guardians when services are denied, and to resolve disputes between mental health agencies and county departments. D. The Act authorizes funding for services for children at risk of out-of-home placement, which are not covered by private insurance, Medicaid, or the family's share.	agency on behalf of their minor child for mental health treatment services WHEN the parents or guardians believe his or her child is at risk for out-of-home placement, as defined in Section 21.200.41. A. For children who are not categorically eligible for Medicaid at the time services are requested, the mental health agency is responsible for clinically assessing the child and providing care management and necessary services that may be appropriate for the child's and family's needs. B. The Children and Youth Mental Health Treatment Act provides a second opinion for the responsible person(s) when services are denied or terminated for a Medicaid child or youth who is at risk of out-of-home placement or a child or youth seeking funding under this act. C. The Children and Youth Mental Health Treatment Act resolves disputes between mental health agencies and county departments when a child is seeking or receiving funding through the Children and Youth Mental Health Treatment Act. D. The Children and Youth Mental Health Treatment Act authorizes funding for services for children at risk of out-of-home placement, which are not covered by COMMERCIAL insurance, Medicaid, or the family.		aligns with statute

21.200.43	Section needs updating to align with updated statute	A. A responsible person may apply to a mental health agency on behalf of his or her minor child for mental health treatment. B. The mental health agency will evaluate the child and clinically assess the child's need for mental health services. When warranted, treatment services will be provided as may be necessary and in the best interests of the child and the child's family. C. Subject to available appropriations, the mental health agency shall be responsible for the provision of care management and necessary treatment services, including any community based mental health treatment, other family preservation services, residential treatment, or any pre- or post-residential services that may be appropriate for the child's or family's needs. D. A face to face clinical assessment and decision regarding requests for treatment shall be performed by the mental health agency within the following time periods after a request for mental health treatment has been made by a responsible person. 1. Emergency situation, defined as a condition that appears to require unscheduled, immediate or special mental health intervention in response to a crisis situation involving the risk of imminent harm to the person or others. Emergency situation evaluations shall be completed within six (6) business hours of the initial assessment request. 2. Urgent situation, defined as a condition that appears to, if not addressed within twenty four (24) hours, be likely to escalate to an emergency situation. Urgent situation evaluations shall be completed within twenty-four (24) hours, one (1) business day, of the initial assessment request. 3. Routine situations, defined as all other situations, shall be completed within three (3) business days of the initial assessment request. 4. If the mental health agency requires additional time to make a decision following an assessment and the responsible person agrees, then the mental health agency may take up to, but no more than, fourteen (14)	A. A responsible person may apply to a mental health agency on behalf of his or her minor child for mental health treatment. B. At any point in applying for, appealing, or receiving children and youth mental health treatment act funding the responsible person(s) may request the assistance from a family advocate, family system navigator, nonprofit advocacy organization, or county department. 1. The mental health agency shall provide the contact information for the organization contracted with the state department to provide these services, free of charge, to the responsible person(s) before an initial evaluation. 2. The state department is not obligated to pay for any services provided by entities with which they do not contract. C. The mental health agency shall evaluate the child and clinically assess the child's need for mental health services. When warranted, funding for services will be provided as may be necessary and in the best interests of the child and the child's family. D. When completing a face to face clinical assessment for a child or youth, the mental health agency shall use a standardized risk stratification tool, in a manner, determined by the State Department. Determination of the assessment for level of care need and eligibility need will be completed jointly by the mental health agency and the State Department. E. When evaluating a child or youth for eligibility, the mental health agency shall evaluate all areas outlined in 21.190. F. The mental health agency shall be responsible for the provision of care management and necessary services, including any community-based mental health treatment, residential treatment, or any services that may be appropriate for the child's or family's needs. G. A face to face clinical assessment and eligibility determination shall be completed within the following time periods after a request for funding has been made by a responsible person(s).	Align with updated statute	Yes, establish how agencies will know who are contracted entities

		calendar days to provide a decision. If the responsible person does not agree, the notification timelines referenced above remain in effect. E. The mental health agency decision shall be communicated verbally and in writing to the responsible person within the time allowed for the completion of the evaluation. Verbal notice shall be face to face with the responsible person when possible. The written decision shall contain notice of the applicable criteria for mental health treatment, the factual basis for the decision, the appeals procedures, and a statement for the responsible person to sign, indicating that they agree with the decision or that they disagree and wish to file an appeal.	1. Urgent situation, defined as a condition that is likely to escalate to a situation in which the child may become a danger to themselves or others and requires a clinical assessment within twenty-four (24) HOURS. Urgent situation evaluations shall be completed by the mental health agency within twenty-four (24) hours, one business day, of the initial assessment request by the responsible person(s). The mental health agency shall continue to provide care management while funded services are identified and provided. 2. Routine situations, defined as all other situations, shall be completed within three (3) business days of the initial assessment request. 3. If the mental health agency requires additional time to make a decision following an assessment and the responsible person agrees, then the mental health agency may take up to, but no more than, fourteen (14) calendar days to provide a decision. If the responsible person does not agree, the notification timelines referenced above remain in effect. H. The mental health agency's decision shall be communicated verbally and in writing to the responsible person(s) within the time allowed for the completion of the evaluation or at least 5 (five) business days before the reduction, increase or termination of funded services. Verbal notice shall be face to face with the responsible person when possible. I. The written decision shall contain the following: 1. Notice of the applicable criteria for mental health treatment,; 2. The factual basis for the decision,; 3. The appeals procedures pursuant to the grievance requirements in section 21.180; 4. If approved, notice that the responsible person(s) may choose to seek services from the provider of their choice, including but not limited to the mental health agency. 5. Notice that the responsible person(s) may request assistance from a family advocate, family system navigator, nonprofit advocacy organization, or county		

			department in applying for, receiving, or appealing children and youth mental health treatment act funding and applying for supplemental security income; 6. The contact information for an organization contracted by the state department to perform family advocacy or family system navigation; 7. Notice that the contracted advocacy provider is not allowed to charge the family a fee; 8. Notice that the state department is not obligated to pay for any service provided by entities with which they do not contract; and, 9. A statement for the responsible person to sign, indicating that they agree with the decision or that they disagree and wish to file an appeal.		
21.200.44	Section needs updating to align with updated statute	A. The community mental health center shall determine the cost of care for children in this program. Insurance and other benefits shall be applied first to the cost of care. Medicaid is the payor of last resort and will be provided, if the child is eligible, if other insurance coverage is not available. Insurance and other benefits for any resident shall be billed at the full cost of care. A responsible person(s) 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. The responsible person(s)' ability to pay for residential treatment shall be calculated using material based on the "Colorado Child Support Guideline" and the "Schedule of Basic Child Support Obligations," as found in Section 14-10-115, C.R.S., and the Department's Child Support Enforcement rules (9 CCR 2504-1). C. The fee for community-based services shall be based on the income of the "responsible persons" defined in Section 21.200.41, using the "Uniform Method of Determining Ability to Pay" in Section 21.800, et seq. The cost of home and community based services shall not exceed fifty percent (50%) of that which would have been charged to the responsible persons for residential treatment. D. The treating facility and/or provider may reserve the	A. The mental health agency shall determine the cost of care for children in this program and youth that receive funding through the Children and Youth Mental Health Treatment Act. All Insurance and other eligible benefits shall be applied first to the cost of care. A responsible person(s) 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. The mental health agency shall determine the responsible person(s)' ability to pay for services based on the following: 1. Per month, the responsible person(s) shall pay 7% of each children and youth mental health treatment act funded service, excluding the initial assessment and all care management; 2. If the responsible person(s) is unable to pay the full amount, the mental health agency shall consider the responsible person(s) total number of dependents, the mental health needs of those dependents, all current outstanding medical liabilities, expected length of services, and the education costs for the dependents. The mental health agency shall receive approval or denial from the state department for all fee adjustments; 3.the responsible person shall pay a minimum total fee	Align with updated statute	Yes, address minimum payment

		right to take any necessary action regarding delinquent payments by the responsible person(s). E. The responsible person(s) 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 responsible person(s) does not cooperate in making insurance and other benefits available, the 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. F. The responsible person(s) must sign a financial agreement indicating an understanding of their financial responsibilities as described in A-E, above, in order to be eligible for funding through the Child Mental Health Treatment Act. G. Within ten (10) business days after the child's admission to the residential treatment facility, the responsible person must apply for Supplemental Security Income (SSI) on behalf of a child at risk of out-of-home placement approved for treatment under the Child Mental Health Treatment Act. H. The responsible person must pay the monthly parental fee to the facility.	of $50 per month; C. The responsible(s) person shall pay fees directly to the agency providing the service; D. The funded provider may reserve the right to take any necessary action regarding delinquent payments by the responsible person(s); E. The responsible person(s) shall sign a financial agreement indicating an understanding of their financial responsibilities as described above, to be eligible for funding through the Children and Youth Mental Health Treatment Act; F. Within ten (10) business days after the child's admission to residential treatment, the responsible person(S) shall apply for Supplemental Security Income (SSI) on behalf of a child approved for funding under the Children and Youth Mental Health Treatment Act; G. If awarded supplemental security income; the responsible person(s) shall disclose the award amount to the mental health agency as determined by the social security administration regulations; H. If awarded supplemental security income and the child has discharged from residential services, the reasonable person(s) shall notify the Social Security Administration immediately; I. If awarded supplemental security income, the child will also be awarded Medicaid which will fund treatment costs while in residential. The parental fee, supplemental security income, all other funding sources, and the Children and Youth Mental Health Treatment Act will fund room and board; J. If denied supplemental security income; the Children and Youth Mental Health Treatment Act will fund room and board and behavioral health treatment services that would otherwise have been funded by supplemental security income and Medicaid.		
21.200.45	To align with updated statute, this section was no longer needed.	As outlined in Section 8.212 of the Colorado Department of Health Care Policy and Financing's Medical Assistance rules (10 CCR 2505-10), costs and services are managed by the corresponding behavioral health organization for children who are categorically eligible for Medicaid at the	Section repealed	To align with updated statute, this section was no longer needed.	No

		time treatment is requested.			
21.200.46	Section needs updating to align with updated statute	A. Except as provided below, the community mental health center shall follow the formalized appeal process that the agency has established pursuant to the grievance requirements in Section 21.180 if the child is at risk of out-of-home placement, as defined in Section 21.200.41. B. If the responsible person(s) requests an appeal of a denial of treatment or a recommendation that a child be discharged from services, either in writing or verbally within fifteen (15) business days of notice of action, the mental health agency shall have two (2) business days within which to complete the internal appeal review process and communicate a decision to the responsible person(s) verbally in person when possible and in writing. Said notice shall contain the information required in Section 21.200.43, E, along with the process for clinical review in Section 21.200.46, C-E, below. If the community mental health center requires more than two (2) business days to complete its internal review and the responsible person(s) is in agreement, then the community mental health center may take up to but no more than five (5) business days to complete the review. If the responsible party is not agreeable, the two (2) business day timeline discussed above will remain in effect. C. Within five (5) business days after the community mental health center's final denial of requested services or recommendation that the child be discharged from treatment, the responsible person(s) may request a clinical review of the need for services by an objective third party, at the Department, who is an independent professional person as that term is defined in Section 27-65102(11), C.R.S., to review the action of the community mental health center. Such a request may be verbal or in writing, but if completed verbally it must be confirmed in writing, and shall be made to the Director of the Office of Behavioral Health or the consumer and Office's family affairs specialist. D. Unless waived by the responsible person(s), said clinical review shall include: 1. A review of the community mental health center's	[Reorganized as section 21.200.45] A. Except as provided below, the mental health agency shall follow the formalized notification process as defined in section 21.200.41 through 21.200.43. B. A responsible person(s) may request an appeal of a decrease, increase, or denial of Children and Youth Mental Health Treatment Act fund services or a recommendation that a child be discharged from funded services, and the following shall apply: 1. If the responsible person(s) notifies the mental health agency of a desire to appeal a decision before termination of services, the state department and the mental health agency shall continue to fund services until the appeal process below has been exhausted. 2. The responsible person(s) shall notify the mental health agency verbally or in writing within fifteen (15) business days of notice of action of a desire to appeal a decision; 3. The mental health agency shall have two (2) business days within which to complete an internal appeal review process and communicate a decision to the responsible person(s) verbally and in writing. 4. The mental health agency's notice of action shall contain the information required in section 21.200.43, e, along with the process for clinical review in section 21.200.46, C-E below. C. If the mental health agency requires more than two (2) business days to complete the internal review, and the responsible person(s) is in agreement, then the mental health agency may take up to but no more than five (5) business days to complete the review. D. Within five (5) business days after the mental health agency's final denial of requested services or recommendation that the child be discharged from treatment, the responsible person(s) may request a clinical review of the need for services by an objective third party, at the State Department, who is an independent professional person as that term is defined in section 27-65- 102(11), C.R.S., to review the action	Align with updated statute	Yes, ensure CYMHTA aligns with Medicaid

		denial of services; 2. A face to face evaluation of the child, so long as the responsible person(s) arranges transportation of the child for the evaluation; and, 3. A review of the evidence provided by the responsible person(s). The responsible person(s) shall be advised of the name and credentials of the reviewing professional, as well as any mental health agency affiliations of the reviewing professional. The responsible person(s) shall have an opportunity to request an alternate reviewing professional at the Department at that time, so long as any delay caused by the request is waived by the responsible person(s) as described below. E. Within three (3) working days of the receipt of the request for clinical review, a decision shall be communicated verbally and in writing by the professional person to the responsible person(s), Department and the community mental health center. The written decision shall include the relevant criteria and factual basis. If the clinical review finds residential or community based treatment to be necessary, the mental health agency shall provide treatment to the child within twenty four (24) hours of said decision. If residential treatment is not available within twenty four hours and placement in residential treatment is recommended, the state level review must recommend appropriate alternatives including emergency hospitalization, if appropriate, if the child is in need of immediate placement out of the home. F. If the professional person requires more than three (3) working days to complete the face to face evaluation, or if the responsible person(s) requires more time to obtain evidence for the clinical review, the responsible person(s) may waive the three day deadline above, so long as said waiver is confirmed in writing. In any event, the face to face evaluation and the clinical review shall be completed within six (6) working days. G. The Department review shall constitute final agency action for non-Medicaid eligible children.	of the mental health agency. Such a request may be verbal or in writing, but if completed verbally it must be confirmed in writing, and shall be made to the director of the office of behavioral health or the office's consumer and family affairs specialist. E. Unless waived by the responsible person(s), said clinical review shall include: 1. A review of the mental health agency's denial of services; 2. A face to face evaluation of the child, so long as the responsible person(s) arranges transportation of the child for the evaluation; and, 3. A review of the evidence provided by the responsible person(s). The responsible person(s) shall be advised of the name and credentials of the reviewing professional, as well as any mental health agency affiliations of the reviewing professional. The responsible person(s) shall have an opportunity to request an alternate reviewing professional at the State Department at that time, so long as any delay caused by the request is waived by the responsible person(s) as described below. F. Within three (3) business days of the receipt of the request for clinical review, a decision shall be communicated verbally and in writing by the professional person to the responsible person(s), state department, and the mental health agency. The written decision shall include the relevant criteria and factual basis. If the clinical review finds residential or community-based services to be necessary and that children and youth mental health treatment act funding is necessary, the mental health agency shall provide services to the child within twenty-four (24) hours of the said decision. If residential treatment is not available within twenty-four hours and placement in residential treatment is recommended, the state level review must recommend appropriate alternatives including emergency hospitalization, if appropriate, if the child is in need of immediate placement out of the home. G. If the professional person requires more than three		

			(3) business days to complete the clinical review, or if the responsible person(s) requires more time to obtain evidence for the clinical review, the responsible person(s) may waive the three day deadline above, so long as said waiver is confirmed in writing. In any event, the face to face evaluation and the clinical review shall be completed within six (6) business days. H. The state department review decision shall constitute final agency action for funding through the Children and Youth Mental Health Treatment Act.		
21.200.47	Section needs updating to align with updated statute	A. For children who are categorically eligible for Medicaid, the responsible person(s) may request an appeal of a denial of treatment pursuant to the Medicaid "recipient appeals" process found at Section 8.057 of the Colorado Department of Health Care Policy and Financing's Medical Assistance rules (10 CCR 2505-10). B. For children who are categorically eligible for Medicaid, the responsible person(s) may request a clinical review by the Department as outlined in Section 21.200.46.	[Reorganized as section 21.200.46] For a Medicaid child or youth, a responsible person may request an objective third party clinical review within 5 business days after all first-level Medicaid appeals processes are exhausted (in accordance with section 8.057 or 8.209 of the Colorado department of health care policy and financing's medical assistance rules [10 CCR 2505-10]). The review must be conducted by a professional person as outlined in section 21.200.46 within 3 business days of the date of request. This review does not obligate funding of services.	Align with updated statute	No
21.200.48	Section needs updating to align with updated statute	A. If a dispute exists between a mental health agency and a county department of human/social services regarding whether mental health services should be provided under the Child Mental Health Treatment Act or by the county department, one or both may request the Colorado Department of Human Services, Office of Behavioral Health, to convene a review panel consisting of family advocates, the Colorado Department of Human Services, Division of Child Welfare, the Colorado Department of Human Services, Office of Behavioral Health, an independent community mental health center, an independent county department of human/social services and, when applicable, the Colorado Department of Health care Policy and Financing to provide dispute resolution. B. The request to invoke the dispute resolution process shall be in writing and submitted within five (5) calendar days of either agency recognizing that a dispute exits. C. The written request for dispute resolution shall include,	[Reorganized as section 21.200.47] A. If a dispute exists between a mental health agency and a county department regarding whether mental health services should be funded under the Children and Youth Mental Health Treatment Act or by the county department, one or both may request the Colorado Office of Behavioral Health, to convene a review panel consisting of family advocates, the Colorado Division of Child Welfare, the Office of Behavioral Health, an independent mental health agency if available, an independent professional person, and an independent county department to provide dispute resolution. The independent agencies and individuals shall document that no conflict of interest exist pertaining to the specific child being reviewed. B. The request to invoke the dispute resolution process shall be in writing and submitted within five (5) calendar	Align with updated statute	No

		at a minimum, the following information: 1. The county department and mental health agency involved in the dispute, including a contact person at each; 2. The child's name, age, and address; 3. The responsible person(s) address, phone number, and e-mail address; 4. Pertinent information regarding the child including, but not limited to, medical or mental health status/assessment; 5. The reason for the dispute, any efforts to resolve the matter locally, and any pertinent information regarding the child; 6. Information about the child's mental health status pertaining to the dispute; and, 7. The responsible person(s) perspective on the matter, if known. D. Within ten (10) calendar days of receiving the dispute resolution request, the Department shall convene a review panel in order for each side to present their position. E. The Department shall provide notice to both agencies that the Department will resolve the dispute. F. Each side will have an opportunity to present its position to the review panel. Interested parties will be allowed to present written or oral testimony at the discretion of the review panel. G. After both agencies present their positions, and other parties present as appropriate, the review panel shall have five (5) working days to issue its determination in writing to the disputing agencies. The review panel's decision shall constitute final agency action, which binds the agency determined responsible for the provision of necessary services.	days of either agency recognizing a dispute exits. C. The written request for dispute resolution shall include, at a minimum, the following information: 1. The county department and mental health agency involved in the dispute, including a contact person at each; 2. The child's name and age; 3. The responsible person(s) address, phone number, and e-mail address; 4. Pertinent information regarding the child including, but not limited to, medical or mental health status/assessment; 5. The reason for the dispute, any efforts to resolve the matter locally, and any pertinent information regarding the child; 6. Information about the child's mental health status pertaining to the dispute; and, 7. The responsible person(s) perspective on the matter, if known. D. The state department shall provide notice to both agencies that the state department will resolve the dispute either verbally or in writing. E. Each side will have an opportunity to present its position to the review panel. Interested parties will be allowed to present written or oral testimony at the discretion of the review panel. F. The review panel shall have five (5) business days to complete the dispute process and issue its determination in writing to the disputing agencies and the responsible person(s). The review panel's decision shall constitute final agency action, which binds the agency determined responsible for the provision of necessary services. G. If neither the county department nor the mental health agency is deemed responsible for care by the panel; then the panel shall provide rational for their determination, the criteria for funding or services that are not being met and offer recommendations for other funding sources and treatment modalities.		

21.200.491	Section needs updating to align with updated statute	Subject to the availability of state appropriations, the community mental health center shall provide Child Mental Health Treatment Act services to youth who are eligible as defined in Sections 20.100 and 20.200. A. Child Mental Health Treatment Act services include, but are not limited to: 1. Clinical behavioral health assessments completed by a licensed mental health professional; 2. Community based services; 3. Care management services; 4. Coordination of residential treatment services; and, 5. Non-residential mental health transition services for youth. B. The community mental health center shall provide to the Department necessary Child Mental Health Treatment Act eligibility, service, and financial information in an agreed upon format. C. The community mental health center shall submit data to the Department as required per Section 27-67-105, C.R.S. D. The community mental health center shall provide or coordinate treatment services in collaboration with youth and families, and community based and residential care providers. E. The community mental health center shall determine the fee for the responsible person(s) and submit the financial agreement to the Department once signed by the responsible person(s) prior to state approval. F. If a child has been determined eligible under the Child Mental Health Treatment Act, the community mental health center shall submit a plan of care for approval to the Department prior to providing services. If necessary services are not immediately available, the community [mental] health center shall submit an alternative plan of care and provide interim services as appropriate. G. The community mental health center shall maintain a comprehensive clinical record for each child receiving services through Child Mental Health Treatment Act funding consistent with the Department's site review protocol. Such records shall be made available for review	[Reorganized as section 21.200.481] The mental health agency shall provide Children and Youth Mental Health Treatment Act funded services to children youth who are eligible as defined in sections 21.200.4. A. Children and Youth Mental Health Treatment Act services include, but are not limited to: 1. Clinical behavioral health assessments completed by a licensed mental health professional; 2. Community-based services; 3. Care management services; 4. Coordination of residential treatment services; and, 5. Non-residential mental health transition services for children youth. B. The mental health agency shall provide to the State Department necessary Children and Youth Mental Health Treatment Act eligibility, service, and financial information in an agreed upon format. C. The mental health agency shall submit data to the state department as required per section 27-67-105, C.R.S. D. The mental health agency shall provide or coordinate treatment services in collaboration with the child or youth, and families, and funded service providers. E. The mental health agency shall determine the fee for the responsible person(s) and submit the financial agreement to the State department once signed by the responsible person(s) before state approval. F. The mental health agency shall submit all eligibility assessments to the state department before funding approval or denial. G. If a child has been determined eligible under the Children and Youth Mental Health Treatment Act, the mental health agency shall submit a plan of care for approval to the state department before providing services. If necessary services are not immediately available, mental health agency shall submit an alternative plan of care and provide interim services as appropriate.	Align with updated statute	No

		by the Department. The individualized service plan in the clinical record shall reflect any services provided directly by the center, including any care management services provided and relevant documentation submitted by a third-party provider. The goal of those care management services may be, at least in part, to oversee the delivery of services by third party providers to assure that adequate progress is achieved, and may reference the state plan of care and the provider's clinical service plan.	H. The mental health agency shall maintain a comprehensive clinical record for each child receiving services through Children and Youth Mental Health Treatment Act funding consistent with 2 CCR 502-1. Such records shall be made available for review by the State Department. The individualized service plan in the clinical record shall reflect any services provided directly by the center, including any care management services provided and relevant documentation submitted by a third-party provider. The goal of those care management services may be, at least in part, to oversee the delivery of services by third-party providers to assure that adequate progress is achieved and may reference the state plan of care and the provider's clinical service plan.		
21.200.492	Section needs updating to align with updated statute	The Department shall be responsible for administering and regulating the provisions of the Child Mental Health Treatment Act. The responsibilities of the Department include: A. Ensuring the Child Mental Health Treatment Act is implemented statewide; B. Reviewing requests for funding and making recommendations regarding approval of service delivery related to plans of care for children who are at risk of out-of-home placement as defined in Section 20.200.41; C. The provision of technical assistance to community mental health centers, residential treatment providers, families and advocacy organizations regarding the technical and financial aspects of the Child Mental Health Treatment Act; D. Oversight and monitoring of service delivery for children receiving Child Mental Health Treatment Act funded services; E. Development and maintenance of dispute resolution processes; F. Management of the fiscal aspects of the Child Mental Health Treatment Act program; and, G. Data Collection and reporting.	[Reorganized as section 21.200.482] The State Department shall be responsible for administering and regulating the provisions of the Children and Youth Mental Health Treatment Act. The responsibilities of the State Department include: A. Ensuring the children and youth mental health treatment act is implemented state wide; B. Reviewing requests for funding and making determinations regarding approval of funded services; C. The provision of technical assistance to mental health agencies, residential treatment providers, families, and advocacy organizations, county departments, mental health providers, and other stakeholders regarding the technical and financial aspects of the Children and Youth Mental Health Treatment Act; D. Oversight and monitoring of service delivery for children receiving Children and Youth Mental Health Treatment Act funded services; E. Clinical oversight of Children and Youth Mental Health Treatment Act services; F. Development and maintenance of the appeal process; G. Development and maintenance of dispute resolution processes;	Align with updated statute	Yes, additional information in program report

			H. Management of the fiscal aspects of the Children and Youth Mental Health Treatment Act program; I. Data collection and public reporting.		

Title of Proposed Rule:	**Revisions to the Rules Implementing the Children and Youth Mental Health Treatment Act**	
CDHS Tracking #:	**18-08-15-01**	
Office, Division, & Program: Office of Behavioral Health, Division of Community Behavioral Health	Rule Author: Ryan Templeton	Phone: 303-866-7405 E-Mail: ryantempleton@state.co.us

STAKEHOLDER COMMENT SUMMARY

Development

The following individuals and/or entities were included in the development of these proposed rules (such as other Program Areas, Legislative Liaison, and Sub-PAC):

The Office of Behavioral Health worked collaboratively with the Child Mental Health Treatment Act Advisory Committee to establish the initial rule revision draft. Committee members and stakeholder involved in the creation of the rule revision draft include representatives from: Colorado Behavioral Healthcare Council, Colorado Hospital Association, Mental Health Colorado, Community Mental Health Centers, Federation of Families- Colorado, the ARC of Colorado, Colorado Counties Inc., Child Mental Health Treatment Act Advisory Committee, Health Care Policy and Financing, Division of Child Welfare, families, youth, residential child care facilities, Colorado Post-Adoption Resource Exchange, Colorado Association of Family and Children's Agencies, Children's Hospital Colorado.

This Rule-Making Package

The following individuals and/or entities were contacted and informed that this rule-making was proposed for consideration by the State Board of Human Services:

The Children and Youth Mental Health Treatment Act rule revision draft, along with a feedback survey was posted on the Colorado Department of Human Services website. The Office of Behavioral Health informed behavioral health stakeholders through direct contact and through the OBH monthly newsletter that the rule draft was available for review and feedback. Stakeholders specifically targeted for review and feedback on the proposed rule include: Colorado Behavioral Health Care Council; Colorado Hospital Association; Mental Health Colorado; Behavioral Health Transformation Council; Mental Health Disorders in the Criminal Justice System Task Force; Department of Public Health and Environment; Department of Regulatory Agencies; Department of Health Care Policy and Financing; Department of Public Safety; Disability Law Colorado; community mental health centers; community mental health clinics; hospitals; patient advocacy agencies; individuals and families with lived experience; and, law enforcement.

Other State Agencies

Are other State Agencies (such as HCPF or CDPHE) impacted by these rules? If so, have they been contacted and provided input on the proposed rules?

[X] Yes [ ] No

If yes, who was contacted and what was their input?

The Colorado Department of Health Care Policy and Financing were contacted and provided input on the proposed rule revisions. HCPF provided input on how Medicaid services align and differ from CYMHTA services to ensure two programs work collaboratively.

Sub-PAC

Have these rules been reviewed by the appropriate Sub-PAC Committee?

[ ] Yes [X] No

Name of Sub-PAC	Not applicable		
Date presented	Not applicable		
What issues were raised?	Not applicable		
Vote Count	*For*	*Against*	*Abstain*

Title of Proposed Rule:	**Revisions to the Rules Implementing the Children and Youth Mental Health Treatment Act**	
CDHS Tracking #:	**18-08-15-01**	
Office, Division, & Program: Office of Behavioral Health, Division of Community Behavioral Health	Rule Author: Ryan Templeton	Phone: 303-866-7405 E-Mail: ryantempleton@state.co.us

If not presented, explain why.	n/a	n/a	n/a
	There is not a Behavioral Health Sub-PAC, so the rule draft was presented to PAC on September 6, 2018 without a Sub-PAC review.		

PAC

Have these rules been approved by PAC?

[X] Yes [ ] No

Date presented	September 6, 2018		
What issues were raised?	No		
Vote Count	*For*	*Against*	*Abstain*
	Unanimous	0	0
If not presented, explain why.	Not applicable		

Other Comments

Comments were received from stakeholders on the proposed rules:

[X] Yes [ ] No

If "yes" to any of the above questions, summarize and/or attach the feedback received, including requests made by the State Board of Human Services, by specifying the section and including the Department/Office/Division response. Provide proof of agreement or ongoing issues with a letter or public testimony by the stakeholder.

Feedback	Response
[General Feedback] Where DHS is identified in the document, I would like to propose that the wording be State Department of Human Services, rather than DHS, as many lay people as well as professionals tend to equate DHS and Child Welfare as being one and the same.	The rules were updated to clarify what "department" was being referenced.
[Section 21.200.41] "Child at risk of out of home placement" letter C: "He or she", should likely read "child or youth". "face to face clinical assessment": the term continuous process is confusing. Just a formal process may be more clear. "Professional person": This should reference the statute if the intent is to mirror that (27-65-102). Is this level of workforce required by statute for the CYMHTA? Was this the standard prior to the 2018 legislation? It may be very limiting to exclude LCSWs, LPCs, and LMFTs. "Ability to Pay": How will mental health agencies assess for this with the family? If not a MHA responsibility, then how will the state/others assess for this? "Child at risk of out-of-home Placement" Section	• Section 21.200.41(C) was updated using "child or youth". • Continuously assessing an individual's treatment needs are a standard practice within behavioral health service provisions. • The definition for "professional person" aligns with statutory definition in Section 27-67-103(11), C.R.S. • "Ability to pay" is outlined in section 200.44.

C: Would undocumented children and youth, or otherwise ineligible for SSI, but not eligible for these services because of this provision? “Child at risk of out-of-home Placement” Section D: Is this change required by the 2018 legislation? This is a shift from the original language that may have limiting consequences. “Responsible Persons”: This may need to be re-evaluated now that the funding can extend beyond 18 years of age. This is true in general to answer several questions (who is responsible? Who signs agreements, notices, documents, appeals, etc., whos income is assess, etc.)	• The proposed rules align with the updated statute. • “Responsible Persons” is defined in statute.
[Section 21.200.41] Under Case Management definition: "verbally or in-person" do you mean via phone or in-person" Under Child at Risk section C: "he or she shall apply for supplemental security income, but any determination for supplemental security income must not be a criterion for a child or youth to receive funding" - is this more of a stipulation in the process versus part of the definition of an at rick child or youth?	• “Verbally” is not defined in order to provide more flexibility to the provider. • Applying for SSI is a statutory requirement established in the definition (27-67-103(2)(c), C.R.S.) for “child or youth at risk of out-of-home placement”.
[Section 21.200.41] How will "'appropriately" and "adequate" be defined in the section of "Care Management?" Please include a reference to a standard or define within the statue what appropriate treatment of a child/youth and what adequate progress is for a child/youth.	“Appropriately” was added to the rule to align with the statutory language. Statute does not define the word and the State Department determined that further definition would unnecessarily hinder provider flexibility to serve and treat children. The CYMHTA advisory committee agreed with this determination.
[Section 21.200.41] First Level Appeal, change "enact" with another word such as file or pursue	This definitions aligns with the statutory definition in section 27-67-103(8), C.R.S.
[Section 21.200.42] In Section A., retain the deleted provision regarding dependency or neglect actions shall not be required. . .	The proposed deleted section will remain deleted as the CYMHTA advisory committee and State Department determined that the deleted section is unnecessary and can cause confusion. The scope of the Act and CYMHTA program is defined in section 200.4.
[Section 21.200.42] Top of this section, it needs to read CYMHTA instead of CMHTA 21.200.42 A: Suggest this reads as “Providing care management and necessary	• The rules were updated address CYMHTA. • The State Department added

services that are clinically indicated and that may be appropriate for the child and family's needs" to ensure that decisions are clinically informed and indicated.	"clinically" based on this request.
[Section 21.200.42]...parents/guardians "believe" that their child is at-risk of out-of-home placement. What constitutes a belief? Will they have to have gone through a Deferred Response assessment with a child welfare agency to "believe" that their child is at risk for out-of-home placement? Or do they simply have to express that their child is beyond their control and ask for help, thus forgoing having to reach out to the child welfare agency? Please be clearer on the parameters for which parents may reach out for help under this act.	"Believe" is not defined and the proposed rules do not express that a child or family will need to go through any deferred response or have any child welfare interactions prior to CYMHTA services. The State Department and CYMHTA advisory committee determined that further definition is not necessary as doing so may lead of families not seeking funding due to a possible incorrect assumption that the child would not qualify for funding.
[Section 21.200.43] B. 1.: This is pretty unclear – who is the agency that is contracted for this work? How would the MHA know how to find them? What information would the MHA need to provide (just contact info?). This needs to be more clear and specific. D: When will the tool be implemented? What is the stakeholder process to select this tool? We strongly urge that the rule builds in some process for selecting the tool that is based on stakeholder feedback. We would caution the state in implementing a standardized tool and expecting it to fit all cases and models. H: The addition to this section should be separated out, as it refers to people who are already in the program while the existing language refers to eligibility determination. Mixing this language is confusing. Furthermore, the time frames are unclear and should mirror the statute requirements more closely. I: There would need to be updates made to the notification letter to reflect these changes. I.6: How will mental health agencies know this information?	• The State Department cannot answer the first question as the contractor has not been selected. It will be the Department's responsibly to notify all concerned stakeholders of the family advocate/navigator contract. • Tool: The State Department and CYMHTA advisory committee determined that the selected tool should not be named in rule as to do so would limited the State Department's ability to adjust the use of the tool once implemented. • Rule section 21.200.43(H) provides a procedure for informing the parents or guardian about potential changes to the services being provided. • Mental health agencies contracted to provide CYMHTA services will be required to follow these regulations and the Office of Behavioral Health provides technical assistance when needed.
[Section 21.200.43] Section G.1. include referral to a	• This rule section was rewritten.

crisis center as an option In Urgent situations Section H. instead of 5 business days make it 10 days to conform with Medicaid Rules.	The Office of Behavioral Health did not include specific referral providers, such as the crisis system, as this may limit utilization of other resources. • This timeframe is established in statutory Section 27-67-104, C.R.S.
[Section 21.200.44] B.3: This may sometimes actually be lower depending on circumstances. It may be helpful to add on a phrase saying "or as determined by the CYMHTA Manager" or something similar.	In the almost 20 years that the Act has been around, there is only been one request to lower the minimum amount. Rules are not written to each exception.
[Section 21.200.45] For Medicaid eligible kids, ensure the provisions square with Medicaid rules regarding a decrease or denial of services.	The proposed rule revisions were drafted in collaboration with representatives from the Department of Health Care Policy and Financing.
[Section 21.200.482] Provide each applicant with a written notice of the appeal and dispute resolution processes. Include stats on the number of denials reductions and terminations that are reversed by the Department.	Office of Behavioral Health reporting requirements are established in statute, Section 27-67-105, C.R.S. Rule section 21.200.482 addresses the general CYMHTA responsibility of the Colorado Department of Human Services, not necessarily the specifics of each responsibility.

(2 CCR 502-1)

21.200.4 ~~CHILD~~ CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT

These rules are intended to implement the mental health treatment services defined in the ~~Child~~ CHILDREN AND YOUTH Mental Health Treatment Act, Sections 27-67-101 through 27-67-108~~9~~, C.R.S., ~~subject to available appropriations,~~ to ensure the maximum use of appropriate least restrictive treatment services and to provide access to the greatest number of children. The purpose of the ~~Child~~ CHILDREN AND YOUTH Mental Health Treatment Act is to provide access to mental health treatment for eligible children who are Medicaid eligible as well as those who are at risk of out-of-home placement, as defined below. ~~In addition, t~~TheSE rules are intended to provide a sliding fee scale for responsible parties to offset the cost of care not covered by ~~private~~ COMMERCIAL insurance or THE FAMILY ~~Medicaid~~ provided under the ChildREN AND YOUTH Mental Health Treatment Act. Appeal procedures for denial of MEDICAID FUNDED RESIDENTIAL SERVICES, AND DENIAL OF CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT ~~residential and community mental health treatment~~ FUNDING are established in the rules as well as a dispute resolution process for county departments and mental health agencies.

21.200.41 Definitions

"Ability to Pay" means the amount of income and assets of the legally responsible person(s) available to pay for the individual cost of CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDED SERVICES~~. community mental health treatment and room and board for a child in residential treatment.~~

~~"BHO" means the Behavioral Health Organization responsible for implementing the Medicaid mental health capitation program through contract with the Colorado Department of Health Care Policy and Financing.~~

"Care Management" means arranging for continuity of care and coordinating the array of service necessary for APPROPRIATELY treating ~~the~~ A child OR YOUTH; communicating VERBALLY OR IN-PERSON with responsible individuals, and FUNDED providers at least every thirty (30) calendar days to assure services are being delivered as planned and adequate progress is being made; DISCHARGE PLANNING AND DEVELOPMENT; and the authority to rescind authorization for any treatment services with proper notice.

"Child at Risk of Out-of-Home Placement" means a child OR YOUTH ~~between the ages of zero (0) and his/her eighteenth (18th) birthday~~ who~~, although not otherwise categorically eligible for Medicaid,~~ meets the following criteria:

A. Has been diagnosed as a person with a mental HEALTH DISORDER ~~illness~~, as defined in Section 27-65-102(~~1~~411.5), C.R.S.;

B. Requires a level of care that is provided in a residential child care facility pursuant to Section 25.5-5-306, C.R.S., or that is provided through ~~in-home or~~ community-based programs and who, without such care, is at risk of UNWARRANTED CHILD WELFARE INVOLVEMENT OR OTHER SYSTEM INVOLVEMENT, AS DESCRIBED IN SECTION 27-67-102, IN ORDER TO RECEIVE FUNDING FOR TREATMENT; ~~further involvement with the county department;~~

C. If determined to be in need of placement in a residential child care facility OR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY, A CHILD OR YOUTH SHALL APPLY FOR SUPPLEMENTAL SECURITY INCOME, BUT ANY DETERMINATION FOR SUPPLEMENTAL SECURITY INCOME MUST NOT BE A CRITERION FOR A CHILD OR YOUTH TO RECEIVE FUNDING; ~~is determined to be eligible for Supplemental Security Income; and,~~

D. THE CHILD OR YOUTH IS A PERSON FOR WHOM THERE IS NO PENDING OR CURRENT ~~For whom it is inappropriate or unwarranted to file an~~ action in dependency or neglect pursuant to Article 3 of Title 19, C.R.S. AND;

(E) THE CHILD OR YOUTH IS YOUNGER THAN EIGHTEEN YEARS OF AGE AT TIME OF APPLYING, BUT HE OR SHE MAY CONTINUE TO REMAIN ELIGIBLE FOR SERVICES UNTIL HIS OR HER TWENTY-FIRST BIRTHDAY.

"Children who are categorically Medicaid eligible" HAS THE SAME MEANING AS DEFINED IN SECTION 25.5-5-101. ~~means a child between the ages of zero (0) and his/her eighteenth (18th) birthday UNDER THE AGE OF 18 who, with a covered mental health diagnosis, is eligible for services through the Capitated Single Entry Point System for Mental Health Services Program described in Section 25.5-5-411402, C.R.S.~~

"Community-Based Services" MEANS ANY INTERVENTION THAT IS DESIGNED TO BE AN ALTERNATIVE TO RESIDENTIAL OR HOSPITAL LEVEL OF CARE IN WHICH THE CHILD OR YOUTH RESIDES WITHIN A NON-INSTITUTIONAL SETTING AND includes, but is not limited to, therapeutic foster care, intensive in-home treatment, intensive case management, and day treatment.

"Community Mental Health Center", HAS THE SAME MEANING as defined in Section 27-66-101(2), C.R.S., ~~means either a physical facility or a group of services under unified administration or affiliated with one another, and includes at least the following services for the prevention and treatment of mental illness in persons residing in a particular community in or near the community mental health center or group so situated:~~

~~A. Inpatient services;~~

~~B. Outpatient services;~~

~~C. Partial hospitalization;~~

~~D. Emergency services; and,~~

~~E. Consultative and educational services.~~

"Cost of Care" includes residential and community-based ~~treatment~~ SERVICES not covered by ~~private~~ THE FAMILY, COMMERCIAL insurance, or Medicaid~~, and room and board~~.

"COUNTY DEPARTMENT" MEANS THE COUNTY OR DISTRICT DEPARTMENT OF HUMAN OR SOCIAL SERVICES.

“DEPENDENT” MEANS A PERSON WHO RELIES ON THE RESPONSIBLE PERSON(S) FOR FINANCIAL SUPPORT.

“Face to Face CLINICAL ASSESSMENT”~~,~~ for ~~the purpose of~~ this Section 21.200.4, means A FORMAL AND CONTINUOUS PROCESS OF COLLECTING AND EVALUATING INFORMATION ABOUT AN INDIVIDUAL FOR SERVICE PLANNING, TREATMENT, REFERRAL, AND FUNDING ELIGIBILITY. THIS INFORMATION ESTABLISHES JUSTIFICATION FOR SERVICES AND CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDING.~~that t~~The child is physically in the same room as the professional person. If the child is out of state or otherwise unable to participate in a face to face assessment, video technology may be used.

~~"County Department" means the county, or district, department of human/social services~~.

"FAMILY ADVOCATE" HAS THE SAME MEANING AS PROVIDED IN SECTION 27-69-102 (5).

"FAMILY SYSTEMS NAVIGATOR" HAS THE SAME MEANING AS PROVIDED IN SECTION 27-69-102 (5.5).

"FIRST-LEVEL APPEAL" MEANS THE INITIAL PROCESS A MEDICAID MEMBER IS REQUIRED TO ENACT TO CONTEST A BENEFIT, SERVICE, OR ELIGIBILITY DECISION MADE BY MEDICAID OR A MEDICAID MANAGED CARE ENTITY.

“Licensed Mental Health Professional” means a psychologist licensed pursuant to Section 12-43-301, et seq., C.R.S., a psychiatrist licensed pursuant to Section 12-36-101, et seq., C.R.S., a clinical social worker licensed pursuant to Section 12-43-401, et seq., C.R.S., a marriage and family therapist licensed pursuant to Section 12-43-501, et seq., a professional counselor licensed pursuant to Section 12-43-601, et seq., C.R.S., or a social worker licensed by pursuant to Section 12-43-401, et seq., C.R.S., that is supervised by a licensed clinical social worker.

“MEDICAID CHILD OR YOUTH WHO IS AT RISK OF OUT-OF-HOME PLACEMENT" MEANS A CHILD OR YOUTH WHO IS CATEGORICALLY ELIGIBLE FOR MEDICAID BUT WHO OTHERWISE MEETS THE DEFINITION OF A CHILD OR YOUTH WHO IS AT RISK OF OUT-OF-HOME PLACEMENT AS DEFINED ABOVE.

"Mental Health Agency" means A BEHAVIORAL HEALTH SERVICES CONTRACTOR THROUGH THE STATE DEPARTMENT OF HUMAN SERVICES SERVING CHILDREN AND YOUTH STATEWIDE OR IN A PARTICULAR GEOGRAPHIC AREA, INCLUDING BUT NOT LIMITED TO COMMUNITY MENTAL HEALTH CENTERS, AND WITH THE ABILITY TO MEET ALL EXPECTATIONS OF 21.200.4 AND 27-67-101. ~~the community mental health center serving children in a particular geographic area or the Behavioral Health Organization, serving children in a particular geographic area who are receiving Medicaid, under contract with the Colorado Department of Health Care Policy and Financing.~~

"Plan of Care" is a STATE Department developed document that at a minimum includes the anticipated frequency and costs of services to be provided for the duration of the plan of care. The plan of care is also a schedule of the fees to be paid by the responsible person including, but not limited to, the estimated amount of Supplemental Security Income payable to the residential ~~treatment~~ facility IF AWARDED TO THE CHILD AT RISK OF OUT-OF-HOME PLACEMENT or ANother provider, and sliding scale fees payable to the contractor, if applicable.

"PROFESSIONAL PERSON" MEANS A PERSON LICENSED TO PRACTICE MEDICINE IN THIS STATE, A PSYCHOLOGIST CERTIFIED TO PRACTICE IN THIS STATE, OR A PERSON LICENSED AND IN GOOD STANDING TO PRACTICE MEDICINE IN ANOTHER STATE OR A PSYCHOLOGIST CERTIFIED TO PRACTICE AND IN GOOD STANDING IN ANOTHER STATE WHO IS PROVIDING MEDICAL OR CLINICAL SERVICES AT A TREATMENT FACILITY IN THIS STATE THAT IS OPERATED BY THE ARMED FORCES OF THE UNITED STATES, THE UNITED STATES PUBLIC HEALTH SERVICE, OR THE UNITED STATES DEPARTMENT OF VETERANS AFFAIRS.

~~"Resident" means a child receiving residential mental health treatment under the Child Mental Health Treatment Act.~~

"Residential Treatment" means services provided by a residential child care facility or psychiatric residential treatment facility licensed as a residential child care facility pursuant to Section 26-6-102(8), C.R.S., which has been approved by the STATE Department to provide mental health treatment.

"Responsible Persons" means parent(s) or legal guardian(s) of a minor.

“STATE DEPARTMENT" MEANS THE STATE DEPARTMENT OF HUMAN SERVICES.

21.200.42 ChildREN AND YOUTH Mental Health Treatment Act Program Description

The ~~Child~~CHILDREN AND YOUTH Mental Health Treatment Act allows parents or guardians to apply to a mental health agency on behalf of their minor child for mental health treatment services ~~whether the child is categorically eligible for Medicaid under the capitated mental health system, or whether~~ WHEN the parents or guardians believe his or her child is at risk for out-of-home placement, as defined in Section 21.200.41.

A. For children who are not categorically eligible FOR MEDICAID at the time services are requested, the ~~community mental health center~~MENTAL HEALTH AGENCY is responsible for clinically assessing the child and providing care management and necessary ~~treatment~~ services~~, including any community-based mental health treatment, other family preservation services, residential treatment or any post-residential follow-up service~~ that may be CLINICALLY appropriate for the child's and family's needs. ~~A dependency or neglect action pursuant to Article 3 of Title 19, C.R.S., shall not be required in order to allow a family access to residential or community-based mental health treatment services for a child.~~

~~B. For children who are categorically eligible for Medicaid as defined Section 21.200.41, the BHO is responsible for clinically assessing the child and providing care management and necessary treatment services, including any community based mental health treatment, other family preservation services, residential treatment or any post-residential follow-up service that may be appropriate for the child's and family's needs.~~

~~C.~~ B. The ChildREN AND YOUTH Mental Health Treatment Act~~, Sections 27-67-101 through 27-67-108, C.R.S.,~~ provides ~~appeal processes~~A SECOND OPINION for THE RESPONSIBLE PERSON(S) ~~parents or guardians~~ when services are denied OR TERMINATED FOR A MEDICAID CHILD OR YOUTH WHO IS AT RISK OF OUT-OF-HOME PLACEMENT OR A CHILD OR YOUTH SEEKING FUNDING UNDER THIS ACT.

~~D.~~ C. ~~and to~~THE CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT r~~R~~esolveS disputes between mental health agencies and county departments WHEN A CHILD IS SEEKING OR RECEIVING FUNDING THROUGH THE CHILD AND YOUTH MENTAL HEALTH TREATMENT ACT.

D. The ChildREN AND YOUTH Mental Health Treatment Act authorizes funding for services for children at risk of out-of-home placement, which are not covered by ~~private~~ COMMERCIAL insurance, Medicaid, or the family~~'s share~~.

21.200.43 Application for ~~Mental Health Treatment for Children~~ FUNDING FROM THE CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT

A. A responsible person may apply to a mental health agency on behalf of his or her minor child for mental health treatment.

B. AT ANY POINT IN APPLYING FOR, APPEALING, OR RECEIVING CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDING THE RESPONSIBLE PERSON(S) MAY REQUEST THE ASSISTANCE FROM A FAMILY ADVOCATE, FAMILY SYSTEM NAVIGATOR, NONPROFIT ADVOCACY ORGANIZATION, OR COUNTY DEPARTMENT.

1. THE MENTAL HEALTH AGENCY SHALL PROVIDE THE CONTACT INFORMATION FOR THE ORGANIZATION CONTRACTED WITH THE STATE DEPARTMENT TO PROVIDE THESE SERVICES, FREE OF CHARGE, TO THE RESPONSIBLE PERSON(S) BEFORE AN INITIAL EVALUATION.

2. THE STATE DEPARTMENT IS NOT OBLIGATED TO PAY FOR ANY SERVICES PROVIDED BY ENTITIES WITH WHICH THEY DO NOT CONTRACT.

~~B.~~ C. The mental health agency ~~will~~ SHALL evaluate the child and clinically assess the child's need for mental health services. When warranted, ~~treatment~~ FUNDING FOR services will be provided as may be necessary and in the best interests of the child and the child's family.

D. WHEN COMPLETING A FACE TO FACE CLINICAL ASSESSMENT FOR A CHILD OR YOUTH, THE MENTAL HEALTH AGENCY SHALL USE A STANDARDIZED RISK STRATIFICATION TOOL, IN A MANNER, DETERMINED BY THE STATE DEPARTMENT. DETERMINATION OF THE ASSESSMENT FOR LEVEL OF CARE NEED AND ELIGIBILITY NEED WILL BE COMPLETED JOINTLY BY THE MENTAL HEALTH AGENCY AND THE STATE DEPARTMENT.

E. WHEN EVALUATING A CHILD OR YOUTH FOR ELIGIBILITY, THE MENTAL HEALTH AGENCY SHALL EVALUATE ALL AREAS OUTLINED IN 21.190.

~~C.~~ F. ~~Subject to available appropriations, t~~The mental health agency shall be responsible for the provision of care management and necessary ~~treatment~~ services, including any community-based mental health treatment, ~~other family preservation services,~~ residential treatment, or any ~~pre- or post-residential~~ service~~s~~ that may be appropriate for the child's or family's needs.

~~D.~~ G. A face to face clinical assessment AND ELIGIBILITY DETERMINATION ~~and decision regarding request for treatment~~ shall be COMPLETED ~~performed by the mental health agency~~ within the following time periods after a request for ~~mental health treatment~~ FUNDING has been made by a responsible person(S).

~~1. Emergency situation, defined as a condition that appears to require unscheduled, immediate or special mental health intervention in response to a crisis situation involving the risk of imminent harm to the person or others. Emergency situation evaluations shall be completed within six (6) business hours of the initial assessment request.~~

~~2.~~ 1. Urgent situation, defined as a condition that ~~appears to,~~ IS LIKELY TO ESCALATE TO A SITUATION IN WHICH THE CHILD MAY BECOME A DANGER TO THEMSELVES OR OTHERS AND REQUIRE A CLINICAL ASSESSMENT WITHIN TWENTY-FOUR (24) HOURS. ~~if not addressed within twenty-four (24) hours, be likely to escalate to an emergency situation.~~ Urgent situation evaluations shall be completed BY THE MENTAL HEALTH AGENCY within twenty-four (24) hours, one business day, of the initial assessment request BY THE RESPONSIBLE PERSON(S). THE MENTAL HEALTH AGENCY SHALL CONTINUE TO PROVIDE CARE MANAGEMENT WHILE FUNDED SERVICES ARE IDENTIFIED AND PROVIDED.

~~3.~~ 2. Routine situations, defined as all other situations, shall be completed within three (3) business days of the initial assessment request.

~~4.~~ 3. If the mental health agency requires additional time to make a decision following an assessment and the responsible person agrees, then the mental health agency may take up to, but no more than, fourteen (14) calendar days to provide a decision. If the responsible person does not agree, the notification timelines referenced above remain in effect.

~~E.~~ H. The mental health agency'S decision shall be communicate~~d~~ verbally and in writing to the responsible person(S) within the time allowed for the completion of the evaluation OR AT LEAST 5 (FIVE) BUSINESS DAYS BEFORE THE REDUCTION, INCREASE OR TERMINATION OF FUNDED SERVICES. Verbal notice shall be face to face with the responsible person when possible.

I. The written decision shall contain THE FOLLOWING:

1. ~~n~~Notice of the applicable criteria for mental health treatment~~.~~;

2. ~~t~~The factual basis for the decision~~.~~;

3. ~~t~~The appeals procedures PURSUANT TO THE GRIEVANCE REQUIREMENTS IN SECTION 21.180;

4. IF APPROVED, NOTICE THAT THE RESPONSIBLE PERSON(S) MAY CHOOSE TO SEEK SERVICES FROM THE PROVIDER OF THEIR CHOICE, INCLUDING BUT NOT LIMITED TO THE MENTAL HEALTH AGENCY.

5. NOTICE THAT THE RESPONSIBLE PERSON(S) MAY REQUEST ASSISTANCE FROM A FAMILY ADVOCATE, FAMILY SYSTEM NAVIGATOR, NONPROFIT ADVOCACY ORGANIZATION, OR COUNTY DEPARTMENT IN APPLYING FOR, RECEIVING, OR APPEALING CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDING AND APPLYING FOR SUPPLEMENTAL SECURITY INCOME;

6. THE CONTACT INFORMATION FOR AN ORGANIZATION CONTRACTED BY THE STATE DEPARTMENT TO PERFORM FAMILY ADVOCACY OR FAMILY SYSTEM NAVIGATION;

7. NOTICE THAT THE CONTRACTED ADVOCACY PROVIDER IS NOT ALLOWED TO CHARGE THE FAMILY A FEE;

8. NOTICE THAT THE STATE DEPARTMENT IS NOT OBLIGATED TO PAY FOR ANY SERVICE PROVIDED BY ENTITIES WITH WHICH THEY DO NOT CONTRACT; AND,

9. ~~and a~~ A statement for the responsible person to sign, indicating that they agree with the decision or that they disagree and wish to file an appeal.

21.200.44 Process of Determining Ability to Pay and Adjusted Charge for Treatment Services ~~Provided to Children at Risk of Out-of-Home Placement~~

A. The ~~community mental health center~~ MENTAL HEALTH AGENCY shall determine the cost of care for children ~~in this program~~ AND YOUTH THAT RECEIVE FUNDING THROUGH THE CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT. ALL Insurance and other ELIGIBLE benefits shall be applied first to the cost of care. ~~Medicaid is the payer of last resort and will be provided, if the child is eligible, if other insurance coverage is not available. Insurance and other benefits for any resident shall be billed at the full cost of care.~~ A responsible person(s) 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. The MENTAL HEALTH AGENCY SHALL DETERMINE THE responsible person(s)' ability to pay for ~~residential treatment~~ SERVICES BASED ON THE FOLLOWING: ~~shall be calculated using material based on the "Colorado Child Support Guideline" and the "Schedule of Basic Child Support Obligations," as found in Section 14-10-115, C.R.S., and the Department's Child Support Enforcement rules (9 CCR 2504-1).~~

1. PER MONTH, THE MENTAL HEALTH AGENCY SHALL COLLECT 7% OF THE TOTAL COST OF ALL CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDED SERVICES FROM THE RESPONSIBLE PERSON EXCLUDING THE COSTS OF the INITIAL ASSESSMENT AND ALL CARE MANAGEMENT;

2. If THE RESPONSIBLE PERSON(S) IS UNABLE TO PAY THE FULL AMOUNT, THE MENTAL HEALTH AGENCY SHALL CONSIDER THE RESPONSIBLE PERSON(S) TOTAL NUMBER OF DEPENDENTS, THE MENTAL HEALTH NEEDS OF THOSE DEPENDENTS, ALL CURRENT OUTSTANDING MEDICAL LIABILITIES, EXPECTED LENGTH OF SERVICES, AND THE EDUCATION COSTS FOR THE DEPENDENTS. THE MENTAL HEALTH AGENCY SHALL RECEIVE APPROVAL OR DENIAL FROM THE STATE DEPARTMENT FOR ALL FEE ADJUSTMENTS;

3. THE MENTAL HEALTH AGENCY SHALL COLLECT NO LESS THAN $50 PER MONTH FROM THE RESPONSIBLE PERSON;

C. The mental health agency shall collect fees directly from THE RESPONSIBLE(S) PERSON;

~~C. The fee for community-based services shall be based on the income of the "responsible persons" defined in Section 21.200.41, using the "Uniform Method of Determining Ability to Pay" (2 CCR 501-1).~~

~~The cost of home and community based services shall not exceed fifty percent (50%) of that which would have been charged to the responsible persons for residential treatment.~~

D. The ~~treating facility and/Or~~ FUNDED provider may reserve the right to take any necessary action regarding delinquent payments by the responsible person(s);

~~E. The charge to the responsible person(s) 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 responsible person(s) does not cooperate in making insurance and other benefits available, the 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.~~

~~F.~~ E. The responsible person(s) ~~must~~ SHALL sign a financial agreement indicating an understanding of their financial responsibilities as described ~~in A-E~~, above, ~~in order~~ to be eligible for funding through the ChildREN AND YOUTH Mental Health Treatment Act;

~~G.~~ F. Within ten (10) business days after the child's admission to ~~the~~ residential treatment ~~facility~~, the responsible person(S) SHALL ~~must~~ apply for Supplemental Security Income (SSI) on behalf of a child ~~at risk of out-of-home placement~~ approved for ~~treatment~~ FUNDING under the ChildREN AND YOUTH Mental Health Treatment Act;

G. IF AWARDED SUPPLEMENTAL SECURITY INCOME; THE RESPONSIBLE PERSON(S) SHALL DISCLOSE THE AWARD AMOUNT TO THE MENTAL HEALTH AGENCY AS DETERMIEND BY THE SOCIAL SECURITY ADMINISTRATION REGULATIONS;

H. IF AWARDED SUPPLEMENTAL SECURITY INCOME AND THE CHILD HAS DISCHARGED FROM RESIDENTIAL SERVICES, THE REASONABLE PERSON(S) SHALL NOTIFY THE SOCIAL SECURITY ADMINISTRATION IMMEDIATELY;

I. IF AWARDED SUPPLEMENTAL SECURITY INCOME, THE CHILD WILL ALSO BE AWARDED MEDICAID WHICH WILL FUND TREATMENT COSTS WHILE IN RESIDENTIAL. THE PARENTAL FEE, SUPPLEMENTAL SECURITY INCOME, ALL OTHER FUNDING SOURCES, AND THE CHILD AND YOUTH MENTAL HEALTH TREATMENT ACT WILL FUND ROOM AND BOARD;

J. IF DENIED SUPPLEMENTAL SECURITY INCOME; THE CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT WILL FUND ROOM AND BOARD AND BEHAVIORAL HEALTH TREATMENT SERVICES THAT WOULD OTHERWISE HAVE BEEN FUNDED BY SUPPLEMENTAL SECURITY INCOME AND MEDICAID.

~~H. The responsible person must pay the monthly parental fee to the facility.~~

~~**21.200.45 Process of Determining Funding for Children who are Categorically Eligible for Medicaid [Eff. 11/1/13]**~~

~~As outlined in Section 8.212 of the Colorado Department of Health Care Policy and Financing's Medical Assistance rules (10 CCR 2505-10), costs and services are managed by the corresponding behavioral health organization for children who are categorically eligible for Medicaid at the time treatment is requested.~~

21.200.45 ~~21.200.46 Dispute Resolution for~~ APPEAL OF THE REDUCTION, TERMINATION, AND ~~D~~denial of Mental Health SERVICES FUNDED BY THE CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT ~~Treatment for Children at Risk of Out-of-Home Placement~~

A. Except as provided below, the ~~community mental health center~~ MENTAL HEALTH AGENCY shall follow the formalized ~~appeal~~ NOTIFICATION process ~~that the agency has established pursuant to the grievance requirements in Section 21.180 if the child is at risk of out-of-home placement,~~ as defined in Section 21.200.41 THROUGH 21.200.43.

B. A RESPONSIBLE PERSON(S) MAY REQUEST AN APPEAL OF A DECREASE, INCREASE, OR DENIAL OF CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUND SERVICES OR A RECOMMENDATION THAT A CHILD BE DISCHARGED FROM FUNDED SERVICES, AND THE FOLLOWING SHALL APPLY:

1. IF THE RESPONSIBLE PERSON(S) NOTIFIES THE MENTAL HEALTH AGENCY OF A DESIRE TO APPEAL A DECISION BEFORE TERMINATION OF SERVICES, THE STATE DEPARTMENT AND THE MENTAL HEALTH AGENCY SHALL CONTINUE TO FUND SERVICES UNTIL THE APPEAL PROCESS BELOW HAS BEEN EXHAUSTED.

2. THE RESPONSIBLE PERSON(S) SHALL NOTIFY THE MENTAL HEALTH AGENCY VERBALLY OR IN WRITING WITHIN FIFTEEN (15) BUSINESS DAYS OF NOTICE OF ACTION OF A DESIRE TO APPEAL A DECISION;

3. THE MENTAL HEALTH AGENCY SHALL HAVE TWO (2) BUSINESS DAYS WITHIN WHICH TO COMPLETE AN INTERNAL APPEAL REVIEW PROCESS AND COMMUNICATE A DECISION TO THE RESPONSIBLE PERSON(S) VERBALLY AND IN WRITING.

4. THE MENTAL HEALTH AGENCY'S NOTICE OF ACTION SHALL CONTAIN THE INFORMATION REQUIRED IN SECTION 21.200.43, E, ALONG WITH THE PROCESS FOR CLINICAL REVIEW IN SECTION 21.200.46, C-E BELOW.

C. IF THE MENTAL HEALTH AGENCY REQUIRES MORE THAN TWO (2) BUSINESS DAYS TO COMPLETE THE INTERNAL REVIEW, AND THE RESPONSIBLE PERSON(S) IS IN AGREEMENT, THEN THE MENTAL HEALTH AGENCY MAY TAKE UP TO BUT NO MORE THAN FIVE (5) BUSINESS DAYS TO COMPLETE THE REVIEW.

~~B. If the responsible person(s) requests an appeal of a denial of treatment or a recommendation that a child be discharged from services, either in writing or verbally within fifteen (15) business days of notice of action, the mental health agency shall have two (2) business days within which to complete the internal appeal review process and communicate a decision to the responsible person(s) verbally in person when possible and in writing. Said notice shall contain the information required in Section 21.200.43, E, along with the process for clinical review in Section 21.200.46, C-E, below. If the community mental health center requires more than two (2 business days to complete its internal review and the responsible person(s) is in agreement, then the community mental health center may take up to but no more than five (5) business days to complete the review. If the responsible party is not agreeable, the two (2) business day timeline discussed above will remain in effect.~~

~~C.~~ D. Within five (5) business days after the ~~community mental health center's~~ MENTAL HEALTH AGENCY'S final denial of requested services or recommendation that the child be discharged from treatment, the responsible person(s) may request a clinical review of the need for services by an objective third party, at the STATE Department, who is an independent professional person as that term is defined in Section 27-65- 102(11), C.R.S., to review the action of the ~~community mental health center~~ MENTAL HEALTH AGENCY. Such a request may be verbal or in writing, but if completed verbally it must be confirmed in writing, and shall be made to the Director of the Office of Behavioral Health or the OFFICE'S consumer and ~~Office's~~ family affairs specialist.

~~D.~~ E. Unless waived by the responsible person(s), said clinical review shall include:

1. A review of the ~~community mental health center's~~ MENTAL HEALTH AGENCY'S denial of services;

2. A face to face evaluation of the child~~,~~ so long as the responsible person(s) arranges transportation of the child for the evaluation; and,

3. A review of the evidence provided by the responsible person(s). The responsible person(s) shall be advised of the name and credentials of the reviewing professional, as well as any mental health agency affiliations of the reviewing professional. The responsible person(s) shall have an opportunity to request an alternate reviewing professional at the STATE Department at that time, so long as any delay caused by the request is waived by the responsible person(s) as described below.

~~E.~~ F. Within three (3) ~~working~~ BUSINESS days of the receipt of the request for clinical review, a decision shall be communicated verbally and in writing by the professional person to the responsible person(s), STATE Department, and the MENTAL HEALTH AGENCY ~~community mental health center~~. The written decision shall include the relevant criteria and factual basis. If the clinical review finds residential or community-based ~~treatment~~ SERVICES to be necessary AND THAT CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDING IS NECESSARY, the mental health agency shall provide ~~treatment~~ SERVICES to the child within twenty-four (24) hours of THE said decision. If residential treatment is not available within twenty-four hours and placement in residential treatment is recommended, the state level review must recommend appropriate alternatives including emergency hospitalization, if appropriate, if the child is in need of immediate placement out of the home.

~~F.~~ G. If the professional person requires more than three (3) ~~working~~ BUSINESS days to complete the ~~face to face evaluation~~ CLINICAL REVIEW, or if the responsible person(s) requires more time to obtain evidence for the clinical review, the responsible person(s) may waive the three day deadline above, so long as said waiver is confirmed in writing. In any event, the face to face evaluation and the clinical review shall be completed within six (6) ~~working~~ BUSINESS days.

~~G.~~ H. The STATE Department ~~review~~ DECISION shall constitute final agency action for FUNDING THROUGH THE CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT. ~~non-Medicaid CMHTA eligible children.~~

21.200.46 ~~21.200.47~~ ~~Dispute Resolution Process for Denial of Mental Health Treatment for Children Who Are Categorically Eligible for~~ Third Party Review Process for a Medicaid Child or Youth

~~A. For children who are categorically eligible for Medicaid, the responsible person(s) may request an appeal of a denial of treatment pursuant to the Medicaid "recipient appeals" process found at Section 8.057 of the Colorado Department of Health Care Policy and Financing's Medical Assistance rules (10 CCR 2505-10).~~ A MEDICAID CHILD OR YOUTH**,** A RESPONSIBLE PERSON MAY REQUEST AN OBJECTIVE THIRD PARTY CLINICAL REVIEW WITHIN 5 BUSINESS DAYS AFTER ALL FIRST-LEVEL MEDICAID APPEALS PROCESSES ARE EXHAUSTED (IN ACCORDANCE WITH SECTION 8.057 OR 8.209 OF THE COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING'S MEDICAL ASSISTANCE RULES [10 CCR 2505-10]). THE REVIEW MUST BE CONDUCTED BY A PROFESSIONAL PERSON AS OUTLINED IN SECTION 21.200.46 WITHIN 3 BUSINESS DAYS OF THE DATE OF REQUEST. THIS REVIEW DOES NOT OBLIGATE FUNDING OF SERVICES.

~~B. For children who are categorically eligible for Medicaid, the responsible person(s) may request a clinical review by the Department as outlined in Section 21.200.46.~~

21.200.47 ~~21.200.48~~ Dispute Resolution Process between County Departments and Mental Health Agencies

A. If a dispute exists between a mental health agency and a county department ~~of human/social services~~ regarding whether mental health services should be ~~provided~~ FUNDED under the ChildREN AND YOUTH Mental Health Treatment Act or by the county department, one or both may request the ~~Colorado Department of Human Services~~ COLORADO Office of Behavioral Health, to convene a review panel consisting of family advocates, the Colorado ~~Department of Human Services,~~ Division of Child Welfare, the ~~Colorado Department of Human Services,~~ Office of Behavioral Health, an independent ~~community mental health center~~ MENTAL HEALTH AGENCY IF AVAILABLE, AN INDEPENDENT PROFESSIONAL PERSON, AND an independent county department ~~of human/social services and, when applicable, the Colorado Department of Health care Policy and Financing~~ to provide dispute resolution. THE INDEPENDENT AGENCIES AND INDIVIDUALS SHALL DOCUMENT THAT NO CONFLICT OF INTEREST EXIST PERTAINING TO THE SPECIFIC CHILD BEING REVIEWED.

B. The request to invoke the dispute resolution process shall be in writing and submitted within five (5) calendar days of either agency recognizing ~~that~~ a dispute exits.

C. The written request for dispute resolution shall include, at a minimum, the following information:

1. The county department and mental health agency involved in the dispute, including a contact person at each;

2. The child's name~~,~~ AND age~~, and address~~;

3. The responsible person(s) address, phone number, and e-mail address;

4. Pertinent information regarding the child including, but not limited to, medical or mental health status/assessment;

5. The reason for the dispute, any efforts to resolve the matter locally, and any pertinent information regarding the child;

6. Information about the child's mental health status pertaining to the dispute; and,

7. The responsible person(s) perspective on the matter, if known.

~~D. Within ten (10) calendar days of receiving the dispute resolution request, the Department shall convene a review panel in order for each side to present their position.~~

~~E.~~ D. The STATE Department shall provide notice to both agencies that the STATE Department will resolve the dispute EITHER VERBALLY OR IN WRITING.

~~F.~~ E. Each side will have an opportunity to present its position to the review panel. Interested parties will be allowed to present written or oral testimony at the discretion of the review panel.

~~G.~~ F. ~~After both agencies present their positions, and other parties present as appropriate,~~ The review panel shall have five (5) ~~working~~ BUSINESS days to COMPLETE THE DISPUTE PROCESS AND issue its determination in writing to the disputing agencies AND THE RESPONSIBLE PERSON(S). The review panel's decision shall constitute final agency action, which binds the agency determined responsible for the provision of necessary services.

G. IF THE PANEL DEEMS THAT NEITHER THE MENTAL HEALTH AGENCY NOR THE COUNTY DEPARTMENT IS RESPONSIBLE FOR THE PROVISION OF FUNDING FOR THE TREATMENT OF THE CHILD, THEN THE PANEL SHALL PROVIDE A RATIONALE FOR THEIR DETERMINATION . THE PANEL SHALL OFFER RECOMMENDATIONS FOR OTHER FUNDING SOURCES AND TREATMENT MODALITIES.

21.200.48 ~~21.200.49~~ Responsibilities

21.200.481 ~~21.200.491~~ Responsibilities of ~~Community Mental Health Centers~~ MENTAL HEALTH AGENCIES

~~Subject to the availability of state appropriations, the community mental health center~~ THE MENTAL HEALTH AGENCY shall provide ChildREN AND YOUTH Mental Health Treatment Act FUNDED services to CHILDREN youth who are eligible as defined in Sections ~~20.100 and 20.200.~~ 21.200.4.

A. ChildREN AND YOUTH Mental Health Treatment Act services include, but are not limited to:

1. Clinical behavioral health assessments completed by a licensed mental health professional;

2. Community~~-~~based services;

3. Care management services;

4. Coordination of residential treatment services; and,

5. Non-residential mental health transition services for CHILDREN youth.

B. The ~~community mental health center~~ MENTAL HEALTH AGENCY shall provide to the STATE Department necessary ChildREN AND YOUTH Mental Health Treatment Act eligibility, service, and financial information in an agreed upon format.

C. The ~~community mental health center~~ MENTAL HEALTH AGENCY shall submit data to the STATE Department as required per Section 27-67-105, C.R.S.

D. The ~~community mental health center~~ MENTAL HEALTH AGENCY shall provide or coordinate treatment services in collaboration with THE CHILD OR youth, ~~and~~ families, and FUNDED SERVICE ~~community based and residential care~~ providers.

E. The ~~community mental health center~~ MENTAL HEALTH AGENCY shall determine the fee for the responsible person(s) and submit the financial agreement to the STATE Department once signed by the responsible person(s) ~~prior to~~ BEFORE state approval.

F. THE MENTAL HEALTH AGENCY SHALL SUBMIT ALL ELIGIBILITY ASSESSMENTS TO THE STATE DEPARTMENT BEFORE FUNDING APPROVAL OR DENIAL.

~~F.~~ G. If a child has been determined eligible under the ChildREN AND YOUTH Mental Health Treatment Act, the ~~community mental health center~~ MENTAL HEALTH AGENCY shall submit a plan of care for approval to the STATE Department ~~prior to~~ BEFORE providing services. If necessary services are not immediately available, ~~the community mental health center~~ MENTAL HEALTH AGENCY shall submit an alternative plan of care and provide interim services as appropriate.

~~G.~~ H. The ~~community mental health center~~ MENTAL HEALTH AGENCY shall maintain a comprehensive clinical record for each child receiving services through ChildREN AND YOUTH Mental Health Treatment Act funding consistent with 2 CCR 502-1 ~~the Department's site review protocol~~. Such records shall be made available for review by the STATE Department. The individualized service plan in the clinical record shall reflect any services provided directly by the center, including any care management services provided and relevant documentation submitted by a third-party provider. The goal of those care management services may be, at least in part, to oversee the delivery of services by third~~-~~party providers to assure that adequate progress is achieved and may reference the state plan of care and the provider's clinical service plan.

21.200.482 ~~21.200.492~~ Responsibilities of the Department

The STATE Department shall be responsible for administering and regulating the provisions of the ChildREN AND YOUTH Mental Health Treatment Act. The responsibilities of the STATE Department include:

A. Ensuring the ChildREN AND YOUTH Mental Health Treatment Act is implemented state-wide;

B. Reviewing requests for funding and making ~~recommendations~~ DETERMINATIONS regarding approval of FUNDED serviceS ~~delivery related to plans of care for children who are at risk of out-of-home placement as defined in Section 20.200.41~~;

C. The provision of technical assistance to ~~community mental health centers~~ MENTAL HEALTH AGENCIES, residential treatment providers, families, ~~and~~ advocacy organizations, COUNTY DEPARTMENTS, MENTAL HEALTH PROVIDERS, AND OTHER STAKEHOLDERS regarding the technical and financial aspects of the ChildREN AND YOUTH Mental Health Treatment Act;

D. Oversight and monitoring of service delivery for children receiving ChildREN AND YOUTH Mental Health Treatment Act funded services;

E. OVERSIGHT OF THE APPROPRIATENESS OF FUNDED SERVICES, SERVICE STANDARDS, AND SERVICE EXPECTATIONS OF CHILD AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDED SERVICES;

F. DEVELOPMENT AND MAINTENANCE OF THE APPEAL PROCESS;

~~E.~~ G. Development and maintenance of dispute resolution processes;

~~F.~~ H. Management of the fiscal aspects of the ChildREN AND YOUTH Mental Health Treatment Act program;

~~G.~~ I. Data Collection and PUBLIC reporting.

Title of Proposed Rule:	**Revisions to the Rules Implementing the Children and Youth Mental Health Treatment Act**	
CDHS Tracking #:	**18-08-15-01**	
Office, Division, & Program: Office of Behavioral Health, Division of Community Behavioral Health	Rule Author: Ryan Templeton	Phone: 303-866-7405 E-Mail: ryantempleton@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***

House Bill 18-1094 reauthorized, renamed, and updated the Child Mental Health Treatment Act (Act). The proposed rule revisions align the program regulations with the statutory changes to the Act from House Bill 18-1094. The renamed Children and Youth Mental Health Treatment Act allows families to access community, residential, and transitional treatment services for their child without requiring a dependency and neglect action, when there is no child abuse or neglect. To be eligible, a child must have a mental health disorder, be under the age of 21, and be at risk of out-of-home placement or at risk of further involvement with a county department of human/social services.

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

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

Justification for emergency:

Not applicable

State Board Authority for Rule:

Code	Description
26-1-107, C.R.S. (2018)	State Board to promulgate rules
26-1-109, C.R.S. (2018)	State department rules to coordinate with federal programs
26-1-111, C.R.S. (2018)	State department to promulgate rules for public assistance and welfare activities.

Program Authority for Rule: *Give federal and/or state citations and a summary of the language authorizing the rule-making function AND authority.*

Code	Description
27-67-106, C.R.S. (2018)	The state board of human services shall promulgate rules implementing a sliding scale for the payment of services.
27-67-107, C.R.S.	The state board of human services shall promulgate rules to assure that a grievance process is available to parents concerning the provision of mental health services and to assure that a dispute resolution process is available for disputes between the county departments and mental health agencies.

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

If yes, please explain. The rule reference Social Security Administration rules regarding the determination of ability to pay for services.

Title of Proposed Rule:	**Revisions to the Rules Implementing the Children and Youth Mental Health Treatment Act**	
CDHS Tracking #:	**18-08-15-01**	
Office, Division, & Program: Office of Behavioral Health, Division of Community Behavioral Health	Rule Author: Ryan Templeton	Phone: 303-866-7405 E-Mail: ryantempleton@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?

The proposed rule revisions align the Children and Youth Mental Health Treatment Act (CYMHTA) regulations with the updated statute. The statutorily required program regulations establish procedures for how CYMHTA shall be implemented in Colorado. CYMHTA benefits families with a child or youth at risk of out-of-home placement by allowing these families to access community, residential, and transitional mental health treatment services for their child without requiring a dependency or neglect action, in cases where this is no child abuse or neglect.

Entities providing the services, including entities assigned to participate in the dispute resolution process, under CYMHTA will be affected by these regulations, as these regulations update procedures for implementing CYMHTA to align with the changes made to the Act by House Bill 18-1094.

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?

For Fiscal Year 2017-18, the Child Mental Health Treatment Act had an appropriation of $1.1 million and provided services to 99 children located in 20 out of the 65 counties in Colorado. House Bill 18-1094 increased the appropriation to $3.2 million annually. The additional appropriation expands the age limit for program services from 18 years of age to 21 years of age; expands statewide utilization of the program; allows for training for communities; and provides family advocacy services from children.

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)*

With additional funding appropriated to the Children and Youth Mental Health Treatment Act (CYMHTA) pursuant to House Bill 18-1094, CYMHTA has an annual General Fund appropriation of $3,199,125.

The Department does not expect a fiscal impact as a result of the proposed rule changes. The changes do not include additional funding requirements to the Department or contracted agencies.

County Fiscal Impact

No County fiscal impact is expected with these proposed rules, as the services provided through CYMHTA is completed funded with Colorado General Funds.

Title of Proposed Rule:	**Revisions to the Rules Implementing the Children and Youth Mental Health Treatment Act**	
CDHS Tracking #:	**18-08-15-01**	
Office, Division, & Program: Office of Behavioral Health, Division of Community Behavioral Health	Rule Author: Ryan Templeton	Phone: 303-866-7405 E-Mail: ryantempleton@state.co.us

Federal Fiscal Impact

No Federal fiscal impact is expected with these proposed rules as this program is specific to Colorado.

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

Additional training requirements may be needed due to the changes House Bill 18-1094 made to CYMHTA. The Office of Behavioral Health has CMYHTA staff assigned to provide training and technical assistance regarding CYMHTA services. CYMHTA training and technical assistance would be provided at no cost, but providers and other entities may experience travel or related costs to attend trainings.

4. Data Description

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

House Bill 18-1094 including the fiscal note for House Bill 18-1094 were used when the Office of Behavioral Health collaborated with stakeholder in the development of the proposed rule revisions.

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 to rule-making were considered due to the authorizing statute requiring rule promulgation.

Title of Proposed Rule:	**Revisions to the Rules Implementing the Children and Youth Mental Health Treatment Act**	
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OVERVIEW OF PROPOSED RULE

Compare and/or contrast the content of the current regulation and the proposed change.

Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
7.000	*Incorrect Statutory Reference*	*Section 26.5.103 C.R.S.*	*Section 26.5-101(3) C.R.S.*		
21.200.4	Section needs updating to align with updated statute	These rules are intended to implement the mental health treatment services defined in the Child Mental Health Treatment Act, Sections 27-67-101 through 27-67-108, C.R.S., subject to available appropriations, to ensure the maximum use of appropriate least restrictive treatment services and to provide access to the greatest number of children. The purpose of the Child Mental Health Treatment Act is to provide access to mental health treatment for eligible children who are Medicaid eligible as well as those who are at risk of out-of-home placement, as defined below. In addition, the rules are intended to provide a sliding fee scale for responsible parties to offset the cost of care not covered by private insurance or Medicaid provided under the Child Mental Health Treatment Act. Appeal procedures for denial of residential and community mental health treatment are established in the rules as well as a dispute resolution process for county departments and mental health agencies.	These rules are intended to implement the mental health treatment services defined in the Children and Youth Mental Health Treatment Act, Sections 27-67-101 through 27-67-109, C.R.S., to ensure the maximum use of appropriate least restrictive treatment services and to provide access to the greatest number of children. The purpose of the Children and Youth Mental Health Treatment Act is to provide access to mental health treatment for eligible children who are Medicaid eligible as well as those who are at risk of out-of-home placement, as defined below. These rules are intended to provide a sliding fee scale for responsible parties to offset the cost of care not covered by commercial insurance or the family provided under the Children and Youth Mental Health Treatment Act. Appeal procedures for denial of Medicaid funded residential services, and denial of Children and Youth Mental Health Treatment Act funding are established in the rules as well as a dispute resolution process for county departments and mental health agencies.	Align with updated statute	No
21.200.41	Section needs updating to align with updated statute	“Ability to Pay” means the amount of income and assets of the legally responsible person(s) available to pay for the individual cost of community mental health treatment and room and board for a child in residential treatment. “BHO” means the Behavioral Health Organization responsible for implementing the Medicaid mental health capitation program through contract with the Colorado Department of Health Care Policy and Financing. “Care Management” means arranging for continuity of care and coordinating the array of service necessary for treating the child; communicating with responsible	"Ability to pay" means the amount of income and assets of the legally responsible person(s) available to pay for the individual cost of children and youth mental health treatment act funded services. "Care management" means arranging for continuity of care and coordinating the array of service necessary for appropriately treating the a child or youth; communicating verbally or in-person with responsible individuals, and funded providers at least every thirty (30) calendar days to assure services are being delivered as planned and adequate progress is being	Align with updated statute	Yes, requests to clarify definitions

		individuals, and providers at least every thirty (30) calendar days to assure services are being delivered as planned and adequate progress is being made; and the authority to rescind authorization for any treatment services with proper notice. “Child at Risk of Out-of-Home Placement” means a child between the ages of zero (0) and his/her eighteenth (18th) birthday who, although not otherwise categorically eligible for Medicaid, meets the following criteria: A. Has been diagnosed as a person with a mental illness, as defined in Section 27-65-102(14), C.R.S.; B. Requires a level of care that is provided in a residential child care facility pursuant to Section 25.5-5-306, C.R.S., or that is provided through in-home or community-based programs and who, without such care, is at risk of out of home placement; C. If determined to be in need of placement in a residential child care facility, is determined to be eligible for Supplemental Security Income; and, D. For whom it is inappropriate or unwarranted to file an action in dependency or neglect pursuant to Article 3 of Title 19, C.R.S. “Children who are categorically Medicaid eligible” means a child between the ages of zero (0) and his/her eighteenth (18th) birthday who, with a covered mental health diagnosis, is eligible for services through the Capitated Single Entry Point System for Mental Health Services Program described in Section 25.5-5411, C.R.S. “Community-Based Services” includes, but is not limited to, therapeutic foster care, intensive in-home treatment, intensive case management, and day treatment. “Community Mental Health Center, as defined in Section 27-66-101, C.R.S., means either a physical facility or a group of services under unified administration or affiliated with one another, and includes at least the following services for the prevention and treatment of mental illness in persons residing in a particular community in or near the community mental health center or group so situated: A. Inpatient services; B. Outpatient services;	made; discharge planning and development; and the authority to rescind authorization for any treatment services with proper notice. "child at risk of out-of-home placement" means a child or youth meets the following criteria: A. Has been diagnosed as a person with a mental health disorder, as defined in section 27-65-102(11.5), C.R.S.; B. Requires a level of care that is provided in a residential child care facility pursuant to section 25.5-5-306, C.R.S, or that is provided through community-based programs and who, without such care, is at risk of unwarranted child welfare involvement or other system involvement, as described in section 27-67-102, in order to receive funding for treatment; C. If determined to be in need of placement in a residential child care facility or psychiatric residential treatment facility, a child or youth shall apply for supplemental security income, but any determination for supplemental security income must not be a criterion for a child or youth to receive funding D. The child or youth is a person for whom there is no pending or current action in dependency or neglect pursuant to article 3 of title 19, C.R.S and; E. The child or youth is younger than eighteen years of age at time of applying, but he or she may continue to remain eligible for services until his or her twenty-first birthday. "Children who are categorically Medicaid eligible" has the same meaning as defined in section 25.5-5-101. "Community-based services" means any intervention that is designed to be an alternative to residential or hospital level of care in which the child or youth resides within a non-institutional setting and includes, but is not limited to, therapeutic foster care, intensive in-home treatment, intensive case management, and day treatment. "Community mental health center", has the same meaning as defined in section 27-66-101(2), C.R.S, "Cost of care" includes residential and community-		

		C. Partial hospitalization; D. Emergency services; and, E. Consultative and educational services. “Cost of Care” includes residential and community-based treatment not covered by private insurance or Medicaid, and room and board. “County Department” means the county, or district, department of human/social services. “Face to Face”, for the purpose of this Section 21.200.4, means that the child is physically in the same room as the professional person. If the child is out of state or otherwise unable to participate in a face to face assessment, video technology may be used. “Licensed Mental Health Professional” means a psychologist licensed pursuant to Section 12-43-301, et seq., C.R.S., a psychiatrist licensed pursuant to Section 12-36-101, et seq., C.R.S., a clinical social worker licensed pursuant to Section 12-43-401, et seq., C.R.S., a marriage and family therapist licensed pursuant to Section 12-43-501, et seq., a professional counselor licensed pursuant to Section 12-43-601, et seq., C.R.S., or a social worker licensed by pursuant to Section 12-43-401, et seq., C.R.S., that is supervised by a licensed clinical social worker. “Mental Health Agency” means the community mental health center serving children in a particular geographic area or the Behavioral Health Organization, serving children in a particular geographic area who are receiving Medicaid, under contract with the Colorado Department of Health Care Policy and Financing. “Plan of Care” is a Department developed document that at a minimum includes the anticipated frequency and costs of services to be provided for the duration of the plan of care. The plan of care is also a schedule of the fees to be paid by the responsible person including, but not limited to, the estimated amount of Supplemental Security Income payable to the residential treatment facility or other provider, and sliding scale fees payable to the contractor, if applicable. “Resident” means a child receiving residential mental health treatment under the Child Mental Health Treatment	based services not covered by the family, commercial insurance, or Medicaid. "County department" means the county or district department of human or social services. “Dependent” means a person who relies on the responsible person(s) for financial support. “Face to face clinical assessment”, for this section 21.200.4, means a formal and continuous process of collecting and evaluating information about an individual for service planning, treatment, referral, and funding eligibility. This information establishes justification for services and children and youth mental health treatment act funding. The child is physically in the same room as the professional person. If the child is out of state or otherwise unable to participate in a face to face assessment, video technology may be used. "Family advocate" has the same meaning as provided in section 27-69-102 (5). "Family systems navigator" has the same meaning as provided in section 27-69-102 (5.5). "First-level appeal" means the initial process a Medicaid member is required to enact to contest a benefit, service, or eligibility decision made by Medicaid or a Medicaid managed care entity. “Licensed mental health professional” means a psychologist licensed pursuant to section 12-43-301, et seq., C.R.S, a psychiatrist licensed pursuant to section 12-36-101, et seq., C.R.S, a clinical social worker licensed pursuant to section 12-43-401, et seq., C.R.S, a marriage and family therapist licensed pursuant to section 12-43-501, et seq., a professional counselor licensed pursuant to section 12-43-601, et seq., C.R.S, or a social worker licensed by pursuant to section 12-43-401, et seq., C.R.S, that is supervised by a licensed clinical social worker. “Medicaid child or youth who is at risk of out-of-home placement" means a child or youth who is categorically eligible for Medicaid but who otherwise meets the definition of a child or youth who is at risk of out-of-		

		Act. “Residential Treatment” means services provided by a residential child care facility or psychiatric residential treatment facility licensed as a residential child care facility pursuant to Section 26-6-102(8), C.R.S., which has been approved by the Department to provide mental health treatment. “Responsible Persons” means parent(s) or legal guardian(s) of a minor.	home placement as defined above. "Mental health agency" means a behavioral health services contractor through the state department of human services serving children and youth statewide or in a particular geographic area, including but not limited to community mental health centers, and with the ability to meet all expectations of 21.200.4 and 27-67-101. "Plan of care" is a state department developed document that at a minimum includes the anticipated frequency and costs of services to be provided for the duration of the plan of care. The plan of care is also a schedule of the fees to be paid by the responsible person including, but not limited to, the estimated amount of supplemental security income payable to the residential facility if awarded to the child at risk of out-of-home placement or another provider, and sliding scale fees payable to the contractor, if applicable. "Professional person" means a person licensed to practice medicine in this state, a psychologist certified to practice in this state, or a person licensed and in good standing to practice medicine in another state or a psychologist certified to practice and in good standing in another state who is providing medical or clinical services at a treatment facility in this state that is operated by the armed forces of the united states, the united states public health service, or the united states department of veterans affairs. "Residential treatment" means services provided by a residential child care facility or psychiatric residential treatment facility licensed as a residential child care facility pursuant to section 26-6-102(8), C.R.S., which has been approved by the state department to provide mental health treatment. "Responsible persons" means parent(s) or legal guardian(s) of a minor. “State department" means the state department of human services.		
21.200.42	Section needs updating to align	The Child Mental Health Treatment Act allows parents or guardians to apply to a mental health agency on behalf of	The Children and Youth Mental Health Treatment Act allows parents or guardians to apply to a mental health	Align with updated statute	Yes, ensure the rule

	with updated statute	their minor child for mental health treatment services whether the child is categorically eligible for Medicaid under the capitated mental health system, or whether the parents or guardians believe his or her child is at risk for out-of-home placement, as defined in Section 21.200.41. A. For children who are not categorically eligible at the time services are requested, the community mental health center is responsible for clinically assessing the child and providing care management and necessary treatment services, including any community-based mental health treatment, other family preservation services, residential treatment or any post-residential follow-up service that may be appropriate for the child's and family's needs. A dependency or neglect action pursuant to Article 3 of Title 19, C.R.S., shall not be required in order to allow a family access to residential or community-based mental health treatment services for a child. B. For children who are categorically eligible for Medicaid as defined in Section 21.200.41, the BHO is responsible for clinically assessing the child and providing care management and necessary treatment services, including any community based mental health treatment, other family preservation services, residential treatment or any post-residential follow-up service that may be appropriate for the child's and family's needs. C. The Child Mental Health Treatment Act, Sections 27-67-101 through 27-67-108, C.R.S., provides appeal processes for parents or guardians when services are denied, and to resolve disputes between mental health agencies and county departments. D. The Act authorizes funding for services for children at risk of out-of-home placement, which are not covered by private insurance, Medicaid, or the family's share.	agency on behalf of their minor child for mental health treatment services WHEN the parents or guardians believe his or her child is at risk for out-of-home placement, as defined in Section 21.200.41. A. For children who are not categorically eligible for Medicaid at the time services are requested, the mental health agency is responsible for clinically assessing the child and providing care management and necessary services that may be appropriate for the child's and family's needs. B. The Children and Youth Mental Health Treatment Act provides a second opinion for the responsible person(s) when services are denied or terminated for a Medicaid child or youth who is at risk of out-of-home placement or a child or youth seeking funding under this act. C. The Children and Youth Mental Health Treatment Act resolves disputes between mental health agencies and county departments when a child is seeking or receiving funding through the Children and Youth Mental Health Treatment Act. D. The Children and Youth Mental Health Treatment Act authorizes funding for services for children at risk of out-of-home placement, which are not covered by COMMERCIAL insurance, Medicaid, or the family.		aligns with statute

21.200.43	Section needs updating to align with updated statute	A. A responsible person may apply to a mental health agency on behalf of his or her minor child for mental health treatment. B. The mental health agency will evaluate the child and clinically assess the child's need for mental health services. When warranted, treatment services will be provided as may be necessary and in the best interests of the child and the child's family. C. Subject to available appropriations, the mental health agency shall be responsible for the provision of care management and necessary treatment services, including any community based mental health treatment, other family preservation services, residential treatment, or any pre- or post-residential services that may be appropriate for the child's or family's needs. D. A face to face clinical assessment and decision regarding requests for treatment shall be performed by the mental health agency within the following time periods after a request for mental health treatment has been made by a responsible person. 1. Emergency situation, defined as a condition that appears to require unscheduled, immediate or special mental health intervention in response to a crisis situation involving the risk of imminent harm to the person or others. Emergency situation evaluations shall be completed within six (6) business hours of the initial assessment request. 2. Urgent situation, defined as a condition that appears to, if not addressed within twenty four (24) hours, be likely to escalate to an emergency situation. Urgent situation evaluations shall be completed within twenty-four (24) hours, one (1) business day, of the initial assessment request. 3. Routine situations, defined as all other situations, shall be completed within three (3) business days of the initial assessment request. 4. If the mental health agency requires additional time to make a decision following an assessment and the responsible person agrees, then the mental health agency may take up to, but no more than, fourteen (14)	A. A responsible person may apply to a mental health agency on behalf of his or her minor child for mental health treatment. B. At any point in applying for, appealing, or receiving children and youth mental health treatment act funding the responsible person(s) may request the assistance from a family advocate, family system navigator, nonprofit advocacy organization, or county department. 1. The mental health agency shall provide the contact information for the organization contracted with the state department to provide these services, free of charge, to the responsible person(s) before an initial evaluation. 2. The state department is not obligated to pay for any services provided by entities with which they do not contract. C. The mental health agency shall evaluate the child and clinically assess the child's need for mental health services. When warranted, funding for services will be provided as may be necessary and in the best interests of the child and the child's family. D. When completing a face to face clinical assessment for a child or youth, the mental health agency shall use a standardized risk stratification tool, in a manner, determined by the State Department. Determination of the assessment for level of care need and eligibility need will be completed jointly by the mental health agency and the State Department. E. When evaluating a child or youth for eligibility, the mental health agency shall evaluate all areas outlined in 21.190. F. The mental health agency shall be responsible for the provision of care management and necessary services, including any community-based mental health treatment, residential treatment, or any services that may be appropriate for the child's or family's needs. G. A face to face clinical assessment and eligibility determination shall be completed within the following time periods after a request for funding has been made by a responsible person(s).	Align with updated statute	Yes, establish how agencies will know who are contracted entities

		calendar days to provide a decision. If the responsible person does not agree, the notification timelines referenced above remain in effect. E. The mental health agency decision shall be communicated verbally and in writing to the responsible person within the time allowed for the completion of the evaluation. Verbal notice shall be face to face with the responsible person when possible. The written decision shall contain notice of the applicable criteria for mental health treatment, the factual basis for the decision, the appeals procedures, and a statement for the responsible person to sign, indicating that they agree with the decision or that they disagree and wish to file an appeal.	1. Urgent situation, defined as a condition that is likely to escalate to a situation in which the child may become a danger to themselves or others and requires a clinical assessment within twenty-four (24) HOURS. Urgent situation evaluations shall be completed by the mental health agency within twenty-four (24) hours, one business day, of the initial assessment request by the responsible person(s). The mental health agency shall continue to provide care management while funded services are identified and provided. 2. Routine situations, defined as all other situations, shall be completed within three (3) business days of the initial assessment request. 3. If the mental health agency requires additional time to make a decision following an assessment and the responsible person agrees, then the mental health agency may take up to, but no more than, fourteen (14) calendar days to provide a decision. If the responsible person does not agree, the notification timelines referenced above remain in effect. H. The mental health agency's decision shall be communicated verbally and in writing to the responsible person(s) within the time allowed for the completion of the evaluation or at least 5 (five) business days before the reduction, increase or termination of funded services. Verbal notice shall be face to face with the responsible person when possible. I. The written decision shall contain the following: 1. Notice of the applicable criteria for mental health treatment,; 2. The factual basis for the decision,; 3. The appeals procedures pursuant to the grievance requirements in section 21.180; 4. If approved, notice that the responsible person(s) may choose to seek services from the provider of their choice, including but not limited to the mental health agency. 5. Notice that the responsible person(s) may request assistance from a family advocate, family system navigator, nonprofit advocacy organization, or county		

			department in applying for, receiving, or appealing children and youth mental health treatment act funding and applying for supplemental security income; 6. The contact information for an organization contracted by the state department to perform family advocacy or family system navigation; 7. Notice that the contracted advocacy provider is not allowed to charge the family a fee; 8. Notice that the state department is not obligated to pay for any service provided by entities with which they do not contract; and, 9. A statement for the responsible person to sign, indicating that they agree with the decision or that they disagree and wish to file an appeal.		
21.200.44	Section needs updating to align with updated statute	A. The community mental health center shall determine the cost of care for children in this program. Insurance and other benefits shall be applied first to the cost of care. Medicaid is the payor of last resort and will be provided, if the child is eligible, if other insurance coverage is not available. Insurance and other benefits for any resident shall be billed at the full cost of care. A responsible person(s) 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. The responsible person(s)' ability to pay for residential treatment shall be calculated using material based on the "Colorado Child Support Guideline" and the "Schedule of Basic Child Support Obligations," as found in Section 14-10-115, C.R.S., and the Department's Child Support Enforcement rules (9 CCR 2504-1). C. The fee for community-based services shall be based on the income of the "responsible persons" defined in Section 21.200.41, using the "Uniform Method of Determining Ability to Pay" in Section 21.800, et seq. The cost of home and community based services shall not exceed fifty percent (50%) of that which would have been charged to the responsible persons for residential treatment. D. The treating facility and/or provider may reserve the	A. The mental health agency shall determine the cost of care for children in this program and youth that receive funding through the Children and Youth Mental Health Treatment Act. All Insurance and other eligible benefits shall be applied first to the cost of care. A responsible person(s) 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. The mental health agency shall determine the responsible person(s)' ability to pay for services based on the following: 1. Per month, the responsible person(s) shall pay 7% of each children and youth mental health treatment act funded service, excluding the initial assessment and all care management; 2. If the responsible person(s) is unable to pay the full amount, the mental health agency shall consider the responsible person(s) total number of dependents, the mental health needs of those dependents, all current outstanding medical liabilities, expected length of services, and the education costs for the dependents. The mental health agency shall receive approval or denial from the state department for all fee adjustments; 3.the responsible person shall pay a minimum total fee	Align with updated statute	Yes, address minimum payment

		right to take any necessary action regarding delinquent payments by the responsible person(s). E. The responsible person(s) 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 responsible person(s) does not cooperate in making insurance and other benefits available, the 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. F. The responsible person(s) must sign a financial agreement indicating an understanding of their financial responsibilities as described in A-E, above, in order to be eligible for funding through the Child Mental Health Treatment Act. G. Within ten (10) business days after the child's admission to the residential treatment facility, the responsible person must apply for Supplemental Security Income (SSI) on behalf of a child at risk of out-of-home placement approved for treatment under the Child Mental Health Treatment Act. H. The responsible person must pay the monthly parental fee to the facility.	of $50 per month; C. The responsible(s) person shall pay fees directly to the agency providing the service; D. The funded provider may reserve the right to take any necessary action regarding delinquent payments by the responsible person(s); E. The responsible person(s) shall sign a financial agreement indicating an understanding of their financial responsibilities as described above, to be eligible for funding through the Children and Youth Mental Health Treatment Act; F. Within ten (10) business days after the child's admission to residential treatment, the responsible person(S) shall apply for Supplemental Security Income (SSI) on behalf of a child approved for funding under the Children and Youth Mental Health Treatment Act; G. If awarded supplemental security income; the responsible person(s) shall disclose the award amount to the mental health agency as determined by the social security administration regulations; H. If awarded supplemental security income and the child has discharged from residential services, the reasonable person(s) shall notify the Social Security Administration immediately; I. If awarded supplemental security income, the child will also be awarded Medicaid which will fund treatment costs while in residential. The parental fee, supplemental security income, all other funding sources, and the Children and Youth Mental Health Treatment Act will fund room and board; J. If denied supplemental security income; the Children and Youth Mental Health Treatment Act will fund room and board and behavioral health treatment services that would otherwise have been funded by supplemental security income and Medicaid.		
21.200.45	To align with updated statute, this section was no longer needed.	As outlined in Section 8.212 of the Colorado Department of Health Care Policy and Financing's Medical Assistance rules (10 CCR 2505-10), costs and services are managed by the corresponding behavioral health organization for children who are categorically eligible for Medicaid at the	Section repealed	To align with updated statute, this section was no longer needed.	No

		time treatment is requested.			
21.200.46	Section needs updating to align with updated statute	A. Except as provided below, the community mental health center shall follow the formalized appeal process that the agency has established pursuant to the grievance requirements in Section 21.180 if the child is at risk of out-of-home placement, as defined in Section 21.200.41. B. If the responsible person(s) requests an appeal of a denial of treatment or a recommendation that a child be discharged from services, either in writing or verbally within fifteen (15) business days of notice of action, the mental health agency shall have two (2) business days within which to complete the internal appeal review process and communicate a decision to the responsible person(s) verbally in person when possible and in writing. Said notice shall contain the information required in Section 21.200.43, E, along with the process for clinical review in Section 21.200.46, C-E, below. If the community mental health center requires more than two (2) business days to complete its internal review and the responsible person(s) is in agreement, then the community mental health center may take up to but no more than five (5) business days to complete the review. If the responsible party is not agreeable, the two (2) business day timeline discussed above will remain in effect. C. Within five (5) business days after the community mental health center's final denial of requested services or recommendation that the child be discharged from treatment, the responsible person(s) may request a clinical review of the need for services by an objective third party, at the Department, who is an independent professional person as that term is defined in Section 27-65102(11), C.R.S., to review the action of the community mental health center. Such a request may be verbal or in writing, but if completed verbally it must be confirmed in writing, and shall be made to the Director of the Office of Behavioral Health or the consumer and Office's family affairs specialist. D. Unless waived by the responsible person(s), said clinical review shall include: 1. A review of the community mental health center's	[Reorganized as section 21.200.45] A. Except as provided below, the mental health agency shall follow the formalized notification process as defined in section 21.200.41 through 21.200.43. B. A responsible person(s) may request an appeal of a decrease, increase, or denial of Children and Youth Mental Health Treatment Act fund services or a recommendation that a child be discharged from funded services, and the following shall apply: 1. If the responsible person(s) notifies the mental health agency of a desire to appeal a decision before termination of services, the state department and the mental health agency shall continue to fund services until the appeal process below has been exhausted. 2. The responsible person(s) shall notify the mental health agency verbally or in writing within fifteen (15) business days of notice of action of a desire to appeal a decision; 3. The mental health agency shall have two (2) business days within which to complete an internal appeal review process and communicate a decision to the responsible person(s) verbally and in writing. 4. The mental health agency's notice of action shall contain the information required in section 21.200.43, e, along with the process for clinical review in section 21.200.46, C-E below. C. If the mental health agency requires more than two (2) business days to complete the internal review, and the responsible person(s) is in agreement, then the mental health agency may take up to but no more than five (5) business days to complete the review. D. Within five (5) business days after the mental health agency's final denial of requested services or recommendation that the child be discharged from treatment, the responsible person(s) may request a clinical review of the need for services by an objective third party, at the State Department, who is an independent professional person as that term is defined in section 27-65- 102(11), C.R.S., to review the action	Align with updated statute	Yes, ensure CYMHTA aligns with Medicaid

		denial of services; 2. A face to face evaluation of the child, so long as the responsible person(s) arranges transportation of the child for the evaluation; and, 3. A review of the evidence provided by the responsible person(s). The responsible person(s) shall be advised of the name and credentials of the reviewing professional, as well as any mental health agency affiliations of the reviewing professional. The responsible person(s) shall have an opportunity to request an alternate reviewing professional at the Department at that time, so long as any delay caused by the request is waived by the responsible person(s) as described below. E. Within three (3) working days of the receipt of the request for clinical review, a decision shall be communicated verbally and in writing by the professional person to the responsible person(s), Department and the community mental health center. The written decision shall include the relevant criteria and factual basis. If the clinical review finds residential or community based treatment to be necessary, the mental health agency shall provide treatment to the child within twenty four (24) hours of said decision. If residential treatment is not available within twenty four hours and placement in residential treatment is recommended, the state level review must recommend appropriate alternatives including emergency hospitalization, if appropriate, if the child is in need of immediate placement out of the home. F. If the professional person requires more than three (3) working days to complete the face to face evaluation, or if the responsible person(s) requires more time to obtain evidence for the clinical review, the responsible person(s) may waive the three day deadline above, so long as said waiver is confirmed in writing. In any event, the face to face evaluation and the clinical review shall be completed within six (6) working days. G. The Department review shall constitute final agency action for non-Medicaid eligible children.	of the mental health agency. Such a request may be verbal or in writing, but if completed verbally it must be confirmed in writing, and shall be made to the director of the office of behavioral health or the office's consumer and family affairs specialist. E. Unless waived by the responsible person(s), said clinical review shall include: 1. A review of the mental health agency's denial of services; 2. A face to face evaluation of the child, so long as the responsible person(s) arranges transportation of the child for the evaluation; and, 3. A review of the evidence provided by the responsible person(s). The responsible person(s) shall be advised of the name and credentials of the reviewing professional, as well as any mental health agency affiliations of the reviewing professional. The responsible person(s) shall have an opportunity to request an alternate reviewing professional at the State Department at that time, so long as any delay caused by the request is waived by the responsible person(s) as described below. F. Within three (3) business days of the receipt of the request for clinical review, a decision shall be communicated verbally and in writing by the professional person to the responsible person(s), state department, and the mental health agency. The written decision shall include the relevant criteria and factual basis. If the clinical review finds residential or community-based services to be necessary and that children and youth mental health treatment act funding is necessary, the mental health agency shall provide services to the child within twenty-four (24) hours of the said decision. If residential treatment is not available within twenty-four hours and placement in residential treatment is recommended, the state level review must recommend appropriate alternatives including emergency hospitalization, if appropriate, if the child is in need of immediate placement out of the home. G. If the professional person requires more than three		

			(3) business days to complete the clinical review, or if the responsible person(s) requires more time to obtain evidence for the clinical review, the responsible person(s) may waive the three day deadline above, so long as said waiver is confirmed in writing. In any event, the face to face evaluation and the clinical review shall be completed within six (6) business days. H. The state department review decision shall constitute final agency action for funding through the Children and Youth Mental Health Treatment Act.		
21.200.47	Section needs updating to align with updated statute	A. For children who are categorically eligible for Medicaid, the responsible person(s) may request an appeal of a denial of treatment pursuant to the Medicaid "recipient appeals" process found at Section 8.057 of the Colorado Department of Health Care Policy and Financing's Medical Assistance rules (10 CCR 2505-10). B. For children who are categorically eligible for Medicaid, the responsible person(s) may request a clinical review by the Department as outlined in Section 21.200.46.	[Reorganized as section 21.200.46] For a Medicaid child or youth, a responsible person may request an objective third party clinical review within 5 business days after all first-level Medicaid appeals processes are exhausted (in accordance with section 8.057 or 8.209 of the Colorado department of health care policy and financing's medical assistance rules [10 CCR 2505-10]). The review must be conducted by a professional person as outlined in section 21.200.46 within 3 business days of the date of request. This review does not obligate funding of services.	Align with updated statute	No
21.200.48	Section needs updating to align with updated statute	A. If a dispute exists between a mental health agency and a county department of human/social services regarding whether mental health services should be provided under the Child Mental Health Treatment Act or by the county department, one or both may request the Colorado Department of Human Services, Office of Behavioral Health, to convene a review panel consisting of family advocates, the Colorado Department of Human Services, Division of Child Welfare, the Colorado Department of Human Services, Office of Behavioral Health, an independent community mental health center, an independent county department of human/social services and, when applicable, the Colorado Department of Health care Policy and Financing to provide dispute resolution. B. The request to invoke the dispute resolution process shall be in writing and submitted within five (5) calendar days of either agency recognizing that a dispute exits. C. The written request for dispute resolution shall include,	[Reorganized as section 21.200.47] A. If a dispute exists between a mental health agency and a county department regarding whether mental health services should be funded under the Children and Youth Mental Health Treatment Act or by the county department, one or both may request the Colorado Office of Behavioral Health, to convene a review panel consisting of family advocates, the Colorado Division of Child Welfare, the Office of Behavioral Health, an independent mental health agency if available, an independent professional person, and an independent county department to provide dispute resolution. The independent agencies and individuals shall document that no conflict of interest exist pertaining to the specific child being reviewed. B. The request to invoke the dispute resolution process shall be in writing and submitted within five (5) calendar	Align with updated statute	No

		at a minimum, the following information: 1. The county department and mental health agency involved in the dispute, including a contact person at each; 2. The child's name, age, and address; 3. The responsible person(s) address, phone number, and e-mail address; 4. Pertinent information regarding the child including, but not limited to, medical or mental health status/assessment; 5. The reason for the dispute, any efforts to resolve the matter locally, and any pertinent information regarding the child; 6. Information about the child's mental health status pertaining to the dispute; and, 7. The responsible person(s) perspective on the matter, if known. D. Within ten (10) calendar days of receiving the dispute resolution request, the Department shall convene a review panel in order for each side to present their position. E. The Department shall provide notice to both agencies that the Department will resolve the dispute. F. Each side will have an opportunity to present its position to the review panel. Interested parties will be allowed to present written or oral testimony at the discretion of the review panel. G. After both agencies present their positions, and other parties present as appropriate, the review panel shall have five (5) working days to issue its determination in writing to the disputing agencies. The review panel's decision shall constitute final agency action, which binds the agency determined responsible for the provision of necessary services.	days of either agency recognizing a dispute exits. C. The written request for dispute resolution shall include, at a minimum, the following information: 1. The county department and mental health agency involved in the dispute, including a contact person at each; 2. The child's name and age; 3. The responsible person(s) address, phone number, and e-mail address; 4. Pertinent information regarding the child including, but not limited to, medical or mental health status/assessment; 5. The reason for the dispute, any efforts to resolve the matter locally, and any pertinent information regarding the child; 6. Information about the child's mental health status pertaining to the dispute; and, 7. The responsible person(s) perspective on the matter, if known. D. The state department shall provide notice to both agencies that the state department will resolve the dispute either verbally or in writing. E. Each side will have an opportunity to present its position to the review panel. Interested parties will be allowed to present written or oral testimony at the discretion of the review panel. F. The review panel shall have five (5) business days to complete the dispute process and issue its determination in writing to the disputing agencies and the responsible person(s). The review panel's decision shall constitute final agency action, which binds the agency determined responsible for the provision of necessary services. G. If neither the county department nor the mental health agency is deemed responsible for care by the panel; then the panel shall provide rational for their determination, the criteria for funding or services that are not being met and offer recommendations for other funding sources and treatment modalities.		

21.200.491	Section needs updating to align with updated statute	Subject to the availability of state appropriations, the community mental health center shall provide Child Mental Health Treatment Act services to youth who are eligible as defined in Sections 20.100 and 20.200. A. Child Mental Health Treatment Act services include, but are not limited to: 1. Clinical behavioral health assessments completed by a licensed mental health professional; 2. Community based services; 3. Care management services; 4. Coordination of residential treatment services; and, 5. Non-residential mental health transition services for youth. B. The community mental health center shall provide to the Department necessary Child Mental Health Treatment Act eligibility, service, and financial information in an agreed upon format. C. The community mental health center shall submit data to the Department as required per Section 27-67-105, C.R.S. D. The community mental health center shall provide or coordinate treatment services in collaboration with youth and families, and community based and residential care providers. E. The community mental health center shall determine the fee for the responsible person(s) and submit the financial agreement to the Department once signed by the responsible person(s) prior to state approval. F. If a child has been determined eligible under the Child Mental Health Treatment Act, the community mental health center shall submit a plan of care for approval to the Department prior to providing services. If necessary services are not immediately available, the community [mental] health center shall submit an alternative plan of care and provide interim services as appropriate. G. The community mental health center shall maintain a comprehensive clinical record for each child receiving services through Child Mental Health Treatment Act funding consistent with the Department's site review protocol. Such records shall be made available for review	[Reorganized as section 21.200.481] The mental health agency shall provide Children and Youth Mental Health Treatment Act funded services to children youth who are eligible as defined in sections 21.200.4. A. Children and Youth Mental Health Treatment Act services include, but are not limited to: 1. Clinical behavioral health assessments completed by a licensed mental health professional; 2. Community-based services; 3. Care management services; 4. Coordination of residential treatment services; and, 5. Non-residential mental health transition services for children youth. B. The mental health agency shall provide to the State Department necessary Children and Youth Mental Health Treatment Act eligibility, service, and financial information in an agreed upon format. C. The mental health agency shall submit data to the state department as required per section 27-67-105, C.R.S. D. The mental health agency shall provide or coordinate treatment services in collaboration with the child or youth, and families, and funded service providers. E. The mental health agency shall determine the fee for the responsible person(s) and submit the financial agreement to the State department once signed by the responsible person(s) before state approval. F. The mental health agency shall submit all eligibility assessments to the state department before funding approval or denial. G. If a child has been determined eligible under the Children and Youth Mental Health Treatment Act, the mental health agency shall submit a plan of care for approval to the state department before providing services. If necessary services are not immediately available, mental health agency shall submit an alternative plan of care and provide interim services as appropriate.	Align with updated statute	No

		by the Department. The individualized service plan in the clinical record shall reflect any services provided directly by the center, including any care management services provided and relevant documentation submitted by a third-party provider. The goal of those care management services may be, at least in part, to oversee the delivery of services by third party providers to assure that adequate progress is achieved, and may reference the state plan of care and the provider's clinical service plan.	H. The mental health agency shall maintain a comprehensive clinical record for each child receiving services through Children and Youth Mental Health Treatment Act funding consistent with 2 CCR 502-1. Such records shall be made available for review by the State Department. The individualized service plan in the clinical record shall reflect any services provided directly by the center, including any care management services provided and relevant documentation submitted by a third-party provider. The goal of those care management services may be, at least in part, to oversee the delivery of services by third-party providers to assure that adequate progress is achieved and may reference the state plan of care and the provider's clinical service plan.		
21.200.492	Section needs updating to align with updated statute	The Department shall be responsible for administering and regulating the provisions of the Child Mental Health Treatment Act. The responsibilities of the Department include: A. Ensuring the Child Mental Health Treatment Act is implemented statewide; B. Reviewing requests for funding and making recommendations regarding approval of service delivery related to plans of care for children who are at risk of out-of-home placement as defined in Section 20.200.41; C. The provision of technical assistance to community mental health centers, residential treatment providers, families and advocacy organizations regarding the technical and financial aspects of the Child Mental Health Treatment Act; D. Oversight and monitoring of service delivery for children receiving Child Mental Health Treatment Act funded services; E. Development and maintenance of dispute resolution processes; F. Management of the fiscal aspects of the Child Mental Health Treatment Act program; and, G. Data Collection and reporting.	[Reorganized as section 21.200.482] The State Department shall be responsible for administering and regulating the provisions of the Children and Youth Mental Health Treatment Act. The responsibilities of the State Department include: A. Ensuring the children and youth mental health treatment act is implemented state wide; B. Reviewing requests for funding and making determinations regarding approval of funded services; C. The provision of technical assistance to mental health agencies, residential treatment providers, families, and advocacy organizations, county departments, mental health providers, and other stakeholders regarding the technical and financial aspects of the Children and Youth Mental Health Treatment Act; D. Oversight and monitoring of service delivery for children receiving Children and Youth Mental Health Treatment Act funded services; E. Clinical oversight of Children and Youth Mental Health Treatment Act services; F. Development and maintenance of the appeal process; G. Development and maintenance of dispute resolution processes;	Align with updated statute	Yes, additional information in program report

			H. Management of the fiscal aspects of the Children and Youth Mental Health Treatment Act program; I. Data collection and public reporting.		

Title of Proposed Rule:	**Revisions to the Rules Implementing the Children and Youth Mental Health Treatment Act**	
CDHS Tracking #:	**18-08-15-01**	
Office, Division, & Program: Office of Behavioral Health, Division of Community Behavioral Health	Rule Author: Ryan Templeton	Phone: 303-866-7405 E-Mail: ryantempleton@state.co.us

STAKEHOLDER COMMENT SUMMARY

Development

The following individuals and/or entities were included in the development of these proposed rules (such as other Program Areas, Legislative Liaison, and Sub-PAC):

The Office of Behavioral Health worked collaboratively with the Child Mental Health Treatment Act Advisory Committee to establish the initial rule revision draft. Committee members and stakeholder involved in the creation of the rule revision draft include representatives from: Colorado Behavioral Healthcare Council, Colorado Hospital Association, Mental Health Colorado, Community Mental Health Centers, Federation of Families- Colorado, the ARC of Colorado, Colorado Counties Inc., Child Mental Health Treatment Act Advisory Committee, Health Care Policy and Financing, Division of Child Welfare, families, youth, residential child care facilities, Colorado Post-Adoption Resource Exchange, Colorado Association of Family and Children's Agencies, Children's Hospital Colorado.

This Rule-Making Package

The following individuals and/or entities were contacted and informed that this rule-making was proposed for consideration by the State Board of Human Services:

The Children and Youth Mental Health Treatment Act rule revision draft, along with a feedback survey was posted on the Colorado Department of Human Services website. The Office of Behavioral Health informed behavioral health stakeholders through direct contact and through the OBH monthly newsletter that the rule draft was available for review and feedback. Stakeholders specifically targeted for review and feedback on the proposed rule include: Colorado Behavioral Health Care Council; Colorado Hospital Association; Mental Health Colorado; Behavioral Health Transformation Council; Mental Health Disorders in the Criminal Justice System Task Force; Department of Public Health and Environment; Department of Regulatory Agencies; Department of Health Care Policy and Financing; Department of Public Safety; Disability Law Colorado; community mental health centers; community mental health clinics; hospitals; patient advocacy agencies; individuals and families with lived experience; and, law enforcement.

Other State Agencies

Are other State Agencies (such as HCPF or CDPHE) impacted by these rules? If so, have they been contacted and provided input on the proposed rules?

[X] Yes [ ] No

If yes, who was contacted and what was their input?

The Colorado Department of Health Care Policy and Financing were contacted and provided input on the proposed rule revisions. HCPF provided input on how Medicaid services align and differ from CYMHTA services to ensure two programs work collaboratively.

Sub-PAC

Have these rules been reviewed by the appropriate Sub-PAC Committee?

[ ] Yes [X] No

Name of Sub-PAC	Not applicable		
Date presented	Not applicable		
What issues were raised?	Not applicable		
Vote Count	*For*	*Against*	*Abstain*

Title of Proposed Rule:	**Revisions to the Rules Implementing the Children and Youth Mental Health Treatment Act**	
CDHS Tracking #:	**18-08-15-01**	
Office, Division, & Program: Office of Behavioral Health, Division of Community Behavioral Health	Rule Author: Ryan Templeton	Phone: 303-866-7405 E-Mail: ryantempleton@state.co.us

If not presented, explain why.	n/a	n/a	n/a
	There is not a Behavioral Health Sub-PAC, so the rule draft was presented to PAC on September 6, 2018 without a Sub-PAC review.		

PAC

Have these rules been approved by PAC?

[X] Yes [ ] No

Date presented	September 6, 2018		
What issues were raised?	No		
Vote Count	*For*	*Against*	*Abstain*
	Unanimous	0	0
If not presented, explain why.	Not applicable		

Other Comments

Comments were received from stakeholders on the proposed rules:

[X] Yes [ ] No

If "yes" to any of the above questions, summarize and/or attach the feedback received, including requests made by the State Board of Human Services, by specifying the section and including the Department/Office/Division response. Provide proof of agreement or ongoing issues with a letter or public testimony by the stakeholder.

Feedback	Response
[General Feedback] Where DHS is identified in the document, I would like to propose that the wording be State Department of Human Services, rather than DHS, as many lay people as well as professionals tend to equate DHS and Child Welfare as being one and the same.	The rules were updated to clarify what "department" was being referenced.
[Section 21.200.41] "Child at risk of out of home placement" letter C: "He or she", should likely read "child or youth". "face to face clinical assessment": the term continuous process is confusing. Just a formal process may be more clear. "Professional person": This should reference the statute if the intent is to mirror that (27-65-102). Is this level of workforce required by statute for the CYMHTA? Was this the standard prior to the 2018 legislation? It may be very limiting to exclude LCSWs, LPCs, and LMFTs. "Ability to Pay": How will mental health agencies assess for this with the family? If not a MHA responsibility, then how will the state/others assess for this? "Child at risk of out-of-home Placement" Section	• Section 21.200.41(C) was updated using "child or youth". • Continuously assessing an individual's treatment needs are a standard practice within behavioral health service provisions. • The definition for "professional person" aligns with statutory definition in Section 27-67-103(11), C.R.S. • "Ability to pay" is outlined in section 200.44.

C: Would undocumented children and youth, or otherwise ineligible for SSI, but not eligible for these services because of this provision? “Child at risk of out-of-home Placement” Section D: Is this change required by the 2018 legislation? This is a shift from the original language that may have limiting consequences. “Responsible Persons”: This may need to be re-evaluated now that the funding can extend beyond 18 years of age. This is true in general to answer several questions (who is responsible? Who signs agreements, notices, documents, appeals, etc., whos income is assess, etc.)	• The proposed rules align with the updated statute. • “Responsible Persons” is defined in statute.
[Section 21.200.41] Under Case Management definition: "verbally or in-person" do you mean via phone or in-person" Under Child at Risk section C: "he or she shall apply for supplemental security income, but any determination for supplemental security income must not be a criterion for a child or youth to receive funding" - is this more of a stipulation in the process versus part of the definition of an at rick child or youth?	• “Verbally” is not defined in order to provide more flexibility to the provider. • Applying for SSI is a statutory requirement established in the definition (27-67-103(2)(c), C.R.S.) for “child or youth at risk of out-of-home placement”.
[Section 21.200.41] How will "'appropriately" and "adequate" be defined in the section of "Care Management?" Please include a reference to a standard or define within the statue what appropriate treatment of a child/youth and what adequate progress is for a child/youth.	“Appropriately” was added to the rule to align with the statutory language. Statute does not define the word and the State Department determined that further definition would unnecessarily hinder provider flexibility to serve and treat children. The CYMHTA advisory committee agreed with this determination.
[Section 21.200.41] First Level Appeal, change "enact" with another word such as file or pursue	This definitions aligns with the statutory definition in section 27-67-103(8), C.R.S.
[Section 21.200.42] In Section A., retain the deleted provision regarding dependency or neglect actions shall not be required. . .	The proposed deleted section will remain deleted as the CYMHTA advisory committee and State Department determined that the deleted section is unnecessary and can cause confusion. The scope of the Act and CYMHTA program is defined in section 200.4.
[Section 21.200.42] Top of this section, it needs to read CYMHTA instead of CMHTA 21.200.42 A: Suggest this reads as “Providing care management and necessary	• The rules were updated address CYMHTA. • The State Department added

services that are clinically indicated and that may be appropriate for the child and family's needs" to ensure that decisions are clinically informed and indicated.	"clinically" based on this request.
[Section 21.200.42]...parents/guardians "believe" that their child is at-risk of out-of-home placement. What constitutes a belief? Will they have to have gone through a Deferred Response assessment with a child welfare agency to "believe" that their child is at risk for out-of-home placement? Or do they simply have to express that their child is beyond their control and ask for help, thus forgoing having to reach out to the child welfare agency? Please be clearer on the parameters for which parents may reach out for help under this act.	"Believe" is not defined and the proposed rules do not express that a child or family will need to go through any deferred response or have any child welfare interactions prior to CYMHTA services. The State Department and CYMHTA advisory committee determined that further definition is not necessary as doing so may lead of families not seeking funding due to a possible incorrect assumption that the child would not qualify for funding.
[Section 21.200.43] B. 1.: This is pretty unclear – who is the agency that is contracted for this work? How would the MHA know how to find them? What information would the MHA need to provide (just contact info?). This needs to be more clear and specific. D: When will the tool be implemented? What is the stakeholder process to select this tool? We strongly urge that the rule builds in some process for selecting the tool that is based on stakeholder feedback. We would caution the state in implementing a standardized tool and expecting it to fit all cases and models. H: The addition to this section should be separated out, as it refers to people who are already in the program while the existing language refers to eligibility determination. Mixing this language is confusing. Furthermore, the time frames are unclear and should mirror the statute requirements more closely. I: There would need to be updates made to the notification letter to reflect these changes. I.6: How will mental health agencies know this information?	• The State Department cannot answer the first question as the contractor has not been selected. It will be the Department's responsibly to notify all concerned stakeholders of the family advocate/navigator contract. • Tool: The State Department and CYMHTA advisory committee determined that the selected tool should not be named in rule as to do so would limited the State Department's ability to adjust the use of the tool once implemented. • Rule section 21.200.43(H) provides a procedure for informing the parents or guardian about potential changes to the services being provided. • Mental health agencies contracted to provide CYMHTA services will be required to follow these regulations and the Office of Behavioral Health provides technical assistance when needed.
[Section 21.200.43] Section G.1. include referral to a	• This rule section was rewritten.

crisis center as an option In Urgent situations Section H. instead of 5 business days make it 10 days to conform with Medicaid Rules.	The Office of Behavioral Health did not include specific referral providers, such as the crisis system, as this may limit utilization of other resources. • This timeframe is established in statutory Section 27-67-104, C.R.S.
[Section 21.200.44] B.3: This may sometimes actually be lower depending on circumstances. It may be helpful to add on a phrase saying "or as determined by the CYMHTA Manager" or something similar.	In the almost 20 years that the Act has been around, there is only been one request to lower the minimum amount. Rules are not written to each exception.
[Section 21.200.45] For Medicaid eligible kids, ensure the provisions square with Medicaid rules regarding a decrease or denial of services.	The proposed rule revisions were drafted in collaboration with representatives from the Department of Health Care Policy and Financing.
[Section 21.200.482] Provide each applicant with a written notice of the appeal and dispute resolution processes. Include stats on the number of denials reductions and terminations that are reversed by the Department.	Office of Behavioral Health reporting requirements are established in statute, Section 27-67-105, C.R.S. Rule section 21.200.482 addresses the general CYMHTA responsibility of the Colorado Department of Human Services, not necessarily the specifics of each responsibility.

(2 CCR 502-1)

21.200.4 ~~CHILD~~ CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT

These rules are intended to implement the mental health treatment services defined in the ~~Child~~ CHILDREN AND YOUTH Mental Health Treatment Act, Sections 27-67-101 through 27-67-108~~9~~, C.R.S., ~~subject to available appropriations,~~ to ensure the maximum use of appropriate least restrictive treatment services and to provide access to the greatest number of children. The purpose of the ~~Child~~ CHILDREN AND YOUTH Mental Health Treatment Act is to provide access to mental health treatment for eligible children who are Medicaid eligible as well as those who are at risk of out-of-home placement, as defined below. ~~In addition, t~~TheSE rules are intended to provide a sliding fee scale for responsible parties to offset the cost of care not covered by ~~private~~ COMMERCIAL insurance or THE FAMILY ~~Medicaid~~ provided under the ChildREN AND YOUTH Mental Health Treatment Act. Appeal procedures for denial of MEDICAID FUNDED RESIDENTIAL SERVICES, AND DENIAL OF CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT ~~residential and community mental health treatment~~ FUNDING are established in the rules as well as a dispute resolution process for county departments and mental health agencies.

21.200.41 Definitions

"Ability to Pay" means the amount of income and assets of the legally responsible person(s) available to pay for the individual cost of CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDED SERVICES~~. community mental health treatment and room and board for a child in residential treatment.~~

~~"BHO" means the Behavioral Health Organization responsible for implementing the Medicaid mental health capitation program through contract with the Colorado Department of Health Care Policy and Financing.~~

"Care Management" means arranging for continuity of care and coordinating the array of service necessary for APPROPRIATELY treating ~~the~~ A child OR YOUTH; communicating VERBALLY OR IN-PERSON with responsible individuals, and FUNDED providers at least every thirty (30) calendar days to assure services are being delivered as planned and adequate progress is being made; DISCHARGE PLANNING AND DEVELOPMENT; and the authority to rescind authorization for any treatment services with proper notice.

"Child at Risk of Out-of-Home Placement" means a child OR YOUTH ~~between the ages of zero (0) and his/her eighteenth (18th) birthday~~ who~~, although not otherwise categorically eligible for Medicaid,~~ meets the following criteria:

A. Has been diagnosed as a person with a mental HEALTH DISORDER ~~illness~~, as defined in Section 27-65-102(~~1~~411.5), C.R.S.;

B. Requires a level of care that is provided in a residential child care facility pursuant to Section 25.5-5-306, C.R.S., or that is provided through ~~in-home or~~ community-based programs and who, without such care, is at risk of UNWARRANTED CHILD WELFARE INVOLVEMENT OR OTHER SYSTEM INVOLVEMENT, AS DESCRIBED IN SECTION 27-67-102, IN ORDER TO RECEIVE FUNDING FOR TREATMENT; ~~further involvement with the county department;~~

C. If determined to be in need of placement in a residential child care facility OR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY, A CHILD OR YOUTH SHALL APPLY FOR SUPPLEMENTAL SECURITY INCOME, BUT ANY DETERMINATION FOR SUPPLEMENTAL SECURITY INCOME MUST NOT BE A CRITERION FOR A CHILD OR YOUTH TO RECEIVE FUNDING; ~~is determined to be eligible for Supplemental Security Income; and,~~

D. THE CHILD OR YOUTH IS A PERSON FOR WHOM THERE IS NO PENDING OR CURRENT ~~For whom it is inappropriate or unwarranted to file an~~ action in dependency or neglect pursuant to Article 3 of Title 19, C.R.S. AND;

(E) THE CHILD OR YOUTH IS YOUNGER THAN EIGHTEEN YEARS OF AGE AT TIME OF APPLYING, BUT HE OR SHE MAY CONTINUE TO REMAIN ELIGIBLE FOR SERVICES UNTIL HIS OR HER TWENTY-FIRST BIRTHDAY.

"Children who are categorically Medicaid eligible" HAS THE SAME MEANING AS DEFINED IN SECTION 25.5-5-101. ~~means a child between the ages of zero (0) and his/her eighteenth (18th) birthday UNDER THE AGE OF 18 who, with a covered mental health diagnosis, is eligible for services through the Capitated Single Entry Point System for Mental Health Services Program described in Section 25.5-5-411402, C.R.S.~~

"Community-Based Services" MEANS ANY INTERVENTION THAT IS DESIGNED TO BE AN ALTERNATIVE TO RESIDENTIAL OR HOSPITAL LEVEL OF CARE IN WHICH THE CHILD OR YOUTH RESIDES WITHIN A NON-INSTITUTIONAL SETTING AND includes, but is not limited to, therapeutic foster care, intensive in-home treatment, intensive case management, and day treatment.

"Community Mental Health Center", HAS THE SAME MEANING as defined in Section 27-66-101(2), C.R.S., ~~means either a physical facility or a group of services under unified administration or affiliated with one another, and includes at least the following services for the prevention and treatment of mental illness in persons residing in a particular community in or near the community mental health center or group so situated:~~

~~A. Inpatient services;~~

~~B. Outpatient services;~~

~~C. Partial hospitalization;~~

~~D. Emergency services; and,~~

~~E. Consultative and educational services.~~

"Cost of Care" includes residential and community-based ~~treatment~~ SERVICES not covered by ~~private~~ THE FAMILY, COMMERCIAL insurance, or Medicaid~~, and room and board~~.

"COUNTY DEPARTMENT" MEANS THE COUNTY OR DISTRICT DEPARTMENT OF HUMAN OR SOCIAL SERVICES.

“DEPENDENT” MEANS A PERSON WHO RELIES ON THE RESPONSIBLE PERSON(S) FOR FINANCIAL SUPPORT.

“Face to Face CLINICAL ASSESSMENT”~~,~~ for ~~the purpose of~~ this Section 21.200.4, means A FORMAL AND CONTINUOUS PROCESS OF COLLECTING AND EVALUATING INFORMATION ABOUT AN INDIVIDUAL FOR SERVICE PLANNING, TREATMENT, REFERRAL, AND FUNDING ELIGIBILITY. THIS INFORMATION ESTABLISHES JUSTIFICATION FOR SERVICES AND CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDING.~~that t~~The child is physically in the same room as the professional person. If the child is out of state or otherwise unable to participate in a face to face assessment, video technology may be used.

~~"County Department" means the county, or district, department of human/social services~~.

"FAMILY ADVOCATE" HAS THE SAME MEANING AS PROVIDED IN SECTION 27-69-102 (5).

"FAMILY SYSTEMS NAVIGATOR" HAS THE SAME MEANING AS PROVIDED IN SECTION 27-69-102 (5.5).

"FIRST-LEVEL APPEAL" MEANS THE INITIAL PROCESS A MEDICAID MEMBER IS REQUIRED TO ENACT TO CONTEST A BENEFIT, SERVICE, OR ELIGIBILITY DECISION MADE BY MEDICAID OR A MEDICAID MANAGED CARE ENTITY.

“Licensed Mental Health Professional” means a psychologist licensed pursuant to Section 12-43-301, et seq., C.R.S., a psychiatrist licensed pursuant to Section 12-36-101, et seq., C.R.S., a clinical social worker licensed pursuant to Section 12-43-401, et seq., C.R.S., a marriage and family therapist licensed pursuant to Section 12-43-501, et seq., a professional counselor licensed pursuant to Section 12-43-601, et seq., C.R.S., or a social worker licensed by pursuant to Section 12-43-401, et seq., C.R.S., that is supervised by a licensed clinical social worker.

“MEDICAID CHILD OR YOUTH WHO IS AT RISK OF OUT-OF-HOME PLACEMENT" MEANS A CHILD OR YOUTH WHO IS CATEGORICALLY ELIGIBLE FOR MEDICAID BUT WHO OTHERWISE MEETS THE DEFINITION OF A CHILD OR YOUTH WHO IS AT RISK OF OUT-OF-HOME PLACEMENT AS DEFINED ABOVE.

"Mental Health Agency" means A BEHAVIORAL HEALTH SERVICES CONTRACTOR THROUGH THE STATE DEPARTMENT OF HUMAN SERVICES SERVING CHILDREN AND YOUTH STATEWIDE OR IN A PARTICULAR GEOGRAPHIC AREA, INCLUDING BUT NOT LIMITED TO COMMUNITY MENTAL HEALTH CENTERS, AND WITH THE ABILITY TO MEET ALL EXPECTATIONS OF 21.200.4 AND 27-67-101. ~~the community mental health center serving children in a particular geographic area or the Behavioral Health Organization, serving children in a particular geographic area who are receiving Medicaid, under contract with the Colorado Department of Health Care Policy and Financing.~~

"Plan of Care" is a STATE Department developed document that at a minimum includes the anticipated frequency and costs of services to be provided for the duration of the plan of care. The plan of care is also a schedule of the fees to be paid by the responsible person including, but not limited to, the estimated amount of Supplemental Security Income payable to the residential ~~treatment~~ facility IF AWARDED TO THE CHILD AT RISK OF OUT-OF-HOME PLACEMENT or ANother provider, and sliding scale fees payable to the contractor, if applicable.

"PROFESSIONAL PERSON" MEANS A PERSON LICENSED TO PRACTICE MEDICINE IN THIS STATE, A PSYCHOLOGIST CERTIFIED TO PRACTICE IN THIS STATE, OR A PERSON LICENSED AND IN GOOD STANDING TO PRACTICE MEDICINE IN ANOTHER STATE OR A PSYCHOLOGIST CERTIFIED TO PRACTICE AND IN GOOD STANDING IN ANOTHER STATE WHO IS PROVIDING MEDICAL OR CLINICAL SERVICES AT A TREATMENT FACILITY IN THIS STATE THAT IS OPERATED BY THE ARMED FORCES OF THE UNITED STATES, THE UNITED STATES PUBLIC HEALTH SERVICE, OR THE UNITED STATES DEPARTMENT OF VETERANS AFFAIRS.

~~"Resident" means a child receiving residential mental health treatment under the Child Mental Health Treatment Act.~~

"Residential Treatment" means services provided by a residential child care facility or psychiatric residential treatment facility licensed as a residential child care facility pursuant to Section 26-6-102(8), C.R.S., which has been approved by the STATE Department to provide mental health treatment.

"Responsible Persons" means parent(s) or legal guardian(s) of a minor.

“STATE DEPARTMENT" MEANS THE STATE DEPARTMENT OF HUMAN SERVICES.

21.200.42 ChildREN AND YOUTH Mental Health Treatment Act Program Description

The ~~Child~~CHILDREN AND YOUTH Mental Health Treatment Act allows parents or guardians to apply to a mental health agency on behalf of their minor child for mental health treatment services ~~whether the child is categorically eligible for Medicaid under the capitated mental health system, or whether~~ WHEN the parents or guardians believe his or her child is at risk for out-of-home placement, as defined in Section 21.200.41.

A. For children who are not categorically eligible FOR MEDICAID at the time services are requested, the ~~community mental health center~~MENTAL HEALTH AGENCY is responsible for clinically assessing the child and providing care management and necessary ~~treatment~~ services~~, including any community-based mental health treatment, other family preservation services, residential treatment or any post-residential follow-up service~~ that may be CLINICALLY appropriate for the child's and family's needs. ~~A dependency or neglect action pursuant to Article 3 of Title 19, C.R.S., shall not be required in order to allow a family access to residential or community-based mental health treatment services for a child.~~

~~B. For children who are categorically eligible for Medicaid as defined Section 21.200.41, the BHO is responsible for clinically assessing the child and providing care management and necessary treatment services, including any community based mental health treatment, other family preservation services, residential treatment or any post-residential follow-up service that may be appropriate for the child's and family's needs.~~

~~C.~~ B. The ChildREN AND YOUTH Mental Health Treatment Act~~, Sections 27-67-101 through 27-67-108, C.R.S.,~~ provides ~~appeal processes~~A SECOND OPINION for THE RESPONSIBLE PERSON(S) ~~parents or guardians~~ when services are denied OR TERMINATED FOR A MEDICAID CHILD OR YOUTH WHO IS AT RISK OF OUT-OF-HOME PLACEMENT OR A CHILD OR YOUTH SEEKING FUNDING UNDER THIS ACT.

~~D.~~ C. ~~and to~~THE CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT r~~R~~esolveS disputes between mental health agencies and county departments WHEN A CHILD IS SEEKING OR RECEIVING FUNDING THROUGH THE CHILD AND YOUTH MENTAL HEALTH TREATMENT ACT.

D. The ChildREN AND YOUTH Mental Health Treatment Act authorizes funding for services for children at risk of out-of-home placement, which are not covered by ~~private~~ COMMERCIAL insurance, Medicaid, or the family~~'s share~~.

21.200.43 Application for ~~Mental Health Treatment for Children~~ FUNDING FROM THE CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT

A. A responsible person may apply to a mental health agency on behalf of his or her minor child for mental health treatment.

B. AT ANY POINT IN APPLYING FOR, APPEALING, OR RECEIVING CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDING THE RESPONSIBLE PERSON(S) MAY REQUEST THE ASSISTANCE FROM A FAMILY ADVOCATE, FAMILY SYSTEM NAVIGATOR, NONPROFIT ADVOCACY ORGANIZATION, OR COUNTY DEPARTMENT.

1. THE MENTAL HEALTH AGENCY SHALL PROVIDE THE CONTACT INFORMATION FOR THE ORGANIZATION CONTRACTED WITH THE STATE DEPARTMENT TO PROVIDE THESE SERVICES, FREE OF CHARGE, TO THE RESPONSIBLE PERSON(S) BEFORE AN INITIAL EVALUATION.

2. THE STATE DEPARTMENT IS NOT OBLIGATED TO PAY FOR ANY SERVICES PROVIDED BY ENTITIES WITH WHICH THEY DO NOT CONTRACT.

~~B.~~ C. The mental health agency ~~will~~ SHALL evaluate the child and clinically assess the child's need for mental health services. When warranted, ~~treatment~~ FUNDING FOR services will be provided as may be necessary and in the best interests of the child and the child's family.

D. WHEN COMPLETING A FACE TO FACE CLINICAL ASSESSMENT FOR A CHILD OR YOUTH, THE MENTAL HEALTH AGENCY SHALL USE A STANDARDIZED RISK STRATIFICATION TOOL, IN A MANNER, DETERMINED BY THE STATE DEPARTMENT. DETERMINATION OF THE ASSESSMENT FOR LEVEL OF CARE NEED AND ELIGIBILITY NEED WILL BE COMPLETED JOINTLY BY THE MENTAL HEALTH AGENCY AND THE STATE DEPARTMENT.

E. WHEN EVALUATING A CHILD OR YOUTH FOR ELIGIBILITY, THE MENTAL HEALTH AGENCY SHALL EVALUATE ALL AREAS OUTLINED IN 21.190.

~~C.~~ F. ~~Subject to available appropriations, t~~The mental health agency shall be responsible for the provision of care management and necessary ~~treatment~~ services, including any community-based mental health treatment, ~~other family preservation services,~~ residential treatment, or any ~~pre- or post-residential~~ service~~s~~ that may be appropriate for the child's or family's needs.

~~D.~~ G. A face to face clinical assessment AND ELIGIBILITY DETERMINATION ~~and decision regarding request for treatment~~ shall be COMPLETED ~~performed by the mental health agency~~ within the following time periods after a request for ~~mental health treatment~~ FUNDING has been made by a responsible person(S).

~~1. Emergency situation, defined as a condition that appears to require unscheduled, immediate or special mental health intervention in response to a crisis situation involving the risk of imminent harm to the person or others. Emergency situation evaluations shall be completed within six (6) business hours of the initial assessment request.~~

~~2.~~ 1. Urgent situation, defined as a condition that ~~appears to,~~ IS LIKELY TO ESCALATE TO A SITUATION IN WHICH THE CHILD MAY BECOME A DANGER TO THEMSELVES OR OTHERS AND REQUIRE A CLINICAL ASSESSMENT WITHIN TWENTY-FOUR (24) HOURS. ~~if not addressed within twenty-four (24) hours, be likely to escalate to an emergency situation.~~ Urgent situation evaluations shall be completed BY THE MENTAL HEALTH AGENCY within twenty-four (24) hours, one business day, of the initial assessment request BY THE RESPONSIBLE PERSON(S). THE MENTAL HEALTH AGENCY SHALL CONTINUE TO PROVIDE CARE MANAGEMENT WHILE FUNDED SERVICES ARE IDENTIFIED AND PROVIDED.

~~3.~~ 2. Routine situations, defined as all other situations, shall be completed within three (3) business days of the initial assessment request.

~~4.~~ 3. If the mental health agency requires additional time to make a decision following an assessment and the responsible person agrees, then the mental health agency may take up to, but no more than, fourteen (14) calendar days to provide a decision. If the responsible person does not agree, the notification timelines referenced above remain in effect.

~~E.~~ H. The mental health agency'S decision shall be communicate~~d~~ verbally and in writing to the responsible person(S) within the time allowed for the completion of the evaluation OR AT LEAST 5 (FIVE) BUSINESS DAYS BEFORE THE REDUCTION, INCREASE OR TERMINATION OF FUNDED SERVICES. Verbal notice shall be face to face with the responsible person when possible.

I. The written decision shall contain THE FOLLOWING:

1. ~~n~~Notice of the applicable criteria for mental health treatment~~.~~;

2. ~~t~~The factual basis for the decision~~.~~;

3. ~~t~~The appeals procedures PURSUANT TO THE GRIEVANCE REQUIREMENTS IN SECTION 21.180;

4. IF APPROVED, NOTICE THAT THE RESPONSIBLE PERSON(S) MAY CHOOSE TO SEEK SERVICES FROM THE PROVIDER OF THEIR CHOICE, INCLUDING BUT NOT LIMITED TO THE MENTAL HEALTH AGENCY.

5. NOTICE THAT THE RESPONSIBLE PERSON(S) MAY REQUEST ASSISTANCE FROM A FAMILY ADVOCATE, FAMILY SYSTEM NAVIGATOR, NONPROFIT ADVOCACY ORGANIZATION, OR COUNTY DEPARTMENT IN APPLYING FOR, RECEIVING, OR APPEALING CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDING AND APPLYING FOR SUPPLEMENTAL SECURITY INCOME;

6. THE CONTACT INFORMATION FOR AN ORGANIZATION CONTRACTED BY THE STATE DEPARTMENT TO PERFORM FAMILY ADVOCACY OR FAMILY SYSTEM NAVIGATION;

7. NOTICE THAT THE CONTRACTED ADVOCACY PROVIDER IS NOT ALLOWED TO CHARGE THE FAMILY A FEE;

8. NOTICE THAT THE STATE DEPARTMENT IS NOT OBLIGATED TO PAY FOR ANY SERVICE PROVIDED BY ENTITIES WITH WHICH THEY DO NOT CONTRACT; AND,

9. ~~and a~~ A statement for the responsible person to sign, indicating that they agree with the decision or that they disagree and wish to file an appeal.

21.200.44 Process of Determining Ability to Pay and Adjusted Charge for Treatment Services ~~Provided to Children at Risk of Out-of-Home Placement~~

A. The ~~community mental health center~~ MENTAL HEALTH AGENCY shall determine the cost of care for children ~~in this program~~ AND YOUTH THAT RECEIVE FUNDING THROUGH THE CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT. ALL Insurance and other ELIGIBLE benefits shall be applied first to the cost of care. ~~Medicaid is the payer of last resort and will be provided, if the child is eligible, if other insurance coverage is not available. Insurance and other benefits for any resident shall be billed at the full cost of care.~~ A responsible person(s) 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. The MENTAL HEALTH AGENCY SHALL DETERMINE THE responsible person(s)' ability to pay for ~~residential treatment~~ SERVICES BASED ON THE FOLLOWING: ~~shall be calculated using material based on the "Colorado Child Support Guideline" and the "Schedule of Basic Child Support Obligations," as found in Section 14-10-115, C.R.S., and the Department's Child Support Enforcement rules (9 CCR 2504-1).~~

1. PER MONTH, THE MENTAL HEALTH AGENCY SHALL COLLECT 7% OF THE TOTAL COST OF ALL CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDED SERVICES FROM THE RESPONSIBLE PERSON EXCLUDING THE COSTS OF the INITIAL ASSESSMENT AND ALL CARE MANAGEMENT;

2. If THE RESPONSIBLE PERSON(S) IS UNABLE TO PAY THE FULL AMOUNT, THE MENTAL HEALTH AGENCY SHALL CONSIDER THE RESPONSIBLE PERSON(S) TOTAL NUMBER OF DEPENDENTS, THE MENTAL HEALTH NEEDS OF THOSE DEPENDENTS, ALL CURRENT OUTSTANDING MEDICAL LIABILITIES, EXPECTED LENGTH OF SERVICES, AND THE EDUCATION COSTS FOR THE DEPENDENTS. THE MENTAL HEALTH AGENCY SHALL RECEIVE APPROVAL OR DENIAL FROM THE STATE DEPARTMENT FOR ALL FEE ADJUSTMENTS;

3. THE MENTAL HEALTH AGENCY SHALL COLLECT NO LESS THAN $50 PER MONTH FROM THE RESPONSIBLE PERSON;

C. The mental health agency shall collect fees directly from THE RESPONSIBLE(S) PERSON;

~~C. The fee for community-based services shall be based on the income of the "responsible persons" defined in Section 21.200.41, using the "Uniform Method of Determining Ability to Pay" (2 CCR 501-1).~~

~~The cost of home and community based services shall not exceed fifty percent (50%) of that which would have been charged to the responsible persons for residential treatment.~~

D. The ~~treating facility and/Or~~ FUNDED provider may reserve the right to take any necessary action regarding delinquent payments by the responsible person(s);

~~E. The charge to the responsible person(s) 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 responsible person(s) does not cooperate in making insurance and other benefits available, the 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.~~

~~F.~~ E. The responsible person(s) ~~must~~ SHALL sign a financial agreement indicating an understanding of their financial responsibilities as described ~~in A-E~~, above, ~~in order~~ to be eligible for funding through the ChildREN AND YOUTH Mental Health Treatment Act;

~~G.~~ F. Within ten (10) business days after the child's admission to ~~the~~ residential treatment ~~facility~~, the responsible person(S) SHALL ~~must~~ apply for Supplemental Security Income (SSI) on behalf of a child ~~at risk of out-of-home placement~~ approved for ~~treatment~~ FUNDING under the ChildREN AND YOUTH Mental Health Treatment Act;

G. IF AWARDED SUPPLEMENTAL SECURITY INCOME; THE RESPONSIBLE PERSON(S) SHALL DISCLOSE THE AWARD AMOUNT TO THE MENTAL HEALTH AGENCY AS DETERMIEND BY THE SOCIAL SECURITY ADMINISTRATION REGULATIONS;

H. IF AWARDED SUPPLEMENTAL SECURITY INCOME AND THE CHILD HAS DISCHARGED FROM RESIDENTIAL SERVICES, THE REASONABLE PERSON(S) SHALL NOTIFY THE SOCIAL SECURITY ADMINISTRATION IMMEDIATELY;

I. IF AWARDED SUPPLEMENTAL SECURITY INCOME, THE CHILD WILL ALSO BE AWARDED MEDICAID WHICH WILL FUND TREATMENT COSTS WHILE IN RESIDENTIAL. THE PARENTAL FEE, SUPPLEMENTAL SECURITY INCOME, ALL OTHER FUNDING SOURCES, AND THE CHILD AND YOUTH MENTAL HEALTH TREATMENT ACT WILL FUND ROOM AND BOARD;

J. IF DENIED SUPPLEMENTAL SECURITY INCOME; THE CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT WILL FUND ROOM AND BOARD AND BEHAVIORAL HEALTH TREATMENT SERVICES THAT WOULD OTHERWISE HAVE BEEN FUNDED BY SUPPLEMENTAL SECURITY INCOME AND MEDICAID.

~~H. The responsible person must pay the monthly parental fee to the facility.~~

~~**21.200.45 Process of Determining Funding for Children who are Categorically Eligible for Medicaid [Eff. 11/1/13]**~~

~~As outlined in Section 8.212 of the Colorado Department of Health Care Policy and Financing's Medical Assistance rules (10 CCR 2505-10), costs and services are managed by the corresponding behavioral health organization for children who are categorically eligible for Medicaid at the time treatment is requested.~~

21.200.45 ~~21.200.46 Dispute Resolution for~~ APPEAL OF THE REDUCTION, TERMINATION, AND ~~D~~denial of Mental Health SERVICES FUNDED BY THE CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT ~~Treatment for Children at Risk of Out-of-Home Placement~~

A. Except as provided below, the ~~community mental health center~~ MENTAL HEALTH AGENCY shall follow the formalized ~~appeal~~ NOTIFICATION process ~~that the agency has established pursuant to the grievance requirements in Section 21.180 if the child is at risk of out-of-home placement,~~ as defined in Section 21.200.41 THROUGH 21.200.43.

B. A RESPONSIBLE PERSON(S) MAY REQUEST AN APPEAL OF A DECREASE, INCREASE, OR DENIAL OF CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUND SERVICES OR A RECOMMENDATION THAT A CHILD BE DISCHARGED FROM FUNDED SERVICES, AND THE FOLLOWING SHALL APPLY:

1. IF THE RESPONSIBLE PERSON(S) NOTIFIES THE MENTAL HEALTH AGENCY OF A DESIRE TO APPEAL A DECISION BEFORE TERMINATION OF SERVICES, THE STATE DEPARTMENT AND THE MENTAL HEALTH AGENCY SHALL CONTINUE TO FUND SERVICES UNTIL THE APPEAL PROCESS BELOW HAS BEEN EXHAUSTED.

2. THE RESPONSIBLE PERSON(S) SHALL NOTIFY THE MENTAL HEALTH AGENCY VERBALLY OR IN WRITING WITHIN FIFTEEN (15) BUSINESS DAYS OF NOTICE OF ACTION OF A DESIRE TO APPEAL A DECISION;

3. THE MENTAL HEALTH AGENCY SHALL HAVE TWO (2) BUSINESS DAYS WITHIN WHICH TO COMPLETE AN INTERNAL APPEAL REVIEW PROCESS AND COMMUNICATE A DECISION TO THE RESPONSIBLE PERSON(S) VERBALLY AND IN WRITING.

4. THE MENTAL HEALTH AGENCY'S NOTICE OF ACTION SHALL CONTAIN THE INFORMATION REQUIRED IN SECTION 21.200.43, E, ALONG WITH THE PROCESS FOR CLINICAL REVIEW IN SECTION 21.200.46, C-E BELOW.

C. IF THE MENTAL HEALTH AGENCY REQUIRES MORE THAN TWO (2) BUSINESS DAYS TO COMPLETE THE INTERNAL REVIEW, AND THE RESPONSIBLE PERSON(S) IS IN AGREEMENT, THEN THE MENTAL HEALTH AGENCY MAY TAKE UP TO BUT NO MORE THAN FIVE (5) BUSINESS DAYS TO COMPLETE THE REVIEW.

~~B. If the responsible person(s) requests an appeal of a denial of treatment or a recommendation that a child be discharged from services, either in writing or verbally within fifteen (15) business days of notice of action, the mental health agency shall have two (2) business days within which to complete the internal appeal review process and communicate a decision to the responsible person(s) verbally in person when possible and in writing. Said notice shall contain the information required in Section 21.200.43, E, along with the process for clinical review in Section 21.200.46, C-E, below. If the community mental health center requires more than two (2 business days to complete its internal review and the responsible person(s) is in agreement, then the community mental health center may take up to but no more than five (5) business days to complete the review. If the responsible party is not agreeable, the two (2) business day timeline discussed above will remain in effect.~~

~~C.~~ D. Within five (5) business days after the ~~community mental health center's~~ MENTAL HEALTH AGENCY'S final denial of requested services or recommendation that the child be discharged from treatment, the responsible person(s) may request a clinical review of the need for services by an objective third party, at the STATE Department, who is an independent professional person as that term is defined in Section 27-65- 102(11), C.R.S., to review the action of the ~~community mental health center~~ MENTAL HEALTH AGENCY. Such a request may be verbal or in writing, but if completed verbally it must be confirmed in writing, and shall be made to the Director of the Office of Behavioral Health or the OFFICE'S consumer and ~~Office's~~ family affairs specialist.

~~D.~~ E. Unless waived by the responsible person(s), said clinical review shall include:

1. A review of the ~~community mental health center's~~ MENTAL HEALTH AGENCY'S denial of services;

2. A face to face evaluation of the child~~,~~ so long as the responsible person(s) arranges transportation of the child for the evaluation; and,

3. A review of the evidence provided by the responsible person(s). The responsible person(s) shall be advised of the name and credentials of the reviewing professional, as well as any mental health agency affiliations of the reviewing professional. The responsible person(s) shall have an opportunity to request an alternate reviewing professional at the STATE Department at that time, so long as any delay caused by the request is waived by the responsible person(s) as described below.

~~E.~~ F. Within three (3) ~~working~~ BUSINESS days of the receipt of the request for clinical review, a decision shall be communicated verbally and in writing by the professional person to the responsible person(s), STATE Department, and the MENTAL HEALTH AGENCY ~~community mental health center~~. The written decision shall include the relevant criteria and factual basis. If the clinical review finds residential or community-based ~~treatment~~ SERVICES to be necessary AND THAT CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDING IS NECESSARY, the mental health agency shall provide ~~treatment~~ SERVICES to the child within twenty-four (24) hours of THE said decision. If residential treatment is not available within twenty-four hours and placement in residential treatment is recommended, the state level review must recommend appropriate alternatives including emergency hospitalization, if appropriate, if the child is in need of immediate placement out of the home.

~~F.~~ G. If the professional person requires more than three (3) ~~working~~ BUSINESS days to complete the ~~face to face evaluation~~ CLINICAL REVIEW, or if the responsible person(s) requires more time to obtain evidence for the clinical review, the responsible person(s) may waive the three day deadline above, so long as said waiver is confirmed in writing. In any event, the face to face evaluation and the clinical review shall be completed within six (6) ~~working~~ BUSINESS days.

~~G.~~ H. The STATE Department ~~review~~ DECISION shall constitute final agency action for FUNDING THROUGH THE CHILDREN AND YOUTH MENTAL HEALTH TREATMENT ACT. ~~non-Medicaid CMHTA eligible children.~~

21.200.46 ~~21.200.47~~ ~~Dispute Resolution Process for Denial of Mental Health Treatment for Children Who Are Categorically Eligible for~~ Third Party Review Process for a Medicaid Child or Youth

~~A. For children who are categorically eligible for Medicaid, the responsible person(s) may request an appeal of a denial of treatment pursuant to the Medicaid "recipient appeals" process found at Section 8.057 of the Colorado Department of Health Care Policy and Financing's Medical Assistance rules (10 CCR 2505-10).~~ A MEDICAID CHILD OR YOUTH**,** A RESPONSIBLE PERSON MAY REQUEST AN OBJECTIVE THIRD PARTY CLINICAL REVIEW WITHIN 5 BUSINESS DAYS AFTER ALL FIRST-LEVEL MEDICAID APPEALS PROCESSES ARE EXHAUSTED (IN ACCORDANCE WITH SECTION 8.057 OR 8.209 OF THE COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING'S MEDICAL ASSISTANCE RULES [10 CCR 2505-10]). THE REVIEW MUST BE CONDUCTED BY A PROFESSIONAL PERSON AS OUTLINED IN SECTION 21.200.46 WITHIN 3 BUSINESS DAYS OF THE DATE OF REQUEST. THIS REVIEW DOES NOT OBLIGATE FUNDING OF SERVICES.

~~B. For children who are categorically eligible for Medicaid, the responsible person(s) may request a clinical review by the Department as outlined in Section 21.200.46.~~

21.200.47 ~~21.200.48~~ Dispute Resolution Process between County Departments and Mental Health Agencies

A. If a dispute exists between a mental health agency and a county department ~~of human/social services~~ regarding whether mental health services should be ~~provided~~ FUNDED under the ChildREN AND YOUTH Mental Health Treatment Act or by the county department, one or both may request the ~~Colorado Department of Human Services~~ COLORADO Office of Behavioral Health, to convene a review panel consisting of family advocates, the Colorado ~~Department of Human Services,~~ Division of Child Welfare, the ~~Colorado Department of Human Services,~~ Office of Behavioral Health, an independent ~~community mental health center~~ MENTAL HEALTH AGENCY IF AVAILABLE, AN INDEPENDENT PROFESSIONAL PERSON, AND an independent county department ~~of human/social services and, when applicable, the Colorado Department of Health care Policy and Financing~~ to provide dispute resolution. THE INDEPENDENT AGENCIES AND INDIVIDUALS SHALL DOCUMENT THAT NO CONFLICT OF INTEREST EXIST PERTAINING TO THE SPECIFIC CHILD BEING REVIEWED.

B. The request to invoke the dispute resolution process shall be in writing and submitted within five (5) calendar days of either agency recognizing ~~that~~ a dispute exits.

C. The written request for dispute resolution shall include, at a minimum, the following information:

1. The county department and mental health agency involved in the dispute, including a contact person at each;

2. The child's name~~,~~ AND age~~, and address~~;

3. The responsible person(s) address, phone number, and e-mail address;

4. Pertinent information regarding the child including, but not limited to, medical or mental health status/assessment;

5. The reason for the dispute, any efforts to resolve the matter locally, and any pertinent information regarding the child;

6. Information about the child's mental health status pertaining to the dispute; and,

7. The responsible person(s) perspective on the matter, if known.

~~D. Within ten (10) calendar days of receiving the dispute resolution request, the Department shall convene a review panel in order for each side to present their position.~~

~~E.~~ D. The STATE Department shall provide notice to both agencies that the STATE Department will resolve the dispute EITHER VERBALLY OR IN WRITING.

~~F.~~ E. Each side will have an opportunity to present its position to the review panel. Interested parties will be allowed to present written or oral testimony at the discretion of the review panel.

~~G.~~ F. ~~After both agencies present their positions, and other parties present as appropriate,~~ The review panel shall have five (5) ~~working~~ BUSINESS days to COMPLETE THE DISPUTE PROCESS AND issue its determination in writing to the disputing agencies AND THE RESPONSIBLE PERSON(S). The review panel's decision shall constitute final agency action, which binds the agency determined responsible for the provision of necessary services.

G. IF THE PANEL DEEMS THAT NEITHER THE MENTAL HEALTH AGENCY NOR THE COUNTY DEPARTMENT IS RESPONSIBLE FOR THE PROVISION OF FUNDING FOR THE TREATMENT OF THE CHILD, THEN THE PANEL SHALL PROVIDE A RATIONALE FOR THEIR DETERMINATION . THE PANEL SHALL OFFER RECOMMENDATIONS FOR OTHER FUNDING SOURCES AND TREATMENT MODALITIES.

21.200.48 ~~21.200.49~~ Responsibilities

21.200.481 ~~21.200.491~~ Responsibilities of ~~Community Mental Health Centers~~ MENTAL HEALTH AGENCIES

~~Subject to the availability of state appropriations, the community mental health center~~ THE MENTAL HEALTH AGENCY shall provide ChildREN AND YOUTH Mental Health Treatment Act FUNDED services to CHILDREN youth who are eligible as defined in Sections ~~20.100 and 20.200.~~ 21.200.4.

A. ChildREN AND YOUTH Mental Health Treatment Act services include, but are not limited to:

1. Clinical behavioral health assessments completed by a licensed mental health professional;

2. Community~~-~~based services;

3. Care management services;

4. Coordination of residential treatment services; and,

5. Non-residential mental health transition services for CHILDREN youth.

B. The ~~community mental health center~~ MENTAL HEALTH AGENCY shall provide to the STATE Department necessary ChildREN AND YOUTH Mental Health Treatment Act eligibility, service, and financial information in an agreed upon format.

C. The ~~community mental health center~~ MENTAL HEALTH AGENCY shall submit data to the STATE Department as required per Section 27-67-105, C.R.S.

D. The ~~community mental health center~~ MENTAL HEALTH AGENCY shall provide or coordinate treatment services in collaboration with THE CHILD OR youth, ~~and~~ families, and FUNDED SERVICE ~~community based and residential care~~ providers.

E. The ~~community mental health center~~ MENTAL HEALTH AGENCY shall determine the fee for the responsible person(s) and submit the financial agreement to the STATE Department once signed by the responsible person(s) ~~prior to~~ BEFORE state approval.

F. THE MENTAL HEALTH AGENCY SHALL SUBMIT ALL ELIGIBILITY ASSESSMENTS TO THE STATE DEPARTMENT BEFORE FUNDING APPROVAL OR DENIAL.

~~F.~~ G. If a child has been determined eligible under the ChildREN AND YOUTH Mental Health Treatment Act, the ~~community mental health center~~ MENTAL HEALTH AGENCY shall submit a plan of care for approval to the STATE Department ~~prior to~~ BEFORE providing services. If necessary services are not immediately available, ~~the community mental health center~~ MENTAL HEALTH AGENCY shall submit an alternative plan of care and provide interim services as appropriate.

~~G.~~ H. The ~~community mental health center~~ MENTAL HEALTH AGENCY shall maintain a comprehensive clinical record for each child receiving services through ChildREN AND YOUTH Mental Health Treatment Act funding consistent with 2 CCR 502-1 ~~the Department's site review protocol~~. Such records shall be made available for review by the STATE Department. The individualized service plan in the clinical record shall reflect any services provided directly by the center, including any care management services provided and relevant documentation submitted by a third-party provider. The goal of those care management services may be, at least in part, to oversee the delivery of services by third~~-~~party providers to assure that adequate progress is achieved and may reference the state plan of care and the provider's clinical service plan.

21.200.482 ~~21.200.492~~ Responsibilities of the Department

The STATE Department shall be responsible for administering and regulating the provisions of the ChildREN AND YOUTH Mental Health Treatment Act. The responsibilities of the STATE Department include:

A. Ensuring the ChildREN AND YOUTH Mental Health Treatment Act is implemented state-wide;

B. Reviewing requests for funding and making ~~recommendations~~ DETERMINATIONS regarding approval of FUNDED serviceS ~~delivery related to plans of care for children who are at risk of out-of-home placement as defined in Section 20.200.41~~;

C. The provision of technical assistance to ~~community mental health centers~~ MENTAL HEALTH AGENCIES, residential treatment providers, families, ~~and~~ advocacy organizations, COUNTY DEPARTMENTS, MENTAL HEALTH PROVIDERS, AND OTHER STAKEHOLDERS regarding the technical and financial aspects of the ChildREN AND YOUTH Mental Health Treatment Act;

D. Oversight and monitoring of service delivery for children receiving ChildREN AND YOUTH Mental Health Treatment Act funded services;

E. OVERSIGHT OF THE APPROPRIATENESS OF FUNDED SERVICES, SERVICE STANDARDS, AND SERVICE EXPECTATIONS OF CHILD AND YOUTH MENTAL HEALTH TREATMENT ACT FUNDED SERVICES;

F. DEVELOPMENT AND MAINTENANCE OF THE APPEAL PROCESS;

~~E.~~ G. Development and maintenance of dispute resolution processes;

~~F.~~ H. Management of the fiscal aspects of the ChildREN AND YOUTH Mental Health Treatment Act program;

~~G.~~ I. Data Collection and PUBLIC reporting.

Notice of Proposed Rulemaking

Tracking number

2018-00516

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

11/01/2018

Time

02:00 PM

Location

1560 Broadway, Ste 110 D, Denver CO 80202

Subjects and issues involved

4-2-43 - ENROLLMENT PERIODS RELATING TO INDIVIDUAL AND GROUP HEALTH BENEFIT PLANS - The purpose of this regulation is to establish rules governing enrollment periods for individual and group health benefit plans in accordance with Article 16 of Title 10 of Colorado Revised Statutes and the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), together referred to as the Affordable Care Act (ACA).

Statutory authority

§§ 10-1-109, 10-16-105(2)(b), 10-16-105.7(1)(e), 10-16-105.7(3)(a)(II)(G), 10-16-105.7(3)(b)(II)(F), 10-16-105.7(3)(c), 10-16-108.5(8), and 10-16-109, C.R.S.

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DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Proposed Amended Regulation 4-2-43

ENROLLMENT PERIODS RELATING TO INDIVIDUAL AND GROUP HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105(2)(b), 10-16-105.7(1)(e), 10-16-105.7(3)(a)(II)(G), 10-16-105.7(3)(b)(II)(F), 10-16-105.7(3)(c), 10-16-108.5(8), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules governing enrollment periods for individual and group health benefit plans in accordance with Article 16 of Title 10 of Colorado Revised Statutes and the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), together referred to as the "Affordable Care Act" (ACA).

The Commissioner finds that the volatility and uncertainty within the individual insurance market, and the potential for consumer harm, constitute a triggering and event requiring a special enrollment period, as specified in Section 7, to reduce the potential for consumer harm and ensure the continued health and stability of the Colorado health insurance market. This regulation replaces emergency regulation 18-E-04 in its entirety.

~~The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary for the preservation of public health, safety, or welfare, in order to ensure consumers and carriers are aware of the upcoming open enrollment dates for the 2019 plan year; to decrease the volatility of the individual health insurance market through the implementation of a special enrollment period to allow consumers sufficient time to enroll in an individual health benefit plan; and to ensure compliance with the federal open enrollment period dates for the 2019 plan year. Therefore, compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interest. This emergency regulation replaces in its entirety Colorado Insurance Regulation 4-2-43 that became effective on December 1, 2017.~~

Section 3 Applicability

This regulation shall apply to all carriers offering individual and/or group health benefit plans subject to the individual and/or group laws of Colorado and the requirements of the ACA.

Section 4 Definitions

A. “Calendar year” means, for the purpose of this regulation, a year beginning on January 1 and ending on December 31.

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

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

D. “Days” mean, for the purpose of this regulation, calendar days, not business days.

E. “Designated beneficiary agreement” shall have the same meaning as found at § 15-22-103(2), C.R.S.

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

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

H. “Qualified health plan” or “QHP” means, for the purposes of this regulation, a health benefit plan that has been reviewed and approved by the Division of Insurance as meeting the standards necessary to be considered an ACA-compliant health benefit plan.

I. “Qualified individual” means, for the purpose of this regulation, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Section 5 Individual Enrollment Periods

A. Carriers offering individual health benefit plans must accept every eligible individual who applies for coverage, and agrees to make the required premium payments and abide by the reasonable provisions of the plan, although carriers may choose to restrict enrollment to open or special enrollment periods.

B. Carriers offering individual health benefit plans must display continuously and prominently on their website:

1. Notice of open enrollment dates;

2. Notice of special enrollment for qualifying and triggering events;

3. Notice of the enrollment periods for each qualifying and triggering event; and

4. Instructions on how to enroll.

C. Open enrollment periods.

1. The open enrollment period for plans effective on or after January 1 shall begin on November 1 of the prior year and extend through December 15 of that same year.

2. Carriers must ensure that coverage is effective on January 1 for health benefit plans purchased on or before December 15 of the open enrollment period.

3. The open enrollment period will be extended through the annual market stabilization special enrollment period each year, as found in Section 7 of this regulation.

4. The benefit year for individual health benefit plans purchased during the annual open enrollment period is a calendar year.

5. During open enrollment periods, carriers must offer guarantee-issue child-only health benefit plans to all applicants under the age of 21.

D. Special enrollment periods.

Carriers must establish special enrollment periods for individuals who experience triggering events, pursuant to § 10-16-105.7, C.R.S.

1. Except as provided in Section 7, following a triggering event, a carrier must provide a special enrollment period of sixty (60) days.

2. Except as provided in Section 7, when an individual is notified or becomes aware of a triggering event that will occur in the future, he or she may apply for enrollment in a new health benefit plan during the thirty (30) calendar days prior to the date of the triggering event, unless otherwise noted in Section 5.D.4., with coverage beginning no earlier than the day the triggering event occurs, to avoid a gap in coverage. The individual must be able to provide written documentation to support the date of the triggering event. The effective date of this enrollment must comply with the coverage effective dates found in Section 5.D.6. of this regulation.

3. Except as provided in Section 7, when a qualified individual is notified or becomes aware of a triggering event that will occur in the future, he or she may apply for enrollment in a new health benefit plan during the sixty (60) calendar days prior to the date of the triggering event, with coverage beginning no earlier than the day the triggering event occurs, to avoid a gap in coverage. The individual must be able to provide written documentation to support the date of the triggering event. The effective date of this enrollment must comply with the coverage effective dates found in Section 5.D.6. of this regulation.

4. Triggering events are:

a. An individual or his or her dependent involuntarily losing existing creditable coverage for any reason other than fraud, misrepresentation, or failure to pay a premium. Such individual or dependent may apply for enrollment in a new health benefit plan during the sixty (60) calendar days before the effective date of the loss of coverage;

b. An individual or his or her dependent loses pregnancy-related Medicaid coverage. The date of the loss of coverage is the last day the consumer would have pregnancy-related Medicaid coverage;

c. When an Exchange enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or if the Exchange enrollee, or his or her dependent, dies;

d. An individual or his or her dependent losing other coverage as described under Section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. § 301 et seq.). Such individual or dependent may apply once during a calendar year for

enrollment in a new health benefit plan during the sixty (60) calendar days before and after the effective date of the loss of coverage;

e. An individual gaining a dependent or becoming a dependent through marriage, civil union, birth, adoption, or placement for adoption, placement in foster care, through a child support order or other court order, or by entering into a designated beneficiary agreement if the carrier offers coverage to designated beneficiaries;

f. An individual's or his or her dependent's enrollment or non-enrollment in a health benefit plan that is unintentional, inadvertent or erroneous and is the result of an error, misrepresentation, or inaction of the carrier, producer, or the Exchange;

g. An individual or his or her dependent demonstrating to the Commissioner that the health benefit plan in which the individual is enrolled has substantially violated a material provision of its contract in relation to the individual or his or her dependent;

h. A qualified individual who:

(1) Becomes newly eligible, or an Exchange enrollee who is newly eligible or ineligible, for the federal advance payment tax credit or has a change in eligibility for cost-sharing reductions available through the Exchange;

(2) Has a dependent enrolled in the same qualified health plan who is determined to be newly eligible or ineligible for the federal advance payment tax credit or has a change in eligibility for cost-sharing reductions available through the Exchange; or

(3) Is enrolled, or has a dependent enrolled, in an eligible employer-sponsored plan and is determined to be newly eligible for the federal advance payment tax credit based in part on a finding that such individual is ineligible for coverage in an eligible employer-sponsored plan that provides minimum creditable coverage, including as a result of his or her employer discontinuing or changing coverage within the next sixty (60) days, provided the enrollee is able to terminate his or her existing coverage. This enrollee may apply for enrollment in a new health benefit plan during the sixty (60) calendar days before and after the effective date of the loss of coverage.

i. An individual or his or her dependent gaining access to other creditable coverage as a result of a permanent change in residence;

j. A parent or legal guardian dis-enrolling a dependent, or a dependent becoming ineligible for the Child Health Plan Plus (CHP+);

k. An individual becoming ineligible under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.);

l. An individual, who was not previously a citizen, a national, or a lawfully present individual, gaining such status;

m. An Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1601 et seq.), or his or her dependent on the same application, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;

n. An individual or his or her dependent currently enrolled in an individual or group non-calendar year health benefit plan may apply for enrollment in a new health benefit plan during the sixty (60) calendar days prior to the effective date of the involuntary loss of coverage, which is the last day of the plan or policy year;

o. An individual or his or her dependent enrolling in a health benefit plan may apply for enrollment in a new health benefit plan during the annual market stabilization special enrollment period, as specified in Section 7 of this regulation;

p. An individual who is a victim of domestic abuse or spousal abandonment, as defined by 26 C.F.R. § 1.36B-2T, including a dependent or unmarried victim within a household, who is enrolled in creditable coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment;

q. An individual who is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;

r. An individual or his or her dependent who applies for coverage during the annual open enrollment period or due to triggering event, and is assessed as potentially eligible for Medicaid or the Child Health Plan Plus (CHP+), and is determined ineligible for Medicaid or CHP+ either after open enrollment has ended or more than sixty (60) days after the triggering or qualifying event, or applies for coverage through a State Medicaid or CHP+ agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHP+ after open enrollment has ended;

s. An individual, or his or her dependent, who has purchased an off-Exchange plan, adequately demonstrates to the Commissioner that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP; or

t. An individual, or his or her dependent, who has purchased an on-Exchange plan, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP;

5. Special Enrollment Period Eligibility Verification and Prior Coverage Requirements

a. Carriers shall establish a special enrollment period eligibility verification process to confirm that an individual applying for coverage through a special enrollment period is eligible for the requested special enrollment period. Carriers may delay the processing of an application or any enrollment documents or premium payments until after completion of verification of eligibility for the requested special enrollment period.

(1) For special enrollment period eligibility verification, carriers shall make the list of required documentation, relevant premium payment information, and the verification process and deadlines available on their website in a conspicuous manner, and encourage individuals to provide the required documentation with their request for a special enrollment.

(2) A carrier shall notify the applicant within fourteen (14) days of receipt of the application if the applicant did not provide sufficient documentation necessary to verify eligibility for the special enrollment period requested. The notice shall include information that a failure to provide the

documentation will result in a denial of enrollment, and that coverage will not be issued until the required documentation confirming eligibility for the special enrollment period has been received.

(3) Individuals shall have no less than thirty (30) days from the date of the insufficient documentation notice to provide a carrier with sufficient documentation to establish eligibility for the requested special enrollment period.

(4) Carriers must make a verification determination within fourteen (14) days of receiving sufficient documentation in order to make an eligibility determination. If the verification determination is not made within the fourteen (14) day period, the individual shall be deemed verified and coverage shall be issued.

(5) A carrier must provide written notice to the individual of the outcome of the verification determination.

(6) The carrier may retroactively terminate or cancel an individual's enrollment if the carrier determines that the individual committed fraud or intentionally misrepresented his or her eligibility for a special enrollment period.

(7) A carrier is not required to provide thirty (30) days notice prior to denying, terminating, or cancelling an individual determined not to be eligible for a special enrollment period.

(8) A carrier shall notify an individual determined ineligible for a special enrollment period for an on-Exchange plan that he or she may appeal that decision with the Exchange, and the carrier shall respond to documentation requests from the Exchange concerning an appeal within seven (7) days of receiving that request.

(9) A carrier shall notify an individual determined ineligible for a special enrollment period for an off-Exchange plan that he or she may appeal that decision with the carrier and that he or she may appeal a carrier's final determination to the Division once the carrier's internal appeal process has been completed.

b. A carrier shall provide written confirmation of an individual's loss of creditable coverage to that individual within ten (10) business days of receiving such a request. The written confirmation must include the date of the loss of coverage and the reason for the loss of coverage.

c. The following documents shall constitute proof of a triggering event and sufficient documentation of eligibility for a special enrollment period:

(1) Evidence of an involuntary loss of creditable coverage shall be considered sufficient if the individual produces:

(a) Written confirmation of the loss of creditable coverage;

(b) An official letter or other notice from an employer or sent on behalf of an employer that provides notice of eligibility for COBRA or for state continuation benefits;

(c) Official documentation for loss due to exhaustion of COBRA or state continuation benefits; or

(d) A letter confirming such loss from the Division.

(2) Evidence of gaining or becoming a dependent shall be considered sufficient if the individual produces:

(a) A marriage license, civil union certificate or common law documentation, if the gaining or becoming a dependent occurs due to marriage or civil union.

(b) A birth certificate, adoption documents, or foster care documents, if the gaining or becoming a dependent occurs due to birth, adoption, placement for adoption, or placement in foster care.

(c) A court order or designated beneficiary documents, if the gaining or becoming a dependent occurs due to a court order.

(3) Evidence of losing a dependent or no longer being considered a dependent shall be considered sufficient if the individual produces:

(a) A copy of the death certificate or the obituary.

(b) Copies of the final divorce or separation documents.

(c) Proof of age and evidence of loss of creditable coverage when an individual turns 26 and is no longer eligible to be covered under a parent's health benefit plan.

(4) Evidence of a permanent change in residence shall be considered sufficient if the individual produces:

(a) Proof of change of address provided to, and acknowledged by, the U.S. Postal Service;

(b) A copy of a lease or purchase agreement listing the new address;

(c) A copy of utility bills listing the new address; or

(d) A copy of a driver's license listing the new address.

(5) Evidence of a material violation of a carrier's contract shall be considered sufficient if the individual produces a letter confirming eligibility for a special enrollment from the Division.

(6) Evidence of a change in citizenship or immigration status shall be considered sufficient if the individual produces official documentation of the change.

(7) Evidence of status as an American Indian/Native American shall be considered sufficient if the individual produces official documentation of his or her status.

(8) Evidence of a new determination of eligibility or ineligibility for Advance Premium Tax Credits or cost-sharing reductions available through the Exchange shall be considered sufficient if the individual produces the determination from the Exchange.

(9) Any other documentation reasonably sufficient to verify eligibility for the special enrollment period requested.

d. Prior coverage requirements.

(1) For special enrollment period requests due to marriage or civil union, carriers may require that at least one individual demonstrate that he or she possessed minimum essential coverage for at least one (1) or more days during the sixty (60) days immediately preceding the date of the special enrollment period triggering event.

(2) For special enrollment period requests due to a permanent move, the requesting individual must demonstrate that he or she possessed minimum essential coverage for at least one (1) or more days during the sixty (60) days immediately preceding the date of the permanent move. If the requesting individual is unable to demonstrate that he or she possessed minimum essential coverage, carriers may require the requesting individual to demonstrate he or she lived outside of the United States or in a United States territory for one (1) or more days during the sixty (60) days immediately preceding the date of the special enrollment period triggering event.

e. The special enrollment period eligibility verification and prior coverage requirements found in Section 5.D.5. of this regulation do not apply to the annual market stabilization special enrollment period found in Section 7 of this regulation.

6. Except as provided in Section 7, coverage effective dates will be:

a. In the case of marriage, civil union, or in the case where an individual loses creditable coverage, coverage must be effective no later than the first day of the month following plan selection.

b. In the case of birth, adoption, placement for adoption, or placement in foster care, coverage must be effective on either:

(1) The date of the event; or

(2) The first day of the month following the birth, adoption, placement for adoption, or placement in foster care, if requested by the primary individual policyholder.

c. In the case of an involuntary loss of existing creditable coverage in accordance with Section 5.D.4.a. of this regulation, coverage shall become effective either:

(1) On the first day of the month following the triggering event if plan selection is made on or before the effective date of the triggering event;

(2) In accordance with the effective dates specified in Section 5.D.6.f. and g. of this regulation if a plan selection is made after the effective date of the triggering event; or

(3) At the option of the Exchange, on the first day of the month following plan selection when plan selection is made after a triggering event.

d. In the case of gaining a dependent or becoming a dependent through a court order, coverage shall become effective either:

(1) On the date the court order is effective; or

(2) In accordance with the effective dates specified in Section 5.D.6.f. and g. of this regulation at the election of the primary individual policyholder.

e. The effective date of coverage for triggering events found in Section 5.D.4.d. and e. of this regulation must be an appropriate date based upon the circumstances of the special enrollment period.

f. In the case of all other triggering events where individual coverage is purchased between the first and fifteenth day of the month, coverage shall become effective no later than the first day of the following month.

g. In the case of all other triggering events where individual coverage is purchased between the sixteenth and last day of the month, coverage shall become effective no later than the first day of the second following month.

E. Notification requirements.

Carriers offering individual health benefit plans during open enrollment periods must provide the notice found in Appendix A to their current individual policyholders whose plans are not being discontinued no later than thirty (30) days prior to the start of each annual open enrollment period.

Section 6 Group Enrollment Periods

A. Carriers that offer small group health benefit plans must guarantee-issue small group health benefit plans throughout the year to any eligible small group that applies for a plan, agrees to make the required premium payments, and abide by the reasonable provisions of the plan, except as noted below.

B. Special enrollment periods for small employers.

1. For small employers that are unable to comply with employer contribution or group participation rules at the time of initial application, carriers may limit the availability of coverage for a group it has declined to an enrollment period that begins on November 15 and ends on December 15 of each year.

2. Coverage must be effective consistent with the dates listed below, unless the initial premium payment is not received by the carrier's cut-off date.

a. Carriers cannot establish a waiting period of more than ninety (90) days.

b. If a fully completed application that includes plan selection is received by the carrier between the first and the fifteenth day of the month, the first effective day of the health benefit plan will be no later than the first day of the following month.

c. If a fully completed application that includes plan selection is received between the sixteenth and last day of the month, the first effective day of the health benefit plan will be no later than the first day of the second following month.

C. Special enrollment periods for employees of small and large employer group plans.

1. Carriers must establish special enrollment periods in the group health benefit plan for individuals who experience any of the following qualifying events pursuant to § 10-16-105.7(3)(b)(II), C.R.S.:

a. Loss of coverage due to:

(1) The death of a covered employee;

(2) The termination or reduction in the number of hours of the employee's employment;

(3) The covered employee becoming eligible for benefits under Title XVIII of the Federal Social Security Act (42 U.S.C. § 301 et seq.); or

(4) The divorce or legal separation from the covered employee's spouse or partner in a civil union.

b. Becoming a dependent through marriage, civil union, birth, adoption, or placement for adoption, or placement in foster care;

c. Becoming a dependent of a covered person by entering into a designated beneficiary agreement, or pursuant to a court or administrative order mandating that the individual be covered;

d. Losing other creditable coverage due to:

(1) Termination of employment or eligibility for coverage, regardless of eligibility for COBRA or state continuation;

(2) A reduction in the number of hours of employment;

(3) Involuntary termination of coverage; or

(4) Reduction or elimination of his or her employer's contributions toward the coverage.

f. Losing coverage under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.) and then requesting coverage under an employer's group health benefit plan within sixty (60) days of the loss of coverage;

g. An employee or dependent becoming eligible for premium assistance under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.) or the Child-Health Plan Plus (CHP+); or

h. A parent or legal guardian dis-enrolling a dependent, or a dependent becoming ineligible for the Child Health Plan Plus (CHP+), and the parent or legal guardian requests enrollment of the dependent in a health benefit plan within sixty (60) days of the disenrollment or determination of ineligibility.

2. Individuals in the group market shall have a thirty (30) day special enrollment period that begins on the date the qualifying event occurs, except as provided in Section 6.C.1.f. and g. of this regulation, which provide a sixty (60) day special enrollment period.

3. When an individual in the group market is notified or becomes aware of a qualifying event that will occur in the future, he or she may apply for coverage during the thirty (30) calendar days prior to the effective date of the qualifying event, with coverage beginning no earlier than the day the qualifying event occurs to avoid a gap in coverage. The individual must be able to provide written documentation to support the effective date of the qualifying event at the time of enrollment. The effective date of this enrollment must comply with the coverage effective dates found in Section 6.C.4. of this regulation.

4. Coverage effective dates.

   a. In the case of birth, adoption, placement for adoption, or placement in foster care, coverage must be effective on the date of the event.

   b. In the case of marriage, civil union, or other qualifying events, coverage must be effective no later than the first day of the following month after the date the Exchange or the carrier receives a completed enrollment form.

Section 7 Annual Market Stabilization Special Enrollment Period

A. Carriers shall establish an annual market stabilization special enrollment period in order to ensure that consumers have sufficient opportunity to enroll in a health benefit plan after the end of the annual open enrollment period, and to ensure the continued health and stability of the Colorado health insurance market.

B. The annual market stabilization special enrollment period shall begin each year on December 16 and extend through January 15.

C. Individual health benefit plans purchased on or off of the Exchange during the annual market stabilization special enrollment period shall be effective no later than February 1 of the plan year.

D. The special enrollment period eligibility verification and prior coverage requirements found in Section 5.D.5. of this regulation do not apply to the annual market stabilization special enrollment period.

Section 8 Severability

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

Section 9 Incorporated materials

26 C.F.R. § 1.36B-2T, published by Government Printing Office shall mean shall mean 26 C.F.R. § 1.36B-2T as published on the effective date of this regulation and does not include later amendments to or editions of 26 C.F.R. § 1.36B-2T. A copy of 26 C.F.R. § 1.36B-2T may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of 26 C.F.R. § 1.36B-2T may be requested from the Colorado Division of Insurance for a fee. A copy may also be obtained online at www.ecfr.gov.

Section 10 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 11 Effective Date

This ~~emergency~~ regulation shall become effective on ~~September 6, 2018~~ January 1, 2019.

Section 12 History

Emergency regulation 13-E-13 effective October, 31, 2013.
Regulation effective February 1, 2014.
Amended regulation effective August 15, 2014.
Amended regulation effective November 1, 2015.
Emergency regulation 17-E-01 effective August 1, 2017.
Amended regulation effective December 1, 2017.
Emergency regulation 18-E-04 effective September 5, 2018
Amended regulation effective January 1, 2019.

APPENDIX A

Annual Open Enrollment Period Notice for Individual Health Benefit Plans

We would like to let you know that your annual open enrollment period starts this year on [Open Enrollment Start Date]. Your open enrollment period will last until [Open Enrollment End Date]. During the open enrollment period, you will be able to purchase new health insurance for the coming year.

You have two choices:

- You can continue with your current plan, where you will need to review changes to your benefits, confirm that your health care providers are still in the plan's network, confirm any prescriptions you take are still covered and make sure to change your auto-pay to match your new premium; or

- You can enroll in a new plan during the open enrollment period.

If you decide to choose a new plan:

- You can choose your new plan from us, or any other carrier offering plans; or

- You may purchase a new plan through Connect for Health Colorado, where you may qualify for federal financial assistance (www.connectforhealthco.com).

Make sure you follow the termination notice requirements in your current plan so that you will be able to avoid a gap in coverage by ending your old plan and beginning your new plan on the appropriate dates.

You can contact us or your insurance advisor for assistance and additional information. [Insert carrier contact information]

Notice of Proposed Rulemaking

Tracking number

2018-00518

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

11/01/2018

Time

02:00 PM

Location

1560 Broadway, Ste 110D, Denver CO 80202

Subjects and issues involved

4-2-49 - CONCERNING THE DEVELOPMENT AND IMPLEMENTATION OF A UNIFORM DRUG BENEFIT PRIOR AUTHORIZATION PROCESS, THE REQUIRED DRUG APPEALS PROCESS, AND THE COVERAGE OF CERTAIN OPIOID DEPENDENCE TREATMENT DRUGS - The purpose of this regulation is to establish the requirements, process, and form to be utilized by carriers and contracted pharmacy benefit management firms for the prior authorization process for prescription drug benefits, and to adopt the changes mandated by House Bill 18-1007.

Statutory authority

§§ 10-1-109, 10-16-124.5(3)(a), and 10-16-124.5(3)(c), C.R.S.

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DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE ACCIDENT AND HEALTH

~~New~~ Proposed Amended Regulation 4-2-49

CONCERNING THE DEVELOPMENT AND IMPLEMENTATION OF A UNIFORM DRUG BENEFIT PRIOR AUTHORIZATION PROCESS, THE REQUIRED DRUG APPEALS PROCESS, AND THE COVERAGE OF CERTAIN OPIOID DEPENDENCE TREATMENT DRUGS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-124.5(3)(a), and 10-16-124.5(3)(c), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish the requirements, process, and form to be utilized by carriers and contracted pharmacy benefit management firms for the prior authorization process for prescription drug benefits, and to adopt the changes mandated by House Bill 18-1007.

Section 3 Applicability

Except as noted, the provisions of this regulation shall apply to all carriers that market individual and group health benefit plans in the state of Colorado which provide prescription drug benefits. Except as required by Section 5.A., ~~T~~the provisions of this regulation do not apply to non-profit health maintenance organizations with respect to managed care plans that provide a majority of covered professional services through a single contracted medical group.

Section 4 Definitions

A. "Adverse determination" shall have the same meaning as found at § 10-16-113(1)(b), C.R.S.

B. "Carrier" shall have the same meaning as found at § 10-16-102(8), C.R.S., and shall, for the purposes of this regulation, include a pharmacy benefit management firm contracted by a carrier.

C. "Covered person" or "patient" means, for the purposes of this regulation, the person entitled to receive benefits or services under a health benefit plan.

~~C~~D. "Drug benefit" means, for the purposes of this regulation, the provision of a drug used to treat a covered medical condition of a covered person.

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

F. "Health Maintenance Organization" shall have the same meaning as found at § 10-16-102(35), C.R.S.

G. "Pharmacy benefit management firm" shall have the same meaning as found at § 10-16-102(49), C.R.S.

H. "Prescribing provider" shall have the same meaning as found at § 10-16-124.5(8)(a), C.R.S.

I. "Urgent prior authorization request" shall have the same meaning as found at § 10-16-124.5(8)(b), C.R.S.

Section 5 Rules

~~A. Beginning on January 1, 2015, all carriers shall utilize the uniform prior authorization process established by this regulation.~~

A. All carriers issuing individual and group health benefit plans shall:

1. Make available and provide coverage for, without prior authorization, a five (5) day supply of at least one (1) of the federal Food and Drug Administration-approved drugs prescribed for the treatment of opioid dependence. This requirement is limited to a first request within a twelve (12) month period;

2. Consider and treat a request for medication-assisted treatment for substance use disorders as an urgent prior authorization request;

3. Include appropriate information on the expedited appeals process as required by 45 C.F.R. § 156.122(c) with any denial of a request made in accordance with Section 5.A.1.; and

4. Have standard and expedited exception processes that allow a covered person, the covered person's designee, or the covered person's prescribing provider to request and gain access to clinically-appropriate drugs not otherwise covered by his or her health benefit plan pursuant to 45 C.F.R. § 156.122(c).

B. A prior authorization process for a drug benefit, as developed by a carrier, shall:

1. Be made available electronically to the prescribing provider;

2. Make the following information available and accessible in a centralized location on the carrier's or its designated pharmacy benefit management firm's website:

a. The prior authorization requirements and restrictions, including, but not limited to:

(1) The prescribing provider's obligation to respond to requests for additional information; and

(2) When requests will be deemed “approved” or “denied”;

b. An alphabetical list of drugs, including both brand name and scientific name, that require prior authorization, including the clinical criteria and supporting references that will be used in making a prior authorization determination;

c. Written clinical criteria that include the criteria for reauthorization of a previously approved drug, if applicable, after the previous approval period has expired; and

d. The standard form for prior authorization for a drug benefit, provided in Appendix A of this regulation.

3. Include evidence-based guidelines to be used by the carrier when making prior authorization determinations;

4. Allow for, but not require, the electronic submission of prior authorization requests for a drug benefit to the carrier.

C. Urgent prior authorization requests.

1. A carrier shall process and provide notification of approval or denial to the patient, prescribing provider, and dispensing pharmacy within one (1) business day of receiving an urgent prior authorization request. Carriers shall include appropriate information on the expedited appeals process related to urgent care situations as required by 45 C.F.R. § 156.122(c), ~~as found in § 10-16-113, C.R.S., and associated regulations,~~ with any denial of an urgent prior authorization request.

a. If additional information is required to process an urgent prior authorization request, the carrier must advise the prescribing provider of any and all information needed within one (1) business day of receiving the request.

b. If additional information is required to process an urgent prior authorization request, the prescribing provider shall submit the information requested by the carrier within two (2) business days of receiving such a request from the carrier.

c. If the additional information requested from the prescribing provider is not received within two (2) business days of the prescribing provider receiving such a request, the request shall be deemed denied. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the denial within one (1) business day of the date the request was deemed denied.

d. Once the requested additional information is received, the carrier shall make a determination in accordance with Section 5.C.1., of this regulation.

2. If a carrier does not request additional information or provide notification of approval or denial, as required by Section 5.C.1., the request shall be deemed approved. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the deemed approval within one (1) business day of date the request was deemed approved.

D. Non-urgent prior authorization requests.

1. A carrier shall process and provide notification of approval or denial to the patient, prescribing provider, and dispensing pharmacy within two (2) business days of receiving a

non-urgent prior authorization request that has been submitted through the carrier's electronic pre-authorization system.

a. If additional information is required, the carrier must advise the prescribing provider of any and all information needed within two (2) business days of receiving the non-urgent prior authorization request.

b. If additional information is required to process a non-urgent prior authorization request, the prescribing provider shall submit the information requested by the carrier within two (2) business days of receiving such a request from the carrier.

c. If the additional information requested from the prescribing provider is not received within two (2) business days of the prescribing provider receiving such a request, the request shall be deemed denied. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the denial within two (2) business days of the date the request was deemed denied.

d. Once the requested additional information is received, the carrier shall make a determination in accordance with Section 5.D.1. or Section 5.D.2., of this regulation, as applicable

2. A carrier shall process and provide notification of approval or denial to the patient, prescribing provider, and dispensing pharmacy within three (3) business days of receiving a non-urgent prior authorization request that has been submitted via facsimile, electronic mail, or verbally with associated written confirmation.

3. If a carrier does not request additional information or provide notification of approval or denial within:

a. Two (2) business days of the receipt of an electronically filed non-urgent prior authorization request, as required by Section 5.D.1., the request shall be deemed approved. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the deemed approval within two (2) business days of the date the request was deemed approved; or

b. Three (3) business days of the receipt of a non-urgent prior authorization request that has been submitted via facsimile, electronic mail, or verbally with associated written confirmation, as required by Section 5.D.2., the request shall be deemed approved. The carrier shall provide the patient, prescribing provider, and the dispensing pharmacy with a confirmation of the deemed approval within two (2) business days of the date the request was deemed approved.

E. When notifying a prescribing provider of a prior authorization approval, a carrier shall include:

1. A unique prior authorization number attributable only to that drug benefit approval request;

2. Specifications for the particular approved drug benefit, and the source and date of the clinical criteria used to make the determination for each particular drug;

3. The next date for review of the approved drug benefit; and

4. A link to the current criteria that will need to be submitted in order to reapprove the current prior authorization.

F. When notifying a prescribing provider of a prior authorization denial, a carrier shall include a notice to the prescribing provider, and dispensing pharmacy, if provided, that the covered person has the right to appeal the adverse determination pursuant to ~~§§ 10-16-113 and 10-16-113.5, C.R.S.~~Section 5.A.4.

G. A prior authorization approval is valid for at least one hundred eighty (180) days after the date of approval.

H. If a prior authorization request is submitted electronically, verbally, via facsimile, or electronic mail, the response to that request shall be made through the same medium, or in a manner specifically requested by the provider.

Section 6 Form

~~Beginning on January 1, 2015,~~A~~a~~ll carriers shall utilize the uniform prior authorization form found in Appendix A of this regulation.

Section 7 Severability

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

Section 8 Incorporated Materials

45 C.F.R. § 156.122(c), published by Government Printing Office shall mean shall mean 45 C.F.R. § 156.122(c) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.122(c). A copy of 45 C.F.R. § 156.122(c) 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. § 156.122(c) may be requested from the Colorado Division of Insurance for a fee. A copy may also be obtained online at www.ecfr.gov.

Section ~~8~~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 ~~9~~10 Effective Date

This regulation shall become effective on ~~July 15~~January 1, 201~~4~~9.

Section 1~~0~~1 History

New regulation effective July 15, 2014.
Amended regulation effective January 1, 2019.

APPENDIX A

[CARRIER LOGO]
[CARRIER NAME]

UNIFORM PHARMACY PRIOR AUTHORIZATION REQUEST FORM

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete this form in its entirety and send to:
[CARRIER OR PHARMACY BENEFIT MANAGEMENT FIRM CONTACT INFORMATION]

☐ **Urgent** [1]	☐ **Non-Urgent**		
Requested Drug Name:			
Is this drug intended to treat opioid dependence?	**Yes** ☐	**No** ☐	
If **Yes,** is this a first request for prior authorization for this drug?	**Yes** ☐	**No** ☐	
If **No,** what was the date of the first request? Date:			

Patient Information:	**Prescribing Provider Information:**
Patient Name:	Prescriber Name:
Member/Subscriber Number:	Prescriber Fax:
Policy/Group Number:	Prescriber Phone:
Patient Date of Birth (MM/DD/YYYY):	Prescriber Pager:
Patient Address:	Prescriber Address:
Patient Phone:	Prescriber Office Contact:
Patient Email Address:	Prescriber NPI:
	Prescriber DEA:
Prescription Date:	Prescriber Tax ID:
	Specialty/Facility Name (If applicable):
	Prescriber Email Address:

Prior Authorization Request for Drug Benefit:	☐ New Request ☐ Reauthorization
Patient Diagnosis and ICD Diagnostic Code(s):	
Drug(s) Requested (with J-Code, if applicable):	
Strength/Route/Frequency:	
Unit/Volume of Named Drug(s):	
Start Date and Length of Therapy:	
Location of Treatment: (e.g. provider office, facility, home health, etc.) including name, Type 2 NPI (if applicable), address and tax ID:	
Clinical Criteria for Approval, Including other Pertinent Information to Support the Request, other Medications Tried, Their Name(s), Duration, and Patient Response: [ADD ADDITIONAL LINES AS NEEDED SO AS TO CONTAIN ALL APPROVAL CRITERIA]	
For use in clinical trial? (If yes, provide trial name and registration number):	
Drug Name (Brand Name and Scientific Name)/Strength:	
Dose:	Route: / Frequency:
Quantity:	Number of Refills:
Product will be delivered to: ☐ Patient's Home ☐ Physician Office	☐ Other:
Prescriber or Authorized Signature:	Date:
Dispensing Pharmacy Name and Phone Number:	

☐ **Approved**	☐ **Denied**
If denied, provide reason for denial, and include other potential alternative medications, if applicable, that are found in the formulary of the carrier:	

1. A request for prior authorization that if determined in the time allowed for non-urgent requests could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; could subject the person to severe pain that cannot be adequately managed without the drug benefit contained in the prior authorization request; or is a prior authorization request for medication-assisted treatment for substance abuse disorders.

Notice of Proposed Rulemaking

Tracking number

2018-00520

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

11/01/2018

Time

02:00 PM

Location

1560 Broadway, Ste 110D, Denver CO 80202

Subjects and issues involved

4-2-61 - CONCERNING NON-CONTRACTED EMERGENCY ROOM CLAIMS - The purpose of this regulation is to establish requirements for carriers to provide in-network cost-sharing for out-of-network emergency room claims and prohibit carriers from limiting coverage for emergency services to only in-network facilities, pursuant to § 10-16-704(5.5), C.R.S. Further, this regulation seeks to address the issue of provider contracting practices and how non-participation in carrier networks may lead to increased premiums and increase the cost of care.

Statutory authority

10-1-109 and 10-16-109, C.R.S.

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DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Proposed New Regulation 4-2-61

CONCERNING NON-CONTRACTED EMERGENCY ROOM CLAIMS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish requirements for carriers to provide in-network cost-sharing for out-of-network emergency room claims and prohibit carriers from limiting coverage for emergency services to only in-network facilities, pursuant to § 10-16-704(5.5), C.R.S. Further, this regulation seeks to address the issue of provider contracting practices and how non-participation in carrier networks may lead to increased premiums and increase the cost of care.

Section 3 Applicability

This regulation applies to all carriers offering managed care plans that provide any benefits with respect to services obtained in an emergency department of a hospital.

Section 4 Definitions

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

B. "Cost-sharing requirements" mean, for the purposes of this regulation, in-network copays, deductibles, co-insurance, and out-of-pocket maximums.

C. "Emergency medical condition" shall have the same meaning as found at § 10-16-704(5.5)(b)(I), C.R.S.

D. "Emergency services" shall have the same meaning as found at § 10-16-704(5.5)(b)(II), C.R.S.

Section 5 Rules

A. Carriers shall apply the same cost-sharing requirements to emergency services provided at in-network facilities and out-of-network facilities.

B. Carriers shall ensure that coverage is not limited for emergency services provided at an out-of-network facility and that coverage is provided at no greater cost to the covered person than if the emergency services were provided at an in-network facility.

C. The explanation of benefits issued by the carrier shall:

1. Provide the covered person with information regarding how the allowable amount was calculated or with specific instructions regarding how to obtain that information from the carrier;

2. Include specific information regarding the covered person's financial responsibility for any applicable in-network cost-sharing amounts; and

3. Include specific instructions for contacting the carrier if any out-of-network provider bills the covered person for amounts in excess of those specified in section 5.C.2.

D. Nothing in this Section 5 prevents a carrier from negotiating a lower reimbursement amount prior to submitting payment for emergency services, or prevents providers from accepting reasonable reimbursement, such as a percent of billed charges, for the emergency services provided.

Section 6 Severability

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

Section 7 Enforcement

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

Section 8 Effective Date

This regulation shall become effective on January 1, 2019.

Section 9 History

New regulation effective January 1, 2019.

Notice of Proposed Rulemaking

Tracking number

2018-00519

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

11/01/2018

Time

02:00 PM

Location

1560 Broadway, Ste 110D, Denver CO 80202

Subjects and issues involved

4-2-53 - NETWORK ADEQUACY STANDARDS AND REPORTING REQUIREMENTS FOR ACA-COMPLIANT HEALTH BENEFIT PLANS - The purpose of this regulation is to provide carriers offering Affordable Care Act (ACA)-compliant health benefit plans with standards and guidance on Colorado filing requirements for health benefit plan network adequacy filings. These standards shall serve as the measurable requirements used by the Division to evaluate the adequacy of carrier networks.

Statutory authority

§§ 10-1-109(1), 10-16-109, 10-16-704(1.5), and 10-16-708, C.R.S.

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DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Proposed Amended Regulation 4-2-53

NETWORK ADEQUACY STANDARDS AND REPORTING REQUIREMENTS FOR ACA-COMPLIANT HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109(1), 10-16-109, 10-16-704(1.5), and 10-16-708, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide carriers offering Affordable Care Act (ACA)-compliant health benefit plans with standards and guidance on Colorado filing requirements for health benefit plan network adequacy filings. These standards shall serve as the measurable requirements used by the Division to evaluate the adequacy of carrier networks.

Section 3 Applicability

This regulation applies to all carriers offering ACA-compliant individual or group health benefit plans subject to the individual, small group, and/or large group laws of Colorado. This regulation excludes individual short-term policies as defined in § 10-16-102(60), C.R.S.

Section 4 Definitions

A. "ACA" ~~or "PPACA"~~ means, for the purposes of this regulation, The Patient Protection and Affordable Care Act, Pub. L. 111-148 and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152.

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

~~A~~C. "Counties with Extreme Access Considerations" or "CEAC" means, for the purposes of this regulation, counties with a population density of less than ten (10) people per square mile, based on U.S. Census Bureau population and density estimates.

~~B~~D. "Community emergency center" means, for the purposes of this regulation, a community clinic that delivers emergency services. The care shall be provided 24 hours per day, 7 days per week every day of the year, unless otherwise authorized herein. A community emergency center may provide primary care services and operate inpatient beds.

~~C~~E. "Covered person" shall have the same meaning as found at § 10-16-102(15), C.R.S.

~~E~~F. "Dentist" and "~~D~~dental ~~P~~provider" mean, for the purposes of this regulation, a dental provider who is skilled in and licensed to practice dentistry for patients in all age groups and is responsible for the diagnosis, treatment, management, and overall coordination of services to meet the patient's oral health needs.

~~F~~G. "Embedded" means, for the purposes of this regulation, dental benefits provided as part of a health benefit plan, which may or may not be subject to the same deductible, coinsurance, copayment and out-of-pocket maximum of the health benefit plan.

~~G~~H. "Emergency services" shall have the same meaning as found ~~i~~nat § 10-16-704(5.5)(b)(II), C.R.S.

~~H~~I. "Enrollment" means, for the purposes of this regulation, the number of covered persons enrolled in a specific health plan or network.

~~I~~J. "Essential community provider" or "ECP" means, for the purposes of this regulation, a provider that serves predominantly low-income, medically underserved individuals, including health care providers defined in ~~p~~Part 4 of ~~a~~Article 5 of ~~t~~Title 25.5, C.R.S. and at 45 C.F.R. § 156.235(c).

~~J~~K. "Health benefit plan" shall~~, for the purposes of this regulation,~~ have the same meaning as found ~~i~~nat § 10-16-102(32), C.R.S.

~~K~~L. “Home health services” shall~~, for the purposes of this regulation,~~ have the same meaning as found ~~in~~at § 25.5-4-103(7), C.R.S., which are provided by a home health agency certified by the Colorado Department of Public Health and Environment.

~~L~~M. “Managed care plan” shall have the same meaning as found at § 10-16-102(43), C.R.S.

~~M~~N. “Mental health, behavioral health, and substance abuse disorder care” means, for the purposes of this regulation, health care services for a range of common mental or behavioral health conditions, or substance abuse disorders provided by a physician or non-physician professionals.

~~N~~O. “Mental health, behavioral health, and substance abuse disorder care providers” for the purposes of this regulation, and for the purposes of network adequacy measurements, includes psychiatrists, psychologists, psychotherapists, licensed clinical social workers, psychiatric practice nurses, licensed addiction counselors, licensed marriage and family counselors, and licensed professional counselors.

~~O~~P. “Network” shall have the same meaning as found at § 10-16-102(45), C.R.S.

Q. “Primary care” means, for the purposes of this regulation, health care services for a range of common physical, mental or behavioral health conditions provided by a physician or non-physician primary care provider.

R. “Primary care provider” or “PCP” means, for the purposes of this regulation, a participating health care professional designated by the carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person. For the purposes of network adequacy measurements, PCPs for adults and children includes physicians (pediatrics, general practice, family medicine, internal medicine, geriatrics, obstetrician/gynecologist) and physician assistants and nurse practitioners supervised by, or collaborating with, a primary care physician.

S. “Specialist” means, for the purposes of this regulation, a physician or non-physician health care professional who:

1. Focuses on a specific area of physical, mental or behavioral health or a group of patients; and

2. Has successfully completed required training and is recognized by the state in which he or she practices to provide specialty care.

“Specialist” includes a subspecialist who has additional training and recognition above and beyond his or her specialty training.

T. “Telehealth” shall have the same meaning as found ~~in~~at § 10-16-123(4)(e), C.R.S.

U. “Urgent care facility” means, for the purposes of this regulation, a facility or office that generally has extended hours, may or may not have a physician on the premises at all times, and is only able to treat minor illnesses and injuries. An urgent care facility does not typically have the facilities to handle an emergency condition, which includes life or limb threatening injuries or illnesses, as defined under emergency services.

Section 5 Reporting Requirements

A. Network adequacy filings for an ACA-compliant health benefit plan shall be filed with the Division through the National Association of Insurance Commissioners System for Electronic Rate and Form Filing (“SERFF”) prior to use and annually thereafter.

B. The following four (4) measurement standards shall be used to evaluate a carrier's network adequacy:

1. Compliance with network adequacy instructions published by the Division;

2. Compliance with network adequacy definitions contained in this regulation;

3. Compliance with the measurement details contained in this regulation; and

4. Compliance with the reporting methodologies contained in this regulation.

C. Attestations of adequate networks, for each network, shall be provided on the "Carrier Network Adequacy Summary and Attestation Form" submitted as part of the network adequacy filing.

Section 6 Network Adequacy Standards

The following access to service and waiting time standards shall be met by all carriers filing ACA-compliant health benefit plans in order to comply with network adequacy requirements:

Service Type	**Time Frame**	**Time Frame Goal**
Emergency Care – Medical, Behavioral, Substance Abuse	24 hours a day, 7 days a week	Met 100% of the time
Urgent Care – Medical, Behavioral, Mental Health and Substance Abuse	Within 24 hours	Met 100% of the time
Primary Care – Routine, non-urgent symptoms	Within 7 calendar days	Met ≥ 90% of the time
Behavioral Health, Mental Health and Substance Abuse Care – Routine, non-urgent, non-emergency	Within 7 calendar days	Met ≥ 90% of the time
Prenatal Care	Within 7 calendar days	Met ≥ 90% of the time
Primary Care Access to after-hours care	Office number answered 24 hours/ 7 days a week by answering service or instructions on how to reach a physician	Met ≥ 90% of the time
Preventive visit/well visits	Within 30 calendar days	Met ≥ 90% of the time
Specialty Care - non urgent	Within 60 calendar days	Met ≥ 90% of the time

Section 7 Availability Standards

A. "Provider to enrollee" ratios for different provider types shall be reported in the filed "Enrollment Document". The groupings/categories for the specific providers are listed in Appendix B.

B. The standards listed below shall be used to measure network adequacy, along with geographic access standards, in counties with "large metro, metro and micro" status, as defined in Appendix A, for the specific provider types listed in Section 7.D. of this regulation.

C. The carrier shall attest that it is compliant with the “provider to enrollee” ratios standards in Section 7.D. of this regulation

D. The following availability standards shall be met by all carriers filing ACA-compliant health benefit plans in order to comply with network adequacy requirements:

Provider/Facility Type	**Large Metro**	**Metro**	**Micro**
Primary Care	1:1000	1:1000	1:1000
Pediatrics	1:1000	1:1000	1:1000
OB/GYN	1:1000	1:1000	1:1000
Mental health, behavioral health and substance abuse disorder care providers	1:1000	1:1000	1:1000

Section 8 Geographic Access Standards

A. The carrier shall attest that at least one (1) of each of the providers and facilities listed below is available within the maximum road travel distance of any enrollee in each specific carrier’s network.

B. Access standards may require that a policyholder cross county or state lines to reach a provider.

C. Network Adequacy Geographic Access Standards by Provider Type:

Specialty	**Geographic Type**				
	Large Metro	**Metro**	**Micro**	**Rural**	**CEAC**
	Maximum Distance (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)
Primary Care	5	10	20	30	60
Gynecology, OB/GYN	5	10	20	30	60
Pediatrics - Routine/Primary Care	5	10	20	30	60
Allergy and Immunology	15	30	60	75	110
Cardiothoracic Surgery	15	40	75	90	130
Cardiovascular Disease	10	20	35	60	85

Chiropracty	15	30	60	75	110
Dermatology	10	30	45	60	100
Endocrinology	15	40	75	90	130
ENT/Otolaryngology	15	30	60	75	110
Gastroenterology	10	30	45	60	100
General Surgery	10	20	35	60	85
Gynecology only	15	30	60	75	110
Infectious Diseases	15	40	75	90	130
Licensed Clinical Social Worker	10	30	45	60	100
Nephrology	15	30	60	75	110
Neurology	10	30	45	60	100
Neurological Surgery	15	40	75	90	130
Oncology - Medical, Surgical	10	30	45	60	100
Oncology - Radiation/ Radiation Oncology	15	40	75	90	130
Ophthalmology	10	20	35	60	85
Orthopedic Surgery	10	20	35	60	85
Physiatry, Rehabilitative Medicine	15	30	60	75	110
Plastic Surgery	15	40	75	90	130
Podiatry	10	30	45	60	100
Psychiatry	10	30	45	60	100
Psychology	10	30	45	60	100
Pulmonology	10	30	45	60	100
Rheumatology	15	40	75	90	130
Urology	10	30	45	60	100
Vascular Surgery	15	40	75	90	130
OTHER MEDICAL PROVIDER	15	40	75	90	130

Dentist	15	30	60	75	110
Pharmacy	5	10	20	30	60
Acute Inpatient Hospitals	10	30	60	60	100
Cardiac Surgery Program	15	40	120	120	140
Cardiac Catheterization Services	15	40	120	120	140
Critical Care Services – Intensive Care Units (ICU)	10	30	120	120	140
Outpatient Dialysis	10	30	50	50	90
Surgical Services (Outpatient or ASC)	10	30	60	60	100
Skilled Nursing Facilities	10	30	60	60	85
Diagnostic Radiology	10	30	60	60	100
Mammography	10	30	60	60	100
Physical Therapy	10	30	60	60	100
Occupational Therapy	10	30	60	60	100
Speech Therapy	10	30	60	60	100
Inpatient Psychiatric Facility	15	45	75	75	140
Orthotics and Prosthetics	15	30	120	120	140
Outpatient Infusion/Chemotherapy	10	30	60	60	100
OTHER FACILITIES	15	40	120	120	140

Section 9 **Geographic Access Standards Waiver Process**

A. A carrier may apply to the Commissioner for a waiver from a single geographic network adequacy requirement for a specific network and service area if all of the following conditions are met:

1. The carrier provides evidence that its good faith efforts to contract on reasonable terms have been unsuccessful;

2. The carrier provides evidence that a provider has acted or is acting in an anti-competitive or monopolistic fashion; and

3. The carrier is able to demonstrate that the granting of the waiver will result in premium savings to covered persons.

B. The waiver application shall include specific details regarding how the carrier will ensure that all covered persons will be notified if the application is approved, and that all covered persons will have access to covered benefits without unreasonable delay.

C. An application for a waiver under this Section must be submitted to the Commissioner no later than ninety (90) days prior to the date that network adequacy filings must be submitted to the Division.

D. Carriers shall provide a copy of the waiver application to the provider(s) referenced in the waiver application at the same time that such an application is submitted to the Commissioner.

E. The application for a waiver and the supporting documentation will be posted to the Division's website for 30 days during which the Division will take and consider comments on the application.

F. The Commissioner will inform a carrier, in writing, of the approval or denial of an application for a waiver under this Section prior to the date that network adequacy filings must be submitted to the Division. The Division's approval or denial of an application for a specific geographic network adequacy waiver application will be publically available on the Division's website.

G. A geographic access standards waiver is valid only for the plan year for which it was submitted and approved, and shall expire at the end of that plan year.

H. A carrier must submit a new waiver application for each plan year in which it seeks a waiver from a specific network adequacy requirement for a specific network and service area.

I. A carrier shall not submit an application for a waiver from the network adequacy requirements for primary care services or emergency services.

Section 10 Essential Community Provider Standards

A. ACA-compliant health benefit plans and dual (both medical and dental) carriers are required to have a sufficient number and geographic distribution of essential community providers (ECPs), where available.

B. Carriers shall ensure the inclusion of a sufficient number of ECPs to ensure reasonable and timely access to a broad range of ECP providers for low-income, medically underserved individuals in their service areas.

C. There are two ECP standards for carrier ECP submissions:

1. General ECP Standard. Carriers utilizing this standard shall demonstrate in their "Essential Community Provider/Network Adequacy Template" that at least thirty ~~30~~ percent (30%), as specified by Colorado, of available ECPs in each plan's service area participate in the plan's network. This standard applies to all carriers except those who qualify for the alternate ECP standard.

2. Alternate ECP Standard. Carriers utilizing this standard shall demonstrate in their "Essential Community Provider/Network Adequacy Template" and justifications, that they have the same number of ECPs as defined in the general ECP standard (calculated as thirty ~~30~~ percent (30%) of the ECPs in the carrier's service area), but the ECPs should be located within Health Professional Shortage Areas (HPSAs) or five-digit ZIP codes in which thirty ~~30~~ percent (30%) or more of the population falls below 200 percent (200%) of the federal poverty level (FPL). An alternate ECP standard carrier is one that provides a majority of covered professional services through physicians it employs or through a single contracted medical group.

Section ~~10~~11 Network Adequacy Requirements for Plans with Embedded Dental Benefits

Health benefit plans that offer embedded dental coverage shall report all aspects of network adequacy required in Section 1~~1~~2 of this regulation for dental providers included in carrier networks. If the dental provider is not within the filing carrier's network, the carrier shall include network adequacy reporting for the "outside" dental network(s) within the medical network adequacy filing.

A. The carrier shall attest that at least one (1) provider listed below is available within the maximum road travel distance for at least ninety percent (90%) of its enrollees in each specific Colorado service area as defined in Appendix A of this regulation:

Geographic Type					
Provider Type – the plan provides access to at least one dental provider for at least ninety percent (90%) of the enrollees	**Large Metro**	**Metro**	**Micro**	**Rural**	**CEAC**
	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)	Maximum Road Travel Distance (Miles)
Dentist	15	30	60	75	110

B. Access standards may require that a policyholder cross county or state lines to reach a provider.

Section ~~11~~12 Requirements for Annual Network Adequacy Reporting

Annual network adequacy filings shall consist of two (2) sections, the Essential Community Providers/Network Adequacy Template filing in the Plan Management (Binder) section in SERFF, and a Network Adequacy form filing, filed with SERFF type of insurance (TOI) code NA01.004. All network adequacy documents must be filed by carrier network, rather than by plan type or group size. Each network (i.e. HMO, PPO, EPO, etc.) in the carrier's service area that is included on the network templates filed in any of a carrier's Binder filings shall be included in the carrier's "Essential Community Provider/Network Adequacy Template" filing and the carrier's Network Adequacy form filing. Templates and instructions specified by the Commissioner shall be used, and will be made available to carriers annually.

A. Elements of the Binder Filing

1. All carriers shall submit network provider and facility listings on the "Essential Community Provider/Network Adequacy Template" in the Binder filing. All essential community providers (ECPs) in each network must be included in this template. The templates must be completed and filed as described in the Division instructions. Templates will require validation before submittal to the Division.

2. The "ECP Write-in Worksheet", if applicable, shall be filed on the "Supporting Documentation" tab of the Binder filing.

3. If a carrier does not meet the Colorado thirty percent (30%) ECP standard, the carrier shall submit a copy of the federal "Supplementary Response: Inclusion of Essential Community Providers" as part of its binder filing. Specific requirements for submitting the "Supplementary Response: Inclusion of Essential Community Providers" form are available from the Centers for Medicare and Medicaid Services (CMS).

B. Elements of the Network Adequacy Form Filing

1. Carriers shall submit network access plans for each network, pursuant to § 10-16-704(9), C.R.S. These must be attached as "Supporting Documentation" on the form filing.

2. Carriers shall submit an "Enrollment Document" containing separate spreadsheets for each network. Enrollment document instructions will be provided to carriers by the Division. Enrollment documents shall be submitted in an Excel format using the "DOI Enrollment Document Template". Counts used for this document shall be based on the projected enrollment of all members in the carrier's individual, small group and large group plans utilizing that specific network.

3. The carrier shall provide screen shots from the provider directory(ies) showing:

   a. Master (entry) page of the carrier's website, directing users to the provider directory(ies);

   b. Introduction screen of the provider directory;

   c. Directory general information, such as inclusion criteria, description of tiering (if applicable), customer service contact information, date of last revisions, and directory disclosures;

   d. Simple search screen;

   e. A page of a provider directory produced from a search; and

   f. Detail screen for at least one (1) provider and one (1) facility.

4. Carriers shall submit maps showing geographic access standards for selected providers and facilities for each network. Instructions for preparation of these documents and the providers to be included will be provided by the Division on an annual basis.

Section ~~12~~13 Required Attestations

A. A carrier shall attest that each of its health benefit plans will maintain a provider network(s) that meets the standards contained in this regulation, and that each provider network is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that the services will be accessible without unreasonable delay.

B. A carrier shall attest that each of its health benefit plans include in its provider network(s) a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in its service areas.

C. Each attestation shall be made on the "Carrier Network Adequacy Summary and Attestation Form" submitted with the network adequacy form filing.

Section ~~13~~14 Severability

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

Section ~~14~~15 Incorporated Materials

45 C.F.R. § 156.235(c) published by the Government Printing Office shall mean 45 C.F.R. § 156.235(c) as published on the effective date of this regulation and does not include later amendments to or editions of 45 C.F.R. § 156.235(c). A copy of 45 C.F.R. § 156.235(c) can be found at the following link: http://www.gpo.gov/ and 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. § 156.235(c) may be requested from the Division of Insurance. A charge for certification or copies may apply.

The "Supplementary Response: Inclusion of Essential Community Providers" published by the Centers for Medicare and Medicaid Services shall mean "Supplementary Response: Inclusion of Essential Community Providers" as published on the effective date of this regulation and does not include later amendments to or editions of the "Supplementary Response: Inclusion of Essential Community Providers". A copy of the "Supplementary Response: Inclusion of Essential Community Providers" can be found at the following link: https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy and may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the "Supplementary Response: Inclusion of Essential Community Providers" may be requested from the Division of Insurance. A charge for certification or copies may apply.

"Essential Community Providers/Network Adequacy Template" published by the Centers for Medicare and Medicaid Services shall mean "Essential Community Providers/Network Adequacy Template" as published on the effective date of this regulation and does not include later amendments to or editions of the "Essential Community Providers/Network Adequacy Template". A copy of the "Essential Community Providers/Network Adequacy Template" can be found at the following link: https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy and may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado, 80202. A certified copy of the "Essential Community Providers/Network Adequacy Template" may be requested from the Division of Insurance. A charge for certification or copies may apply.

Section ~~15~~16 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 ~~16~~17 Effective Date

This amended regulation shall be effective on ~~July~~ January 1, 201~~8~~8.

Section ~~17~~18 History

New regulation effective January 1, 2017

Amended regulation effective July 1, 2018.

Amended regulation effective January 1, 2019.

APPENDIX A – DESIGNATING COUNTY TYPES

The county type, Large Metro, Metro, Micro, Rural, or Counties with Extreme Access Considerations (CEAC), is a significant component of the network access criteria. CMS uses a county type designation methodology that is based upon the population size and density parameters of individual counties.

Density parameters are foundationally based on approaches taken by the U.S. Census Bureau in its delineation of "urbanized areas" and "urban clusters", and the Office of Management and Budget (OMB) in its delineation of "metropolitan" and "micropolitan". A county must meet both the population and density thresholds for inclusion in a given designation. For example, a county with population greater than one million and a density greater than or equal to 1,000 persons per square mile (sq. mile) is designated Large Metro. Any of the population-density combinations listed for a given county type may be met for inclusion within that county type (i.e., a county would be designated "Large Metro" if any of the three (3) Large Metro population-density combinations listed in the following table are met; a county is designated as "Metro" if any of the five (5) Metro population-density combinations listed in the table are met; etc.).

Population and Density Parameters

County Type	Population	Density
Large Metro	≥ 1,000,000	≥ 1,000/sq. mile
---	500,000 – 999,999	≥ 1,500/ sq. mile
---	Any	≥ 5,000/ sq. mile
Metro	≥ 1,000,000	10 – 999.9/sq. mile
---	500,000 – 999,999	10 – 1,499.9/sq. mile
---	200,000 – 499,999	10 – 4,999.9/sq. mile
---	50,000 – 199,999	100 – 4,999.9/sq. mile
---	10,000 – 49,999	1,000 – 4,999.9/sq. mile
Micro	50,000 – 199,999	10 – 99.9 /sq. mile
---	10,000 – 49,999	50 – 999.9/sq. mile
Rural	10,000 – 49,999	10 – 49.9/sq. mile
---	<10,000	10 – 4,999.9/sq. mile
CEAC	Any	<10/sq. mile

COLORADO COUNTY DESIGNATIONS

County	Classification
Adams	Metro
Alamosa	Rural
Arapahoe	Metro
Archuleta	CEAC
Baca	CEAC
Bent	CEAC
Boulder	Metro
Broomfield	Metro
Chaffee	Rural
Cheyenne	CEAC
Clear Creek	Rural
Conejos	CEAC
Costilla	CEAC
Crowley	CEAC
Custer	CEAC
Delta	Rural
Denver	Large Metro
Dolores	CEAC
Douglas	Metro
Eagle	Micro
Elbert	Rural
El Paso	Metro

County	Classification
Fremont	Rural
Garfield	Micro
Gilpin	Rural
Grand	CEAC
Gunnison	CEAC
Hinsdale	CEAC
Huerfano	CEAC
Jackson	CEAC
Jefferson	Metro
Kiowa	CEAC
Kit Carson	CEAC
Lake	Rural
La Plata	Micro
Larimer	Metro
Las Animas	CEAC
Lincoln	CEAC
Logan	Rural
Mesa	Micro
Mineral	CEAC
Moffat	CEAC
Montezuma	Rural
Montrose	Rural

County	Classification
Morgan	Rural
Otero	Rural
Ouray	CEAC
Park	CEAC
Phillips	CEAC
Pitkin	Rural
Prowers	CEAC
Pueblo	Micro
Rio Blanco	CEAC
Rio Grande	Rural
Routt	CEAC
Saguache	CEAC
San Juan	CEAC
San Miguel	CEAC
Sedgwick	CEAC
Summit	Rural
Teller	Rural
Washington	CEAC
Weld	Metro
Yuma	CEAC

APPENDIX B – DESIGNATING PROVIDER/FACILITY TYPES

Provider Types – For ECP/Network Adequacy Template and Enrollment Document
Primary Care (including General Practice, Family Medicine, Internal Medicine, and Geriatric physicians, and Primary Care Physician Assistants and Nurse Practitioners)
Gynecology, OB/GYN
Pediatrics - Routine/Primary Care
Allergy and Immunology
Cardiovascular Disease
Chiropracty
Dermatology
Endocrinology
ENT/Otolaryngology
Gastroenterology
General Surgery
Infectious Diseases
Nephrology
Neurology
Neurological Surgery
Medical Oncology & Surgical Oncology
Radiation Oncology
Ophthalmology
Orthopedic Surgery
Physiatry, Rehabilitative Medicine (including physiatrist, physical medicine and rehabilitation specialist)
Plastic Surgery
Podiatry
Psychiatry
Pulmonology
Rheumatology
Urology
Vascular Surgery
Cardiothoracic Surgery
Licensed Clinical Social Worker
Psychology
OTHER MEDICAL PROVIDER
Dental

Facility Types – For ECP/Network Adequacy Template and Enrollment Document
Pharmacy
General Acute Care Hospital
Cardiac Surgery Program
Cardiac Catheterization Services
Critical Care Services - Intensive Care Units (ICU)
Outpatient Dialysis
Surgical Services (Ambulatory Surgical Centers and Outpatient Hospital)
Skilled Nursing Facilities
Diagnostic Radiology (free-standing; hospital outpatient; ambulatory health facilities with Dx Radiology)
Mammography
Physical Therapy (individual physical therapists providing care in Free-standing; hospital outpatient and ambulatory health care facilities)
Occupational Therapist
Speech Therapy
Inpatient Psychiatry (Free-standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital)
Orthotics and Prosthetics
Home Health Services
Durable Medical Equipment
Ambulatory Health Care Facilities – Infusion Therapy/Oncology/ Radiology
Heart Transplant Program
Heart/Lung Transplant Program
Kidney Transplant Program
Liver Transplant Program
Lung Transplant Program
Pancreas Transplant Program
OTHER FACILITIES

Notice of Proposed Rulemaking

Tracking number

2018-00502

Department

700 - Department of Regulatory Agencies

Agency

725 - Division of Real Estate

CCR number

4 CCR 725-2

Rule title

RULES OF THE COLORADO BOARD OF REAL ESTATE APPRAISERS

Rulemaking Hearing

Date

11/01/2018

Time

09:00 AM

Location

1560 Broadway, Suite 1250-C, Denver, CO

Subjects and issues involved

CHAPTER 10:TEMPORARY PRACTICE IN COLORADO

Statutory authority

Part 7 of Title 12, Article 61, Colorado Revised Statutes, as amended.

Contact information

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DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF REAL ESTATE
BOARD OF REAL ESTATE APPRAISERS
4 CCR 725-2

NOTICE OF PROPOSED PERMANENT RULEMAKING HEARING
November 1, 2018

CHAPTER 10: TEMPORARY PRACTICE IN COLORADO

Pursuant to and in compliance with Title 12, Article 61 and Title 24, Article 4, C.R.S. as amended, notice of proposed rulemaking is hereby given, including notice to the Attorney General of the State of Colorado and to all persons who have requested to be advised of the intention of the Colorado Board of Real Estate Appraisers (the "Board") to promulgate rules, or to amend, repeal or repeal and re-enact the present rules of the Board.

STATEMENT OF BASIS

The statutory basis for the rules titled Rules of the Board of Real Estate Appraisers is Part 7 of Title 12, Article 61, Colorado Revised Statutes, as amended.

STATEMENT OF PURPOSE

The purpose of this rule is to effectuate the legislative directive to promulgate necessary and appropriate rules in conformity with the statute and the provisions of the federal Financial Institutions Reform, Recovery and Enforcement Act of 1989.

SPECIFIC PURPOSE OF THIS RULEMAKING

The specific purpose of this rule is to amend or repeal existing rules with respect to the continuing education requirements for licensed and certified appraisers.

Proposed New, Amended and Repealed Rules

[Deleted material shown ~~struck through~~, new material shown ALL CAPS. Rules, or portions of rules, which are unaffected are reproduced. Readers are advised to obtain a copy of the complete rules of the Board at www.dora.state.co.us/real-estate/rulemaking/BOREA/index.htm]

CHAPTER 10: TEMPORARY PRACTICE IN COLORADO

10.0 Pursuant to section 12-61-711(2) and (3), C.R.S., as amended, a Temporary Practice Permit may be issued to the holder of an active appraiser's license or certificate from another jurisdiction. Such Temporary Practice Permit must be subject to the following restrictions and requirements:

A. The applicant must apply for and be issued a Temporary Practice Permit prior to his or her commencement of a real property appraisal in Colorado that is part of a federally related transaction;

B. The applicant's business is temporary in nature and the applicant must identify in writing the appraisal assignment(s) to be completed under the Temporary Practice Permit prior to being issued a Temporary Practice Permit;

C. The Temporary Practice Permit will be valid only for the appraisal assignment(s) listed thereon;

D. The applicant must be the holder of an active license or certificate in good standing under the laws of another jurisdiction;

E. ~~The jurisdiction in which the applicant holds an active license or certificate in good standing has requirements that are substantially equivalent to those licensure requirements described in Board Rules 1.13, 1.14 or 1.15, and maintains qualification requirements substantially equivalent to those in Board Rules 2.2, 2.3 or 2.4, respectively;~~THE APPLICANT MUST APPLY FOR A TEMPORARY PRACTICE PERMIT ON A FORM PROVIDED BY THE BOARD, PAY THE SPECIFIED FEES, AND MEET ALL OTHER BOARD REQUIREMENTS; AND

F. ~~The appraiser regulatory program of the jurisdiction where the applicant holds a license or certificate in good standing must be in compliance with Title XI, FIRREA, as determined by the ASC as defined in Board Rule 1.42;~~PURSUANT TO SECTION 12-61-711(2) AND (3), C.R.S., TEMPORARY PRACTICE PERMITS ARE AVAILABLE ONLY TO PERSONS HOLDING ACTIVE LICENSURE IN ANOTHER JURISDICTION AT LEVELS SUBSTANTIALLY EQUIVALENT TO THOSE DEFINED IN BOARD RULES 1.13, 1.14, OR 1.15. TEMPORARY PRACTICE PERMITS ARE NOT AVAILABLE TO PERSONS HOLDING LICENSURE IN ANOTHER JURISDICTION AT A TRAINEE, APPRENTICE, ASSOCIATE, INTERN, OR OTHER ENTRY LEVEL.

~~G. The applicant must apply for a Temporary Practice Permit on a form provided by the Board, pay the specified fees, and meet all other Board requirements; and~~

~~H. Pursuant to section 12-61-711(2) and (3), C.R.S., Temporary Practice Permits are available only to persons holding active licensure in another jurisdiction at levels substantially equivalent to those defined in Board Rules 1.13, 1.14 and 1.15. Temporary Practice Permits are not available to persons holding licensure in another jurisdiction at a trainee, apprentice, associate, intern, or other entry level.~~

A hearing on the above subject matter will be held on Thursday, November 1, 2018, at the Colorado Division of Real Estate, 1560 Broadway, Suite 1250C, Denver, Colorado 80202 beginning at 9:00 a.m.

Any interested person may participate in the rule making through submission of written data, views and arguments to the Division of Real Estate. Persons are requested to submit data, views and arguments to the Division of Real Estate in writing no less than ten (10) days prior to the hearing date and time set forth above. However, all data, views and arguments submitted prior to or at the rulemaking hearing or prior to the closure of the rulemaking record (if different from the date and time of hearing), shall be considered.

Please be advised that the rule being considered is subject to further changes and modifications after public comment and formal hearing.

Notice of Proposed Rulemaking

Tracking number

2018-00503

Department

700 - Department of Regulatory Agencies

Agency

725 - Division of Real Estate

CCR number

4 CCR 725-2

Rule title

RULES OF THE COLORADO BOARD OF REAL ESTATE APPRAISERS

Rulemaking Hearing

Date

11/01/2018

Time

09:00 AM

Location

1560 Broadway, Suite 1250-C, Denver, CO

Subjects and issues involved

CHAPTER 1:DEFINITIONS

Statutory authority

Part 7 of Title 12, Article 61, Colorado Revised Statutes, as amended.

Contact information

Name

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Rulemaking Administrator

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DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF REAL ESTATE
BOARD OF REAL ESTATE APPRAISERS
4 CCR 725-2

NOTICE OF PROPOSED PERMANENT RULEMAKING HEARING
November 1, 2018

CHAPTER 1: DEFINITIONS

Pursuant to and in compliance with Title 12, Article 61 and Title 24, Article 4, C.R.S. as amended, notice of proposed rulemaking is hereby given, including notice to the Attorney General of the State of Colorado and to all persons who have requested to be advised of the intention of the Colorado Board of Real Estate Appraisers (the "Board") to promulgate rules, or to amend, repeal or repeal and re-enact the present rules of the Board.

STATEMENT OF BASIS

The statutory basis for the rules titled Rules of the Board of Real Estate Appraisers is Part 7 of Title 12, Article 61, Colorado Revised Statutes, as amended.

STATEMENT OF PURPOSE

The purpose of this rule is to effectuate the legislative directive to promulgate necessary and appropriate rules in conformity with the statute and the provisions of the federal Financial Institutions Reform, Recovery and Enforcement Act of 1989.

SPECIFIC PURPOSE OF THIS RULEMAKING

The specific purpose of this rule is to amend or repeal existing rules with respect to the continuing education requirements for licensed and certified appraisers.

Proposed New, Amended and Repealed Rules

[Deleted material shown ~~struck through~~, new material shown ALL CAPS. Rules, or portions of rules, which are unaffected are reproduced. Readers are advised to obtain a copy of the complete rules of the Board at www.dora.state.co.us/real-estate/rulemaking/BOREA/index.htm]

CHAPTER 1: DEFINITIONS

1.43 TRAIN: STRICTLY APPLIED TO 12-61-702(2)(A)(I), C.R.S., TO ENTICE TO KEEP, OR RETAIN.

A hearing on the above subject matter will be held on Thursday, November 1, 2018, at the Colorado Division of Real Estate, 1560 Broadway, Suite 1250C, Denver, Colorado 80202 beginning at 9:00 a.m.

Any interested person may participate in the rule making through submission of written data, views and arguments to the Division of Real Estate. Persons are requested to submit data, views and arguments to the Division of Real Estate in writing no less than ten (10) days prior to the hearing date and time set forth above. However, all data, views and arguments submitted prior to

or at the rulemaking hearing or prior to the closure of the rulemaking record (if different from the date and time of hearing), shall be considered.

Please be advised that the rule being considered is subject to further changes and modifications after public comment and formal hearing.

Notice of Proposed Rulemaking

Tracking number

2018-00500

Department

700 - Department of Regulatory Agencies

Agency

725 - Division of Real Estate

CCR number

4 CCR 725-2

Rule title

RULES OF THE COLORADO BOARD OF REAL ESTATE APPRAISERS

Rulemaking Hearing

Date

11/01/2018

Time

09:00 AM

Location

1560 Broadway, Suite 1250-C, Denver, CO

Subjects and issues involved

CHAPTER 7:CONTINUING EDUCATION REQUIREMENTS

Statutory authority

Part 7 of Title 12, Article 61, Colorado Revised Statutes, as amended.

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DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF REAL ESTATE
BOARD OF REAL ESTATE APPRAISERS
4 CCR 725-2

NOTICE OF PROPOSED PERMANENT RULEMAKING HEARING
November 1, 2018

CHAPTER 7: CONTINUING EDUCATION REQUIREMENTS

Pursuant to and in compliance with Title 12, Article 61 and Title 24, Article 4, C.R.S. as amended, notice of proposed rulemaking is hereby given, including notice to the Attorney General of the State of Colorado and to all persons who have requested to be advised of the intention of the Colorado Board of Real Estate Appraisers (the "Board") to promulgate rules, or to amend, repeal or repeal and re-enact the present rules of the Board.

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SPECIFIC PURPOSE OF THIS RULEMAKING

The specific purpose of this rule is to amend or repeal existing rules with respect to the continuing education requirements for licensed and certified appraisers.

Proposed New, Amended and Repealed Rules

[Deleted material shown ~~struck through~~, new material shown ALL CAPS. Rules, or portions of rules, which are unaffected are reproduced. Readers are advised to obtain a copy of the complete rules of the Board at www.dora.state.co.us/real-estate/rulemaking/BOREA/index.htm]

CHAPTER 7: CONTINUING EDUCATION REQUIREMENTS

7.25 ~~All licensees who prepare and sign an appraisal for a conservation easement for which a tax credit may be claimed pursuant to Section 39-22-522, C.R.S. must complete the "Conservation Easement Appraiser Update Course." The content of the "Conservation Easement Appraiser Update Course" will be developed by the Board of Real Estate Appraisers and presented by a provider approved by the Board of Real Estate Appraisers. The certificate of course completion must be obtained and dated prior to the effective date of an appraisal for a conservation easement for which a tax credit may be claimed. The certificate of course completion satisifies the requirements of this rule and is valid from the completion date on the certificate through December 31 of the following calendar year. This rule will be effective for an appraisal of a conservation easement with an effective date on or after January 1, 2017.~~REPEALED.

A hearing on the above subject matter will be held on Thursday, November 1, 2018, at the Colorado Division of Real Estate, 1560 Broadway, Suite 1250C, Denver, Colorado 80202 beginning at 9:00 a.m.

Any interested person may participate in the rule making through submission of written data, views and arguments to the Division of Real Estate. Persons are requested to submit data, views and arguments to the Division of Real Estate in writing no less than ten (10) days prior to the hearing date and time set forth above. However, all data, views and arguments submitted prior to or at the rulemaking hearing or prior to the closure of the rulemaking record (if different from the date and time of hearing), shall be considered.

Please be advised that the rule being considered is subject to further changes and modifications after public comment and formal hearing.

Notice of Proposed Rulemaking

Tracking number

2018-00479

Department

700 - Department of Regulatory Agencies

Agency

732 - Division of Professions and Occupations - State Physical Therapy Board

CCR number

4 CCR 732-1

Rule title

PHYSICAL THERAPIST LICENSURE AND PHYSICAL THERAPIST ASSISTANT CERTIFICATION

Rulemaking Hearing

Date

11/02/2018

Time

09:30 AM

Location

1560 Broadway, Suite 1250A

Subjects and issues involved

205. Licensing of Foreign-Trained Physical Therapist Graduates of Non-Accredited Programs. This rule sets forth and clarifies procedures for determining whether a foreign-trained physical therapist applicant who has graduated from a non-accredited program has substantially equivalent education and training.

Statutory authority

12-35-124(1)(g), 24-4-103 and 12-35-107(b)

Contact information

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205. Licensing of Foreign-Trained Physical Therapist Graduates of Non-Accredited Programs

The purpose of this rule is to establish procedures for determining whether a foreign-trained physical therapist applicant who has graduated from a non-accredited program has substantially equivalent education and training as required pursuant to section 12-41-111(1)(a), C.R.S.

A. A foreign-trained applicant who has graduated from a non-accredited program must have education and training in physical therapy substantially equivalent to the entry-level education and training required at accredited physical therapy programs in the United States in effect at the time of the applicant's graduation. This includes an assessment of the applicant's general and professional education, as well as training in wound care and debridement.

B. Applicants who wish to have their general and professional education considered "substantially equivalent" in order to take the National Physical Therapy Examination (NPTE) through Colorado and qualify for licensure shall submit their credentials to the Foreign Credentialing Commission of Physical Therapy (FCCPT). The applicant must submit a credentials evaluation utilizing the version of the Coursework Evaluation Tool for Foreign-Educated Physical Therapists developed by the Federation of State Boards of Physical Therapy (FSBPT) that applies to the applicant's year of graduation in order to evaluate the applicant's credentials against the requirements at accredited physical therapy programs in place at the time of the applicant's graduation. The Board will not accept a credentials evaluation from an organization not listed in this rule.

C. A foreign-trained applicant who has graduated from a non-accredited program and already passed the NPTE may submit a credentials evaluation from a credentialing agency other than FCCPT provided that:

1. The credentialing agency utilized the version of the Coursework Evaluation Tool for Foreign-Educated Physical Therapists developed by FSBPT that applies to the applicant's year of graduation in order to evaluate the applicant's credentials against the requirements at accredited physical therapy programs in place at the time of the applicant's graduation; and

2. The applicant has been licensed in good standing and actively engaged in clinical practice as a licensed physical therapist in the United States for 2 out of the 5 years immediately preceding his/her application for licensure.

D. All expenses associated with the credential evaluation are the responsibility of the applicant.

E. Failure to have a credentials evaluation pursuant to the terms of this rule will result in the Board denying the application.

F. In the event a foreign-trained applicant's general education is found to be deficient, the applicant may take and pass subject examinations from the College-Level Examination Program (CLEP) to overcome the deficiency in general education.

G. In the event a foreign-trained applicant's professional education is found to be deficient, the applicant shall either:

1. Successfully complete a Board-approved plan to overcome deficiencies; or

2. Overcome the deficiency by obtaining a master or doctorate degree at an accredited physical therapy program.

H. Degrees obtained in a transitional program are not equivalent to a professional entry-level physical therapy degree and will not be accepted for initial licensure.

I. On or after January 1, 2019, applicant must submit fingerprints for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the Colorado Bureau of Investigation responsible for retaining the state's criminal records set forth in Section 24-60-3702 (3) (B).

Notice of Proposed Rulemaking

Tracking number

2018-00481

Department

700 - Department of Regulatory Agencies

Agency

732 - Division of Professions and Occupations - State Physical Therapy Board

CCR number

4 CCR 732-1

Rule title

PHYSICAL THERAPIST LICENSURE AND PHYSICAL THERAPIST ASSISTANT CERTIFICATION

Rulemaking Hearing

Date

11/02/2018

Time

09:30 AM

Location

1560 Broadway, Suite 1250A

Subjects and issues involved

211.Requirements for Physical Therapists to Perform Dry Needling. This rule sets forth and clarifies the practice of dry needling, including who may perform.

Statutory authority

12-35-124(1)(g), 2-4-103 and 12-35-107(b)

Contact information

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211. Requirements for Physical Therapists to Perform Dry Needling

A. Dry needling (also known as Trigger Point Dry Needling) is a physical intervention that uses a filiform needle to stimulate trigger points, diagnose and treat neuromuscular pain and functional movement deficits; is based upon Western medical concepts; requires an examination and diagnosis, and treats specific anatomic entities selected according to physical signs. Dry needling does not include the stimulation of auricular or distal points

B. The performance of dry needling in accordance with this rule is not the performance of acupuncture as defined in section 12-2-.5-102 C.R.S. and is not a violation of section 12.29.5-105 C.R.S.

C. Dry needling as defined pursuant to this rule is within the scope of practice of physical therapy.

D. A Physical Therapist must have the knowledge, skill, ability, and documented competency to perform an act that is within the Physical Therapist's scope of practice. Except as part of a course of study on dry needling pursuant to paragraph D.2 of this Rule, a Physical Therapist shall not perform dry needling unless competent to do so.

E. To be deemed competent to perform dry needling, a Physical Therapist must:

1. have practiced for at least two years as a licensed Physical Therapist; and

2. have successfully completed a dry needling course of study that consists of a minimum of 46 hours of in-person (i.e. not online) dry needling training.

F. A provider of a dry needling course of study must meet the educational and clinical prerequisites as defined in this rule, paragraph D above and demonstrate a minimum of two years of dry needling practice techniques. The provider is not required to be a Physical Therapist.

G. Physical Therapists performing dry needling in their practice must have written informed consent for each patient where this technique is used. The patient must sign and receive a copy of the informed consent form. The consent form must, at a minimum, clearly state the following information:

1. Risks and benefits of dry needling; and

2. Physical Therapist's level of education and training in dry needling; and

3. The Physical Therapist will not stimulate any distal or auricular points during dry needling.

H. When dry needling is performed, it must be clearly documented in the procedure notes and must indicate how the patient tolerated the technique, as well as the outcome after the procedure.

I. Dry needling shall not be delegated and must be directly performed by a qualified, licensed Physical Therapist.

J. Dry needling must be performed in a manner consistent with generally accepted standards of practice, including clean needle techniques, and the guidelines and recommendations of the Centers for Disease Control and Prevention ("CDC").

K. The Physical Therapist shall supply written documentation, upon request by the Board, which substantiates appropriate training as required by this Rule. Failure to provide written documentation, upon request, is a violation of this Rule, and is prima facie evidence that

the Physical Therapist is not competent and not permitted to perform dry needling

Notice of Proposed Rulemaking

Tracking number

2018-00482

Department

700 - Department of Regulatory Agencies

Agency

732 - Division of Professions and Occupations - State Physical Therapy Board

CCR number

4 CCR 732-1

Rule title

PHYSICAL THERAPIST LICENSURE AND PHYSICAL THERAPIST ASSISTANT CERTIFICATION

Rulemaking Hearing

Date

11/02/2018

Time

09:30 AM

Location

1560 Broadway, Suite 1250A

Subjects and issues involved

213.Continuing Professional Competency Requirements for Licensure Renewal for Physical Therapists. This rule sets forth and establishes a continuing professional competency program pursuant to section 12-41-114.6, C.R.S., wherein a physical therapist shall maintain and demonstrate continuing professional competency in order to renew a license to practice physical therapy in the state of Colorado.

Statutory authority

12-35-124(1)(g), 2-4-103 and 12-35-107(b)

Contact information

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213. Continuing Professional Competency Requirements for Licensure Renewal for Physical Therapists

The purpose of this rule is to establish a continuing professional competency program pursuant to section 12-41-114.6, C.R.S., wherein a physical therapist shall maintain and demonstrate continuing professional competency in order to renew a license to practice physical therapy in the state of Colorado.

Furthermore, pursuant to section 12-41-114.6(2), C.R.S., records of assessment or other documentation developed or submitted in connection with the continuing professional competency program are confidential and not subject to inspection by the public or discovery in connection with a civil action against a physical therapist. A person or the Board shall not use the records or documents unless used by the Board to determine whether a physical therapist is maintaining continuing professional competency to engage in the profession.

A. Definitions

1. Assessment of Knowledge and Skills (AKS): an objective third-party assessment that compares a licensee's knowledge, skills, and abilities to the standards for entry-level practice.

2. Continuing Professional Competency: the ongoing ability of a physical therapist to learn, integrate, and apply the knowledge, skills, and judgment to practice as a physical therapist according to generally accepted standards and professional ethical standards.

3. Continuing Professional Development (CPD): the Board program through which a licensee can satisfy the continuing professional competency requirements in order to renew, reinstate, or reactivate a license.

4. Deemed Status: A method to satisfy continuing professional competency requirements. A licensee who satisfies the continuing professional competency requirements of a Colorado state agency or department, an accrediting body recognized by the Board, or an entity approved by the Board pursuant to section 12-41-114.6(1)(c), C.R.S., may qualify under this method in lieu of completing the Board's CPD program.

5. Learning Plan: a Board approved form through which a licensee documents his/her goals and plans of learning that were developed from his/her Reflective Self-Assessment (RSAT), which is defined below, and AKS (when appropriately applied).

6. Military Exemption: A method to satisfy continuing professional competency requirements. A licensee who has been approved for this exemption will not be required to meet continuing professional competency requirements during the renewal period in which he/she was approved by the Division of Professions and Occupations.

7. Professional Development Activities (PDA): learning activities undertaken to increase the licensee's knowledge and skill or hone existing knowledge and skill for the purpose of continuing professional development.

8. Reflective Self-Assessment Tool (RSAT): a reflective practice tool in which a licensee can reflect upon his/her knowledge and skills pertaining to the foundational areas of physical therapy practice taking into account the licensee's current level and area of practice.

B. Continuing Professional Competency Requirements

1. Effective after the 2014 license renewal, or upon the completion of the first renewal of a license thereafter, the licensee shall demonstrate continuing professional competency in order to renew a license by:

    a. Participation in the Continuing Professional Development (CPD) program;

    b. Participation in a program of continuing professional competency through a Colorado state agency or department, including continuing competency requirements imposed through a contractual arrangement with a provider as set forth in section 12-41-114.6(1)(c), C.R.S. This status is defined as "Deemed Status" in section A(4) of this rule and further described in section D of this rule; or

    c. Receiving an exemption for military service as defined in section 12-70-102, C.R.S. Military exemptions must be approved by the Division of Professions and Occupations. Licensees seeking a military exemption shall submit a request in writing with evidence that the licensee's military service meets the criteria established in section 12-70-102, C.R.S., and section E of this rule.

2. A licensee shall attest at the time of the renewal of a license to his/her compliance with continuing professional competency requirements.

C. Continuing Professional Development Program

1. The Continuing Professional Development (CPD) program entails the following:

    a. The licensee shall complete the Reflective Self-Assessment Tool (RSAT) once per 2- year renewal period. A licensee shall use the Board approved form.

        i. The execution of a Learning Plan once per 2-year renewal period that is based upon the licensee's Reflective Self-Assessment Tool (RSAT) or Assessment of Knowledge and Skills (AKS). A licensee shall use the Board approved form.

        ii. Accrual of 30 points of Professional Development Activities (PDA) per 2-year renewal period.

2. Professional Development Activities (PDA)

    a. Professional Development Activities must be relevant to the licensee's practice as a physical therapist and pertinent to his/her Learning Plan. The Board will not pre-approve specific courses or providers. The licensee shall determine which activities and topics will meet his/her Learning Plan, and select an appropriate provider.

    b. Professional Development Activities are separated into Category I, Category II, and Category III activities and each category has a corresponding point value. Points are used in lieu of continuing education units (CEU) or contact hours to allow credit for non-continuing education type activities.

    c. Points will be accepted if the activity is included in the Board's *Professional Development Activities List*. The Board may accept or reject activities submitted for consideration that are not identified on its list.

    d. A minimum of 15 of the required 30 points must be Category I activities.

e. Professional Development Activities will only apply for one 2-year renewal period.

f. Professional Development Activities must be measured by a contact hour to credit hour ratio.

3. The completion of an Assessment of Knowledge and Skills (AKS) will not be accepted more than once every 10 years.

   a. An AKS must meet the following criteria:

      i. Be drafted and validated by qualified physical therapists and psychometricians;

      ii. Be comprised of evidence based practice;

      iii. Be maintained for relevancy and advancements in and affecting the profession; and

      iv. Provide feedback to the participant/licensee regarding his/her performance and suggested learning opportunities to enhance his/her knowledge and skills.

   b. Administrative Approval. The Board finds the following AKSs to have met the criteria established in section C(3)(a) of this rule, and are administratively approved by the Board:

      i. The online continuing competence learning and assessment tool (oPTion) administered by the Federation of State Boards of Physical Therapy (FSBPT).

      ii. If the AKS is not listed as administratively approved by the Board in this rule, then additional documentation demonstrating the AKS satisfies the Board criteria will be required prior to registering and completing the AKS.

   c. The licensee may count the completion of an AKS as a Category I activity toward a mandatory 30 PDA points for the corresponding 2-year renewal period in compliance with the State Physical Therapy Board's *Professional Development Activities List* for assigned point values.

4. Audit of Compliance. The following documentation is required for an audit of compliance of a licensee's Continuing Professional Development:

   a. The Learning Plan that is signed and executed which contains the licensee's goals in the form and manner as approved by the Board.

   b. A certificate of completion or other report issued by the AKS provider indicating the name of the licensee, AKS title, content, and the licensee's date of completion.

   c. Documentation of 30 points of Professional Development Activities in compliance with the State Physical Therapy Board's *Professional Development Activities List* for documentation requirements for PDAs.

   d. The Board may accept or reject Professional Development Activities (PDA) that do not meet the criteria established by the Board for PDA or standards of quality as defined in the State Physical Therapy Board's *Professional Development Activities List*, *Standards of Quality for Category I Continuing Education*

Activities, and this rule.

D. Deemed Status. The following criteria must be met in order to claim this status:

1. In order to renew a license, a licensee shall attest to his/her Deemed Status.

2. To qualify, the licensee must be in full compliance with the requirements of his/her state agency or department during the entire 2-year renewal period of his/her physical therapist license and on track to successfully complete that program or have successfully completed it.

3. Licensees claiming Deemed Status are subject to an audit of compliance. To satisfy an audit of compliance, the licensee shall submit appropriate evidence of participation in a qualifying program through submission of:

   a. Proof from the Colorado state agency or department or contractual entity verifying that the licensee is in compliance with its continuing professional competency program; and

   b. A letter from his/her employer certifying dates of employment for the entire 2-year license renewal period, without any break; or

   c. Other documentation approved by the Board which reflects the licensee's compliance with a program of continuing professional competency.

E. Military Exemption. Pursuant to section 12-70-102, C.R.S., licensees who have been called to federally funded active duty for more than 120 days for the purpose of serving in a war, emergency, or contingency may request an exemption from the continuing professional competency requirements for the renewal, reinstatement, or reactivation of his/her license for the 2-year renewal period that falls within the period of service or within six months following the completion of service.

1. Military exemptions must be approved by the Division of Professions and Occupations. Licensees seeking a military exemption shall submit a request in writing with evidence that the licensee's military service meets the criteria established in section 12-70-102, C.R.S.

2. After being granted a military exemption, in order to complete the renewal process, a licensee shall attest to his/her military exemption.

F. Records Retention. A licensee shall retain documentation demonstrating his/her compliance for 2 complete 2-year renewal periods.

G. Non-Compliance. Falsifying an attestation or other documentation regarding the licensee's compliance with continuing professional competency requirements constitutes the falsification of information in an application and may be grounds for discipline pursuant to sections 12-41-115(1)(k) and (r), C.R.S.

H. Reinstatement and Reactivation. A licensee seeking to reinstate or reactivate a license which has been expired or inactivated for 2 years or less shall meet the competency requirements outlined in Rule 207(B).

Notice of Proposed Rulemaking

Tracking number

2018-00480

Department

700 - Department of Regulatory Agencies

Agency

732 - Division of Professions and Occupations - State Physical Therapy Board

CCR number

4 CCR 732-1

Rule title

PHYSICAL THERAPIST LICENSURE AND PHYSICAL THERAPIST ASSISTANT CERTIFICATION

Rulemaking Hearing

Date

11/02/2018

Time

09:30 AM

Location

1560 Broadway, Suite 1250a

Subjects and issues involved

206. Licensure by Endorsement for Physical Therapists. This rule sets forth and clarifies the requirements for licensure by endorsement for physical therapists.

Statutory authority

12-35-124(1)(g), 24-4-103 and 12-35-107(b)

Contact information

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206. Licensure by Endorsement for Physical Therapists

The purpose of this rule is to delineate the requirements for licensure by endorsement for physical therapists pursuant to section 12-41-109, C.R.S. In order to be qualified for licensure by endorsement, an applicant is required to demonstrate that he/she does not currently have a revoked, suspended, restricted, or conditional license to practice as a physical therapist, or is currently pending disciplinary action against such license in another state or territory of the United States. An applicant must meet one of the following requirements:

A. Graduated from an accredited physical therapy program within the past 2 years and passed the National Physical Therapy Examination (NPTE).

B. Practiced in the United States as a licensed physical therapist for at least 2 of the 5 years immediately preceding the date of the application.

C. If an applicant has not practiced as a licensed physical therapist for at least 2 of the 5 years immediately preceding the date of the application, then he/she is required to have passed the NPTE, or its equivalent, and may demonstrate competency through successful completion of 1 of the following:

1. Complete 60 points of Professional Development Activities (PDA) pursuant to Rule 213(C)(2)(a-c) during the 2 years immediately preceding the application.

    a. An applicant seeking to demonstrate competency through this pathway shall:

        i. Complete the Federation of State Boards of Physical Therapy's (FSBPT) online continuing education competence learning and assessment tool (oPTion) or a comparable objective third-party assessment that compares a licensee's knowledge, skills, and abilities to the standards for entry-level practice accepted by the Board; and

        ii. Successfully complete 60 Category I points, directly related to the physical therapist's clinical practice and address any areas of deficiencies identified in the objective third-party assessment.

    b. The applicant must submit the results of the objective third-party assessment and the corresponding 60 Category I points for Board consideration within 1 year of completing the objective third-party assessment.

2. Successfully complete a Board authorized internship.

    a. An applicant seeking to demonstrate competency through an internship shall:

        i. Arrange for a Colorado-licensed, practicing physical therapist (the "supervising physical therapist") to supervise the internship; and

        ii. Ensure that the supervising physical therapist immediately notifies the Board in writing of the establishment of the internship and submits for the Board's approval a plan for supervision using the most current version of the "Physical Therapist Clinical Performance Instrument" (CPI) or a comparable objective third-party assessment that compares a licensee's knowledge, skills, and abilities to standards for entry-level practice accepted by the Board.

b. The internship shall not commence without the Board's written approval of the supervising physical therapist's plan for supervision specified in subparagraph (2)(c) of this rule.

c. The internship shall consist of:

i. The applicant's actual practice of physical therapy as defined in section 12-41-103(6), C.R.S.;

ii. Supervision of the applicant at all times by any Colorado-licensed, practicing physical therapist on the premises where physical therapy services are being rendered; and

iii. A minimum of 240 hours clinical practice within a consecutive 6-month period commencing from the Board's written approval of the plan for supervision.

d. The applicant shall ensure that the supervising physical therapist files a written report at the completion of the internship. This report must indicate whether the applicant demonstrates entry-level performance in all skills assessed by the CPI or comparable objective third-party assessment. Hard copy or electronic copies of the CPI or comparable objective third-party assessment are acceptable.

D. An applicant who is unable to demonstrate competency under sections A, B, or C of this rule may request to demonstrate competency by any other means. The Board shall consider such a request on a case-by-case basis. The decision to approve such a request shall be at the sole discretion of the Board. In considering whether to approve such a request, the Board shall consider public safety, the particular circumstances and hardships faced by the applicant, and such other factors as the Board deems appropriate. If the Board grants a license under this section D, the Board may subject said license to such lawful conditions as the Board finds are necessary to protect the public.

E. On or after January 1, 2019, applicant must submit fingerprints for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the Colorado Bureau of Investigation responsible for retaining the state's criminal records set forth in Section 24-60-3702 (3)(B).

Notice of Proposed Rulemaking

Tracking number

2018-00478

Department

700 - Department of Regulatory Agencies

Agency

732 - Division of Professions and Occupations - State Physical Therapy Board

CCR number

4 CCR 732-1

Rule title

PHYSICAL THERAPIST LICENSURE AND PHYSICAL THERAPIST ASSISTANT CERTIFICATION

Rulemaking Hearing

Date

11/02/2018

Time

09:30 AM

Location

1560 Broadway, Suite 1250a

Subjects and issues involved

Rule 204 - Licensure by Examination for Physical Therapists, the rule sets forth and clarifies the requirements for licensure by examination for physical therapists

Statutory authority

12-35-124(1)(g), 24-4-103 and 12-35-107(b)

Contact information

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204. Licensure by Examination for Physical Therapists

The purpose of this rule is to delineate the requirements for licensure by examination for physical therapists pursuant to section 12-41-107, C.R.S.

A. An applicant is required to demonstrate that he/she has successfully completed a physical therapy program that is either:

1. Accredited by a nationally recognized accrediting agency pursuant to Rule 103; or

2. Substantially equivalent pursuant to Rule 205.

B. If applying to take the National Physical Therapy Examination (NPTE), an applicant:

1. Must have successfully completed a physical therapy program or be eligible to graduate within 90 days of a program pursuant to section A of this rule; and

2. Must meet the Federation of State Boards of Physical Therapy's (FSBPT) current eligibility requirements in effect at the time of registering for the NPTE, including any exam retake or low score limit policies.

C. An applicant for licensure by examination must graduate from a physical therapy program pursuant to section A of this rule and pass the NPTE within the 2 years immediately preceding the date of the application.

D. An applicant who is unable to meet the requirements under section C of this rule may request to demonstrate competency by any other means. The Board shall consider such a request on a case-by-case basis. The decision to approve such a request shall be at the sole discretion of the Board. In considering whether to approve such a request, the Board shall consider public safety, the particular circumstances and hardships faced by the applicant, and such other factors as the Board deems appropriate. If the Board grants a license under this section D, the Board may subject said license to such lawful conditions as the Board finds are necessary to protect the public.

E. On or after January 1, 2019, applicant must submit fingerprints for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the Colorado Bureau of Investigation responsible for retaining the state's criminal records set forth in Section 24-60-3702 (3) (B).

Notice of Proposed Rulemaking

Tracking number

2018-00484

Department

700 - Department of Regulatory Agencies

Agency

732 - Division of Professions and Occupations - State Physical Therapy Board

CCR number

4 CCR 732-1

Rule title

PHYSICAL THERAPIST LICENSURE AND PHYSICAL THERAPIST ASSISTANT CERTIFICATION

Rulemaking Hearing

Date

11/02/2018

Time

09:30 AM

Location

1560 Broadway, Suite 1250a

Subjects and issues involved

304. Certification of Foreign-Trained Physical Therapist Assistant Graduates of Non-Accredited Programs. The purpose of this rule is to establish procedures for determining whether a foreign-trained physical therapist assistant applicant who has graduated from a non-accredited program has substantially equivalent education and training.

Statutory authority

12-35-124(1)(g), 2-4-103 and 12-35-107(b)

Contact information

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304. Certification of Foreign-Trained Physical Therapist Assistant Graduates of Non-Accredited Programs

The purpose of this rule is to establish procedures for determining whether a foreign-trained physical therapist assistant applicant who has graduated from a non-accredited program has substantially equivalent education and training as required pursuant to section 12-41-207(1)(a), C.R.S.

A. A foreign-trained applicant who has graduated from a non-accredited program must have education and training as a physical therapist assistant substantially equivalent to the entry-level education and training required at accredited physical therapist assistant programs in the United States in effect at the time of the applicant's graduation. This includes but is not limited to an assessment of the applicant's foundational studies and applied and technical education, as well as training in non-selective wound care.

B. Applicants who wish to have their foundational studies, and applied/technical education considered "substantially equivalent" in order to take the National Physical Therapy Examination (NPTE) through Colorado and qualify for certification shall submit their credentials to the Foreign Credentialing Commission of Physical Therapy (FCCPT). The applicant must submit a credentials evaluation utilizing the version of the Coursework Tool for Foreign Educated Physical Therapist Assistants developed by the Federation of State Boards of Physical Therapy (FSBPT) that applies to the applicant's year of graduation in order to evaluate the applicant's credentials against the requirements at accredited physical therapist assistant programs in place at the time of the applicant's graduation. The Board will not accept a credentials evaluation from an organization not listed in this rule.

C. A foreign-trained applicant who has graduated from a non-accredited program and already passed the NPTE may submit a credentials evaluation from a credentialing agency other than FCCPT provided that:

1. The credentialing agency utilized the version of the Coursework Evaluation Tool for Foreign-Educated Physical Therapists developed by FSBPT that applies to the applicant's year of graduation in order to evaluate the applicant's credentials against the requirements at accredited physical therapist assistant programs in place at the time of the applicant's graduation; and

2. The applicant has been licensed, certified, or registered in good standing and actively engaged in clinical practice as a physical therapist assistant in the United States for 2 out of the 5 years immediately preceding his or her application for certification.

D. All expenses associated with the credentials evaluation are the responsibility of the applicant.

E. Failure to have a credentials evaluation pursuant to the terms of this rule will result in the Board denying the application.

F. In the event a foreign-trained applicant's foundational studies are found to be deficient, the applicant may take and pass subject examinations from the College-Level Examination Program (CLEP) to overcome the deficiency in general education.

G. In the event a foreign-trained applicant's applied and technical education is found to be deficient, the applicant shall either:

1. Successfully complete a Board-approved plan to overcome deficiencies; or

2. Overcome the deficiency by obtaining an associate degree from an accredited physical therapist assistant program.

H. On or after January 1, 2019, applicant must submit fingerprints for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the Colorado Bureau of Investigation responsible for retaining the state's criminal records set forth in Section 24-60-3702 (3) (B).

Notice of Proposed Rulemaking

Tracking number

2018-00483

Department

700 - Department of Regulatory Agencies

Agency

732 - Division of Professions and Occupations - State Physical Therapy Board

CCR number

4 CCR 732-1

Rule title

PHYSICAL THERAPIST LICENSURE AND PHYSICAL THERAPIST ASSISTANT CERTIFICATION

Rulemaking Hearing

Date

11/02/2018

Time

09:30 AM

Location

1560 Broadway, Suite 1250A

Subjects and issues involved

Rule 303, Certification by Examination for Physical Therapist Assistants.

The purpose of this rule is to delineate the requirements for certification by examination for physical therapist assistants.

Statutory authority

12-35-124(1)(g), 2-4-103 and 12-35-107(b)

Contact information

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303. Certification by Examination for Physical Therapist Assistants

The purpose of this rule is to delineate the requirements for certification by examination for physical therapist assistants pursuant to section 12-41-205, C.R.S.

A. An applicant is required to demonstrate that he/she has successfully completed a physical therapy program pursuant to Rule 204 or a physical therapist assistant program that is either:

1. Accredited by a nationally recognized accrediting agency pursuant to Rule 103; or

2. Substantially equivalent pursuant to Rule 304.

B. If applying to take the National Physical Therapy Examination (NPTE), an applicant:

1. Must have successfully completed a physical therapy or physical therapist assistant program, or be eligible to graduate within 90 days of a program pursuant to section A of this rule; and

2. Must meet the Federation of State Boards of Physical Therapy's (FSBPT) current eligibility requirements in effect at the time of registering for the NPTE, including any exam retake or low score limit policies.

C. An applicant for certification by examination must graduate from a physical therapy or physical therapist assistant program pursuant to section A of this rule and pass the NPTE within the 2 years immediately preceding the date of the application.

D. An applicant who is unable to meet the requirements under section C of this rule may request to demonstrate competency by any other means. The Board shall consider such a request on a case-by-case basis. The decision to approve such a request shall be at the sole discretion of the Board. In considering whether to approve such a request, the Board shall consider public safety, the particular circumstances and hardships faced by the applicant, and such other factors as the Board deems appropriate. If the Board grants a certification under this section D, the Board may subject said certification to such lawful conditions as the Board finds are necessary to protect the public.

E. On or after January 1, 2019, applicant must submit fingerprints for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the Colorado Bureau of Investigation responsible for retaining the state's criminal records set forth in Section 24-60-3702 (3) (B).

Notice of Proposed Rulemaking

Tracking number

2018-00486

Department

700 - Department of Regulatory Agencies

Agency

732 - Division of Professions and Occupations - State Physical Therapy Board

CCR number

4 CCR 732-1

Rule title

PHYSICAL THERAPIST LICENSURE AND PHYSICAL THERAPIST ASSISTANT CERTIFICATION

Rulemaking Hearing

Date

11/02/2018

Time

09:30 AM

Location

1560 Broadway, Suite 1250A

Subjects and issues involved

307.Continuing Professional Competency Requirements for Licensure Renewal for Physical Therapy Assistants. The purpose of this rule is to establish a continuing professional competency program.

Statutory authority

12-35-124(1)(g), 2-4-103 and 12-35-107(b)

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307. Continuing Professional Competency Requirements for Licensure Renewal for Physical Therapy Assistants

The purpose of this rule is to establish a continuing professional competency program pursuant to section 12-41-208.5, C.R.S., wherein a physical therapist assistant shall maintain and demonstrate continuing professional competency in order to renew a license to practice as a physical therapy assistant in the state of Colorado.

Furthermore, pursuant to section 12-41-114.6(2), C.R.S., records of assessment or other documentation developed or submitted in connection with the continuing professional competency program are confidential and not subject to inspection by the public or discovery in connection with a civil action against a physical therapist assistant. A person or the Board shall not use the records or documents unless used by the Board to determine whether a physical therapist assistant is maintaining continuing professional competency to engage in the profession.

A. Definitions

1. Assessment of Knowledge and Skills (AKS): an objective third-party assessment that compares a licensee's knowledge, skills, and abilities to the standards for entry-level practice.

2. Continuing Professional Competency: the ongoing ability of a physical therapist assistant to learn, integrate, and apply the knowledge, skills, and judgment to practice as a physical therapist assistant according to generally accepted standards and professional ethical standards.

3. Continuing Professional Development (CPD): the Board program through which a licensee can satisfy the continuing professional competency requirements in order to renew, reinstate, or reactivate a license.

4. Deemed Status: A method to satisfy continuing professional competency requirements. A licensee who satisfies the continuing professional competency requirements of a Colorado state agency or department, an accrediting body recognized by the Board, or an entity approved by the Board pursuant to section 12-41-114.6(1)(c), C.R.S., may qualify under this method in lieu of completing the Board's CPD program.

5. Learning Plan: a Board approved form through which a licensee documents his/her goals and plans of learning that were developed from his/her Reflective Self-Assessment (RSAT), which is defined below, and AKS (when appropriately applied).

6. Military Exemption: A method to satisfy continuing professional competency requirements. A licensee who has been approved for this exemption will not be required to meet continuing professional competency requirements during the renewal period in which he/she was approved by the Division of Professions and Occupations.

7. Professional Development Activities (PDA): learning activities undertaken to increase the licensee's knowledge and skill or hone existing knowledge and skill for the purpose of continuing professional development.

8. Reflective Self-Assessment Tool (RSAT): a reflective practice tool in which a licensee can reflect upon his/her knowledge and skills pertaining to the foundational areas of physical therapy practice taking into account the licensee's current level and area of

practice.

B. Continuing Professional Competency Requirements

1. Effective after the 2018 license renewal, or upon the completion of the first renewal of a license thereafter, the licensee shall demonstrate continuing professional competency in order to renew a license by:

   a. Participation in the Continuing Professional Development (CPD) program;

   b. Participation in a program of continuing professional competency through a Colorado state agency or department, including continuing competency requirements imposed through a contractual arrangement with a provider as set forth in section 12-41-114.6(1)(c), C.R.S. This status is defined as "Deemed Status" in section A(4) of this rule and further described in section D of this rule; or

   c. Receiving an exemption for military service as defined in section 12-70-102, C.R.S. Military exemptions must be approved by the Division of Professions and Occupations. Licensees seeking a military exemption shall submit a request in writing with evidence that the licensee's military service meets the criteria established in section 12-70-102, C.R.S., and section E of this rule.

2. A licensee shall attest at the time of the renewal of a license to his/her compliance with continuing professional competency requirements.

C. Continuing Professional Development Program

1. The Continuing Professional Development (CPD) program entails the following:

   a. The licensee shall complete the Reflective Self-Assessment Tool (RSAT) once per 2- year renewal period. A licensee shall use the Board approved form.

      i. The execution of a Learning Plan once per 2-year renewal period that is based upon the licensee's Reflective Self-Assessment Tool (RSAT) or Assessment of Knowledge and Skills (AKS). A licensee shall use the Board approved form.

      ii. Accrual of 30 points of Professional Development Activities (PDA) per 2-year renewal period.

2. Professional Development Activities (PDA)

   a. Professional Development Activities must be relevant to the licensee's practice as a physical therapist assistant and pertinent to his/her Learning Plan. The Board will not pre-approve specific courses or providers. The licensee shall determine which activities and topics will meet his/her Learning Plan, and select an appropriate provider.

   b. Professional Development Activities are separated into Category I, Category II, and Category III activities and each category has a corresponding point value. Points

are used in lieu of continuing education units (CEU) or contact hours to allow credit for non-continuing education type activities.

c. Points will be accepted if the activity is included in the Board's *Professional Development Activities List*. The Board may accept or reject activities submitted for consideration that are not identified on its list.

d. A minimum of 15 of the required 30 points must be Category I activities.

e. Professional Development Activities will only apply for one 2-year renewal period.

f. Professional Development Activities must be measured by a contact hour to credit hour ratio.

3. The completion of an Assessment of Knowledge and Skills (AKS) will not be accepted more than once every 10 years.

a. An AKS must meet the following criteria:

i. Be drafted and validated by qualified physical therapists and psychometricians;

ii. Be comprised of evidence based practice;

iii. Be maintained for relevancy and advancements in and affecting the profession; and

iv. Provide feedback to the participant/licensee regarding his/her performance and suggested learning opportunities to enhance his/her knowledge and skills.

b. Administrative Approval. The Board finds the following AKSs to have met the criteria established in section C(3)(a) of this rule, and are administratively approved by the Board:

i. The online continuing competence learning and assessment tool (oPTion) administered by the Federation of State Boards of Physical Therapy (FSBPT).

ii. If the AKS is not listed as administratively approved by the Board in this rule, then additional documentation demonstrating the AKS satisfies the Board criteria will be required prior to registering and completing the AKS.

c. The licensee may count the completion of an AKS as a Category I activity toward a mandatory 30 PDA points for the corresponding 2-year renewal period in compliance with the State Physical Therapy Board's *Professional Development Activities List* for assigned point values.

4. Audit of Compliance. The following documentation is required for an audit of compliance of a licensee's Continuing Professional Development:

a. The Learning Plan that is signed and executed which contains the licensee's goals in the form and manner as approved by the Board.

b. A certificate of completion or other report issued by the AKS provider indicating the name of the licensee, AKS title, content, and the licensee's date of completion.

c. Documentation of 30 points of Professional Development Activities in compliance with the State Physical Therapy Board's *Professional Development Activities List* for documentation requirements for PDAs.

d. The Board may accept or reject Professional Development Activities (PDA) that do not meet the criteria established by the Board for PDA or standards of quality as defined in the State Physical Therapy Board's *Professional Development Activities List*, *Standards of Quality for Category I Continuing Education Activities*, and this rule.

D. Deemed Status. The following criteria must be met in order to claim this status:

1. In order to renew a license, a licensee shall attest to his/her Deemed Status.

2. To qualify, the licensee must be in full compliance with the requirements of his/her state agency or department during the entire 2-year renewal period of his/her physical therapist license and on track to successfully complete that program or have successfully completed it.

3. Licensees claiming Deemed Status are subject to an audit of compliance. To satisfy an audit of compliance, the licensee shall submit appropriate evidence of participation in a qualifying program through submission of:

a. Proof from the Colorado state agency or department or contractual entity verifying that the licensee is in compliance with its continuing professional competency program; and

b. A letter from his/her employer certifying dates of employment for the entire 2-year license renewal period, without any break; or

c. Other documentation approved by the Board which reflects the licensee's compliance with a program of continuing professional competency.

E. Military Exemption. Pursuant to section 12-70-102, C.R.S., licensees who have been called to federally funded active duty for more than 120 days for the purpose of serving in a war, emergency, or contingency may request an exemption from the continuing professional competency requirements for the renewal, reinstatement, or reactivation of his/her license for the 2-year renewal period that falls within the period of service or within six months following the completion of service.

1. Military exemptions must be approved by the Division of Professions and Occupations. Licensees seeking a military exemption shall submit a request in writing with evidence that the licensee's military service meets the criteria established in section 12-70-102, C.R.S.

2. After being granted a military exemption, in order to complete the renewal process, a licensee shall attest to his/her military exemption.

F. Records Retention. A licensee shall retain documentation demonstrating his/her compliance for 2 complete 2-year renewal periods.

G. Non-Compliance. Falsifying an attestation or other documentation regarding the licensee's compliance with continuing professional competency requirements constitutes the falsification of information in an application and may be grounds for discipline pursuant to sections 12-41- 115(1)(k) and (r), C.R.S.

H. Reinstatement and Reactivation. A licensee seeking to reinstate or reactivate a license which has been expired or inactivated for 2 years or less shall meet the competency requirements outlined in Rule 207(B).

Notice of Proposed Rulemaking

Tracking number

2018-00485

Department

700 - Department of Regulatory Agencies

Agency

732 - Division of Professions and Occupations - State Physical Therapy Board

CCR number

4 CCR 732-1

Rule title

PHYSICAL THERAPIST LICENSURE AND PHYSICAL THERAPIST ASSISTANT CERTIFICATION

Rulemaking Hearing

Date

11/02/2018

Time

09:30 AM

Location

1560 Broadway, Suite 1250A

Subjects and issues involved

305. Certification by Endorsement for Physical Therapist Assistants. The purpose of this rule is to delineate the requirements for certification by endorsement.

Statutory authority

12-35-124(1)(g), 2-4-103 and 12-35-107(b)

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305. Certification by Endorsement for Physical Therapist Assistants

The purpose of this rule is to delineate the requirements for certification by endorsement pursuant to section 12-41-206, C.R.S. In order to be qualified for certification by endorsement, an applicant is required to demonstrate that he/she does not currently have a revoked, suspended, restricted, or conditional license, certification, or registration to practice as a physical therapist assistant, or is currently pending disciplinary action against such license, certification, or registration in another state or territory of the United States. An applicant must meet one of the following requirements:

A. Graduated from an accredited physical therapy or physical therapist assistant program within the past 2 years and passed the National Physical Therapy Examination (NPTE).

B. Practiced in the United States as a licensed, certified, or registered physical therapist assistant for at least 2 of the 5 years immediately preceding the date of the application.

C. If an applicant has not practiced as a licensed, certified, or registered physical therapist assistant for at least 2 of the 5 years immediately preceding the date of the application, then he/she is required to have passed the NPTE, or its equivalent, and may demonstrate competency through successful completion of 1 of the following:

1. Completion of 60 hours of continuing education related to the practice of physical therapy during the 2 years immediately preceding the application.

    a. An applicant seeking to demonstrate competency through this pathway shall:

        i. Complete an objective third-party assessment that compares a certificate holder's knowledge, skills, and abilities to the standards for entry-level practice accepted by the Board; and

        ii. Successfully complete all hours as Category I in compliance with the "Physical Therapy Board Standards for Continuing Education Activities", directly related to the physical therapist assistant's clinical practice and address any areas of deficiencies identified in the objective third-party assessment.

    b. The applicant must submit the results of the objective third-party assessment and the corresponding 60 Category I continuing education hours for Board consideration within 1 year of completing the objective third-party assessment.

2. Successful completion of a Board authorized internship.

    a. An applicant seeking to demonstrate competency through an internship shall:

        i. Arrange for a Colorado-licensed, practicing physical therapist (the "supervising physical therapist") to supervise the internship; and

        ii. Ensure that the supervising physical therapist immediately notifies the Board in writing of the establishment of the internship and submits for the Board's approval a plan for supervision using the most current version of the "Physical Therapist Assistant Clinical Performance Instrument" (CPI) or a comparable objective third-party assessment that compares a certificate holder's knowledge, skills, and abilities to the standards for entry-level practice accepted by the Board.

b. The internship shall not commence without the Board's written approval of the supervising physical therapist's plan for supervision specified in subparagraph (2)(c) of this rule.

c. The internship shall consist of:

i. The applicant's actual practice of physical therapy as defined in section 12-41-103(6), C.R.S.;

ii. Direct supervision, as defined in Rule 101(B), of the applicant at all times by the Board approved Colorado-licensed, practicing physical therapist; and

iii. A minimum of 240 hours clinical practice within a consecutive 6-month period commencing from the Board's written approval of the plan for supervision.

d. The applicant shall ensure that the supervising physical therapist files a written report at the completion of the internship. This report must indicate whether the applicant demonstrates entry-level performance in all skills assessed by the CPI or comparable objective third-party assessment. Hard copy or electronic copies of the CPI or comparable objective third-party assessment are acceptable.

D. An applicant who is unable to demonstrate competency under sections A, B, or C of this rule may request to demonstrate competency by any other means. The Board shall consider such a request on a case-by-case basis. The decision to approve such a request shall be at the sole discretion of the Board. In considering whether to approve such a request, the Board shall consider public safety, the particular circumstances and hardships faced by the applicant, and such other factors as the Board deems appropriate. If the Board grants a certification under this section D, the Board may subject said certification to such lawful conditions as the Board finds are necessary to protect the public.

E. On or after January 1, 2019, applicant must submit fingerprints for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the Colorado Bureau of Investigation responsible for retaining the state's criminal records set forth in Section 24-60-3702 (3) (B).

Notice of Proposed Rulemaking

Tracking number

2018-00499

Department

100,800 - Department of Personnel and Administration

Agency

801 - State Personnel Board and State Personnel Director

CCR number

4 CCR 801-1

Rule title

STATE PERSONNEL BOARD RULES AND PERSONNEL DIRECTOR'S ADMINISTRATIVE PROCEDURES

Rulemaking Hearing

Date

10/30/2018

Time

02:00 PM

Location

1525 Sherman St., Room 103 (First Floor) Denver, CO 80203

Subjects and issues involved

Procedures 3-27, 4-3, 5-7, and 5-17. The general purpose is to standardize certain specific practices, and modify practices and procedures pursuant to the deployment of HRWorks.

Statutory authority

State of Colorado Constitution Article XII, Section 13

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DEPARTMENT OF PERSONNEL AND ADMINISTRATION

State Personnel Board and State Personnel Director

STATE PERSONNEL BOARD RULES AND PERSONNEL DIRECTOR'S ADMINISTRATIVE PROCEDURES

4 CCR 801-1

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

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

Preamble

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

This version reflects rulemaking by the State Personnel Director as follows: To modify Procedures 3-27, 4-3, 5-7, and 5-17 effective January 1, 2019.

Chapter 3 - Compensation

Authority for rules promulgated in this chapter is found in one or more of the following: the State of Colorado Constitution Article XII, Section 13, State of Colorado Revised Statutes (C.R.S.) §24-50-104 (1) (a), (b), (c), (e), (f), (4), (5), (6), (9), and 24-50-104.5(1), 109.5, 136, 137, and 208, C.R.S. Board rules are identified by cites beginning with "Board Rule".

General Principles

3-1. The Department of Personnel shall establish rules governing compensation for the state personnel system. Compensation practices shall provide for equitable treatment of similarly situated employees.

3-2. Pay grades shall reflect prevailing labor market compensation and any other pertinent considerations. No individual employee's base pay shall be less than the minimum of the grade or exceed a statutory lid. In the case of disciplinary action, base pay may be less than the minimum of the grade for a period not to exceed 12 months, subject to FLSA requirements.

Annual Compensation Survey

3-3. The Department of Personnel shall conduct the annual compensation survey. The Director shall establish and publish the distribution of annual compensation changes among salaries, including establishment of statewide priority groups and group benefit contributions, which shall be effective as provided by law. (9/1/12)

3-4. When upward pay grade changes are implemented, the grade minimum and maximum shall be adjusted and no employee shall be paid outside of the new grade, except in disciplinary actions resulting in salary temporarily below the new minimum and continuation of saved pay above the new maximum. (7/1/07)

3-5. If pay grade changes are downward, employees' base pay shall remain unchanged, subject to the statutory three-year limitation on saved pay.

Pay Rates

3-6. The Department of Personnel shall publish the annual pay plan. Departments shall use an hourly rate based on an annual salary to compensate employees who do not work a predetermined or full schedule. (1/1/18)

3-7. Saved pay applies to downward movements due to individual allocation, system maintenance studies, and the annual compensation survey to maintain an employee's current base pay when it falls above the new grade maximum. It may also apply when retention rights are exercised pursuant to the "Separation" chapter. In no case shall the employee's base pay remain above the grade maximum after three years from the action, even if it results in a loss in pay. (1/1/18)

3-8. Unless authorized by the Director, the rate resulting from multiple actions effective on the same date shall be computed in the following order. The Director may withhold salary adjustments for any employee with a final overall rating of needs improvement, except as provided in 3-4. (7/1/07)

1. System maintenance studies.

2. Upward, downward, or lateral movements.

3. Repealed. (8/1/08)

4. Changes in pay grade minimums and maximums to implement approved annual compensation changes to the pay structure.

5. Across-the-board increases authorized by the General Assembly. (1/1/18)

6. Adjustments to the base pay of employees due to merit pay in approved annual compensation changes, subject to the new grade maximum and 3-19(C)(1)(a). (1/1/18)

7. Bring salaries to the new grade minimum as a result of compensation survey pay grade changes, except in disciplinary actions. (1/1/18)

8. Non-base merit payments (based on new annual salary). (1/1/18)

3-9. The appointing authority shall determine the hiring salary within the pay grade for a new employee, including one returning after resignation, which is typically the grade minimum unless recruitment difficulty or other unusual conditions exist. (7/1/06)

A. Recruitment difficulty means difficulty in obtaining qualified applicants or an inadequate number of candidates to promote competition despite recruitment efforts.

B. Unusual conditions exist when the position requires experience and competencies beyond the entry level or the best candidate cannot be obtained by hiring at the minimum of the pay grade. (1/1/18)

C. The appointing authority's determination shall consider such factors as, but not limited to, labor market supply, recruitment efforts, nature of the assignment and required competencies, qualifications and salary requirements of the best candidate, salaries of current and recently hired employees in similar positions in the department, available funds and the long-term impact on personal services budgets of hiring above the minimum of the pay grade.

3-10. In the case of fiscal emergency or other budget reasons, an employee may agree to voluntarily reduce current base pay, which shall be approved in writing by the appointing authority and employee. If funds become available at a later date, the department may restore base pay to any rate up to, and including, the former base pay. This policy shall not be used to substitute for other provisions in this chapter.

3-11. When an unclassified position is brought into the state personnel system, the base pay for an employee appointed to the position shall be computed in accordance with the Department of Personnel's directives that shall ensure that total compensation is preserved to the greatest extent possible, except that base pay shall not exceed the grade maximum. (1/1/18)

Downward Adjustments

3-12. Downward movement is a change to a different class with a lower range maximum (e.g., non-disciplinary or disciplinary demotions, individual allocations, system maintenance studies including class placement, or the annual compensation survey).

3-13. In the case of system maintenance studies and individual allocations of positions, the employee's base pay shall remain the same, including saved pay.

A. A department head has sole discretion to grant saved pay when employees exercise retention rights and the decision must be applied consistently throughout the retention area. If saved pay is granted, the employee's name shall not be placed on a reemployment list. (7/1/07)

3-14. In the case of other downward movements, the base pay shall not be above the maximum in the new grade.

A. Upon reversion of a trial service employee to the previously certified class, base pay shall be the amount the employee would be making had the promotion or reinstatement not occurred. (1/1/14)

Upward Adjustments

3-15. Upward movement is a change to a different class with a higher range maximum (e.g., promotions, individual allocations, system maintenance studies including class placement, or the annual compensation survey).

3-16. In the case of system maintenance studies, employees' base pay shall remain the same. If the Director finds that severe and immediate recruitment and retention problems make it imperative to increase pay to maintain critical services, the Director may order that base pay be increased up to the percentage increase for the new class.

3-17. In the case of other upward movements, the employee's base pay may increase or remain the same, in which case the employee would receive the economic opportunity by moving to the new grade. In no case shall the new base rate be lower than the minimum, except in disciplinary actions, or higher than the maximum of the new grade. Continuation of a salary increase is subject to satisfactory completion of the trial service period.

A. When conditional employees move upward, the base pay shall be computed based on the certified class.

Lateral Adjustments

3-18. Lateral movement is a change to a different class or position with the same range maximum (e.g., transfers, individual allocations, system maintenance studies including class placement), or an in-range salary movement in the same class and position. Base pay can be offered at a rate that falls within the pay range of the class and does not exceed the grade maximum. In addition, in-range salary movements are subject to the provisions below. (1/1/14)

In-Range Salary Movements. A department may use these discretionary movements to increase base salaries of permanent employees who remain in their current classes and positions when there is a critical need not addressed by any other pay mechanism. The use of in-range salary movements is not guaranteed and shall be funded within existing budgets. These movements shall not be retroactive and unless specifically noted in these rules, frequency is limited to one in-range salary movement in a 12-month period. No aspect of granting these movements is subject to grievance or appeal, except for alleged discrimination; however, an alleged violation of the department's plan can be disputed. A department's decision in the dispute is final and no further recourse is available. Once granted, a reduction in base salary is subject to appeal. Departments must develop a written plan addressing appropriate criteria for the use of any movement based on sound business practice and needs, e.g., eligibility, funding sources, approval requirements, measures to ensure consistent use. The plan must be communicated within the department and a copy provided to the Director prior to implementation. If granted, there must be an individual written agreement between the employee and the appointing authority that stipulates the terms and conditions of the movement. Records of any aspect of these movements shall be provided to the Director when requested. (02/2017)

A. Salary Range Compression. Used as a salary leveling increase where longer-term or more experienced employees are paid lower in the range for the class than new hires or less experienced employees over a period of time resulting in documented retention difficulties. Thus, there is a valid need to increase one or more employee's base salary in

the class to recognize contributions equal to or greater than the newly hired or less experienced employees. Justification shall be required based on facts. To be eligible, an employee must be performing satisfactorily as evidenced by the most recent final overall performance rating. The increase may be up to 10 percent or the maximum permitted by the department's policy on hiring salaries, whichever is greater, and subject to the pay grade maximum. (9/1/12)

B. Counteroffer. Used when an employee with critical, strategic skills receives a higher salary offer from another department or outside employer and the appointing authority needs to increase the employee's base salary for retention purposes. To be eligible, an employee must be performing satisfactorily as evidenced by the most recent final overall performance rating. Written confirmation of the other entity's salary offer is required. The increase may be up to 10 percent or the maximum permitted by the department's policy on promotional pay, whichever is greater, and subject to the pay grade maximum.

C. Delayed Transfer or Promotional Pay Increase. Used when a transfer or promotion is made with no salary increase or partial salary increase because performance expectations are unproven and/or funds may be unavailable at the time of transfer or promotion. This is a one-time base salary increase within 12 months of the date of transfer or promotion when funds become available and the employee's contributions are fulfilled. The intent to provide a later salary increase must be documented at the time of the transfer or promotion. To be eligible, an employee must be performing satisfactorily as evidenced by the most recent final overall performance rating. The increase may be up to 10 percent or the maximum amount permitted in the department's policy on transfer or promotional pay increases, whichever is greater, and subject to the pay grade maximum. Transfer, promotion, demotion, or separation of the employee will negate the delayed increase. (1/1/18)

D. New Hires. Used at the time an employee is hired when performance expectations are unproven and/or funds may be unavailable. This is a one-time base salary increase within 12 months of hire. The intent to provide a later salary increase must be documented at the time of hire. To be eligible, early satisfactory completion of specified training objectives must be documented. This is limited to a one-time increase up to 10 percent or the maximum permitted by the department's policy on promotional pay increases, whichever is greater, and subject to the pay grade maximum. Transfer, promotion, demotion, or separation of the employee will negate the delayed increase. (02/2017)

E. Competency-Based Increase. Used when an employee applies the complete set, or a subset, of competencies required to successfully perform the work of a specific position. Required competencies must be specifically defined with deadlines and evaluation criteria for achievement, and must be communicated in writing to the employee prior to granting an increase. Competencies that are the basis for this increase must be required to perform permanent, essential functions assigned to the position. The intent of this increase is to promote career development by aligning pay increases with achieving all required competencies to fully perform the job. Increases are limited to no more than two per 12-month period. This type of increase shall not be applied as a substitute for Merit Pay. To be eligible, an employee must demonstrate required competencies as evidenced by a written evaluation by the appointing authority. The increase may be up to 10 percent or the maximum permitted by the department's policy, whichever is greater, and subject to the pay grade maximum. (02/2017)

Merit Pay (9/1/12)

3-19. Merit pay consists of both base and non-base building adjustments. Any permanent employee is

eligible for merit pay, except as provided below and as otherwise provided in this chapter. Prior to the payment of merit pay, the Director shall specify and publish the percentage for any merit pay increase for applicable priority groups. Adjustments are effective on July 1. The employee must be employed on July 1 to receive payment. The employee's current department as of July 1 is responsible for payment, unless arrangements are made whereas the transferring department will provide full payment of a portion of any non-base building merit pay increase. (1/1/18)

A. If the final overall rating is needs improvement, the employee is ineligible for any merit pay. Merit pay shall not be denied because of a corrective or disciplinary action issued for an incident after the close of the previous performance cycle. (9/1/12)

B. Employees hired into the state personnel system during the performance evaluation cycle shall receive a prorated portion of any base or non-base building merit pay. The proration shall be based on the number of calendar months worked. (1/1/18)

C. Base building merit pay shall be based on final performance evaluation and salary position within the pay range on June 1. (1/1/18)

1. Payment of base building merit pay shall not cause an employee's base pay to exceed the grade maximum, and is paid as regular salary. (9/1/12)

a. The payment of any remaining portion of base building merit pay that would cause base pay to exceed grade maximum shall be paid as a onetime, non-base building lump sum in the July payroll. The statutory salary lid does not apply to such a payment. (1/1/14)

2. Payment of base building market pay shall be a comparison of state personnel system salaries to market salaries for the purpose of measuring competitiveness. Market shall result in base building increases to pay, only when an employee's salary is below a newly adjusted pay range minimum. (9/1/12)

D. Non-base building merit pay shall be a non-base building or one-time lump sum payment and shall be calculated after any annual compensation adjustments, including base building merit pay. (1/1/18)

1. Non-base building merit pay must be earned each year and shall be paid as a one-time lump sum in the July payroll. The grade maximum and statutory lid do not apply to non-base building merit pay. (9/1/12)

a. An employee must be employed on the date of the payment in order to be eligible to receive a non-base building merit payment. (9/1/12)

E. Base building or non-base building merit pay may be provided to employees, at a department's discretion if approved by the Governor's Office of State Planning and Budgeting, when funded from a department's state employee reserve fund using department reversions. These discretionary merit payments shall only be paid to certified employees, in order of priority grouping established by the Director. (1/1/18)

1. Base building merit pay increases funded from a department's state employee reserve fund shall be provided only if the department can justify sustainability as determined by the Governor's Office of State Planning and Budgeting. (9/1/12)

2. Merit pay increases funded from a department's state employee reserve fund shall not be provided more than once in a 12-month period per employee. 9/1/12)

3. Repealed. (1/1/18)

F. Repealed. (1/1/18)

Incentives

3-20. Departments are strongly encouraged to use incentives. (7/1/06)

3-21. An appointing authority may grant an immediate non-base cash or non-cash incentive award to an employee in recognition of special accomplishments or contributions throughout the year or to augment merit pay, e.g., on-the-spot cash awards, work-life options, or administrative leave, in accordance with a department's established incentive plan. Other than augmenting merit pay, incentives shall not be used to supplement or substitute for annual compensation adjustments or other base pay movements. The statutory salary lid does not apply to these incentives. (9/1/12)

A. Departments must have an incentive plan prior to the use of incentives. Such plans shall include eligibility criteria, the types of incentives allowed, cash amounts or limits and payment methods, and a communication plan. Such plans shall be developed with the input of employees and managers.

1. If a department uses a type of incentive that shares cost savings from innovations, the following applies.

a. Employees are ineligible if they are wholly responsible for control and operation of a division (or equivalent), the primary assignment includes responsibility for identifying efficiencies and cost reductions, or the position has statewide program or budget authority.

b. Savings are the result of innovative ideas that increase productivity and service levels while decreasing costs. Savings are not the result of normal progressive business evolution, obvious solutions to mandated budget cuts, cost avoidance or revenue enhancement, nor do they have adverse cost impact on other departments.

c. Savings are the difference between anticipated expenditures prior to implementation and actual expenditures following implementation for a full 12-month period. The complete award amount shall be no more than 10 percent of the first year's savings, not to exceed a total of $1,000 per employee.

3-22. Repealed. (8/1/08)

3-23. Repealed. (8/1/08)

Medical Plan

3-24. Employees in the medical pay plan shall be compensated based solely on performance as established in the required annual contract to be negotiated by July 1 of the contract year, or within 30 days of hire or movement within the medical pay plan for the remainder of the contract year. Employees are not eligible for any pay adjustments, such as merit pay. Current performance contracts may be modified during the contract year but not compensation. Change in compensation shall only occur at the end of a contract period, unless an employee moves to another position, and may increase, decrease, or remain unchanged from the previous year. In the case of upward or downward movement in the medical pay plan, compensation must be no lower than the minimum or higher than the maximum rates of the new grade and a new contract

must be negotiated for the remainder of the contract year. (9/1/12)

A. If no contract is negotiated, the existing contract continues and base pay stays the same until a new contract is negotiated. Employees in the medical pay plan may grieve the rate unless it is lower, which is then subject to appeal. If the employee moves into or out of the medical pay plan into another open-range class, the base pay shall be negotiated subject to the grade maximum of the new class.

FLSA and Overtime

3-25. All employees are covered by the Fair Labor Standards Act (FLSA). Under FLSA, the state is considered to be a single employer. Employees cannot waive their rights under FLSA.

3-26. All full-time employees work a minimum of 40 hours during a standard workweek (168 consecutive hours in seven consecutive days). Appointing authorities may adopt different work periods for law enforcement and health care employees as permitted by federal law. (8/1/08)

3-27. Overtime is the time a non-exempt employee works in excess of the 40 hours during a standard workweek or in excess of established work hours in adopted work periods for law enforcement and health care employees. Such excess hours are paid at 1½ times the employee's regular hourly base pay rate, including applicable premium pay. Monetary payment must be made by the next scheduled payday, designated by the State Controller, following the pay period in which it was worked. (1/1/19)

A. Overtime for non-exempt employees shall be approved in accordance with a department's procedure. A department head shall establish a policy to address unauthorized overtime work; however, prohibition of unauthorized overtime does not avoid the requirement to pay if it is actually worked.

B. Compensatory time in lieu of monetary payment is allowed if there is a written agreement between the department and any employee hired after April 15, 1986. Written agreements for those hired prior to April 15, 1986, are unnecessary provided that the department had a regular practice in place for granting compensatory time. Acceptance of compensatory time may be a condition of employment for new employees. Appointing authorities must ensure that compensatory time is scheduled as soon as practical. Compensatory time shall not exceed 240 hours (or 480 hours for law enforcement) and any additional overtime must be paid at the next regular pay period. If a department wants to place limits on the accrual or payment of compensatory time, a policy must be developed and communicated prior to use and on an ongoing basis. Unused compensatory time at termination or transfer to another department must be paid at that time.

<u>Eligibility</u>

3-28. Department heads are responsible for determining if each position is exempt or non-exempt based on the actual duties performed regardless of class. Determinations must be entered into the payroll system and a record kept on file.

3-29. An exempt employee's pay is not subject to reduction except as follows. Deductions in increments of one day are allowed for a major workplace rule violation. Deductions are allowed for any amount of time if a leave of absence was not requested or was denied and accrued leave is not used; or is covered by the Family and Medical Leave Act (FMLA); or accrued leave is exhausted; or for voluntary furlough. In the case of mandatory furloughs for budgetary reasons, exempt status is not changed, except for the workweek in which the furlough occurs and pay is reduced. Improper reductions make the employee non-exempt. (7/1/06)

3-30. Exempt employees shall not be granted extra pay for hours worked in excess of 40 hours in a workweek. An appointing authority may grant discretionary administrative leave or other incentives but such awards shall not be tied to hours worked. (7/1/06)

3-31. An employee may request a review of a decision regarding eligibility, calculation of overtime hours, and payment to the Director in accordance with the “Dispute Resolution” chapter.

Dual Employment

3-32. In a properly authorized dual employment arrangement, the written agreement shall include the exemption status designation based on the combined duties, the department responsible for paying any overtime, and the overtime hourly rate. The overtime rate, if applicable, is either the regular rate from one of the jobs or a weighted rate from both jobs. Work time from both jobs is combined to calculate overtime. (1/1/18)

Work Hours

3-33. In order to minimize overtime liability, appointing authorities may deny, delay, or cancel leave before it is taken. Appointing authorities may require the use of accrued compensatory time but cannot schedule compensatory time if that will make an employee forfeit annual leave at the end of the fiscal year. (1/1/18)

3-34. Compensatory time is not leave, but a form of compensation. Therefore, it is not included in the calculation of work hours for overtime purposes.

3-35. Overtime does not accrue until a non-exempt employee works more than the maximum hours allowed in a workweek or designated work period. All time worked must be recorded on a daily basis. Overtime is calculated based on the total time worked in the workweek or designated work period, rounded to the nearest quarter hour. If operational needs require an employee to regularly report to work early or leave late, that time is counted as work hours for weekly overtime purposes.

3-36. Essential, non-exempt positions, as designated by a department head, shall have paid leave counted as work time. Essential positions perform law enforcement, highway maintenance, and support services directly responsible for the health, safety, and welfare of patients, residents, students, and inmates.

3-37. Scheduled meal periods are discretionary. Scheduled meal periods are not work time and must be at least 20 minutes. However, if the employee is materially interrupted or not completely free from duties, the meal period is counted as work time.

3-38. Work breaks are discretionary. If granted, breaks of up to 20 minutes are work time. Breaks shall not offset other work time or substitute for paid leave, not be taken at the beginning or end of the workday, nor be used to extend meal periods.

3-39. Ordinary travel to and from work is not work time. Travel from work site to work site is work time. When an employee is required to travel a substantial distance to perform a job away from the regular work site, the travel is work time.

3-40. Mandatory training or meetings are work time. Voluntary training during work hours, as approved by the appointing authority, which is directly related to an employee’s job and is designed to enhance performance, is work time. Voluntary training after hours to gain additional skill or knowledge is not work time, even if it is job related.

Recordkeeping

3-41. FLSA requires that certain basic records be maintained for both exempt and non-exempt employees. Each department is accountable for maintaining those records. (7/1/07)

3-42. Time records must be certified by both the employee and the supervisor and are the basis for overtime calculation and compensation.

Other Premium Pay

3-43. Shift Differential is additional pay beyond base pay for employees working shifts. Eligible classes are published in the annual pay plan. Department heads may designate eligibility for individual positions in classes not published and shall maintain records for such cases. Shift differential does not apply to any periods of paid leave. Second shift rate applies when half or more of the scheduled work hours fall between 4:00 p.m. and 11:00 p.m. Third shift rate applies when half or more of the scheduled work hours fall between 11:00 p.m. and 6:00 a.m. If hours are evenly split between shifts, the higher shift differential rate applies to all hours worked during the shift. (1/1/18)

3-44. Call Back applies when an eligible employee is required to report to work before the start or after the end of a scheduled shift. If there is no release from work between the call back hours and regular shift, it is considered a continuation of the shift and call back does not apply. When call back applies, a minimum of two hours of the employee's regular base pay is guaranteed. Eligible employees are those who are eligible for overtime, and any call back time is counted as work time. Employees exempt from overtime are also eligible when approved by a department head. (1/1/18)

3-45. On Call is additional pay beyond base pay for employees specifically assigned, in advance, to be accessible outside of normal work hours and where freedom of movement and use of personal time is significantly restricted. Eligible classes and the rate are published in the annual pay plan. A department head may designate eligibility for individual positions in classes not published and maintain records of such on-call designations. Only time while actually on call shall be paid at the special rate. In call back situations, employees eligible for both on call and call back pay shall receive call back pay only. (1/1/18)

3-46. Second Domicile is additional discretionary pay up to 10 percent of base pay for employees who are required to maintain a second domicile for more than 10 consecutive calendar days while working out-of-state on official state business. The department head must authorize such payments.

3-47. Repealed. (1/1/18)

3-48. Housing Premium is a stipend granted by a department head to designated employees living and working in high housing cost areas with demonstrated recruitment and retention problems. It is not part of the base rate and may begin or end at any time. Records on any aspect of this premium must be provided to the Director when requested.

3-49. Discretionary Pay Differentials. A department may use non-base building discretionary pay differentials on a temporary basis, which shall be funded within existing budgets. Use of these pay differentials is at the discretion of the appointing authority and shall not be used as a substitute for annual compensation adjustments, other pay policies, or promotions. No differential is guaranteed and, if granted, may be discontinued at any time. No aspect of any discretionary pay differential is subject to grievance or appeal, except for discrimination; however, an alleged violation of the department's plan can be disputed. A department's decision in the dispute is final and no further recourse is available. Departments must develop and communicate a written plan addressing appropriate criteria for the use of any differential based on sound business practice and needs. If granted, there must be an individual written agreement between the employee and appointing authority that stipulates the terms and conditions of the differential, including the dates the differential will begin and end. Records of any aspect of these differentials must be provided

to the Director when requested. (8/1/08)

A. Counteroffer to a verifiable job offer may be used when an employee with critical strategic skills receives a higher salary offer from another department or outside employer and the appointing authority needs to retain the employee. The sum of a non-base building differential and current base pay cannot exceed a statutory lid in any given month and may be paid in one or more payments. (8/1/08)

B. Signing bonus is a non-base building lump sum that may be used to attract new permanent employees into the state personnel system. It may be paid in one or several payments; however, the sum of the bonus and current base pay cannot exceed a statutory lid in any given month. Signing bonuses may be used for the following reasons:

1. to fill positions in critical occupations where there is a documented shortage in the labor market and recruitment or retention difficulty in the department that jeopardizes its mission; or,

2. when the applicant possesses a unique, critical skill in relation to the job market.

C. Referral award is a non-base building lump sum that may be granted to a current employee for the referral and subsequent hire of a new employee into the state personnel system where the position requires a unique, specialized skill and there is a documented shortage in the labor market and recruitment or retention difficulty in the department. This award is to be used for permanent employees unless the Director grants an exception. Employees who influence or are responsible for hiring and those performing recruitment as part of their regular assignments are ineligible. The sum of the award and current base pay cannot exceed a statutory lid in any given month.

D. Temporary pay differential is a non-base building award that may be granted to a current permanent employee in the same position. The sum of the temporary award and current base pay shall not exceed a statutory lid in any given month and is paid through regular payroll. This differential shall not be used as a substitute for the promotional or allocation process. Temporary pay differentials may be used for the following reasons:

1. acting assignment where the employee assumes the full set of duties (not “in absence of”) of a higher-level position that is vacant or the incumbent is on extended leave for a period longer than 30 days but less than nine months. The differential shall not exceed nine months for any given acting assignment;

2. long-term project assignment that is not an expected or customary part of the regular assignment and is critical to the mission and operations of the department as defined by the purpose of the project, its time frame, and the critical nature and expected results; or,

3. retain a unique, specialized set of skills or knowledge that is critical to the mission and productivity of the department. The loss would result in documented severe adverse effect on the department’s mission and productivity.

3-50. Hazardous Duty is a non-base building premium that may be granted to positions working in occupations where exposure to physical hazards is not a customary part or expectation of the occupation and its preparation for entry. Such positions work for a majority of their time in settings that involve clear, direct, and unavoidable exposure to risk of major injury or loss of life even after making allowances for safety. This premium is not guaranteed and, if granted, may be discontinued at any time. No aspect of this premium pay can be grieved or appealed, except for alleged discrimination. Departments must develop appropriate criteria for the use of hazard pay based on sound business practice and need, and communicate these criteria prior to use of this

premium. The premium rate will be published in the annual pay plan and, in combination with current base pay and other premium pay, cannot exceed a statutory lid in any given month. (1/1/18)

Postemployment Compensation (9/1/12)

3-51. Postemployment compensation, which includes voluntary separation incentives or severance pay, are discretionary financial payments that may be offered to certified employees when a layoff has happened or may happen based upon documented lack of funds, lack of work, or reorganization. Post employment compensation may include, but is not limited to, a hiring preference, payment towards the continuation of health benefits, tuition or educational training vouchers, portion of salary, placement on a reemployment list. Postemployment compensation may be contingent upon an employee's waiver of retention and reemployment rights, but waiving those rights does not affect the employee's eligibility for reinstatement. A department head must establish a postemployment compensation plan before a department makes any postemployment compensation offers. (1/1/14)

3-52. Any total post employment compensation payment and other benefits shall not exceed an amount equal to one week of an employee's salary for every year of his or her service, up to 18 weeks. Any additional limitations shall be established and published by the director, taking into consideration prevailing market practice and other factors. (1/1/18)

3-53. Repealed. (1/1/18)

3-54. The employee and department must execute a written contract before payment of any post employment compensation. The contract must include the following provisions. (1/1/14)

1. A statement that the employee is required to pay all applicable taxes on the payment;

2. The employee's acknowledgement that the state will withhold taxes according to law before payment;

3. The employee's agreement to waive retention and reemployment rights, if applicable, along with a statement that the contract is voluntary and not coerced or obtained through means other than the terms of the contract; (9/1/12)

4. The date of the employee's last day of work;

5. An acknowledgement that no payment will be made until after the last day of work and compliance with other provisions of the contract; and,

6. Upon signature, a copy of each contract must be provided to the state personnel director. (9/1/12)

7. The employee's agreement to waive any and all claims they may have or assert against the employer, relative to their employment prior to the execution of this agreement. (9/1/12)

Chapter 4 Employment and Status

Authority for the rules promulgated in this chapter is found in Colo. Const. art. XII, Sections 13, 14 and 15, and § § 24-50-109.5, 112.5, 114, 132, 136 and 137, C.R.S. Board rules are identified by cites beginning with "Board Rule". Definitions for many of the terms utilized in this chapter may be found in Chapter 1 "Organization, Responsibilities, Ethics, Payroll Deduction, and Definitions", 4 CCR 801.

General Principles

Board Rule 4-1. State residents and otherwise qualified applicants shall have an equal opportunity for entry into the state personnel system through fair and open competition. Selection and appointment to positions within the state personnel system shall be made according to merit and fitness, based upon the quality of performance and job-related ability as ascertained by the comparative analysis process. The selection process utilized to fill any vacancy shall uphold the protections of Colorado's constitutional merit based personnel system. (3/30/13)

Board Rule 4-2. All applicants must meet minimum and special qualifications for the vacancy in order to be included in the comparative analysis process, referred for an interview or appointed to a position. Any required job qualifications shall be consistent with those minimum qualifications established by the State Personnel Director for classified positions within the state personnel system. (3/30/13)

4-3. Minimum qualifications established by the State Personnel Director may not be changed unless approved in writing by the State Personnel Director. (1/1/19)

4-4. Appointing authorities shall consult with the human resource personnel for their department throughout the selection process and comply with any agreement regarding delegation of selection functions entered into between the department and the Director. Nothing in these rules shall negate the proper delegation of authority of human resource functions from the Director to state agencies' human resources personnel nor constrain the Director's statutory authority to provide consulting services, as well as policy and operation leadership, in the area of professional management of state government's human resources. (3/30/13)

Board Rule 4-5. All applicants will be notified of their appeal rights in the job announcement in accordance with federal and state law or the "Dispute Resolution" chapter. Such notice shall include appeal rights they may have; the time frame for such an appeal; the address for filing the appeal; and the availability of any standard appeal form. All applicants must be notified of their elimination from consideration no later than 10 days after an accepted job offer. (3/30/13)

Board Rule 4-6. Persons with disabilities, in accordance with federal and state law, may request reasonable accommodation throughout the selection process. (3/30/13)

Job Announcement

4-7. Job announcements must be posted in such a manner as to give potential applicants notice of a vacancy; a reasonable opportunity to apply for the vacancy; notice of the required application documentation; notice of appeal rights; and a description of the position. (1/1/14)

4-8. All job announcements must be posted for a reasonable amount of time and in locations where potential applicants might reasonably expect to find them and posted electronically in a manner prescribed by the State Personnel Director. Announcements shall specify the following:

A. The class to which the vacancy is classified within the state personnel system; the pay range or anticipated hiring pay rate for that classification; the working location for the vacancy; and the closing date for accepting applications for the vacancy;

B. The minimum qualifications for the vacancy;

C. The nature of required experience and/or education for the vacancy;

D. That experience may substitute for the required education, except where such education is required by law or accreditation standards. The Department may specify the nature of experience that substitutes for education;

E. Any additional special qualifications for the vacancy;

F. Any preferred qualifications for the vacancy;

G. Any conditions of employment, including physical requirements or background check;

H. The documentation which must be submitted in order for the application to be reviewed and, if any forms must be completed, where those forms may be obtained and;

I. The address to which the application must be submitted. (3/30/13)

Board Rule 4-9. A department may request that the Director grant a residency waiver when the department can show there is an insufficient instate applicant pool. If the Director denies a waiver, the department may submit the request to the Board within 10 days. In its review of the request, the Board may grant the residency waiver if the department can show there is an insufficient instate applicant pool, including, but not limited to, consideration of the following factors:

A. The position(s) involved requires special education or training; or

B. The position(s) involved requires special professional or technical qualifications; and

C. It is not feasible to train and hire from within. (3/30/13)
Comparative Analysis

4-10. The assessment process is considered to be competitive if a reasonable opportunity was provided to potentially qualified persons to apply and compete against the same job-related standards. Any comparative analysis must be a professionally accepted standard that compares specific job-related knowledge, skills, abilities, behaviors and other competencies. Comparative analysis must meet professionally accepted standards for assessments of qualifications, competencies and job fit. (3/30/13)

4-11. Background investigations and physical or psychological examinations are allowed when validated by a competent job analysis or state or federal guidelines. (3/30/13)

4-12. Comparative analysis shall consist of professionally accepted assessments of job-related qualifications, competencies, knowledge, skills, abilities, and job fit, including but not limited to structured interviews, application/resume review, oral examinations, written objective tests, written narrative tests, performance tests, training and/or experience evaluations, and physical capacity tests. Assessment tools and/or examinations shall be developed, administered, and scored in compliance with professional guidelines and state and federal law. If multiple components are used to assess qualifications, the applicant may be required to pass one step before proceeding to the next. All examination materials and scores are confidential except as provided by the Colorado Open Records Act. (3/30/13)

4-13. All examinations and assessments are subject to review and approval by the Director. (3/30/13)

4-14. The appointing authority has the following choices in assessing candidates:

A. Appoint an eligible candidate who is a transfer, non-disciplinary demotion or reinstatement;

B. Appropriate an existing eligible list if a re-employment list does not exist; or

C. Post an announcement and engage in fair and open competition through a comparative analysis. The appointing authority shall not deviate from this decision during the selection process, unless the position is filled by another method of appointment due to valid articulated business reasons. (1/1/14)

4-15. If the department initiates an examination, then:

A. The examination portion of the process must be completed;

B. The examinations scored in accordance with professional standards; and

C. The applicants ranked accordingly. (3/30/13)

4-16. Examinations do not have to be scored if:

A. The departmental human resources director determines that the testing process has been compromised and notifies all qualified applicants of that determination, the basis for the determination and the next step in the selection process; or

B. Permission to fill the position has been withdrawn. (3/30/13)

4-17. Applicants directly affected by the selection and comparative analysis process may file a written appeal with the Director in accordance with federal and state law or the “Dispute Resolution” chapter. (3/30/13)

Board Rule 4-18. Applicants directly affected by the selection and comparative analysis process may petition the Board for review when it appears that the decision of the appointing authority violates an employee’s rights under the federal or state constitution, part 4 of article 34 of title 24, or article 50.5 of title 24. (3/30/13)

Board Rule 4-19. Any person currently or previously employed by the state of Colorado, not within the state personnel system, must successfully complete the selection process before being placed in a position in the state personnel system. Treatment of such person is subject to the provisions of § 24-50-136, C.R.S. This includes political subdivisions of the state with similar merit systems that have a formal arrangement with the Board. (3/30/13)

Employment Lists

4-20. If filling a vacancy from an employment list, employment lists must be used in the following order of priority: departmental reemployment, promotional, then open-competitive. (3/30/13)

4-21. An eligible list shall be considered established at the time when any and all applicable comparative analysis is completed. (3/30/13)

4-22. No eligible list shall be established if: (a) a departmental reemployment list with a qualified and willing individual exists for the class of the position in question, or (b) a current eligible list of equal or higher priority exists for the position in question. (3/30/13)

4-23. Employees on a departmental reemployment list may limit their availability to specific locations and work schedules. Departmental reemployment lists last for one year. (3/30/13)

4-24. The duration of an open competitive or promotional eligible list shall be a minimum of 30 days, and that eligibility list may be extended by the appointing authority for up to 12 months, unless further extended as follows:

A. The Director shall have the discretion to extend a current eligible list.

B. The Director shall have the discretion to resurrect an expired eligible list within one year of the initial expiration date of the list.

C. An appointing authority shall have the discretion to appropriate a qualified applicant pool

for identical or highly similar positions justified through competent job analyses. (3/30/13)

4-25. Cancellation or expiration of a list does not affect the legal rights of employees on military leave. (3/30/13)

4-26. If the selection process results in fewer than six applicants on an eligible list, the list may be supplemented by additional applicants obtained through further posting and comparative analysis for the vacancy, as follows:

A. If none of the qualifications for the vacancy are changed then the same process must be administered and the results from both postings must then be integrated.

B. If any qualifications are changed, a new recruitment will be initiated. (1/1/14)

Board Rule 4-27. Addition of candidates leading to an adjustment of placement on an eligible list due to open continuous recruitment shall not affect prior appointments or referrals from which an appointment has not been made. (1/1/14)

4-28. Persons may be removed from employment lists for consideration by an appointing authority or agency HR office for these specific reasons:

A. Reasons for mandatory removal from all employment lists or from consideration for all vacancies:

1. attempts to use bribery;

2. unauthorized access to examination information;

3. false statements or attempts to practice fraud and deception during the selection process; or

4. existence of a written agreement between the individual and a department that the individual will not seek or accept work from the state.

B. Reasons for mandatory removal from a specific employment list or from consideration for the relevant vacancy:

1. failure to meet the minimum qualifications; or

2. existence of a written agreement between the individual and the department that the individual will not seek or accept work from the department which is removing the individual from the employment list.

C. Reasons for discretionary removal from one or more employment lists or from consideration for relevant vacancies:

1. violation of federal or state law or regulations that affect the ability to perform the job;

2 no longer interested in or available for employment with the department or the state personnel system;

3. failure to appear for examination or participate in any aspect of the comparative analysis process;

4. failure to meet the conditions of employment such as physical requirements,

background check, or others as set forth in the job announcement;

5. failure to respond to a referral within the specified time frame as communicated to the individuals referred, or to complete any portion of the selection process;

6. failure to be appointed after at least three referrals and interviews for vacancies with the same appointing authority, who is removing the person from the employment list, within an 18 month period;

7. documented failure to demonstrate proficiency in a required job-related competency set forth in the job announcement;

8 documentation of unsatisfactory performance indicating an inability to perform in an area directly related to the job;

9. appointment to a position in the class for which a list was established; or

10. refusal of an appointment or condition(s) of employment previously indicated as acceptable. (1/1/14)

4-29. A person who has been removed from an employment list may appeal to the Board or request a review by the Director in accordance with federal and state law or the “Dispute Resolution” chapter. (3/30/13)
Referrals

4-30. If a departmental reemployment list exists, all those qualified are notified and referred in alphabetical order and no other employment lists are used. (3/30/13)

4-31. In the event of a tie as the result of a numeric comparative analysis, the referral list shall be comprised of only the six highest-ranking individuals, plus any individuals tying with those individuals. If a comparative analysis is not conducted because there are six or fewer qualified applicants, the referral list shall be comprised of those applicants. (1/1/14)

Board Rule 4-32. In the case of filling multiple vacancies within the same class from the same eligible list, no more than the top six candidates may be considered for each position as it is filled. If an appointing authority decides to fill multiple vacancies simultaneously, then the appointing authority may consider six plus one additional candidate for every additional position. (1/1/14)

4-33. Upon receipt of a request to fill a vacancy by an open-competitive or promotional method of appointment, a referral will be made from the appropriate eligible lists to the appointing authority. All those referred must be notified of any contact information for the interview. (3/30/13)

4-34. If a non-numerical or combination of numerical and non-numerical comparative analysis is used, the referral list should be comprised of the top six individuals plus any eligible veterans. If a numerical comparative analysis is used, the referral list shall only be comprised of the six highest-ranking individuals. (3/30/13)

4-35. Appointing authorities or their designees shall consider or make a reasonable attempt to interview all applicants on the referral list in compliance with state and federal law. (3/30/13)

4-36. Any additional evaluation or assessment conducted after the referral must be related to the job and administered to all applicants participating in the job interview process. (3/30/13)

Appointment

Board Rule 4-37. An employee or an appointing authority may initiate a transfer. When the appointing

authority(s) initiates the transfer, for reasonable business necessity, within the same department and the employee refuses it, the employee is deemed to have resigned. If the transfer is beyond a 25 mile radius of the employee's current work location, is longer than six months, and was not a condition of employment, the employee's name is placed on the reemployment list. (3/30/13)

4-38. A person may be reinstated to a related class with the same or lower pay range maximum than the previously certified class. (3/30/13)

4-39. Provisional appointments may be made only if the position cannot be filled conditionally. (3/30/13)

Employee Status

Board Rule 4-40. Probationary service applies to appointments to permanent positions of:

A. Employees who have not been previously employed within the state personnel system;

B. At the discretion of the appointing authority, any reinstated former certified employees. (3/30/13)

Board Rule 4-41. The probationary service period must not exceed 12 working months except as provided in the "Time Off" chapter or when there is a selection appeal pending. If the probationary employee separates from employment for any period of time, a new service date is required based on the date of rehire. (3/30/13)

A. Probationary employees do not have a right to a pre-disciplinary meeting, to a mandatory hearing to review discipline for unsatisfactory performance, to be granted a period of time to improve performance, to be placed on a reemployment list, or to the privilege of reinstatement. However, probationary employees may petition the Board for a discretionary hearing on non-disciplinary matters.

Board Rule 4-42. Trial Service applies to appointments to permanent positions as follows:

A. At the discretion of the appointing authority:

1. A current certified employee who voluntarily transfers to a position within the same class;

2. A current certified employee or reemployment applicant who transfers to a position in a different class with the same pay range maximum;

B. A current certified employee or a reemployment applicant who promotes; and

C. Any reinstated applicant unless the appointing authority requires a probationary period. (1/01/15)

Board Rule 4-43. The trial service period must not exceed six working months, except as provided in the "Time Off" chapter or when there is a selection appeal pending. An employee who fails to perform satisfactorily during trial service shall revert to an existing vacancy in the previously certified class in the current department with no right to a hearing or, if there is no existing vacancy in the previously certified class in the current department, shall be accorded any retention rights to which the employee may be entitled under § 24-50-124, C.R.S. and/or Board Rule. The appointing authority has discretion to administer corrective or disciplinary action instead of reversion. (3/30/13)

Board Rule 4-44. The following applicants or employees retain their certified status when appointed to a new class or position:

A. A current certified employee who demotes;

B. A reemployment applicant who is appointed to a position within the same class;

C. A current certified employee who voluntarily transfers to a position within the same class remains certified unless the appointing authority requires a trial service period

D. A current certified employee or a reemployment applicant who voluntarily transfers to a different class with the same pay range maximum remains certified unless the appointing authority requires a trial service period;

E. A current certified employee who involuntarily transfers to a position within the same class or a position within a different class with the same pay range maximum. (3/30/13)

Board Rule 4-45. Early certification is not allowed if a selection appeal is pending. (3/30/13)

Board Rule 4-46. When accepting a state position outside the state personnel system at the request of an elected or appointed state official, a certified employee is subject to the provisions of § 24-50-137, C.R.S. (3/30/13)

Temporary Status

4-47. A temporary appointment refers to a qualified person who is appointed to a position or positions for a period not to exceed nine months in any 12-month period. The nine-month limitation shall be inclusive of all temporary appointments and departments. Temporary appointments include appointments to temporary positions, conditional, provisional and substitute appointments. (3/30/13)

4-48. All temporary positions shall be in the Temporary Aide class. Temporary employees are employed at will and do not have the rights and benefits provided to permanent employees, except those mandated by law and pay range minimum. Effective December 31, 1998, no credit is provided for a temporary position when an employee accepts a permanent position in the same class without a break in service.

A. When the services for the relevant position are permanent and full-time, the position shall not be filled through a succession of temporary appointments.

B. When services are seasonal or annually recurring, department heads should consider creating a permanent part-time position, including analysis of potential partnering with other departments in the same geographic location, as provided in the “Personal Services Contracts” chapter. However, either a permanent part-time or temporary position may be used. (3/30/13)

Board Rule 4-49. A person in conditional status does not have a break in service as a result of having a conditional appointment. If the employee is subsequently appointed, to the position to which s/he was conditionally appointed, from a list, the trial service period begins on the date of the conditional appointment. If not subsequently appointed to the position, the employee reverts to an existing vacancy in the certified class in the current department. If no vacancy exists, layoff provisions apply. (3/30/13)

Board Rule 4-50. If a person with provisional status is subsequently appointed, to the position to which s/he was provisionally appointed, from a list, the probationary period begins on the date of the appointment from the referral list. Provisional employees do not have the rights and benefits provided to classified employees within the state personnel system, except those mandated by law and pay range minimum. (3/30/13)

Board Rule 4-51. A substitute appointment may only be made to perform the duties of a filled position during a leave or for training purposes. This appointment shall not exceed nine months in a 12-month period unless transfer, demotion, or examination fills it. Layoff provisions do not apply and a certified employee is returned to a position in the former class. (3/30/13)

Chapter 5 - Time Off

Authority for rules promulgated in this chapter is found in one or more of the following: the State of Colorado Constitution Article XII, Section 13, The Family Medical Leave Act (FMLA), Americans with Disabilities Act (ADA), Family Care Act (FCA), Uniformed Services Employment and Reemployment Rights Act (USERRA), the State of Colorado Constitution Article XII, Section 13, The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA), and 26 U.S.C. 63, State of Colorado Revised Statutes (C.R.S.) §§ 1-6-115, 1-6-122, 1-7-102, 8-40-101, 14-2-101, 14-15-103, 24-11-101, 24-11-112, 24-18-102, 24-33.5-825, 24-50-104, 24-50-109.5, 24-50-401, 28-1-104, 28-3-601, 28-6-602, 28-3-607, 28-3-609, and 28-3-610. (02/2017).

General Principles

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

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

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

C Unauthorized use of any leave may result in the denial of paid leave and/or corrective or disciplinary action.

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

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

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

5-4. Annual leave is for an employee's personal needs and use is subject to the approval of the appointing authority. The appointing authority may establish periods when annual leave will not be allowed, or must be taken, based on business necessity. These periods cannot create a situation where the employee does not have a reasonable opportunity to use requested leave that will be subject to forfeiture. If the department cancels approved leave that results in forfeiture, the forfeited hours must be paid before the end of the fiscal year. (5/1/10)

5-5. Sick leave is for health reasons only, including diagnostic and preventative examinations, treatment, and recovery. Accrued sick leave may be used for the health needs of the employee, employee's child, parent, spouse, injured military service member as established under Rule 5-20, legal dependent, or a person in the household for whom the employee is the primary care

giver. The appointing authority may require documentation of the familial relationship. (02/2017)

A. Appointing authorities may use discretion to send employees home for an illness or injury that impacts the employee's ability to perform the job or the safety of others. Sick leave shall be charged but annual leave shall be charged if sick leave is exhausted; unpaid leave if both annual and sick leave are exhausted. (02/2017)

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

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

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

Exhaustion of Leave and Administrative Discharge

5-6. If an employee has exhausted all credited paid leave and is unable to return to work, unpaid leave may be granted or the employee may be administratively discharged by written notice following a good faith effort to communicate with the employee. Administrative discharge applies only to exhaustion of leave. (5/1/10)

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

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

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

5-7. Table (1/1/19)

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

Annual Leave					**Sick Leave**				
Years of Service*	**Hrs. / Mon.**	Hrs./Fiscal Year	**Max. Accrual ** **	**Payout**	**Hrs.:Mins./ Mon.**	Hrs./Fiscal Year	**Max Accrual* ** **	**Restoration**	**Payout**
Years 1 - 5 (01 - 60 Months)	8	96	192 hours	Upon termination or death, unused leave is paid out up to the maximum accrual rate.	6:40	Up to 80 hours	360 hours	Previously accrued sick leave up to 360 hours is restored when eligible for reinstatement or reemployment.	Upon death or if eligible to retire, 1/4 of unused leave paid out to the maximum accrual rate. PERA's age and service requirements under the Defined Benefit plan are applied regardless of the plan actually enrolled in.
Years 6 - 10 (61 - 120 Months)	10	120	240 hours						
Years 11 -15 (121 - 180 Months)	12	144	288 hours						
Year 16 or Greater (181 or more Months)	14	168	336 hours						

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

** Over-accrued amounts are forfeited at the beginning of the new fiscal year (July 1st).

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

General Provisions:

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

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

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

Borrowing against any leave that may be earned in the future or "buying back" leave already used is not allowed.

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

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

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

Short-Term Disability: Employees are required to use paid leave during the 30-day waiting period for short-term disability benefits, including the use of accrued annual leave and/or compensatory time once sick leave has been exhausted. Any remaining sick leave beyond the 30-day waiting period must be exhausted prior to eligibility for short-term disability benefit payments.

Leave Sharing

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

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

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

Holiday Leave

5-10. Permanent full-time employees on the payroll when the holiday is observed are granted eight hours of paid holiday leave (prorated for part-time work or unpaid leave in the month) to observe each legal holiday designated by law, the Governor, or the President. Appointing authorities may designate alternative holiday schedules for the fiscal year. (5/1/10)

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

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

Other Employer-Provided Leaves

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

5-12. Bereavement leave is for an employee's personal needs and use is subject to the approval of the appointing authority. The appointing authority may provide up to 40 hours (prorated for part-time work or unpaid leave in the month) of paid leave to permanent employees for the death of a family member or other person. Employees are responsible for requesting the amount of leave needed. Documentation may be required when deemed necessary by the appointing authority. (02/2017)

5-13. Military leave provides up to 15 paid regular workdays in a fiscal year to permanent employees who are members of the National Guard, military reserves, or National Disaster Medical Service to attend the annual encampment or equivalent training or who are called to active service, including declared emergencies. Unpaid leave is granted after exhaustion of the 15 regular workdays. The employee may request the use of annual leave before being placed on unpaid leave. (02/2017)

A. In the case of a state emergency, the employee must return upon release from active

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

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

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

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

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

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

2. One period of administrative leave for the initial call up to active military service in the war against terrorism of which shall not exceed 90 days and applies after exhaustion of paid military leave. Administrative leave is only used to make up the difference between the employee's base salary (excluding premiums) and total gross military pay and allowances. The employee must furnish proof of military pay and allowances. This leave does not apply to regular military obligations such as the annual encampment and training. (02/2017)

3. Employee participation in community or school volunteer activities. (02/2017)

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

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

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

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

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

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

service. (02/2017)

5-16. Administrative leave that exceeds 20 consecutive working days must be reported to the department head and the Director. (02/2017)

5-17. Unpaid leave may be approved by the appointing authority unless otherwise prohibited. The appointing authority may also place an employee on unpaid leave for unauthorized absences and may consider corrective and/or disciplinary action. Probationary and trial service periods are extended by the number of days on unpaid leave and may be extended for periods of paid leave. Unpaid leave is calculated based on the annualized hourly rate. (1/1/19)

A. Short-term disability (STD) leave is a type of unpaid leave of up to six months while either state or PERA STD benefit payments are being made. To be eligible for this leave, employees must have one year of service and an application for the STD benefit must be submitted within 30 days of the beginning of the absence or at least 30 days prior to the exhaustion of all accrued sick leave. The employee must also notify the department at the same time that a benefit application is submitted.

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

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

5-18. Parental Academic leave. Departments may provide up to 18 hours (prorated for part-time) in an academic year for parents or legal guardians to participate in academic-related activities. A department shall adopt and communicate a policy on whether the leave will be unpaid or paid, the amount and type of paid leave, and specifically the substitution of annual leave or use of administrative leave. (02/2017)

Family/Medical Leave (FML)

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

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

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

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

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

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

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

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

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

5-21. To be eligible for FML, an employee must have 12 months of total state service as of the date leave will begin, regardless of employee type. A state temporary employee must also have worked 1250 hours within the 12 months prior to the date leave will begin. Time worked includes overtime hours. (02/2017)

A. Full-time employees will be granted up to 520 hours per rolling 12-month period. The amount of leave is determined by the difference of 520 hours and any FML leave taken in the previous 12-month period and is calculated from the date of the most recent leave. The amount of leave is prorated for part-time employees based on the regular appointment or schedule. Any extension of leave beyond the amount to which the employee is entitled is not FML, see Rule 5-1 B. (02/2017)

5-22. Military caregiver leave is a one-time entitlement of up to 1040 hours (prorated for part-time) in a single 12-month period starting on the date the leave begins. While intermittent leave is permitted, it does not extend beyond the 12-month period. In addition, the combined total for military caregiver and all other types of FML shall not exceed 1040 hours. (5/1/10)

5-23. All other types of leave, compensatory time, and make whole payments under workers' compensation run concurrently with FML and do not extend the time to which the employee is entitled. The employee must use all accrued paid leave subject to the conditions for use of such leave before being placed on unpaid leave for the remainder of FML. An employee on FML cannot be required to accept a temporary "modified duty" assignment even though workers' compensation benefits may be affected. (7/1/13)

5-24. Unpaid leave rules apply to any unpaid FML except the state continues to pay its portion of insurance premiums. An employee's condition that also qualifies for short-term disability benefits must comply with the requirements of that plan.

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

5-26. Employee Requirements. Written notice of the need for leave must be provided by the employee 30 days in advance. If an employee becomes aware of the need for leave in less than 30 days in advance, the employee shall provide notice either the same day or the next business day. Failure to provide timely notice when the need for leave is foreseeable, and when there is no reasonable excuse, may delay the start of FML for up to 30 days after notice is received as long as it is designated as FML in a timely manner. Advance notice is not required in the case of a medical

emergency. In such a case, an adult family member or other responsible party may give notice, by any means, if the employee is unable to do so personally. (5/1/10)

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

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

Medical Certificates

5-29. Employees must provide the State's authorized medical certification form (or other official document containing the same information) when initiating an FML leave request. Appointing authorities have the discretion to require periodic medical certification to determine if FML continues to apply or when the appointing authority has a reasonable basis for suspecting leave abuse. Medical certification for FML may be required for the first leave request in an employee's rolling 12-month period. Additional medical certification may be required every 30 days or the time period established in the initial certification, whichever is longer, unless circumstances change or new information is received. (02/2017)

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

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

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

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

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

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

A. When requested, employees must present a completed fitness-to-return certificate before

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

B. When an incomplete fitness-to-return certification is submitted, the employee must be allowed seven days to obtain complete information, absent reasonable extenuating circumstances. Following receipt of the information or the seven days from which it was requested, the department's human resources director or FMLA coordinator may, with the employee's written permission, contact the health care provider for purposes only of clarification and authentication of the fitness-to-return certification. (02/2017)

5-33. Benefits coverage continues during FML. If the employee is on paid FML, premiums will be paid through normal payroll deduction. If the FML is unpaid, the employee must pay the employee share of premiums as prescribed by benefits and payroll procedures. (5/1/10)

5-34. Upon return to work, the employee is restored to the same, or an equivalent, position, including the same pay, benefits, location, work schedule, and other working conditions. If the employee is no longer qualified to perform the job (e.g., unable to renew an expired license), the employee must be given an opportunity to fulfill the requirement. (5/1/10)

A. If the employee is no longer able to perform the essential functions of the job due to a continuing or new serious health condition, the employee does not have restoration rights under FML, and the appointing authority may separate the employee pursuant to Rule 5-6 subject to any applicable ADA provisions. (02/2017)

B. The employee does not have restoration rights if the employment would not have otherwise continued had the FML leave not been taken, e.g., discharge due to performance, layoff, or the end of the appointment.

5-35. FML does not prohibit adverse action that would have otherwise occurred had the leave not been taken. (5/1/10)

5-36. The use of FML cannot be considered in evaluating performance. If the performance plan includes an attendance factor, any time the employee was on FML cannot be considered. (5/1/10)

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

Injury Leave

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

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

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

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

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

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

DEPARTMENT OF PERSONNEL AND ADMINISTRATION

State Personnel Board and State Personnel Director

STATE PERSONNEL BOARD RULES AND PERSONNEL DIRECTOR'S ADMINISTRATIVE PROCEDURES

4 CCR 801-1

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

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

Preamble

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

~~This version reflects rulemaking by the State Personnel Director as follows: To modify Procedures 2-10, 3-6, 3-7, 3-8, 3-9, 3-11, 3-14, 3-18, 3-19, 3-32, 3-33, 3-43, 3-44, 3-45, 3-50, 3-52, 7-6, 7-11, 7-14 and to repeal Procedures 3-47 and 3-53 effective January 1, 2018.~~

~~This version reflects rulemaking by the State Personnel Board to adopt, as amended, Board Rules in Chapter 8, as follows: Board Rules 8-2, 8-3, 8-3(A),8-4, 8-8(A)(1), 8-8(A)(2)(c), 8-8(B)(1),8-8(B)(2), 8-8(C), 8-8(D), 8-12, 8-14, 8-15, 8-17, 8-18, 8-19(A), 8-20, 8-25, 8-26, 8-26(B), 8-30, 8-31, 8-32, 8-32(A), 8-34, 8-34(A), 8-35, 8-36, 8-36(A through D), 8-38, 8-38(A), 8-38(B), 8-39, 8-40, 8-41, 8-41(A), 8-41(B), 8-45, 8-45(A)(3), 8-45(A)(4), 8-45(B)(3), 8-45(B)(4), 8-45(C), 8-45(D), 8-45(E), 8-45(F), 8-45(G), 8-45(H), 8-46(B), 8-46(C), 8-47, 8-48, 8-50, 8-51, 8-51(A through E), 8-52(A through E), 8-53(B)(1,2,4), 8-54(A through I) 8-55, 8-56, 8-57, 8-58, 8-59, 8-60, 8-61, 8-62, 8-64, 8-67, 8-68, 8-69, effective January 14, 2018.~~

This version reflects rulemaking by the State Personnel Director as follows: To modify Procedures 3-27, 4-3, 5-7, and 5-17 effective January 1, 2019.

Chapter 3 - Compensation

Authority for rules promulgated in this chapter is found in one or more of the following: the State of Colorado Constitution Article XII, Section 13, State of Colorado Revised Statutes (C.R.S.) §24-50-104 (1) (a), (b), (c), (e), (f), (4), (5), (6), (9), and 24-50-104.5(1), 109.5, 136, 137, and 208, C.R.S. Board rules are identified by cites beginning with "Board Rule".

General Principles

3-1. The Department of Personnel shall establish rules governing compensation for the state personnel system. Compensation practices shall provide for equitable treatment of similarly situated employees.

3-2. Pay grades shall reflect prevailing labor market compensation and any other pertinent considerations. No individual employee's base pay shall be less than the minimum of the grade or exceed a statutory lid. In the case of disciplinary action, base pay may be less than the minimum of the grade for a period not to exceed 12 months, subject to FLSA requirements.

Annual Compensation Survey

3-3. The Department of Personnel shall conduct the annual compensation survey. The Director shall establish and publish the distribution of annual compensation changes among salaries, including establishment of statewide priority groups and group benefit contributions, which shall be effective as provided by law. (9/1/12)

3-4. When upward pay grade changes are implemented, the grade minimum and maximum shall be adjusted and no employee shall be paid outside of the new grade, except in disciplinary actions resulting in salary temporarily below the new minimum and continuation of saved pay above the new maximum. (7/1/07)

3-5. If pay grade changes are downward, employees' base pay shall remain unchanged, subject to the statutory three-year limitation on saved pay.

Pay Rates

3-6. The Department of Personnel shall publish the annual pay plan. Departments shall use an hourly rate based on an annual salary to compensate employees who do not work a predetermined or full schedule. (1/1/18)

3-7. Saved pay applies to downward movements due to individual allocation, system maintenance studies, and the annual compensation survey to maintain an employee's current base pay when it falls above the new grade maximum. It may also apply when retention rights are exercised pursuant to the "Separation" chapter. In no case shall the employee's base pay remain above the grade maximum after three years from the action, even if it results in a loss in pay. (1/1/18)

3-8. Unless authorized by the Director, the rate resulting from multiple actions effective on the same date shall be computed in the following order. The Director may withhold salary adjustments for any employee with a final overall rating of needs improvement, except as provided in 3-4. (7/1/07)

1. System maintenance studies.

2. Upward, downward, or lateral movements.

3. Repealed. (8/1/08)

4. Changes in pay grade minimums and maximums to implement approved annual compensation changes to the pay structure.

5. Across-the-board increases authorized by the General Assembly. (1/1/18)

6. Adjustments to the base pay of employees due to merit pay in approved annual compensation changes, subject to the new grade maximum and 3-19(C)(1)(a). (1/1/18)

7. Bring salaries to the new grade minimum as a result of compensation survey pay grade changes, except in disciplinary actions. (1/1/18)

8. Non-base merit payments (based on new annual salary). (1/1/18)

3-9. The appointing authority shall determine the hiring salary within the pay grade for a new employee, including one returning after resignation, which is typically the grade minimum unless recruitment difficulty or other unusual conditions exist. (7/1/06)

A. Recruitment difficulty means difficulty in obtaining qualified applicants or an inadequate number of candidates to promote competition despite recruitment efforts.

B. Unusual conditions exist when the position requires experience and competencies beyond the entry level or the best candidate cannot be obtained by hiring at the minimum of the pay grade. (1/1/18)

C. The appointing authority's determination shall consider such factors as, but not limited to, labor market supply, recruitment efforts, nature of the assignment and required competencies, qualifications and salary requirements of the best candidate, salaries of current and recently hired employees in similar positions in the department, available funds and the long-term impact on personal services budgets of hiring above the minimum of the pay grade.

3-10. In the case of fiscal emergency or other budget reasons, an employee may agree to voluntarily reduce current base pay, which shall be approved in writing by the appointing authority and employee. If funds become available at a later date, the department may restore base pay to any rate up to, and including, the former base pay. This policy shall not be used to substitute for other provisions in this chapter.

3-11. When an unclassified position is brought into the state personnel system, the base pay for an employee appointed to the position shall be computed in accordance with the Department of Personnel's directives that shall ensure that total compensation is preserved to the greatest extent possible, except that base pay shall not exceed the grade maximum. (1/1/18)

Downward Adjustments

3-12. Downward movement is a change to a different class with a lower range maximum (e.g., non-disciplinary or disciplinary demotions, individual allocations, system maintenance studies including class placement, or the annual compensation survey).

3-13. In the case of system maintenance studies and individual allocations of positions, the employee's base pay shall remain the same, including saved pay.

A. A department head has sole discretion to grant saved pay when employees exercise retention rights and the decision must be applied consistently throughout the retention area. If saved pay is granted, the employee's name shall not be placed on a reemployment list. (7/1/07)

3-14. In the case of other downward movements, the base pay shall not be above the maximum in the new grade.

A. Upon reversion of a trial service employee to the previously certified class, base pay shall be the amount the employee would be making had the promotion or reinstatement not occurred. (1/1/14)

Upward Adjustments

3-15. Upward movement is a change to a different class with a higher range maximum (e.g., promotions, individual allocations, system maintenance studies including class placement, or the annual compensation survey).

3-16. In the case of system maintenance studies, employees' base pay shall remain the same. If the Director finds that severe and immediate recruitment and retention problems make it imperative to increase pay to maintain critical services, the Director may order that base pay be increased up to the percentage increase for the new class.

3-17. In the case of other upward movements, the employee's base pay may increase or remain the same, in which case the employee would receive the economic opportunity by moving to the new grade. In no case shall the new base rate be lower than the minimum, except in disciplinary actions, or higher than the maximum of the new grade. Continuation of a salary increase is subject to satisfactory completion of the trial service period.

A. When conditional employees move upward, the base pay shall be computed based on the certified class.

Lateral Adjustments

3-18. Lateral movement is a change to a different class or position with the same range maximum (e.g., transfers, individual allocations, system maintenance studies including class placement), or an in-range salary movement in the same class and position. Base pay can be offered at a rate that falls within the pay range of the class and does not exceed the grade maximum. In addition, in-range salary movements are subject to the provisions below. (1/1/14)

In-Range Salary Movements. A department may use these discretionary movements to increase base salaries of permanent employees who remain in their current classes and positions when there is a critical need not addressed by any other pay mechanism. The use of in-range salary movements is not guaranteed and shall be funded within existing budgets. These movements shall not be retroactive and unless specifically noted in these rules, frequency is limited to one in-range salary movement in a 12-month period. No aspect of granting these movements is subject to grievance or appeal, except for alleged discrimination; however, an alleged violation of the department's plan can be disputed. A department's decision in the dispute is final and no further recourse is available. Once granted, a reduction in base salary is subject to appeal. Departments must develop a written plan addressing appropriate criteria for the use of any movement based on sound business practice and needs, e.g., eligibility, funding sources, approval requirements, measures to ensure consistent use. The plan must be communicated within the department and a copy provided to the Director prior to implementation. If granted, there must be an individual written agreement between the employee and the appointing authority that stipulates the terms and conditions of the movement. Records of any aspect of these movements shall be provided to the Director when requested. (02/2017)

A. Salary Range Compression. Used as a salary leveling increase where longer-term or more experienced employees are paid lower in the range for the class than new hires or less experienced employees over a period of time resulting in documented retention difficulties. Thus, there is a valid need to increase one or more employee's base salary in

the class to recognize contributions equal to or greater than the newly hired or less experienced employees. Justification shall be required based on facts. To be eligible, an employee must be performing satisfactorily as evidenced by the most recent final overall performance rating. The increase may be up to 10 percent or the maximum permitted by the department's policy on hiring salaries, whichever is greater, and subject to the pay grade maximum. (9/1/12)

B. Counteroffer. Used when an employee with critical, strategic skills receives a higher salary offer from another department or outside employer and the appointing authority needs to increase the employee's base salary for retention purposes. To be eligible, an employee must be performing satisfactorily as evidenced by the most recent final overall performance rating. Written confirmation of the other entity's salary offer is required. The increase may be up to 10 percent or the maximum permitted by the department's policy on promotional pay, whichever is greater, and subject to the pay grade maximum.

C. Delayed Transfer or Promotional Pay Increase. Used when a transfer or promotion is made with no salary increase or partial salary increase because performance expectations are unproven and/or funds may be unavailable at the time of transfer or promotion. This is a one-time base salary increase within 12 months of the date of transfer or promotion when funds become available and the employee's contributions are fulfilled. The intent to provide a later salary increase must be documented at the time of the transfer or promotion. To be eligible, an employee must be performing satisfactorily as evidenced by the most recent final overall performance rating. The increase may be up to 10 percent or the maximum amount permitted in the department's policy on transfer or promotional pay increases, whichever is greater, and subject to the pay grade maximum. Transfer, promotion, demotion, or separation of the employee will negate the delayed increase. (1/1/18)

D. New Hires. Used at the time an employee is hired when performance expectations are unproven and/or funds may be unavailable. This is a one-time base salary increase within 12 months of hire. The intent to provide a later salary increase must be documented at the time of hire. To be eligible, early satisfactory completion of specified training objectives must be documented. This is limited to a one-time increase up to 10 percent or the maximum permitted by the department's policy on promotional pay increases, whichever is greater, and subject to the pay grade maximum. Transfer, promotion, demotion, or separation of the employee will negate the delayed increase. (02/2017)

E. Competency-Based Increase. Used when an employee applies the complete set, or a subset, of competencies required to successfully perform the work of a specific position. Required competencies must be specifically defined with deadlines and evaluation criteria for achievement, and must be communicated in writing to the employee prior to granting an increase. Competencies that are the basis for this increase must be required to perform permanent, essential functions assigned to the position. The intent of this increase is to promote career development by aligning pay increases with achieving all required competencies to fully perform the job. Increases are limited to no more than two per 12-month period. This type of increase shall not be applied as a substitute for Merit Pay. To be eligible, an employee must demonstrate required competencies as evidenced by a written evaluation by the appointing authority. The increase may be up to 10 percent or the maximum permitted by the department's policy, whichever is greater, and subject to the pay grade maximum. (02/2017)

Merit Pay (9/1/12)

3-19. Merit pay consists of both base and non-base building adjustments. Any permanent employee is

eligible for merit pay, except as provided below and as otherwise provided in this chapter. Prior to the payment of merit pay, the Director shall specify and publish the percentage for any merit pay increase for applicable priority groups. Adjustments are effective on July 1. The employee must be employed on July 1 to receive payment. The employee's current department as of July 1 is responsible for payment, unless arrangements are made whereas the transferring department will provide full payment of a portion of any non-base building merit pay increase. (1/1/18)

A. If the final overall rating is needs improvement, the employee is ineligible for any merit pay. Merit pay shall not be denied because of a corrective or disciplinary action issued for an incident after the close of the previous performance cycle. (9/1/12)

B. Employees hired into the state personnel system during the performance evaluation cycle shall receive a prorated portion of any base or non-base building merit pay. The proration shall be based on the number of calendar months worked. (1/1/18)

C. Base building merit pay shall be based on final performance evaluation and salary position within the pay range on June 1. (1/1/18)

1. Payment of base building merit pay shall not cause an employee's base pay to exceed the grade maximum, and is paid as regular salary. (9/1/12)

a. The payment of any remaining portion of base building merit pay that would cause base pay to exceed grade maximum shall be paid as a onetime, non-base building lump sum in the July payroll. The statutory salary lid does not apply to such a payment. (1/1/14)

2. Payment of base building market pay shall be a comparison of state personnel system salaries to market salaries for the purpose of measuring competitiveness. Market shall result in base building increases to pay, only when an employee's salary is below a newly adjusted pay range minimum. (9/1/12)

D. Non-base building merit pay shall be a non-base building or one-time lump sum payment and shall be calculated after any annual compensation adjustments, including base building merit pay. (1/1/18)

1. Non-base building merit pay must be earned each year and shall be paid as a one-time lump sum in the July payroll. The grade maximum and statutory lid do not apply to non-base building merit pay. (9/1/12)

a. An employee must be employed on the date of the payment in order to be eligible to receive a non-base building merit payment. (9/1/12)

E. Base building or non-base building merit pay may be provided to employees, at a department's discretion if approved by the Governor's Office of State Planning and Budgeting, when funded from a department's state employee reserve fund using department reversions. These discretionary merit payments shall only be paid to certified employees, in order of priority grouping established by the Director. (1/1/18)

1. Base building merit pay increases funded from a department's state employee reserve fund shall be provided only if the department can justify sustainability as determined by the Governor's Office of State Planning and Budgeting. (9/1/12)

2. Merit pay increases funded from a department's state employee reserve fund shall not be provided more than once in a 12-month period per employee. 9/1/12)

3. Repealed. (1/1/18)

F. Repealed. (1/1/18)

Incentives

3-20. Departments are strongly encouraged to use incentives. (7/1/06)

3-21. An appointing authority may grant an immediate non-base cash or non-cash incentive award to an employee in recognition of special accomplishments or contributions throughout the year or to augment merit pay, e.g., on-the-spot cash awards, work-life options, or administrative leave, in accordance with a department's established incentive plan. Other than augmenting merit pay, incentives shall not be used to supplement or substitute for annual compensation adjustments or other base pay movements. The statutory salary lid does not apply to these incentives. (9/1/12)

A. Departments must have an incentive plan prior to the use of incentives. Such plans shall include eligibility criteria, the types of incentives allowed, cash amounts or limits and payment methods, and a communication plan. Such plans shall be developed with the input of employees and managers.

1. If a department uses a type of incentive that shares cost savings from innovations, the following applies.

a. Employees are ineligible if they are wholly responsible for control and operation of a division (or equivalent), the primary assignment includes responsibility for identifying efficiencies and cost reductions, or the position has statewide program or budget authority.

b. Savings are the result of innovative ideas that increase productivity and service levels while decreasing costs. Savings are not the result of normal progressive business evolution, obvious solutions to mandated budget cuts, cost avoidance or revenue enhancement, nor do they have adverse cost impact on other departments.

c. Savings are the difference between anticipated expenditures prior to implementation and actual expenditures following implementation for a full 12-month period. The complete award amount shall be no more than 10 percent of the first year's savings, not to exceed a total of $1,000 per employee.

3-22. Repealed. (8/1/08)

3-23. Repealed. (8/1/08)

Medical Plan

3-24. Employees in the medical pay plan shall be compensated based solely on performance as established in the required annual contract to be negotiated by July 1 of the contract year, or within 30 days of hire or movement within the medical pay plan for the remainder of the contract year. Employees are not eligible for any pay adjustments, such as merit pay. Current performance contracts may be modified during the contract year but not compensation. Change in compensation shall only occur at the end of a contract period, unless an employee moves to another position, and may increase, decrease, or remain unchanged from the previous year. In the case of upward or downward movement in the medical pay plan, compensation must be no lower than the minimum or higher than the maximum rates of the new grade and a new contract

must be negotiated for the remainder of the contract year. (9/1/12)

A. If no contract is negotiated, the existing contract continues and base pay stays the same until a new contract is negotiated. Employees in the medical pay plan may grieve the rate unless it is lower, which is then subject to appeal. If the employee moves into or out of the medical pay plan into another open-range class, the base pay shall be negotiated subject to the grade maximum of the new class.

FLSA and Overtime

3-25. All employees are covered by the Fair Labor Standards Act (FLSA). Under FLSA, the state is considered to be a single employer. Employees cannot waive their rights under FLSA.

3-26. All full-time employees work a minimum of 40 hours during a standard workweek (168 consecutive hours in seven consecutive days). Appointing authorities may adopt different work periods for law enforcement and health care employees as permitted by federal law. (8/1/08)

3-27. Overtime is the time a non-exempt employee works in excess of the 40 hours during a standard workweek or in excess of established work hours in adopted work periods for law enforcement and health care employees. Such excess hours are paid at 1½ times the employee's regular hourly base pay rate, including applicable premium pay. Monetary payment must be made by the next ~~regularly~~ scheduled payday, designated by the State Controller, following the pay period in which it was worked. ~~(8/1/08)~~(1/1/19)

A. Overtime for non-exempt employees shall be approved in accordance with a department's procedure. A department head shall establish a policy to address unauthorized overtime work; however, prohibition of unauthorized overtime does not avoid the requirement to pay if it is actually worked.

B. Compensatory time in lieu of monetary payment is allowed if there is a written agreement between the department and any employee hired after April 15, 1986. Written agreements for those hired prior to April 15, 1986, are unnecessary provided that the department had a regular practice in place for granting compensatory time. Acceptance of compensatory time may be a condition of employment for new employees. Appointing authorities must ensure that compensatory time is scheduled as soon as practical. Compensatory time shall not exceed 240 hours (or 480 hours for law enforcement) and any additional overtime must be paid at the next regular pay period. If a department wants to place limits on the accrual or payment of compensatory time, a policy must be developed and communicated prior to use and on an ongoing basis. Unused compensatory time at termination or transfer to another department must be paid at that time.

Eligibility

3-28. Department heads are responsible for determining if each position is exempt or non-exempt based on the actual duties performed regardless of class. Determinations must be entered into the payroll system and a record kept on file.

3-29. An exempt employee's pay is not subject to reduction except as follows. Deductions in increments of one day are allowed for a major workplace rule violation. Deductions are allowed for any amount of time if a leave of absence was not requested or was denied and accrued leave is not used; or is covered by the Family and Medical Leave Act (FMLA); or accrued leave is exhausted; or for voluntary furlough. In the case of mandatory furloughs for budgetary reasons, exempt status is not changed, except for the workweek in which the furlough occurs and pay is reduced. Improper reductions make the employee non-exempt. (7/1/06)

3-30. Exempt employees shall not be granted extra pay for hours worked in excess of 40 hours in a workweek. An appointing authority may grant discretionary administrative leave or other incentives but such awards shall not be tied to hours worked. (7/1/06)

3-31. An employee may request a review of a decision regarding eligibility, calculation of overtime hours, and payment to the Director in accordance with the “Dispute Resolution” chapter.

Dual Employment

3-32. In a properly authorized dual employment arrangement, the written agreement shall include the exemption status designation based on the combined duties, the department responsible for paying any overtime, and the overtime hourly rate. The overtime rate, if applicable, is either the regular rate from one of the jobs or a weighted rate from both jobs. Work time from both jobs is combined to calculate overtime. (1/1/18)

Work Hours

3-33. In order to minimize overtime liability, appointing authorities may deny, delay, or cancel leave before it is taken. Appointing authorities may require the use of accrued compensatory time but cannot schedule compensatory time if that will make an employee forfeit annual leave at the end of the fiscal year. (1/1/18)

3-34. Compensatory time is not leave, but a form of compensation. Therefore, it is not included in the calculation of work hours for overtime purposes.

3-35. Overtime does not accrue until a non-exempt employee works more than the maximum hours allowed in a workweek or designated work period. All time worked must be recorded on a daily basis. Overtime is calculated based on the total time worked in the workweek or designated work period, rounded to the nearest quarter hour. If operational needs require an employee to regularly report to work early or leave late, that time is counted as work hours for weekly overtime purposes.

3-36. Essential, non-exempt positions, as designated by a department head, shall have paid leave counted as work time. Essential positions perform law enforcement, highway maintenance, and support services directly responsible for the health, safety, and welfare of patients, residents, students, and inmates.

3-37. Scheduled meal periods are discretionary. Scheduled meal periods are not work time and must be at least 20 minutes. However, if the employee is materially interrupted or not completely free from duties, the meal period is counted as work time.

3-38. Work breaks are discretionary. If granted, breaks of up to 20 minutes are work time. Breaks shall not offset other work time or substitute for paid leave, not be taken at the beginning or end of the workday, nor be used to extend meal periods.

3-39. Ordinary travel to and from work is not work time. Travel from work site to work site is work time. When an employee is required to travel a substantial distance to perform a job away from the regular work site, the travel is work time.

3-40. Mandatory training or meetings are work time. Voluntary training during work hours, as approved by the appointing authority, which is directly related to an employee’s job and is designed to enhance performance, is work time. Voluntary training after hours to gain additional skill or knowledge is not work time, even if it is job related.

Recordkeeping

3-41. FLSA requires that certain basic records be maintained for both exempt and non-exempt employees. Each department is accountable for maintaining those records. (7/1/07)

3-42. Time records must be certified by both the employee and the supervisor and are the basis for overtime calculation and compensation.

Other Premium Pay

3-43. Shift Differential is additional pay beyond base pay for employees working shifts. Eligible classes are published in the annual pay plan. Department heads may designate eligibility for individual positions in classes not published and shall maintain records for such cases. Shift differential does not apply to any periods of paid leave. Second shift rate applies when half or more of the scheduled work hours fall between 4:00 p.m. and 11:00 p.m. Third shift rate applies when half or more of the scheduled work hours fall between 11:00 p.m. and 6:00 a.m. If hours are evenly split between shifts, the higher shift differential rate applies to all hours worked during the shift. (1/1/18)

3-44. Call Back applies when an eligible employee is required to report to work before the start or after the end of a scheduled shift. If there is no release from work between the call back hours and regular shift, it is considered a continuation of the shift and call back does not apply. When call back applies, a minimum of two hours of the employee's regular base pay is guaranteed. Eligible employees are those who are eligible for overtime, and any call back time is counted as work time. Employees exempt from overtime are also eligible when approved by a department head. (1/1/18)

3-45. On Call is additional pay beyond base pay for employees specifically assigned, in advance, to be accessible outside of normal work hours and where freedom of movement and use of personal time is significantly restricted. Eligible classes and the rate are published in the annual pay plan. A department head may designate eligibility for individual positions in classes not published and maintain records of such on-call designations. Only time while actually on call shall be paid at the special rate. In call back situations, employees eligible for both on call and call back pay shall receive call back pay only. (1/1/18)

3-46. Second Domicile is additional discretionary pay up to 10 percent of base pay for employees who are required to maintain a second domicile for more than 10 consecutive calendar days while working out-of-state on official state business. The department head must authorize such payments.

3-47. Repealed. (1/1/18)

3-48. Housing Premium is a stipend granted by a department head to designated employees living and working in high housing cost areas with demonstrated recruitment and retention problems. It is not part of the base rate and may begin or end at any time. Records on any aspect of this premium must be provided to the Director when requested.

3-49. Discretionary Pay Differentials. A department may use non-base building discretionary pay differentials on a temporary basis, which shall be funded within existing budgets. Use of these pay differentials is at the discretion of the appointing authority and shall not be used as a substitute for annual compensation adjustments, other pay policies, or promotions. No differential is guaranteed and, if granted, may be discontinued at any time. No aspect of any discretionary pay differential is subject to grievance or appeal, except for discrimination; however, an alleged violation of the department's plan can be disputed. A department's decision in the dispute is final and no further recourse is available. Departments must develop and communicate a written plan addressing appropriate criteria for the use of any differential based on sound business practice and needs. If granted, there must be an individual written agreement between the employee and appointing authority that stipulates the terms and conditions of the differential, including the dates the differential will begin and end. Records of any aspect of these differentials must be provided

to the Director when requested. (8/1/08)

A. Counteroffer to a verifiable job offer may be used when an employee with critical strategic skills receives a higher salary offer from another department or outside employer and the appointing authority needs to retain the employee. The sum of a non-base building differential and current base pay cannot exceed a statutory lid in any given month and may be paid in one or more payments. (8/1/08)

B. Signing bonus is a non-base building lump sum that may be used to attract new permanent employees into the state personnel system. It may be paid in one or several payments; however, the sum of the bonus and current base pay cannot exceed a statutory lid in any given month. Signing bonuses may be used for the following reasons:

1. to fill positions in critical occupations where there is a documented shortage in the labor market and recruitment or retention difficulty in the department that jeopardizes its mission; or,

2. when the applicant possesses a unique, critical skill in relation to the job market.

C. Referral award is a non-base building lump sum that may be granted to a current employee for the referral and subsequent hire of a new employee into the state personnel system where the position requires a unique, specialized skill and there is a documented shortage in the labor market and recruitment or retention difficulty in the department. This award is to be used for permanent employees unless the Director grants an exception. Employees who influence or are responsible for hiring and those performing recruitment as part of their regular assignments are ineligible. The sum of the award and current base pay cannot exceed a statutory lid in any given month.

D. Temporary pay differential is a non-base building award that may be granted to a current permanent employee in the same position. The sum of the temporary award and current base pay shall not exceed a statutory lid in any given month and is paid through regular payroll. This differential shall not be used as a substitute for the promotional or allocation process. Temporary pay differentials may be used for the following reasons:

1. acting assignment where the employee assumes the full set of duties (not “in absence of”) of a higher-level position that is vacant or the incumbent is on extended leave for a period longer than 30 days but less than nine months. The differential shall not exceed nine months for any given acting assignment;

2. long-term project assignment that is not an expected or customary part of the regular assignment and is critical to the mission and operations of the department as defined by the purpose of the project, its time frame, and the critical nature and expected results; or,

3. retain a unique, specialized set of skills or knowledge that is critical to the mission and productivity of the department. The loss would result in documented severe adverse effect on the department’s mission and productivity.

3-50. Hazardous Duty is a non-base building premium that may be granted to positions working in occupations where exposure to physical hazards is not a customary part or expectation of the occupation and its preparation for entry. Such positions work for a majority of their time in settings that involve clear, direct, and unavoidable exposure to risk of major injury or loss of life even after making allowances for safety. This premium is not guaranteed and, if granted, may be discontinued at any time. No aspect of this premium pay can be grieved or appealed, except for alleged discrimination. Departments must develop appropriate criteria for the use of hazard pay based on sound business practice and need, and communicate these criteria prior to use of this

premium. The premium rate will be published in the annual pay plan and, in combination with current base pay and other premium pay, cannot exceed a statutory lid in any given month. (1/1/18)

Postemployment Compensation (9/1/12)

3-51. Postemployment compensation, which includes voluntary separation incentives or severance pay, are discretionary financial payments that may be offered to certified employees when a layoff has happened or may happen based upon documented lack of funds, lack of work, or reorganization. Post employment compensation may include, but is not limited to, a hiring preference, payment towards the continuation of health benefits, tuition or educational training vouchers, portion of salary, placement on a reemployment list. Postemployment compensation may be contingent upon an employee's waiver of retention and reemployment rights, but waiving those rights does not affect the employee's eligibility for reinstatement. A department head must establish a postemployment compensation plan before a department makes any postemployment compensation offers. (1/1/14)

3-52. Any total post employment compensation payment and other benefits shall not exceed an amount equal to one week of an employee's salary for every year of his or her service, up to 18 weeks. Any additional limitations shall be established and published by the director, taking into consideration prevailing market practice and other factors. (1/1/18)

3-53. Repealed. (1/1/18)

3-54. The employee and department must execute a written contract before payment of any post employment compensation. The contract must include the following provisions. (1/1/14)

1. A statement that the employee is required to pay all applicable taxes on the payment;

2. The employee's acknowledgement that the state will withhold taxes according to law before payment;

3. The employee's agreement to waive retention and reemployment rights, if applicable, along with a statement that the contract is voluntary and not coerced or obtained through means other than the terms of the contract; (9/1/12)

4. The date of the employee's last day of work;

5. An acknowledgement that no payment will be made until after the last day of work and compliance with other provisions of the contract; and,

6. Upon signature, a copy of each contract must be provided to the state personnel director. (9/1/12)

7. The employee's agreement to waive any and all claims they may have or assert against the employer, relative to their employment prior to the execution of this agreement. (9/1/12)

Chapter 4 Employment and Status

Authority for the rules promulgated in this chapter is found in Colo. Const. art. XII, Sections 13, 14 and 15, and § § 24-50-109.5, 112.5, 114, 132, 136 and 137, C.R.S. Board rules are identified by cites beginning with "Board Rule". Definitions for many of the terms utilized in this chapter may be found in Chapter 1 "Organization, Responsibilities, Ethics, Payroll Deduction, and Definitions", 4 CCR 801.

General Principles

Board Rule 4-1. State residents and otherwise qualified applicants shall have an equal opportunity for entry into the state personnel system through fair and open competition. Selection and appointment to positions within the state personnel system shall be made according to merit and fitness, based upon the quality of performance and job-related ability as ascertained by the comparative analysis process. The selection process utilized to fill any vacancy shall uphold the protections of Colorado's constitutional merit based personnel system. (3/30/13)

Board Rule 4-2. All applicants must meet minimum and special qualifications for the vacancy in order to be included in the comparative analysis process, referred for an interview or appointed to a position. Any required job qualifications shall be consistent with those minimum qualifications established by the State Personnel Director for classified positions within the state personnel system. (3/30/13)

4-3. ~~Required experience, education, licensure and/or certification~~ Minimum qualifications established by the State Personnel Director may not be changed unless ~~either validated by a competent job analysis or~~ approved in writing by the State Personnel Director. ~~(3/30/13)~~(1/1/19)

4-4. Appointing authorities shall consult with the human resource personnel for their department throughout the selection process and comply with any agreement regarding delegation of selection functions entered into between the department and the Director. Nothing in these rules shall negate the proper delegation of authority of human resource functions from the Director to state agencies' human resources personnel nor constrain the Director's statutory authority to provide consulting services, as well as policy and operation leadership, in the area of professional management of state government's human resources. (3/30/13)

Board Rule 4-5. All applicants will be notified of their appeal rights in the job announcement in accordance with federal and state law or the "Dispute Resolution" chapter. Such notice shall include appeal rights they may have; the time frame for such an appeal; the address for filing the appeal; and the availability of any standard appeal form. All applicants must be notified of their elimination from consideration no later than 10 days after an accepted job offer. (3/30/13)

Board Rule 4-6. Persons with disabilities, in accordance with federal and state law, may request reasonable accommodation throughout the selection process. (3/30/13)

Job Announcement

4-7. Job announcements must be posted in such a manner as to give potential applicants notice of a vacancy; a reasonable opportunity to apply for the vacancy; notice of the required application documentation; notice of appeal rights; and a description of the position. (1/1/14)

4-8. All job announcements must be posted for a reasonable amount of time and in locations where potential applicants might reasonably expect to find them and posted electronically in a manner prescribed by the State Personnel Director. Announcements shall specify the following:

A. The class to which the vacancy is classified within the state personnel system; the pay range or anticipated hiring pay rate for that classification; the working location for the vacancy; and the closing date for accepting applications for the vacancy;

B. The minimum qualifications for the vacancy;

C. The nature of required experience and/or education for the vacancy;

D. That experience may substitute for the required education, except where such education is required by law or accreditation standards. The Department may specify the nature of experience that substitutes for education;

E. Any additional special qualifications for the vacancy;

F. Any preferred qualifications for the vacancy;

G. Any conditions of employment, including physical requirements or background check;

H. The documentation which must be submitted in order for the application to be reviewed and, if any forms must be completed, where those forms may be obtained and;

I. The address to which the application must be submitted. (3/30/13)

Board Rule 4-9. A department may request that the Director grant a residency waiver when the department can show there is an insufficient instate applicant pool. If the Director denies a waiver, the department may submit the request to the Board within 10 days. In its review of the request, the Board may grant the residency waiver if the department can show there is an insufficient instate applicant pool, including, but not limited to, consideration of the following factors:

A. The position(s) involved requires special education or training; or

B. The position(s) involved requires special professional or technical qualifications; and

C. It is not feasible to train and hire from within. (3/30/13)
Comparative Analysis

4-10. The assessment process is considered to be competitive if a reasonable opportunity was provided to potentially qualified persons to apply and compete against the same job-related standards. Any comparative analysis must be a professionally accepted standard that compares specific job-related knowledge, skills, abilities, behaviors and other competencies. Comparative analysis must meet professionally accepted standards for assessments of qualifications, competencies and job fit. (3/30/13)

4-11. Background investigations and physical or psychological examinations are allowed when validated by a competent job analysis or state or federal guidelines. (3/30/13)

4-12. Comparative analysis shall consist of professionally accepted assessments of job-related qualifications, competencies, knowledge, skills, abilities, and job fit, including but not limited to structured interviews, application/resume review, oral examinations, written objective tests, written narrative tests, performance tests, training and/or experience evaluations, and physical capacity tests. Assessment tools and/or examinations shall be developed, administered, and scored in compliance with professional guidelines and state and federal law. If multiple components are used to assess qualifications, the applicant may be required to pass one step before proceeding to the next. All examination materials and scores are confidential except as provided by the Colorado Open Records Act. (3/30/13)

4-13. All examinations and assessments are subject to review and approval by the Director. (3/30/13)

4-14. The appointing authority has the following choices in assessing candidates:

A. Appoint an eligible candidate who is a transfer, non-disciplinary demotion or reinstatement;

B. Appropriate an existing eligible list if a re-employment list does not exist; or

C. Post an announcement and engage in fair and open competition through a comparative analysis. The appointing authority shall not deviate from this decision during the selection

process, unless the position is filled by another method of appointment due to valid articulated business reasons. (1/1/14)

4-15. If the department initiates an examination, then:

A. The examination portion of the process must be completed;

B. The examinations scored in accordance with professional standards; and

C. The applicants ranked accordingly. (3/30/13)

4-16. Examinations do not have to be scored if:

A. The departmental human resources director determines that the testing process has been compromised and notifies all qualified applicants of that determination, the basis for the determination and the next step in the selection process; or

B. Permission to fill the position has been withdrawn. (3/30/13)

4-17. Applicants directly affected by the selection and comparative analysis process may file a written appeal with the Director in accordance with federal and state law or the “Dispute Resolution” chapter. (3/30/13)

Board Rule 4-18. Applicants directly affected by the selection and comparative analysis process may petition the Board for review when it appears that the decision of the appointing authority violates an employee’s rights under the federal or state constitution, part 4 of article 34 of title 24, or article 50.5 of title 24. (3/30/13)

Board Rule 4-19. Any person currently or previously employed by the state of Colorado, not within the state personnel system, must successfully complete the selection process before being placed in a position in the state personnel system. Treatment of such person is subject to the provisions of § 24-50-136, C.R.S. This includes political subdivisions of the state with similar merit systems that have a formal arrangement with the Board. (3/30/13)

Employment Lists

4-20. If filling a vacancy from an employment list, employment lists must be used in the following order of priority: departmental reemployment, promotional, then open-competitive. (3/30/13)

4-21. An eligible list shall be considered established at the time when any and all applicable comparative analysis is completed. (3/30/13)

4-22. No eligible list shall be established if: (a) a departmental reemployment list with a qualified and willing individual exists for the class of the position in question, or (b) a current eligible list of equal or higher priority exists for the position in question. (3/30/13)

4-23. Employees on a departmental reemployment list may limit their availability to specific locations and work schedules. Departmental reemployment lists last for one year. (3/30/13)

4-24. The duration of an open competitive or promotional eligible list shall be a minimum of 30 days, and that eligibility list may be extended by the appointing authority for up to 12 months, unless further extended as follows:

A. The Director shall have the discretion to extend a current eligible list.

B. The Director shall have the discretion to resurrect an expired eligible list within one year

of the initial expiration date of the list.

C. An appointing authority shall have the discretion to appropriate a qualified applicant pool for identical or highly similar positions justified through competent job analyses. (3/30/13)

4-25. Cancellation or expiration of a list does not affect the legal rights of employees on military leave. (3/30/13)

4-26. If the selection process results in fewer than six applicants on an eligible list, the list may be supplemented by additional applicants obtained through further posting and comparative analysis for the vacancy, as follows:

A. If none of the qualifications for the vacancy are changed then the same process must be administered and the results from both postings must then be integrated.

B. If any qualifications are changed, a new recruitment will be initiated. (1/1/14)

Board Rule 4-27. Addition of candidates leading to an adjustment of placement on an eligible list due to open continuous recruitment shall not affect prior appointments or referrals from which an appointment has not been made. (1/1/14)

4-28. Persons may be removed from employment lists for consideration by an appointing authority or agency HR office for these specific reasons:

A. Reasons for mandatory removal from all employment lists or from consideration for all vacancies:

1. attempts to use bribery;

2. unauthorized access to examination information;

3. false statements or attempts to practice fraud and deception during the selection process; or

4. existence of a written agreement between the individual and a department that the individual will not seek or accept work from the state.

B. Reasons for mandatory removal from a specific employment list or from consideration for the relevant vacancy:

1. failure to meet the minimum qualifications; or

2. existence of a written agreement between the individual and the department that the individual will not seek or accept work from the department which is removing the individual from the employment list.

C. Reasons for discretionary removal from one or more employment lists or from consideration for relevant vacancies:

1. violation of federal or state law or regulations that affect the ability to perform the job;

2 no longer interested in or available for employment with the department or the state personnel system;

3. failure to appear for examination or participate in any aspect of the comparative

analysis process;

4. failure to meet the conditions of employment such as physical requirements, background check, or others as set forth in the job announcement;

5. failure to respond to a referral within the specified time frame as communicated to the individuals referred, or to complete any portion of the selection process;

6. failure to be appointed after at least three referrals and interviews for vacancies with the same appointing authority, who is removing the person from the employment list, within an 18 month period;

7. documented failure to demonstrate proficiency in a required job-related competency set forth in the job announcement;

8 documentation of unsatisfactory performance indicating an inability to perform in an area directly related to the job;

9. appointment to a position in the class for which a list was established; or

10. refusal of an appointment or condition(s) of employment previously indicated as acceptable. (1/1/14)

4-29. A person who has been removed from an employment list may appeal to the Board or request a review by the Director in accordance with federal and state law or the “Dispute Resolution” chapter. (3/30/13)
Referrals

4-30. If a departmental reemployment list exists, all those qualified are notified and referred in alphabetical order and no other employment lists are used. (3/30/13)

4-31. In the event of a tie as the result of a numeric comparative analysis, the referral list shall be comprised of only the six highest-ranking individuals, plus any individuals tying with those individuals. If a comparative analysis is not conducted because there are six or fewer qualified applicants, the referral list shall be comprised of those applicants. (1/1/14)

Board Rule 4-32. In the case of filling multiple vacancies within the same class from the same eligible list, no more than the top six candidates may be considered for each position as it is filled. If an appointing authority decides to fill multiple vacancies simultaneously, then the appointing authority may consider six plus one additional candidate for every additional position. (1/1/14)

4-33. Upon receipt of a request to fill a vacancy by an open-competitive or promotional method of appointment, a referral will be made from the appropriate eligible lists to the appointing authority. All those referred must be notified of any contact information for the interview. (3/30/13)

4-34. If a non-numerical or combination of numerical and non-numerical comparative analysis is used, the referral list should be comprised of the top six individuals plus any eligible veterans. If a numerical comparative analysis is used, the referral list shall only be comprised of the six highest-ranking individuals. (3/30/13)

4-35. Appointing authorities or their designees shall consider or make a reasonable attempt to interview all applicants on the referral list in compliance with state and federal law. (3/30/13)

4-36. Any additional evaluation or assessment conducted after the referral must be related to the job and administered to all applicants participating in the job interview process. (3/30/13)

Appointment

Board Rule 4-37. An employee or an appointing authority may initiate a transfer. When the appointing authority(s) initiates the transfer, for reasonable business necessity, within the same department and the employee refuses it, the employee is deemed to have resigned. If the transfer is beyond a 25 mile radius of the employee's current work location, is longer than six months, and was not a condition of employment, the employee's name is placed on the reemployment list. (3/30/13)

4-38. A person may be reinstated to a related class with the same or lower pay range maximum than the previously certified class. (3/30/13)

4-39. Provisional appointments may be made only if the position cannot be filled conditionally. (3/30/13)

Employee Status

Board Rule 4-40. Probationary service applies to appointments to permanent positions of:

A. Employees who have not been previously employed within the state personnel system;

B. At the discretion of the appointing authority, any reinstated former certified employees. (3/30/13)

Board Rule 4-41. The probationary service period must not exceed 12 working months except as provided in the "Time Off" chapter or when there is a selection appeal pending. If the probationary employee separates from employment for any period of time, a new service date is required based on the date of rehire. (3/30/13)

A. Probationary employees do not have a right to a pre-disciplinary meeting, to a mandatory hearing to review discipline for unsatisfactory performance, to be granted a period of time to improve performance, to be placed on a reemployment list, or to the privilege of reinstatement. However, probationary employees may petition the Board for a discretionary hearing on non-disciplinary matters.

Board Rule 4-42. Trial Service applies to appointments to permanent positions as follows:

A. At the discretion of the appointing authority:

1. A current certified employee who voluntarily transfers to a position within the same class;

2. A current certified employee or reemployment applicant who transfers to a position in a different class with the same pay range maximum;

B. A current certified employee or a reemployment applicant who promotes; and

C. Any reinstated applicant unless the appointing authority requires a probationary period. (1/01/15)

Board Rule 4-43. The trial service period must not exceed six working months, except as provided in the "Time Off" chapter or when there is a selection appeal pending. An employee who fails to perform satisfactorily during trial service shall revert to an existing vacancy in the previously certified class in the current department with no right to a hearing or, if there is no existing vacancy in the previously certified class in the current department, shall be accorded any retention rights to which the employee may be entitled under § 24-50-124, C.R.S. and/or Board Rule. The appointing authority has discretion to administer corrective or disciplinary action instead of reversion. (3/30/13)

Board Rule 4-44. The following applicants or employees retain their certified status when appointed to a new class or position:

A. A current certified employee who demotes;

B. A reemployment applicant who is appointed to a position within the same class;

C. A current certified employee who voluntarily transfers to a position within the same class remains certified unless the appointing authority requires a trial service period

D. A current certified employee or a reemployment applicant who voluntarily transfers to a different class with the same pay range maximum remains certified unless the appointing authority requires a trial service period;

E. A current certified employee who involuntarily transfers to a position within the same class or a position within a different class with the same pay range maximum. (3/30/13)

Board Rule 4-45. Early certification is not allowed if a selection appeal is pending. (3/30/13)

Board Rule 4-46. When accepting a state position outside the state personnel system at the request of an elected or appointed state official, a certified employee is subject to the provisions of § 24-50-137, C.R.S. (3/30/13)

Temporary Status

4-47. A temporary appointment refers to a qualified person who is appointed to a position or positions for a period not to exceed nine months in any 12-month period. The nine-month limitation shall be inclusive of all temporary appointments and departments. Temporary appointments include appointments to temporary positions, conditional, provisional and substitute appointments. (3/30/13)

4-48. All temporary positions shall be in the Temporary Aide class. Temporary employees are employed at will and do not have the rights and benefits provided to permanent employees, except those mandated by law and pay range minimum. Effective December 31, 1998, no credit is provided for a temporary position when an employee accepts a permanent position in the same class without a break in service.

A. When the services for the relevant position are permanent and full-time, the position shall not be filled through a succession of temporary appointments.

B. When services are seasonal or annually recurring, department heads should consider creating a permanent part-time position, including analysis of potential partnering with other departments in the same geographic location, as provided in the “Personal Services Contracts” chapter. However, either a permanent part-time or temporary position may be used. (3/30/13)

Board Rule 4-49. A person in conditional status does not have a break in service as a result of having a conditional appointment. If the employee is subsequently appointed, to the position to which s/he was conditionally appointed, from a list, the trial service period begins on the date of the conditional appointment. If not subsequently appointed to the position, the employee reverts to an existing vacancy in the certified class in the current department. If no vacancy exists, layoff provisions apply. (3/30/13)

Board Rule 4-50. If a person with provisional status is subsequently appointed, to the position to which s/he was provisionally appointed, from a list, the probationary period begins on the date of the appointment from the referral list. Provisional employees do not have the rights and benefits

provided to classified employees within the state personnel system, except those mandated by law and pay range minimum. (3/30/13)

Board Rule 4-51. A substitute appointment may only be made to perform the duties of a filled position during a leave or for training purposes. This appointment shall not exceed nine months in a 12-month period unless transfer, demotion, or examination fills it. Layoff provisions do not apply and a certified employee is returned to a position in the former class. (3/30/13)

Chapter 5 - Time Off

Authority for rules promulgated in this chapter is found in one or more of the following: the State of Colorado Constitution Article XII, Section 13, The Family Medical Leave Act (FMLA), Americans with Disabilities Act (ADA), Family Care Act (FCA), Uniformed Services Employment and Reemployment Rights Act (USERRA), the State of Colorado Constitution Article XII, Section 13, The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA), and 26 U.S.C. 63, State of Colorado Revised Statutes (C.R.S.) §§ 1-6-115, 1-6-122, 1-7-102, 8-40-101, 14-2-101, 14-15-103, 24-11-101, 24-11-112, 24-18-102, 24-33.5-825, 24-50-104, 24-50-109.5, 24-50-401, 28-1-104, 28-3-601, 28-6-602, 28-3-607, 28-3-609, and 28-3-610. (02/2017).

General Principles

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

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

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

C Unauthorized use of any leave may result in the denial of paid leave and/or corrective or disciplinary action.

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

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

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

5-4. Annual leave is for an employee's personal needs and use is subject to the approval of the appointing authority. The appointing authority may establish periods when annual leave will not be allowed, or must be taken, based on business necessity. These periods cannot create a situation where the employee does not have a reasonable opportunity to use requested leave that will be subject to forfeiture. If the department cancels approved leave that results in forfeiture, the forfeited hours must be paid before the end of the fiscal year. (5/1/10)

5-5. Sick leave is for health reasons only, including diagnostic and preventative examinations,

treatment, and recovery. Accrued sick leave may be used for the health needs of the employee, employee's child, parent, spouse, injured military service member as established under Rule 5-20, legal dependent, or a person in the household for whom the employee is the primary care giver. The appointing authority may require documentation of the familial relationship. (02/2017)

A. Appointing authorities may use discretion to send employees home for an illness or injury that impacts the employee's ability to perform the job or the safety of others. Sick leave shall be charged but annual leave shall be charged if sick leave is exhausted; unpaid leave if both annual and sick leave are exhausted. (02/2017)

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

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

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

Exhaustion of Leave and Administrative Discharge

5-6. If an employee has exhausted all credited paid leave and is unable to return to work, unpaid leave may be granted or the employee may be administratively discharged by written notice following a good faith effort to communicate with the employee. Administrative discharge applies only to exhaustion of leave. (5/1/10)

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

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

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

5-7. Table ~~(02/2017)~~(1/1/19)

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

Annual Leave					**Sick Leave**				
Years of Service*	**Hrs. / Mon.**	Hrs./Fiscal Year	**Max. Accrual ****	**Payout**	**Hrs.~~:~~Mins./ Mon.**	Hrs./Fiscal Year	**Max~~.~~ Accrual*** **	**Restoration**	**Payout**
Years 1 - 5 (01 - 60 Months)	8	96	192 hours	Upon termination or death, unused leave is paid out up to the maximum accrual rate.	~~6.66~~ 6:40	Up to 80 hours	360 hours	Previously accrued sick leave up to 360 hours is restored when eligible for reinstatement or reemployment.	Upon death or if eligible to retire, 1/4 of unused leave paid out to the maximum accrual rate. PERA's age and service requirements under the Defined Benefit plan are applied regardless of the plan actually enrolled in.
Years 6 - 10 (61 - 120 Months)	10	120	240 hours						
Years 11 -15 (121 - 180 Months)	12	144	288 hours						
Year 16 or Greater (181 or more Months)	14	168	336 hours						

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

** Over-accrued amounts are forfeited at the beginning of the new fiscal year (July 1st).

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

General Provisions:

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

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

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

Borrowing against any leave that may be earned in the future or "buying back" leave already used is not allowed.

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

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

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

Short-Term Disability: Employees are required to use paid leave during the 30-day waiting period for short-term disability benefits, including the use of accrued annual leave and/or compensatory time once sick leave has been exhausted. Any remaining sick leave beyond the 30-day waiting period must be exhausted prior to eligibility for short-term disability benefit payments.

Leave Sharing

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

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

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

Holiday Leave

5-10. Permanent full-time employees on the payroll when the holiday is observed are granted eight hours of paid holiday leave (prorated for part-time work or unpaid leave in the month) to observe each legal holiday designated by law, the Governor, or the President. Appointing authorities may designate alternative holiday schedules for the fiscal year. (5/1/10)

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

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

Other Employer-Provided Leaves

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

5-12. Bereavement leave is for an employee's personal needs and use is subject to the approval of the appointing authority. The appointing authority may provide up to 40 hours (prorated for part-time work or unpaid leave in the month) of paid leave to permanent employees for the death of a family member or other person. Employees are responsible for requesting the amount of leave needed. Documentation may be required when deemed necessary by the appointing authority. (02/2017)

5-13. Military leave provides up to 15 paid regular workdays in a fiscal year to permanent employees who are members of the National Guard, military reserves, or National Disaster Medical Service to attend the annual encampment or equivalent training or who are called to active service, including declared emergencies. Unpaid leave is granted after exhaustion of the 15 regular workdays. The employee may request the use of annual leave before being placed on unpaid leave. (02/2017)

A. In the case of a state emergency, the employee must return upon release from active

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

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

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

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

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

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

2. One period of administrative leave for the initial call up to active military service in the war against terrorism of which shall not exceed 90 days and applies after exhaustion of paid military leave. Administrative leave is only used to make up the difference between the employee's base salary (excluding premiums) and total gross military pay and allowances. The employee must furnish proof of military pay and allowances. This leave does not apply to regular military obligations such as the annual encampment and training. (02/2017)

3. Employee participation in community or school volunteer activities. (02/2017)

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

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

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

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

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

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

service. (02/2017)

5-16. Administrative leave that exceeds 20 consecutive working days must be reported to the department head and the Director. (02/2017)

5-17. Unpaid leave may be approved by the appointing authority unless otherwise prohibited. The appointing authority may also place an employee on unpaid leave for unauthorized absences and may consider corrective and/or disciplinary action. Probationary and trial service periods are extended by the number of days on unpaid leave and may be extended for periods of paid leave. Unpaid leave is calculated based on the ~~monthly~~annualized hourly rate. ~~(1/1/14)~~(1/1/19)

A. Short-term disability (STD) leave is a type of unpaid leave of up to six months while either state or PERA STD benefit payments are being made. To be eligible for this leave, employees must have one year of service and an application for the STD benefit must be submitted within 30 days of the beginning of the absence or at least 30 days prior to the exhaustion of all accrued sick leave. The employee must also notify the department at the same time that a benefit application is submitted.

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

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

5-18. Parental Academic leave. Departments may provide up to 18 hours (prorated for part-time) in an academic year for parents or legal guardians to participate in academic-related activities. A department shall adopt and communicate a policy on whether the leave will be unpaid or paid, the amount and type of paid leave, and specifically the substitution of annual leave or use of administrative leave. (02/2017)

Family/Medical Leave (FML)

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

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

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

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

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

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

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

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

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

5-21. To be eligible for FML, an employee must have 12 months of total state service as of the date leave will begin, regardless of employee type. A state temporary employee must also have worked 1250 hours within the 12 months prior to the date leave will begin. Time worked includes overtime hours. (02/2017)

A. Full-time employees will be granted up to 520 hours per rolling 12-month period. The amount of leave is determined by the difference of 520 hours and any FML leave taken in the previous 12-month period and is calculated from the date of the most recent leave. The amount of leave is prorated for part-time employees based on the regular appointment or schedule. Any extension of leave beyond the amount to which the employee is entitled is not FML, see Rule 5-1 B. (02/2017)

5-22. Military caregiver leave is a one-time entitlement of up to 1040 hours (prorated for part-time) in a single 12-month period starting on the date the leave begins. While intermittent leave is permitted, it does not extend beyond the 12-month period. In addition, the combined total for military caregiver and all other types of FML shall not exceed 1040 hours. (5/1/10)

5-23. All other types of leave, compensatory time, and make whole payments under workers' compensation run concurrently with FML and do not extend the time to which the employee is entitled. The employee must use all accrued paid leave subject to the conditions for use of such leave before being placed on unpaid leave for the remainder of FML. An employee on FML cannot be required to accept a temporary "modified duty" assignment even though workers' compensation benefits may be affected. (7/1/13)

5-24. Unpaid leave rules apply to any unpaid FML except the state continues to pay its portion of insurance premiums. An employee's condition that also qualifies for short-term disability benefits must comply with the requirements of that plan.

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

5-26. Employee Requirements. Written notice of the need for leave must be provided by the employee 30 days in advance. If an employee becomes aware of the need for leave in less than 30 days in advance, the employee shall provide notice either the same day or the next business day. Failure to provide timely notice when the need for leave is foreseeable, and when there is no reasonable excuse, may delay the start of FML for up to 30 days after notice is received as long as it is designated as FML in a timely manner. Advance notice is not required in the case of a medical

emergency. In such a case, an adult family member or other responsible party may give notice, by any means, if the employee is unable to do so personally. (5/1/10)

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

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

Medical Certificates

5-29. Employees must provide the State's authorized medical certification form (or other official document containing the same information) when initiating an FML leave request. Appointing authorities have the discretion to require periodic medical certification to determine if FML continues to apply or when the appointing authority has a reasonable basis for suspecting leave abuse. Medical certification for FML may be required for the first leave request in an employee's rolling 12-month period. Additional medical certification may be required every 30 days or the time period established in the initial certification, whichever is longer, unless circumstances change or new information is received. (02/2017)

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

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

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

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

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

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

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

B. When an incomplete fitness-to-return certification is submitted, the employee must be allowed seven days to obtain complete information, absent reasonable extenuating circumstances. Following receipt of the information or the seven days from which it was requested, the department's human resources director or FMLA coordinator may, with the employee's written permission, contact the health care provider for purposes only of clarification and authentication of the fitness-to-return certification. (02/2017)

5-33. Benefits coverage continues during FML. If the employee is on paid FML, premiums will be paid through normal payroll deduction. If the FML is unpaid, the employee must pay the employee share of premiums as prescribed by benefits and payroll procedures. (5/1/10)

5-34. Upon return to work, the employee is restored to the same, or an equivalent, position, including the same pay, benefits, location, work schedule, and other working conditions. If the employee is no longer qualified to perform the job (e.g., unable to renew an expired license), the employee must be given an opportunity to fulfill the requirement. (5/1/10)

A. If the employee is no longer able to perform the essential functions of the job due to a continuing or new serious health condition, the employee does not have restoration rights under FML, and the appointing authority may separate the employee pursuant to Rule 5-6 subject to any applicable ADA provisions. (02/2017)

B. The employee does not have restoration rights if the employment would not have otherwise continued had the FML leave not been taken, e.g., discharge due to performance, layoff, or the end of the appointment.

5-35. FML does not prohibit adverse action that would have otherwise occurred had the leave not been taken. (5/1/10)

5-36. The use of FML cannot be considered in evaluating performance. If the performance plan includes an attendance factor, any time the employee was on FML cannot be considered. (5/1/10)

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

Injury Leave

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

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

employee as required by law. (02/2017)

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

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

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

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

Notice of Proposed Rulemaking

Tracking number

2018-00507

Department

1000 - Department of Public Health and Environment

Agency

1002 - Water Quality Control Commission (1002 Series)

CCR number

5 CCR 1002-11

Rule title

REGULATION NO. 11 - COLORADO PRIMARY DRINKING WATER REGULATIONS

Rulemaking Hearing

Date

11/13/2018

Time

09:45 AM

Location

Fremont Room, Summit County Community and Senior Center, 83 Nancy's Place, Frisco, CO 80443

Subjects and issues involved

proposed revisions to address an incorporation by reference issue

Statutory authority

sections 25-1.5-202; 25-8-202(1)(n); and 25-8-401 C.R.S.

Contact information

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COLORADO
Water Quality
Control Commission
Department of Public Health & Environment

NOTICE OF PUBLIC RULEMAKING HEARING
BEFORE THE
COLORADO WATER QUALITY CONTROL COMMISSION

SUBJECT:

For consideration of the adoption of revisions to the Colorado Primary Drinking Water Regulations, Regulation #11 (5 CCR 1002-11) to address an incorporation by reference issue. Revisions to Regulation #11 proposed by the Water Quality Control Division, along with a proposed Statement of Basis, Specific Statutory Authority and Purpose, are attached to this notice as Exhibit 1.

In these attachments, proposed new language is shown with double-underlining and proposed deletions are shown with ~~strikeouts~~. Any alternative proposals related to the subject of this hearing will also be considered.

During the commission's consideration of whether to approve this notice of rulemaking, the commission determined that there is not a likelihood of significant controversy during the rulemaking process. Therefore, the commission has chosen to pursue an alternative rulemaking process consistent with section 24-4-103(4)(a) C.R.S.; and section 21.3(C)(5) of the Procedural Rules. It is the goal of the commission to complete this rulemaking without oral testimony.

SCHEDULE OF IMPORTANT DATES

Proponent's initial comments due	10/17/2018 5 pm	Additional information below.
Responsive comments due	10/31/2018 5 pm	Additional information below.
Rulemaking Deliberations	11/13/2018 9:45 am	Fremont Room Summit County Community and Senior Center 83 Nancy's Place Frisco, Colorado 80443

HEARING SUBMITTALS:

For this hearing, the commission will receive all submittals electronically. Submittals must be provided as PDF documents, except for raw data exhibits which may be provided as Excel workbooks. Sumbittals may be emailed to cdphe.wqcc@state.co.us, provided via an FTP site, CD or flash drive, or otherwise conveyed to the commission office so as to be received no later than the specified date.

PARTY STATUS:

Pursuant to section 21.3(D) of the commission's Procedural Rules, there shall be no party status for this rulemaking proceeding.

WRITTEN COMMENTS:

The commission encourages input from interested members of the pubic. Written comments should be emailed to cdphe.wqcc@state.co.us by 10/31/18.

SPECIFIC STATUTORY AUTHORITY:

The provisions of sections 25-1.5-202; 25-8-202(1)(n); and 25-8-401 C.R.S. provide the specific statutory authority for consideration of the regulatory amendments proposed by this notice. Should the commission adopt the regulatory language as proposed in this notice or alternative amendments, it will also adopt, in compliance with section 24-4-103(4) C.R.S., an appropriate Statement of Basis, Specific Statutory Authority, and Purpose.

Dated this 28th day of September, 2018 at Denver, Colorado.

WATER QUALITY CONTROL COMMISSION

Trisha Oeth, Administrator

EXHIBIT 1
WATER QUALITY CONTROL DIVISION

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Water Quality Control Commission

REGULATION NO. 11 - COLORADO PRIMARY DRINKING WATER REGULATIONS

5 CCR 1002-11

. . . .

11.2(6) Materials Incorporated by Reference

(a) Date of Incorporation

(i) Throughout these regulations, requirements promulgated by the U.S. Environmental Protection Agency have been adopted and incorporated by reference. The federal references cited herein include only those versions that were in effect as of April 9, 2018, and not later amendments to the incorporated material.

(ii) All other materials incorporated by reference in the *Colorado Primary Drinking Water Regulations* include only those versions cited and not later amendments to incorporated material.

(b) Location of Materials Incorporated by Reference

(i) The requirements promulgated by the U.S. Environmental Protection Agency incorporated by reference are available at no cost in the online edition of the Code of Federal Regulations (CFR) hosted by the United States Government Printing Office, online at www.govinfo.gov.

(ii) All other materials incorporated by reference ~~The incorporated material~~ may be examined at any state publications depository library, the Laboratory Services Division of the Department, or the Department at:

Colorado Department of Public Health and Environment
Water Quality Control Division
4300 Cherry Creek Drive South
Denver, Colorado 80246-1530
(303) 692-3500

(c) If the material incorporated by reference refers to other sections of the referenced document that conflict with current language of the *Colorado Primary Drinking Water Regulations*, the current language of the *Colorado Primary Drinking Water Regulations* takes precedence.

. . . .

11.59 STATEMENT OF BASIS, SPECIFIC STATUTORY AUTHORITY AND PURPOSE: November 13, 2018 Decision; Effective Date December 30, 2018

The following section was affected by this rulemaking hearing: 11.2(6) – Materials Incorporated by Reference. The provisions of the Colorado Revised Statutes (CRS), section 25-1.5-202, provide specific statutory authority for adoption of these regulatory amendments. The Commission also adopted, in compliance with section 24-4-103(4), CRS, the following statement of basis and purpose.

BASIS AND PURPOSE

The Commission made changes to section 11.2(6) (Materials Incorporated by Reference) in order to comply with section 24-4-103 (12.5) (a)(IV), C.R.S. of the Colorado Administrative Procedure Act, which requires a statement explaining where copies of the federal code incorporated by reference are available from the agency of the United States originally issuing the code.

Regulation 11 incorporates by reference requirements promulgated by the U.S. Environmental Protection Agency in the Code of Federal Regulations. Therefore to comply with §24-4-103 (12.5)(a)(IV), C.R.S., the Commission added an entirely new paragraph in section 11.2(6)(b), providing that: "The requirements promulgated by the U.S. Environmental Protection Agency incorporated by reference are available at no cost in the online edition of Code of Federal Regulations (CFR) hosted by the United States Government Printing Office, online at www.govinfo.gov." The Commission also made related changes to the original paragraph in 11.2(6)(b) for purposes of clarifying where to find the other materials incorporated by reference.

Notice of Proposed Rulemaking

Tracking number

2018-00504

Department

1000 - Department of Public Health and Environment

Agency

1011 - Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1015-3

Rule title

EMERGENCY MEDICAL SERVICES

Rulemaking Hearing

Date

11/21/2018

Time

10:00 AM

Location

4300 Cherry Creek Drive South, Denver, CO 80246

Subjects and issues involved

The Department is requesting a rulemaking hearing in order to propose revisions to 6 CCR 1015-3, Chapter Four, Licensure of Ground Ambulance Services. The rule revisions delineate the minimum requirements for ground ambulance service licensing by counties including, but not limited to, minimum ambulance equipment standards, staffing requirements, medical oversight and quality improvement for ambulance services, complaint investigation processes, and ambulance service data collection and reporting requirements. The department conducted a comprehensive review of the rules and focused on areas requiring substantive revision to conform to current industry standards for safe patient care and transport.

Statutory authority

Section 25-3.5-308, C.R.S.

Contact information

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Title

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COLORADO
Department of Public Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

To: Members of the State Board of Health

From: Jeanne-Marie Bakehouse, Branch Chief, Emergency Medical and Trauma Services, Health Facilities and Emergency Medical Services Division

Through: Michelle Reese, Interim Division Director, Health Facilities and Emergency Medical Services Division ***MR***

Date: September 19, 2018

Subject: **Request for Rulemaking Hearing**
Proposed Amendments to 6 C.C.R. 1015-3, Chapter Four, Licensure of Ground Ambulance Services with a request for a rulemaking hearing to be set for November of 2018

Ground ambulance regulation is shared by state and county authorities. In 1978, the General Assembly established a coordinated system of emergency medical care through a comprehensive statutory scheme. See § 25-3.5-301, C.R.S., *et seq*. As part of that original coordinated scheme, the legislature determined that Colorado ground ambulance services are subject to regulation by the board of county commissioners in which the service is based, while vesting the State Board of Health with the authority to adopt rules outlining certain minimum requirements for ground ambulance service licensing. Pursuant to statute, therefore, the Board's rules adopt minimum requirements concerning ambulance equipment, staffing, medical oversight and quality improvement, an investigative complaint process, and data collection and reporting. Section 25-3.5-308, C.R.S. The Board of Health has promulgated and adopted the minimum rules as required by statute in 6 C.C.R. 1015-3, Chapter Four, Licensure of Ground Ambulance Services.

The most recent substantive revision of these rules occurred in 2008, when data reporting provisions were updated to be consistent with national standards. Given the passage of time since the last rule revision, the Department convened the EMS Chapter Four Work Group in January 2018 for the purpose of conducting a comprehensive review and update of the ground ambulance rules. The work group was comprised of representatives from the emergency medical services community, with representation from rural and metro ground ambulance services, Regional Emergency Medical and Trauma Advisory Councils (RETACs), and other affected parties. Over the past several months, the work group has worked in a collaborative and thoughtful manner to create proposed rules that reflect current industry and public safety standards but do not stray from the confines of statutory jurisdictional limits.

The Department is proposing to incorporate substantive rule revisions that:

- Add to and clarify the definition section, including ensuring it is evident that all ambulances must be licensed and that the license must be issued by the county where the ambulance is based;
- Add requirements for counties to establish a process for periodically reviewing their license requirements;
- Update vehicle safety standards references;
- Add language that clarifies the counties' responsibilities to enact a policy for complaints;

- Clarify that ambulance services are required to provide patient care information to the Department;
- Add a requirement that each ambulance service has an ongoing medical continuous quality management (CQM) program; and
- Revise language in the minimum equipment standards section as well as the advanced life support (ALS) equipment section to be more general and ensure that the rules represent true minimum standards without compromising patient care.

This set of rules has not been reviewed in its totality for a number of years. As part of its statutory obligations to review all regulations periodically, the Division sought to determine whether the existing rule continues to reflect current practice and is operationally sustainable. After conducting their review, the work group and Division concur that the proposed rule revisions are formulated in the least burdensome manner. As proposed, the revised rules ensure that the licensing of EMS services and the equipment used match practices widely accepted to be the minimum standard, are operationally viable, and assure that the level of care being given to patients is not compromised.

The Department submitted the proposed rules to the State Emergency Medical and Trauma Services Advisory Council (SEMTAC) for review and discussion on July 11, 2018. On that date, SEMTAC recommended the proposed revisions be presented by the Department to the Board for a rulemaking hearing in November 2018. (The SEMTAC letter is attached).

STATEMENT OF BASIS AND PURPOSE
AND SPECIFIC STATUTORY AUTHORITY
for Amendments to
6 C.C.R. 1015-3, Chapter Four, Licensure of Ground Ambulance Services

Basis and Purpose.

Section 25-3.5-308, C.R.S., requires the Board of Health to promulgate rules that delineate the minimum requirements for ground ambulance service licensing by counties including, but not limited to, minimum ambulance equipment standards, staffing requirements, medical oversight and quality improvement for ambulance services, complaint investigation processes, and ambulance service data collection and reporting requirements. To implement the statutory directive for rules, the rules define pertinent terms and delineate the minimum requirements for:

- County issuance of licenses and permits;
- Complaints;
- Denial, revocation, or suspension of licensure and vehicle permits;
- Minimum data collection and reporting;
- Minimum staffing;
- Medical oversight and continuous quality management; and
- Minimum equipment.

While these rules establish minimum statutory standards, local governments retain responsibility for issuing, denying, revoking or suspending licenses and permits.

The work group conducted a comprehensive review of the rules and focused on areas requiring substantive revision to conform to current industry standards for safe patient care and transport. In addition, the work group made clarifying and grammatical changes as necessary. The rules also clarify the statutory intent that an ambulance service must be licensed in every county in which it is based. The following substantive recommended changes include:

Section 2.7: Clarifies that the licensing authority with respect to an ambulance service is the county in which the ambulance is based

Section 2.10: The definition of Medical Continuous Quality Management Program (CQM) is revised to incorporate current programmatic language

Section 2.11: The definition of “medical director” deletes outdated language and clarifies that a medical director’s responsibilities extend to EMS providers who are employed by ambulance service agencies

Deleted Sections 2.13 and 2.14—Definitions of rescue units and quick response teams--have been removed. Section 3.2.2, a county licensure exemption provision, used to refer to rescue units and quick response teams as examples of agencies that were included in the exemption. This section has been revised to delete reference to vehicles owned by specific exempt agencies to conform to the statutory intent to exempt all

privately or publicly owned vehicles that are used to evacuate patients from inaccessible areas.

Section 3.1.1 This language combines the old 3.1.1 and 3.1.2 to clarify that the General Assembly intends each ambulance service that operates in Colorado to be licensed by each county in which it is based, unless a reciprocal agreement is in place between the affected counties. The new language states:

Except as provided in Section 3.2 of these rules, no ambulance service, public or private, shall transport a sick or injured person from any point within Colorado to any point within or outside Colorado unless that ambulance service holds a valid license and permits issued by the county or counties in which the ambulance service and its ambulances are based.

Section 3.1.3: This new language contemplates situations in which counties may not license adequate types or numbers of licensed ambulances, (such as an appropriate specialty licensed ambulance), to transport and meet the needs of patients. Therefore, the rule requires every county to establish a procedure to address that circumstance.

Section 3.2.2: Besides deleting reference to rescue units and quick response team vehicles (see above), the new language permits exempted vehicles to transport patients from inaccessible areas to permitted ambulances or medical facilities (not just hospitals).

Section 3.2.3: This revised language comports with statutory language (“major catastrophe”) and introduces similar language that is utilized by 6 C.C.R. 1015-3, Trauma Chapter 2 rules (“multicasualty (disaster) events).

Section 3.3.1: This provision was revised to require counties to review their adopted ground ambulance licensure processes periodically. The work group sought to correct reported problems regarding certain antiquated processes without imposing burdensome regulation.

3.3.1(G): Provision stricken because the Department has no statutory authority to impose the requirement.

3.3.1(H): The work group revised the vehicle design standards to delete specific standards in favor of imposing the requirement that all ambulances must be manufactured by an organization registered with the National Highway Traffic Safety Administration.

3.3.1(I): New language prohibits ambulance inspectors from operating under disclosed or undisclosed actual or potential conflicts of interest with the ambulance service and/or inspection process.

Section 3.3.2: This language was deleted because the revised rules no longer incorporate outside materials by reference.

Section 3.4.1: An ambulance service license shall be issued by each county in which the ambulance service is based. The county shall ensure compliance with these rules and all license requirements established by that county.

The revised language conforms to the rest of the rule and clarifies that an ambulance service must be licensed by each county in which it is based. The work group also deleted existing language concerning the maximum level of ambulance service that may be provided because it is expressly addressed in the next provision concerning ambulance permits.

Section 3.4.2.C: The work group altered the language to make the identification of ambulance service levels permissive, rather than mandatory.

Section 3.6.1: This revision permits the counties to determine their own licensing renewal process in keeping with statute.

Section 4.2.1 to 4.2.7: These sections include the components that counties must incorporate into their written complaint and investigation policies concerning licensed and unlicensed ambulance complaints. The work group modified the procedure to propose that counties must: post the complaint procedure online for public consumption/education; provide the licensee with a copy of the complaint; notify the Department and service medical director about EMS provider complaints; and notify other counties (and, if applicable, the Department of Regulatory Agencies (DORA)) about complaints concerning other ambulance service medical personnel and/or the medical director.

Section 4.3: The pre-existing language of this provision inferred that counties were required to report unknown violations. This provision proposes that counties must only notify service medical directors of any known alleged complaints or violations of individual medical providers associated with an ambulance service.

Section 6.2.2: The work group revised the vehicle design standards to delete specific standards in favor of imposing the requirement that all ambulances must be manufactured by an organization registered with the National Highway Traffic Safety Administration.

Section 7.1: Added language clarifies that ambulance staff must hold current and valid certifications and licenses, in line with the statute.

Section 7.2: The clause at the end of the rule was deleted as surplusage.

Section 8.1: The timeframe in which ambulance services must provide written notification to the county of a change to the service's medical director or medical oversight was changed from 15 calendar to 14 business days.

Sections 8.2 and 8.3: These provisions have been modified to change their order and to incorporate current terminology, *i.e.*, medical CQM program.

Section 9: The work group reviewed every provision in this section concerning minimum equipment requirements and modified certain language to comport with current equipment terminology. In addition, in some instances the group either altered specific requirements to more generic language, *i.e.*, "multiple bandages and dressings" in Section 9.2.4, or added more specific requirements, such as the child restraint system to accommodate a set weight range, as codified in Section 9.2.9. Certain new equipment requirements are also proposed. For example, the work group proposes requiring the addition of certain pharmacological agents for basic life support ambulances, as listed in Section 9.2.10.

Specific Statutory Authority.

The statute that requires or authorizes rulemaking is Section 25-3.5-308, C.R.S.

Statutes that inform or direct the rule content:

Section 25-3.5-103, C.R.S. contains definitions that apply to this set of rules.
Section 25-3.5-202, C.R.S. pertains to Rule Section 7.
The balance of the rule is informed or directed by Section 25-3.5-301, *et seq.*, C.R.S.

Is this rulemaking due to a change in state statute?

_____ Yes, the bill number is _____. Rules are ___ authorized ___ required.
__X_____ No

Does this rulemaking incorporate materials by reference?

_____ Yes ___ URL or ___ Sent to State Publications Library
___X___ No

Does this rulemaking create or modify fines or fees?

_____ Yes
___X___ No

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

___ No. This rule does not require a local government to perform or increase a specific activity for which the local government will not be reimbursed. Though the rule does not contain a state mandate, the rule may apply to a local government if the local government has opted to perform an activity, or local government may be engaged as a stakeholder because the rule is important to other local government activities.

___ No. This rulemaking reduces or eliminates a state mandate on local government.

_X_ Yes. This rule includes a new state mandate or increases the level of service required to comply with an existing state mandate, and local government will not

be reimbursed for the costs associated with the new mandate or increase in service.

The state mandate is categorized as:

___ Necessitated by federal law, state law, or a court order
___ Caused by the State's participation in an optional federal program
___ Imposed by the sole discretion of a Department
_X__ Other: Imposed by the Department upon recommendation of a workgroup which was comprised of a county commissioner, local fire departments, various ground ambulance agencies, representatives from the emergency medical service association, state government and the State Emergency Medical and Trauma Services Advisory Council (SEMTAC).

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

Please elaborate as to why a rule that contains a state mandate on local government is necessary.

A key component of the current rule is the minimum equipment list. The work group updated this list to be consistent with current medical practices and, consequently, to improve care during transport. Additionally, the work group identified gaps in the existing regulatory scheme that have resulted in inconsistent regulatory conduct among the counties and the provision of insufficient information to the public and/or Department regarding regulatory compliance and process:

3.1.3: This new language contemplates situations in which counties may not license adequate types or numbers of licensed ambulances, (such as an appropriate specialty licensed ambulance), to transport and meet the needs of patients. Therefore, the rule requires every county to establish a procedure to address that circumstance.

3.3.1: This provision has been revised to require counties to review their adopted ground ambulance licensure processes periodically. The work group sought to correct reported problems regarding certain antiquated processes without imposing burdensome regulation.

3.3.1(H): The work group revised the vehicle design standards to delete specific standards in favor of imposing the requirement that all ambulances must be manufactured by an organization registered with the National Highway Traffic Safety Administration.

3.3.1(I): New language prohibits ambulance inspectors from operating under disclosed or undisclosed actual or potential conflicts of interest with the ambulance service and/or inspection process.

4.2.1: Augments rule to require county to institute a policy that informs the public by posting how to file a complaint.

4.2.2 Complaint policy requires county to provide licensee with a copy of complaint upon filing.

4.2.6 Complaint policy must provide the method by which county notifies the Department and medical directors of complaints filed against EMS providers.

4.2.7 Complaint policy must provide a method by which county notifies other counties with jurisdiction over an ambulance service, the Department and, if applicable, DORA, about complaints against the medical director or other medical personnel.

6.3 Counties must submit a list of verified licensed ambulance services and permitted vehicles to the Department upon request.

Section 9 "Minimum Equipment Requirements," lays out the minimum on-board equipment required to be carried in licensed ALS and BLS ground ambulances. The work group has added these minimum equipment requirements that contain state mandates on local government:

For Basic Life Support Ambulances:

9.2.1.B	BBG suction catheter
9.2.2.D	pulse oximeter with adult and pediatric sensors
9.2.4	arterial tourniquet
9.2.8.E	NIOSH-approved filtering respirator of N-95 or superior particulate filtering capabilities
9.2.10.A	pharmacological agents and delivery devices as dictated by the medical director
9.2.10.B	pediatric "length-based' device for sizing drug dosage calculations and equipment
9.2.11.A	pediatric reference tool that addresses drug dosages and equipment sizing based on patient's height and weight
9.2.11.B	pediatric reference tool for vital signs

For Advanced Life Support Ambulances:

9.3.1	all equipment and supplies that must be carried in BLS ambulances
9.3.4.B	inserts intraosseous equipment requirements into Intravenous equipment section

These changes were made at the request of the work group for the purpose of updating the existing rules to reflect the current standard of practice.

REGULATORY ANALYSIS
for Amendments to
6 CCR 1015-3, Chapter Four – Rules Pertaining to
Licensure of Ground Ambulance Services

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

Counties,* county commissions,* privately-owned ambulance services, publicly-owned ambulance services,* ambulance service medical directors, licensed health care facilities that own and/or operate ambulance services*, emergency medical service providers, Coloradans, and the public.

A. <u>Identify each group of individuals/entities that rely on the rule to maintain their own businesses, agencies or operation, and the size of the group:#</u>

24 Privately-owned ambulance services,
142 Publicly-owned ambulance services,*
24 Licensed health care facilities that own and/or operate ambulance services*,
64 Counties and county commissions*

Although EMS and ambulance service medical providers belong in the class of individuals/entities that rely on the rule to maintain operation of ground ambulance transport, these groups were not included in this response because they are not responsible for implementing and following the rules.

Local Government Impact:

If operating a government-owned ambulance service, local government must:

- Develop and implement policies concerning the complaint process, inspector conflicts of interest, ambulance design standards, and permissible uses of unlicensed ambulance services and unpermitted vehicles;
- Review periodically their processes for licensing ambulance services;
- Submit a list of ambulance services and permitted vehicles operating in the county upon Department request; and
- Acquire new minimum equipment

B. <u>Identify each group of individuals/entities interested in the outcomes the rule and those identified in #1.A achieve, and if applicable, the size of the group:</u>

Approximately 400,000 transported EMS patients per year
Approximately 210 ground ambulance agencies
18,190 EMS providers (as of June 30, 2018)
Approximately 110 ground ambulance service medical directors
Emergency Medical Services Association of Colorado (EMSAC)
Colorado Counties Inc.
Special District Association
Colorado Municipal League

Colorado State Fire Chiefs Association
Colorado Firefighters Association
Colorado Hospital Association

C. <u>Identify each group of individuals/Entities that benefit from, may be harmed by or at-risk because of the rule, and if applicable, the size of the group:</u>

Individuals who require emergency medical transport in the State of Colorado will ultimately benefit because the proposed rule revisions require ground ambulances to satisfy minimum design, equipment, staffing, continuous quality management (CQM), and operational safety standards that will improve emergency medical ground ambulance services. The revised rule will also augment and clarify the complaint process for consumers of these services and their families in the event they receive, or believe they have received, deficient emergency medical ground ambulance services. Further, consumers will benefit from the proposed rule revision that now requires counties to ensure that qualified conflict-free representatives perform all annual ambulance inspections.

Counties and county commissions that regulate ground ambulance services will also benefit from clarifications to the proposed rule revisions. The modifications benefit the counties by clarifying their licensing jurisdictions. For example, the work group determined that the pre-existing rules did not adequately explain that the service area of an ambulance service is one way of determining what constitutes its "base." An ambulance service that only provides services in one county must be licensed in that county because that is where it is based. Conversely, ambulance services that provide services in multiple counties are "based" in all of those counties. Therefore, they must secure a ground ambulance license from each such county. (Rules 2.1, 2.7, 3.1.1, 3.4.1.A).

Other proposed rule revisions benefit counties by reducing their mandatory regulatory burdens. For instance, proposed Rule 3.4.1.1 deletes the county's obligation to describe the maximum amount of service that an ambulance service can provide. Likewise, proposed Rule 3.4.2.C no longer requires the county to include in its resolution or regulations requirements for identification of the level of service provided. Proposed Rule 3.6 deletes certain license renewal process requirements that are within the discretion of the counties, while proposed Rule 6.2.2 predicates the county's submission of information upon Department request, as opposed to an annual requirement. Also, proposed Rule 3.2.2 places boundaries upon the transport of patients from inaccessible areas. The new language inures to the county's benefit by clarifying that such transports must terminate at the closest point of access to a licensed ambulance, thereby limiting the county's potential liability. Finally, Section 9, "Minimum Equipment Requirements," broadly benefits counties by ensuring that all permitted ground ambulances operating within their jurisdictions will be soundly designed, possess the equipment minimally necessary to meet patients' needs, and comply with safety standards.

The work group also proposes a revision to Rule 4.3 by clarifying that counties must only report those violations or complaints about ambulance services or their medical providers about which the counties have knowledge. The existing rule infers that counties have the duty to report all violations and complaints, whether known or

unknown. Because the duty to report unknown violations and complaints is neither fair nor logical, the rule has been modified to the counties' benefit.

The work group did not receive any feedback during its rule revision process to indicate that any of the proposed rules might potentially be harmful to counties and county commissions, or impinge upon their authority to regulate ground ambulances. Certain proposed rules do impose new requirements, but these proposals are minor, only dictate processes, and are not intended to add burdensome requirements or to interfere with substantive regulatory matters.

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

A. <u>For those that rely on the rule to maintain their own businesses, agencies or operations</u>:

24 Privately-owned ambulance services,
142 Publicly-owned ambulance services,*
24 Licensed health care facilities that own and/or operate ambulance services,[1]
64 Counties and county commissions*

<u>Health and safety standards</u>:
Describe the anticipated favorable and non-favorable non-economic outcomes (short-term and long-term), and if known, the likelihood of the outcomes:

Favorable non-economic outcomes:

The new requirement that counties designate conflict-free representatives to conduct annual ground ambulance inspections promotes the integrity of the inspection process and ensures that licensed ground ambulances comply with minimum design safety and equipment requirements. This provision will help to eliminate or significantly reduce the risk that non-compliant ambulances are responding to emergencies and transporting patients in an unsafe environment.

A new provision (Rule 3.1.3) requires counties to establish a process by which unlicensed ground ambulances can legally transport patients, as necessary, and provides favorable benefits to the county in the short- and long-term. Typically, licensed ambulance services are able to provide safe emergency transports to address patient needs. When unanticipated events result in voluminous or rare injuries, however, that resource may not be able to provide patients with safe and adequate emergency transport services. The proposed rule provides a process to ensure that safe and adequate medical transport resources are available to respond to the needs of patients in these situations.

This provision also benefits licensed ambulance services. Rather than expecting the available licensed service to provide emergency medical transports that it is unable or

[1] Although there are approximately 210 ground ambulance services in Colorado, the Department has organizational profiles for 190 of these agencies. The data given is drawn from those Department records.

unequipped to offer, the proposed rule allows unlicensed services to provide the needed transport.

The proposed complaint process provisions should also result in collateral favorable outcomes to ambulance services and counties. By providing consumers of emergency medical ground ambulance services with a process to raise complaints about perceived substandard care, ambulance services and their medical directors can timely investigate the allegations and, if substantiated, correct and report the non-compliant violation as required. The process will result in increased transparency and accountability, and improved safety for patients.

***Unfavorable non-economic outcomes*:**

The new, more transparent complaint process provisions may impact EMS and other medical providers unfavorably if consumer complaints result in regulatory disciplinary action. Regarding all other classes, the work group was very careful to stay within the Department's statutory authority to regulate ground ambulances and the licensing process. No unfavorable non-economic outcomes are currently known.

Quantitative Economic/Financial Impact:

Ambulances services:

The proposed rules that impose additional requirements on ambulance services are minimal. The most potentially burdensome proposed rules are those that: (1) require new equipment on board ambulances (Section 9); and (2) require ambulance services that previously operated without a license in a service area to obtain a license from the county that has jurisdiction over the service area.

The Department believes that there are few, if any, ambulance services that will be impacted by the licensing service area requirement. Both the current and proposed rules contain a provision that allows counties to enter into reciprocal licensing and permitting agreements with other counties and neighboring states. (Current Rule 3.1.3) Therefore, those ambulance services operating within a multi-county area with reciprocity agreements will not suffer any economic or financial impact normally associated with additional licensing requirements.

With respect to the minimum equipment additions and modifications, the working group noted that most basic life support and advance life support ambulances already have this equipment. This change is simply the proposed rules reflecting the current state of practice.

EMS Providers and other Medical Personnel:

The Department believes that there are no imminent economic impacts to emergency medical service providers (EMTs, Paramedics) or other medical personnel that work for an ambulance service. However, it is possible that the revised complaint reporting requirements to the Department of Regulatory Affairs and to the Department could impact those professionals' licenses or certifications to work.

***Anticipated financial impact*:**

Anticipated Costs:	Anticipated Benefits:
Description of costs that must be incurred. Some ambulance services already have the minimum equipment required in the proposed rule. To the extent equipment needs to be procured: • <u>New Equipment For Each BLS Ground Ambulance</u>: BBG suction catheter: $3.12 – $7.33 per unit Arterial tourniquet#: $10.95 – $37.48 per unit Adult and Pediatric pulse oximeter: $98.85 - $169.95 per unit Pediatric pulse oximeter sensor*: $17.88 - $54.95 per unit Pediatric length-based measuring device: $24.00 - $34.88 per unit Pediatric reference guide: $1525 per unit plus $395 set-up fee (N.B. It may be possible to comply by carrying Children's Hospital pediatric guide that is provided at no cost annually) #Already required for City and County of Denver, Jefferson, Adams, Arapahoe, Douglas, and City and County of Broomfield *If ambulance already has electronic monitor for adults, only the pediatric sensor is needed to convert for use with pediatric patient	Description of financial benefit. • As noted above, some counties may be the recipients of additional licensing fee revenues that are generated by ambulance services that are based in more than one county. • Consistency across ambulance services as to equipment, increasing the competitiveness of all services.

TOTAL BLS EXPENSE RANGE: With Pediatric reference guide: $1697.68 + $395 set up fee to $1829.59 + $395 set up fee Without Pediatric reference guide/with free Children's Hospital pediatric guide: $172.68 to $304.59 • New Equipment for Each ALS Ground Ambulance: Intraosseous access and administration equipment: $65.98-$68.88 per unit TOTAL ALS EXPENSE RANGE:* With Pediatric reference guide: $65.98 for IO equipment, plus BLS equipment $1697.68 + $395 set up fee (Totaling $2158.66) to $68.88 for IO equipment plus BLS equipment $1829.59 + $395 set up fee plus (Totaling $2293.47) Without Pediatric reference guide/with free Children's Hospital pediatric guide: $65.98 for IO equipment, plus $172.64 BLS equipment (Totaling $238.62) To $68.88 for IO equipment plus BLS equipment $304.59 (Totaling $393.47) *ALS ground ambulances must be equipped with minimum equipment required for BLS and ALS categories.	

Description of costs that may be incurred. • Ambulance services that do not currently carry the additional mandated equipment will incur some or all of the foregoing costs necessary to update their equipment. The Department anticipates that a number of permitted ambulance service vehicles are already so equipped; therefore, in that circumstance, no additional costs will be incurred to the ambulance service. • Concerning the additional policy-making requirements imposed by the proposed rules discussed above, the Department does not anticipate that counties will incur additional cost, FTE, or fiscal impact.	
Cost or cost range. Enter "none" if there are no costs. For BLS ambulances that do not currently carry any newly-required minimum equipment: $172.68 to $1829.59 + $395 set up fee For ALS ambulances that do not currently carry any newly-required ALS and BLS minimum equipment: <u>Without Pediatric reference guide/with free Children's Hospital pediatric guide</u>: $393.47 To <u>With Pediatric reference guide</u>:	Savings or range of savings. $_____ or _X__ No data available.

$2158.66	
Dollar amounts that have not been captured and why: • None	Dollar amounts that have not been captured and why: • None

B. <u>For those that are affected by or interested in the outcomes the rule and those identified in #1.A achieve.</u>

Approximately 400,000 transported EMS patients
Approximately 190 EMS agencies
18,190 EMS providers (as of June 30, 2018)
Approximately 110 ambulance service medical directors
Emergency Medical Services Association of Colorado (EMSAC)
Colorado Counties Inc.
Special District Association
Colorado Municipal League
Colorado State Fire Chiefs Association
Colorado Firefighters Association
Colorado Hospital Association

Describe the favorable or unfavorable outcomes (short-term and long-term), and if known, the likelihood of the outcomes:

Favorable non-economic outcomes:

For ambulance service medical directors, the new complaint process laid out in Proposed Rule 4.2.6 ensures that the counties will adopt a policy and procedure concerning the method by which medical directors will be notified of complaints involving EMS providers. Medical directors will therefore see a favorable outcome from the rule revision because they will receive notice of any alleged regulatory violation or breached standard of practice committed by an ambulance service EMS and/or medical provider, and be able to institute necessary personnel and/or operational improvements.

For EMS patients, see response to Question 1(C), above. Individuals who require emergency medical transport in the State of Colorado will ultimately benefit because the proposed rule revisions require ground ambulances to satisfy minimum design, equipment, staffing, CQM, and operational safety standards that will improve emergency medical ground ambulance services. The revised rule will also augment and clarify the complaint process for consumers of these services and their families in the event they receive, or believe they have received, deficient emergency medical ground ambulance services. Further, consumers will benefit from the proposed rule revision that now requires counties to ensure that qualified conflict-free representatives perform all annual ambulance inspections, thereby protecting the safety of the public who are medically transported.

For EMS agencies, see response to Question 2(A), above. This provision also benefits licensed ambulance services because it recognizes that, in some circumstances, certain permitted ground ambulances cannot adequately respond to emergency transport demands, even if they are available. The new provision institutes a process to accommodate these circumstances, rather than expecting the licensed service to provide emergency medical transports that it is unable or unequipped to offer.

The proposed complaint process provisions should also result in collateral favorable outcome to ambulance services and counties. By providing consumers of emergency medical ground ambulance services with a process by which to raise complaints about perceived substandard care, ambulance services and their medical directors can timely investigate the allegations and, if substantiated, correct and report the non-compliant violation as required. The process will result in increased transparency and accountability, and improved safety for patients.

For EMS Providers, the proposed design safety, inspection, and equipment rules ensure that these medical professionals will be operating in a safe environment and providing emergency medical care with updated equipment.

Unfavorable non-economic outcomes:

As previously noted, the new, more transparent complaint process provisions may impact EMS and other medical providers unfavorably if consumer complaints result in regulatory disciplinary action. Regarding all other classes, the work group was very careful to stay within the Department's statutory authority to regulate ground ambulances and the licensing process. Consequently, the Department is currently unaware of other unfavorable non-economic outcomes.

Anticipated financial costs:

Ambulance services that do not currently carry the additional mandated equipment will incur costs necessary to update their equipment. However, the Department anticipates that a number of ambulance services already maintain this equipment. Therefore, no additional costs will be incurred by these entities.

The Department is unaware of any anticipated financial costs the other individuals or entities might incur.

Anticipated financial benefits:

The Department is unaware of any anticipated financial benefits these individuals or entities might receive.

C. <u>For those that benefit from, are harmed by or are at risk because of the rule, the services provided by individuals identified in #1.A, and if applicable, the stakeholders or partners identified in #1.B.</u>

Describe the favorable or unfavorable outcomes (short-term and long-term), and if known, the likelihood of the outcomes:

The Department does not foresee any potential harm resulting from the proposed rules. The proposed regulation balances the interests of the counties and patients with the interests of regulated ambulance services.

Financial costs to these individuals/entities:

For individuals affected by this rule, the cost is unknown. However, the Department anticipates that any such costs, if incurred, will be minimal.

For entities affected by this rule, see Sections (2)(a) and (3)(a), infra.

Financial benefits to or cost avoidance for these individuals/entities:

N/A as to individuals.

Unknown at this time as to entities.

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

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

There will be no additional cost to CDPHE associated with this proposed rule.

Anticipated CDPHE Revenues:

No additional revenues are anticipated because of the proposed regulation. The proposed rules do not increase fees.

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

N/A

Anticipated Revenues for another state agency:

N/A

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

Check mark all that apply:
_x_ Inaction is not an option because the statute requires rules be promulgated.

___ The proposed revisions are necessary to comply with federal or state statutory mandates, federal or state regulations, and Department funding obligations.

_x__ The proposed revisions appropriately maintain alignment with other states or national standards.

_x__ The proposed revisions implement a Regulatory Efficiency Review (rule review) result, or improve public and environmental health practice.

_x__ The proposed revisions implement stakeholder feedback.

_x__ The proposed revisions advance the following CDPHE Strategic Plan priorities:

Goal 1, Implement public health and environmental priorities Goal 2, Increase Efficiency, Effectiveness and Elegance Goal 3, Improve Employee Engagement Goal 4, Promote health equity and environmental justice Goal 5, Prepare and respond to emerging issues, and Comply with statutory mandates and funding obligations

Strategies to support these goals:
___ Substance Abuse (Goal 1)
___ Mental Health (Goal 1, 2, 3 and 4)
___ Obesity (Goal 1)
___ Immunization (Goal 1)
___ Air Quality (Goal 1)
___ Water Quality (Goal 1)
_X__ Data collection and dissemination (Goal 1, 2, 3, 4 and 5)
___ Implements quality improvement or a quality improvement project (Goal 1, 2, 3 and 5)
___ Employee Engagement (career growth, recognition, worksite wellness) (Goal 1, 2 and 3)
___ Incorporate health equity and environmental justice into decision-making (Goal 1, 3 and 4)
_X__ Establish infrastructure to detect, prepare and respond to emerging issues (Goal 1, 2, 3, 4, and 5)

_x__ Other favorable and unfavorable consequences of inaction:

Unfavorable consequences of inaction include:

- Ambulances may not be carrying the necessary equipment to respond to the needs of EMS and trauma patients,
- The existing rules do not clearly state that ambulance services must be licensed in each county in which they are based,
- The public does not have the necessary information to report complaints concerning ambulance services and/or their providers, and
- The Department may not receive accurate data or necessary regulatory data to assess and monitor the EMS and trauma system effectively.

The Department does not believe that inaction results in any favorable consequences.

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

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

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

Rulemaking is expressly mandated by statute. The only alternative was to leave the rules as they currently stand, which would not reflect current practice or the standard of care. Consequently, no alternatives to rulemaking were considered. The Department provided stakeholders and the public with the opportunity to contribute substantively throughout the entire rule development process.

The work group was mindful throughout the process not to impose unnecessary requirements on ambulance services or local government. During the course of its discussions, the work group did consider and reject certain rule proposals. For example, there was robust conversation concerning the need versus desirability of requiring ambulances to carry certain pieces of equipment. In one instance, the work group reasoned that it makes more sense to require counties to develop a process to allow extra-jurisdictional (unlicensed) specialty ambulances to transport patients under certain circumstances rather than to require every licensed ambulance to purchase seldom-used specialized equipment.

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

The gaps in the current rules were identified by subject matter experts and practitioners. They contributed their ideas for regulatory improvement to the work group, and this proposal is a product of those suggestions.

STAKEHOLDER ENGAGEMENT
for Amendments to
6 CCR 1015-3, Chapter Four – Rules Pertaining to
Licensure of Ground Ambulance Services

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

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

Organization	Representative
County Commissioners	Commissioner Sean Wood, Clear Creek County
For-Profit Ground Ambulance	Shawn Howe, American Medical Response
Hospital-Based Ground Ambulance	Dave Bressler, Banner Northern Colorado
EMS for Children	Sean Caffrey
Emergency Medical Services Association of Colorado	Tim Nowak
State Emergency Medical and Trauma Services Advisory Council (SEMTAC)	Commissioner Sean Wood, Clear Creek County, and Rich Martin, Castle Rock Fire Department
Regional Emergency Medical and Trauma Advisory Councils (RETACs)	Brandon Chambers, and Kim Schallenberger, Plains to Peaks RETAC
Fire-Based Ground Ambulance	Rich Martin, Castle Rock Fire Department

The work group met six times over a period of seven months in 2018. Draft rule proposals were distributed throughout the process. All work group meetings were publicly noticed and available through teleconferencing to any interested person.

Local Government Impact:

A county commissioner was a participating member of the work group and therefore was aware of all discussions and outcomes of local government mandates or provisions. Additionally, Department staff consulted with staff of Colorado Counties Inc. concerning all provisions involving local government requirements.

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

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

____ Yes.

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

The proposed rules are the product of the work group's consensus. Other than the issues noted below, no major factual or policy issues were encountered. The work group was mindful throughout the rule development process not to impose unnecessary requirements on ambulance services or local government.

During the course of its discussions, the work group and the Department considered and rejected certain rule modifications. For example, there were significant conversations concerning the need versus desirability of requiring ambulances to carry certain pieces of equipment. In one instance, the work group reasoned that it was more sensible to require counties to develop a process whereby extra-jurisdictional (unlicensed) specialty ambulances are able to transport patients under certain circumstances rather than to require every licensed ambulance to purchase seldom-used specialized equipment.

Another policy issue that arose was whether ground ambulance personnel should be required to leave patient care assessments and reports at the receiving facility in real time. After discussion, the work group wished to incorporate such a practice into rule. However, the Department rejected the suggestion because it was outside the scope of the Board of Health's rulemaking authority.

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

By standardizing the minimum equipment that an ambulance must carry and requiring counties to improve their complaint policies and processes, the proposed regulation helps set a standard of service by licensed ambulance services and an expectation of sensitivity and responsiveness to customer/patient concerns.

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

Select all that apply.

	Improves behavioral health and mental health; or, reduces substance abuse or suicide risk.	x	Reduces or eliminates health care costs, improves access to health care or the system of care; stabilizes individual participation; or, improves the quality of care for unserved or underserved populations.
x	Improves housing, land use, neighborhoods, local infrastructure, community services, built environment, safe physical spaces or transportation.	x	Reduces occupational hazards; improves an individual's ability to secure or maintain employment; or, increases stability in an employer's workforce.

	Improves access to food and healthy food options.		Reduces exposure to toxins, pollutants, contaminants or hazardous substances; or ensures the safe application of radioactive material or chemicals.
x	Improves access to public and environmental health information; improves the readability of the rule; or, increases the shared understanding of roles and responsibilities, or what occurs under a rule.	X	Supports community partnerships; community planning efforts; community needs for data to inform decisions; community needs to evaluate the effectiveness of its efforts and outcomes.
	Increases a child's ability to participate in early education and educational opportunities through prevention efforts that increase protective factors and decrease risk factors, or stabilizes individual participation in the opportunity.		Considers the value of different lived experiences and the increased opportunity to be effective when services are culturally responsive.
	Monitors, diagnoses and investigates health problems, and health or environmental hazards in the community.	x	Ensures a competent public and environmental health workforce or health care workforce.
	Other:_____ _____		Other:_____ _____

If the rulemaking implements new legislation or you have supplemental information such as a letter of support or a study, insert the legislation (an excerpt may be appropriate) or the supplemental information here in the .doc or in the PDF.

N/A.

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

EMERGENCY MEDICAL SERVICES

6 CCR 1015-3

___ Adopted by the Board of Health on _____, 2018. Effective _____, 2018.

_____

CHAPTER FOUR – RULES PERTAINING TO LICENSURE OF GROUND AMBULANCE SERVICES

Section 1 – Purpose and Scope

1.1 These rules are promulgated pursuant to § 25-3.5-308, CRS. They are consistent with § 25-3.5-301, 302, and 304 -306, CRS. Each county may adopt rules that exceed these rules adopted herein.

Section 2 – Definitions

2.1 Based: an ambulance service headquartered, having a substation, office, ambulance post, SERVICE AREA or other permanent location in a county.

2.2 County: county or city and county government within Colorado.

2.3 Department: the Colorado Department of Public Health and Environment.

2.4 Ambulance: any public or privately owned ~~land~~ LICENSED GROUND vehicle especially constructed or modified and equipped, intended to be used and maintained or operated by, ambulance services for the transportation, upon the ~~roads,~~ streets and highways of this state, of individuals who are sick, injured, or otherwise incapacitated or helpless.

2.5 Ambulance-advanced life support: a type of permit issued by a county to ~~a vehicle~~ AN AMBULANCE equipped in accordance with Section 9 of these rules and operated by an ambulance service authorizing the vehicle to be used to provide ambulance service limited to the scope of practice of the advanced emergency medical technician, emergency medical technician-intermediate or paramedic as defined in the EMS Practice and Medical Director Oversight Rules at 6 CCR 1015-3 Chapter Two.

2.6 Ambulance-basic life support: a type of permit issued by a county to ~~a vehicle~~ AN AMBULANCE equipped in accordance with Section 9 of these rules and authorized to be used to provide ambulance service limited to the scope of practice of the emergency medical technician as defined in the EMS Practice and Medical Director Oversight Rules at 6 CCR 1015-3 Chapter Two.

2.7 Ambulance service license: a legal document issued to an ambulance service by a county IN WHICH THE AMBULANCE IS BASED as evidence that the applicant meets the requirements for licensure to operate an ambulance service as defined by county resolution or regulations.

2.8 Ambulance service: the furnishing, operating, conducting, maintaining, advertising, or otherwise engaging in or professing to be engaged in the transportation of patients by ambulance. Taken in context, it also means the person so engaged or professing to be so engaged. ~~and the~~ THE vehicles used for the emergency transportation of persons injured at a mine are excluded from this definition when the personnel utilized in the operation of said vehicles are subject to the

mandatory safety standards of the federal mine safety and health administration, or its successor agency.

2.9 EMS Provider: refers to all levels of ~~E~~ emergency ~~M~~ medical sERVICE pROVIDER ~~Technician~~ certification issued by the department, including Emergency Medical Technician, Advanced Emergency Medical Technician, Emergency Medical Technician Intermediate and Paramedic.

2.10 MEDICAL CONTINUOUS QUALITY MANAGEMENT (CQM) PROGRAM: A PROCESS CONSISTENT WITH THE EMS PRACTICE AND MEDICAL DIRECTOR OVERSIGHT RULES AT 6 CCR 1015-3, CHAPTER TWO, USED TO OBJECTIVELY, SYSTEMATICALLY AND CONTINUOUSLY MONITOR, ASSESS AND IMPROVE THE QUALITY AND APPROPRIATENESS OF CARE PROVIDED BY THE MEDICAL CARE PROVIDERS OPERATING ON AN AMBULANCE SERVICE.

2.~~10~~11 Medical Director: a Colorado licensed physician who establishes protocols and standing orders for medical acts performed by EMS Providers of ~~a prehospital EMS service agency~~ AN AMBULANCE SERVICE AGENCY and who is specifically identified as being responsible to assure the competency of the performance of those acts by such EMS Providers as described in the physician's medical ~~continuous quality improvement~~ CQM program. ~~Any reference to a "physician advisor" in any previously adopted rules shall apply to a "medical director" as defined in these rules.~~

2.~~11~~12 Patient Care Report: a medical record of an encounter between any patient and a provider of medical care.

2.~~12~~13 Permit: the authorization issued by the governing body of a local government with respect to an ambulance used or to be used to provide ambulance service in this state.

~~2.13 Medical quality improvement program: a process consistent with the EMS Practice and Medical Director Oversight Rules at 6 CCR 1015-3 Chapter Two, used to objectively, systematically and continuously monitor, assess and improve the quality and appropriateness of care provided by the medical care providers operating on an ambulance service.~~

~~2.14 Rescue Unit: any organized group chartered by this state as a corporation not for profit or otherwise existing as a nonprofit organization whose purpose is the search for and the rescue of lost or injured persons and includes, but is not limited to, such groups as search and rescue, mountain rescue, ski patrols, (either volunteer or professional), law enforcement posses, civil defense units, or other organizations of governmental designation responsible for search and rescue.~~

~~2.15 Quick Response Teams: provides initial care to a patient prior to the arrival of an ambulance.~~

Section 3 – County Issuance of Licenses and Permit

3.1 License Required

~~3.1.1 Within one year following adoption of these rules, no person or agency, private or public, shall transport a patient from any point within Colorado in an ambulance, to any point within or outside Colorado unless that person or agency holds a valid license and permits issued by the county where the service is based and by the county where the patient originates, except as provided in Section 3.2 of these rules.~~

3.1.1 EXCEPT AS PROVIDED IN SECTION 3.2 OF THESE RULES, NO AMBULANCE SERVICE, PUBLIC OR PRIVATE, SHALL TRANSPORT A SICK OR INJURED PERSON FROM ANY POINT WITHIN COLORADO TO ANY POINT WITHIN OR OUTSIDE COLORADO UNLESS THAT AMBULANCE SERVICE HOLDS A VALID LICENSE AND

PERMITS ISSUED BY THE COUNTY OR COUNTIES IN WHICH THE AMBULANCE SERVICE IS BASED.

~~3.1.2 Ambulance services that are based outside Colorado, but respond within Colorado and transport patients originating in Colorado are required to be licensed in Colorado by the county in which they provide service.~~

~~3.1.3~~ 3.1.2 Counties may enter into reciprocal licensing and permitting agreements with other counties and neighboring states.

3.2 County Exemptions From Licensure or Permit Requirements

3.2.1 Vehicles used for the transportation of persons injured at a mine when the personnel used on the vehicles are subject to the mandatory safety standards of the federal mine safety and health administration, or its successor agency.

3.2.2 Vehicles used TO EVACUATE PATIENTS FROM AREAS INACCESSIBLE TO A PERMITTED AMBULANCE. VEHICLES USED IN THIS CAPACITY MAY ONLY TRANSPORT PATIENTS TO THE CLOSEST PRACTICAL POINT OF ACCESS TO A PERMITTED AMBULANCE OR MEDICAL FACILITY. ~~by other agencies including quick response teams and rescue units that do not routinely transport patients or vehicles used to transport patients for extrication from areas inaccessible to a permitted ambulance. Vehicles used in this capacity may only transport patients to the closest practical point for access to a permitted ambulance or hospital.~~

3.2.3 Vehicles, including ambulances from another state, used during major catastrophe or ~~mass casualty incident~~ MULTICASUALTY (DISASTER) EVENTS, rendering services when permitted ambulances are insufficient.

3.2.4 An ambulance service that does not transport patients from points originating in Colorado, or transporting a patient originating outside the borders of Colorado.

3.2.5 Vehicles used or designed for the scheduled transportation of convalescent patients, individuals with disabilities, or persons who would not be expected to require skilled treatment or care while in the vehicle.

3.2.6 Vehicles used solely for the transportation of intoxicated persons or persons incapacitated by alcohol as defined in § ~~25-1-302,~~ 25-81-102(11), ~~CRS~~ C.R.S. but who are not otherwise disabled or seriously injured and who would not be expected to require skilled treatment or care while in the vehicle.

3.2.7 Ambulances operated by a department or an agency of the federal government, originating from a federal reservation for the purpose of responding to, or transporting patients under federal responsibility.

3.3 General Requirements For County Licensure Of Ambulance Services AND PERMITTING OF AMBULANCE VEHICLES

3.3.1 Counties shall adopt by resolution or regulations, AND PERIODICALLY REVIEW, a process for licensure of ambulance services. The process shall include, but not be limited to:

A~~).~~ Compliance with ALL applicable ~~federal, state, and local~~ laws and regulations to operate an ambulance service in Colorado.

B~~).~~ An application form adopted by the county.

C). An application fee, as defined in county resolution or regulations.

D). Submission to the county, upon request, of copies of the ambulance service's written policy and procedure manual, operational or medical protocols, or other documentation the county may deem necessary.

E). Demonstration by the applicant of minimum vehicle insurance coverage as defined by § 10-4-609, ~~CRS~~ C.R.S. and § 42-7-103 (2), ~~CRS~~ C.R.S. with the county(s) identified as the certificate holder.

F). Demonstration by the applicant of proof of any additional insurance as identified in county resolution or regulations. In making a decision about additional insurance requirements at any time it deems necessary to promote the public health, safety and welfare, the county shall require a minimum level of worker's compensation consistent with the Colorado worker's compensation act of Colorado Revised Statutes title 8, article 40-47.

~~G. Documentation from the applicant that information regarding the amount of professional liability insurance the ambulance service carries was provided to employees.~~

~~H.~~G) Prior to beginning operations and upon change of ownership of an ambulance service, the new owner or operator must file for and obtain an ambulance license and ambulance permit.

~~I.~~ H) IN ORDER TO ASSURE PATIENT AND CREW SAFETY, THE ~~The~~ county ~~may~~ SHALL REQUIRE THAT ALL AMBULANCES BE MANUFACTURED BY AN ORGANIZATION REGISTERED WITH THE NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION (NHSTA) AS A FINAL STAGE MANUFACTURER. THE COUNTY MAY adopt minimum ~~acceptable~~ vehicle design standards for ambulances. ~~In doing so, the county shall consider vehicle design standards such as those established by the US General Services Administration: federal specifications for ambulances KKK-A-1822 (e), 2003.~~

~~J.~~ I) The county shall verify that each ambulance is inspected annually by qualified representatives, as defined and appointed by the county commissioners, to assure compliance with these rules. COUNTIES SHALL ENSURE THAT ALL SUCH REPRESENTATIVES DO NOT HAVE ANY DISCLOSED OR UNDISCLOSED ACTUAL OR POTENTIAL CONFLICTS OF INTEREST WITH THE AMBULANCE SERVICE OR INSPECTION PROCESS.

~~K.~~ J) Counties shall verify that all equipment on the ambulance is properly secured, and medications and supplies are maintained and stored according to the manufacturer's recommendations and ~~any federal, state or local~~ ALL APPLICABLE requirements.

~~L.~~K) A county may delegate or contract the ambulance inspection process but not the responsibility of licensure as set forth in § 25-3.5-301, *et seq.*, ~~CRS.~~ C.R.S.

~~M.~~L) An ambulance service license or vehicle permit may not be assigned, sold or otherwise transferred.

3.3.2 ~~These rules incorporate by reference vehicle design standards by the US General Services Administration: federal specifications for ambulances KKK-A-1822 (e), 2003 (Section 3.3.1I). These rules do not include later amendments to or editions of the incorporated materials. The Department of Public Health and Environment maintains copies of the complete text of the incorporated materials for public inspection during~~

~~regular business hours, and shall provide certified copies of any non-copyrighted material to the public at cost upon request. The incorporated material may be examined at any state publications depository library.~~

~~A. Information regarding how the incorporated materials may be obtained or examined is available from:~~

~~Emergency Medical and Trauma Services Section Chief~~
~~Health Facilities and Emergency Medical Services Division~~
~~Colorado Department of Public Health and Environment~~
~~4300 Cherry Creek Drive South, Denver, Colorado 80246~~

EVERY COUNTY SHALL ESTABLISH A PROCESS BY WHICH AMBULANCE SERVICES NOT LICENSED WITHIN THE COUNTY'S JURISDICTION MAY PROVIDE TRANSPORT IN THE EVENT THAT ALL LICENSED AMBULANCE SERVICES ARE UNABLE TO MEET THE NEEDS OF THE PATIENT.

3.4 Licensure Process

3.4.1 Ambulance Service License

~~A.~~

An ambulance service license shall be issued by EACH county IN WHICH THE AMBULANCE SERVICE IS BASED. ~~upon~~ THE COUNTY SHALL ENSURE compliance with these rules and all license requirements ~~duly~~ established by that county. ~~The type of license issued shall describe the maximum level of ambulance service that could be provided at any time by the service.~~

3.4.2 Permits Of Vehicles

A)~~.~~ The county shall create a process and procedure for the issuing of permits for each AMBULANCE ~~vehicle~~ used by the ambulance service.

B)~~.~~ The type of permit issued will describe the ~~maximum~~ level of service that could be provided at any time by that ~~vehicle~~ AMBULANCE and appropriate staff. Types of permissible permits are limited to:

1)~~.~~ Ambulance basic life support

2). Ambulance advanced life support.

~~3.~~

C) Each county ~~shall~~ MAY include in ~~their~~ ITS resolution or regulations the requirements for identification of the permitted level of service on each vehicle issued a permit.

3.5 Licensure Period

3.5.1 The licensure period for all ambulance services shall be for twelve months.

3.6 License Renewal

3.6.1 Counties shall create an annual license renewal process. ~~The license renewal process shall require the ambulance service to submit a completed renewal application form and the required licensure fee, as defined in county resolution or regulations.~~ The licensure renewal process shall require the receipt of applications for renewal no less than 30 days before the date of license expiration.

Section 4 – Complaints

4.1 Each county SHALL ~~must~~ have a written complaint and investigation policy and procedure to address:

4.1.1 complaints against any ambulance service licensed in the county.

4.1.2 allegations of unlicensed ambulance services or vehicles without a valid permit operating within the county.

4.2 The policy shall include, but not be limited to:~~,~~

4.2.1 ~~t~~The procedures ~~associated with~~ CONCERNING complaint intake, INCLUDING POSTED INFORMATION TO THE PUBLIC CONCERNING HOW TO FILE A COMPLAINT;

4.2.2 THE COUNTY'S DUTY TO PROVIDE THE LICENSEE WITH A COPY OF THE COMPLAINT AT THE TIME IT IS FILED;

4.2.3 complaint validation;

4.2.4. THE criteria for initiating an investigation;

4.2.5 ~~a~~ THE method for ~~notification to~~ NOTIFYING the complainant about the resolution of the investigation;

4.2.6 THE METHOD FOR NOTIFYING THE DEPARTMENT AND MEDICAL DIRECTORS REGARDING COMPLAINTS INVOLVING EMS PROVIDERS; and

4.2.7 ~~a~~ THE method for ~~the notification of other local entities~~ NOTIFYING OTHER COUNTIES with jurisdiction over ambulance services, the department ~~and/or the Colorado Medical Board for~~ AND, IF APPLICABLE, THE COLORADO DEPARTMENT OF REGULATORY AGENCIES ABOUT complaints regarding ~~EMS Providers or~~ other medical personnel associated with the AMBULANCE service or the medical director.

4.3 The county shall notify the primary medical director of the ambulance service, in writing, of any KNOWN violation of the ambulance licensing regulations by the ambulance service or KNOWN alleged complaints or violations OF THE AMBULANCE LICENSING REGULATIONS by individual medical providers operating on an ambulance service.

Section 5 – Denial, Revocation, Or Suspension Of Licensure And Vehicle Permits

5.1 Each county shall develop policies and procedures for the denial, suspension or revocation of an ambulance service license or ambulance permit consistent with § 25-3.5-304, ~~CRS.~~C.R.S.

Section 6 – Minimum Data Collection And Reporting Requirements

6.1 The county shall require that licensed ambulance services ~~complete a patient care report~~ PROVIDE PATIENT CARE INFORMATION INCLUDING ~~for each patient that is assessed. The patient care report shall include~~ the minimum pre-hospital care data set ~~as set forth in~~ TO THE

DEPARTMENT PURSUANT TO the Rules Pertaining to Emergency Medical Services Data and Information Collection and Record Keeping at 6 CCR 1015-3, Chapter Three.

6.2 ~~The county shall require that the ambulance service provide patient care information to the department pursuant to the Rules Pertaining to Emergency Medical Services Data and Information Collection and Record Keeping at 6 CCR 1015-3, Chapter Three.~~

THE COUNTY SHALL REQUIRE THAT EACH LICENSED AMBULANCE SERVICE COMPLETE AND SUBMIT TO THE DEPARTMENT AN ORGANIZATIONAL PROFILE PURSUANT TO THE RULES PERTAINING TO EMERGENY MEDICAL SERVICES DATA AND INFORMATION COLLECTION AND RECORDKEEPING AT 6 CCR 1015-3, CHAPTER THREE.

6.3 ~~The county shall require that each licensed ambulance service complete and submit to the department an agency profile as defined by the State Emergency Medical and Trauma Services Advisory Council and approved by the department to provide information on resources available for planning and coordination of statewide emergency medical and trauma services on an annual basis.~~

UPON DEPARTMENT REQUEST, THE COUNTY SHALL VERIFY THE LIST OF LICENSED AMBULANCE SERVICES AND THE VEHICLES PERMITTED BY SUCH SERVICES TO PROVIDE EMERGENCY MEDICAL AND TRAUMA SERVICES.

Section 7 – Minimum Staffing Requirements

7.1 AT MINIMUM, ~~T~~the county shall establish by resolution or regulations THE FOLLOWING ambulance staffing requirements ~~to include, but not be limited to~~:

7.1.1 ~~The minimum requirement for~~ FOR the person responsible for providing direct emergency medical care to patients transported in an ambulance, A CURRENT AND VALID ~~is~~ certification as an EMS Provider as defined in the Rules Pertaining to EMS Education and Certification at 6 CCR 1015-3, Chapter One.

7.1.2 ~~The minimum requirement for~~ FOR the ambulance driver, ~~shall be~~ a CURRENT AND valid driver's license.

7.2 Consistent with § 25-3.5-202, ~~CRS~~ C.R.S., in the case of an emergency in any ambulance service area where no person possessing the qualifications required by this section is present or available to respond to a call for the emergency treatment and transportation of patients by ambulance, any person may operate such ambulance to transport any sick, injured, or otherwise incapacitated or helpless person in order to stabilize the medical condition of such person. ~~pending the availability of personnel meeting these minimum qualifications.~~

Section 8 – Medical Oversight and CONTINUOUS Quality ~~Improvement~~ MANAGEMENT

8.1 The county shall require each ambulance service operating within ~~their~~ ITS jurisdiction to have a primary medical director meeting the requirements as defined in the EMS Practice and Medical Director Oversight Rules at 6 CCR 1015-3, Chapter Two to supervise the medical acts performed by ~~all personnel on~~ EMS PROVIDERS OF the ambulance service AGENCY. The county shall require a licensee to inform the county within ~~15 calendar~~ 14 BUSINESS days, in writing, of changes in medical oversight of the ambulance service and/or the medical director of record.

8.2 THE COUNTY SHALL REQUIRE EACH LICENSED AMBULANCE SERVICE OPERATING WITHIN ITS JURISDICTION TO HAVE AN ONGOING MEDICAL CQM PROGRAM CONSISTENT WITH THE REQUIREMENTS AS DEFINED IN THE EMS PRACTICE AND MEDICAL DIRECTOR OVERSIGHT RULES AT 6 CCR 1015-3, CHAPTER TWO.

~~The county ambulance service licensure application shall include an attestation by the medical director of willingness to provide medical oversight and a medical continuous quality improvement program for the ambulance service~~.

8.3 THE COUNTY AMBULANCE SERVICE LICENSURE APPLICATION SHALL INCLUDE AN ATTESTATION BY THE MEDICAL DIRECTOR OF WILLINGNESS TO PROVIDE MEDICAL OVERSIGHT AND THE MEDICAL CQM PROGRAM FOR THE AMBULANCE SERVICE.

~~The county shall require each licensed ambulance service operating within their jurisdiction to have an ongoing medical continuous quality improvement program consistent with the requirements as defined in the EMS Practice and Medical Director Oversight Rules at 6 CCR 1015-3, Chapter Two.~~

Section 9 – Minimum Equipment Requirements

9.1 Counties shall ensure that permitted ambulances are in compliance with the minimum equipment list for the type of service defined by their permitS as defined in 9.2 and 9.3 of these rules.

9.2 Minimum Equipment For Basic Life Support Ambulances

9.2.1 Ventilation And Airway Equipment

A~~).~~ ~~portable~~ PORTABLE suction unit, and a house (fixed system) or backup suction unit, with wide bore tubing, rigid pharyngeal curved suction tip, and soft catheter suction tips to include ADULT AND pediatric sizes~~. 6 fr. through 14 fr.~~

B~~).~~ ~~bulb~~ BULB syringe AND BBG SUCTION CATHETER.

C~~).~~ FIXED (house) oxygen and portable oxygen bottle, each with a variable flow regulator.

D~~).~~ ~~transparent~~ TRANSPARENT, non-rebreather oxygen masks and nasal cannula in adult sizes, and transparent, non-rebreather oxygen masks in pediatric sizes.

E~~).~~ ~~hand~~ HAND operated, self-inflating bag-valve mask resuscitators with oxygen reservoirs and standard 15mm /21mm fittings in the following sizes:

1~~).~~ ~~500cc bag~~ for infant and neonate

2~~).~~ ~~750cc bag~~ for children

3~~).~~ ~~1000cc~~ bag for adult

4~~).~~ ~~Transparent~~ TRANSPARENT masks for infants, neonate patients, children and adults.

F~~).~~ ~~nasopharyngeal~~ NASOPHARYNGEAL airways in adult sizes 24 FR. ~~fr.~~ through 32 FR. ~~fr.~~

G~~).~~ ~~o~~Oropharyngeal airways in adult and pediatric sizes to include: infant, child, small adult, adult and large adult.

9.2.2 Patient Assessment Equipment

A~~).~~ ~~b~~ Blood pressure cuffs to include large adult, regular adult, child and infant sizes.

B). s Stethoscope.

C). penlight AN ILLUMINATION DEVICE CAPABLE OF APPROPRIATELY TESTING FOR PUPILLARY REACTION.

D). PULSE OXIMETER WITH ADULT AND PEDIATRIC SENSORS.

9.2.3 Splinting Equipment

A). l Lower extremity traction splint.

B). u Upper and lower extremity splints.

C). l Long board, scoop TM STRETCHER, vacuum mattress or equivalent with appropriate accessories to immobilize SECURE the patient from head to heels.

D). s Short board, K.E.D. EXTRICATION DEVICE or equivalent, with the ability to immobilize SECURE the patient from head to pelvis.

E). p Pediatric spine LONG board or adult spine LONG board that can be adapted for pediatric use.

F). a Adult and pediatric head immobilization equipment.

G). a Adult and pediatric cervical spine immobilization equipment. per medical director protocol.

9.2.4 Dressing Materials

A). MULTIPLE bandages —AND DRESSINGS OF various types and sizes, INCLUDING OCCLUSIVE DRESSINGS. per agency needs and medical director protocol.

B). multiple dressings (including occlusive dressings), various sizes per ambulance service requirements, needs and medical director protocol.

BC). S Sterile burn sheets.

D C) a Adhesive tape. per ambulance service requirements, needs and medical director protocol.

D) ARTERIAL TOURNIQUET.

9.2.5 Obstetrical Supplies

A). sterile ob OB kit to include: towels, 4x4 dressings, umbilical tape or cord clamps, scissors, bulb syringe, sterile gloves and thermal absorbent blanket.; AND

B). nNeonate stocking cap or equivalent.

9.2.6 Miscellaneous Equipment

A). h Heavy bandage scissors, shears or equivalent capable of cutting clothing, belts, boots, etc.

B). AT LEAST ONE two working flashlights.

C). ~~b~~ Blankets. ~~and appropriate heat source for the ambulance patient compartment.~~

~~9.2.7 Ambulance Service Medical Treatment Protocols.~~

9.2.~~8~~7 Communications Equipment

~~A. All communications equipment shall be maintained in good working order. The communications equipment must be capable of transmitting and receiving clear voice communications.~~

~~B.~~A) Two-way communications IN GOOD WORKING ORDER that will enable ~~the~~ CLEAR VOICE COMMUNICATIONS BETWEEN ambulance personnel ~~to communicate with~~ AND THE:

1) ambulance service's dispatch.

2). medical control facility or ~~a~~ THE MEDICAL CONTROL physician

3). receiving facilities

4). mutual aid agencies.

~~9.2.9 Extrication Equipment~~

~~A. Each ambulance should carry extrication equipment appropriate for the level of extrication the ambulance service provides and in accordance with the requirements established by the county in which the ambulance is licensed.~~

9.2.~~10~~ 8 Body Substance Isolation (BSI) Equipment Properly Sized To Fit All Personnel

A). ~~n~~Non-sterile disposable LATEX FREE gloves~~, to include a minimum 1 box of latex free gloves~~.

B). ~~p~~ Protective eyewear.

C). ~~n~~ Non-sterile surgical masks.

~~D. safety protection gear for extrication consistent with the ambulance service extrication capabilities~~.

~~E~~D). ~~S~~ Sharps containers AND RECEPTACLES for the appropriate disposal and storage of medical waste and biohazards.

~~F.~~E) NATIONAL INSTITUTE OF OCCUPATIONAL SAFETY AND HEALTH (NIOSH) APPROVED N-95 OR SUPERIOR PARTICULATE FILTERING RESPIRATOR (MASK), ~~HEPA masks,~~ which can be of universal size.

9.2.~~11~~9 Safety Equipment

A). ~~a~~ A set of three (3) warning reflectors.

B). ~~o~~0ne (1) ten pound (10 lb.) or two (2) five pound (5 lb.) ~~A~~BC fire extinguishers, with a minimum of one extinguisher accessible from the patient compartment and vehicle exterior.

C). ~~c~~ Child PROTECTIVE RESTRAINT SYSTEM THAT ACCOMMODATES A WEIGHT RANGE BETWEEN 5 AND 99 LBS. ~~safety seat or appropriate protective restraints for patients, crew, accompanying family members and other vehicle occupants.~~

D) APPROPRIATE PROTECTIVE RESTRAINTS FOR PATIENTS, CREW, ACCOMPANYING FAMILY MEMBERS AND OTHER VEHICLE OCCUPANTS.

~~D~~ E). ~~p~~ Properly secured patient transport system (i.e. wheeled stretcher).

~~E~~F). DEPARTMENT APPROVED triage tags ~~as approved by the department~~.

9.2.10 PHARMACALOGICAL AGENTS

A) PHARMACALOGICAL AGENTS AND DELIVERY DEVICES PER MEDICAL DIRECTOR APPROVAL.

B) PEDIATRIC “LENGTH BASED” DEVICE FOR SIZING DRUG DOSAGE CALCULATIONS AND SIZING EQUIPMENT.

9.2.11 PEDIATRIC REFERENCE TOOL

A) ONE (1) PEDIATRIC DRUG DOSAGE CHART OR TAPE: THIS MAY INCLUDE CHARTS LISTING THE DRUG DOSAGES IN MILLILITERS PER KILOGRAM. PRE-CALCULATED DOSES BASED ON WEIGHT, OR A TAPE THAT GENERATES APPROPRIATE EQUIPMENT SIZES AND DRUG DOSES BASED ON THE PATIENT’S HEIGHT OR WEIGHT.

B) VITAL SIGNS.

9.3 Minimum Equipment Requirement for Advanced Life Support Ambulances

9.3.1 All Equipment AND SUPPLIES ~~Listed~~ LISTED In Section 9.2

9.3.2 Ventilation Equipment

A). ~~a~~ Adult and pediatric ADVANCED AIRWAY ~~endotracheal intubation~~ equipment ~~to include stylets and an endotracheal tube stabilization device and endotracheal tubes uncuffed range from 2/5 - 5/5, and cuffed size range from 6.0-8.0~~ per medical director ~~protocol~~ APPROVAL.

~~B. laryngoscope and blades, straight and/or curved of sizes 0-4.~~

~~C~~B). ~~adult~~ ADULT and pediatric ~~m~~Magill forceps.

~~D~~C). ~~e~~End tidal ~~co~~ CO_2 MONITOR OR DETECTION DEVICE FOR DETERMINING ADVANCED AIRWAY DEVICE ~~detector or alternative device, approved by the FDA, for determining end tube~~ placement.

9.3.3 Patient Assessment Equipment

A). ~~p~~Portable, battery operated cardiac monitor-defibrillator with strip chart recorder and adult and pediatric EKG electrodes and defibrillation capabilities.

B~~).~~ ~~pulse oximeter with adult and pediatric probes.~~

~~C~~B~~).~~ ~~e~~ Electronic blood glucose measuring device.

9.3.4 Intravenous Equipment

A~~).~~ ~~a~~ Adult and pediatric:

1) intravenous solutions: AND ~~and~~

~~2)~~ administration equipment. ~~per medical director protocol.~~

B~~).~~ INTRAOSSEOUS:

1) ACCESS DEVICE; AND

2) ADMINISTRATION EQUIPMENT.

C) ~~adult~~ ADULT and pediatric intravenous arm boards.

9.3.5 Pharmacological Agents

A~~).~~ ~~p~~ Pharmacological agents and delivery devices per medical director ~~protocol~~ APPROVAL.

B~~).~~ ~~p~~ Pediatric “length based” device for sizing drug dosage calculations and sizing equipment.

COLORADO
Board of Health
Department of Public Health & Environment

Notice of Public Rule-Making Hearing

November 21, 2018

ID #: 122

NOTICE is hereby given pursuant to the provisions of §24-4-103, C.R.S.; that the Colorado Board of Health will conduct a public rule-making hearing on:

Date: November 21, 2018
Time: 10:00 AM
Place: Sabin-Cleere Conference Room, Building A, 1st Floor, 4300 Cherry Creek Drive South, Denver, CO 80246

To consider the promulgation/amendments or repeal of:

CCR Number(s)
6 CCR 1015-3, Emergency Medical Services, Chapter 4, Licensure of Ground Ambulance

The proposed rules have been developed by the following division or office of the Colorado Department of Public Health and Environment:
Health Facilities and Emergency Medical Services

Statute(s) that requires or authorizes the Board of Health to promulgate, amend, or repeal this rule:

Statute(s)
§25-3.5-308, C.R.S.

Agenda and Hearing Documents
The Board of Health agenda and the proposed rules, together with the proposed statement of basis and purpose, specific statutory authority and regulatory analysis will be available, at least seven (7) days prior to the meeting, on the Board's website, https://colorado.gov/cdphe/boh .

For specific questions regarding the proposed rules, contact the division below:
Health Facilities and Emergency Medical Services Division, HFEMSD-C1, 4300 Cherry Creek Drive S., Denver, CO 80246, (303) 692-2800.

Participation
The Board encourages all interested persons to participate in the hearing by providing written data, views, or comments, or by making oral comments at the hearing. At the discretion of the Chair, oral testimony at the hearing may be limited to three minutes or less depending on the number of persons wishing to comment.

Written Testimony
Pursuant to 6 CCR 1014-8, §3.02.1, written testimony must be submitted no later than five (5) calendar days prior to the rule-making hearing.

Persons wishing to submit written comments should submit them to: Colorado Board of Health, ATTN: Board of Health Unit, Program Assistant, Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, EDO-A5, Denver, Colorado 80246-1530 or by e-mail at: cdphe.bohrequests@state.co.us
Written testimony is due by 5:00 p.m., Thursday, November 15, 2018.

Deborah Nelson, Board of Health Administrator
Date: 2018-09-27T08:32:37

Notice of Proposed Rulemaking

Tracking number

2018-00524

Department

1100 - Department of Labor and Employment

Agency

1101 - Division of Workers' Compensation

CCR number

7 CCR 1101-3

Rule title

WORKERS' COMPENSATION RULES OF PROCEDURE WITH TREATMENT GUIDELINES

Rulemaking Hearing

Date

11/09/2018

Time

10:00 AM

Location

633 17th St. Denver, Co 80202

Subjects and issues involved

Revise allocation of and decrease total surcharge for 7/18-12/18 and modify surcharge rate for 1/19-6/19.

Statutory authority

8-47-107

Contact information

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DEPARTMENT OF LABOR AND EMPLOYMENT

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

Rule 2 Workers' Compensation Insurance Premium And Payroll Surcharges

2-1 SURCHARGE REQUIREMENTS FOR INSURANCE CARRIERS

Pursuant to § 8-44-112(1), insurance carriers must file semiannual surcharge returns based upon the premium amounts for the periods July 1, 2018 through December 31, 2018 and January 1, 2019 through June 30, 2019.

(A) Insurance carriers must use Division Form WC 113 to file semiannual surcharge returns.

(B) The surcharge return must state the amount of premiums written for Colorado workers' compensation insurance, including any policy expense constants, membership fees, finance and service, or other administrative fees charged to the policyholders with the issuance or renewal of policies during the semiannual period covered by such return. These premiums are the same as the premiums reported to the Colorado Division of Insurance (DOI) in accordance with §10-3-208, and regulations promulgated thereunder.

(C) Insurance carriers must verify the surcharge return by affidavits of at least two chief officers or agents, such as president and secretary.

(D) Insurance carriers must pay surcharges to the Division with its semiannual return form on or before January 31, 2019 and July 31, 2019.

(E) Insurance carriers may take a credit for actually refunded premiums as an offset against surcharges due within one year of the date the premium was refunded. The insurance carrier may not offset a credit of one subsidiary against the surcharge owed by another subsidiary.

2-2 SURCHARGE REQUIREMENTS FOR SELF-INSURED EMPLOYERS

Pursuant to § 8-44-112(3) every self-insured employer must report its semiannual payroll to the Division for the periods July 1, 2018 through December 31, 2018 and January 1, 2019 through June 30, 2019 utilizing the Division's online surcharge application.

(A) The payroll must include the National Council on Compensation Insurance (NCCI) class codes, job titles, number of employees, and total payroll, as instructed by the online surcharge application. The Division may request further information to verify the reported payroll data. The failure to report payroll timely or accurately may result in the computation of surcharge without the otherwise applicable discounts.

(B) Self-insured employer surcharges must be based on the manual premium, adjusted by Pinnacol Assurance discount applicable for the covered surcharge assessment period and modified by 1.0 experience rating factor.

(C) Self-insured employers must report total payroll, under oath, in a flat file format using the Division's online surcharge application. For the semiannual assessment period July 1, 2018 through December 31, 2018, self-insured employers must report total payroll no later than January 10, 2019 and pay no later than January 31, 2019. For the semiannual assessment

period January 1, 2019 through June 30, 2019, self-insured employers must report total payroll no later than July 10, 2019 and pay no later than July 31, 2019.

2-3 SURCHARGE RATES

~~The following surcharge rates shall apply beginning July 1, 2018 and continue indefinitely with annual review by the Director:~~

~~(A) The workers' compensation cash fund premium surcharge rate authorized by § 8-44-112(1)(a), shall be 0.9 percent of the amount of all premiums written as defined in section 2-1(B) or the premium equivalent amount established in section 2-2(C) of this rule.~~

~~(B) The additional assessment to fund the cost containment program authorized by § 8-44-112(1)(b)(I), shall be 0.03 percent of all premiums written, as defined in section 2-1(B). This assessment shall not be imposed on self-insured employers.~~

~~(C) The assessment to fund the Subsequent Injury Fund authorized by § 8-46-102(2)(A)(I), and the Major Medical Fund authorized by § 8-46-202 shall be 0.1 percent of all premiums written as defined in section 2-1(B) or the premium equivalent amount established in section 2-2(C) of this rule.~~

(A) THE FOLLOWING SURCHARGE RATES SHALL APPLY FOR THE PERIOD THROUGH JULY 1, 2018 AND CONTINUE THROUGH DECEMBER 31, 2018:

(1) THE WORKERS' COMPENSATION CASH FUND PREMIUM SURCHARGE RATE AUTHORIZED BY §8-44-112(1)(A), SHALL BE 1 PERCENT OF THE AMOUNT OF ALL PREMIUMS WRITTEN AS DEFINED IN SECTION 2-1(B) OR THE PREMIUM EQUIVALENT AMOUNT ESTABLISHED IN SECTION 2-2(C) OF THIS RULE.

(2) THE ADDITIONAL ASSESSMENT TO FUND THE COST CONTAINMENT PROGRAM AUTHORIZED BY § 8-44-112(1)(B)(I), SHALL BE 0.00 PERCENT OF ALL PREMIUMS WRITTEN, AS DEFINED IN SECTION 2-1(B). THIS ASSESSMENT SHALL NOT BE IMPOSED ON SELF-INSURED EMPLOYERS.

(3) THE ASSESSMENT TO FUND THE SUBSEQUENT INJURY FUND AUTHORIZED BY §8-46-102(2)(A)(I), AND THE MAJOR MEDICAL FUND AUTHORIZED BY § 8-46-202 SHALL BE 0.0 PERCENT OF ALL PREMIUMS WRITTEN AS DEFINED IN SECTION 2-1(B) OR THE PREMIUM EQUIVALENT AMOUNT ESTABLISHED IN SECTION 2-2(C) OF THIS RULE.

(B) THE FOLLOWING SURCHARGE RATES SHALL APPLY FOR THE PERIOD BEGINNING JANUARY 1, 2019 AND CONTINUE INDEFINITELY WITH PERIODIC REVIEW BY THE DIRECTOR:

(1) THE WORKERS' COMPENSATION CASH FUND PREMIUM SURCHARGE RATE AUTHORIZED BY §8-44-112(1)(A), SHALL BE 1.35 PERCENT OF THE AMOUNT OF ALL PREMIUMS WRITTEN AS DEFINED IN SECTION 2-1(B) OR THE PREMIUM EQUIVALENT AMOUNT ESTABLISHED IN SECTION 2-2(C) OF THIS RULE.

(2) THE ADDITIONAL ASSESSMENT TO FUND THE COST CONTAINMENT PROGRAM AUTHORIZED BY § 8-44-112(1)(B)(I), SHALL BE 0.00 PERCENT OF ALL PREMIUMS WRITTEN, AS DEFINED IN SECTION 2-1(B). THIS

ASSESSMENT SHALL NOT BE IMPOSED ON SELF-INSURED EMPLOYERS.

(3) THE ASSESSMENT TO FUND THE SUBSEQUENT INJURY FUND AUTHORIZED BY §8-46-102(2)(A)(I), AND THE MAJOR MEDICAL FUND AUTHORIZED BY § 8-46-202 SHALL BE 0.1 PERCENT OF ALL PREMIUMS WRITTEN AS DEFINED IN SECTION 2-1(B) OR THE PREMIUM EQUIVALENT AMOUNT ESTABLISHED IN SECTION 2-2(C) OF THIS RULE.

Notice of Proposed Rulemaking

Tracking number

2018-00505

Department

1100 - Department of Labor and Employment

Agency

1101 - Division of Labor Standards and Statistics (Includes 1103 Series)

CCR number

7 CCR 1103-1

Rule title

COLORADO MINIMUM WAGE ORDER NUMBER 35

Rulemaking Hearing

Date

11/06/2018

Time

01:00 PM

Location

633 17th Street, 6th Floor, Denver, CO 80202

Subjects and issues involved

Pursuant to Article XVIII, Section 15, of the Colorado Constitution, Colorado Minimum Wage Order Number 35 will establish a new state minimum wage of $11.10 per hour, effective January 1, 2019. Colorado Minimum Wage Order Number 35 differs from the current Colorado Minimum Wage Order Number 34 in the state minimum wage.

Statutory authority

C.R.S. § 8-1-107(2)(p), § 8-6-106, § 8-6-108(2), and § 8-6-109 (2018)

Contact information

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DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Labor Standards and Statistics

COLORADO MINIMUM WAGE ORDER NUMBER 35

7 CCR 1103-1

Authority:

This Colorado Minimum Wage Order Number 35 is promulgated under the authority vested by C.R.S. Title 8, Articles 1, 4, 6, and 12 (2018). This Wage Order shall supersede all previous Wage Orders.

Important Information on Minimum Wage:

Colorado Minimum Wage Order Number 35 establishes a Colorado state minimum wage pursuant to the requirements of Article XVIII, Section 15, of the Colorado Constitution.

In addition to state minimum wage requirements, there are also federal minimum wage requirements. If an employee is covered by both state and federal minimum wage laws, the law which provides a higher minimum wage or sets a higher standard shall apply. For information on federal minimum wage law, contact the U.S. Department of Labor.

2019 Colorado State Minimum Wage:

Pursuant to Article XVIII, Section 15, of the Colorado Constitution, if either of the following two situations applies to an employee, then the employee is entitled to the $11.10 state minimum wage or the $8.08 state tipped employee minimum wage, effective January 1, 2019:

1. The employee is covered by the minimum wage provisions of Colorado Minimum Wage Order Number 35.

2. The employee is covered by the minimum wage provisions of the Fair Labor Standards Act.

The Division accepts complaints for minimum wage violations involving employees who receive the state or federal minimum wage.

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16. Investigations

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18. Recovery of Wages

19. Reprisals

20. Violations

21. Posting Requirements

22. Dual Jurisdiction

1. Coverage:

This Colorado Minimum Wage Order Number 35 regulates wages, hours, working conditions and procedures for certain employers and employees for work performed within the boundaries of the state of Colorado in the following industries:

(A) Retail and Service

(B) Commercial Support Service

(C) Food and Beverage

(D) Health and Medical

2. Definitions:

(A) **Retail and Service:** any business or enterprise that sells or offers for sale, any service, commodity, article, good, real estate, wares, or merchandise to the consuming public, and that generates 50% or more of its annual dollar volume of business from such sales. The retail and service industry offers goods or services that will not be made available for resale. It also includes amusement and recreation, public accommodations, banks, credit unions, savings and loans, and

includes any employee who is engaged in the performance of work connected with or incidental to such business or enterprise, including office personnel.

(B) **Commercial Support Service:** any business or enterprise engaged directly or indirectly in providing services to other commercial firms through the use of service employees who perform duties such as: clerical, keypunching, janitorial, laundry or dry cleaning, security, building or plant maintenance, parking attendants, equipment operations, landscaping and grounds maintenance. Commercial support service also includes temporary help firms which provide employees to any business or enterprise covered by this Wage Order. Any employee, including office personnel, engaged in the performance of work connected with or incidental to such business or enterprise, is covered by the provisions of this Wage Order.

(C) **Food and Beverage:** any business or enterprise that prepares and offers for sale, food or beverages for consumption either on or off the premises. Such business or enterprise includes but is not limited to: restaurants, snack bars, drinking establishments, catering services, fast-food businesses, country clubs and any other business or establishment required to have a food or liquor license or permit, and includes any employee who is engaged in the performance of work connected with or incidental to such business or enterprise, including office personnel.

(D) **Health and Medical:** any business or enterprise engaged in providing medical, dental, surgical or other health services including but not limited to medical and dental offices, hospitals, home health care, hospice care, nursing homes, and mental health centers, and includes any employee who is engaged in the performance of work connected with or incidental to such business or enterprise, including office personnel.

Director: the director of the division of labor standards and statistics.

Division: the division of labor standards and statistics in the Colorado Department of Labor and Employment.

Emancipated Minor: any individual less than eighteen years of age who:

a) has the sole or primary responsibility for his or her own support.

b) is married and living away from parents or guardian.

c) is able to show that his or her well-being is substantially dependent upon being gainfully employed.

Emergency: an unpredictable or unavoidable occurrence at unscheduled intervals requiring immediate action with regard to the employment of minors in overtime situations.

Employee: any person performing labor or services for the benefit of an employer in which the employer may command when, where, and how much labor or services shall be performed. For the purpose of this Wage Order, an individual primarily free from control and direction in the performance of contracted labor or services, and who is customarily engaged in an independent trade, occupation, profession, or business related to the service performed is not an employee.

Employer: every person, firm, partnership, association, corporation, receiver, or other officer of court in Colorado, and any agent or officer thereof, of the above-mentioned classes, employing any person in Colorado, except that the provisions of this Wage Order shall not apply to state, federal and municipal governments or political sub-divisions thereof, including; cities, counties, municipal corporations, quasi-municipal corporations, school districts, and irrigation, reservoir, or drainage conservation companies or special districts organized and existing under the laws of Colorado.

Full Time Employee: for the purpose of the exemption described in section 5(b) of this Wage Order, a full time employee is one who performs work for the benefit of an employer for a minimum of 32 hours per work week.

Regular Rate of Pay: the regular rate of pay actually paid to employees for a standard, non-overtime workweek. The regular rate of pay shall include all compensation paid to employees including the set hourly rate, shift differential, minimum wage tip credit, non-discretionary bonuses, production bonuses, and commissions used for the purpose of calculating the overtime hourly rate for non-exempt employees. Business expenses, bonafide gifts, discretionary bonuses, employer investment contributions, vacation pay, holiday pay, sick leave, jury duty, or other pay for non-work hours may be excluded from the regular rate of pay.

Time Worked: the time during which an employee is subject to the control of an employer, including all the time the employee is suffered or permitted to work whether or not required to do so. Requiring or permitting employees to remain at the place of employment awaiting a decision on job assignment or when to begin work or to perform clean up or other duties "off the clock" shall be considered time worked and said time must be compensated.

a) **Travel Time:** all travel time spent at the control or direction of an employer, excluding normal home to work travel, shall be considered as time worked.

b) **Sleep Time:** where an employee's tour of duty is 24 hours or longer, up to 8 hours of sleeping time can be excluded from overtime compensation, if: (1) an express agreement excluding sleeping time exists; and (2) adequate sleeping facilities for an uninterrupted night's sleep are provided; and (3) at least five hours of sleep are possible during the scheduled sleeping periods; and (4) interruptions to perform duties are considered time worked. When said employee's tour of duty is less than 24 hours, periods during which the employee is permitted to sleep are compensable work time, as long as the employee is on duty and must work when required. Only actual sleep time may be excluded up to a maximum of eight (8) hours per work day. When work related interruptions prevent five (5) hours of sleep, the employee shall be compensated for the entire work day.

Tipped Employee: any employee engaged in an occupation in which he or she customarily and regularly receives more than $30.00 a month in tips. Tips include amounts designated as a "tip" by credit card customers on their charge slips. Nothing herein contained shall prevent an employer covered hereby from requiring employees to share or allocate such tips or gratuities on a pre-established basis among other employees of said business who customarily and regularly receive tips. Employer-required sharing of tips with employees who do not customarily and regularly receive tips, such as management or food preparers, or deduction of credit card processing fees from tipped employees, shall nullify allowable tip credits towards the minimum wage authorized in section 3(c).

Wages or Compensation: all amounts due employees for labor or service; whether the amount is fixed or ascertained by the standard of time, task, piece, commission basis, or other method of calculating the same, or whether the labor or service is performed under contract, subcontract, partnership, subpartnership, station plan, or other agreement, provided that the labor or service is performed personally by the person demanding payment.

Workday: any consecutive twenty-four (24) hour period starting with the same hour each day and the same hour as the beginning of the workweek. The workday is set by the employer and may accommodate flexible work shift scheduling.

Work Shift: the hours an employee is normally scheduled to work within a work day.

Workweek: any consecutive seven (7) day period starting with the same calendar day and hour each week. A workweek is a fixed and recurring period of 168 hours, seven (7) consecutive twenty-four (24) hour periods.

3. Minimum Wage and Allowable Credits:

Minimum Wage: all adult employees and emancipated minors, employed in any of the industries covered herein, whether employed on an hourly, piecework, commission, time, task, or other basis, shall be paid not less than $11.10 effective January 1, 2019, less any applicable lawful credits for all hours worked.

Allowable Credits: the only allowable credits that may be taken by an employer toward the minimum wage are as follows:

a) **Lodging:** the reasonable cost or fair market value for lodging (not to exceed $25.00 per week) furnished by the employer and used by the employee may be considered part of the minimum wage when furnished.

b) **Meals:** the reasonable cost or fair market value of meals provided to the employee may be used as part of the minimum hourly wage. No profits to the employer may be included in the reasonable cost or fair market value of such meals furnished. The meal must be consumed before deductions are permitted.

c) **Tips:** employers of "tipped employees" must pay a cash wage of at least $8.08 per hour if they claim a tip credit against their minimum hourly wage obligation. If an employee's tips combined with the employer's cash wage of at least $8.08 per hour do not equal the minimum hourly wage, the employer must make up the difference in cash wages.

Exception: employees whose physical disability has been certified by the director to significantly impair such disabled employee's ability to perform the duties involved in the employment, and unemancipated minors under 18 years of age, may be paid 15% below the current minimum wage less any applicable lawful credits, for all hours worked.

4. Overtime Hours:

Overtime Rate: employees shall be paid time and one-half of the regular rate of pay for any work in excess of: (1) forty (40) hours per workweek; (2) twelve (12) hours per workday, or (3) twelve (12) consecutive hours without regard to the starting and ending time of the workday (excluding duty free meal periods), whichever calculation results in the greater payment of wages. Hours worked in two or more workweeks shall not be averaged for computation of overtime. Performance of work in two or more positions at different pay rates for the same employer shall be computed at the overtime rate based on the regular rate of pay for the position in which the overtime occurs, or at a weighted average of the rates for each position, as provided in the Fair Labor Standards Act.

Note: the requirement to pay overtime for work in excess of twelve (12) consecutive hours will not alter the employee's established workday or workweek, as previously defined.

Exception: in the event of a bonafide emergency situation, an employer may require minors, subject to the Colorado youth employment opportunity act, to work in excess of eight (8) hours in a twenty-four (24) hour period or in excess of forty (40) hours per week. Said minors shall be compensated at time and one-half the regular rate of pay for all hours worked in excess of eight (8) hours in any twenty-four (24) hour period, or for all work in excess of forty (40) hours per week, whichever calculation results in the greater payment of wages. The employer shall keep specific records to substantiate the existence of a bonafide emergency.

Note: a person under eighteen (18) years of age who has received a high school diploma or a passing grade on a General Education Development (GED) examination, is not considered a minor.

5. Exemptions from the Wage Order:

The following employees or occupations, as defined below, are exempt from all provisions of Minimum Wage Order No. 35: administrative, executive/supervisor, professional, outside sales employees, and elected officials and members of their staff. Other exemptions are: companions, casual babysitters, and domestic employees employed by households or family members to perform duties in private residences, property managers, interstate drivers, driver helpers, loaders or mechanics of motor carriers, taxi cab drivers, and bona fide volunteers. Also exempt are: students employed by sororities, fraternities, college clubs, or dormitories, and students employed in a work experience study program and employees working in laundries of charitable institutions which pay no wages to workers and inmates, or patient workers who work in institutional laundries.

Exemption Definitions:

a) **Administrative Employee:** a salaried individual who directly serves the executive, and regularly performs duties important to the decision-making process of the executive. Said employee regularly exercises independent judgment and discretion in matters of significance and their primary duty is non-manual in nature and directly related to management policies or general business operations.

b) **Executive or Supervisor:** a salaried employee earning in excess of the equivalent of the minimum wage for all hours worked in a workweek. Said employee must supervise the work of at least two full-time employees and have the authority to hire and fire, or to effectively recommend such action. The executive or supervisor must spend a minimum of 50% percent of the workweek in duties directly related to supervision.

c) **Professional:** a salaried individual employed in a field of endeavor who has knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study. The professional employee must be employed in the field in which they are trained to be considered a professional employee.

Note: the requirement that a professional employee must be paid on a salary basis does not apply to doctors, lawyers, teachers, and employees in highly technical computer occupations earning at least $27.63 per hour.

d) **Outside Salesperson:** any person employed primarily away from the employer's place of business or enterprise for the purpose of making sales or obtaining orders or contracts for any commodities, articles, goods, real estate, wares, merchandise or services. Such outside sales employee must spend a minimum of 80% of the workweek in activities directly related to their own outside sales.

6. Exemptions from Overtime:

The following employees are exempt from the overtime provisions of Minimum Wage Order No. 35:

a) **Salespersons, parts-persons, and mechanics** employed by automobile, truck, or farm implement (retail) dealers; salespersons employed by trailer, aircraft and boat (retail) dealers.

b) **Commission Sales Exemption:** sales employees of retail or service industries paid on a commission basis, provided that 50% of their total earnings in a pay period are derived from commission sales, and their regular rate of pay is at least one and one-half times the minimum wage. This exemption is only applicable for employees of retail or service employers who receive in excess of 75% of their annual dollar volume from retail or service sales.

c) **Ski Industry Exemption:** employees of the ski industry performing duties directly related to ski area operations for downhill skiing or snow boarding, and those employees engaged in providing food and beverage services at on-mountain locations, are exempt from the forty (40) hour overtime requirement of this Wage Order. The daily overtime requirement of one and one-half the regular rate of pay for all hours worked in excess of twelve (12) in a workday shall apply. This partial overtime exemption does not apply to ski area employees performing duties related to lodging.

d) **Medical Transportation Exemption:** employees of the medical transportation industry who are scheduled to work twenty-four (24) hour shifts, are exempt from the twelve (12) hour overtime requirement provided they receive overtime wages for hours worked in excess of forty (40) hours per work week.

Note: a hospital or nursing home may seek an agreement with individual employees to pay overtime pursuant to the provisions of the Federal Fair Labor Standards Act "8 and 80 rule", whereby employees are paid time and one-half their regular rate of pay for any work performed in excess of eighty (80) hours in a fourteen (14) consecutive day period and for any work in excess of eight (8) hours per day.

7. Meal Periods:

Employees shall be entitled to an uninterrupted and "duty free" meal period of at least a thirty minute duration when the scheduled work shift exceeds five consecutive hours of work. The employees must be completely relieved of all duties and permitted to pursue personal activities to qualify as a non-work, uncompensated period of time. When the nature of the business activity or other circumstances exist that makes an uninterrupted meal period impractical, the employee shall be permitted to consume an "on-duty" meal while performing duties. Employees shall be permitted to fully consume a meal of choice "on the job" and be fully compensated for the "on-duty" meal period without any loss of time or compensation.

8. Rest Periods:

Every employer shall authorize and permit rest periods, which, insofar as practicable, shall be in the middle of each four (4) hour work period. A compensated ten (10) minute rest period for each four (4) hours or major fractions thereof shall be permitted for all employees. Such rest periods shall not be deducted from the employee's wages. It is not necessary that the employee leave the premises for said rest period.

9. Legal Deductions:

No employer shall make a deduction from the wages or compensation of an employee in violation of the Colorado Wage Act, C.R.S. § 8-4-105 (2018).

10. Presents, Tips, or Gratuities:

It shall be unlawful to deny presents, tips, or gratuities intended for employees in violation of the Colorado Wage Act, C.R.S. § 8-4-103(6) (2018).

11. Wearing of Uniforms:

Where the wearing of a particular uniform or special apparel is a condition of employment, the employer shall pay the cost of purchases, maintenance, and cleaning of the uniforms or special apparel. If the uniform furnished by the employer is plain and washable and does not need or require special care such as ironing, dry cleaning, pressing, etc., the employer need not maintain or pay for cleaning. An employer may require a reasonable deposit (up to one-half of actual cost) as security for the return of each uniform furnished to employees upon issuance of a receipt to the employee for such deposit. The entire deposit shall be returned to the employee when the uniform is returned. The cost of ordinary wear and tear of a uniform or special apparel shall not be deducted from the employee's wages or deposit.

Exception: clothing accepted as ordinary street wear and the ordinary white or any light colored plain and washable uniform need not be furnished by the employer unless a special color, make, pattern, logo or material is required.

12. Record Keeping:

Every employer shall keep at the place of employment or at the employer's principal place of business in Colorado, a true and accurate record for each employee which contains the following information:

a) name, address, social security number, occupation and date of hire of said employee.

b) date of birth, if the employee is under eighteen (18) years of age.

c) daily record of all hours worked.

d) record of allowable credits and declared tips.

e) regular rates of pay, gross wages earned, withholdings made and net amounts paid each pay period.

An itemized earnings statement of this information shall be provided to each employee each pay period. An employer shall retain records reflecting the information contained in an employee’s itemized earnings statement as described in this rule for a period of at least three (3) years after the wages or compensation were due.

13. Administration and Interpretation:

The division shall have jurisdiction over all questions of fact arising with respect to the administration and interpretation of this Wage Order.

14. Separability Clause:

If any section, sentence, clause or phrase of this Wage Order is for any reason held to be invalid, such decision shall not affect the validity of the remaining portion of the Wage Order.

15. Filing of Complaints:

Any person may register with the division, a written complaint that alleges a violation of the Minimum Wage Order within two (2) years of said violation(s), except that all actions brought for a willful violation shall be commenced within three (3) years after the cause of action accrues and not after that time.

16. Investigations:

The director or designated agent shall investigate and take all proceedings necessary to enforce the payment of the minimum wage rate and other alleged violations of this Wage Order, pursuant to these

rules and the Colorado Wage Act, C.R.S. § 8-4-101, et seq. (2018). Violations of this Wage Order may be subject to the administrative procedure as described in the Colorado Wage Act, C.R.S. § 8-4-101, et seq.

17. Enforcement:

The director has the power, in person or through any authorized representative, to inspect, examine and make excerpts from any book, reports, contracts, payrolls, documents, papers, and other records of any employer that in any way pertain to the question of wages, and to require from any such employer full and true statement of the wages paid.

18. Recovery of Wages:

An employee receiving less than the legal minimum wage applicable to such employee is entitled to recover in a civil action the unpaid balance of the full amount of such minimum wage, together with reasonable attorney fees and court costs, notwithstanding any agreement to work for a lesser wage, pursuant to C.R.S. § 8-6-118 (2018). Alternatively, an employee may elect to pursue a minimum wage complaint through the division's administrative procedure as described in the Colorado Wage Act, C.R.S. § 8-4-101, et seq. (2018).

19. Reprisals:

Employers shall not threaten, coerce, or discharge any employee because of participation in any investigation or hearing relating to the minimum wage act. Violators may be subject to a fine of not less than two hundred dollars ($200.00), up to one thousand dollars ($1,000.00) for each violation, pursuant to C.R.S. § 8-6-115 (2018).

20. Violations:

Any employer or other person who individually or as an officer, agent or employee of a corporation or other person, pays or causes to be paid an employee covered by this Wage Order less than the minimum wage, is guilty of a misdemeanor. Conviction thereof will subject the offender to a fine of not less than one hundred dollars ($100.00), nor more than five hundred dollars ($500.00), or by imprisonment in the county jail for not less than thirty (30) days, nor more than one (1) year, or both such fine and imprisonment, pursuant to C.R.S. § 8-6-116 (2018).

21. Posting Requirements:

Every employer subject to this Wage Order must display a Wage Order poster in an area frequented by employees where it may be easily read during the work day. If the work site or other conditions make this unpractical, the employer shall keep a copy of this Wage Order and make it available to employees upon request.

22. Dual Jurisdiction:

Whenever employers are subjected to both federal and Colorado law, the law providing greater protection or setting the higher standard shall apply. For information on the federal law contact the nearest office of the U.S. Department of Labor, Wage and Hour Division.

Annotations

Wrongful discharge in violation of public policy was based upon not receiving rest and lunch breaks in violation of Wage Order No. 22, sections 7 and 8, promulgated by the Colorado Department of Labor

and Employment. *Bonidy v. Vail Valley Ctr. for Aesthetic Dentistry, P.C., and James J. Harding, DDS., Colo. App. 06CA1849*

STATEMENT OF BASIS AND PURPOSE
FOR
COLORADO MINIMUM WAGE ORDER NUMBER 35
7 C.C.R. 1103-1

BASIS: C.R.S. § 8-1-107(2)(p), § 8-6-106, § 8-6-108(2), and § 8-6-109 (2018) provide the Director of the Division of Labor Standards and Statistics with the authority to adopt rules and regulations pertaining to state minimum wage rates and workplace conditions.

PURPOSE: The purpose of Colorado Minimum Wage Order Number 35 is to reflect the new state minimum wage of $11.10 per hour.

The new state minimum wage is required by Article XVIII, Section 15 of the Colorado Constitution, which provides:

> Section 15. State minimum wage rate.
> Effective January 1, 2017, Colorado's minimum wage is increased to $9.30 per hour and is increased annually by 0.90 each January 1 until it reaches $12 per hour effective January 2020, and thereafter is adjusted annually for cost of living increases, as measured by the Consumer Price Index used for Colorado. This minimum wage shall be paid to employees who receive the state or federal minimum wage. No more than $3.02 per hour in tip income may be used to offset the minimum wage of employees who regularly receive tips.

Pursuant to C.R.S. § 24-4-103(4)(b), the Director finds that: 1) there is a demonstrated need for the rules; 2) the proper statutory authority exists for the rules; 3) to the extent practicable, the rules are clearly stated so that their meaning will be understood by any party required to comply with the rules; 4) the rules do not conflict with other provisions of law; and 5) the duplicating or overlapping of the rules is explained by the agency proposing the rules.

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF LABOR STANDARDS AND STATISTICS

NOTICE OF PUBLIC HEARING CONCERNING COLORADO MINIMUM WAGE ORDER NUMBER 35

Notice is hereby given of a public hearing to afford all interested persons an opportunity to be heard prior to the adoption of the Colorado Minimum Wage Order Number 35: 7 C.C.R. 1103-1 under the authority granted the Division of Labor Standards and Statistics in C.R.S. § 8-1-107(2)(p), § 8-6-106, § 8-6-108(2), and § 8-6-109 (2018).

Date and Time of Hearing: **Tuesday, November 6, 2018, at 1:00 p.m.**

Place of Hearing: **Colorado Division of Labor Standards and Statistics**
633 17th Street, 6th Floor
Denver, CO 80202

This hearing will be held in accordance with the Colorado Administrative Procedure Act, C.R.S. § 24-4-l01, et seq. (2018), to receive any testimony, written data, views, or arguments that interested parties may wish to submit regarding the proposed rules.

Colorado Minimum Wage Order Number 35:

It is proposed, in accordance with Article XVIII, Section 15, of the Colorado Constitution, that the Director of the Division of Labor Standards and Statistics adopt Colorado Minimum Wage Order Number 35, 7 C.C.R. 1103-1, to reflect the new state minimum wage.

Pursuant to Article XVIII, Section 15, of the Colorado Constitution, Colorado Minimum Wage Order Number 35 will establish a new state minimum wage of $11.10 per hour, effective January 1, 2019.

Colorado Minimum Wage Order Number 35 differs from the current Colorado Minimum Wage Order Number 34 in the state minimum wage.

Copies of the proposed sets of rules shall be available at least five days before the hearing at www.coloradolaborlaw.gov or:

Colorado Division of Labor Standards and Statistics
633 17th Street, Suite 600
Denver, Colorado 80202

To ensure sufficient time for consideration prior to adopting final rules, comments must be provided to the Division by 5:00 pm on Thursday, November 8, 2018. Comments will be accepted at any time prior to the hearing.

Comments may be delivered by mail, faxed to 303-318-8400, or emailed to michael.primo@state.co.us

Comment Deadline: by 5:00 pm, Thursday, November 8, 2018

Notice of Proposed Rulemaking

Tracking number

2018-00538

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 - STATEMENT OF BASIS AND PURPOSE, AND RULE HISTORY

Rulemaking Hearing

Date

11/09/2018

Time

09:00 AM

Location

303 East 17th Avenue, 11th Floor, Denver, CO 80203

Subjects and issues involved

See attached

Statutory authority

25.5-1-301 through 25.5-1-303, C.R.S. (2017)

Contact information

Name

Chris Sykes

Title

Medical Services Board Coordinator

Telephone

3038664416

Email

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, November 9, 2018, beginning at 9:00 a.m., in the eleventh floor conference room at 303 East 17th Avenue, Denver, CO 80203. Reasonable accommodations will be provided upon request for persons with disabilities. Please notify the Board Coordinator at 303-866-4416 or chris.sykes@state.co.us or the 504/ADA Coordinator hcpf504ada@state.co.us at least one week prior to the meeting.

A copy of the full text of these proposed rule changes is available for review from the Medical Services Board Office, 1570 Grant Street, Denver, Colorado 80203, (303) 866-4416, fax (303) 866-4411. Written comments may be submitted to the Medical Services Board Office on or before close of business the Wednesday prior to the meeting. Additionally, the full text of all proposed changes will be available approximately one week prior to the meeting on the Department's website at www.colorado.gov/hcpf/medical-services-board.

This notice is submitted pursuant to § 24-4-103(3)(a) and (11)(a), C.R.S.

MSB 18-08-08-A, Revision to the Medical Assistance Rule concerning Adding Community or Facility Based care to CLLI Respite Services, Section 8.504
Medical Assistance. Home and Community Based Services (HCBS) for Children with Life Limiting Illness (CLLI) Waiver. The Respite Care definition and Respite Care Benefit definition are being amended to include the community or an approved respite center as service location. The rules implementing respite care services for the program are located at 10 C.C.R. 2505-10, Sections 8.504.01.N (Respite Care definition) and 8.504.2.F (Respite Care Benefit definition).

The authority for this rule is contained in 25.5-1-301 through 25.5-1-303, C.R.S. (2017) and C.R.S 25.5-5-305 (2018).

MSB 18-07-06-A, Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Supportive Living Programs, Section 8.515.85
Medical Assistance. HCBS Benefit Rule Concerning Supportive Living Programs, Section 8.515.85 The intention of this rule is to correct citations to the recently updated Assisted Living Residence (ALR) rule within the Supportive Living Programs (SLP) rule, as all SLP providers are required to be licensed as ALRs and are subject to the updated ALR regulations.

The authority for this rule is contained in 25.5-1-301 through 25.5-1-303, C.R.S. (2017) and 25.5-6-704, C.R.S. (2017).

MSB 18-02-12-C, Revision to the Medical Assistance Rule concerning Reimbursement of Nursing Facilities Serving Clients Who Meet the Hospital Back Up Level of Care, Section 8.740.7

Medical Assistance. The Department is implemented a new Hospital Back Up reimbursement methodology to standardize rate setting and eliminate rate negotiations that result in delayed admission; therefore, the rules concerning Hospital Back Up reimbursement, 10 C.C.R. 2505-10, Section 8.470.7, are being revised to replace the current reimbursement methodology to the revised methodology, which will Providers be reimbursed a standardized rate based upon the federally mandated Minimum Data Set that will be effective January 1st, 2019.

The authority for this rule is contained in 42 CFR part 483, subpart B; 25.5-6-201 through 203 and 25.5-1-301 through 25.5-1-303, C.R.S. (2017).

MSB 18-08-24-A, Revision to the Medical Assistance Rule concerning Case Management, Sections 8.393, 8.500.1, 8.500.6, 8.500.12, 8.500.16, 8.500.90, 8.500.95, 8.500.101, 8.500.106, 8.503, 8.503.50, 8.503.120, 8.503.160, 8.600.2, 8.600.4, 8.602.5, 8.607, 8.608, 8.609, 8.611, 8.612.1, 8.612.2, 8.612.3 8.760, 8.761.3 and 8.761.4

Medical Assistance. The above rules have been revised and a new 8.519 section is being added to implement House Bill 17-1343, which requires the Department of Health Care Policy and Financing (Department) to implement Conflict Free Case Management for individuals with intellectual and developmental disabilities and to develop Case Management Agency and Case Manager qualifications.

The Department worked with an outside expert and stakeholders in the development of Case Manager and Case Management Agency qualifications. Many stakeholder meetings occurred along with an informal comment period for stakeholders to send feedback via email. The Department has taken recommendations from stakeholders and applied those changes to the proposed rule where possible, and discussed with stakeholders any recommendations the Department could not adopt at this time.

Additionally, the Department incorporated functions of case management from existing regulations.

The authority for this rule is contained in 25.5-10-211.5, 25.5-1-301 through 25.5-1-303, C.R.S. (2017).

MSB 18-08-16-A, Revision to the Medical Assistance Rule concerning Targeted Case Management – Transition Services, Sections 8.519 and 8.760

Medical Assistance. The statute authorizing HB18-1326 - Support For Transition From Institutional Settings was signed into law on April 30, 2018. Therefore, the rules implementing the program, 10 CCR 2505-10, section 8.519, and 10 CCR 2505-10, section 8.763 are being revised to include new sections specific to this program. The authority for this is found in the Colorado Medicaid State Plan, pending federal approval of the State Plan Amendment.

The authority for this rule is contained in 42 CFR § 441.18; 25.5-1-301 through 25.5-1-303, 25.5.-10-209.5 and CRS 25.5-6-106 C.R.S. (2017).

MSB 18-08-21-A, Revision to the Medical Assistance Rule concerning Transition Independent Living Skills Training, Transition Setup Expenses, Home Delivered Meals, and Peer Mentorship, Sections 8.485 and 8.500

Medical Assistance. The purpose of § 6-1501, 25.5 C.R.S. and the proposed 8.553 is to ensure a successful transition, by regulating services and supports after the transition. The Department is to implement, through six adult HCBS waivers, transition services and supports that allow eligible persons to receive services to support a successful transition from an institutional setting to a Home- or Community-Based setting. The services and supports include Transition Independent Living Skills Training, Transition Setup Expenses, Home Delivered Meals, and Peer Mentorship.

Federally required assessments indicate that more persons living in institutional settings expressed an interest in transitioning to home- or community-based settings than currently have transitions available to them. In order to ensure a successful transition, such persons will need ongoing services and supports after the transition. To serve these purposes, the Department is to implement community transition services and supports that allow eligible persons to receive services to support a successful transition from an institutional setting to a Home- or Community-Based setting. The Department is seeking to implement services to support these purposes through upcoming waiver renewals.

The authority for this rule is contained in 2 U.S.C. 1396n, section 1915(c); 25.5-6-1501 C.R.S. (2018) and 25.5-1-301 through 25.5-1-303, C.R.S. (2017).

MSB 18-06-15-A, Revision to the Medical Assistance Rule concerning Adding Provider Types to FQHC, Section 8.700

Medical Assistance. The rule changes the definition of a payable encounter at Federally Qualified Health Centers. The amended rule adds the supervised mental health license candidates to the provider types that can generate a billable encounter.

The rule is necessary to maintain access to mental health services at FQHCs. Without the rule, FQHCs will be unable to provide the services with the provider types that had been providing the services in the past. The change maintains care practices that were present prior to July 1, 2018.

The authority for this rule is contained in 42 USC 1396a(bb); 25.5-5-102(d), 25.5-5-102(m), 25.5-4-401(1)(a) and 25.5-1-301 through 25.5-1-303, C.R.S. (2017).

Notice of Proposed Rulemaking

Tracking number

2018-00493

Department

500,1008,2500 - Department of Human Services

Agency

2509 - Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)

CCR number

12 CCR 2509-8

Rule title

CHILD CARE FACILITY LICENSING

Rulemaking Hearing

Date

11/02/2018

Time

08:30 AM

Location

1575 Sherman Street, Denver, CO 80203

Subjects and issues involved

Senate Bill 18-162 creating a new less than 24 hour license type was signed into law April 12, 2018 requiring the Department to promulgate a new rule set for the new license type. This package adds new rules regarding the creation of a Substitute Placement Agency.

Statutory authority

26-1-107, C.R.S. (2017)
26-1-109, C.R.S. (2017)
26-1-111, C.R.S. (2017)
26-6-103.3, C.R.S. (2017)
26-6-106(1)(a), C.R.S. (2017)

Contact information

Name

Kathi Wagoner

Title

Rule Author

Telephone

3038665188

Email

kathi.wagoner@state.co.us

Title of Proposed Rule:	**Substitute Placement Agency for Less Than 24 Hour Care Facilities**	
CDHS Tracking #:	**18-07-23-01**	
Office, Division, & Program:	Rule Author:	Phone: 303-866-5188
OEC, ECL, DECL, Licensing	Kathi Wagoner	E-Mail: kathi.wagoner@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 [ ] Initial Board Reading [ ] AG 2nd Review [ ] Second Board Reading / Adoption

This package contains the following types of rules: *(check all that apply)*

Number	
	Amended Rules
X	New Rules
	Repealed Rules
	Reviewed Rules

What month is being requested for this rule to first go before the State Board?	October 2018

What date is being requested for this rule to be effective?	December 2018
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 10/5/18 2nd Board 11/2/18 Effective Date 12/31/18

Title of Proposed Rule:	**Substitute Placement Agency for Less Than 24 Hour Care Facilities**	
CDHS Tracking #:	**18-07-23-01**	
Office, Division, & Program:	Rule Author:	Phone: 303-866-5188
OEC, ECL, DECL, Licensing	Kathi Wagoner	E-Mail: kathi.wagoner@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.

Senate Bill 18-162 creating a new less than 24 hour license type was signed into law April 12, 2018 requiring the Department to promulgate a new rule set for the new license type. This package adds new rules regarding the creation of a Substitute Placement Agency.

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

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

Justification for emergency:

State Board Authority for Rule:

Code	Description
26-1-107, C.R.S. (2017)	State Board to promulgate rules
26-1-109, C.R.S. (2017)	State department rules to coordinate with federal programs
26-1-111, C.R.S. (2017)	State department to promulgate rules for public assistance and welfare activities.

Program Authority for Rule: *Give federal and/or state citations and a summary of the language authorizing the rule-making function AND authority.*

Code	Description
26-6-103.3, C.R.S. (2017)	Substitute Placement Agency
26-6-106(1)(a), C.R.S. (2017)	Standards for facilities and agencies, and authority to promulgate rules;

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

If yes, please explain. The statutory definition of a Substitute Placement Agency is found in this packet.

Title of Proposed Rule:	**Substitute Placement Agency for Less Than 24 Hour Care Facilities**	
CDHS Tracking #:	**18-07-23-01**	
Office, Division, & Program:	Rule Author:	Phone: 303-866-5188
OEC, ECL, DECL, Licensing	Kathi Wagoner	E-Mail: kathi.wagoner@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?

Family Child Care Home Providers, Child Care Centers, Preschools and School Age Child Care will benefit from this by having a more robust substitute pool to use as needed. Parents and families will also benefit as child care providers will have more flexibility in using qualified substitutes when regular staff members are absent so that classrooms do not have to close due to those absences.

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?

Because the reauthorization of the Child Care Development Block Grant requires background checks be complete prior to working with children, legislation was passed to better facilitate placement of qualified, background checked, substitute employees by creating a new facility license-type – Substitute Placement Agency. The Department needs to have a facility license to attach the background checks so that the Agency and the Department can monitor for any disqualifying arrests or convictions. All licensed Family Child Care Home Providers, Child Care Centers, Preschools and School Age Child Care providers will have the ability to use substitutes who meet all required qualifications, including background checks.

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.

State Fiscal Impact *(Identify all state agencies with a fiscal impact, including any Colorado Benefits Management System (CBMS) change request costs required to implement this rule change)*

There is no direct fiscal impact to the state due this rule package. The State fiscal impact, as addressed in the legislation, will be absorbed through the assessment and collection of application and annual continuation fees for this new license type.

County Fiscal Impact

No impact because counties will not be responsible for the regulatory oversight of the Substitute Placement Agencies nor will Substitute Agencies be eligible for CCCAP subsidies.

Federal Fiscal Impact

No negative fiscal impact, as these rules allow the Department to meet Federal standards.

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

New applicants and licensee's holding the substitute placement agency license will be required to pay an application and annual license continuation fee. There will be some costs associated with the administrative duties associated with employee record-keeping in order to comply with federal and state law.

Title of Proposed Rule:	**Substitute Placement Agency for Less Than 24 Hour Care Facilities**	
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OEC, ECL, DECL, Licensing	Kathi Wagoner	E-Mail: kathi.wagoner@state.co.us

4. Data Description

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

Reviewed existing models in Colorado including school districts, other states who have developed similar substitute programs including Washington, Tennessee, Illinois and North Carolina. Reviewed articles including: "Creating a Successful Child Care Substitute Program" and Creating a substitute Bank for Child Care Centers" and Paving Pathways report". Conducted focus groups with various stakeholders including family child care home providers, child care center directors, two existing child care substitute placement agencies, The Rocky Mountain Early Childhood Council, Early Connections Learning Center, Clayton Early Learning Center, CDE, Colorado Children's Campaign; Child Care resource Center at the City of Aspen; Transforming the Workforce 20/20 work group, peer to peer phone conversation with Department of Early Learning in Washington State;

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.

No alternative to the rule making as this is a new license type created by SB18-162.

Title of Proposed Rule:	**Substitute Placement Agency for Less Than 24 Hour Care Facilities**	
CDHS Tracking #:	**18-07-23-01**	
Office, Division, & Program:	Rule Author:	Phone: 303-866-5188
OEC, ECL, DECL, Licensing	Kathi Wagoner	E-Mail: kathi.wagoner@state.co.us

OVERVIEW OF PROPOSED RULE

Compare and/or contrast the content of the current regulation and the proposed change.

Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
7.730.1	Definitions	None, New Rule Set	Definitions for the benefit of the licensee	Describes definitions for the benefit of new SPA governing bodies.	No
7.730.11	Governing Body	None, New Rule Set	Identifies the Governing Body is requirements	Best practice	No
7.730.2	Personnel	None, New Rule Set	Identifies general requirements for substitutes employed by the Governing Body.	Best practice	
7.730.22	Personnel Policies, Orientation and Staff Development	None, New Rule Set	Identifies substitute qualifications for Emergency, Short-Term and Long Term Substitutes	Federal and state requirements for training and personnel	Yes
7.730.23	Substitute Qualifications	None, New Rule Set	Identifies qualifications for the Substitute Placement Agency regarding employment of Substitutes Placed in Child Care Centers	Matches language found in other rule sets	Yes
7.730.24	Family Child Care Home Substitute Qualifications	None, New Rule Set	Identifies qualifications for the Substitute Placement Agency regarding employment of Substitutes placed in Family Child Care Homes	Matches language found in other rule sets	Yes
7.730.25	School age child care substitute qualifications	None, New Rule Set	Identifies qualifications for the Substitute Placement Agency regarding employment of Substitutes placed in School Age Child Care	Matches language found in other rule sets	No
7.730.26	Personnel Files	None, New Rule Set	Identifies requirements for the Substitute Placement Agency personnel files	Matches language found in other rule sets	Yes
7.730.31	Control of Communicable Disease	None, New Rule Set	Identifies requirements for reporting and placement of Substitutes who have been exposed to a communicable disease while placed in a child care facility.	Health and safety for children	Yes
7.730.41	Administrative Records and Reports	None, New Rule Set	Identifies general requirements for the Substitute Placement Agency for maintaining records and reports	Best practice	No

Title of Proposed Rule:	**Substitute Placement Agency for Less Than 24 Hour Care Facilities**	
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Office, Division, & Program:	Rule Author:	Phone: 303-866-5188
OEC, ECL, DECL, Licensing	Kathi Wagoner	E-Mail: kathi.wagoner@state.co.us

STAKEHOLDER COMMENT SUMMARY

Development

The following individuals and/or entities were included in the development of these proposed rules (such as other Program Areas, Legislative Liaison, and Sub-PAC):

Colorado Children's Campaign, Denver Early Childhood Council, Take-A-Break Child Care, Colorado Substitutes, Colorado Children's Hospital, Healthy Child Care Colorado, Early Childhood Education Association of Colorado, Arapahoe Community College Early Childhood Department, Red Rocks Community College Child Care Innovations.

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:

All licensed less-than-24-hour child care facilities, substitute placement agencies currently operating, but not licensed by CDHS.

Other State Agencies

Are other State Agencies (such as HCPF or CDPHE) impacted by these rules? If so, have they been contacted and provided input on the proposed rules?

[ ] Yes [X] No

If yes, who was contacted and what was their input?

Sub-PAC

Have these rules been reviewed by the appropriate Sub-PAC Committee?

[X] Yes [ ] No

Name of Sub-PAC	Early Childhood		
Date presented	7/12/18, 8/2/18, 9/6/18		
What issues were raised?	Add qualifications for Assistant ECT and staff aide to packet		
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.			

PAC

Have these rules been approved by PAC?

[ ] Yes [ ] No

Date presented			
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:

[X] Yes [ ] No

If "yes" to any of the above questions, summarize and/or attach the feedback received, including requests made by the State Board of Human Services, by specifying the section and including the Department/Office/Division response. Provide proof of agreement or ongoing issues with a letter or public testimony by the stakeholder.

Color Code: Purple: Public Comment

Proposed Rules for the Substitute Placement Agency Rules

(12 CCR 2509-8)

THESE RULES WILL ADDRESS THE OPERATION OF A SUBSTITUTE PLACEMENT AGENCY THAT PLACES A SUBSTITUTE CHILD CARE TEACHER OR DIRECTOR INTO A LICENSED CHILD CARE FACILITY FOR THE PURPOSE OF PROVIDING EMERGENCY, SHORT TERM OR LONG TERM SUBSTITUTE CHILD CARE.
12 CCR 2509-8

7.730 RULES REGULATING SUBSTITUTE PLACEMENT AGENCIES

ALL SUBSTITUTE PLACEMENT AGENCIES MUST COMPLY WITH THE CURRENT "GENERAL RULES FOR CHILD CARE FACILITIES" 7.701 AND "RULES REGULATING SUBSTITUTE PLACEMENT AGENCIES (LESS THAN 24-HOUR CARE)"

7.730.1 DEFINITIONS

A. "ADVERSE OR NEGATIVE LICENSING ACTION" MEANS A FINAL AGENCY ACTION RESULTING IN THE DENIAL OF AN APPLICATION, THE IMPOSITION OF FINES, OR THE SUSPENSION OR REVOCATION OF A LICENSE OR THE DEMOTION OF SUCH A LICENSE TO A PROBATIONARY LICENSE.

B. "ARRANGE FOR PLACEMENT" MEANS TO ACT AS AN INTERMEDIARY BY ASSISTING A CHILD CARE FACILITY IN THE PLACEMENT OF A SUBSTITUTE CHILD CARE PROVIDER.

C. "BACKGROUND CHECKS" MEANS A SET OF REQUIRED RECORDS THAT ARE OBTAINED AND ANALYZED TO DETERMINE WHETHER THE HISTORY OF A PROSPECTIVE SUBSTITUTE CHILD CARE EMPLOYEE MEETS LEGAL AND SAFETY CRITERIA WHEN CONSIDERING THE PLACEMENT OF THE INDIVIDUAL IN A LESS THAN 24 HOUR CHILD CARE FACILITY.

D. "CHILD CARE CENTER" MEANS A LICENSED CHILD CARE CENTER, PRESCHOOL OR LICENSED SCHOOL AGE CHILD CARE CENTER.

E. "EMPLOYEE" MEANS ANY INDIVIDUAL WHETHER EMPLOYED BY OR CONTRACTED THROUGH THE AGENCY.

F. “EMERGENCY CHILD CARE CENTER SUBSTITUTE” MEANS A SUBSTITUTE WHO WORKS IN PLACE OF A REGULAR STAFF MEMBER IN A CHILD CARE FACILITY WHO IS UNABLE TO WORK THEIR NORMALLY SCHEDULED WORK HOURS DUE TO AN UNEXPECTED EVENT SUCH AS AN ABSENCE OF A STAFF MEMBER OR PERSONAL EMERGENCY EVENT. THE PURPOSE OF THE EMERGENCY SUBSTITUTE IS TO PROVIDE COVERAGE FOR A STAFF MEMBER FOR NO MORE THAN THREE (3) CALENDAR DAYS.

G. “EMERGENCY FAMILY CHILD CARE HOME SUBSTITUTE” MEANS A SUBSTITUTE WHO WORKS IN PLACE OF A FAMILY CHILD CARE HOME PROVIDER WHO IS UNABLE TO WORK THEIR NORMALLY SCHEDULED WORK HOURS DUE TO AN UNEXPECTED EVENT SUCH AS AN ILLNESS OR PERSONAL EMERGENCY EVENT. THE PURPOSE OF THE EMERGENCY SUBSTITUTE IS TO PROVIDE COVERAGE FOR A FAMILY CHILD CARE HOME PROVIDER UNTIL PARENTS ARE ABLE TO PICK UP THE CHILDREN IN CARE.

H. “EQUALLY QUALIFIED” MEANS THAT THE EMPLOYEE OR SUBSTITUTE PROVIDER HAS THE SAME REQUIRED TRAINING AND QUALIFICATIONS AS THE PRIMARY PROVIDER AS SPECIFIED IN THE RULES REGULATING FAMILY CHILD CARE HOMES; RULES REGULATING CHILD CARE CENTERS OR RULES REGULATING SCHOOL AGE CHILD CARE.

I. “FAMILY CHILD CARE HOME” MEANS A CHILD CARE FACILITY LOCATED WITHIN A RESIDENCE OF A PRIMARY PROVIDER.

J. “LICENSING” MEANS THE PROCESS BY WHICH THE COLORADO DEPARTMENT OF HUMAN SERVICES APPROVES A FACILITY OR AGENCY FOR THE PURPOSE OF CONDUCTING BUSINESS AS A CHILD CARE FACILITY AND/OR SUBSTITUTE PLACEMENT AGENCY.

K. “LONG TERM CHILD CARE CENTER SUBSTITUTE” MEANS A SUBSTITUTE WHO WORKS IN PLACE OF A REGULAR STAFF MEMBER WHO IS UNABLE TO WORK THEIR NORMALLY SCHEDULED WORK HOURS DUE TO A PLANNED OR UNPLANNED EVENT THAT REQUIRES THE REGULAR STAFF MEMBER BE ON LEAVE FOR MORE THAN TWO (2) CALENDAR WEEKS.

L. “LONG TERM FAMILY CHILD CARE HOME SUBSTITUTE” MEANS A SUBSTITUTE WHO WORKS IN PLACE OF A REGULAR FAMILY CHILD CARE HOME PROVIDER

WHO IS UNABLE TO WORK THEIR NORMALLY SCHEDULED WORK HOURS DUE TO A PLANNED OR UNPLANNED EVENT THAT REQUIRES THE REGULAR FAMILY CHILD CARE HOME PROVIDER TO BE ON LEAVE FOR MORE THAN TWO (2) CALENDAR WEEKS.

M. “SHORT TERM CHILD CARE CENTER SUBSTITUTE” MEANS A SUBSTITUTE WHO WORKS IN PLACE OF A REGULAR STAFF MEMBER WHO IS UNABLE TO WORK THEIR NORMALLY SCHEDULED WORK HOURS DUE TO A PLANNED OR UNPLANNED EVENT THAT REQUIRES THE REGULAR STAFF MEMBER BE ON LEAVE FOR MORE THAN THREE (3) DAYS AND LESS THAN TWO (2) CALENDAR WEEKS.

N. “SHORT TERM FAMILY CHILD CARE HOME SUBSTITUTE” MEANS A SUBSTITUTE WHO WORKS IN PLACE OF A REGULAR FAMILY CHILD CARE HOME WHO IS UNABLE TO WORK THEIR NORMALLY SCHEDULED WORK HOURS DUE TO A PLANNED OR UNPLANNED EVENT THAT REQUIRES THE REGULAR FAMILY CHILD CARE HOME TO BE ON LEAVE FOR MORE THAN THREE (3) DAYS AND LESS THAN TWO (2) CALENDAR WEEKS.

O. "SUBSTITUTE CHILD CARE PROVIDER," DEFINED AT SECTION 26-6-102(37), C.R.S., MEANS AN ADULT OVER THE AGE OF EIGHTEEN (18) YEARS WHO PROVIDES TEMPORARY CARE FOR A CHILD OR CHILDREN IN A LICENSED CHILD CARE FACILITY, INCLUDING A CHILD CARE CENTER, PRESCHOOL, SCHOOL AGE CHILD CENTER OR A FAMILY CHILD CARE HOME.

P. “SUBSTITUTE PLACEMENT AGENCY,” DEFINED AT SECTION 26-6-102(37.5), C.R.S., MEANS ANY CORPORATION, PARTNERSHIP, ASSOCIATION, FIRM, AGENCY, OR INSTITUTION THAT PLACES OR THAT FACILITATES OR ARRANGES PLACEMENT OF EMERGENCY, SHORT-TERM OR LONG-TERM SUBSTITUTE CHILD CARE PROVIDERS IN LICENSED CHILD CARE FACILITIES PROVIDING LESS THAN TWENTY-FOUR-HOUR CARE.

Q. “SUBSTITUTE PLACEMENT,” MEANS TO COORDINATE, ARRANGE, AND APPROVE THE PROCESS OF AN ADULT SUBSTITUTE CHILD CARE PROVIDER ENTERING AN UNRELATED FAMILY CHILD CARE HOME OR CHILD CARE FACILITY TO PROVIDE SUBSTITUTE CHILD CARE SERVICES ON AN EMERGENCY, TEMPORARY/SHORT TERM OR LONG-TERM ASSIGNMENT. SUBSTITUTES MAY BE EMPLOYEES OR CONTRACT EMPLOYEES OF THE AGENCY.

7.730.11 GOVERNING BODY

THE GOVERNING BODY MUST BE IDENTIFIED BY ITS LEGAL NAME. THE NAMES AND ADDRESSES OF INDIVIDUALS WHO HOLD PRIMARY FINANCIAL CONTROL AND OFFICERS OF THE GOVERNING BODY MUST BE DISCLOSED FULLY TO THE COLORADO DEPARTMENT OF HUMAN SERVICES. THE GOVERNING BODY IS RESPONSIBLE FOR PROVIDING ADEQUATE FINANCING, QUALIFIED PERSONNEL, SERVICES, AND PROGRAM FUNCTIONS FOR THE SAFETY AND WELL-BEING OF CHILDREN IN ACCORDANCE WITH THESE RULES. WHEN CHANGES OF GOVERNING BODY OCCUR, THE NEW GOVERNING BODY MUST IMMEDIATELY SUBMIT AN ORIGINAL APPLICATION AND PAY THE REQUIRED FEE BEFORE A NEW LICENSE CAN BE ISSUED.

A. A SUBSTITUTE PLACEMENT AGENCY, HEREIN REFERRED TO AS “THE AGENCY” MAY NOT BE OPERATED WITHOUT A LICENSE, AS REQUIRED BY LAW, TO BE ISSUED BY THE STATE DEPARTMENT IN CONFORMITY WITH ALL RULES AND REGULATIONS.

B. THE SUBSTITUTE PLACEMENT AGENCY MUST:

1. MAINTAIN THE WRITTEN PURPOSE AND POLICIES FOR THE GENERAL OPERATION AND MANAGEMENT OF THE AGENCY, INCLUDING THE PLACEMENT OF SUBSTITUTES. WHEN SUCH PURPOSE AND POLICIES ARE REVIEWED AND REVISED, THE STATE DEPARTMENT MUST BE ADVISED OF SUCH CHANGES. THE PURPOSE AND POLICIES AT A MINIMUM MUST INCLUDE:

1) THE TYPES OF CHILD CARE FACILITIES IN WHICH SUBSTITUTES WILL BE PLACED, INCLUDING THE AGES OF CHILDREN SERVED AT THE CHILD CARE FACILITY WHERE SUBSTITUTES WILL BE PLACED AND THE GEOGRAPHIC AREA(S) THE AGENCY EXPECTS TO SERVE;

2) THE RESPONSIBILITIES FOR CHILD CARE FACILITIES UTILIZING THE SUBSTITUTE PLACEMENT AGENCY;

3) ITEMIZED FEE SCHEDULE, INCLUDING CLIENT SET UP FEES, IF APPLICABLE;

4) REFUND POLICY;

5) CANCELLATION POLICY;

6) MILEAGE/TRAVEL POLICY;

7) MINIMUM SCHEDULED TIME POLICY;

8) SERVICES AND TYPES OF SUBSTITUTES AVAILABLE TO THE COMMUNITY;

9) THE RESPONSIBILITIES OF THE AGENCY AND THE CHILD CARE FACILITY FOR REPORTING SUSPECTED CHILD ABUSE OR NEGLECT;

2. BOTH THE AGENCY AND THE CHILD CARE FACILITY MUST HAVE A FULLY EXECUTED, SIGNED CONTRACT PRIOR TO PLACING SUBSTITUTES IN THE CHILD CARE FACILITY.

3. DEVELOP AND IMPLEMENT PERSONNEL POLICIES INCLUDING, BUT NOT LIMITED TO:

a. JOB DESCRIPTIONS FOR SUBSTITUTES;

b. QUALIFICATIONS FOR THE POSITION IN ACCORDANCE WITH CURRENT LICENSING STANDARDS;

c. THE DUTIES AND RESPONSIBILITIES OF SUBSTITUTES;

d. THE RESPONSIBILITIES OF THE SUBSTITUTE WITHIN A CHILD CARE FACILITY;

e. THE PROPER SUPERVISION OF CHILDREN;

f. PROPER GUIDANCE TECHNIQUES;

g. PROPER NAME TO FACE ATTENDANCE AND TRANSITIONS;

h. THE IDENTIFICATION AND SYMPTOMS OF SUSPECTED CHILD ABUSE OR NEGLECT; AND

i. THE REPORTING OF SUSPECTED CHILD ABUSE, INCLUDING THE STATEWIDE CHILD ABUSE REPORTING HOTLINE.

4. SUBSTITUTES MUST BE INFORMED OF THEIR DUTIES AT THE TIME OF EMPLOYMENT OR ACCEPTANCE OF A CONTRACT WITH THE AGENCY, AND BEFORE BEING PLACED IN A CHILD CARE FACILITY.

5. INFORM THE DEPARTMENT, IN WRITING, OF:

a. A CHANGE IN THE EXECUTIVE DIRECTOR OR THE MAIN CONTACT OF THE AGENCY WITHIN TEN (10) CALENDAR DAYS.

b. THE HOURS OF OPERATION THE AGENCY OFFICE IS OPEN AND AVAILABLE FOR INSPECTION OF AGENCY RECORDS.

6. NOTIFY THE DEPARTMENT, IN WRITING, WITHIN 24 HOURS, ANYTIME A SUBSTITUTE WHO IS THE SUBJECT OF A CHILD PROTECTION INVESTIGATION THAT RESULTED WHILE PLACED AT A CHILD CARE FACILITY; ANY SUBSTITUTE WHO WAS THE STAFF MEMBER IN CHARGE OF A CLASSROOM AND A CHILD RECEIVED AN INJURY REQUIRING EMERGENCY MEDICAL TREATMENT; ANY SUBSTITUTE WHO IS RESPONSIBLE FOR A SAFE SLEEP VIOLATION OR ANY SUBSTITUTE WHO HAS BEEN TERMINATED AS A RESULT OF HIS/HER ACTIONS WHILE PLACED AT A CHILD CARE FACILITY.

7. WHEN THE SUBSTITUTE FROM THE AGENCY IS THE STAFF MEMBER RESPONSIBLE FOR THE CHILD(REN,) IN A CHILD CARE FACILITY AND THE CHILD RECEIVES AN INJURY RESULTING IN MEDICAL CARE OR TREATMENT, THE AGENCY MUST DOCUMENT AND REPORT WITHIN 24 HOURS, IN

WRITING, TO THE COLORADO DEPARTMENT OF HUMAN SERVICES ANY ACCIDENT OR ILLNESS OCCURRING AT A CHILD CARE FACILITY THAT RESULTED IN MEDICAL CARE OR TREATMENT BY A PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL, HOSPITALIZATION, OR DEATH.

8. CARRY PUBLIC LIABILITY INSURANCE. THE APPLICANT OR LICENSEE MUST SUBMIT THE AMOUNT OF THE INSURANCE AND THE NAME AND THE ADDRESS OF THE INSURANCE AGENCY PROVIDING THE INSURANCE TO THE AGENCY. DOCUMENTATION OF CURRENT LIABILITY INSURANCE MUST BE ON FILE AND AVAILABLE FOR REVIEW AT ALL TIMES AT THE AGENCY.

9. COMPLETE THE LICENSING RENEWAL REQUIREMENTS BY:

a. SUBMITTING THE LICENSE CONTINUATION NOTICE AND FEE PRIOR TO THE ANNUAL DUE DATE OF THE CONTINUATION NOTICE;

b. PAYING THE PRESCRIBED APPLICATION OR CONTINUATION FEE PURSUANT TO SECTION 7.701.4;

c. COOPERATING WITH ON-SITE MONITORING INSPECTIONS AND INVESTIGATIONS TO ASSESS THE AGENCY'S COMPLIANCE WITH THE RULES FOR SUBSTITUTE PLACEMENT AGENCIES; AND

7.730.2 PERSONNEL

7.730.21 GENERAL REQUIREMENTS FOR ALL SUBSTITUTES

A. THERE MUST BE A DATED LETTER OF AGREEMENT WITH EACH SUBSTITUTE WHICH INCLUDES THE SPECIFIC JOB RESPONSIBILITIES/JOB DESCRIPTION. THE LETTER OF AGREEMENT MUST BE EXECUTED UPON HIRE BY BOTH THE AGENCY AND THE SUBSTITUTE. PRIOR TO BEING PLACED AT A CHILD CARE FACILITY, SUBSTITUTES MUST SIGN A STATEMENT INDICATING THAT THEY HAVE READ AND UNDERSTAND THE AGENCY POLICIES AND PROCEDURES. ALL SUBSTITUTES MUST BE NOTIFIED OF CHANGES TO POLICIES AND PROCEDURES.

B. ALL SUBSTITUTES MUST BE EIGHTEEN (18) YEARS OR OLDER AND QUALIFIED FOR THE POSITION WHICH HE/SHE WILL BE PROVIDING SUBSTITUTE CARE.

C. ALL SUBSTITUTES MUST BE REGISTERED IN THE PROFESSIONAL DEVELOPMENT INFORMATION SYSTEM;

D. ALL SUBSTITUTES MUST HAVE COMPLETED ALL THE PRE-SERVICE TRAINING COURSES LISTED AT 7.730.3D1-6J PRIOR TO BEING PLACED AT A CHILD CARE FACILITY;

E. ALL SUBSTITUTES MUST COMPLETE THE DEPARTMENT-APPROVED PLAYGROUND SAFETY TRAINING PRIOR TO WORKING WITH CHILDREN AND ANNUALLY;

F. ALL SUBSTITUTES MUST COMPLETE THE DEPARTMENT-APPROVED INJURY PREVENTION TRAINING PRIOR TO WORKING WITH CHILDREN AND ANNUALLY;

G. THE PERSONNEL FILE OF EACH SUBSTITUTE MUST CONTAIN CLEARANCE OR ARREST REPORT FROM THE COLORADO BUREAU OF INVESTIGATION RESULTING FROM THE STAFF MEMBER'S CRIMINAL RECORD CHECK IN ACCORDANCE WITH SECTION 7.701.33 OF THE GENERAL RULES FOR CHILD CARE FACILITIES.

H. THE PERSONNEL FILE OF EACH SUBSTITUTE MUST CONTAIN THE RESULTS OF THE STATE DEPARTMENT’S AUTOMATED CHILD ABUSE AND NEGLECT SYSTEM. IN ACCORDANCE WITH SECTION 7.701.32 OF THE GENERAL RULES FOR CHILD CARE FACILITIES.

I. SUBSTITUTES MUST BE CURRENT FOR ALL IMMUNIZATIONS ROUTINELY RECOMMENDED FOR ADULTS BY THEIR HEALTH CARE PROVIDER.

7.730.22 PERSONNEL POLICIES, ORIENTATION AND STAFF DEVELOPMENT

A. A WRITTEN STATEMENT OF PERSONNEL POLICY SHALL BE PROVIDED TO EACH SUBSTITUTE OR QUALIFIED APPLICANT. THIS STATEMENT SHALL, AT A MINIMUM, CONTAIN THE FOLLOWING INFORMATION:

1. A JOB DESCRIPTION WHICH OUTLINES THE DUTIES, RESPONSIBILITIES, QUALIFICATIONS; AND EDUCATIONAL REQUIREMENTS FOR THE POSITION.

2. A PROCEDURE FOR TRACKING THE PLACEMENT HOURS, INCLUDING THE NAME, LICENSE NUMBER, ADDRESSES AND AGES OF CHILDREN WHERE THE SUBSTITUTE IS PLACED.

3. PRIOR TO WORKING WITH CHILDREN, EACH SUBSTITUTE MUST READ AND BE INSTRUCTED ABOUT THE POLICIES AND PROCEDURES OF THE AGENCY, INCLUDING THOSE RELATED TO PROPER SUPERVISION OF CHILDREN, IDENTIFICATION AND SYMPTOMS OF SUSPECTED CHILD ABUSE OR NEGLECT, THE REPORTING OF SUSPECTED CHILD ABUSE.

SUBSTITUTES MUST SIGN A STATEMENT INDICATING THAT THEY HAVE READ AND UNDERSTAND THE AGENCY'S POLICIES AND PROCEDURES.

4. A WRITTEN PRE-SERVICE TRAINING PLAN FOR EACH SUBSTITUTE. EACH SUBSTITUTE MUST COMPLETE THE FOLLOWING TRAINING BEFORE BEING PLACED IN A CHILD CARE FACILITY:

   a. EACH SUBSTITUTE WORKING WITH INFANTS LESS THAN TWELVE (12) MONTHS OLD MUST COMPLETE A DEPARTMENT-APPROVED SAFE SLEEP TRAINING PRIOR TO WORKING WITH INFANTS LESS THAN TWELVE (12) MONTHS OLD. THIS TRAINING MUST BE RENEWED ANNUALLY AND MAY BE COUNTED TOWARDS ONGOING TRAINING REQUIREMENTS.

   b. EACH SUBSTITUTE WORKING WITH CHILDREN LESS THAN THREE (3) YEARS OF AGE MUST COMPLETE A DEPARTMENT-APPROVED PREVENTION OF SHAKEN BABY/ABUSIVE HEAD TRAUMA TRAINING PRIOR TO WORKING WITH CHILDREN LESS THAN THREE (3) YEARS OF AGE. THIS TRAINING MUST BE RENEWED ANNUALLY AND COUNTS TOWARDS ONGOING TRAINING REQUIREMENTS.

   c. EACH SUBSTITUTE MUST COMPLETE A DEPARTMENT-APPROVED STANDARD PRECAUTIONS TRAINING THAT MEETS CURRENT OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) REQUIREMENTS PRIOR TO WORKING WITH CHILDREN. THIS TRAINING MUST BE RENEWED ANNUALLY AND COUNTS TOWARDS ONGOING TRAINING REQUIREMENTS.

   d. PRIOR TO WORKING WITH CHILDREN AND ANNUALLY EACH SUBSTITUTE MUST BE TRAINED USING DEPARTMENT-APPROVED TRAINING ABOUT CHILD ABUSE PREVENTION, INCLUDING COMMON SYMPTOMS AND SIGNS OF CHILD ABUSE.

   e. PRIOR TO WORKING WITH CHILDREN AND ANNUALLY EACH SUBSTITUTE MUST BE TRAINED USING A DEPARTMENT-APPROVED TRAINING ON HOW TO REPORT, WHERE TO REPORT AND WHEN TO REPORT SUSPECTED OR KNOWN CHILD ABUSE OR NEGLECT.

   f. THE AGENCY MUST ENSURE THAT EACH SUBSTITUTE IS FAMILIAR WITH THE LICENSING RULES GOVERNING THE SPECIFIC CHILD CARE LICENSE TYPE IN WHICH THE SUBSTITUTE WILL BE PLACED WITHIN THIRTY (30) CALENDAR DAYS OF EMPLOYMENT AT THE SUBSTITUTE PLACEMENT AGENCY.

g. THE AGENCY MUST ENSURE THAT EACH SUBSTITUTE IS FAMILIAR WITH THE RULES AND REGULATIONS GOVERNING THE HEALTH AND SANITATION OF CHILD CARE FACILITIES IN THE STATE OF COLORADO IF PLACED IN A FACILITY THAT THESE RULES APPLY WITHIN THIRTY (30) CALENDAR DAYS OF EMPLOYMENT AT THE SUBSTITUTE PLACEMENT AGENCY.

h. EACH SUBSTITUTE MUST HAVE CURRENT DEPARTMENT-APPROVED FIRST AID AND CPR CERTIFICATION BEFORE WORKING IN A CLASSROOM ALONE.

i. EACH SUBSTITUTE MUST COMPLETE A MINIMUM OF FIFTEEN (15) CLOCK HOURS OF TRAINING EACH YEAR BEGINNING WITH THE START DATE OF THE EMPLOYEE. AT LEAST THREE (3) CLOCK HOURS PER YEAR MUST BE IN THE FOCUS OF SOCIAL EMOTIONAL DEVELOPMENT.

j. ONGOING TRAINING AND COURSES SHALL DEMONSTRATE A DIRECT CONNECTION TO ONE OR MORE OF THE FOLLOWING COMPETENCY AREAS:

1) CHILD GROWTH AND DEVELOPMENT, AND LEARNING OR COURSES THAT ALIGN WITH THE COMPETENCY DOMAINS OF CHILD GROWTH AND DEVELOPMENT;

2) CHILD OBSERVATION AND ASSESSMENT;

3) FAMILY AND COMMUNITY PARTNERSHIP;

4) GUIDANCE;

5) HEALTH, SAFETY AND NUTRITION;

6) PROFESSIONAL DEVELOPMENT AND LEADERSHIP;

7) PROGRAM PLANNING AND DEVELOPMENT; OR,

8) TEACHING PRACTICES:

k. EACH ONE (1) SEMESTER HOUR COURSE WITH A DIRECT CONNECTION TO THE COMPETENCY AREA LISTED IN SECTION 7.702.33, L, 1-8, TAKEN AT A REGIONALLY ACCREDITED COLLEGE

OR UNIVERSITY SHALL COUNT AS FIFTEEN (15) CLOCK HOURS OF ONGOING TRAINING.

l. TRAINING HOURS COMPLETED CAN ONLY BE COUNTED DURING THE YEAR TAKEN AND CANNOT BE CARRIED OVER.

m. TO BE COUNTED FOR ONGOING TRAINING, THE TRAINING CERTIFICATE MUST HAVE DOCUMENTATION THAT INCLUDES:

1) THE TITLE OF THE TRAINING;

2) THE COMPETENCY DOMAIN;

3) THE DATE AND CLOCK HOURS OF THE TRAINING;

4) THE NAME OR SIGNATURE, OR OTHER APPROVED METHOD OF VERIFYING THE IDENTITY OF TRAINER OR ENTITY;

5) EXPIRATION OF TRAINING IF APPLICABLE; AND

6) CONNECTION TO SOCIAL EMOTIONAL FOCUS IF APPLICABLE.

5. THE SUBSTITUTE MUST HAVE A COMPLETE FILE MAINTAINED AT THE SUBSTITUTE PLACEMENT AGENCY AND HAVE A PORTABLE FILE AVAILABLE FOR REVIEW AT ALL TIMES TO BOTH LICENSING AND THE CHILD CARE FACILITY WHERE THE SUBSTITUTE IS PROVIDING SUBSTITUTE CARE. THE PORTABLE FILE MAY BE IN THE FORM OF HARDCOPY DOCUMENTS OR MAINTAINED ON A DATA STICK. DOCUMENTATION OF QUALIFICATIONS FOR THE POSITION INCLUDES:

a. CERTIFICATE VERIFYING ALL PRE-SERVICE TRAINING, INCLUDING NAME, PHONE NUMBER, AND LICENSE NUMBER OF AGENCY;

b. DEPARTMENT ISSUED DIRECTOR LETTER; OR

c. DEPARTMENT ISSUED EARLY CHILDHOOD TEACHER LETTER; OR

d. OFFICIAL COLLEGE TRANSCRIPT AND LETTERS OF EXPERIENCE; OR

e. CREDENTIAL 2.0 LEVEL 3 OR HIGHER; AND

f. FIRST AID AND CPR CERTIFICATES; AND

g. COMPLETE BACKGROUND CHECK; AND

h. EMERGENCY CONTACT NAME, ADDRESS AND PHONE NUMBER.

6. SUBSTITUTES MUST NOT CONSUME OR BE UNDER THE INFLUENCE OF ANY SUBSTANCE THAT IMPAIRS THEIR ABILITY TO CARE FOR CHILDREN WHILE CARING FOR CHILDREN.

7. ILLEGAL DRUGS, DRUG PARAPHERNALIA, MARIJUANA AND MARIJUANA INFUSED PRODUCTS, AND ALCOHOL MUST NEVER BE PRESENT ON THE PREMISES OF THE FACILITY DURING OPERATING HOURS.

8. SUBSTITUTES MUST MAINTAIN THE CONFIDENTIALITY OF THE CHILDREN, FAMILIES AND THE CHILD CARE FACILITY WHERE THE SUBSTITUTE IS PLACED.

9. SUBSTITUTES ARE RESPONSIBLE FOR DOCUMENTING EXPERIENCE HOURS WITH THE SPECIFIC AGES OF CHILDREN CARED FOR, WHILE PROVIDING SUBSTITUTE CHILD CARE FOR THE PURPOSE OF EMPLOYMENT VERIFICATION WITH THE AGENCY.

10. SUBSTITUTES MUST NOT TAKE PERSONAL PHOTOS OF CHILDREN, OR MAKE REFERENCE TO ANY PERSONAL INFORMATION OF CHILDREN, FAMILIES OR OTHER CHILD CARE FACILITIES, INCLUDING STAFF, ON SOCIAL MEDIA, EMAIL, TEXT MESSAGES OR OTHER MEANS OF COMMUNICATION, WRITTEN OR VERBAL.

11. WHEN CARING FOR CHILDREN, SUBSTITUTES MUST REFRAIN FROM PERSONAL USE OF ELECTRONICS INCLUDING, BUT NOT LIMITED TO, CELL PHONES AND PORTABLE ELECTRONIC DEVICES.

12. SUBSTITUTES MUST SIGN IN AND OUT OF EVERY FACILITY EACH TIME THEY WORK AT A CHILD CARE FACILITY.

7.730.23 SUBSTITUTE QUALIFICATIONS

A. SUBSTITUTE FOR A CHILD CARE CENTER

1. MUST MEET REQUIREMENTS FOUND AT 7.730.21; AND

2. MUST MEET THE CURRENT MINIMUM EDUCATION AND EXPERIENCE REQUIREMENTS FOR THE POSITION IN WHICH THE SUBSTITUTE IS PROVIDING CHILD CARE.

3. LARGE CHILD CARE CENTER DIRECTOR: THE EDUCATIONAL REQUIREMENTS FOR THE DIRECTOR OR SUBSTITUTE DIRECTOR OF A LARGE CENTER MUST BE MET BY SATISFACTORY COMPLETION OF ONE OF THE FOLLOWING. OFFICIAL COLLEGE TRANSCRIPTS MUST BE SUBMITTED TO THE DEPARTMENT FOR EVALUATION OF QUALIFICATIONS.

   a. A BACHELOR DEGREE IN EARLY CHILDHOOD EDUCATION FROM A REGIONALLY ACCREDITED COLORADO COLLEGE OR UNIVERSITY; OR,

   b. A CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL IV VERSION 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION; OR,

   c. A MASTER'S DEGREE WITH A MAJOR EMPHASIS IN CHILD DEVELOPMENT, EARLY CHILDHOOD EDUCATION, EARLY CHILDHOOD SPECIAL EDUCATION; OR,

   d. COMPLETION OF ALL OF THE FOLLOWING THREE (3) SEMESTER HOUR COURSES FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, AT EITHER A TWO YEAR, FOUR YEAR OR GRADUATE LEVEL, IN EACH OF THE FOLLOWING SUBJECT OR CONTENT AREAS:

      1. INTRODUCTION TO EARLY CHILDHOOD PROFESSIONS;

      2. INTRODUCTION TO EARLY CHILDHOOD LAB TECHNIQUES;

      3. EARLY CHILDHOOD GUIDANCE STRATEGIES FOR CHILDREN;

      4. EARLY CHILDHOOD HEALTH, NUTRITION, AND SAFETY;

      5. ADMINISTRATION OF EARLY CHILDHOOD CARE AND EDUCATION PROGRAMS;

      6. ADMINISTRATION: HUMAN RELATIONS FOR EARLY CHILDHOOD PROFESSIONS OR INTRODUCTION TO BUSINESS;

7. EARLY CHILDHOOD CURRICULUM DEVELOPMENT;

8. EARLY CHILDHOOD GROWTH AND DEVELOPMENT.

9. THE EXCEPTIONAL CHILD; AND,

10. INFANT/TODDLER THEORY AND PRACTICE; OR THE DEPARTMENT APPROVED EXPANDING QUALITY INFANT/TODDLER TRAINING; OR,

11. COMPLETION OF A COURSE OF TRAINING APPROVED BY THE DEPARTMENT THAT INCLUDES COURSE CONTENT LISTED AT SECTION 7.730.22C, A-J, AND DOCUMENTED EXPERIENCE.

e. THE EXPERIENCE REQUIREMENTS FOR THE DIRECTOR OF A LARGE CENTER MUST BE MET BY COMPLETION OF THE FOLLOWING AMOUNT OF WORK EXPERIENCE IN A CHILD DEVELOPMENT PROGRAM, WHICH INCLUDES WORKING WITH A GROUP OF CHILDREN IN SUCH PROGRAMS AS A PRESCHOOL, CHILD CARE CENTER, KINDERGARTEN, OR HEAD START PROGRAM:

1. PERSONS WITH BACHELOR'S OR MASTER'S DEGREE WITH A MAJOR EMPHASIS IN CHILD DEVELOPMENT, EARLY CHILDHOOD EDUCATION, EARLY CHILDHOOD SPECIAL EDUCATION, OR AN EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL IV VERSION 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION; NO ADDITIONAL EXPERIENCE IS REQUIRED.

2. PERSONS WITH A 2-YEAR COLLEGE DEGREE IN EARLY CHILDHOOD EDUCATION MUST HAVE TWELVE (12) MONTHS (1,820 HOURS) OF VERIFIED EXPERIENCE WORKING DIRECTLY WITH CHILDREN IN A CHILD DEVELOPMENT PROGRAM.

3. PERSONS WITH A BACHELOR'S DEGREE AND COMPLETION OF COURSES SPECIFIED IN SECTIONS 7.702.42, A, 3, A-J, MUST HAVE TWELVE (12) MONTHS (1,820 HOURS) OF VERIFIED EXPERIENCE WORKING DIRECTLY WITH CHILDREN IN A CHILD DEVELOPMENT PROGRAM.

4. PERSONS WHO HAVE NO DEGREE BUT HAVE COMPLETED THE THIRTY (30) SEMESTER HOURS SPECIFIED IN SECTION 7.702.42, A, 3, A-J, MUST HAVE TWENTY-FOUR (24) MONTHS (3,640 HOURS) OF VERIFIED EXPERIENCE WORKING

DIRECTLY WITH CHILDREN IN A CHILD DEVELOPMENT PROGRAM.

5. VERIFIED EXPERIENCE ACQUIRED IN A LICENSED COLORADO FAMILY CHILD CARE HOME OR SCHOOL-AGE CHILD CARE CENTER MAY COUNT FOR UP TO HALF OF THE REQUIRED EXPERIENCE FOR DIRECTOR QUALIFICATIONS. TO HAVE COLORADO FAMILY CHILD CARE HOME EXPERIENCE CONSIDERED, THE APPLICANT MUST BE OR HAVE BEEN THE LICENSEE. THE OTHER HALF OF THE REQUIRED EXPERIENCE MUST BE WORKING DIRECTLY WITH CHILDREN IN A CHILD DEVELOPMENT PROGRAM.

6. EXPERIENCE WITH FIVE (5) YEAR OLDS MUST BE VERIFIED AS FOLLOWS:

   a. IF EXPERIENCE CARING FOR FIVE-YEAR-OLD CHILDREN OCCURS IN A CHILD CARE CENTER CLASSROOM, THE HOURS WORKED SHALL BE COUNTED AS PRESCHOOL EXPERIENCE; OR,

   b. IF EXPERIENCE CARING FOR FIVE-YEAR-OLD CHILDREN OCCURS IN AN ELEMENTARY SCHOOL PROGRAM, THE HOURS WORKED SHALL BE COUNTED AS SCHOOL-AGE EXPERIENCE.

4. THE SMALL CENTER DIRECTOR QUALIFICATIONS MUST BE MET BY SATISFACTORY COMPLETION OF:

   a. A CURRENT PROFESSIONAL TEACHING LICENSE ISSUED BY THE COLORADO DEPARTMENT OF EDUCATION WITH AN ENDORSEMENT IN THE AREA OF EARLY CHILDHOOD EDUCATION OR EARLY CHILDHOOD SPECIAL EDUCATION;

   b. A CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL III VERSION 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION;

   c. THREE (3) YEARS' SATISFACTORY EXPERIENCE IN THE GROUP CARE OF CHILDREN LESS THAN SIX (6) YEARS OF AGE (5460 HOURS) AND AT LEAST TWO (2) 3-SEMESTER HOURS FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, AT EITHER A TWO-YEAR, FOUR YEAR OR GRADUATE LEVEL, IN EACH OF THE FOLLOWING SUBJECT OR CONTENT AREAS IN EARLY CHILDHOOD EDUCATION; ONE OF THE COURSES MUST BE EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES;

d. TWO (2) YEARS' COLLEGE EDUCATION (SIXTY SEMESTER HOURS) AT A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, AT EITHER A TWO-YEAR, FOUR YEAR OR GRADUATE LEVEL, IN EACH OF THE FOLLOWING SUBJECT OR CONTENT AREAS WITH AT LEAST TWO (2) 3-SEMESTER-HOUR COURSES IN EARLY CHILDHOOD EDUCATION; ONE OF WHICH MUST BE EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES; AND ONE (1) YEAR (1820 HOURS) OF SATISFACTORY EXPERIENCE IN THE GROUP CARE OF CHILDREN LESS THAN SIX (6) YEARS OF AGE;

e. CURRENT CERTIFICATION AS A CHILD DEVELOPMENT ASSOCIATE (CDA) OR OTHER DEPARTMENT APPROVED CREDENTIAL; OR,

f. A TWO (2) YEAR COLLEGE DEGREE IN CHILD DEVELOPMENT OR EARLY CHILDHOOD EDUCATION FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, AT EITHER A TWO-YEAR, FOUR YEAR OR GRADUATE LEVEL, IN EACH OF THE FOLLOWING SUBJECT OR CONTENT AREAS THAT MUST INCLUDE AT LEAST ONE 3- SEMESTER HOUR COURSE IN EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES AND SIX (6) MONTHS (910 HOURS) SATISFACTORY EXPERIENCE IN THE GROUP CARE OF CHILDREN LESS THAN SIX (6) YEARS OF AGE.

5. THE EARLY CHILDHOOD TEACHER MUST BE MET BY SATISFACTORY COMPLETION OF:

A. A BACHELOR'S DEGREE FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY WITH A MAJOR AREA OF STUDY IN ONE OF THE FOLLOWING AREAS:

1. EARLY CHILDHOOD EDUCATION;

2. ELEMENTARY EDUCATION;

3. SPECIAL EDUCATION;

4. FAMILY AND CHILD DEVELOPMENT; OR,

5. CHILD PSYCHOLOGY.

B. A BACHELOR’S DEGREE FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY WITH A MAJOR AREA OF STUDY IN ANY AREA OTHER

THAN THOSE LISTED AT SECTION 7.730XXX AND ADDITIONAL TWO (2) THREE-SEMESTER HOUR EARLY CHILDHOOD EDUCATION COLLEGE COURSES WITH ONE COURSE BEING EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES;

1. CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL III VERSION 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION;

2. A 2-YEAR COLLEGE DEGREE, SIXTY (60) SEMESTER HOURS, IN EARLY CHILDHOOD EDUCATION FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, WHICH MUST INCLUDE AT LEAST TWO (2) THREE-SEMESTER HOUR COURSES, ONE OF WHICH MUST BE EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES; AND AT LEAST SIX (6) MONTHS (910 HOURS) OF SATISFACTORY EXPERIENCE;

3. COMPLETION OF TWELVE (12) SEMESTER HOURS FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, AT EITHER A TWO YEAR, FOUR YEAR OR GRADUATE LEVEL, IN EACH OF THE FOLLOWING SUBJECT OR CONTENT AREAS IN EARLY CHILDHOOD EDUCATION AND ONE OF THE THREE (3) SEMESTER HOUR COURSES MUST BE EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES, PLUS NINE (9) MONTHS (1,395 HOURS) OF VERIFIED EXPERIENCE IN THE CARE AND SUPERVISION OF FOUR (4) OR MORE CHILDREN LESS THAN SIX (6) YEARS OF AGE WHO ARE NOT RELATED TO THE INDIVIDUAL;

4. COMPLETION OF A VOCATIONAL OR OCCUPATIONAL EDUCATION SEQUENCE IN CHILD GROWTH AND DEVELOPMENT PLUS TWELVE (12) MONTHS (1,820 HOURS) OF VERIFIED EXPERIENCE IN THE CARE AND SUPERVISION OF FOUR (4) OR MORE CHILDREN LESS THAN SIX (6) YEARS OF AGE WHO ARE NOT RELATED TO THE INDIVIDUAL; G. CURRENT CERTIFICATION AS A CHILD DEVELOPMENT ASSOCIATE (CDA) OR OTHER DEPARTMENT-APPROVED CREDENTIAL;

5. COMPLETION OF A COURSE OF TRAINING APPROVED BY THE DEPARTMENT THAT INCLUDES TRAINING AND WORK EXPERIENCE WITH CHILDREN IN A CHILD GROWTH AND DEVELOPMENT PROGRAM PLUS TWELVE (12) MONTHS (1,820 HOURS) OF VERIFIED EXPERIENCE IN THE CARE AND SUPERVISION OF FOUR (4) OR MORE CHILDREN LESS THAN SIX (6) YEARS OF AGE WHO ARE NOT RELATED TO THE INDIVIDUAL; OR,

6. TWENTY-FOUR (24) MONTHS (3,640 HOURS) OF VERIFIED EXPERIENCE IN THE CARE AND SUPERVISION OF FOUR (4) OR MORE CHILDREN LESS THAN SIX (6) YEARS OF AGE WHO ARE NOT RELATED TO THE INDIVIDUAL. SATISFACTORY EXPERIENCE INCLUDES BEING A LICENSEE OF A COLORADO FAMILY CHILD CARE HOME; A TEACHER'S AIDE OR TEACHER IN A CHILD CARE CENTER, PRESCHOOL, OR ELEMENTARY SCHOOL, PLUS EITHER:

   a. A CURRENT COLORADO LEVEL I CREDENTIAL; OR,

   b. TWO (2) THREE-SEMESTER HOUR EARLY CHILDHOOD EDUCATION COLLEGE COURSES FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, AT EITHER A TWO-YEAR, FOUR YEAR OR GRADUATE LEVEL, IN EACH OF THE FOLLOWING SUBJECT OR CONTENT AREAS WITH ONE COURSE BEING EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES.

7. ALL COLLEGE COURSE GRADES TOWARD EARLY CHILDHOOD TEACHER QUALIFICATIONS MUST BE "C" OR BETTER.

C. ASSISTANT EARLY CHILDHOOD TEACHER

AN ASSISTANT EARLY CHILDHOOD TEACHER, ASSIGNED RESPONSIBILITY FOR A SINGLE GROUP OF CHILDREN DURING TIMES SPECIFIED IN 7.702.55, MUST MEET ONE OF THE FOLLOWING QUALIFICATIONS:

1. COMPLETION OF ONE OF THE EARLY CHILDHOOD EDUCATION COURSES IN SECTION 7.702.42, A, WITH A COURSE GRADE OF "C" OR BETTER AND TWELVE (12) MONTHS (1820 HOURS) VERIFIED EXPERIENCE IN THE CARE AND SUPERVISION OF FOUR (4) OR MORE CHILDREN LESS THAN SIX (6) YEARS OF AGE, WHO ARE NOT RELATED TO THE INDIVIDUAL. SATISFACTORY EXPERIENCE INCLUDES BEING A LICENSEE OF A FAMILY CHILD CARE HOME; A TEACHER'S AIDE IN A CENTER, PRESCHOOL OR ELEMENTARY SCHOOL. ASSISTANT EARLY CHILDHOOD TEACHERS MUST BE ENROLLED IN AND ATTENDING THE SECOND (2ND) EARLY CHILDHOOD EDUCATION CLASS WHICH WILL BE USED AS THE BASIS FOR THEIR

QUALIFICATION FOR THE POSITION OF EARLY CHILDHOOD TEACHER;

2. PERSONS HAVING COMPLETED TWO (2) OF THE EARLY CHILDHOOD EDUCATION CLASSES REFERENCED IN SECTION 7.702.42, A, WITH A COURSE GRADE OF "C" OR BETTER AND NO EXPERIENCE; OR,

3. A CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL I VERSION 1.0 OR 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION.

D. STAFF AIDE

1. STAFF AIDES MUST BE AT LEAST SIXTEEN (16) YEARS OF AGE AND MUST WORK DIRECTLY UNDER THE SUPERVISION OF THE DIRECTOR OR AN EARLY CHILDHOOD TEACHER.

2. INFANT STAFF AIDES MUST BE AT LEAST EIGHTEEN (18) YEARS OF AGE.

3. STAFF AIDES, WITHOUT SUPERVISION FROM AN EARLY CHILDHOOD TEACHER OR DIRECTOR, MAY SUPERVISE NO MORE THAN TWO (2) PRESCHOOL AGE CHILDREN WHILE ASSISTING THE CHILDREN WITH DIAPERING OR TOILETING.

E. THE KINDERGARTEN TEACHER QUALIFICATIONS MUST BE MET BY SATISFACTORY COMPLETION OF:

1. EACH TEACHER OF A KINDERGARTEN CLASS MUST HAVE THE SAME QUALIFICATIONS AS A DIRECTOR FOR A LARGE CENTER (SEE SECTION 7.702.42), BE STATE CERTIFIED OR LICENSED AS AN ELEMENTARY TEACHER BY THE COLORADO DEPARTMENT OF EDUCATION, OR HAVE A FOUR (4) YEAR DEGREE FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY IN ELEMENTARY OR EARLY CHILDHOOD EDUCATION.

2. A CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL III VERSION 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION.

F. THE INFANT PROGRAM SUPERVISOR QUALIFICATIONS MUST BE MET BY SATISFACTORY COMPLETION OF:

1. A REGISTERED NURSE, LICENSED TO PRACTICE IN COLORADO, WITH A MINIMUM OF 6 MONTHS OF EXPERIENCE IN THE CARE OF INFANTS.

2. A LICENSED PRACTICAL NURSE, LICENSED TO PRACTICE IN COLORADO, WITH TWELVE (12) MONTHS OF EXPERIENCE IN THE CARE OF INFANTS.

3. AN ADULT WHO HOLDS A CERTIFICATE IN INFANT AND TODDLER CARE FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY WITH COMPLETION OF A MINIMUM OF 30 SEMESTER HOURS IN THE DEVELOPMENT AND CARE OF INFANTS AND TODDLERS IN A GROUP SETTING.

4. AN ADULT WHO IS CURRENTLY CERTIFIED AS A CHILD DEVELOPMENT ASSOCIATE (CDA) AND HAS COMPLETED THE DEPARTMENT APPROVED EXPANDING QUALITY IN INFANT AND TODDLER DEVELOPMENT COURSE OF TRAINING.

5. AN ADULT WHO:

   a. HOLDS A CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL III VERSION 2.0, AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION;

   b. HAS COMPLETED ONE THREE-SEMESTER-HOUR CLASS IN INFANT/TODDLER DEVELOPMENT; OR,

   c. HAS COMPLETED THE DEPARTMENT-APPROVED “EXPANDING QUALITY IN INFANT AND TODDLER DEVELOPMENT” AND HOLDS TWELVE MONTHS OF VERIFIABLE FULL-DAY EXPERIENCE WORKING WITH INFANTS AND/OR TODDLERS.

6. AN ADULT WHO:

   a. IS AT LEAST NINETEEN (19) YEARS OF AGE, AND,

   b. IS QUALIFIED AS AN EARLY CHILDHOOD TEACHER AND,

c. HAS A MINIMUM OF TWELVE (12) MONTHS OF VERIFIABLE FULL-DAY EXPERIENCE IN THE GROUP CARE OF INFANTS OR TODDLERS; AND,

d. HAS COMPLETED AT LEAST TWO (2) THREE (3)-SEMESTER HOUR COLLEGE COURSES FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY ON THE DEVELOPMENT AND CARE OF INFANTS AND TODDLERS IN A GROUP SETTING, ONE (1) OF WHICH MUST BE INFANT/TODDLER DEVELOPMENT OR THE DEPARTMENT APPROVED EXPANDING QUALITY IN INFANT AND TODDLER DEVELOPMENT COURSE OF TRAINING.

G. THE INFANT PROGRAM EARLY CHILDHOOD TEACHER QUALIFICATIONS MUST BE MET BY SATISFACTORY COMPLETION OF:

1. AN INFANT PROGRAM EARLY CHILDHOOD TEACHER MUST HAVE COMPLETED EIGHT (8) HOURS OF ORIENTATION IN THE INFANT PROGRAM FROM THE INFANT PROGRAM SUPERVISOR INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING TOPICS:

a. TOYS AND EQUIPMENT, APPROPRIATE ACTIVITIES FOR INFANTS AND TODDLERS, APPROPRIATE SLEEP POSITIONS FOR INFANTS AND TODDLERS, THE SAFE AND APPROPRIATE DIAPER CHANGE TECHNIQUE; AND,

b. AT LEAST SIX (6) MONTHS OF EXPERIENCE IN THE CARE OF INFANTS OR TODDLERS; AND,

c. MEET QUALIFICATIONS FOR AN EARLY CHILDHOOD TEACHER FOUND AT SECTION 7.702.44, A, OR BE QUALIFIED AS AN INFANT PROGRAM SUPERVISOR.

H. THE INFANT PROGRAM STAFF AIDE MUST BE AT LEAST EIGHTEEN (18) YEARS OF AGE, MUST HAVE COMPLETED EIGHT (8) HOURS OF ORIENTATION AS LISTED ABOVE, AT THE INFANT PROGRAM AND MUST WORK UNDER THE DIRECT SUPERVISION OF AN INFANT EARLY CHILDHOOD TEACHER.

1. SUBSTITUTES FOR INFANT PROGRAM STAFF MUST HOLD A CURRENT DEPARTMENT-APPROVED FIRST AID AND SAFETY CERTIFICATE THAT INCLUDES CPR FOR ALL AGES OF CHILDREN.

2. THE TODDLER PROGRAM EARLY CHILDHOOD TEACHER QUALIFICATIONS MUST BE MET BY SATISFACTORY COMPLETION OF:

1. A REGISTERED NURSE, LICENSED TO PRACTICE IN COLORADO, WITH A MINIMUM OF 6 MONTHS OF EXPERIENCE IN THE CARE OF INFANTS AND/OR TODDLERS;

2. AN ADULT WHO HOLDS A CERTIFICATE IN INFANT AND TODDLER CARE FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY WITH COMPLETION OF AT LEAST THIRTY (30) SEMESTER HOURS OR EQUIVALENT IN SUCH COURSES AS CHILD GROWTH AND DEVELOPMENT, NUTRITION, AND CARE PRACTICES WITH CHILDREN BIRTH TO THREE (3) YEARS OF AGE;

3. AN ADULT WHO IS CERTIFIED AS A CHILD DEVELOPMENT ASSOCIATE (CDA) OR CERTIFIED CHILD CARE PROFESSIONAL (CCP) OR HOLDS ANOTHER DEPARTMENT-APPROVED CERTIFICATE;

4. A LICENSED PRACTICAL NURSE WITH AT LEAST TWELVE (12) MONTHS OF VERIFIABLE EXPERIENCE IN THE CARE OF CHILDREN LESS THAN THREE (3) YEARS OF AGE;

5. AN ADULT WHO MEETS THE EDUCATION AND EXPERIENCE REQUIREMENTS FOR EARLY CHILDHOOD TEACHER OF A LARGE CENTER (SECTION 7.702.44, A); OR,

6. A CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL II VERSION 1.0 OR LEVEL III VERSION 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION.

I. THE TODDLER PROGRAM STAFF AIDE MUST BE AT LEAST SIXTEEN (16) YEARS OF AGE, MUST WORK DIRECTLY UNDER THE SUPERVISION OF THE DIRECTOR OR A TODDLER EARLY CHILDHOOD TEACHER, AND MUST HAVE COMPLETED 8 HOURS OF ORIENTATION AT THE TODDLER PROGRAM.

1. SUBSTITUTES FOR TODDLER PROGRAM STAFF MUST HOLD A CURRENT DEPARTMENT-APPROVED FIRST AID AND SAFETY CERTIFICATE THAT INCLUDES CPR FOR ALL AGES OF CHILDREN.

J. SUBSTITUTES PLACED IN AN INFANT AND TODDLER PROGRAM AFFILIATED WITH A TEEN PARENT PROGRAMS THAT ARE OPERATED BY ACCREDITED PUBLIC-SCHOOL SYSTEMS ON SCHOOL PREMISES MUST MEET THE FOLLOWING STAFF REQUIREMENTS BY:

1. DIRECTOR QUALIFICATIONS MAY BE MET BY A CERTIFIED TEACHER WITH A MAJOR IN HOME ECONOMICS EDUCATION OR A VOCATIONALLY CREDENTIALED TEACHER IN CONSUMER AND HOMEMAKING OR EARLY CHILDHOOD OCCUPATIONS. THE DIRECTOR MUST COMPLETE AT LEAST THREE (3) SEMESTER HOURS IN ADMINISTRATION OF A CHILD CARE CENTER.

2. THE DIRECTOR MUST BE PRESENT IN THE INFANT PROGRAM CLASSROOM OR ADJACENT TEEN PARENT CLASSROOM AT LEAST SIXTY PERCENT (60%) OF ANY DAY THE CENTER IS OPEN.

3. IF THE DIRECTOR CANNOT BE PRESENT SIXTY PERCENT (60%) OF ANY DAY, AN INDIVIDUAL WHO MEETS DIRECTOR QUALIFICATIONS MUST SUBSTITUTE FOR THE DIRECTOR.

4. INFANT STAFF AIDES MUST BE AT LEAST FIFTEEN (15) YEARS OF AGE AND MAY BE PARENTS-TO-BE, PARENTS OF ENROLLED INFANTS, OR STUDENTS ENROLLED IN A CHILD CARE RELATED COURSE WITH THE SPONSORING SCHOOL SYSTEM.

5. SUBSTITUTES FOR INFANT PROGRAM STAFF MUST BE FROM THE SPONSORING SCHOOL SYSTEM'S LIST OF APPROVED SUBSTITUTE STAFF MEMBERS. SUBSTITUTES WHO DO NOT MEET MINIMUM STAFF QUALIFICATIONS CAN WORK NO MORE THAN TEN (10) CONSECUTIVE BUSINESS DAYS PER ASSIGNMENT.

6. SUBSTITUTES FOR INFANT PROGRAM STAFF MUST HOLD A CURRENT DEPARTMENT-APPROVED FIRST AID AND SAFETY CERTIFICATE THAT INCLUDES CPR FOR ALL AGES OF CHILDREN.

7.730.24 FAMILY CHILD CARE HOME SUBSTITUTE QUALIFICATIONS

A. REGULAR FAMILY CHILD CARE HOME

1. MUST MEET REQUIREMENTS FOUND AT 7.730.21;

2. BE FAMILIAR WITH THE RULES REGULATING FAMILY CHILD CARE HOMES;

3. BE FAMILIAR WITH THE HOME AND PROVIDER'S POLICIES AND PROCEDURES;

4. KNOW THE NAMES, AGES AND ANY SPECIAL NEEDS OR HEALTH CONCERNS OF THE CHILDREN;

5. KNOW THE LOCATION OF EMERGENCY INFORMATION.

B. INFANT/TODDLER FAMILY CHILD CARE HOMES

1. MUST MEET REQUIREMENTS FOUND AT 7.730.21;

2. BE FAMILIAR WITH THE RULES REGULATING FAMILY CHILD CARE HOMES;

3. BE FAMILIAR WITH THE HOME AND PROVIDER'S POLICIES AND PROCEDURES;

4. KNOW THE NAMES, AGES AND ANY SPECIAL NEEDS OR HEALTH CONCERNS OF THE CHILDREN;

5. KNOW THE LOCATION OF EMERGENCY INFORMATION.

6. MUST HAVE COMPLETED ONE (1) YEAR OF SUPERVISED EXPERIENCE CARING FOR CHILDREN WHO ARE YOUNGER THAN THREE (3) YEARS OLD. THE EXPERIENCE MAY HAVE BEEN OBTAINED AS:

a. A COLORADO LICENSED FAMILY CHILD CARE HOME;

b. A MILITARY LICENSED CHILD CARE HOME;

c. A PROVIDER, IN A FAMILY FOSTER HOME CERTIFIED FOR CHILDREN YOUNGER THAN THREE (3) YEARS OF AGE; OR,

d. AN EMPLOYEE IN A LICENSED CHILD CARE CENTER IN AN INFANT AND/OR TODDLER PROGRAM.

C. THE SUBSTITUTE FOR THE LARGE FAMILY CHILD CARE HOME MUST BE QUALIFIED BY:

1. A MINIMUM OF TWO (2) YEARS OF DOCUMENTED SATISFACTORY EXPERIENCE IN THE GROUP CARE OF CHILDREN UNDER THE AGE OF SIX (6) YEARS OR AS A LICENSED HOME PROVIDER IN COLORADO. EQUAL EXPERIENCE OPERATING AS AN APPROVED MILITARY CHILD CARE HOME IS ACCEPTED; OR,

2. A MINIMUM OF TWO (2) YEARS OF COLLEGE EDUCATION FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, WITH AT LEAST ONE (1) COLLEGE COURSE IN EARLY CHILDHOOD EDUCATION, PLUS ONE (1) YEAR OF DOCUMENTED SATISFACTORY EXPERIENCE IN THE GROUP CARE OF CHILDREN AS:

   a. A LICENSED HOME PROVIDER IN COLORADO;

   b. A MILITARY LICENSED CHILD CARE HOME;

   c. A COLORADO CERTIFIED FAMILY FOSTER HOME; OR,

   d. A STAFF MEMBER IN A LICENSED CHILD CARE CENTER.

   e. CURRENT CERTIFICATION AS A CHILD DEVELOPMENT ASSOCIATE (CDA); OR, D. COMPLETION PRIOR TO LICENSING OF THE STATE DEPARTMENT APPROVED EXPANDING QUALITY INFANT/TODDLER COURSE; AND,

      1) A MINIMUM OF TWO (2) YEARS OF EXPERIENCE AS A LICENSED CHILD CARE PROVIDER HOLDING A PERMANENT LICENSE IN COLORADO IMMEDIATELY BEFORE BECOMING A LICENSEE OF A LARGE CHILD CARE HOME; OR,

      2) A MINIMUM OF TWO (2) YEARS OF FULL-TIME EXPERIENCE IN A LICENSED PROGRAM. THE GROUP CARE SHALL HAVE BEEN WITH CHILDREN WHO ARE UNDER THE AGE OF SIX (6) YEARS.

   f. SUBSTITUTES WORKING IN PLACE AS THE LARGE FAMILY CHILD CARE HOME STAFF AIDES MUST BE AT LEAST SIXTEEN (16) YEARS OF AGE AND MUST WORK DIRECTLY UNDER THE SUPERVISION OF THE PRIMARY PROVIDER OR A SUBSTITUTE WHO IS EQUALLY QUALIFIED AS A LARGE FAMILY CHILD CARE HOME PROVIDER. IF LEFT ALONE WITH CHILDREN, THE STAFF AIDE SUBSTITUTE OR ASSISTANT PROVIDER SUBSTITUTE MUST MEET ALL SAME AGE AND TRAINING REQUIREMENTS AS THE PROVIDER.

7.730.25 SCHOOL AGE CHILD CARE SUBSTITUTE QUALIFICATIONS

A. SUBSTITUTE FOR SCHOOL AGE CHILD CARE:

1. MUST MEET REQUIREMENTS FOUND AT 7.730.21;

B. SUBSTITUTE PROGRAM DIRECTOR

1. MUST MEET REQUIREMENTS AT 7.730.24 A 1 AND 2;

2. THE PROGRAM DIRECTOR SUBSTITUTE MUST BE AT LEAST TWENTY-ONE (21) YEARS OF AGE. THE SUBSTITUTE PROGRAM DIRECTOR MUST HAVE DEMONSTRATED TO THE AGENCY, PRIOR TO PLACEMENT AT A SCHOOL AGE CHILD CARE CENTER, MATURITY OF JUDGMENT, ADMINISTRATIVE ABILITY AND THE SKILL TO APPROPRIATELY SUPERVISE AND DIRECT SCHOOL-AGE CHILDREN IN AN UNSTRUCTURED SETTING.

3. THE SUBSTITUTE PROGRAM DIRECTOR MUST HAVE VERIFIABLE EDUCATION OR TRAINING IN WORK WITH SCHOOL-AGE CHILDREN IN SUCH AREAS AS RECREATION, EDUCATION, SCOUTING OR 4-H; AND THE PROGRAM DIRECTOR MUST HAVE COMPLETED AT LEAST ONE OF THE FOLLOWING QUALIFICATIONS:

a. A FOUR (4) YEAR COLLEGE DEGREE WITH A MAJOR SUCH AS RECREATION, OUTDOOR EDUCATION, EDUCATION WITH A SPECIALTY IN ART, ELEMENTARY OR EARLY CHILDHOOD EDUCATION, OR A SUBJECT IN THE HUMAN SERVICE FIELD; OR

b. TWO YEARS OF COLLEGE TRAINING AND SIX (6) MONTHS (910 HOURS) OF SATISFACTORY AND VERIFIABLE FULL-TIME OR EQUIVALENT PART-TIME, PAID OR VOLUNTEER, EXPERIENCE, SINCE ATTAINING THE AGE OF EIGHTEEN (18), IN THE CARE AND SUPERVISION OF FOUR (4) OR MORE CHILDREN; OR

c. IS QUALIFIED AS A LARGE CHILD CARE CENTER DIRECTOR; OR

d. THREE YEARS (5460 HOURS) OF SATISFACTORY AND VERIFIABLE FULL-TIME OR EQUIVALENT PART-TIME, PAID OR VOLUNTEER, EXPERIENCE AND ONE OF THE FOLLOWING QUALIFICATIONS:

1. COMPLETE SIX SEMESTER HOURS, OR NINE QUARTER HOURS IN COURSE WORK FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY; OR

2. 40 CLOCK HOURS OF TRAINING IN COURSE WORK APPLICABLE TO SCHOOL-AGE CHILDREN AND THE DEPARTMENT-APPROVED COURSES IN INJURY PREVENTION, AND PLAYGROUND SAFETY FOR SCHOOL-AGED CHILD CARE CENTERS WITHIN THE FIRST NINE MONTHS OF EMPLOYMENT.

3. SATISFACTORY EXPERIENCE INCLUDES EXPERIENCE IN THE CARE AND SUPERVISION OF FOUR OR MORE CHILDREN FROM THE AGES OF FOUR (4)-EIGHTEEN (18) YEARS OLD, UNRELATED TO THE INDIVIDUAL, SINCE ATTAINING THE AGE OF EIGHTEEN (18).

B. SUBSTITUTE PROGRAM LEADERS FOR SCHOOL AGE CHILD CARE CENTERS

1. MUST MEET REQUIREMENTS FOUND AT 7.730.21;

2. EACH SUBSTITUTE PROGRAM LEADER MUST BE AT LEAST 18 YEARS OF AGE, DEMONSTRATE ABILITY TO WORK WITH CHILDREN, AND MUST MEET THE FOLLOWING QUALIFICATIONS:

a. COMPLETE THE DEPARTMENT-APPROVED COURSE IN INJURY PREVENTION;

b. COMPLETE THE DEPARTMENT-APPROVED COURSE IN PLAYGROUND SAFETY FOR SCHOOL-AGED CHILD CARE CENTERS. THIS REQUIREMENT DOES NOT APPLY TO DAY CAMPS THAT DO NOT REGULARLY USE A PLAYGROUND; AND

c. MUST HAVE AT LEAST THREE (3) MONTHS (460 HOURS) OF FULL-TIME OR EQUIVALENT PART-TIME SATISFACTORY AND VERIFIABLE EXPERIENCE WITH SCHOOL-AGE CHILDREN.

C. SUBSTITUTE PROGRAM AIDES FOR SCHOOL AGE CHILD CARE CENTERS

1. SUBSTITUTE PROGRAM AIDES MUST BE AT LEAST SIXTEEN (16) YEARS OF AGE. PROGRAM AIDES MUST WORK DIRECTLY UNDER THE SUPERVISION OF THE PROGRAM DIRECTOR OR PROGRAM LEADERS AND MUST NEVER BE LEFT ALONE WITH CHILDREN.

2. SUBSTITUTE PROGRAM AIDES CAN BE COUNTED AS STAFF IN DETERMINING CHILD CARE STAFF RATIOS.

7.730.26 PERSONNEL FILES

A. THE CENTER OFFICE MUST MAINTAIN A RECORD FOR EACH STAFF MEMBER THAT INCLUDES THE FOLLOWING:

1. DOCUMENTATION FOR ANY SUBSTITUTE EMPLOYED BY THE AGENCY TO DETERMINE IF THE INDIVIDUAL HAS EVER BEEN CONVICTED OF A DISQUALIFYING CRIME AS FOUND AT SECTION 7.701.33 OF THE GENERAL RULES FOR CHILD CARE FACILITIES. THE PERSONNEL FILE OF EACH SUBSTITUTE OF THE CENTER MUST CONTAIN CLEARANCE OR ARREST REPORT FROM THE COLORADO BUREAU OF INVESTIGATION;

2. DOCUMENTATION FOR ANY SUBSTITUTE EMPLOYED BY THE AGENCY TO DETERMINE IF THE INDIVIDUAL HAS A CONFIRMED REPORT FOR CHILD ABUSE OR NEGLECT REPORTED TO THE STATE DEPARTMENT'S AUTOMATED SYSTEM AS FOUND AT SECTION 7.701.32 OF THE GENERAL RULES FOR CHILD CARE FACILITIES. THE PERSONNEL FILE OF EACH SUBSTITUTE MUST CONTAIN THE RESULTS OF THE STATE DEPARTMENT'S AUTOMATED SYSTEM.

3. SUBSTITUTES MUST BE CURRENT FOR ALL IMMUNIZATIONS ROUTINELY RECOMMENDED FOR ADULTS BY THEIR HEALTH CARE PROVIDER.

4. PRIOR TO BEING PLACED IN A CHILD CARE FACILITY, SUBSTITUTES MUST SUBMIT TO THE AGENCY A MEDICAL STATEMENT, SIGNED AND DATED BY A LICENSED PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL, VERIFYING THAT THEY ARE IN GOOD MENTAL, PHYSICAL, AND EMOTIONAL HEALTH APPROPRIATE FOR THE POSITION FOR WHICH THEY HAVE BEEN HIRED. THIS STATEMENT MUST BE DATED NO MORE THAN 6 MONTHS PRIOR TO EMPLOYMENT OR WITHIN THIRTY (30) CALENDAR DAYS AFTER THE DATE OF EMPLOYMENT. THIS STATEMENT MUST INDICATE WHEN SUBSEQUENT MEDICAL STATEMENTS ARE REQUIRED. SUBSEQUENT MEDICAL STATEMENTS MUST BE SUBMITTED AS REQUIRED IN WRITING BY A PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL.

5. IF, IN THE OPINION OF A PHYSICIAN OR MENTAL HEALTH PRACTITIONER, AN EMPLOYEE'S EXAMINATION OR TEST RESULTS INDICATE A PHYSICAL, EMOTIONAL, OR MENTAL CONDITION THAT COULD BE HAZARDOUS TO A CHILD, OTHER STAFF, OR SELF, OR THAT WOULD PREVENT SATISFACTORY PERFORMANCE OF DUTIES MUST NOT BE ASSIGNED OR RETURNED TO A POSITION UNTIL THE CONDITION IS CLEARED TO THE SATISFACTION OF THE EXAMINING PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL.

6. NAME, ADDRESS, PHONE NUMBER AND BIRTHDATE OF THE INDIVIDUAL;

7. VERIFICATION OF EDUCATION, WORK EXPERIENCE, EMPLOYMENT, TRAINING, AND COMPLETION OF FIRST AID AND CPR COURSES;

8. DATE OF EMPLOYMENT;

9. RECORD OF PLACEMENTS INCLUDING DATES, NUMBER OF HOURS WORKED, NAME, ADDRESS AND LICENSE NUMBER OF THE CHILD CARE FACILITY WHERE THE SUBSTITUTE WAS PLACED.

10. NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF PERSONS TO BE NOTIFIED IN THE EVENT OF AN EMERGENCY.

11. SUBSTITUTE RECORDS MUST BE AVAILABLE, UPON REQUEST, TO AUTHORIZED PERSONNEL OF THE STATE DEPARTMENT OR DEPARTMENT REPRESENTATIVES.

12. THE RECORDS OF THE SUBSTITUTE MUST BE MAINTAINED BY THE SUBSTITUTE PLACEMENT AGENCY FOR AT LEAST THREE (3) YEARS. THE CURRENT FILES MUST BE MAINTAINED AT THE AGENCY, THE PREVIOUS TWO (2) YEARS MAY BE STORED AT EITHER THE AGENCY OR A CENTRAL LOCATION. IF REQUESTED, THE RECORDS MUST BE PROVIDED TO THE DEPARTMENT OR DEPARTMENT REPRESENTATIVE.

B. THE PERSONNEL FILE FOR EACH SUBSTITUTE MUST CONTAIN ALL REQUIRED INFORMATION BEFORE THE SUBSTITUTE CAN BE PLACED AT A CHILD CARE FACILITY.

7.730.3 HEALTH AND SAFETY

7.730.31 CONTROL OF COMMUNICABLE ILLNESSES

A. WHEN A SUBSTITUTE HAS WORKED IN A CHILD CARE FACILITY WHERE CHILDREN HAVE BEEN DIAGNOSED WITH A COMMUNICABLE ILLNESS SUCH AS HEPATITIS, MEASLES, MUMPS, MENINGITIS, DIPHTHERIA, RUBELLA, SALMONELLA, TUBERCULOSIS, GIARDIA OR SHIGELLA, THE SUBSTITUTE MUST IMMEDIATELY NOTIFY THE AGENCY. CHILDREN'S CONFIDENTIALITY MUST BE MAINTAINED.

B. THE AFFECTED CHILD CARE FACILITY MUST REPORT TO THE AGENCY ANY EXPOSURE TO A COMMUNICABLE ILLNESS AT A CHILD CARE FACILITY, AND, AT THE DISCRETION OF THE AGENCY, WITH HEALTH DEPARTMENT GUIDANCE, THE SUBSTITUTE SHOULD BE EXCLUDED FROM THE WORKING IN A CHILD CARE FACILITY FOR THE PERIOD OF TIME PRESCRIBED BY THE SUBSTITUTE'S PHYSICIAN OR BY THE LOCAL HEALTH DEPARTMENT. THE AGENCY MUST BE NOTIFIED WITHIN 24 HOURS.

C. WHEN THE SUBSTITUTE PLACEMENT AGENCY HAS BEEN NOTIFIED THAT A SUBSTITUTE HAS BEEN IN A PLACEMENT WHERE THE INDIVIDUAL HAS BEEN EXPOSED TO A COMMUNICABLE ILLNESS, THE AGENCY AND THE SUBSTITUTE MUST COMPLY WITH ALL HEALTH DEPARTMENT REQUIREMENTS.

7.730.4 ADMINISTRATIVE

7.730.41 ADMINISTRATIVE RECORDS AND REPORTS

A. THE FOLLOWING RECORDS MUST BE ON FILE AT THE AGENCY:

1. A LIST OF CURRENT SUBSTITUTES, AND SUBSTITUTE PLACEMENTS;

2. REPORTS FROM CONTRACTED CHILD CARE FACILITIES WHERE ANY INCIDENT REPORTS OCCUR.

3. CONTRACTS WITH BOTH SUBSTITUTES AND CHILD CARE FACILITIES.

4. WITHIN THIRTY (30) CALENDAR DAYS OF THE LAST DAY OF EMPLOYMENT, STAFF MEMBERS MUST BE PROVIDED A LETTER VERIFYING THEIR EXPERIENCE AT THE AGENCY. THE LETTER MUST CONTAIN THE AGENCY'S ADDRESS, PHONE NUMBER AND LICENSE NUMBER, THE EMPLOYEE'S START AND END DATE AND THE TOTAL NUMBER OF HOURS WORKED WITH CHILDREN. HOURS WORKED WITH INFANTS AND TODDLERS MUST BE DOCUMENTED SEPARATELY FROM HOURS WORKED WITH OTHER AGE GROUPS. THE LETTER MUST BE SIGNED BY A DIRECTOR, OWNER OR HUMAN RESOURCES AGENT OF THE AGENCY.

Title of Proposed Rule:	**Substitute Placement Agency for Less Than 24 Hour Care Facilities**	
CDHS Tracking #:	**18-07-23-01**	
Office, Division, & Program:	Rule Author:	Phone: 303-866-5188
OEC, ECL, DECL, Licensing	Kathi Wagoner	E-Mail: kathi.wagoner@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 [ ] Initial Board Reading [ ] AG 2nd Review [ ] Second Board Reading / Adoption

This package contains the following types of rules: *(check all that apply)*

Number	
	Amended Rules
X	New Rules
	Repealed Rules
	Reviewed Rules

What month is being requested for this rule to first go before the State Board?	October 2018

What date is being requested for this rule to be effective?	December 2018
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 10/5/18 2nd Board 11/2/18 Effective Date 12/31/18

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STATEMENT OF BASIS AND PURPOSE

Summary of the basis and purpose for new rule or rule change.
Explain why the rule or rule change is necessary and what the program hopes to accomplish through this rule.

Senate Bill 18-162 creating a new less than 24 hour license type was signed into law April 12, 2018 requiring the Department to promulgate a new rule set for the new license type. This package adds new rules regarding the creation of a Substitute Placement Agency.

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

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

Justification for emergency:

State Board Authority for Rule:

Code	Description
26-1-107, C.R.S. (2017)	State Board to promulgate rules
26-1-109, C.R.S. (2017)	State department rules to coordinate with federal programs
26-1-111, C.R.S. (2017)	State department to promulgate rules for public assistance and welfare activities.

Program Authority for Rule: *Give federal and/or state citations and a summary of the language authorizing the rule-making function AND authority.*

Code	Description
26-6-103.3, C.R.S. (2017)	Substitute Placement Agency
26-6-106(1)(a), C.R.S. (2017)	Standards for facilities and agencies, and authority to promulgate rules;

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

If yes, please explain. The statutory definition of a Substitute Placement Agency is found in this packet.

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REGULATORY ANALYSIS

1. List of groups impacted by this rule.

Which groups of persons will benefit, bear the burdens or be adversely impacted by this rule?

Family Child Care Home Providers, Child Care Centers, Preschools and School Age Child Care will benefit from this by having a more robust substitute pool to use as needed. Parents and families will also benefit as child care providers will have more flexibility in using qualified substitutes when regular staff members are absent so that classrooms do not have to close due to those absences.

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?

Because the reauthorization of the Child Care Development Block Grant requires background checks be complete prior to working with children, legislation was passed to better facilitate placement of qualified, background checked, substitute employees by creating a new facility license-type – Substitute Placement Agency. The Department needs to have a facility license to attach the background checks so that the Agency and the Department can monitor for any disqualifying arrests or convictions. All licensed Family Child Care Home Providers, Child Care Centers, Preschools and School Age Child Care providers will have the ability to use substitutes who meet all required qualifications, including background checks.

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.

State Fiscal Impact *(Identify all state agencies with a fiscal impact, including any Colorado Benefits Management System (CBMS) change request costs required to implement this rule change)*

There is no direct fiscal impact to the state due this rule package. The State fiscal impact, as addressed in the legislation, will be absorbed through the assessment and collection of application and annual continuation fees for this new license type.

County Fiscal Impact

No impact because counties will not be responsible for the regulatory oversight of the Substitute Placement Agencies nor will Substitute Agencies be eligible for CCCAP subsidies.

Federal Fiscal Impact

No negative fiscal impact, as these rules allow the Department to meet Federal standards.

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

New applicants and licensee's holding the substitute placement agency license will be required to pay an application and annual license continuation fee. There will be some costs associated with the administrative duties associated with employee record-keeping in order to comply with federal and state law.

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4. Data Description

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

Reviewed existing models in Colorado including school districts, other states who have developed similar substitute programs including Washington, Tennessee, Illinois and North Carolina. Reviewed articles including: "Creating a Successful Child Care Substitute Program" and Creating a substitute Bank for Child Care Centers" and Paving Pathways report". Conducted focus groups with various stakeholders including family child care home providers, child care center directors, two existing child care substitute placement agencies, The Rocky Mountain Early Childhood Council, Early Connections Learning Center, Clayton Early Learning Center, CDE, Colorado Children's Campaign; Child Care resource Center at the City of Aspen; Transforming the Workforce 20/20 work group, peer to peer phone conversation with Department of Early Learning in Washington State;

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.

No alternative to the rule making as this is a new license type created by SB18-162.

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OVERVIEW OF PROPOSED RULE

Compare and/or contrast the content of the current regulation and the proposed change.

Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
7.730.1	Definitions	None, New Rule Set	Definitions for the benefit of the licensee	Describes definitions for the benefit of new SPA governing bodies.	No
7.730.11	Governing Body	None, New Rule Set	Identifies the Governing Body is requirements	Best practice	No
7.730.2	Personnel	None, New Rule Set	Identifies general requirements for substitutes employed by the Governing Body.	Best practice	
7.730.22	Personnel Policies, Orientation and Staff Development	None, New Rule Set	Identifies substitute qualifications for Emergency, Short-Term and Long Term Substitutes	Federal and state requirements for training and personnel	Yes
7.730.23	Substitute Qualifications	None, New Rule Set	Identifies qualifications for the Substitute Placement Agency regarding employment of Substitutes Placed in Child Care Centers	Matches language found in other rule sets	Yes
7.730.24	Family Child Care Home Substitute Qualifications	None, New Rule Set	Identifies qualifications for the Substitute Placement Agency regarding employment of Substitutes placed in Family Child Care Homes	Matches language found in other rule sets	Yes
7.730.25	School age child care substitute qualifications	None, New Rule Set	Identifies qualifications for the Substitute Placement Agency regarding employment of Substitutes placed in School Age Child Care	Matches language found in other rule sets	No
7.730.26	Personnel Files	None, New Rule Set	Identifies requirements for the Substitute Placement Agency personnel files	Matches language found in other rule sets	Yes
7.730.31	Control of Communicable Disease	None, New Rule Set	Identifies requirements for reporting and placement of Substitutes who have been exposed to a communicable disease while placed in a child care facility.	Health and safety for children	Yes
7.730.41	Administrative Records and Reports	None, New Rule Set	Identifies general requirements for the Substitute Placement Agency for maintaining records and reports	Best practice	No

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STAKEHOLDER COMMENT SUMMARY

Development

The following individuals and/or entities were included in the development of these proposed rules (such as other Program Areas, Legislative Liaison, and Sub-PAC):

Colorado Children's Campaign, Denver Early Childhood Council, Take-A-Break Child Care, Colorado Substitutes, Colorado Children's Hospital, Healthy Child Care Colorado, Early Childhood Education Association of Colorado, Arapahoe Community College Early Childhood Department, Red Rocks Community College Child Care Innovations.

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:

All licensed less-than-24-hour child care facilities, substitute placement agencies currently operating, but not licensed by CDHS.

Other State Agencies

Are other State Agencies (such as HCPF or CDPHE) impacted by these rules? If so, have they been contacted and provided input on the proposed rules?

[ ] Yes [X] No

If yes, who was contacted and what was their input?

Sub-PAC

Have these rules been reviewed by the appropriate Sub-PAC Committee?

[X] Yes [ ] No

Name of Sub-PAC	Early Childhood		
Date presented	7/12/18, 8/2/18, 9/6/18		
What issues were raised?	Add qualifications for Assistant ECT and staff aide to packet		
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.			

PAC

Have these rules been approved by PAC?

[ ] Yes [ ] No

Date presented			
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:

[X] Yes [ ] No

If "yes" to any of the above questions, summarize and/or attach the feedback received, including requests made by the State Board of Human Services, by specifying the section and including the Department/Office/Division response. Provide proof of agreement or ongoing issues with a letter or public testimony by the stakeholder.

Color Code: Purple: Public Comment

Proposed Rules for the Substitute Placement Agency Rules

(12 CCR 2509-8)

THESE RULES WILL ADDRESS THE OPERATION OF A SUBSTITUTE PLACEMENT AGENCY THAT PLACES A SUBSTITUTE CHILD CARE TEACHER OR DIRECTOR INTO A LICENSED CHILD CARE FACILITY FOR THE PURPOSE OF PROVIDING EMERGENCY, SHORT TERM OR LONG TERM SUBSTITUTE CHILD CARE.
12 CCR 2509-8

7.730 RULES REGULATING SUBSTITUTE PLACEMENT AGENCIES

ALL SUBSTITUTE PLACEMENT AGENCIES MUST COMPLY WITH THE CURRENT "GENERAL RULES FOR CHILD CARE FACILITIES" 7.701 AND "RULES REGULATING SUBSTITUTE PLACEMENT AGENCIES (LESS THAN 24-HOUR CARE)"

7.730.1 DEFINITIONS

A. "ADVERSE OR NEGATIVE LICENSING ACTION" MEANS A FINAL AGENCY ACTION RESULTING IN THE DENIAL OF AN APPLICATION, THE IMPOSITION OF FINES, OR THE SUSPENSION OR REVOCATION OF A LICENSE OR THE DEMOTION OF SUCH A LICENSE TO A PROBATIONARY LICENSE.

B. "ARRANGE FOR PLACEMENT" MEANS TO ACT AS AN INTERMEDIARY BY ASSISTING A CHILD CARE FACILITY IN THE PLACEMENT OF A SUBSTITUTE CHILD CARE PROVIDER.

C. "BACKGROUND CHECKS" MEANS A SET OF REQUIRED RECORDS THAT ARE OBTAINED AND ANALYZED TO DETERMINE WHETHER THE HISTORY OF A PROSPECTIVE SUBSTITUTE CHILD CARE EMPLOYEE MEETS LEGAL AND SAFETY CRITERIA WHEN CONSIDERING THE PLACEMENT OF THE INDIVIDUAL IN A LESS THAN 24 HOUR CHILD CARE FACILITY.

D. "CHILD CARE CENTER" MEANS A LICENSED CHILD CARE CENTER, PRESCHOOL OR LICENSED SCHOOL AGE CHILD CARE CENTER.

E. "EMPLOYEE" MEANS ANY INDIVIDUAL WHETHER EMPLOYED BY OR CONTRACTED THROUGH THE AGENCY.

F. “EMERGENCY CHILD CARE CENTER SUBSTITUTE” MEANS A SUBSTITUTE WHO WORKS IN PLACE OF A REGULAR STAFF MEMBER IN A CHILD CARE FACILITY WHO IS UNABLE TO WORK THEIR NORMALLY SCHEDULED WORK HOURS DUE TO AN UNEXPECTED EVENT SUCH AS AN ABSENCE OF A STAFF MEMBER OR PERSONAL EMERGENCY EVENT. THE PURPOSE OF THE EMERGENCY SUBSTITUTE IS TO PROVIDE COVERAGE FOR A STAFF MEMBER FOR NO MORE THAN THREE (3) CALENDAR DAYS.

G. “EMERGENCY FAMILY CHILD CARE HOME SUBSTITUTE” MEANS A SUBSTITUTE WHO WORKS IN PLACE OF A FAMILY CHILD CARE HOME PROVIDER WHO IS UNABLE TO WORK THEIR NORMALLY SCHEDULED WORK HOURS DUE TO AN UNEXPECTED EVENT SUCH AS AN ILLNESS OR PERSONAL EMERGENCY EVENT. THE PURPOSE OF THE EMERGENCY SUBSTITUTE IS TO PROVIDE COVERAGE FOR A FAMILY CHILD CARE HOME PROVIDER UNTIL PARENTS ARE ABLE TO PICK UP THE CHILDREN IN CARE.

H. “EQUALLY QUALIFIED” MEANS THAT THE EMPLOYEE OR SUBSTITUTE PROVIDER HAS THE SAME REQUIRED TRAINING AND QUALIFICATIONS AS THE PRIMARY PROVIDER AS SPECIFIED IN THE RULES REGULATING FAMILY CHILD CARE HOMES; RULES REGULATING CHILD CARE CENTERS OR RULES REGULATING SCHOOL AGE CHILD CARE.

I. “FAMILY CHILD CARE HOME” MEANS A CHILD CARE FACILITY LOCATED WITHIN A RESIDENCE OF A PRIMARY PROVIDER.

J. “LICENSING” MEANS THE PROCESS BY WHICH THE COLORADO DEPARTMENT OF HUMAN SERVICES APPROVES A FACILITY OR AGENCY FOR THE PURPOSE OF CONDUCTING BUSINESS AS A CHILD CARE FACILITY AND/OR SUBSTITUTE PLACEMENT AGENCY.

K. “LONG TERM CHILD CARE CENTER SUBSTITUTE” MEANS A SUBSTITUTE WHO WORKS IN PLACE OF A REGULAR STAFF MEMBER WHO IS UNABLE TO WORK THEIR NORMALLY SCHEDULED WORK HOURS DUE TO A PLANNED OR UNPLANNED EVENT THAT REQUIRES THE REGULAR STAFF MEMBER BE ON LEAVE FOR MORE THAN TWO (2) CALENDAR WEEKS.

L. “LONG TERM FAMILY CHILD CARE HOME SUBSTITUTE” MEANS A SUBSTITUTE WHO WORKS IN PLACE OF A REGULAR FAMILY CHILD CARE HOME PROVIDER

WHO IS UNABLE TO WORK THEIR NORMALLY SCHEDULED WORK HOURS DUE TO A PLANNED OR UNPLANNED EVENT THAT REQUIRES THE REGULAR FAMILY CHILD CARE HOME PROVIDER TO BE ON LEAVE FOR MORE THAN TWO (2) CALENDAR WEEKS.

M. “SHORT TERM CHILD CARE CENTER SUBSTITUTE” MEANS A SUBSTITUTE WHO WORKS IN PLACE OF A REGULAR STAFF MEMBER WHO IS UNABLE TO WORK THEIR NORMALLY SCHEDULED WORK HOURS DUE TO A PLANNED OR UNPLANNED EVENT THAT REQUIRES THE REGULAR STAFF MEMBER BE ON LEAVE FOR MORE THAN THREE (3) DAYS AND LESS THAN TWO (2) CALENDAR WEEKS.

N. “SHORT TERM FAMILY CHILD CARE HOME SUBSTITUTE” MEANS A SUBSTITUTE WHO WORKS IN PLACE OF A REGULAR FAMILY CHILD CARE HOME WHO IS UNABLE TO WORK THEIR NORMALLY SCHEDULED WORK HOURS DUE TO A PLANNED OR UNPLANNED EVENT THAT REQUIRES THE REGULAR FAMILY CHILD CARE HOME TO BE ON LEAVE FOR MORE THAN THREE (3) DAYS AND LESS THAN TWO (2) CALENDAR WEEKS.

O. "SUBSTITUTE CHILD CARE PROVIDER," DEFINED AT SECTION 26-6-102(37), C.R.S., MEANS AN ADULT OVER THE AGE OF EIGHTEEN (18) YEARS WHO PROVIDES TEMPORARY CARE FOR A CHILD OR CHILDREN IN A LICENSED CHILD CARE FACILITY, INCLUDING A CHILD CARE CENTER, PRESCHOOL, SCHOOL AGE CHILD CENTER OR A FAMILY CHILD CARE HOME.

P. “SUBSTITUTE PLACEMENT AGENCY,” DEFINED AT SECTION 26-6-102(37.5), C.R.S., MEANS ANY CORPORATION, PARTNERSHIP, ASSOCIATION, FIRM, AGENCY, OR INSTITUTION THAT PLACES OR THAT FACILITATES OR ARRANGES PLACEMENT OF EMERGENCY, SHORT-TERM OR LONG-TERM SUBSTITUTE CHILD CARE PROVIDERS IN LICENSED CHILD CARE FACILITIES PROVIDING LESS THAN TWENTY-FOUR-HOUR CARE.

Q. “SUBSTITUTE PLACEMENT,” MEANS TO COORDINATE, ARRANGE, AND APPROVE THE PROCESS OF AN ADULT SUBSTITUTE CHILD CARE PROVIDER ENTERING AN UNRELATED FAMILY CHILD CARE HOME OR CHILD CARE FACILITY TO PROVIDE SUBSTITUTE CHILD CARE SERVICES ON AN EMERGENCY, TEMPORARY/SHORT TERM OR LONG-TERM ASSIGNMENT. SUBSTITUTES MAY BE EMPLOYEES OR CONTRACT EMPLOYEES OF THE AGENCY.

7.730.11 GOVERNING BODY

THE GOVERNING BODY MUST BE IDENTIFIED BY ITS LEGAL NAME. THE NAMES AND ADDRESSES OF INDIVIDUALS WHO HOLD PRIMARY FINANCIAL CONTROL AND OFFICERS OF THE GOVERNING BODY MUST BE DISCLOSED FULLY TO THE COLORADO DEPARTMENT OF HUMAN SERVICES. THE GOVERNING BODY IS RESPONSIBLE FOR PROVIDING ADEQUATE FINANCING, QUALIFIED PERSONNEL, SERVICES, AND PROGRAM FUNCTIONS FOR THE SAFETY AND WELL-BEING OF CHILDREN IN ACCORDANCE WITH THESE RULES. WHEN CHANGES OF GOVERNING BODY OCCUR, THE NEW GOVERNING BODY MUST IMMEDIATELY SUBMIT AN ORIGINAL APPLICATION AND PAY THE REQUIRED FEE BEFORE A NEW LICENSE CAN BE ISSUED.

A. A SUBSTITUTE PLACEMENT AGENCY, HEREIN REFERRED TO AS “THE AGENCY” MAY NOT BE OPERATED WITHOUT A LICENSE, AS REQUIRED BY LAW, TO BE ISSUED BY THE STATE DEPARTMENT IN CONFORMITY WITH ALL RULES AND REGULATIONS.

B. THE SUBSTITUTE PLACEMENT AGENCY MUST:

1. MAINTAIN THE WRITTEN PURPOSE AND POLICIES FOR THE GENERAL OPERATION AND MANAGEMENT OF THE AGENCY, INCLUDING THE PLACEMENT OF SUBSTITUTES. WHEN SUCH PURPOSE AND POLICIES ARE REVIEWED AND REVISED, THE STATE DEPARTMENT MUST BE ADVISED OF SUCH CHANGES. THE PURPOSE AND POLICIES AT A MINIMUM MUST INCLUDE:

1) THE TYPES OF CHILD CARE FACILITIES IN WHICH SUBSTITUTES WILL BE PLACED, INCLUDING THE AGES OF CHILDREN SERVED AT THE CHILD CARE FACILITY WHERE SUBSTITUTES WILL BE PLACED AND THE GEOGRAPHIC AREA(S) THE AGENCY EXPECTS TO SERVE;

2) THE RESPONSIBILITIES FOR CHILD CARE FACILITIES UTILIZING THE SUBSTITUTE PLACEMENT AGENCY;

3) ITEMIZED FEE SCHEDULE, INCLUDING CLIENT SET UP FEES, IF APPLICABLE;

4) REFUND POLICY;

5) CANCELLATION POLICY;

6) MILEAGE/TRAVEL POLICY;

7) MINIMUM SCHEDULED TIME POLICY;

8) SERVICES AND TYPES OF SUBSTITUTES AVAILABLE TO THE COMMUNITY;

9) THE RESPONSIBILITIES OF THE AGENCY AND THE CHILD CARE FACILITY FOR REPORTING SUSPECTED CHILD ABUSE OR NEGLECT;

2. BOTH THE AGENCY AND THE CHILD CARE FACILITY MUST HAVE A FULLY EXECUTED, SIGNED CONTRACT PRIOR TO PLACING SUBSTITUTES IN THE CHILD CARE FACILITY.

3. DEVELOP AND IMPLEMENT PERSONNEL POLICIES INCLUDING, BUT NOT LIMITED TO:

a. JOB DESCRIPTIONS FOR SUBSTITUTES;

b. QUALIFICATIONS FOR THE POSITION IN ACCORDANCE WITH CURRENT LICENSING STANDARDS;

c. THE DUTIES AND RESPONSIBILITIES OF SUBSTITUTES;

d. THE RESPONSIBILITIES OF THE SUBSTITUTE WITHIN A CHILD CARE FACILITY;

e. THE PROPER SUPERVISION OF CHILDREN;

f. PROPER GUIDANCE TECHNIQUES;

g. PROPER NAME TO FACE ATTENDANCE AND TRANSITIONS;

h. THE IDENTIFICATION AND SYMPTOMS OF SUSPECTED CHILD ABUSE OR NEGLECT; AND

i. THE REPORTING OF SUSPECTED CHILD ABUSE, INCLUDING THE STATEWIDE CHILD ABUSE REPORTING HOTLINE.

4. SUBSTITUTES MUST BE INFORMED OF THEIR DUTIES AT THE TIME OF EMPLOYMENT OR ACCEPTANCE OF A CONTRACT WITH THE AGENCY, AND BEFORE BEING PLACED IN A CHILD CARE FACILITY.

5. INFORM THE DEPARTMENT, IN WRITING, OF:

a. A CHANGE IN THE EXECUTIVE DIRECTOR OR THE MAIN CONTACT OF THE AGENCY WITHIN TEN (10) CALENDAR DAYS.

b. THE HOURS OF OPERATION THE AGENCY OFFICE IS OPEN AND AVAILABLE FOR INSPECTION OF AGENCY RECORDS.

6. NOTIFY THE DEPARTMENT, IN WRITING, WITHIN 24 HOURS, ANYTIME A SUBSTITUTE WHO IS THE SUBJECT OF A CHILD PROTECTION INVESTIGATION THAT RESULTED WHILE PLACED AT A CHILD CARE FACILITY; ANY SUBSTITUTE WHO WAS THE STAFF MEMBER IN CHARGE OF A CLASSROOM AND A CHILD RECEIVED AN INJURY REQUIRING EMERGENCY MEDICAL TREATMENT; ANY SUBSTITUTE WHO IS RESPONSIBLE FOR A SAFE SLEEP VIOLATION OR ANY SUBSTITUTE WHO HAS BEEN TERMINATED AS A RESULT OF HIS/HER ACTIONS WHILE PLACED AT A CHILD CARE FACILITY.

7. WHEN THE SUBSTITUTE FROM THE AGENCY IS THE STAFF MEMBER RESPONSIBLE FOR THE CHILD(REN,) IN A CHILD CARE FACILITY AND THE CHILD RECEIVES AN INJURY RESULTING IN MEDICAL CARE OR TREATMENT, THE AGENCY MUST DOCUMENT AND REPORT WITHIN 24 HOURS, IN

WRITING, TO THE COLORADO DEPARTMENT OF HUMAN SERVICES ANY ACCIDENT OR ILLNESS OCCURRING AT A CHILD CARE FACILITY THAT RESULTED IN MEDICAL CARE OR TREATMENT BY A PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL, HOSPITALIZATION, OR DEATH.

8. CARRY PUBLIC LIABILITY INSURANCE. THE APPLICANT OR LICENSEE MUST SUBMIT THE AMOUNT OF THE INSURANCE AND THE NAME AND THE ADDRESS OF THE INSURANCE AGENCY PROVIDING THE INSURANCE TO THE AGENCY. DOCUMENTATION OF CURRENT LIABILITY INSURANCE MUST BE ON FILE AND AVAILABLE FOR REVIEW AT ALL TIMES AT THE AGENCY.

9. COMPLETE THE LICENSING RENEWAL REQUIREMENTS BY:

a. SUBMITTING THE LICENSE CONTINUATION NOTICE AND FEE PRIOR TO THE ANNUAL DUE DATE OF THE CONTINUATION NOTICE;

b. PAYING THE PRESCRIBED APPLICATION OR CONTINUATION FEE PURSUANT TO SECTION 7.701.4;

c. COOPERATING WITH ON-SITE MONITORING INSPECTIONS AND INVESTIGATIONS TO ASSESS THE AGENCY'S COMPLIANCE WITH THE RULES FOR SUBSTITUTE PLACEMENT AGENCIES; AND

7.730.2 PERSONNEL

7.730.21 GENERAL REQUIREMENTS FOR ALL SUBSTITUTES

A. THERE MUST BE A DATED LETTER OF AGREEMENT WITH EACH SUBSTITUTE WHICH INCLUDES THE SPECIFIC JOB RESPONSIBILITIES/JOB DESCRIPTION. THE LETTER OF AGREEMENT MUST BE EXECUTED UPON HIRE BY BOTH THE AGENCY AND THE SUBSTITUTE. PRIOR TO BEING PLACED AT A CHILD CARE FACILITY, SUBSTITUTES MUST SIGN A STATEMENT INDICATING THAT THEY HAVE READ AND UNDERSTAND THE AGENCY POLICIES AND PROCEDURES. ALL SUBSTITUTES MUST BE NOTIFIED OF CHANGES TO POLICIES AND PROCEDURES.

B. ALL SUBSTITUTES MUST BE EIGHTEEN (18) YEARS OR OLDER AND QUALIFIED FOR THE POSITION WHICH HE/SHE WILL BE PROVIDING SUBSTITUTE CARE.

C. ALL SUBSTITUTES MUST BE REGISTERED IN THE PROFESSIONAL DEVELOPMENT INFORMATION SYSTEM;

D. ALL SUBSTITUTES MUST HAVE COMPLETED ALL THE PRE-SERVICE TRAINING COURSES LISTED AT 7.730.3D1-6J PRIOR TO BEING PLACED AT A CHILD CARE FACILITY;

E. ALL SUBSTITUTES MUST COMPLETE THE DEPARTMENT-APPROVED PLAYGROUND SAFETY TRAINING PRIOR TO WORKING WITH CHILDREN AND ANNUALLY;

F. ALL SUBSTITUTES MUST COMPLETE THE DEPARTMENT-APPROVED INJURY PREVENTION TRAINING PRIOR TO WORKING WITH CHILDREN AND ANNUALLY;

G. THE PERSONNEL FILE OF EACH SUBSTITUTE MUST CONTAIN CLEARANCE OR ARREST REPORT FROM THE COLORADO BUREAU OF INVESTIGATION RESULTING FROM THE STAFF MEMBER'S CRIMINAL RECORD CHECK IN ACCORDANCE WITH SECTION 7.701.33 OF THE GENERAL RULES FOR CHILD CARE FACILITIES.

H. THE PERSONNEL FILE OF EACH SUBSTITUTE MUST CONTAIN THE RESULTS OF THE STATE DEPARTMENT’S AUTOMATED CHILD ABUSE AND NEGLECT SYSTEM. IN ACCORDANCE WITH SECTION 7.701.32 OF THE GENERAL RULES FOR CHILD CARE FACILITIES.

I. SUBSTITUTES MUST BE CURRENT FOR ALL IMMUNIZATIONS ROUTINELY RECOMMENDED FOR ADULTS BY THEIR HEALTH CARE PROVIDER.

7.730.22 PERSONNEL POLICIES, ORIENTATION AND STAFF DEVELOPMENT

A. A WRITTEN STATEMENT OF PERSONNEL POLICY SHALL BE PROVIDED TO EACH SUBSTITUTE OR QUALIFIED APPLICANT. THIS STATEMENT SHALL, AT A MINIMUM, CONTAIN THE FOLLOWING INFORMATION:

1. A JOB DESCRIPTION WHICH OUTLINES THE DUTIES, RESPONSIBILITIES, QUALIFICATIONS; AND EDUCATIONAL REQUIREMENTS FOR THE POSITION.

2. A PROCEDURE FOR TRACKING THE PLACEMENT HOURS, INCLUDING THE NAME, LICENSE NUMBER, ADDRESSES AND AGES OF CHILDREN WHERE THE SUBSTITUTE IS PLACED.

3. PRIOR TO WORKING WITH CHILDREN, EACH SUBSTITUTE MUST READ AND BE INSTRUCTED ABOUT THE POLICIES AND PROCEDURES OF THE AGENCY, INCLUDING THOSE RELATED TO PROPER SUPERVISION OF CHILDREN, IDENTIFICATION AND SYMPTOMS OF SUSPECTED CHILD ABUSE OR NEGLECT, THE REPORTING OF SUSPECTED CHILD ABUSE.

SUBSTITUTES MUST SIGN A STATEMENT INDICATING THAT THEY HAVE READ AND UNDERSTAND THE AGENCY'S POLICIES AND PROCEDURES.

4. A WRITTEN PRE-SERVICE TRAINING PLAN FOR EACH SUBSTITUTE. EACH SUBSTITUTE MUST COMPLETE THE FOLLOWING TRAINING BEFORE BEING PLACED IN A CHILD CARE FACILITY:

   a. EACH SUBSTITUTE WORKING WITH INFANTS LESS THAN TWELVE (12) MONTHS OLD MUST COMPLETE A DEPARTMENT-APPROVED SAFE SLEEP TRAINING PRIOR TO WORKING WITH INFANTS LESS THAN TWELVE (12) MONTHS OLD. THIS TRAINING MUST BE RENEWED ANNUALLY AND MAY BE COUNTED TOWARDS ONGOING TRAINING REQUIREMENTS.

   b. EACH SUBSTITUTE WORKING WITH CHILDREN LESS THAN THREE (3) YEARS OF AGE MUST COMPLETE A DEPARTMENT-APPROVED PREVENTION OF SHAKEN BABY/ABUSIVE HEAD TRAUMA TRAINING PRIOR TO WORKING WITH CHILDREN LESS THAN THREE (3) YEARS OF AGE. THIS TRAINING MUST BE RENEWED ANNUALLY AND COUNTS TOWARDS ONGOING TRAINING REQUIREMENTS.

   c. EACH SUBSTITUTE MUST COMPLETE A DEPARTMENT-APPROVED STANDARD PRECAUTIONS TRAINING THAT MEETS CURRENT OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) REQUIREMENTS PRIOR TO WORKING WITH CHILDREN. THIS TRAINING MUST BE RENEWED ANNUALLY AND COUNTS TOWARDS ONGOING TRAINING REQUIREMENTS.

   d. PRIOR TO WORKING WITH CHILDREN AND ANNUALLY EACH SUBSTITUTE MUST BE TRAINED USING DEPARTMENT-APPROVED TRAINING ABOUT CHILD ABUSE PREVENTION, INCLUDING COMMON SYMPTOMS AND SIGNS OF CHILD ABUSE.

   e. PRIOR TO WORKING WITH CHILDREN AND ANNUALLY EACH SUBSTITUTE MUST BE TRAINED USING A DEPARTMENT-APPROVED TRAINING ON HOW TO REPORT, WHERE TO REPORT AND WHEN TO REPORT SUSPECTED OR KNOWN CHILD ABUSE OR NEGLECT.

   f. THE AGENCY MUST ENSURE THAT EACH SUBSTITUTE IS FAMILIAR WITH THE LICENSING RULES GOVERNING THE SPECIFIC CHILD CARE LICENSE TYPE IN WHICH THE SUBSTITUTE WILL BE PLACED WITHIN THIRTY (30) CALENDAR DAYS OF EMPLOYMENT AT THE SUBSTITUTE PLACEMENT AGENCY.

g. THE AGENCY MUST ENSURE THAT EACH SUBSTITUTE IS FAMILIAR WITH THE RULES AND REGULATIONS GOVERNING THE HEALTH AND SANITATION OF CHILD CARE FACILITIES IN THE STATE OF COLORADO IF PLACED IN A FACILITY THAT THESE RULES APPLY WITHIN THIRTY (30) CALENDAR DAYS OF EMPLOYMENT AT THE SUBSTITUTE PLACEMENT AGENCY.

h. EACH SUBSTITUTE MUST HAVE CURRENT DEPARTMENT-APPROVED FIRST AID AND CPR CERTIFICATION BEFORE WORKING IN A CLASSROOM ALONE.

i. EACH SUBSTITUTE MUST COMPLETE A MINIMUM OF FIFTEEN (15) CLOCK HOURS OF TRAINING EACH YEAR BEGINNING WITH THE START DATE OF THE EMPLOYEE. AT LEAST THREE (3) CLOCK HOURS PER YEAR MUST BE IN THE FOCUS OF SOCIAL EMOTIONAL DEVELOPMENT.

j. ONGOING TRAINING AND COURSES SHALL DEMONSTRATE A DIRECT CONNECTION TO ONE OR MORE OF THE FOLLOWING COMPETENCY AREAS:

1) CHILD GROWTH AND DEVELOPMENT, AND LEARNING OR COURSES THAT ALIGN WITH THE COMPETENCY DOMAINS OF CHILD GROWTH AND DEVELOPMENT;

2) CHILD OBSERVATION AND ASSESSMENT;

3) FAMILY AND COMMUNITY PARTNERSHIP;

4) GUIDANCE;

5) HEALTH, SAFETY AND NUTRITION;

6) PROFESSIONAL DEVELOPMENT AND LEADERSHIP;

7) PROGRAM PLANNING AND DEVELOPMENT; OR,

8) TEACHING PRACTICES:

k. EACH ONE (1) SEMESTER HOUR COURSE WITH A DIRECT CONNECTION TO THE COMPETENCY AREA LISTED IN SECTION 7.702.33, L, 1-8, TAKEN AT A REGIONALLY ACCREDITED COLLEGE

OR UNIVERSITY SHALL COUNT AS FIFTEEN (15) CLOCK HOURS OF ONGOING TRAINING.

l. TRAINING HOURS COMPLETED CAN ONLY BE COUNTED DURING THE YEAR TAKEN AND CANNOT BE CARRIED OVER.

m. TO BE COUNTED FOR ONGOING TRAINING, THE TRAINING CERTIFICATE MUST HAVE DOCUMENTATION THAT INCLUDES:

1) THE TITLE OF THE TRAINING;

2) THE COMPETENCY DOMAIN;

3) THE DATE AND CLOCK HOURS OF THE TRAINING;

4) THE NAME OR SIGNATURE, OR OTHER APPROVED METHOD OF VERIFYING THE IDENTITY OF TRAINER OR ENTITY;

5) EXPIRATION OF TRAINING IF APPLICABLE; AND

6) CONNECTION TO SOCIAL EMOTIONAL FOCUS IF APPLICABLE.

5. THE SUBSTITUTE MUST HAVE A COMPLETE FILE MAINTAINED AT THE SUBSTITUTE PLACEMENT AGENCY AND HAVE A PORTABLE FILE AVAILABLE FOR REVIEW AT ALL TIMES TO BOTH LICENSING AND THE CHILD CARE FACILITY WHERE THE SUBSTITUTE IS PROVIDING SUBSTITUTE CARE. THE PORTABLE FILE MAY BE IN THE FORM OF HARDCOPY DOCUMENTS OR MAINTAINED ON A DATA STICK. DOCUMENTATION OF QUALIFICATIONS FOR THE POSITION INCLUDES:

a. CERTIFICATE VERIFYING ALL PRE-SERVICE TRAINING, INCLUDING NAME, PHONE NUMBER, AND LICENSE NUMBER OF AGENCY;

b. DEPARTMENT ISSUED DIRECTOR LETTER; OR

c. DEPARTMENT ISSUED EARLY CHILDHOOD TEACHER LETTER; OR

d. OFFICIAL COLLEGE TRANSCRIPT AND LETTERS OF EXPERIENCE; OR

e. CREDENTIAL 2.0 LEVEL 3 OR HIGHER; AND

f. FIRST AID AND CPR CERTIFICATES; AND

g. COMPLETE BACKGROUND CHECK; AND

h. EMERGENCY CONTACT NAME, ADDRESS AND PHONE NUMBER.

6. SUBSTITUTES MUST NOT CONSUME OR BE UNDER THE INFLUENCE OF ANY SUBSTANCE THAT IMPAIRS THEIR ABILITY TO CARE FOR CHILDREN WHILE CARING FOR CHILDREN.

7. ILLEGAL DRUGS, DRUG PARAPHERNALIA, MARIJUANA AND MARIJUANA INFUSED PRODUCTS, AND ALCOHOL MUST NEVER BE PRESENT ON THE PREMISES OF THE FACILITY DURING OPERATING HOURS.

8. SUBSTITUTES MUST MAINTAIN THE CONFIDENTIALITY OF THE CHILDREN, FAMILIES AND THE CHILD CARE FACILITY WHERE THE SUBSTITUTE IS PLACED.

9. SUBSTITUTES ARE RESPONSIBLE FOR DOCUMENTING EXPERIENCE HOURS WITH THE SPECIFIC AGES OF CHILDREN CARED FOR, WHILE PROVIDING SUBSTITUTE CHILD CARE FOR THE PURPOSE OF EMPLOYMENT VERIFICATION WITH THE AGENCY.

10. SUBSTITUTES MUST NOT TAKE PERSONAL PHOTOS OF CHILDREN, OR MAKE REFERENCE TO ANY PERSONAL INFORMATION OF CHILDREN, FAMILIES OR OTHER CHILD CARE FACILITIES, INCLUDING STAFF, ON SOCIAL MEDIA, EMAIL, TEXT MESSAGES OR OTHER MEANS OF COMMUNICATION, WRITTEN OR VERBAL.

11. WHEN CARING FOR CHILDREN, SUBSTITUTES MUST REFRAIN FROM PERSONAL USE OF ELECTRONICS INCLUDING, BUT NOT LIMITED TO, CELL PHONES AND PORTABLE ELECTRONIC DEVICES.

12. SUBSTITUTES MUST SIGN IN AND OUT OF EVERY FACILITY EACH TIME THEY WORK AT A CHILD CARE FACILITY.

7.730.23 SUBSTITUTE QUALIFICATIONS

A. SUBSTITUTE FOR A CHILD CARE CENTER

1. MUST MEET REQUIREMENTS FOUND AT 7.730.21; AND

2. MUST MEET THE CURRENT MINIMUM EDUCATION AND EXPERIENCE REQUIREMENTS FOR THE POSITION IN WHICH THE SUBSTITUTE IS PROVIDING CHILD CARE.

3. LARGE CHILD CARE CENTER DIRECTOR: THE EDUCATIONAL REQUIREMENTS FOR THE DIRECTOR OR SUBSTITUTE DIRECTOR OF A LARGE CENTER MUST BE MET BY SATISFACTORY COMPLETION OF ONE OF THE FOLLOWING. OFFICIAL COLLEGE TRANSCRIPTS MUST BE SUBMITTED TO THE DEPARTMENT FOR EVALUATION OF QUALIFICATIONS.

   a. A BACHELOR DEGREE IN EARLY CHILDHOOD EDUCATION FROM A REGIONALLY ACCREDITED COLORADO COLLEGE OR UNIVERSITY; OR,

   b. A CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL IV VERSION 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION; OR,

   c. A MASTER'S DEGREE WITH A MAJOR EMPHASIS IN CHILD DEVELOPMENT, EARLY CHILDHOOD EDUCATION, EARLY CHILDHOOD SPECIAL EDUCATION; OR,

   d. COMPLETION OF ALL OF THE FOLLOWING THREE (3) SEMESTER HOUR COURSES FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, AT EITHER A TWO YEAR, FOUR YEAR OR GRADUATE LEVEL, IN EACH OF THE FOLLOWING SUBJECT OR CONTENT AREAS:

      1. INTRODUCTION TO EARLY CHILDHOOD PROFESSIONS;

      2. INTRODUCTION TO EARLY CHILDHOOD LAB TECHNIQUES;

      3. EARLY CHILDHOOD GUIDANCE STRATEGIES FOR CHILDREN;

      4. EARLY CHILDHOOD HEALTH, NUTRITION, AND SAFETY;

      5. ADMINISTRATION OF EARLY CHILDHOOD CARE AND EDUCATION PROGRAMS;

      6. ADMINISTRATION: HUMAN RELATIONS FOR EARLY CHILDHOOD PROFESSIONS OR INTRODUCTION TO BUSINESS;

7. EARLY CHILDHOOD CURRICULUM DEVELOPMENT;

8. EARLY CHILDHOOD GROWTH AND DEVELOPMENT.

9. THE EXCEPTIONAL CHILD; AND,

10. INFANT/TODDLER THEORY AND PRACTICE; OR THE DEPARTMENT APPROVED EXPANDING QUALITY INFANT/TODDLER TRAINING; OR,

11. COMPLETION OF A COURSE OF TRAINING APPROVED BY THE DEPARTMENT THAT INCLUDES COURSE CONTENT LISTED AT SECTION 7.730.22C, A-J, AND DOCUMENTED EXPERIENCE.

e. THE EXPERIENCE REQUIREMENTS FOR THE DIRECTOR OF A LARGE CENTER MUST BE MET BY COMPLETION OF THE FOLLOWING AMOUNT OF WORK EXPERIENCE IN A CHILD DEVELOPMENT PROGRAM, WHICH INCLUDES WORKING WITH A GROUP OF CHILDREN IN SUCH PROGRAMS AS A PRESCHOOL, CHILD CARE CENTER, KINDERGARTEN, OR HEAD START PROGRAM:

1. PERSONS WITH BACHELOR'S OR MASTER'S DEGREE WITH A MAJOR EMPHASIS IN CHILD DEVELOPMENT, EARLY CHILDHOOD EDUCATION, EARLY CHILDHOOD SPECIAL EDUCATION, OR AN EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL IV VERSION 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION; NO ADDITIONAL EXPERIENCE IS REQUIRED.

2. PERSONS WITH A 2-YEAR COLLEGE DEGREE IN EARLY CHILDHOOD EDUCATION MUST HAVE TWELVE (12) MONTHS (1,820 HOURS) OF VERIFIED EXPERIENCE WORKING DIRECTLY WITH CHILDREN IN A CHILD DEVELOPMENT PROGRAM.

3. PERSONS WITH A BACHELOR'S DEGREE AND COMPLETION OF COURSES SPECIFIED IN SECTIONS 7.702.42, A, 3, A-J, MUST HAVE TWELVE (12) MONTHS (1,820 HOURS) OF VERIFIED EXPERIENCE WORKING DIRECTLY WITH CHILDREN IN A CHILD DEVELOPMENT PROGRAM.

4. PERSONS WHO HAVE NO DEGREE BUT HAVE COMPLETED THE THIRTY (30) SEMESTER HOURS SPECIFIED IN SECTION 7.702.42, A, 3, A-J, MUST HAVE TWENTY-FOUR (24) MONTHS (3,640 HOURS) OF VERIFIED EXPERIENCE WORKING

DIRECTLY WITH CHILDREN IN A CHILD DEVELOPMENT PROGRAM.

5. VERIFIED EXPERIENCE ACQUIRED IN A LICENSED COLORADO FAMILY CHILD CARE HOME OR SCHOOL-AGE CHILD CARE CENTER MAY COUNT FOR UP TO HALF OF THE REQUIRED EXPERIENCE FOR DIRECTOR QUALIFICATIONS. TO HAVE COLORADO FAMILY CHILD CARE HOME EXPERIENCE CONSIDERED, THE APPLICANT MUST BE OR HAVE BEEN THE LICENSEE. THE OTHER HALF OF THE REQUIRED EXPERIENCE MUST BE WORKING DIRECTLY WITH CHILDREN IN A CHILD DEVELOPMENT PROGRAM.

6. EXPERIENCE WITH FIVE (5) YEAR OLDS MUST BE VERIFIED AS FOLLOWS:

   a. IF EXPERIENCE CARING FOR FIVE-YEAR-OLD CHILDREN OCCURS IN A CHILD CARE CENTER CLASSROOM, THE HOURS WORKED SHALL BE COUNTED AS PRESCHOOL EXPERIENCE; OR,

   b. IF EXPERIENCE CARING FOR FIVE-YEAR-OLD CHILDREN OCCURS IN AN ELEMENTARY SCHOOL PROGRAM, THE HOURS WORKED SHALL BE COUNTED AS SCHOOL-AGE EXPERIENCE.

4. THE SMALL CENTER DIRECTOR QUALIFICATIONS MUST BE MET BY SATISFACTORY COMPLETION OF:

   a. A CURRENT PROFESSIONAL TEACHING LICENSE ISSUED BY THE COLORADO DEPARTMENT OF EDUCATION WITH AN ENDORSEMENT IN THE AREA OF EARLY CHILDHOOD EDUCATION OR EARLY CHILDHOOD SPECIAL EDUCATION;

   b. A CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL III VERSION 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION;

   c. THREE (3) YEARS' SATISFACTORY EXPERIENCE IN THE GROUP CARE OF CHILDREN LESS THAN SIX (6) YEARS OF AGE (5460 HOURS) AND AT LEAST TWO (2) 3-SEMESTER HOURS FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, AT EITHER A TWO-YEAR, FOUR YEAR OR GRADUATE LEVEL, IN EACH OF THE FOLLOWING SUBJECT OR CONTENT AREAS IN EARLY CHILDHOOD EDUCATION; ONE OF THE COURSES MUST BE EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES;

d. TWO (2) YEARS' COLLEGE EDUCATION (SIXTY SEMESTER HOURS) AT A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, AT EITHER A TWO-YEAR, FOUR YEAR OR GRADUATE LEVEL, IN EACH OF THE FOLLOWING SUBJECT OR CONTENT AREAS WITH AT LEAST TWO (2) 3-SEMESTER-HOUR COURSES IN EARLY CHILDHOOD EDUCATION; ONE OF WHICH MUST BE EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES; AND ONE (1) YEAR (1820 HOURS) OF SATISFACTORY EXPERIENCE IN THE GROUP CARE OF CHILDREN LESS THAN SIX (6) YEARS OF AGE;

e. CURRENT CERTIFICATION AS A CHILD DEVELOPMENT ASSOCIATE (CDA) OR OTHER DEPARTMENT APPROVED CREDENTIAL; OR,

f. A TWO (2) YEAR COLLEGE DEGREE IN CHILD DEVELOPMENT OR EARLY CHILDHOOD EDUCATION FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, AT EITHER A TWO-YEAR, FOUR YEAR OR GRADUATE LEVEL, IN EACH OF THE FOLLOWING SUBJECT OR CONTENT AREAS THAT MUST INCLUDE AT LEAST ONE 3- SEMESTER HOUR COURSE IN EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES AND SIX (6) MONTHS (910 HOURS) SATISFACTORY EXPERIENCE IN THE GROUP CARE OF CHILDREN LESS THAN SIX (6) YEARS OF AGE.

5. THE EARLY CHILDHOOD TEACHER MUST BE MET BY SATISFACTORY COMPLETION OF:

A. A BACHELOR'S DEGREE FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY WITH A MAJOR AREA OF STUDY IN ONE OF THE FOLLOWING AREAS:

1. EARLY CHILDHOOD EDUCATION;

2. ELEMENTARY EDUCATION;

3. SPECIAL EDUCATION;

4. FAMILY AND CHILD DEVELOPMENT; OR,

5. CHILD PSYCHOLOGY.

B. A BACHELOR’S DEGREE FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY WITH A MAJOR AREA OF STUDY IN ANY AREA OTHER

THAN THOSE LISTED AT SECTION 7.730XXX AND ADDITIONAL TWO (2) THREE-SEMESTER HOUR EARLY CHILDHOOD EDUCATION COLLEGE COURSES WITH ONE COURSE BEING EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES;

1. CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL III VERSION 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION;

2. A 2-YEAR COLLEGE DEGREE, SIXTY (60) SEMESTER HOURS, IN EARLY CHILDHOOD EDUCATION FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, WHICH MUST INCLUDE AT LEAST TWO (2) THREE-SEMESTER HOUR COURSES, ONE OF WHICH MUST BE EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES; AND AT LEAST SIX (6) MONTHS (910 HOURS) OF SATISFACTORY EXPERIENCE;

3. COMPLETION OF TWELVE (12) SEMESTER HOURS FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, AT EITHER A TWO YEAR, FOUR YEAR OR GRADUATE LEVEL, IN EACH OF THE FOLLOWING SUBJECT OR CONTENT AREAS IN EARLY CHILDHOOD EDUCATION AND ONE OF THE THREE (3) SEMESTER HOUR COURSES MUST BE EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES, PLUS NINE (9) MONTHS (1,395 HOURS) OF VERIFIED EXPERIENCE IN THE CARE AND SUPERVISION OF FOUR (4) OR MORE CHILDREN LESS THAN SIX (6) YEARS OF AGE WHO ARE NOT RELATED TO THE INDIVIDUAL;

4. COMPLETION OF A VOCATIONAL OR OCCUPATIONAL EDUCATION SEQUENCE IN CHILD GROWTH AND DEVELOPMENT PLUS TWELVE (12) MONTHS (1,820 HOURS) OF VERIFIED EXPERIENCE IN THE CARE AND SUPERVISION OF FOUR (4) OR MORE CHILDREN LESS THAN SIX (6) YEARS OF AGE WHO ARE NOT RELATED TO THE INDIVIDUAL; G. CURRENT CERTIFICATION AS A CHILD DEVELOPMENT ASSOCIATE (CDA) OR OTHER DEPARTMENT-APPROVED CREDENTIAL;

5. COMPLETION OF A COURSE OF TRAINING APPROVED BY THE DEPARTMENT THAT INCLUDES TRAINING AND WORK EXPERIENCE WITH CHILDREN IN A CHILD GROWTH AND DEVELOPMENT PROGRAM PLUS TWELVE (12) MONTHS (1,820 HOURS) OF VERIFIED EXPERIENCE IN THE CARE AND SUPERVISION OF FOUR (4) OR MORE CHILDREN LESS THAN SIX (6) YEARS OF AGE WHO ARE NOT RELATED TO THE INDIVIDUAL; OR,

6. TWENTY-FOUR (24) MONTHS (3,640 HOURS) OF VERIFIED EXPERIENCE IN THE CARE AND SUPERVISION OF FOUR (4) OR MORE CHILDREN LESS THAN SIX (6) YEARS OF AGE WHO ARE NOT RELATED TO THE INDIVIDUAL. SATISFACTORY EXPERIENCE INCLUDES BEING A LICENSEE OF A COLORADO FAMILY CHILD CARE HOME; A TEACHER'S AIDE OR TEACHER IN A CHILD CARE CENTER, PRESCHOOL, OR ELEMENTARY SCHOOL, PLUS EITHER:

   a. A CURRENT COLORADO LEVEL I CREDENTIAL; OR,

   b. TWO (2) THREE-SEMESTER HOUR EARLY CHILDHOOD EDUCATION COLLEGE COURSES FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, AT EITHER A TWO-YEAR, FOUR YEAR OR GRADUATE LEVEL, IN EACH OF THE FOLLOWING SUBJECT OR CONTENT AREAS WITH ONE COURSE BEING EITHER INTRODUCTION TO EARLY CHILDHOOD EDUCATION OR GUIDANCE STRATEGIES.

7. ALL COLLEGE COURSE GRADES TOWARD EARLY CHILDHOOD TEACHER QUALIFICATIONS MUST BE "C" OR BETTER.

C. ASSISTANT EARLY CHILDHOOD TEACHER

AN ASSISTANT EARLY CHILDHOOD TEACHER, ASSIGNED RESPONSIBILITY FOR A SINGLE GROUP OF CHILDREN DURING TIMES SPECIFIED IN 7.702.55, MUST MEET ONE OF THE FOLLOWING QUALIFICATIONS:

1. COMPLETION OF ONE OF THE EARLY CHILDHOOD EDUCATION COURSES IN SECTION 7.702.42, A, WITH A COURSE GRADE OF "C" OR BETTER AND TWELVE (12) MONTHS (1820 HOURS) VERIFIED EXPERIENCE IN THE CARE AND SUPERVISION OF FOUR (4) OR MORE CHILDREN LESS THAN SIX (6) YEARS OF AGE, WHO ARE NOT RELATED TO THE INDIVIDUAL. SATISFACTORY EXPERIENCE INCLUDES BEING A LICENSEE OF A FAMILY CHILD CARE HOME; A TEACHER'S AIDE IN A CENTER, PRESCHOOL OR ELEMENTARY SCHOOL. ASSISTANT EARLY CHILDHOOD TEACHERS MUST BE ENROLLED IN AND ATTENDING THE SECOND (2ND) EARLY CHILDHOOD EDUCATION CLASS WHICH WILL BE USED AS THE BASIS FOR THEIR

QUALIFICATION FOR THE POSITION OF EARLY CHILDHOOD TEACHER;

2. PERSONS HAVING COMPLETED TWO (2) OF THE EARLY CHILDHOOD EDUCATION CLASSES REFERENCED IN SECTION 7.702.42, A, WITH A COURSE GRADE OF "C" OR BETTER AND NO EXPERIENCE; OR,

3. A CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL I VERSION 1.0 OR 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION.

D. STAFF AIDE

1. STAFF AIDES MUST BE AT LEAST SIXTEEN (16) YEARS OF AGE AND MUST WORK DIRECTLY UNDER THE SUPERVISION OF THE DIRECTOR OR AN EARLY CHILDHOOD TEACHER.

2. INFANT STAFF AIDES MUST BE AT LEAST EIGHTEEN (18) YEARS OF AGE.

3. STAFF AIDES, WITHOUT SUPERVISION FROM AN EARLY CHILDHOOD TEACHER OR DIRECTOR, MAY SUPERVISE NO MORE THAN TWO (2) PRESCHOOL AGE CHILDREN WHILE ASSISTING THE CHILDREN WITH DIAPERING OR TOILETING.

E. THE KINDERGARTEN TEACHER QUALIFICATIONS MUST BE MET BY SATISFACTORY COMPLETION OF:

1. EACH TEACHER OF A KINDERGARTEN CLASS MUST HAVE THE SAME QUALIFICATIONS AS A DIRECTOR FOR A LARGE CENTER (SEE SECTION 7.702.42), BE STATE CERTIFIED OR LICENSED AS AN ELEMENTARY TEACHER BY THE COLORADO DEPARTMENT OF EDUCATION, OR HAVE A FOUR (4) YEAR DEGREE FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY IN ELEMENTARY OR EARLY CHILDHOOD EDUCATION.

2. A CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL III VERSION 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION.

F. THE INFANT PROGRAM SUPERVISOR QUALIFICATIONS MUST BE MET BY SATISFACTORY COMPLETION OF:

1. A REGISTERED NURSE, LICENSED TO PRACTICE IN COLORADO, WITH A MINIMUM OF 6 MONTHS OF EXPERIENCE IN THE CARE OF INFANTS.

2. A LICENSED PRACTICAL NURSE, LICENSED TO PRACTICE IN COLORADO, WITH TWELVE (12) MONTHS OF EXPERIENCE IN THE CARE OF INFANTS.

3. AN ADULT WHO HOLDS A CERTIFICATE IN INFANT AND TODDLER CARE FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY WITH COMPLETION OF A MINIMUM OF 30 SEMESTER HOURS IN THE DEVELOPMENT AND CARE OF INFANTS AND TODDLERS IN A GROUP SETTING.

4. AN ADULT WHO IS CURRENTLY CERTIFIED AS A CHILD DEVELOPMENT ASSOCIATE (CDA) AND HAS COMPLETED THE DEPARTMENT APPROVED EXPANDING QUALITY IN INFANT AND TODDLER DEVELOPMENT COURSE OF TRAINING.

5. AN ADULT WHO:

   a. HOLDS A CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL III VERSION 2.0, AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION;

   b. HAS COMPLETED ONE THREE-SEMESTER-HOUR CLASS IN INFANT/TODDLER DEVELOPMENT; OR,

   c. HAS COMPLETED THE DEPARTMENT-APPROVED “EXPANDING QUALITY IN INFANT AND TODDLER DEVELOPMENT” AND HOLDS TWELVE MONTHS OF VERIFIABLE FULL-DAY EXPERIENCE WORKING WITH INFANTS AND/OR TODDLERS.

6. AN ADULT WHO:

   a. IS AT LEAST NINETEEN (19) YEARS OF AGE, AND,

   b. IS QUALIFIED AS AN EARLY CHILDHOOD TEACHER AND,

c. HAS A MINIMUM OF TWELVE (12) MONTHS OF VERIFIABLE FULL-DAY EXPERIENCE IN THE GROUP CARE OF INFANTS OR TODDLERS; AND,

d. HAS COMPLETED AT LEAST TWO (2) THREE (3)-SEMESTER HOUR COLLEGE COURSES FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY ON THE DEVELOPMENT AND CARE OF INFANTS AND TODDLERS IN A GROUP SETTING, ONE (1) OF WHICH MUST BE INFANT/TODDLER DEVELOPMENT OR THE DEPARTMENT APPROVED EXPANDING QUALITY IN INFANT AND TODDLER DEVELOPMENT COURSE OF TRAINING.

G. THE INFANT PROGRAM EARLY CHILDHOOD TEACHER QUALIFICATIONS MUST BE MET BY SATISFACTORY COMPLETION OF:

1. AN INFANT PROGRAM EARLY CHILDHOOD TEACHER MUST HAVE COMPLETED EIGHT (8) HOURS OF ORIENTATION IN THE INFANT PROGRAM FROM THE INFANT PROGRAM SUPERVISOR INCLUDING, BUT NOT LIMITED TO, THE FOLLOWING TOPICS:

a. TOYS AND EQUIPMENT, APPROPRIATE ACTIVITIES FOR INFANTS AND TODDLERS, APPROPRIATE SLEEP POSITIONS FOR INFANTS AND TODDLERS, THE SAFE AND APPROPRIATE DIAPER CHANGE TECHNIQUE; AND,

b. AT LEAST SIX (6) MONTHS OF EXPERIENCE IN THE CARE OF INFANTS OR TODDLERS; AND,

c. MEET QUALIFICATIONS FOR AN EARLY CHILDHOOD TEACHER FOUND AT SECTION 7.702.44, A, OR BE QUALIFIED AS AN INFANT PROGRAM SUPERVISOR.

H. THE INFANT PROGRAM STAFF AIDE MUST BE AT LEAST EIGHTEEN (18) YEARS OF AGE, MUST HAVE COMPLETED EIGHT (8) HOURS OF ORIENTATION AS LISTED ABOVE, AT THE INFANT PROGRAM AND MUST WORK UNDER THE DIRECT SUPERVISION OF AN INFANT EARLY CHILDHOOD TEACHER.

1. SUBSTITUTES FOR INFANT PROGRAM STAFF MUST HOLD A CURRENT DEPARTMENT-APPROVED FIRST AID AND SAFETY CERTIFICATE THAT INCLUDES CPR FOR ALL AGES OF CHILDREN.

2. THE TODDLER PROGRAM EARLY CHILDHOOD TEACHER QUALIFICATIONS MUST BE MET BY SATISFACTORY COMPLETION OF:

1. A REGISTERED NURSE, LICENSED TO PRACTICE IN COLORADO, WITH A MINIMUM OF 6 MONTHS OF EXPERIENCE IN THE CARE OF INFANTS AND/OR TODDLERS;

2. AN ADULT WHO HOLDS A CERTIFICATE IN INFANT AND TODDLER CARE FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY WITH COMPLETION OF AT LEAST THIRTY (30) SEMESTER HOURS OR EQUIVALENT IN SUCH COURSES AS CHILD GROWTH AND DEVELOPMENT, NUTRITION, AND CARE PRACTICES WITH CHILDREN BIRTH TO THREE (3) YEARS OF AGE;

3. AN ADULT WHO IS CERTIFIED AS A CHILD DEVELOPMENT ASSOCIATE (CDA) OR CERTIFIED CHILD CARE PROFESSIONAL (CCP) OR HOLDS ANOTHER DEPARTMENT-APPROVED CERTIFICATE;

4. A LICENSED PRACTICAL NURSE WITH AT LEAST TWELVE (12) MONTHS OF VERIFIABLE EXPERIENCE IN THE CARE OF CHILDREN LESS THAN THREE (3) YEARS OF AGE;

5. AN ADULT WHO MEETS THE EDUCATION AND EXPERIENCE REQUIREMENTS FOR EARLY CHILDHOOD TEACHER OF A LARGE CENTER (SECTION 7.702.44, A); OR,

6. A CURRENT EARLY CHILDHOOD PROFESSIONAL CREDENTIAL LEVEL II VERSION 1.0 OR LEVEL III VERSION 2.0 AS DETERMINED BY THE COLORADO DEPARTMENT OF EDUCATION.

I. THE TODDLER PROGRAM STAFF AIDE MUST BE AT LEAST SIXTEEN (16) YEARS OF AGE, MUST WORK DIRECTLY UNDER THE SUPERVISION OF THE DIRECTOR OR A TODDLER EARLY CHILDHOOD TEACHER, AND MUST HAVE COMPLETED 8 HOURS OF ORIENTATION AT THE TODDLER PROGRAM.

1. SUBSTITUTES FOR TODDLER PROGRAM STAFF MUST HOLD A CURRENT DEPARTMENT-APPROVED FIRST AID AND SAFETY CERTIFICATE THAT INCLUDES CPR FOR ALL AGES OF CHILDREN.

J. SUBSTITUTES PLACED IN AN INFANT AND TODDLER PROGRAM AFFILIATED WITH A TEEN PARENT PROGRAMS THAT ARE OPERATED BY ACCREDITED PUBLIC-SCHOOL SYSTEMS ON SCHOOL PREMISES MUST MEET THE FOLLOWING STAFF REQUIREMENTS BY:

1. DIRECTOR QUALIFICATIONS MAY BE MET BY A CERTIFIED TEACHER WITH A MAJOR IN HOME ECONOMICS EDUCATION OR A VOCATIONALLY CREDENTIALED TEACHER IN CONSUMER AND HOMEMAKING OR EARLY CHILDHOOD OCCUPATIONS. THE DIRECTOR MUST COMPLETE AT LEAST THREE (3) SEMESTER HOURS IN ADMINISTRATION OF A CHILD CARE CENTER.

2. THE DIRECTOR MUST BE PRESENT IN THE INFANT PROGRAM CLASSROOM OR ADJACENT TEEN PARENT CLASSROOM AT LEAST SIXTY PERCENT (60%) OF ANY DAY THE CENTER IS OPEN.

3. IF THE DIRECTOR CANNOT BE PRESENT SIXTY PERCENT (60%) OF ANY DAY, AN INDIVIDUAL WHO MEETS DIRECTOR QUALIFICATIONS MUST SUBSTITUTE FOR THE DIRECTOR.

4. INFANT STAFF AIDES MUST BE AT LEAST FIFTEEN (15) YEARS OF AGE AND MAY BE PARENTS-TO-BE, PARENTS OF ENROLLED INFANTS, OR STUDENTS ENROLLED IN A CHILD CARE RELATED COURSE WITH THE SPONSORING SCHOOL SYSTEM.

5. SUBSTITUTES FOR INFANT PROGRAM STAFF MUST BE FROM THE SPONSORING SCHOOL SYSTEM'S LIST OF APPROVED SUBSTITUTE STAFF MEMBERS. SUBSTITUTES WHO DO NOT MEET MINIMUM STAFF QUALIFICATIONS CAN WORK NO MORE THAN TEN (10) CONSECUTIVE BUSINESS DAYS PER ASSIGNMENT.

6. SUBSTITUTES FOR INFANT PROGRAM STAFF MUST HOLD A CURRENT DEPARTMENT-APPROVED FIRST AID AND SAFETY CERTIFICATE THAT INCLUDES CPR FOR ALL AGES OF CHILDREN.

7.730.24 FAMILY CHILD CARE HOME SUBSTITUTE QUALIFICATIONS

A. REGULAR FAMILY CHILD CARE HOME

1. MUST MEET REQUIREMENTS FOUND AT 7.730.21;

2. BE FAMILIAR WITH THE RULES REGULATING FAMILY CHILD CARE HOMES;

3. BE FAMILIAR WITH THE HOME AND PROVIDER'S POLICIES AND PROCEDURES;

4. KNOW THE NAMES, AGES AND ANY SPECIAL NEEDS OR HEALTH CONCERNS OF THE CHILDREN;

5. KNOW THE LOCATION OF EMERGENCY INFORMATION.

B. INFANT/TODDLER FAMILY CHILD CARE HOMES

1. MUST MEET REQUIREMENTS FOUND AT 7.730.21;

2. BE FAMILIAR WITH THE RULES REGULATING FAMILY CHILD CARE HOMES;

3. BE FAMILIAR WITH THE HOME AND PROVIDER'S POLICIES AND PROCEDURES;

4. KNOW THE NAMES, AGES AND ANY SPECIAL NEEDS OR HEALTH CONCERNS OF THE CHILDREN;

5. KNOW THE LOCATION OF EMERGENCY INFORMATION.

6. MUST HAVE COMPLETED ONE (1) YEAR OF SUPERVISED EXPERIENCE CARING FOR CHILDREN WHO ARE YOUNGER THAN THREE (3) YEARS OLD. THE EXPERIENCE MAY HAVE BEEN OBTAINED AS:

a. A COLORADO LICENSED FAMILY CHILD CARE HOME;

b. A MILITARY LICENSED CHILD CARE HOME;

c. A PROVIDER, IN A FAMILY FOSTER HOME CERTIFIED FOR CHILDREN YOUNGER THAN THREE (3) YEARS OF AGE; OR,

d. AN EMPLOYEE IN A LICENSED CHILD CARE CENTER IN AN INFANT AND/OR TODDLER PROGRAM.

C. THE SUBSTITUTE FOR THE LARGE FAMILY CHILD CARE HOME MUST BE QUALIFIED BY:

1. A MINIMUM OF TWO (2) YEARS OF DOCUMENTED SATISFACTORY EXPERIENCE IN THE GROUP CARE OF CHILDREN UNDER THE AGE OF SIX (6) YEARS OR AS A LICENSED HOME PROVIDER IN COLORADO. EQUAL EXPERIENCE OPERATING AS AN APPROVED MILITARY CHILD CARE HOME IS ACCEPTED; OR,

2. A MINIMUM OF TWO (2) YEARS OF COLLEGE EDUCATION FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY, WITH AT LEAST ONE (1) COLLEGE COURSE IN EARLY CHILDHOOD EDUCATION, PLUS ONE (1) YEAR OF DOCUMENTED SATISFACTORY EXPERIENCE IN THE GROUP CARE OF CHILDREN AS:

   a. A LICENSED HOME PROVIDER IN COLORADO;

   b. A MILITARY LICENSED CHILD CARE HOME;

   c. A COLORADO CERTIFIED FAMILY FOSTER HOME; OR,

   d. A STAFF MEMBER IN A LICENSED CHILD CARE CENTER.

   e. CURRENT CERTIFICATION AS A CHILD DEVELOPMENT ASSOCIATE (CDA); OR, D. COMPLETION PRIOR TO LICENSING OF THE STATE DEPARTMENT APPROVED EXPANDING QUALITY INFANT/TODDLER COURSE; AND,

      1) A MINIMUM OF TWO (2) YEARS OF EXPERIENCE AS A LICENSED CHILD CARE PROVIDER HOLDING A PERMANENT LICENSE IN COLORADO IMMEDIATELY BEFORE BECOMING A LICENSEE OF A LARGE CHILD CARE HOME; OR,

      2) A MINIMUM OF TWO (2) YEARS OF FULL-TIME EXPERIENCE IN A LICENSED PROGRAM. THE GROUP CARE SHALL HAVE BEEN WITH CHILDREN WHO ARE UNDER THE AGE OF SIX (6) YEARS.

   f. SUBSTITUTES WORKING IN PLACE AS THE LARGE FAMILY CHILD CARE HOME STAFF AIDES MUST BE AT LEAST SIXTEEN (16) YEARS OF AGE AND MUST WORK DIRECTLY UNDER THE SUPERVISION OF THE PRIMARY PROVIDER OR A SUBSTITUTE WHO IS EQUALLY QUALIFIED AS A LARGE FAMILY CHILD CARE HOME PROVIDER. IF LEFT ALONE WITH CHILDREN, THE STAFF AIDE SUBSTITUTE OR ASSISTANT PROVIDER SUBSTITUTE MUST MEET ALL SAME AGE AND TRAINING REQUIREMENTS AS THE PROVIDER.

7.730.25 SCHOOL AGE CHILD CARE SUBSTITUTE QUALIFICATIONS

A. SUBSTITUTE FOR SCHOOL AGE CHILD CARE:

1. MUST MEET REQUIREMENTS FOUND AT 7.730.21;

B. SUBSTITUTE PROGRAM DIRECTOR

1. MUST MEET REQUIREMENTS AT 7.730.24 A 1 AND 2;

2. THE PROGRAM DIRECTOR SUBSTITUTE MUST BE AT LEAST TWENTY-ONE (21) YEARS OF AGE. THE SUBSTITUTE PROGRAM DIRECTOR MUST HAVE DEMONSTRATED TO THE AGENCY, PRIOR TO PLACEMENT AT A SCHOOL AGE CHILD CARE CENTER, MATURITY OF JUDGMENT, ADMINISTRATIVE ABILITY AND THE SKILL TO APPROPRIATELY SUPERVISE AND DIRECT SCHOOL-AGE CHILDREN IN AN UNSTRUCTURED SETTING.

3. THE SUBSTITUTE PROGRAM DIRECTOR MUST HAVE VERIFIABLE EDUCATION OR TRAINING IN WORK WITH SCHOOL-AGE CHILDREN IN SUCH AREAS AS RECREATION, EDUCATION, SCOUTING OR 4-H; AND THE PROGRAM DIRECTOR MUST HAVE COMPLETED AT LEAST ONE OF THE FOLLOWING QUALIFICATIONS:

a. A FOUR (4) YEAR COLLEGE DEGREE WITH A MAJOR SUCH AS RECREATION, OUTDOOR EDUCATION, EDUCATION WITH A SPECIALTY IN ART, ELEMENTARY OR EARLY CHILDHOOD EDUCATION, OR A SUBJECT IN THE HUMAN SERVICE FIELD; OR

b. TWO YEARS OF COLLEGE TRAINING AND SIX (6) MONTHS (910 HOURS) OF SATISFACTORY AND VERIFIABLE FULL-TIME OR EQUIVALENT PART-TIME, PAID OR VOLUNTEER, EXPERIENCE, SINCE ATTAINING THE AGE OF EIGHTEEN (18), IN THE CARE AND SUPERVISION OF FOUR (4) OR MORE CHILDREN; OR

c. IS QUALIFIED AS A LARGE CHILD CARE CENTER DIRECTOR; OR

d. THREE YEARS (5460 HOURS) OF SATISFACTORY AND VERIFIABLE FULL-TIME OR EQUIVALENT PART-TIME, PAID OR VOLUNTEER, EXPERIENCE AND ONE OF THE FOLLOWING QUALIFICATIONS:

1. COMPLETE SIX SEMESTER HOURS, OR NINE QUARTER HOURS IN COURSE WORK FROM A REGIONALLY ACCREDITED COLLEGE OR UNIVERSITY; OR

2. 40 CLOCK HOURS OF TRAINING IN COURSE WORK APPLICABLE TO SCHOOL-AGE CHILDREN AND THE DEPARTMENT-APPROVED COURSES IN INJURY PREVENTION, AND PLAYGROUND SAFETY FOR SCHOOL-AGED CHILD CARE CENTERS WITHIN THE FIRST NINE MONTHS OF EMPLOYMENT.

3. SATISFACTORY EXPERIENCE INCLUDES EXPERIENCE IN THE CARE AND SUPERVISION OF FOUR OR MORE CHILDREN FROM THE AGES OF FOUR (4)-EIGHTEEN (18) YEARS OLD, UNRELATED TO THE INDIVIDUAL, SINCE ATTAINING THE AGE OF EIGHTEEN (18).

B. SUBSTITUTE PROGRAM LEADERS FOR SCHOOL AGE CHILD CARE CENTERS

1. MUST MEET REQUIREMENTS FOUND AT 7.730.21;

2. EACH SUBSTITUTE PROGRAM LEADER MUST BE AT LEAST 18 YEARS OF AGE, DEMONSTRATE ABILITY TO WORK WITH CHILDREN, AND MUST MEET THE FOLLOWING QUALIFICATIONS:

a. COMPLETE THE DEPARTMENT-APPROVED COURSE IN INJURY PREVENTION;

b. COMPLETE THE DEPARTMENT-APPROVED COURSE IN PLAYGROUND SAFETY FOR SCHOOL-AGED CHILD CARE CENTERS. THIS REQUIREMENT DOES NOT APPLY TO DAY CAMPS THAT DO NOT REGULARLY USE A PLAYGROUND; AND

c. MUST HAVE AT LEAST THREE (3) MONTHS (460 HOURS) OF FULL-TIME OR EQUIVALENT PART-TIME SATISFACTORY AND VERIFIABLE EXPERIENCE WITH SCHOOL-AGE CHILDREN.

C. SUBSTITUTE PROGRAM AIDES FOR SCHOOL AGE CHILD CARE CENTERS

1. SUBSTITUTE PROGRAM AIDES MUST BE AT LEAST SIXTEEN (16) YEARS OF AGE. PROGRAM AIDES MUST WORK DIRECTLY UNDER THE SUPERVISION OF THE PROGRAM DIRECTOR OR PROGRAM LEADERS AND MUST NEVER BE LEFT ALONE WITH CHILDREN.

2. SUBSTITUTE PROGRAM AIDES CAN BE COUNTED AS STAFF IN DETERMINING CHILD CARE STAFF RATIOS.

7.730.26 PERSONNEL FILES

A. THE CENTER OFFICE MUST MAINTAIN A RECORD FOR EACH STAFF MEMBER THAT INCLUDES THE FOLLOWING:

1. DOCUMENTATION FOR ANY SUBSTITUTE EMPLOYED BY THE AGENCY TO DETERMINE IF THE INDIVIDUAL HAS EVER BEEN CONVICTED OF A DISQUALIFYING CRIME AS FOUND AT SECTION 7.701.33 OF THE GENERAL RULES FOR CHILD CARE FACILITIES. THE PERSONNEL FILE OF EACH SUBSTITUTE OF THE CENTER MUST CONTAIN CLEARANCE OR ARREST REPORT FROM THE COLORADO BUREAU OF INVESTIGATION;

2. DOCUMENTATION FOR ANY SUBSTITUTE EMPLOYED BY THE AGENCY TO DETERMINE IF THE INDIVIDUAL HAS A CONFIRMED REPORT FOR CHILD ABUSE OR NEGLECT REPORTED TO THE STATE DEPARTMENT'S AUTOMATED SYSTEM AS FOUND AT SECTION 7.701.32 OF THE GENERAL RULES FOR CHILD CARE FACILITIES. THE PERSONNEL FILE OF EACH SUBSTITUTE MUST CONTAIN THE RESULTS OF THE STATE DEPARTMENT'S AUTOMATED SYSTEM.

3. SUBSTITUTES MUST BE CURRENT FOR ALL IMMUNIZATIONS ROUTINELY RECOMMENDED FOR ADULTS BY THEIR HEALTH CARE PROVIDER.

4. PRIOR TO BEING PLACED IN A CHILD CARE FACILITY, SUBSTITUTES MUST SUBMIT TO THE AGENCY A MEDICAL STATEMENT, SIGNED AND DATED BY A LICENSED PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL, VERIFYING THAT THEY ARE IN GOOD MENTAL, PHYSICAL, AND EMOTIONAL HEALTH APPROPRIATE FOR THE POSITION FOR WHICH THEY HAVE BEEN HIRED. THIS STATEMENT MUST BE DATED NO MORE THAN 6 MONTHS PRIOR TO EMPLOYMENT OR WITHIN THIRTY (30) CALENDAR DAYS AFTER THE DATE OF EMPLOYMENT. THIS STATEMENT MUST INDICATE WHEN SUBSEQUENT MEDICAL STATEMENTS ARE REQUIRED. SUBSEQUENT MEDICAL STATEMENTS MUST BE SUBMITTED AS REQUIRED IN WRITING BY A PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL.

5. IF, IN THE OPINION OF A PHYSICIAN OR MENTAL HEALTH PRACTITIONER, AN EMPLOYEE'S EXAMINATION OR TEST RESULTS INDICATE A PHYSICAL, EMOTIONAL, OR MENTAL CONDITION THAT COULD BE HAZARDOUS TO A CHILD, OTHER STAFF, OR SELF, OR THAT WOULD PREVENT SATISFACTORY PERFORMANCE OF DUTIES MUST NOT BE ASSIGNED OR RETURNED TO A POSITION UNTIL THE CONDITION IS CLEARED TO THE SATISFACTION OF THE EXAMINING PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL.

6. NAME, ADDRESS, PHONE NUMBER AND BIRTHDATE OF THE INDIVIDUAL;

7. VERIFICATION OF EDUCATION, WORK EXPERIENCE, EMPLOYMENT, TRAINING, AND COMPLETION OF FIRST AID AND CPR COURSES;

8. DATE OF EMPLOYMENT;

9. RECORD OF PLACEMENTS INCLUDING DATES, NUMBER OF HOURS WORKED, NAME, ADDRESS AND LICENSE NUMBER OF THE CHILD CARE FACILITY WHERE THE SUBSTITUTE WAS PLACED.

10. NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF PERSONS TO BE NOTIFIED IN THE EVENT OF AN EMERGENCY.

11. SUBSTITUTE RECORDS MUST BE AVAILABLE, UPON REQUEST, TO AUTHORIZED PERSONNEL OF THE STATE DEPARTMENT OR DEPARTMENT REPRESENTATIVES.

12. THE RECORDS OF THE SUBSTITUTE MUST BE MAINTAINED BY THE SUBSTITUTE PLACEMENT AGENCY FOR AT LEAST THREE (3) YEARS. THE CURRENT FILES MUST BE MAINTAINED AT THE AGENCY, THE PREVIOUS TWO (2) YEARS MAY BE STORED AT EITHER THE AGENCY OR A CENTRAL LOCATION. IF REQUESTED, THE RECORDS MUST BE PROVIDED TO THE DEPARTMENT OR DEPARTMENT REPRESENTATIVE.

B. THE PERSONNEL FILE FOR EACH SUBSTITUTE MUST CONTAIN ALL REQUIRED INFORMATION BEFORE THE SUBSTITUTE CAN BE PLACED AT A CHILD CARE FACILITY.

7.730.3 HEALTH AND SAFETY

7.730.31 CONTROL OF COMMUNICABLE ILLNESSES

A. WHEN A SUBSTITUTE HAS WORKED IN A CHILD CARE FACILITY WHERE CHILDREN HAVE BEEN DIAGNOSED WITH A COMMUNICABLE ILLNESS SUCH AS HEPATITIS, MEASLES, MUMPS, MENINGITIS, DIPHTHERIA, RUBELLA, SALMONELLA, TUBERCULOSIS, GIARDIA OR SHIGELLA, THE SUBSTITUTE MUST IMMEDIATELY NOTIFY THE AGENCY. CHILDREN'S CONFIDENTIALITY MUST BE MAINTAINED.

B. THE AFFECTED CHILD CARE FACILITY MUST REPORT TO THE AGENCY ANY EXPOSURE TO A COMMUNICABLE ILLNESS AT A CHILD CARE FACILITY, AND, AT THE DISCRETION OF THE AGENCY, WITH HEALTH DEPARTMENT GUIDANCE, THE SUBSTITUTE SHOULD BE EXCLUDED FROM THE WORKING IN A CHILD CARE FACILITY FOR THE PERIOD OF TIME PRESCRIBED BY THE SUBSTITUTE'S PHYSICIAN OR BY THE LOCAL HEALTH DEPARTMENT. THE AGENCY MUST BE NOTIFIED WITHIN 24 HOURS.

C. WHEN THE SUBSTITUTE PLACEMENT AGENCY HAS BEEN NOTIFIED THAT A SUBSTITUTE HAS BEEN IN A PLACEMENT WHERE THE INDIVIDUAL HAS BEEN EXPOSED TO A COMMUNICABLE ILLNESS, THE AGENCY AND THE SUBSTITUTE MUST COMPLY WITH ALL HEALTH DEPARTMENT REQUIREMENTS.

7.730.4 ADMINISTRATIVE

7.730.41 ADMINISTRATIVE RECORDS AND REPORTS

A. THE FOLLOWING RECORDS MUST BE ON FILE AT THE AGENCY:

1. A LIST OF CURRENT SUBSTITUTES, AND SUBSTITUTE PLACEMENTS;

2. REPORTS FROM CONTRACTED CHILD CARE FACILITIES WHERE ANY INCIDENT REPORTS OCCUR.

3. CONTRACTS WITH BOTH SUBSTITUTES AND CHILD CARE FACILITIES.

4. WITHIN THIRTY (30) CALENDAR DAYS OF THE LAST DAY OF EMPLOYMENT, STAFF MEMBERS MUST BE PROVIDED A LETTER VERIFYING THEIR EXPERIENCE AT THE AGENCY. THE LETTER MUST CONTAIN THE AGENCY'S ADDRESS, PHONE NUMBER AND LICENSE NUMBER, THE EMPLOYEE'S START AND END DATE AND THE TOTAL NUMBER OF HOURS WORKED WITH CHILDREN. HOURS WORKED WITH INFANTS AND TODDLERS MUST BE DOCUMENTED SEPARATELY FROM HOURS WORKED WITH OTHER AGE GROUPS. THE LETTER MUST BE SIGNED BY A DIRECTOR, OWNER OR HUMAN RESOURCES AGENT OF THE AGENCY.

Permanent Rules Adopted

Department

Department of Personnel and Administration

Agency

Division of Finance and Procurement

CCR number

1 CCR 101-1

Rule title

1 CCR 101-1 STATE FISCAL RULES 1 - eff 11/01/2018

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STATE OF COLORADO FISCAL RULES

PURPOSE

The purpose of these Fiscal Rules is to implement statutory provisions, set forth principles concerning internal controls, accounting policies, and financial reporting for the State of Colorado, and assist the State Controller in managing the finances and financial affairs of the State.

STATUTORY AUTHORITY

Colorado Revised Statutes created the Office of the State Controller. Title 24, Article 30, Part 2, C.R.S., lists the powers and duties of the State Controller and is incorporated as a reference into each of these Fiscal Rules. §24-30-202(13), C.R.S., provides the authority of the State Controller to issue binding Fiscal Rules and is specifically incorporated into each of these State Fiscal Rules as statutory authority.

DEFINITIONS

In addition to any definitions contained in each Rule, the following general definitions shall apply to and are incorporated into each of these Fiscal Rules:

Agreement – A legal agreement between a State Agency or Institution of Higher Education and another individual or entity that may or may not constitute a State Contract, as defined in Fiscal Rule 3-3.

Chief Executive Officer – An executive director, commissioner, president, and/or any individual delegated to act on behalf of any of the foregoing.

Chief Fiscal Officer – The top financial position in the State Agency or Institution of Higher Education.

Commitment Voucher – A document, the form of which has been approved by the State Controller, which includes a Purchase Order, as defined in Fiscal Rule 3-2, State Contract, as defined in Fiscal Rule 3-3, travel authorization, Advice of Employment, as defined in Fiscal Rule 3-1, Grant, as defined in Fiscal Rule 3-4, license agreement, parking license agreement, Small Purchase Documentation, as defined in Fiscal Rule 3-1, and other written authorizations for disbursement of funds approved by the State Controller. Commercial Cards, as defined in Fiscal Rule 2-7, are not Commitment Vouchers but are instead a method of payment.

CORA – The Colorado Open Records Act, §24-72-200.1, et seq., C.R.S.

Elective Officers – The Governor, Lieutenant Governor, Attorney General, Secretary of State, and Treasurer of the State of Colorado.

Institution of Higher Education – A college or university in Colorado State government created by law, executive order, or any other authority that has not elected to be exempt from these Fiscal Rules under §24-30-202(13)(b), C.R.S.

Procurement Code – Section 24-101-101, et seq., C.R.S.

Procurement Rules – Rules promulgated under the Procurement Code, set forth in 1 CCR 101-9.

State – The State of Colorado.

State Agency – A department, division, section, unit, commission, board, bureau, or institution in Colorado State government created by law, executive order, or any other authority, but does not include an Institution of Higher Education, or a college or university that has elected to be exempt from these

Fiscal Rules under §24-30-202(13)(b), C.R.S.

State Financial System – The official financial system for the State of Colorado, as now or hereafter prescribed by the State Controller. The current State Financial System is composed of the Colorado Operations Resource Engine (CORE), including the various systems and sub-systems that now or may hereafter interface to CORE such as human resource and payroll systems.

APPLICABILITY

These Fiscal Rules are applicable to all State Agencies and Institutions of Higher Education, to all employees of the State in the applicable State Agencies and Institutions of Higher Education, and to all funds in the executive branch of State government, except as provided in the following paragraph.

Pursuant to §24-2-102(4) C.R.S., an Elective Officer and each Elective Officer's second-in-command, such as a deputy or chief of staff, may elect to exempt any solicitation or Commitment Voucher from either or both of §24-30-202 C.R.S., including the Fiscal Rules, and the Procurement Code and the Procurement Rules, on a case-by-case basis. The Elective Officer, or second-in-command, shall authorize the use of the exemption, which shall be documented prior to issuing the solicitation, for exemptions from the Procurement Code, or upon executing the Commitment Voucher, for exemptions from §24-30-202, C.R.S. The departments headed by Elective Officers are otherwise subject to §24-30-202 C.R.S., including these Fiscal Rules, and the Procurement Code and the Procurement Rules, unless the Elective Officer chooses to exempt all solicitations and Commitment Vouchers by expressly documenting the Elective Officer's intent.

VIOLATIONS

If a State Agency or Institution of Higher Education materially violates any of these Fiscal Rules, that State Agency or Institution of Higher Education shall seek ratification of that violation from the Office of the State Controller. Repeated, willful, or unratified material violations of these Fiscal Rules, or a knowing failure to seek ratification of a material violation of these Fiscal Rules, may result in any of the following: removal of or limitation on delegated authority; disciplinary action, up to and including termination, at the discretion of the appointing authority of the individual who violated the Fiscal Rules; or any other remedies as provided by law or elsewhere in these Fiscal Rules.

RESPONSIBILITY

It is the responsibility of the Chief Executive Officer of each State Agency or Institution of Higher Education to ensure compliance with these Fiscal Rules.

ADMINISTRATIVE HARDSHIP

A State Agency or Institution of Higher Education may submit a written request to the State Controller, with notification to the State Agency or Institution of Higher Education's Chief Fiscal Officer, for exemption if any of these Fiscal Rules or the related State Controller policies create undue administrative or financial hardship. The State Controller, in that individual's sole discretion, may approve or deny such request and may waive the requirements of any such Fiscal Rules and State Controller Policies that create the undue administrative or financial hardship.

STATE CONTROLLER POLICIES

The State Controller may issue policies under these Fiscal Rules to provide specific requirements, direction, guidance, and clarification in relation to complying with the requirements of these Fiscal Rules.

All such policies shall be deemed to include all applicable definitions from these Fiscal Rules.

DEPARTMENTAL POLICIES

A State Agency or Institution of Higher Education may implement internal policies r that may be more restrictive than these Fiscal Rules or the State Controller Policies. If a State Agency or Institution of Higher Education develops such policies, then employees at that State Agency or Institution of Higher Education shall comply with those policies in addition to complying with these Fiscal Rules.

SUBSTANCE OVER FORM

When reviewing any action for compliance with these Fiscal Rules, the individual reviewing the action shall review the substance of the action and not just the legal form of that action. These Fiscal Rules apply to the true intent of the transaction as well as its form.

CHAPTER 1: ACCOUNTING AND INTERNAL CONTROLS

RULE 1-1: ACCOUNTING PRINCIPLES AND STANDARDS

1. **AUTHORITY:**

§24-30-202(12), C.R.S. (Accrual System of Accounting)

2. **DEFINITIONS:**

2.1. GAAP - Generally accepted accounting principles, as adopted by the Governmental Accountings Standards Board.

3. **RULE:**

The accounting principles of the State shall be based on GAAP. In addition, all applicable statutory provisions shall be met.

When a conflict between statutory provisions and GAAP exists, GAAP take precedence in financial reporting.

When it is necessary to report compliance of financial transactions with statutory requirements, supplemental schedules may be used. Preparation of separate statutory based reports may also be necessary.

RULE 1-2: INTERNAL CONTROLS

1. **AUTHORITY:**

§24-17-102(1), C.R.S. (Internal Controls)

§24-17-103, C.R.S. (Annual Internal Control Report)

§18-4-401, C.R.S. (Theft)

§18-5-102, C.R.S. (Forgery)

§18-8-407, C.R.S. (Embezzlement of Public Property)

§24-17-101, C.R.S. (State Department Financial Responsibility and Accountability Act)

2. **DEFINITIONS:**

2.1. Fraud – Misstatements Arising from Fraudulent Financial Reporting, Misstatements Arising from Intentional Misappropriation of Assets, and theft or embezzlement of public property.

2.2. Misstatements Arising from Fraudulent Financial Reporting – Intentional misstatements, or omissions of amounts or disclosures in financial statements, with the intent to deceive financial statement users.

2.3. Misstatements Arising from Intentional Misappropriation of Assets – The theft of an entity's assets where the effect of the theft causes the basic financial statements not to be presented in conformity with GAAP.

2.4. Pre-audit – A review for compliance with applicable statutes, Fiscal Rules, and other regulations, and adherence to accepted business practices.

3. **RULE:**

3.1. State Agencies and Institutions of Higher Education have the responsibility for the design and implementation of programs and controls to prevent, deter, and detect Fraud.

3.2. Any suspected Misstatements Arising from Fraudulent Financial Reporting shall be reported in writing to the State Controller as soon as it is suspected.

3.3. Any suspected theft or embezzlement of State funds or assets or sensitive State financial information shall immediately be reported to the Chief Executive Officer, or delegate, and the Chief Fiscal Officer of the State Agency or Institution of Higher Education where the theft or embezzlement may have occurred and appropriate action shall be taken by the State Agency or Institution of Higher Education. A suspected theft or embezzlement of State funds or assets totaling $5,000 or more per incident shall be reported in writing to the State Controller. All suspected theft of sensitive State financial information shall be reported in writing to the State Controller. Also, the results of any investigation or follow-up including corrective measures implemented to prevent or reduce the likelihood of future occurrences must be reported in writing by the Chief Fiscal Officer to the State Controller in a timely manner.

3.4. When complying with §24-17-101, C.R.S., the

certification form, content, and due date shall be determined by the State Controller.

3.5. All accounting documents and financial transactions shall be subjected to a Pre-audit by the State Agency or Institution of Higher Education prior to recording the documents on the State Financial System or on an approved State Agency or Institution of Higher Education accounting system, and prior to making payment. State Agencies and Institutions of Higher Education shall implement internal accounting and administrative controls that reasonably ensure that financial transactions are accurate, reliable, conform to the Fiscal Rules, and reflect the underlying realities of the accounting transaction (substance rather than form). The factors of risk, cost, and business requirements shall be considered when establishing these internal controls.

RULE 1-3: STATE FINANCIAL SYSTEM

1. **AUTHORITY:**

§24-30-202(12), C.R.S. (Accrual System of Accounting)

§2-3-107, C.R.S. (State Auditor)

§2-3-203(1), C.R.S. (Joint Budget Committee)

§24-30-202(11), C.R.S. (State Controller Authority)

§24-30-201(1)(f), C.R.S (Accounts and Control)

2. **DEFINITIONS:**

2.1. Electronic Interface – A standard specifying a set of functional characteristics, common physical interconnection characteristics, and signal characteristics for the exchange of data.

3. **RULE:**

The State Controller is the official custodian of the database included within the State Financial System.

The State Controller, as official custodian of the State Financial System, shall approve access and resolve all disputes regarding access to the State Financial System and information contained in that system in compliance with CORA.

3.1. Use of the State Financial System

3.1.1. All State Agencies and Institutions of Higher Education shall use the State Financial System to record their financial transactions and financial information, develop their financial reports, and prepare their financial statements.

3.1.2. The State Controller hereby grants an exemption to the requirement to use the State Financial System to the governing boards of Institutions of Higher Education that have an internal accounting system and either an Electronic Interface or other process that enables the data to be included in the State Financial System, that has been approved by the State Controller. The State Controller may also grant an exemption to State Agencies to use an internal accounting system and an Electronic Interface that is approved by the State Controller. Redundancies between State Agency or Institution of Higher Education financial systems and the State Financial System should be eliminated to prevent duplication in the development of financial systems, to improve the compatibility of financial systems, to facilitate inter-system communications and to timely access information, and to improve the efficiency of the collection, maintenance, and reporting of financial information throughout State government.

3.1.3. Internal Revenue Filing Requirements

3.1.3.1. State Agencies and Institutions of Higher Education exempt from using the State Financial System shall be responsible for Internal Revenue Service (IRS) filing requirements in accordance with

the Internal Revenue Code, including obtaining a separate Taxpayer Identification Number (TIN) from the IRS.

3.1.3.2. For State Agencies that utilize the State Financial System, IRS filing requirements are coordinated by the Office of the State Controller on behalf of State Agencies. State Agencies shall record contractor and payment transactions properly to ensure proper Federal reporting.

3.2. Electronic Interfaces

3.2.1. An Electronic Interface with the State Financial System shall not be made without the approval of the State Controller. Requests for interface to the State Financial System shall be made prior to the solicitation, acquisition, development, or implementation of a new or replacement internal financial system by a State Agency or Institution of Higher Education. Only approved and tested interfaces shall be allowed to feed data into the State Financial System.

3.2.2. The Electronic Interface of any internal accounting system of any Institution of Higher Education or State Agency that has been granted an exemption from the use of the State Financial System shall provide timely updates to the State Financial System as directed by the State Controller.

3.3. Access to State Network

3.3.1. Access to the State network shall only be granted in accordance with the policies issued by the Office of Information Security in the Governor's Office of Information Technology.

3.4. Access to the State Financial System

3.4.1. State Financial System records contain both public and confidential information. Therefore, an employee who has access to the State Financial System shall only access information that is needed to do the employee's job and shall not browse or otherwise access information contained in the State Financial System that exceeds the minimum necessary to do the employee's job. Individuals with the authority to grant access to the State Financial System shall only grant access to create, modify or approve documents within the State Financial System to users as required by the user's job duties.

3.4.1.1. Individuals with the authority to grant access to the State Financial System shall only grant access to non-State employees if such access is necessary to the work that the non-State employee is performing for the State or to comply with audit requirements. If access is granted to a non-State employee, then the individual granting such authority shall ensure that the access granted is read-only, and limited to the specific purpose for which access was granted and only for the duration of the work that will be performed by the non-State employee.

3.4.2. If the State Controller receives a request from a State Agency or Institution of Higher Education for information belonging to another State Agency or Institution of Higher Education, the State Controller shall notify each State Agency or Institution of Higher Education whose information has been requested of the request for information and furnish such State Agency or

Institution of Higher Education a copy of the information provided.

3.4.3. If the State Controller receives a request from a citizen or entity other than a State Agency or Institution of Higher Education under CORA, the State Controller shall furnish the information in a timely manner, as provided by statute, if the State Controller is the custodian of record for that information. The State Controller shall only respond to requests under CORA if the State Controller is the custodian of record for the information contained in that request; for all requests for which the State Controller is not the custodian of record, the State Controller shall refer the request to the State Agency or Institution of Higher Education who is the custodian of record for that information, if known.

3.5. State Financial System Security

3.5.1. The State Controller and the Governor's Office of Information Technology are responsible for the overall security of the State Financial System. The State Controller may delegate security responsibility to State Agencies and Institutions of Higher Education for access to the State Financial Systems.

RULE 1-4: DELEGATED AUTHORITY

1. **AUTHORITY:**

§24-30-201, C.R.S. (Powers and Duties of the State Controller)

§24-30-202(1), (2), (3), (4), and (5) C.R.S. (Authority for Delegation of Authority)

2. **RULE:**

Any individual who has the direct authority to sign or approve Commitment Vouchers on behalf of a State Agency or Institution of Higher Education, may delegate that authority as described in this Fiscal Rule. The State Controller may delegate the authority granted in §24-30-202, C.R.S. to approve and sign Commitment Vouchers as described in this Fiscal Rule.

2.1. Executive Signature Authority Delegation

2.1.1. The Chief Executive Officer of a State Agency who has authority to sign State Contracts, as defined in Fiscal Rule 3-3, and Grants, as defined in Fiscal Rule 3-4, for the State Agency over which the individual has authority on behalf of the Governor or another Elective Officer may delegate that signature authority as described in the State Controller Contract, Grant, and Purchase Order Policies.

2.1.2. The Chief Executive Officer of an Institution of Higher Education who has authority to sign State Contracts, as defined in Fiscal Rule 3-3, and Grants, as defined in Fiscal Rule 3-4, for the Institution of Higher Education over which the individual has authority on behalf of the Governor may delegate that signature authority as described in the State Controller Contract, Grant, and Purchase Order Policies.

2.2. State Controller Signature Authority

2.2.1. The State Controller may delegate the authority to approve and sign Commitment Vouchers as the final State signatory, as required under §24-30-202, C.R.S., and as described in the State Controller Contract, Grant, and Purchase Order Policies.

2.3. Delegation of Other State Controller Authority

2.3.1. The State Controller may delegate other State Controller authority as permitted under §§24-30-201 and 24-30-202, C.R.S., and these Fiscal Rules, by entering into a delegation agreement with the individual to whom the State Controller is delegating that authority. This may include, without limitation, the authority for Pre-audit responsibilities under §24-30-201(1)(h), C.R.S., and internal controls and system security administration under §24-30-201(1)(f), C.R.S.

2.4. Chief Information Officer Signature Authority

2.4.1. The Chief Information Officer may delegate the authority to approve and sign Commitment Vouchers for Major Information Technology Projects, as required under §24-30-202, C.R.S., and as described in the State Controller Contract, Grant, and Purchase Order Policies.

CHAPTER 2: DISBURSEMENT

RULE 2-1: PROPRIETY OF EXPENDITURES

1. **AUTHORITY:**

§24-77-101, et seq., C.R.S. (Fiscal Year Spending Limits)

§24-30-202(2), and (5)(a), C.R.S. (Propriety of Expenditures)

2. **DEFINITIONS:**

2.1. Donation – Property, services, or money given without receiving consideration for the transfer. The term "Donation" does not include the State's purchase of any good or service; Grants, as defined in Fiscal Rule 3-4, where the grantee is required to provide an accounting of funds and progress reports regarding the work performed; restitution or court judgments; services provided by individuals in their individual capacity; or payments to or on behalf of beneficiaries of State programs defined in State statute or regulations.

3. **RULE:**

All expenditures by State Agencies and Institutions of Higher Education shall meet the following standards of propriety:

3.1. Are for official State business purposes only.

3.2. Are reasonable and necessary under the circumstances.

3.3. Are authorized by the appropriation and required approvals have been received.

3.4. Prices or rates are fair and reasonable.

3.5. Amount is within the available unencumbered balance or is within the balance encumbered specifically for the expenditure.

3.6. Are in compliance with applicable statutes, executive orders, rules, and policies.

State Agencies and Institutions of Higher Education shall not make a Donation to any other entity or individual unless specifically permitted by statute.

All expenditures by State Agencies and Institutions of Higher Education recorded in a State fiscal year shall be for services performed or goods received by the last day of that fiscal year.

RULE 2-2: RECEIVING REPORTS

1. **AUTHORITY:**

§24-30-202 (1), C.R.S. (State Controller Authority to Determine Payment Processes)

2. **RULE:**

Receiving reports, or other sufficient documentation, shall be prepared for all goods and services received, showing actual quantities, any unsatisfactory condition, and compliance with specifications, prior to processing a voucher for payment. This information shall be certified by the receiver of the goods or services.

3. **EXCEPTIONS TO RULE:**

3.1. A receiving report need not be prepared for personal service expenditures.

3.2. When an adequate system of internal accounting and administrative controls exists to provide sufficient verification that goods or services were received, a State Agency or Institution of Higher Education may choose to not require a signed receiving report.

RULE 2-3: PAYMENT TERMS

1. **AUTHORITY:**

§24-30-202 (1), C.R.S. (State Controller Authority to Determine Payment Processes)

§24-30-202.4 (3.5) C.R.S. (Vendor Offset)

2. **DEFINITIONS:**

2.1. Common Policy Payment – A payment made by a State Agency to another State Agency with an internal service fund, such as the Governor's Office of Information Technology, the Department of Personnel and Administration, or the Department of Law, for services provided by those State Agencies to multiple other State Agencies. The General Assembly provides spending authority to both the State Agency purchasing the services and the State Agency providing the services.

2.2. Delinquent Payable – A Payable is delinquent if a disbursement is not made within forty-five days after a liability arises, unless the time of payment has been otherwise provided in the Commitment Voucher. A Payable being disputed by a contractor or State Agency or Institution of Higher Education shall become delinquent if a disbursement is not made within forty-five days after resolution of the dispute.

2.3. Payable – A Payable is a liability incurred by the State. A liability shall arise upon receipt of supplies and services and a correct notice of the amount due. A liability shall not arise if a good faith dispute exists as to the State Agency or Institution of Higher Education's obligation to pay all or a portion of the liability.

2.4. Payment Terms – Contractual obligations between a State Agency or Institution of Higher Education and a contractor regarding timing, amount, and preconditions of payment, as evidenced in a Commitment Voucher or on an invoice.

3. **RULE:**

3.1. Payment on Time

3.1.1. Payments shall be processed in a timely manner and made within the allowable discount period to ensure the State Agency or Institution of Higher Education takes advantage of purchase discounts, if economically beneficial to the State. All payment processing timelines shall begin upon the acceptance of a correct invoice by the State Agency or the Institution of Higher Education and the delivery of goods or completion of the services provided unless specifically stated otherwise in a Commitment Voucher.

3.2. Interest Payment on Delinquent Payables

3.2.1. State Agencies and Institutions of Higher Education shall process invoices and other notices of liability as efficiently as possible in order to ensure payment in accordance with contractual or invoice terms, and in the absence of such terms, as soon as possible, or in accordance with statutory provisions. A Delinquent Payable shall be assessed interest at the 1% per month, or such other amount as may be required by §24-30-202(24), C.R.S. All Commitment Vouchers shall provide for a reasonable time of payment considering the nature of the goods or services provided and review and approval required for

payment. If no time for payment has been provided for in writing, interest on the unpaid balance shall be calculated beginning with the forty-fifth day after the liability for such payment arises under this Fiscal Rule.

3.3. Interagency Purchases and Payments

3.3.1. A State Agency or Institution of Higher Education shall make payment for purchases of goods and services from another State Agency or Institution of Higher Education within 30 days after receipt of a valid invoice. Where possible and practical payments shall be made by an interagency document in lieu of a state warrant.

3.4. Disputes Arising from Interagency Purchases

3.4.1. If a dispute arises as a result of an interagency purchase, the following steps will be used to resolve the dispute:

3.4.1.1. The State Agency or Institution of Higher Education disputing the charge shall notify the State Agency or Institution of Higher Education providing the goods or services and attempt to resolve the dispute. If necessary, the Chief Executive Officer of these State Agencies or Institutions of Higher Education involved shall assist in the resolution.

3.4.1.2. If the State Agencies and/or Institutions of Higher Education involved cannot reach a satisfactory resolution within 60 days, the State Agency or Institution of Higher Education disputing the charge shall, within 30 days of the date on which the State Agencies and/or Institutions of Higher Education determined that they could not resolve the dispute, petition the State Controller to resolve the dispute.

3.4.1.3. If the State Controller is petitioned to resolve the dispute, the decision of the State Controller will be rendered within a reasonable time and be final and binding on all parties concerned.

3.4.1.4. State Agencies shall make Common Policy Payments regardless of any dispute. Disputes related to setting of the common policy appropriations, budgets, and funding sources shall be handled in accordance with Fiscal Rule 7-4.

3.5. Vendor Intercepts

3.5.1. State Agencies and Institutions of Higher Education shall withhold unpaid balance or debts owed to the State by a contractor prior to disbursement of payment in accordance with §24-30-202.4(3.5)(a)(I), C.R.S.

3.5.2. For State Agencies that utilize the State Financial System, the State Financial System automatically withholds the unpaid balance of debts owed to the State, as identified by an intercepting State Agency prior to disbursement to a vendor as outlined in the statute. Payment is then transmitted to the intercepting agency. State Agencies and Institutions of Higher Education that do not use the State Financial System shall be responsible for ensuring compliance with the statute by creating their own internal withholding procedures.

3.6. Unpaid Warrants and Payables

3.6.1. A State Agency or Institution of Higher Education that has an unpaid warrant or check shall perform due diligence to identify if the

payable is valid. If valid, the State Agency or Institution of Higher Education shall reissue payment to a contractor or vendor. A check or warrant that is presumed abandoned under §38-13-106, C.R.S., shall be transferred to the unclaimed property trust fund as described in §38-13-106, C.R.S.

3.6.2. For State Agencies that utilize the State Financial System, transfer of unpaid warrants or checks to the unclaimed property trust fund and completion of reporting requirements is coordinated by the Office of the State Controller after State Agencies complete their due diligence. State Agencies and Institutions of Higher Education that do not use the State Financial System shall be responsible for ensuring compliance with the statute by creating their own internal procedures.

RULE 2-4: OFFICIAL FUNCTIONS AND TRAINING FUNCTIONS

1. **AUTHORITY:**

§24-30-202 (1), C.R.S. (State Controller Authority to Determine Processes for Liabilities)

2. **DEFINITIONS:**

2.1. Official Function – A meeting, conference, meal, training, or other function that is hosted by the Chief Executive Officer, or representative, of a State Agency or Institution of Higher Education, attended by guests and/or State employees, held for official State business purposes and includes an expenditure of State funds.

3. **RULE:**

3.1. Official Functions that include purchases of food and beverages have the potential of being perceived to be for personal benefit and an abuse of public funds. Attendance shall include only those individuals directly related to the purpose of the function. Purchases of food and beverages should be kept to a minimum and shall be approved by the Chief Executive Officer or by a representative of the State Agency or Institution of Higher Education who has been delegated authority by the Chief Executive Officer. All expenditures associated with an Official Function must meet the requirements in Fiscal Rule 2-1.

3.2. Permissible and prohibited Official Functions are further defined in the State Controller Fiscal Policies.

3.3. For all purchases of food and beverages, State Agencies and Institutions of Higher Education shall maintain documentation that includes the following:

3.3.1. Description of Official Function;

3.3.2. Justification for food and beverages;

3.3.3. Attendees; and

3.3.4. Chief Executive Officer or delegate approval.

RULE 2-5: MISCELLANEOUS COMPENSATION AND OTHER BENEFITS (PERQUISITES)

1. **AUTHORITY:**

§24-2-103, C.R.S. (Compensation for State Employees)

§24-30-202(22), C.R.S. (State Controller Authority for Allowing Perquisites)

2. **DEFINITIONS:**

2.1. Fringe Benefits – Any benefit described in §24-50-104(1)(g), C.R.S., including, without limitation, insurance, retirement and leaves of absence with or without pay.

2.2. Metropolitan Area – A region including a city and the densely populated surrounding areas that are socially and economically integrated with it. See State Controller Travel Policies.

2.3. Perquisite – Any payment, benefit or privilege provided by the State to a State employee other than the following, which are not considered Perquisites:

2.3.1. Salary;

2.3.2. Fringe benefits;

2.3.3. Incentives and awards;

2.3.4. Travel and non-travel related reimbursements;

2.3.5. State sponsored job related training;

2.3.6. Temporary housing provided to employees who are working at a work location that is not in the same Metropolitan Area as the employee's normal work location;

2.3.7. Permanent housing on State property, provided for the benefit of the State, where the employee is required to stay as a condition of employment;

2.3.8. The provision of faculty housing or student apartments by Institutions of Higher Education;

2.3.9. Housing or a housing allowance provided to the Chief Executive Officer of an Institution of Higher Education as part of that individual's employment contract consistent with policies developed by the Commission on Higher Education and approved by the State Controller;

2.3.10. Uniforms that are required to be worn by State employees and the necessary maintenance of these uniforms, so long as the uniform is worn as a condition of employment, is not suitable for everyday wear, is distinctive to a particular group, and serves as a means of identification; and

2.3.11. Employee discounts offered to all State employees.

3. **RULE:**

A State employee shall not have the authority to grant any Perquisites, nor shall any State employee receive any Perquisite except as provided by State statute or this Fiscal Rule. Monetary allowances shall not be given to State employees in lieu of Fringe Benefits, except as provided by State statute or approved by the State Controller. Where State statutes provide allowances for maintenance and ordinary expenses incurred in the performance of duty, it is the responsibility of the Chief Executive Officer of the State Agency or Institution of Higher Education to establish specific expenses that are covered by the allowance so that the same expenses are not also directly reimbursed. A State Agency or Institution of Higher Education may provide any payment, benefit, or privilege to a State employee, that is not considered a Perquisite, in its sole discretion. If a State Agency or Institution of Higher Education provides a Perquisite allowed under this Fiscal Rule, then it shall equitably determine which State employees are eligible to receive such Perquisites.

3.1. Allowed Perquisites

3.1.1. Clean Air Transit Perquisite for State Employees – A State Agency or Institution of Higher Education may offer a clean air transit Perquisite to its employees on an equal basis to all permanent full-time employees within the geographic area served by the mass transit provider and, if deemed appropriate by such State Agency or Institution of Higher Education, also may be offered on an equal basis to all of its part-time employees within the same geographic area.

3.1.1.1. Clean air transit perquisites for State employees may include mass-transit passes, such as the Regional Transportation District EcoPass, provided to State employees at a reduced or no cost; the provision of electric vehicle charging stations for use by State employees at a reduced or no cost; or any other Perquisite intended to reduce the effects of State employee transit on air quality as may be determined by the State Controller in the State Controller Policies.

3.1.2. Events Sponsored by State Agencies and Institutions of Higher Education – A reasonable discount may be offered by a State Agency or Institution of Higher Education to State officials and State employees to improve attendance or participation in State sponsored events. Examples include discounts on admission to athletic games and cultural, educational, recreational, or other events.

3.1.3. Meals – Meals prepared at State dining facilities are primarily for the benefit of the students, patients, or inmates housed at these facilities. However, a State Agency or Institution of Higher Education may provide meals to State employees working at these facilities.

3.1.4. Instructional Courses and Job Related Training – A State Agency or Institution of Higher Education may provide job related and career enhancement courses to State employees that are not sponsored by the State or may provide tuition reimbursement for such courses and training. A State Agency or Institution of Higher Education may only offer or provide tuition reimbursement for courses and training that will benefit the State and enhance the employee's performance. Such instructional courses and job related training may include, without limitation, continuing education courses for licensed professionals, regardless of whether such license is a mandatory requirement of the employee’s position; courses provided by private entities to enhance job-related skills; and courses provided by public or private colleges and universities, including State Institutions of Higher Education.

3.1.5. State Housing Provided to State Employees – A State Agency or Institution of Higher Education may provide housing for a State employee where State-owned facilities are available and it is in the best interest of the State. If the employee will pay any rent or otherwise be charged for the housing, then the State Agency or Institution of Higher Education shall execute a rental agreement with the State employee. If the rented unit does not have separate utility meters, the State Agency or Institution of Higher Education shall also include in the rental agreement payment for the estimated utility costs.

3.1.5.1. A State employee may be provided housing as a condition of employment for reasons that may include the employee is required to live in the State facility, the State employee is required to be available twenty-four hours a day to perform the assigned duties, the State employee is required to live in close proximity to the State facility in order to provide protection or discourage trespassers from entering the property, or the State employee's work location is in a remote area that is difficult to reach and has no housing available other than State furnished housing.

3.1.6. De Minimis Employee Appreciation Items – A State Agency or Institution of Higher Education may provide awards, items of clothing, meals and other items intended to show employee appreciation, so long as those items are de minimis. The State Controller may issue policies regarding the frequency with which such items may be provided and value of those items that are considered de minimis.

3.1.7. Bookstore Discounts – An Institution of Higher Education may provide equitable discounts for its faculty members and employees for purchases at its bookstores.

3.1.8. Commuter Use of State Owned Vehicles – A State Agency or Institution of Higher Education may provide a State owned vehicle to an employee to use for commuting purposes when the State Agency or Institution of Higher Education determines that the employee requires the use of the State owned vehicle for work purposes and also allowing the employee to use the State owned vehicle for commuting is the most efficient use of State fleet resources, as described in Fiscal Rule 9-6.

4. **PAYMENTS FOR PERQUISITES:**

4.1. A State Agency or Institution of Higher Education that provides any Perquisite to a State employee may choose to either provide that Perquisite without cost to the employee or may charge the employee for that Perquisite. For each Perquisite offered by a State Agency or Institution of Higher Education for which an employee is charged, the Chief Executive Officer of that State Agency or Institution of Higher Education shall annually determine the amount that the agency will charge its employees. All such charges shall be equitable for all employees to whom the Perquisite is offered.

4.2. If a State Agency or Institution of Higher Education will charge a State employee for any Perquisite, then the State Agency or Institution of Higher Education shall make a payroll deduction from that employee's pay in the amount of the charges for such Perquisites received by that employee.

5. **TAXABILITY OF PERQUISITES:**

5.1. State Agencies and Institutions of Higher Education shall report all payments for Perquisites in accordance with the Internal Revenue Code and its implementing regulations. State Agencies and Institutions of Higher Education shall report all taxable Perquisites received by State employees in accordance with the Internal Revenue Code and its implementing regulations, and State Controller Fiscal Policies.

RULE 2-6: MOVING AND RELOCATION

1. **AUTHORITY:**

§24-50-134, C.R.S. (Moving and Relocation Expenses)

Internal Revenue Service Publication 521 (Moving Expenses)

2. **DEFINITIONS:**

2.1. Incidental Expenses – See Fiscal Rule 5-1 (Travel).

2.2. Moving Expenses – Reasonable expenses of moving a State employee's Household Goods and Personal Effects to the State employee's new home.

2.3. Household Goods and Personal Effects – This includes household and personal effects such as furniture, clothing, musical instruments, household appliances, foods, and other items which are usual and necessary for the maintenance of a household.

2.4. Relocation Expenses – Relocation expenses are equal to the total per diem for the destination location in the latest per diem rates published by the U.S. General Services Administration. The total per diem includes the lodging per diem rate plus the meals and Incidental Expense (M&IE) rate.

2.5. Transportation – See Fiscal Rule 5-1 (Travel).

3. **RULE:**

When an employee in the State personnel system, other than an Elective Officer, qualifies for moving, such State employee shall be allowed moving expenses as set forth in §3.1. In addition, such State employee shall be allowed relocation expenses up to a maximum of thirty days for necessary expenses incurred while relocating to a permanent residence. The State Agency or Institution of Higher Education shall not reimburse or pay moving expenses for a State employee when the move is made solely for personal reasons. Moving expenses shall be authorized by the Chief Executive Officer, or a delegate, of a State Agency or Institution of Higher Education if the move of residence is occasioned by a change in assignment, a promotion, or for another reason related to the State employee's duties. This rule does not apply to new hires.

3.1. Employee Qualification for Moving Expenses

A State employee must meet all of the following conditions to qualify for moving expenses under this Fiscal Rule:

3.1.1. An appointing authority requires the State employee to change the employee's primary place of residence because of a change in assignment or a promotion or for any other reason related to the employee's duties. See §24-50-134, C.R.S.

3.1.2. The State employee's move is closely related to the start of work, both in time (move occurs within one year from the date the employee first reported to work at the new location) and in place (the distance from employee's new home to the new job location is less than the distance from the employee's former home to the new job location).

3.1.3.

3.2. Moving Expenses

3.2.1. Moving of Household Goods and Personal Effects – Overall

3.2.1.1. The State employee shall obtain at least two competitive bids and submit those bids when the employee seeks reimbursement. State payment shall be made at the rate proposed in the lowest responsible bid.

3.2.1.2. The amount of moving expenses shall be reasonable and necessary under the circumstances.

3.2.2. Moving of Household Goods and Personal Effects – Commercial Mover

3.2.2.1. Moving expenses include packing, insurance, Transportation, and storage not to exceed thirty days, unpacking, and installation at the new location of the State employee's Household Goods and Personal Effects. Moving expenses also include charges by commercial vendors for towing of mobile homes.

3.2.2.2. Upon approval by the State Controller or an individual with a delegation from the State Controller, the State employee may arrange for the commercial mover to bill the State Agency or Institution of Higher Education directly.

3.2.3. Moving of Household Goods and Personal Effects – Employee Moves Household Goods and Personal Effects

3.2.3.1. A State employee may move Household Goods and Personal Effects by rental trailer or truck, or portable moving container, in lieu of using a commercial mover, and shall be reimbursed for the actual cost of using that trailer, truck, or portable moving container, so long as such costs are reasonable.

3.2.3.2. If the State employee uses the State employee's vehicle to move, the State employee shall be entitled to the standard State mileage rate for moving, not travel.

3.3. Relocation Expenses

3.3.1. A State employee shall receive the per diem allowance up to a maximum of thirty days for necessary expenses incurred while locating permanent residence at the new location. The per diem shall consist of the lodging, meals, and Incidental Expenses rate for the destination location published by the U.S. General Services Administration. The employee may exclude interruptions caused by sick leave, vacation, other authorized leave of absence, or ordered travel. The maximum amount paid for the per diem allowance shall not exceed the daily rate multiplied by thirty days.

3.3.2.

RULE 2-7: STATE COMMERCIAL CARDS

1. **AUTHORITY:**

§24-102-207, C.R.S. (Statewide Procurement Card)

2. **DEFINITIONS:**

2.1. Commercial Card Program – All card (Procurement, Travel, One Card) accounts and services provided to the State and participating entities by the bank.

2.2. Commercial Cards – State issued payment cards including Procurement Cards, Travel Cards, and One Cards.

2.3. Procurement Card – Used for small purchases of general merchandise and services as governed by State statutes, the Procurement Rules, and these Fiscal Rules. A Procurement Card is a corporate liability card.

2.4. Travel Card – Used for travel related purchases as governed by State statutes, State travel rules, and these Fiscal Rules. A Travel Card may be centrally billed (corporate liability) or individually billed (individual or joint and several liability).

2.5. One Card – Allows for the combination of the functionality of both the Procurement Card and the Travel Card. A One Card is a corporate liability card.

3. **RULE:**

All State Agencies and participating Institutions of Higher Education eligible for the State Commercial Card Programs shall enter into an agreement with the applicable State Commercial Card Program to participate. State Agencies and Institutions of Higher Education may not enroll in other credit or debit card program agreements (including store credit or other extension of credit).

3.1. Personal Services – Commercial Cards may be used to pay for services as well as goods. Under present Internal Revenue Service guidelines, it is the responsibility of the banking institution to fulfill 1099 reporting requirements.

3.2. Purchases in Excess of $5,000 – If authorized by the Chief Fiscal Officer of the State Agency or Institution of Higher Education, Commercial Cards may be used to pay invoices in excess of $5,000. Commercial Cards are a method of payment. Use of the Commercial Card is not a substitute for a Commitment Voucher or Encumbrance, as required by and defined in Fiscal Rule 3-1.

3.3. Pre-audit Responsibility – Use of the Commercial Card does not eliminate the need for a Pre-audit, which shall be completed when the disbursement is made to the bank. The State Agency or Institution of Higher Education is responsible for reconciling the disbursements made to the bank with the total of validated individual charges for the State Agency or Institution of Higher Education. The dispute mechanism in the card agreement shall be used when charges from the bank are challenged.

3.4. Reporting Misuse – All incidents of State Commercial

Card misuse that are recurring, significant, or in excess of $500 shall be reported in writing to the State Controller annually. Reports shall be submitted to the Office of the State Controller by November 1 each year. This report should include results of any investigation or follow-up including corrective measures implemented to prevent or reduce the likelihood of future occurrences. Misuse may include actions such as the purchase of goods/services or travel related transactions for personal use, splitting a purchase to circumvent single purchase dollar limits or cardholder credit limits, travel related transactions on the Procurement Card, purchasing related transactions on the Travel Card, or any other unauthorized transactions disallowed by State Agency or Institution of Higher Education policy. All incidents of Commercial Card suspected theft or embezzlement shall be reported according to Fiscal Rule 1-2.

3.5. Monitoring and Training – Administrators of Commercial Card Programs shall ensure compliance with card agreements, monitor proper usage of the card, and provide direction to State Agencies and Institutions of Higher Education on proper use of the card.

3.6. Cardholders – State Agencies and Institutions of Higher Education shall only issue a Commercial Card to permanent State employees and shall not issue a State Commercial Card to contractors, temporary State employees, or non-State employees.

CHAPTER 3: COMMITMENT VOUCHERS

RULE 3-1: COMMITMENT VOUCHERS

1. **AUTHORITY:**

§24-30-202 (1-4), and (5)(a), C.R.S. (State Controller Authority)

§24-30-1401, et seq., C.R.S. (Professional Services)

§24-102-206, C.R.S. (Contract Performance Outside United States or Colorado)

§24-106-103, C.R.S. (Centralized Contract Management System)

§24-106-106, C.R.S. (Right to Audit Records)

§24-106-107, C.R.S. (Monitoring of Vendor Performance)

2. **DEFINITIONS:**

All references to "contract" or "agreement" refer to legally binding documents between the State and another party or documents describing the agreement between State Agencies and Institutions of Higher Education. The terms "contract", and "agreement" are used interchangeably in the following definitions to reflect their common usage in the State and include any amendments and modifications thereto.

2.1. Advance Payment – A payment made for goods or services prior to the receipt and acceptance of the goods or the completion and acceptance of the services.

2.2. Advice of Employment – A document that includes an offer of employment.

2.3. Contract – Any Commitment Voucher that constitutes a State Contract or Purchase Order under this Fiscal Rule, where the principal purpose is to acquire supplies, services, or construction or to dispose of supplies for the direct benefit of the State.

2.4. Commercial Cards – See Fiscal Rule 2-7 (State Commercial Cards).

2.5. Emergency – A situation which creates a threat to public health, welfare, or safety such as may arise by reason of floods, epidemics, riots, equipment failures, or such other reasons as may be designated by the State Controller or a delegate of the State Controller as an emergency, and that creates an immediate and serious need for goods, services, or construction without time to issue a Purchase Order or State Contract and the lack of which would seriously threaten:

2.5.1. The functioning of State government or its programs;

2.5.2. The preservation or protection of property; or

2.5.3. The health or safety of any person or persons.

2.6. Encumbrance – An amount reserved on the State Financial System or an approved State Agency or Institution of Higher Education financial system to reflect a formal obligation of the State.

2.7. Financing – The receipt of a loan or issuance of bonds or certificates of participation.

2.8. GAAP – See Fiscal Rule 1-1 (Accounting Principles and Standards).

2.9. Grant – See Fiscal Rule 3-4 (Grants).

2.10. Interagency Agreement – See Fiscal Rule 3-5 (Interagency Agreements).

2.11. Major Information Technology Project – See §24-37.5-102(2.6), C.R.S.

2.12. Party – An individual or entity who is not a State Agency or Institution of Higher Education. If appropriate in the context, the term "Party" may also refer to multiple individuals or entities who are not State Agencies or Institutions of Higher Education.

2.13. Personal Services Commitment Voucher – A Commitment Voucher between a State Agency or Institution of Higher Education and a Party, where the Party provides labor, time, or effort for the direct benefit of the State. An individual or entity performing services under a Personal Services Commitment Voucher is an independent contractor and not an employee of the State.

2.14. Procurement Official – The head of the procurement function for an Institution of Higher Education or for a State Agency who has received delegation from the State's Chief Procurement Officer.

2.15. Procurement Code Violation – A purchase made in violation of the Procurement Code and the Procurement Rules. A Procurement Code Violation is subject to ratification in accordance with the Procurement Code and the Procurement Rules.

2.16. Purchase – The act of incurring an obligation on behalf of the State in order to acquire goods or services from another entity

2.17. Purchase Order or PO – See Fiscal Rule 3-2 (Purchase Orders).

2.18. Small Dollar Grant Award – See Fiscal Rule 3-4 (Grants).

2.19. Small Purchase Documentation – Documentation of a purchase, which does not require a Purchase Order, Grant Agreement, Interagency Agreement or State Contract under §4 of this Fiscal Rule, but does require, without limitation, an invoice, billing statement, itemized receipt, court order, travel authorization, approved Vendor Agreement, or any other document appropriate to the transaction and approved by the State Controller.

2.20. State Contract – See Fiscal Rule 3-3 (State Contracts).

2.21. Statutory Violation – Liabilities incurred or payments made on the State's behalf without prior approval of a Purchase Order, Grant Agreement, Small Dollar Grant Award, or State Contract by the State Controller or a proper delegate, when required under this Fiscal Rule, or without the prior approval of a State Contract by the State's Chief Information Officer or a proper delegate for a Major Information Technology Project. A Procurement Code Violation does not necessarily constitute a Statutory Violation

under these Fiscal Rules.

2.22. Vendor Agreement – Any form of agreement provided by a contractor or vendor, including an online or "click-through" agreement, containing contractual provisions relating to the goods and/or services to be provided by such contractor or vendor.

3. **RULE:**

3.1. A State Agency or Institution of Higher Education shall not disburse funds unless the disbursement is supported by a Commitment Voucher and complies with Fiscal Rule 2-1. Prior to entering into a Commitment Vouchers for proposed expenditures, State Agencies and Institutions of Higher Education shall ensure the following:

3.1.1. The purchase satisfies all appropriate procurement requirements;

3.1.2. The Commitment Voucher used meets the requirements for that type of Commitment Voucher, as defined by Fiscal Rules; and

3.1.3. The purchase complies with applicable statutes, executive orders, rules, and policies.

3.2. In addition to the requirements in §3.1 of this Fiscal Rule, State Agencies and Institutions of Higher Education shall ensure the following for all Commitment Vouchers, other than Small Purchase Documentation:

3.2.1. The Commitment Voucher adequately defines all parties involved in the transaction, the respective performance obligations of the parties, the maximum amount payable and pricing, the required performance date, the timing of payments, and the entity responsible for payments;

3.2.2. The Commitment Voucher terms and conditions represent a commercially reasonable allocation of risks between the parties and any risks to the State are outweighed by the benefits to the State; and

3.2.3. The expenditure is encumbered prior to or concurrently with the execution of the Commitment Voucher.

3.2.3.1. The Encumbrance of funds is not required for the following:

3.2.3.1.1. Agreements related to the issuance of Financing where the payment for that work will be paid out of the proceeds of the Financing and the State is not obligated to pay if the Financing is never received by the State.

3.2.3.1.2. Agreements where the total amount of payments are calculated as a portion of revenues received, and the State is not obligated to pay until after the revenues are actually collected.

3.2.3.1.3. Any of the items specified in §5.4 of this Fiscal Rule.

3.2.3.2. Regardless of the total term of a Commitment Voucher, a State Agency or Institution of Higher Education shall only encumber funds for the current State fiscal year of the Commitment Voucher, unless the Agency or Institution of Higher Education has continuous

spending authority for that Commitment Voucher.

4. **COMMITMENT VOUCHERS**

4.1. Purchase Orders – When State Agencies and Institutions of Higher Education are required to use a PO as the Commitment Voucher under this Fiscal Rule, the State Agency or Institution of Higher Education shall use the PO in accordance with Fiscal Rule 3-2 (Purchase Orders) and shall comply with all requirements of that Rule.

4.2. State Contracts – When State Agencies and Institutions of Higher Education are required to use a State Contract as the Commitment Voucher under this Fiscal Rule, the State Agency or Institution of Higher Education shall use the State Contract in accordance with Fiscal Rule 3-3 (State Contracts) and shall comply with all requirements of that Rule.

4.3. Grants – When State Agencies and Institutions of Higher Education are required to use a Grant Agreement or Small Dollar Grant Award as the Commitment Voucher under this Fiscal Rule, the State Agency or Institution of Higher Education shall use the Grant Agreement or Small Dollar Grant Award in accordance with Fiscal Rule 3-4 (Grants) and shall comply with all requirements of that Rule.

4.4. Interagency Agreements – When State Agencies and Institutions of Higher Education are required to use an Interagency Agreement under this Fiscal Rule, the State Agency or Institution of Higher Education shall use the Interagency Agreement in accordance with Fiscal Rule 3-5 (Interagency Agreements) and shall comply with all requirements of that Rule.

4.5. Small Purchase Documentation – When State Agencies and Institutions of Higher Education use Small Purchase Documentation as the Commitment Voucher under this Fiscal Rule, the State Agency or Institution of Higher Education shall ensure that the Small Purchase Documentation describes the following:

4.5.1. The goods or services being purchased and the reason for the disbursement of funds if the description of the goods or services doesn't otherwise clearly specify the reason;

4.5.2. The total amount due for the goods delivered or services provided and sufficient detail or itemization to ensure that the proper amount will be paid and the prices are fair and reasonable; and

4.5.3. Sufficient detail to determine if the delivery of goods or provision of services was successfully completed and accepted.

Separate Small Purchase Documentation is not required for purchases made by travelers that do not require a receipt under Fiscal Rule 5-1(Travel), as the travel authorization constitutes the Small Purchase Documentation for those purchases. As the Commercial Card is only a method of payment, purchases made with a Commercial Card require Small Purchase Documentation and may also require another form of Commitment Voucher.

5. **DOLLAR LIMITS AND REQUIREMENTS:**

5.1. The following table describes the required Commitment Voucher for the different types of agreements.

TYPE OF AGREEMENT	**DOLLAR LIMIT**	**REQUIRED DOCUMENT FOR COMMITMENT**

		VOUCHER
Goods	$5,000 and less	Small Purchase Documentation, PO, or State Contract
	More than $5,000	PO or State Contract
Services	$5,000 and less	Small Purchase Documentation, PO, or State Contract
	More than $5,000 and not more than $150,000	PO or State Contract
	More than $150,000	State Contract
Grants	$5,000 and less	Small Purchase Documentation, Small Dollar Grant Award, or Grant Agreement
	More than $5,000 and not more than $150,000	Small Dollar Grant Award or Grant Agreement
	More than $150,000	Grant Agreement
Capital Construction / Controlled Maintenance	$150,000 and less	Construction PO (See Fiscal Rule 4-1)
	More than $150,000	Construction Contract (See Fiscal Rule 4-1)
Professional Services under §24-30-1401, et seq., C.R.S., including architectural, engineering, land surveying, industrial hygienist, and landscape architect services	Any dollar amount	State Contract

Real Property lease or license of land, buildings, or a portion thereof for term of more than 30 days	Any dollar amount	State Contract
Agreements Between Agencies and/or Institutions of Higher Education	Any dollar amount	No Commitment Voucher Needed; Use Interagency Agreement in accordance with Fiscal Rule 3-5

5.2. Dollar Limits – the dollar limits shown in the table in §5.1 of this Fiscal Rule apply to the total term of the Commitment Voucher. If a single Commitment Voucher will be used for a purchase that will span multiple fiscal years, then the total of all fiscal years included in that Commitment Voucher is the amount to which the dollar limit will apply. State Agencies and Institutions of Higher Education shall use a single Commitment Voucher for purchases in accordance with the State Controller Contract, Grant, and Purchase Order Policies regarding single purchases.

5.3. Protecting the State's Interests – State Contracts shall be used in situations in addition to those described in this Section if other Commitment Vouchers do not adequately protect the State's interests. Refer questions regarding the proper form of Commitment Voucher to the Office of the State Controller.

5.4. Disbursements Exempt from Purchase Order or State Contract – A Purchase Order or State Contract is not required for the following types of disbursements regardless of the amount of funds disbursed:

5.4.1. Access to internet-based, on-demand training classes and webinars;

5.4.2. Advices of Employments;

5.4.3. Calculated payments required under a program within a State Agency or Institution of Higher Education (e.g., formula distributions, other distributions required by regulatory or statutory formulas);

5.4.4. Copier rental agreements when the payment is based on a defined rate per copy;

5.4.5. Conference registrations;

5.4.6. Conference facilities at hotels or other venues that include, but need not be limited to, meeting rooms, audio visual equipment, catering, and guest accommodation rooms.

5.4.7. Financial aid or tuition assistance programs that is paid directly to a beneficiary;

5.4.8. Membership dues and fees, and participation assessments, that do not include services or examinations;

5.4.9. Insurance premiums;

5.4.10. Services needed by the Department of Law, or by another State Agency or Institution of Higher Education with the approval of the Department of Law to seek outside counsel, to support civil or criminal proceedings, civil or criminal enforcement, or legal services (e.g. attorneys, expert consultants, expert witnesses, mediators, and arbitrators).

5.4.11. Court orders related to criminal proceedings, civil enforcement, or legal services.

5.4.12. Intra-agency or intra-institution purchases;

5.4.13. Moving expenses reimbursed to State employees or paid on behalf of State employees;

5.4.14. Payroll and related disbursements to employees (withholding, authorized benefits, etc.), including reimbursements or payment for Travel as described in Fiscal Rule 5-1;

5.4.15. Postal and other delivery charges, including messenger fees, post office boxes and postage meters;

5.4.16. State program payments to or on behalf of individuals qualified for the program's benefits;

5.4.17. Subscriptions for journals, informational publications, informational and research databases or similar materials (print or electronic), that do not include additional services (such as training or configuration);

5.4.18. Utility hook ups, relocations, and line extensions performed by a utility company;

5.4.19. Water; energy (regulated electric and natural gas, and steam); local, long-distance, wireless, satellite, and telephone communication or data services, including pagers, cell phones and other wireless/communication devices; septic pumping services; regular, non-hazardous trash collection services; and bulk fuel (coal, heating oil, gasoline, propane), which are routinely purchased by a State Agency or Institution of Higher Education; and

5.4.20. Other disbursements approved in writing by the State Controller.

5.5. Exemption from Purchase Order and State Contract Only. The exemptions listed in §5.4 are exemptions from the need to have a Purchase Order or State Contract only and does not create any exemption from any other statutory requirement, such as the requirements of the Colorado Procurement Code and the Procurement Rules.

6. **PROHIBITED TERMS AND LIMITATIONS:**

6.1. Indemnification by the State Prohibited – Unless specifically authorized by statute, a State Agency or Institution of Higher Education shall not indemnify and/or hold harmless another Party (no matter how it is phrased) against any liability incurred as a result of the acts or omissions of such State Agency or Institution of Higher Education. The Colorado Constitution prohibits disbursement by the State Treasurer except upon appropriations made by law or as otherwise authorized by law (Article V, §33). Except as authorized by law, any term or provision of any Commitment Voucher or any other agreement that requires the State to indemnify or hold harmless another Party is void as

described in §24-106-109, C.R.S.

6.2. Binding Arbitration Prohibited – A State Agency or Institution of Higher Education shall not be bound by the results of arbitration or any other extrajudicial dispute resolution process in which the final resolution is not determined by the State. Any term or provision of any Commitment Voucher or any other agreement that requires the State to agree to binding arbitration or any other binding extrajudicial resolution process in which the final resolution is not determined by the State is void as described in §24-106-109, C.R.S.

6.3. Limitations of Liability – A State Agency or Institution of Higher Education may not limit another Party's liability for claims or damages arising out of bodily injury, death, or damage to tangible property of the State. Any term or provision of any Commitment Voucher or any other agreement that limits the liability of a Party for bodily injury, death or damage to tangible property of the State is void as described in §24-106-109, C.R.S. Other liability may be limited if the State Agency or Institution of Higher Education determines in writing that the benefits outweigh the risks, the limitation of liability does not apply to any insurance required under the Commitment Voucher, if any, and the Office of the State Controller has approved the limitation.

6.4. Choice of Law Outside of Colorado – A State Agency or Institution of Higher Education may not agree to be bound by the laws of another state. As described in §24-106-109, C.R.S., all agreements except those with another government shall be governed by Colorado law. State Agencies and Institutions of Higher Education may agree to be silent on choice of law in agreements with another governmental entity, but cannot agree to their law as controlling.

6.5. Inclusion of Void Terms – A State Agency or Institution of Higher Education should not include a term or provision that would be void under this §6 or under §24-106-109, C.R.S., in any Commitment Voucher or a Vendor Agreement entered into by a State Agency or Institution of Higher Education with another Party. If another Party requires the inclusion of a void provision, the State Agency or Institution of Higher Education shall inform the Party that those terms or provisions will be void if they are included. If the Party is unwilling or unable to remove those terms or provisions after being notified but is unwilling to accept the Commitment Voucher, Small Purchase Documentation, or Vendor Agreement without the inclusion, the State Agency or Institution of Higher Education may enter into the Commitment Voucher or Vendor Agreement that includes the void provision if the State Controller, Chief Procurement Officer, authorized Procurement Official or delegate, or authorized State Controller delegate approves the inclusion of the void term or provision.

7. COMMITMENT VOUCHER APPROVALS:

The State Controller, or an authorized delegate of the State Controller, shall approve all Purchase Orders, State Contracts, Grant Agreements, and Small Dollar Grant Awards. A State Agency or Institution of Higher Education, at its discretion, may require such additional internal approvals as it deems proper. The State Agency or Institution of Higher Education shall obtain all required approvals and signatures and retain documentation thereof in its files for the period specified in the State Controller Contract, Grant, and Purchase Order Policies. Unless a State Agency or Institution of Higher Education is exempt by statute or has delegated approval authority, prior approval of the Commitment Voucher by one or more of the Central Approvers, defined in Fiscal Rule 3-3, is required as follows:

7.1. Capital Construction and Controlled Maintenance Commitment Vouchers require the approval of the State Architect or a delegate of the State

Architect, unless otherwise exempt by statute or waived by the State Architect. See §24-30-1303(1)(d), C.R.S.

7.2. Commitment Vouchers for services normally provided by the Division of Central Services require the approval of the Director of the Division of Central Services, Department of Personnel and Administration, or a delegate of the Director of the Division of Central Services, for all State Agencies located within Adams, Arapahoe, Boulder, Douglas, Pueblo, El Paso, and Jefferson counties, the City and County of Broomfield, and the City and County of Denver. Institutions of Higher Education are exempt from this requirement. See §24-30-1104(1), C.R.S.

7.3. Contingency-Based Commitment Vouchers require the approval of the Office of State Planning and Budgeting. See §24-17-204, C.R.S.

7.4. Debt Collection Services Commitment Vouchers require the approval of the State Controller or a delegate of the State Controller with specific authority to approve Debt Collection Services Commitment Vouchers. See §24-30-202.4, C.R.S.

7.5. Financial Information Commitment Vouchers used by a State Agency or Institution of Higher Education to record financial transactions and information, develop financial reports, or prepare financial statements require the approval of the State Controller. See §24-30-202(12), C.R.S.

7.6. Information Technology Commitment Vouchers require approval by the Governor's Office of Information Technology as described in the State Controller Contract, Grant, and Purchase Order Policies.

7.7. Legal Services Commitment Vouchers require the approval of the State Attorney General or a delegate of the State Attorney General. See §24-31-101, C.R.S.

7.8. Personal Services Commitment Vouchers require the approval of the State Personnel Director or a delegate of the State Personnel Director. See §24-50-501, et seq., C.R.S. This approval is not required for Personal Services Commitment Vouchers for services that are:

7.8.1. Exempt from the State classified personnel system under Article XII, §13 of the State Constitution, including without limitation, attorneys at law serving as assistant attorneys general; faculty members and certain administrators at Institutions of Higher Education, exempt under §24-50-135, C.R.S., and members, officers, and employees of the judicial and legislative branches of the State, unless specifically provided by the Constitution, and the offices of the Governor and Lieutenant Governor whose functions and duties are confined to such offices.; or

7.8.2. Non-recurring services lasting nine months or less, where the need for such services is not expected to recur on a regular basis. Temporary services that do not meet these criteria require approval from the State Personnel Director or a delegate of the State Personnel Director.

7.9. Real property State Contracts, including leases where the State Agency or Institution of Higher Education is the tenant, easements, and rights-of-way agreements, require the approval of the State Architect or the Director of Real Estate Programs within the Office of the State Architect, Department of Personnel & Administration, or a delegate of either position, unless otherwise exempted by statute. See

§24-30-1303, C.R.S. Real properties administered by the State Board of Land Commissioners, Division of Parks and Wildlife in the Department of Natural Resources, and the Department of Transportation, are exempt from this requirement. See§24-30-1301(15)(b), C.R.S.

7.10. Utility cost-savings Commitment Vouchers require the approval of the State Personnel Director or a delegate of the State Personnel Director. See §24-30-2003(1)(b), C.R.S.

7.11. Commitment Vouchers related to the Business Enterprise Program require the approval of the Business Enterprise Program within the Department of Labor and Employment. See §8-84-201, et seq., C.R.S.

8. **STATUTORY VIOLATIONS:**

A Statutory Violation occurs when liabilities are incurred or payments are made on the State's behalf without prior approval of a State Purchase Order, Small Dollar Grant Award, Grant Agreement, or State Contract, when required under this Fiscal Rule. A Statutory Violation also occurs when liabilities are incurred or payments are made that exceed the unencumbered balance of the appropriation to which the resulting disbursement would be charged.

8.1. Personal Liability – Under §24-30-202(3), C.R.S., any person(s) who incurs, orders or votes for an obligation or makes a payment which creates a Statutory Violation shall be personally liable for such obligation, unless the contractor payment subject to the Statutory Violation is approved by the State Controller and the State Controller permits the State Agency or Institution of Higher Education to make payment to the contractor without recovering the amount of that payment from the person(s) who incurred, ordered or voted for an obligation or made a payment which created the Statutory Violation.

8.2. Payment Prohibition – A State Agency or Institution of Higher Education shall not make payments to a contractor that are subject to a Statutory Violation, unless and until the contractor payment subject to the violation has been approved by the State Controller.

8.3. Commitment Voucher Modification Provision – A State Agency or Institution of Higher Education shall not modify any requirements related to the work contained in a Commitment Voucher if that Commitment Voucher is subject to an unapproved Statutory Violation.

8.4. Approval Allowing Contractor Payment – The State Controller or an authorized delegate of the State Controller, in that individual's sole discretion, may approve a retroactive Commitment Voucher supporting the expenditure or obligation creating a Statutory Violation, and allow payment to the contractor if that individual finds all of the following:

8.4.1. The prices or rates are fair and reasonable;

8.4.2. The amount of the expenditure is authorized by the appropriation and allotment to which it will be charged and is within the unencumbered balance available within that allotment;

8.4.3. The State Agency or Institution of Higher Education provides a written explanation in accordance with the State Controller Contract, Grant, and Purchase Order Policies; and

8.4.4. The contractor did not act in bad faith or in a fraudulent

manner.

8.5. Removal of Personal Liability – As part of any approval allowing contractor payment, the State Controller or an authorized delegate of the State Controller, in that individual's sole discretion, may permit the State Agency or Institution of Higher Education to make payment to the contractor without recovering the amount of that payment from the person(s) who incurred, ordered, or voted for an obligation or made a payment which created the Statutory Violation if that individual finds of the following:

8.5.1. The violation does not show a willful disregard of law, rules, policies or regulations on the part of the person(s) who incurred, ordered, or voted for an obligation, or who made a payment which created the Statutory Violation;

8.5.2. The violation happened accidentally or was unavoidable through no fault of the person(s) who incurred, ordered, or voted for an obligation, or who made a payment which created the Statutory Violation; and

8.5.3. The State Agency or Institution of Higher Education has requested permission to make the payment without recovering the amount of the payment from the person(s) who incurred, ordered, or voted for an obligation or who made a payment which created the Statutory Violation.

8.6. Fiscal Rule Violation Ratification – If the State Controller or an authorized delegate of the State Controller approves a retroactive Commitment Voucher supporting the expenditure or obligation creating a Statutory Violation, then that approval shall also constitute a ratification of the violation of this Fiscal Rule.

9. ADVANCE PAYMENTS

9.1. General Prohibition – Commitment Vouchers shall not provide for Advance Payment for goods supplied and/or services performed or for any other contractual obligation, except as permitted in §§9.4 through 9.6 of this Fiscal Rule.

9.2. Accounting for Advance Payments – Regardless of when a payment is made, State Agencies and Institutions of Higher Education shall account for those payments in accordance with GAAP and any grant requirements applicable to those payments.

9.3. Waiver Process – The State Controller or an authorized delegate of the State Controller, in that individual's sole discretion, may grant the request of a State Agency or Institution of Higher Education for a waiver, allowing an Advance Payment not listed in the exceptions in §§9.4 through 9.6. The waiver request shall include evidence that advance payment is an established industry standard and/or provides a benefit to the State at least equal to the cost and risk of the Advance Payment.

9.4. Exceptions – Prior Approval of State Controller Not Required – Advance Payments where the payment is made no more than one year in advance of the substantial receipt and acceptance of the goods or completion and acceptance of the services to which the payment applies are permitted without prior approval of the State Controller or a delegate of the State Controller for the following, unless the State Controller or delegate determines that the circumstances around the payment require prior approval to minimize risk to the State:

9.4.1. Advertising services and related goods;

9.4.2. Charter Transportation;

9.4.3. Construction permits;

9.4.4. Catering for events at both State and non-State facilities;

9.4.5. Deposits for conference facilities at hotels or other venues that include, but need not be limited to, meeting rooms, audio visual equipment, catering, and guest accommodation rooms.

9.4.6. ExpressToll passes issued by the E-470 Public Highway Authority.

9.4.7. Federal grants awarded by the State to subgrantees (in compliance with Federal requirements) or agreements where the State is acting as a fiscal agent for the disbursement of Federal funds (in compliance with Federal requirements);

9.4.8. Information technology (IT) service agreements (including internet access, systems and database access),

9.4.9. Insurance premiums;

9.4.10. Interagency Agreements;

9.4.11. Janitorial services;

9.4.12. Licenses, including licenses for software;

9.4.13. Maintenance of office equipment or information technology (IT) (software and hardware), and other maintenance agreements;

9.4.14. Membership dues and fees, and participation assessments, that do not include services or examinations;

9.4.15. Personal property leases or rentals;

9.4.16. Postal and other delivery charges, including messenger fees, post office boxes and postage meters;

9.4.17. Purchases made with a Commercial Card through an online retailer (See Fiscal Rule 2-7);

9.4.18. Professional services provided by entertainers and speakers;

9.4.19. Participation in conferences and trade shows as an exhibitor or presenter, including booth rental at those conferences or events;

9.4.20. Real property leases, where the State is a tenant, and perpetual easements, if the entire interest is purchased and all attendant rights are transferred upon payment;

9.4.21. Security alarm and safety systems and monitoring;

9.4.22. Services needed by the Department of Law, or by another State Agency or Institution of Higher Education with the approval of the Department of Law to seek outside counsel, to support criminal or civil proceedings, civil or criminal enforcement, or legal services (e.g. attorneys, expert consultants, expert witnesses, mediators, and arbitrators).

9.4.23. Sponsored projects – See Fiscal Rule 3-3 (State

Contracts);

9.4.24. Subscriptions for journals, informational publications, informational and research databases or similar materials (print or electronic), which do not include additional services (such as training and configuration);

9.4.25. Telecommunications services, such as prepaid local, long-distance, wireless, satellite, and telephone communication or data services, including pagers, cell phones and other wireless/communication devices;

9.4.26. Travel expenses such as hotels, motels, airfare etc. paid in accordance with Fiscal Rule 5-1;

9.4.27. Tuition, registration, and fees charged for trainings, classes, conferences, and seminars;

9.4.28. Utility hook-ups, relocations, and line extensions performed by a utility company;

9.4.29. Utility services including trash and recycling collection, heat, water, and sewer; and

9.4.30. Water rights purchases, temporary water leases, or water storage payments.

9.5. Exceptions – Prior Approval Not Required – Multiple Years. Advance Payments, where the payment may be made any time in advance of the receipt of the goods or completion of the service to which the payment applies, are permitted without prior approval of the State Controller for the following:

9.5.1. Federal contracts where the State Agency or Institution of Higher Education is paying the Federal government and the Federal agency requires Advance Payments under the Anti-Deficiency Act or other Federal rule or regulation;

9.5.2. In-kind payments, where the State Agency or Institution of Higher Education has access to variable quantities of the good or commodity to be used for payment and the State Controller delegate for the State Agency or Institution of Higher Education determines, and documents in the contract file, that it is in the best interest of the State Agency or Institution of Higher Education to be able to prepay in years where the State Agency or Institution of Higher Education has access to high quantities to offset years where lower quantities are available (e.g. when a State Agency or Institution of Higher Education is required to pay in water, it may need to prepay in "wet" years in order to offset drought years).

9.6. Exceptions – Prior Delegate Approval Required – One or More Years. Advance Payments of up to $10,000, may be made any time in advance of the receipt and acceptance of goods or the completion and acceptance of services, if the State Controller delegate for the State Agency or Institution of Higher Education determines, and documents in the Contract file, that the Advance Payment provides a benefit to the State at least equal to the cost and risk of the Advance Payment. Advance Payments shall not be split in order to stay below the $10,000 maximum. In no instance shall more than $10,000 be advanced under a single Commitment Voucher without State Controller approval.

10. **REQUIREMENTS FOR PERSONAL SERVICES COMMITMENT VOUCHERS**

10.1. Designation of Contract Manager – In accordance with §24-106-107, C.R.S., for each Personal Services Commitment Voucher, State Agencies and Institutions of Higher Education shall designate at least one person with subject matter expertise as a contract manager to be responsible for day-to-day management of the Personal Services Commitment Voucher, including performance monitoring as required by §24-106-107(3), C.R.S.

10.2. Monitoring – Each State Agency and Institution of Higher Education shall monitor its Personal Services Commitment Vouchers to ensure that the work is performed in accordance with the performance measures and standards of the Personal Services Commitment Voucher and that the contractor was paid in accordance with the payment schedule in the Personal Services Commitment Voucher. State Agencies and Institutions of Higher Education shall follow the State Controller Contract, Grant, and Purchase Order Policies and the accountability standards in §24-106-107(2)(b), C.R.S.

10.3. Contract Management System – In accordance with §24-106-103(3)(d), C.R.S., State Agencies and Institutions of Higher Education subject to §24-106-103, C.R.S., shall include all Personal Services Commitment Vouchers over $100,000.00 in the State's centralized contract management system, maintained by the Department of Personnel and Administration, within 30 days following their execution, regardless of the type of Commitment Voucher used.

10.4. Personal Services Provided By Retirees – State Agencies and Institutions of Higher Education that purchase services from an independent contractor who is also a retired State employee shall make employer contributions to Public Employees' Retirement Association (PERA) in accordance with per §24-51-1101(2), C.R.S. For State Agencies that utilize the State Financial System, full disclosure of the relationship with the retired State employee working as independent contractor shall be provided to the Office of the State Controller to allow coordination of employer contribution payments to PERA on behalf of State Agencies. Agencies and Institutions of Higher Education that do not use the State Financial System shall be responsible for ensuring that the proper contribution payments are made to PERA.

10.5. Personal Services Commitment Voucher Terms – In addition to the elements otherwise required for each type of Commitment Voucher, each Personal Services Commitment Voucher over $100,000 shall include all of the following terms, as required by §24-106-107, C.R.S.:

10.5.1. Performance measures and standards developed specifically for the Commitment Voucher by the administering State Agency or Institution of Higher Education;

10.5.2. Accountability standards requiring regular contractor reports on achievement of the specified performance measures and standards;

10.5.3. Payment provisions allowing the State Agency or Institution of Higher Education to withhold payment until successful completion of all or specified parts of the Commitment Voucher and requiring prompt payment upon successful completion;

10.5.4. Monitoring requirements specifying how the State Agency or Institution of Higher Education will evaluate the contractor's performance, including progress reports, site visits, inspections, and reviews of performance data; and

10.5.5. Processes for resolving disputes between the State Agency or Institution of Higher Education and the contractor.

11. **EMERGENCIES:**

Emergency disbursements for procurements that would require a State Contract or Purchase Order may be made upon presentation of invoices, receipts, or other statements describing goods or services purchased and the amount to be paid. Goods and services necessary to respond to an Emergency may be procured immediately, without issuing a Commitment Voucher or obtaining a written waiver from the Office of the State Controller, where all of the following conditions are met:

11.1. The nature of the situation requires an immediate response and there is insufficient time to issue a Commitment Voucher;

11.2. The procurement is authorized in accordance with the Procurement Code and the Procurement Rules;

11.3. The expenditure is approved by a State Controller delegate;

11.4. If there are any future performance obligations necessary to resolve the Emergency, a Commitment Voucher is executed as soon as possible to define those future performance obligations, as required by Fiscal Rules; and

11.5. The State Agency or Institution of Higher Education notifies the State Controller's Office in writing, as soon as possible, of the circumstances, the goods and services purchased, and the dollar amount of the commitment. Failure to provide notice in a timely manner, as determined by the State Controller's Office, will constitute a Statutory Violation.

12. **VENDOR AGREEMENTS:**

12.1. Prohibited Use – A Vendor Agreement shall not be used in lieu of a State Purchase Order or State Contract, where one is required, absent the prior written approval of the State Controller or an approved delegate. A Vendor Agreement shall not be used where a State Purchase Order or State Contract is not required, except as provided in §12.2 or in the State Controller Contract, Grant, and Purchase Order Policies.

12.2. Permitted Use – The Chief Fiscal Officer or Procurement Official of a State Agency or Institution of Higher Education, or a delegate of either individual, may authorize the use of Vendor Agreements up to $5,000, if a State Contract or Purchase Order is not required.

12.3. Conditions of Use – All of the conditions set forth in the State Controller Contract, Grant, and Purchase Order Policies related to Vendor Agreements shall be met whenever a Vendor Agreement is used.

13. **INDEPENDENT CONTRACTOR RELATIONSHIP:**

State Agencies and Institutions of Higher Education shall ensure that all Commitment Vouchers create only an independent contractor relationship and do not create an employer-employee relationship. State Agencies and Institutions of Higher Education shall not engage in any practices that would result in the creation of an employer-employee relationship.

RULE 3-2: PURCHASE ORDERS

1. **AUTHORITY:**

§24-30-202(1-4) and (5)(a), C.R.S. (State Controller Authority)

§24-106-103, C.R.S. (Centralized Contract Management System)

§24-102-206, C.R.S. (Contract Performance Outside United States or Colorado)

§24-106-106, C.R.S. (Right to Audit Records)

§24-106-107, C.R.S. (Monitoring of Vendor Performance)

2. **DEFINITIONS:**

2.1. Purchase Order – A unilaterally approved Commitment Voucher, the form of which has been approved by the State Controller, issued by a State Agency or Institution of Higher Education to purchase goods, services, or construction for the direct benefit of the State, as described in this Fiscal Rule.

3. **RULE:**

Each State Agency or Institution of Higher Education shall use a Purchase Order as described in this Rule when Fiscal Rule 3-1 requires the use of a Purchase Order as the Commitment Voucher.

4. **CONTENT OF PURCHASE ORDERS:**

4.1. Standard Provisions – All Purchase Orders issued by State Agencies and Institutions of Higher Education shall include all of the following:

4.1.1. Identification of the parties;

4.1.2. A description of all goods to be delivered and/or services to be performed;

4.1.3. Payment Terms, as defined in Fiscal Rule 2-3, including the maximum dollar amount;

4.1.4. Dates that define the term of the Purchase Order; and

4.1.5. Any other content required under the State Controller Contract, Grant, and Purchase Order Policies.

5. **APPROVED PURCHASE ORDER FORMS**

5.1. All Purchase Orders shall be in a form approved by the State Controller. The State Controller has approved the following Purchase Order forms and may approve additional forms in the State Controller's sole discretion.

5.1.1. Model Purchase Orders – State Agencies and Institutions of Higher Education shall use the model Purchase Order forms as described in the State Controller Contract, Grant, and Purchase Order Policies.

5.1.2. Purchase Order Modifications – All modifications to a Purchase Order shall be made by a formal written change order approved by the State Controller or a delegate, unless an alternative modification tool has been approved by the State Controller. A Purchase Order for services or one that has

already been accepted by performance cannot be modified or extended (revived) after its term has expired.

5.1.2.1. If unaccepted goods are delivered after the expiration of a Purchase Order for goods only, the State Agency of Institution of Higher Education may accept those goods by modifying the Purchase Order to extend the term to the date the goods were delivered so long as the goods had not been used by the State prior to the extension. In this circumstance, the use of goods prior to the execution of the extension of the Purchase Order constitutes a Statutory Violation as described in Fiscal Rule 3-1, §8.

5.1.3. Other Purchase Order Forms – State Agencies and Institutions of Higher Education may use any other Purchase Order form that is approved by the State Controller from time-to-time.

6. **STATE CONTROLLER REVIEW AND APPROVAL:**

6.1. Performance of State Controller Functions

6.1.1. Delegation to State Agencies and Institutions of Higher Education – The State Controller has delegated the authority to approve Purchase Orders to the State's Chief Procurement Officer, as defined in §24-101-301(6), C.R.S., with special approval to sub delegate that authority. The State Controller may also delegate the authority to approve Purchase Orders to any other individual through a delegation agreement in accordance with Fiscal Rule 1-4.

6.2. Process for Review, Approval, and Signature

6.2.1. Review of Purchase Orders – All Purchase Orders shall be reviewed by the State's Chief Procurement Officer, a Procurement Official or another individual with either a delegation from the State Controller or a sub-delegation from the Chief Procurement Officer or a Procurement Official to review Purchase Orders to determine if the Purchase Order complies with Fiscal Rule 3-1, §3 and all procurement laws and regulations.

6.2.2. Approval of Purchase Orders – All Purchase Orders shall be approved by the State's Chief Procurement Officer, a Procurement Official, or another individual with either a delegation from the State Controller or a sub-delegation from the Chief Procurement Officer or a Procurement Official to approve Purchase Orders, prior to any Purchase Order becoming effective. If approved, the person approving the Purchase Order shall evidence such approval in the State Financial System, or other such system used by the State Agency or Institution of Higher Education in accordance with Fiscal Rule 1-3, or by signing the Purchase Order.

RULE 3-3: STATE CONTRACTS

1. **AUTHORITIES:**

Article V, Section 33, Constitution of Colorado – Disbursement of public money

Article XI, Section 1, Constitution of Colorado – Pledging credit of state, county, city, town or school district forbidden

Article XII, Section 13 (2), Constitution of Colorado – State personnel system – merit system

Governor's Executive Order signed April 7, 1978 (Authority to Sign Contracts, Deeds, and Leases)

Governor's Executive Order D 016 07 – Improving State Information Technology Management

State of Colorado Procurement Rules – 1 CCR 101-9

§4-1-101, et seq., C.R.S. (Uniform Commercial Code)

§24-2-102(4), C.R.S. (Appointment of Officers and Employees)

§2-2-320(2), C.R.S. (Legislative Contracts Approval)

§24-17-201, et seq., C.R.S. (State Contingency-based Contracts)

§24-30-202, C.R.S. (State Controller Authority)

§24-30-1104(1)(h), C.R.S. (Central Services Approval Authority)

§24-30-1107, C.R.S. (Central Services Approval authority)

§24-30-1303(1)(a) and (d), C.R.S. (Office of State Architect Approval Authority)

§24-30-1404(4), C.R.S. (Prohibition against Contingency Fees)

§24-30-2001, et seq., C.R.S. (Utility Cost-savings Measures)

§24-31-101(1)(c), C.R.S. (State Attorney General Powers and Duties)

§24-31-104, C.R.S. (Appointment of Subordinate Officers and Employees)

§24-34-101, et seq., C.R.S. (Department of Regulatory Agencies)

§24-37.5-101, et seq., C.R.S. (Office of Information Technology)

§24-37.5-601, et seq., C.R.S. (Telecommunications Approval Authority)

§24-50-135, C.R.S. (Exemptions from Personnel System)

§24-50-501, et seq., C.R.S. (Contracts for Personal Services)

§24-75-302, C.R.S. (Capital Construction Fund)

§24-101-101, et seq., C.R.S. (Procurement Code)

§§33-1-105 and 105.5, C.R.S. (Acquisition of Property – Parks and Wildlife Commission)

§33-10-107, C.R.S. (Acquisition of Property – Parks and Wildlife Commission)

2. **DEFINITIONS:**

The following definitions include terms used in this Fiscal Rule as well as various types of Agreements entered into by State Agencies and Institutions of Higher Education.

2.1. Agreement – A legal agreement between a State Agency

or Institution of Higher Education and another individual or entity that may or may not constitute a State Contract under this Fiscal Rule.

2.2. Capital Construction – A Capital Construction Project or Controlled Maintenance Project funded wholly or in part by the State Capital Construction Fund (§24-75-302, C.R.S.) or wholly or in part with any cash resources of a State Agency or Institution of Higher Education. See Fiscal Rule 4-2.

2.3. Central Approvers – Certain division directors, executive directors of State Agencies, and Elective Officers, or their respective delegates, whose prior approval is required by statute or Fiscal Rule for certain types of State Contracts. Central approvers include, without limitation, the State Personnel Director, the State Architect, the Director of the Real Estate Programs, the State Communications Coordinator, the State Attorney General, the Director of the Division of Central Services, the State Risk Manager, and the Executive Director of the Governor's Office of Information Technology.

2.4. Central Services Contract – A State Contract between a State Agency or Institution of Higher Education and another Party for the acquisition of services, services related to equipment, and software related to services. Centralized services include, without limitation, motor pool operation, motor vehicle maintenance, mail or messenger services, office copying, graphic design for print media, printing and binding, microfilming, or design of forms. See §24-30-1104, C.R.S.

2.5. Contingency-Based Contract – A State Contract for services between a State Agency or Institution of Higher Education and a contractor where all or part of the contractor's compensation is computed by multiplying a stated percentage by the measurable savings in the State Agency's or Institution of Higher Education's expenditures or costs of operation attributable to the contractor's services under the State Contract. The term "Contingency-Based Contract" does not include State Contracts where the contingency-based compensation is specifically authorized by statute, as described in §24-17-203, C.R.S, including State Contracts where the contractor collects a debt on behalf of the State Agency or Institution of Higher Education and receives a portion of those amounts collected as payment. Contingent fees are prohibited in Professional Services Contracts. See §24-30-1404(4), C.R.S.

2.6. Debt Contract – A State Contract in which the State receives money from a lender and agrees to repay the money to the lender, including the payment of any interest due. All Debt Contracts must comply with the requirements of the Taxpayer Bill of Rights. Examples of Debt Contracts include lease purchase agreements, short-term debt, notes, bonds, and certificates of participation.

2.7. Delegated State Agency or Delegated Institution of Higher Education – A State Agency or Institution of Higher Education whose controller has been granted delegated signature authority by the State Controller.

2.8. Employee Voluntary Separation Agreement – An Agreement between a State Agency or Institution of Higher Education and a State employee setting forth the terms of the employee's voluntary separation from State employment.

2.9. Expenditure Contract – A State Contract where a State Agency or Institution of Higher Education is required to make a payment, either in funds or in-kind, to another Party, directly or indirectly, and includes any agreements that divert revenue that would otherwise be due to the State. An agreement where the State is required to perform a service for another Party is an Expenditure Contract if it is likely that the State's failure to perform would result in the payment of State funds to the other Party.

2.10. Franchise Agreement – An Agreement where a State Agency or Institution of Higher Education grants to another Party a concession or right to provide goods or services in a particular market or geographical area controlled by the State, such as concession stands, hotels, and other services provided in certain State parks. The State Agency or Institution of Higher Education may regulate service level, quality, and price, but users of the service pay the other Party directly and the other Party provides the goods or services and exercises control over other management decisions. For the purposes of this Fiscal Rule, an Agreement by a State Agency or Institution of Higher Education to buy a franchise from another Party is an Expenditure Contract, not a Franchise Agreement.

2.11. Fund Management Services Agreement – A State Contract for professional consulting services regarding the management of State funds.

2.12. Goods Contract – A State Contract between a State Agency or Institution of Higher Education and another Party for the purchase of goods. The term "goods" includes commodities, supplies, and products as such terms are used in the State Procurement Code, the Procurement Rules), and Uniform Commercial Code (§4-2-105, C.R.S.).

2.13. Information Technology Contract – A State Contract between a State Agency or Institution of Higher Education and another Party, where the other Party provides information technology services or products and services. An Information Technology Contract is a type of personal services contract. See §24-37.5-102(2), C.R.S. and the State Controller Contract, Grant, and Purchase Order Policies regarding Information Technology Contracts for a description of information technology products and services.

2.14. Intergovernmental Contract – An Agreement between a State Agency or Institution of Higher Education and a political subdivision of the State, another state, a political subdivision or public Institution of Higher Education of another state, or an agency of the Federal government. An Intergovernmental Contract may be an Expenditure Contract or a Non-Expenditure Contract.

2.15. Investment Advisory Services Agreement – A State Contract for professional consulting services regarding securities and investments.

2.16. License – A grant by the owner of rights in real or personal property to another of a personal privilege to use such property, without the transfer of the underlying ownership interest therein.

2.17. Loan Agreement – An Agreement between a State Agency or Institution of Higher Education and another Party, where the State Agency or Institution of Higher Education agrees to loan funds to such other Party.

2.18. Major Information Technology Project – See Fiscal Rule 3-1 (Commitment Vouchers).

2.19. Modification Policies – the State Controller Contract, Grant, and Purchase Order Policies related to the modification of State Contracts.

2.20. Non-Expenditure Contract – An Agreement between a State Agency or Institution of Higher Education and another Party involving an exchange of resources, goods, or services, that does not result in the expenditure of funds by the State Agency or Institution of Higher Education or that is a Revenue Contract, and the likely result of a failure to perform by the State Agency or Institution of Higher Education would not result in the expenditure of State funds.

2.21. Outsource Contract-Third Party Payor – A State

Contract between a State Agency or Institution of Higher Education and another Party for personal services, where the State Agency or Institution of Higher Education:

2.21.1. Is charged with providing the function or services that are the subject matter of the Outsource Contract to members of the public;

2.21.2. Delegates performance of all or a part of the function or service to the other Party, but does not dictate the Party's operations beyond providing limited input regarding the Party's performance of its obligation; and

2.21.3. Mandates that members of the public, and not the State Agency or Institution of Higher Education, are responsible for paying the other Party to perform the function or service; for example, where an applicant seeking a license or certification from the State pays the other Party for providing testing services that are required as a prerequisite to the grant of such license or certification.

2.22. Party – See Fiscal Rule 3-1 (Commitment Vouchers).

2.23. Personal Property Lease or License Agreement – A State Contract between a State Agency or Institution of Higher Education, as lessee or licensee, and the owner of personal property, as lessor or licensor, where the State Agency or Institution of Higher Education pays the lessor for the right to use such personal property for the term of the lease or license. A Personal Property Lease Agreement may be an operating lease or a capital lease. See the State Controller Contract, Grant, and Purchase Order Policies.

2.24. Price Agreement – A State Contract between the Department of Personnel and Administration, State Purchasing and Contracts Office, and a contractor, which allows State Agencies and Institutions of Higher Education to order goods or services from the contractor, pursuant to the terms of the price agreement, by issuing a Purchase Order, task order, or other approved order form.

2.25. Professional Services Contract – A State Contract between a State Agency or Institution of Higher Education and another Party for the performance of any of the following services: architectural, engineering, land surveying, industrial hygienist, and landscape architect, as defined in §24-30-1402, C.R.S.

2.26. Real Property Lease/License Agreement – An Agreement between a State Agency or Institution of Higher Education and another Party, where the State Agency or Institution of Higher Education:

2.26.1. As landlord or licensor, owns the real property subject to the Real Property Lease/License Agreement and gives the other Party to the Real Property Lease/License Agreement, as tenant, the right of possession of such property for the term of the Real Property Lease/License Agreement; or

2.26.2. As tenant or licensee, obtains the right of possession of the real property subject to the Real Property Lease/License Agreement from the owner of such property, as landlord or licensor, for the term or the Real Property Lease/License Agreement.

2.27. Real Property Purchase Agreement – An Agreement for the purchase of an interest in land (fee title or lesser interests) and improvements to land, such as buildings and other structures.

2.28. Revenue Contract – An Agreement between a State Agency or Institution of Higher Education and another Party where cash or property or both

are paid to the State, resulting in revenue recognition, which does not require the expenditure of State funds or create a financial obligation to the other Party on the part of the State Agency or Institution of Higher Education.

2.29. Reviewing Attorney – An assistant attorney general, special assistant attorney general or other attorney authorized by the State Attorney General and employed by a State Agency or Institution of Higher Education, who has received a written designation as a Reviewing Attorney from the State Controller. A written designation from the State Controller is personal to the Reviewing Attorney and may not be assigned or further delegated. The designation is limited to the specific responsibilities and authority set forth in the written designation and may be terminated or modified at any time at the sole discretion of the State Controller.

2.30. Sale of Securities – The offer, issuance or sale of securities by the State of Colorado or any State Agency or Institution of Higher Education. Securities may include certain Debt Contracts.

2.31. Settlement Agreement – A State Contract between a State Agency or Institution of Higher Education and another Party for the purpose of ratifying agreements concerning employment, contractual, or legal disputes, where a State Agency or Institution of Higher Education is required to make a payment, either in funds or in-kind, to the other Party, directly or indirectly, and includes any agreement that diverts revenue that would otherwise be due to the State, requires the State to forgo the right to receive funds, property or services, or obligates the State to perform a service for another Party, where failure to perform such service would result in payment of State funds to the other Party.

2.32. Sponsored Project Agreement – A State Contract between an Institution of Higher Education and another Party, where the Institution of Higher Education receives or expends funding for use in connection with oversight responsibilities for research and development or other specified programmatic activities sponsored by Federal, state, or local governments, or private agencies or organizations.

2.33. State Contract – A Commitment Voucher between a State Agency and/or Institution of Higher Education and another Party to acquire supplies, services, or construction, to lease supplies or real property or to dispose of supplies for the direct benefit of the State, and that does not include Small Purchase Documentation, Purchase Orders, Grant Agreements, or Small Dollar Grant Awards, each as described in Fiscal Rule 3-1. Interagency Agreements, as described in Fiscal Rule 3-5 are not State Contracts because they are not Commitment Vouchers.

2.34. Utility Cost-Savings Contract – An energy performance State Contract, shared-savings State Contract, or other State Contract in which utility cost savings are used to pay for services or equipment. See §24-30-2001(6), C.R.S.

3. **CATEGORIES OF STATE CONTRACTS:**

The following categories provide examples of different types of State Contracts, but are not all inclusive and any State Contract may combine any two or more of these types.

3.1. Expenditure Contracts

3.1.1. Capital Construction Contracts;

3.1.2. Central Services Contracts;

3.1.3. Contingency-Based Contracts;

3.1.4. Employee Voluntary Separation Agreements;

3.1.5. Fund Management Services Agreements;

3.1.6. Goods Contracts;

3.1.7. Information Technology Contracts;

3.1.8. Intergovernmental Agreements – State has a financial obligation;

3.1.9. Investment Advisory Services Agreements;

3.1.10. Outsource Contracts-Third Party Payor;

3.1.11. Personal Property Leases/Licenses – State as lessee or licensee;

3.1.12. Professional Services Contracts;

3.1.13. Real Property Leases/ Licenses – State as tenant or licensee;

3.1.14. Real Property Purchase Agreements – State as buyer; and

3.1.15. Settlement Agreements.

3.2. Revenue Agreements

3.2.1. Franchise Agreements;

3.2.2. Real Property Leases/Licenses – State as landlord or licensor; and

3.2.3. Real Property Purchase Agreements – State as seller.

3.3. Other Agreement Types

3.3.1. Debt Contracts – State as borrower;

3.3.2. Intergovernmental Agreements – State has no financial obligation

3.3.3. Loan Contracts – State as lender;

3.3.4. Non-Expenditure Contracts other than Revenue Contracts;

3.3.5. Price Agreements;

3.3.6. Sale Of Securities Agreements;

3.3.7. Sponsored Project Agreements; and

3.3.8. Utility Cost-Savings Agreements.

4. **RULE:**

4.1. Each State Agency or Institution of Higher Education shall use a State Contract as described in this Rule when Fiscal Rule 3-1 requires the use of a State Contract as the Commitment Voucher.

5. **CONTENT OF STATE CONTRACTS:**

5.1. Expenditure Contracts and Other Contract Types that result in an expenditure of State funds, including Debt Contracts and Price Agreements – The general provisions of this subsection shall apply to all State Contracts that result in an expenditure of State funds or the disposition of State property, except as limited or excluded in the specific subsections covering: (a) real property purchases (State as buyer), leases (State as tenant), and licenses (State as licensee) and (b) Settlement Agreements and Employee Voluntary Separation Agreements. See the State Controller Contract, Grant, and Purchase Order Policies.

5.1.1. The following provisions shall be included in (a) Expenditure Contracts, (b) Debt Contracts, and (c) Price Agreements:

5.1.1.1. Identification of the State Agency or Institution of Higher Education and the other Party or Parties;

5.1.1.2. Statutory authority (except for Institutions of Higher Education);

5.1.1.3. Statement of work;

5.1.1.4. Payment terms, as defined in Fiscal Rule 2-3, including maximum dollar amount;

5.1.1.5. Effective date and termination date of the State Contract;

5.1.1.6. General terms and conditions;

5.1.1.7. Special Provisions (see §13 of this Fiscal Rule);

5.1.1.8. Signature and cover page(s) as described in the State Controller Contract, Grant, and Purchase Order Policies; and

5.1.1.9. Statement that the Contract shall not be valid until it has been approved by the State Controller or delegate.

5.1.1.9.1. If the Contract is for a Major Information Technology Project, then a statement that the Contract shall not be valid until it has been approved by the State's Chief Information Officer or delegate.

5.1.2. Real Property Purchase Agreements (State as buyer), Leases (State as tenant) and Licenses (State as licensee) – State Contracts for the purchase, lease or license of real property shall contain the following provisions:

5.1.2.1. Identification of the parties;

5.1.2.2. Statutory authority (except for Institutions of Higher Education);

5.1.2.3. A description of the property and any services or allowances included with the lease;

5.1.2.4. Payment terms, including maximum dollar amount;

5.1.2.5. The effective date and termination date of the State Contract;

5.1.2.6. General terms and conditions;

5.1.2.7. If a State Agency or Institution of Higher Education is the buyer, tenant or licensee, the State Contract shall include the

following Special Provisions:

5.1.2.7.1. State Controller's Approval;

5.1.2.7.2. Funds Availability;

5.1.2.7.3. Governmental Immunity;

5.1.2.7.4. Compliance with Law; and

5.1.2.7.5. Vendor Offset and Erroneous Payments.

5.1.2.8. If a State Agency or Institution of Higher Education is the buyer, tenant, or licensee, the State Contract may include the other Special Provisions, at the discretion of the State Agency or Institution of Higher Education.

5.1.2.9. If a State Agency or Institution of Higher Education is the tenant or licensee, the State Contract shall include provisions specifying cancellation rights, if the real property leased or licensed is destroyed by fire and/or becomes subject to eminent domain.

5.1.2.10. A State Agency or Institution of Higher Education shall not be in holdover after the expiration of a Real Property Lease for a period of longer than 6 months without the prior approval of the Office of the State Architect.

5.1.2.11. Statement that the State Contract shall not be valid until it has been approved by the State Controller or delegate.

5.1.3. Capital Construction Contracts – See Fiscal Rule 4-2, "Capital Construction Projects". See also approved State Contract forms, available on the website of the Office of the State Architect.

5.1.4. Settlement Agreements and Employee Voluntary Separation Agreements – See the State Controller Contract, Grant, and Purchase Order Policies.

5.1.5. Intergovernmental Contracts

5.1.5.1. Federal Government Contracts – All intergovernmental State Contracts with any agency of the Federal government shall be reviewed by the Office of the State Controller or a Reviewing Attorney except as described in the State Controller Contract, Grant, and Purchase Order Policies.

5.1.5.2. Sponsored Project Agreements – see the State Controller Contract, Grant, and Purchase Order Policies regarding sponsored projects.

5.2. Revenue Contracts and Other Contract Types that do not result in an expenditure of State funds – The general provisions of this subsection shall apply to all State Contracts that do not result in either an expenditure of State funds or in the disposition of State property, but that still create a performance obligation for the State where failure to perform such obligation would result in payment of State funds to another Party.

5.2.1. The following provisions shall be included in all Revenue Contracts and all Other Contract Types that are described in §5.2 but not included in §5.1 of this Fiscal Rule:

5.2.1.1. Identification of the State Agency or Institution of Higher Education and the other Party or Parties;

5.2.1.2. Payment terms, if any payment will be made to the State;

5.2.1.3. A description of any work the State must perform or obligations the State must fulfill in order to comply with the State Contract or to earn any payments under the State Contract; and

5.2.1.4. The effective date and termination date of the State Contract.

6. **APPROVED STATE CONTRACT FORMS:**

All Expenditure Contracts shall be in a form approved by the State Controller. The State Controller has approved the following contract forms and may approve additional forms in the State Controller's sole discretion.

6.1. Capital Construction Contracts – See Fiscal Rule 4-1. See also approved contract forms available on the website of the Office of the State Architect.

6.2. Model Contracts – State Agencies and Institutions of Higher Education shall use the model contract forms as described in the State Controller Contract, Grant, and Purchase Order Policies.

6.3. Contract Amendments – All modifications to a State Contract shall be made by a formal written amendment signed by the State Agency or Institution of Higher Education and the other Party or Parties to the State Contract and approved by the State Controller or a delegate of the State Controller, unless an alternative modification tool has been approved by the State Controller. A State Contract cannot be amended or extended (revived) after the State Contract term has expired. A form of contract amendment and forms of alternative modification tools are set forth in the Modification Policies.

6.4. Alternative Modification Tools and Forms – A State Agency or Institution of Higher Education may use an approved alternate modification tool to modify a State Contract in lieu of a contract amendment only in the specific circumstances identified in the Modification Policies. A State Agency or Institution of Higher Education shall obtain written approval from the Office of the State Controller prior to making a change to the form of an alternative modification tool or using an alternative modification tool in a manner not described in the Modification Policies. A State Contract cannot be modified or extended after the expiration of the term of the State Contract. Approved alternative modification tool forms are set forth in the Modification Policies.

6.4.1. Required Provision and Attachment – An approved modification tool may be included as a part of a State Contract only if the State Contract contains a provision referencing the specific modification tool, in the form set forth in the Modification Policies, and the form of the specific modification tool is attached as an exhibit to the State Contract.

6.4.2. Each contract modification tool was created for use in connection with specific types of State Contracts and scopes of services and is not universally applicable. Each modification tool shall be used only for its intended purposes, as set forth in the Modification Policies, and shall not be changed or combined with any other contract modification tool except as specifically allowed

in the Modification Policies.

6.5. Real Property Lease Agreements – Lease agreements involving real property shall be in a form approved by and set forth on the website of the Office of the State Architect, except for Real Property leases exempted by statute, and Real Property leases where the Department of Personnel and Administration is a party, which may be in any form approved by the State Controller.

6.6. Special Provisions – All State (a) Expenditure Contracts, (b) Debt Contracts, and (c) Price Agreements, shall contain the State Special Provisions. See §13 of this Fiscal Rule. No modification shall be made to a Special Provision without the prior written approval of the Office of the State Controller and, in the case of the Choice of Law Special Provision, a Reviewing Attorney, except as otherwise expressly provided in subsection 5.1.2.8 of this Fiscal Rule.

6.7. Waived Contracts – If a State Agency or Institution of Higher Education has a contract that was approved as a "Phase I Waived Contract" under the State Controller Contract, Grant, and Purchase Order Policies, then that contract shall be an approved contract form.

6.8. Other Contract Forms – Any other contract form which may be approved by the State Controller from time-to-time.

7. **STATE CONTRACT LEGAL REVIEW:**

The State Controller may request the Office of the State Attorney General to review any State Contract at the State Controller's discretion.

8. **STATE CONTROLLER REVIEW AND APPROVAL:**

State Controller review and approval of all Expenditure Contracts, task order contracts, and price agreements is mandatory. The Office of the State Controller may, in its discretion, review other types of contracts, for example, non-expenditure contracts, if requested by a State Agency or Institution of Higher Education. All State Controller reviews and approvals shall be conducted in accordance with the provisions of this §8.

8.1. Outsource Contracts – Third Party Payor – All Outsource Contracts shall be submitted to the State Controller or delegate for review and approval, including without limitation, any Outsource Contract that diverts revenues due to the State, unless specifically exempted by State statute. For example, see §24-34-101, C.R.S.

8.2. Performance of State Controller Functions

8.2.1. Delegated State Agencies – Delegated State Agencies shall be responsible for determining the level of risk for their State Contracts. A Delegated State Agency shall classify the risk of each of its State Contracts in accordance with the State Controller Contract, Grant, and Purchase Order Policies regarding review and approval for delegated State Agencies. The individual or individuals at the Delegated State Agency who have a delegation from the State Controller to sign State Contracts may sign State Contracts on behalf of the State Controller that are not required to be sent to the Office of the State Controller in accordance with their delegation agreement and the State Controller Contract, Grant, and Purchase Order Policies.

8.2.2. Non-delegated State Agencies and Institutions of Higher

Education – Non-delegated State Agencies and non-delegated Institutions of Higher Education shall submit all State Contracts to the Office of the State Controller for review and approval in accordance with the State Controller Contract, Grant, and Purchase Order Policies regarding review and approval of non-delegated State Agencies and Institutions of Higher Education.

8.2.3. Delegated Institutions of Higher Education – Delegated Institutions of Higher Education shall determine if a State Contract requires legal review prior to execution in accordance with the State Controller Contract, Grant, and Purchase Order Policies regarding review and approval for Delegated Institutions of Higher Education. The individual or individuals at the Delegated Institution of Higher Education who have a delegation from the State Controller to sign State Contracts may sign State Contracts on behalf of the State Controller, that are not required to be sent to the Office of the State Controller and that either do not require legal review or have been signed by a Reviewing Attorney, in accordance with the Institution of Higher Education's delegation agreement and the State Controller Contract, Grant, and Purchase Order Policies.

8.3. Process for Review, Approval, and Signature

8.3.1. Review – The State Controller or delegate shall review all Expenditure Contracts to determine if the contract complies with Fiscal Rule 3-1, §3.

8.3.2. Approval and Signature – After review, the State Controller or delegate shall approve or disapprove the State Contract. If approved, the State Controller or delegate shall evidence such approval by signing the State Contract.

8.4. Contracts Not Approved by State Controller

8.4.1. Not Binding – An Expenditure Contract is not binding on or enforceable against the State unless and until it is signed by the State Controller or delegate. An Information Technology Contract for a Major Information Technology Project is also not binding on or enforceable against the State unless and until it is signed by the State's Chief Information Officer or delegate.

8.4.2. Null and Void – Any Expenditure Contract disapproved by the State Controller or delegate is null and void.

8.4.3. Statutory Violation – Any obligation created under a contract that has not been signed by the State Controller or delegate or has been disapproved by the State Controller or delegate constitutes a Statutory Violation as described in Fiscal Rule 3-1, §8. Any obligation created under an Information Technology Contract for a Major Information Technology Project that has not been signed by the State's Chief Information Officer or delegate constitutes a Statutory Violation as described in Fiscal Rule 3-1, §8.

9. **ACCOUNTING FOR STATE CONTRACTS:**

9.1. Encumbrances – All State Agencies and Institutions of Higher Education shall encumber Expenditure Contracts in accordance with Fiscal Rule 3-1 and the Fiscal Procedures Manual.

9.2. Outsource Contracts – Third Party Payor – State

Agencies and Institutions of Higher Education shall record all gross revenues and expenditures for each Outsource Contract in the State Financial System or on an approved State Agency or Institution of Higher Education accounting system and shall not net the expenditures against the revenues, unless specifically exempted by State statute.

10. MONITORING OF STATE CONTRACTS

10.1. All State Agencies and Institutions of Higher Education shall designate a contract manager with subject matter expertise who will be responsible for day-to-day management of each State Contract. See §24-106-107(3), C.R.S.

10.2. Each State Agency and Institution of Higher Education shall monitor its Expenditure Contracts and Other Contract Types that result in an expenditure of State funds with respect to all of the following elements, as well as any additional elements a State Agency or Institution of Higher Education may choose to monitor:

10.2.1. Compliance with requirements, standards, and measures of the Expenditure Contract provisions in §5.1 of this Fiscal Rule;

10.2.2. Completion of the State Contract according to the State Contract's performance schedule;

10.2.3. Satisfactory performance and completion of the State Contract's scope of work; and

10.2.4. Extent to which the contractor met or exceeded budgetary requirements of the State Contract

10.3. Contract Management System – State Agencies and Institutions of Higher Education shall include all information specified in CRS §24-106-103(3) for all State Contracts for personal services subject to that statute.

10.4. This §10 shall not apply to the following State Contracts:

10.4.1. Any State Contract under Medicare;

10.4.2. Any State Contract for indigent care under §25.5-3-101 et seq., C.R.S.;

10.4.3. Any State Contract under the Colorado Medical Assistance Act. See §25.5-4-101 through §25.5-6-101, et seq., C.R.S.;

10.4.4. Any State Contract under the Children's Basic Health Plan. See §25.5-8-101 et seq., C.R.S.; and

10.4.5. Any State Contract for Sponsored Projects

10.5. State Agencies and Institutions of Higher Education shall comply with all requirements of State Controller Contract, Grant, and Purchase Order Policies regarding monitoring of State Contracts.

11. INDEPENDENT CONTRACTOR RELATIONSHIP:

State Agencies and Institutions of Higher Education shall take care in maintaining the distinctions between services performed by persons who are employees of the State and services performed by independent contractors, and their employees, agents and representatives, pursuant to a State Contract

for personal services. The State's responsibilities and obligations with respect to employee/employer arrangements differ from its responsibilities and obligations with respect to independent contractors. The State may be liable to a third party for the actions of its employees, whereas independent contractors and their employees, agents and representatives are liable for their own actions. The State is responsible for social security taxes and benefits for its employees, whereas independent contractors are responsible for social security taxes and benefits of their employees. State Agencies and Institutions of Higher Education shall follow guidelines issued by the Internal Revenue Service, the Colorado Division of Human Resources, Colorado statutes, and opinions of the State Attorney General in determining whether an individual is an employee or independent contractor.

12. **EXCEPTIONS TO FISCAL RULE 3-3:**

12.1. Personal Services – This Fiscal Rule does not apply to Commitment Vouchers for personal services paid through an authorized State payroll system, which are exempted from the State personnel system by the Colorado Constitution or Colorado statutes. See §24-50-135 C.R.S. Examples of exempted Commitment Vouchers include advices of employment engaging the services of the following:

12.1.1. Appointees by Elective Officers and their administrative staffs;

12.1.2. Members of State boards or commissions;

12.1.3. Faculty and other exempted members of Institutions of Higher Education;

12.1.4. Attorneys-at-law serving as an assistant attorney generals; and

12.1.5. Employees of the Legislative and Judicial Departments of the State.

12.2. Elective Officers – An Elective Officer acting within the scope of that Elective Officer's authority may elect to exempt any Commitment Voucher from the requirements of either or both of §24-30-202, C.R.S. including the Fiscal Rules, the Procurement Code and the Procurement Rules, by personally signing a State Contract or by having that person's next-in-command sign the State Contract. See §24-2-102(4), C.R.S. If the contract signed by the Elective Officer is outside the scope of that Elective Officer's authority, the Elective Officer may be personally liable for all claims arising therefrom.

13. **SPECIAL PROVISIONS:**

These Special Provisions apply to and shall be included in all State Contracts except where noted in italics.

1. STATUTORY APPROVAL. §24-30-202(1) C.R.S. This Contract shall not be valid until it has been approved by the Colorado State Controller or designee. If this Contract is for a Major Information Technology Project, as defined in §24-37.5-102(2.6), then this Contract shall not be valid until it has been approved by the State's Chief Information Officer or designee.
2. FUND AVAILABILITY. §24-30-202(5.5) C.R.S. Financial obligations of the State payable after the current fiscal year are contingent upon funds for that purpose being appropriated, budgeted, and otherwise made available.
3. GOVERNMENTAL IMMUNITY. Liability for claims for injuries to persons or property arising from the negligence of the State, its departments, boards, commissions committees,

bureaus, offices, employees and officials shall be controlled and limited by the provisions of the Colorado Governmental Immunity Act, §24-10-101, et seq., C.R.S.; the Federal Tort Claims Act, 28 U.S.C. Pt. VI, Ch. 171 and 28 U.S.C. 1346(b), and the State's risk management statutes, §§24-30-1501, et seq. C.R.S. No term or condition of this Contract shall be construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or other provisions, contained in these statutes.

4. INDEPENDENT CONTRACTOR. Contractor shall perform its duties hereunder as an independent contractor and not as an employee. Neither Contractor nor any agent or employee of Contractor shall be deemed to be an agent or employee of the State. Contractor shall not have authorization, express or implied, to bind the State to any agreement, liability, or understanding, except as expressly set forth herein. **Contractor and its employees and agents are not entitled to unemployment insurance or workers compensation benefits through the State and the State shall not pay for or otherwise provide such coverage for Contractor or any of its agents or employees. Contractor shall pay when due all applicable employment taxes and income taxes and local head taxes incurred pursuant to this Contract. Contractor shall (a) provide and keep in force workers' compensation and unemployment compensation insurance in the amounts required by law, (b) provide proof thereof when requested by the State, and (c) be solely responsible for its acts and those of its employees and agents.**

5. COMPLIANCE WITH LAW. Contractor shall comply with all applicable federal and State laws, rules, and regulations in effect or hereafter established, including, without limitation, laws applicable to discrimination and unfair employment practices.

6. CHOICE OF LAW, JURISDICTION, AND VENUE. Colorado law, and rules and regulations issued pursuant thereto, shall be applied in the interpretation, execution, and enforcement of this Contract. Any provision included or incorporated herein by reference which conflicts with said laws, rules, and regulations shall be null and void. All suits or actions related to this Contract shall be filed and proceedings held in the State of Colorado and exclusive venue shall be in the City and County of Denver.

7. PROHIBITED TERMS. Any term included in this Contract that requires the State to indemnify or hold Contractor harmless; requires the State to agree to binding arbitration; limits Contractor's liability for damages resulting from death, bodily injury, or damage to tangible property; or that conflicts with this provision in any way shall be void ab initio. Nothing in this Contract shall be construed as a waiver of any provision of §24-106-109 C.R.S. Any term included in this Contract that limits Contractor's liability that is not void under this section shall apply only in excess of any insurance to be maintained under this Contract, and no insurance policy shall be interpreted as being subject to any limitations of liability of this Contract.

8. SOFTWARE PIRACY PROHIBITION. State or other public funds payable under this Contract shall not be used for the acquisition, operation, or maintenance of computer software in violation of federal copyright laws or applicable licensing restrictions. Contractor hereby certifies and warrants that, during the term of this Contract and any extensions, Contractor has and shall maintain in place appropriate systems and controls to prevent such improper use of public funds. If the State determines that Contractor is in violation of this provision, the State may exercise any remedy available at law or in equity or under this Contract, including, without limitation, immediate termination of this Contract and any remedy consistent with federal copyright laws or applicable licensing restrictions.

9. EMPLOYEE FINANCIAL INTEREST/CONFLICT OF INTEREST. §§24-18-201 and 24-50-507 C.R.S. The signatories aver that to their knowledge, no employee of the State has any

personal or beneficial interest whatsoever in the service or property described in this Contract. Contractor has no interest and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of Contractor's services and Contractor shall not employ any person having such known interests.

10. VENDOR OFFSET AND ERRONEOUS PAYMENTS. §§24-30-202 (1) and 24-30-202.4 C.R.S. [*Not Applicable to intergovernmental agreements*] The State Controller may withhold payment under the State's vendor offset intercept system for debts owed to state agencies for: **(a)** unpaid child support debts or child support arrearages; **(b)** unpaid balances of tax, accrued interest, or other charges specified in §39-21-101, et seq. C.R.S.; **(c)** unpaid loans due to the Student Loan Division of the Department of Higher Education; **(d)** amounts required to be paid to the Unemployment Compensation Fund; and **(e)** other unpaid debts owing to the State as a result of final agency determination or judicial action. The State may also recover, at the State's discretion, payments made to Contractor in error for any reason, including, but not limited to, overpayments or improper payments, and unexpended or excess funds received by Contractor by deduction from subsequent payments under this Contract, deduction from any payment due under any other contracts, grants or agreements between the State and Contractor, or by any other appropriate method for collecting debts owed to the State.

11. PUBLIC CONTRACTS FOR SERVICES. §8-17.5-101 C.R.S. [*Not Applicable to agreements relating to the offer, issuance, or sale of securities, investment advisory services or fund management services, sponsored projects, intergovernmental agreements, or information technology services or products and services*] Contractor certifies, warrants, and agrees that it does not knowingly employ or contract with an illegal alien who will perform work under this Contract and will confirm the employment eligibility of all employees who are newly hired for employment in the United States to perform work under this contract, through participation in the E-Verify Program or the Department program established pursuant to §8-17.5-102(5)(c), C.R.S. Contractor shall not knowingly employ or contract with an illegal alien to perform work under this Contract or enter into a contract with a subcontractor that fails to certify to Contractor that the subcontractor shall not knowingly employ or contract with an illegal alien to perform work under this Contract. Contractor **(a)** shall not use E-Verify Program or the program procedures of the Colorado Department of Labor and Employment ("Department Program") to undertake pre-employment screening of job applicants while this Contract is being performed, **(b)** shall notify the subcontractor and the contracting state agency or institution of higher education within three days if Contractor has actual knowledge that a subcontractor is employing or contracting with an illegal alien for work under this Contract, **(c)** shall terminate the subcontract if a subcontractor does not stop employing or contracting with the illegal alien within three days of receiving the notice, and **(d)** shall comply with reasonable requests made in the course of an investigation, undertaken pursuant to §8-17.5-102(5) C.R.S., by the Colorado Department of Labor and Employment. If Contractor participates in the Department program, Contractor shall deliver to the contracting state agency, institution of higher education or political subdivision a written, notarized affirmation, affirming that Contractor has examined the legal work status of such employee, and shall comply with all of the other requirements of the Department program. If Contractor fails to comply with any requirement of this provision or §8-17.5-101 et seq., C.R.S., the contracting state agency, institution of higher education or political subdivision may terminate this Contract for breach and, if so terminated, Contractor shall be liable for damages.

12. PUBLIC CONTRACTS WITH NATURAL PERSONS. §24-76.5-101 C.R.S. Contractor, if a natural person eighteen (18) years of age or older, hereby swears and affirms under penalty of perjury that Contractor **(a)** is a citizen or otherwise lawfully present in the United States

pursuant to federal law, **(b)** shall comply with the provisions of §24-76.5-101, et seq., C.R.S., and **(c)** has produced one form of identification required by §24-76.5-103, C.R.S., prior to the effective date of this Contract.

RULE 3-4: GRANTS

1. **AUTHORITY:**

§24-30-202(1-4) and (5)(a), C.R.S. (State Controller Authority)

§24-106-103, C.R.S. (Centralized Contract Management System)

§24-102-206, C.R.S. (Contract Performance Outside United States or Colorado)

§24-106-106, C.R.S. (Right to Audit Records)

§24-106-107, C.R.S. (Monitoring of Vendor Performance)

2. **DEFINITIONS:**

2.1. Grant – An agreement in which a State Agency or Institution of Higher Education as grantor transfers anything of value to a grantee to carry out a public purpose of support or stimulation authorized by law instead of acquiring property or services for the direct benefit or use of that State Agency or Institution of Higher Education. A Grant may include a distribution of funds. Grants do not include Donations, as defined in Fiscal Rule 2-1.

2.2. Grantee – The recipient of a Grant.

2.3. Modification Policies – See Fiscal Rule 3-3 (State Contracts).

2.4. Procurement Official – See Fiscal Rule 3-1 (Commitment Vouchers).

2.5. Small Dollar Grant Award – A unilaterally approved Commitment Voucher, the form of which has been approved by the State Controller, issued by a State Agency or Institution of Higher Education as a Grant, as described in this Fiscal Rule, when permitted under Fiscal Rule 3-1 (Commitment Vouchers).

3. **RULE:**

3.1. Each State Agency or Institution of Higher Education shall use a Grant as described in this Rule when Fiscal Rule 3-1 requires the use of a Grant as the Commitment Voucher.

4. **CONTENTS OF GRANTS:**

4.1. Standard Provisions – All Grants issued by State Agencies and Institutions of Higher Education shall include all of the following:

4.1.1. Identification of the State Agency or Institution of Higher Education and the Grantee;

4.1.2. A description of the work that the Grantee will perform under the Grant and the goals to be achieved under the Grant;

4.1.3. Payment or reimbursement terms, including the maximum dollar amount;

4.1.4. The effective date and termination date of the Grant;

4.1.5. The statutory or regulatory authority authorizing the Grant;

4.1.6. The Special Provisions, as described in Fiscal Rule 3-3; and

4.1.7. Any other content required under the State Controller Contract, Grant, and Purchase Order Policies.

5. **APPROVED GRANT FORMS:**

All Grants and modifications to Grants shall be in a form approved by the State Controller. The State Controller has approved the following Grant forms and may approve additional forms in the State Controller's sole discretion.

5.1. Model Grants – State Agencies and Institutions of Higher Education shall use the Grant forms as described in the State Controller Contract, Grant, and Purchase Order Policies.

5.2. Grant Modifications – All modifications to a Grant, other than modifications to an Intergovernmental Grant described in §5.4 of this Fiscal Rule and Small Dollar Grant Awards issued in accordance with the State Controller Contract, Grant, and Purchase Order Policies, shall be made by a formal written amendment signed by the State Agency or Institution of Higher Education and the Grantee, and approved by the State Controller or a delegate of the State Controller, unless an alternative modification tool has been approved by the State Controller. A Grant cannot be amended or extended (revived) after the Grant term has expired. All such modifications to Grants shall use the amendment form and forms of alternative modification tools set forth in the Modification Policies related to modifications of Grants.

5.3. Small Dollar Grant Award Modifications – All modifications to a Small Dollar Grant Award shall be made by a formal written change order approved by the State Controller or a delegate, unless an alternative modification tool has been approved by the State Controller. A Small Dollar Grant Award cannot be modified or extended (revived) after the award term has expired.

5.4. Intergovernmental Grant Modifications – A Grant between a State Agency or Institution of Higher Education and a political subdivision of the State, such as a city, county, special district or authority, may be modified by any method available to modify any other Grant, as described in §5.2, or by issuing an updated Intergovernmental Grant Award Letter, as described in the State Controller Contract, Grant, and Purchase Order Policies, that replaces the existing Intergovernmental Grant Award Letter.

5.5. Alternative Modification Tools and Forms – A State Agency or Institution of Higher Education may use an approved alternate modification tool to modify a Grant in lieu of a Grant amendment only in the specific circumstances identified in the Modification Policies. A State Agency or Institution of Higher Education shall obtain written approval from the Office of the State Controller prior to making a change to the form of an alternative modification tool, other than non-substantive changes necessary to match terminology to the Grant, or using an alternative modification tool in a manner not described in the Modification Policies. A Grant cannot be modified or extended after the expiration of the Grant term. Approved alternative modification tool forms are set forth in the Modification

Policies.

5.5.1. Required Provision and Attachment – An approved modification tool may be included as a part of a Grant only if the Grant contains a provision referencing the specific modification tool and how it may be used in accordance with the Modification Policies, and the form of the specific modification tool is attached as an exhibit to the Grant.

5.5.2. Each modification tool shall be used only for its intended purposes, as set forth in the Modification Policies, and shall not be changed or combined with any other modification tool except as specifically allowed in the Modification Policies.

5.6. Other Grant Forms – Any other Grant form which may be approved by the State Controller from time-to-time.

6. **GRANT LEGAL REVIEW:**

The State Controller may request the Office of the State Attorney General to review any Grant at the State Controller's sole discretion.

7. **STATE CONTROLLER REVIEW AND APPROVAL:**

7.1. Performance of Controller Functions.

7.1.1. Delegated State Agencies – Delegated State Agencies shall be responsible for determining the level of risk for their Grants. A Delegated State Agency shall classify the risk of each of its Grants in accordance with the State Controller Contract, Grant, and Purchase Order Policies regarding review and approval for delegated State Agencies. The individual or individuals at the Delegated State Agency who have a delegation from the State Controller to sign Grants may sign Grants on behalf of the State Controller that are not required to be sent to the Office of the State Controller in accordance with their delegation agreement and the State Controller Contract, Grant, and Purchase Order Policies.

7.1.2. Non-delegated State Agencies and Institutions of Higher Education – Non-delegated State Agencies and non-delegated Institutions of Higher Education shall submit all Grants to the Office of the State Controller for review and approval in accordance with the State Controller Contract, Grant, and Purchase Order Policies regarding review and approval for non-delegated State Agencies and Institutions of Higher Education.

7.1.3. Delegated Institutions of Higher Education – Delegated Institutions of Higher Education shall determine if a Grant requires legal review prior to execution in accordance with the State Controller Contract, Grant, and Purchase Order Policies regarding review and approval for delegated Institutions of Higher Education. The individual or individuals at the Delegated Institution of Higher Education who have a delegation from the State Controller to sign Grants may sign Grants on behalf of the State Controller that are not required to be sent to the Office of the State Controller and that either do not require legal review or have been signed by a Reviewing Attorney in accordance with their delegation agreement and the State Controller Contract, Grant, and Purchase Order Policies.

7.2. Process for Review, Approval, and Signature

7.2.1. Review – All Grants shall be reviewed by a Procurement Official or delegate, or a member of the unit or section in the Agency or Institution of Higher Education responsible for Grants, as determined by Agency policy. The State Controller or delegate signing the Grant shall also review all Grants to determine if the Grant complies with Fiscal Rule 3-1, §3.

7.2.2. Approval and Signature – Except for Grants issued as Small Dollar Grant Awards in accordance with the State Controller Contract, Grant, and Purchase Order Policies, the State Controller or delegate shall approve or disapprove the Grant, and, if approved, shall evidence such approval by signing the Grant. For Grants issued as a Small Dollar Grant Award in accordance with the State Controller Contract, Grant, and Purchase Order Policies, the State Controller, a Procurement Official, or a delegate of either shall approve or disapprove the Grant, and, if approved, shall evidence such approval by approving the Grant in the State Financial System or other such system used by the State Agency or Institution of Higher Education in accordance with Fiscal Rule 1-3, or by signing the Grant.

7.3. Grants Not Approved by State Controller

7.3.1. Not Binding – A Grant is not binding on or enforceable against the State unless and until it is approved in accordance with §7.2.2 of this Fiscal Rule.

7.3.2. Null and Void – Any Grant disapproved by the State Controller, a Procurement Official or a delegate or either is null and void.

7.3.3. Statutory Violation – Any obligation created under a Grant that has not been approved in accordance with §7.2.2 of this Fiscal Rule or has been disapproved by the State Controller, a Procurement Official or a delegate or either constitutes a Statutory Violation as described in Fiscal Rule 3-1, §8.

RULE 3-5: INTERAGENCY AGREEMENTS

1. **AUTHORITY**

§24-30-202(1-4) and (5)(a), C.R.S. (State Controller Authority)

2. **DEFINITIONS**

2.1. Encumbrance – See Fiscal Rule 3-1

2.2. Interagency Agreement – An agreement between two or more State Agencies, two or more Institutions of Higher Education, or any number of State Agencies and Institutions of Higher Education that involves a transfer of funds from one State Agency or Institution of Higher Education to another. The term Interagency Agreement does not include any agreement that has an entity that is not a State Agency or Institution of Higher Education as a party.

3. **RULE**

Each State Agency or Institution of Higher Education shall use an Interagency Agreement as described in this Rule when Fiscal Rule 3-1 requires the use of an Interagency Agreement to document the transfer of funds.

4. **CONTENT OF INTERAGENCY AGREEMENTS**

4.1. Standard Provisions – All Interagency Agreements shall include all of the following:

4.1.1. Identification of the State Agencies and Institutions of Higher Education involved in the Interagency Agreement;

4.1.2. A description of the work that will be performed;

4.1.3. A description of the amounts to be paid or how those amounts will be determined;

4.1.4. The effective date and termination date of the Interagency Agreement; and

4.1.5. Any applicable special terms and conditions required under a grant or by Federal or state laws, regulations, or policies.

4.2. Encumbrances – All Interagency Agreements that will transfer $100,000.00 or more during a fiscal year shall be encumbered, except for Interagency Agreements charged to a special line item appropriation dedicated to that commitment. A delegate of the State Controller at a State Agency or Institution of Higher Education may choose, in that individual's discretion, to require an Encumbrance on any Interagency Agreement to ensure that proper funding is available for that Interagency Agreement.

5. **APPROVED INTERAGENCY FORMS**

All Interagency Agreements shall be in a form approved by the State Controller. The State Controller has approved the following forms and may approve additional forms at the State Controller's sole discretion.

5.1. Statement of Work and Encumbrance Document – For Interagency Agreements that will be encumbered, State Agencies and Institutions of Higher

Education may develop a mutually agreeable statement of work, which includes all standard provisions required in §4.1 of this Fiscal Rule and has been approved by each State Agency and Institution of Higher Education that is party to the agreement. The State Agency or Institution of Higher Education transferring funds under the Interagency Agreement shall attach that statement of work to the Encumbrance document in the State Financial System or other approved financial system used by that State Agency or Institution of Higher Education. The statement of work may also be any type of invoice or quote, so long as that invoice or quote contains the standard provisions required in §4.1 of this Fiscal Rule.

5.2. Statement of Work and Transfer Document – For Interagency Agreements that will not be encumbered, State Agencies and Institutions of Higher Education may develop a mutually agreeable statement of work, which includes all standard provisions required in §4.1 of this Fiscal Rule. The statement of work shall be approved by each State Agency and Institution of Higher Education that is party to the Interagency Agreement. The State Agency or Institution of Higher Education transferring funds shall attach that statement of work to the transfer document in the State Financial System or other approved financial system used by that State Agency or Institution of Higher Education. The statement of work may also be any type of invoice or quote, so long as that invoice or quote contains the standard provisions required in §4.1 of this Fiscal Rule.

5.3. Work Completion Documentation – For Interagency Agreements under $5,000.00, for which the State Agency or Institution of Higher Education will not encumber funds and will make payment outside of the State Financial System or other approved financial system, the State Agency or Institution of Higher Education may use an invoice or quote to document the transfer in the same manner that the State Agency or Institution of Higher Education would for Small Purchase Documentation as described in Fiscal Rule 3-1.

5.4. Commitment Vouchers and Other Agreements - State Agencies and Institutions of Higher Education may develop a mutually agreeable statement of work, which includes all standard provisions required in §4.1 of this Fiscal Rule. The statement of work shall be approved by each State Agency and Institution of Higher Education and attached to any model Commitment Voucher form or any other form of agreement. In this event, the State Agencies and Institutions of Higher Education may make any modifications to such form as they determine is appropriate.

6. **APPROVALS REQUIRED FOR INTERAGENCY AGREEMENTS**

6.1. Approval of Transferring Entity – A State Agency or Institution of Higher Education shall obtain all of the following approvals for all Interagency Agreements for which the State Agency or Institution of Higher Education will engage in an exchange with another State Agency or Institution of Higher Education:

6.1.1. For all Interagency Agreements the approval of the State Controller or a delegate of the State Controller. This approval shall be evidenced either by the State Controller's or a delegate's signature on the document which contains the required items in §4.1 of this Fiscal Rule. Approval also may be evidenced by electronic scans of the signature, or by an approval of the Encumbrance or transfer document in the State Financial System or other financial system used by the State Agency or Institution of Higher Education to which the document which contains the required items in §4.1 is attached.

6.1.1.1. For Interagency Agreements of $100,000 or less the

State Controller delegate may further delegate this approval authority in that individual's discretion.

6.1.2. For all Interagency Agreements the approval of an individual with authority to bind the State Agency or Institution of Higher Education to the amount to be paid. This authority shall be based on the policies of the State Agency or Institution of Higher Education and a proper delegation from the Chief Executive Officer of the State Agency or Institution of Higher Education, if required by the policies of that State Agency or Institution of Higher Education. Approval shall be evidenced by the individual's signature, including electronic scans of the signature, on the document which contains the required items in §4.1 of this Fiscal Rule.

6.2. Approval of Receiving Entity – A State Agency or Institution of Higher Education shall obtain all of the following approvals for all Interagency Agreements for which the State Agency or Institution of Higher Education will receive funds from another State Agency or Institution of Higher Education:

6.2.1. For all Interagency Agreements the approval of an individual with authority to bind the State Agency or Institution of Higher Education to the work to be performed. This authority shall be based on the policies of the State Agency or Institution of Higher Education and a proper delegation from the Chief Executive Officer of the State Agency or Institution of Higher Education, if required by the policies of that State Agency or Institution of Higher Education. Approval shall be evidenced by the individual's signature on the document which contains the required items in §4.1 of this Fiscal Rule, including electronic scans of the signature.

7. RESOLUTION OF DISPUTES IN INTERAGENCY AGREEMENTS

In the event of disputes concerning performance under or related to any Interagency Agreement, the State Agencies or Institutions of Higher Education that are parties to the Interagency Agreement shall attempt to resolve them at the divisional level. If that fails, the dispute shall be referred to senior State Agency or Institution of Higher Education management staff designated by each State Agency or Institution of Higher Education for resolution. If that fails, the dispute shall be referred to the Chief Executive Officers of the State Agencies or Institutions of Higher Education for resolution. If this fails, the matter shall be submitted for resolution, in writing by both parties, to the State Controller, whose decision shall be final.

CHAPTER 4: CONSTRUCTION

RULE 4-1: CAPITAL CONSTRUCTION ADMINISTRATION

1. **AUTHORITY:**

§24-30-1301, C.R.S. (State Buildings)

§24-30-1303, C.R.S. (Office of the State Architect)

§24-75-302, C.R.S., *et seq.*, C.R.S. (Capital Construction Fund)

Title 24, Article 91, C.R.S. (Construction Contracts)

Title 24, Article 92, C.R.S. (Construction Bidding)

§38-26-106, C.R.S. (Contractor Bonds)

§38-26-107, C.R.S. (Supplier Claims)

2. **DEFINITIONS:**

2.1. Capital Construction – Any work defined as "Capital Construction" in §24-30-1301(2), C.R.S., regardless of the funding source for that work.

2.2. Capital Construction Fund – A fund created by statute for the purpose of purchasing and/or maintaining land, buildings and equipment and for constructing buildings for use by the State, as described in §24-75-302, C.R.S.

3. **RULE:**

The State Capital Construction Fund was established to provide a source for appropriations to State Agencies and Institutions of Higher Education to acquire and maintain their physical facilities. The fund has special requirements that must be followed by State Agencies and Institutions of Higher Education receiving appropriations from the State Capital Construction Fund.

3.1. Capital Construction Contracts

3.1.1. Formal State Contracts are required when expending funds in excess of $150,000 appropriated for emergency maintenance projects including construction services or installation of fixed equipment unless previous approval has been obtained from the Office of the State Architect to use a Purchase Order.

3.1.1.1. Purchases of fixed equipment that do not require installation services may be purchased with a Purchase Order.

3.1.1.2. A Purchase Order may be used for construction not exceeding $150,000 if the State Architect or a delegate records written approval on the face of the Purchase Order. Such approval by the State Architect or a delegate shall require compliance with approved building codes and signify compliance with bonding requirements in §§38-26-106 and 24-105-201 C.R.S. In addition, the Purchase Order shall be bilateral requiring written acknowledgment of acceptance by the contractor prior to beginning work.

3.1.2. Capital Construction Contracts shall follow the State Contract routing procedures established by the State Controller's Office.

RULE 4-2: CAPITAL CONSTRUCTION PROJECTS

1. **AUTHORITY:**

§24-30-1301, C.R.S. (State Buildings)

§24-30-1404, C.R.S. (Professional Services Contracts)

Title 24, Article 75, Part 3, C.R.S. (Capital Construction Fund)

§24-91-103, C.R.S. (Retainage)

Title 24, Article 92, C.R.S. (Construction Bidding)

§38-26-106, C.R.S. (Contractor Bonds)

§38-26-107, C.R.S. (Supplier Claims)

2. **DEFINITIONS:**

2.1. Capital Construction Fund – See Fiscal Rule 4-1

2.2. Capital Construction Project – A project for Capital Construction as described in §24-30-1301(2), C.R.S.

2.3. Controlled Maintenance Project – A project for Controlled Maintenance, as described in §24-30-1301(4), C.R.S.

3. **RULE:**

3.1. Capital Construction Projects

3.1.1. Use of Funding – All funds for Capital Construction Projects shall be used for their intended purpose. A State Agency or Institution of Higher Education shall not use the Capital Construction Fund to pay or reimburse State employees for construction management, administrative activities, direct labor performed, or any other expense of the Capital Construction Project or Controlled Maintenance Project. Capital Construction funding may be used for personal services payments to independent contractors for activities within the scope of the Capital Construction Project or Controlled Maintenance Project, including design or construction services. The State Controller may create additional restrictions on the use of Capital Construction Funds in policy or the Fiscal Procedures Manual.

3.1.2. Six Month Rule – State Contracts for Capital Construction Projects shall be executed and the funds encumbered within the time limits established by and in accordance with the requirements of §24-30-1404(7), C.R.S. If a State Agency or Institution of Higher Education determines that the deadlines imposed by the statute cannot be met, the State Agency or Institution of Higher Education may request the General Assembly's Capital Development Committee to recommend to the State Controller that the deadline be waived. The State Controller may, but is not required to, grant the waiver. This Fiscal Rule does not apply to projects at Institutions of Higher Education that are funded solely from cash funds held by the Institution or other exemptions provided in statute.

3.1.3. Availability of Capital Construction Funds – Appropriated Capital Construction Funds are available immediately upon signature of the Governor, as current year appropriations. Appropriated Capital Construction Projects must be initiated by the end of the fiscal year following the original appropriation and will remain available for a period of three years or, if encumbered, will remain available until completion of the project.

3.2. Capital Construction Project Retainage

3.2.1. A State Agency shall withhold retainage for all construction and Controlled Maintenance Projects where the total amount of the Capital Construction Contract exceeds the limit established by §24-91-103, C.R.S. Institutions of Higher Education shall withhold this retainage for all projects that are not cash funded. The retainage shall be in the form of monies withheld from the contractor or in any other form authorized by statute and acceptable to the State Agency or Institution of Higher Education.

3.2.2. Partial retainage may be released as discrete portions of work are completed, accepted, and advertised for partial settlement. Final retainage shall be released by the State Agency or Institution of Higher Education only when the Capital Construction Contract has been satisfactorily completed and accepted, the State Agency or Institution of Higher Education has proof of publication of "Notice of Final Settlement", in accordance with §38-26-107, C.R.S., and there are no outstanding claims against the project.

3.2.3. The retainage requirement does not apply to Professional Services Contracts.

RULE 4-3: CAPITAL CONSTRUCTION CARRYFORWARDS AND REVERSIONS

1. **AUTHORITY:**

§24-30-1301, C.R.S. (State Buildings)

Title 24, Article 75 Part 3, C.R.S. (Capital Construction Fund)

Title 24, Article 91, C.R.S. (Construction Contracts)

2. **DEFINITIONS:**

2.1. Capital Construction – See Fiscal Rule 4-1.

2.2. Capital Construction Project – See Fiscal Rule 4-2.

2.3. Encumbrance – See Fiscal Rule 3-1.

3. **RULE:**

3.1. Carryforward of Capital Construction appropriations – Any unexpended Capital Construction budget is automatically carried forward for three fiscal years (the initial fiscal year of appropriation and the subsequent two fiscal years). If any amount of the available appropriation is restricted, the restricted amount must be carried forward as restricted.

3.1.1. At the end of the third fiscal year of a Capital Construction appropriation, the amount of a valid Encumbrance recorded on the State Financial System or on an approved State Agency or Institution of Higher Education accounting system may be carried forward until the Encumbrance has been fully liquidated.

3.2. Reversion of Capital Construction Appropriations – Upon completion of a Capital Construction Project or the end of a Project's three-year lifecycle, whichever comes first, the amount of any unexpended/unencumbered appropriation must be reverted.

CHAPTER 5: TRAVEL

RULE 5-1: TRAVEL

RULE 5-1: TRAVEL

1. **AUTHORITIES**

§24-9-104(2), C.R.S. (Mileage Allowances)

§24-30-202(20.1), C.R.S. (Travel Advance Limits)

§24-30-202(26), C.R.S. (State Controller's Authority)

U.S. Code, Title 26, §§162(a), 262, and 274(d) (Internal Revenue Code)

26 CFR Ch. 1, §1.274-5T Substantiation Requirements (Temporary) (Treasury Regulations)

Rev Rul. 99-7, 1999-5 C.B. 4, Deductibility of Daily Transportation Expenses

Internal Revenue Service Publication 463 – Travel, Entertainment, Gift, and Car Expenses

2. **DEFINITIONS:**

2.1. Approving Authority – An individual who has authority to approve travel for State Business and related matters.

2.2. Commercial Card – See Fiscal Rule 2-7 (State Commercial Cards).

2.3. Commercial Card Program – See Fiscal Rule 2-7 (State Commercial Cards).

2.4. CONUS – The 48 continental United States, including the District of Columbia.

2.5. Electronic Signature – Any identifier or authentication technique attached to or logically associated with an electronic record that is intended by the person using it to have the same force and effect as a manual signature. "Electronic signature" includes digital signatures.

2.6. Expenses Incurred for the Benefit of the State – Expenses incurred that enable a State employee or state official to perform assigned duties or enable a State Agency or Institution of Higher Education to carry out responsibilities required by law.

2.7. Foreign Travel – Travel to any out-of-country destination not included within the definitions of In-State Travel or Out-of-State Travel.

2.8. In-State Travel – Travel within the State of Colorado and to the immediate area outside the State that is a necessary part of an otherwise "in-state" trip.

2.9. Incidental Expenses – Tips given to porters, baggage carriers, bellhops, hotel maids, and skycaps for airport check-in.

2.10. Lodging – Any commercial accommodations available or offered for use for which a rate schedule has been established and payment is required, as described in the State Controller Travel Policies.

2.11. Metropolitan Area – See Fiscal Rule 2-5 (Miscellaneous

Compensation and Other Benefits (Perquisites)).

2.12. One Card – See Fiscal Rule 2-7 (State Commercial Cards).

2.13. Out-of-State Travel – Travel within CONUS, other than In-State Travel, or within Alaska or Hawaii.

2.14. Political Expenses – Expenses incurred in relation to activities that are primarily designed to further the interests of a candidate, political party, or special interest group.

2.15. Price Agreement – See Fiscal Rule 3-3 (State Contracts).

2.16. Procurement Card – See Fiscal Rule 2-7 (State Commercial Cards).

2.17. Reimbursement Request – A request for reimbursement of travel expenses submitted by a Traveler pursuant to §9 of this Fiscal Rule.

2.18. State Business – Official State business or other duties undertaken for State purposes and for the benefit of the State.

2.19. State Commercial Card Program Manager – The individual designated to assist the bank in the administration of the Commercial Card Program and manager of the State Contract between the State and the bank. The liaison between entities participating in the program and the bank.

2.20. Temporary Work Location – A location where employment is expected to continue, and does continue, for one year or less that is not the Traveler's Regular Work Location.

2.21. Travel Advance – The advance of funds to a Traveler for approved travel expenses by a State Agency or Institution of Higher Education pursuant to §5 of this Fiscal Rule.

2.22. Travel Card – See Fiscal Rule 2-7 (State Commercial Cards).

2.23. Traveler – A State employee who receives required approvals to travel on State Business.

2.24. Traveler's Regular Work Location – Generally, the primary location where the Traveler works, including the entire Metropolitan Area of the Traveler's regular work location. See State Controller Travel Policies for exceptions.

2.25. Traveler's Residence – The location where the Traveler maintains the Traveler's primary family home.

2.26. Traveling Away from Home – A Traveler is traveling away from home if:

2.26.1. The Traveler's duties require the Traveler to be away from the Traveler's Regular Work Location substantially longer than an ordinary day's work; and

2.26.2. The Traveler needs to sleep or rest to meet the demands of the Traveler's work while away from the Traveler's Regular Work Location.

2.27. Transportation – Travel by any means of conveyance as

described in the State Controller Travel Policies.

3. **RULE:**

3.1. Scope – All Travelers shall comply with this Fiscal Rule when Traveling Away from Home and for all other situations included in this Fiscal Rule.

3.2. Reimbursement – A Traveler may be reimbursed for travel expenses only if the:

3.2.1. Traveler is Traveling Away from Home, or meets the criteria in one of the special situations described in §11 of this Fiscal Rule;

3.2.2. Travel is:

3.2.2.1. For State Business – travel charged to the State, regardless of the funding source, shall be for the benefit of the State;

3.2.2.2. Only for the time period necessary;

3.2.2.3. Completed using the most economical means available which will satisfactorily accomplish the State Business; and

3.2.2.4. Approved by the Approving Authority as required by §4 of this Fiscal Rule;

3.2.3. Expenses are reasonable under the circumstances;

3.2.4. Traveler submits adequate documentation of the travel expenses to the Approving Authority in accordance with State statute, Internal Revenue Service regulations, grant requirements, and other requirements as determined by the State Agency or Institution of Higher Education; and

3.2.5. Reimbursement Requests and Travel Advances are settled as required by §9 of this Fiscal Rule.

3.3. Traveler's Responsibilities – A Traveler is responsible for controlling expenses at a reasonable level, ensuring that the State receives adequate value for the amounts expended and minimizing risk to the State. A Traveler shall identify Expenses Incurred for the Benefit of the State while Traveling Away from Home and request a purchase, advance, or reimbursement for only those expenses.

3.4. Approving Authority's Responsibilities – The Approving Authority shall review the expenses claimed by a Traveler and authorize a purchase, advance, or reimbursement for only those expenses incurred for State Business. The Approving Authority may require documentation, in addition to the documentation prescribed by this Fiscal Rule, deemed necessary or advisable by the Approving Authority in connection with the review and authorization of expenses.

4. **TRAVEL AUTHORIZATION:**

All travel shall be authorized in accordance with the procedures in this §4, regardless of the sources of funding (including reimbursements by third parties).

4.1. In-State Travel – Prior authorization by the Approving Authority for all In-State Travel may be required, at the discretion of the State Agency or Institution of Higher Education.

4.2. Out-of-State Travel – Prior written or electronic

authorization by the Chief Executive Officer, or delegate, of a State Agency or Institution of Higher Education shall be required for all Out-of-State travel.

4.3. Foreign Travel – Prior written or electronic authorization by the Governor, an Elective Officer, the Commissioner of the Department of Education, or a delegate of any of them, and the Chief Executive Officer, or delegate, of the State Agency benefiting from the Foreign Travel shall be required for all Foreign Travel, except for Foreign Travel undertaken by employees of the Department of Higher Education. Prior written authorization by the Chief Executive Officer of the Department of Higher Education shall be required for all Foreign Travel by employees within the Department of Higher Education, including employees of Institutions of Higher Education. The Chief Executive Officer of the Department of Higher Education, with the approval of the State Controller, may delegate the authority to approve Foreign Travel to the Chief Executive Officer, or a delegate, of a specific Institution of Higher Education.

4.4. Travel at No Cost to the State – Prior authorization by the Approving Authority is required for any State Business travel for which reimbursement will be made directly to the State or a State employee by a non-State organization.

5. **TRAVEL ADVANCE:**

5.1. Travel Advance Form – A Traveler shall complete a Travel Advance form to obtain an advance for approved travel expenses, which shall contain a statement as to the purpose of the travel. Each State Agency and Institution of Higher Education shall develop a Travel Advance form for use by its Travelers.

5.2. Amount of Advance – The amount of the advance shall be computed using the applicable per diem rates, set forth in §12 of this Fiscal Rule, and other allowable estimated out of pocket amounts. A Travel Advance shall not exceed the lesser of the $2,500 statutory limit or the amount approved by the State Controller, or the State Controller's designee, per Traveler per trip. See §24-30-202(20.1), C.R.S.

5.3. Approval – Travel Advances requested from the State require prior authorization from the Approving Authority and approval by the Chief Fiscal Officer, or delegate, for the State Agency or Institution of Higher Education authorizing the travel.

5.4. Settlement of Travel Advance – Upon completion of travel, a Traveler shall settle all Travel Advances made to the Traveler by following the requirements for timing, content and receipts set forth in §9 of this Fiscal Rule. The Traveler shall reimburse the State to the extent that the amount of a Travel Advance received by the Traveler pursuant to this §5 exceeds the actual expenditures for reimbursable items in §6 of this Fiscal Rule.

6. **TRAVELING AWAY FROM HOME:**

A Traveler Traveling Away from Home shall be reimbursed for the items set forth in this §6, if all of the requirements of §3 of this Fiscal Rule are met.

6.1. Lodging – Lodging may be booked using one of the State Commercial Cards. If a State Commercial Card is not available, the Traveler may use a personal card or personal funds, or a Travel Advance may be obtained by the Traveler, to pay for lodging. The Traveler shall submit receipts for Lodging as documentation of the expense.

6.2. Meals and Incidental Expenses – Under regulations issued by the Internal Revenue Service, Travelers are required to use the method chosen by

the State for reimbursement of meals and Incidental Expenses. The State has chosen to use the standard allowance method for meals and Incidental Expenses, rather than the actual cost method. Under the standard meal allowance method, a Traveler shall claim the authorized meal per diem rate for each meal the Traveler would normally have eaten while Traveling Away from Home. If a meal is included in a conference fee or is provided with the cost of Lodging, a Traveler shall not request reimbursement for the standard meal allowance, unless the meal provided is determined to be inadequate by the Traveler. The Traveler shall include the total Incidental Expense per diem rate for each overnight stay, but shall not request reimbursement for Incidental Expenses that do not include an overnight stay. Under no circumstances shall a Traveler request reimbursement for more than the applicable per diem rate. Because meals and Incidental Expenses are paid on a per diem basis, receipts for meals and Incidental Expenses are not required. See §12 of this Fiscal Rule for reference to the current standard per diem rates for meals and Incidental Expenses. Centrally billed Commercial Cards (i.e. One Cards, centrally billed Travel Cards, and Procurement Cards) shall not be used to pay for meals or Incidental Expenses while Traveling Away From Home. Individually billed Travel Cards may be used to pay for meals and Incidental Expenses while Traveling Away From Home.

6.3. Meals and Incidental Expenses for Days Traveler Departs and Returns – A State Agency or Institution of Higher Education may use either of the following methods for an advance or reimbursement for meals during partial travel days, except each State Agency or Institution of Higher Education must use the same method for all of that State Agency's or Institution of Higher Education's Travelers:

6.3.1. A Traveler may claim 75% of destination city's per diem rate, including Incidental Expenses, for the day of departure, and 75% of the departing city's per diem rate, Including Incidental Expenses, on the day of return; or

6.3.2. A Traveler may claim meals based on departure and arrival time. Breakfast cannot be claimed unless departure is 5:00 A.M or earlier at the city of departure. Lunch cannot be claimed unless departure is before 11:00 a.m. at the departing city or arrival is after 1:00 p.m. at the city of arrival. Dinner cannot be claimed, unless arrival is 8:00 P.M. or later at the city of arrival. Under this method, the applicable per diem rate is based on where the meal is eaten.

6.4. Transportation – A Traveler shall be reimbursed only for the dollar equivalent of the most economical means of Transportation available to the Traveler that satisfactorily accomplishes the State Business. Reimbursement shall be limited to the actual cost of commercial Transportation. A Traveler requesting reimbursement shall submit receipts for all Transportation expenses except as provided in §6.11 of this Fiscal Rule.

6.5. State Fleet Vehicles – Travelers are encouraged to use State fleet vehicles when they are available and meet the needs of the Traveler, unless the Traveler's State Agency or Institution of Higher Education has a more restrictive policy.

6.6. Rental Vehicles – State Agencies and Institutions of Higher Education shall use State Price Agreements for automobile rentals in order to ensure adequate liability insurance coverage, unless the State Price Agreement does not meet the needs of the Traveler. In instances where a State Price Agreement is not used for automobile rental, the Traveler shall purchase liability insurance in the amount of $1,000,000 through the automobile rental company the Traveler uses. Various upgrades provided at extra cost by vehicle rental companies, such as satellite radio, GPS units, etc., are not reimbursable unless

necessary for State Business or safety reasons and approved by the Approving Authority. A Traveler shall submit receipts for rental vehicles as documentation of the expense and shall be reimbursed for the actual cost of rental vehicles, provided the Traveler complies with §3 of this Fiscal Rule.

6.7. Use of Personal Vehicles

6.7.1. Insurance – If a Traveler uses the Traveler's personal vehicle on State Business the Traveler is not covered by the State's automotive insurance.

6.7.2. Mileage for Personal Vehicles – A Traveler shall be allowed mileage reimbursement for each mile actually and necessarily traveled on State Business using the Traveler's personal vehicle as provided in the State Controller Travel Policies. A Traveler normally shall be reimbursed at the mileage rate designated for two-wheel drive vehicles. A Traveler shall be reimbursed at the mileage rate designated for four-wheel drive vehicles only when the use of four-wheel drive is necessary because of road, terrain, or adverse weather conditions. Commuting expenses incurred while traveling between a Traveler's Residence and Traveler's Regular Work Location are non-reimbursable personal expenses. §24-9-104(2), C.R.S establishes the mileage rate to be used for reimbursement of State Business travel. The current mileage rates are posted on the website of the Office of the State Controller.

6.8. Airfare – Travelers shall use the most advantageous airline based on cost, time, and schedule. A Traveler shall be reimbursed for approved fees if not included in the airfare, as described in the State Controller Travel Policies.

6.9. Tips – A Traveler cannot claim tips as a separate item on a Reimbursement Request. Tips paid to porters, baggage carriers, bellhops, hotel maids, and skycaps for airport check-in are included in Incidental Expenses. Tips paid in conjunction with meals are included in the standard meal allowance. Tips for commercial Transportation, such as taxi and shuttle drivers, shall be reimbursable as part of and shall be included in the cost of the Transportation.

6.10. Other Allowable Travel Expenses – In addition to Lodging, Meals, and Transportation, the actual expenses identified below, incurred as a part of approved travel, are allowable if necessary to complete State Business:

6.10.1. Commercial Transportation such as taxi and shuttle expenses – A receipt shall be required for each individual ride in a commercial vehicle costing over $25, including tip;

6.10.2. Camping site fees paid for a commercial camp ground or a state or national park – A receipt shall be required for any fee over $25;

6.10.3. Parking fees – A receipt shall be required for any single fee over $25;

6.10.4. Airline baggage fees – A receipt shall be required for baggage fees in excess of the standard fee for a single bag.

6.10.5. Telephone, fax, internet access, and other similar miscellaneous business expenses paid for State Business – A receipt shall be required for any single charge over $25;

6.10.6. Toll road charges – A receipt shall be required for

charges over $25; and

6.10.7. Transaction charges for the use of the State Commercial Card.

6.11. Summary of Allowable Travel Expenses

Type of Travel Expense	Reimbursement	Receipt Required?
Lodging	Actual	Yes
Meals (Standard)	Per Diem Rate	No
Meals (Camping)	60% of the applicable Per Diem Rate	No
Incidental Expenses	Per Diem Rate	No
Transportation (other than airfare)	Actual	Yes if over $25
Rental Vehicles	Actual	Yes
Mileage for Personal Vehicles	The reimbursement rate in §24-9-104(2) C.R.S.	No
Airfare	Actual	Yes
Tips	Included in Per Diem Rate	No
Other Allowable Travel Expenses not Paid with a Commercial Card	Actual	Yes if over $25
Other Allowable Travel Expenses Paid with a Commercial Card	Actual	Yes

7. **NON-ALLOWABLE TRAVEL EXPENSES:**

A Traveler shall not be reimbursed or use any State funds for the following expenses, which are not allowable travel expenses:

7.1. Alcoholic beverages or recreational marijuana;

7.2. Entertainment expenses;

7.3. Personal expenses incurred during travel that are primarily for the benefit of the Traveler and not directly related to State Business;

7.4. Political expenses;

7.5. Traffic fines and parking tickets;

7.6. Late fees for individually billed Travel Cards;

7.7. Premium add-on costs on airline tickets, unless pre-approved by the Traveler's State Agency or Institution of Higher Education, as defined in the State Controller Travel Policies; and

7.8. Certain insurance coverage – The State Commercial Card Program provides travel insurance for Travelers who use one of the State Commercial Cards listed in §10.2 of this Fiscal Rule, but the State does not provide insurance if a Traveler

uses the Traveler's personal credit card. The cost of additional or other types of coverage shall not be reimbursed by the State, unless required by §6.6 of this Fiscal Rule or permitted by the policy of the Institution of Higher Education, including without limitation, expenses paid by a Traveler for the following:

7.8.1. Collision damage waiver or loss-of-use waiver for rental vehicles, as this coverage is automatically provided with use of one of the State Commercial Cards;

7.8.2. Additional or supplemental liability insurance on vehicles rented through a State Price Agreement Vendor;

7.8.3. Trip cancellation insurance;

7.8.4. Personal accident and personal effects insurance on rental vehicles; and

7.8.5. Supplemental life insurance for airline or common carrier travel.

8. **CERTIFICATION AND APPROVAL:**

8.1. Certification – Each Travel Advance form or Reimbursement Request shall contain the following certification signed manually or electronically, if allowed by the Traveler's State Agency or Institution of Higher Education, by the Traveler:

"I certify that the statements in the above schedule are true and correct in all respects; that payment of the amounts claimed herein has not and will not be reimbursed or paid by any other source; that travel performed for which an advance or reimbursement is claimed was or will be performed by me while on State Business and that no claims are included for expenses of a personal or political nature or for any other expenses not authorized by the Fiscal Rules; and that I actually incurred or paid the operating expenses of the motor vehicle for which reimbursement is claimed on a mileage basis. Further, I hereby authorize the State to deduct from my pay any amount paid to me in excess of my authorized expenses as provided by Fiscal Rule 5-1."

8.2. Approval – If approved, the Approving Authority shall endorse the Reimbursement Request or Travel Advance request manually, by electronic signature, or by approval through a dedicated approval system.

9. **REIMBURSEMENT REQUIREMENTS:**

9.1. Timing – A Reimbursement Request shall be filed within 60 days of completion of travel to allow for proper recording of expenses and to obtain reimbursement for approved travel expenses. Reimbursement Requests submitted between 61-90 days of completion of travel must be accompanied by a justification as to why the submission was late, and the employee may be taxed in accordance with the Internal Revenue Code and its implementing regulations. Any Reimbursement Requests submitted after 90 days will not be reimbursed.

9.2. Content – Each State Agency and Institution of Higher Education shall develop a Reimbursement Request form for use by its Travelers. The Reimbursement Request form shall contain all of the following:

9.2.1. Amount – The amount of each separate expenditure incurred while Traveling Away from Home, such as the cost of Transportation or

Lodging;

9.2.2. Time – Dates of departure for and return from the destination city and the number of days spent on State Business while Traveling Away from Home;

9.2.3. Place – Destinations or locality of travel, described by name of city or town or other similar designation; and

9.2.4. Purpose – Reason for travel or a description of the State Business being conducted during the travel.

9.3. Receipts

9.3.1. Receipts Required – Receipts are required for all expenses over $25, except for meals, Incidental Expenses, and mileage for personal vehicles, which do not require receipts regardless of dollar amount. Receipts are required for Lodging, rental vehicles and airfare, regardless of the amount, and for other expenses as described in §6.10 of this Fiscal Rule. Receipts shall be itemized vendor receipts. Nonitemized charge card transaction slips shall not be accepted as proper documentation. If a receipt is not available, the Traveler shall provide documentation explaining why an itemized receipt is not available and each State Agency or Institution of Higher Education shall determine what documentation will be required in that circumstance.

9.3.2. Waiver – The Approving Authority may waive the requirement for a receipt in extenuating circumstances, upon receipt of a written certification from the Traveler, certifying that the cost was incurred and providing the reason why a receipt was not obtained or available. Further, the Approving Authority may establish alternative documentation requirements for recurring travel to certain locations (e.g. Foreign Travel) or for group travel, where compliance with the receipt requirement is determined to be impractical by the Approving Authority, with concurrence from the Office of the State Controller or State Controller delegate.

9.4. Application to Travel Advances – The requirements with respect to Timing, Content and Receipts set forth in this §9 shall apply to the settlement of Travel Advances as provided in §5 of this Fiscal Rule.

9.5. Compliance – A Traveler shall comply with the reimbursement requirements in this §9 regardless of the method of payment used.

10. **PAYMENT OF TRAVEL EXPENSES:**

A State Agency or Institution of Higher Education shall use one or more of the methods set forth in this §10 to pay for travel expenses or reimburse Travelers.

10.1. Electronic Reimbursement – A State Agency or Institution of Higher Education shall pay a Traveler for expenses claimed on the Reimbursement Request form or the Travel Advance form by direct deposit using electronic funds transfer (EFT). State warrants shall not be used for the payment of travel reimbursement for employees of a State Agency or Institution of Higher Education.

10.2. State Commercial Cards – State Agencies and Institutions of Higher Education may pay travel expenses directly or indirectly with State Commercial Cards.

10.2.1. Types of State Credit Cards Approved for State Travel

10.2.1.1. State Commercial Cards – When possible, travel arrangements (airfare, lodging, rental cars, and other Transportation) shall be booked using one of the State Commercial Cards.

10.2.1.1.1. Travel Cards – Travel Cards may be centrally billed (tax-exempt) or individually billed (not tax-exempt). Travel Cards may provide for corporate liability, joint/several liability or individual liability. A State Agency or Institution of Higher Education may issue a Travel Card to an individual employee or official for the purpose of State travel, or to a specific contractor in order to book travel (ghost account).

10.2.1.1.2. One Cards – A One Card may be used for travel subject to the policy of the State Agency or Institution of Higher Education. The State is liable for the use of the card and transactions paid for with the card are tax-exempt. A State Agency or Institution of Higher Education may issue a One Card to an individual employee or Elective Officer for State travel.

10.2.1.1.3. Procurement Card – The Procurement Card shall not be used to pay for travel expenses.

10.2.2. Use of Travel Cards and One Cards – Each State Agency and Institution of Higher Education shall develop its own policy regarding the appropriate use of State Travel Cards and One Cards, which shall:

10.2.2.1. Be consistent with the allowable charges for each type of card;

10.2.2.2. Have appropriate internal controls regarding the use of the cards and administration of the program;

10.2.2.3. Establish a single purchase limit standard for Travel Cards and One Cards. Institutions of Higher Education shall establish single purchase limits based on the small purchase limits determined by the Institution of Higher Education for Travel Cards and One Cards; and

10.2.2.4. Require the use of Travel Cards or One Cards whenever possible, with exceptions to be approved by the State Controller or a delegate of the State Controller.

10.3. Use of Personal Cards – Whenever possible travelers should use a State Commercial Card to pay for travel expenses. If the Traveler has a State Commercial Card, personal credit cards should not be used in lieu of the State Commercial Cards listed in this §10 to pay travel expenses. Use of personal cards for travel expenses are not tax-exempt, but taxes paid may be reimbursed to the Traveler.

10.4. Travel Advance – See §5 and §9 of this Fiscal Rule.

11. **SPECIAL SITUATIONS:**

11.1. Travel within a Single Day – If travel outside the

Traveler's Regular Work Location is completed wholly within a single day, reimbursement for lunch shall not be allowed. If, however, an employee or official leaves home at 5:00 A.M. or earlier on State Business that requires the employee to extend the workday, the Approving Authority may allow a meal per diem for breakfast. In addition, if an employee or official remains away from home until 8:00 P.M or later on State Business, the Approving Authority may allow a meal per diem for dinner. See State Controller Travel Policies.

11.2. Travel to a Temporary Work Location – A Traveler may be reimbursed for Transportation expenses to a Temporary Work Location in accordance with the State Controller Travel Policies.

11.3. Travel to Conferences, Meetings, Training Sessions, and Other Business-related Activities – A Traveler may be reimbursed for Transportation expenses for these activities in accordance with the State Controller Travel Policies regarding travel and mileage reimbursements.

11.4. Allowances for Members of Statutory Boards or Commissions – Members of boards and commissions shall be paid in accordance with the statute establishing the board or commission. If the establishing statutes do not provide for reimbursement for members of a board or commission, members of boards and commissions may be reimbursed in accordance with the policies of the State Agency or Institution of Higher Education paying the expenses for that board or commission; which may include per diem or actual and necessary expenses, accompanied with receipts. Actual and necessary expenditures or per diem shall be reasonable under the circumstances and the members of the board or commission shall be made aware that public funds are the source of the reimbursement. Members of boards and commissions also may be reimbursed for childcare services. The Chief Executive Officer of a State Agency or Institution of Higher Education paying the expenses for that board or commission, or a delegate of that individual, shall determine the need for childcare reimbursement. Reimbursement shall not be made for services provided by a family member.

11.5. Allowances for State Job Applicants – To obtain the best-qualified individual for a given State employment position, it may be necessary to pay interview related travel expenses for job applicants. At the discretion of the Chief Executive Officer of a State Agency or Institution of Higher Education, or delegate, such travel expenses, including the meal per diem rate established by the State Controller for Travelers, may be reimbursed to the applicant consistent with the expenses allowed for State employees.

11.6. Allowances for Travel Not Solely for State Business – In some instances, the purpose of travel may be partially for State Business and partially for personal or political reasons. If a State employee obtains lower rates for Lodging because travel is extended for personal or political reasons, these lower rates shall also apply to the State Business portion of the travel. Any lodging, meals, or Transportation (other than airfare) for personal travel will not be reimbursed. Each State Agency or Institution of Higher Education shall develop a State Agency-wide or Institution-wide policy regarding allocation of airfare costs, if any, when an employee is extending State Business travel for personal or political purposes.

11.7. Allowances for Travel Paid Directly by a Non-State Entity – In limited instances, State officials and employees may be invited to attend a meeting, seminar, conference, or other event concerning State Business where their travel expenses are paid directly or reimbursed by the sponsor of the meeting, seminar, conference, or event. In such instances the official or employee may accept the invitation if the travel has been approved by the appropriate Approving Authority and does not violate other State

statutes, guidance provided by the Colorado Independent Ethics Commission, or constitutional provisions.

11.8. Allowances for Travel with Spouse, Relatives, or Friends – The State shall not reimburse the cost of an employee's spouse or other person(s) accompanying the State employee on a business trip. The State shall also not reimburse any incremental increases in costs associated with an employee's spouse or other person(s) accompanying the State employee on a business trip.

11.9. Allowances for Travel by Leased or Privately Owned Aircraft

11.9.1. A State Agency or Institution of Higher Education shall not lease an aircraft without the prior written approval of the Aircraft Section of the Colorado State Patrol in the Department of Public Safety, regardless of the source of funds. Prior written approval also is required for the lease of any replacement for aircraft currently operated by a State Agency or Institution of Higher Education.

11.9.2. A State Agency or Institution of Higher Education shall not authorize the use of a privately owned aircraft without prior written approval from the Office of Risk Management. Reimbursement for the use of a privately owned aircraft shall not be allowed unless the required prior written approval has been secured.

11.10. Allowances for Travelers Furnishing Their Own Lodging – Travelers will not be reimbursed any amount for lodging costs when furnishing their own Lodging.

12. **PER DIEM RATES – MEALS AND INCIDENTAL EXPENSES:**

The current maximum meal and Incidental Expense per diem rates are posted on the website of the Office of the State Controller. These rates include the following:

Appendix A1 – Domestic (CONUS) Per Diem Rates (if a specific City or County rate is not listed, the base rate for the state in which that City or County is located shall be used)

Appendix A2 – Allocation of Domestic (CONUS) Per Diem Rates

Appendix B – Alaska, Hawaii, and US Possessions Per Diem Rates

Appendix C1 – Foreign Per Diem Rates

Appendix C2 – Allocation of Non-CONUS Per Diem Rates Including Foreign, Alaska, Hawaii, and US Possessions

Appendix C3 – Footnote References for Foreign Per Diem Rates

CHAPTER 6: CASH

RULE 6-1: CASH RECEIPTS AND DEPOSITS

1. **AUTHORITY:**

§24-36-103, C.R.S. (Moneys Transmitted to State Treasurer)

§24-36-104, C.R.S. (Moneys to Be Deposited)

2. **DEFINITIONS:**

2.1. Bank Account – An account approved by the State Controller and State Treasurer that is established by a State Agency or Institution of Higher Education in any financial institution for the purpose of conducting State business.

3. **RULE:**

A State Agency or Institution of Higher Education that receives money for any reason shall make timely deposits to the State Treasury, unless otherwise provided by statute or Fiscal Rule. All money received and not deposited during the month shall be deposited within seven business days following calendar month-end. Deposits or transfers to the State Treasury from any bank account shall be made as required by the State Treasurer.

RULE 6-2: CHANGE FUNDS AND PETTY CASH FUNDS

1. **AUTHORITY:**

§24-36-103(2), C.R.S. (Moneys Transmitted to State Treasury)

§24-30-202 (20.1) C.R.S. (State Controller Authority)

2. **DEFINITIONS:**

2.1. Change Fund – A fund established at a State Agency or Institution of Higher Education that receives cash to allow for making change.

2.2. Commercial Card – See Fiscal Rule 2-7 (State Commercial Cards).

2.3. Petty Cash Fund – A fund established at a State Agency or Institution of Higher Education to allow cash payment for small, incidental expenses.

3. **RULE:**

3.1. Change Funds and Petty Cash Funds may be established based upon a written request from the Chief Fiscal Officer of a State Agency or Institution of Higher Education and approval of the State Controller, or the Controller's delegate. The request for approval shall state the purpose of the fund and contain justification for the amount requested.

3.2. Change Funds shall only be used for making change when cash receipts are accepted from the public, such as for fees and fines. No expenditures of any kind shall be authorized from a Change Fund.

3.3. Petty Cash Funds shall only be used for payment of incidental expenses of a nominal amount such as postage, parking or expenses not otherwise paid by Commercial Card or warrant. Petty cash expenditures shall be consistent with all applicable statutes, rules, regulations, and executive orders.

3.4. All Petty Cash Funds and all change funds shall be recorded on the State Financial System or on an approved State Agency or Institution of Higher Education accounting system.

RULE 6-3: IMPREST CASH ACCOUNTS AND BANK ACCOUNTS

1. **AUTHORITY:**

§24-36-103(2), C.R.S. (Moneys Transmitted to State Treasury)

§24-36-104, C.R.S. (Moneys to Be Deposited)

§24-75-202, C.R.S. (Imprest Cash Accounts)

2. **DEFINITION:**

2.1. Bank Account – An account that is established by a State Agency or Institution of Higher Education in any eligible financial institution for the purpose of conducting State business.

2.2. Imprest Cash Account – A cash account that is established by a State Agency or Institution of Higher Education for the purpose of paying operating expenses.

3. **RULE:**

3.1. Written approval is required from the State Controller and State Treasurer prior to a State Agency or Institution of Higher Education establishing a Bank Account or Imprest Account. All cash Imprest Accounts and Bank Accounts shall be recorded on the State Financial System or on an approved State Agency or Institution of Higher Education accounting system. The request for approval of an Imprest Account shall state the purpose and justification for the Imprest Account, methodology in calculating the estimated Account balance, and any other information that is pertinent to the establishment of this Account.

3.2. Bank Account balances shall be limited to the minimum amount necessary to be consistent with legal requirements and operating efficiency.

3.3. Deposits to cash Imprest Accounts shall be in the form of reimbursements for actual expenditures, other than deposits used to establish and maintain a minimum balance, and shall be consistent with all applicable statutes, rules, regulations, and executive orders. Request for reimbursements shall be made so that all disbursements are properly reported on the State Financial System or an approved State Agency or Institution of Higher Education accounting system.

RULE 6-4: REFUNDS AND REIMBURSEMENTS

1. **AUTHORITY:**

§24-30-202 (19) C.R.S. (State Controller Authority)

2. **DEFINITIONS:**

2.1. Non-augmenting Revenue Account – An account used to record a refund or reimbursement from a prior fiscal year. Such Non-augmenting Revenue Accounts do not serve as funding sources for appropriated expenditures.

2.2. Refund – An amount or credit received because of an overpayment or the return of an item purchased.

2.3. Reimbursement – Repayment received for amounts remitted on behalf of another party.

3. **RULE:**

State Agencies and Institutions of Higher Education will normally use either an account receivable or a revenue account to record Refunds and Reimbursements. However, incidental and non-recurring Refunds or Reimbursements may be credited against the original account coding if the recovery occurs in the same fiscal year as the original expenditure and is for activities that involve a routine State Agency or Institution of Higher Education function. If such recoveries are made in a subsequent fiscal year, such as an audit recovery or accounts payable reversion, they should be credited to a Non-augmenting Revenue Account.

4. **EXCEPTIONS TO RULE:**

4.1. Capital Construction Funds – Refunds or Reimbursements received for expenditures of Capital Construction Fund appropriations during the life of the project shall be treated as if they were received in the same fiscal year as the original expenditure. If the recovery is made after the term of the appropriation has expired, the recovery shall be credited to a Non-augmenting Revenue Account.

4.2. Federal Funds – Refunds or Reimbursements received for expenditures of federal funds, prior to the expiration of the award, shall be treated as if they were received in the same state fiscal year as the original expenditure. If the recovery is made after the award has expired, the recovery shall be refunded to the Federal government, unless otherwise directed by the Federal government.

4.3. Contracts and Grants – Refunds or reimbursements received for expenditures made from Contracts and Grants shall be handled as set forth in the terms of the Contract or the conditions of the Grant.

RULE 6-5: PAYMENTS RETURNED BY FINANCIAL INSTITUTIONS

1. **AUTHORITY:**

§24-30-202 (25), C.R.S. (Returned Check Penalty)

2. **RULE:**

A State Agency or Institution of Higher Education that receives a returned payment, such as insufficient or non-sufficient funds, ACH/credit card chargebacks, refer to maker, stop payment, or closed account, shall assess a reasonable fee against the person who issued the payment. The fee assessed shall be at least equal to the additional bank charges incurred by the State Agency or Institution of Higher Education and may include up to an additional 25% of the additional bank charges to cover the State Agency or Institution of Higher Education's administrative costs. This penalty is in addition to any other penalty provided by statute except the penalty provided by §24-35-114, C.R.S.

RULE 6-6: FEDERAL CASH MANAGEMENT

1. **AUTHORITY:**

31 CFR, Part 205 (Rules and Procedures for Efficient Federal-State Funds Transfers)

§24-22-107 (6), C.R.S. (Duties of the State Treasurer)

2. **RULE:**

2.1. Unless Federal funds have been advanced to the State Agency or Institution of Higher Education, State Agencies and Institutions of Higher Education shall make draws of Federal funds as closely as possible to the use of those funds and shall ensure compliance with applicable Federal and State laws, including any liability for interest payable to the Federal government for major Federal programs.

2.2. The State Treasurer shall be the State's cash management officer responsible for the efficient management of all State cash and shall perform the duties necessary to carry out such function, in consultation with the Governor.

CHAPTER 7: BUDGET

RULE 7-1: SPENDING AUTHORITY

RULE 7-2: EXPIRATION AND ROLLFORWARD OF APPROPRIATIONS

RULE 7-3: OVEREXPENDITURES AND REQUIRED REPORTING

RULE 7-4: COMMON POLICY DISPUTES

RULE 7-1: SPENDING AUTHORITY

1. **AUTHORITY:**

§24-37-303, C.R.S. (Governor's Budget Authority)

§24-37-304, C.R.S. (Office of State Planning and Budgeting)

2. **RULE:**

2.1. Spending authority shall be subject to approval by the State Controller under delegated authority from the Office of State Planning and Budgeting, unless the State Agency requesting spending authority is not subject to the authority of the Office of State Planning and Budgeting.

2.2. Spending authority requests must be supported by law (such as statute or legislation), certain grant awards, or other authority as determined by the State Controller.

3. **EXCEPTIONS TO RULE:**

This Fiscal Rule does not apply to Institution of Higher Education expenditures not subject to appropriation by the General Assembly.

RULE 7-2: EXPIRATION AND ROLLFORWARD OF APPROPRIATIONS

1. **AUTHORITY:**

§24-75-102, C.R.S. (Appropriation Expiration)

2. **DEFINITIONS:**

2.1. Carryforward – The remaining amount of a multi-year appropriation transferred into a subsequent fiscal year until the expiration of that multi-year appropriation.

2.2. Encumbrance – See Fiscal Rule 3-1 (Commitment Vouchers).

2.3. Multi-Year Appropriation – Funding that is legally authorized for use in more than one fiscal year, including, but not limited, to Capital Construction appropriations.

2.4. Rollforward – The remaining amount of an appropriation transferred into a subsequent fiscal year that is beyond the expiration of that appropriation.

3. **RULE:**

3.1. Current Year Appropriations

Unless otherwise authorized by law, unexpended appropriations expire at the end of each fiscal year and do not continue into a subsequent fiscal year. Open Encumbrances at the end of a fiscal year do not constitute an obligation against that year's appropriation. Open Encumbrances that are carried over to the next fiscal year and the resulting expenditures are charged against the next fiscal year appropriation, if available.

3.2. Carryforward

Unexpended appropriations authorized for more than one fiscal year may be carried forward into a subsequent fiscal year until the expiration of the appropriation. Authorization for more than one year may be in the form of express legislative intent enacted in legislation or a legislative action signed by the Governor or the Joint Budget Committee. Common forms of express legislative intent may be included in letternotes and footnotes in the Long Bill, Supplemental Bills, and Long-Bill add-ons.

3.3. Carryforward of Capital Construction – See Fiscal Rule 4-3 (Capital Construction Carryforwards and Reversions)

3.4. Exceptions To Rule:

3.4.1. Rollforward – The State Controller may approve the Rollforward of unexpended expiring appropriations based on either of the following:

3.4.1.1. Extenuating Circumstances – Extenuating circumstances must be beyond the control of the State Agency or Institution of Higher Education and mitigated to the greatest extent possible by advanced planning, documented early ordering, early and frequent order status

monitoring, and documented goods or services delivery deadlines communicated to and acknowledged by the contractor. The following items do not qualify as extenuating circumstances and this list is not intended to be all inclusive:

3.4.1.1.1. Inadequate time to implement a new program before the statutory deadline,

3.4.1.1.2. Failure of the selected contractor to perform for any reason other than force majeure,

3.4.1.1.3. Shipping delays, or

3.4.1.1.4. Customs delays.

3.4.1.2. Purchases from Colorado Correctional Industries – The appropriated funds have been legally committed by Interagency Agreement with the Division of Correctional Industries, also known as Colorado Correctional Industries, and the order is placed by the ordering deadline set by Colorado Correctional Industries.

RULE 7-3: OVEREXPENDITURES AND REQUIRED REPORTING

1. **AUTHORITY:**

§24-37-303, C.R.S. (Governor's Budget Authority)

§24-75-109, C.R.S. (Overexpenditures)

§24-75-111(4), C.R.S. (Restriction)

§24-30-202(3), C.R.S. (Personal Liability)

§24-30-202(14), C.R.S. (Misdemeanor and Penalty)

2. **DEFINITIONS:**

2.1. Overexpenditure of Funds – An overexpenditure of funds exists when:

2.1.1. Total expenditures charged to a specific line item, based on the accrual basis of accounting, or based on the cash basis of accounting if statute requires expenditures to be recorded on a cash basis, exceed the established spending authority, as defined in §24-75-109(1.5), C.R.S and reflected on the State Financial System or on an approved State Agency or Institution of Higher Education accounting system.

2.1.2. Non general funded appropriations within the General Fund have insufficient revenue to support expenditures.

2.1.3. Appropriations within a cash fund have insufficient revenue and fund balance to support expenditures.

3. **RULE:**

3.1. Expenditures shall not exceed established spending authority unless specifically allowed by law. Expenditures shall not exceed the amount of either the accrued and collected revenue or the available fund balance at the end of the State fiscal year.

3.2. Required Notification of Overexpenditures

When the Chief Executive Officer becomes aware of an Overexpenditure of Funds within the State Agency or Institution of Higher Education, the Chief Executive Officer shall submit notice within 10 working days to the Governor through the Office of State Planning and Budgeting and to the State Controller.

3.3. Statutory Penalty

Unless the Overexpenditure of Funds is approved by the State Controller in accordance with §4.1.1 of this Fiscal Rule, any official, officer, or employee of the State convicted of knowingly causing an Overexpenditure of Funds shall be subject to statutory fines and/or imprisonment in county jail. In addition, the individual may be personally liable for the overexpenditure amount.

4. **EXCEPTIONS TO RULE:**

4.1. Overexpenditure of Funds Approved by the Governor

(§24-75-109 C.R.S.)

4.1.1. The State Controller, with the approval of the Governor, may allow an Overexpenditure of Funds. Prior to recommending to the Governor that the Overexpenditure of Funds be approved, the State Controller shall verify that the statutory requirements allowing the Overexpenditure of Funds have been met. Overexpenditure of Funds shall only be approved between May 1 of any fiscal year and the close of that fiscal year. This authority is only valid so long as §24-75-109 C.R.S. remains in effect and is not repealed.

4.1.2. For any Overexpenditure of Funds the State Controller shall restrict an amount equal to the overexpenditure in the next fiscal year's appropriation for the State Agency or Institution of Higher Education involved. The amount shall be restricted from a corresponding item or items of appropriation. Any amounts so restricted shall not be expended unless and until such restriction is released.

4.2. Overexpenditure of Funds Approved by the Joint Budget Committee

4.2.1. Overexpenditures occurring when the General Assembly is not in session arising out of unforeseen circumstances may be authorized by the Joint Budget Committee.

RULE 7-4: COMMON POLICY DISPUTES

1. **AUTHORITY:**

§24-37-303, C.R.S. (Governor's Budget Authority)

2. **DEFINITIONS:**

2.1. Common Policy – A policy adopted by the Joint Budget Committee that is consistently applied for State Agencies. For many line items affected by common policy, amounts are initially appropriated in individual departments and then transferred to another department where they appear a second time as reappropriated funds.

3. **RULE:**

3.1. Common Policy funding shall only be disputed during the budgeting process. To dispute a Common Policy appropriation or budget, the State Agency that will be making the Common Policy payments shall submit its dispute to the State Agency that will be billing for the Common Policy payments. The billing State Agency shall review the dispute and determine if it can agree to a resolution with the paying State Agency. If the State Agencies cannot agree on a resolution to the dispute, then they shall submit the dispute to the Office of the State Controller for final resolution.

CHAPTER 8: REPORTING

RULE 8-1: FINANCIAL STATEMENTS

RULE 8-2: QUARTERLY FINANCIAL REPORTING

RULE 8-1: FINANCIAL STATEMENTS

1. **AUTHORITY:**

§24-30-201(1)(d), C.R.S. (State Controller Approval of Financial Statements)

§24-30-204(1), C.R.S. (Financial Statement Due Date and Extension)

2. **DEFINITIONS:**

2.1. Financial Reports – Financial information compiled periodically to assist in management decision-making or for reasons other than financial statement purposes.

2.2. GAAP – See Fiscal Rule 1-1 (Accounting Principles and Standards).

2.3. Prepared Financial Statements – Comprehensive reports prepared in accordance with GAAP, as adopted by the Governmental Accounting Standards Board.

2.4. System Generated Financial Statements – A balance sheet and an income statement for each State Agency or Institution of Higher Education that is generated by the State Financial System.

3. **RULE:**

3.1. State Agency or Institution of Higher Education Financial Statements

3.1.1. Any State Agency or Institution of Higher Education that has individual audits of its prepared financial statements by the Office of the State Auditor, or a contractor of the Office of the State Auditor, shall provide draft financial statements to the Office of the State Auditor or its contractor to facilitate a timely and efficient audit. The draft financial statements shall be submitted to the Office of the State Controller at the same time.

3.1.2. Prepared Financial Statements shall be reconciled to the State Financial System. A copy of this reconciliation shall be provided to the State Controller.

3.1.3. Prepared Financial Statements and reconciliations to the State Financial System shall be subject to approval by the Office of the State Controller as required by statute.

3.1.4. Financial statements prepared by a State Agency or Institution of Higher Education for formal third party reporting shall be prepared in accordance with GAAP.

3.1.5. Exhibit information required in the fiscal year-end closing instructions issued by the State Controller and any post-closing adjustments are an integral part of the financial statements and are considered part of the State Agency's or Institution of Higher Education's reporting requirement.

3.2. Financial Statements for the State of Colorado – The Comprehensive Annual Financial Report (CAFR) for the State of Colorado shall be prepared

by the Office of the State Controller in accordance with GAAP. The CAFR shall reflect all of the financial activities of State government and its component units.

3.3. Financial Reports – Financial Reports provided as required by statute or regulation, or upon written request, shall be based on financial data obtained from or reconciled to the State Financial System.

3.4. Other Reporting – State Agencies and Institutions of Higher Education shall comply with all Federal reporting requirements under Federal regulations and guidance, such as the OMB Uniform Guidance and FFATA, except to the extent that the State Agency or Institution of Higher Education is exempt from reporting under those Federal regulations and guidance. All State Agencies and Institutions of Higher Education shall comply with all reporting requirements contained in State Controller Fiscal Policies.

4. **EXCEPTIONS TO RULE:**

4.1. This Fiscal Rule does not apply to Medicaid cash-basis reporting or other instances identified in a subsequent statute which specifically authorize alternate treatment.

RULE 8-2: QUARTERLY FINANCIAL REPORTING

1. **AUTHORITY:**

§24-30-201, C.R.S. (Powers and Duties of the State Controller)

§24-30-204 (2), C.R.S. (Quarterly Report of Financial Information)

2. **DEFINITIONS:**

2.1. Financial Reports – See Fiscal Rule 8-1 (Financial Statements).

3. **RULE:**

All State Agencies and Institutions of Higher Education shall submit quarterly financial reports as required by the State Controller.

3.1. The State Financial System shall be used to record the State's financial information and prepare the standard Financial Reports, which shall be forwarded to the State Controller in compliance with the reporting requirements of this Fiscal Rule.

3.2. The State Controller shall determine what information is reasonable and necessary to be included in the Financial Report, including which funds and the due date.

3.3. Quarterly financial reports shall be available for use by the Governor, state legislators, executive management, and their respective staffs for planning purposes and decision-making.

3.4. Each quarterly reporting period shall be regarded as an integral part of the fiscal year. Revenues and expenditures, such as salaries and operating expenditures and related accruals shall be allocated to interim periods in which they are incurred or, where appropriate, allocated among quarterly periods on the basis of revenue earned, benefit received, or time expended. Arbitrary assignment to a quarterly period shall not be allowed.

CHAPTER 9: PAYROLL

RULE 9-1: USE OF THE STATE PAYROLL SYSTEM

1. **AUTHORITY:**

§24-30-201(1)(e), C.R.S. (Authority to Manage Financial Affairs of the State)

§24-30-202(1) and (8.5), C.R.S. (Authority to Control Expenditures and Make Electronic Payments)

2. **DEFINITIONS:**

2.1. State Payroll System – The official payroll system for the State of Colorado as designated by the State Controller.

3. **RULE:**

All State Agencies shall use the State Payroll System to record and maintain employee payroll information and data and to pay employees, unless the State Controller has granted an exception.

RULE 9-2: DIRECT DEPOSIT PAYROLL FOR STATE EMPLOYEES PAID ON THE STATE PAYROLL SYSTEM

1. **AUTHORITY:**

§24-30-201(1)(e), C.R.S. (Authority to Manage Financial Affairs of the State)

§24-30-202(1) and (8.5), C.R.S. (Authority to Control Expenditures and Make Electronic Payments)

§24-50-104(8)(a), C.R.S. (Payment of Salaries)

2. **DEFINITIONS:**

2.1. Direct Deposit Payroll Program – A payroll program where an employee's net pay is deposited directly to the employee's legally established checking or savings account via an electronic fund transfer system.

2.2. State Payroll System – See Fiscal Rule 9-1 (Use of the State Payroll System).

3. **RULE:**

State employees paid through the State Payroll System shall be on the Direct Deposit Payroll Program, unless an exception is approved by the State Controller or delegate of the State Controller.

RULE 9-3: FINAL PAY FOR A TERMINATING STATE EMPLOYEE

1. **AUTHORITY:**

§24-30-201(1)(e), C.R.S. (Authority to Manage Financial Affairs of the State)

§24-30-202(1) and (8.5), C.R.S. (Authority to Control Expenditures and Make Electronic Payments)

§24-50-104(8)(a), C.R.S. (Payment of Salaries)

2. **RULE:**

Final pay shall be available to terminating State employees as follows:

2.1. When a State employee terminates employment with the State, with or without giving notice, final payment shall be made no later than the employee's next regular pay day, unless the payroll is already processing for that pay day, in which event it shall be made no later than the following regular payday.

2.2. When a State Agency or Institution of Higher Education terminates a State employee, final payment shall be made within three business days of the date of termination. The 24-hour pay provision of §8-4-109, C.R.S., does not apply to public sector employees.

2.3. A State Agency or Institution of Higher Education shall deduct any amounts a State employee owes the State from that State employee's final pay. If the State employee's final pay is insufficient to cover the amount the State employee owes the State, then the State employee shall be liable for the remaining outstanding balance.

RULE 9-4: OVERPAYMENTS TO STATE EMPLOYEES

1. **AUTHORITY:**

§24-30-201, C.R.S. (Powers and Duties of the State Controller)

§24-50-104(9)(a), C.R.S. (Liability for Overpayments to State Employees)

§24-30-203.5, C.R.S. (Recovery Audits)

2. **DEFINITIONS:**

2.1. Overpayment – An overpayment is any payment that results from overstating the rate of pay, overstating the hours worked, understating the employee deductions, or any other payments to which the employee is not entitled.

3. **RULE:**

3.1. If a State employee is paid more than the amount due, provisions shall be made for the repayment of the Overpayment.

3.2. If the Overpayment is nominal, it shall all be deducted from the State employee's next paycheck. However, in some cases the Overpayment may require a repayment schedule extending over a period of time. The Chief Executive Officer of the State Agency, or a delegate of that individual, shall establish a repayment schedule based on the particular facts involved in each case. Any repayment schedule extending for more than six months shall be subject to approval by the State Controller.

3.3. A State employee's maximum liability for repayment of a payroll-related Overpayment shall be limited to the total amount of the overpayment in the present calendar year plus the total amount of any Overpayment in the three prior calendar years. A State employee's maximum liability for repayment of a non-payroll-related Overpayment shall be limited to the total amount of the Overpayment in the present fiscal year plus the total amount of any Overpayment in the three prior fiscal years.

3.4. Any amount that an employee of a State Agency has not repaid in accordance with this rule is subject to the Accounts Receivable Collections Administrative Rule, set forth in 1 CCR 101-6. Any amount that an employee of an Institution of Higher Education has not repaid in accordance with this Fiscal Rule is subject to the accounts receivable policies of that Institution of Higher Education.

RULE 9-5: MISCELLANEOUS COMPENSATION

1. **AUTHORITY**

§24-30-201(1)(e), C.R.S. (Authority to Manage Financial Affairs of the State)

2. **DEFINITIONS**

2.1. Honorarium – the payment of cash or a cash equivalent in recognition of services provided for no or a nominal charge

3. **RULE:**

3.1. Honorariums

3.1.1. State officials and employees may be asked to address an audience for which they receive an Honorarium. If the State official or employee does so, the State official or employee may retain the Honorarium. Any travel expenses related to the engagement will qualify for reimbursement by the State if the engagement occurs during normal working hours, or within the State official's or employee's normal workload.

RULE 9-6: ASSIGNMENT OF STATE-OWNED VEHICLES

1. **AUTHORITY:**

§24-30-1112, C.R.S. (Permanent Assignment of Vehicles)

§24-30-1113. C.R.S. (Assignment of Vehicles to State Agency Officers or Employees)

Internal Revenue Service Publication 15-B (Employer's Tax Guide to Fringe Benefits)

Internal Revenue Service Publication 5137 (Fringe Benefit Guide, Office of Federal State and Local Governments)

2. **DEFINITIONS:**

2.1. Eligibility – The State employee meets the eligibility requirements for assignment of a State vehicle as provided in this Fiscal Rule.

2.2. State Business – See Fiscal Rule 5-1 (Travel).

2.3. State Fleet – State Fleet Management, in the Division of Central Services, Department of Personnel & Administration.

2.4. Taxability – The use of the State-assigned vehicle may be either taxable or non-taxable, depending on the facts and circumstances.

2.5. Technical Guidance – Technical guidance on the Taxability of State-assigned vehicles prepared by the Office of the State Controller and based on the Internal Revenue Code and its implementing regulations.

2.6. Transportation – See Fiscal Rule 5-1 (Travel).

3. **RULE:**

State Agencies and Institutions of Higher Education shall comply with Eligibility requirements for assigning State-owned vehicles. If a State employee does not meet the Eligibility requirements, the State Agency shall not assign a State-owned vehicle to that employee.

State Agencies shall comply with the Taxability of assignment of State-owned vehicles included in the Technical Guidance and the Internal Revenue Code and its implementing regulations.

State Agencies shall submit annual documentation of compliance with both Eligibility requirements and Taxability requirements for assignment of state-owned vehicles.

3.1. Eligibility for Assignment of State-owned vehicles

3.1.1. A State employee must meet all of the following conditions to be eligible for assignment of a State-owned vehicle:

3.1.1.1. Assignment of the vehicle is necessary to conduct official and legitimate State Business, and

3.1.1.2. Assignment of the vehicle satisfies at least one of the following requirements:

3.1.1.2.1. The vehicle meets the Internal Revenue Service definition of qualified nonpersonal use in 26 CFR 1.274-5(k), or

3.1.1.2.2. The assignment of the vehicle is the most cost-efficient

means of Transportation, as defined in this Fiscal Rule.

3.2. Responsibilities of State Agencies

3.2.1. A Chief Executive Officer or designee of a State Agency shall authorize the assignment of a State vehicle to a State employee of that State Agency.

3.2.2. Each State Agency shall maintain documentation of the assignment of the State vehicle, including the Chief Executive Officer's justification for authorizing the assignment of the vehicle.

3.2.3. Each year, on or before October 1, the Chief Executive Officer of a State Agency, or a designee of that individual, shall review each assignment of a vehicle to ensure the assignment complies with the Eligibility requirements in this Fiscal Rule, the Taxability requirements in the Technical Guidance, and the Internal Revenue Code and its implementing regulations. Each State Agency shall send this information to the Office of the State Controller and to State Fleet.

3.3. Responsibilities of the Department of Personnel and Administration (DPA)

3.3.1. The Office of the State Controller and State Fleet shall review the information submitted by the State Agencies and Institutions of Higher Education for the initial application and for subsequent annual renewals. The Office of the State Controller and State Fleet shall:

3.3.1.1. Verify that the assignment of the vehicles complies with the Eligibility requirements of State vehicles; and

3.3.1.2. Verify that the Taxability is in compliance with the Technical Guidance and the Internal Revenue Code and its implementing regulations.

3.3.2. If the verification process establishes that the assignment of a vehicle no longer complies with the Eligibility requirements of State vehicles, then DPA shall revoke the assignment of the vehicle.

3.4. Cost Analysis

3.4.1. State Fleet has developed a spreadsheet for State Agencies to evaluate whether use of State vehicles or the use of the employee's personal vehicle is the most cost efficient means of Transportation.

3.4.2. State Agencies shall submit this spreadsheet with the initial application and annual reviews to the Office of the State Controller and State Fleet.

3.5. Taxability of State-Assigned Vehicles

3.5.1. Any Elective Officer or State employee who is assigned a State-owned vehicle because it is the most cost-efficient means of Transportation receives a taxable fringe benefit and the State Agency shall include the value of this fringe benefit in the income of the Elective Officer or State employee.

3.5.2. The Technical Guidance the Office of the State Controller should be followed by all State Agencies, branches of government, and Institutions of Higher Education. Executive agencies shall follow policies on

State-Assigned Vehicles issued by State Fleet and the Office of the State Controller.

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Office of the Attorney General

Tracking number: 2018-00284

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Finance and Procurement

on 08/29/2018

1 CCR 101-1

STATE FISCAL RULES

The above-referenced rules were submitted to this office on 09/10/2018 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.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

September 17, 2018 12:19:53

Permanent Rules Adopted

Department

Department of Revenue

Agency

Division of Motor Vehicles

CCR number

1 CCR 204-10

Rule title

1 CCR 204-10 TITLE AND REGISTRATION SECTION 1 - eff 10/30/2018

Effective date

10/30/2018

DEPARTMENT OF REVENUE

Division of Motor Vehicles – Title and Registration Section

1 CCR 204-10

RULE 33. SPECIAL USE TRUCKS

Basis: The statutory bases for this rule are 42-1-102(108), 42-1-204, 42-3-306(5)(c) and 42-3-306(9)(d), (f), (g) & (h), C.R.S.

Purpose: This rule is promulgated to designate vehicles as a Special Use Truck for the purpose of vehicle registration.

1.0 Definitions

1.1 "Special Use Truck" means any motor vehicle that meets the definition of a truck under section 42-1-102(108), C.R.S., is designed and used for a special purpose and is designated as a Special Use Truck by the executive director of the Department.

2.0 Requirements

2.1 The following motor vehicle types, when designed and used for a special purpose, are designated as a Special Use Truck.

a. Motor vehicles as designated in sections 42-3-306(9)(d), (f), (g), and (h), C.R.S.

b. Roll-off trash trucks

c. Trucks used specifically to haul only recyclable materials

d. Roll-off trucks used specifically to haul only recyclable materials

e. Trucks used specifically to pump concrete, commercially known as "concrete pumpers"

f. Beverage canister and delivery trucks with roll-up sides

g. Mobile blood donation/collection vehicles

h. Mobile medical testing and screening vehicles

2.2 In addition to the taxes and fee required to register a motor vehicle, a Special Use Truck will pay the registration fees required in section 42-3-306(5)(c), C.R.S.

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Office of the Attorney General

Tracking number: 2018-00250

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Motor Vehicles

on 09/04/2018

1 CCR 204-10

TITLE AND REGISTRATION SECTION

The above-referenced rules were submitted to this office on 09/05/2018 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.

September 19, 2018 08:32:11

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Natural Resources

Agency

Colorado Parks and Wildlife (405 Series, Parks)

CCR number

2 CCR 405-1

Rule title

2 CCR 405-1 CHAPTER P-1 - PARKS AND OUTDOOR RECREATION LANDS 1 - eff 11/01/2018

Effective date

11/01/2018

FILING – 09/26/2018

FINAL REGULATIONS - CHAPTER P-1 - PARKS AND OUTDOOR RECREATION LANDS

ARTICLE I - GENERAL PROVISIONS APPLICABLE TO ALL PARKS AND OUTDOOR RECREATION LANDS AND WATERS

 # 100 - PARKS AND OUTDOOR RECREATION LANDS

COMMERCIAL USE

10. To use Parks and Outdoor Recreation Lands for a commercial purpose, except:

    a. Special resource use which shall be authorized by the Commission on a case-by-case basis at a public meeting of the Commission (i.e., mining, timber cutting, grazing, haying, and other similar uses.)

    b. Uses authorized pursuant to concession contracts issued in accordance with state procurement and fiscal rules; or

    c. Pursuant to a cooperative agreement with the Division. Commercial use which conflicts with area management plans will not be approved.

    d. For incidental commercial services that:
    (1) Are provided by a commercial entity that is providing services incidental to the public use and operation of a State Park. Such services include: renting of pack animals or their services to remove harvested animals; vehicle and vessel repair; locksmith and tow services; vessel launch, retrieval or recovery services; product deliver services; and ride sharing or taxi services;
    (2) The commercial entity does not solicit for business at, or use the name of, a State Park(s) for advertising;
    (3) The commercial entity maintains a separate place of business; and
    (4) The incidental commercial service is not one for which the provider is required by law to obtain a guide or outfitter license.
    (5) Incidental commercial services does not include commercial boat launch and load services at Navajo State Park.

PARK-SPECIFIC RESTRICTIONS

D. In addition to the general land and water regulations, the following restrictions shall also apply:

1. Arkansas Headwaters Recreation Area

a. Except in established campgrounds where toilet facilities are provided, all overnight campers must provide and use a portable toilet device capable of carrying human waste out of the Arkansas Headwaters Recreation Area. Contents of the portable toilet must be emptied in compliance with law and may not be deposited within the Arkansas Headwaters Recreation Area, unless at a facility specifically designated by the Arkansas Headwaters Recreation Area.

b. Building or tending fires is allowed pursuant to regulation # 100b.7., except at the Arkansas Headwaters Recreation Area fire containers must have at least a two inch rigid side. Fire containers must be elevated up off the ground.

c. Swimming is permitted in the Arkansas River from the confluence of the East Fork/Lake Fork of the Arkansas within the boundaries of the Arkansas Headwaters Recreation Area. All persons under the age of 13 swimming in the Arkansas River within the Arkansas Headwaters Recreation Area must wear a properly fitting U.S. Coast Guard approved wearable personal flotation device.
d. No motorboats shall be permitted on the Arkansas River from the confluence of the East Fork/Lake Fork of the Arkansas to the west end of Pueblo Reservoir.
e. Innertubes, air mattresses, and similar devices are permitted on the Arkansas River from the confluence of the East Fork/Lake Fork of the Arkansas within the boundaries of the Arkansas Headwaters Recreation Area. All occupants of these devices must wear a U.S. Coast Guard approved wearable personal flotation device.
f. During any hunting season all year, lawful methods of hunting may be used in areas not prohibiting such use.
g. Recreational gold mining within the Arkansas Headwaters Recreation Area is allowed, except where prohibited as indicated by posted signs.

2. Barr Lake State Park

a. No dogs or other pets shall be permitted in the wildlife refuge area.
b. Visitors shall be required to remain on designated trails and boardwalks in the wildlife refuge area.
c. No fishing or boating shall be permitted in the wildlife refuge area.
d. Visitors shall be required to remain on the designated trails on Barr Lake Dam.
e. No horses shall be permitted on the Barr Lake Dam.
f. Only hand-propelled craft, sailboats and boats with electric trolling motors or gasoline motors of 10 horsepower or less shall be permitted.
g. Only shotguns loaded with birdshot may be used for waterfowl hunting during the regular waterfowl hunting seasons, in the areas and at the times posted.
h. Shotguns loaded with birdshot may also be used for dove hunting in the areas and at the times posted.
i. All hunters must register prior to beginning hunting and check out at the conclusion of hunting, at the hunter registration area.

3. Boyd Lake State Park

a. During the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, only bows and arrows including crossbow and hand-held bow, unless otherwise restricted, and shotguns loaded with birdshot may be used for hunting during hunting seasons, and only in areas not posted as prohibiting such use.

4. Cameo Shooting and Education Complex

a. Public access is allowed only from sunrise to sunset, except as otherwise authorized by an approved Special Activity or Commercial Use Permit.
b. All fires may be prohibited, as posted, to comply with current burn restrictions.
c. Camping is prohibited, except when authorized by an approved Special Activity or Commercial Use Permit, and then only allowed in areas specifically designated on the permit.
d. Dogs are prohibited outside of vehicles, unless specifically authorized by an approved Special Activity or Commercial Use Permit, and then only allowed in areas specifically designated on the permit.
e. Hunting is prohibited, except in the area north of, and no closer than 100 yards of, the Coal Canyon Main Canyon Divide.
f. All persons must adhere to range safety rules, as posted.

g. Alcoholic beverages are prohibited, unless specifically authorized by an approved Special Activity or Commercial Use Permit, and then only allowed in areas specifically designated on the permit.
h. The possession of marijuana is prohibited.
i. Biking is allowed in designated areas only, as posted.

5. Castlewood Canyon State Park

a. No dogs or other pets shall be permitted in the East Canyon area.
b. No horses shall be permitted in the east canyon area.
c. It shall be unlawful to climb, traverse, or rappel, on or from rock formations in the East Canyon area.
d. Visitors shall be required to remain on the designated trails in the East Canyon area.

6. Chatfield State Park

a. Entrance to and exit from the dog off leash areas are permitted only at designated access points.
b. A handler may bring a maximum of three dogs at one time into the designated dog off leash area.
c. Handlers must possess a leash and at least one waste bag for each dog in the designated dog off leash area.
d. Sport dog trainers shall obtain a special use permit to access and use the designated upland and flat-water sport dog training areas.
e. Handlers in the dog off leash area and the sport dog training areas must have a visible and valid dog off leash annual pass or dog off leash daily pass.
f. Fishing is prohibited on the ponds within the dog off leash area.
g. Only pistols or other mechanisms incapable of discharging live ammunition may be used at the dog training area.
h. A valid permit is required to launch or land any hot-air balloon.
i. Only float tubes or craft propelled by hand shall be permitted on the ponds within the park, excluding the main reservoir.

7. Cherry Creek State Park

a. Entrance to and exit from the dog off leash areas is permitted only at designated access points.
b. A handler may bring a maximum of three dogs at one time into the designated dog off leash area.
c. Handlers must possess a leash and at least one waste bag for each dog in the designated dog off leash area.
d. Sport dog trainers shall obtain a special use permit to access and use the designated upland sport dog training area.
e. Handlers in the dog off leash area and the sport dog training area must have a visible and valid dog off leash annual pass or dog off leash daily pass.
f. Use of shotgun shells on the trap/skeet range with shot size larger than size 7 is prohibited.
g. Only pistols or other mechanisms incapable of discharging live ammunition may be used at the dog training area.

8. Cheyenne Mountain State Park

a. Dogs and other pets shall be prohibited except leashed dogs and pets shall be permitted in the developed areas of the park and on the following select trails only: Acorn Alley, Bobcat Way, Raccoon Ridge, and that portion of Soaring Kestral west of the eastern most intersection with Bobcat Way. All visitors that have dogs or other pets on the select trails must have in their possession at least one waste bag per animal.

b. Smoking shall be limited to developed areas only and shall not be permitted in the backcountry, or on the archery range, parking lot or trail system.
c. Hunting shall be prohibited.
d. It shall be unlawful to climb, traverse or rappel on or from rock formations.
e. Any person 17 years of age or older who is shooting on the field/3D portion of the archery range must obtain and maintain on one's person a proper and valid daily or annual Cheyenne Mountain Park archery range individual permit.
f. Public access is prohibited on the archery range from sunset to sunrise.
g. Any person 16 years of age or younger entering the archery range must be under adult supervision at all times.
h. Broadheads, crossbows, alcoholic beverages, and firearms, including, but not limited to, BB guns, pellet guns, and air rifles, are prohibited on the archery range.
i. No dogs or other pets shall be permitted on the archery range.

9. Crawford State Park

a. During any hunting season all year, lawful methods of hunting may be used in areas not prohibiting such use.

10. Eldorado Canyon State Park

a. The use of all portable grills and stoves (including, but not limited to, charcoal, gas, and wood) is prohibited outside of designated high-use pads.
b. During the period beginning the Tuesday after Labor Day and continuing through March 31, only hand-held bows and shotguns loaded with birdshot may be used for hunting during hunting seasons in the western portion of the parks known as crescent meadows.
c. During the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, only primitive weapons (hand-held bow and muzzle-loading rifles) may be used to hunt big game animals in the western portion of Eldorado Canyon State Park known as Crescent Meadows.

11. Eleven Mile State Recreation Area

a. It shall be unlawful, except by law enforcement officers on official duty, to operate or park snowmobiles on land or on the frozen water surface of the reservoir, unless otherwise posted at the park entrances.
b. It shall be unlawful to operate or occupy boats on the surface of the reservoir from one-half hour after sunset until one-half hour before sunrise.
c. It shall be unlawful to enter upon, use or occupy the islands on the reservoir.
d. It shall be unlawful to enter, use or occupy the lands or waters of Eleven Mile State Recreation Area lying to the east of the restrictive buoy line.
e. Water skiing is prohibited on Eleven Mile Reservoir.
f. During any hunting season all year, lawful methods of hunting may be used in areas not prohibiting such use.

12. Golden Gate Canyon

a. No boats, rafts or other floating devices of any kind shall be permitted on lakes within Golden Gate Canyon State Park, except as part of an organized class in canoeing sponsored by the Division.

b. In Jefferson County, excluding the 160-acre parcel known as the Vigil Ranch and the posted strip of land along Gilpin County Road 2: During deer and elk seasons, any lawful method of hunting may be used for hunting such big game; and beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, any lawful method of hunting may be used during hunting seasons for small game, in areas not posted as prohibiting such use or uses. Provided further that hunters must visit the designated check station to check in prior to hunting and check out after hunting.

c. During deer and elk seasons that are in the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, any lawful method of hunting deer and elk may be used in areas not posted as prohibiting such use in that portion of Golden Gate Canyon State Park located in Gilpin County, otherwise known as the Green Ranch. Only hunters selected through a special drawing prior to the beginning of big game seasons are permitted to hunt the Green Ranch portion of Golden Gate Canyon State Park.

13. Harvey Gap State Recreation Area

a. No dogs or other pets shall be permitted except when used for hunting during the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day.

b. Only hand-propelled craft, sailboats and boats with electric trolling motors or gasoline motors of 20 horsepower or less shall be permitted on Harvey Gap Reservoir.

c. Water skiing is prohibited on Harvey Gap Reservoir.

d. During the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, only bows and arrows including crossbow and hand-held bow, unless otherwise restricted, and shotguns loaded with birdshot may be used for hunting during hunting seasons, and only in areas not posted as prohibiting such use.

14. Highline Canal State Trail

a. No swimming, tubing or rafting shall be permitted.

b. No fires shall be permitted.

15. Highline Lake State Park

a. Only hand-propelled craft, sailboats and boats with electric motors shall be permitted on Mack Mesa Reservoir.

b. Boats shall be prohibited on Highline Lake from the first day in October through the last day in February, except that hand-propelled craft may be used to set out and pick up decoys and retrieve downed waterfowl in the area open to hunting.

c. Only shotguns loaded with birdshot may be used for waterfowl hunting during the regular waterfowl hunting seasons, in the areas and at the times posted.

d. Small game hunting is also allowed at Highline Lake State Park, using only shotguns, in the areas and at the times posted.

e. All hunters must register prior to beginning hunting and check out at the conclusion of hunting, at the hunter registration area.

16. Jackson Lake State Park

a. During the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, only bows and arrows including crossbow and hand-held bow, unless otherwise restricted, and shotguns loaded with birdshot may be used for hunting during hunting seasons, and only in areas not posted as prohibiting such use.

17. James M. Robb - Colorado River State Park

a. Colorado River Wildlife Area

(1) In accordance with applicable management plans, no dogs or other pets shall be permitted, except on designated trails.
(2) No fires shall be permitted.
(3) No swimming shall be permitted.
(4) In accordance with applicable management plans, public access is restricted to designated roads and trails from March 15 to May 30 of each year.
(5) No boats, rafts or other floating devices of any kind shall be permitted on lakes.

b. Fruita, Connected Lakes, Corn Lake and Island Acres Sections

(1) Except for the swim area at Island Acres, only hand-propelled craft, sailboats and boats with electric motors shall be permitted.
(2) Only shotguns loaded with birdshot may be used for waterfowl hunting during the regular waterfowl hunting seasons, in the areas and at the times posted. All hunters must hunt from designated blinds and hunters with reservations take priority.
(3) Hunting is prohibited in Fruita and Connected Lakes sections.

c. 34 Road Parcel

(1) No public access except for waterfowl hunting on weekends during designated waterfowl hunting seasons.
(2) Only shotguns loaded with birdshot may be used for waterfowl hunting during the regular waterfowl hunting seasons, in the areas and at the times posted. Waterfowl hunters must have a valid reservation to hunt the 34 Road blind.
(3) Hunters may hunt from designated blinds only.
(4) All other use of this property is prohibited.

d. Pear Park Section

(1) No boats, rafts or other floating devices of any kind shall be permitted on lakes between 30 Road and 29 Road.
(2) Only shotguns loaded with birdshot may be used for waterfowl hunting during the regular waterfowl hunting seasons, in the areas and at the times posted. All hunters must hunt from designated blinds and hunters with reservations take priority.

18. John Martin Reservoir State Recreation Area

a. No public access shall be permitted on the north shore area of John Martin Reservoir State Recreation Area from the first day of November through March 15 of every year or as posted except to retrieve downed waterfowl.
b. Only hand-propelled craft, sailboats and boats with electric motors shall be permitted on Lake Hasty.
c. No unauthorized boats, rafts, or other floating devices of any kind shall be permitted on the waters below John Martin Dam to the Arkansas River bridge.
d. No public access shall be permitted east of the waterfowl closure line to the dam from the first day of November through March 15 of every year or as posted except to retrieve downed waterfowl.

19. Lake Pueblo State Park

a. 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.
b. Innertubes, air mattresses and similar devices are permitted, below the dam on that part of the Arkansas River within the boundaries of Pueblo State Recreation Area. All occupants of these devices must wear a U.S. Coast Guard approved wearable personal flotation device.

c. During the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, only bows and arrows including crossbow and hand-held bow, unless otherwise restricted, and shotguns loaded with birdshot may be used for hunting during hunting seasons, and only in areas not posted as prohibiting such use.

20. Lathrop State Park

a. Boats shall be prohibited on Horseshoe Reservoir from the first Monday in November through the last day of migratory waterfowl seasons, except as posted and except that hand-propelled craft may be used to set out and pick up decoys and retrieve downed waterfowl on the areas of such lakes open to hunting of migratory waterfowl.

b. Water skiing is prohibited on Horseshoe Reservoir.

c. During the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, only bows and arrows including crossbow and hand-held bow, unless otherwise restricted, and shotguns loaded with birdshot may be used for hunting during hunting seasons west from a north-south line corresponding with the existing barbed-wire fence between Horseshoe Lake and Martin Lake.

21. Lone Mesa State Park

a. During any authorized big game hunting season, any lawful method of hunting deer, elk, and bear may be used in areas not posted as prohibiting such use in Lone Mesa State Park. Only hunters who possess a valid Lone Mesa State Park hunting permit are permitted to hunt.

22. Lory State Park

a. During deer and elk seasons, any lawful method of hunting may be used for hunting such big game; and beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, any lawful method of hunting may be used during hunting seasons for small game, in areas not posted as prohibiting such use or uses; except that hunting is not permitted on Saturdays and Sundays.

b. During the spring turkey hunt at Lory State Park, it shall be permitted to hunt turkey by legal methods on Mondays and Tuesdays only. All other days of the week shall be closed to spring turkey hunting.

23. Mancos State Park

a. Only hand-propelled craft, sailboats, boats with electric trolling motors and boats with gasoline motors operated at a wakeless speed shall be permitted on Mancos Reservoir.

b. Water skiing is prohibited on Mancos Reservoir.

24. Mueller State Park

a. No dogs or other pets shall be permitted outside of the developed facilities area.

b. It shall be unlawful, except by law enforcement officers on official duty, to operate snowmobiles and off-highway vehicles.

c. No boats, rafts or other floating devices of any kind shall be permitted on lakes within Mueller State Park.

d. During the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, any lawful method of controlled hunting may be used, during hunting seasons, in areas not prohibiting such use on Mueller State Park. Hunters may access the posted hunting area only from Trail 5 at the Visitor Center, Trail 11 at the Livery parking lot or Lost Pond Picnic Area and Trail 13 at

the group campground. All weapons must be completely unloaded when the hunter is outside the posted hunting area boundary.

25. Navajo State Park

a. During any hunting season all year, lawful methods of hunting may be used in areas not prohibiting such use.

26. North Sterling State Park

a. Boats shall be prohibited on North Sterling Reservoir from the first Monday in November through the last day of migratory waterfowl seasons, except as posted and except that hand-propelled craft may be used to set out and pick up decoys and retrieve downed waterfowl on the areas of such lakes open to hunting of migratory waterfowl.

b. During the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, only bows and arrows and shotguns loaded with birdshot may be used for hunting in areas not prohibiting such use on North Sterling State Park, except as follows:
   (i) Hunting is prohibited from the dam, and
   (ii) Hunting is prohibited from the frozen surface of the lake.

27. Paonia State Park

a. During any hunting season all year, lawful methods of hunting may be used in areas not prohibiting such use.

28. Pearl Lake State Park

a. Only hand-propelled craft, sailboats, boats with electric trolling motors and boats with gasoline motors operated at a wakeless speed shall be permitted.

b. Water skiing is prohibited on Pearl Lake.

c. During deer and elk seasons, any lawful method of hunting may be used for hunting such big game; and beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, any lawful method of hunting may be used during hunting seasons for small game, in areas not posted as prohibiting such use or uses.

29. Ridgway State Park

a. No boats, rafts, or other floating devices shall be permitted on any waters within the Pa-Co-Chu-Puk Recreation Site, below Ridgway Dam.

b. On all areas of the park east of Highway 550: during deer and elk seasons, any lawful method of hunting may be used for hunting such big game; and, during the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, any lawful method of hunting may be used during hunting seasons for small game, in areas not posted as prohibiting such use or uses.

c. During any authorized hunting season from October 1 to April 30 of each year, and any approved special season, any lawful method of hunting may be used on all lands at Ridgway State Park open to public access west of Ridgway Reservoir, except that the area bounded by Dallas Creek on the south and the site closure signs on the north shall be closed to all hunting.

d. During any authorized waterfowl hunting season from October 1 to April 30 of each year, and any approved special season, waterfowl hunting shall be permitted within the Dallas Creek Recreation Site at Ridgway State Park; except that hunting shall be prohibited between the park road and U.S. Highway 550 and in other areas posted as prohibiting such use.

e. During approved special seasons, any lawful method of hunting may be used in the following areas (or special hunting zones) as defined:

(i) (Zone 1) Elk Ridge Mesa, including the closed Elk Ridge Campground, and

(ii) (Zone 2) That area bounded by a distance of 100 yards south of park headquarters, on the north; Ridgway Reservoir on the west; ¼ mile from Colorado Highway 550 on the south; and ¼ mile from the main park road on the east and,

(iii) That area bounded by Ridgway reservoir's main cove on the north; ¼ mile from the Elk Ridge road on the west; the intersection of the Elk Ridge and main park roads on the south; and ¼ mile from the main park road on the east at Ridgway State Park and,

(iv) The Pa-Co-Chu-Puk Recreation site at Ridgway State Park.

30. Rifle Falls State Park

a. It shall be unlawful to climb, traverse, or rappel on or from rock formations.

31. Rifle Gap State Park

a. During any hunting season all year, lawful methods of hunting may be used in areas not prohibiting such use.

32. Roxborough State Park

a. No dogs or other pets shall be permitted.
b. No fires shall be permitted.
c. It shall be unlawful to climb, traverse or rappel on or from rock formations.

33. Saint Vrain State Park

a. Only hand-propelled craft, sailboats and boats with electric motors shall be permitted, except on Blue Heron Reservoir.
b. Only hand or trailer launched vessels with electric or gasoline motors of 10 horsepower or less, operated at a wakeless speed shall be permitted on Blue Heron Reservoir.

34. Spinney Mountain State Recreation Area

a. It shall be unlawful, except by law enforcement officers on official duty, to operate or park snowmobiles on land or on the frozen water surface of the reservoir, unless otherwise posted at the park entrances.
b. It shall be unlawful to operate or occupy boats on the surface of the reservoir from one-half hour after sunset until one-half hour before sunrise.
c. It shall be unlawful to enter upon, use or occupy the islands on the reservoir.
d. It shall be unlawful to enter, use or occupy the lands or waters of Spinney Mountain State Recreation Area between November 16 and April 30, unless the reservoir is ice-free and the area is otherwise posted as open for public use.
e. It shall be unlawful to enter, use or occupy the lands or waters of Spinney Mountain State Recreation Area between the hours of one hour after sunset and one-half hour before sunrise, or as otherwise posted.
f. Water skiing is prohibited on Spinney Mountain Reservoir.
g. During any hunting season all year, lawful methods of hunting may be used in areas not prohibiting such use.

35. Stagecoach State Park

a. During the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, only bows and arrows including crossbow and hand-held bow, unless otherwise restricted, and shotguns loaded with birdshot may be used for hunting during hunting seasons on the western half of the reservoir.

36. State Forest State Park

a. No boats, rafts or other floating devices of any kind shall be permitted on lakes within The State Forest, except that wakeless boating shall be allowed on North Michigan Reservoir.
b. Only hand-propelled craft, sailboats, boats with electric trolling motors and boats with gasoline motors operated at a wakeless speed shall be permitted on North Michigan Reservoir.
c. Water skiing is prohibited on North Michigan Reservoir.
d. During any hunting season all year, lawful methods of hunting may be used in areas not prohibiting such use.

37. Staunton State Park

a. No boats, rafts or other floating devices of any kind shall be permitted on lakes within the park.

38. Steamboat Lake State Park

a. During deer and elk seasons, any lawful method of hunting may be used for hunting such big game; and from the Tuesday after Labor Day through the Friday prior to Memorial Day, any lawful method of hunting may be used during hunting seasons for small game, in areas not posted as prohibiting such use or uses.

39. Sweitzer Lake State Park

a. During the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, only bows and arrows including crossbow and hand-held bow, unless otherwise restricted, and shotguns loaded with birdshot may be used for hunting during hunting seasons, and only in areas not posted as prohibiting such use.

40. Sylvan Lake State Park

a. Only hand-propelled craft, sailboats and boats with electric motors shall be permitted.
b. Water skiing is prohibited on Sylvan Lake.
c. During any hunting season all year, lawful methods of hunting may be used in areas not prohibiting such use.

41. Trinidad Lake State Park, Archery Range

a. Dogs or other pets are prohibited.
b. Smoking is prohibited.
c. Broadheads, crossbows, and firearms, including, but not limited to, BB guns, pellet guns, and air rifles are prohibited.
d. Alcoholic beverages are prohibited.
e. Any person 16 years of age or younger, must be under the direct supervision of an adult at all times.
f. Public access is prohibited between sunset and sunrise.
g. During the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, only bows and arrows including crossbow and hand-held bow, unless otherwise restricted, and shotguns loaded with birdshot may be used for hunting during hunting seasons, and only in areas not posted as prohibiting such use.

42. Vega State Park

a. During the period beginning the Tuesday after Labor Day and continuing through the Friday prior to Memorial Day, only bows and arrows including crossbow and hand-held bow, unless otherwise restricted, and shotguns loaded with birdshot

may be used for hunting during hunting seasons, and only in areas not posted as prohibiting such use.

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Tracking number: 2018-00359

Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado Parks and Wildlife (405 Series, Parks)

on 09/06/2018

2 CCR 405-1

CHAPTER P-1 - PARKS AND OUTDOOR RECREATION LANDS

The above-referenced rules were submitted to this office on 09/13/2018 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.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

September 25, 2018 09:02:41

Permanent Rules Adopted

Department

Department of Natural Resources

Agency

Colorado Parks and Wildlife (405 Series, Parks)

CCR number

2 CCR 405-5

Rule title

2 CCR 405-5 CHAPTER P-5 - OFF-HIGHWAY VEHICLE REGULATIONS 1 - eff 11/01/2018

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11/01/2018

FILING – 09/26/2018

FINAL REGULATIONS - CHAPTER P-5 - OFF-HIGHWAY VEHICLE REGULATIONS

ARTICLE I - Pursuant to the authority vested in the Parks and Wildlife Commission by Article 14.5 of Title 33, C.R.S., the following regulations concerning required equipment, off-highway use permits, and the registration of off-highway vehicles are hereby adopted:

 # 500 - Registration information required on the application:

a. Information to be furnished by the applicant:

1. Vehicle make

2. Vehicle model

3. Vehicle identification number

4. Model year

5. Cubic centimeters displacement

6. Date purchased

7. Proof of ownership. Acceptable proof of ownership forms include:

(a) Bill of sale that includes both the seller and buyer's printed names and signatures, the vessel/vehicle identification number (if any), the vessel/vehicle make, model and year (if known), and the date of the sale;

(b) Previous registration certificate issued by a governmental entity that lists the applicant as registered owner;

(c) Manufacturers Certificate of Origin (MCO)/Manufacturer Statement of Origin (MSO);

(d) Certificate of Title;

(e) Any court issued document proving ownership;

(f) A collection of personal property by affidavit form pursuant to 15-12-1201, C.R.S.; or

(g) A physical inspection form completed by a CPW agent.

8. Name and address of applicant

9. Date of birth

10. How the machine is used

b. Additional information set forth on the registration certificate:

1. Registration number

2. Expiration date of registration

3. Notice to owner of procedure to follow when owner changes address

4. Notice to owner of procedure to follow when the machine is transferred, destroyed, abandoned or permanently removed from the state

5. Notice to owner that the operator must carry the certificate of registration while operating the off-highway vehicle

c. Pending registration of an off-highway vehicle, a temporary registration or a dated bill of sale, in the possession of the operator, permits the operator of the newly purchased off-highway vehicle to operate in the State of Colorado for a period not to exceed thirty (30) days from the date of purchase.

 # 501 - Display of validation decals

a. Validation decals shall be permanently affixed in a location on the upper forward half of the off-highway vehicle to assure good visibility of the decals.

b. Dealers and manufacturers may display validation decals on a detachable plate.

c. Prior to issuing validation decals, the distinctive registration number assigned by the Division shall be permanently marked upon the validation decal.

 # 502 - Display of Off-Highway Use Permits

A. When owners or operators of vehicles identified in C.R.S. 33-14.5-112 are required to obtain and display off-highway use permits, such permits shall be displayed as follows:

1. For motorcycles and three wheelers: permanently affixed to the outside face of the upper end of the left fork.

2. For all-terrain vehicles (ATVs): permanently affixed to the upper left fender in an observable location.

3. For side-by-sides and utility terrain vehicles (UTVs): permanently affixed to the outside face of left roll bar in an observable location.

4. For plated, full size vehicles: permanently affixed to the front bumper left side of the license plate.

5. Printed non-sticker permits must be carried in the vehicle or on the operator’s person and shall, upon demand of any peace officer authorized to enforce this law, produce the off-highway use permit for inspection.

 # 503 - Safety Equipment

A. Except as provided in section 33-14.5-109 C.R.S., no person shall operate an off-highway vehicle upon public land in this state unless:

1. The off-highway vehicle is equipped with a muffler that is properly maintained and in good working order.

2. The muffler must conform to noise abatement standards set forth in 25-12-110, C.R.S. as amended.

B. Except as provided in section 33-14.5-109 C.R.S., no person shall operate an off-highway vehicle upon public land in this state unless the off-highway vehicle is equipped with a spark arrester in good working order which has been approved by the U.S. Forest Service as evidenced by the bona fide permanent marking of “qualified” or “approved” on the spark arrester. A spark arrester is a device which traps or pulverizes exhaust particles as they are expelled from an internal combustion engine exhaust system and is effective in reducing exhaust sparks and protecting against exhaust spark fires.

C. No off-highway vehicle shall be operated upon public land in this state between the hours of sunset and sunrise unless it is equipped with at least one headlamp having minimum candlepower of sufficient intensity to reveal persons or objects at a distance of at least 100 feet ahead under normal atmospheric conditions. Such headlamp shall be aimed so that glaring rays are not projected into the eyes of operators in oncoming vehicles when operated on a straight level surface.

D. No off-highway vehicle shall be operated upon public land in this state between the hours of sunset and sunrise unless it is equipped with at least one red tail lamp having a minimum candlepower of sufficient intensity to exhibit a red light plainly visible from a distance of 500 feet to the rear under normal atmospheric conditions.

E. Except as provided in section 33-14.5-109 C.R.S., no person shall operate any off-highway vehicle upon public land in this state unless the off-highway vehicle is equipped with a braking system that may be operated by hand or foot, capable of producing deceleration of 14 feet per second on level ground at a speed of 20 miles per hour. The braking system must be adequate to control the movement of, and to stop and to hold the off-highway vehicle stationary on any grade upon which operated.

 # 504 - Operation of Off-Highway Vehicles

A. Where the State, the United States, or any agency thereof, has designated any public street, road, or highway of this state open to off-highway vehicles or where local political subdivisions have authorized by ordinance or resolution the establishment of off-highway vehicle routes to permit the operation of off-highway vehicles on city streets or county roads pursuant to the authority granted in C.R.S. 33-14.5-108(1), or upon public land in this state, no person shall operate an off-highway vehicle while carrying any person riding in any position that will interfere with the operation or control of an off-highway vehicle or the view of the operator.

B. Where the State, the United States, or any agency thereof, has designated any public street, road, or highway of this state open to off-highway vehicles or where local political subdivisions have authorized by ordinance or resolution the establishment of off-highway vehicle routes to permit the operation of off-highway vehicles on city streets or county roads pursuant to the authority granted in C.R.S. 33-14.5-108(1), no person under the age of ten years may operate an off-highway vehicle on such public street, road, or highway of this state or on such city street or county road. No person ten years of age or older may operate an off-highway vehicle on such public street, road, or highway of this state or on such city street or county road unless:

1. The person has in his possession a valid driver's license issued by the State of Colorado or another state; or

2. The person is accompanied by and under the immediate supervision of a person who has in his possession a valid driver's license issued by the State of Colorado or another state.

The phrase “under immediate supervision” shall mean that, at a minimum, the unlicensed operator is within direct visual contact of the licensed supervisor.

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Office of the Attorney General

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on 09/06/2018

2 CCR 405-5

CHAPTER P-5 - OFF-HIGHWAY VEHICLE REGULATIONS

The above-referenced rules were submitted to this office on 09/13/2018 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.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

September 25, 2018 09:03:06

Permanent Rules Adopted

Department

Department of Natural Resources

Agency

Colorado Parks and Wildlife (405 Series, Parks)

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2 CCR 405-7

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2 CCR 405-7 CHAPTER P-7 - PASSES, PERMITS AND REGISTRATIONS 1 - eff 11/01/2018

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FINAL REGULATIONS - CHAPTER P-7 - PASSES, PERMITS AND REGISTRATIONS

ARTICLE I - GENERAL PROVISIONS AND FEES RELATING TO PASSES, PERMITS AND REGISTRATIONS

SPECIAL ACTIVITIES

 # 703 - SPECIAL ACTIVITIES REQUIRING PERMITS

1. “Special activities” means those noncommercial events which have the potential for an adverse impact on park values or health, safety or welfare of park visitors or which may otherwise require special planning/scheduling for proper management. Special activities shall require prior approval in the form of a special-activities permit. Applications thereof generally shall be made to the Park Manager or Operational Manager at least ninety (90) days prior to the event. Such application must be accompanied by the appropriate application filing fee. This requirement for an application to be filed ninety days prior to an event will be waived in rare circumstances where arrangements can be made in a shorter time without putting undue administrative burden on the Park Manager or Operational Manager, or when no special arrangements are necessary.

2. The decision of whether to approve special activity permits will be made by the Park Manager or Operational Manager when it is determined that the special activities will not involve the use of a park or recreation area by a group of persons totaling more than the park or recreation area's established carrying capacity. Otherwise, the Regional Manager shall make the decision of whether to approve the permits. The decision of whether to approve special activities permits will be based on the impact on park values and/or the health, safety and welfare of park visitors and other affected persons, and also will be based on:

    a. The nature of the park or recreation area and the types of recreational opportunities/resources it is intended to provide the public

    b. The carrying capacity of the facility or facilities to be utilized during the special activity compared to:

        (1) The total number of park visitors (including participants and spectators in the special activity) expected to utilize such facilities; and

        (2) The total number of vehicles, vessels or persons expected to participate in or be attracted to such activities.

    c. The extent to which the special activity will contribute to the variety of outdoor recreational opportunities available to the people of this state and its visitors.

    d. The extent to which the activity places an administrative burden on the staff of the park area.

3. Whenever it is determined that any special activity will involve the use of a park or recreation area by a group of persons totaling more than the park's or recreation area's established carrying capacity a thirty day written public comment period and a public meeting shall be required prior to the granting of a permit. The Park Manager or Operational Manager shall publish notice of both the written comment period and the meeting at least once in a newspaper of general circulation in the county or counties wherein said park or recreation area is located. The meeting shall be

conducted by the Division representative responsible for the permit issuance decision and shall be held either at the park or recreation area, or within a county in which the park or recreation area is located. Such public meeting is not intended to be an adjudicatory licensing hearing under the provisions of the Colorado Administrative Procedures Act, but only as an opportunity for public comment.

4. An application for a permit shall be acted upon promptly, and the applicant shall be notified immediately after the taking of action on the application. If the application is denied, the applicant shall be notified in writing within five working days of such action. Such written notification shall include the basis for the denial. The applicant may submit a written appeal of a denial to the Division Director within sixty days of receipt of the denial, requesting a hearing pursuant to section 24-4-104(9), C.R.S., If the date of the proposed special activity is to occur within the sixty day appeal period, then the applicant shall submit any written appeal as soon as practicable so as to allow a reasonable time for the Director to act upon the appeal. Absent special circumstances justifying a later submittal and depending upon the nature of the proposed special activity and the amount of preparation required on the part of the Division for such activity, generally an appeal submitted less than twenty-five days prior to the proposed special activity will be deemed untimely.

5. Upon written request, the Division shall waive the requirement for a parks pass for those vehicles when all the occupants are entering state recreation areas and state parks for the purpose of administering permitted special activities and not for the purpose of their own recreation.

6. For special activities where the Division representative responsible for the permit issuance decision determines it will be a greater administrative ease for the Division to administer the activity, an alternative fee of $2.00 per person per day may be charged for admission of persons attending or participating in the special activity. This permission shall apply only to groups of twenty or more persons.

7. Nothing in this regulation impairs the specific authority of the Commission pursuant to 33-10-107(1)(d) C.R.S. to enter into cooperative agreements for the development and promotion of Division programs, or the general authority of the Commission pursuant to 33-10-106 C.R.S. to manage all state recreation areas and state parks for both commercial and noncommercial purposes. The authority granted to park managers and regional managers is intended to allow them to address events of limited and local impact, and is specifically intended to coexist with, and not to exclude, the Commission's statutory authorities.

 # 708 - PASS AND PERMIT FEE SCHEDULE

1. The fees for the types of vehicle passes issued by the Division are as follows.

   a. Aspen leaf annual pass.....$60.00

   b. Annual vehicle pass.....$70.00

   c. (1) Each additional annual vehicle pass for noncommercial vehicles……...$35.00

      (2) Each additional Aspen Leaf vehicle pass for noncommercial vehicles.....$30.00

   d. Each replacement annual vehicle pass…….$5.00

   e. Each daily vehicle pass (exceptions follow)…….$7.00

(1) At Cherry Creek, Chatfield, and Boyd Lake State Recreation Areas, and Eldorado Canyon State Park.....$8.00

f. Each daily vehicle pass for a passenger van or bus operated by a commercial business:

(1) carrying up to fifteen passengers…….....$10.00

(2) carrying sixteen to thirty passengers……..…....$40.00

(3) carrying more than thirty passengers……..…....$50.00

2. The fees for the types of individual passes issued by the Division are as follows. Eligibility requirements are stated in regulation # 701.

a. Columbine or Centennial annual pass……..$14.00

b. Each replacement Columbine or Centennial annual pass…….$5.00

c. Individual daily passes (applies to persons sixteen years of age or older) for Eldorado Canyon, Colorado State Forest, Lory State Parks and Arkansas Headwaters Recreation Area.....$3.00

3. The fees associated with special activities, as provided for in regulation # 703 are:

a. Special activity alternate individual fee (applies to groups of twenty or more people in size).....$2.00

b. Special activity application filing fee.....$20.00

4. The fees for the type of campground-use permits issued by the Division are as follows. Campground classes are defined in regulation # 704.

a. Campground-use permit for "Full Hookup Campgrounds" ……..…….$28.00/night

b. Campground-use permit for "Electrical Campgrounds" ……..…….$24.00/night

c Campground-use permit for "Basic Campgrounds" ……..…….$18.00/night

d. Campground-use permit for "Primitive Campgrounds" ……..……..$10.00/night

e. From May 1 through September 30 at Chatfield, Cherry Creek, Cheyenne Mountain, Golden Gate, Highline, Mueller, Pearl Lake, Rifle Falls, Ridgway, St. Vrain, Steamboat and Sylvan Lake the camping fees shall be:

(1) Campground-use permit for "full hookup campgrounds" …….....$30.00/night

(2) Campground-use permit for "electrical campgrounds" ……..$26.00/night

(3) Campground-use permit for "basic campgrounds" ……..$20.00/night

(4) Campground-use permit for "primitive campgrounds" ……..$12.00/night

5. The fees for reduced rate Aspen Leaf and senior Columbine, Centennial or Volunteer park pass campground-use permits issued by the Division are as follows. Eligibility requirements are stated

in regulation # 701, # 705 and # 712. Reduced rates are offered all days of the year when the campground is open, except weekends and holidays.

a. Campground-use permit for "Full Hookup Campgrounds" ……..…….$25.00/night

b. Campground-use permit for "Electrical Campgrounds" ……..……..$21.00/night

c. Campground-use permit for "Basic Campgrounds" ……...….$15.00/night

d. Campground-use permit for "Primitive Campgrounds" ……..…….$7.00/night

e. From May 1 through September 30 at Chatfield, Cherry Creek, Cheyenne Mountain, Golden Gate, Highline, Mueller, Pearl Lake, Rifle Falls, Ridgway, St. Vrain, Steamboat and Sylvan Lake the camping fees for reduced rate Aspen Leaf and senior volunteer pass campground-use permits shall be:

(1) Campground-use permit for "full hookup campgrounds" ……..$27.00/night

(2) Campground-use permit for "electrical campgrounds" ……..$23.00/night

(3) Campground-use permit for "basic campgrounds" ……...$17.00/night

(4) Campground-use permit for "primitive campgrounds" ….……..….$9.00/night

6. The fees for types of campground-use areas are as follows. Campground classes are defined in regulation # 704.

a. In group camp areas of “Full Hookup Campgrounds,” the fee shall be $28.00 per night per campsite assigned to such group area.

b. In group camp areas of “Electrical Campgrounds,” the fee shall be $24.00 per night per campsite assigned to such group area.

c. In group camp areas of “Basic Campgrounds,” the fee shall be $18.00 per night per campsite assigned to such group area.

d. In group camp areas of “Primitive Campgrounds,” the fee shall be $10.00 per night per campsite assigned to such group area.

e. In group camp areas from May 1 through September 30 at Chatfield, Cherry Creek, Cheyenne Mountain, Golden Gate, Highline, Mueller, Pearl Lake, Rifle Falls, Ridgway, St. Vrain, Steamboat and Sylvan Lake the camping fees shall be:

(1) Campground-use permit for “Full Hookup Campgrounds” …...$30.00/night

(2) Campground-use permit for “Electrical Campgrounds” ……...$26.00/night

(3) Campground-use permit for “Basic Campgrounds” ……..$20.00/night

(4) Campground-use permit for “Primitive Campgrounds”.…….....$12.00/night

7. The fees for types of cabins and yurts are as follows:

a. For small cabins and yurts that may accommodate a maximum of six people:

(1) Standard……..…….$80.00/night

(2) Premium……..……..……$110.00/night

b. For large cabins and yurts that may accommodate seven or more people:

(1) Standard……..…….....$110.00/night

(2) Premium two bedroom.....$140.00/night

(3) Premium three bedroom…….....$180.00/night

(4) Premium four bedroom…….……$240.00/night

(5) Each additional premium bedroom over four bedrooms……...$60.00/night

c. For Mueller State Park Cabins and Harmsen Ranch at Golden Gate Canyon State Park:

(1) Premium two bedroom……$150.00/night

(2) Premium three bedroom.……$210.00/night

(3) Premium four bedroom.……..$270.00/night

d. The maximum occupancy shall be posted in each cabin and yurt.

e. There shall be an additional fee of $10.00/night for pets where pets are allowed. For barn and corral facilities, there shall be a boarding fee of $10.00/animal/night.

f. Premium facilities contain showers and flush toilets.

8. The fees associated with the reservation system for phone or internet sales are as follows:

a. Campsite, cabin and yurt reservation fee…….$10.00/campsite, cabin or yurt

b. Each reservation change or cancellation…….$6.00/each

(1) For cancellations made fourteen days or more prior to the beginning date of the reservation, the campsite reservation fee will be retained and the cancellation fee will be charged.

(2) For cancellations made less than fourteen days prior to the beginning date of the reservation, the campsite reservation fee will be retained and the first night's camping fee will be charged.

c. On-park facility reservation fee……..……...$10.00/facility

(1) For group camping areas, group picnic areas, and event facilities, the cancellation fees shall be as described in regulations # 704, # 706, and # 708, respectively.

9. The group picnic area permit fees for the permits issued by the Division are as follows. Group picnic area classes are defined in regulation # 706.

a. Permit for “Class A - Deluxe Group Picnic Area” ……$90.00

b. Permit for “Class B - Improved Group Picnic Area” ……$60.00

c. Permit for “Class C - Basic Group Picnic Area” ……...$30.00

10. Event facility permit fees are as follows.

a. For Bridge Canyon Overlook and Pikes Peak Amphitheater at Castlewood Canyon State Park, Prairie Falcon Amphitheater at Cheyenne Mountain State Park, Panorama Point at Golden Gate Canyon State Park, Soldier Canyon Shelter at Lory State Park, and Lyons Overlook at Roxborough State Park:

(1) Monday through Friday……$150.00/2 HOURS

(2) Saturday and Sunday……$300.00/2 HOURS

b. For event facilities numbers 1 and 3 at Castlewood Canyon State Park and Timber Event Facility at Lory State Park:

(1) Monday through Friday……..$100.00

(2) Saturday and Sunday……$150.00

c. For event facility number 2 at Castlewood Canyon State Park, Fountain Valley Overlook at Roxborough State Park and South Eltuck Event Facility at Lory State Park:

(1) Monday through Friday……..$75.00

(2) Saturday and Sunday……..$125.00

d. For the Red Barn at Golden Gate Canyon State Park:

(1) Monday through Friday……$150.00

(2) Saturday and Sunday……..$200.00

e. For Mariner Point at Boyd Lake State Park:

(1) Monday through Friday……..$90.00

(2) Saturday, Sunday, and holidays……$180.00

f. For Prairie Skipper event facility at Cheyenne Mountain State Park:

(1) Monday through Friday ……$150.00/DAY

(2) Saturday and Sunday……..……$200.00/DAY

g. For PA-CO-CHU-PUK event facilities at Ridgway State Park:

(1) Single event shelter A or B:

(a) Monday through Thursday……$125.00 plus $10 non-refundable reservation fee/DAY

(b) Friday through Sunday and holidays ….$190.00 plus $10 non-refundable reservation fee/DAY

h. For Overlook event facility at Ridgway State Park:

(1) Monday through Thursday…….$190 plus $10 non-refundable reservation fee/ 4 HOURS

(2) Friday through Sunday and holidays….$240 plus $10 non-refundable reservation fee/ 4 HOURS

i. Conference and/or meeting rooms……..……...$100.00/DAY

j. Cancellation fees for event facility reservations are equal to 25% of the base fee if the cancellation is made more than fourteen days prior to the reserved date. If a cancellation is made within fourteen days prior to the event, the cancellation fee shall be 100% of the total event permit fee.

k. The maximum occupancy and hours of operation shall be posted at each event facility.

11. The fees associated with dog off leash areas at Chatfield State Park and Cherry Creek State Park, as provided for in regulation # 100 are:

a. Dog off-leash annual pass……..$20.00

b. Dog off-leash daily pass……...$2.00

12. The fee associated with the mandatory youth education course for motorboat operators…$15.00

13. The fees associated with the Cheyenne Mountain State Park Field/3D Archery Range are as follows:

a. Daily individual archery range permit…….$3.00

b. Annual individual archery range permit…….$30.00

14. The fees associated with the Cameo Shooting and Education Complex are as follows:

a. Individual passes:

(1) Individual day use pass (single day) ……$12.00

(2) Individual day use pass (5 consecutive days) …..……..$48.00

(3) Individual day use pass (10 consecutive days) ..……$84.00

(4) Individual annual pass ……$150.00

(5) Individual three-year pass ……$400.00

b. Youth (ages 7-17) individual passes:

(1) Youth individual day use pass (single day) ……$3.00

(2) Youth individual day use pass (5 consecutive days) …… $12.00

(3) Youth individual day use pass (10 consecutive days)……$21.00

(4) Youth individual annual pass …….. $50.00

c. Two adult (Buddy) passes:

(1) Two adult day use passes (single day) ……..$20.00

(2) Two adult day use passes (5 consecutive days) ……..$80.00

(3) Two adult day use passes (10 consecutive days) ……..$140.00

(4) Both adult passes must be used on the same day(s).

d. Family passes (Two adults and all children (ages 7-17) that live at the same address):

(1) Family annual pass ……$300.00

(2) Family three-year pass ……..$600.00

e. Group day use passes:

(1) Day use passes for 10 to 19 individuals ……$9.00/person

(2) Day use passes for 20 to 29 individuals ……$7.00/person

(3) Day use passes for 30 or more individuals ……..$3.00/person

f. Corporate passes:

(1) Annual corporate pass (10 unassigned passes per day) ...$3,000.00

g. All annual passes for the Cameo Shooting and Education Complex are valid 365 days from the date of purchase.

15. It is unlawful for any person to transfer, sell, or assign any pass or permit issued by the Division, including special activity permits, campground use permits, and group picnic area permits, unless otherwise permitted by these regulations.

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Office of the Attorney General

Tracking number: 2018-00362

Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado Parks and Wildlife (405 Series, Parks)

on 09/06/2018

2 CCR 405-7

CHAPTER P-7 - PASSES, PERMITS AND REGISTRATIONS

The above-referenced rules were submitted to this office on 09/13/2018 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.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

September 25, 2018 09:03:22

Permanent Rules Adopted

Department

Department of Natural Resources

Agency

Colorado Parks and Wildlife (406 Series, Wildlife)

CCR number

2 CCR 406-1

Rule title

2 CCR 406-1 CHAPTER W-1 - FISHING 1 - eff 11/01/2018

Effective date

11/01/2018

FILING – 09/26/2018

FINAL REGULATIONS - CHAPTER W-1 FISHING

ARTICLE II - SPECIAL REGULATION WATERS

#108 – Special Daily Bag and Possession Limits, Size Restrictions, and Other Water-Specific Provisions

A. Various cutthroat waters, specifically those considered Cutthroat Conservation and Recreation waters, are protected throughout the state as listed below. In those waters:

1. Fishing is by artificial flies and lures only. All cutthroat trout must be returned to the water immediately upon catch.

Note: This is to accommodate the growing number of cutthroat trout streams and lakes that are being included in conservation and recovery actions according to management plans.

B. In place of or in addition to regulations # 101, 103, 104, 105, 106, 107 (bag and possession limits, manner of take, fishing dates, fishing hours, special conditions and restrictions, or other fishing activities), and 108 A, the following regulations apply to the named waters:

Note: Additional conditions and restrictions for state wildlife areas are found in Chapter 9

74. <u>Chatfield Reservoir and Chatfield State Park - Jefferson and Douglas Counties</u>

a. Within Chatfield State Park, including the South Platte River and all ponds within the park boundary:
   1. The bag limit and minimum size for walleye is three fish, 18 inches in length.
   2. No more than one walleye greater than 21 inches in length may be taken per day.
   3. The minimum size for largemouth and smallmouth bass is 15 inches in length.
   4. Fishing is prohibited from the dam and within 100 feet of the dam or walleye spawning operation nets, from March 15 through April 15, or until walleye spawning operations are completed.
   5. Fishing is prohibited on the ponds within the dog off leash area.

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Tracking number: 2018-00366

Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado Parks and Wildlife (406 Series, Wildlife)

on 09/06/2018

2 CCR 406-1

CHAPTER W-1 - FISHING

The above-referenced rules were submitted to this office on 09/13/2018 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.

September 25, 2018 09:03:34

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Natural Resources

Agency

Colorado Parks and Wildlife (406 Series, Wildlife)

CCR number

2 CCR 406-2

Rule title

2 CCR 406-2 CHAPTER W-2 - BIG GAME 1 - eff 11/01/2018

Effective date

11/01/2018

FILING – 09/26/2018

FINAL REGULATIONS - CHAPTER W-2 - BIG GAME

ARTICLE VI - MOUNTAIN LION

#242 - RIFLE AND ASSOCIATED METHODS MOUNTAIN LION SEASONS

A. General and Extended Seasons

1. Dogs may be used to hunt mountain lion. However, the pack size shall be limited to no more than eight (8) dogs.

2. The hunter that takes a mountain lion shall be present at the time and place that any dogs are released on the track of a mountain lion and must continuously participate in the hunt until it ends. After a mountain lion has been pursued, treed, cornered or held at bay, a properly licensed person shall take or release the mountain lion immediately. No person shall in any manner restrict or hinder the mountain lion's ability to escape for the purpose of allowing a person who was not present at the time and place that any dogs were released, to arrive and take the mountain lion.

3. Hunt Type, Dates, Units (as described in Chapter 0 of these regulations), and Harvest Limit Quotas.

a. Mountain Lion, Either-sex Season and Harvest Limit Quota – In Game Management Units, as follows, the day after the close of the final combined rifle season through March 31 annually:

Units	Lion Harvest Limit Quota
1, 2	5
3, 301	5
4 (north of Co Rd 27 and USFS 110), 5	8
4 (south of Co Rd 27 and USFS 110), 14, 214, 441	5
6, 16, 17, 161, 171	4
7	1
8	4
9	3
10	10
11	12
12	18
13 (west of Hayden Divide Road)	12
13 (east of Hayden Divide Road), 131, 231	5
15	5
18, 27, 28, 37, 181, 371	12
19	5
20	9
21	15
22	17
23	17
24	6
25, 26, 34	7
29	2

Units	Lion Harvest Limit Quota
30	10
31	12
32	5
33	13
35, 36, 361	9
38	7
39, 391	7
40	7
41	5
42	10
43	7
44	6
45	1
46	6
47	1
48, 56, 481, 561	10
49, 57, 58, 581	45
50, 500, 501	10
51	7
52, 411	10
53, 63	10
54, 55, 551	7
59, 591	7
60	5
61	10
62	9
64	5
65	7
66, 67	8
68, 681, 682	6
69, 84, 86, 691, 861	15
70 east of Colo 141	10
70 west of Colo 141	6
71, 711	9
72	4
73	10
74, 741	6
75	4
76, 79, 791	5
77	6
78	5
80	5
81	4
82	6
83	10
85, 140, 851	24
87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 106, 107, 109, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 951	5
104, 105, 110	5
123, 124, 125, 126, 127, 128, 129, 130, 132, 133, 134, 135, 136, 137, 138, 139, 141, 142, 143, 144, 145, 146, 147	20

Units	Lion Harvest Limit Quota
191	8
201	5
211	17
421	10
444	7
461	7
511	4
521	6
751, 771	5
TOTAL	**677**

b. Mountain Lion, Either-sex Season and Harvest Limit Quota – In Game Management Units, as follows, April 1 – April 30 2018:

Units	Lion Harvest Limit Quota
1, 2	2
7	1
8	3
9	1
10	5
11	5
12	1
13 (west of Hayden Divide Road)	3
13 (east of Hayden Divide Road), 131, 231	3
19	2
20	6
21	2
23	1
24	1
29	2
30	1
31	5
32	2
33	4
38	4
39, 391	6
46	4
50, 500, 501	4
51	1
68, 681, 682	1
70 east of Colo 141	4
70 west of Colo 141	2
71, 711	1
72	3
73	4
81	1
87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 106, 107, 109, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 951	5
104, 105, 110	3
123, 124, 125, 126, 127, 128, 129, 130, 132, 133, 134, 135, 136, 137, 138, 139, 141, 142, 143, 144,	5

Units	Lion Harvest Limit Quota
145, 146, 147	
191	4
201	3
211	12
461	4
TOTAL	**121**

B. Licenses and GMU Harvest Limit Quota Status

1. A valid mountain lion license is required to hunt any mountain lion.

2. Except as provided in 33-3-106 C.R.S., it is unlawful for any person to purchase or obtain a mountain lion hunting license or hunt mountain lions unless the person obtains a mountain lion education certificate issued by the Division attesting to the person's successful completion of the Division's certified mountain lion education and identification course. Any person required to obtain such a certificate shall have the certificate on his or her person while hunting or taking mountain lion.

3. Prior to each hunting trip in any game management unit, but not earlier than 5:00 p.m. of the day before hunting, lion hunters must check the *Available Lion Harvest Limit Report* on the Division website or contact 1-888-940-LION (1-888-940-5466), or any Division office to determine which game management units have not reached the unit harvest limit quota and are open to hunting. It shall be unlawful to hunt in a unit after it is closed.

   Beginning April 1, 2019 and thereafter, lion hunters must check the *Available Lion Harvest Limit Report* on the Division website or contact any Division office to determine which game management units have not reached the unit harvest limit quota and are open to hunting.

C. Special Restrictions

1. Reporting and Sealing

   a. The taking of mountain lions by licensed hunters shall be reported to the Division within 48 hours after the taking thereof, and except as provided in these regulations, the lion shall be personally presented by the hunter for inspection and sealing within five (5) days after the taking thereof. Mountain lion heads and hides must be unfrozen when presented for inspection. If not unfrozen, the Division may retain heads and hides as necessary for thawing sufficient to extract a premolar tooth. A mandatory check report shall be accurately completed by the hunter at the time of inspection, which shall include certification that all information provided is accurate.

   b. At the time of the mandatory check, the Division shall be authorized to extract and retain a premolar tooth.

2. The legal possession seal when attached to the mountain lion skull or hide shall authorize possession, transportation, tanning or mounting thereof. No fee shall be required for the inspection and issuance of a legal possession seal which shall remain attached to the skull or hide until processed. Mountain lions shall not be transported, shipped or otherwise taken out of Colorado until the hide and skull are inspected and sealed.

3. All mountain lion taken or destroyed under Commission regulation #1702 or §33-3-106(3) C.R.S., as amended, shall remain the property of the state and shall be delivered to an officer of the Division within five (5) days. A report shall be given to an officer of the Division at the time of delivery which contains the following:

    1) Name(s) of person(s) who killed the animal(s).

    2) The county and the specific location of the kill.

    3) The species and number of animals killed.

    4) The reason for such action.

4. Lions with Kittens – No person shall kill a mountain lion accompanied by one or more kittens or kill a kitten.

5. “Kitten” shall mean a lion with spots.

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Office of the Attorney General

Tracking number: 2018-00367

Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado Parks and Wildlife (406 Series, Wildlife)

on 09/06/2018

2 CCR 406-2

CHAPTER W-2 - BIG GAME

The above-referenced rules were submitted to this office on 09/13/2018 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.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

September 25, 2018 09:03:47

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Insurance

CCR number

3 CCR 702-4 Series 4-2

Rule title

3 CCR 702-4 Series 4-2 LIFE, ACCIDENT AND HEALTH, Series 4-2 Accident and Health (General) 1 - eff 03/01/2019

Effective date

03/01/2019

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Amended Regulation 4-2-37

REQUIRED INFORMATION FOR CARRIERS TO OBTAIN ON ALL FULL-LENGTH APPLICATIONS FOR INDIVIDUAL HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105.2(1.5), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish a standard affidavit form to be used upon application for an individual health benefit plan when a small employer intends on reimbursing an employee for any portion of the premium.

Section 3 Applicability

The requirements of this regulation apply to all carriers issuing individual health benefit plans on or after the effective date of this regulation. It does not apply to applications for short-term limited duration health insurance policies.

Section 4 Definitions

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

B. "Eligible employee" shall have the same definition as found at § 10-16-102(18), C.R.S.

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

D. "Short-term limited duration health insurance policies" shall have the same meaning as found at § 10-16-102(60), C.R.S.

E. "Qualified small employer health reimbursement arrangement" and "QSEHRA" shall have the same meaning as found at 26 U.S.C. § 9831(d)(2).

Section 5 Rules

A. All full-length applications for individual health benefit plans must contain the questions provided in Appendix A, as supplemental form with a separate applicant signature.

B. If an applicant for an individual health benefit plan is required to submit an affidavit executed by the employer, the affidavit in Appendix B must be used.

1. The affidavit form must have been executed by the employer no earlier than ninety (90) calendar days prior to, or no later than ninety (90) calendar days after, the submission of the individual application to the carrier.

2. If the affidavit is beyond the ninety (90) calendar day time period, the carrier shall require a new affidavit be submitted with the full-length application.

Section 6 Severability

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

Section 7 Enforcement

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

Section 8 Effective Date

This regulation shall become effective on March 1, 2019.

Section 9 History

Emergency regulation E-11-04 effective May 19, 2011.
New regulation effective September 1, 2011.
Amended regulation effective November 1, 2013.
Amended regulation effective March 1, 2019.

Appendix A: Required Questions

1. Will an employer of one hundred (100) or fewer eligible employees be paying for or reimbursing an employee through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for?

   ____Yes ____No

   If you answered “yes”, please continue. If you answered “no”, you may stop.

2. If the employer will be reimbursing an employee through a health reimbursement arrangement, does it qualify as a “qualified small employer health reimbursement arrangement” or QSEHRA *?

   ____Yes ____No

3. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve (12) months prior to the date of this application?

   ____Yes ____No

   If the answer to both questions 1 and 3 is “yes” and the answer to question 2 is ‘”no”, the applicant may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

   The applicant must submit a signed affidavit from the employer, IF:

   The answer to questions 1 and 2 is “yes” and the answer to question 3 is “no”

   OR

   The answer to question 1 is “yes” and the answer to questions 2 and 3 is “no”.

   The affidavit form to be executed by the employer is attached. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier.

* Employers are required by 26 U.S.C. 9831(d)(4) to provide employees written notice regarding QSEHRAs.

Appendix B: Form of Affidavit

Employer's Name: _____

Employer's Address: _____

_____

The undersigned officer or principal of the employer identified above certifies that:

1. The employer is a small employer as defined in § 10-16-102(61), C.R.S., with ~~fifty~~one hundred (~~5~~100) or fewer eligible employees;

2. The employer has either not had in place a small group health benefit plan for the twelve (12) months prior to the execution of this affidavit or that it is using a qualified small employer health reimbursement arrangement (QSEHRA) to reimburse its employees' individual health insurance premiums.

~~3.~~A false certification may cause the rescission of the employee's individual health insurance policy and subject the employer to penalties for perjury and liability to the employee.

Signed: _____

Printed Name: _____

Position: _____

Date: _____

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Office of the Attorney General

Tracking number: 2018-00350

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Insurance

on 09/17/2018

3 CCR 702-4 Series 4-2

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

The above-referenced rules were submitted to this office on 09/20/2018 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.

September 25, 2018 16:31:37

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Insurance

CCR number

3 CCR 702-5

Rule title

3 CCR 702-5 PROPERTY AND CASUALTY 1 - eff 11/01/2018

Effective date

11/01/2018

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-5

PROPERTY AND CASUALTY

Amended Regulation 5-2-15

CONCERNING CONSUMER PROTECTION FOR VEHICLE VALUATION AND RENTAL REIMBURSEMENT

Section 1 Authority

This regulation is promulgated under the authority of §§ 10-1-109, 10-3-1110(2), 10-4-601.5 and 10-4-639 (3) and (4), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish standards for payment of claims for vehicle rental and collision damage waivers, and for valuation of total loss claims under private passenger auto insurance policies.

Section 3 Applicability

This regulation shall apply to all insurers that provide automobile insurance policies.

Section 4 Definitions

A. "Collision Damage Waiver" means, for the purpose of this regulation, the contractual agreement between an automobile rental company and the consumer renting an automobile whereby the rental company agrees to forfeit its right to recover property damage to the rented automobile from that consumer, regardless of fault.

B. "Comparable Class" means, for the purpose of this regulation, the same or similar vehicle type. This includes, but is not limited to, vehicle type (passenger car, cross-over, sport utility or truck) and number of passengers.

C. "Third-Party Claimant" means the individual other than the insured or the insurer who has incurred a loss as a result of the negligent acts or omissions of the insured and is legally entitled to receive reimbursement for damages resulting from that loss.

D. “Total Loss” means the condition of a motor vehicle when it is damaged or destroyed to such an extent that the insurer determines it cannot be rebuilt or repaired to its condition prior to the loss; or the cost of the loss (including, but not limited to, rental expenses, specialized labor and part availability) makes the repairs of the vehicle uneconomical.

E. “Valuation” means the method of determining the worth of property that has been lost or damaged.

Section 5 Rules

A. Total Loss Claims

1. The insurer shall develop and maintain written procedures that will be consistently used when determining the value of a vehicle declared a total loss.

2. Claims files shall include the credible source used for valuation by vendor name and the methodology for determining the amount of the loss. Claims files shall document that the valuation considered unique characteristics of a total loss vehicle, such as classic status, unique finishes, mileage and/or, special accessories.

B. Payment for Temporary Replacement of Damaged Motor Vehicles

1. An insurer shall provide payment to a third-party claimant for a collision damage waiver required by a motor vehicle rental company when the third-party claimant does not have collision coverage, or coverage does not extend to a rental vehicle through his or her own motor vehicle insurance. The insurer may request the following:

   a. Verification that the third-party claimant did not have collision coverage on the damaged vehicle, at the time of loss, or that the collision coverage on his/her automobile policy does not extend to rental vehicles; and

   b. Verification that the Collision Damage Waiver was signed by the third-party claimant and collision coverage was secured.

2. Payments for third-party coverage for a replacement motor vehicle must begin the day of the loss if the vehicle is inoperable and coverage is confirmed and liability accepted or, if drivable, begin the date the vehicle is scheduled for repairs and left at the repair facility. The replacement motor vehicle must be of a comparable class and shall not be discontinued until:

   a. Three (3) business days after payment for the total loss of the motor vehicle was mailed, via US Postal Service, to the last known address of the third-party claimant or after a reasonable settlement offer has been made and communicated in writing, which includes electronic mail delivery, in compliance with § 10-3-1104 (1)(h), C.R.S.; or,

   b. One (1) day after payment for the total loss of the motor vehicle was transmitted via overnight delivery to the last known address of the third-party claimant or directly to the financial account of the third-party claimant; or,

   c. Payment is made directly to the entity repairing the motor vehicle and the repaired vehicle is returned to the third-party claimant or the third-party claimant has a reasonable opportunity to take possession of the vehicle from the repair facility.

3. The insurer shall issue payment within three (3) business days of the date of the third-party claimant accepts, in writing, the written settlement offer, and the insurer has received a transferrable title to the vehicle. If the insurer receives the transferrable title and the settlement acceptance on separate dates it shall issue payment within three (3) business days from the latest date of receipt.

4. An insurer shall not be required to pay for a replacement motor vehicle or any portion of such expense directly related to:

   a. Delays by the third-party claimant; or

   b. Delays by a repair facility selected by the third-party claimant unless the repair facility is a participating preferred repair shop.

C. Failure to comply with this regulation constitutes an unfair or deceptive act or practice in the business of insurance.

Section 6 Severability

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

Section 7 Enforcement

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

Section 8 Effective Date

This regulation shall become effective on November 1, 2018.

Section 9 History

New regulation issued effective December 1, 2004.
Amended regulation effective August 1, 2012.
Amended regulation effective November 1, 2018.

CYNTHIA H. COFFMAN
Attorney General

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Office of the Attorney General

Tracking number: 2018-00374

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Insurance

on 09/19/2018

3 CCR 702-5

PROPERTY AND CASUALTY

The above-referenced rules were submitted to this office on 09/20/2018 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.

September 25, 2018 16:31:59

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Labor and Employment

Agency

Division of Workers' Compensation

CCR number

7 CCR 1101-3

Rule title

7 CCR 1101-3 WORKERS' COMPENSATION RULES OF PROCEDURE WITH TREATMENT GUIDELINES 1 - eff 01/01/2019

Effective date

01/01/2019

DEPARTMENT OF LABOR AND EMPLOYMENT

Division of Workers' Compensation

7 CCR 1101-3

WORKERS' COMPENSATION RULES OF PROCEDURE

Rule 16 UTILIZATION STANDARDS

16-1 STATEMENT OF PURPOSE

In an effort to comply with its legislative charge to assure appropriate and timely medical care at a reasonable cost, the Director (Director) of the Division of Workers' Compensation (Division) has promulgated these utilization standards, effective January 1, 2019. This Rule defines the standard terminology, administrative procedures, and dispute resolution procedures required to implement the Division's Medical Treatment Guidelines and Medical Fee Schedule.

16-2 STANDARD TERMINOLOGY FOR RULES 16, 17, AND 18

(A) Ambulatory Surgical Center (ASC) – licensed as an ambulatory surgery center by the Colorado Department of Public Health and Environment.

(B) Authorized Treating Provider (ATP) – may be any of the following:

(1) The treating physician designated by the employer and selected by the injured worker;

(2) A health care provider to whom an authorized treating physician refers the injured worker for treatment, consultation, or impairment rating;

(3) A physician selected by the injured worker when the injured worker has the right to select a provider;

(4) A physician authorized by the employer when the employer has the right or obligation to make such an authorization;

(5) A health care provider determined by the Director or an administrative law judge to be an ATP;

(6) A provider who is designated by the agreement of the injured worker and the payer.

(C) Billed Service(s) – any billed service, procedure, equipment, or supply provided to an injured worker by a provider.

(D) Billing Party – a service provider or an injured worker who has incurred authorized medical costs.

(E) Children's Hospital – federally qualified, and certified by the Colorado Department of Public Health and Environment.

(F) Convalescent Center – licensed by the Colorado Department of Public Health and Environment.

(G) Critical Access Hospital (CAH) – federally qualified, and certified by the Colorado Department of Public Health and Environment.

(H) Day – defined as a calendar day unless otherwise noted. In computing any period of time prescribed or allowed by Rules 16 or 18, the parties shall refer to Rule 1-2.

(I) Free-Standing Facility – an entity that furnishes healthcare services and is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or provider–based entity.

(J) Hospital – licensed by the Colorado Department of Public Health and Environment.

(K) Long-Term Care Facility –federally qualified, and certified by the Colorado Department of Public Health and Environment.

(L) Medical Fee Schedule – Division's Rule 18, its exhibits, and the documents incorporated by reference in that Rule.

(M) Medical Treatment Guidelines – the medical treatment guidelines as incorporated into Rule 17.

(N) Over-the-Counter Drugs – medications that are available for purchase by the general public without a prescription.

(O) Payer – an insurer, self-insured employer, or designated agent(s) responsible for payment of medical expenses. Use of agents, including but not limited to Preferred Provider Organizations (PPO) networks, bill review companies, Third Party Administrators (TPAs), and case management companies, shall not relieve the self-insured employer or insurer from their legal responsibilities for compliance with these Rules.

(P) Prior Authorization – assurance that appropriate reimbursement for a specific treatment will be paid in accordance with Rule 18, its exhibits, and the documents incorporated by reference in that Rule.

(Q) Provider – a person or entity providing authorized health care service, whether involving treatment or not, to a worker in connection with work-related injury or occupational disease.

(R) Psychiatric Hospital – licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

(S) Rehabilitation Hospital Facility – licensed as a rehabilitation hospital by the Colorado Department of Public Health and Environment.

(T) Rural Health Clinic Facility – federally qualified, and certified by the Colorado Department of Public Health and Environment.

(U) Skilled Nursing Facility (SNF) – licensed as a skilled nursing facility by the Colorado Department of Public Health and Environment.

(V) Telehealth – a broad term describing a mode of delivery of health care services through telecommunications systems, including information, electronic, and communication

technologies, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, and/or self-management of an injured worker's health care while the injured worker is located at an originating site and the provider is located at a distant site. The term includes synchronous interactions and store-and-forward transfers. The term does not include the delivery of health care services via telephone with audio only function, facsimile machine, or electronic mail systems.

(W) Telemedicine – two-way, real time interactive communication between the injured worker, and the provider at the distant site. This electronic communication involves, at minimum, audio and video telecommunications equipment. Telemedicine enables the remote diagnoses and evaluation of injured workers in addition to the ability to detect fluctuations in their medical condition(s) at a remote site in such a way as to confirm or alter the treatment plan, including medications and/or specialized therapy.

(X) Veterans' Administration Medical Facilities – all medical facilities overseen by the United States Department of Veterans' Affairs.

16-3 RECOGNIZED HEALTH CARE PROVIDERS

(A) Physician and Non-Physician Providers

(1) For the purpose of this Rule, recognized health care providers are divided into the major categories of "physician" and "non-physician." Recognized providers are defined as follows:

(a) "Physician providers" are those individuals who are licensed by the State of Colorado through one of the following boards:

(i) Colorado Medical Board;
(ii) Colorado Board of Chiropractic Examiners;
(iii) Colorado Podiatry Board; or
(iv) Colorado Dental Board.

Only physicians licensed by the Colorado Medical Board may be included as individual physicians on the employer's or insurer's designated provider list required under § 8-43-404(5)(a)(I).

(b) "Non-physician providers" are those individuals who are registered, certified, or licensed by the Colorado Department of Regulatory Agencies (DORA), the Colorado Secretary of State, or a national entity recognized by the State of Colorado as follows:

(i) Acupuncturist (LAc) – licensed by the Office of Acupuncture Licensure, Colorado Department of Regulatory Agencies;

(ii) Advanced Practice Nurse (APN) – licensed by the Colorado Board of Nursing; Advanced Practice Nurse Registry;

(iii) Anesthesiologist Assistant (AA) – licensed by the Colorado Medical Board, Colorado Department of Regulatory Agencies;

(iv) Athletic Trainers (ATC) –registered by the Office of Athletic Trainer Registration, Colorado Department of Regulatory Agencies;

(v) Audiologist (AU.D. CCC-A) – licensed by the Office of Audiology and Hearing Aid Provider Licensure, Colorado Department of Regulatory Agencies;

(vi) Certified Registered Nurse Anesthetist (CRNA) – licensed by the Colorado Board of Nursing;

(vii) Clinical Social Worker (LCSW) – licensed by the Board of Social Work Examiners, Colorado Department of Regulatory Agencies;

(viii) Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) Supplier – licensed by the Colorado Secretary of State;

(ix) Marriage and Family Therapist (LMFT) – licensed by the Board of Marriage and Family Therapist Examiners, Colorado Department of Regulatory Agencies;

(x) Massage Therapist (MT) – licensed as a massage therapist by the Office of Massage Therapy Licensure, Colorado Department of Regulatory Agencies.

(xi) Nurse Practitioner (NP) – licensed as an APN and authorized by the Colorado Board of Nursing;

(xii) Occupational Therapist (OTR) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies;

(xiii) Occupational Therapist Assistant (OTA) – licensed by the Office of Occupational Therapy, Colorado Department of Regulatory Agencies;

(xiv) Optometrist (OD) – licensed by the Board of Optometry, Colorado Department of Regulatory Agencies;

(xv) Orthopedic Technologist (OTC) – certified by the National Board for Certification of Orthopedic Technologists;

(xvi) Pharmacist – licensed by the Board of Pharmacy, Colorado Department of Regulatory Agencies;

(xvii) Physical Therapist (PT) – licensed by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

(xviii) Physical Therapist Assistant (PTA) –certified by the Physical Therapy Board, Colorado Department of Regulatory Agencies;

(xix) Physician Assistant (PA) – licensed by the Colorado Medical Board;

(xx) Practical Nurse (LPN) – licensed by the Colorado Board of Nursing;

(xxi) Professional Counselor (LPC) – licensed by the Board of Professional Counselor Examiners, Colorado Department of Regulatory Agencies;

(xxii) Psychologist (PsyD, PhD, EdD) – licensed by the Board of Psychologist Examiners, Colorado Department of Regulatory Agencies;

(xxiii) Registered Nurse (RN) – licensed by the Colorado Board of Nursing;

(xxiv) Respiratory Therapist (RTL) – certified by the National Board of Respiratory Care and licensed by the Office of Respiratory Therapy Licensure, Colorado Department of Regulatory Agencies;

(xxv) Speech Language Pathologist (CCC-SLP) – certified by the Office of Speech-Language Pathology Certification, Colorado Department of Regulatory Agencies; and

(2) Upon request, health care providers must provide copies of license, registration, certification, or evidence of health care training for billed services.

(3) Any provider not listed in section 16-3(A)(1)(a) or (b) must comply with section 16-6, Prior Authorization when providing all services.

(4) Referrals:

(a) A payer or employer shall not redirect or alter the scope of an ATP's referral to another provider for treatment or evaluation of a compensable injury. Any party who has concerns regarding a referral or its scope shall advise the other parties and providers involved.

(b) All non-physician providers must have a referral from an authorized treating physician. An authorized treating physician making the referral to any listed or unlisted non-physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the reasonableness or necessity of the care.

(c) Any listed or non-listed non-physician provider is required to clarify any questions concerning the scope of the referral, prescription, or the

reasonableness or necessity of the care with the referring authorized treating physician.

(5) Use of PAs and NPs in Colorado Workers' Compensation Claims:

(a) All Colorado workers' compensation claims (medical only or lost time claims) shall have an "authorized treating physician" responsible for all services rendered to an injured worker by any PA or NP.

(b) The authorized treating physician must be immediately available in person or by telephone to furnish assistance and/or direction to the PA or NP while services are being provided to an injured worker.

(c) The service is within the scope of the PA's or NP's practice and complies with all applicable provisions of the Colorado Medical Practice Act or the Colorado Nurse Practice Act, and all applicable rules promulgated by the Colorado Medical Board or the Colorado Board of Nursing.

(d) For services performed by an NP or a PA, the authorized treating physician must counter-sign patient records related to the injured worker's inability to work resulting from the claimed work injury or disease, and the injured worker's ability to return to regular or modified employment, as required by §§ 8-42-105(2)(b) and (3). The authorized treating physician also must counter-sign Form WC 164. The signature of the physician provider shall serve as a certification that all requirements of this rule have been met.

(e) The authorized treating physician must evaluate the injured worker within the first three visits to the physician's office.

(B) Out-of-State Provider

(1) Relocated Injured Worker

(a) Upon receipt of the "Employer's First Report of Injury" or the "Worker's Claim for Compensation" form, the payer shall notify the injured worker that the procedures for change of provider, should s/he relocate out-of- state, can be obtained from the payer.

(b) A change of provider must be made:

(i) Through referral by the injured worker's authorized treating physician; or

(ii) In accordance with § 8-43-404(5)(a).

(2) Referred Injured Worker

In the event an injured worker has not relocated out-of-state but is referred to an out-of-state provider for treatment or services not available within Colorado, the referring provider shall obtain prior authorization from the payer as set forth in section 16-6. The referring provider's written request for out-of-state treatment shall include the following information:

(a) Medical justification prepared by the referring provider;

(b) Written explanation as to why the requested treatment/services cannot be obtained within Colorado;

(c) Name, complete mailing address and telephone number of the out-of- state provider;

(d) Description of the treatment/services requested, including the estimated length of time and frequency of the treatment/service, and all associated medical expenses; and

(e) Out-of-state provider's qualifications to provide the requested treatment or services.

16-4 REQUIRED USE OF THE MEDICAL TREATMENT GUIDELINES

When an injury or occupational disease falls within the purview of Rule 17, Medical Treatment Guidelines and the date of injury occurs on or after July 1, 1991, providers and payers shall use the medical treatment guidelines, in effect at the time of service, to prepare or review their treatment plan(s) for the injured worker. A payer may not dictate the type or duration of medical treatment or rely on its' own internal guidelines or other standards for medical determination.

When treatment exceeds or is outside of the Medical Treatment Guidelines, prior authorization is required. Requesters and reviewers should consider how their decision will affect the overall treatment plan for the individual patient. In all instances of contest, appropriate processes to deny are required. Refer to applicable sections of 16-5, 16-6, 16-7, and/or 16-11.

16-5 NOTIFICATION

(A) The Notification process is for treatment consistent with the Medical Treatment Guidelines that has an established value under the Medical Fee Schedule. Providers may, but are not required to, utilize the Notification process to ensure payment for medical treatment that falls within the purview of the Medical Treatment Guidelines. Therefore, lack of response from the payer within the time requirement set forth in section 16-5(D) shall deem the proposed treatment/service authorized for payment.

(B) Notification may be made by phone, during regular business hours.

(1) Providers can accept verbal confirmation; or

(2) Providers may request written confirmation of an approval, which the payer should provide upon request.

(C) Notification may be submitted using the "Authorized Treating Provider's Notification to Treat" (Form WC 195). The completed form shall include:

(1) Provider's certification that the proposed treatment/service is medically necessary and consistent with the Medical Treatment Guidelines.

(2) Documentation of the specific Medical Treatment Guideline(s) applicable to the proposed treatment/service.

(3) Provider's email address or fax number to which the payer can respond.

(D) Payers shall respond to a Notification submission within five (5) business days from receipt of the request with an approval or contest of the proposed treatment.

(1) The payer may limit its approval to the number of treatments or treatment duration specified in the relevant Medical Treatment Guideline(s), without a medical review. If subsequent medical records document functional progress, additional treatment may be approved.

(2) If payer proposes to discontinue treatment before the maximum number of treatments/treatment duration has been reached due to lack of functional progress, payer shall support that decision with a medical review compliant with section 16-7(B).

(E) Payers may contest the proposed treatment only for the following reasons:

(1) For claims which have been reported to the Division, no admission of liability or final order finding the injury compensable has been issued:

(2) Proposed treatment is not related to the admitted injury;

(3) Provider submitting Notification is not an ATP, or is proposing for treatment to be performed by a provider who is not eligible to be an ATP;

(4) Injured worker is not entitled to proposed treatment pursuant to statute or settlement;

(5) Medical records contain conflicting opinions among the ATPs regarding proposed treatment;

(6) Proposed treatment falls outside the Medical Treatment Guidelines.

(F) If the payer contests Notification under sections 16-5(E)(2), (5) or (6) above, the payer shall notify the provider, allow the submission of relevant supporting medical documentation as defined in section 16-6(E), and review the submission as a prior authorization request, allowing an additional seven (7) business days for review.

(G) Contests for denied Notification by a provider shall be made in accordance with the prior authorization dispute process outlined in 16-7(C).

(H) Any provider or payer who incorrectly applies the Medical Treatment Guidelines in the Notification process may be subject to penalties under the Workers' Compensation Act.

16-6 PRIOR AUTHORIZATION

(A) Granting of prior authorization is a guarantee of payment in accordance with Rule 18, RBRVS, and CPT® for the services/procedures requested by the provider pursuant to section 16-6(E). Prior authorization may be requested using the "Authorized Treating Provider's Request for Prior Authorization" (Form WC 188) or, in the alternative, shall be clearly labeled as a prior authorization request.

(B) Prior authorization for payment shall only be requested by the provider when:

(1) A prescribed service exceeds the recommended limitations set forth in the Medical Treatment Guidelines;

(2) The Medical Treatment Guidelines otherwise require prior authorization for that specific service;

(3) A prescribed service is identified within the Medical Fee Schedule as requiring prior authorization for payment; or

(4) A prescribed service is not identified in the Medical Fee Schedule as referenced in section 16-8(C).

(C) Prior authorization for a prescribed service or procedure may be granted immediately and without a medical review. However, the payer shall respond to all prior authorization requests in writing within seven (7) business days from receipt of the provider's completed request, as defined in section 16-6(E). The duty to respond to a provider's request applies regardless of who transmitted the request.

(D) The payer, unless it has previously notified said provider, shall give notice to the provider of these procedures for obtaining prior authorization for payment upon receipt of the initial bill from that provider.

(E) To complete a prior authorization request, the provider shall concurrently explain the reasonableness and the medical necessity of the services requested, and shall provide relevant supporting medical documentation. Supporting medical documentation is defined as documents used in the provider's decision-making process to substantiate the need for the requested service or procedure. The following documentation is required:

(1) An adequate definition or description of the nature, extent, and necessity for the procedure;

(2) Identification of the appropriate Medical Treatment Guideline, if applicable; and

(3) Final diagnosis.

(F) The Division recommends payers confirm in writing, to providers and all parties, when a request for prior authorization is approved.

(G) If, after the service was provided, the payer agrees the service was reasonable and necessary, lack of prior authorization does not warrant denial of payment. However, the provider is still required to provide, with the bill, the documentation required by section 16-6(E) for any unlisted service or procedure for payment.

16-7 CONTEST OF A REQUEST FOR PRIOR AUTHORIZATION

(A) If an ATP requests prior authorization and indicates in writing, including reasoning and relevant documentation, that he or she believes the requested treatment is related to the admitted workers' compensation claim, the insurer cannot deny solely for relatedness without a medical opinion as required by section 16-7(B). The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the prior authorization request.

(B) The payer may contest a request for prior authorization for medical or non-medical reasons. Examples of non-medical reasons are listed in section 16-11(B)(1). If the payer is contesting a request for prior authorization for medical reasons, the payer shall, within seven (7) business days of the completed request:

(1) Have all the submitted documentation under section 16-6(E) reviewed by a "physician provider" as defined in section 16-3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physicians or chiropractors performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review prior authorization requests for medications without having received Level I or Level II accreditation.

(2) After reviewing all the submitted documentation and other documentation referenced in the prior authorization request and available to the payer, the reviewing provider may call the requesting provider to expedite communication and processing of prior authorization requests. However, the written contest or approval still needs to be completed within the seven (7) business days specified under this section.

(3) Furnish the provider and the parties with a written contest that sets forth the following information:

(a) An explanation of the specific medical reasons for the contest, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion.

(b) The specific cite from the Medical Treatment Guidelines, when applicable;

(c) Identification of the information deemed most likely to influence the reconsideration of the contest when applicable; and

(d) Documentation of response to the provider and parties.

(C) Prior Authorization Appeals

(1) The requesting party or provider shall have seven (7) business days from the date of the written contest to provide a written response to the payer. The response is not considered a "special report" when prepared by the provider of the requested service.

(2) The payer shall have seven (7) business days from the date of the response to issue a final decision and provide documentation of that decision to the provider and parties.

(3) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(D) An urgent need for prior authorization of health care services, as recommended in writing by an ATP, shall be deemed good cause for an expedited hearing.

(E) Failure of the payer to timely comply in full with section 16-7(A), (B), or (C) shall be deemed authorization for payment of the requested treatment unless the payer has scheduled an independent medical examination (IME) and notified the requesting provider of the IME within the time prescribed for responding set forth in section 16-7(B).

(1) The IME must occur within 30 days, or upon first available appointment, of the prior authorization request, not to exceed 60 days absent an order extending the deadline.

(2) The IME physician must serve all parties concurrently with his or her report within 20 days of the IME.

(3) The insurer shall respond to the prior authorization request within five business days of the receipt of the IME report.

(4) If the injured worker does not attend or reschedules the IME, the payer may deny the prior authorization request pending completion of the IME.

(5) The IME shall comply with Rule 8 as applicable.

(F) Unreasonable delay or denial of prior authorization, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

16-8 REQUIRED USE OF THE FEE SCHEDULE

(A) All providers and payers shall use the Medical Fee Schedule to determine the maximum allowable payments for any medical treatments or services within the purview of the Workers' Compensation Act of Colorado and the Colorado Workers' Compensation Rules of Procedure, unless one of the following exceptions applies:

(1) If billed charges are less than the fee schedule, the payment shall not exceed the billed charges.

(2) The payer and an out-of-state provider may negotiate reimbursement in excess of the fee schedule when required to obtain reasonable and necessary care for an injured worker.

(3) Pursuant to § 8-67-112(3), the Uninsured Employer Board may negotiate rates of reimbursement for medical providers.

(B) The fee schedule does not limit the billing charges.

(C) Payment for billed services not identified or identified but without established value in the Medical Fee Schedule shall require prior authorization from the payer pursuant to section 16-6, except when the billed non-established valued service or procedure is an emergency or a payment mechanism under Rule 18 is identifiable, but not explicit. Examples of these exception(s) include ambulance bills or supply bills that are covered under Rule 18 with an identified payment mechanism. Similar established code values from the Medical Fee Schedule, recommended by the requesting physician, shall govern the maximum fee schedule payment.

16-9 REQUIRED BILLING FORMS, CODES, AND PROCEDURES

(A) Medical providers shall use only the billing forms listed below or their electronic reproductions. Any reproduction shall be an exact duplication of the form(s) in content and appearance. If the payer agrees, providers may place identifying information in the margin of the form. Payment for any services not billed on the forms identified in this Rule may be denied. However, the payer shall comply with the applicable provisions set forth in section 16-11.

(1) CMS (Centers for Medicare & Medicaid Services) -1500 shall be used by all providers billing for professional services, durable medical equipment (DME) and ambulance services, with the exception of those providers billing for dental services or procedures. Health care providers shall provide their name and credentials in the appropriate box of the CMS-1500. Non-hospital based ASCs may bill on the CMS-1500, however an SG modifier must be appended to the technical component of services to indicate a facility charge and to qualify for reimbursement as a facility claim.

(2) UB-04 - shall be used by all hospitals, hospital-based ambulance/air services, Children's Hospitals, CAHs, Veterans' Administration Medical Facilities, home health and facilities meeting the definitions found in section 16-2, when billing for hospital services or any facility fees billed by any other provider, such as hospital-based ASCs.

(a) Some outpatient hospital therapy services (Physical, Occupational, or Speech) may also be billed on a UB-04. For these services, the UB-04 must have Form Locator Type 013x, 074x, 075x, or 085x, and one of the following revenue code(s):

- Revenue Code 042X Physical Therapy
- Revenue Code 043X Occupational Therapy
- Revenue Code 044X Speech/Language Therapy

(b) CAHs designated by Medicare or Exhibit # 3 to Rule 18 may use a UB- 04 to bill professional services if the professional has reassigned his or her billing rights to the CAH using Medicare's Method II. The CAH shall list bill type 851-854, as well as one of the following revenue code(s) and Health Care Common Procedure Coding System (HCPCS) codes in the HCPCS Rates field number 44:

- 0960 - Professional Fee General
- 0961 - Psychiatric
- 0962 - Ophthalmology
- 0963 - Anesthesiologist (MD)
- 0964 - Anesthetist (CRNA)
- 0971 - Professional Fee For Laboratory
- 0972 - Professional Fee For Radiology Diagnostic
- 0973 – Professional Fee - Radiology - Therapeutic
- 0974 - Professional Fee - Radiology - Nuclear
- 0975 - Professional Fee - Operating Room
- 0981 - Emergency Room Physicians
- 0982 - Outpatient Services
- 0983 - Clinic

- 0985 - EKG Professional
- 0986 - EEG Professional
- 0987 - Hospital Visit Professional (MD/DO)
- 0988 - Consultation (Professional (MD/DO)

All professional services billed by a CAH are subject to the same coding and payment rules as professional services billed independently. The following modifiers shall be appended to HCPCS codes to identify the type of provider rendering the professional service:

GF Services rendered in a CAH by a NP, clinical nurse specialist, certified registered nurse, or PA

SB Services rendered in a CAH by a nurse midwife

AH Services rendered in a CAH by a clinical psychologist

AE Services rendered in a CAH by a nutrition professional/registered dietitian

AQ Physician services in a physician-scarcity area

(c) No provider except those listed above shall bill for the professional fees using a UB-04.

(3) American Dental Association's Dental Claim Form, Version 2012 shall be used by all providers billing for dental services or procedures.

(4) With the agreement of the payer, the ANSI ASC X12 (American National Standards Institute Accredited Standards Committee) or NCPDP (National Council For Prescription Drug Programs) electronic billing transaction containing the same information as in (1), (2) or (3) in this subsection may be used.

Dispensing pharmacies and pharmacy benefit managers shall use NCPDP Workers' Compensation/Property and Casualty (P&C) universal claim form, version 1.1, for prescription drugs billed on paper. Physicians may use the CMS-1500 billing form as described in section 16-9(A)(1).

(B) International Classification of Diseases (ICD) Codes

All provider bills shall list the ICD-10 Clinical Modification (CM) diagnosis code(s) that are current, accurate, specific to each patient encounter, and preferably include the Chapter 20 External Causes of Morbidity code(s). If ICD-10-CM requires a seventh character, the provider must apply it in accordance with the ICD-10-CM Chapter Guidelines provided by the Centers for Medicare and Medicaid Services (CMS). The ICD-10-CM diagnosis codes shall not be used as a sole factor to establish work-relatedness of an injury or treatment.

(C) Providers must accurately report their services using applicable billing codes, modifiers, instructions, and parenthetical notes listed in the Medical Fee Schedule; the National Relative Value File, as published by Medicare in the February 2018 Resource Based Relative Value Scale (RBRVS); and the American Medical Association's Current Procedural Terminology (CPT®) 2018 edition. The provider may be subject to penalties for inaccurate billing when the provider knew or should have known that the services billed were inaccurate, as determined by the Director or an administrative law judge.

(D) National provider identification (NPI) numbers are required for workers' compensation bills; providers who cannot obtain NPI numbers are exempt from this requirement. When billing on a CMS-1500, the NPI shall be that of the rendering provider and shall include the correct place of service codes at the line level.

(E) Providers shall submit their bills for services rendered within 120 days of the date of service or the bill may be denied unless extenuating circumstances exist. Extenuating circumstances may include, but are not limited to, delays in compensability being decided or the provider has not been informed where to send the bill.

16-10 REQUIRED MEDICAL RECORD DOCUMENTATION

(A) The treating provider shall maintain medical records for each injured worker when billing for the provided services. The rendering provider shall sign the medical records. Electronic signatures are accepted.

(B) All medical records shall legibly document the services billed. The documentation shall itemize each contact with the injured worker. The documentation also shall detail at least the following information per contact or, if contact occurs more than once per week, detail at least once per week:

(1) Patient's name;

(2) Date of contact, office visit or treatment;

(3) Name and professional designation of person providing the billed service;

(4) Assessment or diagnosis of current condition with appropriate objective findings;

(5) Treatment status or patient's functional response to current treatment;

(6) Treatment plan including specific therapy with time limits and measurable goals and detail of referrals;

(7) Pain diagrams, where applicable;

(8) If being completed by an authorized treating physician, all pertinent changes to work and/or activity restrictions which reflect lifting, standing, stooping, kneeling, hot or cold environment, repetitive motion or other appropriate physical considerations; and

(9) All prior authorization(s) for payment received from the payer (i.e., who approved prior authorization, services authorized, dollar amount, length of time, etc.).

(C) All services provided to patients are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not made timely. In this event, the documentation will need to be amended, corrected, or entered after rendering the service. Amendments, corrections, and delayed entries must comply with Medicare's widely accepted recordkeeping principles as outlined in the April 2018 Medicare Program Integrity Manual Chapter 3, section 3.3.2.5. (This section does not apply to patients' requests to amend records as permitted by the Health Insurance Portability and Accountability Act (HIPAA)).

(D) Authorized treating physicians must sign (or counter-sign) and submit to the payer, with their initial and final visit billings, a completed "Physician's Report of Workers' Compensation Injury" (Form WC 164) specifying:

(1) The report type as "initial" when the injured worker has his or her initial visit with the authorized treating physician managing the total workers' compensation claim (generally the designated or selected physician). If applicable, the emergency department (ED) or urgent care authorized treating physician for this workers' compensation injury also may create a Form WC 164 initial report. Unless requested or preauthorized by the payer to a specific workers' compensation claim, no other authorized physician should complete and bill for the initial Form WC 164. This form shall include completion of items 1-7 and 11. Note that certain information in item 2 (such as Insurer Claim #) may be omitted if unknown by the provider.

(2) The report type as "closing" when the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim determines the injured worker has reached maximum medical improvement (MMI) for all covered injuries or diseases, with or without permanent impairment. The form requires the completion of items 1-5, 6.B, 6.C, 7, 9, and 11. If the injured worker has sustained a permanent impairment, item 10 also must be completed and the following information shall be attached to the bill at the time of MMI:

(a) All necessary permanent impairment rating reports, including a narrative report and appropriate worksheets, when the authorized treating physician managing the total workers' compensation claim of the patient is Level II Accredited; or

(b) Referral to a Level II Accredited physician requested to perform the permanent impairment rating when a rating is necessary and the authorized treating physician managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.

(3) At no charge, the physician shall supply the injured worker with one legible copy of the completed Form WC 164 at the time the form iscompleted.

(4) The provider shall submit to the payer the completed Form WC 164 no later than 14 days from the date of service.

(E) Providers other than hospitals shall provide the payer with all supporting documentation at the time of billing unless the parties have made other agreements. This shall include copies of the examination, surgical, and/or treatment records. Hospitals shall provide documentation to the payer upon request. Payers shall specify what portion of a hospital record is being requested (for example, only the ED chart notes, in-patient physician orders and chart notes, x-rays, pathology reports, etc.).

(F) In accordance with section 16-11(B), the payer may contest payment for billed services until the provider submits the relevant required documentation.

16-11 PAYMENT OF MEDICAL BENEFITS

(A) Payer Requirements for Processing Medical Service Bills

(1) For every medical service bill submitted by a provider, the payer shall reply with a written notice or explanation of benefits (EOB). If the payer reimburses the exact billed amount, identification of the patient's name, the payer, the paid bill, the amount paid and the dates of service are required. If any adjustments are made, the payer's written notice shallinclude:

(a) Name of the injured worker;

(b) Specific identifying information coordinating the notice with any payment instrument associated with the bill;

(c) Date(s) of service(s), if date(s) was (were) submitted on the bill;

(d) Payer's claim number and/or Division's workers' compensation claim number, if one has been created;

(e) Reference to the bill and each item of the bill;

(f) Notice that the billing party may submit corrected bill or appeal within 60 days;

(g) For compensable services related to a work-related injury or occupational disease the payer shall notify the billing provider that the injured worker shall not be balance-billed;

(h) Name of insurer with admitted, ordered or contested liability for the workers' compensation claim, when known;

(i) Name, address, e-mail (if any), phone number and fax of a person who has responsibility and authority to discuss and resolve disputes on the bill;

(j) Name and address of the employer, when known; and

(k) Name and address of the third party administrator (TPA) and name and address of the bill reviewer if separate company when known; and

(l) If applicable, a statement that the payment is being held in abeyance because a hearing is pending on a relevant issue.

(2) The payer shall send the billing party written notice that complies with sections 16-11(A)(1) and (B) or (C) within 30 days of receipt of the bill. Any notice that fails to include the required information is defective and does not satisfy the 30-day notice requirement set forth in this section.

(3) Unless the payer provides timely and proper reasons set forth by sections 16-11(B)-(D), all bills submitted by a provider are due and payable in accordance with the Medical Fee Schedule within 30 days after receipt by the payer.

(4) If the payer discounts a bill and the provider requests clarification in writing, the payer shall furnish to the requester the specifics of the discount within 30 days including a copy of any contract relied on for the discount. If no response is forthcoming within 30 days, the payer must pay the maximum Medical Fee Schedule allowance or the billed charges, whichever is less.

(5) Date of receipt of the bill may be established by the payer's date stamp or electronic acknowledgement date; otherwise, presumed receipt is presumed to occur three (3) business days after the date the bill was mailed to the payer's correct address.

(6) Unreasonable delay in processing payment or denial of payment of medical service bills, as determined by the Director or an administrative law judge, may subject the payer to penalties under the Workers' Compensation Act.

(7) If the payer fails to make timely payment of uncontested billed services, the billing party may report the incident to the Division's Carrier Practices Unit to be used during an audit.

(B) Process for Contesting Payment of Billed Services Based on Non-Medical Reasons

(1) Non-medical reasons are administrative issues. Examples of non-medical reasons for contesting payment include the following: no claim has been filed with the payer; compensability has not been established; the provider is not authorized to treat; the insurance coverage is at issue; typographic, gender or date errors in the bill; failure to submit medical documentation; unrecognized CPT® code.

(2) If an ATP bills for medical services and indicates in writing, including reasoning and relevant documentation that he or she believes the medical services are related to the admitted WC claim, the payer cannot deny payment solely for relatedness without a medical opinion as required by section 16-11(C). The medical review, IME report, or report from an ATP that addresses the relatedness of the requested treatment to the admitted claim may precede the received billed service.

(3) In all cases where a billed service is contested for non-medical reasons, the payer shall send the billing party written notice of the contest within 30 days of receipt of the bill. The written notice shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if submitted on the bill;

(b) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services;

(c) Reference to the bill and each item of the bill being contested; and

(d) Clear and persuasive reasons for contesting the payment of any item specific to that bill, including the citing of appropriate statutes, rules, and/or documents supporting the payer's reasons.

Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the 30-day notice requirement set forth in this section.

(4) Prior to modifying a billed code, the payer must contact the billing provider and determine if the code is accurate. If the payer disagrees with the level of care billed, the payer may deny the claim or contact the provider to explain why the billed code does not meet the level of care criteria.

(a) If the billing provider agrees with the payer, then the payer shall process the service with the agreed upon code and shall document on the EOB the agreement with the provider. The EOB shall include the name of the person at the provider's office who made the agreement.

(b) If the provider disagrees, then the payer shall proceed according to section 16-11(B) or (C), as appropriate.

(5) If, after the service was provided, the payer agrees the service was reasonable and necessary, lack of prior authorization does not warrant denial of payment.

(6) When no established fee is given in the Medical Fee Schedule and the payer agrees the service or procedure is reasonable and necessary, the payer shall list on the written notice of contest one of the following payment options:

(a) A reasonable value based upon the similar established code value recommended by the requesting provider, or

(b) The provider's requested payment based on an established similar code value.

If the payer disagrees with the provider's recommended code value, the payer's notice of contest shall include an explanation of why the requested fee is not reasonable, the code(s) used by the payer, and how the payer calculated/derived its maximum fee recommendation. If the payer is contesting the medical necessity of any non-valued procedure after prior authorization was requested, the payer shall follow section 16-11(C).

(C) Process for Contesting Payment of Billed Services Based on Medical Reasons

When contesting payment of billed services based on medical reasons, the payer shall:

(1) Have the bill and all supporting medical documentation reviewed by a "physician provider" as defined in section 16-3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physicians or chiropractors performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. After reviewing the supporting medical documentation, the reviewing provider may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(2) In all cases where a billed service is contested for medical reasons, the payer shall send the provider and the parties written notice of the contest within 30 days of receipt of the bill. The written notice shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if submitted on the bill;

(b) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services;

(c) Reference to the bill and each item of the bill being contested;

(d) Clear and persuasive medical reasons for the decision, including the name and professional credentials of the person performing the medical review and a copy of the medical reviewer's opinion;

(e) The specific cite from the Medical Treatment Guidelines, when applicable; and

(f) Identification of the information deemed most likely to influence the reconsideration of the contest, when applicable.

(3) Any notice that fails to include the required information set forth in this section is defective. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(4) If the payer is contesting the medical necessity of any non-valued procedure provided without prior authorization, the payer shall follow the procedures given in sections 16-11(C)(1) and (2).

(D) Process for Ongoing Contest of Billed Services

(1) The billing party shall have 60 days to respond to the payer's written notice under section 16-11(A)–(C). The billing party's timely response must include:

(a) A copy of the original or corrected bill;

(b) A copy of the written notice or EOB received;

(c) A statement of the specific item(s) contested;

(d) Clear and persuasive supporting documentation or reasons for appeal; and

(e) Any available additional information requested in the payer's written notice.

(2) If the billing party responds timely and in compliance with section 16-11(D)(1), the payer shall:

(a) When contesting for medical reasons, have the bill and all supporting medical documentation and reasoning reviewed by a "physician provider" as defined in section 16-3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physicians or chiropractors performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. After reviewing the documentation and response, the reviewing provider may call the billing provider to expedite communication and timely processing of the contested or paid medical bill.

(b) When contesting for non-medical reasons, have the bill and all supporting documentation and reasoning reviewed by a person who has knowledge of the bill. After reviewing the provider's documentation and response, the reviewer may call the provider to expedite communication and timely processing of the contested or paid medical bill.

(3) If before or after conducting a review pursuant to section 16-11(D)(2), thepayer agrees with the billing party's response, the billed service is due and payable in accordance with the Medical Fee Schedule within 30 days after receipt of the billing party's response. Date of receipt may be established by the payer's date stamp or electronic acknowledgement date; otherwise, receipt is presumed to occur three (3) business days after the date the response was mailed to the payer's correct address.

(4) After conducting a review pursuant to section 16-11(D)(2), if there is still a dispute regarding the billed services, the payer shall send the billing party written notice of contest within 30 days of receipt of the response. The written notice shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:

(a) Date(s) of service(s) being contested, if submitted by the provider;

(b) If applicable, acknowledgement of specific uncontested and paid items submitted on the same bill as contested services;

(c) Reference to the bill and each item of the bill beingcontested;

(d) An explanation of the clear and persuasive medical or non-medical reasons for the decision, including the name and professionalcredentials of the person performing the medical or non-medical review and a copy of the medical reviewer's opinion when the contest is over a medical reason; and

(e) The explanation shall include the citing of statutes,rules and/or documents supporting the payer's reasons for contesting payment.

(5) Any notice that fails to include the required information set forth in thissection is defective. Such defective notice shall not satisfy the payer's 30-day notice requirement set forth in this section.

(6) In the event of continued disagreement, the parties should follow dispute resolution and adjudication procedures available through the Division or Officeof Administrative Courts. The parties shall do so within 12 months of the date the original bill should have been processed in compliance with section 16-11, unless extenuating circumstances exist.

(E) Retroactive review of Medical Bills

(1) All medical bills paid by a payer shall be considered final at 12 months afterthe date of the original EOB unless the provider is notified that:

(a) A hearing is requested within the 12 month period, or

(b) A request for utilization review has been filed pursuant to § 8-43-501.

(2) If the payer conducts a retroactive review to recover overpayments from a provider based on medical reasons, the payer shall have the bill and all supporting documentation reviewed by a "physician provider" as defined in section 16-3(A)(1)(a), who holds a license and is in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. The physicians or chiropractors performing this review shall be Level I or Level II accredited. In addition, a clinical pharmacist (Pharm.D.) as defined by section 16-3(A)(1)(b)(xvi) may review billed services for medications without having received Level I or Level II accreditation. The payer shall send the billing party written notice that shall include all notice requirements set forth in section 16-11(A)(1) and also shall include:

(a) Reference to each item of the bill where payer seeks to recover overpayments;

(b) Clear and persuasive medical reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

(3) If the payer conducts a retroactive review to recover overpayments from a provider based on non-medical reasons, the payer shall send the billing party written notice that shall include all notice requirements set forth in section 16-11(A)(1) and shall also include:

(a) Reference to each item of the bill where payer seeks to recover overpayments;

(b) Clear and persuasive reason(s) for seeking recovery of overpayment(s). The explanation shall include the citing of appropriate statutes, rules, and/or other documents supporting the payer's reason for seeking to recover overpayment; and

(c) Evidence that these payments were in fact made to the provider.

(4) In the event of continued disagreement, the parties may follow dispute resolution and adjudication procedures available through the Division or Office of Administrative Courts.

(F) An injured worker shall never be required to directly pay for admitted or ordered medical benefits covered under the Workers' Compensation Act. In the event the injured worker has directly paid for medical services that are then admitted or ordered under the Workers' Compensation Act, the payer shall reimburse the injured worker for the amounts actually paid for authorized services within 30 days after receipt of the bill. If the actual costs exceed the maximum fee allowed by the Medical Fee Schedule, the payer may seek a refund from the

medical provider for the difference between the amount charged to the injured worker and the maximum fee. Each request for a refund shall indicate the service provided and the date of service(s) involved.

(G) To the extent not otherwise precluded by the laws of this state, contracts between providers, payers and any agents acting on behalf of providers or payers shall comply with section 16-11.

(H) Onsite Review of Hospital or Other Medical Charges

(1) The payer may conduct a review of billed and non-billed hospital or medical facility charges related to a specific workers' compensation claim.

(2) The payer shall comply with the following procedures:

Within 30 days of receipt of the bill, notify the hospital or other medical facility of its intent to conduct a review. Notification shall be in writing and shall set forth the following information:

(a) Name of the injured worker;

(b) Claim and/or hospital or other medical facility I.D. number associated with the injured worker's bill;

(c) An outline of the items to be reviewed; and

(d) If applicable, the name, address and telephone number of any person who has been designated by the payer to conduct the review (reviewer).

(3) The hospital or other medical facility shall comply with the following procedures:

(a) Allow the review to begin within 30 days of the payer's notification;

(b) Upon receipt of the patient's signed release of information form, allow the reviewer access to all items identified on the injured worker's signed release of information form;

(c) Designate an individual(s) to serve as the primary liaison(s) between the hospital or other medical facility who will acquaint the reviewer with the documentation and charging practices of the hospital or other medical facility;

(d) Provide a written response to each of the preliminary review findings within ten (10) business days of receipt of those findings; and

(e) Participate in the exit conference in an effort to resolve discrepancies.

(4) The reviewer shall comply with the following procedures:

(a) Obtain from the injured worker a signed information release form;

(b) Negotiate the starting date for the review;

(c) Assign staff members who are familiar with medical terminology, general hospital or other medical facility charging and medical records documentation procedures or have a level of knowledge equivalent at least to that of an LPN;

(d) Establish the schedule for the review which shall include, at a minimum, the dates for the delivery of preliminary findings to the hospital or other medical facility, a ten (10) business day response period for the hospital or other medical facility, and the delivery of an itemized list of discrepancies at an exit conference upon the completion of the review; and

(e) Provide the payer and hospital or other medical facility with a written summary of the review within 20 business days of the exit conference.

16-12 DISPUTE RESOLUTION PROCESS

When seeking dispute resolution from the Division's Medical Dispute Resolution Unit, the requesting party must complete the Division's "Medical Dispute Resolution Intake Form" (Form WC 181) found on the Division's web page. The items listed on the bottom of the form must be provided at the time of submission. If necessary items are missing or if more information is required, the Division will forward a request for additional information and initiation of the process may be delayed.

When the request is properly made and the supporting documentation submitted, the Division will issue a confirmation of receipt. If, after reviewing the materials, the Division believes the dispute criteria have not been met, the Division will issue an explanation of those reasons. If the Division determines there is cause for facilitating the disputed items, the other party will be sent a request for a written response due in ten (10) business days.

The Division will facilitate the dispute by reviewing the parties' compliance with Rules 11, 16, 17, and 18 within 30 days of receipt of the complete supporting documentation; or as soon thereafter as possible. In addition, the payer shall pay interest at the rate of eight percent per annum in accordance with § 8-43-410(2), upon all sums not paid timely and in accordance with the Division Rules. The interest shall be paid at the same time as any delinquent amount(s).

Upon review of all submitted documentation, disputes resulting from violation of Rules 11, 16, 17 and 18, as determined by the Director, may result in a Director's Order that cites the specific violation.

Evidence of compliance with the order shall be provided to the Director. If the party does not agree with the findings, it shall state with particularity and in writing its reasons for all disagreements by providing a response with all relevant legal authority, and/or other relevant proof upon which it relies in support of its position(s) concerning disagreements with the order.

Failure to respond or cure violations may result in penalties in accordance with § 8-43-304. Daily fines up to $1,000/day for each such offence will be assessed until the party complies with the Director's Order.

Resolution of disputes not pertaining to Rule violations will be facilitated by the Division to the extent possible. In the event both parties cannot reach an agreement, the parties will be provided additional information on pursuing resolution and adjudication procedures available through the Office of Administrative Courts. Use of the dispute resolution process does not extend the 12 month application period for hearing.

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 STATEMENT OF PURPOSE

Pursuant to § 8-42-101(3)(a)(I) and § 8-47-107, the Director promulgates this Medical Fee Schedule to review and establish maximum allowable fees for health care services falling within the purview of the Workers' Compensation Act of Colorado. The Director adopts and hereby incorporates by reference, as modified and published by Medicare, the April 2018 National Physician Fee Schedule Relative Value file (RBRVS-Resource Based Relative Value Scale); the Current Procedural Terminology (CPT®) 2018, Professional Edition, published by the American Medical Association (AMA); and Medicare Severity Diagnosis Related Groups (MS-DRGs) Definitions Manual, Version 36 using MS-DRGs effective October 1, 2018. The incorporation of all materials is limited to the specific editions named and does not include later revisions or additions. The Director adopts all guidelines and instructions set forth in the RBRVS, CPT®, and MS-DRGs, as well as all CPT® modifiers, unless otherwise specified in this Rule.

This Rule applies to all services rendered on or after January 1, 2019. All other bills shall be reimbursed in accordance with the fee schedule in effect at the time service was rendered.

18-2 STANDARD TERMINOLOGY FOR THIS RULE

(A) CPT® - Current Procedural Terminology CPT® 2018, copyrighted and distributed by the AMA and incorporated by reference in 18-1.

(B) DoWC Zxxxx – Colorado Division of Workers' Compensation created codes. See Exhibit #9.

(C) MS-DRGs – version 36.0 incorporated by reference in 18-1.

(D) Medicare's April 2018 National Physician Fee Schedule Relative Value file (RBRVS) as modified by Rule 18 and its exhibits to establish the Medical Fee Schedule. For a list of Division-created and modified rates and values, see Exhibit #9.

(E) For other terms, see Rule 16, Utilization Standards.

18-3 HOW TO OBTAIN COPIES

For information about inspecting or obtaining copies of the incorporated materials, interested parties may contact the Medical Services Manager, 633 17th Street, Suite 400, Denver, CO 80202-3626. These materials are available at any state publications depository library. The RBRVS may be obtained from Medicare, www.cms.gov/Medicare/Medicare-Fee-For-Service-Payment/PhysicianFeeSched/Index.html. The CPT® 2018 Edition may be purchased from the AMA. The MS-DRGs Definitions Manual may be purchased from 3M Health Information Systems. The unofficial copies of the Workers' Compensation Rules of Procedure, the Medical Treatment Guidelines, 7 CCR 1101-3, and the Interpretive Bulletins are available on the Division's website, https://www.colorado.gov/pacific/cdle/dwc or they may be purchased from LexisNexis. An official copy of the rule is available on the Colorado Secretary of State's webpage, http://www.sos.state.co.us/CCR/Welcome.do.

18-4 CONVERSION FACTORS (CFs)

The following CFs determine the maximum fees. The fees are determined by multiplying the CFs by the established facility or non-facility total relative value units (RVUs) found in the corresponding RBRVS sections:

RBRVS SECTION	CF
Anesthesia	$50.00/RVU

Surgery	$72.00/RVU
Radiology	$72.00/RVU
Pathology	$72.00/RVU
Medicine	$72.00/RVU
Physical Medicine and Rehabilitation (Includes Medical Nutrition Therapy and Acupuncture)	$43.75/RVU
Evaluation & Management (E&M)	$54.81/RVU

Table #1 lists the place of service codes used with the RBRVS facility RVUs. All other maximum fee calculations shall use the non-facility RVUs listed in the RBRVS.

Table #1	
Place of Service Code	Place of Service Code Description
02	Telehealth Services
19	Off Campus – Outpatient Hospital
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

18-5 INSTRUCTIONS AND MODIFICATIONS INCORPORATED BY REFERENCE IN RULE 18-1

(A) MAXIMUM ALLOWANCE

Maximum allowance for all providers under Rule 16-3 is 100% of the RBRVS value or as specified in this Rule. The maximum allowance for professional services of 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 16-3(A)(5) have been met and one of the following conditions applies:

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

(a) a county outside a Metropolitan Statistical Area (MSA) or

(b) 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.

(2) The PA or NP has received Level I accreditation.

(B) RBRVS, CPT®, HCPCS, NATIONAL DRUG CODE, AND Z CODES

(1) Division-created codes and values supersede CPT®, Health Care Common Procedure Coding System (HCPCS), and National Drug Code (NDC) codes and values. Codes listed with RVUs of "BR" (by report), not listed, or listed with a zero value and not included by Medicare in another procedure(s), require prior authorization (see Rule 16-6).

(2) Correct Reporting of Services/Procedures and Payment Policies:

(a) Providers shall report codes and number of units based on all applicable code descriptions and Rule 18. In addition, providers shall document all services/procedures in the medical record.
(b) Providers shall report the most comprehensive code that represents the entire service.
(c) Providers shall report only the primary services and not the services that are integral to the primary services.
(d) Providers shall document the time spent performing all time-based services or procedures in accordance with applicable code descriptions.
(e) Providers shall apply modifiers to clarify services rendered and/or adjust the maximum allowances as indicated in Rule 18. Prior to correcting a modifier, payers shall comply with Rule 16-11(B)(4).
(f) The Division does not recognize Medicare's Medically Unlikely Edits.

(3) The following RBRVS fields and attributes are adopted, including additional fields as defined by the Division:

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

(b) Modifier;

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

(d) Status Code:

Code	**Meaning**
A	Active Code
B	Bundled Code
C	Payer-Priced
D, F & H	Deleted Code or Modifier
E, G, I, N, R, or X	Not Valid or Covered for Medicare, but Valid for CO WC
J	Anesthesia Code

M & Q	Measurement or Functional Information Codes - No Value
P	Bundled or Medicare-Excluded Codes
T	Injections

(e) Increment of Service/Billable (when specified);

(f) Conversion Factors (CFs) listed in section 18-4 or an exhibit to this Rule to establish value.

(g) Anesthesia Base Unit(s), see section 18-5(D);

(h) Non-Facility (NF) Total RVUs;

(i) Facility (F) Total RVUs;

(j) 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.

(k) Global Days: the number of follow-up days beginning on the day after the surgery and continuing for the defined period.

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 on the same day as procedures and 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.

(l) 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 column lists the pre-operative percentage of the total surgical fee value.

(m) 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 column lists the intra-operative percentage of the total surgical fee value.

(n) 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 column lists the post-operative percentage of the total surgical fee value.

(o) Multiple-Procedure Modifier

Payers shall reimburse the highest-valued procedure at 100% of the fee schedule, even if the provider appends modifier 51. Payers shall reimburse the lesser-valued procedures performed in the same operative setting at 50% of the fee schedule, as follows:

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.

(p) Bilateral Procedures

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 should be reported on one line with modifier 50 and "1" in the units box. Provider performing the same bilateral procedure during the same operative setting multiple times 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 fee is increased to 150% of the fee schedule value. If provider performs 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. Indicator 3 codes are primarily diagnostic radiology and other diagnostic medicine procedures.
9	Not eligible for the bilateral payment adjustment because the concept does not apply.

(q) Assistant Surgeon, Modifiers 80, 81, 82, or AS

The designation of "almost always" for a surgical code in the Physicians as Assistants at Surgery: 2018 Update (February 2018), published by the American College of Surgeons shall indicate that separate payment for an assistant surgeon is allowed for that code. See section 18-5(E)(1). 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.

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.

(r) Co-Surgeons, 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 fee value is increased to 125% of the fee schedule value. The payment is apportioned to each surgeon in relation to his or her 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.

(s) Team Surgeons, 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.

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

(u) All other fields are not recognized.

(4) CPT® Category III codes listed in the RBRVS may be used for billing with payer agreement. Payment shall comply with Rule 16-8(C).

(C) EVALUATION AND MANAGEMENT (E&M)

(1) Evaluation and management codes may be billed by physician providers as defined in Rule 16-3(A)(1)(a), nurse practitioners (NP), and physician assistants (PA). To justify the billed level of E&M service, medical record documentation shall utilize the 2018 CPT® E&M Services Guidelines and either the "E&M Documentation Guidelines" criteria adopted in Exhibit #7, or Medicare's 1997 Evaluation and Management Documentation Guidelines.

Disability counseling should be an integral part of managing workers' compensation injuries. The counseling shall be completely documented in the medical records, including, but not limited to, the amount of time spent with the injured worker and the specifics of the discussion as it relates to the individual patient. Disability counseling shall include, but not be limited to, return to work, temporary and permanent work restrictions, self-management of symptoms while working, correct posture/mechanics to perform work functions, job task exercises for muscle strengthening and stretching, and appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury.

For adjusted RVUs and rates, see Exhibit #9.

(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 (3) 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 reported 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 (1) office visit per patient, per day, per workers' compensation claim, unless prior authorization is obtained (see Rule 16-6).

(4) Treating Physician Telephone or On-line Services:

Telephone or on-line services may be billed if the medical records/documentation specifies all the following:

(a) The amount of time and date;
(b) The patient, family member, or healthcare provider talked to; and
(c) Specific discussion and/or decision made during the communication.

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

(5) Face-to-Face or Telephonic Treating Physician or Qualified Non-physician Medical Team Conferences

A medical team conference can only be billed if all CPT® criteria are met. A medical team conference shall consist of medical professionals caring for the injured worker. The billing statement shall be prepared pursuant to Rule 16.

(6) Consultation/Referrals/Transfers of Care/Independent Medical Examinations

A consultation occurs when a treating physician seeks an opinion from another physician regarding a patient's diagnosis and/or treatment.

A transfer of care occurs when one physician turns over the responsibility for the comprehensive care of a patient to another physician.

An independent medical exam (IME) occurs when a physician is requested to evaluate a patient by any party or party's representative and is billed in accordance with section 18-6(G).

To bill for any inpatient or outpatient consultation codes, the provider must document the following:

(a) Identity of the requesting physician for the opinion.
(b) The need for a consultant's opinion.
(c) Statement that the report was submitted to the requesting provider.

(7) 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 health care professionals (MDs, DOs, DCs, DMPs, NPs, and PAs) with or without direct patient contact.

(i) An E&M code shall accompany prolonged services codes.

(ii) The provider must exceed the average times listed in the E&M section of CPT® by 30 minutes or more, in addition to the prolonged services codes.

(iii) If using time spent (rather than three key components) to justify the level of primary E&M service, the provider must bill the highest level of service available in the applicable E&M subcategory before billing for prolonged services.

(iv) The provider 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 health care professional supervision:

(i) The supervising physician or other qualified health care 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.

(D) ANESTHESIA

(1) All anesthesia base values are set forth in Medicare's 2018 Anesthesia Base Values. For adjusted RVUs and rates, see Exhibit #9. 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 includes the following:

(i) performs a pre-anesthesia examination and evaluation,
(ii) prescribes the anesthesia plan,
(iii) personally participates in the most demanding procedures in the anesthesia plan including induction and emergence,
(iv) ensures that any procedure in the anesthesia plan that s/he does not perform 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) The supervision of AAs shall be in accordance with the Medical Practice Act.

(3) HCPCS Level II modifiers are required when billing for anesthesia services. Modifier AD shall be used when an anesthesiologist supervises more than four (4) concurrent (occurring at the same time) anesthesia service cases. Maximum allowance for supervising multiple cases is calculated using three (3) base anesthesia units to each case, regardless of the number of base anesthesia units assigned to each specific anesthesia episode of care.

(4) Physical status modifiers are reimbursed as follows, using the anesthesia CF:

(a)	P-1	Healthy patient	0 RVUs
(b)	P-2	Patient with mild systemic disease	0 RVUs
(c)	P-3	Patient with severe systemic disease	1 RVU
(d)	P-4	Patient with severe systemic disease that is a constant threat to life	2 RVUs
(e)	P-5	A moribund patient who is not expected to survive without the operation	3 RVUs
(f)	P-6	A declared brain-dead patient	0 RVUs

(5) Qualifying circumstance codes are reimbursed using the anesthesia CF.

(6) 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 billed with the total anesthesia time for all procedures.

(7) Total minutes are reported for reimbursement. Each 15-minutes of anesthesia time equals 1 additional RVU. Five minutes or more is considered significant time and adds 1 RVU to the payment calculation.

(8) Calculation of Maximum Fees for Anesthesia

Base Anesthesia value from the Medicare's 2018 Anesthesia Base Values

+1 Unit/15 minutes of anesthesia time
+Any physical status modifier units
Total Relative Value Anesthesia Units
Multiplied by the Anesthesia CF in section 18-4
Total Maximum Anesthesia Fees

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

(E) 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: 2018 Update (February 2018), available from the American College of Surgeons, Chicago, IL, or from its web page. The incorporation is limited to the edition named and does not include later revisions or additions.

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

(b) Payment for more than one (1) assistant surgeon or minimum assistant surgeon requires prior authorization (see Rule 16-6).

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

(d) Maximum allowance for an assistant surgeon or minimum assistant surgeon, reported by a non-physician, as indicated by modifier AS with modifier 80, 81 or 82, is 10% of the surgeon's fees (the 85% adjustment in section 18-5(A) does not apply).

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

(f) See section 18-5(B)(3)(q) for additional payment policies applicable to assistant surgeons.

(2) Global Package

(a) All surgical procedures include the following:

(i) local infiltration, metacarpal/metatarsal/digital block, or typical anesthesia;

(ii) one related E&M encounter on the date immediately prior to or on the date of the procedure (including history and physical);

(iii) intra-operative services that are normally a usual and necessary part of a surgical procedure;

(iv) immediate post-operative care, including dictating operative notes, talking with the family and other physicians;

(v) evaluating the patient in the post-anesthesia recovery room;

(vi) post-surgical pain management by the surgeon;

(vii) typical post-operative follow-up care during the global period of the surgery that is related to recovery, see section 18-5(B)(3)(k).

(viii) supplies integral to an operative procedure. See section 18-6(H) to determine reimbursement for unrelated supplies or Durable Medical Equipment, Orthotics or Prosthetics (DMEPOS).

Casting supplies are separately payable only if related fracture or surgical care code is not billed. The HCPCS Level II "Q" code(s) are used for reporting any associated DMEPOS fees.

(ix) pre or post-operative services integral to the operative procedure and performed within the global follow-up period are not separately payable. These services include, but are not limited to the following:

- dressing changes;
- local incisional care;
- removal of operative pack;
- removal of cutaneous sutures and staples, lines, wires, tubes, or drains;

- initial application of casts and splints;
- insertion, irrigation, and removal of urinary catheters;
- routine peripheral IV lines;
- nasogastric and rectal tubes;
- changes and removal of tracheostomy tubes;
- post-surgical pain management by the surgeon;
- all complications leading to additional procedures performed by the surgeon, but not requiring an operating room. Complications requiring an operating room are separately payable with modifier 78.

(b) Modifiers:

Code	Payment policy
22	The payer and provider shall negotiate the value based on the fee schedule and the amount of additional work.
54	Surgical care only. This modifier can be combined with either modifier 55 or 56, but not both. Maximum fee is the applicable percentage in the “intra-op %” RBRVS column multiplied by the fee schedule value.
55	Post-operative management only. This modifier can be combined with either modifier 54 or 56, but not both. Maximum fee is the applicable percentage in the “post-op %” RBRVS column multiplied by the fee schedule value.
56	Pre-operative management only. This modifier can be combined with either modifier 54 or 55, but not both. Maximum fee is the applicable percentage in the “pre-op %” RBRVS column multiplied by the fee schedule value.
58	Maximum fee value is 100% of prospective procedures that occur on the same day or staged over a couple of days.
62	Co-Surgeon use when different surgical skills are necessary to perform a surgical procedure.
76	
78	Maximum fees for this unplanned trip 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).
79	

(c) Significant and separately identifiable services performed during the global period are separately payable. The services involve unusual circumstances, complications, exacerbations, or recurrences; and/or unrelated diseases or injuries.

Modifiers 24, 25, and 57 shall be used to over-ride the global package edits/limits:

Modifier	Payment and billing policies	Applicability/Documentation
24	E&M services unrelated to the primary surgical procedure. The reasonableness and necessity for an E&M service that is separate and identifiable from the surgical global period shall be documented in the medical record. If possible, an appropriate identifying diagnosis code shall identify the E&M service as unrelated to the surgical global period. Disability management of an injured worker for the same diagnosis requires the physician to identify the specific disability management detail performed during that visit.	Services necessary to stabilize the patient for the primary surgical procedure. Services not considered part of the surgical procedure, including an E&M visit by an authorized treating physician for disability management. The definitions of disability counseling are located under section 18-5(C)(1) and in Exhibit #7.
25	Initial or follow up visit that occurred on the same day/encounter as a minor surgical procedure.	E&M documentation must support the patient's condition. The visit must be significant and separately identifiable from the minor surgical procedure and the usual pre- and post-operative care required.
57	The surgeon's E&M visit that resulted in the decision for major surgery performed on either the same day or the day after the visit.	The E&M documentation must identify the medical necessity of the procedure and the discussion with the patient.

(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) A diagnostic arthroscopy that resulted in a surgical arthroscopy at the same surgical encounter is bundled into the surgical arthroscopy and is not separately payable.
(c) 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.
(d) 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.
(e) Only the joints/compartments listed in subsections (4) through (6) below are recognized for separate payment purposes.

(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.
(c) Limited synovectomy involving one knee compartment is not separately payable with another arthroscopic procedure on the same knee.
(d) Payment for a major synovectomy procedure shall require a synovial diagnosis and two or more knee compartments without any other arthroscopic surgical procedures performed in the same compartment.

(5) Shoulder Arthroscopies

(a) Glenohumeral, acromioclavicular, and subacromial bursal space are the shoulder regions recognized for purposes of separate payment.
(b) Limited debridement performed with a shoulder arthroscopy is bundled into the arthroscopy and is not separately payable unless subsection (c) applies.
(c) Limited debridement performed in the glenohumeral region is separately payable if it is the only procedure performed in that region in the surgical encounter.
(d) Extensive debridement is separately payable if documented in the medical record.

(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 18-5(B)(3)(o) 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 18-5(B)(3)(o) 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 covered under Exhibit #8.

(8) Platelet Rich Plasma (PRP) Injections

The Medical Treatment Guidelines (Rule 17) govern PRP injections. Any PRP injections outside of the Medical Treatment Guidelines require prior authorization.

The provider performing PRP injections in an office setting shall bill DoWC Z0813 for professional fees.

The provider performing PRP injections in a facility setting shall bill CPT® 0232T, for professional fees. For adjusted RVUs and rates, see Exhibit #9.

The above allowances include and apply to all body parts, imaging guidance, harvesting, preparation, the injection itself, kits, and supplies.

(F) RADIOLOGY

(1) General Policies

(a) Payers and providers shall use professional component (26) or technical component (TC) modifiers per CPT® guidelines. The technical component represents the cost of equipment, supplies and personnel necessary to perform the procedure.

(b) A stand-alone procedure code describes the selected diagnostic tests for which there are associated codes that describe (a) the professional component of a test only, (b) the technical component of a test only and (c) the global test only. Modifiers 26 and TC cannot be billed with these codes.

(2) 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 separately reporting Z9999 certify accreditation status. The payer may also request proof of accreditation.

(b) The professional component for MRIs, CTs, and nuclear medicine scans is reimbursable at 130% of the fee schedule.

(c) The cost of dyes and contrast shall be reimbursed in accordance with section 18-6(H).

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

(e) The payer may use available billing information such as provider credential(s) and clinical record(s) to determine if appropriate CPT®/RBRVS modifier should have been used on the bill. To modify a billed code, refer to Rule 16-11(B)(4).

(f) Providers using film instead of digital X-rays shall append the FX modifier. The fee 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 (1) 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 fee for an X-ray consultation shall be no greater than the maximum fee 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.

(3) Thermography

(a) The provider supervising and interpreting the thermographic evaluation shall be board certified by the examining board of one (1) 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

DoWC Z0201 Lower body w/Autonomic Stress Testing

(c) Prior authorization (see Rule 16-6) is required for thermography services only if the requested study does not meet the indicators for thermography as outlined in the Division's Chronic Regional Pain Syndrome Medical

Treatment Guideline (Rule 17, Exhibit #7). The bill shall include a report that supplies the thermographic evaluation and complies with section 18-5(F)(2).

(4) Urea breath test C-14 (isotopic), acquisition for analysis, and the analysis maximum fees are listed under Exhibit #8.

(G) PATHOLOGY

(1) General Policies

(a) Providers and payers shall use professional component (PC) or technical component (TC) modifiers per CPT® guidelines. The technical component represents the cost of equipment, supplies and personnel necessary to perform the procedure.

(b) A stand-alone procedure code describes the selected diagnostic tests for which there are associated codes that describe (a) the professional component of a test only, (b) the technical component of a test only, and (c) the global test only. Modifiers 26 and TC cannot be billed with these codes.

(2) Clinical Laboratory Improvement Amendments (CLIA)

Laboratories with a CLIA certificate of waiver may perform only those 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 to claim lines.

(3) Payments

All clinical pathology laboratory tests, except as allowed by this Rule, are reimbursed at the total component value listed under Exhibit #8 or billed charges, whichever is less. Technical or professional component maximum split is not separately payable. However, the billing parties may agree how to split the total maximum fees listed in Exhibit #8.

When a physician clinical pathologist is required for consultation and interpretation, and a separate written report is created, the maximum fee is determined by using RBRVS values and the Pathology CF. The Pathology CF determines the Maximum Fee Schedule value 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 proper CPT® code and RBRVS values, not DoWC Z0755.

(4) Clinical Drug Screening/Testing Codes and Values (for adjusted RVUs and rates, see Exhibit #9):

(a) Clinical drug screening/testing evaluates whether:

(i) prescribed medications are at or below therapeutic or toxic levels (therapeutic drug monitoring); or
(ii) the patient is taking prescribed controlled substance medications; or
(iii) the patient is taking any illicit or non-prescribed drugs.

(b) Billing requirements for clinical drug testing:

(i) the ordering physician shall document the medical necessity of the clinical drug test.
(ii) the ordering physician shall specify which drugs require definitive testing to meet the patient's medical needs.
(iii) quantification of illicit or non-prescribed drugs or drug classes requires a physician order.
(iv) Medicare codes used in the 2018 Medicare Fee Schedule shall be billed for presumptive and definitive urine drug tests.
(v) all recognized codes and maximum fee values are listed in Exhibit #8.

(c) Presumptive Tests

All drug class immunoassays or enzymatic methods are considered presumptive. Providers may only bill one presumptive code per date of service, regardless of the number of drug classes tested.

(d) 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. 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 tetrahydrocannabinol (THC) 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 18-8(A) for examples). Providers may only bill one definitive HCPCS Level II code per day.

  The table below should be used to determine the appropriate drug class(es) when billing G0480-G0483. CPT® may be consulted for examples of individual drugs within each class. Each class of drug can only be billed once per day.

Definitive classes			
Alcohol(s)	Antiepileptics, not otherwise specified	Gabapentin, non-blood	Phencyclidine
Alcohol Biomarkers	Antipsychotics, not otherwise specified	Heroin metabolite	Pregabalin
Alkaloids, not otherwise specified	Barbiturates	Ketamine and Norketamine	Propoxyphene
Amphetamines	Benzodiazepines	Methadone	Sedative Hypnotics (nonbenzodiazepines)
Anabolic steroids	Buprenorphine	Methylenedioxyamp-hetamines	Skeletal Muscle Relaxants
Analgesics, non-opioids	Cannabinoids, natural	Methylphenidate	Stereoisomer (enantiomer) analysis
Antidepressants, serotonergic class	Cannabinoids, synthetic	Opiates	Stimulants, synthetic
Antidepressants, Tricyclic and other cyclicals	Cocaine	Opioids and Opiate analogs	Tapentadol
Antidepressants, not otherwise specified	Fentanyls	Oxycodone	Tramadol
Drug(s) or substance(s), definitive, qualitative or quantitative, not otherwise specified			

(H) MEDICINE

(1) See section 18-6(M) for medicine home care services.

(2) Anesthesia qualifying circumstance values are reimbursed in accordance with section 18-5(D)(5).

(3) 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 patient's authorized treating physician, psychologist, or psychiatrist. Professionals integrating biofeedback with any form of psychotherapy must be licensed as a psychologist, a social worker, a marriage or a family therapist, or a licensed professional counselor.

Biofeedback treatment must be provided in conjunction with other psychosocial or medical interventions.

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.

For adjusted RVUs and rates, see Exhibit #9.

(4) Appendix J of 2018 CPT® identifies mixed, motor, and sensory nerve conduction studies and applicable billing requirements. Electromyography (EMG) and nerve conduction velocity (NCV) values generally include an evaluation and management (E&M) service. However, an E&M service may be separately payable if the requirements listed in Appendix A of 2018 CPT® for billing modifier 25 have been met.

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

(a) Prior authorization (see Rule 16-6) shall be obtained before billing for more than four body regions in one (1) visit. Manipulative therapy is limited to the maximum allowed in the Medical Treatment Guidelines. The provider's medical records shall reflect medical necessity and prior authorization if treatment exceeds these limitations.

(b) An office visit may be billed on the same day as manipulation codes when the documentation meets the E&M requirements and an appropriate modifier is used.

(c) For adjusted RVUs and rates, see Exhibit #9.

(6) Psychiatric/Psychological Services (for adjusted RVUs and rates, see Exhibit #9):

(a) A licensed psychologist (PsyD, PhD, EdD) is reimbursed a maximum of 100% of the Medical Fee Schedule. Other non-physician providers performing psychological/psychiatric services shall be paid at 85% of the fee allowed for physicians.

(b) Prior authorization is required if the limitations discussed in this section are exceeded in a single day.

Psychiatric diagnostic evaluation code(s) are limited to one per provider, per admitted claim, unless prior authorization is received from the payer.

(c) Central Nervous System (CNS) Assessments/Tests, (neuro-cognitive, mental status, speech) requiring more than six (6) hours require prior authorization.

Brief psychological screens (including, but not limited to, the Distress Risk and Assessment Method (DRAM), Primary Care Evaluation of Mental

Disorders (PRIME-MD), Zung Self-Rating Depression Scale, Beck Depression Inventory, and CES-D (Center for Epidemiologic Studies Depression Scale) are not equivalent to psychological testing codes listed in the CNS section of CPT®.

Most initial evaluations for delayed recovery, exclusive of testing, can be completed in two (2) hours.

(d) The limit for psychotherapy services is 60 minutes per visit.

Prior authorization is required any time the 60 minutes per visit limitation is exceeded. The time for internal record review/documentation is included in this limit.

Psychotherapy for work-related conditions requiring more than 20 visits or continuing for more than three (3) months after the initiation of therapy, whichever comes first, requires prior authorization unless specifically addressed in the Medical Treatment Guidelines.

(e) When billing an evaluation and management (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) Upon request of a party to a workers' compensation claim and pursuant to HIPAA regulations, a psychiatrist, psychologist or other qualified health care professional may generate a separate report and bill for that service.

(7) Qualified Non-Physician Provider Telephone or On-Line Services

Reimbursement to qualified non-physician providers for coordination of care with medical professionals shall be based upon the telephone codes for qualified non-physician providers found in the RBRVS Medicine Section. Coordination of care reimbursement is limited to telephone calls made to professionals outside of the non-physician provider's facility(ies) and to the injured worker or his or her family.

For reimbursement of face-to face or telephonic meetings by a treating physician with employer, claim representative, or attorney, see section 18-6(A)(1).

(8) 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 (2) 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) Bill DoWC Z0401 QSART, 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.

(9) Intra-Operative Monitoring (IOM)

IOM is used to identify 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 for IOM: Technical and Professional

(i) Technical staff: A qualified specifically trained technician shall set up the monitoring equipment in the operating room and is expected to 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 monitoring 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 monitoring physician shall not monitor more than three (3) surgical patients at one time. The monitoring 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 for any reason. There is no additional payment for the back-up neuromonitoring physician, unless he/she is utilized in a specific case.

(iii) Technical Electronic Capacity for Real-Time Communication Requirements

The electronic communication equipment shall use a 16-channel monitoring and minimum real-time auditory system, with the possible addition of video connectivity between monitoring staff, operating surgeon and anesthesia. The equipment must also provide for all of the monitoring modalities that may be applied with the IOM procedure code.

(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 throughout the surgical procedure have separate professional and technical components, which may be separately payable if documented and otherwise allowed in this Rule.

The monitoring physician is the only party allowed to report these codes.

For adjusted RVUs and rates, see Exhibit #9.

(10) Speech-language therapist/pathology or any care rendered under a speech-language therapist/pathology plan of care shall be billed with a GN modifier appended to all billing codes.

(11) Vaccine and toxoids shall be billed using the appropriate J code or CPT® code listed in the Medicare Part B Drug Average Sale Price (ASP), 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.

(12) IV Infusions Performed in Physicians' Offices or Sent Home with Patient

IV infusion therapy performed in a physician's office 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 infused therapeutic drugs are payable at cost to the provider's office.

Maximum fees for supplies and medications provided by a physician's office for self-administered home care infusion therapy are covered in section 18-6(M)(1).

(13) Moderate (Conscious) Sedation

Providers billing for moderate sedation services shall comply with all applicable 2018 CPT® billing instructions. The Maximum Fee Schedule value is determined using the Medicine CF.

(14) Special Services, Procedures and Reports in the Medicine Section of CPT® (for adjusted RVUs and rates, see Exhibit #9):

(a) Handling and conveyance of specimens in connection with a transfer from an office to a laboratory is a flat rate. Any other handling and conveyance in connection with implementation of an order involving devices (such as orthotics) is a flat rate.

(b) Post-operative follow-up visit is included in the global package and is not separately payable.

(c) Educational supplies are considered "at cost" to the provider and may be billed based upon an agreement between the payer and provider.

(d) Any stored clinical or physiological data analysis is not recognized unless the provider shows the reasonableness and necessity of these services and obtains prior authorization from the payer.

(e) The charges for services performed after regular business hours, during holidays, or during scheduled disruptions of regular office services are not payable unless the provider shows the reasonableness and necessity of these services and obtains prior authorization.

(f) Unusual travel expenses require prior authorization by the payer. The payer and billing provider shall agree upon maximum fees.

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

Restorative services are an integral part of the healing process for a variety of injured workers. For adjusted RVUs and rates, see Exhibit #9.

(1) Billing and documentation requirements:

Physical therapy or any care provided under a physical therapist's plan of care shall be billed with a GP modifier appended to all billed codes.

Occupational therapy or any care provided under an occupational therapist's plan of care shall be billed with a GO modifier appended to all billed codes.

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

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.

(2) Medical nutrition therapy requires prior authorization.

(3) For recommendations on the use of the PM&R procedures, modalities, and testing, see the Medical Treatment Guidelines.

(4) Special Note to all PM&R Providers:

The ATP shall obtain prior authorization (see Rule 16-6) from the payer for any PM&R treatment not listed in or exceeding the frequency or duration recommendations in the Medical Treatment Guidelines.

The injured worker shall be re-evaluated by the prescribing physician within 30 calendar days from the initiation of the prescribed treatment and at least once every month while that treatment continues to establish achievement of functional goals. Prior authorization shall be required for treatment of a condition not covered under the Medical Treatment Guidelines or exceeding 60 calendar days from the initiation of treatment.

(5) Interdisciplinary Rehabilitation Programs – require prior authorization to determine fees.

An interdisciplinary rehabilitation program is one that provides focused, coordinated, and goal-oriented services using a team of professionals from varying disciplines to deliver care. These programs can benefit persons who have limitations that interfere with their physical, psychological, social, and/or vocational functioning. As defined in the Medical Treatment Guidelines, 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 their proposed fees for the entire program and all professionals. 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.

If the individual interdisciplinary rehabilitation professionals bill separately for their participation in an interdisciplinary rehabilitation program, the applicable CPT® codes shall be used to bill for their services. Demonstrated participation in an interdisciplinary rehabilitation program allows the use of the frequencies and durations listed in the relevant Medical Treatment Guideline's recommendations.

(6) Procedures (therapeutic exercises, neuromuscular re-education, aquatic therapy, gait training, massage, acupuncture, dry needling of trigger points, manual therapy techniques, therapeutic activities, cognitive development, sensory integrative techniques and any unlisted physical medicine procedures.)

The provider's medical records shall reflect the medical necessity and the provider shall obtain prior authorization if the procedures are not recommended or the frequency and duration exceeds the recommendations of the Medical Treatment Guidelines.

The maximum amount of time allowed is one (1) hour of procedures per day per discipline unless medical necessity is documented and prior authorization is obtained from the payer. The total amount of billed unit time cannot exceed the total time spent performing the procedures.

For Dry Needling of Trigger Points, single or multiple needles, use DoWC Z0501 or Z0502 as appropriate.

(7) Modalities

There is a total limit of two (2) modalities (whether timed or non-timed) per visit, per discipline, per day.

NOTE: Instruction and application of a transcutaneous electric nerve stimulation (TENS) unit for the patient's independent use at home shall be billed only once per workers' compensation claim using CPT® 64550. Rental or purchase of a TENS unit requires prior authorization. For Maximum Fee Schedule value, see section 18-6(H).

The maximum value for unlisted modalities is equal to the value of an ultrasound.

(8) Evaluation Services for Therapists: Physical Therapy (PT), Occupational Therapy (OT) and Athletic Trainers (ATC).

(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 the 2018 CPT®. The provider shall clearly state the reason for the evaluation, the nature and results of the physical examination of the patient, and the reasoning for recommending the continuation or adjustment of the treatment protocol. Without appropriate supporting documentation, the payer may deny payment. 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 professional 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. Therapists should not bill these codes for a progress note. Therapists may bill a re-evaluation code only if:

(i) professional assessment indicates a significant improvement or decline or change in the patient'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.
(iii) the patient fails to respond to the treatment outlined in the current plan of care.

(b) A PT or OT may utilize a Rehabilitation Communication Form (WC196) in addition to a progress note no more than every 2 weeks for the first 6 weeks, and once every 4 weeks thereafter.

The WC196 form should not be used for an evaluation, re-evaluation or re-assessment.

The WC196 form must be completed and include which validated functional tool was used for assessing the patient.

The form shall be sent to the referring physician before or at the patient's

follow up appointment with the physician, to aid in communication. Bill DoWC Z0817.

(c) Payers are only required to pay for evaluation services directly performed by a PT, OT, or ATC. All evaluation notes or reports must be written and signed by the PT, OT or ATC.

(d) A patient may be seen by more than one (1) health care professional on the same day. Each professional may charge an evaluation service with appropriate documentation per patient, per day.

(e) Reimbursement to PTs and OTs for coordination of care with professionals shall be based upon the telephone codes for qualified non-physician providers found in the Medicine Section of CPT®. Coordination of care reimbursement is limited to telephone calls made to outside professionals and/or to the injured worker or his or her family.

(f) Interdisciplinary team conferences shall be billed per subsection (5) above.

(9) Special Tests

(a) The following are considered special tests:

(i) Job Site Evaluation
(ii) Functional Capacity Evaluation
(iii) Assistive Technology Assessment
(iv) Speech
(v) Computer Enhanced Evaluation (DoWC Z0503)
(vi) Work Tolerance Screening (DoWC Z0504)

(b) Billing Restrictions:

(i) Job site evaluations exceeding two (2) hours require prior authorization. Computer-Enhanced Evaluations and Work Tolerance Screenings for more than four (4) hours per test or more than three (3) tests per claim require prior authorization. Functional Capacity Evaluations for more than four (4) hours per test or two (2) tests per claim require prior authorization.

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

(iii) The value for 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, speech language pathologist/therapist or audiologist. Final reports must be written

and signed by the physician, PT, OT, speech language pathologist/therapist or audiologist.

(10) Physical medicine supplies are reimbursed in accordance with section 18-6(H).

(11) If a patient uses a facility or its equipment for unattended procedures, in an individual or group setting, bill DoWC Z0505 (once per day).

(12) Non-Medical Facility Fees

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

(13) Unlisted services require a report.

(14) Work Conditioning, Work Hardening, Work Simulation

(a) Work Conditioning is a non-interdisciplinary program that is focused on the individual needs of the patient to return to work. Usually one (1) discipline oversees the patient in meeting goals to return to work.

(b) Work Hardening is an interdisciplinary program that uses a team of disciplines to meet the goal of employability and return to work. This type of program entails a progressive increase in the number of hours a day that an individual completes work tasks until they can tolerate a full workday. In order to do this, the program must address the medical, psychological, behavioral, physical, functional and vocational components of employability and return to work.

(c) Work Simulation is a program where an individual completes specific work-related tasks for a particular job and return to work. Use of this program is appropriate when modified duty can only be partially accommodated in the work place, when modified duty in the work place is unavailable, or when the patient requires more structured supervision. The need for work simulation should be based upon the results of a functional capacity evaluation and/or job analysis.

(d) Treatment Plan:

(i) The provider shall submit a treatment plan including expected frequency and duration of treatment. If requested by the provider, the payer will prior authorize payment for the treatment plan services or shall identify any concerns including those based on the reasonableness or necessity of care.

(ii) If the frequency and duration is expected to exceed the Medical Treatment Guidelines' recommendation, prior authorization is required.

(iii) All procedures must be performed by or under the onsite supervision of a physician, psychologist, PT, OT, speech language pathologist or audiologist.

(15) Wound Care

Wound care is separately payable only when devitalized tissue is debrided using a recognized method (chemical, water, vacuums). CPT® 97602 is not recognized for payment.

(J) TELEHEALTH

(1) "Telehealth" and "Telemedicine" are defined in Rule 16-2. The healthcare services listed in Appendix P of CPT® and Division Z-codes (when appropriate) may be provided via telehealth or telemedicine. The provider shall append modifier 95 to the services listed in Appendix P to indicate synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.

All healthcare services provided through telehealth or 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.

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

(3) The physician-patient / psychologist-patient relationship needs to be established.

(a) This relationship is established through assessment, diagnosis and treatment of the patient. Two-way live audio / video services are among acceptable methods to 'establish' a patient relationship.

(b) The patient is required to provide the appropriate consent for treatment.

(4) Payment for telehealth and telemedicine services (for adjusted RVUs and rates, see Exhibit #9):

(a) Telehealth services performed outside of an authorized originating site must be billed without an originating site fee. The distance (rendering) provider may be the only provider involved in the provision of telehealth services. The rendering provider shall bill CPT® place of service (POS) code 02, with modifier 95. This POS code does not apply to the originating site billing a facility fee.

The originating site is responsible for establishing and verifying injured worker and provider identity. Authorized originating sites include:

- The office of a physician or practitioner
- A hospital (inpatient or outpatient)
- A critical access hospital (CAH)
- A rural health clinic (RHC)
- A federally qualified health center (FQHC)
- A hospital based or critical access hospital based renal dialysis center (including satellites)
- A skilled nursing facility (SNF)
- A community mental health center (CMHC)

(b) Reimbursement is the RBRVS unit value for the CPT® code times the appropriate CF + $5.00 when modifier 95 is appended to the appropriate CPT® code(s).

95 – Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.

(c) Telehealth:

(i) Approved telehealth facilities can bill Q3014 per 15 minutes for the originating fee.

All locations not associated with medical care, such as a private residence where an injured worker is located when receiving telehealth services may not bill the originating fee.

(ii) Payment for telehealth services that have professional and technical components:

The originating site provider shall bill the technical component (modifier TC). The distant site provider interpreting the results shall bill the professional component (modifier 26).

(iii) The equipment or supplies at distant sites are not separately payable.

(iv) Professional fees of the supporting providers at originating sites are not separately payable.

(d) Telemedicine:

(i) The medical providers shall bill codes G0425-G0427 for telehealth consultations, emergency department or initial inpatient. The maximum fee values are determined by multiplying the RBRVS RVUs and the E&M CF listed in section 18-4.

(ii) The medical providers shall bill codes G0406-G0408 for follow up inpatient telehealth consultations. The maximum fee values are determined by multiplying the RBRVS RVUs and the E&M CF listed in section 18-4.

18-6 DIVISION ESTABLISHED CODES AND VALUES

(A) FACE-TO-FACE OR TELEPHONIC MEETINGS

(1) Face-to-face or telephonic meeting by a treating physician (as defined by Rule 16-3(A)(1)(a)) or a psychologist (PsyD, PhD, or EdD) 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 (see Rule 16-6). 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 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) Billing code is DoWC Z0701, 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 18-5(H)(7).

(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.

Billing Code DoWC is Z0601, 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 18-6(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 16-6(E).

Billing Code DoWC is Z0602, 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 three (3) business days prior to the appointment.

The payer shall pay one-half of the usual fee for the scheduled services, or $180.00, whichever is less:

Billing Code is 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 (4) hours or longer, the payer shall pay one-half of the usual fee for the scheduled service.

Billing Code is 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 claimants fail to keep scheduled appointments, the provider should contact the payer within two (2) business days. Upon reporting the missed appointment, the provider may inquire if the payer wishes to reschedule the appointment for the claimant. If the claimant fails to keep the payer's rescheduled appointment, the provider may bill for a cancellation fee according to this section.

(C) 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. If the requester and provider agree, the copy may be provided on a disc. If the requester and provider agree and appropriate security is in place, including, but not limited to, compatible encryption, the copies may be submitted electronically. Requester and provider should attempt to agree on a reasonable fee. Absent an agreement to the contrary, the fee shall be $0.10 per page. Copying charges do not apply for the initial submission of records that are part of the required documentation for billing.

Copying Fee Billing Codes and Maximum Fees:

DoWC Z0721 for first 10 or fewer paper page(s), including faxed documents

DoWC Z0725 per paper page for the next 11-40 paper page(s), including faxed documents

DoWC Z0726 per paper page for remaining paper page(s), including faxed documents

DoWC Z0727 per microfilm page

DoWC Z0728 per computer disc or as agreed

DoWC Z0729 per electronic page or as agreed

DoWC Z0802 actual postage paid

(D) DEPOSITION AND TESTIMONY FEES

(1) When requesting deposition or testimony from physicians or any other type of provider, guidance should be obtained from the Interprofessional Code, as 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, in an individual case, a party can show good cause to an Administrative Law Judge (ALJ) for exceeding the Maximum Fee Schedule value, that ALJ may allow a greater fee than listed in this section.

(2) 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.

Preparation Time:

Treating or non-treating physician as defined by Rule 16-3(A)(1)(a) or psychologist (PsyD, PhD, or EdD):

DoWC Z0730, billed in half-hour increments. Other providers shall be paid 85% of this fee.

(3) Deposition:

Payment for a treating or non-treating provider's testimony at a deposition shall not exceed the hourly rate for DoWC Z0730 for physicians or psychologists, billed in half-hour increments. Calculation of the provider's time shall be "portal to portal." Other providers shall be paid 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 seven (7) business days prior to the scheduled deposition, the provider shall be paid the number of hours s/he has reasonably spent in preparation and shall refund to the deposing party any portion of an advance payment in excess of time actually spent preparing and/or testifying. Bill DoWC Z0731.

If the provider is notified of the cancellation of the deposition at least five (5) business days but less than seven (7) business days prior to the scheduled deposition, the provider shall be paid the number of hours s/he has reasonably spent in preparation and one-half the time scheduled for the deposition. Bill DoWC Z0732.

If the provider is notified less than five (5) business days in advance of a cancellation, or the deposition is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the deposition. Bill DoWC Z0733.

Treating or non-treating physician as defined by Rule 16-3(A)(1)(a) or psychologist (PsyD, PhD, or EdD):

DoWC Z0734, billed in half-hour increments. Other providers shall be paid 85% of this fee.

(4) Testimony:

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 (4) hour deposit in advance in order to schedule the testimony.

If the provider is notified of the cancellation of the testimony at least seven (7) business days prior to the scheduled testimony, the provider shall be paid the

number of hours s/he has reasonably spent in preparation and shall refund any portion of an advance payment in excess of time actually spent preparing and/or testifying. Bill DoWC Z0735.

If the provider is notified of the cancellation of the testimony at least five (5) business days but less than seven (7) business days prior to the scheduled testimony, the provider shall be paid the number of hours s/he has reasonably spent in preparation and one-half the time scheduled for the testimony. Bill DoWC Z0736.

If the provider is notified of a cancellation less than five (5) business days prior to the date of the testimony or the testimony is shorter than the time scheduled, the provider shall be paid the number of hours s/he has reasonably spent in preparation and has scheduled for the testimony. Bill DoWC Z0737.

Treating or non-treating physician as defined by Rule 16-3(A)(1)(a) or psychologist (PsyD, PhD, or EdD):

DoWC Z0738, billed in half-hour increments. Other providers shall be paid 85% of this fee.

(E) INJURED WORKER TRAVEL EXPENSES

The payer shall pay an injured worker for reasonable and necessary expenses for travel to and from medical appointments and reasonable mileage to obtain prescribed medications. The rate for mileage shall be 53 cents per mile. The injured worker shall submit a request to the payer showing the date(s) of travel and mileage, and explain any other reasonable and necessary travel expenses incurred or anticipated.

Mileage Expense Billing Code: DoWC Z0723

Other Travel Expenses Billing Code: DoWC Z0724

(F) PERMANENT IMPAIRMENT RATING

(1) The payer is only required to pay for one (1) 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 Level II accredited authorized treating physician (see Rule 5) shall determine the permanent impairment rating.

(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 authorized treating physician (generally the

designated or selected physician) managing the total workers' compensation claim of the patient should complete the Physician's Report of Workers' Compensation Injury (Closing Report), WC164 (see section 18-6(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) WC164.

Extensive medical records take longer than one (1) hour to review and a separate report is created. 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 under special reports for written reports only and requires prior authorization and agreement from the payer for the separate record review fees.

(b) Bill the appropriate DoWC code:

(i) DoWC Z0759, for the Level II Accredited Authorized Treating Physician Providing Primary Care.
(ii) DoWC Z0760, for the Referral, Level II Accredited Authorized Physician (the claimant is not a previously established patient to that physician for that workers' compensation injury).
(iii) A return visit for a range of motion (ROM) validation shall be billed with the appropriate code in the Medicine Section of CPT®.
(iv) Multiple Impairment Evaluation Requiring More Than One Level II Accredited Physician:

All physicians providing consulting services for the completion of a whole person impairment rating shall bill using the appropriate E&M consultation code and shall forward their portion of the rating to the authorized physician determining the combined whole person rating.

(G) REPORT PREPARATION

(1) Routine Reports

Providers shall submit routine reports free of charge as directed in Rule 16-10(D) and by statute. Requests for additional copies of routine reports and for reports not in Rule 16-10 or in 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 (WC164)

(a) Initial Report

The authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient completes the initial WC164 and submits it to the payer and to the injured worker after the first visit with the injured worker. When applicable, the emergency department or urgent care authorized treating physician for this workers' compensation injury may also create a WC164 initial report. Unless requested or prior authorized by the payer in a specific workers' compensation claim, no other authorized physician should complete and bill for the initial WC164 form. This form shall include completion of items 1-7 and 11. Note that certain information in Item 2 (such as Insurer Claim #) may be omitted if not known by the provider.

(b) Closing Report

The WC164 closing report is required from the authorized treating physician (generally the designated or selected physician) managing the total workers' compensation claim of the patient when the injured worker is at maximum medical improvement for all injuries or diseases covered under this workers' compensation claim, with or without a permanent impairment. The form requires the completion of items 1-5, 6 B-C, and 7-11. If the injured worker has sustained a permanent impairment, the following additional information shall be attached to the bill at the time MMI is determined:

(i) All necessary permanent impairment rating reports, medical reports and narrative relied upon by the authorized treating physician (ATP), when the ATP (generally the designated or selected physician) managing the total workers' compensation claim of the patient 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 (generally the designated or selected physician) managing the total workers' compensation claim of the patient is not determining the permanent impairment rating.

(c) Payer Requested WC164 Report

If the payer requests a provider complete the WC164 report, the payer shall pay the provider for the completion and submission of the completed WC164 report.

(d) Provider Initiated WC164 Report

If a provider wants to use the WC164 report as a progress report or for any purpose other than those designated in section 18-6(G)(2)(a), (b), or (c), and seeks reimbursement for completion of the form, the provider shall get prior approval from the payer.

(e) Billing Codes and Maximum Allowance for completion and submission of the WC164 report:

DoWC Z0750 Initial Report

DoWC Z0751 Progress Report (Payer Requested or Provider Initiated)

DoWC Z0752 Closing Report

DoWC Z0753 Initial and Closing Reports are completed on the same form for the same date of service

(3) Request for physicians to complete additional forms sent to them by a payer or employer shall be paid by the requesting party. A form requiring 15 minutes or less of a physician's time shall be billed using DoWC Z0754. Forms requiring more than 15 minutes shall be paid as a special report.

(4) Special Reports

The term "special reports" includes any form, questionnaire or letter with variable content not otherwise addressed in Rules. This includes, but is not limited to: (a) independent medical evaluations or reviews when the physician is requested to review files and examine the patient to provide an opinion for the requesting party, performed outside § 8-42-107.2 (the Division IME process) and (b) treating or non-treating medical reviewers or evaluators producing written reports pertaining to injured workers not otherwise addressed. Special reports also include payment for meeting, reviewing another's written record, and amending or signing that record.

Billable Hours: Because narrative reports may have variable content, 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 (2) hour deposit in advance in order to schedule a patient exam associated with a special report.

Cancellation:

Written Reports Only: In cases of cancellation for those special reports not requiring a scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation up to the date of cancellation. Bill DoWC Z0761.

IME/report with patient exam: In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation at least seven (7) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and shall refund to the party requesting the special report any portion of an advance payment in excess of time actually spent preparing. Bill DoWC Z0762.

In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation at least five (5) business days but less than seven (7) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and one-half the time scheduled for the patient exam. Any portion of a deposit in excess of this amount shall be refunded. Bill DoWC Z0763.

In cases of special reports requiring a scheduled patient exam, if the provider is notified of a cancellation less than five (5) business days prior to the scheduled patient exam, the provider shall be paid for the time s/he has reasonably spent in preparation and has scheduled for the patient exam. Bill DoWC Z0764.

Billing Codes:

Written Report Only	DoWC Code:	Z0755
Lengthy Form Completion	DoWC Code:	Z0757
Meeting and Report with Non-treating Physician	DoWC Code:	Z0758

RIME: Respondent requested Independent Medical Examination (RIME)/Report with patient exam DoWC Code: Z0756

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.

IME Audio Recording	DoWC Code:	Z0766
IME Audio Copying Fee	DoWC Code:	Z0767

CIME: Claimant requested Independent Medical Examination (CIME)/Report with patient exam DoWC Code: Z0770

DIME: Division Independent Medical Examination (DIME)/Report with patient exam See Rule 11

All RIME, CIME and DIME reports must be served concurrently to all parties no later than 20 calendar days after the examination.

(H) SUPPLIES, DURABLE MEDICAL EQUIPMENT, ORTHOTICS AND PROSTHESES

(1) Supplies necessary to perform a service or procedure are considered inclusive and 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.

(2) Unless other limitations exist in this Rule, medical professionals shall bill supplies, including orthotics, prostheses, durable medical equipment (DME), injectable or non-injectable drugs using a HCPCS Level II code, when one exists, as established in the January 2018 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) schedule for rural (R) or non-rural (NR) areas. Rural is identified in Medicare's DME Rural Zip and Formats file on its website or the January 2018 Medicare's Part B Drug Average Sale Price (ASP). Otherwise, the billing provider shall identify its cost by submitting a copy of its invoice with its bill. The DMEPOS schedule and Medicare Part B Drug ASP fees are available at https://www.cms.gov.

Maximum fees for any orthotic created using casting materials shall be billed using Medicare's Q codes and values listed under Medicare's DMEPOS fee schedule for

Colorado. The therapist time necessary to create the orthotic shall be billed using CPT® 97760.

(3) Medical providers shall be reimbursed based on Medicare's January 2018 DMEPOS Colorado HCPCS Level II maximum fee values or Medicare's Part B Drug ASP values listed for the codes billed. If no code exists, the payer shall pay 120% of the cost for the item as indicated on the provider's invoice. Payers shall not recognize the KE modifier.

(4) Unless other limitations exist in this Rule, DMEPOS suppliers shall be reimbursed using Medicare's HCPCS Level II codes, when one exists, as established in the January 2018 DMEPOS schedule. Otherwise, the supplier shall be reimbursed at 100% of Colorado Medicaid's January 2018 fee schedule. See https://www.colorado.gov/hcpf/provider-rates-fee-schedule for the Colorado Medicaid Fee Schedule. If no Medicare or Medicaid fee schedule value exists, payers shall reimburse suppliers the published Manufactures Suggested Retail Price (MSRP), the item will be reimbursed at MSRP less 20%. If there is no established fee schedule value or MSRP, reimbursement shall be based on 120% of the cost of the item as indicated on the supplier's invoice. Shipping and handling charges are not separately payable.

(5) Durable Medical Equipment (DME) is equipment that can withstand repeated use and allows injured workers accessibility in the home, work, and community. DME can be categorized as:

(a) Inexpensive or Routinely Purchased: These items cost less than $50.00. The maximum fee for these items is identified in subsection (9) below.

(b) Capped Rental/Purchased Equipment:

(i) Rented DME items must be purchased or discontinued after 15 months of continuous use.
(ii) 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). The payer shall not pay for rental fees once the total fee scheduled price of the rented item has been reached. 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.
(iii) Items that cost $100.00 or less (according to provider's invoice) shall be purchased and reimbursed pursuant to section 18-6(H).
(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.

(c) All electrical stimulators are bundled kits that include the portable unit(s), 2 to 4 leads and pads, initial battery(s), electrical adapters, and carrying case. The kits that cost more than $100.00 shall be rented for the first month of use before a potential purchase. The monthly rental rate shall not exceed 10% of the total fee scheduled price. Provider shall request prior authorization and document the effectiveness of the kit for the injured worker prior to purchasing an item that costs more than $100.00. Effectiveness should include functional improvement and decreased pain. The billing provider shall append modifiers NU for new or UE for used

purchased items or modifier RR for rented items. Billing codes for the items are as follows:

(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 2 leads or E0730 for a kit with 4 leads;
(ii) Electrical Muscle Stimulation machines/kits: E0744 for scoliosis; or E0745 for neuromuscular stimulator, electric shock unit;
(iii) Osteogenesis electrical stimulation: E0748 or E0749 for non-invasive spinal application, or E0760 for ultrasound low intensity;
(iv) All replacement supplies may be billed no more than once a month using A4595 for electrical stimulator supplies, 2 leads, or A4557 for replacement leads. A4557 shall not be billed with the first month's rent.
(v) Conductive Garments: E0731;

(d) Continuous Passive Motion Devices (CPMs):

E0935 – continuous passive motion exercise device for use on the knee only; or E0936 – continuous passive motion exercise device for use on body parts other than knee. These devices are bundled into the facility fees and not separately payable, unless the Medial Treatment Guidelines recommend their use after discharge for the particular condition.

(e) Intermittent Pneumatic Devices (including, but not limited to, Game Ready and cold compression) are bundled into the facility fees and not separately payable. The use of these devices after discharge requires prior authorization. The billing codes are as follows:

E0650-E0676 – Codes based on body part(s), segmental or not, gradient pressure and cycling of pressure and purpose of use; and

A4600 – Sleeve for intermittent limb compression device, replacement only, per each limb.

(6) Auto-shipping of monthly DMEPOS supplies is not allowed.

(7) Reimbursement of supplies to facilities shall comply with sections 18-6(I) – (L).

(8) 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.

(9) Take home exercise supplies with a total cost of $50 or less may be billed without an invoice at a maximum fee of actual billed charges; however, payers reserve the right to request an invoice, at any time, to validate the provider's cost. 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.

(10) Complex Rehabilitation Technology dispensed and billed by Non-Physician DMEPOS Suppliers

(a) Complex rehabilitation technology (CRT) items, including products such as complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, and other specialized equipment, such as 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.

(c) CRT shall be reimbursed as set out in section 18-6(H)(4).

(I) INPATIENT HOSPITAL FACILITY FEES

(1) Provider Restrictions

All non-emergency, inpatient admissions require prior authorization (see Rule 16-6).

(2) Bills for Services

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

(b) The maximum inpatient facility fee is determined by applying the Center for Medicare and Medicaid Services (CMS) “Medicare Severity Diagnosis Related Groups” (MS-DRGs) classification system in effect at the time of discharge. Exhibit #1 shows the relative weights per MS-DRGs that are used in calculating the maximum allowance.

The hospital shall indicate the MS-DRG code number 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 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.

(c) Exhibit #1 establishes the maximum length of stay (LOS) using the “arithmetic mean LOS”. However, no additional allowance for exceeding this LOS, other than through the cost outlier criteria under section 18-6(I)(3)(e) is allowed.

(d) Any inpatient admission requiring the use of both an acute care hospital (admission/discharge) and its Medicare certified rehabilitation facility (admission/discharge) is considered as one (1) admission and MS-DRG. This does not apply to long-term care and licensed rehabilitation facilities.

(3) Inpatient Facility Reimbursement:

(a) The following types of inpatient facilities are reimbursed at 100% of billed inpatient charges:

(i) Children's hospitals
(ii) Veterans' Administration hospitals
(iii) State psychiatric hospitals

(b) The following types of inpatient facilities are reimbursed at 80% of billed inpatient charges:

(i) Medicare certified Critical Access Hospitals (CAH) (listed in Exhibit #3)

(ii) Colorado Department of Public Health and Environment (CDPHE) licensed rehabilitation facilities,

(iii) CDPHE licensed psychiatric facilities that are privately owned.

(iv) CDPHE licensed skilled nursing facilities (SNF).

(c) Medicare Long Term Care Hospitals (MLTCH)

MLTCHs are reimbursed at $3,350 per day, not to exceed 75% of billed charges. If total billed charges exceed $300,000, reimbursement shall be at 75% of billed charges. All charges shall be submitted on a final bill, unless the parties agree on interim billing.

(d) All other inpatient facilities are reimbursed as follows:

Retrieve the relative weights for the assigned MS-DRG from the MS-DRG table in effect at the time of discharge in Exhibit #1 and locate the hospital's base rate in Exhibit #2.

The "Maximum Fee Allowance" is determined by calculating:

(i) (MS-DRG Relative Wt x Specific hospital base rate x 185%) + (trauma center activation allowance) + (organ acquisition, when appropriate).

(ii) For trauma center activation allowance, (revenue codes 680-685) see section18-6(J)(6)(d).

(iii) For organ acquisition allowance, (revenue codes 810-819) see section 18-6(I)(3)(i).

(e) Outliers are admissions with extraordinary cost warranting additional reimbursement beyond the maximum allowance under subsection (d) above. To calculate the additional reimbursement, if any:

(i) Determine the "Hospital's Cost":

Total billed charges (excluding any trauma center activation or organ acquisition billed charges) multiplied by the hospital's cost-to-charge ratio.

(ii) Each hospital's cost-to-charge ratio is given in Exhibit #2.

(iii) The “Difference” = “Hospital’s Cost” – “Maximum Fee Allowance” excluding any trauma center activation or organ acquisition allowance (see (d) above).

(iv) If the “Difference” is greater than $27,545.00, additional reimbursement is warranted. The additional reimbursement is determined by the following equation:

“Difference” x .80 = additional fee allowance

(f) Inpatient combined with Emergency Department (ED), Trauma Center or organ acquisition reimbursement.

(i) If an injured worker is admitted to the hospital, the ED reimbursement is included in the inpatient reimbursement under section 18-6(I)(3),

(ii) Trauma center activation fees (see section 18-6(J)(6)(d)) and organ acquisition allowance (see section 18-6(I)(3)(i)) are paid in addition to inpatient fees (see sections 18-6(I)(3)(d)-(e)).

(g) If an injured worker is admitted to one hospital and is subsequently transferred to another hospital, the payment to the transferring hospital will be based upon a per diem value of the MS-DRG maximum value. The per diem value is calculated based upon the transferring hospital’s MS-DRG relative weight multiplied by the hospital’s specific base rate (Exhibit #2) divided by the MS-DRG geometric mean length of stay (Exhibit #1). This per diem amount is multiplied by the actual LOS. If the patient is admitted and transferred on the same day, the actual LOS equals one (1). The receiving hospital shall receive the appropriate MS-DRG maximum value.

(h) 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 charges to the organ acquisition maximum fees.

The MS-DRG adjusted billed charges are determined by subtracting the trauma center activation billed charges 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.

(i) 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%.

(J) OUTPATIENT HOSPITAL FACILITY FEES

(1) Provider Restrictions

(a) All non-emergency outpatient surgeries require prior authorization (see Rule 16-6).

(b) A separate facility fee is only payable if the location of where the services are provided is licensed as a hospital or ASC for surgical episodes, by the Colorado Department of Public Health and Environment (CDPHE) or applicable out of state governing agency and statute.

(2) Types of Bills for Service:

(a) Outpatient facility fees shall be billed on the 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 include, but are not limited to, PT/OT, anesthesia, speech therapy, etc.) are subject to the RBRVS and Dental Fee Schedules as incorporated by this Rule and applicable to all facilities regardless of whether the facility fees are based upon Exhibit #4 or a percentage of billed charges.

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

(3) Outpatient Facility Reimbursement:

(a) The following types of outpatient facilities are reimbursed at 100% of billed outpatient charges, except for any associated professional fees (see section 18-6(J)(2)(b) above):

(i) Children's hospitals
(ii) Veterans' Administration hospitals
(iii) State psychiatric hospitals

(b) The CAHs listed in Exhibit #3 are reimbursed at 80% of billed outpatient facility charges, except for any associated professional fees.

(c) Ambulatory Payment Classifications (APC) Codes and Values:

Hospital reimbursement is based upon Medicare's 2018 Outpatient Prospective Payment System (OPPS) as modified in Exhibit #4. Exhibit #4 lists Medicare's Outpatient Hospital APC Codes and the Division's established rates for hospitals and other types of providers as follows:

(i) Column 1 lists the APC code number.
(ii) Column 2 lists APC code description.
(iii) Column 3 is used to determine maximum fees for all hospital facilities not listed under sections 18-6(J)(3)(a) and (b).
(iv) Column 4 is used to determine maximum fees for all ASCs when outpatient surgery is performed in an ASC.

To identify which APC grouper is aligned with an Exhibit #4 APC code number and dollar value, use Medicare's 2018 Addendum B. Spinal fusion CPT® codes listed with a "C" status indicator in Medicare's Addendum B, shall have an equivalent value no greater than APC 5115.

(4) The APC Exhibit #4 values include the services and revenue codes listed below; therefore, these are generally not separately payable. However, the maximum

allowable fee in Exhibit #4 may be exceeded in the rare case a more expensive implant is medically necessary. The facility must request prior authorization for additional payment with a separate report documenting medical reasonableness and necessity and submit an invoice showing cost of the implant(s) to the facility. Payers must report authorized exceptions to the Division's Medical Policy Unit on a monthly basis. 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 in Exhibit #4 or 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 when not allowed under Exhibit #4;
(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.

Packaged Services	
Rev Code	Description
0250	Pharmacy; General Classification
0251	Pharmacy; Generic Drugs
0252	Pharmacy; Non-Generic Drugs
0254	Pharmacy; Drugs Incident to Other Diagnostic Services
0255	Pharmacy; Drugs Incident to Radiology
0257	Pharmacy; Non-Prescription
0258	Pharmacy; IV Solutions
0259	Pharmacy; Other Pharmacy
0260	IV Therapy; General Classification
0261	IV Therapy; Infusion Pump
0262	IV Therapy; IV Therapy/Pharmacy Services
0263	IV Therapy; IV Therapy/Drug/Supply Delivery
0264	IV Therapy; IV Therapy/Supplies
0269	IV Therapy; Other IV Therapy
0270	Medical/Surgical Supplies and Devices; General Classification
0271	Medical/Surgical Supplies and Devices; Non-sterile Supply
0272	Medical/Surgical Supplies and Devices; Sterile Supply
0275	Medical/Surgical Supplies and Devices; Pacemaker
0276	Medical/Surgical Supplies and Devices; Intraocular Lens
0278	Medical/Surgical Supplies and Devices
0279	Medical/Surgical Supplies and Devices
0280	Oncology; General Classification
0289	Oncology; Other Oncology
0343	Nuclear Medicine; Diagnostic Radiopharmaceuticals

Packaged Services	
Rev Code	Description
0344	Nuclear Medicine; Therapeutic Radiopharmaceuticals
0370	Anesthesia; General Classification
0371	Anesthesia; Anesthesia Incident to Radiology
0372	Anesthesia; Anesthesia Incident to Other DX Services
0379	Anesthesia; Other Anesthesia
0390	Administration, Processing & Storage for Blood & Blood Components; General Classification
0392	Administration, Processing & Storage for Blood & Blood Components; Processing & Storage
0399	Administration, Processing & Storage for Blood & Blood Components; Other Blood Handling
0621	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Radiology
0622	Medical Surgical Supplies - Extension of 027X; Supplies Incident to Other DX Services
0623	Medical Supplies - Extension of 027X, Surgical Dressings
0624	Medical Surgical Supplies - Extension of 027X; FDA Investigational Devices
0630	Pharmacy - Extension of 025X; Reserved
0631	Pharmacy - Extension of 025X; Single Source Drug
0632	Pharmacy - Extension of 025X; Multiple Source Drug
0633	Pharmacy - Extension of 025X; Restrictive Prescription
0700	Cast Room; General Classification
0710	Recovery Room; General Classification
0720	Labor Room/Delivery; General Classification
0721	Labor Room/Delivery; Labor
0732	EKG/ECG (Electrocardiogram); Telemetry
0821	Hemodialysis-Outpatient or Home; Hemodialysis Composite or Other Rate
0824	Hemodialysis-Outpatient or Home; Maintenance - 100%
0825	Hemodialysis-Outpatient or Home; Support Services
0829	Hemodialysis-Outpatient or Home; Other OP Hemodialysis
0942	Other Therapeutic Services (also see 095X, an extension of 094x); Education/Training
0943	Other Therapeutic Services (also see 095X, an extension of 094X), Cardiac Rehabilitation
0948	Other Therapeutic Services (also see 095X, an extension of 094X), Pulmonary Rehabilitation

(5) Recognized Status Indicators from Medicare's Addendum B are applied as follows:

Indicator	**Meaning**
A	Use another fee schedule instead of Exhibit #4, such as conversion factors listed in section 18-4, RBRVS RVUs, Ambulance Fee Schedule, or Exhibit #8.
B	Is not recognized by Medicare for Outpatient Hospital Services Part B bill type (12x and 130x) and therefore is not separately payable

	unless separate fees are applicable under another section of this Rule.
C	Recognized by Medicare as inpatient-only procedures. However, the Division recognizes these procedures on an outpatient basis with prior authorization.
D	Discontinued code.
E1 or E2	Not paid by Medicare 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 Exhibit #4.
F	Corneal tissue acquisition and 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" are separately payable under Exhibit #4 as an APC value.
H	A "Pass-Through Device" is separately payable based on cost to the facility.
J1 or J2	The services are paid through a "comprehensive APC" for Medicare. However, the DoWC has not adopted the "comprehensive APC." Therefore, an agreement between the payer and the provider is necessary.
K	A separately payable "Pass-Through Drug or Biological or Device" for therapeutic radiopharmaceuticals, brachytherapy sources, blood and blood products as listed under Exhibit #4 APC value.
L	Represents Influenza Vaccine/Pneumococcal Pneumonia Vaccine and therefore is generally considered to be unrelated to work injuries.
M	Not separately payable.
N	Service is bundled and is not separately payable.
P	Partial hospitalization paid based on observation fees outlined in section 18-6(J).
R	Blood and blood products
Q	Any "Packaged Codes" with Q1, Q2, Q3, Q4 or STVX combinations are not recognized unless the parties make a prior agreement.
S or T	Multiple procedures, the highest-valued code allowed at 100% of the Exhibit #4 value and up to three (3) additional codes allowed at 50% of the Exhibit #4 value, per episode of care.

U	Brachytherapy source and is separately payable under Exhibit #4 APC value.
V	Represents a clinic or an ED visit and is separately payable for hospitals as specified in section 18-6(J).
Y	Non-implantable Durable Medical Equipment paid pursuant to Medicare's Durable Medical Equipment Regional Carrier fee schedule for Colorado.

(6) Total maximum facility value for an outpatient hospital episode of care:

(a) The highest-valued CPT® code aligned to APC code per Exhibit #4 plus 50% of any lesser-valued CPT® code aligned APC code values.

Facility fee reimbursement is limited to a maximum of four (4) CPT® procedure codes per episode, with a maximum of only one (1) procedure reimbursed at 100% of the allowed Exhibit #4 value for the type of facility:

(i) Hospitals are reimbursed based upon Column 3.
(ii) ASCs are reimbursed based upon Column 4.

(b) Hospitals billing type "A" or "B" ED visits shall meet one of the following hospital licensure and billing criteria:

(i) The EDs 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 billed using revenue code 450 and applicable CPT® codes; or

(ii) A freestanding type "B" ED, must have equivalent operations and staffing as a licensed ED, must be physically located inside of 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 24/7;

(c) ED level of care is identified based upon one (1) of five (5) levels of care for either a type "A" or type "B" ED visit. The level of care is defined by CPT® E&M definitions and internal level of care guidelines developed by the hospital in compliance with Medicare regulations. The hospital's guidelines should establish an appropriate graduation of hospital resources (ED staff and other resources) as the level of service increases. Upon request, the provider shall supply a copy of their level of care guidelines to the payer. (Only the higher one (1) of any ED levels or critical care codes shall be paid).

(d) APC 5045, Trauma Response with Critical Care, is not recognized for separate payment. Trauma Center fees are not paid for alerts. Trauma activation revenue codes are 681, 682, 683, or 684.

These fees are in addition to ED and inpatient fees. Activation fees mean a trauma team has been activated, not just alerted. The level of trauma

activation shall be determined by CDPHE's assigned hospital trauma level designation.

(e) If an injured worker is admitted to the hospital through that hospital's ED, the ED reimbursement is included in the inpatient reimbursement under section 18-6(I)(3).

(f) Multiple APCs identified by multiple CPT® codes are indicated by the use of modifier 51. Bilateral procedures require each procedure to be billed on separate lines using RT and LT for the procedure to be correctly paid. The 50% reduction applies to all lower-valued procedures, even if they are identified in the CPT® as modifier 51 exempt. The reduction also applies to the second "primary" procedure of bilateral procedures.

(i) All surgical procedures performed in one (1) operating room, regardless of the number of surgeons, are considered one (1) outpatient surgical episode of care for purposes of facility fee reimbursement.

(ii) If an arthroscopic procedure is converted to an open procedure on the same joint, only the open procedure is payable. If an arthroscopic procedure and open procedure are performed on different joints, the two (2) procedures may be separately payable with anatomic modifiers.

(iii) When reported in conjunction with other knee arthroscopy codes, any combination of surgical knee arthroscopies for removal of loose body, foreign body, and/or debridement/shaving of articular cartilage shall be paid only if performed in a different compartment of the knee using G0289.

(iv) Discontinued surgeries require the use of modifier 73 (discontinued prior to administration of anesthesia) or modifier 74 (discontinued after administration of anesthesia). Modifier 73 results in a reimbursement of 50% of the APC value for the primary procedure only. Modifier 74 allows reimbursement of 100% of the primary procedure value only.

(v) The sum of section 18-6(J)(3)(c) Columns 1-5 is compared to the total facility fee billed charges. The lesser of the two amounts shall be the maximum facility allowance for the surgical episode of care. A line-by-line comparison of billed charges to section 18-6(J)(3)(c) maximum allowance is not appropriate.

(g) Any diagnostic testing clinical labs or therapies with a status indicator of "A" may be reimbursed using Exhibit #8 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. The maximum fees are based upon Exhibit #8.

(h) Observation room Maximum Fee Schedule value is limited to six (6) hours without prior authorization. Documentation should support the medical necessity for observation or convalescent care. Observation time begins when the patient is placed in a bed for the purpose of initiating observation

care in accordance with the physician's order. Observation or daily outpatient convalescence time ends when the patient is actually discharged from the hospital or ASC or admitted into a licensed facility for an inpatient stay. Observation time would not include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home. Hospital or convalescence licensure is required for billing observation or convalescence time beyond 23 hours.

Billing Code is G0378 per hour, round to the nearest hour. For adjusted RVUs and rates, see Exhibit #9.

(i) Professional fees are reimbursed according to the fee schedule times the appropriate CF regardless of the facility type. Additional reimbursement is payable for the following services not included in the values found in Exhibit #4:

(i) ambulance services (revenue rode 540), see section 18-6(R)
(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 speech/language, revenue codes 420, 430,440) are paid based upon the RBRVS unit value multiplied by the applicable CF. Modifiers are required to indicate the type of care plan or therapist being billed. See section 18-5(I) for appropriate modifiers.

(j) Any prescription for a drug supply to be used longer than a 24 hour period, filled at any clinic, shall fall under the requirements of and be reimbursed as a pharmacy fee, see section 18-6(N).

(k) Clinics (part of a hospital or a freestanding clinic) (Form Locator (FL) 4 are 07xx and revenue codes 51x-53x):

(i) Provider Restrictions - types of facilities that are recognized for separate clinic facility fees:

- Rural Health Clinics as identified in Exhibit #5 and/or as certified by the Colorado Department of Public Health and Environment;
- Critical Access Hospitals as identified in Exhibit #3 and/or as certified by the Colorado Department of Public Health and Environment;
- Any specialty care clinic (wound/infections) that requires expensive drugs/supplies that are not typically provided in a physician's office.

(ii) Billing and Maximum Fees

- Clinics designated as rural health facilities and listed in Exhibit #5 may be reimbursed a single separate clinic fee at 80% of billed charges per date of service, regardless of whether the clinic has been designated by the employer, the urgency of the episode of care, or the time of day.

- CAHs listed in Exhibit #5 may be reimbursed a single separate clinic fee at 80% of billed charges per date of service.
- Any specialty care clinic (wound/infections) that requires drugs/supplies that are typically not provided in a physician's office may be allowed a separate clinic fee with prior approval from the payer, as outlined in Exhibit #4.
- No other clinic facility fees are payable except those listed in sections 18-6(I), (J), (K) or (L).
- Maximum fees for hospital urgent care facilities or services are covered under section 18-6(L). These are identified by either place of service code 20, as billed on a CMS-1500, or by revenue code(s) 516 or 526 on a UB-04.

(iii) Clinic fees are paid based on Exhibit #4 and as outlined in this Rule.

(l) IV infusion therapy performed in an outpatient hospital facility is reimbursed per section 18-6(J).

(m) Off campus (place of service code 19) freestanding imaging centers shall be reimbursed using the RBRVS TC value(s) instead of the APC value.

(K) AMBULATORY SURGERY CENTERS

(1) Provider Restrictions

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

(b) All outpatient surgical procedures performed in an ASC shall be reasonable and necessary and warrant performance at an ASC level.

(2) ASCs are reimbursed in accordance with section 18-6(J) for any surgical episodes of care. Column 4 from Exhibit #4 lists the values used to determine the maximum fees.

(L) 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 certified by the Urgent Care Association of America (UCAOA) to be recognized for a separate facility payment for the initial visit.

(2) Billing and Maximum Fees:

(a) Prior authorization is recommended for all facilities billing a separate Urgent Care fee. Facilities must provide documentation of the required Urgent Care facility certification if requested by the payer.

(b) Urgent Care 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 the UB-04 using revenue code 516 or 526 and the facility HCPCS code S9088 with 1 unit. All maximum fees 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, on the CMS-1500 with professional services. All other services and procedures provided in an urgent care facility, including a freestanding facility, are reimbursed according to the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate CF.

(c) All professional physician or non-physician fees shall be billed on a CMS-1500 with a Place of Service Code 20. The maximum fees shall be in accordance with the appropriate CPT® code relative weight from RBRVS multiplied by the appropriate CF.

(d) The Observation Room allowance is limited to a maximum of three (3) hours without prior authorization (see Rule 16-6). Bill G0378 per hour. For adjusted RVUs and rates, see Exhibit #9.

(e) All supplies are included in the facility fee for urgent care facilities.

(f) Any prescription for a drug supply to be used for longer than 24 hours, filled at any clinic, shall fall under the requirements of and be reimbursed as a pharmacy fee. See section 18-6(N).

(M) HOME CARE SERVICES

Prior authorization (see Rule 16-6) is required for all home care services. 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 and duration of care at each visit, and any financial arrangements to prevent disputes. For adjusted RVUs and rates, see Exhibit #9.

(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 patient’s home.

Skilled Nursing fees are separately payable when the nurse travels to the injured worker’s home to perform initial and subsequent patient evaluation(s), education,

and coordination of care. Skilled nursing fees are billed and payable as indicated under section 18-6(L)(2).

(a) Parenteral Nutrition:

Code	Quantity	Max Bill Frequency
S9364	<1 Liter	once per day
S9365	1 liter	once per day
S9366	1.1 - 2.0 liter	once per day
S9367	2.1 - 3.0 liter	once per day
S9368	> 3.0 liter	once per day

The daily rate includes the standard total parenteral nutrition (TPN) formula. Lipids, specialty amino acid formulas, and drugs other than in standard formula are separately payable under section 18-6(N).

(b) Antibiotic Therapy per day rate by professional + drug cost at Medicare's Average Sale Price (ASP). If ASP is not available, use Average Wholesale Price (AWP) (see section 18-6(N)).

Code	Time	Max Bill Frequency
S9494	hourly	once per day
S9497	once every 3 hours	once per day
S9500	every 24 hours	once per day
S9501	once every 12 hours	once per day
S9502	once every 8 hours	once per day
S9503	once every 6 hours	once per day
S9504	once every 4 hours	once per day

(c) Chemotherapy per day rate + drug cost at ASP. If ASP is not available, use AWP.

Code	Description	Max Bill Frequency
S9329	Administrative Services	once per day
S9330	Continuous (24 hrs. or more) chemotherapy	once per day

S9331	Intermittent (less than 24 hrs.)	once per day

(d) Enteral nutrition (enteral formula and nursing services are separately payable):

Code	Description	Max Bill Frequency
S9341	Via Gravity	once per day
S9342	Via Pump	once per day
S9343	Via Bolus	once per day

(e) Pain Management per day or refill + drug cost at ASP. If ASP is not available, use AWP.

Code	Description	Max Bill Frequency
S9326	Continuous (24 hrs. or more)	once per day
S9327	Intermittent (less than 24 hrs.)	once per day
S9328	Implanted pump (no separate daily rate)	Per refill

(f) Fluid Replacement per day rate + drug cost at ASP. If ASP is not available, use AWP.

Code	Quantity	Max Bill Frequency
S9373	< 1 liter per day	once per day
S9374	1 liter per day	once per day
S9375	>1 but <2 liters per day	once per day
S9376	>2 liters but <3 liters	once per day
S9377	>3 liters per day	once per day

(g) Multiple Therapies:

Highest cost per day or refill only + drug cost at ASP. If ASP is not available, use AWP.

(2) Nursing Services—there is a limit of two (2) hours without prior authorization, unless otherwise indicated in the Medical Treatment Guidelines:

Code	Type of Nurse	Max Bill Frequency
S9123	RN	2 hrs
S9124	LPN	2 hrs
S9122	CNA	The amount of time spent with the injured worker must be specified in the medical records and on the bill. No prior authorization required.

(3) Physical medicine procedures are payable at the rates listed in section 18-5(I).

(4) Mileage

The parties should agree upon travel allowances and the mileage rate should not exceed the fee schedule rate for DoWC Z0772-per mile, portal to portal.

(5) Travel Time

Travel is typically included in the fees listed. Travel time greater than one (1) hour one-way shall be reimbursed. The fee shall be agreed upon at the time of prior authorization and shall not exceed the hourly fee schedule rate for DoWC Z0773.

(6) Drugs/Supplies/DME/Orthotics/Prosthetics Used For At-Home Care

As defined in section 18-6(H), any drugs/supplies/DME/Orthotics/Prosthetics considered integral to at-home professional's service are not separately payable.

The maximum fees for non-integral drugs/supplies/DME/Orthotics/Prosthetics used during a professional's home care visits are listed in section 18-6(H). All IV infusion supplies are included in the per diem or refill rates listed in this Rule.

(N) 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 medications "not recommended" in the Medical Treatment Guidelines for a particular diagnosis or if Rules 16-6(B) and 17-4(A) apply.

(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 16-9(A)(2) 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 classified as Schedule II or Schedule III controlled substances that are prescribed for treatment lasting longer than 7 days shall be provided through a pharmacy.

(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 RBRVS 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.

(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 in (1) or (2) in this sub-section 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 his/her authorized representative has received the prescription.

(4) Average Wholesale Price (AWP)

(a) AWP for brand name and generic pharmaceuticals may be determined through the use of such monthly publications as Price Alert, Red Book, or Medispan. In case of a dispute on AWP values for a specific NDC, the parties should 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 §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, 13-21-108.7, 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) Drugs administered in the course of the provider's direct care (injectables) shall be reimbursed at Medicare's Part B Drug Average Sale Price (ASP), 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 per 30 day supply

Any anti-inflammatory medication or any local anesthetic single agent.

Category II Z0791 per 30 day supply

Any anti-inflammatory agent or agents in combination with any local anesthetic agent or agents.

Category III Z0792 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 per 30 day supply

Two (2) 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 Medical Treatment Guidelines 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 fees 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 fee. The 30 day Maximum Fee Schedule 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 Price Alert, RedBook, 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 reimbursement for any topical muscle relaxant, analgesic, anti-inflammatory and/or anti-neuritic medications containing only active ingredients available without a prescription shall be reimbursed at cost to the billing provider up to $30.00 per 30 day supply for any application (excludes patches). Maximum reimbursement for a patch is cost to the billing provider up to $70.00 per 30 day supply.

DoWC Z0794 per 30 day supply for any application (excludes patches).

DoWC Z0795 per 30 day supply for patches.

See section 18-6(N)(5) 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 Medical Treatment Guidelines. The 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, the payer shall reimburse the injured worker for the amounts actually paid for authorized prescriptions or authorized over-the-counter drugs within 30 days after submission of the injured worker's receipt. See Rule 16-11(F).

(O) ALTERNATIVE INTEGRATIVE MEDICINE

Alternative 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 alternative integrative medicine may be both licensed and non-licensed health practitioners with training in one (1) or more forms of therapy and certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) in acupuncture and/or Chinese herbology. Alternative integrative medicine services not priced in the fee schedule or not recommended in the Medical Treatment Guidelines require prior authorization.

(P) ACUPUNCTURE

Acupuncture is an accepted procedure for the relief of pain and tissue inflammation. While commonly used for treatment of pain, it may also be used as an adjunct to physical rehabilitation and/or surgery to hasten return of functional recovery. Acupuncture may be performed with or without the electrical current on the needles at the acupuncture site.

(1) Provider Restrictions

All non-physician acupuncture providers must be a Licensed Acupuncturist (LAc) by the Colorado Department of Regulatory Agencies as provided in Rule 16. Both physician and non-physician providers must provide evidence of training, and licensure upon request of the payer.

(2) Billing Restrictions

(a) For treatment frequencies exceeding the maximum allowed in the Medical Treatment Guidelines, the provider must obtain prior authorization (see Rule 16-6).

(b) Unless the provider's medical records reflect medical necessity and the provider obtains prior authorization, the maximum amount of time allowed for acupuncture and procedures is one (1) hour of procedures, per day, per discipline.

(3) Billing Codes:

(a) Reimburse acupuncture, including or not including electrical stimulation, per the values listed in the RBRVS, times the appropriate CF.

(b) Non-Physician evaluation services

(i) New or established patient services are reimbursable only if the medical record specifies the appropriate history, physical examination, treatment plan or evaluation of the treatment plan. Payers are only required to pay for evaluation services directly performed by an LAc. All evaluation notes or reports must be written and signed by the LAc. Without appropriate supporting documentation, the payer may deny payment. (See Rule 16-11)

(ii) LAc new patient visit: DOWC Z0800

(iii) LAc established patient visit: DOWC Z0801

(c) Herbs require prior authorization and fee agreements (see section 18-6(N)(8)).

(d) See the appropriate Physical Medicine and Rehabilitation section of the RBRVS for other billing codes and limitations (see also section 18-5(I)).

(e) Acupuncture supplies are reimbursed pursuant to section 18-6(H).

(Q) USE OF AN INTERPRETER

Rates and terms shall be negotiated. Prior authorization (see Rule 16-6) is required except for emergency treatment. Bill DoWC Z0722.

(R) MEDICAL TRANSPORTATION

(1) Fee Schedule:

The fee schedule for medical transportation consists of a base rate and a payment for mileage. Both the transport of the injured worker to the nearest facility and all items and services associated with such transport are included in the base rate and mileage rate. For adjusted RVUs and rates, see Exhibit #9.

(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 origin (point of pickup) 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.

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, updated May 15, 2018, available at https://www.cms.gov.

(4) Non-Emergent Medical Transportation Billing Codes and Fees:

The payer shall reimburse for non-emergent medical transportation of the injured worker to and from reasonable and necessary medical services. The payment shall be for the least expensive means appropriate for the injured worker's condition.

Billing Code	Billing Code Description	Unit
A0130	Wheelchair Van Base Rate	One Way Trip
S0209	Wheelchair Van Mileage	Per Mile
T2005	Stretcher Van Base Rate	One Way Trip
T2049	Stretcher Van Mileage	Per Mile
A0120	Mobility Van Base Rate	One Way Trip

(5) Modifiers

Modifiers identify place of origin and destination of the trip. The modifier is to be placed next to the HCPCS code billed. The following is a list of current modifiers. Each of the modifiers may be utilized to make up the first and/or second half of a two-letter modifier. The first letter must describe the origin of the transport, and the second letter must describe the destination (Example: if a patient is picked up at his/her home and transported to the hospital, the modifier to describe the origin and destination would be RH).

Code	Description
D	Diagnostic or therapeutic site other than “P” or “H”
E	Residential, domiciliary, custodial facility, nursing home other than a skilled nursing facility
G	Hospital-based dialysis facility (hospital or hospital-related) which includes: - Hospital administered/Hospital located - Non-Hospital administered/Hospital located
GM	Multiple patients on one ambulance trip
H	Hospital
I	Site of transfer (i.e., airport, ferry, or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility - Hospital administered/Hospital located - Non-Hospital administered/Hospital located
N	Skilled Nursing Facility
P	Physician’s Office (includes non-hospital facility, clinic, etc.)
QL	Patient pronounced dead after ambulance called.
QM	Ambulance service under arrangement by a provider of service

QN	Ambulance service furnished directly by a provider of service.

(6) Mileage Charges for mileage must be based on loaded mileage only, i.e., from the pickup of a patient to his/her arrival at the destination. The miles billed must be in whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.

R	Residence
S	Scene of Accident or Acute Event
X	Destination Code Only (Intermediate stop at physician's office en route to the hospital, includes non-hospital facility, clinic, etc.)

18-7 DENTAL FEE SCHEDULE

The dental fee schedule is adopted using the American Dental Association's Current Dental Terminology, 2018 (CDT®-2018). However, surgical treatment for dental trauma and subsequent related procedures shall be billed using medical codes from the 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 #6 for the listing and Maximum Fee Schedule value for CDT®-2018 dental 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.

18-8 QUALITY INITIATIVES

(A) OPIOID MANAGEMENT

(1) Codes and maximum fees are payable to the 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 patient's past and current functional status of work, leisure, and activities of daily living.

The patient 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 §§ 12-36-117.7, 12-38-125.5, 12-42.5-120, or 13-21-108.7. If the patient is deemed to be at risk for an opiate overdose, an opioid antagonist may be prescribed (see section 18-6(N)(5)(c)).

Opioid Management Billing Codes:

Acute Phase: 30 minutes per report	DoWC Code Z0771 per 15 minutes, maximum of
Subacute/Chronic Phase: 30 minutes per report	DoWC Code Z0765 per 15 minutes, maximum of

(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 6 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 6 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 seven (7) 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 the ATP prescribes long-term opioid treatment, s/he shall comply with the Division's Chronic Pain Disorder Medical Treatment Guideline (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 18-5(G)(4) 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 patient;
(ii) Abnormal results on previous testing;
(iii) Change in management of dosage or pain; and
(iv) Chronic daily opioid dosage above 50 MMEs.

(B) FUNCTIONAL ASSESSMENTS

(1) Pre-and post-injection assessments by a trained physician, nurse, physician's assistant, occupational therapist, physical therapist, chiropractor or a medical assistant may be billed with spinal or sacroiliac (SI) joint injection codes. The following three (3) elements are required:

(a) A brief commentary on the procedures, including the anesthesia used in the injection and verification of the needle placement by fluoroscopy, CT or MRI.

(b) Pre-and post-injection procedure shall have at least three (3) objective, diagnostically appropriate, functional measures identified, measured and documented. These may include spinal range of motion; tolerance and time limits for sitting, walking and lifting; straight leg raises for herniated discs; a variety of provocative SI joint maneuvers such as Patrick's sign, Gaenslen, distraction or gapping and compression tests. Objective descriptions, preferably with measurements, shall be provided initially and post procedure at the appropriate time for medication effect, usually 30 minutes post procedure.

(c) There shall be a trained physician or trained non-physician health care professional detailed report with a pre- and post-procedure pain diagram, normally using a 0-10 point scale. The patient(s) should be instructed to keep a post-injection pain diary that details the patient's pain level for all pertinent body parts, including any affected limbs. The patient pain diary should be kept for at least eight (8) hours post injection and preferably up to seven (7) days. The patient should be encouraged to also report any changes in activity level post injection.

(2) If all three (3) elements are documented, the billing codes and maximum fees are as follows:

DOWC Z0811 per episode for the initial functional assessment of pre-injection care, billed with the appropriate E&M code, related to spinal or SI joint injections.

DOWC Z0812 for a subsequent visit of therapeutic post-injection care (preferably done by a non-injectionist and at least seven (7) 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 pain data, including a pain diary.

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

(C) 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.

If these elements are met, the billing code and maximum fee are as follows:

DOWC Z0815 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 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 causes him or her to modify the treatment plan. The provider should not bill this code more than once every 2 to 4 weeks.

(2) QPOP for post-MMI patients requires prior authorization based on clearly documented functional goals.

(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.
(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 patients, enrollment patterns, utilization patterns, impact on health outcomes, system effects and the need for future health planning.

18-9 INDIGENCE STANDARDS

(A) A person shall be found to be indigent only if:

(1) income is at or below eligibility guidelines with liquid assets of $1,500 or less; or

(2) income is up to 25% above the eligibility guidelines, liquid assets equal $1,500 or less, and the claimant's monthly expenses equal or exceed monthly income; or,

(3) if "extraordinary circumstances" exist which merit a determination of indigence.

(B) Income Eligibility Guidelines:

Family Size	Monthly income guidelines	Monthly income guideline plus 25%
1	$1,265	$1,581
2	$1,715	$2,143
3	$2,165	$2,706
4	$2,615	$3,268
5	$3,065	$3,831
6	$3,515	$4,393
7	$3,965	$4,956
8	$4,461	$5,577

*For family units with more than eight members, add $390 per month for "monthly income" or $4,675 per year for "yearly income" for each additional family member.

(1) Income is gross income from all members of the household who contribute monetarily to the common support of the household.

(2) Liquid assets include cash on hand or in accounts, stocks, bonds, certificates of deposit, equity and personal property or investments which could readily be converted into cash without jeopardizing the applicant's ability to maintain home and employment. "Liquid assets" exclude any equity in any vehicle which the injured worker or his/her family must use for essential transportation unless the ALJ makes an affirmative finding of fact that the worker is credit worthy, can borrow against the equity in this vehicle, and can afford to pay back a loan without compromising food, clothing, shelter, and transportation needs.

(3) Expenses for nonessential items such as cable television, club memberships, entertainment, dining out, alcohol, cigarettes, etc. shall not be included.

18-10 LIST OF EXHIBITS

Exhibit 1 – MS-DRG Relative Weights

Exhibit 2 - Hospital Base Rates and Cost to Charge Ratios (CCRs)

Exhibit 3 - Critical Access Hospitals

Exhibit 4 - Hospital and ASC APCs

Exhibit 5 - Rural Health Clinics

Exhibit 6 - Dental Fee Schedule

Exhibit 7 - Evaluation and Management (E&M)

Exhibit 8 - Clinical Lab

Exhibit 9 - Division established RVUs and Z-Codes

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
1	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W MCC	26.4106	29.1	37.5
2	PRE	SURG	HEART TRANSPLANT OR IMPLANT OF HEART ASSIST SYSTEM W/O MCC	13.4227	15.1	18.0
3	PRE	SURG	ECMO OR TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	18.2974	23.4	30.1
4	PRE	SURG	TRACH W MV >96 HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	11.4192	19.5	23.6
5	PRE	SURG	LIVER TRANSPLANT W MCC OR INTESTINAL TRANSPLANT	10.2545	14.6	20.0
6	PRE	SURG	LIVER TRANSPLANT W/O MCC	4.8655	7.9	8.6
7	PRE	SURG	LUNG TRANSPLANT	10.6510	16.7	20.2
8	PRE	SURG	SIMULTANEOUS PANCREAS/KIDNEY TRANSPLANT	5.2490	8.9	10.1
10	PRE	SURG	PANCREAS TRANSPLANT	4.5139	7.8	8.5
11	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W MCC	4.9124	10.9	13.4
12	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W CC	3.8137	8.7	9.8
13	PRE	SURG	TRACHEOSTOMY FOR FACE, MOUTH & NECK DIAGNOSES OR LARYNGECTOMY W/O CC/MCC	2.3265	5.9	6.7
14	PRE	SURG	ALLOGENEIC BONE MARROW TRANSPLANT	11.9503	24.1	27.4
16	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W CC/MCC OR T-CELL IMMUNOTHERAPY	6.5394	17.1	18.4
17	PRE	SURG	AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	4.3811	7.9	10.7
20	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W MCC	10.4253	13.6	16.5
21	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W CC	7.9056	12.1	13.7
22	01	SURG	INTRACRANIAL VASCULAR PROCEDURES W PDX HEMORRHAGE W/O CC/MCC	5.1575	6.3	8.1

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
23	01	SURG	CRANIOTOMY W MAJOR DEVICE IMPLANT OR ACUTE COMPLEX CNS PDX W MCC OR CHEMOTHERAPY IMPLANT OR EPILEPSY W NEUROSTIMULATOR	5.4601	7.3	10.2
24	01	SURG	CRANIO W MAJOR DEV IMPL/ACUTE COMPLEX CNS PDX W/O MCC	3.9194	4.3	5.7
25	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W MCC	4.2775	6.7	8.8
26	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W CC	3.0157	4.3	5.7
27	01	SURG	CRANIOTOMY & ENDOVASCULAR INTRACRANIAL PROCEDURES W/O CC/MCC	2.4057	2.1	2.7
28	01	SURG	SPINAL PROCEDURES W MCC	5.3748	9.0	11.8
29	01	SURG	SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	3.1557	4.4	5.8
30	01	SURG	SPINAL PROCEDURES W/O CC/MCC	2.1757	2.3	3.0
31	01	SURG	VENTRICULAR SHUNT PROCEDURES W MCC	4.1829	7.2	10.1
32	01	SURG	VENTRICULAR SHUNT PROCEDURES W CC	2.3021	3.3	4.8
33	01	SURG	VENTRICULAR SHUNT PROCEDURES W/O CC/MCC	1.6877	1.8	2.3
34	01	SURG	CAROTID ARTERY STENT PROCEDURE W MCC	3.5998	4.7	6.8
35	01	SURG	CAROTID ARTERY STENT PROCEDURE W CC	2.2203	2.1	3.0
36	01	SURG	CAROTID ARTERY STENT PROCEDURE W/O CC/MCC	1.7260	1.2	1.4
37	01	SURG	EXTRACRANIAL PROCEDURES W MCC	3.2098	5.1	7.4
38	01	SURG	EXTRACRANIAL PROCEDURES W CC	1.6717	2.2	3.1
39	01	SURG	EXTRACRANIAL PROCEDURES W/O CC/MCC	1.1324	1.3	1.5
40	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W MCC	3.9282	7.6	10.7
41	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	2.3584	4.2	5.3
42	01	SURG	PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W/O CC/MCC	1.8715	2.5	3.1
52	01	MED	SPINAL DISORDERS & INJURIES W CC/MCC	1.7004	4.1	5.8

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
53	01	MED	SPINAL DISORDERS & INJURIES W/O CC/MCC	0.9141	2.7	3.3
54	01	MED	NERVOUS SYSTEM NEOPLASMS W MCC	1.3166	3.8	5.1
55	01	MED	NERVOUS SYSTEM NEOPLASMS W/O MCC	1.0472	3.1	4.4
56	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	2.1245	5.5	8.1
57	01	MED	DEGENERATIVE NERVOUS SYSTEM DISORDERS W/O MCC	1.2089	3.9	5.6
58	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W MCC	1.7596	5.0	6.9
59	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W CC	1.0993	3.7	4.5
60	01	MED	MULTIPLE SCLEROSIS & CEREBELLAR ATAXIA W/O CC/MCC	0.8327	3.0	3.5
61	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W MCC	2.8477	5.0	6.5
62	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W CC	1.9437	3.4	4.0
63	01	MED	ISCHEMIC STROKE, PRECEREBRAL OCCLUSION OR TRANSIENT ISCHEMIA W THROMBOLYTIC AGENT W/O CC/MCC	1.6280	2.4	2.7
64	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	1.8692	4.4	6.1
65	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	1.0315	3.1	3.8
66	01	MED	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W/O CC/MCC	0.7268	2.1	2.5
67	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W MCC	1.5014	3.6	4.8
68	01	MED	NONSPECIFIC CVA & PRECEREBRAL OCCLUSION W/O INFARCT W/O MCC	0.8987	2.3	2.8
69	01	MED	TRANSIENT ISCHEMIA W/O THROMBOLYTIC	0.7655	2.1	2.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
70	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	1.6453	4.5	6.2
71	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W CC	0.9858	3.3	4.3
72	01	MED	NONSPECIFIC CEREBROVASCULAR DISORDERS W/O CC/MCC	0.7420	2.4	2.9
73	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W MCC	1.4111	3.7	5.1
74	01	MED	CRANIAL & PERIPHERAL NERVE DISORDERS W/O MCC	0.9739	2.9	3.7
75	01	MED	VIRAL MENINGITIS W CC/MCC	1.4816	4.8	6.0
76	01	MED	VIRAL MENINGITIS W/O CC/MCC	0.8248	2.8	3.3
77	01	MED	HYPERTENSIVE ENCEPHALOPATHY W MCC	1.5520	4.1	5.2
78	01	MED	HYPERTENSIVE ENCEPHALOPATHY W CC	0.9701	3.1	3.8
79	01	MED	HYPERTENSIVE ENCEPHALOPATHY W/O CC/MCC	0.7465	2.1	2.5
80	01	MED	NONTRAUMATIC STUPOR & COMA W MCC	1.8788	4.5	6.8
81	01	MED	NONTRAUMATIC STUPOR & COMA W/O MCC	0.8546	2.7	3.7
82	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W MCC	2.1586	3.8	6.0
83	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W CC	1.2950	3.2	4.2
84	01	MED	TRAUMATIC STUPOR & COMA, COMA >1 HR W/O CC/MCC	0.9233	2.2	2.7
85	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W MCC	2.1800	4.7	6.5
86	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W CC	1.2431	3.2	4.1
87	01	MED	TRAUMATIC STUPOR & COMA, COMA <1 HR W/O CC/MCC	0.8453	2.1	2.6
88	01	MED	CONCUSSION W MCC	1.4796	3.6	4.7
89	01	MED	CONCUSSION W CC	1.0675	2.7	3.5
90	01	MED	CONCUSSION W/O CC/MCC	0.7934	1.9	2.3
91	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	1.6120	4.2	5.7

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
92	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W CC	0.9433	3.0	3.8
93	01	MED	OTHER DISORDERS OF NERVOUS SYSTEM W/O CC/MCC	0.7378	2.2	2.7
94	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W MCC	3.6779	8.0	11.0
95	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W CC	2.3809	5.7	7.1
96	01	MED	BACTERIAL & TUBERCULOUS INFECTIONS OF NERVOUS SYSTEM W/O CC/MCC	2.1110	4.4	5.2
97	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W MCC	3.5389	8.4	11.4
98	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W CC	1.8505	5.4	6.9
99	01	MED	NON-BACTERIAL INFECT OF NERVOUS SYS EXC VIRAL MENINGITIS W/O CC/MCC	1.2729	3.7	4.7
100	01	MED	SEIZURES W MCC	1.8124	4.3	5.9
101	01	MED	SEIZURES W/O MCC	0.8693	2.7	3.4
102	01	MED	HEADACHES W MCC	1.0765	3.0	4.0
103	01	MED	HEADACHES W/O MCC	0.7814	2.3	3.0
113	02	SURG	ORBITAL PROCEDURES W CC/MCC	2.3027	4.5	6.2
114	02	SURG	ORBITAL PROCEDURES W/O CC/MCC	1.2551	2.3	2.9
115	02	SURG	EXTRAOCULAR PROCEDURES EXCEPT ORBIT	1.3621	3.5	4.5
116	02	SURG	INTRAOCULAR PROCEDURES W CC/MCC	1.7080	4.0	5.8
117	02	SURG	INTRAOCULAR PROCEDURES W/O CC/MCC	1.0025	2.3	3.1
121	02	MED	ACUTE MAJOR EYE INFECTIONS W CC/MCC	1.0593	4.0	5.2
122	02	MED	ACUTE MAJOR EYE INFECTIONS W/O CC/MCC	0.7058	3.2	4.1
123	02	MED	NEUROLOGICAL EYE DISORDERS	0.7529	2.0	2.5
124	02	MED	OTHER DISORDERS OF THE EYE W MCC	1.3313	3.6	4.9
125	02	MED	OTHER DISORDERS OF THE EYE W/O MCC	0.8102	2.6	3.3
129	03	SURG	MAJOR HEAD & NECK PROCEDURES W CC/MCC OR MAJOR DEVICE	2.4310	3.7	5.5
130	03	SURG	MAJOR HEAD & NECK PROCEDURES W/O CC/MCC	1.4912	2.3	2.9
131	03	SURG	CRANIAL/FACIAL PROCEDURES W CC/MCC	2.6284	4.2	5.7

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
132	03	SURG	CRANIAL/FACIAL PROCEDURES W/O CC/MCC	1.5286	2.0	2.5
133	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W CC/MCC	2.0986	4.0	5.8
134	03	SURG	OTHER EAR, NOSE, MOUTH & THROAT O.R. PROCEDURES W/O CC/MCC	1.1987	2.0	2.5
135	03	SURG	SINUS & MASTOID PROCEDURES W CC/MCC	2.2982	4.4	6.4
136	03	SURG	SINUS & MASTOID PROCEDURES W/O CC/MCC	1.2125	1.8	2.8
137	03	SURG	MOUTH PROCEDURES W CC/MCC	1.3771	3.6	4.8
138	03	SURG	MOUTH PROCEDURES W/O CC/MCC	0.8452	2.0	2.4
139	03	SURG	SALIVARY GLAND PROCEDURES	1.1604	2.1	2.8
146	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W MCC	1.9231	5.3	7.4
147	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W CC	1.2505	3.7	5.2
148	03	MED	EAR, NOSE, MOUTH & THROAT MALIGNANCY W/O CC/MCC	0.7238	2.1	2.8
149	03	MED	DYSEQUILIBRIUM	0.7111	2.0	2.5
150	03	MED	EPISTAXIS W MCC	1.3275	3.5	4.8
151	03	MED	EPISTAXIS W/O MCC	0.7038	2.2	2.8
152	03	MED	OTITIS MEDIA & URI W MCC	1.0421	3.2	4.1
153	03	MED	OTITIS MEDIA & URI W/O MCC	0.7118	2.4	2.9
154	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W MCC	1.4465	4.0	5.3
155	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W CC	0.8833	2.9	3.7
156	03	MED	OTHER EAR, NOSE, MOUTH & THROAT DIAGNOSES W/O CC/MCC	0.6599	2.2	2.7
157	03	MED	DENTAL & ORAL DISEASES W MCC	1.6730	4.4	6.1
158	03	MED	DENTAL & ORAL DISEASES W CC	0.8903	2.8	3.6
159	03	MED	DENTAL & ORAL DISEASES W/O CC/MCC	0.6784	2.1	2.6
163	04	SURG	MAJOR CHEST PROCEDURES W MCC	4.9193	9.7	12.1
164	04	SURG	MAJOR CHEST PROCEDURES W CC	2.5689	4.8	5.9
165	04	SURG	MAJOR CHEST PROCEDURES W/O CC/MCC	1.8524	2.9	3.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
166	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	3.4980	7.9	10.2
167	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W CC	1.8976	4.3	5.6
168	04	SURG	OTHER RESP SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3416	2.4	3.0
175	04	MED	PULMONARY EMBOLISM W MCC	1.4649	4.3	5.3
176	04	MED	PULMONARY EMBOLISM W/O MCC	0.8990	2.8	3.4
177	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	1.8408	5.5	6.8
178	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	1.2744	4.3	5.3
179	04	MED	RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	0.9215	3.2	4.0
180	04	MED	RESPIRATORY NEOPLASMS W MCC	1.6960	4.9	6.5
181	04	MED	RESPIRATORY NEOPLASMS W CC	1.1409	3.4	4.5
182	04	MED	RESPIRATORY NEOPLASMS W/O CC/MCC	0.7951	2.2	2.8
183	04	MED	MAJOR CHEST TRAUMA W MCC	1.4909	4.4	5.5
184	04	MED	MAJOR CHEST TRAUMA W CC	1.0044	3.2	3.8
185	04	MED	MAJOR CHEST TRAUMA W/O CC/MCC	0.7323	2.4	2.8
186	04	MED	PLEURAL EFFUSION W MCC	1.5595	4.4	5.8
187	04	MED	PLEURAL EFFUSION W CC	1.0540	3.3	4.1
188	04	MED	PLEURAL EFFUSION W/O CC/MCC	0.7672	2.4	3.0
189	04	MED	PULMONARY EDEMA & RESPIRATORY FAILURE	1.2353	3.8	4.8
190	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1.1907	3.8	4.7
191	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	0.9139	3.1	3.7
192	04	MED	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W/O CC/MCC	0.7241	2.5	3.0
193	04	MED	SIMPLE PNEUMONIA & PLEURISY W MCC	1.3167	4.2	5.2
194	04	MED	SIMPLE PNEUMONIA & PLEURISY W CC	0.9002	3.3	3.9
195	04	MED	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	0.6868	2.6	3.1
196	04	MED	INTERSTITIAL LUNG DISEASE W MCC	1.6381	4.8	6.2

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
197	04	MED	INTERSTITIAL LUNG DISEASE W CC	1.0017	3.3	4.0
198	04	MED	INTERSTITIAL LUNG DISEASE W/O CC/MCC	0.7585	2.5	3.1
199	04	MED	PNEUMOTHORAX W MCC	1.7828	5.3	6.9
200	04	MED	PNEUMOTHORAX W CC	1.0748	3.4	4.3
201	04	MED	PNEUMOTHORAX W/O CC/MCC	0.6989	2.4	3.0
202	04	MED	BRONCHITIS & ASTHMA W CC/MCC	0.9401	3.0	3.7
203	04	MED	BRONCHITIS & ASTHMA W/O CC/MCC	0.6970	2.4	2.9
204	04	MED	RESPIRATORY SIGNS & SYMPTOMS	0.7676	2.2	2.8
205	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W MCC	1.5179	4.0	5.4
206	04	MED	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	0.8635	2.5	3.1
207	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT >96 HOURS OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	5.5965	12.0	13.9
208	04	MED	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <=96 HOURS	2.4374	4.9	6.7
215	05	SURG	OTHER HEART ASSIST SYSTEM IMPLANT	12.8861	5.2	8.7
216	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	9.8209	12.5	15.3
217	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	6.3628	7.3	8.8
218	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	5.9053	4.1	5.5
219	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	7.6916	9.1	11.1
220	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W CC	5.2053	6.1	6.7

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
221	05	SURG	CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W/O CC/MCC	4.6074	4.2	4.8
222	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W MCC	8.1372	9.2	11.1
223	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W AMI/HF/SHOCK W/O MCC	6.3562	5.3	6.4
224	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W MCC	7.4247	7.7	9.6
225	05	SURG	CARDIAC DEFIB IMPLANT W CARDIAC CATH W/O AMI/HF/SHOCK W/O MCC	5.7194	4.1	4.8
226	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W MCC	6.8182	6.5	8.4
227	05	SURG	CARDIAC DEFIBRILLATOR IMPLANT W/O CARDIAC CATH W/O MCC	5.3167	3.1	4.1
228	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W MCC	6.5762	6.7	9.7
229	05	SURG	OTHER CARDIOTHORACIC PROCEDURES W/O MCC	4.6484	3.4	4.7
231	05	SURG	CORONARY BYPASS W PTCA W MCC	8.3989	10.3	12.0
232	05	SURG	CORONARY BYPASS W PTCA W/O MCC	6.1604	8.0	8.8
233	05	SURG	CORONARY BYPASS W CARDIAC CATH W MCC	7.6377	11.5	12.9
234	05	SURG	CORONARY BYPASS W CARDIAC CATH W/O MCC	5.1472	8.1	8.6
235	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W MCC	5.8099	8.8	10.1
236	05	SURG	CORONARY BYPASS W/O CARDIAC CATH W/O MCC	3.9263	6.0	6.5
239	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W MCC	4.7093	10.2	13.0
240	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W CC	2.7449	7.0	8.5
241	05	SURG	AMPUTATION FOR CIRC SYS DISORDERS EXC UPPER LIMB & TOE W/O CC/MCC	1.5960	4.4	5.2

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
242	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W MCC	3.7369	5.4	7.0
243	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W CC	2.5543	3.3	4.0
244	05	SURG	PERMANENT CARDIAC PACEMAKER IMPLANT W/O CC/MCC	2.1108	2.3	2.7
245	05	SURG	AICD GENERATOR PROCEDURES	5.0121	4.4	6.1
246	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	3.2388	4.1	5.4
247	05	SURG	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	2.0771	2.2	2.6
248	05	SURG	PERCUTANEOUS CARDIOVASCULAR PROCEDURES W NON-DRUG-ELUTING STENT W MCC OR 4+ ARTERIES OR STENTS	3.1726	4.7	6.3
249	05	SURG	PERC CARDIOVASC PROC W NON-DRUG-ELUTING STENT W/O MCC	1.9901	2.4	3.0
250	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W MCC	2.5868	3.9	5.3
251	05	SURG	PERC CARDIOVASC PROC W/O CORONARY ARTERY STENT W/O MCC	1.6778	2.2	2.7
252	05	SURG	OTHER VASCULAR PROCEDURES W MCC	3.2598	5.3	7.6
253	05	SURG	OTHER VASCULAR PROCEDURES W CC	2.5943	4.1	5.4
254	05	SURG	OTHER VASCULAR PROCEDURES W/O CC/MCC	1.8100	2.3	2.8
255	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W MCC	2.5403	6.5	8.1
256	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W CC	1.7487	5.2	6.2
257	05	SURG	UPPER LIMB & TOE AMPUTATION FOR CIRC SYSTEM DISORDERS W/O CC/MCC	1.1261	3.5	4.3
258	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W MCC	2.9888	5.0	6.4
259	05	SURG	CARDIAC PACEMAKER DEVICE REPLACEMENT W/O MCC	2.0970	2.7	3.4

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
260	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W MCC	3.6195	6.8	9.2
261	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W CC	1.9918	3.3	4.2
262	05	SURG	CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT W/O CC/MCC	1.6309	2.3	2.7
263	05	SURG	VEIN LIGATION & STRIPPING	2.3922	4.2	6.3
264	05	SURG	OTHER CIRCULATORY SYSTEM O.R. PROCEDURES	3.1586	6.5	9.2
265	05	SURG	AICD LEAD PROCEDURES	3.1167	3.7	5.1
266	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W MCC	7.1915	4.0	6.1
267	05	SURG	ENDOVASCULAR CARDIAC VALVE REPLACEMENT W/O MCC	5.8481	2.3	2.9
268	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W MCC	6.7037	6.4	9.5
269	05	SURG	AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON W/O MCC	4.1509	1.7	2.4
270	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W MCC	5.0617	6.6	9.5
271	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W CC	3.4938	4.3	5.8
272	05	SURG	OTHER MAJOR CARDIOVASCULAR PROCEDURES W/O CC/MCC	2.6181	2.1	2.8
273	05	SURG	PERCUTANEOUS INTRACARDIAC PROCEDURES W MCC	3.6525	5.3	7.3
274	05	SURG	PERCUTANEOUS INTRACARDIAC PROCEDURES W/O MCC	2.9783	2.0	2.6
280	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	1.6571	4.2	5.4
281	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W CC	0.9796	2.6	3.2
282	05	MED	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W/O CC/MCC	0.7490	1.8	2.2
283	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W MCC	1.8047	3.0	4.8

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
284	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W CC	0.7666	1.7	2.3
285	05	MED	ACUTE MYOCARDIAL INFARCTION, EXPIRED W/O CC/MCC	0.5964	1.3	1.6
286	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W MCC	2.1808	5.2	6.9
287	05	MED	CIRCULATORY DISORDERS EXCEPT AMI, W CARD CATH W/O MCC	1.1389	2.4	3.0
288	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W MCC	2.6941	7.3	9.6
289	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W CC	1.7099	5.4	6.7
290	05	MED	ACUTE & SUBACUTE ENDOCARDITIS W/O CC/MCC	1.0114	3.4	4.3
291	05	MED	HEART FAILURE & SHOCK W MCC OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	1.3454	4.1	5.2
292	05	MED	HEART FAILURE & SHOCK W CC	0.9198	3.3	4.0
293	05	MED	HEART FAILURE & SHOCK W/O CC/MCC	0.6656	2.4	2.8
294	05	MED	DEEP VEIN THROMBOPHLEBITIS W CC/MCC	1.1608	3.4	4.4
295	05	MED	DEEP VEIN THROMBOPHLEBITIS W/O CC/MCC	0.5513	2.3	3.1
296	05	MED	CARDIAC ARREST, UNEXPLAINED W MCC OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	1.5355	2.0	3.2
297	05	MED	CARDIAC ARREST, UNEXPLAINED W CC	0.6524	1.3	1.5
298	05	MED	CARDIAC ARREST, UNEXPLAINED W/O CC/MCC	0.4825	1.1	1.2
299	05	MED	PERIPHERAL VASCULAR DISORDERS W MCC	1.4504	3.9	5.2
300	05	MED	PERIPHERAL VASCULAR DISORDERS W CC	1.0237	3.3	4.1
301	05	MED	PERIPHERAL VASCULAR DISORDERS W/O CC/MCC	0.7262	2.3	2.8
302	05	MED	ATHEROSCLEROSIS W MCC	1.0695	2.7	3.6
303	05	MED	ATHEROSCLEROSIS W/O MCC	0.6655	1.9	2.3
304	05	MED	HYPERTENSION W MCC	1.0811	3.0	3.9
305	05	MED	HYPERTENSION W/O MCC	0.7199	2.2	2.7
306	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W MCC	1.4088	3.8	5.2

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
307	05	MED	CARDIAC CONGENITAL & VALVULAR DISORDERS W/O MCC	0.8560	2.4	3.1
308	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W MCC	1.2036	3.6	4.6
309	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W CC	0.7635	2.5	3.0
310	05	MED	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS W/O CC/MCC	0.5623	1.9	2.2
311	05	MED	ANGINA PECTORIS	0.6872	1.9	2.4
312	05	MED	SYNCOPE & COLLAPSE	0.8015	2.3	2.9
313	05	MED	CHEST PAIN	0.7073	1.7	2.1
314	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W MCC	2.0231	4.8	6.5
315	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	0.9559	2.8	3.6
316	05	MED	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC/MCC	0.7513	2.0	2.4
326	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	5.2559	10.1	13.5
327	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W CC	2.4843	4.9	6.7
328	06	SURG	STOMACH, ESOPHAGEAL & DUODENAL PROC W/O CC/MCC	1.5421	2.2	2.8
329	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	4.9927	10.8	13.4
330	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	2.5233	6.2	7.4
331	06	SURG	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.6947	3.7	4.2
332	06	SURG	RECTAL RESECTION W MCC	3.3982	6.9	8.8
333	06	SURG	RECTAL RESECTION W CC	1.9278	4.4	5.4
334	06	SURG	RECTAL RESECTION W/O CC/MCC	1.3062	2.4	2.9
335	06	SURG	PERITONEAL ADHESIOLYSIS W MCC	4.0620	10.1	12.3
336	06	SURG	PERITONEAL ADHESIOLYSIS W CC	2.2982	6.3	7.7
337	06	SURG	PERITONEAL ADHESIOLYSIS W/O CC/MCC	1.6033	3.9	4.8

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
338	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W MCC	2.8648	6.6	8.2
339	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W CC	1.7406	4.3	5.2
340	06	SURG	APPENDECTOMY W COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.1878	2.4	2.9
341	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W MCC	2.2845	4.6	6.3
342	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W CC	1.4188	2.7	3.5
343	06	SURG	APPENDECTOMY W/O COMPLICATED PRINCIPAL DIAG W/O CC/MCC	1.0853	1.7	2.0
344	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W MCC	2.9872	7.6	10.1
345	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.6376	4.6	5.7
346	06	SURG	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC	1.2366	3.2	3.8
347	06	SURG	ANAL & STOMAL PROCEDURES W MCC	2.4111	5.7	7.8
348	06	SURG	ANAL & STOMAL PROCEDURES W CC	1.4000	3.6	4.7
349	06	SURG	ANAL & STOMAL PROCEDURES W/O CC/MCC	0.9497	2.1	2.6
350	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W MCC	2.4465	5.1	6.9
351	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W CC	1.5001	3.4	4.1
352	06	SURG	INGUINAL & FEMORAL HERNIA PROCEDURES W/O CC/MCC	1.0535	2.1	2.5
353	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W MCC	2.9659	6.0	7.8
354	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W CC	1.7310	3.8	4.7
355	06	SURG	HERNIA PROCEDURES EXCEPT INGUINAL & FEMORAL W/O CC/MCC	1.3548	2.5	3.0
356	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W MCC	3.9757	7.8	10.3

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
357	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W CC	2.1367	4.7	5.9
358	06	SURG	OTHER DIGESTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.3483	2.8	3.5
368	06	MED	MAJOR ESOPHAGEAL DISORDERS W MCC	1.9440	4.7	6.2
369	06	MED	MAJOR ESOPHAGEAL DISORDERS W CC	1.1088	3.2	3.9
370	06	MED	MAJOR ESOPHAGEAL DISORDERS W/O CC/MCC	0.7433	2.2	2.8
371	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	1.7388	5.4	7.0
372	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W CC	1.0384	4.0	4.9
373	06	MED	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W/O CC/MCC	0.7576	3.1	3.7
374	06	MED	DIGESTIVE MALIGNANCY W MCC	2.0650	5.6	7.5
375	06	MED	DIGESTIVE MALIGNANCY W CC	1.2067	3.7	4.8
376	06	MED	DIGESTIVE MALIGNANCY W/O CC/MCC	0.9157	2.5	3.1
377	06	MED	G.I. HEMORRHAGE W MCC	1.7888	4.5	5.7
378	06	MED	G.I. HEMORRHAGE W CC	0.9903	3.0	3.6
379	06	MED	G.I. HEMORRHAGE W/O CC/MCC	0.6532	2.1	2.5
380	06	MED	COMPLICATED PEPTIC ULCER W MCC	1.9460	5.1	6.6
381	06	MED	COMPLICATED PEPTIC ULCER W CC	1.0950	3.3	4.0
382	06	MED	COMPLICATED PEPTIC ULCER W/O CC/MCC	0.7678	2.5	2.9
383	06	MED	UNCOMPLICATED PEPTIC ULCER W MCC	1.3510	4.0	5.0
384	06	MED	UNCOMPLICATED PEPTIC ULCER W/O MCC	0.8553	2.6	3.2
385	06	MED	INFLAMMATORY BOWEL DISEASE W MCC	1.6979	5.3	7.3
386	06	MED	INFLAMMATORY BOWEL DISEASE W CC	0.9801	3.5	4.4
387	06	MED	INFLAMMATORY BOWEL DISEASE W/O CC/MCC	0.6967	2.8	3.3
388	06	MED	G.I. OBSTRUCTION W MCC	1.5307	4.8	6.4
389	06	MED	G.I. OBSTRUCTION W CC	0.8432	3.3	4.0
390	06	MED	G.I. OBSTRUCTION W/O CC/MCC	0.5910	2.5	2.9
391	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W MCC	1.2215	3.7	4.9
392	06	MED	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	0.7554	2.6	3.2

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	**MDC**	**TYPE**	**MS-DRG Title**	**Weights**	**Geometric mean LOS**	**Arithmetic mean LOS**
393	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W MCC	1.6326	4.4	6.1
394	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	0.9411	3.1	4.0
395	06	MED	OTHER DIGESTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.6765	2.3	2.8
405	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W MCC	5.3791	9.6	12.8
406	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W CC	2.8326	5.6	7.0
407	07	SURG	PANCREAS, LIVER & SHUNT PROCEDURES W/O CC/MCC	2.0068	3.8	4.5
408	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W MCC	4.0465	9.2	11.9
409	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W CC	2.3227	5.6	6.9
410	07	SURG	BILIARY TRACT PROC EXCEPT ONLY CHOLECYST W OR W/O C.D.E. W/O CC/MCC	1.6526	3.7	4.5
411	07	SURG	CHOLECYSTECTOMY W C.D.E. W MCC	3.9981	8.3	11.1
412	07	SURG	CHOLECYSTECTOMY W C.D.E. W CC	2.3819	5.5	6.5
413	07	SURG	CHOLECYSTECTOMY W C.D.E. W/O CC/MCC	1.6862	3.5	4.3
414	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W MCC	3.5772	8.0	9.8
415	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W CC	2.0188	5.2	6.1
416	07	SURG	CHOLECYSTECTOMY EXCEPT BY LAPAROSCOPE W/O C.D.E. W/O CC/MCC	1.3931	3.2	3.8
417	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	2.4234	5.4	6.7
418	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W CC	1.6642	3.7	4.4
419	07	SURG	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W/O CC/MCC	1.3042	2.5	2.9
420	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W MCC	3.5176	7.7	10.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
421	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W CC	1.7791	4.1	5.4
422	07	SURG	HEPATOBILIARY DIAGNOSTIC PROCEDURES W/O CC/MCC	1.5076	2.8	3.4
423	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W MCC	3.9460	8.6	12.3
424	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W CC	2.1911	5.6	7.4
425	07	SURG	OTHER HEPATOBILIARY OR PANCREAS O.R. PROCEDURES W/O CC/MCC	1.4929	3.4	4.1
432	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W MCC	1.8260	4.7	6.4
433	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W CC	1.0279	3.3	4.2
434	07	MED	CIRRHOSIS & ALCOHOLIC HEPATITIS W/O CC/MCC	0.6511	2.3	2.8
435	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W MCC	1.6977	4.8	6.3
436	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W CC	1.1359	3.5	4.5
437	07	MED	MALIGNANCY OF HEPATOBILIARY SYSTEM OR PANCREAS W/O CC/MCC	0.8658	2.4	3.1
438	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W MCC	1.6382	4.6	6.3
439	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	0.8623	3.2	4.0
440	07	MED	DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	0.6213	2.5	2.9
441	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	1.8572	4.7	6.5
442	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	0.9389	3.2	4.1
443	07	MED	DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	0.6958	2.5	3.0
444	07	MED	DISORDERS OF THE BILIARY TRACT W MCC	1.6109	4.4	5.7
445	07	MED	DISORDERS OF THE BILIARY TRACT W CC	1.0676	3.2	3.9
446	07	MED	DISORDERS OF THE BILIARY TRACT W/O CC/MCC	0.7950	2.3	2.7

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
453	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	9.4969	7.6	9.7
454	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	6.3368	4.0	4.7
455	08	SURG	COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	5.0000	2.6	3.0
456	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W MCC	9.1252	9.5	11.6
457	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W CC	6.5446	5.3	6.1
458	08	SURG	SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W/O CC/MCC	5.1212	3.2	3.6
459	08	SURG	SPINAL FUSION EXCEPT CERVICAL W MCC	6.3848	6.3	7.9
460	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O MCC	4.0375	2.9	3.4
461	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	4.4825	5.6	6.7
462	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.1941	2.9	3.2
463	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	5.1319	9.8	13.0
464	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.9440	5.5	7.0
465	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.8374	2.7	3.5
466	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W MCC	5.1132	6.6	8.3
467	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W CC	3.4704	3.4	4.1
468	08	SURG	REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	2.7914	2.2	2.5
469	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MCC OR TOTAL ANKLE REPLACEMENT	3.1742	4.9	6.2

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
470	08	SURG	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	1.9898	2.2	2.5
471	08	SURG	CERVICAL SPINAL FUSION W MCC	5.0107	6.3	8.6
472	08	SURG	CERVICAL SPINAL FUSION W CC	2.9468	2.4	3.2
473	08	SURG	CERVICAL SPINAL FUSION W/O CC/MCC	2.3729	1.5	1.8
474	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	3.7951	8.9	11.1
475	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	2.1488	5.8	7.1
476	08	SURG	AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	1.1507	3.1	4.0
477	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	3.1384	8.2	10.2
478	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	2.2792	5.3	6.6
479	08	SURG	BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	1.7980	3.4	4.2
480	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	3.0304	6.4	7.5
481	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	2.0623	4.4	4.8
482	08	SURG	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	1.6645	3.5	3.7
483	08	SURG	MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF UPPER EXTREMITIES	2.3835	1.6	1.9
485	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W MCC	3.3041	8.0	9.6
486	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W CC	2.2184	5.3	6.3
487	08	SURG	KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	1.6502	3.7	4.2
488	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	2.1125	3.8	5.0
489	08	SURG	KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	1.2974	2.1	2.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
492	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	3.3905	6.1	7.7
493	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	2.2461	4.0	4.8
494	08	SURG	LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	1.7539	2.7	3.2
495	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	3.4623	7.3	9.8
496	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	1.9609	3.5	4.5
497	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	1.4350	1.9	2.4
498	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W CC/MCC	2.2780	5.1	6.8
499	08	SURG	LOCAL EXCISION & REMOVAL INT FIX DEVICES OF HIP & FEMUR W/O CC/MCC	1.1192	2.1	2.6
500	08	SURG	SOFT TISSUE PROCEDURES W MCC	3.0680	7.3	9.7
501	08	SURG	SOFT TISSUE PROCEDURES W CC	1.6874	4.2	5.2
502	08	SURG	SOFT TISSUE PROCEDURES W/O CC/MCC	1.2911	2.5	3.0
503	08	SURG	FOOT PROCEDURES W MCC	2.5622	6.8	8.5
504	08	SURG	FOOT PROCEDURES W CC	1.7295	4.8	5.8
505	08	SURG	FOOT PROCEDURES W/O CC/MCC	1.5798	2.8	3.4
506	08	SURG	MAJOR THUMB OR JOINT PROCEDURES	1.4103	3.8	4.8
507	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W CC/MCC	1.9425	4.5	5.9
508	08	SURG	MAJOR SHOULDER OR ELBOW JOINT PROCEDURES W/O CC/MCC	1.4474	2.1	2.6
509	08	SURG	ARTHROSCOPY	1.6703	4.4	5.6
510	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W MCC	2.7324	5.0	6.3
511	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W CC	1.8473	3.4	4.0
512	08	SURG	SHOULDER,ELBOW OR FOREARM PROC,EXC MAJOR JOINT PROC W/O CC/MCC	1.5221	2.2	2.5
513	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W CC/MCC	1.6396	4.1	5.3

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
514	08	SURG	HAND OR WRIST PROC, EXCEPT MAJOR THUMB OR JOINT PROC W/O CC/MCC	0.9998	2.3	2.9
515	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W MCC	3.0820	6.4	8.3
516	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W CC	1.8854	3.8	4.7
517	08	SURG	OTHER MUSCULOSKELET SYS & CONN TISS O.R. PROC W/O CC/MCC	1.3809	2.2	2.7
518	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W MCC OR DISC DEVICE/NEUROSTIM	3.1002	3.4	5.4
519	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W CC	1.8620	3.1	4.0
520	08	SURG	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	1.3141	1.9	2.3
533	08	MED	FRACTURES OF FEMUR W MCC	1.5305	4.2	5.7
534	08	MED	FRACTURES OF FEMUR W/O MCC	0.7755	2.9	3.5
535	08	MED	FRACTURES OF HIP & PELVIS W MCC	1.2548	3.8	4.9
536	08	MED	FRACTURES OF HIP & PELVIS W/O MCC	0.7570	2.9	3.4
537	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W CC/MCC	0.9105	3.1	3.7
538	08	MED	SPRAINS, STRAINS, & DISLOCATIONS OF HIP, PELVIS & THIGH W/O CC/MCC	0.7270	2.5	2.9
539	08	MED	OSTEOMYELITIS W MCC	2.0192	6.1	8.2
540	08	MED	OSTEOMYELITIS W CC	1.2969	4.5	5.7
541	08	MED	OSTEOMYELITIS W/O CC/MCC	0.8827	3.2	4.0
542	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W MCC	1.8253	5.2	6.9
543	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W CC	1.0725	3.7	4.6
544	08	MED	PATHOLOGICAL FRACTURES & MUSCULOSKELET & CONN TISS MALIG W/O CC/MCC	0.7984	2.8	3.3
545	08	MED	CONNECTIVE TISSUE DISORDERS W MCC	2.4791	5.6	8.0
546	08	MED	CONNECTIVE TISSUE DISORDERS W CC	1.2144	3.6	4.6

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
547	08	MED	CONNECTIVE TISSUE DISORDERS W/O CC/MCC	0.8576	2.7	3.3
548	08	MED	SEPTIC ARTHRITIS W MCC	2.0672	6.1	7.8
549	08	MED	SEPTIC ARTHRITIS W CC	1.2442	4.1	5.1
550	08	MED	SEPTIC ARTHRITIS W/O CC/MCC	0.9238	3.0	3.6
551	08	MED	MEDICAL BACK PROBLEMS W MCC	1.5916	4.4	5.7
552	08	MED	MEDICAL BACK PROBLEMS W/O MCC	0.9010	3.0	3.6
553	08	MED	BONE DISEASES & ARTHROPATHIES W MCC	1.2376	3.9	5.0
554	08	MED	BONE DISEASES & ARTHROPATHIES W/O MCC	0.7569	2.8	3.4
555	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W MCC	1.2792	3.7	5.0
556	08	MED	SIGNS & SYMPTOMS OF MUSCULOSKELETAL SYSTEM & CONN TISSUE W/O MCC	0.7677	2.7	3.3
557	08	MED	TENDONITIS, MYOSITIS & BURSITIS W MCC	1.4324	4.6	5.7
558	08	MED	TENDONITIS, MYOSITIS & BURSITIS W/O MCC	0.8635	3.2	3.8
559	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	1.7987	4.8	6.6
560	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	1.0217	3.6	4.6
561	08	MED	AFTERCARE, MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	0.7561	2.7	3.5
562	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W MCC	1.4081	4.1	5.2
563	08	MED	FX, SPRN, STRN & DISL EXCEPT FEMUR, HIP, PELVIS & THIGH W/O MCC	0.8381	3.0	3.4
564	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W MCC	1.5722	4.7	6.1
565	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W CC	0.9758	3.4	4.1
566	08	MED	OTHER MUSCULOSKELETAL SYS & CONNECTIVE TISSUE DIAGNOSES W/O CC/MCC	0.7623	2.6	3.2
570	09	SURG	SKIN DEBRIDEMENT W MCC	3.0347	7.6	10.2
571	09	SURG	SKIN DEBRIDEMENT W CC	1.7029	5.2	6.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
572	09	SURG	SKIN DEBRIDEMENT W/O CC/MCC	1.1786	3.4	4.2
573	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W MCC	5.2515	10.7	15.3
574	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W CC	3.0459	7.5	10.4
575	09	SURG	SKIN GRAFT FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.7586	4.8	6.0
576	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W MCC	4.8807	8.4	12.8
577	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W CC	2.5092	4.7	6.9
578	09	SURG	SKIN GRAFT EXC FOR SKIN ULCER OR CELLULITIS W/O CC/MCC	1.5297	2.7	3.5
579	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W MCC	2.7978	6.5	8.8
580	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W CC	1.5898	4.1	5.3
581	09	SURG	OTHER SKIN, SUBCUT TISS & BREAST PROC W/O CC/MCC	1.2364	2.4	3.0
582	09	SURG	MASTECTOMY FOR MALIGNANCY W CC/MCC	1.5695	2.4	3.4
583	09	SURG	MASTECTOMY FOR MALIGNANCY W/O CC/MCC	1.3781	1.7	2.0
584	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W CC/MCC	1.8714	3.6	4.7
585	09	SURG	BREAST BIOPSY, LOCAL EXCISION & OTHER BREAST PROCEDURES W/O CC/MCC	1.5657	2.2	2.7
592	09	MED	SKIN ULCERS W MCC	1.7082	5.4	7.1
593	09	MED	SKIN ULCERS W CC	1.1294	4.2	5.3
594	09	MED	SKIN ULCERS W/O CC/MCC	0.8102	3.2	3.9
595	09	MED	MAJOR SKIN DISORDERS W MCC	1.9869	5.2	7.1
596	09	MED	MAJOR SKIN DISORDERS W/O MCC	1.0115	3.5	4.4
597	09	MED	MALIGNANT BREAST DISORDERS W MCC	1.7200	4.9	6.6
598	09	MED	MALIGNANT BREAST DISORDERS W CC	1.1623	3.5	4.7
599	09	MED	MALIGNANT BREAST DISORDERS W/O CC/MCC	0.7164	2.2	2.9

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
600	09	MED	NON-MALIGNANT BREAST DISORDERS W CC/MCC	0.9560	3.5	4.3
601	09	MED	NON-MALIGNANT BREAST DISORDERS W/O CC/MCC	0.6192	2.7	3.0
602	09	MED	CELLULITIS W MCC	1.4440	4.7	5.9
603	09	MED	CELLULITIS W/O MCC	0.8477	3.3	3.9
604	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W MCC	1.4168	3.9	5.0
605	09	MED	TRAUMA TO THE SKIN, SUBCUT TISS & BREAST W/O MCC	0.8605	2.7	3.3
606	09	MED	MINOR SKIN DISORDERS W MCC	1.3808	4.2	5.8
607	09	MED	MINOR SKIN DISORDERS W/O MCC	0.8010	2.8	3.6
614	10	SURG	ADRENAL & PITUITARY PROCEDURES W CC/MCC	2.3636	3.5	4.8
615	10	SURG	ADRENAL & PITUITARY PROCEDURES W/O CC/MCC	1.4812	2.0	2.3
616	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W MCC	4.1352	10.1	12.7
617	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W CC	2.0736	5.9	7.0
618	10	SURG	AMPUTAT OF LOWER LIMB FOR ENDOCRINE,NUTRIT,& METABOL DIS W/O CC/MCC	1.1593	3.5	4.3
619	10	SURG	O.R. PROCEDURES FOR OBESITY W MCC	2.9207	3.0	4.7
620	10	SURG	O.R. PROCEDURES FOR OBESITY W CC	1.8096	2.0	2.5
621	10	SURG	O.R. PROCEDURES FOR OBESITY W/O CC/MCC	1.5783	1.5	1.7
622	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W MCC	3.7980	8.7	12.0
623	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W CC	1.9232	5.5	6.6
624	10	SURG	SKIN GRAFTS & WOUND DEBRID FOR ENDOC, NUTRIT & METAB DIS W/O CC/MCC	1.2960	3.3	4.0
625	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W MCC	2.7833	4.8	7.0

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
626	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W CC	1.6106	2.5	3.6
627	10	SURG	THYROID, PARATHYROID & THYROGLOSSAL PROCEDURES W/O CC/MCC	1.0850	1.4	1.7
628	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W MCC	3.6750	7.3	10.0
629	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W CC	2.3387	6.0	7.2
630	10	SURG	OTHER ENDOCRINE, NUTRIT & METAB O.R. PROC W/O CC/MCC	1.5345	2.9	3.6
637	10	MED	DIABETES W MCC	1.3813	3.9	5.1
638	10	MED	DIABETES W CC	0.8722	2.9	3.6
639	10	MED	DIABETES W/O CC/MCC	0.6319	2.1	2.6
640	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC	1.1902	3.3	4.5
641	10	MED	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	0.7519	2.6	3.3
642	10	MED	INBORN AND OTHER DISORDERS OF METABOLISM	1.2635	3.2	4.3
643	10	MED	ENDOCRINE DISORDERS W MCC	1.6341	5.0	6.3
644	10	MED	ENDOCRINE DISORDERS W CC	1.0125	3.5	4.3
645	10	MED	ENDOCRINE DISORDERS W/O CC/MCC	0.7429	2.7	3.2
652	11	SURG	KIDNEY TRANSPLANT	3.3146	5.3	6.1
653	11	SURG	MAJOR BLADDER PROCEDURES W MCC	5.4890	10.5	13.5
654	11	SURG	MAJOR BLADDER PROCEDURES W CC	2.8733	6.2	7.3
655	11	SURG	MAJOR BLADDER PROCEDURES W/O CC/MCC	2.0772	3.7	4.4
656	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W MCC	3.3276	6.0	7.9
657	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W CC	1.9474	3.6	4.3
658	11	SURG	KIDNEY & URETER PROCEDURES FOR NEOPLASM W/O CC/MCC	1.5664	2.3	2.6

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
659	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W MCC	2.7271	6.1	8.2
660	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W CC	1.4476	3.2	4.2
661	11	SURG	KIDNEY & URETER PROCEDURES FOR NON-NEOPLASM W/O CC/MCC	1.0728	2.0	2.3
662	11	SURG	MINOR BLADDER PROCEDURES W MCC	3.1787	7.3	10.3
663	11	SURG	MINOR BLADDER PROCEDURES W CC	1.6403	3.9	5.2
664	11	SURG	MINOR BLADDER PROCEDURES W/O CC/MCC	1.1857	2.0	2.4
665	11	SURG	PROSTATECTOMY W MCC	3.1788	8.2	10.5
666	11	SURG	PROSTATECTOMY W CC	1.7791	4.2	5.8
667	11	SURG	PROSTATECTOMY W/O CC/MCC	1.0804	2.2	2.8
668	11	SURG	TRANSURETHRAL PROCEDURES W MCC	2.8146	7.1	9.2
669	11	SURG	TRANSURETHRAL PROCEDURES W CC	1.5825	4.0	5.2
670	11	SURG	TRANSURETHRAL PROCEDURES W/O CC/MCC	0.9635	2.1	2.6
671	11	SURG	URETHRAL PROCEDURES W CC/MCC	1.6835	3.9	5.3
672	11	SURG	URETHRAL PROCEDURES W/O CC/MCC	1.0569	1.9	2.3
673	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	3.5773	7.9	10.9
674	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W CC	2.3121	5.3	7.0
675	11	SURG	OTHER KIDNEY & URINARY TRACT PROCEDURES W/O CC/MCC	1.6253	2.8	3.6
682	11	MED	RENAL FAILURE W MCC	1.5320	4.5	5.9
683	11	MED	RENAL FAILURE W CC	0.9190	3.2	4.0
684	11	MED	RENAL FAILURE W/O CC/MCC	0.6198	2.3	2.7
686	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W MCC	1.7176	5.1	6.8
687	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W CC	1.0537	3.3	4.3
688	11	MED	KIDNEY & URINARY TRACT NEOPLASMS W/O CC/MCC	0.7909	2.0	2.4
689	11	MED	KIDNEY & URINARY TRACT INFECTIONS W MCC	1.1116	3.9	4.8

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
690	11	MED	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	0.7941	3.0	3.6
691	11	MED	URINARY STONES W ESW LITHOTRIPSY W CC/MCC	1.6242	3.0	3.9
692	11	MED	URINARY STONES W ESW LITHOTRIPSY W/O CC/MCC	1.1306	2.0	2.4
693	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W MCC	1.3236	3.8	5.1
694	11	MED	URINARY STONES W/O ESW LITHOTRIPSY W/O MCC	0.7021	2.1	2.6
695	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W MCC	1.1487	3.6	4.7
696	11	MED	KIDNEY & URINARY TRACT SIGNS & SYMPTOMS W/O MCC	0.6886	2.4	3.0
697	11	MED	URETHRAL STRICTURE	0.9600	2.5	3.6
698	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	1.6151	4.9	6.2
699	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W CC	1.0279	3.4	4.2
700	11	MED	OTHER KIDNEY & URINARY TRACT DIAGNOSES W/O CC/MCC	0.7597	2.5	3.1
707	12	SURG	MAJOR MALE PELVIC PROCEDURES W CC/MCC	1.7914	2.3	3.2
708	12	SURG	MAJOR MALE PELVIC PROCEDURES W/O CC/MCC	1.4065	1.3	1.4
709	12	SURG	PENIS PROCEDURES W CC/MCC	2.0318	3.6	5.8
710	12	SURG	PENIS PROCEDURES W/O CC/MCC	1.6695	1.7	2.2
711	12	SURG	TESTES PROCEDURES W CC/MCC	2.0835	5.2	7.2
712	12	SURG	TESTES PROCEDURES W/O CC/MCC	1.0768	2.4	2.9
713	12	SURG	TRANSURETHRAL PROSTATECTOMY W CC/MCC	1.4634	2.9	4.2
714	12	SURG	TRANSURETHRAL PROSTATECTOMY W/O CC/MCC	0.9105	1.7	2.1
715	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W CC/MCC	2.2099	5.4	7.6

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
716	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC FOR MALIGNANCY W/O CC/MCC	1.4630	1.5	1.8
717	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W CC/MCC	1.9543	4.2	5.8
718	12	SURG	OTHER MALE REPRODUCTIVE SYSTEM O.R. PROC EXC MALIGNANCY W/O CC/MCC	1.2326	2.5	3.0
722	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W MCC	1.6597	5.1	7.0
723	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W CC	1.1015	3.5	4.5
724	12	MED	MALIGNANCY, MALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.6892	1.9	2.5
725	12	MED	BENIGN PROSTATIC HYPERTROPHY W MCC	1.2143	4.0	5.1
726	12	MED	BENIGN PROSTATIC HYPERTROPHY W/O MCC	0.7645	2.6	3.3
727	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W MCC	1.4380	4.7	6.0
728	12	MED	INFLAMMATION OF THE MALE REPRODUCTIVE SYSTEM W/O MCC	0.7914	3.0	3.6
729	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W CC/MCC	1.0820	3.3	4.5
730	12	MED	OTHER MALE REPRODUCTIVE SYSTEM DIAGNOSES W/O CC/MCC	0.5684	1.9	2.3
734	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W CC/MCC	2.3059	3.7	5.2
735	13	SURG	PELVIC EVISCERATION, RAD HYSTERECTOMY & RAD VULVECTOMY W/O CC/MCC	1.3650	1.8	2.1
736	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W MCC	4.0306	8.9	11.6
737	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W CC	2.0314	4.6	5.4
738	13	SURG	UTERINE & ADNEXA PROC FOR OVARIAN OR ADNEXAL MALIGNANCY W/O CC/MCC	1.3923	2.8	3.1

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
739	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W MCC	3.5977	6.6	9.4
740	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W CC	1.7429	3.0	4.0
741	13	SURG	UTERINE,ADNEXA PROC FOR NON-OVARIAN/ADNEXAL MALIG W/O CC/MCC	1.3278	1.7	2.0
742	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W CC/MCC	1.7140	3.0	3.9
743	13	SURG	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	1.1156	1.8	2.0
744	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W CC/MCC	1.6903	4.1	5.6
745	13	SURG	D&C, CONIZATION, LAPAROSCOPY & TUBAL INTERRUPTION W/O CC/MCC	1.0694	2.1	2.6
746	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W CC/MCC	1.6777	3.5	5.1
747	13	SURG	VAGINA, CERVIX & VULVA PROCEDURES W/O CC/MCC	0.9582	1.6	2.0
748	13	SURG	FEMALE REPRODUCTIVE SYSTEM RECONSTRUCTIVE PROCEDURES	1.2940	1.6	2.0
749	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W CC/MCC	2.6020	5.7	7.8
750	13	SURG	OTHER FEMALE REPRODUCTIVE SYSTEM O.R. PROCEDURES W/O CC/MCC	1.2239	2.4	2.9
754	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W MCC	1.8414	5.2	7.1
755	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W CC	1.0699	3.3	4.4
756	13	MED	MALIGNANCY, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7801	2.2	2.6
757	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W MCC	1.4409	4.9	6.3
758	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W CC	1.0204	3.7	4.6
759	13	MED	INFECTIONS, FEMALE REPRODUCTIVE SYSTEM W/O CC/MCC	0.7107	2.6	3.2

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
760	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W CC/MCC	0.8717	2.6	3.3
761	13	MED	MENSTRUAL & OTHER FEMALE REPRODUCTIVE SYSTEM DISORDERS W/O CC/MCC	0.5494	1.8	2.1
768	14	SURG	VAGINAL DELIVERY W O.R. PROC EXCEPT STERIL &/OR D&C	1.1314	2.7	4.2
769	14	SURG	POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	1.4579	3.2	4.3
770	14	SURG	ABORTION W D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY	1.0679	1.8	2.6
776	14	MED	POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	0.6590	2.5	3.1
779	14	MED	ABORTION W/O D&C	0.7543	1.7	2.7
783	14	SURG	CESAREAN SECTION W STERILIZATION W MCC	1.7455	4.6	6.3
784	14	SURG	CESAREAN SECTION W STERILIZATION W CC	1.1021	3.4	4.1
785	14	SURG	CESAREAN SECTION W STERILIZATION W/O CC/MCC	0.8455	2.7	3.0
786	14	SURG	CESAREAN SECTION W/O STERILIZATION W MCC	1.5548	4.4	5.9
787	14	SURG	CESAREAN SECTION W/O STERILIZATION W CC	1.0811	3.5	4.2
788	14	SURG	CESAREAN SECTION W/O STERILIZATION W/O CC/MCC	0.9007	3.0	3.2
789	15	MED	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	1.6637	1.8	1.8
790	15	MED	EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE	5.4863	17.9	17.9
791	15	MED	PREMATURITY W MAJOR PROBLEMS	3.7470	13.3	13.3
792	15	MED	PREMATURITY W/O MAJOR PROBLEMS	2.2608	8.6	8.6
793	15	MED	FULL TERM NEONATE W MAJOR PROBLEMS	3.8489	4.7	4.7
794	15	MED	NEONATE W OTHER SIGNIFICANT PROBLEMS	1.3623	3.4	3.4
795	15	MED	NORMAL NEWBORN	0.1844	3.1	3.1

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
796	14	SURG	VAGINAL DELIVERY W STERILIZATION/D&C W MCC	1.4682	3.4	5.0
797	14	SURG	VAGINAL DELIVERY W STERILIZATION/D&C W CC	0.8469	2.2	2.4
798	14	SURG	VAGINAL DELIVERY W STERILIZATION/D&C WO CC/MCC	0.8469	2.2	2.4
799	16	SURG	SPLENECTOMY W MCC	4.7016	8.3	11.0
800	16	SURG	SPLENECTOMY W CC	2.6268	4.7	6.1
801	16	SURG	SPLENECTOMY W/O CC/MCC	1.5563	2.5	2.8
802	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W MCC	3.3472	7.4	10.0
803	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W CC	1.7221	4.1	5.2
804	16	SURG	OTHER O.R. PROC OF THE BLOOD & BLOOD FORMING ORGANS W/O CC/MCC	1.2305	2.1	2.6
805	14	MED	VAGINAL DELIVERY W/O STERILIZATION/D&C W MCC	1.0232	3.0	4.1
806	14	MED	VAGINAL DELIVERY W/O STERILIZATION/D&C W CC	0.7074	2.4	2.7
807	14	MED	VAGINAL DELIVERY W/O STERILIZATION/D&C W/O CC/MCC	0.6140	2.1	2.2
808	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W MCC	2.1492	5.5	7.5
809	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W CC	1.2045	3.6	4.5
810	16	MED	MAJOR HEMATOL/IMMUN DIAG EXC SICKLE CELL CRISIS & COAGUL W/O CC/MCC	0.9220	2.6	3.2
811	16	MED	RED BLOOD CELL DISORDERS W MCC	1.3560	3.7	4.9
812	16	MED	RED BLOOD CELL DISORDERS W/O MCC	0.8832	2.7	3.5
813	16	MED	COAGULATION DISORDERS	1.6115	3.7	4.9
814	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W MCC	1.6630	4.5	6.3
815	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W CC	0.9777	3.1	3.9
816	16	MED	RETICULOENDOTHELIAL & IMMUNITY DISORDERS W/O CC/MCC	0.7216	2.2	2.7

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
817	14	SURG	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W MCC	2.5317	3.8	6.5
818	14	SURG	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W CC	1.3585	2.8	4.1
819	14	SURG	OTHER ANTEPARTUM DIAGNOSES W O.R. PROCEDURE W/O CC/MCC	0.8390	1.6	2.1
820	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W MCC	5.4437	10.9	15.2
821	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W CC	2.3943	4.3	6.1
822	17	SURG	LYMPHOMA & LEUKEMIA W MAJOR O.R. PROCEDURE W/O CC/MCC	1.2098	1.9	2.4
823	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W MCC	4.5246	10.4	13.8
824	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W CC	2.1944	5.3	7.1
825	17	SURG	LYMPHOMA & NON-ACUTE LEUKEMIA W OTHER PROC W/O CC/MCC	1.3590	2.5	3.5
826	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W MCC	4.9479	9.9	12.7
827	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W CC	2.2517	4.7	6.1
828	17	SURG	MYELOPROLIF DISORD OR POORLY DIFF NEOPL W MAJ O.R. PROC W/O CC/MCC	1.6354	3.0	3.7
829	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W CC/MCC	3.1097	6.4	9.6
830	17	SURG	MYELOPROLIFERATIVE DISORDERS OR POORLY DIFFERENTIATED NEOPLASMS W OTHER PROCEDURE W/O CC/MCC	1.4188	2.6	3.2
831	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W MCC	1.0281	3.2	4.5
832	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W CC	0.7188	2.5	3.6
833	14	MED	OTHER ANTEPARTUM DIAGNOSES W/O O.R. PROCEDURE W/O CC/MCC	0.4803	1.9	2.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
834	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W MCC	5.5078	10.0	16.5
835	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W CC	2.1360	4.5	7.1
836	17	MED	ACUTE LEUKEMIA W/O MAJOR O.R. PROCEDURE W/O CC/MCC	1.2126	2.6	3.9
837	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX OR W HIGH DOSE CHEMO AGENT W MCC	5.3741	12.8	18.3
838	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W CC OR HIGH DOSE CHEMO AGENT	2.3526	5.8	7.8
839	17	MED	CHEMO W ACUTE LEUKEMIA AS SDX W/O CC/MCC	1.2559	4.5	4.9
840	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W MCC	3.2929	7.0	10.0
841	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W CC	1.6348	4.2	5.7
842	17	MED	LYMPHOMA & NON-ACUTE LEUKEMIA W/O CC/MCC	1.1211	2.9	3.8
843	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W MCC	1.8460	5.3	7.3
844	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W CC	1.1788	3.7	4.9
845	17	MED	OTHER MYELOPROLIF DIS OR POORLY DIFF NEOPL DIAG W/O CC/MCC	0.8662	2.6	3.4
846	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W MCC	2.8179	6.2	8.7
847	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W CC	1.3265	3.6	4.1
848	17	MED	CHEMOTHERAPY W/O ACUTE LEUKEMIA AS SECONDARY DIAGNOSIS W/O CC/MCC	0.9326	2.9	3.3
849	17	MED	RADIOTHERAPY	1.9702	5.0	7.0
853	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	5.0571	9.9	12.8
854	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W CC	2.2028	5.7	7.1
855	18	SURG	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W/O CC/MCC	1.5600	3.6	4.5

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
856	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	4.4883	8.9	12.0
857	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W CC	2.0567	5.4	6.7
858	18	SURG	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W/O CC/MCC	1.3801	3.7	4.5
862	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W MCC	1.8277	5.0	6.6
863	18	MED	POSTOPERATIVE & POST-TRAUMATIC INFECTIONS W/O MCC	0.9848	3.5	4.3
864	18	MED	FEVER AND INFLAMMATORY CONDITIONS	0.8643	2.8	3.4
865	18	MED	VIRAL ILLNESS W MCC	1.3822	3.9	5.3
866	18	MED	VIRAL ILLNESS W/O MCC	0.8204	2.7	3.4
867	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W MCC	2.1329	5.6	7.6
868	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W CC	1.0769	3.6	4.6
869	18	MED	OTHER INFECTIOUS & PARASITIC DISEASES DIAGNOSES W/O CC/MCC	0.7679	2.7	3.3
870	18	MED	SEPTICEMIA OR SEVERE SEPSIS W MV >96 HOURS OR PERIPHERAL EXTRACORPOREAL MEMBRANE OXYGENATION (ECMO)	6.2953	12.4	14.4
871	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	1.8564	4.8	6.3
872	18	MED	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	1.0529	3.7	4.4
876	19	SURG	O.R. PROCEDURE W PRINCIPAL DIAGNOSES OF MENTAL ILLNESS	3.3014	7.2	14.8
880	19	MED	ACUTE ADJUSTMENT REACTION & PSYCHOSOCIAL DYSFUNCTION	0.8111	2.6	3.6
881	19	MED	DEPRESSIVE NEUROSES	0.7585	3.8	5.0
882	19	MED	NEUROSES EXCEPT DEPRESSIVE	0.7750	3.2	4.4
883	19	MED	DISORDERS OF PERSONALITY & IMPULSE CONTROL	1.3199	4.8	8.0
884	19	MED	ORGANIC DISTURBANCES & INTELLECTUAL DISABILITY	1.3479	4.3	6.7

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
885	19	MED	PSYCHOSES	1.1961	5.8	8.2
886	19	MED	BEHAVIORAL & DEVELOPMENTAL DISORDERS	0.9887	3.7	6.3
887	19	MED	OTHER MENTAL DISORDER DIAGNOSES	1.0645	3.0	4.7
894	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE, LEFT AMA	0.5169	2.1	2.9
895	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W REHABILITATION THERAPY	1.4328	8.6	11.5
896	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W MCC	1.7468	4.9	6.9
897	20	MED	ALCOHOL/DRUG ABUSE OR DEPENDENCE W/O REHABILITATION THERAPY W/O MCC	0.8208	3.4	4.3
901	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W MCC	4.4649	9.2	13.7
902	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.9204	4.9	6.6
903	21	SURG	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.1639	2.9	3.7
904	21	SURG	SKIN GRAFTS FOR INJURIES W CC/MCC	3.2260	6.7	9.8
905	21	SURG	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.7692	3.5	4.8
906	21	SURG	HAND PROCEDURES FOR INJURIES	1.8432	2.8	4.7
907	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W MCC	4.2161	7.2	10.2
908	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W CC	1.9928	4.0	5.2
909	21	SURG	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.3254	2.5	3.1
913	21	MED	TRAUMATIC INJURY W MCC	1.4719	3.6	5.2
914	21	MED	TRAUMATIC INJURY W/O MCC	0.8378	2.5	3.2
915	21	MED	ALLERGIC REACTIONS W MCC	1.6769	3.7	4.9
916	21	MED	ALLERGIC REACTIONS W/O MCC	0.6353	1.8	2.2
917	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W MCC	1.4737	3.5	4.8
918	21	MED	POISONING & TOXIC EFFECTS OF DRUGS W/O MCC	0.7787	2.3	3.1
919	21	MED	COMPLICATIONS OF TREATMENT W MCC	1.8243	4.3	6.0

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
920	21	MED	COMPLICATIONS OF TREATMENT W CC	1.0031	2.9	3.8
921	21	MED	COMPLICATIONS OF TREATMENT W/O CC/MCC	0.7066	2.2	2.7
922	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W MCC	1.5584	3.8	5.6
923	21	MED	OTHER INJURY, POISONING & TOXIC EFFECT DIAG W/O MCC	0.8698	2.7	3.9
927	22	SURG	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W SKIN GRAFT	18.3845	22.2	29.0
928	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	5.8756	10.7	15.0
929	22	SURG	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.9722	5.8	7.9
933	22	MED	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W/O SKIN GRAFT	2.8603	2.6	4.5
934	22	MED	FULL THICKNESS BURN W/O SKIN GRAFT OR INHAL INJ	1.8335	4.2	6.0
935	22	MED	NON-EXTENSIVE BURNS	1.8217	3.4	5.3
939	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W MCC	3.2787	6.5	9.4
940	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC	2.1745	3.7	5.0
941	23	SURG	O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W/O CC/MCC	1.8514	2.3	3.0
945	23	MED	REHABILITATION W CC/MCC	1.3649	9.4	11.6
946	23	MED	REHABILITATION W/O CC/MCC	1.0427	7.1	7.9
947	23	MED	SIGNS & SYMPTOMS W MCC	1.2056	3.5	4.8
948	23	MED	SIGNS & SYMPTOMS W/O MCC	0.7802	2.6	3.3
949	23	MED	AFTERCARE W CC/MCC	1.1462	4.5	6.4
950	23	MED	AFTERCARE W/O CC/MCC	0.7449	3.4	4.8
951	23	MED	OTHER FACTORS INFLUENCING HEALTH STATUS	0.7984	2.5	3.4
955	24	SURG	CRANIOTOMY FOR MULTIPLE SIGNIFICANT TRAUMA	6.0969	7.4	10.8

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
956	24	SURG	LIMB REATTACHMENT, HIP & FEMUR PROC FOR MULTIPLE SIGNIFICANT TRAUMA	3.7838	6.1	7.5
957	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	7.5985	9.7	13.6
958	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	4.1798	7.0	8.7
959	24	SURG	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.4507	3.8	4.7
963	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	2.7950	5.3	8.0
964	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W CC	1.4749	4.0	4.9
965	24	MED	OTHER MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	0.9743	2.7	3.2
969	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W MCC	5.5987	11.7	15.9
970	25	SURG	HIV W EXTENSIVE O.R. PROCEDURE W/O MCC	2.7877	6.5	8.7
974	25	MED	HIV W MAJOR RELATED CONDITION W MCC	2.7230	6.4	9.0
975	25	MED	HIV W MAJOR RELATED CONDITION W CC	1.2899	4.1	5.3
976	25	MED	HIV W MAJOR RELATED CONDITION W/O CC/MCC	0.9386	3.1	3.9
977	25	MED	HIV W OR W/O OTHER RELATED CONDITION	1.1699	3.4	4.6
981		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	4.3705	8.4	11.4
982		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W CC	2.4529	4.9	6.5
983		SURG	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.5691	2.5	3.3
987		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	3.3326	8.1	10.8
988		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	1.6931	4.4	5.9
989		SURG	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W/O CC/MCC	1.0407	2.1	2.8
998		**	PRINCIPAL DIAGNOSIS INVALID AS DISCHARGE DIAGNOSIS	.		

Final Exhibit #1						
MSDRG Relative Weights						
For Inpatient Hospital Discharges Occurring on or after 1/1/2019						
MS-DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
999		**	UNGROUPABLE	.		

**MS-DRGs 998 and 999 contain cases that could not be assigned to valid DRGs.

Final Exhibit #2			
Hospital Base Rates and Cost To Charge Ratios (CCRs)			
For Hospital Discharge Dates of Service on and after 1/1/2019			
Provider Number	**Name**	**Individual Hospital Base Rate**	**Cost to Charge Ratio (CCR)**
60001	NORTH COLORADO MEDICAL CENTER	$ 6,928.63	0.268
60003	LONGMONT UNITED HOSPITAL	$ 6,414.55	0.323
60004	PLATTE VALLEY MEDICAL CENTER	$ 6,295.02	0.42
60006	MONTROSE MEMORIAL HOSPITAL	$ 6,128.69	0.404
60008	SAN LUIS VALLEY REGIONAL MEDICAL CENTER	$ 6,063.49	0.386
60009	EXEMPLA LUTHERAN MEDICAL CENTER	$ 6,369.71	0.235
60010	POUDRE VALLEY HOSPITAL	$ 6,632.49	0.302
60011	DENVER HEALTH MEDICAL CENTER	$ 8,183.68	0.324
60012	CENTURA HEALTH-ST MARY CORWIN MEDICAL CENTER	$ 7,040.75	0.229
60013	MERCY REGIONAL MEDICAL CENTER	$ 8,029.30	0.287
60014	PRESBYTERIAN/ST LUKE'S MEDICAL CENTER	$ 6,904.09	0.154
60015	CENTURA HEALTH-ST ANTHONY CENTRAL HOSPITAL	$ 6,364.03	0.205
60016	CENTURA HEALTH-ST THOMAS MORE HOSP & PROG CARE CTR	$ 6,957.06	0.37
60020	PARKVIEW MEDICAL CENTER INC	$ 6,737.81	0.164
60022	MEMORIAL HEALTH SYSTEM	$ 6,568.28	0.221
60023	ST MARY'S HOSPITAL AND MEDICAL CENTER	$ 6,994.18	0.308
60024	UNIVERSITY OF COLORADO HOSPITAL ANSCHUTZ INPATIENT	$ 7,900.99	0.169
60027	BOULDER COMMUNITY HOSPITAL	$ 6,311.17	0.218
60028	EXEMPLA SAINT JOSEPH HOSPITAL	$ 7,000.06	0.196
60030	MCKEE MEDICAL CENTER	$ 6,501.58	0.366
60031	CENTURA HEALTH-PENROSE ST FRANCIS HEALTH SERVICES	$ 6,385.76	0.212
60032	ROSE MEDICAL CENTER	$ 6,734.01	0.136
60034	SWEDISH MEDICAL CENTER	$ 6,537.87	0.12
60036	ARKANSAS VALLEY REGIONAL MEDICAL CENTER	CAH	CAH
60043	KEEFE MEMORIAL HOSPITAL	CAH	CAH
60044	COLORADO PLAINS MEDICAL CENTER	$ 6,621.22	0.264
60049	YAMPA VALLEY MEDICAL CENTER	$ 9,490.46	0.539
60054	COMMUNITY HOSPITAL	$ 6,063.49	0.322
60064	CENTURA HEALTH-PORTER ADVENTIST HOSPITAL	$ 6,269.52	0.23
60065	NORTH SUBURBAN MEDICAL CENTER	$ 6,597.26	0.115
60071	DELTA COUNTY MEMORIAL HOSPITAL	$ 6,063.49	0.427
60075	VALLEY VIEW HOSPITAL ASSOCIATION	$ 8,299.43	0.414
60076	STERLING REGIONAL MEDCENTER	$ 7,873.82	0.495

Final Exhibit #2			
Hospital Base Rates and Cost To Charge Ratios (CCRs)			
For Hospital Discharge Dates of Service on and after 1/1/2019			
Provider Number	**Name**	**Individual Hospital Base Rate**	**Cost to Charge Ratio (CCR)**
60096	VAIL VALLEY MEDICAL CENTER	$ 12,152.56	0.516
60100	MEDICAL CENTER OF AURORA, THE	$ 6,464.50	0.146
60103	CENTURA HEALTH-AVISTA ADVENTIST HOSPITAL	$ 6,295.02	0.3
60104	CENTURA HEALTH-ST ANTHONY NORTH HOSPITAL	$ 7,175.00	0.272
60107	NATIONAL JEWISH HEALTH	$ -	0
60112	SKY RIDGE MEDICAL CENTER	$ 6,140.31	0.115
60113	CENTURA HEALTH-LITTLETON ADVENTIST HOSPITAL	$ 6,187.10	0.198
60114	PARKER ADVENTIST HOSPITAL	$ 6,244.85	0.231
60116	EXEMPLA GOOD SAMARITAN MEDICAL CENTER LLC	$ 6,201.63	0.21
60117	ANIMAS SURGICAL HOSPITAL, LLC	$ 6,063.49	0.356
60118	ST ANTHONY SUMMIT MEDICAL CENTER	$ 6,295.02	0.338
60119	MEDICAL CENTER OF THE ROCKIES	$ 6,287.96	0.257
60124	ORTHOCOLORADO HOSPITAL AT ST ANTHONY MED CAMPUS	$ 6,125.10	0.184
60125	CASTLE ROCK ADVENTIST HOSPITAL	$ 6,188.03	0.274
60126	BANNER FORT COLLINS MEDICAL CENTER	$ 6,063.49	0.535
69999	ANY NEW HOSPITAL	$ 6,188.03	0.274

Final Exhibit #3	
Critical Access Hospitals	
Effective for Dates of Service on and After 1/1/2019	
Hospital Name	**Location in Colorado**
Arkansas Valley Regional Medical Center	La Junta
Aspen Valley Hospital	Aspen
Colorado Canyon Hospital and Medical Center	Fruita
East Morgan County Hospital	Brush
Estes Park Medical Center	Estes Park
Grand River Hospital District	Rifle
Gunnison Valley Hospital	Gunnison
Haxtun Hospital District	Haxtun
Heart of the Rockies Regional Medical Center	Salida
Keefe Memorial Hospital	Cheyenne Wells
Kit Carson County Memorial Hospital	Burlington
Lincoln Community Hospital	Hugo
Melissa Memorial Hospital	Holyoke
Middle Park Medical Center	Kremmling/Granby
Mt San Rafael Hospital	Trinidad
Pagosa Springs Medical Center	Pagosa Springs
Pikes Peak Regional Hospital	Woodland Park
Pioneers Medical Center	Meeker
Prowers Medical Center	Lamar
Rangely District Hospital	Rangely
Rio Grande Hospital	Del Norte
San Luis Valley Hospital	La Jara
Sedgwick County Health Center	Julesburg
Southeast Colorado Hospital	Springfield
Southwest Memorial Hospital	Cortez
Spanish Peaks Regional Health Center	Walsenburg
St Vincent General Hospital District	Leadville
The Memorial Hospital	Craig
UC Health Pikes Peak Regional Hospital	Woodland Park
Weisbrod Memorial County Hospital	Eads
Wray Community District Hospital	Wray
Yuma District Hospital	Yuma

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
701	Sr89 strontium	$2,532.58	$2,152.69	
726	Dexrazoxane HCl injection	$401.79	$341.52	
731	Sargramostim injection	$68.02	$57.82	
736	Amphotericin b liposome inj	$37.27	$31.68	
738	Rasburicase	$474.32	$403.17	
751	Mechlorethamine hcl inj	$526.46	$447.49	
752	Dactinomycin injection	$2,527.22	$2,148.14	
759	Naltrexone, depot form	$5.86	$4.98	
800	Leuprolide acetate	$1,957.41	$1,663.80	
802	Etoposide oral	$132.80	$112.88	
807	Aldesleukin injection	$6,477.09	$5,505.53	
809	Bcg live intravesical vac	$239.01	$203.16	
810	Goserelin acetate implant	$676.25	$574.81	
812	Carmustine injection	$6,935.01	$5,894.76	
820	Daunorubicin injection	$78.42	$66.66	
823	Docetaxel injection	$3.13	$2.66	
825	Nelarabine injection	$273.45	$232.43	
832	Idarubicin hcl injection	$78.12	$66.40	
836	Interferon alfa-2b inj	$56.67	$48.17	
838	Interferon gamma 1-b inj	$11,354.64	$9,651.44	
840	Inj melphalan hydrochl	$2,147.40	$1,825.29	
843	Pegaspargase injection	$25,815.73	$21,943.37	
844	Pentostatin injection	$3,560.36	$3,026.31	
849	Rituximab injection	$1,580.10	$1,343.09	
850	Streptozocin injection	$606.07	$515.16	
851	Thiotepa injection	$1,349.85	$1,147.37	
856	Porfimer sodium injection	$38,195.22	$32,465.94	
858	Inj cladribine	$38.12	$32.40	
864	Mitoxantrone hydrochl	$57.67	$49.02	
868	Oral aprepitant	$12.02	$10.22	
873	Hyalgan supartz visco-3 dose	$153.37	$130.36	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
874	Synvisc or synvisc-one	$22.07	$18.76	
875	Euflexxa inj per dose	$279.41	$237.50	
877	Orthovisc inj per dose	$252.19	$214.36	
887	Azathioprine parenteral	$423.29	$359.80	
890	Lymphocyte immune globulin	$3,497.00	$2,972.45	
901	Alpha 1 proteinase inhibitor	$8.17	$6.94	
902	Injection,onabotulinumtoxinA	$11.03	$9.38	
903	Cytomegalovirus imm IV /vial	$2,032.43	$1,727.57	
910	Interferon beta-1b / .25 MG	$683.57	$581.03	
925	Factor viii	$1.95	$1.66	
927	Factor viii recombinant	$2.30	$1.96	
928	Factor ix complex	$2.53	$2.15	
929	Anti-inhibitor	$3.61	$3.07	
931	Factor IX non-recombinant	$2.07	$1.76	
932	Factor ix recombinant nos	$2.72	$2.31	
943	Octagam injection	$64.06	$54.45	
944	Gammagard liquid injection	$73.30	$62.31	
946	Hepagam b im injection	$113.71	$96.65	
947	Flebogamma injection	$60.58	$51.49	
948	Gamunex-C/Gammaked	$73.27	$62.28	
961	Albumin (human),5%, 50ml	$21.24	$18.05	
963	Albumin (human), 5%, 250 ml	$98.50	$83.73	
964	Albumin (human), 25%, 20 ml	$40.48	$34.41	
965	Albumin (human), 25%, 50ml	$96.19	$81.76	
1015	Injection glatiramer acetate	$381.09	$323.93	
1052	Injection, voriconazole	$4.03	$3.43	
1064	I131 iodide cap, rx	$35.96	$30.57	
1083	Adalimumab injection	$2,118.47	$1,800.70	
1138	Hepagam b intravenous, inj	$113.71	$96.65	
1139	Protein c concentrate	$27.29	$23.20	
1142	Supprelin LA implant	$52,158.02	$44,334.32	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
1150	I131 iodide sol, rx	$21.38	$18.17	
1166	Cytarabine liposome inj	$1,132.03	$962.23	
1168	Inj, temsirolimus	$129.05	$109.69	
1178	Busulfan injection	$56.52	$48.04	
1203	Verteporfin injection	$19.36	$16.46	
1207	Octreotide injection, depot	$343.22	$291.74	
1213	Antihemophilic viii/vwf comp	$1.76	$1.50	
1214	Inj IVIG privigen 500 mg	$69.27	$58.88	
1232	Mitomycin injection	$253.46	$215.44	
1235	Valrubicin injection	$2,156.98	$1,833.43	
1236	Levoleucovorin injection	$0.55	$0.47	
1237	Inj iron dextran	$23.46	$19.94	
1238	Topotecan oral	$186.62	$158.63	
1253	Triamcinolone A inj PRS-free	$6.97	$5.92	
1263	Antithrombin iii injection	$6.72	$5.71	
1268	Xyntha inj	$2.30	$1.96	
1274	Edetate calcium disodium inj	$10,059.00	$8,550.15	
1280	Corticotropin injection	$6,775.71	$5,759.35	
1281	Bevacizumab injection	$3.45	$2.93	
1289	AbobotulinumtoxinA	$14.83	$12.61	
1291	Rilonacept injection	$43.36	$36.86	
1295	Sm 153 lexidronam	$24,055.30	$20,447.01	
1296	Degarelix injection	$6.54	$5.56	
1297	Ferumoxytol, non-esrd	$1.67	$1.42	
1311	Canakinumab injection	$194.46	$165.29	
1312	Hizentra injection	$17.70	$15.05	
1327	Imiglucerase injection	$75.05	$63.79	
1340	Collagenase, clost hist inj	$75.30	$64.01	
1341	Amobarbital 125 MG inj	$421.24	$358.05	
1352	Wilate injection	$1.85	$1.57	
1353	Belimumab injection	$77.27	$65.68	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
1408	Cyclophosphamide 100 MG inj	$76.09	$64.68	
1413	Lumizyme injection	$287.56	$244.43	
1415	Glassia injection	$8.42	$7.16	
1416	Factor xiii anti-hem factor	$14.79	$12.57	
1417	Gel-one	$938.83	$798.01	
1420	Aflibercept injection	$1,749.50	$1,487.08	
1421	Imported lipodox inj	$915.17	$777.89	
1426	Eribulin mesylate injection	$199.03	$169.18	
1431	Centruroides immune f(ab)	$8,026.23	$6,822.30	
1433	Calcitonin salmon injection	$4,080.64	$3,468.54	
1440	Inj desmopressin acetate	$23.22	$19.74	
1442	Non-HEU TC-99M add-on/dose	$18.00	$15.30	
1443	Icatibant injection	$633.27	$538.28	
1446	Visualization adjunct	$7.06	$6.00	
1458	Phentolaine mesylate inj	$700.35	$595.30	
1466	Inj, vincristine sul lip 1mg	$4,863.20	$4,133.72	
1467	Factor ix recombinan rixubis	$2.48	$2.11	
1468	Inj Aripiprazole Ext Rel 1mg	$9.04	$7.68	
1469	Inj filgrastim excl biosimil	$1.80	$1.53	
1471	Injection, Pertuzumab, 1 mg	$20.58	$17.49	
1472	Inj beta interferon im 1 mcg	$90.31	$76.76	
1474	Certolizumab pegol inj 1mg	$14.28	$12.14	
1475	Golimumab for iv use 1mg	$43.70	$37.15	
1476	Obinutuzumab inj	$109.15	$92.78	
1478	Human fibrinogen conc inj	$2.10	$1.79	
1480	Elosulfase alfa, injection	$415.65	$353.30	
1482	Darbepoetin alfa, esrd use	$7.03	$5.98	
1484	Pentazocine injection	$119.47	$101.55	
1485	Ferumoxytol, esrd use	$1.67	$1.42	
1486	Factor ix fc fusion recomb	$5.39	$4.58	
1488	Injection, ramucirumab	$102.66	$87.26	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
1489	Injection, vedolizumab	$33.41	$28.40	
1490	Inj pembrolizumab	$86.16	$73.24	
1491	New Technology - Level 1A ($0-$10)	$9.00	$7.65	
1492	New Technology - Level 1B ($11-$20)	$27.90	$23.72	
1493	New Technology - Level 1C ($21-$30)	$45.90	$39.02	
1494	New Technology - Level 1D ($31-$40)	$63.90	$54.32	
1495	New Technology - Level 1E ($41-$50)	$81.90	$69.62	
1496	New Technology - Level 1A ($0-$10)	$9.00	$7.65	
1497	New Technology - Level 1B ($11-$20)	$27.90	$23.72	
1498	New Technology - Level 1C ($21-$30)	$45.90	$39.02	
1499	New Technology - Level 1D ($31-$40)	$63.90	$54.32	
1500	New Technology - Level 1E ($41-$50)	$81.90	$69.62	
1502	New Technology - Level 2 ($51 - $100)	$135.90	$115.52	
1503	New Technology - Level 3 ($101 - $200)	$270.90	$230.27	
1504	New Technology - Level 4 ($201 - $300)	$450.90	$383.27	
1505	New Technology - Level 5 ($301 - $400)	$630.90	$536.27	
1506	New Technology - Level 6 ($401 - $500)	$810.90	$689.27	
1507	New Technology - Level 7 ($501 - $600)	$990.90	$842.27	
1508	New Technology - Level 8 ($601 - $700)	$1,170.90	$995.27	
1509	New Technology - Level 9 ($701 - $800)	$1,350.90	$1,148.27	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
1510	New Technology - Level 10 ($801 - $900)	$1,530.90	$1,301.27	
1511	New Technology - Level 11 ($901 - $1000)	$1,710.90	$1,454.27	
1512	New Technology - Level 12 ($1001 - $1100)	$1,890.90	$1,607.27	
1513	New Technology - Level 13 ($1101 - $1200)	$2,070.90	$1,760.27	
1514	New Technology - Level 14 ($1201- $1300)	$2,250.90	$1,913.27	
1515	New Technology - Level 15 ($1301 - $1400)	$2,430.90	$2,066.27	
1516	New Technology - Level 16 ($1401 - $1500)	$2,610.90	$2,219.27	
1517	New Technology - Level 17 ($1501-$1600)	$2,790.90	$2,372.27	
1518	New Technology - Level 18 ($1601-$1700)	$2,970.90	$2,525.27	
1519	New Technology - Level 19 ($1701-$1800)	$3,150.90	$2,678.27	
1520	New Technology - Level 20 ($1801-$1900)	$3,330.90	$2,831.27	
1521	New Technology - Level 21 ($1901-$2000)	$3,510.90	$2,984.27	
1522	New Technology - Level 22 ($2001-$2500)	$4,050.90	$3,443.27	
1523	New Technology - Level 23 ($2501-$3000)	$4,950.90	$4,208.27	
1524	New Technology - Level 24 ($3001-$3500)	$5,850.90	$4,973.27	
1525	New Technology - Level 25 ($3501-$4000)	$6,750.90	$5,738.27	
1526	New Technology - Level 26 ($4001-$4500)	$7,650.90	$6,503.27	
1527	New Technology - Level 27 ($4501-$5000)	$8,550.90	$7,268.27	
1528	New Technology - Level 28 ($5001-$5500)	$9,450.90	$8,033.27	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
1529	New Technology - Level 29 ($5501-$6000)	$10,350.90	$8,798.27	
1530	New Technology - Level 30 ($6001-$6500)	$11,250.90	$9,563.27	
1531	New Technology - Level 31 ($6501-$7000)	$12,150.90	$10,328.27	
1532	New Technology - Level 32 ($7001-$7500)	$13,050.90	$11,093.27	
1533	New Technology - Level 33 ($7501-$8000)	$13,950.90	$11,858.27	
1534	New Technology - Level 34 ($8001-$8500)	$14,850.90	$12,623.27	
1535	New Technology - Level 35 ($8501-$9000)	$15,750.90	$13,388.27	
1536	New Technology - Level 36 ($9001-$9500)	$16,650.90	$14,153.27	
1537	New Technology - Level 37 ($9501-$10000)	$17,550.90	$14,918.27	
1539	New Technology - Level 2 ($51 - $100)	$135.90	$115.52	
1540	New Technology - Level 3 ($101 - $200)	$270.90	$230.27	
1541	New Technology - Level 4 ($201 - $300)	$450.90	$383.27	
1542	New Technology - Level 5 ($301 - $400)	$630.90	$536.27	
1543	New Technology - Level 6 ($401 - $500)	$810.90	$689.27	
1544	New Technology - Level 7 ($501 - $600)	$990.90	$842.27	
1545	New Technology - Level 8 ($601 - $700)	$1,170.90	$995.27	
1546	New Technology - Level 9 ($701 - $800)	$1,350.90	$1,148.27	
1547	New Technology - Level 10 ($801 - $900)	$1,530.90	$1,301.27	
1548	New Technology - Level 11 ($901 - $1000)	$1,710.90	$1,454.27	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
1549	New Technology - Level 12 ($1001 - $1100)	$1,890.90	$1,607.27	
1550	New Technology - Level 13 ($1101 - $1200)	$2,070.90	$1,760.27	
1551	New Technology - Level 14 ($1201- $1300)	$2,250.90	$1,913.27	
1552	New Technology - Level 15 ($1301 - $1400)	$2,430.90	$2,066.27	
1553	New Technology - Level 16 ($1401 - $1500)	$2,610.90	$2,219.27	
1554	New Technology - Level 17 ($1501-$1600)	$2,790.90	$2,372.27	
1555	New Technology - Level 18 ($1601-$1700)	$2,970.90	$2,525.27	
1556	New Technology - Level 19 ($1701-$1800)	$3,150.90	$2,678.27	
1557	New Technology - Level 20 ($1801-$1900)	$3,330.90	$2,831.27	
1558	New Technology - Level 21 ($1901-$2000)	$3,510.90	$2,984.27	
1559	New Technology - Level 22 ($2001-$2500)	$4,050.90	$3,443.27	
1560	New Technology - Level 23 ($2501-$3000)	$4,950.90	$4,208.27	
1561	New Technology - Level 24 ($3001-$3500)	$5,850.90	$4,973.27	
1562	New Technology - Level 25 ($3501-$4000)	$6,750.90	$5,738.27	
1563	New Technology - Level 26 ($4001-$4500)	$7,650.90	$6,503.27	
1564	New Technology - Level 27 ($4501-$5000)	$8,550.90	$7,268.27	
1565	New Technology - Level 28 ($5001-$5500)	$9,450.90	$8,033.27	
1566	New Technology - Level 29 ($5501-$6000)	$10,350.90	$8,798.27	
1567	New Technology - Level 30 ($6001-$6500)	$11,250.90	$9,563.27	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
1568	New Technology - Level 31 ($6501-$7000)	$12,150.90	$10,328.27	
1569	New Technology - Level 32 ($7001-$7500)	$13,050.90	$11,093.27	
1570	New Technology - Level 33 ($7501-$8000)	$13,950.90	$11,858.27	
1571	New Technology - Level 34 ($8001-$8500)	$14,850.90	$12,623.27	
1572	New Technology - Level 35 ($8501-$9000)	$15,750.90	$13,388.27	
1573	New Technology - Level 36 ($9001-$9500)	$16,650.90	$14,153.27	
1574	New Technology - Level 37 ($9501-$10000)	$17,550.90	$14,918.27	
1575	New Technology - Level 38 ($10,001-$15,000)	$22,500.90	$19,125.77	
1576	New Technology - Level 39 ($15,001-$20,000)	$31,500.90	$26,775.77	
1577	New Technology - Level 40 ($20,001-$25,000)	$40,500.90	$34,425.77	
1578	New Technology - Level 41 ($25,001-$30,000)	$49,500.90	$42,075.77	
1579	New Technology - Level 42 ($30,001-$40,000)	$63,000.90	$53,550.77	
1580	New Technology - Level 43 ($40,001-$50,000)	$81,000.90	$68,850.77	
1581	New Technology - Level 44 ($50,001-$60,000)	$99,000.90	$84,150.77	
1582	New Technology - Level 45 ($60,001-$70,000)	$117,000.90	$99,450.77	
1583	New Technology - Level 46 ($70,001-$80,000)	$135,000.90	$114,750.77	
1584	New Technology - Level 47 ($80,001-$90,000)	$153,000.90	$130,050.77	
1585	New Technology - Level 48 ($90,001-$100,000)	$171,000.90	$145,350.77	
1589	New Technology - Level 38 ($10,001-$15,000)	$22,500.90	$19,125.77	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
1590	New Technology - Level 39 ($15,001-$20,000)	$31,500.90	$26,775.77	
1591	New Technology - Level 40 ($20,001-$25,000)	$40,500.90	$34,425.77	
1592	New Technology - Level 41 ($25,001-$30,000)	$49,500.90	$42,075.77	
1593	New Technology - Level 42 ($30,001-$40,000)	$63,000.90	$53,550.77	
1594	New Technology - Level 43 ($40,001-$50,000)	$81,000.90	$68,850.77	
1595	New Technology - Level 44 ($50,001-$60,000)	$99,000.90	$84,150.77	
1596	New Technology - Level 45 ($60,001-$70,000)	$117,000.90	$99,450.77	
1597	New Technology - Level 46 ($70,001-$80,000)	$135,000.90	$114,750.77	
1598	New Technology - Level 47 ($80,001-$90,000)	$153,000.90	$130,050.77	
1599	New Technology - Level 48 ($90,001-$100,000)	$171,000.90	$145,350.77	
1607	Eptifibatide injection	$36.89	$31.36	
1608	Etanercept injection	$1,059.42	$900.51	
1609	Rho(D) immune globulin h, sd	$45.56	$38.73	
1613	Trastuzumab injection	$181.17	$153.99	
1630	Hep b ig, im	$208.80	$177.48	
1631	Baclofen intrathecal trial	$77.19	$65.61	
1643	Y90 ibritumomab, rx	$85,903.58	$73,018.04	
1656	Factor viii fc fusion recomb	$3.63	$3.09	
1658	Injection, belinostat, 10mg	$64.99	$55.24	
1660	Injection, oritavancin	$41.83	$35.56	
1662	Inj tedizolid phosphate	$2.47	$2.10	
1669	Erythro lactobionate /500 mg	$130.24	$110.70	
1670	Tetanus immune globulin inj	$874.07	$742.96	
1675	P32 Na phosphate	$460.80	$391.68	
1683	Basiliximab	$6,384.31	$5,426.66	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
1684	Corticorelin ovine triflutal	$15.51	$13.18	
1685	Darbepoetin alfa, non-esrd	$7.03	$5.98	
1686	Epoetin alfa, non-esrd	$21.84	$18.56	
1687	Digoxin immune fab (ovine)	$6,158.87	$5,235.04	
1688	Ethanolamine oleate	$799.38	$679.47	
1689	Fomepizole	$13.58	$11.54	
1690	Hemin	$40.24	$34.20	
1694	Ziconotide injection	$13.39	$11.38	
1695	Nesiritide injection	$131.98	$112.18	
1696	Palifermin injection	$34.37	$29.21	
1697	Pegaptanib sodium injection	$1,298.25	$1,103.51	
1700	Inj secretin synthetic human	$62.61	$53.22	
1701	Treprostinil injection	$110.23	$93.70	
1704	Humate-P, inj	$1.97	$1.67	
1705	Factor viia	$3.58	$3.04	
1709	Azacitidine injection	$2.84	$2.41	
1710	Clofarabine injection	$261.81	$222.54	
1711	Vantas implant	$5,914.86	$5,027.63	
1712	Paclitaxel protein bound	$19.86	$16.88	
1739	Pegademase bovine, 25 iu	$646.18	$549.25	
1743	Nandrolone decanoate 50 mg	$130.64	$111.04	
1745	Radium ra223 dichloride ther	$235.98	$200.58	
1746	Factor xiii recomb a-subunit	$27.16	$23.09	
1747	Monovisc inj per dose	$1,524.17	$1,295.54	
1748	Inj tbo filgrastim 1 microg	$1.10	$0.94	
1761	Rolapitant, oral, 1mg	$4.06	$3.45	
1809	Injection, alemtuzumab	$3,262.98	$2,773.53	
1822	Inj filgrastim gcsf biosimil	$1.25	$1.06	
1823	Injection, dalbavancin	$26.58	$22.59	
1824	Ceftaroline fosamil inj	$4.69	$3.99	
1825	Ceftazidime and avibactam	$138.74	$117.93	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
1826	Hyqvia 100mg immuneglobulin	$25.31	$21.51	
1827	Factor viii recomb obizur	$5.08	$4.32	
1828	Carbidopa levodopa ent 100ml	$3.85	$3.27	
1829	Penicillin g benzathine inj	$23.05	$19.59	
1832	Dimethyl sulfoxide 50% 50 ml	$998.22	$848.49	
1844	Factor viii pegylated recomb	$3.20	$2.72	
1845	Tacrol envarsus ex rel oral	$2.22	$1.89	
1846	Factor viii nuwiq recomb 1iu	$2.94	$2.50	
1847	Inj., infliximab biosimilar	$135.93	$115.54	
1848	Artiss fibrin sealant	$200.47	$170.40	
1849	Foscarnet sodium injection	$135.31	$115.01	
1850	Gamma globulin 1 cc inj	$59.32	$50.42	
1851	Gamma globulin > 10 cc inj	$593.24	$504.25	
1852	Interferon beta-1a inj	$1,087.92	$924.73	
1853	Minocycline hydrochloride	$2.85	$2.42	
1854	Pentobarbital sodium inj	$92.14	$78.32	
1856	Factor viii recomb novoeight	$2.26	$1.92	
1857	Inj, factor x, (human), 1iu	$12.31	$10.46	
1858	Leuprolide acetate injeciton	$47.94	$40.75	
1859	Argatroban nonesrd use 1mg	$2.69	$2.29	
1860	Monoclonal antibodies	$12.24	$10.40	
1861	Inj., bendeka 1 mg	$42.59	$36.20	
1862	Gelsyn-3 injection 0.1 mg	$3.92	$3.33	
1863	Inj diclofenac sodium 0.5mg	$0.33	$0.28	
1901	New Technology - Level 49 ($100,001-$115,000)	$193,500.90	$164,475.77	
1902	New Technology - Level 49 ($100,001-$115,000)	$193,500.90	$164,475.77	
1903	New Technology - Level 50 ($115,001-$130,000)	$220,500.90	$187,425.77	
1904	New Technology - Level 50 ($115,001-$130,000)	$220,500.90	$187,425.77	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
1905	New Technology - Level 51 ($130,001-$145,000)	$247,500.90	$210,375.77	
1906	New Technology - Level 51 ($130,001-$145,000)	$247,500.90	$210,375.77	
1907	New Technology - Level 52 ($145,001-$160,000)	$274,500.90	$233,325.77	
1908	New Technology - Level 52 ($145,001-$160,000)	$274,500.90	$233,325.77	
2616	Brachytx, non-str,Yttrium-90	$30,091.66	$25,577.91	
2632	Iodine I-125 sodium iodide	$47.97	$40.77	
2634	Brachytx, non-str, HA, I-125	$211.79	$180.02	
2635	Brachytx, non-str, HA, P-103	$46.69	$39.69	
2636	Brachy linear, non-str,P-103	$48.74	$41.43	
2638	Brachytx, stranded, I-125	$62.51	$53.13	
2639	Brachytx, non-stranded,I-125	$62.39	$53.03	
2640	Brachytx, stranded, P-103	$141.70	$120.45	
2641	Brachytx, non-stranded,P-103	$115.69	$98.34	
2642	Brachytx, stranded, C-131	$158.20	$134.47	
2643	Brachytx, non-stranded,C-131	$157.32	$133.72	
2644	Brachytx cesium-131 chloride	$189.16	$160.79	
2645	Brachytx, non-str, Gold-198	$220.70	$187.60	
2646	Brachytx, non-str, HDR Ir-192	$530.26	$450.72	
2647	Brachytx, NS, Non-HDRIr-192	$34.49	$29.32	
2648	Brachytx planar, p-103	$8.44	$7.17	
2698	Brachytx, stranded, NOS	$62.51	$53.13	
2699	Brachytx, non-stranded, NOS	$34.49	$29.32	
2731	Immune globulin, powder	$61.95	$52.66	
2770	Quinupristin/dalfopristin	$752.76	$639.85	
4001	Echo guidance radiotherapy	$42.77	$36.35	
4002	Stereoscopic x-ray guidance	$103.66	$88.11	
4003	Radiation treatment delivery, MeV <= 5; simple	$364.14	$309.52	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
4004	Radiation treatment delivery, 6-10 MeV; simple	$270.18	$229.65	
4005	Radiation treatment delivery, 11-19 MeV; simple	$269.53	$229.10	
4006	Radiation treatment delivery, MeV>=20; simple	$270.18	$229.65	
4007	Radiation treatment delivery, MeV<=5; intermediate	$546.86	$464.83	
4008	Radiation treatment delivery, 6-10 MeV; intermediate	$373.86	$317.78	
4009	Radiation treatment delivery, 11-19 MeV; intermediate	$372.56	$316.68	
4010	Radiation treatment delivery, MeV >=20; intermediate	$369.97	$314.47	
4011	Radiation treatment delivery, MeV<=5; complex	$519.64	$441.69	
4012	Radiation treatment delivery, 6-10 MeV; complex	$494.37	$420.21	
4013	Radiation treatment delivery, 11-19 MeV; complex	$494.37	$420.21	
4014	Radiation treatment delivery, MeV >=20; complex	$495.02	$420.77	
4015	Radiation tx delivery imrt	$645.34	$548.54	
4016	Delivery comp imrt	$643.39	$546.88	
5012	Clinic Visits and Related Services	$204.64	N/A	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
5021	Level 1 Type A ED Visits	$123.59	N/A	
5022	Level 2 Type A ED Visits	$224.37	N/A	
5023	Level 3 Type A ED Visits	$394.38	N/A	
5024	Level 4 Type A ED Visits	$639.95	N/A	
5025	Level 5 Type A ED Visits	$937.53	N/A	
5031	Level 1 Type B ED Visits	$184.48	N/A	
5032	Level 2 Type B ED Visits	$163.48	N/A	
5033	Level 3 Type B ED Visits	$283.79	N/A	
5034	Level 4 Type B ED Visits	$376.22	N/A	
5035	Level 5 Type B ED Visits	$514.58	N/A	
5041	Critical Care	$1,320.53	N/A	
5045	Trauma Response with Critical Care	N/A	N/A	See Rule 18-6(J)(for Trauma Activation Fees
5051	Level 1 Skin Procedures	$304.11	$258.49	
5052	Level 2 Skin Procedures	$559.44	$475.52	
5053	Level 3 Skin Procedures	$878.76	$746.95	
5054	Level 4 Skin Procedures	$2,823.17	$2,399.69	
5055	Level 5 Skin Procedures	$4,878.86	$4,147.03	
5061	Hyperbaric Oxygen	$205.51	$174.68	
5071	Level 1 Excision/ Biopsy/ Incision and Drainage	$1,031.13	$876.46	
5072	Level 2 Excision/ Biopsy/ Incision and Drainage	$2,426.45	$2,062.48	
5073	Level 3 Excision/ Biopsy/ Incision and Drainage	$4,184.77	$3,557.05	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	$4,910.11	$4,173.59	
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	$8,661.38	$7,362.17	
5093	Level 3 Breast/Lymphatic Surgery and Related Procedures	$13,297.91	$11,303.22	
5094	Level 4 Breast/Lymphatic Surgery and Related Procedures	$20,499.39	$17,424.48	
5101	Level 1 Strapping and Cast Application	$243.76	$207.20	
5102	Level 2 Strapping and Cast Application	$427.10	$363.04	
5111	Level 1 Musculoskeletal Procedures	$386.82	$328.80	
5112	Level 2 Musculoskeletal Procedures	$2,429.89	$2,065.41	
5113	Level 3 Musculoskeletal Procedures	$4,761.41	$4,047.20	
5114	Level 4 Musculoskeletal Procedures	$10,091.56	$8,577.83	
5115	Level 5 Musculoskeletal Procedures	$18,221.26	$15,488.07	
5116	Level 6 Musculoskeletal Procedures	$27,667.80	$23,517.63	
5151	Level 1 Airway Endoscopy	$282.74	$240.33	
5152	Level 2 Airway Endoscopy	$675.85	$574.47	
5153	Level 3 Airway Endoscopy	$2,382.66	$2,025.26	
5154	Level 4 Airway Endoscopy	$4,709.83	$4,003.36	
5155	Level 5 Airway Endoscopy	$8,755.51	$7,442.18	
5161	Level 1 ENT Procedures	$321.30	$273.11	
5162	Level 2 ENT Procedures	$827.77	$703.60	
5163	Level 3 ENT Procedures	$2,048.72	$1,741.41	
5164	Level 4 ENT Procedures	$3,958.31	$3,364.56	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
5165	Level 5 ENT Procedures	$7,809.82	$6,638.35	
5166	Cochlear Implant Procedure	$58,679.96	$49,877.97	
5181	Level 1 Vascular Procedures	$1,102.63	$937.24	
5182	Level 2 Vascular Procedures	$1,769.35	$1,503.95	
5183	Level 3 Vascular Procedures	$4,486.93	$3,813.89	
5184	Level 4 Vascular Procedures	$7,676.93	$6,525.39	
5191	Level 1 Endovascular Procedures	$5,064.48	$4,304.81	
5192	Level 2 Endovascular Procedures	$9,153.00	$7,780.05	
5193	Level 3 Endovascular Procedures	$18,918.83	$16,081.01	
5194	Level 4 Endovascular Procedures	$28,836.70	$24,511.20	
5200	Implantation Wireless PA Pressure Monitor	$58,731.43	$49,921.72	
5211	Level 1 Electrophysiologic Procedures	$1,636.67	$1,391.17	
5212	Level 2 Electrophysiologic Procedures	$9,565.78	$8,130.91	
5213	Level 3 Electrophysiologic Procedures	$33,329.03	$28,329.68	
5221	Level1 Pacemaker and Similar Procedures	$5,162.31	$4,387.96	
5222	Level 2 Pacemaker and Similar Procedures	$13,267.78	$11,277.61	
5223	Level 3 Pacemaker and Similar Procedures	$17,546.38	$14,914.42	
5224	Level 4 Pacemaker and Similar Procedures	$31,653.97	$26,905.87	
5231	Level 1 ICD and Similar Procedures	$39,798.94	$33,829.10	
5232	Level 2 ICD and Similar Procedures	$55,731.83	$47,372.06	
5241	Level 1 Blood Product Exchange and Related Services	$675.13	$573.86	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
5242	Level 2 Blood Product Exchange and Related Services	$2,199.13	$1,869.26	
5243	Level 3 Blood Product Exchange and Related Services	$6,660.20	$5,661.17	
5244	Level 4 Blood Product Exchange and Related Services	$54,798.16	$46,578.44	
5301	Level 1 Upper GI Procedures	$1,338.28	$1,137.54	
5302	Level 2 Upper GI Procedures	$2,569.30	$2,183.91	
5303	Level 3 Upper GI Procedures	$4,938.19	$4,197.46	
5311	Level 1 Lower GI Procedures	$1,277.96	$1,086.27	
5312	Level 2 Lower GI Procedures	$1,685.50	$1,432.68	
5313	Level 3 Lower GI Procedures	$4,168.13	$3,542.91	
5331	Complex GI Procedures	$7,728.52	$6,569.24	
5341	Abdominal/Peritoneal/Biliary and Related Procedures	$5,240.09	$4,454.08	
5361	Level 1 Laparoscopy and Related Services	$8,079.62	$6,867.68	
5362	Level 2 Laparoscopy and Related Services	$13,671.76	$11,621.00	
5371	Level 1 Urology and Related Services	$413.15	$351.18	
5372	Level 2 Urology and Related Services	$1,018.08	$865.37	
5373	Level 3 Urology and Related Services	$3,052.22	$2,594.39	
5374	Level 4 Urology and Related Services	$4,854.17	$4,126.04	
5375	Level 5 Urology and Related Services	$6,670.85	$5,670.22	
5376	Level 6 Urology and Related Services	$13,673.27	$11,622.28	
5377	Level 7 Urology and Related Services	$28,256.08	$24,017.67	
5401	Dialysis	$1,076.45	$914.98	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
5411	Level 1 Gynecologic Procedures	$289.26	$245.87	
5412	Level 2 Gynecologic Procedures	$483.03	$410.58	
5413	Level 3 Gynecologic Procedures	$1,036.08	$880.67	
5414	Level 4 Gynecologic Procedures	$4,090.99	$3,477.34	
5415	Level 5 Gynecologic Procedures	$7,401.26	$6,291.07	
5416	Level 6 Gynecologic Procedures	$11,317.25	$9,619.66	
5431	Level 1 Nerve Procedures	$2,898.90	$2,464.07	
5432	Level 2 Nerve Procedures	$8,329.66	$7,080.21	
5441	Level 1 Nerve Injections	$440.46	$374.39	
5442	Level 2 Nerve Injections	$978.08	$831.37	
5443	Level 3 Nerve Injections	$1,209.92	$1,028.43	
5461	Level 1 Neurostimulator and Related Procedures	$5,182.88	$4,405.45	
5462	Level 2 Neurostimulator and Related Procedures	$10,900.10	$9,265.09	
5463	Level 3 Neurostimulator and Related Procedures	$33,064.00	$28,104.40	
5464	Level 4 Neurostimulator and Related Procedures	$50,205.22	$42,674.44	
5471	Implantation of Drug Infusion Device	$29,593.44	$25,154.42	
5481	Laser Eye Procedures	$878.36	$746.61	
5491	Level 1 Intraocular Procedures	$3,457.96	$2,939.27	
5492	Level 2 Intraocular Procedures	$6,499.35	$5,524.45	
5493	Level 3 Intraocular Procedures	$16,536.74	$14,056.23	
5494	Level 4 Intraocular Procedures	$17,158.34	$14,584.59	
5495	Level 5 Intraocular Procedures	$31,610.32	$26,868.77	
5501	Level 1 Extraocular, Repair, and Plastic Eye Procedures	$481.79	$409.52	
5502	Level 2 Extraocular, Repair, and Plastic Eye Procedures	$1,455.07	$1,236.81	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
5503	Level 3 Extraocular, Repair, and Plastic Eye Procedures	$3,260.43	$2,771.37	
5504	Level 4 Extraocular, Repair, and Plastic Eye Procedures	$5,312.83	$4,515.91	
5521	Level 1 Imaging without Contrast	$111.82	$95.05	
5522	Level 2 Imaging without Contrast	$206.03	$175.13	
5523	Level 3 Imaging without Contrast	$418.16	$355.44	
5524	Level 4 Imaging without Contrast	$876.04	$744.63	
5571	Level 1 Imaging with Contrast	$454.93	$386.69	
5572	Level 2 Imaging with Contrast	$821.47	$698.25	
5573	Level 3 Imaging with Contrast	$1,227.38	$1,043.27	
5591	Level 1 Nuclear Medicine and Related Services	$628.99	$534.64	
5592	Level 2 Nuclear Medicine and Related Services	$815.54	$693.21	
5593	Level 3 Nuclear Medicine and Related Services	$2,164.82	$1,840.10	
5594	Level 4 Nuclear Medicine and Related Services	$2,479.00	$2,107.15	
5611	Level 1 Therapeutic Radiation Treatment Preparation	$225.63	$191.79	
5612	Level 2 Therapeutic Radiation Treatment Preparation	$581.56	$494.33	
5613	Level 3 Therapeutic Radiation Treatment Preparation	$2,136.02	$1,815.62	
5621	Level 1 Radiation Therapy	$224.51	$190.83	
5622	Level 2 Radiation Therapy	$395.69	$336.34	
5623	Level 3 Radiation Therapy	$940.16	$799.14	
5624	Level 4 Radiation Therapy	$1,285.40	$1,092.59	
5625	Level 5 Radiation Therapy	$1,896.34	$1,611.89	
5626	Level 6 Radiation Therapy	$3,019.00	$2,566.15	
5627	Level 7 Radiation Therapy	$13,618.24	$11,575.50	

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Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
5661	Therapeutic Nuclear Medicine	$429.26	$364.87	
5671	Level 1 Pathology	$80.46	$68.39	
5672	Level 2 Pathology	$232.52	$197.64	
5673	Level 3 Pathology	$387.77	$329.60	
5674	Level 4 Pathology	$973.73	$827.67	
5691	Level 1 Drug Administration	$66.65	$56.65	
5692	Level 2 Drug Administration	$104.76	$89.05	
5693	Level 3 Drug Administration	$343.96	$292.37	
5694	Level 4 Drug Administration	$535.63	$455.29	
5721	Level1 Diagnostic Tests and Related Services	$245.38	$208.57	
5722	Level 2 Diagnostic Tests and Related Services	$447.89	$380.71	
5723	Level 3 Diagnostic Tests and Related Services	$799.90	$679.92	
5724	Level 4 Diagnostic Tests and Related Services	$1,625.36	$1,381.56	
5731	Level 1 Minor Procedures	$31.45	$26.73	
5732	Level 2 Minor Procedures	$57.24	$48.65	
5733	Level 3 Minor Procedures	$100.73	$85.62	
5734	Level 4 Minor Procedures	$189.07	$160.71	
5735	Level 5 Minor Procedures	$594.02	$504.92	
5741	Level 1 Electronic Analysis of Devices	$67.93	$57.74	
5742	Level 2 Electronic Analysis of Devices	$207.32	$176.22	
5743	Level 3 Electronic Analysis of Devices	$471.40	$400.69	
5771	Cardiac Rehabilitation	$209.99	$178.49	
5781	Resuscitation and Cardioversion	$922.79	$784.37	
5791	Pulmonary Treatment	$335.48	$285.16	
5801	Ventilation Initiation and Management	$829.26	$704.87	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
5811	Manipulation Therapy	$48.29	$41.05	
5821	Level 1 Health and Behavior Services	$54.76	$46.55	
5822	Level 2 Health and Behavior Services	$129.49	$110.07	
5823	Level 3 Health and Behavior Services	$223.11	$189.64	
5853	Partial Hospitalization (3 or more services) for CMHCs	$257.96	$219.27	
5863	Partial Hospitalization (3 or more services) for Hospital-based PHPs	$374.81	$318.59	
5871	Dental Procedures	$1,390.37	$1,181.81	
5881	Ancillary Outpatient Services When Patient Dies	$12,739.99	$10,828.99	
7000	Amifostine	$1,753.27	$1,490.28	
7011	Oprelvekin injection	$840.99	$714.84	
7034	Somatropin injection	$134.37	$114.21	
7035	Teniposide	$4,435.05	$3,769.79	
7041	Tirofiban HCl	$16.37	$13.91	
7043	Infliximab not biosimil 10mg	$154.46	$131.29	
7046	Doxorubicin inj 10mg	$694.38	$590.22	
7048	Alteplase recombinant	$152.91	$129.97	
7308	Aminolevulinic acid hcl top	$728.26	$619.02	
8004	Ultrasound Composite	$539.80	$458.83	
8005	CT and CTA without Contrast Composite	$494.71	$420.50	
8006	CT and CTA with Contrast Composite	$901.53	$766.30	
8007	MRI and MRA without Contrast Composite	$1,001.11	$850.94	
8008	MRI and MRA with Contrast Composite	$1,569.35	$1,333.95	
8010	Mental Health Services Composite	$374.81	$318.59	

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Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
8011	Comprehensive Observation Services	$4,229.68	$3,595.23	
9002	Tenecteplase injection	$200.79	$170.67	
9003	Palivizumab	$2,725.51	$2,316.68	
9005	Reteplase injection	$4,143.44	$3,521.92	
9006	Tacrolimus injection	$338.10	$287.39	
9012	Arsenic trioxide injection	$127.90	$108.72	
9014	Injection, cerliponase alfa	$171.72	$145.96	
9015	C-1 esterase, haegarda	$17.94	$15.25	
9016	Inj, triptorelin ext rel	$5,088.00	$4,324.80	
9018	Inj, rimabotulinumtoxinB	$21.58	$18.34	
9019	Caspofungin acetate	$32.64	$27.74	
9024	Amphotericin b lipid complex	$26.86	$22.83	
9028	Inj. inotuzumab ozogamicin	$3,964.40	$3,369.74	
9029	Injection, guselkumab	$184.77	$157.05	
9031	Inj, etelcalcetide, 0.1 mg	$6.24	$5.30	
9032	Baclofen 10 MG injection	$320.14	$272.12	
9033	Cidofovir injection	$838.59	$712.80	
9034	Inj cuvitru, 100 mg	$24.82	$21.10	
9038	Inj estrogen conjugate	$543.09	$461.63	
9042	Glucagon hydrochloride	$394.46	$335.29	
9043	Inj, afstyla, 1 i.u.	$2.55	$2.17	
9044	Ibutilide fumarate injection	$360.09	$306.08	
9052	Fluciciovine F-18	$701.19	$596.01	
9056	Gallium Ga-68	$120.13	$102.11	
9058	Buprenorphine implant 74.2mg	$2,262.79	$1,923.37	
9059	Vonvendi inj 1 iu vwf:rco	$4.10	$3.49	
9064	Aripiprazole injection	$1.36	$1.16	
9065	Argatroban esrd dialysis 1mg	$2.69	$2.29	
9066	Inj dihydroergotamine mesylt	$188.58	$160.29	
9071	Capsaicin 8% patch	$5.68	$4.83	

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Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
9072	Fosphenytoin inj pe	$7.04	$5.98	
9074	Makena, 10 mg	$49.70	$42.25	
9075	Inj, kovaltry, 1 i.u.	$2.24	$1.90	
9076	Dimecaprol injection	$92.21	$78.38	
9077	Epoetin beta non esrd	$2.93	$2.49	
9078	Testosterone undecanoate 1mg	$2.32	$1.97	
9079	Genvisc 850, inj, 1mg	$11.56	$9.83	
9080	Fludarabine phosphate inj	$152.44	$129.57	
9081	Tisagenlecleucel car-pos t	$906,300.00	$770,355.00	
9104	Antithymocyte globuln rabbit	$1,281.96	$1,089.67	
9108	Thyrotropin injection	$2,884.74	$2,452.03	
9119	Injection, pegfilgrastim 6mg	$7,996.15	$6,796.73	
9120	Injection, Fulvestrant	$174.38	$148.22	
9122	Triptorelin pamoate	$748.40	$636.14	
9124	Daptomycin injection	$0.90	$0.77	
9125	Risperidone, long acting	$16.12	$13.70	
9126	Natalizumab injection	$34.95	$29.71	
9130	Inj, Imm Glob Bivigam, 500mg	$126.93	$107.89	
9131	Inj, Ado-trastuzumab Emt 1mg	$54.37	$46.21	
9132	Kcentra, per i.u.	$3.35	$2.85	
9133	Rabies ig, im/sc	$544.45	$462.78	
9134	Rabies ig, heat treated	$598.38	$508.62	
9135	Varicella-zoster ig, im	$2,442.65	$2,076.25	
9139	Rabies vaccine, im	$512.96	$436.02	
9140	Rabies vaccine, id	$353.77	$300.70	
9171	Factor ix idelvion inj	$7.48	$6.36	
9207	Bortezomib injection	$84.51	$71.83	
9208	Agalsidase beta injection	$308.53	$262.25	
9209	Laronidase injection	$55.11	$46.84	
9210	Palonosetron hcl	$36.54	$31.06	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
9213	Pemetrexed injection	$119.36	$101.46	
9214	Bevacizumab injection	$137.99	$117.29	
9215	Cetuximab injection	$106.60	$90.61	
9217	Leuprolide acetate suspnsion	$380.17	$323.14	
9224	Galsulfase injection	$684.85	$582.12	
9225	Fluocinolone acetonide implt	$36,180.30	$30,753.26	
9228	Tigecycline injection	$5.08	$4.32	
9229	Ibandronate sodium injection	$152.79	$129.87	
9230	Abatacept injection	$87.39	$74.28	
9231	Decitabine injection	$29.04	$24.68	
9232	Idursulfase injection	$977.15	$830.58	
9233	Ranibizumab injection	$695.79	$591.42	
9234	Alglucosidase alfa injection	$287.33	$244.23	
9235	Panitumumab injection	$200.50	$170.43	
9236	Eculizumab injection	$411.06	$349.40	
9237	Inj, lanreotide acetate	$102.05	$86.74	
9240	Injection, ixabepilone	$131.40	$111.69	
9242	Injection, fosaprepitant	$3.68	$3.13	
9243	Inj., treanda 1 mg	$54.24	$46.10	
9245	Romiplostim injection	$122.50	$104.13	
9251	C1 esterase inhibitor inj	$102.90	$87.47	
9252	Plerixafor injection	$565.99	$481.09	
9253	Temozolomide injection	$17.21	$14.63	
9255	Paliperidone palmitate inj	$18.67	$15.87	
9256	Dexamethasone intra implant	$361.00	$306.85	
9258	Telavancin injection	$9.68	$8.23	
9259	Pralatrexate injection	$462.79	$393.37	
9260	Ofatumumab injection	$101.64	$86.39	
9261	Ustekinumab sub cu inj, 1 mg	$336.81	$286.29	
9263	Ecallantide injection	$813.81	$691.74	
9264	Tocilizumab injection	$8.15	$6.93	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
9265	Romidepsin injection	$592.57	$503.68	
9269	C-1 esterase, berinert	$88.03	$74.83	
9270	Gammaplex IVIG	$72.06	$61.25	
9271	Velaglucerase alfa	$619.07	$526.21	
9272	Inj, denosumab	$31.95	$27.16	
9273	Sipuleucel-T auto CD54+	$71,863.30	$61,083.81	
9274	Crotalidae Poly Immune Fab	$5,403.60	$4,593.06	
9276	Cabazitaxel injection	$286.46	$243.49	
9278	Incobotulinumtoxin A	$9.14	$7.77	
9281	Injection, pegloticase	$3,708.86	$3,152.53	
9284	Ipilimumab injection	$264.03	$224.43	
9286	Belatacept injection	$7.04	$5.98	
9287	Brentuximab vedotin inj	$260.92	$221.78	
9289	Erwinaze injection	$724.94	$616.20	
9293	Injection, glucarpidase	$536.91	$456.37	
9294	Inj, taliglucerase alfa 10 u	$72.69	$61.79	
9295	Injection, Carfilzomib, 1 mg	$59.73	$50.77	
9296	Inj, ziv-aflibercept, 1mg	$14.57	$12.38	
9297	Inj, Omacetaxine Mep, 0.01mg	$5.12	$4.35	
9298	Inj, Ocriplasmin, 0.125 mg	$1,884.24	$1,601.60	
9300	Omalizumab injection	$62.89	$53.46	
9301	Aminolevulinic acid, 10% gel	$2.51	$2.13	
9302	Inj, daunorubicin-cytarabine	$336.07	$285.66	
9441	Inj ferric carboxymaltos 1mg	$1.89	$1.61	
9445	Injection, ruconest	$50.36	$42.81	
9448	Netupitant palonosetron oral	$717.89	$610.21	
9449	Injection, blinatumomab	$193.93	$164.84	
9450	Fluocinol acet intravit imp	$882.86	$750.43	
9451	Injection, peramivir	$3.02	$2.57	
9452	Inj ceftolozane tazobactam	$9.25	$7.86	
9453	Injection, nivolumab	$48.22	$40.99	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
9454	Inj, pasireotide long acting	$490.18	$416.65	
9455	Injection, siltuximab	$166.91	$141.87	
9456	Injection, isavuconazonium	$1.24	$1.05	
9458	Florbetaben f18 diagnostic	$5,342.40	$4,541.04	
9459	Flutemetamol f18 diagnostic	$6,296.40	$5,351.94	
9460	Injection, cangrelor	$27.22	$23.14	
9461	Choline c-11, diagnostic, per study dose up to 20 millicuries	$10,260.00	$8,721.00	
9470	Aripiprazole lauroxil 1mg	$4.37	$3.71	
9471	Hymovis injection 1 mg	$34.66	$29.46	
9472	Inj talimogene laherparepvec	$86.88	$73.85	
9473	Injection, mepolizumab, 1mg	$51.91	$44.12	
9474	Inj irinotecan liposome 1 mg	$77.25	$65.66	
9475	Injection, necitumumab, 1 mg	$9.66	$8.21	
9476	Injection, daratumumab 10 mg	$89.10	$75.74	
9477	Injection, elotuzumab, 1mg	$11.42	$9.71	
9478	Inj sebelipase alfa 1 mg	$954.00	$810.90	
9479	Instill, ciprofloxacin otic	$53.94	$45.85	
9480	Injection trabectedin 0.1mg	$523.15	$444.68	
9481	Injection, reslizumab	$16.39	$13.93	
9482	Sotalol hydrochloride IV	$17.97	$15.27	
9483	Inj, atezolizumab,10 mg	$136.43	$115.97	
9484	Inj, eteplirsen, 10 mg	$304.68	$258.98	
9485	Inj, olaratumab, 10 mg	$89.91	$76.42	
9486	Inj, granisetron, xr, 0.1 mg	$8.29	$7.05	
9487	Ustekinumab, iv inject,1 mg	$23.13	$19.66	
9488	Conivaptan hcl	$55.32	$47.02	
9489	Inj, nusinersen, 0.1mg	$1,985.93	$1,688.04	
9490	Inj, bezlotoxumab, 10 mg	$72.33	$61.48	
9491	Injection, avelumab, 10 mg	$142.87	$121.44	
9492	Injection, durvalumab	$132.47	$112.60	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
9493	Injection, edaravone	$34.53	$29.35	
9494	Injection, ocrelizumab	$102.75	$87.34	
9495	Gemtuzumab ozogamicin inj	$347.68	$295.53	
9497	Loxapine, inhalation powder	$271.13	$230.46	
9500	Platelets, irradiated	$322.45	$274.08	
9501	Platelet pheres leukoreduced	$858.60	$729.81	
9502	Platelet pheresis irradiated	$998.01	$848.31	
9503	Fr frz plasma donor retested	$87.03	$73.98	
9504	RBC deglycerolized	$757.49	$643.87	
9505	RBC irradiated	$384.82	$327.10	
9507	Platelets, pheresis	$758.16	$644.44	
9508	Plasma 1 donor frz w/in 8 hr	$130.34	$110.79	
9509	Frozen plasma, pooled, sd	$109.03	$92.68	
9510	Whole blood for transfusion	$282.46	$240.09	
9511	Cryoprecipitate each unit	$79.22	$67.34	
9512	RBC leukocytes reduced	$330.79	$281.17	
9513	Plasma, frz between 8-24hour	$133.63	$113.59	
9514	Plasma protein fract,5%,50ml	$27.72	$23.56	
9515	Platelets, each unit	$206.91	$175.87	
9516	Plaelet rich plasma unit	$222.32	$188.97	
9517	Red blood cells unit	$257.02	$218.47	
9518	Washed red blood cells unit	$691.70	$587.95	
9519	Plasmaprotein fract,5%,250ml	$84.42	$71.76	
9520	Blood split unit	$184.82	$157.10	
9521	Platelets leukoreduced irrad	$301.77	$256.50	
9522	RBC leukoreduced irradiated	$468.36	$398.11	
9523	Cryoprecipitatereducedplasma	$189.97	$161.47	
9524	Blood, l/r, cmv-neg	$346.81	$294.79	
9525	Platelets, hla-m, l/r, unit	$1,384.78	$1,177.06	
9526	Platelets leukocytes reduced	$210.06	$178.55	
9527	Blood, l/r, froz/degly/wash	$510.30	$433.76	

Final Exhibit #4				
Hospital and ASC APC Codes and Values				
Effective for Dates of Service on and After 1/1/2019				
APC	**Group Title**	**Outpatient Hospital Rate 180% of Medicare $**	**ASC Rate is 85% of Hospital Rate**	**Notes**
9528	Plt, aph/pher, l/r, cmv-neg	$611.91	$520.12	
9529	Blood, l/r, irradiated	$279.43	$237.52	
9530	Plate pheres leukoredu irrad	$1,124.39	$955.73	
9531	Plt, pher, l/r cmv-neg, irr	$971.69	$825.94	
9532	RBC, frz/deg/wsh, l/r, irrad	$507.15	$431.08	
9533	RBC, l/r, cmv-neg, irrad	$428.49	$364.22	
9534	Pathogen reduced plasma pool	$133.63	$113.59	
9535	Pathogen reduced plasma sing	$130.34	$110.79	
9536	Platelets, pathogen reduced	$1,124.39	$955.73	

Final Exhibit #5

Rural Health Clinics

find the most updated list at: https://www.colorado.gov/pacific/cdphe/find-and-compare-facilities

(effective 1/1/2019)

Facility	Address	City	State	Zip	County	Phone	Fax
AKRON CLINIC	82 MAIN	Akron	CO	80720	Washington	(970)345-6336	(970)345-6576
ARKANSAS VALLEY FAMILY PRACTICE, LLC	2317 SAN JUAN AVE	La Junta	CO	81050	Otero	(719)383-2325	(719)383-2327
BASIN CLINIC	421 WEST ADAMS ROAD	Naturita	CO	80723	Montrose	(970)865-2665	(970)825-2674
BANNER FAMILY MEDICINE BRUSH CLINIC	2400 W EDISON	Brush	CO	81211	Morgan	(970)842-6740	(970)842-6241
BUENA VISTA HEALTH CENTER	28374 COUNTY ROAD 317	Buena Vista	CO	81211	Chaffee	(719)395-9048	(719)395-9064
BUTTON FAMILY PRACTICE	715 SOUTH 9TH STREET	Canon City	CO	81212	Fremont	(719)269-8820	(719)204-0230
CENTENNIAL FAMILY HEALTH CENTER	319 MAIN STREET	Ordway	CO	81063	Crowley	(719)267-3503	(719)267-4153
CORTEZ PRIMARY CARE CLINIC	118 NORTH CHESTNUT	Cortez	CO	81321	Montezuma	(970)564-9777	(970)564-8833
CREEDE FAMILY PRACTICE OF RIO GRANDE HOSPITAL	802 RIO GRANDE AVENUE	Creede	CO	81130	Mineral	(719)658-0929	(719)657-2851
CUSTER COUNTY MEDICAL CENTER	704 EDWARDS	Westcliffe	CO	81252	Custer	(719)783-2380	(719)783-2377
EADS MEDICAL CLINIC	1211 LUTHER STREET	Eads	CO	81036	Kiowa	(719)438-2251	(719)438-2254
EASTERN PLAINS MEDICAL CLINIC OF CALHAN	560 CRYSTOLA STREET	Calhan	CO	80808	El Paso	(719)347-0100	(719)347-0551
FAMILY PRACTICE OF HOLYOKE	1001 EAST JOHNSON STREET	Holyoke	CO	80734	Phillips	(970)854-2500	(970)854-3440
FLORENCE MEDICAL CENTER	501 W 5TH ST	Florence	CO	81226	Fremont	(719)784-4816	(719)784-6014
GRAND RIVER HEALTH CLINIC WEST	201 SIPPERELLE DRIVE	Parachute	CO	81635	Garfield	(970)285-7046	(970)285-6064
GRAND RIVER PRIMARY CARE	501 AIRPORT ROAD	Rifle	CO	81650	Garfield	(970)625-1100	(970)625-0725

Final Exhibit #5

Rural Health Clinics

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(effective 1/1/2019)

Facility	Address	City	State	Zip	County	Phone	Fax
KIT CARSON CLINIC	102 EAST 2ND AVENUE	Kit Carson	CO	80825	Cheyenne	(719)962-3501	(719)962-3403
LAKE CITY AREA MEDICAL CENTER	700 N HENSON STREET	Lake City	CO	81235	Hinsdale	(970)944-2331	(970)944-2320
LAMAR MEDICAL CLINIC	403 KENDALL DRIVE	Lamar	CO	81052	Prowers	(719)336-6767	(719)336-7217
MANCOS VALLEY HEALTH CENTER	111 RAILROAD AVE	Mancos	CO	81328	Montezuma	(970)564-2104	(970)564-2134
MEEKER FAMILY HEALTH CENTER	345 CLEVELAND STREET	Meeker	CO	81641	Rio Blanco	(970)878-4014	(970)878-3285
MEMORIAL HOSPITAL	750 Hospital Loop	Craig	CO	81625	Moffat	(970) 826-3161	(970) 826-3285
MIDDLE PARK MEDICAL CENTER	47 Cooper Creek Way	Winter Park	CO	80482	Grand	(970)887-5800	(970)724-9606
MONTE VISTA RHC OF RIO GRANDE HOSPITAL	1033 2ND AVENUE	Monte Vista	CO	81144	Rio Grande	(719)852-8827	(719)852-2739
MT SAN RAFAEL HOSPITAL HEALTH CLINIC	400 BENEDICTA STE A	Trinidad	CO	81082	Las Animas	(719)846-2206	(719)846-7823
NORTH PARK MEDICAL CENTER - WALDEN	350 MCKINLEY STREET	Walden	CO	80480	Jackson	(970)723-4255	(970)723-4268
PAGOSA MOUNTAIN CLINIC	95 SOUTH PAGOSA BLVD	Pagosa Springs	CO	81147	Archuleta	(970)731-3700	(970)731-3707
PARKE HEALTH CLINIC	182 16TH ST	Burlington	CO	80807	Kit Carson	(719)346-9481	(719)346-9485
PEDIATRIC ASSOCIATION OF CANON CITY	1335 PHAY AVENUE, SUITE A	Canon City	CO	81212	Fremont	(719)269-1727	(719)269-1730
PRAIRIE VIEW RURAL HEALTH CLINIC	615 WEST 5TH NORTH	Cheyenne Wells	CO	80810	Cheyenne	(719)767-5669	(719)767-5098
RIO GRANDE HOSPITAL CLINIC	0310C COUNTY RD 14	Del Norte	CO	81132	Rio Grande	(719)657-2418	(719)658-3001
ROCKY FORD FAMILY HEALTH	1014 ELM AVENUE	Rocky Ford	CO	81067	Otero	(719)254-7421	(719)254-6966

Final Exhibit #5

Rural Health Clinics

find the most updated list at: https://www.colorado.gov/pacific/cdphe/find-and-compare-facilities

(effective 1/1/2019)

Facility	Address	City	State	Zip	County	Phone	Fax
CENTER							
SABATINI PEDIATRICS PC	612 YALE PLACE	Canon City	CO	81212	Fremont	(719)275-3442	(719)275-2306
SAN LUIS VALLEY HEALTH ANTONITO CLINIC	115 MAIN STREET	Antonito	CO	81120	Conejos	(719)376-2308	(719)376-2395
SAN LUIS VALLEY LA JARA MEDICAL CLINIC	509 MAIN STREET	La Jara	CO	81140	Conejos	(719)274-5000	(719)274-4111
SOUTHEAST COLORADO PHYSICIANS CLINIC	900 CHURCH STREET	Springfield	CO	81073	Baca	(719)523-6628	(719)523-4513
SOUTHWEST MEMORIAL PRIMARY CARE	33 NORTH ELM STREET	Cortez	CO	81321	Montezuma	(970)565-8556	(970)564-1134
SOUTHWEST SCHOOL-BASED HEALTH CENTER	418 S SLIGO STREET	Cortez	CO	81321	Montezuma	(970)564-2104	(970)564-2134
SOUTHWEST WALK-IN CARE	2095 NORTH DOLORES ROAD, STE C	Cortez	CO	81321	Montezuma	(970)564-1037	(970)564-1041
SPANISH PEAKS FAMILY CLINIC	23400 US HIGHWAY 160	Walsenburg	CO	81089	Huerfano	(719)738-4591	(719)738-4553
STERLING REGIONAL MEDICAL CENTER	102 Hays Ave	Sterling	CO	80751	Logan	(970)521-3223	(970)521-3266
STRATTON MEDICAL CLINIC	500 NEBRASKA AVENUE	Stratton	CO	80836	Kit Carson	(719)348-4650	(719)348-4653
SURFACE CREEK FAMILY PRACTICE	255 SW 8TH AVE	Cedaredge	CO	81413	Delta	(970)856-3146	(970)856-4385
VALLEY MEDICAL CLINIC	116 E NINTH STREET	Julesburg	CO	80737	Sedgwick	(970)474-3376	(970)474-2461
WALSH MEDICAL CLINIC	137 KANSAS STREET	Walsh	CO	81090	Baca	(719)324-5253	(719)324-5621
WASHINGTON COUNTY CLINIC	482 ADAMS AVENUE	Akron	CO	80720	Washington	(970)345-2262	(970)345-2265
YUMA CLINIC	1000 W 8TH	Yuma	CO	80759	Yuma	(970)848-	(970)848-

Final Exhibit #5							
Rural Health Clinics							
find the most updated list at: https://www.colorado.gov/pacific/cdphe/find-and-compare-facilities							
(effective 1/1/2019)							
Facility	**Address**	**City**	**State**	**Zip**	**County**	**Phone**	**Fax**
	AVENUE					4676	4952

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D0120	$62.25
D0140	$104.38
D0145	$97.00
D0150	$109.75
D0160	$219.75
D0170	$73.13
D0171	$73.13
D0180	$119.00
D0190	$62.25
D0191	$44.13
D0210	$170.88
D0220	$33.88
D0230	$30.88
D0240	$52.88
D0250	$64.75
D0251	$59.75
D0270	$33.75
D0272	$54.00
D0273	$65.63
D0274	$76.00
D0277	$114.75
D0310	$512.88
D0320	$906.00
D0321	BR
D0322	$734.88
D0330	$159.00
D0340	$179.63
D0350	$85.25
D0351	$85.25
D0364	$285.50
D0365	$364.25
D0366	$364.25

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D0367	$410.38
D0368	$422.50
D0369	$239.38
D0370	$136.88
D0371	BR
D0380	$294.00
D0381	$398.38
D0382	$398.38
D0383	$398.38
D0384	$427.50
D0385	$2,624.38
D0386	$656.38
D0391	BR
D0393	BR
D0394	BR
D0395	BR
D0414	$65.13
D0415	$47.25
D0416	$70.13
D0417	$63.38
D0418	$65.13
D0422	$47.25
D0423	BR
D0425	$40.63
D0431	$65.13
D0460	$65.13
D0470	$143.63
D0472	$89.88
D0473	$189.13
D0474	$212.00
D0475	$114.13
D0476	$110.75

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D0477	$151.75
D0478	$138.63
D0479	$212.00
D0480	$130.50
D0481	$489.50
D0482	$163.13
D0483	$163.13
D0484	$244.75
D0485	$337.63
D0486	$156.75
D0502	BR
D0600	BR
D0601	$97.75
D0602	$97.75
D0603	$97.75
D0999	BR
D1110	$111.75
D1120	$77.25
D1206	$62.50
D1208	$41.38
D1310	$58.38
D1320	$63.38
D1330	$80.00
D1351	$65.13
D1352	$83.63
D1353	$83.63
D1354	$65.13
D1510	$413.00
D1515	$577.88
D1520	$454.00
D1525	$702.13
D1550	$89.38

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D1555	$86.13
D1575	$454.00
D1999	BR
D2140	$180.38
D2150	$233.25
D2160	$281.75
D2161	$343.50
D2330	$194.25
D2331	$247.88
D2332	$303.63
D2335	$358.88
D2390	$398.00
D2391	$227.50
D2392	$297.88
D2393	$370.00
D2394	$453.38
D2410	$345.38
D2420	$575.88
D2430	$998.00
D2510	$913.63
D2520	$1,036.38
D2530	$1,194.50
D2542	$1,171.38
D2543	$1,225.50
D2544	$1,274.38
D2610	$1,074.88
D2620	$1,134.75
D2630	$1,208.25
D2642	$1,174.63
D2643	$1,266.88
D2644	$1,343.63
D2650	$706.50

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D2651	$841.38
D2652	$884.63
D2662	$767.63
D2663	$902.88
D2664	$967.13
D2710	$573.00
D2712	$573.00
D2720	$1,411.88
D2721	$1,323.25
D2722	$1,352.25
D2740	$1,449.00
D2750	$1,429.63
D2751	$1,331.00
D2752	$1,363.38
D2780	$1,371.50
D2781	$1,290.88
D2782	$1,332.88
D2783	$1,410.25
D2790	$1,379.88
D2791	$1,307.13
D2792	$1,331.00
D2794	$1,411.88
D2799	$573.00
D2910	$127.13
D2915	$127.13
D2920	$128.75
D2921	$185.25
D2929	$509.75
D2930	$351.00
D2931	$396.88
D2932	$423.38
D2933	$485.25

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D2934	$485.25
D2940	$134.25
D2941	$134.25
D2949	$134.25
D2950	$335.25
D2951	$75.75
D2952	$529.25
D2953	$264.50
D2954	$423.38
D2955	$326.50
D2957	$211.50
D2960	$1,023.38
D2961	$1,160.75
D2962	$1,261.38
D2971	$202.75
D2975	$617.38
D2980	$247.00
D2981	$247.00
D2982	$247.00
D2983	$247.00
D2990	$88.13
D2999	BR
D3110	$117.75
D3120	$94.00
D3220	$241.00
D3221	$264.63
D3222	$245.00
D3230	$244.00
D3240	$300.25
D3310	$957.50
D3320	$1,173.50
D3330	$1,455.00

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D3331	$375.50
D3332	$713.63
D3333	$328.75
D3346	$1,276.75
D3347	$1,502.13
D3348	$1,858.88
D3351	$603.38
D3352	$270.50
D3353	$832.50
D3355	$603.38
D3356	$270.50
D3357	BR
D3410	$1,196.25
D3421	$1,331.25
D3425	$1,508.38
D3426	$509.63
D3427	$1,081.75
D3428	$1,576.88
D3429	$1,504.13
D3430	$374.38
D3431	$1,851.63
D3432	$1,591.63
D3450	$780.25
D3460	$2,912.50
D3470	$1,487.63
D3910	$208.25
D3920	$592.75
D3950	$270.50
D3999	BR
D4210	$1,106.88
D4211	$492.00
D4212	$393.63

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D4230	$1,549.50
D4231	$737.88
D4240	$1,401.88
D4241	$811.75
D4245	$1,032.88
D4249	$1,537.25
D4260	$2,336.50
D4261	$1,254.13
D4263	$836.25
D4264	$713.00
D4265	BR
D4266	$860.88
D4267	$1,106.88
D4268	BR
D4270	$1,660.13
D4273	$2,029.00
D4274	$1,151.00
D4275	$1,524.88
D4276	$2,275.00
D4277	$1,721.63
D4278	$565.75
D4283	$1,728.88
D4285	$1,301.13
D4320	$565.63
D4321	$514.00
D4341	$325.50
D4342	$188.50
D4346	$188.50
D4355	$222.63
D4381	BR
D4910	$200.50
D4920	$145.88

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D4921	BR
D4999	BR
D5110	$2,197.63
D5120	$2,197.63
D5130	$2,396.00
D5140	$2,396.00
D5211	$1,854.75
D5212	$2,155.50
D5213	$2,428.00
D5214	$2,428.00
D5221	$2,023.50
D5222	$2,350.00
D5223	$2,646.63
D5224	$2,646.63
D5225	$1,854.75
D5226	$2,155.50
D5281	$1,415.63
D5410	$120.38
D5411	$120.38
D5421	$120.38
D5422	$120.38
D5511	BR
D5512	BR
D5520	$200.38
D5611	BR
D5612	BR
D5621	BR
D5622	BR
D5630	$341.00
D5640	$220.63
D5650	$300.75
D5660	$360.88

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D5670	$882.25
D5671	$882.25
D5710	$892.38
D5711	$852.25
D5720	$842.25
D5721	$842.25
D5730	$503.25
D5731	$503.25
D5740	$461.00
D5741	$461.00
D5750	$671.63
D5751	$671.63
D5760	$661.75
D5761	$661.75
D5810	$1,062.75
D5811	$1,142.75
D5820	$822.00
D5821	$872.25
D5850	$210.63
D5851	$210.63
D5862	BR
D5863	$2,326.00
D5864	$3,068.00
D5865	$2,326.00
D5866	$3,188.13
D5867	BR
D5875	BR
D5899	BR
D5911	$557.38
D5912	$557.38
D5913	$11,738.25
D5914	$11,738.25

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D5915	$15,884.75
D5916	$4,236.88
D5919	BR
D5922	BR
D5923	BR
D5924	BR
D5925	BR
D5926	BR
D5927	BR
D5928	BR
D5929	BR
D5931	$6,320.50
D5932	$11,820.38
D5933	BR
D5934	$10,773.63
D5935	$9,374.13
D5936	$10,528.88
D5937	$1,323.38
D5951	$1,720.50
D5952	$5,586.38
D5953	$10,609.38
D5954	$9,831.38
D5955	$9,093.38
D5958	BR
D5959	BR
D5960	BR
D5982	$892.38
D5983	$2,005.13
D5984	$2,005.13
D5985	$2,005.13
D5986	$200.38
D5987	$3,007.75

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D5988	$601.50
D5991	$230.50
D5992	BR
D5993	BR
D5994	$230.50
D5999	BR
D6010	$3,671.50
D6011	BR
D6012	$3,468.88
D6013	$3,671.50
D6040	$12,632.25
D6050	$9,424.13
D6051	BR
D6052	$1,555.88
D6055	$1,103.00
D6056	$762.00
D6057	$942.38
D6058	$2,113.25
D6059	$2,085.50
D6060	$1,971.00
D6061	$2,011.13
D6062	$2,003.00
D6063	$1,744.38
D6064	$1,824.75
D6065	$2,079.13
D6066	$2,025.13
D6067	$1,965.13
D6068	$2,095.38
D6069	$2,085.50
D6070	$1,971.00
D6071	$2,011.13
D6072	$2,035.13

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D6073	$1,858.88
D6074	$1,975.13
D6075	$2,079.13
D6076	$2,025.13
D6077	$1,965.13
D6080	$172.50
D6081	$88.25
D6085	$605.75
D6090	BR
D6091	$832.25
D6092	$162.38
D6093	$254.88
D6094	$1,654.25
D6095	BR
D6096	BR
D6100	BR
D6101	$595.38
D6102	$818.00
D6103	$681.63
D6104	$681.63
D6110	$2,741.13
D6111	$2,741.13
D6112	$2,741.13
D6113	$2,741.13
D6114	$4,800.13
D6115	$4,800.13
D6116	$3,681.38
D6117	$3,681.38
D6118	BR
D6119	BR
D6190	$371.00
D6194	$1,704.50

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D6199	BR
D6205	$942.63
D6210	$1,441.13
D6211	$1,350.25
D6212	$1,405.00
D6214	$1,450.00
D6240	$1,422.75
D6241	$1,314.00
D6242	$1,386.50
D6245	$1,468.13
D6250	$1,405.00
D6251	$1,296.00
D6252	$1,337.50
D6253	$605.38
D6545	$543.25
D6548	$597.50
D6549	$391.75
D6600	$1,078.00
D6601	$1,130.75
D6602	$1,152.13
D6603	$1,267.38
D6604	$1,129.13
D6605	$1,196.63
D6606	$1,111.00
D6607	$1,232.63
D6608	$1,171.88
D6609	$1,223.00
D6610	$1,242.75
D6611	$1,359.38
D6612	$1,236.00
D6613	$1,292.13
D6614	$1,209.63

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D6615	$1,257.50
D6624	$1,152.13
D6634	$1,209.63
D6710	$1,234.38
D6720	$1,440.25
D6721	$1,366.13
D6722	$1,390.75
D6740	$1,514.25
D6750	$1,474.75
D6751	$1,376.00
D6752	$1,409.00
D6780	$1,390.75
D6781	$1,390.75
D6782	$1,292.13
D6783	$1,431.88
D6790	$1,423.75
D6791	$1,349.50
D6792	$1,399.13
D6793	$584.38
D6794	$1,399.13
D6920	$355.75
D6930	$207.63
D6940	$470.50
D6950	$909.13
D6980	BR
D6985	$790.50
D6999	BR
D7111	$163.00
D7140	$216.63
D7210	$332.00
D7220	$416.00
D7230	$553.75

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D7240	$649.88
D7241	$816.50
D7250	$350.88
D7251	$688.00
D7260	$2,856.88
D7261	$1,190.13
D7270	$892.75
D7272	$1,190.13
D7280	$833.13
D7282	$416.63
D7283	$357.25
D7285	$1,666.63
D7286	$714.13
D7287	$285.63
D7288	$285.63
D7290	$714.13
D7291	BR
D7292	$1,142.63
D7293	$714.13
D7294	$595.25
D7295	BR
D7296	BR
D7297	BR
D7979	BR
D7310	$491.75
D7311	$430.50
D7320	$799.25
D7321	$676.13
D7340	$3,381.38
D7350	$9,837.13
D7410	$1,475.50
D7411	$2,336.38

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D7412	$2,582.13
D7413	$1,721.50
D7414	$2,582.13
D7415	$2,889.75
D7440	$2,336.38
D7441	$3,442.75
D7450	$1,475.50
D7451	$2,016.63
D7460	$1,475.50
D7461	$2,016.63
D7465	$799.25
D7471	$1,827.25
D7472	$2,171.75
D7473	$2,048.63
D7485	$1,827.25
D7490	$14,755.75
D7510	$528.63
D7511	$799.25
D7520	$2,518.50
D7521	$2,766.63
D7530	$907.38
D7540	$1,005.75
D7550	$627.38
D7560	$4,980.00
D7610	$8,053.88
D7620	$6,040.00
D7630	$10,471.63
D7640	$6,645.13
D7650	$5,033.88
D7660	$2,968.38
D7670	$2,316.75
D7671	$4,365.25

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D7680	$15,102.25
D7710	$9,466.00
D7720	$6,645.13
D7730	$13,693.25
D7740	$6,775.38
D7750	$8,617.25
D7760	$3,457.88
D7770	$4,684.88
D7771	$3,615.25
D7780	$20,136.63
D7810	$8,858.13
D7820	$1,451.13
D7830	$831.38
D7840	$12,075.13
D7850	$10,427.50
D7852	$11,940.00
D7854	$12,320.88
D7856	$8,742.50
D7858	$24,919.63
D7860	$10,621.63
D7865	$17,116.50
D7870	$565.63
D7871	$1,131.50
D7872	$6,037.38
D7873	$7,269.75
D7874	$10,427.50
D7875	$11,423.38
D7876	$12,316.00
D7877	$10,869.75
D7880	$1,357.63
D7881	$147.63
D7899	BR

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D7910	$806.50
D7911	$2,014.38
D7912	$3,625.00
D7920	$5,939.13
D7921	$548.63
D7940	BR
D7941	$15,124.38
D7943	$13,894.75
D7944	$12,382.25
D7945	$16,477.38
D7946	$20,412.25
D7947	$17,165.88
D7948	$22,281.13
D7949	$29,019.50
D7950	BR
D7951	BR
D7952	BR
D7953	$836.25
D7955	BR
D7960	$676.13
D7963	$1,106.50
D7970	$983.88
D7971	$368.88
D7972	$1,377.38
D7980	$1,549.50
D7981	BR
D7982	$3,664.25
D7983	$3,516.50
D7990	$3,024.88
D7991	$7,377.75
D7995	BR
D7996	BR

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D7997	$565.63
D7998	$2,459.50
D7999	BR
D8010	BR
D8020	BR
D8030	BR
D8040	BR
D8050	BR
D8060	BR
D8070	BR
D8080	BR
D8090	BR
D8210	BR
D8220	BR
D8660	$700.13
D8670	$525.09
D8680	$1,154.73
D8681	BR
D8690	$545.76
D8691	$512.95
D8692	$571.28
D8693	$528.75
D8694	BR
D8695	BR
D8999	BR
D9110	$166.25
D9120	$188.13
D9210	$84.25
D9211	$92.63
D9212	$144.88
D9215	$69.50
D9219	$165.25

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D9222	BR
D9223	$377.00
D9230	$139.38
D9239	BR
D9243	$319.13
D9248	$203.00
D9310	$242.38
D9311	$242.38
D9410	$277.25
D9420	$448.63
D9430	$151.94
D9440	$151.63
D9450	$76.00
D9610	BR
D9612	BR
D9630	BR
D9910	$91.00
D9911	$127.63
D9920	BR
D9930	BR
D9932	$223.88
D9933	$223.88
D9934	$223.88
D9935	$223.88
D9940	$754.13
D9941	$260.13
D9942	$312.13
D9943	$156.00
D9950	$494.25
D9951	$221.00
D9952	$1,040.25
D9970	$117.00

Final Exhibit #6
Dental Fees

Effective for Dates of Service
on and after 1/1/2019

2018 CDT Code	2019 Rate
D9971	$150.88
D9972	$520.00
D9973	$86.00
D9974	$455.25
D9975	$520.00
D9985	BR
D9986	BR
D9987	BR
D9991	$91.00
D9992	$91.00
D9993	$91.00
D9994	$124.88
D9995	BR
D9996	BR
D9999	BR

Exhibit #7

Evaluation and Management (E&M) Documentation Guidelines for Colorado Workers' Compensation Claims

Effective for Dates of Service on and after 1/1/2019

This E&M Guidelines for Colorado Workers' Compensation Claims is intended for the providers who manage injured workers' medical and non-medical care. Providers may also use the "1997 Documentation Guidelines for Evaluation and Management Services" as developed by Medicare. The Level of Service is determined by these three components:

1. History (Hx),
2. Examination (Exam), and
3. Medical Decision Making (MDM)

OR Time (as per CPT© and Rule 18)

Documentation requirements for any billed office visit:

- Chief complaint and medical necessity.
- Patient specific and pertain directly to the current visit.
- Information copied directly from prior records without change is not considered current or counted.
- CPT© criteria for a consultation is required to bill a consultation code.

Table I – History (Hx) Component: All three elements in the table must be met and documented.

HISTORY ELEMENTS	Requirements for a Problem Focused (PF) Level	Requirements for an Extended Problem Focused (EPF) Level	Requirements for a Detailed (D) Level	Requirements for a Comprehensive (C) Level
A. History of Present Illness/Injury (HPI)	1-3 elements	1-3 elements	4+ elements (requires a detailed patient specific description of the patient's progress with the current TX plan, which **should include objective functional gains/losses, ADLs)**	4+ elements (requires a detailed patient specific description of the patient's progress with the current TX plan, which **should include objective functional gains/losses, ADLs)**
B. Review of Systems (ROS)	Present	Present	Present	Present
C. Past Medical, Family and Social/Work History (PMFSH)	None	None	Pertinent 1-2 types of histories	Pertinent 3 or more types of histories

A. HPI Elements represents the injured worker relaying their condition to the physician and should include the following:

1. Location (where?)
2. Quality (sharp, dull?)
3. Severity (pain level 1-10 or pain diagram)
4. Duration (how long?)
5. Timing (how often, regularity of occurrence, only at night, etc.?)
6. Context (what ADLs or functions aggravates/relieves, accident described?)
7. Modifying factors (doing what, what makes it worse or better?)
8. Associated signs (nausea, numbness or tingling when?)

For the provider to achieve an *"extended" HPI* in an initial patient/injured workers visit it is necessary for the provider to discuss the causality of the patient/injured worker's work related injury(s) to the patient/injured worker's job duties.

For the provider to achieve an *"extended" HPI* in an established patient/injured worker visit it is necessary to document a detailed description of the patient's progress since the last visit with current treatment plan that includes patient pertinent objective functional gains, such as ADLs, physical therapy goals and return to work.

B. Review of Systems (ROS): Review of systems should be qualitative versus quantitative, documenting what is pertinent to that patient for the date of service.

1. Constitutional symptoms (e.g., fever, weight loss)
2. Eyes
3. Ears, Nose, Mouth, Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary (skin and/or breast)
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/Lymphatic
14. Allergic/Immunologic

C. PMFSH consists of a review of four areas (NOTE: Employers should **not** have access to any patient's or the family's genetic/hereditary diagnoses or testing information, etc.)

1. Past history – the patient's past experiences with illnesses, operations, injuries and treatments.

2. Family history – a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk and any family situations that can interfere with or support the injured worker's treatment plan and returning to work.

3. Occupational/Social History/Military – an age appropriate review of past and current work activities, occupational history, current work status, any work situations that support or interfere with return to work. For established visits specific updates of progress must be discussed.

4. Non-Occupational/Social History – Hobbies, current recreational physical activities and the patient's support relationships, etc. For established visits specific updates of progress must be discussed.

TABLE II: Examination Component: Each bullet is counted only when it is pertinent and related to the workers' compensation injury and the medical decision making process.

Physician's Examination Component	
Level of Examination Performed and Documented	**# of Bullets Required for each level**
Problem Focused	1-5 elements identified by a bullet as indicated in the guideline
Expanded Problem Focused	6 elements identified by a bullet as indicated in this guideline
Detailed	7-12 elements identified by a bullet as indicated in this guideline
Comprehensive	≥13 elements identified by a bullet as indicated in this guideline

Examination Components:

Constitutional Measurement:

- Vital signs (may be measured and recorded by ancillary staff) – any of three (3) vital signs is counted as one bullet:
  1. sitting or standing blood pressure
  2. supine blood pressure
  3. pulse rate and regularity
  4. respiration
  5. temperature
  6. height
  7. weight or BMI
- One bullet for commenting on the general appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)

Musculoskeletal: Each of the six body areas with three (3) assessments is counted as one bullet.

1. head and or neck
2. spine or ribs and pelvis or all three
3. right upper extremity (shoulder, elbow, wrist, entire hand)
4. left upper extremity (shoulder, elbow, wrist, entire hand)
5. right lower extremity (hip, knee, ankle, entire foot)
6. left lower extremity (hip, knee, ankle, entire foot)

Assessment of a given body area includes:

- Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
- Assessment of range of motion with notation of any pain (e.g., straight leg raise), crepitation or

contracture

- Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (fasciculation, tardive dyskinesia)
- Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechia, ischemia, infections, nodes)

Gait and Station: assessment equals one bullet

Neck: One bullet for both examinations.

- Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) and
- Examination of thyroid (e.g., enlargement, tenderness, mass)

Neurological: One bullet for each neurological examination/assessment(s) per extremity.

1. Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities)
2. Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski)
3. Examination of sensation (e.g., by touch, pin, vibration, proprioception)
4. One bullet for all of the 12 cranial nerves assessments with notations of any deficits

Cardiovascular:

1. One bullet per extremity examination/assessment of peripheral vascular system by:
    a. Observation (e.g., swelling, varicosities)
    b. Palpation (e.g., pulses, temperature, edema, tenderness)
2. One bullet for palpation of heart (e.g., location, size, thrills)
3. One bullet for auscultation of heart with notation of abnormal sounds and murmurs
4. One bullet for examination of each one of the following:
    a. carotid arteries (e.g., pulse amplitude, bruits)
    b. abdominal aorta (e.g., size, bruits)
    c. femoral arteries (e.g., pulse amplitude, bruits)

Skin: One bullet for pertinent body part(s) inspection and/or palpation of skin and subcutaneous tissue (e.g., scars, rashes, lesions, café au lait spots, ulcers)

Respiratory: One bullet for each examination/assessment.

1. Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement)
2. Percussion of chest (e.g., dullness, flatness, hyperresonance)
3. Palpation of chest (e.g., tactile fremitus)
4. Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

Gastrointestinal: One bullet for each examination /assessment.

1. Examination of abdomen with notation of presence of masses or tenderness and liver and spleen

2. Examination of presence or absence of hernia

3. Examination (when indicated) of anus, perineum and rectum, including sphincter tone, present of hemorrhoids, rectal masses and/or obtain stool sample of occult blood test when indicated

Psychiatric:

1. One bullet for assessment of mood and affect (e.g., depression, anxiety, agitation) if not counted under the Neurological system

2. One bullet for a mental status examination which includes:

a. Attention span and concentration; and

b. Language (e.g., naming objects, repeating phrases, spontaneous speech) orientation to time, place and person; and

c. Recent and remote memory; and

d. Fund of knowledge (e.g., awareness of current events, past history, vocabulary)

Eyes: One bullet for both eyes and all three examinations/assessments.

1. Inspection of conjunctivae and lids; and

2. Examination of pupils and irises (e.g., reaction of light and accommodation, size and symmetry); and

3. Opthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)

Ears and Nose, Mouth and Throat:

One bullet for all of the following examination/assessment:

1. External inspection of ears and nose (e.g., overall appearance, scars, lesions, asses)

2. Otoscopic examination of external auditory canals and tympanic membranes

3. Assessment of hearing with tuning fork and clinical speech reception thresholds (e.g., whispered voice, finger rub, tuning fork)

One bullet for all of the following examinations/assessments:

1. Inspection of nasal mucosa, septum and turbinates

2. Inspection of lips, teeth and gums

3. Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx (e.g., asymmetry, lesions, hydration of mucosal surfaces)

Genitourinary MALE: One bullet for each of the following examination of the male genitalia:

1. The scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass)

2. Epididymides (e.g., size, symmetry, masses)

3. Testes (e.g., size symmetry, masses)

4. Urethral meatus (e.g., size location, lesions, discharge)

5. Examination of the penis (e.g., lesions, presence of absence of foreskin, foreskin retract ability, plaque, masses, scarring, deformities)

6. Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity, tenderness)

7. Inspection of anus and perineum

Genitourinary FEMALE: One bullet for each of the following female pelvic examination(s) (with or without specimen collection for smears and cultures):

1. Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele rectocele)
2. Examination of urethra (e.g., masses, tenderness, scarring)
3. Examination of bladder (e.g., fullness, masses, tenderness)
4. Cervix (e.g., general appearance, lesions, discharge)
5. Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent or support)
6. Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)

Chest: One bullet for both examinations/assessments of both breasts.

1. Inspection of breasts (e.g., symmetry, nipple discharge); and
2. Palpation of breasts and axillae (e.g., masses or lumps, tenderness)

Lymphatic palpation of lymph nodes: Two or more areas is counted as one bullet.

1. Neck
2. Axillae
3. Groin
4. Other

Verify all of the completed examination components listed in the report documents the relevance/relatedness to the injury and or "reasonable and necessity" for that specified patient's condition. Any examination bullet that is not clearly related to the injury or a patient's specific condition will not be counted/considered in the total number of bullets for the level of service.

TABLE III: Medical Decision Making Component (MDM): TABLES A, B, AND C

Overall MDM is determined by the highest 2 out of 3 categories below:

Table III.

Medical Decision Making (MDM) Component			
Type of Decision Making	**A. # of Points for the # of Diagnosis and Management Options**	**B. # of Points for Amount and Complexity of Data**	**C. Level of Risk**
Straightforward	0-1	0-1	Minimal
Low	2	2	Low
Moderate	3	3	Moderate
High	4+	4+	High

TABLE III A:

A. Number of Diagnosis & Management Options					
Category of Problem(s)	**Occurrence of Problem(s)**		**Value**		**Total**
Self-limited or minor problem	(max 2)	X	1		
Established problem, stable or improved		X	1		
Established problem, minor worsening		X	2		
New problem with no additional workup planned or established patient with worsening of condition and no additional workup planned	(max 1)	X	3		
New problem, additional workup planned or established patient with less than anticipated improvement or worsening of condition and additional workup planned		X	4		

TABLE III B:

B. Amount and/or Complexity of Data Reviewed	
Date Type:	Points
Lab(s) ordered and/or reports reviewed	1
X-ray (s) ordered and/or reports reviewed	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than the patient	1
Medicine section (90701-99199) ordered and /or physical therapy records reviewed and commented on progress state whether the patient is progressing and how they are functionally progressing or not and document any planned changes to the plan of care	2
Review and summary of old records and/or discussion with other health provider	2
Independent visualization of images, tracing or specimen	2
TOTAL	

TABLE III C:

C. Table of Risk (the highest one in any category determines the overall risk for this portion.)			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered**	**Management Option(s) Section**
Minimal	One self-limiting or minor problem, e.g., cold, insect bite, tinea corporis, minor non-sutured laceration.	Lab tests requiring venipuncture; Chest X-rays; EKG, EEG; Urinalysis; Ultrasound; KOH prep	Rest; Gargles; Elastic bandages; Superficial dressings
Low	Two or more self-limited or minor problems; One stable chronic illness, e.g., well controlled HTN, DM2, cataract, BPH; Acute, uncomplicated illness or injury, e.g., allergic rhinitis, sprain.	Physiologic tests not under stress, e.g., PFTs; Non-cardiovascular imaging studies with contrast, e.g., barium enema; Superficial needle biopsy; ABG; Skin biopsies	Over the counter drugs; Minor surgery with no identified risk factors; PT/OT; IV fluids w/o additives; Simple or layered closure; Vaccine injection
Moderate	One or more chronic illness with mild exacerbation, progression or side effects of treatment; Two or more stable chronic illnesses; Undiagnosed new problem with uncertain prognosis, e.g., new extremity neurologic complaints; Acute illness with systemic symptoms, e.g., pyelonephritis colitis; Acute complicated injury, e.g., head injury, with brief loss of consciousness.	Physiologic tests under stress, e.g., cardiac stress test; Discography; Diagnostic injections; Deep needle, or incisional biopsies; Cardiovascular imaging studies, with contrast, and no identified risk factors, e.g., arteriogram, cardiac catheterization; Obtain fluid from body cavity, e.g., LP/thoracentesis.	Minor surgery, with identified risk factors; Elective major surgery (open, percutaneous, or endoscopic), with no identified risk factors; Prescription drug management; Therapeutic nuclear medicine; IV fluids, with additives; Closed treatment of fracture or dislocation, without manipulation; Inability to return the injured worker to work and requires detailed functional improvement plan.

High	One or more chronic illness, with severe exacerbation, progression or side effects of treatment; Acute or chronic illness or injury, which poses a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others; An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss.	Cardiovascular imaging studies with contrast, with identified risk factors; Cardiac EP studies; Diagnostic endoscopies, with identified risk factors.	Elective major surgery (open, percutaneous, endoscopic), with identified risk factors; Emergency major surgery; Parenteral controlled substances; Decision not to resuscitate, or to de- escalate care because of poor prognosis; Potential for 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.

Time Component:

- If greater than 50% of a physician's time at an E&M visit is spent either face-to-face with the patient counseling and/or coordination of care, with or without an interpreter, and there is detailed patient specific documentation of the counseling and/or coordination of care, then time can determine the level of service.
- If time is used to establish the level of visit and total amount of time falls in between two levels, then the provider's time shall be more than half way to reaching the higher level.

A. Counseling: Primary care physicians should have *shared decision making conferences* with their patients to *establish viable functional goals* prior to making referrals for diagnostic testing and/or to specialists. Shared decision making occurs when the physician shares with the patient all the treatment alternatives reflected in the Colorado Medical Treatment Guidelines as well as any possible side effects or limitations, and the patient shares with the primary physician their desired outcome from the treatment. Patients should be encouraged to express their goals, outcome expectations and desires from treatment as well as any personal habits or traits that may be impacted by procedures or their possible side effects.

1. The physician's time spent face-to-face with the patient and/or their family counseling him/her or them in one or more of the following:

    - Injury/disease education that includes discussion of diagnostic tests results and a disease specific treatment plan.
    - Return to work
    - Temporary and/or permanent restrictions
    - Self-management of symptoms while at home and/or work
    - Correct posture/mechanics to perform work functions
    - Job task exercises for muscle strengthening and stretching
    - Appropriate tool and equipment use to prevent re-injury and/or worsening of the existing injury/condition
    - Patient/injured worker expectations and specific goals
    - Family and other interpersonal relationships and how they relate to psychological/social issues
    - Discussion of pharmaceutical management (includes drug dosage, specific drug side effects and potential of addiction /problems
    - Assessment of vocational plans (i.e., restrictions as they relate to current and future employment job requirements)

B. Coordination of Care: Coordination of care requires the physician to either call another health care provider (outside of their own clinic) regarding the patient's diagnosis and/or treatment or the physician telephones or visits the employer in person to safely return the patient to work.

Table V: New Patient/Office Consultations Level of Service: CPT consultation criteria must be met before a consultation can be billed for any level of service.

New Patient/ Level of Service (requires all three key components at the same level or higher)	**History**	**Examination**	**Medical Decision Making (MDM)**	**Average Time** (minutes) as listed for the specific CPT© code
99201/99241	Problem Focused (PF)	PF	Straight Forward (SF)	10
99202/99242	Extended PF	EPF	SF	20
99203/99243	Detailed (D)	D	Low	30
99204/99244	Comprehensive (C)	C	Moderate	45
99205/99245	Comprehensive (C)	C	High	60

Table VI: Established Patient Office Visit Level of Service

Established Patient/ Level of Service (Requires at least **two of the three key** components at the same level or higher and one of the two must be MDM)	**History**	**Examination**	**Medical Decision Making (MDM)**	**Average Time** (minutes) as listed for the specific CPT© code
99211	N/A	N/A	N/A	5
99212	Problem Focused (PF)	PF	SF	10
99213	Extended PF	EPF	Low	15
99214	Detailed (D)	D	Moderate	25
99215	Comprehensive (C)	C	High	40

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
36415		$5.10	Routine venipuncture
36416		$5.10	Capillary blood collection
78267		$18.80	Breath tst attain/anal c-14
78268		$160.50	Breath test analysis c-14
80047		$23.34	Metabolic panel ionized ca
80047	QW	$23.34	Metabolic panel ionized ca
80048		$17.75	Metabolic panel total ca
80048	QW	$17.75	Metabolic panel total ca
80050		$49.30	General Health Panel (80053+85004+85027)
80051		$14.72	Electrolyte panel
80051	QW	$14.72	Electrolyte panel
80053		$22.17	Comprehen metabolic panel
80053	QW	$22.17	Comprehen metabolic panel
80055		$100.33	Obstetric panel
80061		$28.10	Lipid panel
80061	QW	$28.10	Lipid panel
80069		$18.22	Renal function panel
80069	QW	$18.22	Renal function panel
80074		$99.98	Acute hepatitis panel
80076		$17.15	Hepatic function panel
80081		$157.11	Obstetric panel
80150		$31.64	Assay of amikacin
80155		$65.57	Drug assay caffeine
80156		$30.57	Assay carbamazepine total
80157		$27.81	Assay carbamazepine free
80158		$37.88	Drug assay cyclosporine
80159		$38.81	Drug assay clozapine
80162		$27.86	Assay of digoxin total
80163		$27.86	Assay of digoxin free
80164		$28.42	Assay dipropylacetic acd tot
80165		$28.42	Dipropylacetic acid free
80168		$34.29	Assay of ethosuximide
80169		$28.83	Drug assay everolimus

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
80170		$34.37	Assay of gentamicin
80171		$36.84	Drug screen quant gabapentin
80173		$30.57	Assay of haloperidol
80175		$27.81	Drug screen quan lamotrigine
80176		$30.84	Assay of lidocaine
80177		$27.81	Drug scrn quan levetiracetam
80178		$13.87	Assay of lithium
80178	QW	$13.87	Assay of lithium
80180		$37.88	Drug scrn quan mycophenolate
80183		$27.81	Drug scrn quant oxcarbazepin
80184		$26.01	Assay of phenobarbital
80185		$27.81	Assay of phenytoin total
80186		$28.88	Assay of phenytoin free
80188		$34.82	Assay of primidone
80190		$102.00	Assay of procainamide
80192		$35.16	Assay of procainamide
80194		$30.65	Assay of quinidine
80195		$28.83	Assay of sirolimus
80197		$28.83	Assay of tacrolimus
80198		$29.68	Assay of theophylline
80199		$46.09	Drug screen quant tiagabine
80200		$33.85	Assay of tobramycin
80201		$25.02	Assay of topiramate
80202		$28.42	Assay of vancomycin
80203		$27.81	Drug screen quant zonisamide
80299		$31.69	Quantitative assay drug
80305		$22.88	Drug test prsmv dir opt obs
80305	QW	$22.88	Drug test prsmv dir opt obs
80306		$30.53	Drug test prsmv instrmnt
80307		$122.11	Drug test prsmv chem anlyzr
80400		$68.46	Acth stimulation panel
80402		$182.50	Acth stimulation panel
80406		$164.25	Acth stimulation panel

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
80408		$263.40	Aldosterone suppression eval
80410		$56.24	Calcitonin stimul panel
80412		$1,362.75	Crh stimulation panel
80414		$108.38	Testosterone response
80415		$117.28	Estradiol response panel
80416		$355.84	Renin stimulation panel
80417		$92.33	Renin stimulation panel
80418		$1,216.23	Pituitary evaluation panel
80420		$275.20	Dexamethasone panel
80422		$96.70	Glucagon tolerance panel
80424		$105.98	Glucagon tolerance panel
80426		$311.47	Gonadotropin hormone panel
80428		$140.00	Growth hormone panel
80430		$219.86	Growth hormone panel
80432		$283.54	Insulin suppression panel
80434		$484.55	Insulin tolerance panel
80435		$216.21	Insulin tolerance panel
80436		$191.34	Metyrapone panel
80438		$105.81	Trh stimulation panel
80439		$141.07	Trh stimulation panel
81000		$6.83	Urinalysis nonauto w/scope
81001		$6.66	Urinalysis auto w/scope
81002		$5.92	Urinalysis nonauto w/o scope
81003		$4.71	Urinalysis auto w/o scope
81003	QW	$4.71	Urinalysis auto w/o scope
81005		$4.54	Urinalysis
81007		$50.97	Urine screen for bacteria
81007	QW	$50.97	Urine screen for bacteria
81015		$6.39	Microscopic exam of urine
81020		$7.99	Urinalysis glass test
81025		$14.64	Urine pregnancy test
81050		$6.31	Urinalysis volume measure
81105		$256.51	Hpa-1 genotyping

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
81106		$256.51	Hpa-2 genotyping
81107		$256.51	Hpa-3 genotyping
81108		$256.51	Hpa-4 genotyping
81109		$256.51	Hpa-5 genotyping
81110		$256.51	Hpa-6 genotyping
81111		$256.51	Hpa-9 genotyping
81112		$256.51	Hpa-15 genotyping
81120		$328.53	Idh1 common variants
81121		$502.84	Idh2 common variants
81161		$474.30	Dmd dup/delet analysis
81162		$3,829.98	Brca1&2 seq & full dup/del
81170		$510.00	Abl1 gene
81175		$1,201.93	Asxl1 full gene sequence
81176		$507.69	Asxl1 gene target seq alys
81200		$80.33	Aspa gene
81201		$1,326.00	Apc gene full sequence
81202		$476.00	Apc gene known fam variants
81203		$340.00	Apc gene dup/delet variants
81205		$161.48	Bckdhb gene
81206		$344.11	Bcr/abl1 gene major bp
81207		$303.98	Bcr/abl1 gene minor bp
81208		$364.85	Bcr/abl1 gene other bp
81209		$66.83	Blm gene
81210		$298.18	Braf gene
81211		$4,072.93	Brca1&2 seq & com dup/del
81212		$748.00	Brca1&2 185&5385&6174 var
81213		$940.10	Brca1&2 uncom dup/del var
81214		$2,212.41	Brca1 full seq & com dup/del
81215		$637.93	Brca1 gene known fam variant
81216		$314.70	Brca2 gene full sequence
81217		$637.93	Brca2 gene known fam variant
81218		$507.69	Cebpa gene full sequence
81219		$255.27	Calr gene com variants

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
81220		$946.22	Cftr gene com variants
81221		$165.27	Cftr gene known fam variants
81222		$739.62	Cftr gene dup/delet variants
81223		$848.30	Cftr gene full sequence
81224		$286.88	Cftr gene intron poly t
81225		$495.31	Cyp2c19 gene com variants
81226		$766.55	Cyp2d6 gene com variants
81227		$297.18	Cyp2c9 gene com variants
81228		$1,530.00	Cytogen micrarray copy nmbr
81229		$1,972.00	Cytogen m array copy no&snp
81230		$297.18	Cyp3a4 gene common variants
81231		$297.18	Cyp3a5 gene common variants
81232		$297.18	Dpyd gene common variants
81235		$551.79	Egfr gene com variants
81238		$1,020.00	F9 full gene sequence
81240		$111.67	F2 gene
81241		$128.25	F5 gene
81242		$62.25	Fancc gene
81243		$96.97	Fmr1 gene detection
81244		$76.31	Fmr1 gene characterization
81245		$281.37	Flt3 gene
81246		$141.10	Flt3 gene analysis
81247		$297.18	G6pd gene alys cmn variant
81248		$637.93	G6pd known familial variant
81249		$1,020.00	G6pd full gene sequence
81250		$99.43	G6pc gene
81251		$80.33	Gba gene
81252		$171.90	Gjb2 gene full sequence
81253		$104.58	Gjb2 gene known fam variants
81254		$59.50	Gjb6 gene com variants
81255		$87.47	Hexa gene
81256		$137.17	Hfe gene
81257		$173.84	Hba1/hba2 gene

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
81258		$637.93	Hba1/hba2 gene fam vrnt
81259		$1,020.00	Hba1/hba2 full gene sequence
81260		$66.83	Ikbkap gene
81261		$415.53	Igh gene rearrange amp meth
81262		$116.54	Igh gene rearrang dir probe
81263		$618.12	Igh vari regional mutation
81264		$313.40	Igk rearrangeabn clonal pop
81265		$451.33	Str markers specimen anal
81266		$518.18	Str markers spec anal addl
81267		$435.40	Chimerism anal no cell selec
81268		$547.33	Chimerism anal w/cell select
81269		$344.08	Hba1/hba2 gene dup/del vrnts
81270		$192.39	Jak2 gene
81272		$560.17	Kit gene targeted seq analys
81273		$212.28	Kit gene analys d816 variant
81275		$328.53	Kras gene variants exon 2
81276		$328.53	Kras gene addl variants
81280		$707.34	Long qt synd gene full seq
81281		$484.50	Long qt synd known fam var
81282		$2,125.00	Long qt syn gene dup/dlt var
81283		$128.25	Ifnl3 gene
81287		$211.89	Mgmt gene methylation anal
81288		$326.94	Mlh1 gene
81290		$66.83	Mcoln1 gene
81291		$111.08	Mthfr gene
81292		$1,148.18	Mlh1 gene full seq
81293		$562.70	Mlh1 gene known variants
81294		$344.08	Mlh1 gene dup/delete variant
81295		$648.89	Msh2 gene full seq
81296		$574.14	Msh2 gene known variants
81297		$362.61	Msh2 gene dup/delete variant
81298		$1,091.15	Msh6 gene full seq
81299		$523.60	Msh6 gene known variants

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
81300		$404.60	Msh6 gene dup/delete variant
81301		$607.72	Microsatellite instability
81302		$897.38	Mecp2 gene full seq
81303		$204.00	Mecp2 gene known variant
81304		$255.00	Mecp2 gene dup/delet variant
81310		$419.08	Npm1 gene
81311		$502.84	Nras gene variants exon 2&3
81313		$433.59	Pca3/klk3 antigen
81314		$560.17	Pdgfra gene
81315		$435.10	Pml/raralpha com breakpoints
81316		$435.10	Pml/raralpha 1 breakpoint
81317		$1,201.93	Pms2 gene full seq analysis
81318		$562.70	Pms2 known familial variants
81319		$345.95	Pms2 gene dup/delet variants
81321		$1,020.00	Pten gene full sequence
81322		$89.85	Pten gene known fam variant
81323		$510.00	Pten gene dup/delet variant
81324		$1,289.21	Pmp22 gene dup/delet
81325		$1,308.29	Pmp22 gene full sequence
81326		$89.85	Pmp22 gene known fam variant
81327		$ -	Sept9 methylation analysis
81328		$297.18	Slco1b1 gene com variants
81330		$79.90	Smpd1 gene common variants
81331		$86.82	Snrpn/ube3a gene
81332		$91.61	Serpina1 gene
81334		$560.17	Runx1 gene targeted seq alys
81335		$297.18	Tpmt gene com variants
81340		$438.46	Trb@ gene rearrange amplify
81341		$104.07	Trb@ gene rearrange dirprobe
81342		$422.89	Trg gene rearrangement anal
81346		$297.18	Tyms gene com variants
81350		$397.80	Ugt1a1 gene
81355		$149.94	Vkorc1 gene

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
81361		$297.18	Hbb gene com variants
81362		$637.93	Hbb gene known fam variant
81363		$344.08	Hbb gene dup/del variants
81364		$551.79	Hbb full gene sequence
81370		$843.97	Hla i & ii typing lr
81371		$687.68	Hla i & ii type verify lr
81372		$686.10	Hla i typing complete lr
81373		$233.72	Hla i typing 1 locus lr
81374		$152.68	Hla i typing 1 antigen lr
81375		$463.28	Hla ii typing ag equiv lr
81376		$256.51	Hla ii typing 1 locus lr
81377		$192.70	Hla ii type 1 ag equiv lr
81378		$725.27	Hla i & ii typing hr
81379		$703.89	Hla i typing complete hr
81380		$372.01	Hla i typing 1 locus hr
81381		$288.83	Hla i typing 1 allele hr
81382		$259.57	Hla ii typing 1 loc hr
81383		$229.04	Hla ii typing 1 allele hr
81400		$108.73	Mopath procedure level 1
81401		$232.90	Mopath procedure level 2
81402		$255.56	Mopath procedure level 3
81403		$314.84	Mopath procedure level 4
81404		$467.21	Mopath procedure level 5
81405		$512.30	Mopath procedure level 6
81406		$480.90	Mopath procedure level 7
81407		$1,438.66	Mopath procedure level 8
81408		$3,400.00	Mopath procedure level 9
81410		$856.80	Aortic dysfunction/dilation
81411		$2,295.32	Aortic dysfunction/dilation
81412		$4,162.55	Ashkenazi jewish assoc dis
81413		$1,227.57	Car ion chnnlpath inc 10 gns
81414		$1,227.57	Car ion chnnlpath inc 2 gns
81415		$8,126.00	Exome sequence analysis

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
81416		$20,400.00	Exome sequence analysis
81417		$544.00	Exome re-evaluation
81420		$1,290.39	Fetal chrmoml aneuploidy
81422		$1,290.39	Fetal chrmoml microdeltj
81425		$ -	Genome sequence analysis
81426		$ -	Genome sequence analysis
81427		$ -	Genome re-evaluation
81430		$2,762.50	Hearing loss sequence analys
81431		$1,155.27	Hearing loss dup/del analys
81432		$1,425.16	Hrdtry brst ca-rlatd dsordrs
81433		$921.21	Hrdtry brst ca-rlatd dsordrs
81434		$1,016.45	Hereditary retinal disorders
81435		$1,227.57	Hereditary colon ca dsordrs
81436		$1,227.57	Hereditary colon ca dsordrs
81437		$921.21	Heredtry nurondcrn tum dsrdr
81438		$921.21	Heredtry nurondcrn tum dsrdr
81439		$1,227.57	Hrdtry cardmypy gene panel
81440		$5,650.80	Mitochondrial gene
81442		$3,644.12	Noonan spectrum disorders
81445		$1,016.45	Targeted genomic seq analys
81448		$1,227.57	Hrdtry perph neurphy panel
81450		$1,291.20	Targeted genomic seq analys
81455		$4,963.32	Targeted genomic seq analys
81460		$2,187.90	Whole mitochondrial genome
81465		$1,591.20	Whole mitochondrial genome
81470		$ -	X-linked intellectual dblt
81471		$ -	X-linked intellectual dblt
81490		$1,429.11	Autoimmune rheumatoid arthr
81493		$1,785.00	Cor artery disease mrna
81500		$442.85	Onco (ovar) two proteins
81503		$1,524.90	Onco (ovar) five proteins
81504		$884.00	Oncology tissue of origin
81506		$137.75	Endo assay seven anal

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
81507		$1,351.50	Fetal aneuploidy trisom risk
81508		$92.31	Ftl cgen abnor two proteins
81509		$2,528.53	Ftl cgen abnor 3 proteins
81510		$94.42	Ftl cgen abnor three anal
81511		$260.95	Ftl cgen abnor four anal
81512		$118.18	Ftl cgen abnor five anal
81519		$6,584.10	Oncology breast mrna
81520		$5,268.33	Onc breast mrna 58 genes
81521		$6,584.10	Onc breast mrna 70 genes
81525		$5,297.20	Oncology colon mrna
81528		$865.08	Oncology colorectal scr
81535		$985.08	Oncology gynecologic
81536		$301.85	Oncology gynecologic
81538		$4,880.70	Oncology lung
81539		$1,292.00	Oncology prostate prob score
81540		$6,375.00	Oncology tum unknown origin
81541		$6,584.10	Onc prostate mrna 46 genes
81545		$6,120.00	Oncology thyroid
81551		$ -	Onc prostate 3 genes
81595		$5,508.00	Cardiology hrt trnspl mrna
82009		$9.49	Test for acetone/ketones
82010		$17.15	Acetone assay
82010	QW	$17.15	Acetone assay
82013		$23.44	Acetylcholinesterase assay
82016		$29.12	Acylcarnitines qual
82017		$35.41	Acylcarnitines quant
82024		$81.06	Assay of acth
82030		$54.15	Assay of adp & amp
82040		$10.39	Assay of serum albumin
82040	QW	$10.39	Assay of serum albumin
82042		$13.23	Other source albumin quan ea
82042	QW	$13.23	Other source albumin quan ea
82043		$12.14	Ur albumin quantitative

Final Exhibit #8 Clinical Laboratory Fee Schedule			
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HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
82043	QW	$12.14	Ur albumin quantitative
82044		$10.59	Ur albumin semiquantitative
82044	QW	$10.59	Ur albumin semiquantitative
82045		$71.23	Albumin ischemia modified
82075		$51.00	Assay of breath ethanol
82085		$20.38	Assay of aldolase
82088		$85.53	Assay of aldosterone
82103		$28.20	Alpha-1-antitrypsin total
82104		$30.36	Alpha-1-antitrypsin pheno
82105		$35.21	Alpha-fetoprotein serum
82106		$35.21	Alpha-fetoprotein amniotic
82107		$135.18	Alpha-fetoprotein l3
82108		$53.48	Assay of aluminum
82120		$10.18	Amines vaginal fluid qual
82120	QW	$10.18	Amines vaginal fluid qual
82127		$29.12	Amino acid single qual
82128		$29.12	Amino acids mult qual
82131		$39.07	Amino acids single quant
82135		$34.53	Assay aminolevulinic acid
82136		$35.41	Amino acids quant 2-5
82139		$35.41	Amino acids quan 6 or more
82140		$30.58	Assay of ammonia
82143		$15.90	Amniotic fluid scan
82150		$13.60	Assay of amylase
82150	QW	$13.60	Assay of amylase
82154		$60.52	Androstanediol glucuronide
82157		$61.44	Assay of androstenedione
82160		$52.48	Assay of androsterone
82163		$43.08	Assay of angiotensin ii
82164		$30.65	Angiotensin i enzyme test
82172		$35.85	Assay of apolipoprotein
82175		$39.81	Assay of arsenic
82180		$20.74	Assay of ascorbic acid

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
82190		$31.30	Atomic absorption
82232		$33.95	Assay of beta-2 protein
82239		$35.94	Bile acids total
82240		$55.78	Bile acids cholylglycine
82247		$10.52	Bilirubin total
82247	QW	$10.52	Bilirubin total
82248		$10.52	Bilirubin direct
82252		$9.57	Fecal bilirubin test
82261		$35.41	Assay of biotinidase
82270		$7.45	Occult blood feces
82271		$9.04	Occult blood other sources
82271	QW	$9.04	Occult blood other sources
82272		$7.19	Occult bld feces 1-3 tests
82274		$33.39	Assay test for blood fecal
82274	QW	$33.39	Assay test for blood fecal
82286		$10.83	Assay of bradykinin
82300		$48.59	Assay of cadmium
82306		$62.14	Vitamin d 25 hydroxy
82308		$56.24	Assay of calcitonin
82310		$10.83	Assay of calcium
82310	QW	$10.83	Assay of calcium
82330		$28.70	Assay of calcium
82330	QW	$28.70	Assay of calcium
82331		$22.68	Calcium infusion test
82340		$12.65	Assay of calcium in urine
82355		$24.29	Calculus analysis qual
82360		$27.01	Calculus assay quant
82365		$27.06	Calculus spectroscopy
82370		$26.28	X-ray assay calculus
82373		$37.89	Assay c-d transfer measure
82374		$10.25	Assay blood carbon dioxide
82374	QW	$10.25	Assay blood carbon dioxide
82375		$25.86	Assay carboxyhb quant

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
82376		$23.92	Assay carboxyhb qual
82378		$39.80	Carcinoembryonic antigen
82379		$35.41	Assay of carnitine
82380		$19.36	Assay of carotene
82382		$46.41	Assay urine catecholamines
82383		$52.58	Assay blood catecholamines
82384		$53.01	Assay three catecholamines
82387		$37.89	Assay of cathepsin-d
82390		$22.54	Assay of ceruloplasmin
82397		$29.63	Chemiluminescent assay
82415		$26.59	Assay of chloramphenicol
82435		$9.66	Assay of blood chloride
82435	QW	$9.66	Assay of blood chloride
82436		$10.56	Assay of urine chloride
82438		$10.25	Assay other fluid chlorides
82441		$12.61	Test for chlorohydrocarbons
82465		$9.13	Assay bld/serum cholesterol
82465	QW	$9.13	Assay bld/serum cholesterol
82480		$16.52	Assay serum cholinesterase
82482		$16.68	Assay rbc cholinesterase
82485		$43.35	Assay chondroitin sulfate
82495		$42.57	Assay of chromium
82507		$58.36	Assay of citrate
82523		$39.22	Collagen crosslinks
82523	QW	$39.22	Collagen crosslinks
82525		$26.04	Assay of copper
82528		$47.26	Assay of corticosterone
82530		$35.07	Cortisol free
82533		$34.20	Total cortisol
82540		$9.72	Assay of creatine
82542		$40.95	Col chromotography qual/quan
82550		$13.67	Assay of ck (cpk)
82550	QW	$13.67	Assay of ck (cpk)

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
82552		$28.10	Assay of cpk in blood
82553		$24.24	Creatine mb fraction
82554		$24.91	Creatine isoforms
82565		$10.76	Assay of creatinine
82565	QW	$10.76	Assay of creatinine
82570		$10.86	Assay of urine creatinine
82570	QW	$10.86	Assay of urine creatinine
82575		$19.84	Creatinine clearance test
82585		$24.04	Assay of cryofibrinogen
82595		$13.57	Assay of cryoglobulin
82600		$40.72	Assay of cyanide
82607		$31.64	Vitamin b-12
82608		$30.06	B-12 binding capacity
82610		$31.48	Cystatin c
82615		$17.14	Test for urine cystines
82626		$53.04	Dehydroepiandrosterone
82627		$46.67	Dehydroepiandrosterone
82633		$65.03	Desoxycorticosterone
82634		$61.44	Deoxycortisol
82638		$25.70	Assay of dibucaine number
82652		$80.80	Vit d 1 25-dihydroxy
82656		$24.21	Pancreatic elastase fecal
82657		$37.89	Enzyme cell activity
82658		$74.85	Enzyme cell activity ra
82664		$104.55	Electrophoretic test
82668		$39.44	Assay of erythropoietin
82670		$58.63	Assay of estradiol
82671		$67.80	Assay of estrogens
82672		$45.53	Assay of estrogen
82677		$50.75	Assay of estriol
82679		$52.38	Assay of estrone
82679	QW	$52.38	Assay of estrone
82693		$31.28	Assay of ethylene glycol

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
82696		$49.50	Assay of etiocholanolone
82705		$10.69	Fats/lipids feces qual
82710		$35.28	Fats/lipids feces quant
82715		$39.05	Assay of fecal fat
82725		$31.91	Assay of blood fatty acids
82726		$37.89	Long chain fatty acids
82728		$28.61	Assay of ferritin
82731		$135.18	Assay of fetal fibronectin
82735		$38.91	Assay of fluoride
82746		$30.86	Assay of folic acid serum
82747		$36.35	Assay of folic acid rbc
82757		$36.38	Assay of semen fructose
82759		$45.08	Assay of rbc galactokinase
82760		$23.49	Assay of galactose
82775		$44.22	Assay galactose transferase
82776		$19.96	Galactose transferase test
82777		$75.23	Galectin-3
82784		$19.52	Assay iga/igd/igg/igm each
82785		$34.54	Assay of ige
82787		$16.83	Igg 1 2 3 or 4 each
82800		$18.70	Blood ph
82803		$44.32	Blood gases any combination
82805		$133.91	Blood gases w/o2 saturation
82810		$18.31	Blood gases o2 sat only
82820		$22.68	Hemoglobin-oxygen affinity
82930		$11.42	Gastric analy w/ph ea spec
82938		$37.13	Gastrin test
82941		$37.01	Assay of gastrin
82943		$29.99	Assay of glucagon
82945		$8.25	Glucose other fluid
82946		$31.64	Glucagon tolerance test
82947		$8.25	Assay glucose blood quant
82947	QW	$8.25	Assay glucose blood quant

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
82948		$8.57	Reagent strip/blood glucose
82950		$9.96	Glucose test
82950	QW	$9.96	Glucose test
82951		$27.01	Glucose tolerance test (gtt)
82951	QW	$27.01	Glucose tolerance test (gtt)
82952		$8.23	Gtt-added samples
82952	QW	$8.23	Gtt-added samples
82955		$20.35	Assay of g6pd enzyme
82960		$12.70	Test for g6pd enzyme
82962		$5.58	Glucose blood test
82963		$45.08	Assay of glucosidase
82965		$22.36	Assay of gdh enzyme
82977		$15.11	Assay of ggt
82977	QW	$15.11	Assay of ggt
82978		$29.92	Assay of glutathione
82979		$19.82	Assay rbc glutathione
82985		$31.64	Assay of glycated protein
82985	QW	$31.64	Assay of glycated protein
83001		$39.00	Assay of gonadotropin (fsh)
83001	QW	$39.00	Assay of gonadotropin (fsh)
83002		$38.86	Assay of gonadotropin (lh)
83002	QW	$38.86	Assay of gonadotropin (lh)
83003		$34.99	Assay growth hormone (hgh)
83006		$128.52	Growth stimulation gene 2
83009		$141.37	H pylori (c-13) blood
83010		$26.40	Assay of haptoglobin quant
83012		$45.71	Assay of haptoglobins
83013		$141.37	H pylori (c-13) breath
83014		$16.49	H pylori drug admin
83015		$39.53	Heavy metal qual any anal
83018		$46.10	Heavy metal quant each nes
83020		$27.01	Hemoglobin electrophoresis
83021		$37.89	Hemoglobin chromotography

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
83026		$6.82	Hemoglobin copper sulfate
83030		$18.26	Fetal hemoglobin chemical
83033		$13.60	Fetal hemoglobin assay qual
83036		$20.38	Glycosylated hemoglobin test
83036	QW	$20.38	Glycosylated hemoglobin test
83037		$20.38	Glycosylated hb home device
83037	QW	$20.38	Glycosylated hb home device
83045		$11.03	Blood methemoglobin test
83050		$15.39	Blood methemoglobin assay
83051		$15.35	Assay of plasma hemoglobin
83060		$17.36	Blood sulfhemoglobin assay
83065		$15.30	Assay of hemoglobin heat
83068		$17.77	Hemoglobin stability screen
83069		$8.30	Assay of urine hemoglobin
83070		$9.96	Assay of hemosiderin qual
83080		$35.41	Assay of b hexosaminidase
83088		$61.98	Assay of histamine
83090		$35.41	Assay of homocystine
83150		$40.61	Assay of homovanillic acid
83491		$36.79	Assay of corticosteroids 17
83497		$27.06	Assay of 5-hiaa
83498		$57.02	Assay of progesterone 17-d
83500		$47.53	Assay free hydroxyproline
83505		$51.02	Assay total hydroxyproline
83516		$24.21	Immunoassay nonantibody
83516	QW	$24.21	Immunoassay nonantibody
83518		$17.80	Immunoassay dipstick
83518	QW	$17.80	Immunoassay dipstick
83519		$31.28	Ria nonantibody
83520		$29.36	Immunoassay quant nos nonab
83520	QW	$29.36	Immunoassay quant nos nonab
83525		$23.99	Assay of insulin
83527		$27.17	Assay of insulin

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
83528		$33.69	Assay of intrinsic factor
83540		$13.58	Assay of iron
83550		$18.34	Iron binding test
83570		$18.58	Assay of idh enzyme
83582		$29.75	Assay of ketogenic steroids
83586		$26.86	Assay 17- ketosteroids
83593		$55.20	Fractionation ketosteroids
83605		$22.42	Assay of lactic acid
83605	QW	$22.42	Assay of lactic acid
83615		$12.67	Lactate (ld) (ldh) enzyme
83625		$26.86	Assay of ldh enzymes
83630		$41.21	Lactoferrin fecal (qual)
83631		$41.21	Lactoferrin fecal (quant)
83632		$42.45	Placental lactogen
83633		$19.13	Test urine for lactose
83655		$25.42	Assay of lead
83655	QW	$25.42	Assay of lead
83661		$46.14	L/s ratio fetal lung
83662		$39.70	Foam stability fetal lung
83663		$39.70	Fluoro polarize fetal lung
83664		$39.70	Lamellar bdy fetal lung
83670		$19.23	Assay of lap enzyme
83690		$14.47	Assay of lipase
83695		$27.17	Assay of lipoprotein(a)
83698		$78.73	Assay lipoprotein pla2
83700		$23.63	Lipopro bld electrophoretic
83701		$57.56	Lipoprotein bld hr fraction
83704		$66.22	Lipoprotein bld quan part
83718		$17.20	Assay of lipoprotein
83718	QW	$17.20	Assay of lipoprotein
83719		$24.41	Assay of blood lipoprotein
83721		$20.03	Assay of blood lipoprotein
83721	QW	$20.03	Assay of blood lipoprotein

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
83727		$36.07	Assay of lrh hormone
83735		$14.06	Assay of magnesium
83775		$15.47	Assay malate dehydrogenase
83785		$51.63	Assay of manganese
83789		$40.99	Mass spectrometry qual/quan
83825		$34.12	Assay of mercury
83835		$35.56	Assay of metanephrines
83857		$22.54	Assay of methemalbumin
83861		$38.22	Microfluid analy tears
83861	QW	$38.22	Microfluid analy tears
83864		$48.45	Mucopolysaccharides
83872		$12.31	Assay synovial fluid mucin
83873		$36.11	Assay of csf protein
83874		$27.12	Assay of myoglobin
83876		$86.46	Assay myeloperoxidase
83880		$71.23	Assay of natriuretic peptide
83880	QW	$71.23	Assay of natriuretic peptide
83883		$28.54	Assay nephelometry not spec
83885		$51.44	Assay of nickel
83915		$23.41	Assay of nucleotidase
83916		$46.56	Oligoclonal bands
83918		$40.12	Organic acids total quant
83919		$34.53	Organic acids qual each
83921		$36.06	Organic acid single quant
83930		$13.87	Assay of blood osmolality
83935		$14.31	Assay of urine osmolality
83937		$62.65	Assay of osteocalcin
83945		$27.01	Assay of oxalate
83950		$135.18	Oncoprotein her-2/neu
83951		$135.18	Oncoprotein dcp
83970		$86.63	Assay of parathormone
83986		$7.51	Assay ph body fluid nos
83986	QW	$7.51	Assay ph body fluid nos

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
83987		$7.51	Exhaled breath condensate
83993		$41.21	Assay for calprotectin fecal
84030		$11.54	Assay of blood pku
84035		$7.68	Assay of phenylketones
84060		$15.50	Assay acid phosphatase
84066		$20.28	Assay prostate phosphatase
84075		$10.86	Assay alkaline phosphatase
84075	QW	$10.86	Assay alkaline phosphatase
84078		$15.32	Assay alkaline phosphatase
84080		$31.03	Assay alkaline phosphatases
84081		$34.66	Assay phosphatidylglycerol
84085		$19.82	Assay of rbc pg6d enzyme
84087		$21.66	Assay phosphohexose enzymes
84100		$9.95	Assay of phosphorus
84105		$10.86	Assay of urine phosphorus
84106		$9.89	Test for porphobilinogen
84110		$17.71	Assay of porphobilinogen
84112		$166.79	Eval amniotic fluid protein
84119		$22.71	Test urine for porphyrins
84120		$30.87	Assay of urine porphyrins
84126		$66.49	Assay of feces porphyrins
84132		$9.66	Assay of serum potassium
84132	QW	$9.66	Assay of serum potassium
84133		$9.04	Assay of urine potassium
84134		$30.62	Assay of prealbumin
84135		$40.17	Assay of pregnanediol
84138		$39.73	Assay of pregnanetriol
84140		$43.38	Assay of pregnenolone
84143		$47.87	Assay of 17-hydroxypregneno
84144		$43.79	Assay of progesterone
84145		$56.24	Procalcitonin (pct)
84146		$40.66	Assay of prolactin
84150		$71.01	Assay of prostaglandin

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
84152		$38.61	Assay of psa complexed
84153		$38.61	Assay of psa total
84154		$38.61	Assay of psa free
84155		$7.70	Assay of protein serum
84155	QW	$7.70	Assay of protein serum
84156		$7.70	Assay of protein urine
84157		$7.70	Assay of protein other
84157	QW	$7.70	Assay of protein other
84160		$10.86	Assay of protein any source
84163		$31.60	Pappa serum
84165		$22.54	Protein e-phoresis serum
84166		$37.42	Protein e-phoresis/urine/csf
84181		$35.73	Western blot test
84182		$49.66	Protein western blot test
84202		$30.11	Assay rbc protoporphyrin
84203		$18.07	Test rbc protoporphyrin
84206		$45.37	Assay of proinsulin
84207		$58.97	Assay of vitamin b-6
84210		$24.62	Assay of pyruvate
84220		$19.82	Assay of pyruvate kinase
84228		$24.41	Assay of quinine
84233		$149.40	Assay of estrogen
84234		$136.17	Assay of progesterone
84235		$121.09	Assay of endocrine hormone
84238		$76.74	Assay nonendocrine receptor
84244		$46.16	Assay of renin
84252		$42.47	Assay of vitamin b-2
84255		$53.58	Assay of selenium
84260		$65.03	Assay of serotonin
84270		$45.61	Assay of sex hormone globul
84275		$28.20	Assay of sialic acid
84285		$49.40	Assay of silica
84295		$10.10	Assay of serum sodium

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
84295	QW	$10.10	Assay of serum sodium
84300		$10.20	Assay of urine sodium
84302		$10.20	Assay of sweat sodium
84305		$44.63	Assay of somatomedin
84307		$38.35	Assay of somatostatin
84311		$14.67	Spectrophotometry
84315		$5.58	Body fluid specific gravity
84375		$66.30	Chromatogram assay sugars
84376		$11.54	Sugars single qual
84377		$11.54	Sugars multiple qual
84378		$24.19	Sugars single quant
84379		$24.19	Sugars multiple quant
84392		$9.96	Assay of urine sulfate
84402		$53.47	Assay of free testosterone
84403		$54.18	Assay of total testosterone
84410		$107.64	Testosterone bioavailable
84425		$44.56	Assay of vitamin b-1
84430		$24.41	Assay of thiocyanate
84431		$59.69	Thromboxane urine
84432		$33.71	Assay of thyroglobulin
84436		$14.42	Assay of total thyroxine
84437		$13.57	Assay of neonatal thyroxine
84439		$18.92	Assay of free thyroxine
84442		$31.03	Assay of thyroid activity
84443		$35.28	Assay thyroid stim hormone
84443	QW	$35.28	Assay thyroid stim hormone
84445		$106.73	Assay of tsi globulin
84446		$29.77	Assay of vitamin e
84449		$37.77	Assay of transcortin
84450		$10.86	Transferase (ast) (sgot)
84450	QW	$10.86	Transferase (ast) (sgot)
84460		$11.12	Alanine amino (alt) (sgpt)
84460	QW	$11.12	Alanine amino (alt) (sgpt)

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
84466		$26.79	Assay of transferrin
84478		$12.05	Assay of triglycerides
84478	QW	$12.05	Assay of triglycerides
84479		$13.57	Assay of thyroid (t3 or t4)
84480		$29.77	Assay triiodothyronine (t3)
84481		$35.56	Free assay (ft-3)
84482		$33.08	T3 reverse
84484		$21.20	Assay of troponin quant
84485		$15.11	Assay duodenal fluid trypsin
84488		$15.32	Test feces for trypsin
84490		$16.88	Assay of feces for trypsin
84510		$21.83	Assay of tyrosine
84512		$17.15	Assay of troponin qual
84520		$8.30	Assay of urea nitrogen
84520	QW	$8.30	Assay of urea nitrogen
84525		$8.72	Urea nitrogen semi-quant
84540		$9.96	Assay of urine/urea-n
84545		$13.87	Urea-n clearance test
84550		$9.49	Assay of blood/uric acid
84550	QW	$9.49	Assay of blood/uric acid
84560		$9.96	Assay of urine/uric acid
84577		$35.28	Assay of feces/urobilinogen
84578		$7.60	Test urine urobilinogen
84580		$17.14	Assay of urine urobilinogen
84583		$10.56	Assay of urine urobilinogen
84585		$32.52	Assay of urine vma
84586		$74.15	Assay of vip
84588		$71.23	Assay of vasopressin
84590		$24.36	Assay of vitamin a
84591		$29.00	Assay of nos vitamin
84597		$28.80	Assay of vitamin k
84600		$33.75	Assay of volatiles
84620		$24.87	Xylose tolerance test

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
84630		$23.90	Assay of zinc
84681		$43.69	Assay of c-peptide
84702		$31.60	Chorionic gonadotropin test
84703		$15.79	Chorionic gonadotropin assay
84703	QW	$15.79	Chorionic gonadotropin assay
84704		$31.60	Hcg free betachain test
84830		$21.59	Ovulation tests
85002		$9.47	Bleeding time test
85004		$13.57	Automated diff wbc count
85007		$7.21	Bl smear w/diff wbc count
85008		$7.21	Bl smear w/o diff wbc count
85009		$8.62	Manual diff wbc count b-coat
85013		$11.90	Spun microhematocrit
85014		$4.98	Hematocrit
85014	QW	$4.98	Hematocrit
85018		$4.98	Hemoglobin
85018	QW	$4.98	Hemoglobin
85025		$16.30	Complete cbc w/auto diff wbc
85025	QW	$16.30	Complete cbc w/auto diff wbc
85027		$13.57	Complete cbc automated
85032		$9.04	Manual cell count each
85041		$6.34	Automated rbc count
85044		$9.04	Manual reticulocyte count
85045		$8.38	Automated reticulocyte count
85046		$11.70	Reticyte/hgb concentrate
85048		$5.32	Automated leukocyte count
85049		$9.40	Automated platelet count
85055		$60.76	Reticulated platelet assay
85130		$24.96	Chromogenic substrate assay
85170		$27.71	Blood clot retraction
85175		$34.63	Blood clot lysis time
85210		$27.25	Clot factor ii prothrom spec
85220		$37.04	Blooc clot factor v test

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
85230		$37.57	Clot factor vii proconvertin
85240		$37.57	Clot factor viii ahg 1 stage
85244		$42.86	Clot factor viii reltd antgn
85245		$48.14	Clot factor viii vw ristoctn
85246		$48.14	Clot factor viii vw antigen
85247		$48.14	Clot factor viii multimetric
85250		$39.97	Clot factor ix ptc/chrstmas
85260		$37.57	Clot factor x stuart-power
85270		$37.57	Clot factor xi pta
85280		$40.61	Clot factor xii hageman
85290		$34.29	Clot factor xiii fibrin stab
85291		$18.67	Clot factor xiii fibrin scrn
85292		$39.73	Clot factor fletcher fact
85293		$39.73	Clot factor wght kininogen
85300		$24.87	Antithrombin iii activity
85301		$22.70	Antithrombin iii antigen
85302		$25.21	Clot inhibit prot c antigen
85303		$29.04	Clot inhibit prot c activity
85305		$24.36	Clot inhibit prot s total
85306		$32.16	Clot inhibit prot s free
85307		$32.16	Assay activated protein c
85335		$27.01	Factor inhibitor test
85337		$29.36	Thrombomodulin
85345		$9.04	Coagulation time lee & white
85347		$8.94	Coagulation time activated
85348		$7.82	Coagulation time otr method
85360		$17.65	Euglobulin lysis
85362		$14.47	Fibrin degradation products
85366		$136.78	Fibrinogen test
85370		$23.83	Fibrinogen test
85378		$16.52	Fibrin degrade semiquant
85379		$21.35	Fibrin degradation quant
85380		$21.35	Fibrin degradj d-dimer

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
85384		$17.83	Fibrinogen activity
85385		$24.58	Fibrinogen antigen
85390		$26.32	Fibrinolysins screen i&r
85397		$52.46	Clotting funct activity
85400		$16.17	Fibrinolytic plasmin
85410		$16.17	Fibrinolytic antiplasmin
85415		$36.07	Fibrinolytic plasminogen
85420		$13.70	Fibrinolytic plasminogen
85421		$21.37	Fibrinolytic plasminogen
85441		$8.81	Heinz bodies direct
85445		$14.31	Heinz bodies induced
85460		$16.24	Hemoglobin fetal
85461		$15.91	Hemoglobin fetal
85475		$18.62	Hemolysin acid
85520		$27.47	Heparin assay
85525		$24.85	Heparin neutralization
85530		$27.47	Heparin-protamine tolerance
85536		$13.57	Iron stain peripheral blood
85540		$18.05	Wbc alkaline phosphatase
85547		$18.05	Rbc mechanical fragility
85549		$39.36	Muramidase
85555		$14.03	Rbc osmotic fragility
85557		$28.03	Rbc osmotic fragility
85576		$45.08	Blood platelet aggregation
85576	QW	$45.08	Blood platelet aggregation
85597		$37.72	Phospholipid pltlt neutraliz
85598		$37.72	Hexagnal phosph pltlt neutrl
85610		$8.25	Prothrombin time
85610	QW	$8.25	Prothrombin time
85611		$8.28	Prothrombin test
85612		$29.73	Viper venom prothrombin time
85613		$20.11	Russell viper venom diluted
85635		$20.67	Reptilase test

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
85651		$7.45	Rbc sed rate nonautomated
85652		$5.66	Rbc sed rate automated
85660		$11.56	Rbc sickle cell test
85670		$12.10	Thrombin time plasma
85675		$14.37	Thrombin time titer
85705		$20.21	Thromboplastin inhibition
85730		$12.61	Thromboplastin time partial
85732		$13.57	Thromboplastin time partial
85810		$24.50	Blood viscosity examination
86000		$14.65	Agglutinins febrile antigen
86001		$13.29	Allergen specific igg
86003		$10.95	Allg spec ige crude xtrc ea
86005		$16.73	Allg spec ige multiallg scr
86008		$37.64	Allg spec ige recomb ea
86021		$31.60	Wbc antibody identification
86022		$38.56	Platelet antibodies
86023		$26.15	Immunoglobulin assay
86038		$25.36	Antinuclear antibodies
86039		$23.43	Antinuclear antibodies (ana)
86060		$15.32	Antistreptolysin o titer
86063		$12.10	Antistreptolysin o screen
86140		$10.86	C-reactive protein
86141		$27.17	C-reactive protein hs
86146		$53.41	Beta-2 glycoprotein antibody
86147		$53.41	Cardiolipin antibody ea ig
86148		$33.73	Anti-phospholipid antibody
86152		$515.68	Cell enumeration & id
86155		$33.56	Chemotaxis assay
86156		$14.06	Cold agglutinin screen
86157		$16.92	Cold agglutinin titer
86160		$25.18	Complement antigen
86161		$25.18	Complement/function activity
86162		$42.65	Complement total (ch50)

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
86171		$21.01	Complement fixation each
86200		$27.17	Ccp antibody
86215		$27.80	Deoxyribonuclease antibody
86225		$28.85	Dna antibody native
86226		$25.42	Dna antibody single strand
86235		$37.64	Nuclear antigen antibody
86255		$25.30	Fluorescent antibody screen
86256		$25.30	Fluorescent antibody titer
86277		$33.03	Growth hormone antibody
86280		$17.20	Hemagglutination inhibition
86294		$43.47	Immunoassay tumor qual
86294	QW	$43.47	Immunoassay tumor qual
86300		$43.69	Immunoassay tumor ca 15-3
86301		$43.69	Immunoassay tumor ca 19-9
86304		$43.69	Immunoassay tumor ca 125
86305		$43.69	Human epididymis protein 4
86308		$10.86	Heterophile antibody screen
86308	QW	$10.86	Heterophile antibody screen
86309		$13.57	Heterophile antibody titer
86310		$15.47	Heterophile antibody absrbj
86316		$43.69	Immunoassay tumor other
86317		$31.45	Immunoassay infectious agent
86318		$30.75	Immunoassay infectious agent
86318	QW	$30.75	Immunoassay infectious agent
86320		$50.86	Serum immunoelectrophoresis
86325		$46.94	Other immunoelectrophoresis
86327		$50.86	Immunoelectrophoresis assay
86329		$29.48	Immunodiffusion nes
86331		$25.14	Immunodiffusion ouchterlony
86332		$51.15	Immune complex assay
86334		$46.90	Immunofix e-phoresis serum
86335		$61.59	Immunfix e-phorsis/urine/csf
86336		$32.71	Inhibin a

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
86337		$44.93	Insulin antibodies
86340		$31.64	Intrinsic factor antibody
86341		$41.53	Islet cell antibody
86343		$26.15	Leukocyte histamine release
86344		$17.66	Leukocyte phagocytosis
86352		$285.14	Cell function assay w/stim
86353		$102.90	Lymphocyte transformation
86355		$79.19	B cells total count
86356		$56.20	Mononuclear cell antigen
86357		$79.19	Nk cells total count
86359		$79.19	T cells total count
86360		$98.62	T cell absolute count/ratio
86361		$56.20	T cell absolute count
86367		$132.23	Stem cells total count
86376		$30.53	Microsomal antibody each
86382		$35.50	Neutralization test viral
86384		$23.90	Nitroblue tetrazolium dye
86386		$37.03	Nuclear matrix protein 22
86386	QW	$37.03	Nuclear matrix protein 22
86403		$21.39	Particle agglut antbdy scrn
86406		$22.32	Particle agglut antbdy titr
86430		$11.90	Rheumatoid factor test qual
86431		$11.90	Rheumatoid factor quant
86480		$130.08	Tb test cell immun measure
86481		$170.00	Tb ag response t-cell susp
86590		$23.19	Streptokinase antibody
86592		$8.96	Syphilis test non-trep qual
86593		$9.25	Syphilis test non-trep quant
86602		$21.35	Antinomyces antibody
86603		$27.01	Adenovirus antibody
86606		$31.60	Aspergillus antibody
86609		$27.03	Bacterium antibody
86611		$21.35	Bartonella antibody

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
86612		$27.08	Blastomyces antibody
86615		$27.68	Bordetella antibody
86617		$32.52	Lyme disease antibody
86618		$35.73	Lyme disease antibody
86618	QW	$35.73	Lyme disease antibody
86619		$28.08	Borrelia antibody
86622		$18.75	Brucella antibody
86625		$27.54	Campylobacter antibody
86628		$25.19	Candida antibody
86631		$24.82	Chlamydia antibody
86632		$26.62	Chlamydia igm antibody
86635		$24.09	Coccidioides antibody
86638		$25.45	Q fever antibody
86641		$30.24	Cryptococcus antibody
86644		$30.21	Cmv antibody
86645		$35.36	Cmv antibody igm
86648		$31.91	Diphtheria antibody
86651		$27.68	Encephalitis californ antbdy
86652		$27.68	Encephaltis east eqne anbdy
86653		$27.68	Encephaltis st louis antbody
86654		$27.68	Encephaltis west eqne antbdy
86658		$27.34	Enterovirus antibody
86663		$27.54	Epstein-barr antibody
86664		$32.10	Epstein-barr nuclear antigen
86665		$38.08	Epstein-barr capsid vca
86666		$21.35	Ehrlichia antibody
86668		$24.07	Francisella tularensis
86671		$25.72	Fungus nes antibody
86674		$30.89	Giardia lamblia antibody
86677		$30.45	Helicobacter pylori antibody
86682		$27.30	Helminth antibody
86684		$33.25	Hemophilus influenza antibdy
86687		$17.61	Htlv-i antibody

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
86688		$29.39	Htlv-ii antibody
86689		$40.63	Htlv/hiv confirmj antibody
86692		$36.02	Hepatitis delta agent antbdy
86694		$30.21	Herpes simplex nes antbdy
86695		$27.68	Herpes simplex type 1 test
86696		$40.63	Herpes simplex type 2 test
86698		$26.23	Histoplasma antibody
86701		$18.65	Hiv-1antibody
86701	QW	$18.65	Hiv-1antibody
86702		$28.37	Hiv-2 antibody
86703		$28.76	Hiv-1/hiv-2 1 result antbdy
86704		$25.30	Hep b core antibody total
86705		$24.72	Hep b core antibody igm
86706		$22.54	Hep b surface antibody
86707		$24.28	Hepatitis be antibody
86708		$25.99	Hepatitis a antibody
86709		$23.63	Hepatitis a igm antibody
86710		$28.44	Influenza virus antibody
86711		$30.21	John cunningham antibody
86713		$32.11	Legionella antibody
86717		$25.70	Leishmania antibody
86720		$27.68	Leptospira antibody
86723		$27.68	Listeria monocytogenes
86727		$27.01	Lymph choriomeningitis ab
86732		$27.68	Mucormycosis antibody
86735		$27.39	Mumps antibody
86738		$27.78	Mycoplasma antibody
86741		$27.68	Neisseria meningitidis
86744		$27.68	Nocardia antibody
86747		$31.55	Parvovirus antibody
86750		$27.68	Malaria antibody
86753		$25.99	Protozoa antibody nos
86756		$27.05	Respiratory virus antibody

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
86757		$40.63	Rickettsia antibody
86759		$30.99	Rotavirus antibody
86762		$30.21	Rubella antibody
86765		$27.03	Rubeola antibody
86768		$27.68	Salmonella antibody
86771		$41.62	Shigella antibody
86774		$31.06	Tetanus antibody
86777		$30.21	Toxoplasma antibody
86778		$30.23	Toxoplasma antibody igm
86780		$27.78	Treponema pallidum
86780	QW	$27.78	Treponema pallidum
86784		$26.37	Trichinella antibody
86787		$27.03	Varicella-zoster antibody
86788		$35.36	West nile virus ab igm
86789		$30.21	West nile virus antibody
86790		$27.03	Virus antibody nos
86793		$27.68	Yersinia antibody
86794		$35.36	Zika virus igm antibody
86800		$33.39	Thyroglobulin antibody
86803		$29.94	Hepatitis c ab test
86803	QW	$29.94	Hepatitis c ab test
86804		$32.52	Hep c ab test confirm
86805		$322.17	Lymphocytotoxicity assay
86806		$99.88	Lymphocytotoxicity assay
86807		$133.71	Cytotoxic antibody screening
86808		$62.29	Cytotoxic antibody screening
86812		$54.16	Hla typing a b or c
86813		$121.72	Hla typing a b or c
86816		$58.46	Hla typing dr/dq
86817		$180.44	Hla typing dr/dq
86821		$76.74	Lymphocyte culture mixed
86825		$186.13	Hla x-math non-cytotoxic
86826		$62.10	Hla x-match noncytotoxc addl

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
86828		$109.12	Hla class i&ii antibody qual
86829		$109.12	Hla class i/ii antibody qual
86830		$169.46	Hla class i phenotype qual
86831		$145.25	Hla class ii phenotype qual
86832		$550.38	Hla class i high defin qual
86833		$553.86	Hla class ii high defin qual
86834		$750.43	Hla class i semiquant panel
86835		$677.82	Hla class ii semiquant panel
86850		$16.61	Rbc antibody screen
86880		$11.31	Coombs test direct
86885		$12.02	Coombs test indirect qual
86886		$10.86	Coombs test indirect titer
86900		$6.27	Blood typing serologic abo
86901		$6.27	Blood typing serologic rh(d)
86902		$10.80	Blood type antigen donor ea
86904		$27.78	Blood typing patient serum
86905		$8.04	Blood typing rbc antigens
86906		$16.27	Bld typing serologic rh phnt
86940		$17.22	Hemolysins/agglutinins auto
86941		$25.42	Hemolysins/agglutinins
87003		$35.34	Small animal inoculation
87015		$14.01	Specimen infect agnt concntj
87040		$21.66	Blood culture for bacteria
87045		$19.82	Feces culture aerobic bact
87046		$19.82	Stool cultr aerobic bact ea
87070		$18.09	Culture othr specimn aerobic
87071		$19.82	Culture aerobic quant other
87073		$19.82	Culture bacteria anaerobic
87075		$19.87	Cultr bacteria except blood
87076		$16.95	Culture anaerobe ident each
87077		$16.95	Culture aerobic identify
87077	QW	$16.95	Culture aerobic identify
87081		$13.91	Culture screen only

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
87084		$46.02	Culture of specimen by kit
87086		$16.93	Urine culture/colony count
87088		$16.98	Urine bacteria culture
87101		$16.17	Skin fungi culture
87102		$17.65	Fungus isolation culture
87103		$34.78	Blood fungus culture
87106		$21.66	Fungi identification yeast
87107		$21.66	Fungi identification mold
87109		$32.30	Mycoplasma
87110		$41.12	Chlamydia culture
87116		$22.68	Mycobacteria culture
87118		$24.84	Mycobacteric identification
87140		$11.70	Culture type immunofluoresc
87143		$26.28	Culture typing glc/hplc
87147		$10.86	Culture type immunologic
87149		$42.09	Dna/rna direct probe
87150		$73.66	Dna/rna amplified probe
87152		$13.16	Culture type pulse field gel
87153		$242.11	Dna/rna sequencing
87158		$13.16	Culture typing added method
87164		$22.54	Dark field examination
87166		$23.72	Dark field examination
87168		$8.96	Macroscopic exam arthropod
87169		$8.96	Macroscopic exam parasite
87172		$8.96	Pinworm exam
87176		$12.34	Tissue homogenization cultr
87177		$18.68	Ova and parasites smears
87181		$9.96	Microbe susceptible diffuse
87184		$14.47	Microbe susceptible disk
87185		$9.96	Microbe susceptible enzyme
87186		$18.14	Microbe susceptible mic
87187		$68.29	Microbe susceptible mlc
87188		$13.94	Microbe suscept macrobroth

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
87190		$12.43	Microbe suscept mycobacteri
87197		$31.54	Bactericidal level serum
87205		$8.96	Smear gram stain
87206		$11.31	Smear fluorescent/acid stai
87207		$12.58	Smear special stain
87209		$37.72	Smear complex stain
87210		$9.89	Smear wet mount saline/ink
87210	QW	$9.89	Smear wet mount saline/ink
87220		$8.96	Tissue exam for fungi
87230		$41.43	Assay toxin or antitoxin
87250		$41.06	Virus inoculate eggs/animal
87252		$54.71	Virus inoculation tissue
87253		$42.40	Virus inoculate tissue addl
87254		$41.06	Virus inoculation shell via
87255		$71.08	Genet virus isolate hsv
87260		$25.16	Adenovirus ag if
87265		$25.16	Pertussis ag if
87267		$25.16	Enterovirus antibody dfa
87269		$25.16	Giardia ag if
87270		$25.16	Chlamydia trachomatis ag if
87271		$25.16	Cytomegalovirus dfa
87272		$25.16	Cryptosporidium ag if
87273		$25.16	Herpes simplex 2 ag if
87274		$25.16	Herpes simplex 1 ag if
87275		$25.16	Influenza b ag if
87276		$27.32	Influenza a ag if
87278		$26.52	Legion pneumophilia ag if
87279		$27.93	Parainfluenza ag if
87280		$25.16	Respiratory syncytial ag if
87281		$25.16	Pneumocystis carinii ag if
87283		$103.36	Rubeola ag if
87285		$25.16	Treponema pallidum ag if
87290		$25.16	Varicella zoster ag if

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
87299		$27.37	Antibody detection nos if
87300		$25.16	Ag detection polyval if
87301		$25.16	Adenovirus ag ia
87305		$25.16	Aspergillus ag ia
87320		$25.50	Chylmd trach ag ia
87324		$25.16	Clostridium ag ia
87327		$25.16	Cryptococcus neoform ag ia
87328		$25.16	Cryptosporidium ag ia
87329		$25.16	Giardia ag ia
87332		$25.16	Cytomegalovirus ag ia
87335		$25.16	E coli 0157 ag ia
87336		$27.20	Entamoeb hist dispr ag ia
87337		$25.16	Entamoeb hist group ag ia
87338		$30.19	Hpylori stool ia
87338	QW	$30.19	Hpylori stool ia
87339		$27.20	H pylori ag ia
87340		$21.68	Hepatitis b surface ag ia
87341		$21.68	Hepatitis b surface ag ia
87350		$24.19	Hepatitis be ag ia
87380		$34.44	Hepatitis delta ag ia
87385		$25.16	Histoplasma capsul ag ia
87389		$50.54	Hiv-1 ag w/hiv-1 & hiv-2 ab
87389	QW	$50.54	Hiv-1 ag w/hiv-1 & hiv-2 ab
87390		$40.90	Hiv-1 ag ia
87391		$37.23	Hiv-2 ag ia
87400		$25.16	Influenza a/b ag ia
87420		$25.16	Resp syncytial ag ia
87425		$25.16	Rotavirus ag ia
87427		$25.16	Shiga-like toxin ag ia
87430		$28.58	Strep a ag ia
87449		$25.16	Ag detect nos ia mult
87449	QW	$25.16	Ag detect nos ia mult
87450		$20.13	Ag detect nos ia single

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
87451		$20.13	Ag detect polyval ia mult
87471		$73.66	Bartonella dna amp probe
87472		$89.90	Bartonella dna quant
87475		$42.09	Lyme dis dna dir probe
87476		$73.66	Lyme dis dna amp probe
87480		$42.09	Candida dna dir probe
87481		$73.66	Candida dna amp probe
87482		$94.76	Candida dna quant
87483		$874.74	Cns dna amp probe type 12-25
87485		$42.09	Chylmd pneum dna dir probe
87486		$73.66	Chylmd pneum dna amp probe
87487		$89.90	Chylmd pneum dna quant
87490		$42.09	Chylmd trach dna dir probe
87491		$73.66	Chylmd trach dna amp probe
87492		$90.90	Chylmd trach dna quant
87493		$73.66	C diff amplified probe
87495		$51.05	Cytomeg dna dir probe
87496		$73.66	Cytomeg dna amp probe
87497		$89.90	Cytomeg dna quant
87498		$73.66	Enterovirus probe&revrs trns
87500		$73.66	Vanomycin dna amp probe
87501		$107.70	Influenza dna amp prob 1+
87502		$178.60	Influenza dna amp probe
87502	QW	$178.60	Influenza dna amp probe
87503		$49.67	Influenza dna amp prob addl
87505		$269.25	Nfct agent detection gi
87506		$447.93	Iadna-dna/rna probe tq 6-11
87507		$874.74	Iadna-dna/rna probe tq 12-25
87510		$42.09	Gardner vag dna dir probe
87511		$73.66	Gardner vag dna amp probe
87512		$87.64	Gardner vag dna quant
87516		$73.66	Hepatitis b dna amp probe
87517		$89.90	Hepatitis b dna quant

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
87520		$53.07	Hepatitis c rna dir probe
87521		$73.66	Hepatitis c probe&rvrs trnsc
87522		$89.90	Hepatitis c revrs trnscrpj
87525		$50.66	Hepatitis g dna dir probe
87526		$73.66	Hepatitis g dna amp probe
87527		$87.64	Hepatitis g dna quant
87528		$42.09	Hsv dna dir probe
87529		$73.66	Hsv dna amp probe
87530		$89.90	Hsv dna quant
87531		$98.60	Hhv-6 dna dir probe
87532		$73.66	Hhv-6 dna amp probe
87533		$87.64	Hhv-6 dna quant
87534		$42.09	Hiv-1 dna dir probe
87535		$73.66	Hiv-1 probe&reverse trnscrpj
87536		$178.60	Hiv-1 quant&revrse trnscrpj
87537		$42.09	Hiv-2 dna dir probe
87538		$73.66	Hiv-2 probe&revrse trnscripj
87539		$99.65	Hiv-2 quant&revrse trnscripj
87540		$42.09	Legion pneumo dna dir prob
87541		$73.66	Legion pneumo dna amp prob
87542		$87.64	Legion pneumo dna quant
87550		$42.09	Mycobacteria dna dir probe
87551		$82.01	Mycobacteria dna amp probe
87552		$89.90	Mycobacteria dna quant
87555		$45.70	M.tuberculo dna dir probe
87556		$73.66	M.tuberculo dna amp probe
87557		$89.90	M.tuberculo dna quant
87560		$46.39	M.avium-intra dna dir prob
87561		$73.66	M.avium-intra dna amp prob
87562		$89.90	M.avium-intra dna quant
87580		$42.09	M.pneumon dna dir probe
87581		$73.66	M.pneumon dna amp probe
87582		$514.45	M.pneumon dna quant

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Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
87590		$45.70	N.gonorrhoeae dna dir prob
87591		$73.66	N.gonorrhoeae dna amp prob
87592		$89.90	N.gonorrhoeae dna quant
87623		$73.66	Hpv low-risk types
87624		$73.66	Hpv high-risk types
87625		$73.66	Hpv types 16 & 18 only
87631		$269.25	Resp virus 3-5 targets
87631	QW	$269.25	Resp virus 3-5 targets
87632		$447.93	Resp virus 6-11 targets
87633		$874.74	Resp virus 12-25 targets
87633	QW	$874.74	Resp virus 12-25 targets
87634		$147.32	Rsv dna/rna amp probe
87640		$73.66	Staph a dna amp probe
87641		$73.66	Mr-staph dna amp probe
87650		$42.09	Strep a dna dir probe
87650	QW	$42.09	Strep a dna dir probe
87651		$73.66	Strep a dna amp probe
87651	QW	$73.66	Strep a dna amp probe
87652		$87.64	Strep a dna quant
87653		$73.66	Strep b dna amp probe
87660		$42.09	Trichomonas vagin dir probe
87661		$73.66	Trichomonas vaginalis amplif
87662		$107.70	Zika virus dna/rna amp probe
87797		$51.05	Detect agent nos dna dir
87798		$73.66	Detect agent nos dna amp
87799		$89.90	Detect agent nos dna quant
87800		$84.20	Detect agnt mult dna direc
87801		$147.32	Detect agnt mult dna ampli
87801	QW	$147.32	Detect agnt mult dna ampli
87802		$25.16	Strep b assay w/optic
87803		$27.20	Clostridium toxin a w/optic
87804		$28.14	Influenza assay w/optic
87804	QW	$28.14	Influenza assay w/optic

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
87806		$55.71	Hiv antigen w/hiv antibodies
87806	QW	$55.71	Hiv antigen w/hiv antibodies
87807		$25.16	Rsv assay w/optic
87807	QW	$25.16	Rsv assay w/optic
87808		$25.99	Trichomonas assay w/optic
87808	QW	$25.99	Trichomonas assay w/optic
87809		$36.99	Adenovirus assay w/optic
87809	QW	$36.99	Adenovirus assay w/optic
87810		$59.99	Chylmd trach assay w/optic
87850		$41.75	N. gonorrhoeae assay w/optic
87880		$28.10	Strep a assay w/optic
87880	QW	$28.10	Strep a assay w/optic
87899		$27.32	Agent nos assay w/optic
87899	QW	$27.32	Agent nos assay w/optic
87900		$273.56	Phenotype infect agent drug
87901		$540.33	Genotype dna hiv reverse t
87902		$540.33	Genotype dna/rna hep c
87903		$1,025.58	Phenotype dna hiv w/culture
87904		$54.71	Phenotype dna hiv w/clt add
87905		$25.64	Sialidase enzyme assay
87905	QW	$25.64	Sialidase enzyme assay
87906		$270.16	Genotype dna/rna hiv
87910		$540.33	Genotype cytomegalovirus
87912		$540.33	Genotype dna hepatitis b
88130		$37.72	Sex chromatin identification
88140		$16.76	Sex chromatin identification
88142		$42.52	Cytopath c/v thin layer
88143		$42.52	Cytopath c/v thin layer redo
88147		$85.95	Cytopath c/v automated
88148		$31.89	Cytopath c/v auto rescreen
88150		$24.91	Cytopath c/v manual
88152		$46.99	Cytopath c/v auto redo
88153		$40.85	Cytopath c/v redo

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
88155		$24.91	Cytopath c/v index add-on
88164		$24.91	Cytopath tbs c/v manual
88165		$71.77	Cytopath tbs c/v redo
88166		$24.91	Cytopath tbs c/v auto redo
88167		$24.91	Cytopath tbs c/v select
88174		$44.85	Cytopath c/v auto in fluid
88175		$55.61	Cytopath c/v auto fluid redo
88230		$244.49	Tissue culture lymphocyte
88233		$295.36	Tissue culture skin/biopsy
88235		$309.08	Tissue culture placenta
88237		$265.08	Tissue culture bone marrow
88239		$309.60	Tissue culture tumor
88240		$22.22	Cell cryopreserve/storage
88241		$21.20	Frozen cell preparation
88245		$363.46	Chromosome analysis 20-25
88248		$363.46	Chromosome analysis 50-100
88249		$363.46	Chromosome analysis 100
88261		$449.38	Chromosome analysis 5
88262		$261.60	Chromosome analysis 15-20
88263		$315.42	Chromosome analysis 45
88264		$261.60	Chromosome analysis 20-25
88267		$377.32	Chromosome analys placenta
88269		$349.08	Chromosome analys amniotic
88271		$44.95	Cytogenetics dna probe
88272		$69.19	Cytogenetics 3-5
88273		$67.42	Cytogenetics 10-30
88274		$73.07	Cytogenetics 25-99
88275		$87.02	Cytogenetics 100-300
88280		$56.90	Chromosome karyotype study
88283		$143.97	Chromosome banding study
88285		$45.75	Chromosome count additional
88289		$72.27	Chromosome study additional
88371		$46.65	Protein western blot tissue

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
88372		$47.74	Protein analysis w/probe
88720		$10.52	Bilirubin total transcut
88738		$10.52	Hgb quant transcutaneous
88740		$15.93	Transcutaneous carboxyhb
88741		$15.93	Transcutaneous methb
89050		$9.91	Body fluid cell count
89051		$11.56	Body fluid cell count
89055		$8.96	Leukocyte assessment fecal
89060		$15.01	Exam synovial fluid crystals
89125		$10.00	Specimen fat stain
89160		$8.25	Exam feces for meat fibers
89190		$9.96	Nasal smear for eosinophils
89300		$18.75	Semen analysis w/huhner
89300	QW	$18.75	Semen analysis w/huhner
89310		$18.07	Semen analysis w/count
89320		$25.30	Semen anal vol/count/mot
89321		$25.30	Semen anal sperm detection
89321	QW	$25.30	Semen anal sperm detection
89322		$32.52	Semen anal strict criteria
89325		$22.41	Sperm antibody test
89329		$41.11	Sperm evaluation test
89330		$20.76	Evaluation cervical mucus
89331		$41.11	Retrograde ejaculation anal
0001M		$122.72	Infectious dis hcv 6 assays
0001U		$ -	Rbc dna hea 35 ag 11 bld grp
0002M		$855.78	Liver dis 10 assays w/ash
0002U		$ -	Onc clrct 3 ur metab alg plp
0003M		$855.78	Liver dis 10 assays w/nash
0003U		$1,615.00	Onc ovar 5 prtn ser alg scor
0004M		$ -	Scoliosis dna alys
0005U		$1,292.00	Onco prst8 3 gene ur alg
0006M		$ -	Onc hep gene risk classifier
0006U		$419.76	Rx mntr 120+ drugs & sbsts

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
0007M		$ -	Onc gastro 51 gene nomogram
0007U		$194.53	Rx test prsmv ur w/def conf
0008U		$1,016.45	Hpylori detcj abx rstnc dna
0009M		$ -	Fetal aneuploidy trisom risk
0009U		$ -	Onc brst ca erbb2 amp/nonamp
0010U		$ -	Nfct ds strn typ whl gen seq
0011U		$194.53	Rx mntr lc-ms/ms oral fluid
0012U		$ -	Germln do gene reargmt detcj
0013U		$ -	Onc sld org neo gene reargmt
0014U		$ -	Hem hmtlmf neo gene reargmt
0016U		$344.11	Onc hmtlmf neo rna bcr/abl1
0017U		$192.39	Onc hmtlmf neo jak2 mut dna
G0027		$13.65	Semen analysis
G0103		$38.61	Psa screening
G0123		$42.52	Screen cerv/vag thin layer
G0143		$45.99	Scr c/v cyto,thinlayer,rescr
G0144		$74.75	Scr c/v cyto,thinlayer,rescr
G0145		$55.61	Scr c/v cyto,thinlayer,rescr
G0147		$24.91	Scr c/v cyto, automated sys
G0148		$54.30	Scr c/v cyto, autosys, rescr
G0306		$16.30	Cbc/diffwbc w/o platelet
G0307		$13.57	Cbc without platelet
G0328		$33.39	Fecal blood scrn immunoassay
G0328	QW	$33.39	Fecal blood scrn immunoassay
G0432		$33.27	Eia hiv-1/hiv-2 screen
G0433		$31.09	Elisa hiv-1/hiv-2 screen
G0433	QW	$31.09	Elisa hiv-1/hiv-2 screen
G0435		$25.16	Oral hiv-1/hiv-2 screen
G0471		$8.50	Ven blood coll snf/hha
G0472		$78.80	Hep c screen high risk/other
G0472	QW	$78.80	Hep c screen high risk/other
G0475		$50.54	Hiv combination assay
G0475	QW	$50.54	Hiv combination assay

Final Exhibit #8 Clinical Laboratory Fee Schedule			
Effective for Dates of Service on and after 1/1/2019			
HCPCS	**MOD**	**MAXIMUM FEES**	**SHORTDESC**
G0476		$73.66	Hpv combo assay ca screen
G0480		$194.53	Drug test def 1-7 classes
G0481		$266.20	Drug test def 8-14 classes
G0482		$337.86	Drug test def 15-21 classes
G0483		$419.76	Drug test def 22+ classes
G0499		$59.33	Hepb screen high risk indiv
G0659		$122.11	Drug test def simple all cl
G9143		$253.35	Warfarin respon genetic test
P2028		$10.39	Cephalin floculation test
P2029		$10.39	Congo red blood test
P2031		$10.39	Hair analysis
P2033		$10.39	Blood thymol turbidity
P2038		$10.39	Blood mucoprotein
P3000		$24.91	Screen pap by tech w md supv
P9612		$5.10	Catheterize for urine spec
P9615		$5.10	Urine specimen collect mult
Q0111		$24.91	Wet mounts/ w preparations
Q0112		$9.91	Potassium hydroxide preps
Q0113		$8.96	Pinworm examinations
Q0114		$16.56	Fern test
Q0115		$42.50	Post-coital mucous exam

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
90791		Medicine		9.91	9.60				18-5(G)(6)(b)
90792		Medicine		11.12	10.80				18-5(G)(6)(b)
90889		Medicine		1.40	1.40				18-5(G)(6)(c)
90901		Medicine		2.14	1.14				18-5(G)(3)
90911		Medicine		4.76	2.48				18-5(G)(3)
96101		Medicine		3.00	2.91				18-5(G)(6)(c)
96102		Medicine		1.79	0.65				18-5(G)(6)(c)
96103		Medicine		1.36	1.33				18-5(G)(6)(c)
96116		Medicine		3.40	3.16				18-5(G)(6)(c)
96118		Medicine		4.11	3.31				18-5(G)(6)(c)
96119		Medicine		2.51	0.74				18-5(G)(6)(c)
96120		Medicine		2.30	1.24				18-5(G)(6)(c)
96150		Medicine		0.80	0.79				18-5(G)(6)(c)
96151		Medicine		0.78	0.77				18-5(G)(6)(c)
96152		Medicine		0.74	0.73				18-5(G)(6)(c)
96153		Medicine		0.18	0.17				18-5(G)(6)(c)
96154		Medicine		0.74	0.73				18-5(G)(6)(c)
96155		Medicine		0.73	0.73				18-5(G)(6)(c)
97035		PM&R		0.36	0.00				18-5(H)(7)
97039		PM&R		0.36	0.00				18-5(H)(7)
97139		PM&R		0.92	0.92				18-5(H)(6)
97161		PM&R		1.66	1.66				18-5(H)(8)(b)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
97162		PM&R		2.48	2.48				18-5(H)(8)(b)
97163		PM&R		3.71	3.71				18-5(H)(8)(b)
97164		PM&R		1.60	1.60				18-5(H)(8)(b)
97165		PM&R		1.66	1.66				18-5(H)(8)(b)
97166		PM&R		2.48	2.48				18-5(H)(8)(b)
97167		PM&R		3.71	3.71				18-5(H)(8)(b)
97168		PM&R		1.60	1.60				18-5(H)(8)(b)
97169		PM&R		1.41	1.41				18-5(H)(8)(b)
97170		PM&R		2.10	2.10				18-5(H)(8)(b)
97171		PM&R		3.10	3.10				18-5(H)(8)(b)
97172		PM&R		1.36	1.36				18-5(H)(8)(b)
97545		PM&R		3.40	3.40				18-5(H)(14)(d)
97546		PM&R		1.70	1.70				18-5(H)(14)(d)
98940		Medicine		1.00	0.79				18-5(G)(5)
99000		Division	$ 25.00	1.00	1.00				18-5(G)(14)(a)
99001		Division	$ 25.00	1.00	1.00				18-5(G)(14)(a)
99002		Division	$ 13.00	1.00	1.00				18-5(G)(14)(a)
99100		Anesthesia		1.00	1.00				18-5(C)(5)
99116		Anesthesia		5.00	5.00				18-5(C)(5)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
99135		Anesthesia		5.00	5.00				18-5(C)(5)
99140		Anesthesia		2.00	2.00				18-5(C)(5)
99231		E&M			2.21				18-5(I)(6)(c)
99232		E&M			3.15				18-5(I)(6)(c)
99233		E&M			4.22				18-5(I)(6)(c)
99241		E&M		2.57	2.15				18-5(I)(6)(c)
99242		E&M		3.77	3.18				18-5(I)(6)(c)
99243		E&M		4.71	3.96				18-5(I)(6)(c)
99244		E&M		6.39	5.57				18-5(I)(6)(c)
99245		E&M		8.15	7.23				18-5(I)(6)(c)
99251		E&M			2.79				18-5(I)(6)(c)
99252		E&M			3.83				18-5(I)(6)(c)
99253		E&M			4.95				18-5(I)(6)(c)
99254		E&M			6.39				18-5(I)(6)(c)
99255		E&M			8.47				18-5(I)(6)(c)
0232T		Surgery	$ 269.50		1.00				18-5(D)(8)(c)
A0425		Transportation	$ 18.11	1.00		per Urban mile		Urban	18-6(R)(3)
A0425		Transportation	$ 18.28	1.00		per Rural mile	R	Rural	18-6(R)(3)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
A0425		Transportation	$ 18.28	1.00		per Super Rural mile	B	Super Rural	18-6(R)(3)
A0426		Transportation	$ 680.67					Urban	18-6(R)(3)
A0426		Transportation	$ 687.34				R	Rural	18-6(R)(3)
A0426		Transportation	$ 842.68				B	Super Rural	18-6(R)(3)
A0427		Transportation	$ 1,077.72					Urban	18-6(R)(3)
A0427		Transportation	$ 1,088.29				R	Rural	18-6(R)(3)
A0427		Transportation	$ 1,334.24				B	Super Rural	18-6(R)(3)
A0428		Transportation	$ 567.22					Urban	18-6(R)(3)
A0428		Transportation	$ 572.28				R	Rural	18-6(R)(3)
A0428		Transportation	$ 702.23				B	Super Rural	18-6(R)(3)
A0429		Transportation	$ 907.55					Urban	18-6(R)(3)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
A0429		Transportation	$ 916.45				R	Rural	18-6(R)(3)
A0429		Transportation	$ 1,123.57				B	Super Rural	18-6(R)(3)
A0432		Transportation	$ 992.64					Urban	18-6(R)(3)
A0432		Transportation	$ 1,002.37				R	Rural	18-6(R)(3)
A0432		Transportation	$ 1,002.37				B	Super Rural	18-6(R)(3)
A0433		Transportation	$ 1,559.86					Urban	18-6(R)(3)
A0433		Transportation	$ 1,575.15				R	Rural	18-6(R)(3)
A0433		Transportation	$ 1,931.14				B	Super Rural	18-6(R)(3)
A0434		Transportation	$ 1,843.47					Urban	18-6(R)(3)
A0434		Transportation	$ 1,861.54				R	Rural	18-6(R)(3)
A0434		Transportation	$ 2,282.25				B	Super Rural	18-6(R)(3)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
A0888		Transportation	$ -						18-6(R)(3)
A0998		Transportation	$ -						18-6(R)(3)
A0999		Transportation	$ -						18-6(R)(3)
G0378		Facility Only	$ 45.00	0.00	1.00	per hour			18-6(L)(2)(d)
Q3014		Division	$ 35.00			per 15 min			18-5(J)(4)(c)
S9088		Urgent Care Facility Fee	$ 75.00	1.00	1.00	per episode			18-6(L)(2)(b)
S9122		Home Health	$ 45.00	1.00		per hour			18-6(M)(2)(b)
S9123		Home Health	$ 111.00	1.00		per hour			18-6(M)(2)(a)
S9124		Home Health	$ 89.00	1.00		per hour			18-6(M)(2)(a)
S9326		Home Health	$ 79.00	1.00		Per day			18-6(M)(1)(e)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
S9327		Home Health	$ 103.00	1.00		Per day			18-6(M)(1)(e)
S9328		Home Health	$ 116.00	1.00		Per day			18-6(M)(1)(e)
S9329		Home Health	$ -	1.00		Per day			18-6(M)(1)(c)
S9330		Home Health	$ 91.00	1.00		Per day			18-6(M)(1)(c)
S9331		Home Health	$ 103.00	1.00		Per day			18-6(M)(1)(c)
S9341		Home Health	$ 44.09	1.00		Per day			18-6(M)(1)(d)
S9342		Home Health	$ 24.23	1.00		Per day			18-6(M)(1)(d)
S9343		Home Health	$ 24.23	1.00		Per day			18-6(M)(1)(d)
S9364		Home Health	$ 160.00	1.00		Per day			18-6(M)(1)(a)
S9365		Home Health	$ 174.00	1.00		Per day			18-6(M)(1)(a)
S9366		Home Health	$ 200.00	1.00		Per day			18-6(M)(1)(a)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
S9367		Home Health	$ 227.00	1.00		Per day			18-6(M)(1)(a)
S9368		Home Health	$ 254.00	1.00		Per day			18-6(M)(1)(a)
S9373		Home Health	$ 61.00	1.00		Per day			18-6(M)(1)(f)
S9374		Home Health	$ 85.00	1.00		Per day			18-6(M)(1)(f)
S9375		Home Health	$ 85.00	1.00		Per day			18-6(M)(1)(f)
S9376		Home Health	$ 85.00	1.00		Per day			18-6(M)(1)(f)
S9377		Home Health	$ 85.00	1.00		Per day			18-6(M)(1)(f)
S9494		Home Health	$ 158.00	1.00		Per day			18-6(M)(1)(b)
S9497		Home Health	$ 152.00	1.00		Per day			18-6(M)(1)(b)
S9500		Home Health	$ 97.00	1.00		Per day			18-6(M)(1)(b)
S9501		Home Health	$ 110.00	1.00		Per day			18-6(M)(1)(b)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
S9502		Home Health	$ 122.00	1.00		Per day			18-6(M)(1)(b)
S9503		Home Health	$ 134.00	1.00		Per day			18-6(M)(1)(b)
S9504		Home Health	$ 146.00	1.00		Per day			18-6(M)(1)(b)
Z0200		Division	$ 980.00					Upper body w/Autonomic Stress Testing	18-5(E)(3)(d)
Z0201		Division	$ 980.00					Lower Body w/autonomic Stress Testing	18-5(E)(3)(d)
Z0401		Division	$ 1,066.00			once per WC claim		QSART	18-5(G)(8)(b)
Z0500		Division	negotiated			per program		Interdisciplinary Rehabilitation Programs	18-5(H)(5)
Z0501		PM&R		1.30	0.77	per 15 min		Single or multiple needles - dry needling	18-5(H)(6)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
Z0502		PM&R		0.77	0.72	per 15 min		Each add'l 15 minutes of dry needling	18-5(H)(6)
Z0503		PM&R		0.93	0.93	per 15 min		Computer Enhanced Evaluation	18-5(H)(9)(a)(v)
Z0504		PM&R		0.93	0.93	per 15 min		Work Tolerance Screening	18-5(H)(9)(a)(vi)
Z0505		PM&R		0.23		per day		Unattended Treatment	18-6(H)(11)
Z0601		Division	$ 74.00			per 15 min		Face-to-face or telephonic meeting	18-6(A)(2)
Z0602		Division	$ 74.00			per 15 min		Peer-to-peer review by a treating physician with a medical reviewer	18-6(A)(4)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
Z0701		Division	$ 42.50			per 8 min		Face-to-face or telephone meeting treating with employee (SAMS)	18-6(A)(1)(c)
Z0720		Division	$ 180.00					Cancellation Fee 1/2 usual fee or rate whichever is less	18-6(B)(1)
Z0721		Division	$ 18.53			first 10 or fewer paper page(s)		Copying Fee for first 10 or fewer paper page(s)	18-6(C)
Z0722		Division	negotiated					Interpreter	18-6(Q)
Z0723		Division	$ 0.53			per mile		Mileage for Injured Worker	18-6(E)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
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Z0724		Division	actual paid					Other Travel Expenses for Injured Worker	18-6(E)
Z0725		Division	$ 0.85			per paper page next 11-40 paper page(s)		Copying Fee per paper page for the next 11-40 paper page(s)	18-6(C)
Z0726		Division	$ 0.57			per paper page for remaining paper		Copying Fee per paper page for remaining paper page(s)	18-6(C)
Z0727		Division	$ 1.50			per microfilm		Copying Fee per microfilm page	18-6(C)
Z0728		Division	$ 14.00			per computer disc or as agreed		Copying Fee per computer disc or as agreed	18-6(C)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
Z0729		Division	$ 0.10			per electronic page or as agreed		Copying Fee per electronic page or as agreed	18-6(C)
Z0730		Division	$ 183.50			per 30 min		Prep Time Deposition and Testimony by Physician or Psychologist	18-6(D)(2)
Z0731		Division	$ 183.50			per 30 min		Deposition cancellation 7+ business days	18-6(D)(3)
Z0732		Division	$ 183.50			per 30 min		Deposition cancellation >5 but <7 business days	18-6(D)(3)
Z0733		Division	$ 183.50			per 30 min		Deposition cancellation <5 business days	18-6(D)(3)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
Z0734		Division	$ 183.50			per 30 min		Deposition fee per hr	18-6(D)(3)
Z0735		Division	$ 254.00			per 30 min		Testimony cancellation 7+ business days	18-6(D)(4)
Z0736		Division	$ 254.00			per 30 min		Testimony cancellation >5 but <7 business days	18-6(D)(4)
Z0737		Division	$ 254.00			per 30 min		Testimony cancellation <5 business days	18-6(D)(4)
Z0738		Division	$ 254.00			per 30 min		Testimony Fee	18-6(D)(4)
Z0750		Division	$ 49.00					Initial WC 164	18-6(G)(2)(e)
Z0751		Division	$ 49.00					Progress Report	18-6(G)(2)(e)
Z0752		Division	$ 49.00					Closing Report	18-6(G)(2)(e)
Z0753		Division	$ 49.00					Initial and Closing on same report	18-6(G)(2)(e)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
Z0754		Division	$ 49.00					Completion add'l forms	18-6(G)(3)
Z0755		Division	$ 91.75			per 15 min		Special Report - Written Report only	18-6(G)(4)
Z0756		Division	$ 91.75			per 15 min		Respondent requested IME (RIME)/Report with patient exam	18-6(G)(4)
Z0757		Division	$ 91.75			per 15 min		Special Report - Lengthy Form Completion	18-6(G)(4)
Z0758		Division	$ 91.75			per 15 min		18-5(I)(8) Meeting & Report with Non-treating Physician	18-6(G)(4)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
Z0759		Division	$ 575.00			per exam		Impairment Rating Treating Physician	18-6(F)(4)(b)(i)
Z0760		Division	$ 775.00			per exam		Impairment Rating Referral	18-6(F)(4)(b)(ii)
Z0761		Division	$ 91.75			per 15 min		Special Report - cancellation not requiring patient exam	18-6(G)(4)
Z0762		Division	$ 91.75			per 15 min		Special Report - IME/Report W Patient Exam Cancellation +7 business days	18-6(G)(4)

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RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
Z0763		Division	$ 91.75			per 15 min		Special Report - IME/Report W Patient Exam Cancellation >5 but <7 business days	18-6(G)(4)
Z0764		Division	$ 91.75			per 15 min		Special Report - IME/Report W Patient Exam Cancellation <5 business days	18-6(G)(4)
Z0765		Division	$ 84.00			per 15 min		Chronic Opioid Management	18-8(B)(2)(f)
Z0766		Division	$ 34.00			per exam		CRS 8-43-404 IME Audio Recording	18-6(G)(4)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
Z0767		Division	$ 23.00			per copy		CRS 8-43-404 IME Audio Copying Fee	18-6(G)(4)
Z0768		Division	$ 1,000.00					Division Independent Medical Examination (DIME)/Report with patient exam	18-6(G)(4)
Z0769		Division	$ 1,400.00					DIME/Report with patient exam > 2 years or 3 regions	18-6(G)(4)
Z0770		Division	$ 91.75			per 15 min		Claimant requested IME (CIME)/Report with patient exam	18-6(G)(4)
Z0771		Division	$ 50.00			per report		Acute Opioid Management	18-8(A)(4)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
Z0772		Division	$ 0.53			per mile		Mileage for provider of Home Care	18-6(M)(4)
Z0773		Division	$ 34.00			per hr		Travel Time for provider of Home Care	18-6(M)(5)
Z0790		Division	$ 80.00			per 30 day supply		Category I Compounded Drugs	18-6(N)(6)
Z0791		Division	$ 160.00			per 30 day supply		Category II Compounded Drugs	18-6(N)(6)
Z0792		Division	$ 265.00			per 30 day supply		Category III Compounded Drugs	18-6(N)(6)
Z0793		Division	$ 370.00			per 30 day supply		Category IV Compounded Drugs	18-6(N)(6)
Z0794		Division	$ 30.00			per 30 day supply		Any topical OTC drug except patches	18-6(7)(b)

Final Exhibit #9									
RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
Z0795		Division	$ 70.00			per 30 day supply		OTC patches	18-6(7)(b)
Z0800		Division	$ 99.80			per visit		LAc new patient	18-6(P)(3)(b)(ii)
Z0801		Division	$ 67.60			per visit		LAc established patient	18-6(P)(3)(b)(iii)
Z0802		Division	actual paid			per invoice		Postage	18-6(C)
Z0811		Division	$ 62.00			per episode		Initial functional assessment of pre-injection care	18-8(C)(2)
Z0812		Division	$ 33.00			per episode		Subsequent visit of therapeutic post-injection care	18-8(C)(2)

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RVU Values and Division Z-Codes									
effective 1/1/2019									
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Z0813		Division	$ 744.00					Platelet Rich Plasma injection in an office setting	18-5(D)(8)(b)
Z0814		Division	$ 33.00			per episode		Post-diagnostic injection care	18-8(C)(2)
Z0815		Division	$ 80.00			per episode		QPOP Initial Assessment	18-8(D)(1)(c)
Z0816		Division	$ 40.00			per visit		QPOP subsequent visit	18-8(D)(1)(c)
Z0817		Division	$ 15.00			per form		Rehabilitation Communication Form (WC196)	18-5(H)(8)(c)
Z9999		Division	$ -					Providers reporting Z9999 certify accreditation status	18-5(E)(2)(a)

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RVU Values and Division Z-Codes									
effective 1/1/2019									
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	50	Division			1.50			Bi-Lateral Payment Adjustment	18-5(B)(3)(o)
	51	Division			0.50			Multiple Procedure Modifier	18-5(B)(3)(n)
	62	Division			1.25			Co-Surgeon; distinct procedure	18-5(D)(5)
	73	Division			0.50			Discontinued service prior to Anesthesia	18-6(J)(6)(f)(iv)
	74	Division			1.00			Discontinued service after Anesthesia	18-6(J)(6)(f)(iv)
	80	Division			0.20			Max allowance, Asst Surgeon	18-5(D)(c)

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RVU Values and Division Z-Codes									
effective 1/1/2019									
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	81	Division			0.10			Max allowance, Clinical Nurse Specialist and Registered Surgical Asst	18-5(D)(e)
	82	Division			0.20			Max allowance, Qualified Resident Surgeon	18-5(D)(d)
	95	Division	$ 5.00	1.00	1.00	per visit		Telehealth add-on	18-5(J)(4)(b)
	AA	Anesthesia			1.00				18-5(C)(3)

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RVU Values and Division Z-Codes									
effective 1/1/2019									
CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
	AD	Anesthesia				Maximum allowance: three (3) base anesthesia units for each case, regardless of the number of base anesthesia units assigned to each specific anesthesia episode of care.			18-5(C)(3)
	AS	Division			0.10			Max allowance, AS performed by NP or PA	18-5(D)(e)
	FX	Division			0.80			Film X-Ray	18-5(E)(2)(f)
	P1	Anesthesia			0.00				18-5(C)(4)

Final Exhibit #9									
RVU Values and Division Z-Codes									
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CPT®, HCPCS, or DoWC Z-Code	**Modifier**	**Conversion Factor or Fee Category**	**Rate**	**Non-Facility RVU**	**Facility RVU**	**Billing Increments**	**Indicator**	**Description**	**Rule 18 reference**
	P2	Anesthesia			0.00				18-5(C)(4)
	P3	Anesthesia			1.00				18-5(C)(4)
	P4	Anesthesia			2.00				18-5(C)(4)
	P5	Anesthesia			3.00				18-5(C)(4)
	P6	Anesthesia			0.00				18-5(C)(4)
	QK	Anesthesia			0.50				18-5(C)(3)
	QX	Anesthesia			0.50				18-5(C)(3)
	QY	Anesthesia			0.50				18-5(C)(3)
	QZ	Anesthesia			0.90				18-5(C)(3)

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Office of the Attorney General

Tracking number: 2018-00249

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Workers' Compensation

on 09/10/2018

7 CCR 1101-3

WORKERS' COMPENSATION RULES OF PROCEDURE WITH TREATMENT GUIDELINES

The above-referenced rules were submitted to this office on 09/10/2018 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.

September 28, 2018 15:40:18

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Labor and Employment

Agency

Colorado Uninsured Employers Board

CCR number

7 CCR 1106-1

Rule title

7 CCR 1106-1 Colorado Uninsured Employers Fund 1 - eff 10/30/2018

Effective date

10/30/2018

Rule 1 General Provisions

1-1 The following definitions shall apply unless otherwise indicated in these rules:

1-2 Meetings

(A) The Board shall meet four times per year or more often if a majority of the board determines it is necessary. Meetings shall be noticed as required by law.

(B) All meetings of the Board shall be open to the public and conducted on the record except as permitted by the Colorado Open Meetings Act.

(C) Travel reimbursement to Board members shall be paid in accordance with the rules promulgated by the Colorado State Controller's Office and guidance issued by the CDLE.

1-3 The Board is not an insurer or employer for purposes of the Colorado Workers' Compensation Act or Workers' Compensation Rules of Procedure.

Rule 2 Claims

2-1 Notice to the Board

(A) The CUE Board shall be notified by the Division monthly of any claim deemed or appearing to be uninsured.

(B) Any Application for Hearing or Response to Application for Hearing filed in a claim in which the issue of insurance coverage is endorsed or which is considered uninsured by the Division or which has been accepted by the Board for payment of benefits shall be served upon the Board or its designated representative at the time of filing. Should OAC or the Director issue any Order without proper notice to the Board, said Order shall not be binding upon the Board and may be voided for purposes of applying to the CUE fund at the discretion of the Board upon notice to all parties.

(C) The Board may notify all parties of its intent to join the claim by filing a Response to the Application for Hearing or upon motion and order to join the claim. If the deadline for filing a response to the application for hearing has expired, an extension shall be granted by a prehearing administrative law judge upon good cause shown.

2-2 Initial Application

(A) Application for payment of benefits from the Fund may only be made after issuance of a final order finding the claim to be compensable and the employer to

be uninsured. Any such application shall be made within 90 days of the order becoming final. The Board shall notify the claimant of the 90 day deadline for application.

(B) Where the Board participated in the hearing, the application for benefits may not be rejected unless the Fund is closed pursuant to 3-2(B).

(C) Where the Board received notice and did not participate in the hearing, it is bound by the final order with regard to compensability of the claim. Applications for benefits may only be denied if:

(1) The Board or its agents determine an insured entity such as a statutory employer is responsible for payment of benefits.

(2) The application for benefits appears to be fraudulent.

(3) The Fund has been temporarily closed pursuant to the Board's authority under Rule 3-2

(D) Upon rejection of an initial application for entry into the Fund the Applicant may file an application for hearing to contest the determination of the Board. Any such application for hearing shall be filed within 90 days of the date the Board issues notice the application for benefits was rejected. Notice shall include a statement of the right to apply for hearing within 90 days. Failure to file an application for hearing within the time provided shall be deemed a waiver of the right to appeal.

2-3 Benefits

(A) At the time of initial acceptance into the Fund a Claimant shall be entitled to receive payment for all benefits which accrued prior to the date of acceptance, subject to the benefit levels set by the Board in the annual report required by Rule 3-1 which were applicable at the time the benefits accrued.

(B) At the time of initial acceptance into the Fund all reasonable and necessary medical provider bills which remain unpaid will be paid pursuant to Workers' Compensation Rule of Procedure 16. The injured worker will be reimbursed for any such payments made out of pocket. Any medical bills more than three years old at the time of application must be reviewed by the Board and will be paid only upon a majority vote.

(C) Following acceptance into the Fund, benefits shall be paid in the same manner as workers' compensation benefits paid pursuant to the Workers' Compensation Act, except that:

(1) The Board may modify, terminate or suspend payments from the CUE Fund pursuant to 8-67-107(1)(b).

(2) For any period where payments are so modified, terminated or suspended, the Claimant shall have no claim to accrued payments from the Fund other than medical benefits.

(a) Nothing in this section shall be construed as reducing the liability of the non-insured employer to pay the full amount of benefits as required by the Workers' Compensation Act.

(b) Any bills for medical services which accrue during a period of reduced benefits shall have first priority upon any subsequent increase or resumption of benefits.

(D) Any claimant entitled to receive any benefits under the Workers' Compensation Act must file a notice of entitlement to benefits to the Fund for benefits between February 1 and April 1 of each year.

(1) The Board shall send each claimant that received benefits the prior year a notice form to complete.

(2) Failure to properly file the required notice will result in the suspension of payment of indemnity benefits from the Fund.

(E) Any medical bills authorized and approved and not paid due to a limitation of funds shall be retained by the Board and paid first in the following fiscal year.

2-4 Adjusting Procedures

(A) At any point after acceptance into the Fund the Board may take any action permitted by the Workers' Compensation Act on behalf of the employer.

(1) The employer may object to any action by following the same procedure set forth by statute for claimant to object. Where statute does not provide a procedure for objecting, the employer may request a prehearing conference.

(2) Nothing in this section shall be construed so as to prohibit or prevent the uninsured employer from filing an application for hearing on any contested issues.

(B) The Board will be the only entity permitted to file admissions of liability for accepted claims with the Division of Workers' Compensation

(C) Any admissions filed by the Board shall represent the benefits to which the injured worker is legally entitled under the Workers' Compensation Act, without regard to restrictions on payments from the Fund imposed by the Board due to funding.

(D) Twice a year the Board shall provide the injured worker and Division, on a form designated by the Division, a statement of benefits actually paid by the Board and owed by the employer.

Rule 3 Funding and Review

3-1 Annual Review

(A) On an annual basis the Board shall review funding received the previous year, anticipated funding for the upcoming year as well as actual expenditures for the prior year and anticipated expenditures for the upcoming fiscal year.

(B) On or before June 1 of each year the Board shall release an annual report identifying the benefit level that will be paid for the upcoming fiscal year subject to the Board's authority to lower benefits based on funding levels as set forth in §8-67-107(1)(b). The report shall also include the total number of uninsured claims filed with the Division, the number of claims for which benefits were paid in the previous year, the total amount paid from the Fund to injured workers listed by category of benefit as well as information regarding efforts at recovery from uninsured employers.

3-2 Interim reviews

(A) The Board may at any time review funding levels and issue a modified report.

(B) If funding levels are insufficient to continue paying benefits at the benefit level announced in the annual report the Board may, at its discretion, lower benefit levels for the remainder of the year and/or close the Fund to new applicants.

(1) Any claimant denied access to the Fund upon initial application because of lack of funding may reapply the following fiscal year, provided said claimant is still entitled to receive benefits. Any claimant so admitted will be entitled to have only their outstanding medical bills paid dating back to the date of injury subject to the limitations in Rule 2-3(B).

Rule 4 Medical Providers

4-1 Upon notice of designation a new authorized treating physician, Claimant shall schedule an appointment with the new provider within 30 days or request that the Board or its agent schedule the appointment. The Board may schedule a demand appointment at any time after designation.

4-2 The Board or its agent shall forward all medical reports available, and identifying information for the claimant being referred, to the newly designated physician within 7 days of designation

4-3 The Board or its agent shall include a request to the provider that the claimant be contacted within 7 days to schedule an initial appointment.

CYNTHIA H. COFFMAN
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Office of the Attorney General

Tracking number: 2018-00244

Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado Uninsured Employers Board

on 08/27/2018

7 CCR 1106-1

Colorado Uninsured Employers Fund

The above-referenced rules were submitted to this office on 08/27/2018 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.

September 17, 2018 12:18:26

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Public Safety

Agency

Division of Homeland Security and Emergency Management

CCR number

8 CCR 1507-44

Rule title

8 CCR 1507-44 School Access for Emergency Response (SAFER) Grant Program 1 - eff 10/30/2018

Effective date

10/30/2018

DEPARTMENT OF PUBLIC SAFETY
DIVISION OF HOMELAND SECURITY AND EMERGENCY MANAGEMENT

School Access for Emergency Response

(SAFER) Grant Program

8 CCR 1507-44

STATEMENT OF BASIS, STATUTORY AUTHORITY, AND PURPOSE

Pursuant to Section 24-33.5-2104 (4), C.R.S., the Division of Homeland Security and Emergency Management shall promulgate rules and regulations concerning the administration, criteria and time frames for applying for and distributing funds associated with the grant program.

The General Assembly declared that this act is necessary to better serve schools or public safety network owners in the state by providing funds to improve interoperable communications between schools and first responders. The absence of implementing rules to carry out the purpose of the statute would be contrary to this declaration. For these reasons, it is imperatively necessary that the proposed rules be adopted.

_____ _____

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

8 CCR 1507-44

School Access for Emergency Response (SAFER) Grant Program

1. Authority

This regulation is adopted pursuant to the authority in section 24-33.5-2104 (4), 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 School Access for Emergency Response (SAFER) 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 School Access for Emergency Response (SAFER) grant program that provides grants to schools and public safety communications system owners for the purpose set forth in 24-33.5-2104(2) for interoperable communication hardware, software, equipment maintenance, and training to allow for seamless communications between new or existing school communications systems and first responder communications systems.

"School" means a school district, public school within a school district, local educational agency (LEA), charter school authorized by a school district pursuant to part 1 of article 30.5 of title 22, charter school authorized by the state charter school institute pursuant to part 5 of article 30.5 of title 22, or board of cooperative services created and operating pursuant to article 5 of title 22 that operates one or more public schools.

"Recipient" means an eligible applicant receiving an award.

"Award" means 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.

"Memorandum of understanding" means an agreement between two or more parties that is not legally binding to formalize a working relationship.

"Crisis Management Plan" means a plan including tactical strategies and actions for responding to an emergency.

"Interoperability" means the ability of one or more radio systems to communicate with another radio system and other communications devices.

"Interoperable Technology" means software and/or hardware that enables two different radio systems and other devices to communicate, exchange data and use the information which has been exchanged.

"Other Communications Network" means any public or private wire or wireless communications network that allows for real-time voice or data communications between a public safety 911 answering point,

schools, and first responders.

“Radio System” means a private network for voice communications.

“Safety Teams” means personnel who have role in crisis management plans.

5. Program Requirements

5.1 Eligibility

A. Applicant must be a school or a public safety communications system owner in order to apply.

B. Eligible school applicants are required to have a memorandum of understanding with any of its regional public safety 911 answering point or the local law enforcement agency or agencies which serve the school for communications interoperability 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. The grant funds may only be used for the following purposes:

1. To deliver training programs to teach district-based security personnel and appropriate school personnel basic procedures for effective communications with first responders during an emergency;

2. To implement an interoperable technology solution to provide or to upgrade the following:

- A system or technology that can be activated and deactivated by the public safety 911 answering point, the network administrator, and the school, using both the radio system and other communications networks;

- Radio and other technology bridge ability that is not radio vendor specific for connecting independent school networks across the school district and public safety networks in the regions; and

- An interoperability solution that operates over radio networks and other communications networks;

3. To maintain or improve a school’s existing interoperable communication hardware or software or to provide interoperable communication hardware and/or software to a school that does not yet have it; and

4. For any necessary radio system capacity expansions where school loading has been determined to have significant impact on public safety system loading.

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.

F. Additionally, the following criteria will be evaluated in awarding any grant:

1. The likelihood that funding of the application will improve communications between the school and first responder communication systems.

2. The extent to which the school is fully compliant with the Colorado School Response Framework pursuant to section 22-32-109.1 (4) or 22-30.5-503.5; and

3. Whether the school has a crisis management plan in place with safety team members

designated for communications with first responders.

5.2 Award Details

A. Period of Performance: 6 months for year 1, 12 months for year 2-6 (see below)

B. Funding Instrument: Discretionary Grant

5.3 Time Frames for Application

A. Time Frames

Year 1:

Application Submission Deadline:	December 3, 2018; 5:00 PM MST
Grant Awarded to Applicants Deadline:	December 31, 2018
Grant Fund Distribution Deadline:	January 30, 2019
Period of Performance – 6 months:	December 31, 2018 – June 30, 2019

Year 2- 6 (2019-2023):

Application Submission Deadline:	May 15, 20XX; 5:00 PM MST
Grant Awarded to Applicants Deadline:	July 1, 20XX
Grant Fund Distribution Deadline:	August 1, 20XX
Period of Performance – 12 months:	July 1, 20XX – June 30, 20XX

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 can submit their signed application via U.S. mail or via email as listed in the grant application.

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.

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Office of the Attorney General

Tracking number: 2018-00358

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Homeland Security and Emergency Management

on 09/07/2018

8 CCR 1507-44

School Access for Emergency Response (SAFER) Grant Program

The above-referenced rules were submitted to this office on 09/07/2018 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.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

September 25, 2018 09:09:14

Permanent Rules Adopted

Department

Department of Human Services

Agency

County Personnel and Merit System (Volume 2)

CCR number

9 CCR 2502-1

Rule title

9 CCR 2502-1 RULE MANUAL VOLUME 2, COUNTY PERSONNEL RULES 1 - eff 11/01/2018

Effective date

11/01/2018

DEPARTMENT OF HUMAN SERVICES

County Personnel and Merit System (Volume 2)

RULE MANUAL VOLUME 2, COUNTY PERSONNEL RULES

9 CCR 2502-1

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

STATEMENT OF BASIS AND PURPOSE, FISCAL IMPACT AND SPECIFIC STATUTORY AUTHORITY OF REVISIONS MADE TO VOLUME 2

Revisions to sections 2.221; 2.241.1; 2.240.21 through 2.240.9 were finally adopted at the 12/6/85 State Board meeting with an effective date of 2/1/86 (Document 2). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 2.221; 2.221.1; 2.221.22; 2.421.5; 2.423.4; 2.425.2; were finally adopted and sections 2.600 through 2.610.2 were deleted at the 12/6/85 State Board meeting with an effective date of 2/1/86 (Document 1). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 2.113.13, 2.113.14; 2.113.32; 2.212 were finally adopted at the 7/11/86 State Board meeting with an effective date of 9/1/86 (Document 1). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Rewrite of Volume 2 Staff Manual was finally adopted at the 11/7/86 State Board meeting with an effective date of 1/1/87 (Document 16). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 2.040 through 2.980 were finally adopted following publication at the 5/1/87 State Board meeting, with an effective date of 7/1/87 (Document 1). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to section 2.272 were finally adopted following publication at the 6/5/87 State Board meeting with an effective date of 9/1/87 (Document 11). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 2.000 through 2.980 were finally adopted following publication at the 9/11/87 State Board meeting, with an effective date of 11/1/87 (Document 23). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 2.272 and 2.424 through 2.428 were finally adopted following publication at the 11/6/87 State Board meeting, with an effective date of 1/1/88 (Documents 2 and 5). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 2.000 – 2.031, 2.800 – 8.822 and 2.980 were finally adopted following publication at the 5/6/88 State Board meeting, with an effective date of 7/1/88 (CSPR# 87-12-29-1). Statement of Basis and Purpose, Fiscal Impact, and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Administrator, Department of Social Services.

Revisions to sections 2.221 – 2.242, 2.531 – 2.532, 2.642 – 2.660, 2.800 – 8.811, 2.850 – 2.880, 2.930 and "Definitions" were finally adopted following publication at the 11/4/88 State Board meeting, with an effective date of 1/1/89 (CSPR# 88-8-26-1, 88-8-26-2. and 88-8-29-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions and additions to sections 2.000 – 2.031, 2.035, 2.424 – 2.426 and 2.531 – 2.532 were finally adopted following publication at the 2/3/89 State Board meeting, with an effective date of 4/1/89 (CSPR# 88-11-2-1 and 88-11-21-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 2.532 were adopted emergency at the 6/2/89 State Board meeting, with an effective date of 6/2/89 (CSPR# 89-4-26-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 2.532 were final adoption of emergency at the 7/7/89 State Board meeting, with an effective date of 6/2/89 (CSPR# 89-4-26-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 2.000 – 2.031 were final adoption following publication at the 10/6/89 State Board meeting, with an effective date of 12/1/89 (CSPR# 89-2-22-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 2.035, 2.246–2.261, 2.272, 2.531–2.532 and 2.812 were final adoption following publication at the 11/3/89 State Board meeting, with an effective date of 1/1/90 (CSPR#'s 89-7-31-1 and 89-8-17-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 2.272 were final adoption following publication at the 2/2/90 State Board meeting, with an effective date of 4/1/90 (CSPR# 89-12-13-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 2.900 – 2.910 and 2.920 – 2.930 were final adoption following publication at the 10/5/90 State Board meeting, with an effective date of 12/1/90 (CSPR# 90-2-1-1). Statement of Basis and

Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 2.200 – 2.264, 2.272, and Definitions were final adoption following publication at the 11/2/90 State Board meeting, with an effective date of 2/1/91 (CSPR# 90-8-7-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 2.000 – 2.031, 2.032, 2.222 – 2.240 and 2.270 – 2.272 were final adoption following publication at the 11/1/91 State Board meeting, with an effective date of 1/1/92 (CSPR#'s 91-8-20-2 and 91-8-20-3). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 2.400 and 2.429 through 2.453 were adopted emergency at the 12/6/91 State Board meeting, with an effective date of 1/1/92 (CSPR# 91-11-18-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 2.400 and 2.429 through 2.453 were final adoption of emergency at the 1/10/92 State Board meeting, with an effective date of 1/1/92 (CSPR# 91-11-18-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 2.400 – 2.423 and 2.700 – 2.741 were final adoption following publication at the 1/10/92 State Board meeting, with an effective date of 3/1/92 (CSPR# 91-9-24-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 2.272 were final adoption following publication at the 5/1/92 State Board meeting, with an effective date of 7/1/92 (CSPR# 92-2-26-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 2.300 – 2.321, 2.524 – 2.532, 2.653 – 2.741, and 2.822 – 2.840 were final adoption following publication at the 10/2/92 State Board meeting, with an effective date of 12/1/92 (CSPR# 92-7-27-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 2.272 were final adoption following publication at the 11/6/92 State Board meeting, with an effective date of 1/1/93 (CSPR# 92-7-27-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 2.100 – 2.112, 2.300 – 2.335, 2.354 – 2.423, and 2.524 – 2.730 were final adoption following publication at the 11/5/93 State Board meeting, with an effective date of 1/1/94 (CSPR# 93-8-9-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 2.200 – 2.221, 2.251 – 2.264, 2.800 – 2.890, and “Definitions” were final adoption following publication at the 12/3/93 State Board meeting, with an effective date of 2/1/94 (CSPR# 93-8-26-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to sections 2.100 – 2.110, 2.246, 2.341 – 2.354, 2.427 – 2.453, 2.600 – 2.642, 2.700 – 2.750, 2.822 – 2.830, and “Definitions” were final adoption following publication at the 3/4/94 State Board meeting, with an effective date of 5/1/94 (CSPR# 93-12-21-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of the State Board Liaison, Department of Social Services.

Revisions to section 2.272 were final adoption following publication at the 8/5/94 State Board meeting, with an effective date of 11/1/94 (CSPR# 94-5-13-3). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of External Affairs, Department of Human Services.

Revisions to sections 2.270 through 2.272 were final adoption following publication at the 11/4/94 State Board meeting, with an effective date of 1/1/95 (CSPR# 94-8-25-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of External Affairs, Department of Human Services.

Revisions to sections 2.040 – 2.264, 2.354 – 2.453, 2.532, 2.632 – 2.660, 2.742, 2.921 – 2.930, and “Definitions” were final adoption following publication at the 8/4/95 State Board meeting, with an effective date of 10/1/95 (CSPR# 95-4-21-2). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of External Affairs, Department of Human Services.

Revisions to sections 2.272 and 2.920 were final adoption following publication at the 11/3/95 State Board meeting, with an effective date of 1/1/96 (CSPR#'s 95-7-28-1 and 95-8-22-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of External Affairs, Department of Human Services.

Revisions to sections 2.270 through 2.272 were final adoption following publication at the 11/8/96 State Board meeting, with an effective date of 1/1/97 (CSPR# 96-8-15-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of External Affairs, Department of Human Services.

Revisions to sections 2.246, 2.272, 2.600 through 2.636, and 2.900 through 2.980 were final adoption following publication at the 3/7/97 State Board meeting, with an effective date of 5/1/97 (CSPR# 96-12-27-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of External Affairs, Department of Human Services.

Revisions to sections 2.000 through 2.030 were final adoption following publication at the 8/1/97 State Board meeting, with an effective date of 10/1/97 (CSPR# 97-6-13-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of External Affairs, Department of Human Services.

Revisions to sections 2.200 and 2.272 were final adoption following publication at the 11/7/97 State Board meeting, with an effective date of 1/1/98 (CSPR# 97-7-24-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These

materials are available for review by the public during normal working hours at the Office of External Affairs, Department of Human Services.

Revisions to section 2.200 Table of Contents and sections 2.230 – 2.232 were final adoption following publication at the 10/2/98 State Board meeting, with an effective date of 12/1/98 (CSPR# 98-8-4-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of External Affairs, Department of Human Services.

Revisions to sections 2.272 through 2.280, 2.341 through 2.351, 2.520 through 2.531, and 2.620 through 2.640 were final adoption following publication at the 11/6/98 State Board meeting, with an effective date of 1/1/99 (CSPR#s 98-8-21-1 and 98-8-26-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of External Affairs, Department of Human Services.

Revisions to sections 2.272 through 2.280 were final adoption following publication at the 11/5/99 State Board meeting, with an effective date of 1/1/2000 (CSPR# 99-7-30-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Office of External Affairs, Department of Human Services.

Entirely rewritten manual was final adoption following publication at the 05/04/2001 State Board meeting, with an effective date of 7/1/2001 (CSPR# 00-10-23-1). Statement of Basis and Purpose and specific statutory authority for these revisions were incorporated by reference into the rule. These materials are available for review by the public during normal working hours at the Colorado Department of Human Services, Office of Performance Improvement. Boards and Commissions Division.

2.000 COUNTY PERSONNEL

2.100 COUNTY RESPONSIBILITIES

Effective January 1, 2001, statutory authority for State administered county merit systems was repealed.

Each county shall provide for a merit system for the selection, retention, and promotion of employees of the county department of human/social services. The county's merit system for personnel administration shall meet the criteria set forth in these rules and the Federal Regulations issued by the Office of Personnel Management of the U.S Department of Health and Human Services found at 5 C.F.R Section 900.601 et seq (2018) which are hereby incorporated by reference. No later editions or amendments are incorporated. These regulations are available at no cost from the U.S Services Administration, Office of Communications, 5600 Fishers Lane, Rockville, MD 20857, or at http://www.ecfr.gov/. These regulations are also available for public inspection and copying at the Colorado Department of Human Services, Office of Community Partnerships, 1575 Sherman St. Denver, CO 80203, during regular business hours.

A county may combine with another county or group of counties to form a district to provide a merit system for its employees.

2.200 MINIMUM CRITERIA FOR THE COUNTY MERIT SYSTEM

The county merit system shall provide for the following:

A. The recruitment, selection, and advancement of employees shall be on the basis of relative abilities, knowledge, and skills, including open consideration of qualified applicants for initial appointment.

B. The system shall provide equitable and adequate compensation.

C. The employees shall be trained as needed to assure high quality of performance.

D. The system shall provide for retaining employees on the basis of the adequacy of their performance, correcting inadequate performance, and separating employees whose inadequate performance cannot be corrected.

E. The system shall assure fair treatment of applicants and employees in all aspects of personnel administration without regard to political affiliation, race, color, national origin, sex, religious creed, age, or disability and with proper regard for the privacy and constitutional rights of such persons as citizens. This fair treatment principle shall include compliance with all Federal equal opportunity and nondiscrimination laws.

F. The system shall assure that employees are protected against coercion for partisan political purposes and are prohibited from using their official authority for the purpose of interfering with or affecting the results of an election or a nomination for office.

Annual Certification of Merit System

Each county shall annually submit to the Colorado Department of Human Services a certification that the above criteria are being maintained by the county department of human/social services. This certification must be received as prescribed by the State Department on or before January 1 of each year. The certification must be validated by the county board of commissioners or designee.

2.300 MINIMUM QUALIFICATIONS FOR COUNTY MERIT SYSTEM POSITIONS

Minimum qualifications for certain positions are established as determined by the State Board of Human Services to necessitate uniform standards.

Minimum Qualifications for Professional Services in Child Welfare or Adult Protective Services

The county merit system shall adhere to the following minimum qualifications or standards in the hiring, retention, and promotion of employees who supervise or provide professional services in child welfare, as outlined in 12 CCR 2509-7, 7.603.1, or adult protective services, as outlined in 12 CCR 2518-1, 30.310.

Waiver Process

If proven recruitment difficulties exist, county departments may request a waiver of educational and/or training requirements as per 12 CCR 2509-7, 7.603.1 (G-H) for child welfare services and as per 12 CCR 2518-1, 30.310 (B) for adult protective services.

2.400 MAXIMUM SALARY REIMBURSEMENT LEVEL FOR COUNTIES

The maximum salary reimbursement level shall not exceed the amount authorized for salaries by the county's merit system.

Editor’s Notes

History

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Office of the Attorney General

Tracking number: 2018-00292

Opinion of the Attorney General rendered in connection with the rules adopted by the

County Personnel and Merit System (Volume 2)

on 09/07/2018

9 CCR 2502-1

RULE MANUAL VOLUME 2, COUNTY PERSONNEL RULES

The above-referenced rules were submitted to this office on 09/14/2018 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.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

September 25, 2018 09:06:05

Permanent Rules Adopted

Department

Department of Human Services

Agency

Income Maintenance (Volume 3)

CCR number

9 CCR 2503-1

Rule title

9 CCR 2503-1 GENERAL RULES 1 - eff 11/01/2018

Effective date

11/01/2018

DEPARTMENT OF HUMAN SERVICES

Income Maintenance (Volume 3)

GENERAL RULES

9 CCR 2503-1

3.100 (RESERVED FOR FUTURE USE)

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Tracking number: 2018-00290

Opinion of the Attorney General rendered in connection with the rules adopted by the

Income Maintenance (Volume 3)

on 09/07/2018

9 CCR 2503-1

GENERAL RULES

The above-referenced rules were submitted to this office on 09/13/2018 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.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

September 25, 2018 09:07:05

Permanent Rules Adopted

Department

Department of Human Services

Agency

Income Maintenance (Volume 3)

CCR number

9 CCR 2503-2

Rule title

9 CCR 2503-2 GENERAL FINANCIAL ELIGIBILITY CRITERIA 1 - eff 11/01/2018

Effective date

11/01/2018

DEPARTMENT OF HUMAN SERVICES

Income Maintenance (Volume 3)

GENERAL FINANCIAL ELIGIBILITY CRITERIA

9 CCR 2503-2

3.200 (RESERVED FOR FUTURE USE)

=====

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Tracking number: 2018-00291

Opinion of the Attorney General rendered in connection with the rules adopted by the

Income Maintenance (Volume 3)

on 09/07/2018

9 CCR 2503-2

GENERAL FINANCIAL ELIGIBILITY CRITERIA

The above-referenced rules were submitted to this office on 09/13/2018 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.

September 25, 2018 09:06:54

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Human Services

Agency

Income Maintenance (Volume 3)

CCR number

9 CCR 2503-5

Rule title

9 CCR 2503-5 ADULT FINANCIAL PROGRAMS 1 - eff 11/01/2018

Effective date

11/01/2018

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3.520.71 Financial Eligibility Requirements [Eff. 6/1/15]

A. To receive Adult Financial program assistance, the client shall meet all financial requirements in addition to all other program eligibility requirements. The client shall:

1. Have countable resources below the resource limit as outlined in Section 3.520.72; and,
2. Have income below the income limit, as outlined in Section 3.520.78; and,
3. Make reasonable attempts to pursue all available income and resources at the client's disposal.

B. The AND-SO client shall apply for Supplemental Security Income (SSI) benefits. If the client has work hours during his/her lifetime, the client shall also apply for Social Security Disability Insurance (SSDI). The client shall appeal all negative decisions regarding their SSI eligibility. Failure to appeal all negative decisions shall result in denial or discontinuation of AND benefits. For OAP, the client shall apply for Social Security and/or SSI benefits, as follows:

1. Clients sixty (60) years of age and older who report a disability may be eligible for SSI or SSDI.
2. Clients sixty (60) years of age and older may be eligible for Social Security survivor benefits.
3. Clients sixty-two (62) years of age and older may be eligible for early Social Security retirement benefits; otherwise the client shall provide documentation from the SSA that he/she is ineligible due to insufficient work hours.
4. Clients sixty-five (65) years of age and older may be eligible for Social Security retirement benefits and/or SSI benefits when the client's income from any source is less than the SSI grant standard plus $20.00.

C. For all Adult Financial programs other than AND-SO, clients referred to the SSA to apply for any SSA related benefit shall be required to provide verification of application for such benefits within ten (10) calendar days of application for SSA benefits.

For AND-SO, clients referred to the SSA to apply for any SSA related benefit shall be required to provide verification of application for such benefits within sixty (60) calendar days from the initial interview date with the county department. The client will have up to sixty days of conditional approval from the date of the initial interview with the county department for AND-SO. Subsequent applications for AND-SO submitted by the client shall not be approved prior to receipt of proof of application for SSA benefits. Subsequent applications for AND-SO require verification of application for SSA benefits within thirty (30) calendar days.

D. For OAP, the client shall apply for SSI or continue to appeal negative decisions unless good cause is provided. Good cause is defined as follows:

1. The client's and the client's spouse's gross income exceeds the maximum allowed for SSI for an individual or a couple; or,
2. The client's and the client's spouse's total resources exceed that allowed for SSI for an individual or a couple; or,
3. The client is not disabled as defined in Section 3.541; or,
4. As otherwise directed by the SSA.

E. Clients newly approved for SSI benefits who have been charged an in-kind support and maintenance (ISM) deduction by the SSA shall apply to SSA to remove the ISM as soon as the client begins paying his/her fair share for shelter costs. The county department shall deduct an identical ISM amount for Adult Financial programs until the SSA ISM is removed.

F. The client shall apply for TANF/Colorado Works when he/she might be eligible, as follows:

1. An Adult Financial program client with a dependent child is required to apply for and accept, if eligible, TANF/Colorado Works financial benefits.

a. A grandparent or any other specified caretaker who is not a parent is not required to be a member of the TANF/Colorado Works case when they are not requesting assistance for his/herself.

b. A TANF/Colorado Works client is not required to apply for an extension to be potentially eligible for Adult Financial program benefits.

c. The TANF/Colorado Works funds received for the support of a child are not used in determining the specified caretaker's eligibility for Adult Financial program benefits.

2. The client shall be ineligible for Adult Financial program benefits if his/her TANF/Colorado Works case was denied or discontinued:

a. Due to a sanction or disqualification; or,

b. Because the client withdrew from the program prior to exhausting all benefits; and,

c. The ineligibility period shall continue until the sanction or disqualification is removed or until the client rejoins the program and has exhausted all TANF/Colorado Works benefits.

G. The client shall apply for any other retirement income for which the client is eligible.

H. The client shall take reasonable steps to pursue all other income and resources that may be available, to include, but not be limited to, alimony, equitable distribution of resources in a divorce, inheritance income or resources, child support arrears, co-ownership of property, lottery or sweepstakes winnings that are due to the client, lawsuit judgments that are due to the client, or insurance settlements, unless it is demonstrated that good cause exists.

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3.540.1 DEFINITIONS [Eff. 3/2/14]

“Administrative error” means the county department incorrectly applied the disability certification, as documented on the medical certification form, and/or incorrectly applied the social factors used to determine the client's residual functional capacity.

“Aid to the Needy Disabled (AND)” includes the Aid to the Needy Disabled-State Only (AND-SO), which include persons disabled due to blindness, and the Aid to the Needy Disabled-Colorado Supplement (AND-CS) programs.

“Blind or blindness” means central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which has a limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having a central visual acuity of 20/200 or less.

“Disability” means a physical or mental impairment that is disabling and combined with other factors impacting the client's residual functional capacity substantially precludes the client from engaging in a useful occupation in any employment in the community for which he/she has competence as a wage earner or through self-employment. Disability also means blindness, as defined in this Section.

“Disability determination error” means the prior determination of disability was incorrect, based on documented evidence.

“Employment which exists in the community” means there are jobs for which the client has competence located within an area where the client might reasonably be expected to commute

(see definition of “reasonable commute”). It does not mean that there are actual job vacancies that the client could fill or that the client would be hired to fill a job vacancy.

“Improvement” related to the client's medical condition means that in comparison to the most recent medical certification, the physical or mental impairment(s) which prevented the client from engaging in a useful occupation has decreased to the point that the client is able to engage in a useful occupation or the client's residual functional capacity has increased to the point that the client is able to engage in a useful occupation.

“Medical provider” means a Colorado licensed physician, psychiatrist, licensed psychologist, licensed clinical social worker, licensed professional counselor, physician's assistant, advanced practice nurse, or registered nurse. The physician may be a general practitioner or a specialist. A medical provider determining blindness shall be an ophthalmologist licensed in Colorado. A medical provider may be licensed in a bordering state when the nearest Colorado provider is more than one hour from the client's home and the provider in the bordering state is closer.

“Reasonable commute” means a commute no further than one hour one way.

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3.541 DISABILITY REQUIREMENTS [Eff. 3/2/14]

A. To meet the disability eligibility requirement for AND-CS, the client must be approved for Supplemental Security Income (SSI) due to a disability or blindness. The county department shall verify SSI eligibility through SVES and document in the statewide automated system case comments.

B. To meet the disability requirement for AND-SO, the client shall be certified by a medical professional as defined by Section 3.541.1, under one of the following categories:

1. Disabled due to substance abuse, as outlined in Section 3.541.3; or,

2. Totally disabled, as outlined in Section 3.541, C; or,

3. With a medical disability that prevents the client from working in his/her usual occupation and when the disability is combined with additional functional deficits related to certain social factors, the client's residual functional capacity to work in any type of employment is severely disabling, as outlined in Section 3.541, D-F.

C. To be determined totally disabled the client shall meet the criteria below or have other disabling conditions identified by the Social Security Administration (SSA):

1. Be blind or have a physical or mental impairment that is severely disabling. These conditions are generally permanent, fully debilitating, and may be expected to result in death. These impairments include:

a. Respiratory disorders, such as cystic fibrosis, chronic persistent lung infections, or chronic pulmonary insufficiency;

b. Cardiovascular disorders, such as chronic heart failure despite medication, congenital heart disease, or recurrent arrhythmias not related to a reversible cause;

c. Digestive disorders, such as liver dysfunction or gastrointestinal hemorrhage;

d. Genitourinary disorders, such as chronic renal failure resulting in chronic hemodialysis;

e. Hematological disorders, such as sickle-cell disease, hemophilia, or aplastic anemia;

f. Congenital disorders, such as fragile X syndrome or phenylketonuria (PKU);

g. Neurological disorders, such as multiple sclerosis, muscular dystrophy, head trauma, or cerebral palsy;

h. Disorders of speech or other senses, such as blindness, tinnitus in combination with progressive hearing loss, or loss of speech;

i. Musculoskeletal disorders, such as a gross anatomical deformity, spinal stenosis or other spinal disorder resulting in nerve root compression, or amputation of both hands;

j. Mental or cognitive disorders, such as schizophrenia, affective disorders, personality disorders, intellectual and developmental disabilities, or substance abuse to the extent that the disorder results in at least two of the following activities:

1) Marked restriction of activities of daily living; or,

2) Marked difficulties in maintaining social functioning; or,

3) Marked difficulties in maintaining concentration, persistence, or pace; or,

4) Repeated episodes of decompensation, each of extended duration.

2. Have an impairment or blindness that is expected to last twelve (12) months or more; and,

3. Must be completely unable to participate in a substantial gainful activity. Substantial gainful activity (SGA) means a level of work activity and earnings that is both substantial and gainful. The activity involves performance of significant physical or mental activities, or a combination of both. For a work activity to be considered substantial it does not need to equal full time. If impairment is anything other than blindness, earnings averaging over the current AND grant standard a month generally demonstrates a SGA. Gainful work activity is:

a. Work performed for pay or profit; or,

b. Work generally performed for pay or profit; or,

c. Work intended for profit, whether or not a profit is realized.

D. The client shall be considered disabled due to a lack of residual functional capacity when the client has a medical disability that is moderately to severely disabling and when combined with additional functional deficits due to social factors, such as age, training, experience, and social setting, severely limits the client's residual functional capacity if he/she:

1. Is blind or has a physical or mental impairment that is disabling; and,

2. Has an impairment or blindness that is expected to last six (6) months or longer, as documented on the medical certification form; and,

3. Has additional functional deficits related to certain social factors that create a barrier to employment to the extent that the client is unable to work or learn skills necessary to work as a wage earner in any type of employment that exists in the community.

E. To determine if the client's residual functional capacity would preclude him/her from employment, or from learning skills necessary for employment, the county department shall document other medical data and functional strengths and deficits, as follows:

1. Review medical records from licensed medical personnel; and,

2. Review disability assessments performed by other disability specialists; and,

3. Shall weigh more heavily:

A. A medical certification form completed by the client's usual doctor than a form completed by a doctor who has had no previous history with the client, unless the doctor with no known history is a specialist in the field of medicine pertaining to the client's disability, if there is more than one form provided by the applicant.

B. A disability determination completed through a Medicaid disability determination process than a medical certification form completed by a medical provider.

F. The county department shall review all documentation collected to determine if certain social factors combined with a medical disability reasonably prevent the client from working or from learning new skills.

3.541.1 MEDICAL CERTIFICATION FORM [Eff. 3/2/14]

A. Medical certification shall be completed on the State Department's prescribed medical report form.

1. The county department shall provide the form to the client or the medical provider at the time of application or interview and at each re-examination date. The client shall arrange for the medical exam with an appropriate medical provider of his/her choosing.

a. It is the county department's responsibility to provide the medical form to the client or the client's provider of choice within ten (10) calendar days of application.

b. If the client fails to make arrangement for or submit to the required medical examination within thirty (30) calendar days following the interview, the client has failed to comply with the requirements for eligibility and the program will be denied or discontinued. The county department shall provide a notice of adverse action to the client.

c. If the client requests a second opinion, the subsequent medical examination shall be at the client's expense. The county department shall not be obligated to pay for more than one medical exam per client per application or medical certification period.

d. If the county department requests a second opinion, the subsequent medical examination shall be at the county department's expense.

e. The county department shall review the medical certification form for completeness and to determine whether the information submitted is in conflict with other medical data, records, documentation, and information and/or observations received from the client, family, friends, professionals, community members, or the county department. The county department shall:

1) Ensure any incomplete forms are returned to the provider to be completed; and,

2) Consult and verify with the provider any questionable or contradictory information.

2. The medical certification shall be completed and signed by a Colorado licensed physician, psychiatrist, licensed psychologist, licensed clinical social worker, licensed professional counselor, physician's assistant, an advanced practice nurse, or a registered nurse. The physician may be a general practitioner or a specialist. Medical certification for blindness shall be completed only by an ophthalmologist licensed in Colorado.

a. The client shall be allowed to choose a medical provider licensed in a bordering state when the nearest Colorado provider is more than one hour from the client's home.

b. No other health care or counseling professionals shall be allowed to complete the medical form.

3. The medical certification form shall contain the disability limitations, including the length and scope of the disability, if any; and,

4. The medical re-examination date shall be based upon the date of the initial exam and the length of the disability, as documented by the medical provider, but shall not exceed twelve (12) months. However, if the client has been determined disabled by the State disability review contractor, the medical re-examination date shall be established by the review contractor.

B. The county department shall authorize payment for examinations for AND-SO medical certification examinations.

1. Fees and costs shall be reimbursed to the county department using the 80% state share, 20% county share reimbursement methodology.

2. The county department shall set the provider fee and shall make such payments in a timely manner.

3. Providers shall accept fees for services as negotiated as payment in full. No client shall be assessed any additional or supplementary fee.

4. Providers may be excluded from completing medical certification examinations if there is adequate documentation that the provider:

a. Is not completing a thorough examination on which to base his/her decision; or,

b. Falsified a medical certification form.

C. A determination of medical eligibility shall be completed by each medical re-examination date. The county department shall be allowed to request the client submit a medical re-examination at the time of financial redetermination or when the county has information that the client's medical condition may have changed.

1. At the time of medical re-examination the county department shall obtain a release of information from the client and send the prior medical certification forms to the client or the medical provider.

2. The provider shall be required to indicate on the form whether there has been any improvement in the client's medical condition since the last medical certification.

3. If the client fails to make arrangement for or submit the required medical re-examination within ten (10) calendar days of the request, the county department shall terminate assistance and provide notice of adverse action to the client.

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3.542 DETERMINATION [Rev. eff. 6/1/15]

A. The county department shall enter all client, resource, and income information into the statewide automated system.

1. The county department shall determine eligibility.

2. If the client is missing any verification, the statewide automated system or the county department shall send a check list of required verifications to the client. The verification check list shall include:

a. A specific list of verifications necessary to determine eligibility;

b. The due date for when the verifications must be returned; and,

c. Notification that if the client fails to return the verifications by the due date, the county department shall process the application without those verifications, which may lead to a denial of benefits.

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Tracking number: 2018-00288

Opinion of the Attorney General rendered in connection with the rules adopted by the

Income Maintenance (Volume 3)

on 09/07/2018

9 CCR 2503-5

ADULT FINANCIAL PROGRAMS

The above-referenced rules were submitted to this office on 09/13/2018 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.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

September 25, 2018 09:06:40

Permanent Rules Adopted

Department

Department of Human Services

Agency

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DEPARTMENT OF HUMAN SERVICES

Income Maintenance (Volume 3)

OTHER ASSISTANCE PROGRAMS

9 CCR 2503-7

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

3.750 LOW-INCOME ENERGY ASSISTANCE PROGRAMS

3.750.1 AUTHORITY

3.750.11 Low-Income Home Energy Assistance Act [Rev. eff. 12/1/14]

Programs authorized under the Low-Income Home Energy Assistance Act include a Heating Fuel Assistance Program and a Crisis Intervention Program.

3.750.12 Intent of the Heating Fuel Assistance Program [Rev. eff. 12/1/14]

The Heating Fuel Assistance Program is intended to help meet winter home heating costs of households composed of low-income families and individuals.

3.750.13 Intent of the Crisis Intervention Program [Rev. eff. 12/1/14]

The Crisis Intervention Program (CIP) is intended to assist with the repair or replacement of the non-working primary heating system of approved Heating Fuel Assistance Program applicants.

3.750.14 (None) [Rev. eff. 2/1/12]

3.750.15 Funding [Rev. eff. 9/1/11]

This program is federally and privately funded and is subject to availability of funds. If funds are increased, decreased or become unavailable, the services provided herein shall be increased, decreased or terminated accordingly.

3.751 GENERAL PROVISIONS

3.751.1 DEFINITIONS [Rev. eff. 12/1/14]

“Applicant”: The person who completes and signs the basic LEAP application form. This is also the only household member who is required to provide proof of lawful presence as defined in these rules.

“Approved Vendor” means a vendor that has signed a state specified agreement as it is prescribed in Section 3.758.46.

“Bulk Fuel”: Bulk fuel is an energy source for home heating which may be purchased in quantity from a fuel supplier and stored by the household to be used as needed. Normally, bulk fuel includes wood, propane, kerosene, coal and fuel oil.

“Collateral Contact means a verbal or written confirmation of a household’s circumstances by a person outside the household who has first-hand knowledge of the information. The name/title of the collateral contact, as well as the information provided must be documented in the report of contact (ROC).

“Completed Application”: A basic LEAP application shall be considered to be a completed application when:

A. The applicant has provided an adequate response to all application questions which are necessary to determine eligibility and payment level;

B. The applicant has provided all required verification. A Social Security Number (SSN) for each household member or proof of application for a SSN must be provided. A SSN is required to determine eligibility. If no SSN is provided for a household member, that member will not be included in the household, but the member’s income will be counted;

C. The application is signed;

D. The applicant has provided proof of lawful presence in the United States (see Section 3.753).

“Date of Application”: For purposes of the Low-Income Energy Assistance Programs, the date of application shall be the date an application form that contains a legible name and address is received by the county department.

“Discrepancy”: For the purposes of these rules, discrepancy means a lack of similarity between the application and a corresponding data field in the LEAP system. All discrepancies require a record of contact note to be entered into the L.EAP system.

“Disabled or Handicapped”: For purposes of the Low-Income Energy Assistance Programs, the term disabled or handicapped means persons who receive vocational rehabilitation assistance; Social Security disability, SSI, AB, AND, veterans disability payments, or who provide a physician's statement which indicates incapacity to engage in substantial gainful employment. This definition may be different for other public assistance programs.

“Elderly”: For the purposes of these rules, the term elderly means aged 60 or over.

“Eligibility Period”: There shall be one eligibility period for the Basic Low-Income Energy Assistance Programs from November 1st through April 30th. If April 30th for a particular calendar year falls on a holiday or weekend, then the eligibility period shall be extended until midnight the next business day. This program is contingent upon the continued availability of funds in accordance with Sections 3.750.15 and 3.758.48.

“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.

Applications for households 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.

“Estimated Home Heating Costs (EHHC)”: The amount of the heating costs incurred during the previous heating season for the applicant's address at the time of application to be used as an estimate, or projection, of the anticipated heating costs for the current heating season (November 1st through April 30th). Such estimated heating costs shall not include payment arrearages, investigative charges, reconnection fees, or other such charges not related to residential fuel prices and consumption levels. An EHHC can only be obtained from approved vendors, for all other vendors use flat rates.

“Heat Related Arrearage”: Any past due amounts for the primary heating fuel and/or supportive fuel.

“Home Heating Costs”: Charges related directly to the primary heating fuel used in a residential dwelling.

“Household”: The term “household” shall mean any individual or group of individuals who are living together as one economic unit for whom primary heating fuel is customarily purchased in common or who make undesignated payments for heat in the form of rent.

“Income Verification Period”: The income verification period is from the date of application to the same date of the prior month (approximately thirty (30) calendar days prior to date of application) when used to verify income except for earned ongoing income in accordance with Section 3.752.22, B.

“Life Threatening Crisis” means a household whose members’ health and/or well-being would likely be endangered if energy assistance or repair or replacement of the primary heating system is not provided.

“Non-Bulk Fuel”: Non-bulk or metered fuel is an energy source for home heating which is provided by a utility company and is regulated and metered by the utility company. Normally, non-bulk fuel includes natural gas and electricity.

“Non-Traditional Dwelling”: A non-traditional dwelling means a structure that provides housing that is not affixed to a permanent physical address or is enumerated as such in this rule (see Section 3.752.25), including, but not limited to, cars, vans, buses, tents and lean-tos.

“Point in Time”: Point in time indicates that eligibility is determined by accounting for the circumstances of the household on the date of the application, regardless of any changes thereafter.

“Poverty Level”: The term poverty level as used in these rules describes federal guidelines updated annually by the U.S. Department of Health and Human Services. The guidelines, printed in the Federal Register, establish minimum subsistence income levels by household size.

“Primary Heating Fuel”: The primary heating fuel is the main type of fuel used to provide heat within the dwelling. When heat (such as natural gas and/or electric) is included in the rent, this may be reflected as “utilities” included in rent.

“Primary Heating Source”: The primary heating system that provides heat to the dwelling such as a furnace, wood burning stove or boiler. Temporary or portable heating sources are not considered a primary heating source and, therefore, are not eligible for LEAP assistance.

“Program Year”: means from November 1st through April 30th for the Heating Fuel Assistance Program. If April 30th for a particular calendar year falls on a holiday or weekend, then the eligibility periods shall be extended until midnight the next business day. This program is contingent upon the continued availability of funds in accordance with Sections 3.750.15 and 3.758.48.

"Prudent Person Principle": means that, based on experience and knowledge of the program, the county department/contractor exercises a degree of discretion, care, judiciousness, and circumspection, as would a reasonable person, in a given case.

"Propane Bottles are small propane containers that hold less than one hundred (100) gallons.

"Public Assistance Income": For purposes of verifying income under the Low-Income Energy Assistance Programs, the term public assistance income shall mean income received from the following types of Department of Human Services programs:

A. Colorado Works;

B. OAP (Old Age Pension, both the SSI-supplement and State-only groups);

C. AND (Aid to the Needy Disabled, both the SSI-supplement and State-only groups);

D. AB (Aid to the Blind, both the SSI-supplement and State-only groups);

E. NCRA (Non-Categorical Refugee Assistance);

F. SSDI (Social Security Disability Insurance) for clients on another state program, such as a Medicaid waiver or buy in program.

"Reapplication" means a household who has been denied for the current program year and is reapplying for a LEAP benefit. The application is to be treated as a new application whose point in time is reset to the date of the new application.

"Report of Contact (ROC)" means the electronic chronological history of the case which contains both system generated entries and manual entries.

"Subsidized Housing": Subsidized housing means housing in which a tenant receives an ongoing governmental or other subsidy (e.g., assistance provided by a church) and the amount of rent paid is based on the amount of the tenant's income.

"Supportive Fuel": Supportive fuel is an energy source needed to operate the primary heating system in a residential setting. For example, electricity is a supportive fuel required to operate a natural gas furnace. Supportive fuels are not eligible for LEAP assistance.

"Traditional Dwelling": Traditional dwelling means a structure that provides a housing or residential environment that is affixed to a permanent physical address.

"Tiny Home": A residential structure up to 500 square feet in size.

"Vendor": A vendor is an individual, a group of individuals, or a company who is regularly in the business of selling fuel (bulk or non-bulk) to customers for residential home heating purposes.

3.751.2 HOUSEHOLDS [Eff. 12/1/14]

A. Any individual considered as part of an approved household cannot subsequently be considered as part of another household during the same eligibility period.

B. Each person living at a dwelling must be counted as either a member of the applicant's household or a member of a separate household.

C. The maximum number of household members shall be fifteen (15). The maximum number of separate households shall be nine (9).

D. The following cannot be classified as separate households:

1. Husband and wife living together;

2. Children under eighteen (18) years of age and living in the same dwelling as the parent or guardian, unless emancipated;

3. Individuals that enter into civil unions.

E. A parent with his or her children may be listed as a separate household when residing in the same dwelling with his or her ex-spouse in cases of legal separation or divorce.

3.751.21 Permanent Separation [Eff. 12/1/14]

A married couple is considered to be permanently separated when:

A. They are divorced or legally separated; or,

B. Both physical and financial ties have been dissolved and a relationship as spouses no longer exists.

3.751.22 Presumption of Marriage [Eff. 12/1/14]

Unless there has been a divorce or legal separation, the presumption is made that the couple is still married. Such presumption must be refuted by persons, other than the spouses, who can establish that they are in a position to know and assert that a complete and permanent separation does, in fact, exist.

3.751.3 NON DISCRIMINATION POLICIES/RIGHT AND OPPORTUNITY TO APPLY

3.751.31 Non-Discrimination [Rev. eff. 12/1/14]

Non-discrimination policies as outlined in this rule manual shall apply to all households applying for the Heating Fuel Assistance Program.

3.751.32 Opportunity to Apply [Rev. eff. 11/1/84]

All persons shall be provided an opportunity to file an application form on the date of initial contact with the county department during the application period.

3.751.33 Interpreters [Rev. eff. 9/1/11]

An interpreter shall be available to assist persons known to the Department to be non-English speaking in completing application forms and to provide information between the applicant and the county department.

3.751.34 Authorized Representative [Rev. eff. 11/1/13]

A formal, legal authorized representative may apply on behalf of an applicant household when the applicant household is unable to apply on its own behalf. Proper legal documentation of guardianship and/or durable power of attorney must be presented.

3.751.35 Authorized Signature by Mark [Rev. eff. 12/1/14]

Applicants who are partially or totally illiterate and who cannot write their names shall make a mark, and such mark shall be witnessed by the signature of at least one witness. The address of such witness shall follow the signature. County/Contractor workers may act as witnesses if not related to the applicant.

3.751.4 NOTICE AND HEARINGS

3.751.41 Timely and Adequate Notice [Rev. eff. 12/1/14]

The requirements for providing timely and adequate notice of proposed actions and opportunity for hearings and appeals are as provided in the chapter on "Administrative Procedures" in Section 3.830 (9 CCR 2503-8), except as specifically provided in the rules governing the Heating Fuel Assistance Program.

3.751.42 Denials [Rev. eff. 12/1/14]

Notices of denial shall advise the applicant of the reason for the denial; the regulation citation relied on by the county department, and appeal rights and procedures. For advance payments of the Heating Fuel Assistance Program, notices of denial shall advise the applicants of their right to a forthwith hearing.

3.751.43 Request for a State Level Fair Hearing [Rev. eff. 12/1/14]

County departments/Contractor shall notify the State LEAP office in writing within seven (7) days upon receipt of a request for a State level fair hearing by an applicant on Heating Fuel Assistance Program. See Sections 3.850.1 – 3.850.56 (9 CCR 2503-8).

3.751.44 Notice of Appropriate Use of Electronic Benefit Transfer (EBT) Card [Rev. eff. 11/1/15]

An explanation shall be provided regarding the process of utilizing the Electronic Benefit Transfer (EBT) card. This explanation shall include:

A. Identification of the following establishments in which clients shall not be allowed to access cash benefits through the electronic benefits transfer service from automated teller machines:

1. Licensed gaming establishments;

2. In-state simulcast facilities;

3. Tracks for racing;

4. Commercial bingo facilities;

5. Stores or establishments in which the principal business is the sale of firearms;

6. Retail establishments licensed to sell malt, vinous, or spirituous liquors;

7. Establishments licensed to sell medical marijuana or medical marijuana infused products, or retail marijuana or retail marijuana products, effective June 30, 2015; and,

8. Establishments that provide adult-oriented entertainment in which performers disrobe or perform in an unclothed state for entertainment, effective June 30, 2015.

B. An explanation that the cash portion issued on the EBT card may be suspended with identified misuse.

3.751.45 ELECTRONIC BENEFIT TRANSFER AND POINT OF SALE RESTRICTION

Participants are prohibited from using his/her EBT card at automated teller machines and point of sale (POS) devices located in establishments as described in Section 3.751.44 A 1-8.

Individuals' transactions shall be monitored monthly. Individuals who use prohibited ATMs or POS devices shall be contacted by the State Department. Inappropriate usage shall result in:

1. Warning that use of the EBT card in prohibited establishments will result in the card being disabled. The state department shall provide education about appropriate use, access, and alternatives.

2. If continued misuse occurs (identified in the usage report after a warning has occurred), the State Department will coordinate with the county department to disable the card and initiate contact with the individual for additional assessment.

3.751.5 RECOVERY AND FRAUD PROCEDURES

3.751.51. Recoveries [Eff. 12/1/14]

County departments/Contractor must institute recoveries to ensure that Heating Fuel Assistance Program benefits do not exceed the maximum amounts described in these rules. Recovery procedures shall be the same as in adult program rules as described in the "Administrative Procedures" Chapter or as otherwise specified in these rules. Note: Sections 3.810.13, 3.810.14, and 3.810.32 (9 CCR 2503-8) do not apply to LEAP.

3.751.52 Determination of Recovery of Overpayment [Rev. eff. 10/1/01]

When overpayments, made directly to the client, have been verified by the county department/Contractor, a determination as to whether recovery is appropriate shall be made within fifteen (15) calendar days after receipt of reports issued by the State Department designed to assist county departments in identifying and correcting such payments.

3.751.53 Definition of Overpayment [Rev. Eff. 12/1/14]

Overpayment of Heating Fuel Assistance Program benefits shall mean a household has received benefits in excess of the amount due that household based on eligibility and payment determination in accordance with these rules.

3.751.54 Establishment of Recovery [Rev. eff. 11/1/08]

Recoveries shall be established for households that have received program benefits and are subsequently determined to be ineligible or which received benefit amounts greater than the household was entitled to for the eligibility period.

3.751.55 Recovery Procedures [Rev. eff. 12/1/07]

Recovery proceedings shall be handled in accordance with the procedures described in the "Administrative Procedures" chapter of this rule manual when applicable. (Note: Sections 3.810.73 through 3.810.75 do not apply to LEAP.)

3.751.56 Penalties for Individuals Who Are Found Guilty of Committing Fraud [Rev.11/1/15]

Individuals who are found guilty of committing fraud, pursuant to Section 26-1-127, C.R.S., in a prior program year shall be ineligible to participate in LEAP in the subsequent program year for the first violation, two program years for the second violation, and permanently for the third violation.

3.751.6 REPORTING AND MONITORING

3.751.61 Reporting

All recoveries shall be reported to the State Department at the conclusion of the program year.

3.751.62 Reports and Fiscal Information [Rev. eff. 11/1/98]

County departments/Contractor shall provide the State Department with reports and fiscal information as deemed necessary by the State Department.

3.751.63 Monitoring [Rev. Eff. 11/1/98]

The State Department shall have responsibility for monitoring programs administered by the county departments/Contractor based on a monitoring plan developed by the State Department. Such plan shall include provisions for programmatic and local reviews and methods for corrective actions.

3.751.64 County Case File Review [Eff. 12/1/14]

County department/Contractor supervisory personnel shall review eligibility determinations monthly, from October 1st to May 30th, and submit the results of those reviews when requested by the state. At minimum the supervisor shall:

A. Pull a random sample of two determinations per technician;

B. Determine the correctness of eligibility determinations accomplished.

C. Ensure timely correction of any determination errors; and,

D. Maintain a record of the cases reviewed for audit purposes.

3.751.7 REIMBURSEMENT AND SANCTIONS

3.751.71 Reimbursements [Rev. eff. 12/1/14]

Subject to allocations as determined by the State Department, county departments shall be reimbursed up to 100% for all allowable costs incurred for the operation of the Heating Fuel Assistance Program, outreach, and other administrative costs.

3.751.72 Sanctions [Rev. eff. 12/1/14]

County departments/Contractor, which fail to follow the rules of the Heating Fuel Assistance Program shall be subject to administrative sanctions as determined by the State Department (see 11 CCR 2508-1).

3.752 LOW-INCOME ENERGY ASSISTANCE PROGRAM: HEATING FUEL ASSISTANCE PROGRAM [Rev. eff. 12/1/14]

3.752.1 APPLICATION PERIOD [Rev. eff. 11/1/13]

To apply for LEAP, the general public shall submit a State prescribed application form (IML-4) during the period of November 1st through April 30th. If April 30th for a particular calendar year falls on a holiday or weekend, then the eligibility periods shall be extended until midnight the next business day. These programs are contingent upon the continued availability of funds in accordance with Sections 3.750.15 and 3.758.48. The county department shall accept all application forms that are received or postmarked during the application period. Facsimile copies of completed application forms shall be accepted as valid. Preference shall be given to application forms received from public assistance households (such as Colorado Works, Old Age Pension (OAP), Aid to the Needy Disabled (AND), Aid to the Blind (AB), and Food Assistance). Such applications received prior to November 1st shall be accepted and may be processed; however, eligibility shall not be effective until November 1st. Application forms received or postmarked after the closing date shall be denied. Eligibility will be determined based on the applicant's circumstances on the date the application is received by the county department. Although applications may be accepted and processed earlier, the effective date of application shall not be before November 1st.

3.752.2 PROGRAM ELIGIBILITY REQUIREMENTS [Rev. eff. 12/1/14]

To be determined eligible for a Heating Fuel Assistance Program payment, households must, at time of application, be vulnerable to the rising costs of home heating, and meet income and other requirements of the program as defined in these regulations.

The following factors shall be considered as of the date of application: Colorado state residency, U.S. citizenship/alien status, lawful presence, income, vulnerability, fuel type, household composition, shared living arrangements, dwelling type, and estimated home heating costs.

3.752.21 Countable Unearned Income [Rev. eff. 12/1/14]

Countable unearned income includes but is not limited to the following, as well as payments from any other source, which is considered to be a gain or benefit to the applicant or recipient:

A. Inheritance, gifts, and prizes;

B. Dividends and interest received on savings bonds, leases, etc.;

C. Income from rental property;

D. Proceeds of a life insurance policy to the extent that they exceed the amount expended by the beneficiary for the purpose of the insured recipient's last illness or burial that are not covered by other benefits;

E. Proceeds of a health insurance policy or personal injury lawsuit to the extent that they exceed the amount to be expended or required to be expended for medical care;

F. Strike benefits;

G. Income from jointly owned property: - in a percentage at least equal to the percentage of ownership or, if receiving more than percentage of ownership, the actual amount received;

H. Lease bonuses (oil or mineral) received by the lessor as an inducement to lease land for exploration are income in the month received;

I. Oil or mineral royalties received by the lessor are income in the month received;

J. Supplemental Security Income (SSI) benefits received by an applicant or recipient shall be considered income in the month received. When determining income, do not consider cents in the gross benefit amount.

K. Income derived from monies (or other property acquired with such monies) received pursuant to the “Civil Liberties Act of 1988”, P.L. 100-383;

L. Amounts withheld from unearned income because of a garnishment are countable as unearned income.

M. Public Assistance Income as defined in 3.751.1: Colorado Works, Old Age Pension (OAP); Aid To The Needy Disabled (AND); Aid To The Blind (AB); Non-Categorical Refugee Assistance (NCRA); Social Security Disability Insurance (SSDI).

3.752.211 Periodic Payments [Eff. 12/1/14]

The following types of periodic payments are among those included in countable unearned income:

A. Annuities - payments calculated on an annual basis which are in the nature of returns on prior payments or services; they may be received from any source;

B. Pension or retirement payments - payments to an applicant or recipient following retirement from employment; such payments may be made by a former employer or from any insurance or other public or private fund;

C. Disability or survivor's benefits - payment to an applicant or recipient who has suffered injury or impairment, or, to such applicant's or recipient's dependents or survivors; such payments may be made by an employer or from any insurance or other public or private fund;

D. Worker's compensation payments - payments awarded under federal and state law to an injured employee or to such employee's dependents; amounts included in such awards for medical, legal, or related expenses incurred by an applicant or recipient in connection with such claim are deducted in determining the amount of countable unearned income;

E. Veteran compensation and pension - payments based on service in the armed forces; such payments may be made by the U.S. Veterans Administration, another country, a state or local government, or other organization. Any portion of a VA pension that is paid to a veteran for support of a dependent shall be considered countable unearned income to the dependent rather than the veteran.

F. Unemployment compensation - payments in the nature of insurance for which one qualifies by reason of having been employed and which are financed by contributions made to a fund during periods of employment;

G. Railroad retirement payments - payments, such as sick pay, annuities, pensions, and unemployment insurance benefits, which are paid by the Railroad Retirement Board (RRB) to an applicant or recipient who is or was a railroad worker, or to such worker's dependents or survivors;

H. Social Security Benefits - Old Age (or Retirement), Survivors and Disability Insurance payments (OASDI or RSDI) made by the Social Security Administration; also included are special payments

at age seventy-two (72) (Prouty benefits) and black lung benefits. When determining income, do not consider cents in the gross income amount.

I. Supplemental Security Income (SSI) - public assistance payments made by the Social Security Administration to an applicant or recipient sixty five (65) years of age or older, or who is blind or disabled; such payments are considered in accordance with requirements specified in the applicable assistance program chapter. When determining income, do not consider cents in the gross benefit amount.

3.752.212 Military Allotment [Eff. 12/1/14]

A military allotment received on behalf of an applicant or recipient for those individuals included in the budget unit shall be considered as income in the month received.

3.752.22 Income and Household Size Criteria [Rev. eff. 11/1/15]

A. All countable unearned income shall be the countable gross unearned income received in the income verification period, not to exceed one month’s income.

B. For purposes of determining a household's eligibility, earned ongoing income shall be the countable gross income in any four (4) weeks of the eight (8) weeks prior to the application date.

C. Determining Monthly Income

If a household member is paid less than monthly, the county department shall determine gross monthly income by:

1. Weekly/Bi-Weekly Income

   a. Weekly Income

      Adding four gross weekly income amounts to obtain total monthly income.

   b. Bi-Weekly Income

      Adding two gross bi-weekly income amounts to obtain total monthly income.

2. Semi-Monthly Income

   Adding two gross semi-monthly income amounts to obtain total monthly income.

3. Partial Month Income

   a. Terminated Income

      If a household member's income is terminated as of the application date, use actual income received in the income verification period.

   b. Earned New Income

      If a household member has a new source of earned income as of the application date, use income received in the income verification period.

c. Unemployment/Other Unearned Income

If a household member has not received his/her first check from this source of income as of the income verification period, do not count any income from this source. If the household member has received the income as of the income verification period, use actual income for the income verification period.

4. In-kind income is income received in exchange for employment and shall be considered as earned income whose value is based on the services rendered. The amount considered as earned income when a recipient is paid in lieu of cash is the declared value of the item or service provided.

D. All applicant households whose countable income for the eligibility period is one hundred sixty five percent (165%) of the federal poverty level 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 federal poverty guidelines published in the Federal Register effective January 13, 2018, no later editions or amendments are included. The following table contains the income standards:

HOUSEHOLD SIZE	MONTHLY GROSS INCOME 165% of Poverty
1	$1,670
2	$2,264
3	$2,858
4	$3,452
5	$4,046
6	$4,640
7	$5,234
8	$5,828
Each Additional Person	$594

E. Households which have been denied basic benefits and have had changes in circumstances may reapply.

3.752.23 Income Exclusions [Rev. eff. 11/1/15]

To determine eligibility for financial assistance and the amount of the assistance payment, the following shall be exempt from consideration as either resources or income. Verification is not required in the case file but must be notated in the Report of Contact (ROC).

A. The value of food assistance and USDA donated foods;

B. Benefits received under Title III, Nutrition Program for the Elderly, of the Older Americans Act;

C. The value of supplemental food assistance received under the special food services program for children provided for in the National School Lunch Act and under the Child Nutrition Act, including benefits received from the special supplemental food program for Women, Infants and Children (WIC);

D. Home produce utilized for personal consumption;

E. The value of any assistance paid with respect to a dwelling unit under:

1. The United States Housing Act of 1937;

2. The National Housing Act;

3. Section 101 of the Housing and Urban Development Act of 1965;

4. Title V of the Housing Act of 1949; or,

5. Section 202(h) of the Housing Act of 1959.

F. Payments to volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (score) and Active Corps of Executives (ace) and any other program under Title I (Vista) when the value of all such payments adjusted to reflect the number of hours such volunteers are serving is not equivalent to or greater than the minimum wage, and Title II and III of the Domestic Volunteer Services Act;

G. Compensation received by the applicant or recipient pursuant to the Colorado Crime Victims Compensation Act shall not be considered as income, property, or support available to the applicant or recipient. This is compensation paid to innocent victims or dependents of victims of criminal acts who suffer bodily injury;

H. Monies received pursuant to the Civil Liberties Act of 1988;

I. Any payment made from the Agent Orange Settlement Fund;

J. The value of any commercial transportation ticket, for travel by an applicant or recipient (or spouse) among the fifty (50) states, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the northern Mariana Islands, which is received as a gift by such applicant or recipient (or such spouse) and is not converted to cash;

K. Reparation payments made under Germany's law for compensation of national socialist persecution (German Restitution Act);

L. Any money received from the Radiation Exposure Compensation Trust Fund;

M. Reparation payments made under Sections 500 through 506 of the Austrian General Social Insurance Act;

N. Payments to applicants or recipients because of their status as victims of Nazi persecution;

O. Income paid to children of Vietnam veterans who were born with spina bifida;

P. All financial aid monies, including educational loans, scholarships, and grants, including work study;

Q. Earned income of children under the age of eighteen (18) who are residing with a parent or guardian;

R. Reimbursement received for expenses incurred in connection with employment from an employer;

S. Reimbursement for past or future expenses, to the extent they do not exceed actual expenses, and do not represent gain or benefit to the household;

T. Payments made on behalf of the household directly to others;

U. Payment received as foster care income; foster care individuals are not considered LEAP household members;

V. Home care allowance or Attendant Support Allowance Care, if paid to a non-household member;

W. State/county diversion payments;

X. Reverse mortgages;

Y. Subsidized housing utility allowances;

Z. G.I. Bill educational allowances, including housing and food allowances;

AA. A one-time resettlement grant received under the refugee admissions program.

BB. A bona fide loan is a debt that the borrower has an obligation to repay and expresses his or her intention to repay, as documented in a written agreement;

CC. Funds received by persons fifty five (55) years of age and older under the Senior Community Service Employment Program (SCSEP) under Title V of the Older Americans Act;

DD. Income that is deemed necessary for the fulfillment of a Plan for Achieving Self-Support (PASS) under Title XVI of the Social Security Act.

EE. Money received in the form of non-recurring lump sum payments for income tax refunds, rebates, or credits; retroactive lump-sum social security, SSI, and public assistance payments.

FF. Supportive Services income received under the Colorado Works Program.

3.752.24 Resources [Rev. eff. 10/1/01]

There are no resource criteria for the Low-Income Energy Assistance Program.

The value of the household's resources shall not be considered for the purpose of determining eligibility for assistance.

3.752.25 Vulnerability [Rev. eff. 11/1/15]

A. A household shall be vulnerable in order to qualify for Heating Fuel Assistance Program benefits. Vulnerability shall mean the household must be responsible for the costs of home heating as defined below:

1. The household is paying home heating costs directly to a vendor and is subject to home heating cost increases.

2. The household is living in non-subsidized housing and is paying home heating costs either in the form of rent or as a separate charge in addition to rent.

3. The household resides in subsidized housing as defined in the "Definitions" Section of these rules; and, 1) the unit has an individual meter which identifies specific heating usage of that unit and the household is subject to increased cost for home heating, or 2) the tenant is subject to a heating surcharge assessed by means other than an individual

meter. Such surcharges may include percentage fees assessed to the tenant for home heating. Excess utility charges are to be specific to home heating and verified by the County Department/Contractor. Under no circumstances shall rental costs be assumed to be subject to change due to an increase in home heating costs unless otherwise verified by the county department/Contractor.

4. The applicant household in a residence where more than one household resides shall be considered vulnerable if the applicant household contributes toward the total expenses of the residence. These expenses include, but are not limited to, shelter and utilities.

5. The applicant household must live in a traditional dwelling.

6. Any applicant who shares a primary fuel, such as a shared natural gas meter, electric meter or propane tank, will be considered a shared household and the Estimated Home Heating Cost (EHHC) will be divided by the number of parties responsible for paying the shared heat expense.

B. Households in the following living arrangements shall not be considered to be vulnerable:

1. Institutional group care facilities, public or private, such as nursing homes, foster care homes, group homes, substance abuse treatment centers , or other such living arrangements where the provider is liable for the costs of shelter and home heating, in part or in full, on behalf of such individuals;

2. Room and board, bed and breakfast;

3. Correctional facilities;

4. Dormitory, fraternity or sorority house;

5. Subsidized housing as defined in the “Definitions” section of these rules which does not have an individual check meter for heat for each unit or which cannot provide other evidence of responsibility for paying home heating surcharges;

6. Any applicant, or applicant household who is considered homeless or resides in non-traditional dwellings;

7. Commercial properties that also serve as the client’s dwelling;

8. Hotels, unless proof that the household has lived or will live in the hotel continuously for thirty (30) calendar days at the time of application and that heat is included in rent. Proof may be shown by providing a monthly statement, billing statement or receipt indicating the monthly arrangement.

C. Landlords or other providers of shelter shall not be considered to be vulnerable unless they meet the definition of household and the eligibility requirements of the Heating Fuel Assistance Program.

D. Vulnerability shall be verified for all applicant households as defined in these rules.

3.752.26 Mandatory Weatherization [Rev. eff. 12/1/14]

Households approved to receive a LEAP benefit must agree to have their dwelling weatherized if contacted by a state-authorized weatherization agency. Failure to permit or complete weatherization may result in denial of LEAP benefits for the following year.

A. Exemptions

1. Households containing a member(s) whose mental or physical health could be exacerbated by weatherization shall be exempt.

2. A household whose landlord refuses to allow weatherization shall not have benefits denied.

3. The local weatherization agency shall fully document the circumstances permitting the exemption.

B. Households Who Refuse Weatherization

1. Households who refuse or terminate weatherization before completion shall not be approved for LEAP benefits for the following year and a LEAP denial hold shall be placed on the household at that address by the State LEAP office. The hold can only be removed by the State LEAP office.

2. If the household has moved to another address that has been weatherized, the household may be approved for a LEAP benefit if otherwise eligible. If the new dwelling is not already weatherized, weatherization must be completed before approved for LEAP.

3. If a denied household subsequently allows the dwelling to be weatherized or weatherization completed, the household must reapply and, as long as other eligibility criteria are met, may be approved for LEAP benefits after notification from the local weatherization agency that the weatherization is completed.

C. State Weatherization Office Responsibilities

1. Assure that standards, as delineated in Sections A and B above are applied uniformly and equitably.

2. Notify the state LEAP office by September 30th of all households who refuse weatherization.

3. Notify households who refuse weatherization, by first-class mail that their refusal may result in denial of LEAP benefits for the following year.

4. Weatherization shall be completed as soon as possible on dwellings where the household previously refused or didn't complete weatherization and subsequently allows the dwelling to be weatherized.

3.752.27 Mandatory Crisis Intervention Program (CIP) Inspection [Eff. 12/1/14]

Households that received assistance from the Crisis Intervention Program (CIP) must agree to have an inspection of the work performed, to ensure that the equipment is safe, when contacted by a state-authorized agency. Failure to permit the inspection may result in denial of leap benefits for the following year.

A. Exemptions

1. Households containing a member(s) whose mental health concerns could be exacerbated by presence of the inspector shall be exempt.

2. A household whose landlord refuses to allow the inspector in the property shall not have benefits denied.

B. Households Who Refuse CIP Inspection

1. Households who refuse to allow the inspection shall not be approved for LEAP benefits for the following year and a LEAP denial hold shall be placed on the household at that address by the state LEAP office. The hold can only be removed by the state LEAP office.

2. If the household has moved to another address, the household may be approved for a LEAP benefit if otherwise eligible.

3. If a denied household subsequently allows the dwelling to be inspected, the household must reapply and, as long as other eligibility criteria are met, may be approved for LEAP benefits after notification from the inspecting agency that the inspection is completed.

C. State CIP Contractor's Responsibilities

The state contractor will:

1. Assure that standards, as delineated in Sections A and B, above, are applied uniformly and equitably.

2. Notify the state LEAP office by September 30th of each year of all households that refuse inspection.

3. Notify households that refuse inspection that their refusal may result in denial of LEAP benefits for the following year.

3.753 GENERAL REQUIREMENTS FOR CITIZENSHIP AND LAWFUL PRESENCE [Eff. 12/1/14]

3.753.1 CITIZENSHIP AND ALIEN STATUS [Eff. 12/1/14]

The following are citizens of the United States and are generally eligible to receive social services and public assistance.

A. Persons born in the United States, Puerto Rico, Guam, Virgin Islands (U.S.), American Samoa, or Swain's Island;

B. Persons who have become citizens through the naturalization process;

C. Persons born to U.S. citizens outside the United States with appropriate documentation.

3.753.11 Verification of Citizenship in the United States [Eff. 12/1/14]

Documents that are acceptable as verification of citizenship can be found at 1 CCR 204-30, Appendix A.

3.753.111 Verification of Questionable Citizenship Information [Eff. 12/1/14]

The following shall be used in considering questionable statement(s) of citizenship from applicant:

A. The claim of citizenship is inconsistent with statements made by the applicant, or with other information on the application, or on previous applications.

B. The claim of citizenship is inconsistent with information received from another reliable source.

Application of the above criteria by the eligibility worker must not result in discrimination based on race, religion, ethnic background or national origin, and groups such as migrant farm workers or Native Americans shall not be targeted for special verification. The eligibility worker shall not rely on a surname, accent, or appearance that seems foreign to find a claim to citizenship questionable. Nor shall the eligibility worker rely on a lack of English speaking, reading or writing ability as grounds to question a claim to citizenship.

3.753.12 Verification of Lawful Presence in the United States [Eff. 12/1/14]

Pursuant to Section 24-76.5-103, Colorado Revised Statutes (C.R.S.), verification of lawful presence in the United States is required for applicants of state or local benefits, and federal benefits provided by the Colorado Department of Human Services or by the county departments of human/social services/Contractor under the supervision of the State Department.

A. For purposes of this section:

"Affidavit" means a state prescribed form wherein an applicant attests, subject to the penalties of perjury, that he/she is lawfully present in the United States. An affidavit need not be notarized.

"Applicant" means a natural person eighteen years of age or older who submits an application to receive a state or local public benefit, or a federal public benefit, on his or her own behalf.

"Application" means an initial or re-application for benefits.

"Federal public benefits" has the same meaning as provided in 8 U.S.C. Section 1611 (1998); no later amendments or editions of this section are incorporated. Copies may be available for inspection during regular business hours by contacting Colorado Department of Human Services, Food and Energy Assistance Division, 1575 Sherman Street, Denver, Colorado 80203, or any state publications library.

"Produce" means to provide for inspection either: 1) an original or 2) a true and complete copy of the original document. A document may be produced either in person, by mail or any form of electronic submission.

"State or local public benefits" has the same meaning as provided in 8 U.S.C. 1621 (1998); no later amendments or editions of this section are incorporated. Copies may be available for inspection during regular business hours by contacting the Colorado Department of Human Services, Food and Energy Assistance Division, 1575 Sherman Street, Denver, Colorado 80203, or any state publications library.

B. In order to verify his or her lawful presence in the United States, an applicant must:

1. Produce and provide:

a. A valid Colorado driver's license or a VALID Colorado identification card issued pursuant to Article 2 of Title 42, C.R.S.; or,

b. A United States military card or military dependent's identification card; or,

c. A United States coast guard merchant mariner card; or,

d. A Native American tribal document; or,

e. Any other document authorized by rules adopted by the Department of Revenue 1 CCR 204-30; or,

f. Those applicants who cannot produce one of the required documents may demonstrate lawful presence by both executing the affidavit and executing a request for waiver. The request for waiver must be provided to the Colorado Department of Revenue in person, by mail, or online, and must be accompanied by all documents the applicant can produce to prove lawful presence. A request for a waiver can be provided to the Department of Revenue by an applicant representative.

Once approved by the Department of Revenue, the waiver is assumed to be permanent, but may be rescinded and cancelled if, at any time, the Department of Revenue becomes aware of the applicant's violation of immigration laws. If the waiver is rescinded and cancelled, the applicant has the opportunity to appeal.

The county department is responsible for verifying that the applicant is the same individual indicated as being lawfully present through the waiver.

2. Execute an affidavit saying that:

a. He or she is a United States citizen or legal permanent resident; or,

b. He or she is otherwise lawfully present in the United States pursuant to federal law.

3.753.13 Legal Immigrant [Eff. 12/1/14]

"Legal immigrant" means an individual who is not a citizen or national of the United States and who was lawfully admitted to the United States by the Citizenship and Immigration Services (CIS) as an actual or prospective permanent resident or whose physical presence is known and allowed by the CIS.

3.753.14 Documentation of Legal Immigrant [Eff. 12/1/14]

An alien considered a legal immigrant will normally possess one of the following forms provided by the Citizenship and Immigration Services (CIS) as verification:

A. I-94 arrival/departure record.

B. I-551: resident alien card I-551).

C. Forms I-688b or I-766 employment authorization document.

D. A letter from CIS indicating a person's status.

E. Letter from the U.S. Dept. of Health and Human Services (HHS) certifying a person's status as a victim of a severe form of trafficking.

F. Iraqi and afghan individuals who worked as translators for the U.S. military, or on behalf of the U.S. government, or families of such individuals; and have been admitted under a Special Immigrant Visa (SIV) with specific Visa categories of SI1, SI2, SI3, SI6, SI7, SI9, SQ1, SQ2, SQ3, SQ6, SQ7, or SQ9. Eligibility limitations are outlined in Section 3.710.31, I.

G. Any of the documents permitted by the Colorado Department of Revenue rules for evidence of lawful presence 1 CCR 204-30, APPENDIX B).

3.753.15 Verification with Systematic Alien Verification of Entitlement (SAVE) Program [Eff. 12/1/14]

Legal immigrants applying for public assistance must present documentation from CIS showing the applicant's status. All documents must be verified through SAVE (Systematic Alien Verification for Entitlements) to determine the validity of the document.

3.753.16 Qualified Alien [Eff. 12/1/14]

A “qualified alien” is defined as follows:

A. An alien lawfully admitted for permanent residence;

B. An alien paroled into the United States under the Immigration and Naturalization Act (INA) for a period of at least one year;

C. An alien granted conditional entry pursuant to Section 203(a) (7) of the INA prior to April 1, 1980;

D. A refugee;

E. An asylee;

F. An alien whose deportation is being withheld;

G. A Cuban or Haitian entrant;

H. A victim of severe form of trafficking who has been certified as such by the U.S. Department of health and Human Services (HHS);

I. Iraqis and Afghans granted Special Immigrant Visa status;

J. An alien who has been battered or subjected to extreme cruelty in the U.S. by a family member;

K. An alien admitted to the U.S. as an Amerasian immigrant;

L. An individual who was born in Canada and possesses at least fifty percent (50%) American Indian blood or is a member of an Indian tribe;

3.753.17 Aliens and Temporary Residents Not Eligible for Assistance [Eff. 12/1/14]

The following individuals are not eligible for public assistance or social services programs:

A. An alien with no status verification from the U.S. Citizenship and Immigration Service;

B. An alien granted a specific voluntary departure date;

C. An alien applying for a status; or,

D. A citizen of foreign nations residing temporarily in the United States on the basis of Visas issued to permit employment, education, or a visit.

3.753.18 Citizenship - Lawful Presence Requirements [Eff. 12/1/14]

An applicant who does not meet lawful presence requirements or a household member who does not meet citizenship requirements shall not be included as a household member; however, all countable income of this individual shall be counted as part of the household's total income. The household's application shall not be denied due to lack of documentation regarding citizenship or lawful presence requirements if there are other household members who meet the citizenship requirements (i.e., minors born in the United States).

3.753.19 Alternate Verification Identification to Establish Lawful Presence [Eff. 12/1/14]

In order to verify the applicants lawful presence in the United States, a county department/Contractor can use a print out from the Department of Motor Vehicle's database, or applicable Colorado Benefits Management System (CBMS) Interface Screens documenting a valid status of the applicant's Colorado driver's license or identification as verification, if it indicates that the applicant is lawfully present.

3.753.2 Residence [Eff. 12/1/14]

3.753.21 Colorado Residency [Eff. 12/1/14]

To be eligible for assistance, an applicant shall be a resident of Colorado at the time application is made. There shall be no durational residence requirement. An applicant or recipient who establishes intent to remain in Colorado shall, for public assistance purposes, is considered a current resident. "Intent to remain" may be established by any or all of the following:

A. Acquiring by purchase, rental, or other arrangements housing facilities used as a home;

B. Household effects, equipment, and personal belongings being located in the home or being in transit;

C. Securing employment or engaging in other self-supporting activity based in Colorado;

D. Parents entering children in local schools;

E. Completing the affidavit of intent – residence form; and/or;

F. Entering Colorado with a job commitment or in search of employment in Colorado.

3.753.22 Residency Requirements [Eff. 12/1/14]

Applicant households must meet the state residency requirements as contained in these rules. The household must reside at the address for which it applied to receive LEAP benefits.

3.754 REASONS FOR DENIAL OF ASSISTANCE [Eff. 12/1/14]

"Denial" means that an application shall be denied when the applicant fails to meet the eligibility requirements of the program. A denial also may be assessed on the basis of such factors as, but not limited to:

A. Refusal of the applicant to furnish information necessary to determine eligibility;

B. Applicant unwilling to have the county department/Contractor contact a collateral source to secure information and refusal of the applicant to sign the state-approved authorization for release of information form;

C. Applicant does not supply information or otherwise fails to cooperate with the county department within the standards of promptness time limits and after having received notification of the reason for delay;

D. Applicant moves to an unknown address before determination of eligibility has been completed;

E. Refusal of a third party to provide documentation of essential verifications.

3.754.1 FACTORS FOR DENIAL [Rev. eff. 11/1/15]

Any of the following factors shall be the basis for the denial of an applicant household:*

A. Excess income; 3.752.22 (04).

B. Not vulnerable to rising home heating costs; 3.752.25 (03).

C. Not a U.S. citizen or a qualified alien; 3.753.16 (13).

D. A household is a duplicate household or was previously approved as part of another household; 3.751.2.A (06).

E. The household has voluntarily withdrawn its application; 3.756.18 (09).

F. The household has received Heating Fuel Assistance Program benefits from another county; 3.756.17 (10).

G. The household has failed to provide complete application information or required verification; 3.751.1, “Completed Application” (11).

H. The household is not a resident of Colorado; 3.753.21 (07).

I. The household failed to sign the application form; 3.751.1, “Completed Application”, (21).

J. The household filed an application outside of the application period; 3.752.1 (14).

K. Unable to locate the applicant; 3.756.19 (25).

L. Refused weatherization services from a state weatherization agency; 3.752.26 (26).

M. The applicant failed to provide valid identification; 3.753.11 (05).

N. The applicant failed to provide an affidavit; 3.753.12.B.2 (08).

O. The applicant failed to provide valid identification; 3.753.11, and the applicant failed to provide an affidavit; 3.753.12.B.2 (18).

P. Non-traditional dwelling; 3.751.1, (23).

Q. The household does not reside at the address for which it applied to receive benefits; 3.753.22 (24).

R. LEAP can only assist with the primary heating fuel for the primary heating source; 3.751.1, (22).

S. The applicant household refused a bulk fuel delivery, thereby relinquishing the benefit; 3.758.46.C (28).

T. The household refused inspection of the Crisis Intervention Program work; 3.752.27 (27).

U. The applicant has been convicted of fraud; 3.751.56 (29).

V. THE household failed to provide necessary verification of income; 3.752.22 (02)

3.754.11 Appropriate Reason for Denial [Eff. 12/1/14]

The county department shall use the most appropriate reason for denial; if the county department is unclear as to the most appropriate reason for denial, it shall consult the State Department.

3.754.12 Notice of Denial [Eff. 12/1/14]

A notice of denial shall be provided to the applicant within seven (7) calendar days of the decision; the state will provide the notices to the county department/Contractor for distribution.

3.755 VERIFICATION POLICIES AND CASE RECORD DOCUMENTATION

3.755.1 GENERAL

3.755.11 Verification in Determining Initial Eligibility and Payment Amount [Rev. eff. 12/1/14]

Income, estimated home heating costs, and vulnerability shall be verified in determining initial eligibility and/or payment amount. If a household applied during the prior LEAP program year and there are no changes in the applicant, address and fuel provider, vulnerability and lawful presence (provided that IDs are valid in accordance with Section 3.753) may be copied from the prior year case file and provided in the current case file.

3.755.12 Conflicting Information [Rev. eff. 12/1/14]

If the county/Contractor obtains information which would affect the initial determination of an applicant household's eligibility or payment level and which is different than information provided by the applicant, the county shall inform the applicant and provide an opportunity for response or explanation. Eligibility shall be determined by using the correct information. In these cases, an applicant who meets eligibility criteria shall not be denied because the applicant provided information that was different than information subsequently obtained by the county. Information used to determine eligibility and benefit level shall be documented in the system. However, in appropriate cases, the counties may institute fraud proceedings.

3.755.13 Case Record [Rev. eff. 12/1/14]

The case record shall contain at a minimum:

A. The application and any other supplemental forms the applicant is required to submit;

B. Documentation of all verification as required in these rules;

C. Written explanation on the report of contact of any discrepancy between information contained on the application and information in the LEAP system;

D. Calculations used to compute income, documentation of the source of estimated home heating costs and any other written notations on the report of contact necessary to provide a clear and adequate record of action taken on the case. E. Documentation of all written notices sent to the

applicant household requesting missing information and/or verification necessary to determine eligibility and/or payment level.

F. Complete documentation in emergency or expedited cases including when, to whom, and how a vendor and/or client contact is made.

G. All historical data used must be present in the file and documented in the Report of Contact (ROC).

3.755.14 Written Policy [Eff. 12/1/14]

Each county department/Contractor shall develop a written policy stipulating the order of the case record, and the content of all records in that county department shall be filed according to that county department policy. If the case record is not an electronic file the county department must stipulate that case record material must be fastened to the file folder in order to secure the information and maintain the filing order.

3.755.15 County Storage of Records [Eff. 12/1/14]

The county department shall be responsible for the provision of a safe place for storage of case records and confidential material. If a county department/Contractor shares building space with other county offices, locked files to store case material shall be used. Janitors and other maintenance personnel shall be instructed concerning the confidential nature of information.

3.755.16 State Authority Required for Removal of Case Records [Eff. 12/1/14]

Case records are the property of and shall be restricted to use by the State Department and county department or Contractor. Only on authority of the State Department may case records be removed from the office of the county department or Contractor.

3.755.17 Archiving Case Files [Eff. 12/1/14]

The county department/Contractor shall archive three (3) program years plus the current program year files and make them available to the State upon request.

3.755.2 VERIFYING INCOME

3.755.21 Adequate Verification of Income [Rev. eff. 11/1/15]

The case record shall contain adequate verification of income. Adequate verification is defined as any of the following:

A. Unearned income, such as pensions or retirement income, veteran's benefits, worker's compensation, unemployment or supplemental security income shall be verified in writing, such as an award letter or cost of living adjustment (COLA) letter, issued after the last general increase for that type of assistance, which shows the gross amount before any deductions. Acceptable verification includes documentation from federal/state/system inquiries (i.e., a copy of applicable CBMS screens). Copies of bank deposits or checks shall not be adequate verification of gross income.

B. Verification of child support income shall include at a minimum:

1. Verification through the Automated Child Support Enforcement System (ACSES); or,

2. Verification through the Family Support Registry (FSR); or,

3. Copies of checks, money orders or other document(s) including written statements or affidavits from the non-custodial parent that documents the income paid directly to the custodial parent.

4. An exception shall be made in cases of domestic violence as defined in Section 18-6-800.3(1), C.R.S., when the applicant provides evidence from a court or participation in the state's Address Confidentiality Program (ACP) pursuant to Section 24-30-2104, C.R.S. Client declaration shall be sufficient in such cases.

C. Social Security income may be verified by an award letter, issued by the social security administration, after the last general increase. Acceptable verification includes documentation from federal/state/system inquiries (i.e., a copy of applicable CBMS screens). Gross Social Security income includes income before any deductions for Medicare or other medical insurance. Copies of bank deposit or checks shall not be adequate verification of gross Social Security income.

D. Earned ongoing income shall be verified for at least four (4) weeks of the eight (8) weeks prior to the application date and shall consist of pay stubs or statements from employers which state the period worked, pay frequency and the actual gross income earned.

E. Public assistance income shall be verified through the most current active county records. The Low-Income Energy Assistance Program case record must specifically reference the source document of the income information via federal and/or state system inquiries (i.e., a copy of applicable CBMS screens).

F. Verification of income other than public assistance income of applicant households may be obtained through the most current active county records. The Low-Income Energy Assistance Program case record must specifically reference the source document of the income verification (i.e., source document name and/or number and document date).

G. Verification may be obtained by collateral contact, provided that the case record contains complete information on the name and title of the person contacted, the name of the employer or agency, the period of employment and the actual gross income received, earned or unearned.

H. In verifying zero income, including situations where the shelter expenses exceed income, the county shall examine income of all adult members of the household by using the Department of Labor and Employment (DOLE) verification system and one or more of the following methods:

1. Obtain a reasonable explanation from the household on how they meet shelter expenses and notate in the Record of Contact (ROC) when the explanation is verbally communicated.

2. Verify final date of employment with last employer;

3. Colorado Benefits Management System (CBMS).

I. Verification of self-employment income shall include, at a minimum:

1. Written or verbal declaration of monthly gross income, which may include: Profit and loss statements, i.e., self-employment ledger; and,

2. Receipts for business-related expenses are required in order to be considered as deductions:

    a. Rent or mortgage is not an allowable expense when the applicant is operating a business from his or her residence.

    b. Utilities, data and phone bills including cell phones are not allowable expenses when the account is in the name of an individual.

    c. Fuel expenses are allowable for vehicles used solely for business and for individuals who use personal vehicles that are directly related to the work and necessary to conduct business. The county may accept gas receipts and/or documentation of mileage for those vehicles that are not used solely for business. If using a mileage log, the deduction is then based on the number of miles times the county's established reimbursement rate.

3. Credit card and bank statements are not allowable receipts for business related expenses.

J. Owners of LLC's or S-Corps are considered employees of the corporation and therefore cannot be considered self-employed. Because they are not considered self-employed, they are not entitled to the exclusion of allowable costs of producing self-employment income. The income from these types of corporations should be counted as regular earned income, not self-employment income.

3.755.3 (None)

3.755.4 VULNERABILITY

3.755.41 Evidence of Vulnerability [Rev. eff. 11/1/13]

All households shall be required to provide evidence of vulnerability for the primary heating fuel for the residence at the time of application. Evidence of vulnerability may be shown by one of the following:

1. A copy of the current or most recent fuel bill that the household is responsible for paying. The fuel bill is not to exceed one (1) year prior to the date of application for non-approved vendors.

2. Collateral contact with the fuel provider to establish vulnerability. Contact is to be documented in the report of contact (ROC).

3. A copy of the current or previous month's rent receipt if heat is included in rent is also acceptable. The rent receipt must specifically notate that heat and/or utilities are included in rent. A lease, collateral contact or rent statement from the applicant's landlord is required if the rent receipt is not specific.

4. The county/Contractor may use prior year's fuel bill if the information supplied matches the current application/information. If historical information is being used to verify vulnerability, a notation must be made in the case record. If the fuel bill that is submitted as evidence of vulnerability is in the name of a person other than the applicant household, the case record shall contain a notation that explains the discrepancy in names.

3.755.42 Subsidized Housing Rent Documentation [Rev. eff. 11/1/13]

Applicant households living in subsidized housing units shall be required to provide documentation specifying that the household is subject to heating surcharges when home heating usage exceeds the amount of the household's heating allowance, within the current LEAP program year, or evidence of a separate heating bill.

3.755.43 Wood Permits [Rev. eff. 6/1/09]

Applicants who cut their own wood shall be required to provide a copy of their wood cutting permit. If a permit is not available, the applicants must provide a written and signed statement that they cut their own wood, plus documented proof that they cut it on their own land or that they have permission from the landowner.

3.755.44 Wood Purchase [Eff. 12/1/14]

Applicants who use wood as their primary heating fuel must provide a receipt from a wood vendor. Receipts must include the vendor's name, address, telephone number, date and the name and address of the buyer; it must also contain the amount of wood purchased, the date of the purchase and the cost. If the required information is not provided on the receipt, the county must document in ROC and provide further explanation.

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, address, telephone number, date, and the name and address of the buyer, amount of fuel purchased, the date of the purchase, and the cost.

Applicants, who utilize propane bottles, as described in definitions in these rules, are required to provide a copy of a receipt of purchase only from a retail store or other propane provider.

3.755.5 ESTIMATED HOME HEATING COSTS

3.755.51 Verification [Rev. eff. 11/1/15]

County departments/Contractor shall obtain verification of estimated home heating costs. Verification shall consist of evidence provided by the approved LEAP fuel vendor for the residence at the time of application.

If the county/Contractor changes the Estimated Home Heating Costs (EHHC) originally provided by the fuel vendor, the county/Contractor must obtain written verification or collateral contact of this change from the fuel vendor. The verification from the vendor shall be placed in the case record.

3.755.6 OTHER FACTORS AFFECTING ELIGIBILITY AND PAYMENT AMOUNTS [Rev. eff. 9/1/11]

Other factors affecting eligibility and payment amounts of an applicant household may be verified if determined necessary.

3.756 PROCEDURES FOR PROCESSING APPLICATIONS AND NOTIFYING APPLICANT HOUSEHOLDS

3.756.1 PROCEDURES

3.756.11 Application [Rev. eff. 12/1/14]

Heating Fuel Assistance Program applicants shall submit a completed application form as defined in the "Definitions" section 3.751.1 of these rules to the county department in order to be considered for Heating Fuel Assistance Program benefits. The county department/Contractor shall not require office interviews for purposes of determining eligibility.

3.756.12 Application Processing [Rev. eff. 11/1/13]

A. The county department/Contractor shall be required to date stamp all application forms, verification, and information upon receipt.

B. Beginning November 1st, all applications are to be screened upon receipt to determine if the application is in emergency status. All potential emergency applications are to be pended in two (2) business days from the date of application. All regular applications must be entered into the LEAP database in a pending status within ten (10) business days from the date the application is received in the county LEAP office. All applications received within the eligibility period must be added and either approved or denied no later than June 19th.

C. The county department/Contractor shall be required to review for duplicate applications. The county department/Contractor shall determine if an application is complete as defined in the "Definitions" section of these rules. If an application is not complete, the county department/Contractor shall notify the applicant household, in writing through a LEAP system-generated letter, of information or verification necessary to determine eligibility and/or payment level.

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 be denied on the following business day. 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.

3.756.13 Lost Applications [Rev. 11/1/13]

If a household reports to the county/Contractor that it has mailed or otherwise made application for basic benefits and the county department/Contractor cannot locate the application for the household, such application shall be deemed "lost". The procedures for handling "lost" applications shall be prescribed by the State Department. The client must notify the county/Contractor of the lost application no later than thirty (30) calendar days from the submission date.

3.756.14 Determination of Eligibility [Rev. eff. 11/1/93]

A county department shall have up to thirty (30) calendar days from the date of application as defined in the "Definitions" section of these rules to determine eligibility.

3.756.15 Notification of Approval or Denial [Rev. eff. 10/1/01]

Upon determination of eligibility, the household shall be notified in writing of approval or denial in accordance with the notice requirements in these rules.

3.756.16 County of Residence [Rev. eff. 10/1/09]

The county of residence for applicant households shall be the county where the applicant household is residing as of the date of application. An application received from a non-resident of the county shall be forwarded to the county of residence within five (5) working days. Processing time begins upon receipt of the application by the county of residence. The county forwarding the application shall, simultaneously, notify the applicant household, in writing, of the name, address, and phone number of the county to which the application was forwarded.

3.756.17 Relocation [Rev. eff. 11/1/94]

If an approved household moves from one county to another within Colorado, the original county of residence in which eligibility was determined, shall remain responsible for processing that case throughout the program year. The new county of residence shall provide assistance to the case processing county as requested. If an applicant then applies in the new county of residence, the application shall be denied, and the applicant notified that benefits will be paid by the original county.

3.756.18 Withdrawn Application [Rev. eff. 11/1/08]

An applicant who voluntarily withdraws his/her application prior to eligibility being determined shall be denied. The applicant may notify the county either in writing or verbally that they are voluntarily withdrawing their application. Verbal notice must be documented in the report of contact (ROC).

3.756.19 Unlocated Applicant [Rev. eff. 10/1/09]

An applicant who cannot be located prior to eligibility being determined shall be denied. The county/Contractor must attempt to locate the applicant by mailing a forwardable letter to the last known address. If the applicant does not respond within fifteen (15) business days, the application shall be denied.

3.756.2 ADVANCE PAYMENT OF THE HEATING FUEL ASSISTANCE PROGRAM BENEFIT (applicable only when a signed Vendor Agreement has not been secured) [Rev. eff. 12/1/14]

A. A shut-off notice or other documentation of intent to terminate heating services by the heating supplier or landlord or that termination of service has occurred; or,

B. For households that use bulk fuel, a written or verbal declaration by the household that the fuel supply has been or will be depleted within the next two weeks and the specific amount needed to maintain heat in the home until payroll runs.

C. For households where heat is included in rent, an eviction notice and a written statement from the landlord that the client will not be evicted for thirty (30) days if request for advance of the payment is accepted.

For purposes of advance payment, notices of denial shall advise the applicants of the reason for denial, appeal rights and procedures including, but not limited to, a hearing.

3.757 PROCEDURE FOR REPORTING ELIGIBILITY AND PAYMENT INFORMATION

3.757.11 [Rev. eff. 9/1/11]

The county/Contractor will be required to correct any inaccuracies as they may result in an erroneous payment amount and/or incorrect eligibility determination. Information reported on the household's income, family size, estimated home heating costs, subsidized housing heat allowance, and number of separate households is the basis for the amount of LEAP benefit.

3.757.12 [Rev. eff. 9/1/11]

County departments/Contractor shall enter completed applications into the LEAP automated system as eligibility is determined.

3.758 PAYMENT POLICIES

3.758.1 (NONE)

3.758.2 (NONE)

3.758.3 CHANGES IN HOUSEHOLD COMPOSITION AFFECTING ISSUANCE OF PAYMENT

3.758.31 Change in Household Circumstances [Rev. eff. 12/1/14]

If, prior to payment, an eligible household's circumstances change, which involves separation or divorce of a marriage or common law arrangement, and the household includes dependent children, the Heating Fuel Assistance Program payment(s) shall be provided to the parent or guardian who resides with and has the responsibility for the care of the dependent children.

If the household does not include dependent children, the Heating Fuel Assistance Program payment(s) shall be paid to the person listed as applicant.

3.758.32 Death of Payee Affecting Issuance of Payment [Rev. eff. 12/1/14]

When the payee for a Heating Fuel Assistance Program benefit dies, any payment to which the payee was entitled shall be kept available according to the following rules:

A. The surviving spouse or other household member shall be entitled to the Heating Fuel Assistance Program payee's benefit provided that the surviving spouse or other household member was included as part of the Heating Fuel Assistance Program payee's household upon Heating Fuel Assistance Program eligibility determination.

B. In the case of a single member household client payment, the payment will expunge after three hundred sixty-five (365) days. In the case of a single member household vendor payment, the vendor will follow the process outlined in the vendor agreement.

3.758.4 PAYMENT METHODS

3.758.41 Heating Fuel Assistance Program Payment [Rev. eff. 12/1/14]

For an approved household which pays home heating costs directly to a fuel vendor, payment shall be made as a vendor payment, provided a written vendor agreement has been secured. The State Department shall be required to provide vendors servicing their county with an opportunity to sign the state prescribed vendor agreement. County departments/Contractor shall provide vendors with applications, brochures, envelopes, and other outreach material. In cases where a written vendor agreement has not been secured, payment shall be issued directly to the eligible household.

For an approved household that pays home heating costs to a landlord, payment of the Heating Fuel Assistance Program payment shall be made directly to the eligible household. Under no circumstances shall a direct payment be made to a landlord.

3.758.42 - 3.758.45 (None)

3.758.46 Vendor Payment Procedures [Rev. eff. 12/1/14]

A. When a direct vendor payment is made, the county department/Contractor shall be required:

1. To notify each household of the amount and month such assistance is scheduled to be paid on its behalf,

2. To notify the household of the vendor to be paid on the household's behalf,

3. To contact the vendor to explain the vendor payment process, when applicable.

4. To notify each eligible household in writing of the eligible household's responsibilities to continue to pay toward the household's heating costs. Such notification shall advise the household that the Heating Fuel Assistance Program payment is not intended to totally pay a household's heating costs.

   If the household has received a notice from the vendor to terminate services or has already had services terminated, the household is responsible to negotiate a payment arrangement with their vendor.

5. To notify the vendor in writing of each household's eligibility and projected payment amount.

B. Prior to any Heating Fuel Assistance Program payment being made directly to a fuel vendor on behalf of an eligible household, the following terms of agreement shall be obtained from the fuel vendor in writing and notice of the same shall be included with the Heating Fuel Assistance Program payment in accordance with a State prescribed form. Any revision or modification of the assurances below, necessitated by unique circumstances, shall be submitted in writing to the State Department for approval prior to execution of the vendor agreement.

C. Refer to the State approved vendor agreement for specific requirements, conditions and procedures. This agreement is available on the Colorado Department of Human Services web site at www.colorado.gov/CDHS/LEAP.

3.758.47 Methodology for Calculating Heating Fuel Assistance Program Benefits [Rev. eff. 11/1/15]

The payment amount for an eligible Heating Fuel Assistance Program household shall be determined in accordance with the following method:

Step A. Determine Estimated Home Heating Costs (EHHC)

The county department/Contractor shall determine estimated home heating costs for November 1st through April 30th for the household's current residence at the time of application. The methodology for calculating estimated home heating costs is outlined below.

The county department/Contractor shall determine the applicant household's estimated home heating costs as follows:

1. An applicant household's estimated home heating cost shall consist of the total actual home heating costs for the primary heating fuel for November 1st through April 30th, of the prior year's heating season. Vendors serving applicant households shall be required to supply actual home heating costs for November 1st through April 30th of the prior year's heating season.

2. For any applicant whose home heating costs for the prior year's heating season are not available or determined by the county department to be invalid, the county department shall use the flat rate amount. The State Department shall adjust the flat rate amounts annually based on the average actual home heating costs found in the LEAP system by dwelling type for the prior year's heating season contained in the following table:

	NAT. GAS	PROPANE FUEL OIL	ELEC.	WOOD	COAL	PROPANE BOTTLES	WOOD GATHERING
House, Mobile Home	$342	$725	$980	$536	$575	$503	$300
Duplex, Triplex, Fourplex, Townhouse	$280	$552	$743	$614	$482	$341	$200
Apartment, Condominium, Hotel, Cabin, Tiny Home	$216	$712	$547	$594	$482	$237	$200
Camper, 5th Wheel, RV	$301	$585	$665	$560	$432	$335	$200

3. The State Department shall adjust the standard rates for heating costs that are included in rent annually based on the flat rate amounts adjustment contained in the following table:

	NATURAL GAS	PROPANE FUEL OIL	ELECTRIC	WOOD	COAL
House, Mobile Home	$156	$310	$458	$241	$193
Duplex, Triplex, Fourplex, Townhouse	$123	$243	$346	$246	$193
Apartment, Condominium, Hotel, Cabin, Tiny Home	$94	$245	$230	$238	$193
Camper, 5th Wheel, RV	$174	$252	$323	$224	$173

Step B. Initial Statewide Adjustment

The State LEAP office will adjust benefit levels at the beginning of each LEAP program year based upon the projected number of leap applications to be received and the estimated level of funding. Annually, this calculation determines the percentage of the estimated home heating costs (EHHC) of the applicant household to be adjusted.

Step C. Adjustment for Electric Heat

Households using electric heat will have their electric usage costs reduced to the percentage amounts listed below.

HEAT PORTION OF TOTAL ELECTRIC EHHC

House/mobile home	62% for heat
Townhouse / duplex / triplex / fourplex	48% for heat
Apartment, condominium, hotel, Cabin, Tiny Home	43% for heat
RV, 5th wheel, camper	50% for heat

Step D. Adjustment for Shared Living Arrangements

The estimated home heating costs shall be adjusted if the household shares living arrangements with other households but is determined to be a separate household as defined in the "Definitions" section of these rules. If the household shares living arrangements with other households, the estimated home heating cost shall be divided by the number of separate households sharing the living arrangements, whether or not all households sharing the living arrangements are eligible for the Heating Fuel Assistance Program.

Step E. Adjustment for Subsidized Housing Home Heating Allowance

The State Department shall adjust the amount of estimated home heating cost remaining after Step B if the household resides in subsidized housing (as defined in the "Definitions" section of these rules). A flat rate rental cost allowance for heating ($30 per month or $180 per heating season) shall be deducted from the remaining amount of estimated home heating costs. If the household does not live in subsidized housing, the amount remaining after Step B shall be the estimated home heating cost.

Step F. Determine Heating Fuel Assistance Program Amount

The State Department shall determine a benefit amount for each eligible household by subtracting the applicable adjustments listed above, in Steps B-E from the household's estimated home heating costs (EHHC) determined in Step A, 1-3. Any eligible household will receive at least the minimum, up to and including, the maximum benefit amount established by the Department for the LEAP program year.

3.758.48 Adjustments [Rev. eff. 9/1/11]

The State Department will provide the county departments advance written notice of any statewide benefit level adjustments.

Any statewide adjustment to the LEAP benefit level cannot be appealed.

The benefit amount in a prior LEAP program year is not indicative of a current LEAP program year benefit amount and benefit levels may vary from program year to program year depending on funding and the applicant pool.

3.758.49 Forfeiture of Benefit [Eff. 11/1/98]

If the benefit is not properly claimed within the current federal fiscal year for the period of intended use, the household will forfeit the remaining benefit.

3.759 OUTREACH AND REFERRAL

3.759.1 COUNTY DEPARTMENTS

3.759.11 Operation [Rev. eff. 12/1/14]

The county department has responsibility for the operation of a county wide outreach program. The outreach program shall be operated in accordance with guidelines contained in this section. The county

may opt to contract with other agencies to perform all or part of the required outreach activities. Counties must assure that outreach includes:

A. Coordination with other agencies, organizations, and groups to facilitate the participation of potentially eligible persons with emphasis on most vulnerable (e.g., elderly, disabled, home bound, non-English speaking);

B. Access to Heating Fuel Assistance Program information and application forms. Outreach staff must identify locations in the county, such as community action programs, Social Security offices, low income housing sites, etc., for distribution of information, taking of applications, etc., through these sites. In addition, the county must have sufficient telephone lines to ensure access to information without requiring office visits;

C. An effective county wide information and referral system involving local agencies and organizations;

D. A referral system to weatherization and other energy conservation programs in the county;

E. Special efforts to meet the needs of target groups (e.g., home visits for home bound, out stationing of outreach staff, etc.). County departments shall assist disabled and elderly (as defined in the "Definitions" section of these rules) applicants in completing applications and securing the required verification;

F. Regular communications with cooperating agencies to identify concerns, problems, etc.;

G. Encourage utility companies to refer their customers to the county departments.

3.759.12 Outreach Plan [Rev. eff. 11/1/03]

The county department shall develop an outreach plan which describes specific activities the county will perform to carry out the specific responsibilities outlined in 3.759.11, above. The plan shall be available for public inspection at the county department.

3.759.13 Reporting Requirements

County departments shall comply with outreach reporting requirements as prescribed by the State Department. Failure to comply may result in the recovery of outreach funds.

3.759.2 OUTREACH ACTIVITIES

3.759.21

Outreach materials shall be distributed to various community agencies targeting groups such as elderly, persons with disabilities, veterans, migrant seasonal workers, renters, Native Americans, and non-English or limited English speaking communities.

3.759.3 (None) [Rev. eff. 2/1/12]

3.759.4 WEATHERIZATION REFERRAL

3.759.41 [Rev. eff. 11/1/83]

Eligible households shall be referred for participation in weatherization, energy conservation and other related assistance upon the household's request.

3.760 (NONE) [Rev. eff. 9/15/12]

3.770 ALLOCATION FOR ADMINISTRATION AND OUTREACH [Rev. eff. 11/1/96]

The county may transfer funds from Program Code 4510 Administration to Program Code 4520 Outreach. The county may not transfer funds from Program Code 4520 Outreach to Program Code 4510 Administration.

The county is to budget its allocation of funds for Program Code 4510 Administration and Program Code 4520 Outreach to cover all expenditures which may be incurred from October 1 to the following September 30. The county department shall not be reimbursed for expenditures in excess of the county's allocation of Program Code 4510 and Program Code 4520 funds. The county's allocation of Program Code 4510 Administration funds will not be increased unless the State Department allocates additional funds to all counties or unless the county meets the following criteria:

A. The county submits a written letter of request which includes the county's original budget plan for expenditure of its allocation of administrative funds, a description of expenditures to date for administrative costs, a budget of anticipated costs for the remainder of the program, and a narrative justification of actual and anticipated expenditures for the program.

B. The request for additional funds must be justified on the basis of one or both of the following factors:

1. That the county incurred or expects to incur extraordinary costs which were or are beyond county control and were or will be necessary to implement the program:

2. That the county's caseload in relation to its allocation of administrative funds was significantly greater than the caseload of other similar sized counties in relation to their allocation of administrative funds.

Actual provision of additional funds is contingent upon availability of administrative funds.

The county's allocation of Program Code 4520 Outreach funds shall not be increased unless the county submits a request for additional outreach funds, which explains and justifies the need for such funds or unless the state department allocates additional funds to all counties.

Editor's Notes

Primary sections of 9 CCR 2503-1 have been recodified effective 09/15/2012. See list below. Versions and rule history prior to 09/15/2012 can be found in 9 CCR 2503-1. Prior versions can be accessed from the All Versions list on the current rule page.

Rule section 3.000 – 3.100, et seq. has been recodified as 9 CCR 2503-1, GENERAL RULES.

Rule section 3.200, et seq. has been recodified as 9 CCR 2503-2, GENERAL FINANCIAL ELIGIBILITY CRITERIA.

Rule section 3.300, et seq. has been recodified as 9 CCR 2503-3, OLD AGE PENSION.

Rule section 3.400, et seq. has been recodified as 9 CCR 2503-4, AID TO THE NEEDY DISABLED AND AID TO THE BLIND.

Rule section 3.500, et seq. has been recodified as 9 CCR 2503-5, (Reserved for Future Use).

Rule section 3.600, et seq. has been recodified as 9 CCR 2503-6, COLORADO WORKS PROGRAM.

Rule section 3.700, et seq. has been recodified as 9 CCR 2503-7, OTHER ASSISTANCE PROGRAMS.

Rule section 3.800, et seq. has been recodified as 9 CCR 2503-8, ADMINISTRATIVE PROCEDURES.

Rule section 3.900, et seq. has been recodified as 9 CCR 2503-9, COLORADO CHILD CARE ASSISTANCE PROGRAM.

History

Sections 3.750.12-13, 3.751.1, 3.751.31, 3.751.41-43, 3.751.51, 3.751.53, 3.751.71-72, 3.752.1, 3.752.22-23, 3.754.1, 3.756.2 eff. 09/15/2012. Section 3.760-3.760.53 repealed eff. 09/15/2012.

Sections 3.744.F-G, 3.746.A-F, emer. rules eff. 11/09/2012.

Sections 3.720, 3.721.22, 3.744.A-B emer. rules eff. 02/01/2013.

Sections 3.744.F-G, 3.746. A-F eff. 03/02/2013.

Sections 3.720-3.720.32, 3.721.22, 3.744.A-B eff. 05/01/2013.

Sections 3.751.1, 3.751.34, 3.752.1-3.752.22.E, 3.752.25, 3.754.1, 3.754.1.K, 3.755.13-3.755.42, 3.756.12-3.756.13, 3.756.2, 3.758.1, 3.758.47 eff. 11/01/2013.

Sections 3.700, 3.720-7.746 eff. 03/02/2014.

Sections 3.750-3.751.53, 7.751.6-3.756.11, 7.756.2-7.759.13 eff. 12/01/2014.

Sections 3.751.44, 3.751.56, 3.752.22, 3.752.22.D, 3.752.23, 3.752.23.P-DD, 3.752.25, 3.754.1, 3.754.1.C, 3.755.21, 3.755.21.A, 3.755.21.B.4, 3.755.21.I.3, 3.755.45, 3.755.51, 3.758.47, 3.758.47 Step A.2-3 eff. 11/01/2015.

Section 3.751.56 eff. 04/01/2016.

Sections 3.710, 3.711 recodified as 9 CCR 2503-3 eff. 09/01/2016.

Section 3.750 eff. 11/01/2016.

Entire rule eff. 11/01/2017.

Annotations

Rule 3.751.44 (adopted 10/03/2014) was not extended by Senate Bill 15-100 and therefore expired 05/15/2015.

Rule 3.751.56 (adopted 09/09/2016) was not extended by Senate Bill 17-083 and therefore expired 05/15/2017.

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Office of the Attorney General

Tracking number: 2018-00289

Opinion of the Attorney General rendered in connection with the rules adopted by the

Income Maintenance (Volume 3)

on 09/07/2018

9 CCR 2503-7

OTHER ASSISTANCE PROGRAMS

The above-referenced rules were submitted to this office on 09/13/2018 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.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

September 25, 2018 09:06:24

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 2505-3

Rule title

10 CCR 2505-3 FINANCIAL MANAGEMENT OF THE CHILDREN'S BASIC HEALTH PLAN 1 - eff 10/30/2018

Effective date

10/30/2018

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to Child Health Plan Plus Rule concerning Income Verification for Those Receiving Continuous Coverage, Section 430
Rule Number: MSB 18-05-15-B
Division / Contact / Phone: Health Information Office / Ana Bordallo / 3558

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 18-05-15-B, Revisions to Child Health Plan Plus Rule concerning Income Verification for Those Receiving Continuous Coverage, Section 430
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) 430, Colorado Department of Health Care Policy and Financing, Child Health Plan *Plus* (10 CCR 2505-3).
5. Does this action involve any temporary or emergency rule(s)? 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 Section 430 with the proposed text beginning at Section 430.1 through the end of Section 430.5. This rule is effective October 31, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to Child Health Plan Plus Rule concerning Income Verification for Those Receiving Continuous Coverage, Section 430
Rule Number: MSB 18-05-15-B
Division / Contact / Phone: Health Information Office / Ana Bordallo / 3558

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this rule change is to add clarification for members receiving continuous coverage within a child or a pregnant category, whose income is not reasonably compatible based on the self-reported income and the electronic income verified. When the income is not reasonably compatible and it's the first income discrepancy if the discrepancy is not resolved within the reasonable opportunity period(ROP) of 90 days, their benefits will be terminated. Additional changes have been made to section 430.2.b.v by updating the language to align with the Medicaid language.

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:

   Code of Federal Regulation §435.952.(c)(2)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   25.5-8-109.(4.5)(a)(I) and(II)

Initial Review	**08/10/18**	Final Adoption	**09/14/18**
Proposed Effective Date	**10/30/18**	Emergency Adoption	

DOCUMENT #08

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to Child Health Plan Plus Rule concerning Income Verification for Those Receiving Continuous Coverage, Section 430
Rule Number: MSB 18-05-15-B
Division / Contact / Phone: Health Information Office / Ana Bordallo / 3558

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The classes of persons who will be affected by this proposed rule clarification are members enrolled in the Child Health Plan Plus category receiving continuous coverage who is a child or pregnant women. The benefits of this rule change will provide clear guidance to the populations listed, who are receiving benefits and whose benefits may be impacted if they fail to respond to the discrepancy notice.

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

   The proposed rule will provide clarification for those members whose income is not reasonably compatible and it's the first income discrepancy, if the discrepancy is not resolved within the reasonable opportunity period(ROP) of 90 days, their benefits will be terminated.

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

   There are no costs to the Department as this is only adding clarification to the Departments current rules to align with current policy.

4. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There is no other less costly method to update this rule change.

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 alternatives methods for the proposed rule that were considered.

FINANCIAL MANAGEMENT OF THE CHILDREN'S BASIC HEALTH PLAN

10 CCR 2505-3

430 ENROLLMENT DATE

430.1 Eligibility for the Children's Basic Health Plan shall be effective on the latter of:

A. The first day of the month of application for Medical Assistance; or

B. The first day of the month the person becomes eligible for the Children's Basic Health Plan program.

430.2 Upon being enrolled in the Children's Basic Health Plan, continuous eligibility applies to children under the age of 19, who through an eligibility determination, reassessment or redetermination are found eligible for the Children's Basic Health Plan program. The continuous eligibility period may last for up to 12 months and will begin on the month of application or from the authorization date.

A. The continuous eligibility period applies without regard to changes in income or other factors that would otherwise cause the child to be ineligible.

i) A 14-day no fault period shall begin on the date the child is determined eligible for Medical Assistance. During the 14-day period, updates or corrections may be made to the child's case. Any changes to the child's case made during the 14-day no fault period may impact his or her eligibility for Medical Assistance.

B. A child's continuous eligibility period will end effective the earliest possible month, if any of the following occur:

i) Child is deceased

ii) Becomes an inmate of a public institutio

iii) The child states that she/he has moved out of the household permanently

iv) Is no longer a Colorado resident

v) Is unable to be located based on evidence or reasonable assumption

vi) Requests to be withdrawn from continuous eligibility

vii) Fails to provide documentation during a reasonable opportunity period as specified in section 8.100.3.H.9

viii) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90-day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

ix) An eligible person shall not be enrolled in other health insurance coverage

430.3. If determined eligible, the enrollment date of a pregnant woman shall be effective as of the first of the month of the date of application or the first day of the month the pregnant woman becomes eligible. The enrollment span shall end at the end of the month following 60 days after the birth of the child or termination of the pregnancy. Once eligibility has been approved, coverage must be provided regardless of changes in the woman's financial circumstances, once the income verification requirements are met.

A. A pregnant women's eligibility period will end effective the earliest possible month, if any of the following occur:

i) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90-day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

430.4 An eligible person's enrollment date in the selected MCO shall be no later than:

A. The first of the month following eligibility determination and MCO selection if eligibility is determined before the 17th of the month.

B. The first of the second month following eligibility determination and MCO selection if eligibility is determined on or after the 17th of the month.

430.5 A child born to a mother who is enrolled in the Children's Basic Health Plan at the time of the child's birth is guaranteed coverage for one year.

A. To receive Medical Assistance under the Children's Basic Health Plan, the birth must be reported verbally or in writing to the County Department of Human Services or Eligibility site. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time by any person. Once reported, a newborn meeting the above criteria shall be added to the mother's Medical Assistance case, or his or her own case if the newborn does not reside with the mother, according to timelines defined by the Department. If adopted, the newborn's agent does not need to file an application or provide a Social Security Number or proof of application for a Social Security Number for the newborn.

CYNTHIA H. COFFMAN
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Office of the Attorney General

Tracking number: 2018-00347

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 09/14/2018

10 CCR 2505-3

FINANCIAL MANAGEMENT OF THE CHILDREN'S BASIC HEALTH PLAN

The above-referenced rules were submitted to this office on 09/18/2018 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.

September 26, 2018 11:00:03

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Permanent Rules Adopted

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

CCR number

10 CCR 2505-10

Rule title

10 CCR 2505-10 MEDICAL ASSISTANCE - STATEMENT OF BASIS AND PURPOSE, AND RULE HISTORY 1 - eff 10/30/2018

Effective date

10/30/2018

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Adult Day Services, Section 8.491

Rule Number: MSB 18-05-25-A

Division / Contact / Phone: Benefits and Services Division / Cassandra Keller / 866-5181

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 18-05-25-A, Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Adult Day Services, 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(s) 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 text at 8.491 with the proposed text beginning at 8.491.1 through the end of 8.491.5. This rule is effective October 31, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Adult Day Services, Section 8.491

Rule Number: MSB 18-05-25-A

Division / Contact / Phone: Benefits and Services Division / Cassandra Keller / 866-5181

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 intention of this rule is to ensure providers meet both State and Federal guidelines for critical incident reporting, care planning, and the HCBS Final Settings Rule. The new regulations will make clear the new requirements for the providers. This will help to ensure the Department is in compliance with federal regulations, as well as better align policies with our sister agencies. That collaboration will lead to improved oversight of adult day centers as well as more comprehensive inspections by the Department of Public Health and Environment (DPHE).

   Additionally, the revised criteria for specialized adult day services, food safety regulations, and updated language and clarification throughout will provide more comprehensive regulations and safer settings for the HCBS waiver participants and clarity for providers.

   The Department has worked closely with DPHE, providers, participants and the trade groups to revise these regulations.

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:

Initial Review **07/13/18** Final Adoption **08/10/18**

Proposed Effective Date **09/30/18** Emergency Adoption

DOCUMENT #06

DO NOT PUBLISH THIS PAGE

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);

   25.5-6-313, C.R.S.

Initial Review	**07/13/18**	Final Adoption	**08/10/18**
Proposed Effective Date	**09/30/18**	Emergency Adoption	

DOCUMENT #06

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Adult Day Services, Section 8.491

Rule Number: MSB 18-05-25-A

Division / Contact / Phone: Benefits and Services Division / Cassandra Keller / 866-5181

REGULATORY ANALYSIS

5. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Individuals who will be affected by this rule are individuals who attend Adult Day Centers on the Elderly Blind and Disabled (EBD), Community Mental Health Supports (CMHS), and Spinal Cord Injury (SCI) Waivers. They will benefit from this rule change due to improved critical incident reporting; revised criteria for specialized adult day services; care planning requirements; HCBS Final Settings Rule requirements; food safety regulations; and updated language and clarification throughout. They will not bear any cost from this rule change. Adult Day Centers may have a slight additional administrative burden, but the Department does not anticipate the providers bearing any additional costs.

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

   All EBD, CMHS, and SCI waiver clients who attend Adult Day Centers will benefit from the new requirements and additional oversight it will bring to the program, as described in paragraph one.

7. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There will not be a cost increase to the Department.

8. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The clarification to the Adult Day rule will significantly benefit participants, which outweighs any additional administrative burdens on the part of the Centers. There are no benefits of inaction in behalf of the Department.

9. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   The additional requirements in the proposed regulations are required by CMS and must be implemented. The additional regulations and clarifications will require minimal additional output from the Department. There are no less costly or less intrusive methods of achieving the purpose of this rule.

10. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

    No alternative methods were considered.

8.491 ADULT DAY SERVICES

8.491.1 Definitions

Adult Day 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 Center 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.

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.

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.

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 Adult Day Services regardless of payment source.

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 Center within its certification category and populations served may be admitted to the ADS Center.
2. ADS shall include, but are not limited to, the following:
    a. Daily 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. (ADLs include but are not limited to eating, ambulation, positioning, transferring, toileting, and incontinence care).

b. Daily services provided to monitor the participant's health status, monitor or administer medications, and carry out physicians' orders as set forth in participant's individual Care Plan.

c. Services 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.

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. The ADS Center 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 on reassessment by the case manager, or 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 Center 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 Center 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 Centers 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 Center is selected by the individual from among setting options including non-disability specific settings;

   c. ADS Center ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;

   d. ADS Center 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 Center 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 Centers 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.
2. ADS Centers 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 shall be stored in a locked cabinet when unattended by QMAP or LMP staff.
4. Non-prescription medications 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. ADS Center 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, the policies, and procedures relevant to the ADS Center and the services provided;
   f. A service agreement signed by the participant and/or the designated representative and appropriate center staff; and
   g. A copy of the PMIP, or diagnosis documentation from the participant's LMP.

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 at the Adult Day Services Center, and whether they are being self-administered;
      ii. Special dietary considerations, instructions, or restrictions;
      iii. Services that are administered to the participant while at the ADS Center (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 Center was selected by the individual and/or designated representative or legal representative;
      ii. Individual choices, 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 is 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 Center shall adjust staffing ratios based on the individual acuity and needs of the participants in the Center. 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 at an ADS Center 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. 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.

c. 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 and must be provided by an 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 a ADS Center 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 Center shall require any individual seeking employment with the Center 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 Center 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 Center 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 Center 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 Center staff and volunteers must be trained in the ADS Centers' programmatic policies and procedures.
2. ADS Centers 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 Center 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 Center 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. Written Policies

1. The ADS Center 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 in the ADS Center;
   b. Intake procedures conducted for participants and/or designated representatives prior to admission to the ADS Center;
   c. The meals and nourishments including special diets that are provided;
   d. The hours and days the ADS Center is open and services 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; and
   g. Emergency services including written procedures to meet medical crises, and natural and manmade disasters.
2. There shall be a written, signed agreement between the participant and/or designated representative and the ADS Center outlining the rules and responsibilities of the ADS Center and the participant. Each party in the agreement shall be provided a copy.

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, shall be based upon a single all-inclusive payment rate per unit of service for each participating provider which shall be prospectively determined. Units are to be billed in accordance to the current rate schedule:

1. A unit is defined as:
   one (1) unit = a partial day = three (3) to five (5) hours of service
   two (2) units = a full day = more than five (5) hours of service

B. For persons in the HCBS waiver for Persons with a Brain Injury (BI), reimbursement for BI-ADS shall be based upon a single all-inclusive payment rate per unit of service for each participating provider.

1. A unit is defined as:

one (1) unit = two or more hours per 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. 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 Pharmacist Provider Type Addition, Section 8.200.2

Rule Number: MSB 18-09-02-A

Division / Contact / Phone: Health Programs Office / Richard Delaney / 303 866-3436

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 18-09-02-A, Revision to the Medical Assistance Rule concerning Pharmacist Provider Type Addition, Section 8.200.2
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) 8.200.2, 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:	10/31/2018
Is rule to be made permanent? (If yes, please attach notice of hearing).	<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.200.2 with the proposed text beginning at 8.200.2.A through the end of 8.200.2.E. This rule is effective October 31, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Pharmacist Provider Type Addition, Section 8.200.2

Rule Number: MSB 18-09-02-A

Division / Contact / Phone: Health Programs Office / Richard Delaney / 303 866-3436

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The Rule will allow pharmacists to be paid for vaccine administration services. These services are medical services and require reimbursement through the MMIS.

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:

   Title XIX Social Security Act, Section 1905(a)(6) medical care recognized under state law furnished by a licensed practioners within the scoope of their practice as defined by state law.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2016);

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Title of Rule: Revision to the Medical Assistance Rule concerning Pharmacist Provider Type Addition, Section 8.200.2

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REGULATORY ANALYSIS

5. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Pharmacists and adults enrolled in Medicaid will be affected. Pharmacists will be able to provide a medical service and adults will be able to receive specific vaccines at more locations in the state.

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

   There is not expected to be any economic impact. There is expected to be expanded access to the vaccines pharmacists can provider with this rule change.

7. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There is not expected to be any costs to the department. Other states that have implemented the policy of allowing pharmacists to administer vaccines did not incur additional costs

8. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The rule will increase access to the vaccines pharmacists are allowed to administer in Colorado.

9. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There is no other method to allow pharmacists to provide vaccine administration services.

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10. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

    The change is needed to comply with Colorado Statutes.

8.200 PHYSICIAN SERVICES

8.200.2 Providers

8.200.2.A. A doctor of medicine or a doctor of osteopathy may order and provide all medical care goods and services within the scope of their license that are covered benefits of the Colorado Medical Assistance Program.

1. A provider of covered dental care surgery may be enrolled as either a dentist or oral surgeon, but not as both. A dentist may order and provide covered dental care.

8.200.2.B. Physician services that may be provided by non-physician providers without a physician order.

1. Advanced Practice Nurses may provide and order covered goods and services in accordance with the scope of practice as described in the Colorado Department of Regulatory Agencies rules without a physician order.

2. Licensed Psychologists may provide and order covered mental health goods and services in accordance with the scope of practice as described in the Colorado Department of Regulatory Agencies rules without a physician order.

    a. Services ordered by a Licensed Psychologist but rendered by a non-licensed mental health provider must be signed and dated by the Licensed Psychologist contemporaneously with the rendering of the service by a non-licensed mental health provider.

3. Optometrists may provide covered optometric goods and services within their scope of practice as described by the Colorado Department of Regulatory Agencies rules without a physician order.

4. Podiatrists may provide covered foot care services within their scope of practice as described by the Colorado Department of Regulatory Agencies rules without a physician order.

5. Licensed dental hygienists may provide unsupervised covered dental hygiene services in accordance with the scope of practice for dental hygienists as described in the Colorado Department of Regulatory Agencies rules without a physician order.

8.200.2.C. Physician services that may be provided by a non-physician provider when ordered by a provider acting under the authority described in Sections 8.200.2.A. and 8.200.2.B.

1. Registered occupational therapists, licensed physical therapists, licensed audiologists, certified speech-language pathologists, and licensed physician assistants may provide services ordered by a physician.

    a. Services must be rendered and supervised in accordance with the scope of practice for the non-physician provider described in the Colorado Department of Regulatory Agencies rules.

2. Licensed pharmacists, in accordance with the scope of practice for pharmacists as described in the Colorado Department of Regulatory Agencies rules 3 CCR 749-1 and C.R.S. 12-42.5-101 et. seq., may provide covered services.

8.200.2.D. Physician services that may be provided by a non-physician provider when supervised by an enrolled provider.

1. With the exception of the non-physician providers described in Sections 8.200.2.A. through 8.200.2.C. and 8.200.2.D.1.a., a non-physician provider may provide covered goods and services only under the Direct Supervision of an enrolled provider who has the authority to supervise those services, according to the Colorado Department of Regulatory Agencies rules. If Colorado Department of Regulatory Agencies rules do not designate who has the authority to supervise, the non-physician provider must provide services under the Direct Supervision of an enrolled physician.

a. Registered Nurses (RNs) are authorized to provide delegated medical services within their scope of practice as described in the Colorado Department of Regulatory Agencies rules under General Supervision.

8.200.2.E. Licensure and required certification for all physician services providers must be in accordance with their specific specialty practice act and with current state licensure statutes and regulations.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Immunization Services, Section8.815

Rule Number: MSB 18-06-20-B

Division / Contact / Phone: Operations Section / Whitney McOwen / 303-866-4441

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 18-06-20-B, Revision to the Medical Assistance Rule concerning Immunization Services, Section8.815
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) 8.815, 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)?	No
If yes, state effective date:	N/A
Is rule to be made permanent? (If yes, please attach notice of hearing).	<Select One>

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text at 8.815. This rule is effective October 31, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Immunization Services, Section8.815

Rule Number: MSB 18-06-20-B

Division / Contact / Phone: Operations Section / Whitney McOwen / 303-866-4441

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 immunization services benefit is being converted to rule in order to codify existing practice currently documented in the Immunization Benefit Coverage Standard. The rule will also extend eligibility to administer immunizations to pharmacists. Allowing pharmacists to administer immunizations will increase access for Medicaid clients that are eligible for the vaccines.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 USC 1396s;

   42 CFR 440.120

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);

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Title of Rule: Revision to the Medical Assistance Rule concerning Immunization Services, Section8.815

Rule Number: MSB 18-06-20-B

Division / Contact / Phone: Operations Section / Whitney McOwen / 303-866-4441

REGULATORY ANALYSIS

5. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Pharmacists will benefit from this proposed rule because administering immunizations is within the scope of their licensure. Clients will benefit from adoption of this rule because this rule will increase access to immunization administration services. The Department does not anticipate that this will increase costs associated with immunization services, but will instead shift some utilization from physicians to pharmacists.

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

   Quantitatively, the Department estimates that this change will be budget neutral because some utilization will shift from physicians to pharmacists. Qualitatively, pharmacists will benefit because their eligibility will now align with their eligibility under their licensure, and clients will benefit from an increase in access to immunization administration services.

7. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The Department estimates that this change will be budget neutral.

8. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   This change is estimated to be budget neutral. The benefit of increased access to immunization administration services for clients, outweigh any costs of the proposed rule.

9. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less costly or less intrusive methods to convert existing policy from benefit coverage standard to rule or extend immunization administration eligibility to pharmacists.

10. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

    The Department did not consider any alternative methods for converting existing policy from benefit coverage standard to rule, or extending immunization administration eligibility to pharmacists.

8.810.5 NON-COVERED SERVICES

8.810.5.A. The following Podiatry services are not covered by Colorado Medicaid:

1. Surgical assistant services (differing from assisting surgeons).
2. Local anesthetics that are billed as a separate procedure.
3. Operating room facility charges for in-office procedures.
4. Treatment of subluxation of the foot.
5. Treatment of flat feet.
6. Routine supplies provided in the office.

8.815 IMMUNIZATION SERVICES

8.815.1 Definitions

8.815.1.A. Advisory Committee on Immunization Practices (ACIP) means a 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 a federally funded program 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 must also be enrolled as a VFC provider.

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 covered by the VFC program.

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 to groups of clients at nursing facilities, group homes, or residential treatment centers that are provided by home health agencies, physicians, or other non-physician practitioners are covered only as follows:

1. Clients who are residents of nursing facilities and clients receiving home health services may receive Immunization services if ordered by their physician. The skilled nursing component for Immunization administration provided at a nursing facility is included in the facility's rate or part of a regularly scheduled home health service for clients receiving home health services.

2. Clients who are residents of an Alternative Care Facility, as defined at Section 8.495.1, may receive Immunization services from their own physician. They may also receive Immunization services as part of a home health service in accordance with Section 8.815.4.C.1.

8.815.5 Prior Authorization Requirements

8.815.5.A. Prior authorization is not required for this benefit.

8.815.6 Non-covered Services

8.815.6.A. The following services are not covered by Colorado Medicaid:

1. For clients 18 years of age and younger, Vaccines that have been obtained from a source other than VFC;

2. Immunization and Vaccine Administration Services provided by a school district provider; and

3. Travel-related Immunization and Vaccine Administration Services.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Pharmacist Over the Counter Prescriptive Authority, Section 8.800
Rule Number: MSB 18-03-07-A
Division / Contact / Phone: Client and Clinical Care / Kristina Gould / 303-866-6715

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 18-03-07-A, Revision to the Medical Assistance Rule concerning Pharmacist Over the Counter Prescriptive Authority, Section 8.800
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) 8.800.1, 8.800.10.B and 8.800.12.A.2, 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 8.800 with the proposed text beginning at 8.800.1 through the end of 8.800.12. This rules is effective October 31, 2018.

*to be completed by MSB Board Coordinator

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STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this rule change is to modify the definitions section to incorporate a new term, "Prescriber". This term will encompass a healthcare professional who, as licensed by Colorado state law, may prescribe and authorize the use of medicine or treatment to a member. This term will include pharmacists, as they are authorized to prescribe over-the-counter (OTC) medications to members, pursuant to Colorado Revised Statutes 25.5-5-322. Additionally, this update incorporates the rules that pharmacists must comply with when prescribing OTC's to members for the purpose of receiving reimbursement under the Medical Assistance Program.

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:

   Social Security Act 1927(k)(4)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2016);
   25.5-5-322, C.R.S. (2017).

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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.

   Pharmacists will be positively impacted by this proposed rule because prescribing over-the-counter (OTC) medications is within their scope of licensure. Members will be positively impacted because they can more easily obtain access to OTC medications; this will decrease doctor and emergency room visits because OTC medications will be more easily attainable. The Department will be positively impacted because any slight increase in expenditures for these OTC drugs is anticipated to offset ED use; in addition to potential reductions in higher cost drugs that are currently prescribed by physicians.

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

   Quantitatively, the estimated impact associated with this change is a decrease of $74,877 total funds in FY 2018-19 and a decrease of $184,280 total funds in FY 2019-20 or one full year of implementation. This estimate is based on the assumption that increases in OTC drug expenditure would be offset by avoided expenditures associated with ED use and pregnancies. Qualitatively, this will positively impact pharmacists because these changes align more closely with what is within their scope of licensure. Members will be positively impacted because they will have increased access to OTC medications.

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 probable costs to the Department are a slight increase in OTC expenditures. The probable costs to other agencies for the implementation and enforcement of this proposed rule are estimated to be none because:

   1. Pharmacists have the option to enroll (i.e. they are not mandated to do so),

   2. The technology needed to submit these claims will be the same as with any other pharmacy claim (i.e. does not require system updates) and,

3. Enrolling with the Department as a pharmacist to prescribe OTC medications will not require an admission fee.

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

   The probable costs to the Department are a slight increase in OTC expenditures. However, the benefits of decreased ED utilization, increased comradery between pharmacists and the Department and increased access to medication for members, far outweigh the potential cost increases related to OTC expenditures. Ultimately, inaction would result in non-compliance with statute 25.5-5-322, C.R.S. (2017); in addition to lessened comradery between the pharmacist community and the Department.

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

   None.

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.

   None.

8.800 PHARMACEUTICALS

8.800.1 DEFINITIONS

A. 340B Pharmacy means any pharmacy that participates in the Federal Public Health Service's 340B Drug Pricing Program as described in Title 42 of the United States Code, Section 256b (2014). Title 42 of the United States Code, Section 256b (2014) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. §24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

B. Average Acquisition Cost (AAC) means the average acquisition cost for like drugs grouped by Generic Code Number (GCN). For GCNs with both generic and brand drugs, the Department shall determine two separate AAC rates for the GCN. One AAC rate shall be based on the average acquisition cost for all generic drugs while the other shall be based on the average acquisition cost for all brand drugs.

C. Conflict of Interest means having competing professional or personal obligations or personal or financial interests that would make it difficult to fulfill duties in an objective manner.

D. Department means the Colorado Department of Health Care Policy and Financing.

E. Dispensing Fee means the reimbursement amount for costs associated with filling a prescription. Costs include salary costs, pharmacy department costs, facility costs, and other costs.

F. Dispensing Prescriber means a health care professional who, as licensed by Colorado state law, prepares, dispenses and instructs members to self-administer medication.

G. Drug Class means a group composed of drugs that all treat a particular disease, symptom or indication.

H. Emergency Situation means any condition that is life threatening or requires immediate medical intervention as determined in good faith by the pharmacist.

I. E-prescription means the transmission of a prescription through an electronic application.

J. Fiscal agent means a contractor that supports and operates the pharmacy benefit management system on behalf of the Medical Assistance Program.

K. Federal Upper Limit (FUL) means the upper limit for multiple source drugs as set by the Centers for Medicare and Medicaid Services pursuant to Title 42 of the Code of Federal Regulations, Part 447.512-447.516 (2016). Title 42 of the Code of Federal Regulations, Part 447.512-447.516 (2016) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. §24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

L. Generic Code Number (GCN) means a standard number to group together drugs that have the same ingredients, route of administration, drug strength, and dosage form.

M. Good Cause means failing to disclose a Conflict of Interest; participating in wrongdoing or misconduct in the case of serving as a member of a committee or other advisory body for the Department; failing to perform required duties; or missing two scheduled meetings per calendar year.

N. Government Pharmacy means any pharmacy whose primary function is to provide drugs and services to members of a facility whose operating funds are appropriated directly from the State of Colorado or the federal government excluding pharmacies funded through Indian Health Services.

O. Institutional Pharmacy means any pharmacy whose primary function is to provide drugs and services to hospitalized patients and others receiving health care provided by the facility with which the pharmacy is associated.

P. Mail Order Pharmacy means any pharmacy that delivers drugs primarily by mail.

Q. Maintenance Medication means any drug, as determined by the Department, which is used to treat a chronic illness or symptoms of a chronic illness.

R. Medical Assistance Program shall have the meaning defined in Section 25.5-1-103(5), C.R.S. (2016).

S. Medical Assistance Program Allowable Charge means the allowed ingredient cost plus a dispensing fee or the provider's Usual and Customary Charge, whichever is less, minus the member's copayment as determined according to 10 C.C.R. 2505-10, Section 8.754.

T. Medical Director means the physician or physicians who advise the Department.

U. Medicare Part D means the prescription drug benefit provided to Part D eligible individuals pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

V. Medicare Part D Drugs means drugs defined at Title 42 of the United States Code, Section 1395w-102(e) (2014) and Title 42 of the Code of Federal Regulations, Section 423.100 (2015). Title 42 of the United States Code, Section 1395w-102(e) (2014) and Title 42 of the Code of Federal Regulations, Section 423.100 (2015) are hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. §24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

W. Non-preferred Drug means a drug that is designated as non-preferred by the Medical Director pursuant to 10 CCR 2505-10, Section 8.800.16, and requires prior-authorization before being payable by the Medical Assistance Program.

X. Old Age Pension Health Care Program and Old Age Pension Health Care Supplemental Program (OAP State Only) means the program established to provide necessary medical care for clients that qualify for Old Age Pension but do not qualify for the Medical Assistance Program under Title XIX of the Social Security Act and Colorado statutes.

Y. Over-the-Counter (OTC) means a drug that is appropriate for use without the supervision of a health care professional such as a physician, and which can be purchased by a consumer without a prescription.

Z. Part D eligible individual has the same meaning as defined in 10 C.C.R. 2505-10, Section 8.1000.1.

AA. Pharmacy and Therapeutics Committee (P&T Committee) means an advisory board that shall perform reviews and make recommendations which facilitate the development and maintenance of the Preferred Drug List as described in 10 C.C.R. 2505-10, Section 8.800.17.

BB. Preferred Drug means a drug that is designated preferred by the Medical Director pursuant to 10 CCR 2505-10, Section 8.800.16.B, that is payable by the Medical Assistance Program without first obtaining a prior authorization unless otherwise required to protect the health and safety of specific members.

CC. Preferred Drug List (PDL) means a list, applicable only to fee-for-service and primary care physician Medical Assistance Program members, which identifies the Preferred Drugs and Non-preferred Drugs within a drug class.

DD. Prescriber means a healthcare professional who, as licensed by Colorado state law, may prescribe and authorize the use of medicine or treatment to a member. Prescribers must be enrolled in the Medical Assistance Program to receive reimbursement.

~~DD.~~EE. Provider Bulletin means a document published and distributed by program and policy staff to communicate information to providers related to the Department.

~~EE.~~FF. Retail Pharmacy means any pharmacy that is not a 340B Pharmacy, Government Pharmacy, Institutional Pharmacy, Mail Order Pharmacy, or Rural Pharmacy.

~~FF.~~GG. Rural Pharmacy means any pharmacy that is the only pharmacy within a twenty-mile radius.

~~GG.~~HH. Submitted Ingredient Cost means a pharmacy's calculated ingredient cost. For drugs purchased through the Federal Public Health Service's 340B Drug Pricing Program, the Submitted Ingredient Cost means the 340B purchase price.

~~HH.~~II. Total Prescription Volume means all new and refill prescriptions dispensed for all payer types. Payer types include but are not limited to Medicaid, Medicare, commercial, third-party, and uninsured.

~~II.~~JJ. Usual and Customary Charge means the reimbursement amount the provider charges the general public to pay for a drug.

~~JJ.~~KK. Wholesale Acquisition Cost (WAC) means with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

8.800.2 CONDITIONS OF PARTICIPATION

8.800.2.A. A pharmacy must be licensed or certified by the appropriate regulatory body in the state in which it is located. Pharmacies located outside of Colorado must also be registered in Colorado if required by the Colorado Board of Pharmacy.

8.800.2.B. Any pharmacy or Dispensing Prescriber, whether in-state or out-of-state, that submits claims for reimbursement must be enrolled in the Medical Assistance program in accordance with 8.040.1 and 8.013.1. The Department may deny a provider application, and the Department may terminate or not renew a provider agreement in accordance with 10 C.C.R. 2505-10, Sections 8.076, 8.125, and 8.130.

8.800.2.C. An out-of-state pharmacy may enroll as a Medical Assistance Program provider subject to the same conditions of participation as an in-state pharmacy.

8.800.3 MAIL ORDER

8.800.3.A. Only Maintenance Medications may be delivered through the mail.

8.800.4 DRUG BENEFITS

8.800.4.A. Only those drugs designated by companies participating in the federally approved Medical Assistance Program drug rebate program and not otherwise excluded according to these rules are regular drug benefits. Notwithstanding the foregoing, drugs not covered by rebate agreements may be reimbursed if the Department has made a determination that the availability of the drug is essential, such drug has been given an “A” rating by the U. S. Food and Drug Administration (FDA), and a prior authorization has been approved. Reimbursement of any drugs that are regular drug benefits may be restricted as set forth in these rules.

8.800.4.B. The following drug categories may be excluded from being a drug benefit or may be subject to restrictions:

1. Agents when used for anorexia, weight loss or weight gain;

2. Agents when used to promote fertility;

3. Agents when used for cosmetic purposes or hair growth;

4. Agents when used for symptomatic relief of cough and colds;

5. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;

6. Non-prescription Drugs;

7. Covered outpatient drugs that the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; and

8. Agents used for the treatment of sexual or erectile dysfunction unless such agents are used to treat a condition, other than a sexual or erectile dysfunction, for which the agents have been approved by the FDA.

8.800.4.C. The following are not pharmacy benefits of the Medical Assistance Program:

1. Spirituous liquors of any kind;

2. Dietary needs or food supplements;

3. Personal care items such as mouth wash, deodorants, talcum powder, bath powder, soap of any kind, dentifrices, etc.;

4. Medical supplies;

5. Drugs classified by the FDA as "investigational" or "experimental"; except for the following:

   a. Stiripentol may be covered if the coverage has been ordered by the member's physician, has been deemed medically necessary by the Department and has been authorized for the specific member's use by the U.S. Food & Drug Administration.

6. Less-than-effective drugs identified by the Drug Efficacy Study Implementation (DESI) program; and

7. Medicare Part D Drugs for Part D eligible individuals.

8.800.4.D. Aspirin, OTC insulin and medications that are available OTC and that have been designated as Preferred Drugs on the PDL are the only OTC drugs that are regular benefits without restrictions.

8.800.4.E. Restrictions may be placed on drugs in accordance with Title 42 of the United States Code, Section 1396r-8(d)(2014). Title 42 of the United States Code, Section 1396r-8(d)(2014) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. §24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

1. Without limiting the foregoing, restrictions may be placed on drugs for which it has been deemed necessary to address instances of fraud or abuse, potential for, and history of, drug diversion and other illegal utilization, overutilization, other inappropriate utilization or the availability of more cost-effective comparable alternatives.

8.800.4.F. To the extent the drug categories listed in Section 8.800.4.B are not Medicare Part D Drugs, they shall be covered for Part D eligible individuals in the same manner as they are covered for all other eligible Medical Assistance Program members.

8.800.4.G. Generic drugs shall be dispensed to members in fee-for-service programs unless:

1. Only a brand name drug is manufactured.

2. A generic drug is not therapeutically equivalent to the brand name drug.

3. The final cost of the brand name drug is less expensive to the Department.

4. The drug is in one of the following exempted classes for the treatment of:

a. Mental Illness;

b. Cancer;

c. Epilepsy; or

d. Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome.

5. The Department shall grant an exception to this requirement if:

a. The member has been stabilized on a medication and the treating physician, or a pharmacist with the concurrence of the treating physician, is of the opinion that a transition to the generic equivalent of the brand name drug would be unacceptably disruptive; or

b. The member is started on a generic drug but is unable to continue treatment on the generic drug.

Such exceptions shall be granted in accordance with procedures established by the Department.

8.800.5 DRUGS ADMINISTERED OR PROVIDED IN PHYSICIAN OFFICES OR CLINICS

8.800.5.A. Any drugs administered in a physician's office or clinic are considered part of the physician's services and not a pharmacy benefit. Such drugs shall be billed on the physician claim form. Pharmacies shall not bill for any products that are administered in a physician's office or clinic.

8.800.5.B. Dispensing Prescribers whose offices or sites of practice are located within 25 miles from the nearest participating pharmacy shall not be reimbursed for drugs or services that are dispensed from their offices.

8.800.6 COMPOUNDED PRESCRIPTIONS

8.800.6.A Compounded prescriptions shall be billed by submitting all ingredients in the prescription as one multiple-line claim. The provider will be reimbursed for each ingredient of the prescription according to Section 8.800.13.A-F, and will also be reimbursed for the dispensing fee according to Section 8.800.13.H. A compounding fee, over and above the stated dispensing fee, will not be paid.

8.800.7 PRIOR AUTHORIZATION REQUIREMENTS

8.800.7.A. Prior authorization shall be obtained before drugs that are subject to prior authorization restrictions may be provided as a benefit. Prior authorization requests may be made by the member's physician, any other health care provider who has authority under Colorado law to prescribe the medication being requested or any long-term-care pharmacy or infusion pharmacy that fills prescriptions on behalf of the member and is acting as the agent of the prescriber. The prior authorization request shall be made to the Fiscal Agent. The prescriber shall provide any information requested by the Fiscal Agent including, but not limited to, the following:

1. Member name, Medical Assistance Program state identification number, and birth date;

2. Name of the drug(s) requested;

3. Strength and quantity of drug(s) requested; and

4. Prescriber's name and medical license number, Drug Enforcement Administration number, or National Provider Identifier.

8.800.7.B. When the prior authorization request is received, it shall be reviewed to determine if the request is complete. If it is complete, the requesting provider shall be notified of the approval or denial of the prior authorization request via telephone and/or facsimile at the time the request is made, if possible, but in no case later than 24 hours after the request is made. If the prior authorization request is incomplete or additional information is needed, an inquiry to the party requesting the prior authorization shall be initiated within one working day from the day the request was received. If no response is received from that party within 24 hours of the Department's inquiry, the prior authorization shall be denied.

8.800.7.C. In an emergency situation, the pharmacy may dispense up to a 72-hour supply of a covered drug that requires a prior authorization if it is not reasonably possible to request a prior authorization for the drug before it must be dispensed to the member for proper treatment. The pharmacist may call the prior authorization help desk to receive override approval. Prescriptions dispensed under the override approval are eligible for reimbursement.

8.800.7.D. The Department shall solicit and maintain a list of any interested parties who wish to comment on any proposed additions to the drugs that are subject to prior authorization. The list of interested parties shall be notified of any proposal and shall be given reasonable time, not to exceed 30 days, to comment or recommend changes before any drugs become subject to prior authorization. Notwithstanding the foregoing, if a new drug is approved by the FDA and that drug is in a class of drugs already subject to prior authorization, the new drug shall also be subject to prior authorization without any comment period.

8.800.7.E. Any changes to the drugs that are subject to prior authorization or any documentation required to obtain a prior authorization shall be published in the Provider Bulletin. Notification in the Provider Bulletin shall satisfy any notification requirements of any such changes.

8.800.8 LIMIT REQUIREMENTS

8.800.8.A. Limits shall include a limit on the number of units of a drug that a member may receive in a 30-day or 100-day period, as applicable. Limits placed on the coverage of any drugs under the Medical Assistance Program shall result in pharmaceutical services still being sufficient in the amount, duration and scope to meet all applicable federal laws and regulations.

8.800.8.B. The Department shall solicit and maintain a list of any interested parties who wish to comment on any proposed limits on drugs. The list of interested parties shall be notified of any proposal and shall be given reasonable time, not to exceed 30 days, to comment or recommend changes before any such drugs are limited. Notwithstanding the foregoing, if a new drug is approved by the FDA and that drug is in a class of drugs already subject to limits, the new drug shall also be subject to limits without any comment period.

8.800.8.C. Any limits on drugs or changes to the drugs that are subject to limits shall be published in the Provider Bulletin. Notification in the Provider Bulletin shall satisfy any notification requirements of any such limits or changes to the limits.

8.800.9 DRUG UTILIZATION REVIEW

8.800.9.A. Prospective Drug Utilization Review

1. A pharmacist shall review the available member record information with each drug order presented for dispensing for purposes of promoting therapeutic appropriateness by considering the following:

    a. Over-utilization or under-utilization;

    b. Therapeutic duplication;

    c. Drug-disease contraindications;

    d. Drug-drug interactions;

    e. Incorrect drug dosage or duration of drug treatment;

    f. Drug-allergy interactions; and

    g. Clinical abuse/misuse.

2. When in the pharmacist's professional judgment a potential problem is identified, the pharmacist shall take appropriate steps to avoid or resolve the problem, which may, if necessary, include consultation with the prescriber.

8.800.9.B. Member Counseling

1. A pharmacist or pharmacist designee shall offer drug therapy counseling to each Medical Assistance Program member or the caregiver of such member with a new prescription or with a refill prescription if the pharmacist or pharmacist designee believes that it is in the best interest of the member. The offer to counsel shall be face-to-face communication whenever practicable or by telephone.

2. If the offer to counsel is accepted, a pharmacist or pharmacist designee shall review the member’s record and then discuss with the member or the member’s caregiver those matters that, in the exercise of his or her professional judgment, the pharmacist or pharmacist designee considers significant including the following:

    a. The name and description of the drug;

    b. The dosage form, dose, route of administration, and duration of drug therapy;

    c. Intended use of the drug and expected action;

    d. Special directions and precautions for preparation, administration, and use by the member;

    e. Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;

    f. Techniques for self-monitoring drug therapy;

    g. Proper storage;

    h. Prescription refill information; and

    i. Action to be taken in the event of a missed dose.

3. Alternative forms of member information shall not be used in lieu of the personal discussion requirement for member counseling but may be used to supplement this discussion when appropriate. Examples of such alternative forms of member information include written information leaflets, auxiliary or pictogram labels, and video programs.

4. Member counseling by a pharmacist or pharmacist designee as described in this section shall not be required for members of a hospital or institution where other licensed health care professionals administer the prescribed drugs pursuant to a chart order.

5. A pharmacist or pharmacist designee shall not be required to counsel a member or caregiver when the member or caregiver refuses such consultation. The pharmacist or pharmacist designee shall keep records indicating when counseling was not or could not be provided.

8.800.9.C. Retrospective Drug Utilization Review

1. The Department shall periodically review claims data in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists and members receiving drug benefits or associated with specific drugs or categories of drugs.

2. Such reviews shall be based on predetermined criteria that monitor for therapeutic problems including but not limited to therapeutic appropriateness, over-utilization, under-utilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration of drug treatment, and clinical abuse/misuse.

8.800.9.D. Drug Utilization Review (DUR) Board

1. The DUR Board shall serve in an advisory capacity to the Department. The DUR Board's activities shall include but are not limited to the following:

   a. Approving the application of standards;

   b. Conducting retrospective DUR;

   c. Conducting ongoing interventions with pharmacists and physicians concerning therapy problems identified in the course of the DUR program;

   d. Making recommendations regarding certain Department policy issues as determined by the Department; however, the Department shall consider all such recommendations but shall not be bound by them; and

   e. Engaging in any other activities as designated by the Department.

2. The DUR Board shall meet no less frequently than quarterly.

3. The DUR Board shall consist of nine members appointed by the Executive Director of the Department based upon recommendations of relevant professional associations. Membership on the Board shall consist of four physicians and four pharmacists, all of whom are licensed and actively practicing in Colorado, and one non-voting representative from the pharmaceutical industry. The physicians and pharmacists shall serve two-year terms and may be reappointed to additional terms at the discretion of the Executive Director. The terms shall be staggered so that in each year, there are two physician

members and two pharmacist positions that are reappointed. The pharmaceutical industry representative shall serve a one-year term and shall not be reappointed.

4. The membership of the DUR Board shall include health care professionals who have recognized knowledge and expertise in one or more of the following:

   a. The clinically appropriate prescribing of covered outpatient drugs;

   b. The clinically appropriate dispensing and monitoring of outpatient drugs;

   c. Drug utilization review, evaluation and intervention; or

   d. Medical quality assurance.

5. The DUR Board shall have those responsibilities as set forth in Title 42 of the Code of Federal Regulations, Section 456.716(d)(2015). Title 42 of the Code of Federal Regulations, Section 456.716(d)(2015) are hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. This statute is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. §24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

6. The DUR Board is also responsible for preparing and submitting a report to the Department on an annual basis which shall include the following information:

   a. A description of the activities of the DUR Board, including the nature and scope of the prospective and retrospective drug utilization review programs;

   b. A summary of the interventions used;

   c. An assessment of the impact of these educational interventions on quality of care; and

   d. An estimate of the cost savings generated as the result of the program.

7. The DUR Board under the direction of the Department may delegate to a retrospective DUR contractor the responsibility of preparation of continuing education programs, the conduct of interventions and the preparation of any reports.

8.800.10 BILLING PROCEDURES

8.800.10.A. Charges for prescribed drugs shall be submitted on an appropriate pharmacy claim form or electronically in a Department approved format. All entries shall be legible.

8.800.10.B. Each claim must identify the member, Prescriber, date of service, National Drug Code number of the drug actually dispensed, prescription number, quantity dispensed, days' supply, the Usual and Customary Charge and any other information required by the Department.

8.800.11 PRESCRIPTION RECORD REQUIREMENTS

8.800.11.A. The original prescription shall be a hard copy written, faxed or electronically mailed or otherwise transmitted by the prescriber or reduced to writing by pharmacy staff when received by telephone. All information required by the Colorado State Board of Pharmacy shall appear on each prescription including any information required if a substitution for a drug is made. All refill information shall be recorded in accordance with the Colorado State Board of Pharmacy requirements.

8.800.11.B. All records for new prescriptions and refills for which payment from the Medical Assistance Program is requested shall be maintained in accordance with Colorado State Board of Pharmacy requirements except that such records must be retained for the length of time set forth in 10 C.C.R. 2505-10, Section 8.040.2.

8.800.11.C. The pharmacist shall be responsible for assuring that reasonable efforts have been made to obtain, record, and maintain the following member information from the member or his/her apparent agent for each new prescription:

1. Name, address, telephone number, date of birth or age, and gender;

2. Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive, chronological list of medications and prescribed relevant devices; and

3. Additional comments relevant to the member's pharmaceutical care as described in the Prospective Drug Review and Member Counseling sections set forth in 10 C.C.R. 2505-10, Section 8.800.9.

8.800.11.D. TAMPER-RESISTANT PRESCRIPTION DRUG PADS OR PAPER

1. The use of tamper-resistant prescription drug pads or paper is required for all written or electronically printed prescriptions for all Medical Assistance Program members when:

   a. Prescriptions are issued for outpatient drugs, including controlled and uncontrolled substances, or OTC drugs that are reimbursable through the Medical Assistance Program and dispensed by a pharmacy; and

   b. The Medical Assistance Program is the primary or secondary payer of the prescription being filled.

2. To be considered tamper-resistant, the pad/paper used for a written or electronically printed prescription shall integrate three distinct characteristics. The three characteristics and the specific features required are as follows:

   a. Characteristic #1: One or more industry-recognized features designed to prevent unauthorized copying of completed or blank prescription form. A prescription shall contain at least one of the following features:

      i) Void/Illegal/Copy Pantograph with or with the Reverse Rx feature. The word “Void”, “Illegal”, or “Copy” appears when the prescription is photocopied. If the paper has the Reverse Rx feature, the Rx symbol must disappear when photocopied at light setting. The Reverse Rx feature is not allowed as a feature by itself.

      ii) Micro-fine printed security message generated by a computer, electronic medical records system or other electronic means. The message may serve as a signature line or border. This must be printed in 0.5 font or

smaller and readable when viewed at 5x magnification or greater and illegible when copied.

iii) Coin-reactive ink or security mark. The pad or paper identifies an area on the pad/paper where the ink changes color or reveals wording or a picture when that area is rubbed by a coin. This must be accompanied by a message describing what is necessary to demonstrate authenticity.

iv) Security print watermark. Specific wording is printed on the front or back of the prescription paper and can only be seen when viewed at an angle.

v) Paper with a watermark. This is paper that contains a watermark that can be seen when backlit.

b. Characteristic #2: One or more industry recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber. A prescription shall contain at least one of the following features:

i) An erasure-revealing background. This is a background that consists of a non-white solid color or consistent pattern that has been printed onto the paper. If an erasure or modification is attempted, the background will show marks or the color of the underlying paper where the alterations were made.

ii) Toner fusing technology for laser-printed prescriptions. This is a treatment that is added to the surface of the paper to create a strong bond between the laser-printed text and the paper. The computer-printed information cannot be lifted from the surface of the paper without damaging the paper.

iii) Chemical-reactive paper. This is paper that contains features that show discoloration or reveals a hidden message if solvents are used to attempt to wash the ink from its surface.

iv) Plain bond paper combined with inkjet-printing. The inkjet printing is absorbed into the high grade paper stock. Erasures and modifications cannot be made without damaging the paper.

v) Pre-printed quantity check-off boxes indicated in ranges of no more than 25 per range combined with a written quantity. The range box corresponding to the quantity prescribed must be checked by the prescriber for the prescription to be valid.

vi) Pre-printed refill indicator where the number of refills allowed is marked or no refills or “NR” is marked when no refills are authorized. Refill information must be completed by the prescriber for the prescription to be valid.

vii) Characters surrounding the authorized dispensing quantity and the number of refills. Special characters such as a series of asterisks must be repeated on both sides of the numbers indicating the quantity and the number of refills authorized (e.g., Quantity ***50*** Refill ***3***). This is acceptable only for prescriptions that are generated by a computer, electronic medical records system or other electronic means.

c. Characteristic #3: One or more industry recognized features designed to prevent the use of counterfeit forms. A prescription must contain at least one of the following features:

i) Security features listed visibly in a box, band or border on the prescription. This must be a complete listing of all of the security features incorporated into the prescription pad/paper in order to minimize tampering.

ii) Security threads. Metal, fluorescent or plastic security threads are embedded into the prescription pad/paper.

iii) Thermochromic ink. All or some of the pad or paper is pre-printed with ink that changes color when exposed to heat and then changes back to its original color when cooled. This must be accompanied by a message describing what is necessary to demonstrate authenticity.

3. The use of tamper-resistant prescription pads or paper is not required when:

a. Prescriptions are transmitted by telephone, fax or E-prescription directly to the pharmacy by the prescriber or prescriber's staff that is authorized to act on the prescriber's behalf; or

b. A prescriber administers or provides the drug directly to the member; or

c. A prescriber in an institutional setting writes the order into the medical record and then the order is given by medical staff directly to the pharmacy; or

d. A Medical Assistance Program managed care entity pays for or dispenses the prescription; or

e. A prescription is written for any medical item, service or equipment that is not considered an outpatient drug; or

f. A drug that is provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made as part of payment for the following and not as direct reimbursement for the drug):

i) Inpatient hospital services;

ii) Hospice services;

iii) Dental services (except when a State Plan authorizes direct reimbursement to the dispensing dentist);

iv) Physician services;

v) Outpatient hospital services;

vi) Nursing facilities and intermediate care facilities for the mentally retarded;

vii) Other laboratory and x-ray services; or

viii) Renal dialysis.

4. The pharmacy may dispense up to a 72-hour supply of a covered outpatient prescription drug in an emergency situation, provided that the pharmacy obtains a compliant prescription in writing, or by telephone, facsimile, or E-prescription, within 72 hours of filling the prescription.

5. When a Medical Assistance Program member is determined retroactively eligible after a pharmacy has filled the recipient's prescription, the prescription shall be deemed to comply with the tamper-resistant pad/paper requirements. This presumption applies only to prescriptions that were filled before the member was determined eligible. Prescriptions that are filled or refilled after the member is determined eligible require a new, tamper-resistant prescription or the pharmacy may obtain verbal confirmation of the prescription from the prescriber or may obtain the prescription from the prescriber by facsimile or E-prescription.

8.800.11.E. Prescription tracking and claim reversals

1. The pharmacy shall keep:

   a. A chronological log that contains the member's name, his or her signature or agent's signature and date of the receipt of the prescription; or

   b. An electronic prescription tracking system that records the status of prescriptions through the fill process including the date and time that the prescription was transferred to a person whom pharmacy personnel verified was the member or agent of the member.

2. Pharmacies using a chronological log shall review all Medical Assistance Program prescriptions in shall-call status (filled but not released to the member or the member's agent) at least weekly and enter a reversal of prescriptions not picked up within 14 days of billing. In no case shall prescriptions be kept in shall-call status for more than 21 days. The pharmacy shall maintain a record of each reversal for audit purposes.

3. Pharmacies using an electronic prescription tracking system shall review all Medical Assistance Program prescriptions in shall-call status on a daily basis and enter a reversal of prescriptions not picked up within 10 days of billing. In no case shall prescriptions be kept in shall-call status for more than 14 days. The pharmacy shall maintain a record of each reversal for audit purposes.

4. Upon receipt of a written request from the Department or the Medicaid Fraud Unit for a record of Medical Assistance Program claims and reversals, the pharmacy has up to 72 hours or three working days to provide the requested information or to enter into an agreement with the Department or Unit stating the specific time within which the data shall be produced.

8.800.11.F. Any information, documents or records required to be retained under 10 C.C.R. 2505-10, Section 8.800.11 shall be made available for inspection to authorized personnel of the Department, U.S. Department of Health and Human Services or the Medicaid Fraud Control Unit.

8.800.12 BASIS FOR REIMBURSEMENT

8.800.12.A. Reimbursement shall be made for prescribed drugs provided to members when all of the following conditions are met:

1. The item dispensed is a covered benefit under the Medical Assistance Program and meets any and all restriction requirements as set forth in 10 C.C.R. 2505-10, Section 8.800 or any policies thereunder;

2. The person prescribing the item is licensed to do so under applicable law;

   a. A pharmacist licensed in the state of Colorado may prescribe the over-the-counter (OTC) medications listed on the Department's Pharmacist OTC Prescriptive Authority List which shall be posted on the Department's website.

   b. A pharmacist prescribing and dispensing over-the-counter medications shall comply with the rules set forth by the Colorado State Board of Pharmacy.

3. The item is dispensed pursuant to a valid prescription order;

4. The prescription is dispensed in accordance with applicable federal and state laws, rules, and regulations, including those regulations governing the Medical Assistance Program; and

5. The prescription is written on a tamper-resistant prescription drug pad or paper or is excluded from the tamper-resistant prescription drug pad or paper requirements set forth in 10 C.C.R. 2505-10, Section 8.800.11.D.

8.800.13 REIMBURSEMENT CALCULATION

8.800.13.A. Covered drugs for all members except for OAP State Only clients shall be reimbursed the lesser of:

1. The Usual and Customary Charge minus the member's copayment, as determined according to 10 C.C.R. 2505-10, Section 8.754; or

2. The allowed ingredient cost plus a Dispensing Fee minus the member's copayment, as determined according to 10 C.C.R. 2505-10, Section 8.754.

Covered drugs for the OAP State Only Program shall be reimbursed according to 10 C.C.R. 2505-10, Section 8.941.9.

8.800.13.B. The allowed ingredient cost for Retail Pharmacies, 340B Pharmacies, Institutional Pharmacies, Government Pharmacies and Mail Order Pharmacies shall be the lesser of AAC, or Submitted Ingredient Cost. If AAC is not available, the allowed ingredient cost shall be the lesser of WAC, or Submitted Ingredient Cost.

8.800.13.C. AAC rates shall be rebased monthly using invoices and/or purchase records provided to the Department through a representative group of pharmacies. If the Department cannot establish a process to obtain invoices and/or purchase records on a monthly basis, the Department shall survey one-fourth (1/4) of all Medicaid enrolled pharmacies every quarter to rebase AAC rates.

8.800.13.D. A pharmacy wanting to inquire about a listed AAC rate shall complete the Average Acquisition Cost Inquiry Worksheet posted on the Department's website. The pharmacy shall email the completed worksheet with a copy of the receipt invoice to the Department or designated vendor as indicated on the Average Acquisition Cost Inquiry Worksheet. The Department shall have five (5) days to provide an inquiry response to the pharmacy. If the AAC rate requires revision, the Department shall then have 5 additional days to update the AAC rate.

8.800.13.E. To address weekly fluctuations in drug prices, the Department shall apply a percent adjustment to existing AAC rates for drugs experiencing significant changes in price. The percent adjustment shall be determined using weekly changes in price based on national pricing benchmarks. Every week, the Department shall post an updated AAC price list, with the adjusted AAC rates, on the Department's website (www.colorado.gov/hcpf). A percent adjustment shall only be applied to an AAC rate until the Department can rebase the rate through the process discussed in 10 C.C.R. 2505-10, 8.800.13.C.

8.800.13.F. Any pharmacy, except a Mail Order Pharmacy, that is the only pharmacy within a twenty mile radius may submit a letter to the Department requesting the designation as a Rural Pharmacy. If the designation is approved by the Department, the allowed ingredient cost shall be AAC. If AAC is not available, the allowed ingredient cost shall be WAC.

8.800.13.G. Dispensing Fees shall be determined based upon reported dispensing costs provided through a Cost of Dispensing (COD) survey completed every two fiscal years. The Dispensing Fees for Retail Pharmacies, 340B Pharmacies, Institutional Pharmacies and Mail Order Pharmacies shall be tiered based upon annual Total Prescription Volume. The Dispensing Fees shall be tiered at:

1. Less than 60,000 total prescriptions filled per year = $13.40

2. Between 60,000 and 90,000 total prescriptions filled per year = $11.49

3. Between 90,000 and 110,000 total prescriptions filled per year = $10.25

4. Greater than 110,000 total prescriptions filled per year = $9.31

8.800.13.H. The designation of a pharmacy's Dispensing Fee shall be updated annually. Every October, the Department shall contact a pharmacy requesting the completion of an attestation letter stating the pharmacy's Total Prescription Volume for the period September 1 to August 31. A pharmacy shall have until October 31 to provide the completed attestation letter to the Department. Using the attestation letter, the Department shall update a pharmacy's Dispensing Fee effective January 1. A pharmacy failing to provide the Department an attestation letter on or before October 31, regardless of their previous Dispensing Fee, shall be reimbursed the $9.31 Dispensing Fee.

8.800.13.I. The Department shall determine the Dispensing Fee for a pharmacy enrolling as a Medicaid provider based on the pharmacy's Total Prescription Volume. During the enrollment process, a pharmacy shall provide the Department an attestation letter stating their Total Prescription Volume for the previous twelve (12) months. Using the attestation letter, the Department shall determine the pharmacy's Dispensing Fee effective upon approval of enrollment. If a pharmacy has been open for less than 12 months, the Department shall annualize the Total Prescription Volume to determine the pharmacy's Dispensing Fee. A pharmacy failing to provide the Department an attestation letter during the enrollment process shall be reimbursed the $9.31 Dispensing Fee. The Dispensing Fee shall be used until it can be updated the following year in accordance with 10 C.C.R. 2505-10, 8.800.13.H.

8.800.13.J. In November of each year, the Department shall compare a pharmacy's Total Prescription Volume and Medicaid percent provided with the attestation letter to their Medicaid claims data. If the Department identifies any inconsistencies, the Department shall request a pharmacy to provide documentation that substantiates their Total Prescription Volume for the period September 1 to August 31 within thirty (30) days. If the Department determines that the pharmacy incorrectly reported their Total Prescription Volume, the pharmacy shall be reimbursed at the correct tier based on their actual Total Prescription Volume. If a pharmacy does not provide

the documentation to the Department within the 30 days, the pharmacy shall be reimbursed the $9.31 Dispensing Fee.

8.800.13.K. The tiered Dispensing Fee shall not apply to Government Pharmacies which shall instead be reimbursed a $0.00 Dispensing Fee.

8.800.13.L. The tiered Dispensing Fee shall not apply to Rural Pharmacies which shall instead be reimbursed a $14.14 Dispensing Fee.

8.800.13.M. Dispensing Prescribers who dispense medications that are reimbursed as a pharmacy benefit pursuant to 8.800 shall be reimbursed a $1.89 Dispensing Fee.

8.800.14 PRESCRIPTION QUANTITIES

8.800.14.A For chronic conditions requiring maintenance drugs, the maximum dispensing quantities for new and refill prescriptions shall be a 100-day supply. For all other drugs, the maximum dispensing quantities for new and refill prescriptions shall be a 30-day supply. The Department may set or change minimum or maximum dispensing quantities of certain drugs.

8.800.15 REIMBURSEMENT FROM PHARMACIES REDISPENSING UNUSED MEDICATION

8.800.15.A. A pharmacy participating in the Medical Assistance Program may accept unused medication from a hospital, hospital unit, hospice, nursing care facility, or assisted living residence that is required to be licensed pursuant to Section 25-3-101, C.R.S. (2016), or a licensed health care provider for the purpose of dispensing the medication to another person.

8.800.15.B. A pharmacy shall reimburse the Department for the Medical Assistance Program Allowable Charge that the Department has paid to the pharmacy if medications are returned to a pharmacy and the medications are available to be dispensed to another person.

8.800.16 PREFERRED DRUG LIST

8.800.16.A. ESTABLISHING THE PREFERRED DRUG LIST

1. To develop and maintain the PDL, the Department shall take the following steps:

    a. Determine which drugs and Drug Classes shall be reviewed for inclusion on the PDL.

    b. Refer selected drugs and Drug Classes to the P&T Committee for clinical reviews performed without consideration of drug cost-effectiveness. The P&T Committee shall make recommendations pursuant to 10 C.C.R. 2505-10, Section 8.800.17.C.

    c. Make recommendations to the Medical Director based on evaluations of relevant criteria, including but not limited to:

        i) Drug safety;

        ii) Drug efficacy;

        iii) The recommendations of the P&T Committee;

        iv) Public comments received by the Department before a drug or Drug Class is reviewed at the relevant P&T Committee meeting;

v) Cost-effectiveness; and

vi) Scientific evidence, standards of practice and other relevant drug information for such evaluation.

2. After the P&T Committee meets, the Medical Director shall review the recommendations of the P&T Committee and the Department and determine whether a reviewed drug is designated a Preferred Drug or a Non-preferred Drug.

3. After the Medical Director has designated a reviewed drug as Preferred or Non-preferred and designates prior authorization criteria to protect the health and safety of members, the Department shall refer that drug to the DUR Board for recommendations on prior authorization criteria.

4. After the DUR Board meets, the Medical Director shall review the recommendations of the P&T Committee, the DUR Board and the Department and determine the efficacy, safety and appropriate prior authorization criteria for Preferred and Non-preferred Drugs to ensure the health and safety of members.

5. The Department shall provide public notice of PDL updates at least thirty days before such changes take effect.

6. Drug Classes included on the PDL shall be reviewed annually.

8.800.16.B. NEW DRUGS

1. Notwithstanding any other provision of this section, a new drug entity, including new generic drugs and new drug product dosage forms of existing drug entities, in a Drug Class already included on the PDL:

a. Shall be automatically designated a Non-preferred Drug; unless

b. A preliminary evaluation by the Department finds that a new drug must be designated a Preferred Drug because it is medically necessary.

2. The Preferred or Non-preferred designation for a new drug shall continue until the relevant Drug Class is reviewed and the designation is changed pursuant to 10 C.C.R. 2505-10, Section 8.800.16.A.

8.800.16.C. EXCLUSION OF DRUGS, DRUG CLASSES OR INDIVIDUALS FROM THE PDL

1. The following exclusions are intended to promote good health outcomes and clinically appropriate drug utilization and to protect the most vulnerable Medical Assistance Program members.

2. After reviewing the recommendations of the P&T Committee and the Department, the Medical Director may, notwithstanding any other provision of this section and to the extent allowed by federal and state law:

a. Exclude drugs or Drug Classes from consideration for inclusion on the PDL.

b. Determine continuity of care protocols that exempt Medical Assistance Program members stabilized on specified Non-preferred Drugs from prior authorization requirements.

c. Exclude specific Medical Assistance Program populations from prior authorization requirements for all Non-preferred Drugs.

3. Individual Medical Assistance Program members shall be exempted, on an annual basis, from prior authorization requirements for all Non-preferred Drugs if:

a. A member meets clinical criteria recommended by the Department and P&T Committee and approved by the Medical Director; and

b. A member's physician submits a request for exemption and meets the criteria for approval.

8.800.16.D. AUTHORITY OF THE EXECUTIVE DIRECTOR

1. The decisions of the Medical Director, made under the authority of this section, shall be implemented by the Department at the sole discretion of the Executive Director.

2. If the Medical Director position is unfilled, the duties and obligations of that position, as described in this section, shall be performed by the Executive Director.

8.800.16.E. SUPPLEMENTAL REBATES The Department may enter into supplemental rebate agreements with drug manufacturers for Preferred Drugs. The Department may contract with a vendor and/or join a purchasing pool to obtain and manage the supplemental rebates.

8.800.17 PHARMACY AND THERAPEUTICS COMMITTEE

8.800.17.A. MEMBERSHIP

1. The P&T Committee shall consist of at least nine members, but not more than thirteen members, appointed by the Executive Director.

a. The P&T Committee membership shall include:

i) Four pharmacists;

ii) Two member representatives;

iii) One physician who specializes in the practice of psychiatry;

iv) One physician who specializes in the practice of pediatrics;

v) One physician who specializes in the treatment of members with disabilities; and

vi) Four physicians from any other medical specialty.

b. Physicians and pharmacists must be licensed and actively practicing in the State of Colorado while a member of the P&T Committee.

c. The Department shall solicit recommendations for P&T Committee members from professional associations, member advocacy groups and other Medical Assistance Program stakeholders.

d. The P&T Committee may meet and conduct business when at least any nine members are appointed to the P&T Committee. A majority of the appointed P&T

Committee members constitutes a quorum for the transaction of business at any P&T Committee meeting.

e. All P&T Committee members may vote on P&T Committee business when a vote is required. The affirmative vote of the majority of the appointed P&T Committee members is required to take action.

f. P&T Committee members shall serve two-year terms and may be reappointed to additional terms at the discretion of the Executive Director.

g. The terms shall be staggered so that in each year at least two pharmacists, one consumer representative and any three physicians are reappointed.

h. The Executive Director may appoint initial P&T Committee members to serve less than two years to provide for staggered terms.

i. The Executive Director may terminate the appointment of any P&T Committee member for Good Cause.

j. The Executive Director shall fill a vacancy occurring in the membership of the P&T Committee for the remainder of the unexpired term. Such replacement shall meet all applicable requirements as set forth in this section.

2. Physicians and pharmacists on the P&T Committee shall have knowledge and expertise in one or more of the following:

a. The clinically appropriate prescribing of covered outpatient drugs;

b. The clinically appropriate dispensing of outpatient drugs;

c. Drug use review, evaluation and intervention;

d. Medical quality assurance; or

e. The treatment of Medical Assistance Program members.

8.800.17.B. CONFLICT OF INTEREST

1. P&T Committee members must complete and sign a conflict of interest disclosure form, prior to their appointment to the P&T Committee, which discloses any financial or other affiliation with organizations that may have a direct or indirect interest in business before the P&T Committee.

2. At any meeting, a P&T Committee member must recuse himself or herself from discussion and decision making for an entire Drug Class if he or she has a Conflict of Interest with any drug in that Drug Class.

8.800.17.C. DUTIES

1. Among other duties, the P&T Committee shall:

a. Review drugs or Drug Classes selected by the Department.

b. Utilize scientific evidence, standards of practice and drug information.

c. Consider drug safety and efficacy and other review criteria requested by the Department.

d. Request information, recommendations or testimony from any health care professional or other person with relevant knowledge concerning a drug or Drug Class subject to P&T Committee review, at their discretion.

e. Make clinical recommendations on drugs or Drug Classes. Such recommendations shall be considered by the Executive Director, when making final determinations on PDL implementation and maintenance.

f. Perform any other act requested by the Department necessary for the development and maintenance of the PDL as described in 10 C.C.R. 2505-10, Section 8.800.16.A.

g. Adopt a Department approved plan of operation that sets forth the policies and procedures that shall be followed by the P&T Committee.

h. Meet at least quarterly and other times at the discretion of the Department or the P&T Committee.

8.800.17.D. NOTICE/OPEN MEETINGS

1. P&T Committee meetings and the proposed agenda shall be posted publicly at least thirty days before the meeting.

2. The P&T Committee meetings shall be open to the public. If a P&T Committee meeting is required to be held in executive session pursuant to state or federal law, the executive session shall be convened after conclusion of the open meeting.

8.800.18 PRESCRIPTION DRUG CONSUMER INFORMATION AND TECHNICAL ASSISTANCE PROGRAM

8.800.18.A The Prescription Drug Consumer Information and Technical Assistance Program provides Medical Assistance Program members the opportunity to meet with a pharmacist to review the member's medications, receive information on the prudent use of prescription drugs and, with the approval of the appropriate prescribing health care provider, how to avoid dangerous drug interactions, improve member outcomes, and save the state money for the drugs prescribed.

8.800.18.B. REQUIREMENTS FOR PARTICIPATION IN THE PROGRAM

1. The Department shall refer members to pharmacists based on location.

2. Pharmacists shall:

a. Have and maintain an unrestricted license in good standing to practice pharmacy in Colorado; and

b. Maintain liability insurance; and

c. Complete an application; and

d. Enter into a contract with the Department; and

e. Meet one of the following qualifications:

i) Provide proof of completion of a pharmacy practice residency accredited by the American Society of Health Systems Pharmacists or the American Pharmaceutical Association; or

ii) Earned a bachelor of pharmacy degree and completed a certificate program accredited by the Accreditation Council for Pharmacy Education (ACPE) in each area of practice, and 40 hours of on-site supervised clinical practice and training in each area in which the pharmacist is choosing to practice; or

iii) Earned a Doctor of Pharmacy degree and completed at least 40 hours of ACPE-approved continuing education regarding clinical practice and 40 hours of on-site supervised clinical practice and training in the area in which the pharmacist is choosing to practice; or

iv) Possess current board specialty certification from the Board of Pharmaceutical Specialties, current certification from the National Institute for Standards in Pharmacist Credentialing, or current certification from the Commission for Certification in Geriatric Pharmacy. Such credentials must be in the area of pharmacy practice undertaken in the drug therapy management

3. Members may participate in the program if they are a fee-for-service member who receives prescription drug benefits, is at high risk of complications from drug interactions and who otherwise lacks access to informational consultation with a pharmacist.

8.800.18.C. SERVICES

1. Pharmacists participating in the program shall:

a. Schedule a face-to-face meeting with the member within ten days of the referral. If the member is unable or refuses to participate in a face-to-face meeting, the pharmacist may conduct the consultation by telephone.

b. Collect and review member drug histories.

c. Hold face-to-face or telephonic consultations with members.

d. Notify members that they will provide clinical recommendations to the member, the prescribing health care provider and the Department.

e. Provide the member with information regarding:

i) The prudent use of prescription drugs.

ii) How to avoid dangerous drug interactions.

iii) The appropriate use of medication to optimize therapeutic outcomes.

iv) How to reduce the risk of adverse events, including adverse drug interactions.

2. The Department shall notify members participating in the program in writing that a pharmacist has been assigned to review the member's records and that the pharmacist will contact the member within ten days from the date of notification.

8.800.18.D. REPORTING Within ten days following the consultation, the pharmacist shall provide a letter to the member, all appropriate health-care providers and the Department outlining the face-to-face meeting. The letter shall include the pharmacist's recommendations for possible alternatives available for the member.

8.800.18.E. REIMBURSEMENT The Department shall pay each pharmacist participating in the program a predetermined amount.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to MAGI-Medicaid concerning Income Verification for those receiving Continuous Coverage at sections 8.100.3.G and 8.100.4.G
Rule Number: MSB 18-06-12-A
Division / Contact / Phone: Health Information Office / Ana Bordallo / 303-866-3558

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 18-06-12-A, Revisions to MAGI-Medicaid concerning Income Verification for those receiving Continuous Coverage at sections 8.100.3.G and 8.100.4.G
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.3.Q and 8.100.4.G, 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 8.100.3.Q with the proposed text beginning at 8.100.3.Q through the end of 8.100.3.Q. Replace the current text at 8.100.4.G with the proposed text beginning at 8.100.4.G through the end of 8.100.4.G.7. This rule is effective October 31, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revisions to MAGI-Medicaid concerning Income Verification for those receiving Continuous Coverage at sections 8.100.3.G and 8.100.4.G
Rule Number: MSB 18-06-12-A
Division / Contact / Phone: Health Information Office / Ana Bordallo / 303-866-3558

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this rule change is to add clarification for members receiving continuous coverage within a child or a pregnant category, whose income is not reasonably compatible based on the self-reported income and the electronic income verified. When the income is not reasonably compatible and it's the first income discrepancy, if the discrepancy is not resolved within the reasonable opportunity period(ROP) of 90 days, their benefits will be terminated.

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:

   Code of Federal Regulation §435.952.(c)(2)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);

DO NOT PUBLISH THIS PAGE

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Rule Number: MSB 18-06-12-A
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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.

   The classes of persons who will be affected by this proposed rule clarification are members enrolled in a MAGI Medicaid category receiving continuous coverage who is a child or pregnant women. The benefits of this rule change will provide clear guidance to the populations listed, who are receiving benefits and whose benefits may be impacted if they fail to respond to the discrepancy notice.

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

   The proposed rule will provide clarification for those members whose income is not reasonably compatible and it's the first income discrepancy, if the discrepancy is not resolved within the reasonable opportunity period (ROP) of 90 days, their benefits will be terminated.

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

   There are no costs to the Department as this is only adding clarification to the Department's current rules to align with current policy.

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

   Because this rule change already reflects current practice, and the Department is just providing clarification, there will be no difference between the rule change and inaction.

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

   There is no other less costly method to update this rule change.

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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 alternatives methods for the proposed rule that were considered.

8.100.3.Q. Continuous Eligibility (CE) for Medical Assistance programs

1. Continuous eligibility applies to children under age 19, who through an eligibility determination, reassessment or redetermination, are found eligible for a Medical Assistance program. The continuous eligibility period may last for up to 12 months.

    a. The continuous eligibility period applies without regard to changes in income or other factors that would otherwise cause the child to be ineligible.

        i) A 14-day no fault period shall begin on the date the child is determined eligible for Medical Assistance. During the 14-day period, any changes to income or other factors made to the child's case during the 14-day no fault period may change his or her eligibility for Medical Assistance.

    b. Exception: A child's continuous eligibility period will end effective the earliest possible month if any of the following occur:

        i) Child is deceased

        ii) Becomes an inmate of a public institution

        iii) The child is no longer part of the Medical Assistance required household

        iv) Is no longer a Colorado resident

        v) Is unable to be located based on evidence or reasonable assumption

        vi) Requests to be withdrawn from continuous eligibility

        vii) Fails to provide documentation during a reasonable opportunity period as specified in section 8.100.3.H.9

        viii) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90-day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

2. The continuous eligibility period will begin on the first day of the month the application is received or from the date all criteria is met. Continuous eligibility is applicable to children enrolled in the following Medical Assistance programs:

    a. MAGI-Medical Assistance, program as specified in section 8.100.4.G.2

    b. SSI Mandatory, as specified in section 8.100.6.C

        i.) When a child is no longer eligible for SSI Mandatory they will be categorized as eligible within the MAGI-Child category for the remainder of the eligibility period.

    c. Long- Term Care services

        i.) When a child is no longer eligible for Long-Term Care services they will be categorized as eligible within the MAGI- Child category for the remainder of the eligibility period.

d. Medicaid Buy-In program specified in section 8.100.6.Q

i) Exception: Enrollment will be discontinued if there is a failure to pay premiums

e. Pickle

f. Disabled Adult Child DAC)

3. Children, under the age of 19, no longer enrolled in Foster Care Medicaid will be eligible for the MAGI-Medical Assistance program. The continuous eligibility period will begin the month the child is no longer enrolled in Foster Care Medicaid as long as they meet one of the following conditions:

a. Begin living with other Relatives

b. Are reunited with Parents

c. Have received guardianship

8.100.4.G. MAGI Covered Groups

1. For MAGI Medical Assistance, any person who is determined to be eligible for Medical Assistance based on MAGI at any time during a calendar month shall be eligible for benefits during the entire month.

2. Children applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Refer to the MAGI-Medicaid income guidelines chart available on the Department's website.

a. Children are eligible for Children's MAGI Medical Assistance through the end of the month in which they turn 19 years old. After turning 19, the individual may be eligible for a different Medical Assistance category.

3. Parents and Caretaker Relatives applying for Medical Assistance whose total household income does not exceed 60% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Parents or Caretaker Relatives eligible for this category shall have a dependent child in the household.

a. A dependent child is considered to be living in the home of the parent or caretaker relative as long as the parent or specified relative exercises responsibility for the care and control of the child even if:

i) The child is under the jurisdiction of the court (for example, receiving probation services);

ii) Legal custody is held by an agency that does not have physical possession of the child;

iii) The child is in regular attendance at a school away from home;

iv) Either the child or the relative is away from the home to receive medical treatment;

v) Either the child or the relative is temporarily absent from the home;

vi) The child is in voluntary foster care placement for a period not expected to exceed three months. Should the foster care plan change within the three months and the placement become court ordered, the child is no longer considered to be living in the home as of the time the foster care plan is changed.

4. Adults applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance. This category includes adults who are parents or caretaker relatives of dependent children whose income exceeds the income threshold to qualify for the Parents and Caretaker Relatives MAGI category and who meet all other eligibility criteria.

   a. A dependent child living in the household of a parent or caretaker relative shall have minimum essential coverage, in order for the parent or caretaker relative to be eligible for Medical Assistance under this category. Refer to section 8.100.4.G.3.a on who is considered a dependent child.

5. Pregnant Women whose household income does not exceed 185% of the federal poverty level (MAGI-equivalent) are eligible for the Pregnant Women MAGI Medical Assistance program. Medical Assistance shall be provided to a pregnant woman for a period beginning with the date of application for Medical Assistance through the last day of the month following 60 days from the date the pregnancy ends. Once eligibility has been approved, Medical Assistance coverage will be provided regardless of changes in the woman's financial circumstances once the income verification requirements are met.

      a. A pregnant women’s eligibility period will end effective the earliest possible month, if the following occurs:

         i) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90 day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

6. A lawfully admitted non-citizen who is pregnant and who has been in the United States for less than five years is eligible for Medical Assistance if she meets all of the other eligibility requirements specified at 8.100.4.G.5 and fits into one of the immigration categories listed in 8.100.3.G.1.g.iii.1-5 and 8.100.3.G.1.g.vi.1-15. This population is referenced as Legal Immigrant Prenatal.

7. A child whose mother is receiving Medical Assistance at the time of the child's birth is continuously eligible for one year. This population is referred to as “Eligible Needy Newborn”. This coverage also applies in instances where the mother received Medical Assistance to cover the child’s birth through retroactive Medical Assistance. The child is not required to live with the mother receiving Medical Assistance to qualify as an Eligible Needy Newborn.

a. To receive Medical Assistance under this category, the birth must be reported verbally or in writing to the County Department of Human Services or eligibility site. Information provided shall include the baby's name, date of birth, and mother's name or Medical Assistance number. A newborn can be reported at any time by any person. Once reported, a newborn meeting the above criteria shall be added to the mother's Medical Assistance case, or his or her own case if the newborn does not reside with the mother, according to timelines defined by the Department. If adopted, the newborn's agent does not need to file an application or provide a Social Security Number or proof of application for a Social Security Number for the newborn

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Tracking number: 2018-00346

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 09/14/2018

10 CCR 2505-10

MEDICAL ASSISTANCE - STATEMENT OF BASIS AND PURPOSE, AND RULE HISTORY

The above-referenced rules were submitted to this office on 09/18/2018 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.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

September 26, 2018 10:59:35

Emergency Rules Adopted

Department

Department of Revenue

Agency

Taxpayer Service Division - Tax Group

CCR number

1 CCR 201-4

Rule title

1 CCR 201-4 SALES AND USE TAX 1 - eff 12/01/2018

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DEPARTMENT OF REVENUE

Taxpayer Service Division – Tax Group

SALES AND USE TAX

1 CCR 201-4

Regulation 39-26-102(1.3). Auctioneers.

(1) Auctioneer's Duty to Collect Tax

(a) Definitions

(i) *Auction sale*. An auction sale is a sale conducted by an auctioneer who solicits offers to purchase tangible personal property or services until the highest offer is made.

(ii) *Auctioneer*. An auctioneer is a person who sells an interest in tangible personal property or taxable services owned by the auctioneer or another person at an auction sale. An auctioneer has the legal authority to accept on behalf of the seller an offer to buy. An interest in property or services includes a lease and license. A person selling goods on consignment for another is an auctioneer if the sale is made at an auction sale. An auctioneer includes a person who is a lienholder, such as storageman, pawnbroker, motor vehicle mechanic, or artisan, and is selling the property at an auction sale to foreclose such lien.

(b) *General Rule*. An auctioneer is a retailer and, therefore, must collect, report, and remit Colorado sales tax and state-administered local sales taxes to the Department, even if the auctioneer is a disclosed agent of the owner.

(c) *Calculation of Tax*. Sales tax is calculated on the gross price paid by the buyer for the purchase of taxable tangible personal property or a taxable service, including any non-optional fee that only successful bidders must pay in order to purchase taxable goods or services, even if the non-optional fee is separately stated from the bid price paid for the auctioned item.

(i) *Examples.*

(A) Auctioneer sells restaurant equipment at auction for $10,000 and charges a fee of ten percent of the selling price, which is deducted from the total sale proceeds paid by the purchaser(s). Sales tax is calculated on the selling price paid by a successful bidder ($10,000), which includes the ten percent auctioneer's fee. Similarly, the fee is included in the sales tax calculation if the purchaser is required to pay the fee in addition to the successful bid price (i.e., tax calculated on $11,000) because the fee is included in the overall purchase price of the item.

(B) Auctioneer charges owners or bidders a flat “entrance” fee which compensates auctioneer for its cost to rent the auction facilities, advertising, insurance, and/or auctioneer's administrative overhead. The fee is collected from sellers and bidders regardless of whether the

owner's good(s) sells or the bidder purchases auctioned property or a service. The fee is not included in the calculation of sales tax because the fee is charged regardless of whether there is a taxable sale of goods or services. However, the fee is included in the calculation of sales tax if the fee (whether a flat or percentage fee) is due and payable only when goods or services are sold.

(C) Auctioneer charges buyer a fee for additional services that buyer has the option, but is not required, to purchase as part of buyer's purchase of auctioned property or services, such as an optional fee for auctioneer's or seller's service of delivering the auctioned goods to buyer. The optional fee paid by buyer is not included in the sales tax calculation if, and only if, the fee is separately stated on the buyer's invoice.

(d) *Local Sales Taxes*. Auctioneers must collect any applicable state-administered local sales taxes. For motor vehicles sold at auction, an auctioneer, who is required to collect sales tax (see paragraph (2)(b), below), must collect any applicable state-administered local sales taxes, unless the motor vehicle is exempted from such local sales tax by § 29-2-105(1)(e), C.R.S.

(2) **Exceptions to Auctioneer's Duty to Collect**

(a) *Licensed Owners.* An auctioneer is not required to collect sales tax if the auctioneer sells taxable tangible personal property or services on behalf of a seller who, at the time of the sale, holds a current Colorado sales tax license issued by the Department. The licensed owner is responsible for collecting, remitting, and filing a sales tax return, even if the auctioneer was contractually obligated to the owner to collect the sales tax from the purchaser(s) and report and remit the tax to the Department, or if the auctioneer was contractually required to remit such collected tax to the licensed owner. An auctioneer, who is not legally required to collect tax because the owner is a licensed retailer but is collecting such tax on behalf of the owner, must disclose to the successful bidder the owner's name and owner's retail license number. An auctioneer who is not legally responsible to collect sales tax because the owner is a licensed retailer, but who nevertheless collects sales tax from a purchaser must hold the same in trust on behalf of the State of Colorado, and is liable for such tax if the tax is not remitted to the licensed seller or the Department.

(b) *Sales of motor vehicles.* An auctioneer is not required to collect sales taxes due on the sale of a motor vehicle, unless the auctioneer is licensed by Colorado as an automotive dealer pursuant to §12-6-101, et seq., C.R.S and the sale or use of the vehicle is subject to tax. § §39-26-113(7)(a) and (b), C.R.S.

(c) *Property Exempt from Sales Tax*. An auctioneer does not collect sales tax if the property is exempt from sales tax, such as an exempt farm close-out sale.

(d) *Burden of Proof*. An auctioneer has the burden of establishing with objective, verifiable documentation an exception or exemption from collecting, reporting, and remitting sales tax. An auctioneer selling on behalf of a licensed seller or to a purchaser with a sales tax exemption certificate must obtain a copy of the owner's sales tax license or, in the case of an exempt sale, the sales tax license number or the purchaser's sales tax exemption certificate, and verify that such license or certificate is valid at the time of the sale.

Cross Reference(s):

1. Please visit the Department's website (www.colorado.gov/revenue/tax) for online services available for verifying tax licenses and exemption certificates.

2. See Regulation 39-26-716.4(a), 1 CCR 201-4 regarding an auctioneer's duties for an exempt farm close-out sale.

3. See Regulation 39-26-718, 1 CCR 201-4 for information on charitable entities conducting fundraising by auction sales.

4. See, Department Publication FYI Sales 56, “Sales Tax on Leases of Motor Vehicles and Other Tangible Personal Property” for additional information about when local sales taxes must be collected by retailers on sales of motor vehicles.

5. See Regulation 39-26-102.9, 1 CCR 201-4 for the sourcing of sales for state and local sales tax purposes.

REGULATION 39- 26-102.3 (Repealed)

Regulation 39-26-102(9). Retail Sales.

Basis and Purpose. The bases for this rule are §§ 29-2-105(1)(b), 39-21-112(1), 39-26-102(9), 39-26-102(10), 39-26-104, 39-26-107, 39-26-204(2), and 39-26-713, C.R.S. The purpose of this rule is to establish the location to which a retail sale is sourced within Colorado.

(1) "Retail sale" includes all sales on which sales tax is imposed under § 39-26-104, C.R.S.

(2) A retail sale is a sale to the user or consumer of tangible personal property or service whether the sale is made by a licensed vendor or is between private parties.

(3) "Retail sale" includes only those sales made within Colorado. For purposes of determining whether a sale of tangible personal property or services, other than leases or rentals controlled by subparagraphs (4), (5), or (6) below, and sales of mobile telecommunications services under §39-26-104(1)(c), C.R.S., is made within Colorado, the following rules apply:

(a) When tangible personal property or services are received by the purchaser at a business location of the seller, the sale is sourced to that business location.

(b) When tangible personal property or services are not received by the purchaser at a business location of the seller, the sale is sourced to the location where receipt by the purchaser (or the purchaser's donee, designated as such by the purchaser) occurs, including the location indicated by instructions for delivery to the purchaser (or donee), if that location is known to the seller.

(c) When subparagraphs (3)(a) and (3)(b) do not apply, the sale is sourced to the location indicated by an address for the purchaser that is available from the business records of the seller that are maintained in the ordinary course of the seller's business when use of this address does not constitute bad faith.

(d) When subparagraphs (3)(a) through (3)(c) do not apply, the sale is sourced to the location indicated by an address for the purchaser obtained during the consummation of the sale, including the address of a purchaser's payment instrument, if no other address is available, when use of this address does not constitute bad faith.

(e) When subparagraphs (3)(a) through (3)(d) do not apply, including the circumstance in which the seller is without sufficient information to apply the previous rules, then the location will be determined by the address from which tangible personal property was shipped.

(f) For the purpose of applying subparagraphs (3)(a) through (3)(e), the terms "receive" and "receipt" mean:

(i) Taking possession of tangible personal property; or

(ii) Making first use of services; but not

(iii) Possession by a shipping company on behalf of the purchaser.

(4) The lease or rental of tangible personal property, other than property identified in subparagraphs (5) or (6) shall be sourced as follows:

(a) For a lease or rental that requires recurring periodic payments, the first periodic payment is sourced the same as a retail sale in accordance with subparagraph (3) of this rule. Periodic payments made subsequent to the first payment are sourced to the primary

property location for each period covered by the payment. The primary property location shall be as indicated by an address for the property provided by the lessee that is available to the lessor from its records maintained in the ordinary course of business, when use of this address does not constitute bad faith. The property location shall not be altered by intermittent use at different locations, such as use of business property that accompanies employees on business trips and service calls.

(b) For a lease or rental that does not require periodic payments, the payment is sourced the same as a retail sale in accordance with the provisions of subparagraph (3) of this rule.

(c) This subparagraph does not affect the imposition or computation of sales or use tax on leases or rentals based on a lump sum or accelerated basis, or on the acquisition of property for lease.

(5) The lease or rental of motor vehicles, trailers, semi-trailers, or aircraft that do not qualify as transportation equipment, as defined in subparagraph (6), shall be sourced as follows:

(a) For a lease or rental that requires recurring periodic payments, each periodic payment is sourced to the primary property location. The primary property location shall be as indicated by an address for the property provided by the lessee that is available to the lessor from its records maintained in the ordinary course of business, when use of this address does not constitute bad faith. The location shall not be altered by intermittent use at different locations.

(b) For a lease or rental that does not require recurring periodic payments, the payment is sourced the same as a retail sale in accordance with the provisions of subparagraph (3).

(c) This subparagraph does not affect the imposition or computation of sales or use tax on leases or rentals based on a lump sum or accelerated bases, or on the acquisition of property for lease.

(6) The retail sale, including the lease or rental, of transportation equipment shall be sourced the same as a retail sale in accordance with the provisions of subparagraph (3), notwithstanding the exclusion of lease or rental in subparagraph (3). “Transportation equipment” means any of the following:

(a) Locomotives and railcars that are utilized for the carriage of persons or property in interstate commerce.

(b) Trucks and truck-tractors with a Gross Vehicle Weight Rating (GVWR) of 10,001 pounds or greater, trailers, semi-trailers, or passenger buses that are:

(i) Registered through the International Registration Plan; and

(ii) Operated under authority of a carrier authorized and certificated by the U.S. Department of Transportation or another federal or a foreign authority to engage in the carriage of persons or property in interstate or foreign commerce.

(c) Aircraft that are operated by air carriers authorized and certificated by the U.S. Department of Transportation or another federal or foreign authority to engage in the carriage of persons or property in interstate or foreign commerce.

(d) Containers designed for use on and component parts attached or secured on the items set forth in subparagraphs (6)(a) through (6)(c).

Regulation 39-26-103.5. Direct Payment Permit.

(1) **General Rule.** A purchaser who holds a direct payment permit ("Qualified Purchaser") shall remit sales and use taxes directly to the Colorado Department of Revenue ("Department") and not to the retailer. Retailers who sell taxable goods or services to a Qualified Purchaser shall not collect sales tax from such purchasers.

(2) **Qualified Purchaser Qualifications.** An applicant, which can be an entity or individual, for a direct payment permit must meet the following conditions.

(a) *Dollar Threshold*. An applicant must have had a minimum of $7,000,000 in purchases on which Colorado state sales or use tax was owed during the twelve months preceding the application. The dollar threshold excludes purchases that are exempt from Colorado state sales and use tax, even if such purchases are subject to state-administered local sales or use taxes. See, §29-2-105, C.R.S. for a description of the local tax base. For example, the dollar threshold excludes exempt wholesale purchases of inventory. Additionally, commodities or tangible personal property that are to be erected upon or affixed to real property, such as building and construction materials and fixtures, are not included in the dollar threshold. See, §39-26-103.5(1)(a), C.R.S.

(b) Good Standing. If an applicant has been subject to any tax administered by the Department for at least three years prior to the date of the application, an applicant cannot have been delinquent in collecting, remitting, or reporting any sales, use, income, or other tax administered by the Department for the immediate three years prior to the date applicant submits its application. If an applicant has not been subject to any tax administered by the Department for at least three years, the applicant cannot have been delinquent in collecting, remitting, or reporting taxes for any period after the date the applicant was first obligated to collect, remit, and report such taxes. The Department can waive this requirement if an applicant demonstrates to the satisfaction of the director or their designee that the failure to comply with the collecting, remitting, and reporting requirements was due to reasonable cause. In determining whether reasonable cause exists, the Department will consider, among other relevant aggravating and mitigating factors, whether:

(i) the failure was due to willful or reckless disregard of applicant's tax obligations;

(ii) the applicant failed to comply on more than one occasion;

(iii) the magnitude of the failure was significant in terms of dollars or time; and

(iv) the applicant made subsequent efforts to avoid future failures.

(c) *Accounting Systems and Practices*. An applicant must have in place an accounting system and set of practices that are acceptable to the Department. The accounting system and practices must fully and accurately report the amount of sales or use tax to be reported on the appropriate sales or use tax return(s), including state-administered local tax jurisdictions. The Department may revoke a direct payment permit and may make assessments of tax, penalties, or interest if such system or practices are not adequate to enable the Department to fully and accurately collect and allocate to cities, counties, and other local taxing entities all the sales and use taxes that the Department collects on behalf of such entities.

(d) A Qualified Purchaser is not required to be subject to the collection, remittance, and reporting requirements for sales taxes in order to obtain such a permit. Rather, a

Qualified Purchaser can be subject to the collection, remittance, and reporting requirements for any tax administered by the Department.

(3) **Effective Date.** A direct payment permit is effective from the date of issuance until December 31 of the third year following the year in which it is issued unless sooner revoked.

(4) **Purchaser's Funds.** When a Qualified Purchaser uses a direct payment permit, the Qualified Purchaser must use its own funds when paying a retailer for a transaction to which the direct payment permit applies. Retailers cannot accept payment from persons other than the Qualified Purchaser, including payment from the personal funds of an individual if the permit is held in the name of an entity. Retailers must collect tax if a Qualified Purchaser is making a purchase with funds other than the Qualified Purchaser's funds and will be liable for unpaid taxes for transactions paid in contravention of this subsection (4).

(5) **Revocation of Permits.**

(a) The Department may revoke a direct payment permit if the Qualified Purchaser violates any statute or rule governing the administration of sales and use taxes, or if in the opinion of the Department the Qualified Purchaser becomes otherwise unable to meet any of the conditions for holding a direct payment permit. The Department shall provide written notice of the revocation by first-class mail to the last known address of the Qualified Purchaser thirty days prior to the effective date of such revocation. The notice of revocation shall set forth:

(i) the factual and legal basis for revocation,

(ii) advise the Qualified Purchaser of its right to appeal, and

(iii) the date the Department issued the notice.

The Department will issue a denial of a direct payment permit application in the same manner.

(b) An applicant who is denied a permit or a Qualified Purchaser whose permit was revoked, may appeal the decision by submitting to the Department's executive director a written request for hearing. The notice of appeal must be received by the Department within thirty days of the date of issuance of the notice of revocation or denial and contain the permit holder's name, address, permit account number (for revocations), and the legal and factual basis explaining why the permit should not be revoked or denied. Qualified Purchaser's notice of appeal shall suspend the effective date of the revocation until a final order resolving the appeal is issued by the executive director or the director's designee. The executive director or director's designee shall conduct a hearing and issue a final ruling on such appeal within a reasonable time.

(6) **Reporting Requirements.**

(a) A Qualified Purchaser holding a direct payment permit must directly remit to the Department all state and state-administered city, county and special district sales taxes that would have been collected by the retailer had the Qualified Purchaser purchased such goods or services without a direct payment permit.

(i) *Exceptions.* A Qualified Purchaser holding a direct payment permit cannot pay county lodging taxes, county short-term rental taxes, and local marketing district taxes directly to the Department because such taxes are not sales taxes. Retailer

must collect such taxes from the Qualified Purchaser and remit them to the Department. See, §30-11-107.5 and §30-11-107.7, C.R.S.

(b) A Qualified Purchaser must report and remit state and state-administered local taxes on or before the 20th day of each month following the month the Qualified Purchaser purchases taxable goods or services with a direct payment permit.

(c) The vendor must retain a copy of Qualified Purchaser's direct pay permit.

Cross References

1. See Rule 39-26-102.9, 1 CCR 201-4 for the sourcing of sales for state and local sales tax purposes.

Regulation 39-26-104(1)(b)(I). Exchanged Tangible Personal Property.

(1) **General Rule.** When tangible personal property is received by a retailer as part or full payment for the sale of tangible personal property, sales tax shall be calculated upon the purchase price of the tangible personal property sold, minus the fair market value of the tangible personal property exchanged by the purchaser, provided the property taken by the retailer in the exchange is to be resold in the usual course of the retailer's trade or business.

(2) **Exceptions**. The general rule does not apply if:

(a) The property transferred from purchaser, or by a third party on behalf of the purchaser, to seller is not tangible personal property.

(i) *Examples.*

(A) Intangible property, such as stock certificates, and real property are not subject to sales or use tax.

(B) Services (because they are not property).

(b) Retailer does not resell, in the usual course of its business, the property transferred from purchaser.

(i) *Examples.*

(A) Retailer does not resell the property in a commercially reasonable period.

(B) Retailer takes a used computer from buyer in exchange for the sale of a new computer to buyer. Retailer then donates the used computer to a school. A donation does not constitute a sale and, therefore, the initial exchange does not qualify under the general rule.

(C) Retailer is in the business of selling only construction equipment. Buyer exchanges a boat as partial payment of its purchase of a large compressor. Retailer cannot reduce the price on which sales tax is calculated for the compressor by the fair market value of the boat even if the seller resells the boat. The resale of boats is not part of the retailer's usual course of business. Retailer and buyer also do not qualify for the vehicle exchange, even though the boat qualifies as a vehicle, because both the buyer and retailer must exchange vehicles. Therefore, both the retailer, as a licensed vendor, and buyer are liable for the sales tax on the purchase of the equipment and the retailer, as a buyer, is liable for sales tax on the fair market value of the boat (buyer would also be liable for the sales tax on the boat if buyer is a licensed retailer).

(ii) *Exception to the Resale Requirement - Vehicles.* The resale requirement does not apply if the property transferred (exchanged) by the seller to buyer is a vehicle and the property transferred (exchanged) by the buyer to the seller is a vehicle. Both vehicles must be subject to licensing, registration, or certification by the laws of Colorado. "Vehicles" include:

(A) Trailers, semi-trailers, trailer coach,

(B) Special mobile machinery (except such machinery used solely on property of the owner),

(C) Vehicles designed primarily to be operated or drawn on public highways, (§§ 42-3-103(1) and 104, C.R.S.),

(D) Watercraft (§ 33-13-103, C.R.S.),

(E) Aircraft (Colorado does not license aircraft but Colorado law requires aircraft possessed in this state be licensed by FAA) (§ 43-10-114(1), C.R.S.).

Purchaser, on whom the obligation to pay sales tax is levied, is the person who pays money or other consideration in addition to the exchanged vehicle. If the seller is a licensed retailer, then the retailer must collect sales tax from the purchaser. Persons who engage in three or more such exchanges may be required to obtain a motor vehicle dealer's license

(c) Exchanges that do not occur at the same time and place. See, § 39-26-104(1)(b).

(i) *Examples.*

(A) Motor vehicle dealer sells a motor vehicle to buyer, who pays cash. Two weeks later, buyer decides to sell another vehicle he owns to the dealer. Buyer cannot claim a refund for taxes paid for the first purchase because the second vehicle was not exchanged as part of the first sale.

(B) Retailer is in the business of leasing equipment. Customer rents a forklift for 30 days and retailer and customer agree at the time the lease is signed that customer will give retailer, as part of the payment, a used compressor that retailer intends to lease to third parties. The exchange does not qualify because the use of the forklift occurs over thirty days and does not occur at the same time and place as the exchange of the compressor. In contrast, a finance lease is treated as a credit sale and not as a true lease. An exchange involving a finance lease is treated as occurring at the same time and place as the other party's exchange of property.

Cross Reference(s):

1. For additional requirements regarding the collection of tax for motor vehicles, see § 39-26-113, C.R.S.

2. See, § 39-26-104(1)(b)(I)(B), C.R.S. and § 12-6-101, et seq., C.R.S. for laws governing motor vehicle dealer licensing.

Regulation 39-26-105. Remittance of Tax.

Basis and Purpose. The statutory bases for this rule are §§ 39-21-112(1) and 39-21-119, 39-26-105, 39-26-107, 39-26-109, 39-26-112, 39-26-118, and 39-26-704(2), C.R.S. The purpose of this rule is to clarify sales tax remittance requirements and conditions under which a retailer is eligible to deduct a retailer's service fee from the sales tax they remit.

(1) **Retailer Requirements.**

(a) A retailer is liable and responsible for tax on the retailer's taxable sales made during the tax period prescribed for the retailer pursuant to 1 CCR 201-4, Rule 39-26-109, calculated using the tax rate in effect at the time of the sale and applied to all taxable sales, including all taxable sales made for less than the minimum amount subject to tax pursuant to § 39-26-106, C.R.S. A retailer is also liable and responsible, pursuant to § 39-26-112, C.R.S., for the payment of any tax collected in excess of the tax rate in effect at the time of the sale and must remit such excess amount to the Department.

(b) A retailer shall file with the Department a return reporting its sales, including any sales exempt from taxation under article 26 of title 39, C.R.S., made during the preceding tax period. If a retailer makes no retail sales during its preceding tax period, the retailer must file a return reporting zero sales. Returns and any required supplemental forms must be completed in full.

(c) A retailer must file returns and remit any tax due to the Department in accordance with the filing schedules prescribed by 1 CCR 201-4, Rule 39-26-109.

(2) **Due Date of Returns.** Sales tax returns and payments of tax reported thereon are due the twentieth day of the month following the close of the tax period. If the twentieth day of the month following the close of the tax period is a Saturday, Sunday, or legal holiday, the due date shall be the next business day.

(3) **Retailer's Service Fee.** Except as provided in this paragraph (3), a retailer may, in the remittance of collected sales tax, deduct and retain a retailer's service fee in the amount prescribed by § 39-26-105(1)(c), C.R.S.

(a) If the retailer is delinquent in remitting any portion of the tax due, other than in unusual circumstances shown to the satisfaction of the executive director, the retailer shall not retain a retailer's service fee for any portion of the tax for which the retailer is delinquent.

(b) If a retailer has retained a retailer's service fee pursuant to paragraph (3) of this rule and, subsequent to the applicable due date, owes additional tax for the filing period as the result of an amended return or an adjustment made by the Department, the retailer shall not be permitted to retain a retailer's service fee with respect to the additional tax, but the retailer may retain the retailer's service fee associated with the original return, so long as the retailer filed the original return in good faith.

(4) **Application.**

(a) The liability and responsibility imposed by § 39-26-105, C.R.S. and this rule apply to any retailer that has substantial nexus with Colorado and is doing business in this state, as defined in § 39-26-102(3), C.R.S. Retailers are considered to have a substantial nexus with Colorado for sales tax purposes if they meet any of the following criteria:

(I) the retailer maintains a physical presence in Colorado pursuant to §§ 39-26-102(3)(a), (d), and (e), C.R.S.; or

(II) in the previous calendar year or the current calendar year:

(A) the retailer's gross revenue from the sale of tangible personal property or services delivered into Colorado exceeds one hundred thousand dollars; or

(B) the retailer sold tangible personal property or services for delivery into Colorado in two hundred or more separate transactions.

(b) Paragraph (4)(a)(II) of this rule shall not apply in determining a retailer's liability and responsibility for tax pursuant to § 39-26-105, C.R.S. and this rule for any sale made prior to December 1, 2018.

(c) A retailer that has substantial nexus with Colorado as defined in paragraph (4)(a) of this rule is not a "remote seller" as defined in § 39-26-102(7.7), C.R.S. and sales made by any such retailers are not "remote sales" as defined in § 39-26-102(7.6), C.R.S.

Cross Reference(s):

1. Forms, returns, and instructions can be found online at www.colorado.gov/tax.

2. For additional information about excess tax collected by a retailer, see § 39-26-112, C.R.S. and Rule 39-26-106, 1 CCR 201-4.

3. For information about electronic funds transfer (EFT) requirements and the timeliness of payments made via EFT, see Special Rule 1 Electronic Funds Transfer, 1 CCR 201-1.

4. For information about dates payments or returns are deemed to have been made, see § 39-21-119, C.R.S. and Rule 39-21-119, 1 CCR 201-1.

5. For information about electronic filing, see § 39-21-120, C.R.S. and Rule 39-21-120, 1 CCR 201-1.

Regulation 39-26-105(1)(A) TAX RATE (Repealed)

Regulation 39-26-204(2). Retailer's Use Tax.

(1) Every retailer that has substantial nexus with Colorado and is doing business in this state, as defined in § 39-26-102(3), C.R.S., shall collect retailer's use tax, pursuant to § 39-26-204(2), C.R.S., with respect to any sale of tangible personal property for storage, use, or consumption in Colorado for which the retailer was not, under state and federal law, required to collect sales tax. Retailers are considered to have a substantial nexus with Colorado for sales tax purposes if they meet any of the following criteria:

(a) the retailer maintains a physical presence in Colorado pursuant to §§ 39-26-102(3)(a), (d), and (e), C.R.S.; or

(b) in the previous calendar year or the current calendar year:

(I) the retailer's gross revenue from the sale of tangible personal property or services delivered into Colorado exceeds one hundred thousand dollars; or

(II) the retailer sold tangible personal property or services for delivery into Colorado in two hundred or more separate transactions.

(2) Paragraph (1)(b) of this rule shall not apply in determining a retailer's obligation to collect tax under § 39-26-204(2), C.R.S. and this rule for any sale made prior to December 1, 2018.

(3) A retailer that has substantial nexus with Colorado as defined in paragraph (4)(a) of this rule is not a "remote seller" as defined in § 39-26-102(7.7), C.R.S. and sales made by any such retailers are not "remote sales" as defined in § 39-26-102(7.6), C.R.S.

Regulation 39-26-704(2).

(1) All sales which the state of Colorado is prohibited from taxing under the constitution or laws of the United States or the state of Colorado are exempt, including sales to ambassadors, consuls, and their employees who are citizens of the nation they are representing.

(2) Sales involving interstate commerce are exempt only in cases where the tax would be unconstitutional.

(3) All sales to railroads, except as provided in C.R.S. 1973, 39-26-710(1)(a) and to other common carriers doing an interstate business, to telephone and telegraph companies, and to all other agencies engaged in interstate commerce are taxable in the same manner as are sales to other persons.

COLORADO
Department of Revenue
Taxation Division

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Colorado Department of Revenue
Statement of Emergency Justification and Adoption
Emergency Amendment to Rules 39-26-102(1.3), 39-26-102.3, 39-26-102(9), 39-26-103.5, 39-26-104(1)(b)(I), 39-26-105, 39-26-105(1)(A), 39-26-204(2), and 39-26-704(2)

Pursuant to sections 24-4-103(6), 39-21-112, 39-26-102, 39-26-103.5, 39-26-104, 39-26-105, 39-26-204, and 39-26-704, C.R.S., I, Michael S. Hartman, Executive Director of the Department of Revenue, hereby adopt emergency amendments to tax rules 39-26-102(1.3), 39-26-102.3, 39-26-102(9), 39-26-103.5, 39-26-104(1)(b)(I), 39-26-105, 39-26-105(1)(A), 39-26-204(2), and 39-26-704(2).

Section 24-4-103(6), C.R.S., authorizes the Executive Director to adopt temporary or emergency rules if the Executive Director finds that the immediate adoption of the rules are imperatively necessary to comply with a state or federal law or for the preservation of public health, safety, or welfare, and that compliance with the requirements of section 24-4-103, C.R.S. regarding promulgation of permanent rules would be contrary to the public interest.

I find that the immediate adoption of amendments to these rules is imperatively necessary to provide guidance to retailers and consumers in light of the recent decision in *South Dakota v. Wayfair, Inc.*, 585 U.S. ___ (2018). In *Wayfair*, the United States Supreme Court overruled *Quill Corp. v. North Dakota*, 504 U.S. 298 (1992), and *National Bellas Hess, Inc. v. Department of Revenue of Illinois*, 386 U.S. 753 (1967), and held that physical presence is not required for a state to impose sales and use tax collection requirements on an out-of-state retailer.

Retailers who do not have a physical presence in Colorado may now be subject to state and local sales and use tax licensing and collection requirements under Colorado law. Without immediate guidance, these retailers could face substantial tax liabilities that they must pay from their own accounts but which Colorado law would have allowed them to collect from their customers had they known of the tax collection obligation at the time of the relevant transactions. Further, confusion among retailers may adversely impact Colorado consumers. I find that compliance with the requirements of section 24-4-103, C.R.S., would be contrary to the public interest under these circumstances.

Statutory Authority

The statutory authorities for these amendments are cited above.

Purpose

To provide explicit guidance regarding the application of Colorado's sales and use taxes in light of *South Dakota v. Wayfair, Inc.*, 585 U.S. ___ (2018).

Adoption

For the reasons set forth above, I hereby adopt emergency rules 39-26-102(1.3), 39-26-102.3, 39-26-102(9), 39-26-103.5, 39-26-104(1)(b)(I), 39-26-105, 39-26-105(1)(A), 39-26-204(2), and 39-26-704(2), which are attached to this Statement. These rules shall be effective on or after December 1, 2018 and shall apply prospectively. These emergency rules shall be in force and effect for a period of one hundred and twenty days from the date of this Statement, unless sooner terminated or replaced by permanent rules adopted in accordance with section 24-4-103, C.R.S.

Adopted this _11th__ day of _September, 2018.

Michael S. Hartman
Executive Director
Colorado Department of Revenue

CYNTHIA H. COFFMAN
Attorney General

MELANIE J. SNYDER
Chief Deputy Attorney General

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Office of the Attorney General

Tracking number: 2018-00451

Opinion of the Attorney General rendered in connection with the rules adopted by the

Taxpayer Service Division - Tax Group

on 09/11/2018

1 CCR 201-4

SALES AND USE TAX

The above-referenced rules were submitted to this office on 09/11/2018 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.

September 28, 2018 15:38:53

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Emergency Rules Adopted

Department

Department of Education

Agency

Colorado State Board of Education

CCR number

1 CCR 301-95

Rule title

1 CCR 301-95 RULES FOR THE ADMINISTRATION OF THE SCHOOL TRANSFORMATION GRANT PROGRAM 1 - eff 10/30/2018

Effective date

10/30/2018

DEPARTMENT OF EDUCATION

Colorado State Board of Education

RULES FOR THE ADMINISTRATION OF THE SCHOOL TRANSFORMATION GRANT PROGRAM

1 CCR 301-95

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

Authority: Article IX, Section 1, Colorado Constitution. 22-2-106(1)(a) and (c); 22-2-107(1)(c); 22-7409(1.5); 22-13-103 of the Colorado Revised Statutes (C.R.S.).

1.00 Statement of Basis and Purpose.

The statutory basis for these rules is Sec 22-13-103, C.R.S., which requires the State Board of Education to promulgate rules to implement and administer the School Transformation Grant Program.

2.0 Definitions.

2.00(1) Charter School: A charter school authorized by a school district pursuant to part 1 of article 30.5 of title 22 or an institute charter school authorized by the state charter school institute pursuant to part 5 of article 30.5 of title 22 of the Colorado Revised Statutes.

2.00(2) Department: The Department of Education created and existing pursuant to section 24-1-115, C.R.S.

2.00(3) Institute: The State Charter School Institute established in section 22-30.5-503, C.R.S.

2.00(4) Program: The School Transformation Grant program created in section 22 13-103.

2.00(5) Provider: A public or private entity that offers a high-quality turnaround leadership development program for Colorado educators.

2.00(6) School District: A school district organized pursuant to article 30 of title 22, C.R.S.

2.00(7) School Turnaround Leader: A principal or teacher leader in a school that is required to adopt a priority improvement plan or turnaround plan pursuant to section 22-11-210, C.R.S. or a district-level administrator or employee of the State Charter School Institute that coordinates and supports turnaround efforts in schools of the School District or Institute Charter schools that implement priority improvement plans or turnaround plans.

2.00(8) State Board: The State Board of Education created pursuant to Section 1 of Article IX of the Colorado Constitution.

2.1 Turnaround Leadership Development Providers Request for Proposals

The Department must issue a request for proposals (RFP) from providers who seek to participate in the program. Based on the criteria outlined below, the Department will identify one or more providers to provide turnaround leadership development programs for school districts, the Institute, and charter schools that receive grants.

2.01(1) Criteria for identifying approved Turnaround Leadership Development Providers

The Department must develop an RFP, which consists of an application and scoring rubric template. Thereafter, the Department must undertake a fair and equitable application review. In such review, the Department must consider the following for identifying providers from among those that respond to the RFP:

2.01(1)(a) Each Provider's experience in developing successful, effective leadership in low-performing schools and school districts;

2.01(1)(b) The leadership qualities that each Provider's turnaround leadership development program is expected to develop;

2.01(1)(c) A Provider's capacity to implement identified program components that make up a comprehensive leadership development experience; and

2.01(1)(d) The availability of turnaround leadership development programs for school turnaround leaders in public schools throughout the state. The grant program shall seek to ensure approved providers are available for leaders in all regions of the state.

2.01(2) Timeline for approving new Turnaround Leadership Development Providers. Applications for new providers to apply will open at the Department's discretion and a decision notification will occur within 90 days of the closing application date.

2.01(3) Review of approved Turnaround Leadership Development Providers. The department, on a regular basis, shall review each provider's turnaround leadership development programs, including the success achieved by the persons who complete the programs, and revise the list of identified providers as appropriate to ensure that the turnaround leadership development programs that are available through the program are of the highest quality.

2.01(4) Reporting requirements for approved Turnaround Leadership Development Providers. Each approved provider shall track the effectiveness of persons who are engaged in and who complete a turnaround leadership development program and report the effectiveness to the department on or before July 1 of the year following the training. The report must use department surveys to measure the effectiveness of persons who complete the turnaround leadership development program. Each grant recipient must report on the following:

2.01(5)(a) Number of participants in program;

2.01(5)(b) Schools served; and

2.01(5)(c) Change in principals' or aspiring leaders' actions/behavior (as data is available).

2.2 School Transformation Grants.

2.02(1) Use of funds for School Transformation Grants. Subject to available appropriations, the State Board shall award School Transformation Grants to one or more school districts or charter schools or the Institute to use in:

2.02(1)(a) Identifying and recruiting practicing and aspiring school turnaround leaders;

2.02(1)(b) Subsidizing the costs incurred for school turnaround leaders and their staff, if appropriate, to participate in turnaround leadership development programs offered by identified providers;

2.02(1)(c) Reimbursing the school turnaround leaders for costs they incur in completing turnaround leadership development programs offered by identified providers;

2.02(1)(d) Providing educator professional development for educators working in public schools that are required to adopt priority improvement or turnaround plans for the immediate or preceding school year;

2.02(1)(e) Providing services, support, and materials to transform instruction in public schools that are required to adopt priority improvement or turnaround plans for the immediate or preceding school year; and

2.02(1)(f) Planning for and implementing one or more of the following rigorous school redesign strategies:

(I) Converting a district public school to a charter school if it is not already authorized as a charter school;

ii) Granting innovation school status to a district public school pursuant to section 22-32.5-104;

iii) With regard to a district or institute charter school, replacing the school's operator or governing board;

iv) Contracting with a public or private entity other than the school district to partially or wholly manage a district public school, which entity is accepted by the department and the local school board as using research-based strategies and having a proven record of success working with schools under similar circumstances; or

v) Closing a public school or revoking the charter for a district or institute charter school.

2.02(2) Timeline for School Transformation Grants. For the 2018-19 school year and each year thereafter, subject to available appropriations, School Transformation Grant applications will be due each year no later than January 15. Application decision notification will occur directly after State Board approval, no later than by the following April meeting.

2.02(3) Application procedures for School Transformation Grants. The Department must develop a grant application and scoring rubric template. Thereafter, the Department must undertake a fair and equitable application review.

2.02(4) Application requirements for School Transformation Grants—turnaround leadership development applicants. The following minimum requirements will be included in applications for School Transformation Grants for turnaround leadership development programs:

2.02(4)(a) The goals that the applicant expects to achieve through the grant; 2.02(4)

(b) The number of individuals to participate in leadership programs, including: existing leaders, aspiring leaders, district managers or support staff;

2.02(4)(c) A clear plan for leadership development, implementation, and application of skills in the schools and district; and

2.02(4)(d) A plan to evaluate impact of program.

2.02(5) Application requirements for School Transformation Grants—all other applicants. The following minimum requirements will be included in all other applications for School Transformation Grants:

2.02(5)(a) The goals that the applicant expects to achieve through the grant;

2.02(5)(b) A clear action plan and corresponding budget for grant activities comprised of reasonable and necessary requests for funding; and

2.02(5)(c) A plan for monitoring and reporting on the effectiveness of grant funds.

2.02(6) Criteria for selecting recipients of School Transformation Grants. The following minimum criteria will be considered in selecting School Transformation Grant recipients:

2.02(6)(a) For applying school districts, the concentration of schools of the school district or, for the Institute, the concentration of Institute charter schools, that must implement priority improvement or turnaround plans. For applying charter schools, those that are implementing priority improvement or turnaround plans will be prioritized.

2.02(6)(b) Quality of grant applications and demonstrated need, based on the applicant's:

i) Goals to be achieved through the grant;

ii) Action plan and corresponding budget for grant activities comprised of reasonable and necessary requests for funding; and

iii) A plan for monitoring and reporting on the effectiveness of grant funds.

2.02(7) Duration of School Transformation Grant awards. Each grant may continue for up to three budget years. The Department shall annually review each grant recipient's use of the grant money and may rescind the grant if the Department finds that the grant recipient is not making adequate progress toward achieving the goals identified in the grant application.

2.02(8) Reporting requirements for School Transformation Grant—turnaround leadership development. Each grant recipient will annually track the effectiveness of persons who complete a turnaround leadership development program and report the effectiveness to the department on or before July 1 of the year following the training. The report must use department surveys to measure the effectiveness of persons who complete the turnaround leadership development program and include the following information, at a minimum:

2.02(8)(a) Number of people who participated and in which programs;

2.02(8)(b) Schools served;

2.02(8)(c) Impact of the grant on raising student achievement and establishing a positive school culture; and

2.02(8)(d) Change in principals' or aspiring leaders' actions/behavior.

2.02(9) Reporting requirements for School Transformation Grant— all other grantees. Each grant recipient will annually report the following at a minimum:

2.02(9)(a) Impact of the grant on raising student achievement and establishing a positive school culture.

2.02(10) Evaluation of School Transformation Grant Program. The Department will analyze and summarize the reports received from grant recipients and annually submit to the State Board, the Governor, and the Education Committees of the Senate and the House of Representatives, or any successor committees, a report of the effectiveness of the School Transformation Grants awarded pursuant to this section. The Department will also post the annual report on its web site.

Editor's Notes

History

Entire rule emer. rule eff. 09/10/2014; expired 01/08/2015.

Entire rule eff. 01/15/2015.

Entire rule eff. 01/30/2016.

Sections 2.01(2)-2.01(5) eff. 01/30/2017.

COLORADO
Department of Education

MEMO

TO: State Board of Education Members
FROM: Brenda Bautsch, Accountability Specialist
RE: Emergency Rules for the Administration of the School Transformation Grant Program
DATE: Sept. 12, 2018

This memo provides information to support the action item regarding the adoption of emergency rules for the Administration of the School Transformation Grant Program at the September board meeting.

The state board is being asked to adopt emergency rules due to the passage of HB 18-1355, which expanded the scope of the grant (previously named the School Turnaround Leadership Development Grant) to include various uses of the funds in support of school improvement. In addition to leadership development grant activities, schools and districts in Priority Improvement or Turnaround in the immediate or preceding school year will be able to apply for grant funds to support educator professional development, implement activities geared towards instructional transformation, or plan for or implement one of the statutory options for schools and districts with persistent low performance. As a result, CDE staff have made technical changes to these rules and recommend that the state board approve the emergency rules to ensure funding can be distributed to school districts during the 2018-19 academic year grant process to address immediate student performance challenges.

For detailed information supporting this item, please see:

- Red-line version of 1 CCR 301-95 Rules for the Administration of the School Transformation Grant Program
- Clean version of 1 CCR 301-95 Rules for the Administration of the School Transformation Grant Program
- Rule to statute crosswalk

Action Needed at the September Board Meeting

- A vote to adopt emergency rules for 1 CCR 301-95 Rules for the Administration of the School Transformation Grant Program

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Office of the Attorney General

Tracking number: 2018-00476

Opinion of the Attorney General rendered in connection with the rules adopted by the

Colorado State Board of Education

on 09/12/2018

1 CCR 301-95

RULES FOR THE ADMINISTRATION OF THE SCHOOL TRANSFORMATION GRANT PROGRAM

The above-referenced rules were submitted to this office on 09/17/2018 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.

September 26, 2018 15:32:40

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Insurance

CCR number

3 CCR 702-4 Series 4-2

Rule title

3 CCR 702-4 Series 4-2 LIFE, ACCIDENT AND HEALTH, Series 4-2 Accident and Health (General) 1 - eff 09/07/2018

Effective date

09/07/2018

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-4

LIFE, ACCIDENT AND HEALTH

Emergency Regulation 18-E-04

ENROLLMENT PERIODS RELATING TO INDIVIDUAL AND GROUP HEALTH BENEFIT PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-109, 10-16-105(2)(b), 10-16-105.7(1)(e), 10-16-105.7(3)(a)(II)(G), 10-16-105.7(3)(b)(II)(F), 10-16-105.7(3)(c), 10-16-108.5(8), and 10-16-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish rules governing enrollment periods for individual and group health benefit plans in accordance with Article 16 of Title 10 of Colorado Revised Statutes and the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), together referred to as the “Affordable Care Act” (ACA).

The Commissioner finds that the volatility and uncertainty within the individual insurance market, and the potential for consumer harm, constitute a triggering event requiring a special enrollment period, as specified in Section 7, to reduce the potential for consumer harm and ensure the continued health and stability of the Colorado health insurance market.

The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary for the preservation of public health, safety, or welfare, in order to ensure consumers and carriers are aware of the upcoming open enrollment dates for the 2019 plan year; to decrease the volatility of the individual health insurance market through the implementation of a special enrollment period to allow consumers sufficient time to enroll in an individual health benefit plan; and to ensure compliance with the federal open enrollment period dates for the 2019 plan year. Therefore, compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interest. This emergency regulation replaces in its entirety Colorado Insurance Regulation 4-2-43 that became effective on December 1, 2017.

Section 3 Applicability

This regulation shall apply to all carriers offering individual and/or group health benefit plans subject to the individual and/or group laws of Colorado and the requirements of the ACA.

Section 4 Definitions

A. “Calendar year” means, for the purpose of this regulation, a year beginning on January 1 and ending on December 31.

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

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

D. “Days” mean, for the purpose of this regulation, calendar days, not business days.

E. “Designated beneficiary agreement” shall have the same meaning as found at § 15-22-103(2), C.R.S.

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

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

H. “Qualified health plan” or “QHP” means, for the purposes of this regulation, a health benefit plan that has been reviewed and approved by the Division of Insurance as meeting the standards necessary to be considered an ACA-compliant health benefit plan.

I. “Qualified individual” means, for the purpose of this regulation, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Section 5 Individual Enrollment Periods

A. Carriers offering individual health benefit plans must accept every eligible individual who applies for coverage, and agrees to make the required premium payments and abide by the reasonable provisions of the plan, although carriers may choose to restrict enrollment to open or special enrollment periods.

B. Carriers offering individual health benefit plans must display continuously and prominently on their website:

1. Notice of open enrollment dates;

2. Notice of special enrollment for qualifying and triggering events;

3. Notice of the enrollment periods for each qualifying and triggering event; and

4. Instructions on how to enroll.

C. Open enrollment periods.

1. The open enrollment period for plans effective on or after January 1 shall begin on November 1 of the prior year and extend through December 15 of that same year.

2. Carriers must ensure that coverage is effective on January 1 for health benefit plans purchased on or before December 15 of the open enrollment period.

3. The open enrollment period will be extended through the annual market stabilization special enrollment period each year, as found in Section 7 of this regulation.

4. The benefit year for individual health benefit plans purchased during the annual open enrollment period is a calendar year.

5. During open enrollment periods, carriers must offer guarantee-issue child-only health benefit plans to all applicants under the age of 21.

D. Special enrollment periods.

Carriers must establish special enrollment periods for individuals who experience triggering events, pursuant to § 10-16-105.7, C.R.S.

1. Except as provided in Section 7, following a triggering event, a carrier must provide a special enrollment period of sixty (60) days.

2. Except as provided in Section 7, when an individual is notified or becomes aware of a triggering event that will occur in the future, he or she may apply for enrollment in a new health benefit plan during the thirty (30) calendar days prior to the date of the triggering event, unless otherwise noted in Section 5.D.4., with coverage beginning no earlier than the day the triggering event occurs, to avoid a gap in coverage. The individual must be able to provide written documentation to support the date of the triggering event. The effective date of this enrollment must comply with the coverage effective dates found in Section 5.D.6. of this regulation.

3. Except as provided in Section 7, when a qualified individual is notified or becomes aware of a triggering event that will occur in the future, he or she may apply for enrollment in a new health benefit plan during the sixty (60) calendar days prior to the date of the triggering event, with coverage beginning no earlier than the day the triggering event occurs, to avoid a gap in coverage. The individual must be able to provide written documentation to support the date of the triggering event. The effective date of this enrollment must comply with the coverage effective dates found in Section 5.D.6. of this regulation.

4. Triggering events are:

a. An individual or his or her dependent involuntarily losing existing creditable coverage for any reason other than fraud, misrepresentation, or failure to pay a premium. Such individual or dependent may apply for enrollment in a new health benefit plan during the sixty (60) calendar days before the effective date of the loss of coverage;

b. An individual or his or her dependent loses pregnancy-related Medicaid coverage. The date of the loss of coverage is the last day the individual would have pregnancy-related Medicaid coverage;

c. When an Exchange enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by state law in the state in which the divorce or legal separation occurs, or if the Exchange enrollee, or his or her dependent, dies;

d. An individual or his or her dependent losing other coverage as described under Section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. § 301 et seq.). Such individual or dependent may apply once during a calendar year for

enrollment in a new health benefit plan during the sixty (60) calendar days before and after the effective date of the loss of coverage;

e. An individual gaining a dependent or becoming a dependent through marriage, civil union, birth, adoption, or placement for adoption, placement in foster care, through a child support order or other court order, or by entering into a designated beneficiary agreement if the carrier offers coverage to designated beneficiaries;

f. An individual's or his or her dependent's enrollment or non-enrollment in a health benefit plan that is unintentional, inadvertent or erroneous and is the result of an error, misrepresentation, or inaction of the carrier, producer, or the Exchange;

g. An individual or his or her dependent demonstrating to the Commissioner that the health benefit plan in which the individual is enrolled has substantially violated a material provision of its contract in relation to the individual or his or her dependent;

h. A qualified individual who:

(1) Becomes newly eligible, or an Exchange enrollee who is newly eligible or ineligible, for the federal advance payment tax credit or has a change in eligibility for cost-sharing reductions available through the Exchange;

(2) Has a dependent enrolled in the same qualified health plan who is determined to be newly eligible or ineligible for the federal advance payment tax credit or has a change in eligibility for cost-sharing reductions available through the Exchange; or

(3) Is enrolled, or has a dependent enrolled, in an eligible employer-sponsored plan and is determined to be newly eligible for the federal advance payment tax credit based in part on a finding that such individual is ineligible for coverage in an eligible employer-sponsored plan that provides minimum creditable coverage, including as a result of his or her employer discontinuing or changing coverage within the next sixty (60) days, provided the enrollee is able to terminate his or her existing coverage. This enrollee may apply for enrollment in a new health benefit plan during the sixty (60) calendar days before and after the effective date of the loss of coverage.

i. An individual or his or her dependent gaining access to other creditable coverage as a result of a permanent change in residence;

j. A parent or legal guardian dis-enrolling a dependent, or a dependent becoming ineligible for the Child Health Plan Plus (CHP+);

k. An individual becoming ineligible under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.);

l. An individual, who was not previously a citizen, a national, or a lawfully present individual, gaining such status;

m. An Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1601 et seq.), or his or her dependent on the same application, may enroll in a qualified health plan or change from one qualified health plan to another one time per month;

n. An individual or his or her dependent currently enrolled in an individual or group non-calendar year health benefit plan may apply for enrollment in a new health benefit plan during the sixty (60) calendar days prior to the effective date of the involuntary loss of coverage, which is the last day of the plan or policy year;

o. An individual or his or her dependent enrolling in a health benefit plan may apply for enrollment in a new health benefit plan during the annual market stabilization special enrollment period, as specified in Section 7 of this regulation;

p. An individual who is a victim of domestic abuse or spousal abandonment, as defined by 26 C.F.R. § 1.36B-2T, including a dependent or unmarried victim within a household, who is enrolled in creditable coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment;

q. An individual who is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;

r. An individual or his or her dependent who applies for coverage during the annual open enrollment period or due to triggering event, and is assessed as potentially eligible for Medicaid or the Child Health Plan Plus (CHP+), and is determined ineligible for Medicaid or CHP+ either after open enrollment has ended or more than sixty (60) days after the triggering or qualifying event, or applies for coverage through a State Medicaid or CHP+ agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHP+ after open enrollment has ended;

s. An individual, or his or her dependent, who has purchased an off-Exchange plan, adequately demonstrates to the Commissioner that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP; or

t. An individual, or his or her dependent, who has purchased an on-Exchange plan, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP;

5. Special Enrollment Period Eligibility Verification and Prior Coverage Requirements

a. Carriers shall establish a special enrollment period eligibility verification process to confirm that an individual applying for coverage through a special enrollment period is eligible for the requested special enrollment period. Carriers may delay the processing of an application or any enrollment documents or premium payments until after completion of verification of eligibility for the requested special enrollment period.

(1) For special enrollment period eligibility verification, carriers shall make the list of required documentation, relevant premium payment information, and the verification process and deadlines available on their website in a conspicuous manner, and encourage individuals to provide the required documentation with their request for a special enrollment.

(2) A carrier shall notify the applicant within fourteen (14) days of receipt of the application if the applicant did not provide sufficient documentation necessary to verify eligibility for the special enrollment period requested. The notice shall include information that a failure to provide the

documentation will result in a denial of enrollment, and that coverage will not be issued until the required documentation confirming eligibility for the special enrollment period has been received.

(3) Individuals shall have no less than thirty (30) days from the date of the insufficient documentation notice to provide a carrier with sufficient documentation to establish eligibility for the requested special enrollment period.

(4) Carriers must make a verification determination within fourteen (14) days of receiving sufficient documentation in order to make an eligibility determination. If the verification determination is not made within the fourteen (14) day period, the individual shall be deemed verified and coverage shall be issued.

(5) A carrier must provide written notice to the individual of the outcome of the verification determination.

(6) The carrier may retroactively terminate or cancel an individual's enrollment if the carrier determines that the individual committed fraud or intentionally misrepresented his or her eligibility for a special enrollment period.

(7) A carrier is not required to provide thirty (30) days notice prior to denying, terminating, or cancelling an individual determined not to be eligible for a special enrollment period.

(8) A carrier shall notify an individual determined ineligible for a special enrollment period for an on-Exchange plan that he or she may appeal that decision with the Exchange, and the carrier shall respond to documentation requests from the Exchange concerning an appeal within seven (7) days of receiving that request.

(9) A carrier shall notify an individual determined ineligible for a special enrollment period for an off-Exchange plan that he or she may appeal that decision with the carrier and that he or she may appeal a carrier's final determination to the Division once the carrier's internal appeal process has been completed.

b. A carrier shall provide written confirmation of an individual's loss of creditable coverage to that individual within ten (10) business days of receiving such a request. The written confirmation must include the date of the loss of coverage and the reason for the loss of coverage.

c. The following documents shall constitute proof of a triggering event and sufficient documentation of eligibility for a special enrollment period:

(1) Evidence of an involuntary loss of creditable coverage shall be considered sufficient if the individual produces:

(a) Written confirmation of the loss of creditable coverage;

(b) An official letter or other notice from an employer or sent on behalf of an employer that provides notice of eligibility for COBRA or for state continuation benefits;

(c) Official documentation for loss due to exhaustion of COBRA or state continuation benefits; or

(d) A letter confirming such loss from the Division.

(2) Evidence of gaining or becoming a dependent shall be considered sufficient if the individual produces:

(a) A marriage license, civil union certificate or common law documentation, if the gaining or becoming a dependent occurs due to marriage or civil union.

(b) A birth certificate, adoption documents, or foster care documents, if the gaining or becoming a dependent occurs due to birth, adoption, placement for adoption, or placement in foster care.

(c) A court order or designated beneficiary documents, if the gaining or becoming a dependent occurs due to a court order.

(3) Evidence of losing a dependent or no longer being considered a dependent shall be considered sufficient if the individual produces:

(a) A copy of the death certificate or the obituary.

(b) Copies of the final divorce or separation documents.

(c) Proof of age and evidence of loss of creditable coverage when an individual turns 26 and is no longer eligible to be covered under a parent's health benefit plan.

(4) Evidence of a permanent change in residence shall be considered sufficient if the individual produces:

(a) Proof of change of address provided to, and acknowledged by, the U.S. Postal Service;

(b) A copy of a lease or purchase agreement listing the new address;

(c) A copy of utility bills listing the new address; or

(d) A copy of a driver's license listing the new address.

(5) Evidence of a material violation of a carrier's contract shall be considered sufficient if the individual produces a letter confirming eligibility for a special enrollment from the Division.

(6) Evidence of a change in citizenship or immigration status shall be considered sufficient if the individual produces official documentation of the change.

(7) Evidence of status as an American Indian/Native American shall be considered sufficient if the individual produces official documentation of his or her status.

(8) Evidence of a new determination of eligibility or ineligibility for Advance Premium Tax Credits or cost-sharing reductions available through the Exchange shall be considered sufficient if the individual produces the determination from the Exchange.

(9) Any other documentation reasonably sufficient to verify eligibility for the special enrollment period requested.

d. Prior coverage requirements.

(1) For special enrollment period requests due to marriage or civil union, carriers may require that at least one individual demonstrate that he or she possessed minimum essential coverage for at least one (1) or more days during the sixty (60) days immediately preceding the date of the special enrollment period triggering event.

(2) For special enrollment period requests due to a permanent move, the requesting individual must demonstrate that he or she possessed minimum essential coverage for at least one (1) or more days during the sixty (60) days immediately preceding the date of the permanent move. If the requesting individual is unable to demonstrate that he or she possessed minimum essential coverage, carriers may require the requesting individual to demonstrate he or she lived outside of the United States or in a United States territory for one (1) or more days during the sixty (60) days immediately preceding the date of the special enrollment period triggering event.

e. The special enrollment period eligibility verification and prior coverage requirements found in Section 5.D.5. of this regulation do not apply to the annual market stabilization special enrollment period found in Section 7 of this regulation.

6. Except as provided in Section 7, coverage effective dates will be:

a. In the case of marriage, civil union, or in the case where an individual loses creditable coverage, coverage must be effective no later than the first day of the month following plan selection.

b. In the case of birth, adoption, placement for adoption, or placement in foster care, coverage must be effective on either:

(1) The date of the event; or

(2) The first day of the month following the birth, adoption, placement for adoption, or placement in foster care, if requested by the primary individual policyholder.

c. In the case of an involuntary loss of existing creditable coverage in accordance with Section 5.D.4.a. of this regulation, coverage shall become effective either:

(1) On the first day of the month following the triggering event if plan selection is made on or before the effective date of the triggering event;

(2) In accordance with the effective dates specified in Section 5.D.6.f. and g. of this regulation if a plan selection is made after the effective date of the triggering event; or

(3) At the option of the Exchange, on the first day of the month following plan selection when plan selection is made after a triggering event.

d. In the case of gaining a dependent or becoming a dependent through a court order, coverage shall become effective either:

(1) On the date the court order is effective; or

(2) In accordance with the effective dates specified in Section 5.D.6.f. and g. of this regulation at the election of the primary individual policyholder.

e. The effective date of coverage for triggering events found in Section 5.D.4.d. and e. of this regulation must be an appropriate date based upon the circumstances of the special enrollment period.

f. In the case of all other triggering events where individual coverage is purchased between the first and fifteenth day of the month, coverage shall become effective no later than the first day of the following month.

g. In the case of all other triggering events where individual coverage is purchased between the sixteenth and last day of the month, coverage shall become effective no later than the first day of the second following month.

E. Notification requirements.

Carriers offering individual health benefit plans during open enrollment periods must provide the notice found in Appendix A to their current individual policyholders whose plans are not being discontinued no later than thirty (30) days prior to the start of each annual open enrollment period.

Section 6 Group Enrollment Periods

A. Carriers that offer small group health benefit plans must guarantee-issue small group health benefit plans throughout the year to any eligible small group that applies for a plan, agrees to make the required premium payments, and abide by the reasonable provisions of the plan, except as noted below.

B. Special enrollment periods for small employers.

1. For small employers that are unable to comply with employer contribution or group participation rules at the time of initial application, carriers may limit the availability of coverage for a group it has declined to an enrollment period that begins on November 15 and ends on December 15 of each year.

2. Coverage must be effective consistent with the dates listed below, unless the initial premium payment is not received by the carrier's cut-off date.

a. Carriers cannot establish a waiting period of more than ninety (90) days.

b. If a fully completed application that includes plan selection is received by the carrier between the first and the fifteenth day of the month, the first effective day of the health benefit plan will be no later than the first day of the following month.

c. If a fully completed application that includes plan selection is received between the sixteenth and last day of the month, the first effective day of the health benefit plan will be no later than the first day of the second following month.

C. Special enrollment periods for employees of small and large employer group plans.

1. Carriers must establish special enrollment periods in the group health benefit plan for individuals who experience any of the following qualifying events pursuant to § 10-16-105.7(3)(b)(II), C.R.S.:

a. Loss of coverage due to:

(1) The death of a covered employee;

(2) The termination or reduction in the number of hours of the employee's employment;

(3) The covered employee becoming eligible for benefits under Title XVIII of the Federal Social Security Act (42 U.S.C. § 301 et seq.); or

(4) The divorce or legal separation from the covered employee's spouse or partner in a civil union.

b. Becoming a dependent through marriage, civil union, birth, adoption, or placement for adoption, or placement in foster care;

c. Becoming a dependent of a covered person by entering into a designated beneficiary agreement, or pursuant to a court or administrative order mandating that the individual be covered;

d. Losing other creditable coverage due to:

(1) Termination of employment or eligibility for coverage, regardless of eligibility for COBRA or state continuation;

(2) A reduction in the number of hours of employment;

(3) Involuntary termination of coverage; or

(4) Reduction or elimination of his or her employer's contributions toward the coverage.

e. Losing coverage under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.) and then requesting coverage under an employer's group health benefit plan within sixty (60) days of the loss of coverage;

f. An employee or dependent becoming eligible for premium assistance under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.) or the Child-Health Plan Plus (CHP+); or

g. A parent or legal guardian dis-enrolling a dependent, or a dependent becoming ineligible for the Child Health Plan Plus (CHP+), and the parent or legal guardian requests enrollment of the dependent in a health benefit plan within sixty (60) days of the disenrollment or determination of ineligibility.

2. Individuals in the group market shall have a thirty (30) day special enrollment period that begins on the date the qualifying event occurs, except as provided in Section 6.C.1.e. and f. of this regulation, which provide a sixty (60) day special enrollment period.

3. When an individual in the group market is notified or becomes aware of a qualifying event that will occur in the future, he or she may apply for coverage during the thirty (30) calendar days prior to the effective date of the qualifying event, with coverage beginning no earlier than the day the qualifying event occurs to avoid a gap in coverage. The individual must be able to provide written documentation to support the effective date of the qualifying event at the time of enrollment. The effective date of this enrollment must comply with the coverage effective dates found in Section 6.C.4. of this regulation.

4. Coverage effective dates.

   a. In the case of birth, adoption, placement for adoption, or placement in foster care, coverage must be effective on the date of the event.

   b. In the case of marriage, civil union, or other qualifying events, coverage must be effective no later than the first day of the following month after the date the Exchange or the carrier receives a completed enrollment form.

Section 7 Annual Market Stabilization Special Enrollment Period

A. Carriers shall establish an annual market stabilization special enrollment period in order to ensure that consumers have sufficient opportunity to enroll in a health benefit plan after the end of the annual open enrollment period, and to ensure the continued health and stability of the Colorado health insurance market.

B. The annual market stabilization special enrollment period shall begin each year on December 16 and extend through January 15 of each year.

C. Individual health benefit plans purchased on or off of the Exchange during the annual market stabilization special enrollment period shall be effective no later than February 1 of the plan year.

D. The special enrollment period eligibility verification and prior coverage requirements found in Section 5.D.5. of this regulation do not apply to the annual market stabilization special enrollment period.

Section 8 Severability

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

Section 9 Incorporated materials

26 C.F.R. § 1.36B-2T, published by Government Printing Office shall mean shall mean 26 C.F.R. § 1.36B-2T as published on the effective date of this regulation and does not include later amendments to or editions of 26 C.F.R. § 1.36B-2T. A copy of 26 C.F.R. § 1.36B-2T may be examined during regular business hours at the Colorado Division of Insurance, 1560 Broadway, Suite 850, Denver, Colorado 80202. A certified copy of 26 C.F.R. § 1.36B-2T may be requested from the Colorado Division of Insurance for a fee. A copy may also be obtained online at www.ecfr.gov.

Section 10 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 11 Effective Date

This emergency regulation shall become effective on September 7, 2018.

Section 12 History

Emergency regulation 13-E-13 effective October, 31, 2013.
Regulation effective February 1, 2014.
Amended regulation effective August 15, 2014.
Amended regulation effective November 1, 2015.
Emergency regulation 17-E-01 effective August 1, 2017.
Amended regulation effective December 1, 2017.
Emergency regulation 18-E-04 effective September 7, 2018

APPENDIX A

Annual Open Enrollment Period Notice for Individual Health Benefit Plans

We would like to let you know that your annual open enrollment period starts this year on [Open Enrollment Start Date]. Your open enrollment period will last until [Open Enrollment End Date]. During the open enrollment period, you will be able to purchase new health insurance for the coming year.

You have two choices:

- You can continue with your current plan, where you will need to review changes to your benefits, confirm that your health care providers are still in the plan's network, confirm any prescriptions you take are still covered and make sure to change your auto-pay to match your new premium; or

- You can enroll in a new plan during the open enrollment period.

If you decide to choose a new plan:

- You can choose your new plan from us, or any other carrier offering plans; or

- You may purchase a new plan through Connect for Health Colorado, where you may qualify for federal financial assistance (www.connectforhealthco.com).

Make sure you follow the termination notice requirements in your current plan so that you will be able to avoid a gap in coverage by ending your old plan and beginning your new plan on the appropriate dates.

You can contact us or your insurance advisor for assistance and additional information. [Insert carrier contact information]

The Division of Insurance finds, pursuant to § 24-4-103(6)(a), C.R.S., that immediate adoption of this regulation is imperatively necessary for the preservation of public health, safety, or welfare, in order to ensure consumers and carriers are aware of the upcoming open enrollment dates for the 2019 plan year; to decrease the volatility of the individual health insurance market through the implementation of a special enrollment period to allow consumers sufficient time to enroll in an individual health benefit plan; and to ensure compliance with the federal open enrollment period dates for the 2019 plan year. Therefore, compliance with the requirements of § 24-4-103, C.R.S., would be contrary to the public interest. This emergency regulation replaces in its entirety Colorado Insurance Regulation 4-2-43 that became effective on December 1, 2017.

CYNTHIA H. COFFMAN
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Office of the Attorney General

Tracking number: 2018-00448

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Insurance

on 09/07/2018

3 CCR 702-4 Series 4-2

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

The above-referenced rules were submitted to this office on 09/14/2018 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.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

September 19, 2018 15:53:24

Emergency Rules Adopted

Department

Department of Human Services

Agency

Food Assistance Program (Volume 4B)

CCR number

10 CCR 2506-1

Rule title

10 CCR 2506-1 RULE MANUAL VOLUME 4B, FOOD ASSISTANCE 1 - eff 09/07/2018

Effective date

09/07/2018

4.207.3 Benefit Allotment

A. After eligibility has been established, the monthly Food Assistance benefit allotment will be determined. The state automated system will compute the household's allotment. The following formula shall be used to determine a household's benefit allotment.

1. Multiply the net monthly income by thirty percent (30%).

2. Round the product down to the next whole dollar if it ends in one (1) through ninety-nine (99) cents.

3. Subtract the result from the maximum benefit allowed for the appropriate household size, as shown in D below.

B. If the calculation of benefits for an initial month yields an allotment of less than the federal minimum allotment referenced in 4.207.3, D, no benefits shall be issued to the household for the initial month.

For eligible households that are entitled to no benefits in their initial month of application, but are entitled to benefits in subsequent months, the county department shall certify the household for a certification period beginning with the month of application.

Except for households that are eligible under basic or expanded categorical eligibility, households with three or more members who are entitled to zero benefits shall have their Food Assistance application denied. This provision does not apply if zero benefits are due to the pro-ration requirements or due to the initial month's allotment being less than the federal minimum allotment referenced in 4.207.3,D.

C. Except for an initial month, if the allotment for a one- or two-person household is less than the federal minimum allotment referenced in 4.207.3, D, round the allotment up to the minimum benefit allowed for a one- or two-person household.

D. The Food Assistance maximum and minimum monthly benefit allotment tables will be adjusted as announced by the United States Department of Agriculture (USDA, Food and Nutrition Service (FNS)).

HOUSEHOLD SIZE	**MAXIMUM MONTHLY ALLOTMENT EFFECTIVE OCTOBER 1, 2018**
1	$192
2	$353
3	$505
4	$642
5	$762
6	$914
7	$1,011
8	$1,155
Each Additional Person	+ $144

HOUSEHOLD SIZE	MINIMUM MONTHLY ALLOTMENT EFFECTIVE OCTOBER 1, 2018
1-2	$15

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4.401.1 Gross Income Eligibility Determination

A household evaluated under standard eligibility rules may be eligible if its monthly nonexempt earned and unearned income does not exceed the gross income level. If after deducting any legally obligated child support payments and no other deductions, the household exceeds the gross income level there are no further computations required to consider the household's net income level. Instead, a Notice of Action form is completed to deny the household.

A. The gross income level for households eligible under standard eligibility rules that do not include a member who is elderly and/or a person with a disability is one hundred thirty percent (130%) of the federal poverty level.

B. Gross Income Levels Effective October 1, 2018, the gross income level for one hundred thirty percent (130%), two hundred percent (200%), and one hundred sixty-five percent (165%) of the federal poverty level for the corresponding household size is as follows:

Household Size	130% Gross Income Level	200% Gross Income Level	165% Gross Income Level
1	$1,316	$2,024	$1,670
2	$1,784	$2,744	$2,264
3	$2,252	$3,464	$2,858
4	$2,720	$4,184	$3,452
5	$3,188	$4,904	$4,046
6	$3,656	$5,624	$4,640
7	$4,124	$6,344	$5,234
8	$4,592	$7,064	$5,828
Each additional person	+$468	+$720	+$594

****

4.401.2 Net Income Eligibility Determination

A. Households evaluated under standard eligibility rules whose income does not exceed the gross income level as outlined in this section shall have their eligibility for benefits computed allowing the earned income, standard, dependent care, medical, and shelter deductions, as appropriate. The household shall be eligible only if its monthly gross income, less the allowable Food Assistance deductions, is below the maximum net eligibility level for their household size. A standard eligibility household that exceeds the net eligibility level must be denied.

B. A standard eligibility household shall be eligible for Food Assistance benefits if its monthly nonexempt earned and unearned income, less all applicable deductions, including the earned income, standard, medical, dependent care, and unlimited excess shelter deduction, does not exceed the maximum net income level.

C. If a household contains a member who is fifty-nine (59) years old on the date of application, but who will become sixty (60) years of age before the end of the month of application, the local office shall determine the household's eligibility as if the person is sixty (60) years of age.

D. Net Income Levels

Effective October 1, 2018, the net income level of one hundred percent (100%) of the federal poverty level for the corresponding household size is as follows:

Household Size	100% Net Income Level
1	$1,012
2	$1,372
3	$1,732
4	$2,092
5	$2,452
6	$2,812
7	$3,172
8	$3,532
Each Additional Person	+$360

****

4.407.1 Standard Deduction

A standard deduction of 8.31% of the federal poverty income guidelines for the household size will be used to calculate the amount that is allowed to all households. The established standard amount will be adjusted annually as announced by the Food and Nutrition Service, USDA. The calculation of 8.31% of the federal poverty income guidelines for eligible members will be used for all households up to the household size of six (6). All households with six (6) or more eligible members will use the six (6) person standard deduction.

Standard Deduction Amount				
Household Size	1-3	4	5	6+
Effective October 1, 2018	$164	$174	$204	$234

****

4.407.3 Excess Shelter Deduction

A. Households shall receive a deduction for the allowable monthly shelter costs that are in excess of fifty percent (50%) of the household's income after all other deductions. Shelter expenses are allowed as billed to a household member or as paid or billed to a disqualified individual. Shelter costs that are paid by or billed to a person disqualified for fraud shall be allowed as a deduction for eligible members in their entirety. Shelter costs, paid or billed to a person disqualified for being an ineligible non-citizen or for failure to provide a Social Security Number shall be divided evenly among all household members and the disqualified individual. All except the disqualified person's pro rata share is counted as a shelter cost of the household.

B. A shelter deduction cap, as specified below, applies to households that do not contain person who is elderly and/or a person with a disability as defined in Section 4.304.41. Those households containing a person who is elderly and/or a person with a disability shall receive an excess shelter deduction for the monthly cost of shelter that exceeds fifty percent (50%) of the household's monthly income after all other applicable deductions.

SHELTER DEDUCTION CAP

Effective October 1, 2018	$552

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4.407.31 Four-Tiered Mandatory Standard Utility Allowance

Effective October 1, 2008, a four tiered mandatory standard utility allowance deduction was implemented in determining a household's excess shelter deduction. Households cannot claim actual utility expenses and are only entitled to one of the four utility allowances. The four utility allowances shall be reviewed annually and adjusted each year, based on Federal approval, to reflect Colorado's cost of utilities. No utility expenses can be allowed as an income exclusion for self-employed households when a mandatory utility allowance is given to the household.

When determining expedited eligibility, the appropriate utility allowance shall be applied when establishing the household's shelter costs.

The four (4) tiers are as follows:

A. Heating and Cooling Utility Allowance (HCUA)

1. "Cooling costs" are defined as utility costs relating to the operation of air conditioning systems, room air conditioners, swamp coolers, or evaporative coolers. Fans are not an allowable cooling cost. A heating and cooling utility allowance (HCUA) is available only to households who:

   a. Incur or anticipate heating or cooling costs separate and apart from their rent or mortgage;

   b. Received a Low-Income Energy Assistance Program (LEAP) payment within the previous twelve (12) month period, regardless of whether or not the individual is still residing at the address for which he/she received the LEAP payment;

   c. Live in private rental housing and are billed by their landlords on the basis of individual usage or are charged a flat rate separately from their rent for heating and cooling;

   d. Share a residence and who incur at least a portion of the heating or cooling cost; each household will be entitled to the full HCUA; or,

   e. Live in public housing and are responsible for excess heating and/or cooling costs.

2. A Food Assistance household, which incurs or anticipates a heating or cooling costs on an irregular basis, may continue to receive the HCUA between billing periods.

3. Operation of a space heater, electric blanket, heat lamp, cooking stove and the like when used as a supplemental heating source are allowable costs when determining eligibility for the basic utility allowance (BUA), but do not qualify a household for the HCUA.

4. The HCUA standard is as follows:

Effective October 1, 2018	$476

B. Basic Utility Allowance (BUA)

1. The Basic Utility Allowance (BUA) is mandated for any households that are not entitled to the HCUA and that incur at least two (2) non-heating or non-cooling utility costs, such as electricity, water, sewer, trash, cooking fuel, or telephone.

2. If more than one assistance group shares in paying non-heating or non-cooling utility costs of the dwelling, the full BUA will be allowed for each assistance group sharing in the utility costs.

3. The BUA standard is as follows:

Effective October 1, 2018	$304

C. One Utility Allowance (OUA)

1. The OUA is mandated for any household that is not entitled to the HCUA or BUA but is responsible for only one (1) non-heating or one (1) non-cooling utility expense. The OUA is not allowed if the household's only utility expense is a telephone.

2. If more than one (1) assistance group shares in paying one (1) non-heating or one non-cooling utility costs of the dwelling, the full OUA will be allowed for each assistance group sharing in the utility costs.

3. The OUA standard is as follows:

Effective October 1, 2018	$57

D. Telephone Allowance

1. The telephone allowance is available to households whose only utility cost is for a telephone. If more than one assistance group shares in paying the telephone costs and that is the only utility costs of the dwelling, the full phone standard will be allowed for each assistance group sharing in the telephone costs.

2. The telephone allowance is as follows:

Effective October 1, 2018	$78

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Title of Proposed Rule:	**Food Assistance FFY18 Standard Utility Allowance Updates and Cost of Living Adjustments**	
CDHS Tracking #:	**18-08-08-01**	
Office, Division, & Program:	Rule Author:	Phone: 303-866-5813
OES, FEA, Food Assistance	Teri Chasten	E-Mail: teri.chasten@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.

The United States Department of Agriculture, Food and Nutrition Service annually evaluates Federal income poverty guidelines and cost of living increases to determine appropriate adjustments to income eligibility standards, benefit allotments, and deductions for the upcoming Federal Fiscal Year. The modified figures are typically made available to states during the month of August immediately proceeding the next fiscal year.

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

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

Justification for emergency:

Each year, FNS disseminates the new standards to states for use in the upcoming federal fiscal year. The COLA adjustments will not be made available until August 2018.

State Board Authority for Rule:

Code	Description
26-1-107, C.R.S. (2015)	State Board to promulgate rules
26-1-109, C.R.S. (2015)	State department rules to coordinate with federal programs
26-1-111, C.R.S. (2015)	State department to promulgate rules for public assistance and welfare activities.

Program Authority for Rule:

Code	Description
26-2-301 (2017), C.R.S.	Designates the Colorado Department of Human Services as the responsible agency to administer the Food Assistance Program in the State of Colorado.
26-2-302 (2017), C.R.S.	Prohibits any interference that would prevent the Colorado Department of Human Services from complying with federal mandates prescribed under the federal “Food Stamp Act” as amended.
Agricultural Act of 2014 (Public Law 113-79)	Federal program authority
7 CFR 273.8(b)	Outlines resource standards
7 CFR 273.9(a)	Outlines the income eligibility thresholds
7 CFR 273.9(d)(1)(i)	Outlines the standard deduction
7 CFR 273.9(d)(6)(iii)	Outlines the standard utility allowances
7 CFR 273.10(e)(4)(i)	Outlines the maximum food assistance allotment levels
7 CFR 273.10(e)(2)(ii)(c)	Outlines the minimum food assistance allotment levels for eligible one and two person households
7 CFR 273.12(e)	Outlines mass changes
7 CFR 273.9(D)(6)(ii)	Outlines the maximum shelter deduction

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.

DOCUMENT 2

Title of Proposed Rule:	**Food Assistance FFY18 Standard Utility Allowance Updates and Cost of Living Adjustments**	
CDHS Tracking #:	**18-08-08-01**	
Office, Division, & Program:	Rule Author:	Phone: 303-866-5813
OES, FEA, Food Assistance	Teri Chasten	E-Mail: teri.chasten@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?

Increases to income eligibility thresholds, standard deductions, and allowable shelter expenses will benefit all Food Assistance applicants and participants.

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?

Adjustments to the four-tiered standard utility allowance (SUA), standard deduction, maximum allotments, and income threshold guidelines have the potential to increase current benefit amounts for participants and increase program accessibility for future applicants.

3. Fiscal Impact

For each of the categories listed below explain the distribution of dollars; please identify the costs, revenues, matches or any changes in the distribution of funds even if such change has a total zero effect for any entity that falls within the category. If this rule-making requires one of the categories listed below to devote resources without receiving additional funding, please explain why the rule-making is required and what consultation has occurred with those who will need to devote resources. ***Answer should NEVER be just "no impact" answer should include "no impact because…."***

State Fiscal Impact *(Identify all state agencies with a fiscal impact, including any Colorado Benefits Management System (CBMS) change request costs required to implement this rule change)*

There is no impact because the costs associated with the Colorado Benefits Management System to incorporate these changes have already been allocated in the system maintenance budget.

County Fiscal Impact

There are no county fiscal impacts associated with this rule change.

Federal Fiscal Impact

There are no federal fiscal impacts associated with this rule change.

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

There are no other fiscal impacts associated with this rule change.

4. Data Description

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

Federal memorandums from the Food and Nutrition Services as well as data from the Consumer Price Index for all Urban Consumers were used in the development of this rule.

5. Alternatives to this Rule-making

Describe any alternatives that were seriously considered. Are there any less costly or less intrusive ways to accomplish the purpose(s) of this rule? Explain why the program chose this rule-making rather than taking no action or using another alternative. **Answer should NEVER be just "no alternative" answer should include "no alternative because…"**

As this is a Federal mandate, there are no available alternatives that exist to incorporate these program changes state-wide.

Title of Proposed Rule: **Food Assistance FFY18 Standard Utility Allowance Updates and Cost of Living Adjustments**

CDHS Tracking #: **18-08-08-01**

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OES, FEA, Food Assistance	Teri Chasten	E-Mail: teri.chasten@state.co.us

OVERVIEW OF PROPOSED RULE

Compare and/or contrast the content of the current regulation and the proposed change.

<table>
<tr><th>Rule section Number</th><th>Issue</th><th>Old Language</th><th>New Language or Response</th><th>Reason / Example / Best Practice</th><th>Public Comment No / Detail</th></tr>
<tr><td>4.207.3,D</td><td>Outdated information</td><td>
<table>
<tr><th>Household Size</th><th>Maximum Monthly Allotment Effective October 1, 2017</th></tr>
<tr><td>1</td><td>$192</td></tr>
<tr><td>2</td><td>$352</td></tr>
<tr><td>3</td><td>$504</td></tr>
<tr><td>4</td><td>$640</td></tr>
<tr><td>5</td><td>$760</td></tr>
<tr><td>6</td><td>$913</td></tr>
<tr><td>7</td><td>$1,009</td></tr>
<tr><td>8</td><td>$1,153</td></tr>
<tr><td>Each Additional Person</td><td>+$144</td></tr>
</table>
<table>
<tr><th>Household Size</th><th>Minimum Monthly Allotment Effective October 1, 2017</th></tr>
<tr><td>1-2</td><td>$15</td></tr>
</table>
</td><td>
<table>
<tr><th>Household Size</th><th>Maximum Monthly Allotment Effective October 1, 2018</th></tr>
<tr><td>1</td><td>$192</td></tr>
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<tr><td>3</td><td>$505</td></tr>
<tr><td>4</td><td>$642</td></tr>
<tr><td>5</td><td>$762</td></tr>
<tr><td>6</td><td>$914</td></tr>
<tr><td>7</td><td>$1,011</td></tr>
<tr><td>8</td><td>$1,155</td></tr>
<tr><td>Each Additional Person</td><td>$144</td></tr>
</table>
<table>
<tr><th>Household Size</th><th>Minimum Monthly Allotment Effective October 1, 2018</th></tr>
<tr><td>1-2</td><td>$15</td></tr>
</table>
</td><td>The maximum monthly Food Assistance benefit allotments and the minimum allotment for households are represented in table form. The effective date needs to be updated to reflect the current year.</td><td></td></tr>
<tr><td>4.401.1,B</td><td>Outdated information</td><td>Effective October 1, 2017, the gross income level for one hundred thirty percent (130%), two hundred percent (200%), and one hundred sixty-five percent (165%) of the federal poverty level for the corresponding household size is as follows:
<table>
<tr><th>Household Size</th><th>130% Gross Income Level</th><th>200% Gross Income Level</th><th>165% Gross Income Level</th></tr>
<tr><td>1</td><td>$1,307</td><td>$2,010</td><td>$1,659</td></tr>
<tr><td>2</td><td>$1,760</td><td>$2,708</td><td>$2,233</td></tr>
<tr><td>3</td><td>$2,213</td><td>$3,404</td><td>$2,808</td></tr>
<tr><td>4</td><td>$2,665</td><td>$4,100</td><td>$3,383</td></tr>
<tr><td>5</td><td>$3,118</td><td>$4,798</td><td>$3,958</td></tr>
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<tr><th>Household Size</th><th>130% Gross Income Level</th><th>200% Gross Income Level</th><th>165% Gross Income Level</th></tr>
<tr><td>1</td><td>$1,316</td><td>$2,024</td><td>$1,670</td></tr>
<tr><td>2</td><td>$1,784</td><td>$2,744</td><td>$2,264</td></tr>
<tr><td>3</td><td>$2,252</td><td>$3,464</td><td>$2,858</td></tr>
<tr><td>4</td><td>$2,720</td><td>$4,184</td><td>$3,452</td></tr>
<tr><td>5</td><td>$3,188</td><td>$4,904</td><td>$4,046</td></tr>
</table>
</td><td>The gross income limits for households subject to income thresholds for 130%, 165%, and 200% of the Federal Poverty Level (FPL) are represented in table form.</td><td></td></tr>
</table>

Title of Proposed Rule: **Food Assistance FFY18 Standard Utility Allowance Updates and Cost of Living Adjustments**

CDHS Tracking #: **18-08-08-01**

Office, Division, & Program:	Rule Author:	Phone: 303-866-5813
OES, FEA, Food Assistance	Teri Chasten	E-Mail: teri.chasten@state.co.us

<table>
<tr><th>Rule section Number</th><th>Issue</th><th>Old Language</th><th>New Language or Response</th><th>Reason / Example / Best Practice</th><th>Public Comment No / Detail</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>6</td><td>$3,571</td><td>$5,494</td><td>$4,532</td></tr>
<tr><td>7</td><td>$4,024</td><td>$6,190</td><td>$5,107</td></tr>
<tr><td>8</td><td>$4,477</td><td>$6,888</td><td>$5,682</td></tr>
<tr><td>Each additional person</td><td>+$453</td><td>+$698</td><td>+$575</td></tr>
</table>
</td><td>
<table>
<tr><td>6</td><td>$3,656</td><td>$5,624</td><td>$4,640</td></tr>
<tr><td>7</td><td>$4,124</td><td>$6,344</td><td>$5,234</td></tr>
<tr><td>8</td><td>$4,592</td><td>$7,064</td><td>$5,828</td></tr>
<tr><td>Each additional person</td><td>+$468</td><td>+$720</td><td>+$594</td></tr>
</table>
</td><td></td><td></td></tr>
<tr><td>4.401.2,D</td><td>Outdated information</td><td>Effective October 1, 2017, the net income level of one hundred percent (100%) of the federal poverty level for the corresponding household size is as follows:
<table>
<tr><th>Household Size</th><th>100% Net Income Level</th></tr>
<tr><td>1</td><td>$1,005</td></tr>
<tr><td>2</td><td>$1,354</td></tr>
<tr><td>3</td><td>$1,702</td></tr>
<tr><td>4</td><td>$2,050</td></tr>
<tr><td>5</td><td>$2,399</td></tr>
<tr><td>6</td><td>$2,747</td></tr>
<tr><td>7</td><td>$3,095</td></tr>
<tr><td>8</td><td>$3,444</td></tr>
<tr><td>Each Additional Person</td><td>+$349</td></tr>
</table>
</td><td>Effective October 1, 2018, the net income level of one hundred percent (100%) of the federal poverty level for the corresponding household size is as follows:
<table>
<tr><th>Household Size</th><th>100% Net Income Level</th></tr>
<tr><td>1</td><td>$1,012</td></tr>
<tr><td>2</td><td>$1,372</td></tr>
<tr><td>3</td><td>$1,732</td></tr>
<tr><td>4</td><td>$2,092</td></tr>
<tr><td>5</td><td>$2,452</td></tr>
<tr><td>6</td><td>$2,812</td></tr>
<tr><td>7</td><td>$3,172</td></tr>
<tr><td>8</td><td>$3,532</td></tr>
<tr><td>Each Additional Person</td><td>+$360</td></tr>
</table>
</td><td>The net income limits reflecting 100% of the Federal Poverty Level (FPL) are represented in table form as applicable to each household size.</td><td></td></tr>
<tr><td>4.407.1</td><td>Outdated information</td><td>
<table>
<tr><th colspan="5">Standard Deduction Amount</th></tr>
<tr><td>Household Size</td><td>1-3</td><td>4</td><td>5</td><td>6+</td></tr>
<tr><td>Effective October 1, 2017</td><td>$160</td><td>$170</td><td>$199</td><td>$228</td></tr>
</table>
</td><td>
<table>
<tr><th colspan="5">Standard Deduction Amount</th></tr>
<tr><td>Household Size</td><td>1-3</td><td>4</td><td>5</td><td>6+</td></tr>
<tr><td>Effective October 1, 2018</td><td>$164</td><td>$174</td><td>$204</td><td>$234</td></tr>
</table>
</td><td>The standard deduction amount of 8.31% of the Federal Poverty Level (FPL) is automatically granted to all Food Assistance participants and is displayed in rule in table form.</td><td></td></tr>
<tr><td>4.407.3, B</td><td>Outdated information</td><td>
<table>
<tr><th colspan="2">Shelter Deduction Cap</th></tr>
<tr><td>Effective October 1, 2017</td><td>$535</td></tr>
</table>
</td><td>
<table>
<tr><th colspan="2">Shelter Deduction Cap</th></tr>
<tr><td>Effective October 1, 2018</td><td>$552</td></tr>
</table>
</td><td>Participant households are granted a shelter expense deduction for shelter costs in excess of 50% of the household’s total monthly income (minus all other applicable deductions). A</td><td></td></tr>
</table>

Title of Proposed Rule: **Food Assistance FFY18 Standard Utility Allowance Updates and Cost of Living Adjustments**

CDHS Tracking #: **18-08-08-01**

Office, Division, & Program:	Rule Author:	Phone: 303-866-5813
OES, FEA, Food Assistance	Teri Chasten	E-Mail: teri.chasten@state.co.us

Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
				cap is applied to the maximum amount for this deduction for households that do not contain a member who is considered elderly or disabled.	
4.407.31, A, 4	Outdated information	The HCUA standard is as follows: Effective October 1, 2017 | $469	The HCUA standard is as follows: Effective October 1, 2018 | $476	The heating and cooling utility allowance (HCUA) is a standard utility deduction afforded to households who are responsible for paying heating and or cooling costs.	
4.407.31, B, 3	Outdated information	The BUA standard is as follows: Effective October 1, 2017 | $298	The BUA standard is as follows: Effective October 1, 2018 | $304	The basic utility allowance (BUA) is a standard utility deduction afforded to households who are responsible for paying at least 2 non-heating or cooling utility costs.	
4.407.31, C, 3	Outdated information	The OUA standard is as follows: Effective October 1, 2017 | $56	The OUA standard is as follows: Effective October 1, 2018 | $57	The one utility allowance (OUA) is a standard utility deduction afforded to households who are responsible for paying just one non-heating/cooling or phone utility cost.	
4.407.31, D, 2	Outdated information	The telephone allowance is as follows: Effective October 1, 2017 | $76	The telephone allowance is as follows: Effective October 1, 2018 | $78	The telephone allowance is a standard utility deduction afforded to households who are responsible for paying a telephone utility cost and no other utilities.	

Title of Proposed Rule:	**Food Assistance FFY18 Standard Utility Allowance Updates and Cost of Living Adjustments**	
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OES, FEA, Food Assistance	Teri Chasten	E-Mail: teri.chasten@state.co.us

STAKEHOLDER COMMENT SUMMARY

Development

The following individuals and/or entities were included in the development of these proposed rules (such as other Program Areas, Legislative Liaison, and Sub-PAC):

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:

Other State Agencies

Are other State Agencies (such as HCPF or CDPHE) impacted by these rules? If so, have they been contacted and provided input on the proposed rules?

☐ Yes ☐ No

If yes, who was contacted and what was their input?

Sub-PAC

Have these rules been reviewed by the appropriate Sub-PAC Committee?

☐ Yes ☐ No

Name of Sub-PAC			
Date presented			
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.			

PAC

Have these rules been approved by PAC?

☐ Yes ☐ No

Date presented			
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.			

Other Comments

Comments were received from stakeholders on the proposed rules:

☐ Yes ☐ No

If "yes" to any of the above questions, summarize and/or attach the feedback received, including requests made by the State Board of Human Services, by specifying the section and including the Department/Office/Division response. Provide proof of agreement or ongoing issues with a letter or public testimony by the stakeholder.

4.207.3 Benefit Allotment

A. After eligibility has been established, the monthly Food Assistance benefit allotment will be determined. The state automated system will compute the household's allotment. The following formula shall be used to determine a household's benefit allotment.

1. Multiply the net monthly income by thirty percent (30%).

2. Round the product down to the next whole dollar if it ends in one (1) through ninety-nine (99) cents.

3. Subtract the result from the maximum benefit allowed for the appropriate household size, as shown in D below.

B. If the calculation of benefits for an initial month yields an allotment of less than the federal minimum allotment referenced in 4.207.3, D, no benefits shall be issued to the household for the initial month.

For eligible households that are entitled to no benefits in their initial month of application, but are entitled to benefits in subsequent months, the county department shall certify the household for a certification period beginning with the month of application.

Except for households that are eligible under basic or expanded categorical eligibility, households with three or more members who are entitled to zero benefits shall have their Food Assistance application denied. This provision does not apply if zero benefits are due to the pro-ration requirements or due to the initial month's allotment being less than the federal minimum allotment referenced in 4.207.3,D.

C. Except for an initial month, if the allotment for a one- or two-person household is less than the federal minimum allotment referenced in 4.207.3, D, round the allotment up to the minimum benefit allowed for a one- or two-person household.

D. The Food Assistance maximum and minimum monthly benefit allotment tables will be adjusted as announced by the United States Department of Agriculture (USDA, Food and Nutrition Service (FNS)).

HOUSEHOLD SIZE	**MAXIMUM MONTHLY ALLOTMENT EFFECTIVE OCTOBER 1, ~~2017~~ 2018**
1	$192
2	~~$352~~ $353
3	~~$504~~ $505
4	~~$640~~ $642
5	~~$760~~ $762
6	~~$913~~ $914
7	~~$1,009~~ $1,011
8	~~$1,153~~ $1,155
Each Additional Person	+ $144

HOUSEHOLD SIZE	MINIMUM MONTHLY ALLOTMENT EFFECTIVE OCTOBER 1, ~~2017~~ 2018
1-2	$15

****

4.401.1 Gross Income Eligibility Determination

A household evaluated under standard eligibility rules may be eligible if its monthly nonexempt earned and unearned income does not exceed the gross income level. If after deducting any legally obligated child support payments and no other deductions, the household exceeds the gross income level there are no further computations required to consider the household's net income level. Instead, a Notice of Action form is completed to deny the household.

A. The gross income level for households eligible under standard eligibility rules that do not include a member who is elderly and/or a person with a disability is one hundred thirty percent (130%) of the federal poverty level.

B. Gross Income Levels Effective October 1, 201~~7~~8, the gross income level for one hundred thirty percent (130%), two hundred percent (200%), and one hundred sixty-five percent (165%) of the federal poverty level for the corresponding household size is as follows:

Household Size	130% Gross Income Level	200% Gross Income Level	165% Gross Income Level
1	~~$1,307~~ $1,316	~~$2,010~~ $2,024	~~$1,659~~ $1,670
2	~~$1,760~~ $1,784	~~$2,708~~ $2,744	~~$2,233~~ $2,264
3	~~$2,213~~ $2,252	~~$3,404~~ $3,464	~~$2,808~~ $2,858
4	~~$2,665~~ $2,720	~~$4,100~~ $4,184	~~$3,383~~ $3,452
5	~~$3,118~~ $3,188	~~$4,798~~ $4,904	~~$3,958~~ $4,046
6	~~$3,571~~ $3,656	~~$5,494~~ $5,624	~~$4,532~~ $4,640
7	~~$4,024~~ $4,124	~~$6,190~~ $6,344	~~$5,107~~ $5,234
8	~~$4,477~~ $4,592	~~$6,888~~ $7,064	~~$5,682~~ $5,828
Each additional person	~~+$453~~ $468	~~+$698~~ $720	~~+$575~~ $594

****

4.401.2 Net Income Eligibility Determination

A. Households evaluated under standard eligibility rules whose income does not exceed the gross income level as outlined in this section shall have their eligibility for benefits computed allowing the earned income, standard, dependent care, medical, and shelter deductions, as appropriate. The household shall be eligible only if its monthly gross income, less the allowable Food Assistance deductions, is below the maximum net eligibility level for their household size. A standard eligibility household that exceeds the net eligibility level must be denied.

B. A standard eligibility household shall be eligible for Food Assistance benefits if its monthly nonexempt earned and unearned income, less all applicable deductions, including the earned income, standard, medical, dependent care, and unlimited excess shelter deduction, does not exceed the maximum net income level.

C. If a household contains a member who is fifty-nine (59) years old on the date of application, but who will become sixty (60) years of age before the end of the month of application, the local office shall determine the household's eligibility as if the person is sixty (60) years of age.

D. Net Income Levels

Effective October 1, ~~2017~~ 2018, the net income level of one hundred percent (100%) of the federal poverty level for the corresponding household size is as follows:

Household Size	100% Net Income Level
1	~~$1,005~~ $1,012
2	~~$1,354~~ $1,372
3	~~$1,702~~ $1,732
4	~~$2,050~~ $2,092
5	~~$2,399~~ $2,452
6	~~$2,747~~ $2,812
7	~~$$3,095~~ $3,172
8	~~$3,444~~ $3,532
Each Additional Person	~~+$349~~ $360

****

4.407.1 Standard Deduction

A standard deduction of 8.31% of the federal poverty income guidelines for the household size will be used to calculate the amount that is allowed to all households. The established standard amount will be adjusted annually as announced by the Food and Nutrition Service, USDA. The calculation of 8.31% of the federal poverty income guidelines for eligible members will be used for all households up to the household size of six (6). All households with six (6) or more eligible members will use the six (6) person standard deduction.

Standard Deduction Amount				
Household Size	1-3	4	5	6+
Effective October 1, ~~2017~~ 2018	~~$160~~ $164	~~$170~~ $174	~~$199~~ $204	~~$228~~ $234

****

4.407.3 Excess Shelter Deduction

A. Households shall receive a deduction for the allowable monthly shelter costs that are in excess of fifty percent (50%) of the household's income after all other deductions. Shelter expenses are allowed as billed to a household member or as paid or billed to a disqualified individual. Shelter costs that are paid by or billed to a person disqualified for fraud shall be allowed as a deduction for eligible members in their entirety. Shelter costs, paid or billed to a person disqualified for being an ineligible non-citizen or for failure to provide a Social Security Number shall be divided evenly among all household members and the disqualified individual. All except the disqualified person's pro rata share is co nted as a shelter cost of the household.

B. A shelter deduction cap, as specified below, applies to households that do not contain person who is elderly and/or a person with a disability as defined in Section 4.304.41. Those households containing a person who is elderly and/or a person with a disability shall receive an excess shelter deduction for the monthly cost of shelter that exceeds fifty percent (50%) of the household's monthly income after all other applicable deductions.

SHELTER DEDUCTION CAP	
Effective October 1, ~~2017~~ 2018	~~$535~~ $552

****

4.407.31 Four-Tiered Mandatory Standard Utility Allowance

Effective October 1, 2008, a four tiered mandatory standard utility allowance deduction was implemented in determining a household's excess shelter deduction. Households cannot claim actual utility expenses and are only entitled to one of the four utility allowances. The four utility allowances shall be reviewed annually and adjusted each year, based on Federal approval, to reflect Colorado's cost of utilities. No utility expenses can be allowed as an income exclusion for self-employed households when a mandatory utility allowance is given to the household.

When determining expedited eligibility, the appropriate utility allowance shall be applied when establishing the household's shelter costs.

The four (4) tiers are as follows:

A. Heating and Cooling Utility Allowance (HCUA)

1. "Cooling costs" are defined as utility costs relating to the operation of air conditioning systems, room air conditioners, swamp coolers, or evaporative coolers. Fans are not an allowable cooling cost. A heating and cooling utility allowance (HCUA) is available only to households who:

   a. Incur or anticipate heating or cooling costs separate and apart from their rent or mortgage;

   b. Received a Low-Income Energy Assistance Program (LEAP) payment within the previous twelve (12) month period, regardless of whether or not the individual is still residing at the address for which he/she received the LEAP payment;

   c. Live in private rental housing and are billed by their landlords on the basis of individual usage or are charged a flat rate separately from their rent for heating and cooling;

   d. Share a residence and who incur at least a portion of the heating or cooling cost; each household will be entitled to the full HCUA; or,

   e. Live in public housing and are responsible for excess heating and/or cooling costs.

2. A Food Assistance household, which incurs or anticipates a heating or cooling costs on an irregular basis, may continue to receive the HCUA between billing periods.

3. Operation of a space heater, electric blanket, heat lamp, cooking stove and the like when used as a supplemental heating source are allowable costs when determining eligibility for the basic utility allowance (BUA), but do not qualify a household for the HCUA.

4. The HCUA standard is as follows:

Effective October 1, ~~2017~~ 2018	~~$469~~ $476

B. Basic Utility Allowance (BUA)

1. The Basic Utility Allowance (BUA) is mandated for any households that are not entitled to the HCUA and that incur at least two (2) non-heating or non-cooling utility costs, such as electricity, water, sewer, trash, cooking fuel, or telephone.

2. If more than one assistance group shares in paying non-heating or non-cooling utility costs of the dwelling, the full BUA will be allowed for each assistance group sharing in the utility costs.

3. The BUA standard is as follows:

Effective October 1, ~~2017~~ 2018	~~$298~~ $304

C. One Utility Allowance (OUA)

1. The OUA is mandated for any household that is not entitled to the HCUA or BUA but is responsible for only one (1) non-heating or one (1) non-cooling utility expense. The OUA is not allowed if the household's only utility expense is a telephone.

2. If more than one (1) assistance group shares in paying one (1) non-heating or one non-cooling utility costs of the dwelling, the full OUA will be allowed for each assistance group sharing in the utility costs.

3. The OUA standard is as follows:

Effective October 1, ~~2017~~ 2018	~~$56~~ $57

D. Telephone Allowance

1. The telephone allowance is available to households whose only utility cost is for a telephone. If more than one assistance group shares in paying the telephone costs and that is the only utility costs of the dwelling, the full phone standard will be allowed for each assistance group sharing in the telephone costs.

2. The telephone allowance is as follows:

Effective October 1, ~~2017~~ 2018	~~$76~~ $78

****

CYNTHIA H. COFFMAN
Attorney General

MELANIE J. SNYDER
Chief Deputy Attorney General

LEORA JOSEPH
Chief of Staff

FREDERICK R. YARGER
Solicitor General

STATE OF COLORADO
DEPARTMENT OF LAW

RALPH L. CARR
COLORADO JUDICIAL CENTER
1300 Broadway, 10th Floor
Denver, Colorado 80203
Phone (720) 508-6000

Office of the Attorney General

Tracking number: 2018-00464

Opinion of the Attorney General rendered in connection with the rules adopted by the

Food Assistance Program (Volume 4B)

on 09/07/2018

10 CCR 2506-1

RULE MANUAL VOLUME 4B, FOOD ASSISTANCE

The above-referenced rules were submitted to this office on 09/14/2018 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.

September 25, 2018 09:05:51

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

Emergency Rules Adopted

Department

Department of Human Services

Agency

State Board of Human Services (Volume 12; Special Projects)

CCR number

12 CCR 2512-2

Rule title

12 CCR 2512-2 RULE MANUAL VOLUME 12, SPECIAL PROJECTS 1 - eff 09/07/2018

Effective date

09/07/2018

Title of Proposed Rule:	**Incorporation by Reference Domestic Violence Advocacy Services**		
CDHS Tracking #:	**18-08-20-01**		
CCR #:	**12 CCR 2512-2**		
Office, Division, & Program:	OCYF, DVP	Phone:	x3321
Rule Author:	Brooke Ely-Milen	E-Mail:	Brooke.elymilen@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.

To amend an error regarding an incorporation by reference.

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

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

Justification for emergency:

Fixing an error that was identified after final adoption.

State Board Authority for Rule:

Code	Description
26-1-107, C.R.S. (2016)	State Board to promulgate rules
26-1-109, C.R.S. (2016)	State department rules to coordinate with federal programs
26-1-111, C.R.S. (2016)	State department to promulgate rules for public assistance and welfare activities.

Program Authority for Rule: *Give federal and/or state citations and a summary of the language authorizing the rule-making function AND authority.*

Code	Description
26-7.5-104 (2), C.R.S	State department shall establish and enforce rules for all domestic abuse programs established pursuant to this article

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.

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

a. [X] Board or [ ] Executive Director
b. [ ] Regular or [X] Emergency

DOCUMENT 1

Title of Proposed Rule:	**Incorporation by Reference Domestic Violence Advocacy Services**		
CDHS Tracking #:	**18-08-20-01**		
CCR #:	**12 CCR 2512-2**		
Office, Division, & Program:	OCYF, DVP	Phone:	x3321
Rule Author:	Brooke Ely-Milen	E-Mail:	Brooke.elymilen@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?

Although the DVP rules impact organizations funded by DVP and survivors of domestic violence who receive services, this rule change is not anticipated to have any adverse impact or direct benefit because it is correcting a technical error.

2. Describe the qualitative and quantitative impact.

How will this rule-making impact those groups listed above? How many people will be impacted? What are the short-term and long-term consequences of this rule?

None anticipated because it is correcting a technical error.

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)*

None

County Fiscal Impact

None

Federal Fiscal Impact

None

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

None

4. Data Description

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

None needed

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 alternative other than leaving the error in rule.

Title of Proposed Rule:	**Incorporation by Reference Domestic Violence Advocacy Services**		
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Office, Division, & Program:	OCYF, DVP	Phone:	x3321
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OVERVIEW OF PROPOSED RULE

Compare and/or contrast the content of the current regulation and the proposed change.

Rule section Number	Issue	Old Language	New Language or Response	Reason / Example / Best Practice	Public Comment No / Detail
12.202.3. D	Incorrect incorporation by reference	Programs funded wholly or in part by DVP shall ensure full compliance with the requirements of the federal department of health and human services administration for children and families, 45 CFR Part 1370. If a funded program wishes to provide sex segregated or sex-specific programming, they shall submit a written plan to be approved by DVP, which outlines the following:	Programs funded wholly or in part by DVP shall ensure full compliance with the requirements of the federal department of health and human services administration for children and families, 45 CFR Part 1370 (2017). No later editions or amendments are incorporated. These 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/. These regulations are also available for public inspection and copying at the Colorado Department of Human Services, Office of Community Partnerships, 1575 Sherman St, Denver, CO 80203, during regular business hours. If a funded program wishes to provide sex segregated or sex-specific programming, they shall submit a written plan to be approved by DVP, which outlines the following:	Correct citation for incorporation by reference	None

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STAKEHOLDER COMMENT SUMMARY

Development

The following individuals and/or entities were included in the development of these proposed rules (such as other Program Areas, Legislative Liaison, and Sub-PAC):

None because this is correcting a technical error

This Rule-Making Package

The following individuals and/or entities were contacted and informed that this rule-making was proposed for consideration by the State Board of Human Services:

None because this is correcting a technical error

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	n/a		
Date presented			
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.	This is correcting a technical error. Emergency Packet		

PAC

Have these rules been approved by PAC?

[ ] Yes [X] No

Date presented	n/a		
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.	This is correcting a technical error. Emergency Packet		

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.

12 CCR 2512-2

12.202.3. D

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No alternative other than leaving the error in rule.

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Title of Proposed Rule:	**Incorporation by Reference Domestic Violence Advocacy Services**		
CDHS Tracking #:	**18-08-20-01**		
CCR #:	**12 CCR 2512-2**		
Office, Division, & Program:	OCYF, DVP	Phone:	x3321
Rule Author:	Brooke Ely-Milen	E-Mail:	Brooke.elymilen@state.co.us

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Have these rules been reviewed by the appropriate Sub-PAC Committee?

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Name of Sub-PAC	n/a		
Date presented			
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
If not presented, explain why.	This is correcting a technical error. Emergency Packet		

PAC

Have these rules been approved by PAC?

[ ] Yes [X] No

Date presented	n/a		
What issues were raised?			
Vote Count	*For*	*Against*	*Abstain*
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12 CCR 2512-2

12.202.3. D

Programs funded wholly or in part by DVP shall ensure full compliance with the requirements of the federal department of health and human services administration for children and families, 45 CFR Part 1370 (2017). NO LATER EDITIONS OR AMENDMENTS ARE INCORPORATED. THESE 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/. THESE REGULATIONS ARE ALSO AVAILABLE FOR PUBLIC INSPECTION AND COPYING AT THE COLORADO DEPARTMENT OF HUMAN SERVICES, OFFICE OF COMMUNITY PARTNERSHIPS, 1575 SHERMAN ST, DENVER, CO 80203, DURING REGULAR BUSINESS HOURS. If a funded program wishes to provide sex segregated or sex-specific programming, they shall submit a written plan to be approved by DVP, which outlines the following:

CYNTHIA H. COFFMAN
Attorney General

MELANIE J. SNYDER
Chief Deputy Attorney General

LEORA JOSEPH
Chief of Staff

FREDERICK R. YARGER
Solicitor General

STATE OF COLORADO
DEPARTMENT OF LAW

RALPH L. CARR
COLORADO JUDICIAL CENTER
1300 Broadway, 10th Floor
Denver, Colorado 80203
Phone (720) 508-6000

Office of the Attorney General

Tracking number: 2018-00463

Opinion of the Attorney General rendered in connection with the rules adopted by the

State Board of Human Services (Volume 12; Special Projects)

on 09/07/2018

12 CCR 2512-2

RULE MANUAL VOLUME 12, SPECIAL PROJECTS

The above-referenced rules were submitted to this office on 09/14/2018 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.

Frederick R. Yarger

Cynthia H. Coffman
Attorney General
by Frederick R. Yarger
Solicitor General

September 25, 2018 09:05:34

Nonrulemaking Public Notices and other Miscellaneous Rulemaking Notices

Filed on 10/04/2018

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

COLORADO
Department of Health Care Policy & Financing

PUBLIC NOTICE

October 10, 2018

Targeted Case Management Services: Transition Services

The Department of Health Care Policy and Financing (Department) intends to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to add Targeted Case Management – Transition Services (TCM-TS) by modifying Supplement 1A to Attachment 3.1-A – Item 19.1 Targeted Case Management Services: Transition Services and Attachment 4.19-B – Methods and Standards for Establishing Payment Rates-Other Types of Care – Item 19.1 Targeted Case Management Services: Transition Services , effective January 1, 2019. TCM-TS was previously provided as a pilot program benefit under the federally funded Money Follows the Person (MFP) program, Colorado Choice Transitions (CCT). HB18-1326, passed into Colorado law on April 30, 2018, directs the Department to seek the necessary state plan and waiver amendments to implement the transitions program permanently. Benefits and services to continue the transitions program must be implemented by January 1, 2019 to avoid a gap in new enrollments.

This addition impacts Medicaid recipients who are eligible for Home and Community Based Services, reside in a nursing home, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), or Regional Center, and are willing to participate and have expressed interest in moving to a home and community-based setting.

The annual aggregate increase in TCM-TS expenditures (including state funds and federal funds) is $0 in FFY 2017-18 and $416,689 in FFY 2018-19.

General Information

A link to this notice will be posted on the Department's website starting on October 10, 2018. Written comments may be addressed to:

Director, Health Programs Office
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Nonrulemaking Public Notices and other Miscellaneous Rulemaking Notices

Filed on 10/09/2018

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

COLORADO
Department of Health Care Policy & Financing

PUBLIC NOTICE

October 10, 2018

Supplemental Medicaid Payments and Disproportionate Share Hospital (DSH) Payments for Colorado Hospital Providers

The Department of Health Care Policy and Financing (Department) intends to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to increase supplemental Medicaid payments for inpatient hospital services and Disproportionate Share Hospital (DSH) payments effective October 11, 2018.

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) Act authorizes the Department to increase Medicaid payments to hospitals up to the available federal upper payment limit, to increase payments to hospitals that participate in the Colorado Indigent Care Program (CICP) up to 100 percent of costs, and to pay quality incentive payments to hospitals. Supplemental Medicaid payments for inpatient hospital services and DSH payments will be modified to meet these provisions.

This adjustment will result in an increase to annual aggregate expenditures because of expected increases in Colorado's DSH allotment and the inpatient hospital upper payment limit. The Department estimates that DSH payments will increase by approximately $5.2 million in total expenditures and inpatient supplemental Medicaid payments will increase by approximately $6.5 million in total expenditures. These payments will be made to Colorado hospitals and will be funded through provider fees and matching Medicaid funds. No state general funds will be used. Aggregate payments to hospitals will not exceed federal upper payment limits and aggregate DSH payments will not exceed the annual federal allotment.

General Information

A link to this notice will be posted on the Department's website starting on October 10, 2018. Written comments may be addressed to:

Director, Health Programs Office
Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

Calendar of Hearings

Hearing Date/Time	Agency	Location
10/30/2018 09:00 AM	Taxpayer Service Division - Tax Group	1313 Sherman Street, Room 220, Denver, CO 80203
10/30/2018 09:00 AM	Taxpayer Service Division - Tax Group	1313 Sherman Street, Room 220, Denver, CO 80203
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10/30/2018 02:00 PM	Taxpayer Service Division - Tax Group	1313 Sherman Street, Room 220, Denver, CO 80203
11/01/2018 09:00 AM	Division of Liquor Enforcement	1707 Cole Blvd., Golden, CO 80401, Suite 300, Marijuana Enforcement Division "Red Rocks" Conference Room.
11/19/2018 09:30 AM	Division of Motor Vehicles	1881 Pierce Street Room 110
11/19/2018 09:30 AM	Division of Motor Vehicles	1881 Pierce Street Room 110
11/19/2018 09:30 AM	Division of Motor Vehicles	1881 Pierce Street Room 110
11/14/2018 03:30 PM	Colorado State Board of Education	201 E. Colfax Ave., Room 101 - State Board Room
11/14/2018 01:30 PM	Colorado State Board of Education	201 E. Colfax Ave., Room 101 - State Board Room
11/15/2018 10:30 AM	Colorado State Board of Education	201 E. Colfax Ave., Room 101 - State Board Room
11/15/2018 08:30 AM	Colorado Parks and Wildlife (405 Series, Parks)	Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807
11/15/2018 08:30 AM	Colorado Parks and Wildlife (405 Series, Parks)	Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807
11/15/2018 08:30 AM	Colorado Parks and Wildlife (406 Series, Wildlife)	Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807
11/15/2018 08:30 AM	Colorado Parks and Wildlife (406 Series, Wildlife)	Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807
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11/15/2018 08:30 AM	Colorado Parks and Wildlife (406 Series, Wildlife)	Old Town Museum Barn, 420 S. 14th St., Burlington, CO 80807
11/02/2018 08:30 AM	Mental Health Services	1575 Sherman Street, Denver, CO 80203
11/01/2018 02:00 PM	Division of Insurance	1560 Broadway, Ste 110 D, Denver CO 80202
11/01/2018 02:00 PM	Division of Insurance	1560 Broadway, Ste 110D, Denver CO 80202
11/01/2018 02:00 PM	Division of Insurance	1560 Broadway, Ste 110D, Denver CO 80202
11/01/2018 02:00 PM	Division of Insurance	1560 Broadway, Ste 110D, Denver CO 80202
11/01/2018 09:00 AM	Division of Real Estate	1560 Broadway, Suite 1250-C, Denver, CO
11/01/2018 09:00 AM	Division of Real Estate	1560 Broadway, Suite 1250-C, Denver, CO
11/01/2018 09:00 AM	Division of Real Estate	1560 Broadway, Suite 1250-C, Denver, CO
11/02/2018 09:30 AM	Division of Professions and Occupations - State Physical Therapy Board	1560 Broadway, Suite 1250A
11/02/2018 09:30 AM	Division of Professions and Occupations - State Physical Therapy Board	1560 Broadway, Suite 1250A
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Calendar of Hearings

Hearing Date/Time	Agency	Location
11/02/2018 09:30 AM	Division of Professions and Occupations - State Physical Therapy Board	1560 Broadway, Suite 1250A
11/02/2018 09:30 AM	Division of Professions and Occupations - State Physical Therapy Board	1560 Broadway, Suite 1250A
10/30/2018 02:00 PM	State Personnel Board and State Personnel Director	1525 Sherman St., Room 103 (First Floor) Denver, CO 80203
11/13/2018 09:45 AM	Water Quality Control Commission (1002 Series)	Fremont Room, Summit County Community and Senior Center, 83 Nancy's Place, Frisco, CO 80443
11/21/2018 10:00 AM	Health Facilities and Emergency Medical Services Division (1011, 1015 Series)	4300 Cherry Creek Drive South, Denver, CO 80246
11/09/2018 10:00 AM	Division of Workers' Compensation	633 17th St. Denver, Co 80202
11/06/2018 01:00 PM	Division of Labor Standards and Statistics (Includes 1103 Series)	633 17th Street, 6th Floor, Denver, CO 80202
11/09/2018 09:00 AM	Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)	303 East 17th Avenue, 11th Floor, Denver, CO 80203
11/02/2018 08:30 AM	Social Services Rules (Volume 7; Child Welfare, Child Care Facilities)	1575 Sherman Street, Denver, CO 80203